Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust Quality Accounts 2021-22 V4

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What is a Quality Account?

All providers of NHS Services in England are required to produce an Annual Quality Account. The purpose of a Quality Account is to inform the public about the quality of services delivered by us. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence-based quality improvement and to explain progress to the public. This is our eleventh Quality Account.

Part 1: Statement from the Chief Executive

I am delighted to present the 2021/22 Quality Report for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

We are immensely proud to provide healthcare services to both the people of Wigan and those from further afield and we set high standards in relation to the care we provide and the services we offer.

Quality underpins everything we do at WWL and informs our most strategic decision-making. We have built on our status as a teaching hospital, and we are continuing to work towards becoming a university teaching organisation within the next five years. We already have a good relationship with our university partners, and we will further develop this for the benefit of our patients and our staff. As one of our corporate objectives for the coming year, we intend to build on the excellent work already done by our clinical teams and our research department because we believe that, in doing so, we will be able to provide even higher quality services and attract the highest calibre of staff.

During our last inspection by the Care Quality Commission, which took place in October and November 2019, we were rated as 'Good' overall, as well as being rated 'Good' across each of the five key domains – safe, effective, caring, responsive and well led. Our use of resources was similarly determined to be 'Good' by NHS Improvement. All our acute sites have individually been rated as 'Good' with the Thomas Linacre Centre being rated as 'Outstanding'. During 2021/22, we have continued to work with the CQC to showcase some of the exemplary work that is being carried out, as well as being open and honest about some of the challenges that are being faced, not just at WWL, but within the entire NHS system.

We have worked hard to come out from the Covid-19 pandemic and restart elective procedures and, whilst waiting lists have been a challenge, we have a robust system of monitoring and prioritising patients to reduce the risk of further complications in the health. The challenge for the next financial year will be to continue the work to reduce this and we recognise that we face this with the wider NHS.

We recognise that delivery of quality is dependent on a number of factors, the most significant of which is our workforce. We believe in the importance of fostering and maintaining a positive culture and we aim to be the employer of choice in the borough and beyond. We have continued developing *Our Family, Our Future, Our Focus* – a programme of activities designed to maintain and further improve the support we provide. The programmes are promoted at every opportunity to develop a safe and effective workforce and this will continue into the next financial year.

We know that when staff feel happy and comfortable at work, they go on to deliver better quality services and we are committed to doing what we can to make WWL an outstanding place to work. I would like to take this opportunity to place on record my thanks to all staff, both clinical and non-clinical, who work tirelessly to provide excellent care to our patients. It does not go unnoticed.

We also recognise the importance of learning lessons when things do not go as planned and during the year, we have focused on improving the quality of responses to any complaints we receive. This focus continues as we strive to deliver continuous improvement in this important area. This financial year we will roll out the national Patient Safety Incident Response Framework and this will allow us to learn better and more efficiently in the future from things that do not go the way we intend, as well as learning from the excellent work that happens on a daily basis in all areas of our organisation.

The Board of Directors is committed to quality and WWL continues to actively participate in a number of initiatives, such as NHS QUEST which is a network of foundation trust that work together collaboratively with the triple aim of improving quality and safety, leading the way in technology-enabled innovation and striving to be the best employers in the NHS. We firmly believe that working with other organisations who are as committed to the quality agenda as we are can only be beneficial for all concerned and we work hard to make sure that organisational boundaries do not prevent the improvement of services for the benefit of our patients.

This report sets out our performance in detail and I am pleased to confirm that, to the best of my knowledge, the information it contains is an accurate and fair reflection of our performance.

Silas Nicholls

Chief Executive and Accounting Officer

Part 2: Priorities for Improvement and Statements of Assurances from the Board

Part 2.1: Priorities for Improvement in 2021/22

Quality Strategy [2021/22]

Patient Safety (Safe)

Priority 1:	**95% of patients with Red Flag sepsis will receive antibiotic treatment within 1 hour in both Accident and Emergency (ED) and on wards**
Priority 2:	**95% of patients with an elevated NEWS2 score (5 in total or 3 in one domain) will be screened for Sepsis in ED and on the wards**
Priority 3:	**To reduce grade 3, grade 4 and unstageable pressure ulcers contributed to by lapses in care by 50%**
Priority 4:	**To reduce the number of CDT infections by 20% where there have been lapses in care**

Clinical Effectiveness (Effective)

Priority 1:	**To achieve a Summary Hospital Level Mortality Indicator (SHMI) within the expected range**
Priority 2:	**Compliance with the National Patient Safety Strategy (NPSS)**

Patient Experience (Caring)

Priority 1:	**To ensure all complaint responses are timely and have learning identified and demonstrable action is taken**
Priority 2:	**To improve patients, experience of discharge**
Priority 3:	**To embed an organisational culture of psychological safety, civility and respect**

Quality Priorities for 2022/23

WWL has four strategic priorities. We aim to deliver these through a suite of annual objectives which we aim to refresh on an annual basis taking into consideration the dynamic nature of the communities we serve and the wider NHS. This section outlines the improvements we plan to take over the next year.

All quality priorities have a timescale for achievement by the 31st of March 2023 and progress to achieve them is monitored by our Quality and Safety Committee. The Trust is committed to driving forward these quality priorities and the improvements required. It should be noted that the management of the COVID-19 pandemic and associated actions remains one of the Trust's greatest priorities.

	**Strategic Priority One** **Patients: To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience**

Objective	**Lead Executive**
We will improve the safety and quality of our clinical services by achieving a 25% reduction in mortality related to sepsis by 31st March 2023 and sustain the improvement in mortality relating to AKI achieved during 2021/22.	**Dr Sanjay Arya**
We will increase the % of patients who die in their Preferred Place of Death, with a target for improvement to be set following completion of a baseline audit in the first quarter of 2022/23.	**Dr Sanjay Arya**
We will improve the safety and delivery of harm-free care by achieving a zero preventable category 3 and 4 pressure ulcers in both the hospital and community setting. 100% of NEWS, PEWS and MEWS will be recorded accurately reducing the risk of failure to recognise a deteriorating patient by 31st March 2023. As an enabler to this objective 400 of clinical staff will have received human factors training by the 31st March 2023.	**Rabina Tindale**
We will improve the quality of care delivered through pursuing our journey of excellence through our Accreditation programme. Seven in-patient wards will progress to achieving the silver rating in our accreditation programme, with the remaining wards maintaining their bronze rating. Additionally, the accreditation programme will be extended to see some other clinical and non-ward areas achieve the bronze rating by the 31st March 2023.	**Rabina Tindale**
We will improve our complaint response rates by ensuring 85% of complaints received are responded to and acted upon within our agreed timeframes by the 31st March 2023	**Rabina Tindale**

Strategic Priority Two

People: To create an inclusive and people centred experience at work that enables our WWL family to flourish

Objective	Lead Executive
We will advance and embed the implementation of our just and learning culture programme through leadership development, civility and team development / culture programmes that improve experience of work in a sustainable way and encourage our people to speak up.	**Alison Balson**
We will support the physical health and mental wellbeing of our WWL family by ensuring we have a range of wellbeing activities and services that are accessible to our colleagues, supported by real time and accurate absence data.	**Alison Balson**
We will improve the equality, diversity and inclusion of our Trust by increasing diversity and accessibility, reducing inequality and improving the experience of protected groups.	**Rabina Tindale**
We will prioritise personal and professional development to enable our people to flourish, making full use of all available funding sources by aligning our programmes to the learning needs analysis and strategic aspirations such as university teaching hospital status	**Alison Balson**

	**Strategic Priority Three** **Performance: To consistently deliver efficient, effective and equitable patient care**

Objective	Lead Executive
We will deliver our financial plan for 2022/23, demonstrated through meeting the agreed I&E position, delivery of planned efficiencies and delivery of agreed capital investments in line with the capital plan.	**Ian Boyle**
We will minimise harm to patients in recovering and restoring our elective services in line with national recommendations by identifying and treating patients most at risk to by the 31st March 2023: • Eradicating 104 week waits by the end of June 2022 (unless patients have chosen to wait longer) • Increase elective activity delivered to 94.8% of the 2019/20 baseline (103F% by value) Sustainably reduce the number of patients on a 62-day that are waiting 63 days or more to pre-pandemic levels	**Mary Fleming**
We will deliver improvements to community and urgent emergency care services and pathways alongside our locality partners, demonstrated by 12 hour waits in the Emergency Department being no more than 2% of all attendances and the number of no right to reside patients returning to pre-pandemic levels (39 patients in total with no more than 15 on the acute site) by the 31st March 2023.	**Mary Fleming**
We will bring our recently approved Green Plan to life, integrating it within our governance structures to inform better decision making and creating a green social movement, making it everyone's responsibility to deliver on the year one actions identified within the Green Plan.	**Ian Boyle**

Strategic Priority Four

Partnerships: To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Objective	Lead Executive
We will develop our role as an anchor institution within the Borough through active participation in community wealth building groups with the aim of increasing the number of people employed who have a Wigan postcode, and increasing the value of non-pay spend with local suppliers.	**Richard Mundon**
We will continue to develop effective relationships across the Wigan locality and wider Greater Manchester ICB to positively contribute and influence locality and ICB workplans, ensuring these align to our priorities and programmes of work and benefit WWL and the patients that we serve.	**Dr Sanjay Arya**
We will deliver all milestones and outcomes due within 2022/23 from our development and delivery plan for achieving the criteria required to become a University Teaching Hospital organisation in a maximum of four years' time.	**Richard Mundon**

Part 2.2: Statements of Assurances from the Board

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts.

2.2.1 Review of Services

During 2021/22 Wrightington Wigan and Leigh NHS Foundation Trust ("WWL") provided and/or sub-contracted 67 relevant health services detailed in the Trust's mandated services.

WWL has reviewed all the data available to them on the quality of care in these relevant health services.

Due to the nature of funding the Trust received during the Covid-19 Pandemic it is not possible to identify the income generated by the relevant health services reviewed in 2021/22 in relation to the total income generated from the provision of health services by WWL for 2021/22.

2.2.2 Participation in Clinical Audits

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Account. A high level of participation provides a level of assurance that quality is taken seriously, and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

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During 2021/2022, WWL participated in 46 National Clinical Audits and 7 National Confidential Enquiries covering relevant health services that WWL is eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that WWL participated in and for which data collection was completed during 2021/22 is listed in **Appendix 1.**

The reports of National Clinical Audits were reviewed by the provider in 2021/22 and WWL intends to take the following actions to improve the quality of healthcare provided. Other national reports will be presented once published.

Audit	Reported Outcomes
National Diabetes Audit 2019/2020	Results of the audit showed excellent results and an improvement on the previous year. Overall health checks completion rate was 96.1% compared to 88.6% nationally. Hospital admissions were much lower than the national results. Improvements are needed on advice on carb counting which currently stands at 33%.
National Epilepsy 12 Audit	Results compared well to NICE quality statements, and seven key performance indicators achieved 100%, time to first assessment is better than regional and national averages. Improvements can be made for onward referral to the epilepsy specialist nurses as soon as the diagnosis has been made. Epilepsy nurses has been working on transition of children, with nurseries, schools & colleges.
BAUS National Stone Audit	The audit provided a baseline of activity of acute colic pathway, across the NHS for compliance with NICE Quality standard for stones. The results show we stent more than the national average but we only seven patients in the audit so low numbers to compare against. Stone prevention diet and fluid advice was given in all cases, compared to 72.5% nationally.
Audit of Pain Control in Children (RCEM)	100% of patients had pain score assessed in triage 92% of patients were given analgesia within 30 minutes All results are above the RCEM national average.
National Emergency Laparotomy Audit – Year 7	Both anaesthetic & surgeon consultant presence during surgery 96.7% comparable to 90% nationally, mean length of stay is 13.9 days compared to 15.1 nationally. Improvement is needed for patients receiving antibiotics administered within 1 hours for those with suspected sepsis, this is an improvement which is poor nationally.

The reports of 198 Local Clinical Audits were reviewed by the provider in 2021/22. A selection of these audits outlined below show improvements which have taken place from previous audits.

Speciality	Title	Success
A&E	**Audit of Pain Control in Children (RCEM)**	100% of patients had pain score assessed in triage, 92% of patients were given analgesia within 30 minutes
Medicine	**Early Experience of the Freestyle Libre at WWL**	The majority (90%) of patients who were received the Freestyle Libre were appropriate. 74% of patients noticed a reduction in the number of hypos over 6 months.
Medicine	**Barrets 5 Year Audit**	A dedicated Barrett's service shows improved dysplasia detection and guideline adherence.
Anaesthetics	**Antacid prophylaxis in obstetrics audit**	Antacid prophylaxis and NBM guidance well followed for women undergoing elective LSCS. Women in labour with risk factors for LSCS not all starved in line with NICE guidance. Women in labour with risk factors for LSCS not given antacid prophylaxis consistent with consensus practice
General Surgery	**Clinical Audit of Urinary Catheterisation Practice and Documentation in Surgical Inpatients**	All the wards showed 100% efficacy in appropriately positioning the urinary bag in both the cycles of audit. Documentation of catheter care plan improved globally to 100% across all wards, either in flowsheets or in some form of progress notes or in Urinary Catheter Insertion Documents. Most of the wards improved in performance as compared to the standard (NICE – Infection Prevention and Control QS61, 2014) NICE – Infection Prevention and Control QS61.
Obs and Gynae	**Term Admissions to NNU**	Trust guidelines were followed in 94% of cases of term admissions to NNU (compared to 66% in previous audit). Good improvement shown for hypoglycemia babies in recording temperature and monitoring blood glucose.
Obs and Gynae	**Re-Audit of VTE Prophylaxis on Swinley Ward**	As an action from the previous VTE in gynae audit, the ward round checklist now includes a flag that is raised on HIS to remind clinicians to reassess patients after 24 hours.
Obs and Gynae	**Late Booker Audit**	The results showed that Midwives are exploring and understanding the reasons for completing health and social risk assessments. Safeguarding concerns were identified in 3 of the 12 cases and appropriately managed by midwifery.

Speciality	Title	Success
Obs and Gynae	**Routine Enquiry Audit**	The antenatal clinic staff have a robust process in place/ failsafe to ask the question about domestic abuse.
Ophthalmology	**Low Vision Audit**	The majority of patients attending Low Vision Clinic have their functional reading vision improved. 94% of patients are able to access at least large print material Overall outcomes from LVA clinic appear to be stable. This audit Meets the Quality standard
Ophthalmology	**Atropine Audit**	Atropine treatment provides good visual outcomes in the amblyopic eye: 0.06
Trauma & Orthopaedics	**Update of COVID-19 status of patients undergoing Orthopaedic surgery at Wrightington Hospital by Green Pathway**	2906 orthopaedic admissions admitted to Wrightington, with 1 patient testing COVID-19 positive (0.03%) compared to 0.6% in the previous audit.
Trauma & Orthopaedics	**Management of Ankle Fractures**	Apart from – Adequacy of X-rays, Time to surgery, Documentation of post manipulation evaluation, Intra-op Assessment of syndesmosis. Rest all standards were fully adhered to. This is an improvement from the previous audits.
Community - Adult Services	**End of Life within the District Nursing Services – cycle 5**	Increase use in the IPOC documentation has seen an increase in compliance within each holistic assessment
Community - Adult Services	**COVID Early Supported Discharge on Oxygen**	Huge success in avoiding prolonged hospital stays and easing bed pressures. Readmissions / A&E attendances were lower than expected - 5% within 30 days of discharge. October 2020 - March 2021 - 1308 bed days saved.
Community Adult Services	**NWAS & Falls Referrals**	NWAS have increasingly been sending referrals to the Falls team to prevent further harm to the patients due to falls

Audit Actions are monitored at monthly audit meetings as well as at Divisional Quality Executive meetings. Actions are signed off as complete (on the audit database) when feedback is relayed back to the audit department by those responsible for implementing the actions.

2.2.3 Research

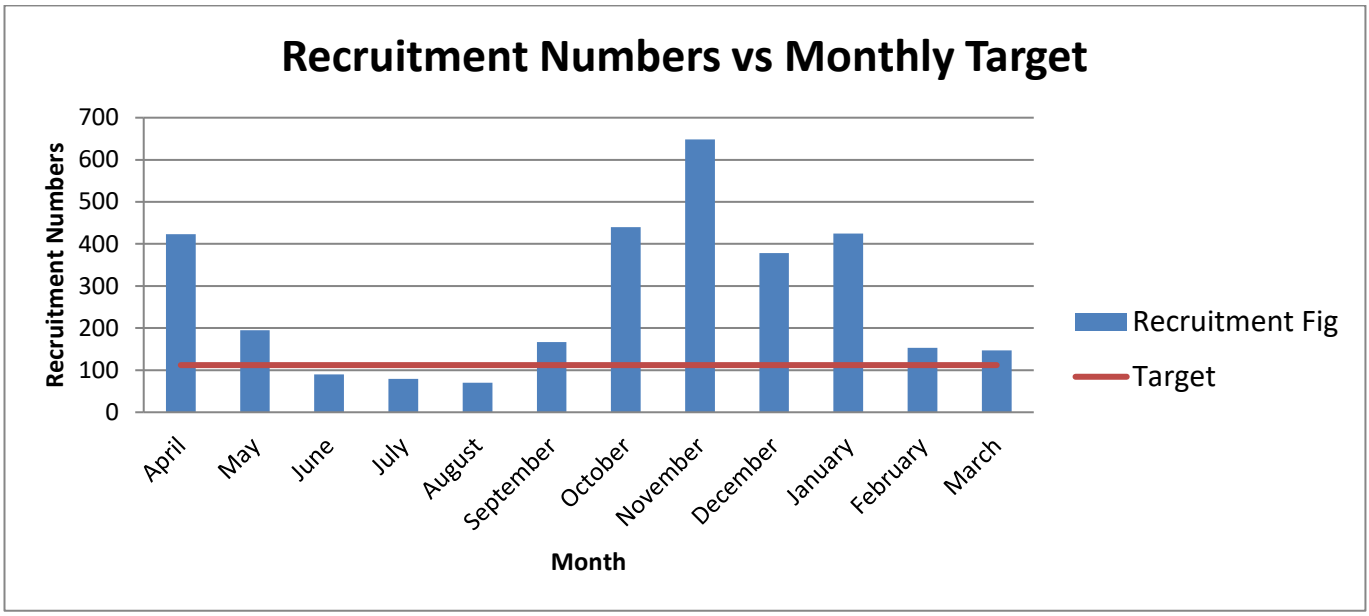
Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' refers to research that has received a favourable opinion from a Research Ethics Committee within the National Research Ethics Service (NRES). Trusts must keep a *local record of research projects.*

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by WWL in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio') was 3215 an average of 268 patients per month. The Trust target agreed with the National Institute for Health Research (NIHR) was 1343 recruits (an average of 112 per month). We have exceeded the set target.

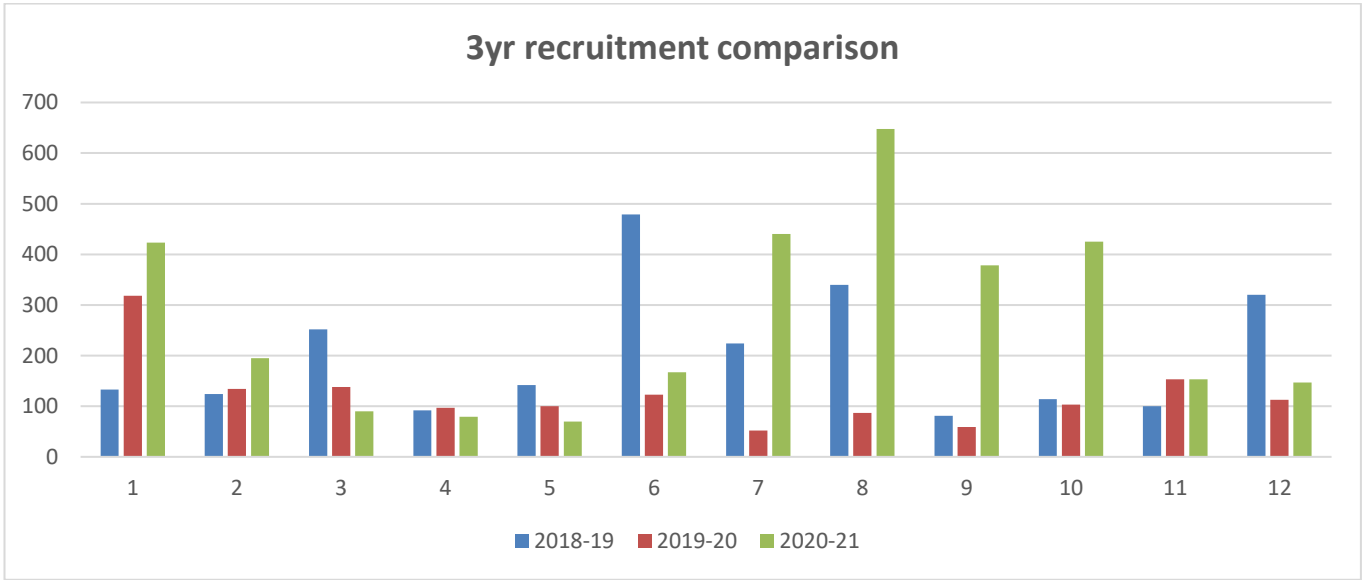
Patient Recruitment 2021/22

The chart overleaf illustrates target recruitment versus actual recruitment to research studies in 2020/21.



Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are continually updated about the latest treatments. We were involved in conducting several NIHR Portfolio clinical research studies and Non-Portfolio studies in a variety of specialities during the year 2019/20.

The chart below illustrates recruitment into National Institute for Health Research registered studies between 1st April 2021 and 31st March 2022.



It is globally recognised that a commitment to clinical research leads to better outcomes for patients. We are continuously scrutinised, and the data provided is monitored by recognised, expert teams who ensure that confidentiality and the conduct of every trial meets European Legislation.

We have been recognised at a regional awards ceremony for our success in attracting international research projects for the benefit of our patient population.

Our Research Strategy aims to include all clinical staff in research. Every year the Research Department identifies a clinical area for promoting and supporting research. This has proved successful, and areas of interest have greatly increased with strong recruitment in the following clinical specialities: Rheumatology, Cardiology, Diabetes, Surgery, Respiratory, Paediatrics, Obstetrics, Cancer, Ear Nose and Throat (ENT), Gastroenterology, Dermatology, Musculo-skeletal and Infection Control, Fertility and Ophthalmology.

Training and Development opportunities are provided by the Research Department to support staff in conducting quality research studies in a safe and effective manner. All staff that support clinical research activity are trained in Good Clinical Practice (GCP) which is an international quality standard transposed into legally required regulations for clinical trials involving human subjects.

The development of our Research Patient Public Involvement (PPI) group influences the way that research is planned. They help to identify which research questions are important. By influencing the way research is carried out we aim to improve the experience of people who take part in research.

Publications have resulted from both our engagement in NIHR Portfolio research and Foundation Trust supported research, which has secured Ethical Approval.

It is important that we continue to support both pilot studies in preparation for larger research projects and smaller research studies which do not qualify for adoption onto the NIHR Portfolio because they do not require access to a funding stream. This shows our commitment to transparency and our strong desire to improve patient outcomes and experience across the NHS.

The clinical research team supports all clinical teams conducting research studies, ensuring the safe care of patients and adherence to the European Directive, Good Clinical Practice guidelines and data collection standards. As a result of this expert support, the larger clinical community within the Foundation Trust is able to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

2.2.4 Goals agreed with Commissioners

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

The CQUIN payment framework aims to embed quality at the heart of commissioner-provider discussions and indicates that we are actively engaged in quality improvements with our commissioners. Achievement of the CQUIN quality goals impacts on income received by WWL.

CQUIN schemes were suspended for 2021/22, however these are scheduled to resume in 2022/23

2.2.5 What others say about WWL

Statements from the Care Quality Commission (CQC)

All NHS Trusts are required to register with the Care Quality Commission. The CQC undertakes checks to ensure that Trusts are meeting the Fundamental Standards and Key Lines of Enquiry (KLOE) under safe, effective, caring, responsive and well-led. If the CQC has concerns that providers are non-compliant there are a wide range of enforcement powers that it can utilise which include issuing a warning notice and suspending or cancelling registration.

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2021/22, is registration without compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2021/22.

WWL has not participated in any special reviews or investigations by the CQC during the reporting period.

There were no on-site formal inspections by the CQC of our services in 2021/22. However, regular contact was maintained between the Trust and the CQC during the year as part of the CQC's changing approach to regulation known as Transitional Monitoring Arrangements.

The Trust's most recently published CQC reports were issued on 26 February 2020. The reports can be accessed via the link on the Trust's website or by accessing the CQC's website via https://www.cqc.org.uk/provider

The Trust's latest overall CQC rating for WWL is **'Good'** and WWL has maintained a rating of **'Good'** for every domain (safe, effective, caring, responsive and well-led). Our Use of Resources is also rated as **'Good'.**

100% of our services and locations are now rated either **'Outstanding'** or **'Good'** by the CQC, the two highest ratings. Whilst the Trust has not been formally inspected within 2021/22, the Trust continues to carry out a number of internal inspections and we therefore believe that is still reasonable to expect that these ratings are valid.

Progress against actions required by the CQC from the latest inspections in 2019/20 have continued at pace during 2021/22 and all actions that were identified as 'must do' actions were completed within 2021/22.

The Trust continues our improvement journey to be Outstanding in everything that we do, working together to ensure that our patients and community continue to receive the best possible care.

2.2.6 NHS Number and General Medical Practice Code Validity

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

WWL submitted records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 100% for admitted patient care.
- 100% for outpatient care, and
- 98.89% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care,
- 100% for outpatient care, and
- 100% for accident and emergency care.

2.2.7 Information Governance Toolkit Attainment Levels

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Data Security and Protection Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by NHS Digital. It draws together the legal rules and central guidance related to Information Governance and data security.

WWL's Data Security Protection Toolkit was submitted in June 2021. The assessment was scored as Standards Met/Not Met however an action plan has been submitted and agreed with NHS Digital**.** The Data Security Protection Toolkit is based on the National Data Guardian's ten data security standards.

2.2.9 Statement on relevance of Data Quality and your actions to improve your Data Quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The Board of Directors is required to sign a 'Statement of Directors' Responsibilities in respect of the Quality Report part of which is to confirm that data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Although the Trust already has historically had good Data Quality 2021/2022 has been a challenging year and that is reflected by the Trust's position within the Model Hospital. Over the last 12 months the Trust has a continuing programme of work for the development and improvement of the Data Quality, however this has been impacted by the pandemic.

The Trust released its latest iteration of the DQ App which allows for a more comprehensive picture of how the Trust is performing against key data quality metrics. The key focus for this year in regard DQ iterations is Community Data. The purpose of the app is to provide frontline services with clear visibility on where there are issues or areas of concern. Again, this will allow the individuals and services entering the data to investigate and remedy any issues, as well also learning for the future and review.

This supports the NHS "Get It Right First Time" (GIRFT) approach and is aligned to Article 5 of the General Data Protection Regulation (GDPR)

WWL will be taking the following actions to improve data quality:

The Trust will continue to develop and roll out the next iteration of DQ app ensuring that Key Performance Indicators across all services are reviewed, amended, added to and utilised to support the Trusts ability to give assurance and continue improvement against the DQ Programme.

The Trust will look at ways in which we can identify data quality issues earlier, utilising automation technologies with a view to reduce the amount of retrospective fixing of data.

2.2.10 Learning from Deaths

In March 2017 the National Quality Board published a document called *'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'.* The purpose of the guidance was to help initiate a standardised approach to learning from deaths.

During 2021/22 1259 of WWL in- patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period. These figures also include deaths in the Emergency Department, which gives a total of 1426.

- 291 in the first quarter.
- 335 in the second quarter.
- 393 in the third quarter.
- 407 in the fourth quarter.

WWL has had a process for reviewing deaths for over thirteen years. WWL commenced the review of deaths in a structured way that met the Learning from Deaths Guidance published in March 2017.

By the end of March 2022, 1027 case record reviews and 1027 investigations have been carried out in accordance with the Learning from Deaths Guidance in relation to 72% of the deaths referenced in the introduction. In 1027 cases, a death was subjected to both a case record review and/or an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was.

- 209 in the first quarter
- 245 in the second quarter
- 256 in the third quarter.
- 317 in the fourth quarter

Three, representing 0.2% of 1426 deaths in 2021/22, of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance.

A summary of what WWL has learnt from case record reviews and investigations conducted in relation to deaths identified above is as follows:

- Care problems within the Vascular Network
- Failed follow up for a possible Caecal Tumour on CT scan
- Diagnostic error with Femoral Hernia and related intestinal obstruction
- Missed CVA on MRI scan
- Patient who is admitted in arrest having not been able to get a GP appointment
- Patient awaiting colonoscopy for GI related death. There is a possibility that the colonoscopy may potentially have altered the outcome had it been done in a more timely way
- Patient who died in the Emergency Department after 20 hours

- Patient in heart failure treated as pneumonia.
- Patient who died of GI bleed who may have benefited from an earlier OGD
- Patients admitted when there are advanced care plans in place
- Patient in whom doses of phenobarbital were missed on admission
- Patient with status epilepticus for 24 hrs and suffered hypoxic damage. Possibly due to management of seizure and airway
- Concerns over suitability of surgery at Wrightington
- Patient with a 26 day wait for cancer surgery with four cancellations
- Patients admitted without any realistic expectation that the patients would benefit from the admission
- Grade four pressure ulcer
- Hospital Acquired COVID
- VTE prophylaxis failure
- Late presentation of cancer
- Missed Pulmonary Embolism in a patient with major trauma
- Slow response to evolving sepsis
- Febrile neutropenia managed incorrectly as simple sepsis
- Excess IV fluid in a patient with resultant heart failure
- COVID vaccine failure
- Missed medications in a patient with Parkinson's disease
- Extensive thrombosis post vaccination

2.2.11 Seven Day Services

Ten clinical standards for seven-day services in hospitals were developed in 2013. These standards define what seven-day services should achieve, no matter when or where patients are admitted. Four of the ten clinical standards were identified as priorities based on their potential to positively affect patient outcomes. NHS Trusts are required to include a statement in their Quality Report regarding implementation of the priority clinical standards for seven-day hospital services.

This was Suspended for 2021/22

2.2.12 Speaking up

In its response to the Gasport Independent Panel Report, the Governance committed to legislation requiring all NHS Trusts to report annually on staff who speak up. Ahead of such legislation NHS Trusts are required to provide details of ways in which staff can speak up, and how it is ensured that staff do not suffer detriment as a result of speaking up.

The Trust aims to ensure that staff feel comfortable and safe to raise concerns with their line managers in the first instance. Concerns may relate to quality of care, patient safety or bullying and harassment. We recognise that by valuing our staff who raise concerns, listening and acting on the issues, speaking up can really make a difference to staff wellbeing and patient safety. When a concern is raised with managers it is important that they know how to handle the concern and have the correct escalation processes to ensure action is taken to resolve those concerns.

If staff do not feel able to raise concerns with their managers or they are unsatisfied with any feedback they have been given there are other routes available to staff. Staff can raise concerns with their Union, Human Resources or with the Freedom to Speak Up Guardian. One of the critical roles of the Freedom to Speak Up Guardian is to ensure that staff raising concerns do not suffer detriment. The Freedom to Speak Up Guardian can also provide the following support:

- an independent route and safe space for staff to raise concerns
- report or escalate concerns on the behalf of the staff
- act as an advocate for staff and protect identity of staff wishing to remain anonymous
- obtain information or act as a ‘go between’ within any investigation into a concern
- agree support, ongoing communications and feedback on the progress of any investigation.

The Trust is committed to ensuring that concerns raised by staff are treated seriously and dealt with in a sensitive, positive manner and as quickly as possible.

2.2.13 NHS Doctors in Training

One of the functions which oversee the safety of NHS Doctors in Training is the Guardian of Safe Working Hours. The guardian ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate. The guardian provides assurance to the Board that doctors' working hours are safe. NHS Trusts are required to provide plan for improvement to reduce these gaps

This section is intended to illustrate the number of exception reports raised against the vacancy rate by the grade of doctor. Fill rates for ad hoc shifts are provided to illustrate how successfully vacant shifts are filled. This section also illustrates the actions taken to mitigate the risk of having unfilled shifts and any adverse impact on the training experience of Doctors in Training whilst on rotation to WWL

High level data

Number of doctors and dentists in training (total): 178
Number of doctors and dentists in training on 2016 Terms and Conditions of Service (total): 178

Annual data summary

Specialty	Grade	Exception Report Raised				Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
		Q 1	Q 2	Q 3	Q 4			
General Surgery	F1	2	39	39	31	0	1	N/A
General Surgery	F2/ST 1-2	15	3	7	4	2	118	2
General Surgery	ST3+	0	0	0	0	0	5	N/A
General Medicine	F1	4	38	28	31	0	7	N/A
General Medicine	F2/ST 1-2	3	14	19	0	0	837	16
General Medicine	ST3+	0	0	0	0	0	585	11
Emergency Medicine	F1	0	0	0	4	0	0	N/A
Emergency Medicine	ST1/2	2	6	2	0	0	66	1
Orthopaedics	F1	0	2	3	1	1	0	N/A
Orthopaedics	F2/ST 1-2	0	0	0	0	1	5	N/A
Orthopaedics	ST3+	0	0	0	0	0	6	N/A
Ear Nose and Throat	ST3+	0	0	0	0	0	6	N/A
Paediatrics	F2/ST 1-3	0	1	2	2	1	12	N/A
Obstetrics and Gynecology	F1	0	0	0	0	0	**0**	**N/A**
Obstetrics and Gynecology	F2/st1-2	6	4	5	0	0	**1**	**N/A**
Obstetrics and Gynecology	ST3+	0	0	0	0	0	**2**	**N/A**
Psychiatry	ST1/2	1	2	0	0	0		**N/A**
Anesthetics	ST1/2	0	0	0	0	0	**22**	**N/A**
Anesthetics	ST3+	0	0	0	0	0	**31**	**N/A**
Urology	ST3+	1	2	0	0	0	**0**	**N/A**
Total		**34**	**111**	**105**	**73**	**5**	**1,704**	

This report contains a full year's result of exception reports, vacancies and unfilled shifts.

The Trust has very few doctors in training vacancies however there are vacancies for the non- training grade doctors who participate on the training grade rotas. Those vacancies are reflective in the increased number of unfilled shifts particularly in Medicine which had a 36% growth in unfilled ST1/2 level shifts. The total number and top reason for unfilled shifts was due to vacancies at 1,271 shifts, the second highest reason for unfilled shifts was covid at 396 shifts.

In contrast the number of exception reports has decreased from 468 exception reports in 19/20 to 331 in 20/21 resulting in a 29% reduction during a national pandemic. The reasons for this are that there were much more people on the acute rota due to redeployment meaning that handovers were easier, and staff could get away on time. However, this not a sustainable solution.

Issues arising:

Increased educational exception reports

Q4 demonstrated an increase in exception reports for educational reasons, mainly for FY1 in Medicine. The doctors had been complaining about missed training and teaching opportunities however there was not the evidence in exception reports to back up the complaints. Following discussions at the junior doctor's forum it was agreed that the doctors would exception report so that this could be captured.

An example of an exception report following a missed training opportunity has been illustrated as *"I am currently on my BtFP rotation - 1 clinic per week. Due to minimum safe staffing levels on our ward; as well as accommodating other juniors (GPST/IMT/PFTD) who need to attend teaching and clinic sessions; it was not possible to attend this week. This report is made in reflection to the whole week; where I was not able to attend"*

Actions taken

The Exception Reports for missed educational opportunities relate to three key areas:

1. Missed Clinics
2. Missed Protected Teaching (PT)
3. Missed Self-development Time (SDT)

- Medical Education has raised the issue of missed clinics with rota co-ordinators to raise awareness of the Clinic requirements, particularly for trainees on BtFP track. Medical Education and Rota Co-Ordinators are working together to ways in which clinical attendance can be improved.
- Post Foundation Doctors (PFD) have now completed their 3-month settling in period. PFDs will be available to provide ward cover for HEE trainees for attendance at PT session (including mandatory teaching on Tues/Wed afternoons and Fri lunchtime); SDT and clinic attendance.
- Medical Education are working with the Allocate Project Team to ensure PT and SDT is built into the new e-rota and e-roster platform. This will make it easier for Rota Co-Ordinators to ensure safe staffing levels can be maintained during the times when trainees are unavailable due to teaching requirements.

Medical Education closely monitor missed teaching opportunities as reported via Exception Reports and via Clinical and Educational Supervisor Meetings. The governance structure for Medical Education allows issues and concerns to be escalated to DMDs, CDs and the MD quickly and accurately. In addition, the DME has built strong relationships with service leads to allow for an open and response environment in relation to trainee concerns.

Surgical F1 exception reports for hours and rest

The surgical F1 exception reports are consistently high for hour and rest due to clinical needs. There is a theme that the post take ward rounds are taking longer than planned and there is a clinical need for doctors to stay late to complete the jobs created from the mornings ward round. One factor that compounds the problem is the cross-cover arrangements between General Surgery, Urology & ENT. Due to the working hours, there is often no F1 in Urology or ENT therefore a F1 in general surgery will need to cross cover.

Action taken to resolve the issue

A new rota has been designed which includes two new F1 posts in Urology & ENT this will provide more cover for those areas and reduce the amount of cross cover required. A business case is being created by the surgical management team and if approved the new posts will be in place from August 21.

General Medicine exception reports for hours and rest

In General medicine the majority of exception reports were due to late finishes and these are best illustrated by example

"I stayed late because a patient I had managed in the day deteriorated and the consultant Dr Gulliford agreed a DNACPR would now be appropriate. I documented and managed appropriately and contacted this patient's family; as I don't like handing over sensitive family discussions to the night team."

"Bleeped to assess two potentially unwell patients. Stayed to assess and perform initial investigations for these before handing over to the on-call SHO."

"Over-ran my shift by an hour - I was the only junior on my side of the ward; both SHOs were on leave / on call; therefore due to ward pressures I struggled to finish on time."

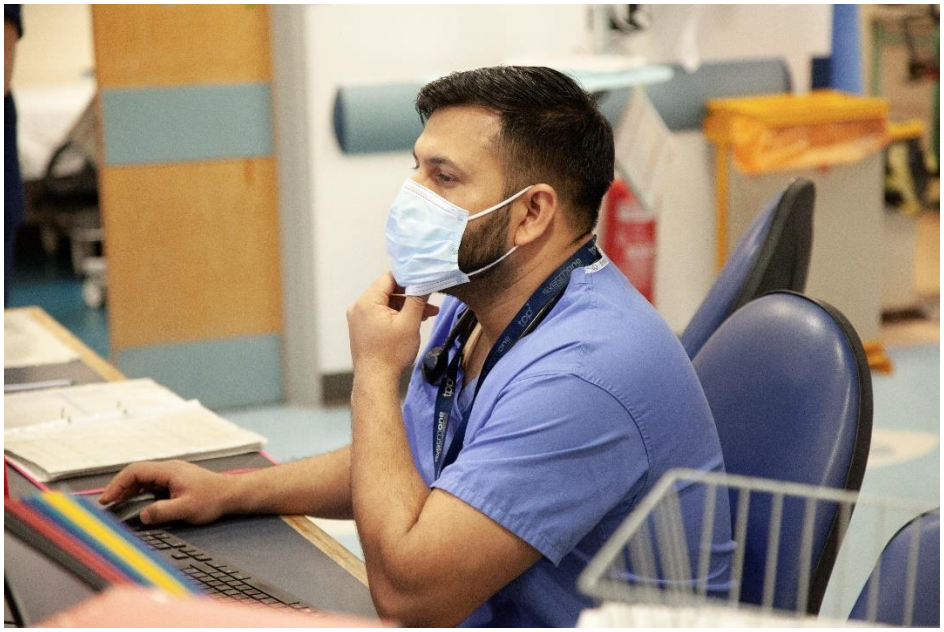
Generic actions taken

Overseas recruitment to help with the vacancies:

The GTEC Team are currently recruiting international doctors for WWL to help relieve staffing pressures across the Trust. We have recently been in touch with various departments across the Trust to establish any upcoming doctors' vacancies we can fill using our MCh/MMed programme. Last year we were able to successfully recruit 18 international doctors on to our 13th Cohort for WWL, and this year we are aiming to recruit 17 international doctors for Cohort 14. We are currently arranging interviews to take place in May, and we are aiming for these doctors to be in post by November this year.

The Trust is exploring temporary staffing managed service options with a view to having one platform to request locum shifts from. This managed service will provide the Trust with more NHS locum doctors by tapping into STH&K 10,000 doctors and creating an attractive user-friendly bank for doctors to join, resulting in less unfilled shifts and les agency usage.

In conjunction with this a medical rostering project has commenced which will enable all medical staff to be on a e rostering system similar to the nursing staff. This change in practice will provide doctors with a more user-friendly rota management system enabling them to book leave easier and make swaps. This change in system should reduce the times when there is not adequate staffing due to leave/ rostered rest days etc which in return will result in less exception reports



Part 2.3: Reporting against core indicators

We are required to report performance against a core set of indicators using data made available to us by NHS Digital. For each indicator, the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods, is presented in the table below. In addition, where the required data is made available by NHS Digital, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS Trusts indicators with:

a) National average for the same, and;
b) Those NHS Trusts with highest and lowest for the same.

We are required to include formal narrative outlining reasons why the data is as described and any actions to improve the data.

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Mortality				
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	October 2020 - February 2021	Value: 1.0452, Banding : 1	Value: 1.0026	Best: IMPERIAL COLLEGE HEALTHCARE NHS TRUST (RYJ) - Value: 0.6979, Banding: 3 Worst: DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST (RBD) - Value: 1.1877, Banding: 1
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	October 2020 - March 2021	42.6%	36.0%	Best: SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST (RK5) - Value : 14.3% Worst: ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST (RA2) - Value: 59.0%

Assurance Statement

Whilst SHMI been high for the last 5 years, it has significantly reduced within 2021/22 and is now well within expected range for the Trust as compared with the national average.

There is extensive work to review all deaths, with identification of Potentially Preventable Deaths and work to learn from areas where care falls short of the standards expected. Issues related to the calculation of SHMI still remain, for example in relation to the low bed base. This is potentially helpful to a well-run, efficient organisation, but within the calculation of SHMI it means that the number of deaths is concentrated into a lower number of admissions and so the death rate artificially appears raised. WWL is increasing its bed base, with significant change during the last year (2020). That will to some extent mitigate the problem, but it will remain an issue until the bed base approximates levels more typical across the NHS. The increase in the WWL bed base is also essential given the patterns of frailty and dependence we are experiencing. The pattern of older, more frail patients arriving in hospital is set to increase as the demographic bulge known as "baby boomers" reach old age and require increasing healthcare.

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Patient Reported Outcome Measures Scores (PROMs) The Trust's patient reported outcome measures scores during the reporting period for:				
i) Groin Hernia Surgery	April 2017 - March 2018	0.058	0.089	Best: CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.137 Worst: SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST (RXK) - Value: 0.029
ii) Varicose Vein Surgery	April 2017 - March 2018	N\A	0.096	Best: THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Value: 0.134 Worst: BUCKINGHAMSHIRE HEALTHCARE NHS TRUST (RXQ) - Value: 0.035
iii) Hip Replacement Surgery	April 2018 - March 2019	0.405	0.338	Best: SPIRE SOUTHAMPTON HOSPITAL (NT304) - Value: 0.405 Worst: SPIRE LITTLE ASTON HOSPITAL (NT321) - Value: 0.266
iv) Knee Replacement Surgery	April 2018 - March 2019	0.405	0.338	Best: SPIRE SOUTHAMPTON HOSPITAL (NT304) - Value: 0.405 Worst: SPIRE LITTLE ASTON HOSPITAL (NT321) - Value: 0.266
Assurance Statement The data shows that we are collecting PROMs data in a reasonable way and in line with national guidelines and that our results are around the national average. There is currently a lot of work around improving the PROMs data collection by putting in a digital system. Therefore, these scores can be competed remotely and in real time. This will mean the data can be used in a more meaningful way for both the Trust and the patient.				

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Hospital Readmission:				
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2017 - March 2018	10.1	11.9	Best: SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST (RXX) - Value: 1.3 Worst: BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RYW) - Value: 32.9
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	April 2017 - March 2018	15.9	14.1	Best: HATHAWAY MEDICAL CENTRE (NXP04) - Value: 2.6 Worst: MERSEY CARE NHS FOUNDATION TRUST (RW4) - Value: 33.0

Assurance Statement

WWL has taken the following actions to improve this indicator and so the quality of services by:

- Multi Agency Complex multi-disciplinary MDT to review high intensity users and provide community-based support is being re-stablished following COVID.
- Community Response Team provide follow up calls for all patients discharged over 65 and over.
- Ongoing word in respect of End-of-Life pathways. Recent developments include integration of Hospice Staff in care planning within community and Primary Care.
- Revised discharge pathway will see an improved discharge process with increased wrap around support and home-based assessments.

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Responsiveness to Personal Needs				
The Trust's responsiveness to the personal needs of its patients during the reporting period	National Inpatient Survey 2018 - 2019	65.6%	67.2%	Best: Queen Victoria Hospital NHS Foundation Trust (RPC) - Value: 85.0% Worst: Croydon Health Services NHS Trust (RJ6) - Value: 58.9%

Assurance Statement

The Trust acknowledges that our results are slightly below the national average for results in this category. Disappointingly there is also a slight decline on last year's results which does reflect the national situation. Following an inspection in late 2019, the CQC rated the trust as good for caring and noted that staff treated patients with kindness and compassion whilst taking account of their individual needs.

WWL has taken the following actions to improve this indicator and so the quality of services by:

- There has been significant investment into nursing to increase numbers of trained staff within clinical areas along with a commitment to increase more senior presence and leadership.
- An Admiral Nurse role has been introduced into the trust with a planned second nurse recruitment to support the service. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support; they are continually trained, developed and supported by Dementia UK. An Admiral Nursing service in an acute setting represents an opportunity to improve outcomes for people with dementia, facilitate improvements in staff understanding of dementia through training and quality improvement projects.
- The Palliative Care team are now able to provide a seven-day service following trust investment to support patients and their families who are at the end of their life and ensure their personal needs and choices are met.

The trust uses a discharge to assess model to support and facilitate more effective discharge for patients. It is based on a partnership approach, centred around collaborative working between organisations, individual and family members to ensure the best outcome for the patient on discharge.

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Friends and Family Test (Staff)				
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends (Acute Trusts only)	National NHS Staff Survey 2019	77.00%	71.00%	Best: The Newcastle upon Tyne Hospitals NHS Foundation Trust (RTD) Value - 90%
	National NHS Staff Survey 2020	71.8%	74.3%	Best: 91.7% Alder Hey Children's NHS Foundation Trust (RBS) Worst: 49.7% United Lincolnshire Hospitals NHS Trust (RWD)
Assurance Statement *WWL considers that this data is as described for the following reasons:* It is important to recognise that 2020 was not been "business as usual" and the impact of the Covid-19 pandemic has had a profound impact. National staff survey results this year show that WWL are now below the national average for this question and our scores have decreased since last year. Triangulating the results with the data from our internal survey shows a slightly different picture. When asked the same question at a similar point in time the result was 74.3% which is the same as the national average. Since then, the most recent internal survey result (February 2021) shows this to have increased to 77.4%. Furthermore, this result has stayed relatively stable (within 3.5%) every quarter for the past 15 months. *WWL intends to take the following actions to improve this percentage and, so the quality of its services, by:* We recognise the importance of staff engagement and have committed to a strategic staff engagement reset, "Our family…Our future…Our focus, led and overseen by our Deputy Chief Executive and with leadership from all Executive Directors". We will be focussing on key themes that have informed by our staff feedback and which evidence tells us has an impact on how our people will feel working in WWL and the positive impact that improved employee engagement has on patient care and outcomes. Our themes are culture, leadership & team development, well-being and communications & visibility.				
Venous Thromboembolism				
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	October 2019 - December 2019	96.40%	95.25%	Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) & LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (RY5) - Value: 100% Worst: NORTHERN DEVON HEALTHCARE NHS TRUST (RBZ) - Value: 71.59%
Assurance Statement WWL is performing well against the national average. It is continuing to educate and raise awareness of the importance of VTE prophylaxis in increasing compliance even further and reducing patient harm.				

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Clostridium difficile (C. *difficile*)				
The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	April 2019 – March 2020	31.3	National average 22 North West average 24.9	Best in NW: Liverpool Women's 0, Alder Hey 8, East Cheshire 9 Worst in NW: Christie 57, Blackpool 55, Lancashire 46

Assurance Statement

WWL considers that this data is as described for the following reasons:

In 2021/22 there were 43 cases, compared to 48 in 2019/20. Due to the pandemic, it was not possible to do a full review with the CCG and Executive team on all cases, but root cause analysis (RCA) was still completed, and the cases assessed at Divisional level and actions undertaken to help prevent reoccurrence where relevant.

Ribotyping was carried out on over half of the cases, especially where patient's pathways crossed over with others who had *C. difficile*, but there were several strains in circulation and there was no evidence of direct cross infection. Again, due to the pandemic and a lack of ward to decant to, only a small number of wards received a Deep clean this year. There were also consistently high activity and acuity levels on the wards and an ongoing lack of side-rooms, which was exacerbated by COVID this year.

WWL intends to take the following actions to improve this percentage and so the quality of its services by:

Full RCAs continue to be carried out on each case and the Executive reviews with involvement of the CCG continue to take place. Comprehensive action plans are drawn up to address any learning that results from these RCAs and progress monitored by the Infection Prevention and Control Committee (IPC)

IPC continue to track patients with *C. difficile* through the hospital and will send samples for typing where cases crossover with one another to see if they have the same strain.

Despite the lack of Deep cleaning, IPC and Facilities continue to liaise closely to focus this team to carry out additional cleaning in higher risk areas and ensure rooms and bed spaces receive an infected terminal clean when patients with *C. difficile* are discharged.

The *C. difficle* risk assessment is being reviewed in line with the new Trust guidance and IPC will continue to carry out audits of commodes and stool charts on a regular basis to monitor compliance with policy.

The IPC team are looking to reinforce all standard IPC precautions this year through a series of high-profile initiatives, including having a month long IPC Awareness Campaign and identifying and training link nurses on the wards to help drive best practice.

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Patient Safety Incidents				
The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	October 2019 - March 2020	3674 Incidents Reported (Rate per 1000 Bed Days 48.2) / 14 Serious Incidents (0.38%)	765221 Incidents Reported (Rate per 1000 Bed Days 45.2) / 2458 Serious Incidents (0.32%)	Best: North Tees and Hartlepool NHS Foundation Trust (RVW): Incidents Reported 1580 (Rate per 1000 bed days 16.9) / 15 Serious Incidents (0.95%) Worst: Croydon Health Services NHS Trust (RJ6): Incidents Reported 8289 (Rate per 1000 bed days 95.9) / 28 Serious Incidents (0.34%)

Assurance Statement

WWL considers that this data is as described for the following reasons:

We continue to report a high number of patient safety incidents during 2021/22. The data just show a slight decrease in reporting in Q1, evidence suggests there was a decrease in the number of patients admitted into hospital during this period, which may account for the downward trend. Our rate of incidents reported per 1000 bed days does not show any evidence for under reporting and our rate remains in the top 25% of all Trusts. We aim to promote a just culture to ensure that staff feel confident to report incidents. This is reflective in the numbers of incidents reported, particularly near misses and incidents resulting in low harm

WWL intends to take the following actions to improve this indicator further and so the quality of services:

Implementation of the new Patient Safety Incident Response Framework on release to ensure that more efficient ways of investigations are implemented. This will include After Action Reviews and thematic reviews.

Part 3: Other Information

Part 3.1: Review of Quality Performance

This section of the Quality Account provides information on our quality performance during 2021/22. Performance against the priorities identified in our previous quality account and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of several initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2021/22

We agreed several priorities for improvement in 2021/22 published in last year's Quality Account. These were selected following the development of our Quality Strategy 2017/21 in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Objective:	To achieve a Summary Hospital Level Mortality Indicator (SHMI) within the expected range
Where we were in 2020/21	Trust's SHMI for this time period was high. That has remained true through most of the last 5 years. At the end of 2019/20 WWLs SHMI ratio was 1.649 This is marginally better than the previous update of 1.20.
Where we are at the end of 2021/22	The Trust has significantly reduced the SHMI position and is now well within the normal range when compared to its peers. This was as a result of extensive work review all deaths, with identification of Potentially Preventable Deaths and workstreams to learn from areas where care falls short of the standards expected. The mortality improvement plan has been progressed through the financial year and have been continuing to implement improvements within key areas of potentially preventable deaths, including AKI and Sepsis. Whilst there are still challenges, significant work has been done to reduce the risk of these within WWL. At the end of 2021/22 the Trust has seen a decrease in the SHMI ratio to 1.0452, which is well within the expected range.

Objective:	25% reduction in mortality related to Sepsis
Where we were in 2020/21	During this financial year the target was around ensuring that antibiotic prescribing was done in 95% of applicable patients. We achieved 96% within ED and 100% within our wards.
Where we are at the end of 2021/22	The focus on this target has continued as reduction in mortality has a direct correlation on the speed of administering antibiotic medication. We maintained our position for ED achieving 96% within the financial year Figures have demonstrated an increase in compliance in the administration of antibiotics within one hour from 76.9% to 96%. ED Sepsis Task Force was introduced in August 2020 to explore, identify and address aspects of care that previously had prevented adherence to administering antibiotics within one hour of Time Zero. During the pandemic it was difficult to meet the target as we had planned. However, the department was committed to driving this forward and smaller projects continued throughout 2020 to help achieve this improvement. Work that is currently ongoing to continue to drive this improvement include: • PGDs have been introduced in ED. Compliance of nurses having achieved competence = 96%. However, adoption to use PGDs remain variable going into a new financial year • Blood Cultures education, training and competency remains ongoing but as at the end of March 2022 compliance for nurses being to obtain blood cultures is 74.7% Compliance to achieve this measure in Sepsis 6 in improving but remains below 50% • Sepsis on HIS – Sepsis Nurse spent several days in the department to embed Sepsis in HIS among the team. There is evidence that on the days where Sepsis was high on the Agenda with having the Sepsis Nurse in the department HIS documentation is used effectively • Sepsis Response Nurse – There has been a fabulous opportunity in the department in which a Sepsis response nurse was allocated to the shift to recognise, screen and manage the Sepsis patient through their journey. The role included first hand response to achieving Sepsis 6 for all patients, educate and train nurses to care for patients with Sepsis and use HIS documentation and complete a Sepsis audit at a time specific in the day <u>On the wards</u> Demonstrably patients who have been identified as Sepsis receive optimal treatment for Sepsis. Ie Oxygen, IV antibiotics and IV fluids. There is poor compliance in patients having blood cultures and lactate within one hour. Fluid Balance charts remain variable in compliance Sepsis Task Forces commenced but were stepped down as a result poor attendance and buy-in from clinicians. This was replaced with Sepsis Focus work which mimicked the piece of work that had just been undertaken in A&E. There are 12 clinical areas remaining

	<u>Auditing</u> Sepsis Nurse is auditing to measure this objective on a ward by ward basis and is continuing to undertake AQ Sepsis and Mortality work with Coding

Objective:	**To reduce category 3, category 4 and unstageable pressure ulcers contributed to by lapses in care by 50%**
Where we were in 2020/21	Trust reported 31 hospital acquired pressured ulcer incidents to StEIS in this financial year, which was an increase on the previous year.
Where we are at the end of 2021/22	The Trust has begun to see a decrease in the number of reportable pressure ulcers. Within the financial year, the Trust focussed significant attention on Harm Free Care, re-generating this ethos. As a result a number of improvement initiatives were implemented including a review of incident investigations, redesign of the template, SSKIn buddy training for all ward leaders and deputies, and the establishment of Pressure Ulcer Review Panels for both Category 2 & Deep Tissue Injury incidents, as well as a separate Panel for Category 3, 4 and Unstageable Pressure Ulcers. These meet weekly to review all incidents of pressure ulcer development in the hospital and community. The panels are key to our continuous improvement journey. The pressure ulcer improvement plan has been reviewed and updated to ensure that all themes and trends are captured and to ensure that all actions are measurable and provide assurance that learning has occurred and embedded in practice. Due to the continued increase in pressure ulcers the Trust has established a task and finish group to review the entire process in which pressure ulcers are both prevented and managed and remains committed to reducing this harm. In total 10 were reported to StEIS, which confirms that this target was met with a 67% reduction.

Objective:	Improvement of the patient experience by ensuring all clinical areas participating in the ward accreditation programme achieved BRONZE rating by the 31sth March
Where we were in 2020/21	The Ward Accreditation programme, Aspire, was paused during the pandemic. This was to reflect that all wards needed to be responsive to the priorities of managing through this time.
Where we are at the end of 2021/22	This programme recommenced towards the second half of the financial year. The accreditation programme was revitalised to ensure that it could capture key information to reflect minimum clinical standards, as well as incorporating national standards such as the CQC key Lines of Enquiry. 21 Wards were accredited using this new assessment programme. From these 21, scoring was also revitalised to ensure that there was robust challenge. Whilst it was clear that there are still improvements that need to be made within all wards, 15 wards achieved Bronze accreditation and 6 achieved Silver status, therefore this objective was met in full. Within 2022/23 the Trust will aim to go further and introduce criteria for all wards to work to a higher rating, including gold and platinum. Therefore we are proud that we, not only achieved this target but exceeded this by 6 of those wards attaining silver status. In order to facilitate this we are committed to developing our ward leaders who are undergoing the quality improvement training and 6 month coaching programme to develop their leadership skills and have supported them by giving time within their working week to engage with this extensive leadership training and education programme.

Objective:	To deliver Human Factors training to 50% of ward managers
Where we were in 2020/21	This begin in September 2021 and was initially facilitated by an external trainer.
Where we are at the end of 2021/22	Human Factors Training is recognised as a valuable tool to ensuring better patient safety within organisations. It will also form part of the new Patient Safety Incident Response Framework, due to be released by NHS England in the first quarter of 2022/23. We were committed to this re patient safety and psychological safety. The Trust invested in training up a number of its own staff as accredited trainers to enable a wider delivery of this training within 2021/22. This also allowed for local knowledge to be given and a human factors faculty to be developed, which will continue to be developed in 2022/23. Within this financial year, therefore, 71% of all ward managers undertook the human factors training. We will continue to roll this out and have put a further target for the new financial year to achieve 400 member of staff trained.

Clinical Effectiveness (Effective)

Objective:	Compliance with the National Patient Safety Strategy (NPSS)
Where we were in 2019/20	Following the release of the National Patient Safety Strategy in July 2019, the Trust developed an action plan to monitor the progress of each priority; this is monitored via Corporate Quality Executive Committee. It was acknowledged that most of the recommendations were dependent upon National progress and therefore could not be implemented locally until the National objectives had been implemented. There were, however, several recommendations that were immediately considered by WWL to ensure that the Trust met the local deadlines (defined in the strategy).
Where we are at the end of 2021/22	In February 2021 NHS England released a document highlighting updates to the National Patient Safety Strategy. The Trusts action plan now includes all the new updates to the original recommendations outlined in the strategy. Progress is monitored at the newly created Patient Safety Group and Quality Safety Committee. The Trust continues to make preparations to implement the new Patient Safety Improvement Framework on launch by NHS England in June 2022. This has involved rolling out Human Factors Training as well as After Action Review Training to staff.

Patient Experience (Caring)

Objective:	To ensure all complaint responses are timely and have learning identified and demonstrable action is taken
Where we were in 2019/20	497 formal complaints were due to be responded to on time – 266 achieved this: with a Trust overall performance rate of 54% Quality Priorities 2020/2021 was identified as above
Where we are at the end of 2021/22	332 formal complaints were due to be responded to on time – 109 achieved this: with a Trust overall performance of 33%. The above priority was affected by the Complaints Procedure being formally put on hold in March 2020 until 1 July 2020. The Patient Relations Department re-introduced the back log of complaints on the 1 July 2020, alongside the daily formal complaints being received by the department. As clinical staff were still prioritising treatment and care of our patients, as well staff still shielding investigations were difficult to complete. The importance of learning from patient experience via the complaints process for partially and fully upheld complaints was identified as a key priority. 'Messages for my loved ones' continued and this gave relatives who were not able to visit their loved ones whilst in hospital a way of sending comforting messages to patients who were not able to receive visitors. We also established the Patient Experience Group that reviews and triangulates experience .

Objective:	To improve patients, experience of discharge
Where we were in 2019/20	• Bi-monthly Discharge improvement meetings • Increasing Discharge related incidents • No standardised discharge checklist
Where we are at the end of 2021/22	• Monthly Discharge Improvement Group meetings commenced July 2020 with new chair (Chief AHP) and with multi-disciplinary and multi-agency representation • Discharge risk assessment with associated action plans devised and monitored by the group on a monthly basis • Paper discharge checklist implemented across all in-patient wards with plans to audit on a monthly basis commencing March 2021 • On-going work with the HIS team in relation to implementation of the Discharge Tracking Boards and creation of an electronic version of the paper discharge checklist

Objective:	To embed an organisational culture of psychological safety, civility and respect
Where we were in 2019/20	At the end of 2019, WWL participated in a psychological safety survey, along with other Trusts in Greater Manchester. Outputs from this showed that WWL had a psychological safety score of 3.5 out of 5, which was amongst the lowest in Greater Manchester. This was also evidenced through the national staff survey results.
Where we are at the end of 2021/22	We have now implement our psychological safety programme of work within the Trust to support the improvements in safe culture. The culture theme of work in "Our family, Our future, Our focus" prioritised psychological safety, civility at work and compassionate leadership. Teams have been identified to be part of a pilot, which will include education, experiential learning, action learning sets and reflective practice and we will refine the programme using participant feedback before wider roll out inn 2021/22. We have a Medical Consultant championing the programme and approach. Our leadership and team development programmes will be built on compassionate leadership, psychological safety and human factors principles. Our disciplinary policy was updated and published in March 2021, embedding the just culture ethos within conduct processes. During the year we also introduced an executive led review panel to consider all conduct matters. This uses the just culture decision tree and looks for informal resolution of issues where possible and appropriate. We intend to review all our People policies in 2021/22 to have a more person-centred focus. Freedom to speak up Guardian services were reviewed and an external provider was commissioned to provide this service so staff are able to raise any concerns. The independence of the service provider also helps to ensure that appropriate actions are taken in response to concerns and that this is done in a timely manner.

Performance against the relevant indicators and performance thresholds set out in NHS Improvement's Single Oversight Framework

The following indicators are set out in NHS Improvement's Single Oversight Framework. *Please note Summary Hospital-level Mortality Indicator (SHMI) and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.*

Key

	Performing on or above target
	Performing below trajectory; robust recovery plan required
	Failed target or significant risk of failure
↑	Improved position
↓	Worsening position
↔	Steady position

Indicator	2018/19		2019/20		2021/22	
Infection Control						
Clostridium difficile (C. *difficile*)	11 Threshold= 18	↓	48 Threshold = 20	↑	43 Threshold = 20	↓
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	2	↔	0	↓	2	↑

C.difficile:

The rules governing how to identify Hospital Acquired Cases changed on 01/04/19, resulting in an increase in Hospital Reportable Cases. In addition, the threshold set by the Department of Health for 2019/20 was based on 2018/19 data, where WWL had the lowest ever number of cases.

In 2021/22 each case underwent a detailed individual patient review but due to COVID pressures only around half the cases were reviewed collaboratively with our commissioners. Irrespective of this, comprehensive action plans were drawn up to address any learning that resulted from these RCAs and progress monitored at the IPC Committee. There have been 12 'Lapses in Care' identified; the most common reason was related to samples being taken later than they should have been, followed by inappropriate use of antibiotics. Actions are ongoing to remind staff of the importance of timely sampling and the Consultant Microbiologists and Antibiotic Pharmacist continue to promote and monitor antibiotic use.

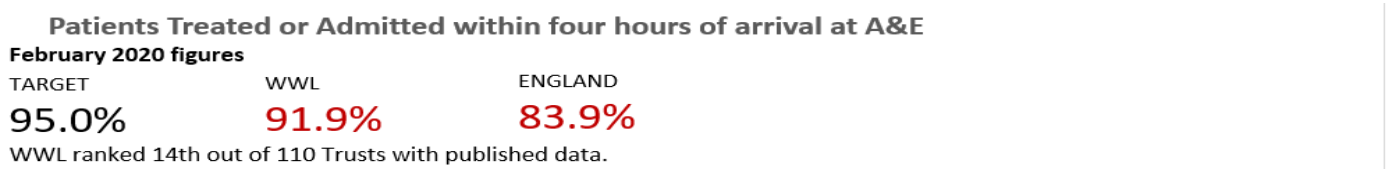
MRSA Bacteraemia:

Cases in 2021/22; one was due to a delayed diagnosis of a pre-existing MRSA infection and could not have been prevented. The second appears to have been associated with a catheter associated urinary tract infection; there was poor documentation of the blood culture and the vascular access device so an action plan was put in place following this. Work to standardise the approach to ANTT (Aseptic Non-Touch Technique) stalled in 2021/22 due to COVID, but the aim is to make ANTT assessments part of the annual mandatory training schedule and put the blood culture documentation on to HIS, which should support compliance with the SOPs.

Data Source: National Health Protection Agency data collection, as governed by standard national definitions.

Indicator	2018/19		2019/20		2021/22	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	5	↑	4	↓	1	
In 2021/22 in the Trust has seen a reduction in the number of Never Events reported. In 2021/22 there was one incident reported relating to a wrong route medication. LOcSSIPs remain part of the annual audit programme. *Data Source: Datix Risk Management System. 'Never Events' are governed by standard national definitions.*						

Accident and Emergency (ED)	**2018/19**		**2019/20**		**2021/22**	
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	82.11% *	↓	84.00%	↑	87.48%	↑



WWL ED performance against the National 4-hour target of 95% has started to improve since December 2020 after a low of 73.42% in November 2020. Performance in February 2021 reached 91.85%.

To aid recovery in ED the aim was that attendances should remain below 75% of pre-Covid levels; RAEI ED has exceeded this number from May onwards and increased month on month, peaking in August. Numbers have reduced since then, February 2021 being 7.4% lower than the previous February but remaining above the 75% pre-Covid levels.
Attendances at the Walk in Centre dropped dramatically during the Covid pandemic, April showing a 70% drop. Numbers did increase month on month, peaking in August, however, numbers started to decrease in September and remain below the 75% recovery target, February attendances being 32.8% lower than February last year.

Nationally in February, WWL ranked 14th out of 110 Acute Trusts with published data, at 91.9%, 2nd in the region for Quarter 4 and 1st in Greater Manchester

Data Source: Management Systems Services (MSS), as governed by national standard definitions.

Cancer Waits	**2018/19**		**2019/20**		**2021/22**	
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	88.04% 89.53%	↓* ↓**	85.34%%	↓	74.58%	↓
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	97.04% 97.52%	↓* ↓**	92.92%	↓	91.98%	↓

Please note where there are two percentages for one year, one represents * after repatriation and one represents ** before repatriation. After repatriation are Greater Manchester agreed figures using the new national policy for allocation of breaches and compliances. From April 2019 the national system NHS digital

which all trusts are required to upload their data to will automatically re-allocate which should result in just one set of figures for 2019/20.

Data Source: National Open Exeter System, as governed by standard national definitions.

WWL's overall performance for all standards related to the 62-day cancer waiting times in 2021/22 have been affected throughout the year by the ongoing COVID pandemic. Several months of the year experienced delays in Cancer pathways due to COVID which caused diagnostic delays and many patients wanting to wait or defer treatment due to the potential risk of catching the virus when attending hospital appointments – all of which had a significant impact on performance and subsequently caused a backlog of patients waiting for investigations. However, most of the cancer standards were still achieved despite being such a difficult year, only the 62-day cancer target was not achieved. We have worked hard to adapt to new ways of providing services and to deliver the best possible care for patients, we hope to see an improvement in performance over the coming months

We continue to collaborate with our partners across Greater Manchester to improve patient pathways and deliver the best possible outcomes for our patients.

Referral to Treatment (RTT)	**2018/19**		**2019/20**		**2021/22**	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway (Threshold= 92%)	92.29%	↓	85.70%	↓	59.04%	↓

Achievement of the 18-week referral to treatment standard for all of our elective services has been extremely challenging throughout the last year due to the far-reaching impact of the COVID pandemic, not least due to the high numbers of medical, nursing, allied health professional and support staff that were redeployed into different roles to support the Trust's response.

Non-urgent face to face outpatient activity was paused completely during the initial COVID surge, virtual clinic activity was quickly increased in response to this however waiting lists for both new and follow-up patients quickly grew. The increased access times to first appointment have negatively impacted on meeting the 18-week pathways.

The interruption to elective, non-urgent, surgery and huge reduction in theatre capacity for most of the last year has also negatively impacted on achievement of this standard. In line with NHSE and Royal College of Surgeons guidance all available capacity was used to treat patients in order of clinical priority, the number of patients waiting in excess of 52 weeks for their surgery are also being carefully managed and accommodated as more capacity becomes available.

Detailed recovery plans are in place for all services, progress against the trajectory is monitored through Greater Manchester and Nationally.

Data Source: Patient Administration System (PAS), as governed by standard national definitions.

Diagnostic Procedures	2018/19		2019/20		2021/22	
Maximum 6-week wait for diagnostic procedures (Threshold=99%)	99.25%	↓	93.40%	↓	92.94%	↓

We failed to achieve the national standard of 99% of patients receiving diagnostics within 6-weeks. This was primarily due to backlogs generated throughout the Covid-19 pandemic because of social distancing and reduced capacity.

The largest volume of procedures is undertaken in imaging and Radiology performs extremely well against this standard; this is despite rising numbers of referrals and increasing complexity of examinations. The standard does not measure all Radiology examinations, but some of the main tests fall within Magnetic Resonance (MR), Computer Tomography (CT), Non Obstetric Ultrasound (NOUS) and DEXA which equates to about 10,200 examinations per month. Overall, we undertake approximately 330,000 examinations per year, although this was reduced last year because of Covid-19. Current imaging activity levels are higher than 2019/20 & 2021/22 attributable to recovery programmes and increasing demand in unscheduled care.

Patients receiving endoscopy within 6 weeks remains challenging due to high levels of demand and environment on the RAEI site which require investment to meet National accreditation standards, however, patients are prioritised from a patient safety perspective according to clinical need and with the input of senior clinicians.

We are engaged in the process to deliver a Community Diagnostic Hub (CDH) within the Wigan borough to expand diagnostic capacity on a non-acute site. This facility will host essential imaging procedures (CT, MR, NOUS and Projectional Radiography) physiological testing and has the potential to deliver endoscopy if a large scale CDH is developed.

Complaints, Patient Advice and Liaison Service and the Ombudsman

Patient Relations and Patient Advice and Liaison Service (PALS) are dedicated to enhancing the patient, carer and relative's experience. We welcome complaints and concerns to ensure that continuous improvement to our services takes place and to improve experience through lessons learned.

The Patient Relations and PALS Team has continued their proactive role dealing with concerns and all other contacts; providing information, guidance and advice, appointment and admission queries, legal and access to records requests; many of which had the potential to becoming a formal complaint. The department continues to work closely with the Divisions to promote a positive patient experience and to actively encourage a swift response to concerns which may be received by letter, e-mail, telephone or visitor to PALS, providing resolution in real time.

All complaints and concerns are shared at our Executive Scrutiny Group which is held on a weekly basis. The more complex and serious complaints are reviewed and discussed in detail to ensure that a prompt decision is made regarding the progression of these complaints and, where appropriate, instigation of a concise or comprehensive investigation. These meetings also provide the opportunity to triangulate information with previous incidents, possible claims or HM Coroner Inquests.

Statistical information in respect of complaints and concerns is collected and monitored to identify trends. We continue to share statistical information from formal complaints nationally (KO41a) which is required on a quarterly basis. This includes information on the Subject of Complaint, the Services Area (in-patient; out-patient; ED and Maternity), amongst other information for each individual site under our responsibility.

The team understand that every concern or complaint is an opportunity to learn and make improvements for our future patients, their relatives and carers. The team recognise that handling complaints and concerns effectively matters for people who use our services and explanations and apologies, if required, are provided. We welcome complaints to learn and reflect on how we work and to make the appropriate improvements. Whilst we provide an apology to our complainants, the table overleaf outlines actions taken, and lessons learned from a sample of complaints received. These learning points are not just shared with the service concerned but with the wider Trust in order that we may improve the experience of patients, relatives and members of the public who interact with our services.

Complaints Theme and Brief Summary	Actions Taken and Lessons Learned
Values and Behaviours: Patient attended department and states is exempt from wearing face mask. Unhappy with attitude of staff member who insisted they wear one. Generally found the staff member rude and disrespectful.	Staff member was not fully aware of the guidelines for mask wearing. Individual feedback to staff member involved in relation to the current guidelines for patients who are exempt from wearing a mask. Staff member involved to undertake customer care course, with support from manager
Communication: Family, friends and relatives could not get through on the telephone to ward(s) and area(s) to obtain an update on their loved one. Lack of communication to families regarding the care and treatment provided to patients in hospital.	The Patient Relations Team implemented an email messaging service – messages and pictures are emailed into the department, these are picked up by the team, printed off and delivered to the ward(s) and area(s). The team also requested the Trust to pay for Patient Line to use for all our patients, and for a period of time patients received Freeview TV and free outgoing calls, with incoming calls a significantly reduced cost
Patient Care: Complainant unhappy with care and treatment from the district nurses and lack of supplies that were available for the patient.	Division of community have established an End-of-Life Lead Nurse who is working on a number of initiatives to improve the quality of the patient/carer experience. Training is being undertaken for all staff regarding the IPOC and an end-of-life register is now in place within each team.
Clinical Treatment: Patient has concerns regarding treatment, diagnosis, and discharge he received in department after attending due to having a fall. Patient re-admitted due to injuries being missed at previous attendance and has further concerns raised regarding his care, treatment, medication and discharge	Shared learning with all clinical divisions with emphasis on the importance of the secondary survey in all patients experiencing trauma including those with normal CT imaging, particularly in cases where there is a normal reported CT scan. Process for receiving 3rd party discrepancy reports to be identified and to be discussed at WWL discrepancy meetings. CT trauma images to be reviewed with multi-planar reformats (MPRs) to increase the detection rate of abnormalities visualised in the coronal and sagittal orientation.

Improvement Plans as a result of complaints referred to the Parliamentary Health Service Ombudsman

The role of the Parliamentary and Health Service Ombudsman (PHSO) is to provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS England, have not acted properly or fairly or have provided a poor service.

The aim of the PHSO is to provide an independent, high quality complaint handling service that rights individual wrongs, drives improvement in the public service and informs public policy.

During 2021/22 the PHSO requested information regarding 6 complaints. Decisions have been received for 2 cases which were: 2 closed and not investigating, with 4 remaining under investigation. These cases relate to the years, 2015, 2016, 2017, 2019 (x2), and 2020. A further 2 cases were updated in this year, 1 was suspended by the PHSO (relating to 2017), and 1 was not upheld, relating to year 2015. Final reports for investigations concluded in 2021/22 have not required financial redress.

Patient Experience

We have continually achieved excellent scores for cleanliness throughout the hospitals placing us in the top 20% of Trusts in this area of assessment in the National Urgent and Emergency Care Survey 2020.

We continue to obtain feedback on the patients experience through the Friends and Family Test. Overall 90% (March 2021) of patients expressing a good experience of the service they have used.

Patient and Public Engagement

Patients and Carers attended an online Experience Based Design Focus Group event to assist with the redesign of the Diabetes Service. The patients spoke about their experience, drawing out the positive and the negative elements of their care with a view to bringing changes that will lead to the establishment of a gold standard patient experience. Some of the initiatives the CCG and the trust will take forward is more education for patients GPs and Practice nurses. Better access to dieticians.

A group of patients and the public attended our first socially distanced meeting since the pandemic to give feedback on the new development of the Jean Heyes Rehabilitation Unit. (JHRU) The group gave positive feedback on the colours and décor of the facilities. They particularly thought the dinning and social area would be of great benefit to the patients during their recovery. They did have concerns about the beds, chairs and seating and that their needs to be a variety of chairs and beds to support the patient needs and brought this to the attention of the estates and facilities team, designers and architects.
The estates and facilities team now involve the falls specialists and the moving and handling specialist in their design team to look at which type of chairs and beds any new facilities they design or build need in the future. We also have a lay representative and a governor representative on the JHRU programme board and the Model of Care task and finish group.

We have worked in partnership with the CCG with the Maternity Voices Partnership. Parents told us that continuity of care was particularly important to them during their pregnancy. The Meadow Continuity of Care Team was launched in July 2020, this is a small team of midwives who provide care for mums throughout pregnancy, birth and the immediate post-natal period. Wigan Maternity Services have plans in place for further Continuity of Care Teams to be implemented 2021.

The Patient and Public Involvement Team along with the Equality and Diversity Project Lead engaged with members of the public along with the provider of the new website to develop the Trusts new website. With one of our patient representatives having visual impairment and also working for RNIB we had the privilege to have full involvement and support from the RNIB organisation in helping us to make our website accessible for all. The lay representatives and Governors said they wanted the website to be easy to access easy to find things by using key words. With the patients and public involvement and feedback we now have a new easy to access website.

The patient and public engagement campaign on “Shared Decision Making – Ask 3 Questions” continues to be successful by engaging with patients, public and staff through touch points. The touch point includes all patient information leaflets including information on Ask 3 Questions. The continued campaign informs and empowers patients to be involved in decisions about their care and treatment.

We value the contribution of lay representatives who attend the Patient Experience and Improvement Group, Patient Safety Quality Improvement Group, Divisional Quality Executive Committees, Discharge Improvement Group, Palliative Care Group, Research and Development and Patient-Led Assessments of the Care environment (PLACE) assessment, to give the patients’ perspective to the meetings.

We have a Patient Experience and Improvement Group. The Committee’s remit is to ensure that patient and public involvement remains integral to the Trust. Healthwatch is key member of the group who also bring the patients and public voice to the group.

The Head of Patient and Public Involvement has regular meetings with the Trust Governors to relay feedback on any patient experience activity the team has been undertaking so they have insight to what our patients and public are experiencing when using our services.

We will continue with all the initiatives and activities described. Achieving a positive patient experience remains a key priority for us.

Part 3.2 Quality Initiatives

We have introduced a number of initiatives to strengthen quality governance systems and improve the care, treatment and support provided to patients across the organisation. A summary of progress during 2021/22 is outlined below**.**

Ward Accreditation

Ward Accreditation process was previoulsy halted throughout the pandemic to allow wards to concentrate on core activities at that time. This accreditation programme was revised during 2021/22 and a new accreditation programme was commenced in the second half of the financial year. The new programme drew in indicators on fundamental clinical care and reflects local, regional and national standards that we would expect to have within all of our wards and teams.

21 wards were assessed as part of the accreditation programme within the finaniclal year. Of this, 15 achieved BRONZE status and 6 achieved SILVER status. The programme ended in an awards ceremony where all wards that had been assessed were presented with their accreditation certificates, to coincide within International Nurses Day

Staff Engagement – "Our Family…Our Future…Our Focus"

We measure staff engagement using both the National Staff Survey and a quarterly 'pulse' survey – 'Your Voice'. The National Staff Survey results indicate that staff engagement has declined slightly in the last year, from 7.3 in 2019 to 7.1 out of 10 in 2020. At present WWL falls slightly above the average range for staff engagement compared to 128 other Acute and Community Combined NHS Trusts (7.0 out of 10). Prior to 2018, engagement levels measure by 'Your Voice' were above 4 out of 5, which meant on average all staff felt positively engaged. 2018 saw the first dip in engagement below 4, indicating growing levels of dissatisfaction but there are some positive signs of improvement at the start of 2021.

As identified through the latest Your Voice Survey results, there is a perception that we do not always act on staff feedback, and staff are not clear on what happens with the results of the survey. Work needs to be done to promote the changes that have happened as a result of their feedback from the different surveys

Looking at the available data in more detail, we have a number of areas of strength regarding staff experience, which score slightly above the national average:

- Equality, diversity and inclusion
- Morale
- Quality of care
- Staff engagement (including motivation, ability to contribute to improvements and recommendation as a place to work/receive treatment).

There are also indications of a need for continued development, with certain areas scoring slightly below the national average:

- Health and well-being
- Immediate managers
- Bullying and harassment
- Safety culture
- Team working

“Our family.. Our future… Our focus” under the themes of culture, leadership & team development, well-being and communications & visibility is how we will be improving engagement in the Trust. Each theme has an Executive lead and the programme is co-ordinated by our Deputy Chief Executive. The Trust Board endorsed this approach at the April 2021 workshop. There will also be shared objectives for the executive and senior management teams around the delivery of the programme and the way we do things at WWL, built around our behaviour framework.

Continued Recruitment and Development of the Quality Faculty

2020-21 Overview of Trust-Wide Continuous Improvement Training within the Transformation Team

The Transformation Team has flexed to the needs of the organisation throughout 2020-21 following the onset of Covid-19 and the trust-wide response to the pandemic. For the Continuous Improvement (CI) faculty, the first part of the year was spent in redeployed roles supporting the Covid-19 response, including PPE distribution and provision of well-being support to staff.

During Q2, the Continuous Improvement faculty supported a project focussed on learning from Covid and the changes required to respond to the pandemic. In collaboration with Organisational Development and the Operational Resilience team, the Transformation Team worked with clinical and operational teams to reflect on the first wave of the Covid-19 response and use the learning to inform future response plans and longer term service development. The Covid-19 Learning Debriefing Sessions (June to August 2020) received feedback from clinical and non-clinical department participants that there was wide scale rapid change that occurred during the first wave of Covid in order to adapt to the Infection Prevention and Control (IPC) requirements whilst maintaining core clinical services. These rapid changes had been led by clinical and operational teams and had found innovative solutions to the challenges posed by Covid-19. It was reflected that teams may have found benefit in a framework to refine and embed these changes, such as the Plan-Do-Study-Act improvement cycle (PDSA). In direct response to this, all current training programmes now include detailed instruction on how to incorporate the PDSA improvement cycle into documenting and testing change ideas.

During September to October 2020, the Transformation Team transformed the classroom-based Quality Champions learning modules into an online ‘self-paced’ learning package. Hosted on Microsoft Teams platform, it provides a socially distanced and safe alternative means to complete the Quality Champions training programme using a range of blended learning approaches. These included:

- Three additional online Zoom Workshops covering: The A3 Project Charter and PDSA Improvement Cycle; Problem Solving Techniques; and Value Stream Mapping

- Support and guidance for all Quality Champions provided through online coaching and check-in sessions
- Additional content and learning material including exercises and practical use of templates incorporated into the online learning system
- A Learning Guide providing 'step-by-step' instructions on using the video lessons that support the learning journey through the programme
- A new combined Celebration Event and Quality Champions Committee Bronze Badge recorded presentations introduced, for employees completing the training programme during the pandemic

Intake of New Candidates

Between November 01, 2020 and March 31, 2021, 32 employees commenced training on the new online blended learning Quality Champions training programme. However, some of those who started the training programme needed to pause the course due to work pressures brought on by the second wave of the Covid-19 pandemic. The flexibility of the new programme supported these changing demands on WWL staff allowing them to recommence the programme when suitable.

Quality Champions Conference

The Quality Champions Conference Webinar took place in 2021/22 and this was the first virtual event held to celebrate the work of the Quality Champions.. The event providing a forum for reflecting on the excellent work delivered throughout the past year and set out the new direction for the blended-learning Quality Champions training programme.

The next 12 months

Building on the flexible approach taken to the training programme this year, the Quality Champions course will continue to evolve over the next 12 months to incorporate both online and face to face sessions, when safe and appropriate to do so. The Transformation Team will also be developing a wider range of training offers including an Introduction to Continuous Improvement offer, an Advanced CI Training Programme and a Senior Management CI Awareness Programme. In addition to this, there will be a dedicated programme for Ward Managers and Matrons to support their development and quality improvement projects. This increased offer aims to embed Continuous Improvement principles across all levels and disciplines of WWL, supporting the delivery of Corporate Objectives and Quality priorities.

Pressure Ulcer Improvement

Within 2021/22, we launched a number of improvements. Stop the Pressure week occurred towards the end of quarter 3, and our Tissue Viability Nursing Team conducted roadshows and wards displayed posters on best management of pressure ulcers. We also launched a series of pressure ulcer education and training sessions such as the SKiN buddy training and secured funding for a number of staff to undergo further specialist education in the management of pressure, sourced from a local university.

PU champion training was commenced in November 2021 for band 4 & 5 nursing staff. At the end of the financial year 81 band 4 & 5 registered nursing staff had completed this training. Band 6 and above training was delivered by an external trainer to provide further training and emphasis on verification of pressure ulcers. In total 80 staff have undergone this training. We intend to train all registered nursing staff, band 4 and above, by the end of March 2023.

Clinical Quality Walkrounds

During 2021/22, the Trust refreshed and recommenced clinical quality walkrounds within a number of wards. These were designed utilising the CQC Key Lines of Enquiry as a baseline template to facilitate supportive discussions regarding quality and safety, as well as triangulating patient experience, staff experience and governance information about a particular ward. Each visit is unannounced and conducted by a varied team of staff not connected to that ward or area. This allows for a more independent review of the area and can offer different perspectives on quality and safety.

Realtime feedback is always provided to the ward leader and Matron of the area in relation to positive issues identified, as well as areas for improvement so that this can be actioned without delays.

Feedback received from patients and staff who were spoken to at the time of the visit has been overwhelmingly positive. Patients noted good clinical care and felt the privacy and dignity was always maintained thought. They felt that they were aware of there are plan and happy with the caring nature of the staff.

Staff feedback was also generally positive with good relationships within the teams. Some staff had noted that they had been redeployed during the pandemic and, for some staff, this was a positive experience that gave them an insight into another area that they ultimately transferred to on a permanent basis.

For 2022/23 we intend to involve Non Executive Directors as part of these walkrounds as this will enhance the skillset within the walkround teams.

CONCLUSION

Overall, we are very proud of the care delivered by our staff on a daily basis. Significant improvements have been made over the year and want to thank our staff for their hard work and dedication to quality over the last financial year.

The improvements made have only come from the commitment of all teams within the Trust and it has been incredible to see that care and treatment standards have not only been maintained, but improved. When we speak to our patients and families, the overwhelming majority are complimentary of the care they receive whilst under our care and we are keen to build on learning from this excellence going into the next financial year.

Appendix 1 – National Clinical Audits

Count	Programme / work stream (A-Z)	Provider organisation	Eligible to Participate	Participated
1.	Case Mix Programme 4	Intensive Care National Audit & Research Centre	YES	YES
2.	Child Health Clinical Outcome Review Programme [1]	National Confidential Enquiry into Patient Outcome and Death	YES	YES
3.	Chronic Kidney Disease registry	The Renal Association/The UK Renal Registry	NO	N/A
4.	Cleft Registry and Audit NEtwork Database	Royal College of Surgeons - Clinical Effectiveness Unit	NO	N/A
5.	Elective Surgery (National PROMs Programme)	NHS Digital	Reported on in section 2.3 of QA report	
6.	Emergency Medicine QIPs			
a.	Pain in Children (care in Emergency Departments)	Royal College of Emergency Medicine	YES	Local data collection only
b.	Severe sepsis and septic shock (care in Emergency Departments)	Royal College of Emergency Medicine	YES	Local data collection only

Count	Programme / work stream (A-Z)	Provider organisation	Eligible to Participate	Participated
7.	Falls and Fragility Fracture Audit Programme			
a.	Fracture Liaison Service Database	Royal College of Physicians	YES	YES
b.	National Audit of Inpatient Falls	Royal College of Physicians	YES	YES
c.	National Hip Fracture Database	Royal College of Physicians	YES	YES
8.	Inflammatory Bowel Disease Audit	IBD Registry	YES	NO - Waiting for a business case to be approved to appoint an IBD admin team member.
9.	Learning Disabilities Mortality Review Programme	NHS England	YES	YES
10.	Maternal and Newborn Infant Clinical Outcome Review Programme [1, 4]	University of Oxford / MBRRACE-UK collaborative	YES	YES
11.	Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	YES	YES
12.	Mental Health Clinical Outcome Review Programme	University of Manchester / NCISH	YES	YES
13.	National Adult Diabetes Audit			
a.	National Diabetes Core Audit	NHS Digital	YES	YES
b.	National Pregnancy in Diabetes Audit	NHS Digital	YES	YES
c.	National Diabetes Footcare Audit	NHS Digital	YES	YES
d.	National Inpatient	NHS Digital	YES	YES

Count	Programme / work stream (A-Z)	Provider organisation	Eligible to Participate	Participated
	Diabetes Audit, including National Diabetes In-patient Audit – Harms			
14.	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme			
a.	Paediatric Asthma Secondary Care	Royal College of Physicians	YES	YES
b.	Adult Asthma Secondary Care	Royal College of Physicians	YES	YES
c.	Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians	YES	YES
d.	Pulmonary Rehabilitation-Organisational and Clinical Audit	Royal College of Physicians	YES	YES
15.	National Audit of Breast Cancer in Older Patients [1, 2]	Royal College of Surgeons	YES	YES - Automatically collected via NCRAS, HES data
16.	National Audit of Cardiac Rehabilitation	University of York	YES	YES
17.	National Audit of Cardiovascular Disease Prevention	NHS Benchmarking Network	NO	N/A
18.	National Audit of Care at the End of Life	NHS Benchmarking Network	YES	YES
19.	National Audit of Dementia	Royal College of Psychiatrists	YES	Now delayed until 2022/2023
20.	National Audit of Pulmonary Hypertension	NHS Digital	NO	N/A
21.	National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	YES	YES

Count	Programme / work stream (A-Z)	Provider organisation	Eligible to Participate	Participated
	(Epilepsy 12)			
22.	National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK	YES	YES
23.	National Cardiac Audit Programme			
a.	National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	YES	YES
b.	Myocardial Ischaemia National Audit Project	Barts Health NHS Trust	YES	YES
c.	National Adult Cardiac Surgery Audit	Barts Health NHS Trust	NO	N/A
d.	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Barts Health NHS Trust	YES	YES
e.	National Heart Failure Audit	Barts Health NHS Trust	YES	YES
f.	National Congenital Heart Disease	Barts Health NHS Trust	NO	N/A
24.	National Child Mortality Database	University of Bristol	NO	N/A
25.	National Clinical Audit of Psychosis	Royal College of Psychiatrists	NO	N/A
26.	National Comparative Audit of Blood Transfusion			
a.	2021 Audit of Patient Blood Management & NICE Guidelines	NHS Blood and Transplant	YES	NO
b.	2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	NHS Blood and Transplant	NO	N/A

Count	Programme / work stream (A-Z)	Provider organisation	Eligible to Participate	Participated
27.	National Early Inflammatory Arthritis Audit	British Society of Rheumatology	YES	YES
28.	National Emergency Laparotomy Audit	Royal College of Anaesthetists	YES	YES
29.	National Gastro-intestinal Cancer Programme			
a.	National Oesophago-gastric Cancer	NHS Digital	YES	YES
b.	National Bowel Cancer Audit	NHS Digital	YES	YES
30.	National Joint Registry	Healthcare Quality Improvement Partnership	YES	YES
31.	National Lung Cancer Audit [1,]	Royal College of Physicians	YES	YES
32.	National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	YES	YES
33.	National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	YES	YES
34.	National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	YES	YES
35.	National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative	NO	N/A
36.	National Prostate Cancer Audit	Royal College of Surgeons	YES	YES
37.	National Vascular Registry	Royal College of Surgeons	YES	YES
38.	Neurosurgical National Audit Programme	The Society of British Neurological Surgeons	NO	N/A

Count	Programme / work stream (A-Z)	Provider organisation	Eligible to Participate	Participated
39.	Out-of-Hospital Cardiac Arrest Outcomes Registry	University of Warwick	NO	N/A
40.	Paediatric Intensive Care Audit	University of Leeds / University of Leicester	NO	N/A
41.	Prescribing Observatory for Mental Health			
a.	Prescribing for depression in adult mental health services	Royal College of Psychiatrists	NO	N/A
b.	Prescribing for substance misuse: alcohol detoxification	Royal College of Psychiatrists	NO	N/A
42.	Respiratory Audits			
a.	National Outpatient Management of Pulmonary Embolism[3]	British Thoracic Society	YES	YES
43.	Sentinel Stroke National Audit Programme	King's College London	YES	YES
44.	Serious Hazards of Transfusion	Serious Hazards of Transfusion	YES	YES
45.	Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	YES	YES
46.	Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	BURST Collaborative / British Urology Researchers in Surgical Training	YES	YES
47.	Trauma Audit & Research Network	The Trauma Audit & Research Network	YES	YES
48.	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	YES	YES
49.	Urology Audits			
a.	Cytoreductive Radical Nephrectomy Audit	British Association of Urological Surgeons	NO	N/A

Count	Programme / work stream (A-Z)	Provider organisation	Eligible to Participate	Participated
b.	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	British Association of Urological Surgeons	NO	N/A

Participation in NCEPOD Studies (National Confidential Enquires into Patient Outcomes & Death)

Study Title	Eligible to Participate	Participated
Dysphagia in Parkinson's Disease	YES	YES
In Hospital Management of Out of Hospital Cardiac Arrests	YES	YES
Physical Healthcare in mental health hospitals	YES	YES
Transition from child to adult health services	YES	YES
Epilepsy	YES	YES
Crohn's Disease	YES	YES
Community Acquired Pneumonia	YES	YES

Annex A:

This section outlines the comments received from stakeholders on this Quality Account prior to publication.

Wigan Borough Clinical Commissioning Group Response to Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust Quality Account 2021/22

Wigan Borough Clinical Commissioning Group (the CCG) welcomes the opportunity to comment on the fourteenth Quality Account for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWLFT).

The CCG acknowledges the level of partnership working that has been undertaken by WWLFT during 2021/22 to improve the quality, safety and experience of care for our residents and to support the Boroughs response to and recovery from the COVID-19 pandemic.

In respect of the quality priorities identified in the 2021/22 Quality Account the CCG acknowledges progress has been made in a number of areas; of particular note is:

▪ A 67% reduction in category 3, category 4 and unstageable pressure ulcers contributed to by lapses in care

▪ A reduction in Summary Hospital Level Mortality Indicator to 1.0452, which is within the expected range

▪ Work undertaken improve patients experience of discharge

▪ The delivery of human factors training to 71% of ward managers

During 2021/22 there has been an increase in the number of serious incidents reported under the category of 'Treatment Delay meeting the SI criteria'. The CCG has worked with the Trust to understand the reasons for the increase and to identify the actions required to reduce harm from these. Additional work is required in 2022/23 to further reduce harm caused by delays in treatment.

The CCG supports the quality priorities identified for 2022/23 and particularly welcomes the focus on the following areas which the CCG has also identified as priority areas for improvement:

▪ Achieving a 25% reduction in mortality related to sepsis

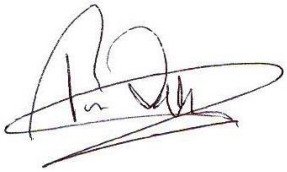
▪ Achieving a zero preventable category 3 and 4 pressure ulcers in both the hospital and community setting

▪ Accurately recording 100% of National Early Warning Score 2, Paediatric Early Warning Score and Modified Early Warning Score to reduce the risk of failure to recognise deteriorating patients

▪ A reduction in 12 hour waits in the Emergency Department

▪ Improving the equality, diversity and inclusion of the Trust by increasing diversity and accessibility, reducing inequality and improving the experience of protected groups

We note the Trust continues to be rated ‘Good’ overall by the CQC and ‘Good, in the Safe, Effective, Caring, Responsive and Well Led domains. The Trusts ‘Use of Resources’ is also rated ‘Good’.
We will continue work in partnership with the Trust and other stakeholders during 2022/23 to ensure the continuous focus upon improvement in order to provide the best possible care for our residents and to ensure smooth transfer of our current system into the Greater Manchester Integrated Care System.



Dr Tim Dalton, Chairman,
Wigan Borough CCG

Morag Olsen, Chief Nurse
Wigan Borough CCG

30 June 2022

Annex B: Statement of Directors' Responsibilities in respect of the Quality Report

The Directors of Wrightington, Wigan and Leigh NHS Foundation Trust ("WWL") are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that the NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2020 to March 2021
  - Papers relating to Quality reported to the Board over the period April 2020 to March 2021
  - Feedback from commissioners 28th June 2021
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, May 2021
  - The 2020 national patient survey [not due for publication until June 2021 therefore the Trust has been unable to reference in this report]
  - The 2020 national staff survey dated May 2021
  - CQC inspection report dated February 2020
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

30 June 2022 Chairman

30 June 2022 Chief Executive

Annex C: How to provide feedback on the account

Feedback on the content of this report and suggestions for the content of future reports can be provided by calling the Foundation Trust Freephone Number 0800 073 1477 or by emailing: foundationstrust@wwl.nhs.uk