Wrightington, Wigan and
Leigh Teaching Hospitals
NHS Foundation Trust

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust Quality Accounts 2024-25

Contents

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.

Part 1: Statement from the Chief Executive

I am very pleased to present the 2024/25 Quality Report for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

We are 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.

The Trust is always strengthening its focus on quality and continuous improvement, and we welcome this opportunity to outline our performance during 2024/25. We have continued to progress improvements and enhance our services for our patients, colleagues, and the public. Therefore, this Quality Account demonstrates the significant work that has been undertaken to develop and enhance our services, progress against key performance indicators and improve the quality of our services; highlighting some of the work we have undertaken during 2024/25. Finally, the Quality Account details key areas for continuous improvement during 2025/26.

We continue to build on our status as a teaching hospital and continue work towards becoming a university teaching organisation within the next few 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.

The delivery of quality is dependent on several 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. 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. Every interaction with patients, relatives, carers and beyond by our staff contributes to the excellent patient care we provide.

We also recognise the importance of learning lessons when things do not go as planned and during the year. This focus has been further embedded during the financial year 2024/25, using the Patient Safety Incident Response Framework and we have embraced the systematic change in the way we manage and investigate incidents to harness quicker learning and therefore able to implement changes sooner following incidents.

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.

Mary Fleming

Chief Executive and Accounting Officer

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

Part 2.1: Our new priorities for Improvement in 2025/26

Quality Priorities for 2025/26

WWL has four strategic areas that have priorities around them. These surround our patients, our people, our performance and our partnerships. These have been updated for 2025/26, taking into consideration the changing requirements of the NHS and recognising the dynamic nature of the communities. 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 2026 and progress to achieve them is ultimately monitored by the Board of Directors.

Our Patients **Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience**		
Objective purpose		**Lead Executive**
To improve the quality of care for our patients and residents.	✓ Right patient, right ward, right professional, right time for 80% of patients with heart attack, stroke, acute abdomen or fractured neck of femur to reduce harm and mortality ✓ Fundamentals of care ✓ Harm free Care ✓ Ensuring no unnecessary interventions	**Medical Director / Chief Nurse**
To ensure that our residents and patients have the best possible experience of our care	✓ Putting patients and residents at the heart of decision making; about their own care and about design of services ✓ Developing a culture among our teams which gives patients the power ✓ Support patients to manage their own care, particularly making use of digital approaches (e.g. patient initiated follow ups, digital apps, self-booking) ✓ Clear, accurate patient communication ✓ Review our estates through the eyes of our patients and residents ✓ Develop a deeper understanding of patient experience by making it easier for them to provide feedback, e.g. provide digitally enabled feedback via QR codes	**Medical Director / Chief Nurse**

To promote early detection and intervention, preventing avoidable ill-health.	✓ Redesigning community services across Wigan around the needs of communities and reducing duplication (working in partnership with primary care, social care, mental health, voluntary sector, WWL community services) ✓ Focus on prevention, with specialties using data and working with primary care to support identification of inequality in outcomes and opportunities to intervene earlier ✓ Alignment of health promotion opportunities within our services	**Medical Director / Chief Nurse**

Our People **To ensure wellbeing and motivation at work and to minimise workplace stress**		
Objective purpose	**Focus of objective**	**Lead Executive**
Make WWL a great place to work and ensure that our staff feel valued	✓ Well-developed compassionate and brilliant leaders ✓ Visible leaders who listen to feedback and act upon it ✓ Ensure clear wellbeing offer is present ✓ Provide opportunity for our staff to be recognised for the great work they do. ✓ Work with Wigan Locality partners to ensure we are supporting people into employment ✓ Empower our staff to be creative and innovative to enable improvement ✓ Prioritise recruitment into hard to fill roles ✓ Support our staff to speak up ✓ Ensure equality, diversity and inclusion exists for all and raise the voice of minority groups ✓ Develop a financially sustainable workforce plan that meets the transformation needs both relevant to WWL and that of the NHS Plan.	**Chief People Officer**

Our Performance Our ambition is to consistently deliver efficient, effective and equitable patient care		
Objective purpose	**Focus of objective**	**Lead Executive**
Foster a sustainable, efficient and productive financial environment	✓ Delivery of financial statutory duties ✓ Transform and innovate to achieve sustainable improvement and to manage within our resources ✓ Enhance productivity across all areas through implementing best practices, leveraging technology and streamlining processes to improve outcomes.	**Chief Finance Officer**
Drive improvements in our overall performance, placing patients at the centre of everything we do. Take our opportunities to be outstanding	✓ Embed doing the basics brilliantly as our standard ✓ Continue improving integration across our divisions and with external organisations ✓ Ensure that WWL is the preferred place of treatment for our patients, where appropriate ✓ Ensure relevant dashboard information is available to wards leaders to influence quality of care delivery ✓ Utilise staff surveys and patient feedback to drive improvements ✓ External projection of good news stories ✓ Active targeting of income opportunities (i.e. repatriation from private providers)	**Chief Operating Officer**
Optimise delivery of our elective and non-elective services	✓ Implementation of the Better Lives programme and work with the wider system to keep patients out of acute settings where suitable to release pressure on UEC services and rationalise demand for elective services to those who truly need them. ✓ Improve UEC flow to positively impact staff morale and patient experience ✓ Optimise the usage of our Elective Hubs to improve waiting list performance. Opportunity to further increase the acuity threshold at Leigh through innovation (e.g. use of telemedicine) ✓ Leverage the status of our Elective Hubs as GM assets	**Chief Operating Officer / Chief Finance Officer**

Our Partnerships: To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester		
Objective purpose	**Focus of objective**	**Lead Executive**
To further strengthen existing partnerships and develop new ones to complement and support our NHS services and research activities	✓ Shared ownership across organisations in Wigan to solve tricky system issues. ✓ Development of a workforce without organisational barriers across the locality. ✓ Working with primary care to develop shared specialist care (including advice and guidance, shared care, special interest) ✓ Focus on new and existing partners within Wigan, across GM and with neighbouring ICBs ✓ Our Commercial Opportunities programme will seek to identify and support income generation for the Trust via the development of private patient and corporate opportunities while maintaining our commitment to patient care	**Deputy Chief Executive / Executive Director of Comms**

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 Participation in Clinical Audits

During 2023/24, WWL participated in 46 National Clinical Audits and 8 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 Participation in clinical audit 2023/24 is listed in **Appendix 1.**

The reports of National Clinical Audits were reviewed by the provider in 2023/24 and WWL intends to take the following actions to improve the quality of healthcare provided. Other national reports will be presented once published.

National Audit	Reported Outcomes
National Paediatric Diabetes Audit NPDA 2021-2022	For completion of health checks, the Trust are 99.3% compliant in HbA1c. This is following an improvement plan to increase compliance. The Trust are 100% compliant in offering additional appointments/advice /training, screening at diagnosis.
National Paediatric Diabetes Audit of PREMS 2021 - 2022	90% of patients would recommend clinic to friends or family if they had diabetes. Our results are higher than England and Wales who scored 89%. Most of the comments from parents/carers were positive. Both parents/carers and children felt face to face appointments were better.
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Plans are in place to improve on appropriate first paediatric assessment, to ensure ECG is done in all children presenting with convulsive seizures and to adhere to NICE recommendation that children and young people presenting with suspected seizure are seen by a specialist in the diagnosis and management of epilepsies within 2 weeks of presentation (Quality statement 1).
National Neonatal Audit Programme (NNAP)	When giving antenatal steroids to mothers who deliver babies between 24-34 weeks we achieved a rate of 65% compared to 57% in the NW and 52% nationally in 2022. Improvement has been seen in 2022 in the number of babies <32/40 who had their temperature taken within an hour after birth; the result of which was in target range of 36.5-37.5. In 2022 we were 9% higher than the national and regional rate. There are improvement projects underway, including a ward care bundle.

National Audit	Reported Outcomes
The National Asthma and COPD (chronic obstructive pulmonary disease) Audit Programme	The COPD national audit showed WWL to have a low number of patients who received the discharge bundle. An improvement plan was put in place which has shown an improvement.
TARN audit (Trauma Audit and Research Network) now NMTR (National Major Trauma Registry)	Data showed that WWL did not have good case ascertainment, an improvement plan has been put in place to increase the number of patients submitted, however, results will not be evident for a while due to the changes made to the national audit.
Child Health Clinical Outcome Review Programme 1 - Transition from child to adult health services	Report shared at Divisional Quality Meeting and improvement plan implemented to meet the recommendations of the report.

The reports of 280 Local Clinical Audits were reviewed by the provider in 2023/24. A selection of these audits outlined below show improvements which have taken place from previous audits.

Speciality	Title	Success
Community	Diagnosis & Treatment of Community Acquired Pneumonia within the Community React Team	Improvement from 55% to 100% in patients prescribed the correct dosage and duration of doxycycline following improvement work to highlight awareness of NICE guidance and latest practice.
Audiology	Implementation of Hearing Aid Verification – community audiology paediatric	Improvement from 44% to 92% in patients receiving real ear measurements following improvement work to ensure patients receive new ear moulds prior to annual review.
Orthopaedic	Assessing bone health referral in acute vertebral fractures under Orthopaedic care	New referral pathway instigated for patients with osteoporosis. Teaching and awareness sessions implemented. IT changes to electronic patient record to allow recording of scoring, resulting in improvement in the number of patients attending specialist clinics (11% to 56%), patients initiated on bone protection (28% to 80) resulting in improved care with the potential to reduce fractures.
Urology	Audit of documentation of bladder cancer diagnostic information at flexible cystoscopy	A change in pathway and introduction of bespoke proforma led to improvement from 71% to 97% for documentation of stratification located tumours.
Neonatal	Shoulder Dystocia Audit	Documentation of anterior shoulder / occipital position was only recorded for 56% of cases, improvement plan instigated to include an IT solution to promote improvement documentation, seeing an increase to 100%.

Speciality	Title	Success
Endocrinology	Inpatient audit on use of IV insulin	Only 65% of patients had insulin prescribed and correctly administered. Extensive bespoke training, and generalised training to around 200 staff saw an improvement to 85%. The remaining 15% was in one area, which has now had bespoke intensive training.
Gynaecology	VTE Audit	VTE reassessment had markedly declined to 6%, improvement work put in place including VTE champion. Subsequent audit showed an improvement to 98%.
Orthopaedic	Pre-operative hydration of patients undergoing elective orthopaedic surgeries	Only 64% of patients had a fluid plan in theatre, improvement work including creating designated staff role and standardised proforma saw an improvement to 78%.
General Medicine	AKI Mortality Improvement Plan	Mortality rates for AKI were higher than expected (SHMI value over 100). Improvement work regarding care of patients with AKI alongside work around documentation and coding led to a decrease in mortality relative risk of 32 which is markedly below average.
Ophthalmology	Glaucoma Follow up Appointments	Only 47% of patients were being seen in the required time-period. Improvement plan initiated including local database of high-risk patients. Re-audit showed an improvement to 71%, improvement work is still on-going and further re-audits planned.
Anaesthetics (Pain Team)	Care of Patients with Fractured Ribs	Standards for patients with fractured ribs needed to improve, improvement plan including change of culture, increased education, change of practice and cohesive MDT working led to a pronounced improvement in all metrics, including rib fracture score completed in A&E from 10% to 61%, completed during admission 20% to 96% and admitted directly to surgical ward 50% to 85%.

Speciality	Title	Success
Care of the Elderly	Improving Advanced Care Planning in Severe Frailty – Two Year Summary.	An initial audit had shown that no patients with a Clinical Frailty Score of 7 or over had an element of an Advanced Care Plan completed as recorded on the discharge letter. An improvement plan including education, awareness, MDT working, IT solutions and prompts led to an overall improvement to 56%. Work is still ongoing.
Orthopaedic	Reducing Length of Stay in Hip Replacement	Length of Stay following hip replacement was 3 days. An improvement plan using GIRFT recommendations was instigated involving an MDT approach, improving mobilisation and pain relief, which saw an improvement to 1.9 days.
Corporate	Improving Sepsis Care at WWL using AQ (Advancing Quality)	The Trust recognised a need to improve care of sepsis, and an improvement plan agreed to improve compliance of the sepsis 6 bundle. This saw an improvement in all areas, most notably an increase in blood cultures from 8.7% to 50%.

2.2.2 Research

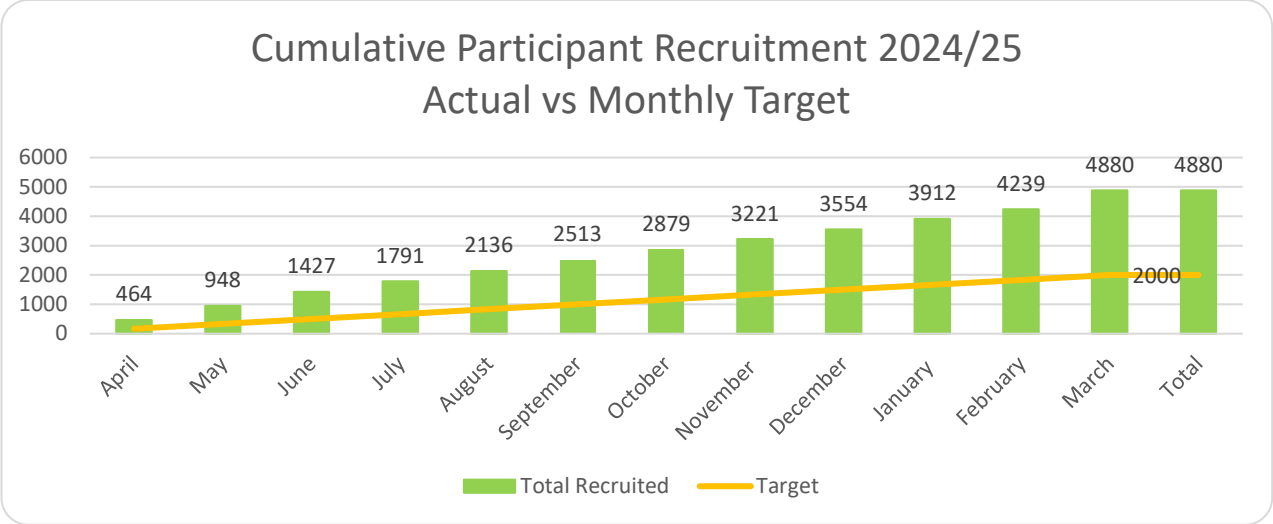
Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement and offering *Research for All*. Our clinical staff are continually invited to express interest in new NIHR Research Delivery Network (RDN) Portfolio studies and growth in research is a core aim of WWL's 5-year Research Strategy (*Research for All* 2022-26).

It is globally recognised that a commitment to clinical research leads to better outcomes for patients. Reflecting these objectives to:

- ✓ **Increase research taking place across the Trust and Primary Care.**

Currently, there are 20 different specialities delivering 96 RDN Portfolio adopted clinical studies.
The number of WWL patients that were recruited to participate in research during 2024-2025 (approved by the HRA and adopted onto the RDN Portfolio was 4880 (a substantial increase to the previous report for 2022-23 of 2467 recruits), an average of 406 patients per month (compared with 196 patients per month in 2022/23). The Trust target agreed with the NIHR Clinical Research Network (CRN) for the 2024/25 financial year was 2000 recruits. WWL has therefore substantially exceeded the Research Network set target.

The chart below illustrates target versus actual participant recruitment to research studies in 2024/25.



The portfolio of studies continues to thrive in 2024-25 as the current figures demonstrate, following a period of fluctuation during the COVID-19 pandemic (2020-21) where the number of studies reduced from 100 to 79 and in 2022-23 restoring to pre-pandemic levels.

Our Research Strategy aims to increase the research capacity and capability, and the number of clinical staff involved and interested in research has grown. The number of clinicians acting as Principal Investigators increased from 55 in 2019-20 to 77 in 2022-23, with 61 currently delivering 96 active studies in 2025-25.

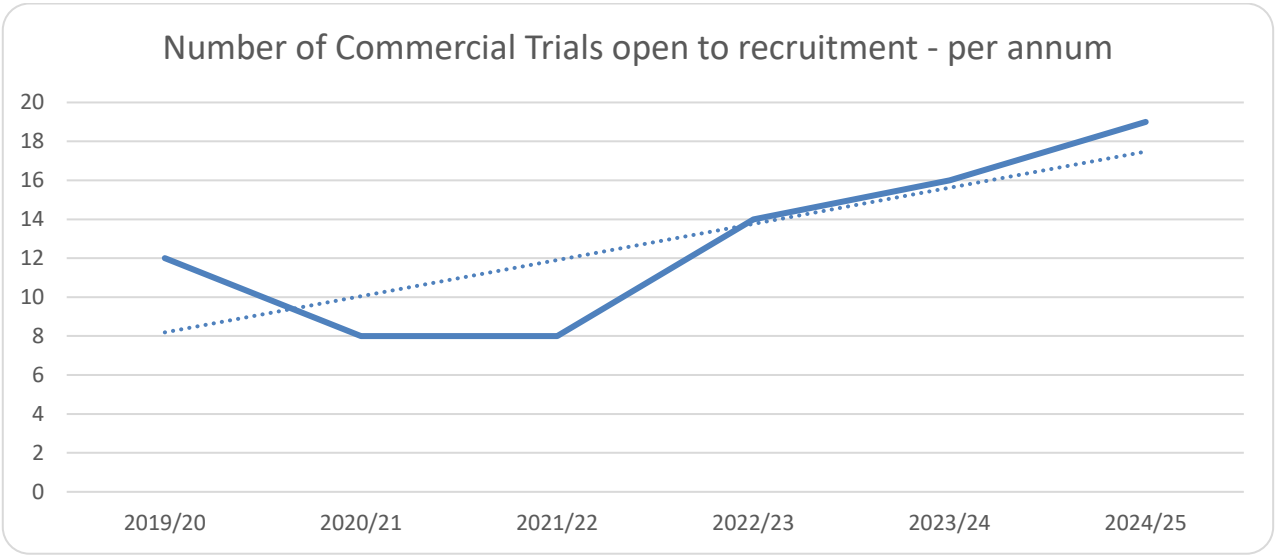
Research active specialties include: Ageing & Complex Needs, Cardiology, Cancer, Critical Care, Diabetes, Ear Nose and Throat (ENT), Emergency Medicine, Gastroenterology, Orthopaedics, Reproductive Medicine, Respiratory and Surgery. Areas of focus for improvement in research activity include: Dermatology, Rheumatology, Paediatrics and Community Services.

Primary Care - A strategic project was delivered in 2024 across our health and care providers in the Wigan Borough, developing relationships and partnerships for research, links with GP practices, Primary Care Networks and GP Federations have been initiated and subsequent collaboration in the delivery of research is planned.

A Wigan Health and Care Research Forum has also been established in July 2024 along with Wigan Borough Council Public Health Team and including all interested stakeholders across the Borough. Four forums have been held with the latest event focussing on diabetes. There are 77 current members registered and each meeting attracted around 35-45 delegates from across health and care sectors and the voluntary sector.

- ✓ **Increase number of commercial trials delivered with high performance meeting national KPIs.**

The number of commercial trials has increased each year since 2019-20.



The portfolio is monitored and delivered to achieve the national Key Performance Indicators (KPIs) e.g.

- Initiation of Research (set-up time and to opening – 60 days following HRA approval)
- First participant recruited (within a further 30 days)
- Research delivered to Time and to recruitment Target (RTT >80% of studies achieving RTT)

✓ **Increase research knowledge and capability to deliver research.**

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. Additional induction and training/development opportunities are provided by the Research Department to support staff in conducting quality research studies in a safe and effective manner reducing the inherent risk of research delivery.

The clinical research team supports all clinical teams conducting research studies across the Trust.
The Community Clinical Research Hub, established in 2023 brings research closer to patients' homes and provides a more accessible venue for our patients to engage and take part in research (with favourable feedback), and provides open access to the facility to our healthcare partners across the Healthier Wigan Partnership.

The Research Team provide expert support and advice to all colleagues ensuring the safe care of patients when they are recruited to research at WWL, and ensure adherence to the European Directive, Good Clinical Practice guidelines and data protection and all relevant laws. As a result of this expert support, the larger clinical community within the Trust is enabled to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

The ongoing development of our Research Patient Public Involvement (PPI) group influences the way that research is designed and to encourage more awareness and interest, we continue to engage with Wigan residents to continue to expand the diversity of the patient and public involvement. The numbers contributing to our research have increased in the last 2 years from 17 to 60+ individuals with topic specific lived experiences. Members help to identify which research questions are important and help to influence the way research is carried out to help WWL improve the experience of people who take part in research.

Publications are encouraged to ensure research knowledge and outputs are shared in multiple ways with the healthcare sector across the world and with our patients and staff.

- ✓ **Increasing NIHR funded research studies/programmes led by WWL.**

It is important that we continue to support both pilot studies in preparation for grant submissions to the National Institute for Health Research (NIHR), and to support this aim, the Research Team has developed links with Edgehill University and other universities to build new collaborations and locally provide initial advice and support via our grant support service. The Sponsorship of research has also been strengthened with the development of the Sponsorship Policy and review process and the team currently manages 9 WWL Sponsored studies. These improvements demonstrate our commitment to patient safety, assurance and to improve patient outcomes and experience of research in the NHS.

Over the last 5 years, the Trust has attracted 3 NIHR project grants (1 trial is still active) and has submitted at least 2 project competitive grant submissions to the NIHR annually, with no new project grant successes as yet. The Trust has however been very successful in attracting NIHR fellowships/training funding (NIHR Pre-doctoral Fellowship x1, preparation for NIHR Doctoral Fellowships x2, NIHR INSIGHT x1, NIHR Credentials x1, NIHR Senior Research Leader Nursing and Midwifery x1, NIHR Developing Research Leader x1 submitted pending.

WWL, through its NIHR research capacity funding, funds protected time for 5 Clinical Research Leads across the Trust working to improve research engagement within the clinical divisions, community and the non-medical professions. The latter 2 Clinical Leads, alongside the Sponsorship Team, have established a Research Incubator of staff interested in research and in developing research careers, and hosts ~70 interested individuals who receive training and newsletters/communications about research training, funding opportunities and research stories, awards, publications and conference presentations to be celebrated. Around 40 of this group also volunteer to promote research in their departments as Research Champions. Five of these professionals have been supported to apply to the aforementioned training and fellowship schemes with successful funding/protected time to develop their research knowledge and academic skills/careers.

- ✓ **Increasing the number of WWL honorary clinical academics employed substantively with EHU.**

The Trust has increased the number of clinical academics (substantively employed by a University) from 1 in 2021, to 5 in post in 2024-25.

The Trust's ambition is to increase the number of University substantively employed clinical academics holding an honorary contract with WWL, and as such, is in close discussion with our main partner Edgehill University and other universities to achieve growth in this area. There are numerous clinicians who hold honorary appointments with Edgehill University and other Universities.

2.2.3 What others say about WWL

Feedback from the Care Quality Commission (CQC)

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2024/25, is registration without any compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2024/25.

Within 2024/25, WWL was not subject to any onsite inspections.

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 possible. The Trust has continued to carry out a schedule of internal inspections through our ASPIRE ward accreditation process and we therefore believe that is still reasonable to expect that these ratings are valid.

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.

2.2.5 Information Governance Toolkit Attainment Levels

WWL's Data Security Protection Toolkit was submitted in June 2024. The assessment was scored as Standards Met**.** The current Data Security Protection Toolkit has been overhauled and has been renamed as the Cyber Assessment Framework, aligned to the National Cyber Security Centre recommendations. For 2024/25 the Trust will be submitting an improvement plan on June 2025, with an improvement plan submitted to NHS England for approval.

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

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Over the last 12 months the Trust has continued its programme of work for the development and improvement of the Data Quality.

The Trust has been working on improving the series of DQ Apps launched last year which supports 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.

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

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Over the last 12 months the Trust has continued it's programme of work for the development and improvement of the Data Quality.

The Trust has been working on improving the series of quality apps launched last year which supports a more comprehensive picture of how the Trust is performing against key data quality metrics. This has progressed further and there are a number of apps where data is either manually validated and inputted or automatically inputted from systems within the Data Warehouse where data accuracy can be guaranteed.

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.

2.2.7 Learning from Deaths

During the calendar year 2024 there were 1382 deaths in hospital under the care of WWL. Included are deaths within A/E, but not community deaths where the patient dies out of the hospital but still within community care.

Since 2008, there has been a process for reviewing deaths and the process is structured in a way that meets the Learning from Deaths Guidance published in 2017.
The Learning from Deaths team reviewed 698 deaths approximating to half of the deaths within the organisation. These were done within a week of each death occurring and learning is shared widely on a weekly basis. Within the deaths reviewed, there were 5 deaths that were highlighted as being potentially preventable. This represents less than 1% of the reviewed cases.

The learning is summarised as an annual report and this is shared widely within the organisation. This year the report highlighted:

- The pattern of deaths and its links to our aging population. Both locally and nationally.
- Capacity problems faced by the organisation and the normalisation of patients waiting over 24 hours in A/E for a bed.
- Delays in care because of the long wait for admission in A/E.
- Clinical problems with IV fluids, missed diagnoses, corridor care, missed deterioration and deconditioning of elderly patients from extended stays in hospital.

Within the weekly audits issues are raised about individual patients and then further investigation happens through the divisional clinical governance teams. These have addressed issues on a wide range of problems but included:

- Airway issues
- Limb ischaemia
- Sepsis
- Deterioration
- Medication problems

Whilst monitoring care for problems there is also the opportunity to monitor standards of care. Sepsis and Acute Kidney Injury are just such standards, and the work indicates that the standard of care in both these areas is maintained with improvement seen in the care of patients with Sepsis. 68% of patients with sepsis were judged to have care that fulfilled all the components of good sepsis care. The commonest problem being with sending blood cultures.

2.2.8 Seven Day Services

This was Suspended for 2023/24

2.2.9 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 escalated concern.

2.2.10 NHS Doctors in Training

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.

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.

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. 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.

Please note that not all data included within this report is for 2023/24, this is due to publishing timescales from national data collection agencies.

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
Mortality				
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	January 2023 - December 2023	Value: 1.065 Banding – 'as expected'	Value: 1.0034	Best: CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.7202, Banding: 3
				Worst: EAST CHESHIRE NHS TRUST (RJN) - Value: 1.2548, Banding: 1
	December 2023 – November 2024	Value: 1.0492 Banding – 'as expected'	Value: 1.0041	Best: Imperial College Healthcare NHS Trust – Value 0.7016
				Worst: East Lancashire Hospitals NHS Trust – Value 1.2849
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	January 2023 - December 2023	48.0%	42.0%	Best: UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST (RRV) - Value: 67.0%
				Worst: SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST Value : 16.0%
	December 2023 - November 2024	48.0%	44.0%	Best: University College London Hospitals NHS Trust – Value 66%
				Worst: Sherwood Forrest Hospitals NHS Foundation Trust – Value 17%

Patient Reported Outcome Measures Scores (PROMS)

i) Groin Hernia Surgery	*April 2016 - March 2017*	*0.060*	*0.086*	*Best: NEW HALL HOSPITAL (NVC09) & POOLE HOSPITAL NHS FOUNDATION TRUST () - Value: 0.135*
				Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 0.006
	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 2016 - March 2017*	*N\A*	*0.092*	*Best: TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (RMP) - Value: 0.155*
				Worst: ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST (RBN) - Value: 0.010
	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 2022 - March 2023		21.744	Best: SPIRE WASHINGTON HOSPITAL (NT333) - Value: 26.6038
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 6.95254
	April 2023 – March 2024	24.381	22.303	Best: EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST (RVR) - Value: 23.5717
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 7.4951
iv) Knee Replacement Surgery	April 2021 - March 2022		17.482	Best: AIREDALE NHS FOUNDATION TRUST (RCF) - Value: 20.4879
				Worst: ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST (RAN) - Value: 13.8526
	April 2020 - March 2021		17.483	Best: UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST (RTG) - Value: 18.793
				Worst: TGUY'S AND ST THOMAS' NHS FOUNDATION TRUST (RJ1) - Value: 11.7243

Hospital Readmission

The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2021 - March 2022	10.1	12.5	Best: THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RL1) & THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RRJ) - Value: 3.3
				Worst: BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST (RWX) - Value: 46.9
	April 2022 - March 2023	7.5	12.8	Best: THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RL1) - Value: 3.7
				Worst: ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST (RGM) - Value: 302.9
The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from	April 2021 - March 2022	15.1	14.7	Best: BMI - THE HAMPSHIRE CLINIC (NT418) - Value: 2.1
				Worst: TEDDINGTON MEMORIAL HOSPITAL (NNV2J) - Value: 142.0

hospital which forms part of the Trust during the reporting period: aged 16 or over	April 2022 - March 2023	15.8	14.4	Best: HUMBER TEACHING NHS FOUNDATION TRUST (RV9) - Value: 2.5
				Worst: ORTHOPAEDICS & SPINE SPECIALIST HOSPITAL SITE (NQM01) - Value: 46.8

Responsiveness to Personal Needs

The Trust's responsiveness to the personal needs of its patients during the reporting period	*National Inpatient Survey 2019 - 2020*	*66.2%*	*67.1%*	*Best: The Royal Marsden NHS Foundation Trust (RPY) - Value: 84.2%*
				Worst: Lewisham and Greenwich NHS Trust (RJ2) - Value: 59.5%
	National Inpatient Survey 2020 - 2021	*72.5%*	*74.5%*	*Best: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RL1) & Queen Victoria Hospital NHS Foundation Trust (RPC) - Value: 85.4%*
				Worst: Medway NHS Foundation Trust (RPA) - Value: 67.3%

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.	National NHS Staff Survey 2022	62.43%	62.95%	Best: Alder Hey Children's NHS Foundation Trust (RBS) Value - 86.38%
				Worst: The Shrewsbury and Telford Hospital NHS Trust (RXW) - Value: 39.27%
	National NHS Staff Survey 2023	62.47%	64.97%	Best: Alder Hey Children's NHS Foundation Trust (RBS) Value - 88.82%
				Worst: United Lincolnshire Hospitals NHS Trust (RWD) - Value: 44.31%

Venous Thomboembolism

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	*July 2019 - September 2019*	*96.64%*	*95.40%*	*Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) & LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (RY5) - Value: 100%*
				Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 71.72%
	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%

ClostridiumDifficile (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 2023 - March 2024	23.74	18.61	Best: Liverpool Womens (REP) & Moorfields Eye Hospital (RP6) - Value: 0.00
				Worst: Wye Valley (RLQ) - Value: 59.03
	April 2024 - March 2025	30.49	20.29	Best: Liverpool Womens (REP), Moorfields Eye Hospital (RP6) & Birmingham Women's and Children's (RQ3) - Value: 0.00
				Worst: Wye Valley (RLQ) - Value: 59.03

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 if such patient safety incidents that resulted in severe harm or death.	April 2020 - March 2021	8333 Incidents Reported (Rate per 1000 Bed Days 61.9) / 8 Serious Incidents (0.10%)	1550533 Incidents Reported / 6767 Serious Incidents (0.44%)	Best: MEDWAY NHS FOUNDATION TRUST (RPA): Incidents Reported 3169 (Rate per 1000 bed days 27.2) / 56 Serious Incidents (1.77%)
				Worst: NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RM1): Incidents Reported 32917 (Rate per 1000 bed days 118.7) / 67 Serious Incidents (0.20%)

	April 2021 - March 2022	7428 Incidents Reported (Rate per 1000 Bed Days 47.67) / 17 Serious Incidents (0.23%)	1767264 Incidents Reported / 7116 Serious Incidents (0.40%)	Best: MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RD8): Incidents Reported 3839 (Rate per 1000 bed days 23.67) / 18 Serious Incidents (0.47%)
				Worst: PENNINE ACUTE HOSPITALS NHS TRUST (RW6): Incidents Reported 11903 (Rate per 1000 bed days 205.52) / 49 Serious Incidents (0.41%)

Part 3: Other Information

Part 3.1: Review of Quality Performance

This section of the Quality Account provides information on our quality performance during 2023/24. 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.

Patient Safety

Objective:	To enhance patient care through digital transformation
Where we were in 2023/24	This was identified as a new corporate objective for 2024/25 to support the faster development of digital transformation for efficiency within patient care
Where we are at the end of 2024/25	There have been a number of developments over the financial year, including: • We have implemented a new digital system for supporting patient flow, this incorporates the requesting of beds for emergency and elective admissions along with the management of beds for infection prevention, cleaning and for porters to support patient transfers. • As a pilot organisation for Martha's Rule we have implemented a digital solution for the Nurse in Charge to talk to patients on a daily basis and understand how they feel today compared to yesterday to ensure any patient concerns or family concerns are escalated and reviewed. • Within our community react team service we have implemented capability for ePrescribing to enable medications to be dispensed and collected from the patients nominated pharmacy • We have implemented and are rolling out an outpatient radiology results acknowledgement solution to provide support in ensuring al results are seen and actioned by a consultant in an efficient and timely manner. • As part of a greater Manchester initiative we have implemented a chest x-ray artificial intelligence solution to supplement clinical decision and support accurate diagnosis for multiple conditions. This has also provided an efficiency of reviewing urgent findings first to ensure patient pathway management is actioned quickly for better patient outcomes.

Objective:	To improve the compliance of Sepsis-6 care bundles as per Advancing Quality Audit, with the aim to reduce mortality from sepsis
Where we were in 2023/24	During the financial year, whilst some metrics were not at the levels we wanted them to be, we significantly improved indicators including blood cultures, administration of IV antibiotics, serum lactate and appropriate care scores. Sepsis training also increased and was included within induction, face to face sessions and specific training within the Emergency Village, as well as during deteriorating patient training. An ED sepsis quality improvement programme to trial a sepsis nurse bleep for suspected sepsis commenced to support the pathway. Coding meetings were established monthly to ensure that deaths and discharges are coded accurately as sepsis
Where we are at the end of 2024/25	Sepsis training continued within the financial year and we improved overall within the year on every metric. There was a dip towards the end of the financial year and we are working with frontline colleagues to ensure that these improve again. All 6 metrics increased during the financial year overall

Objective:	To improve the care of paediatric patients with Type 1 diabetes up to age 19 focussing on 5 care processes
Where we were in 2023/24	This was a new metric included within the 2024/25 financial year, recognising some areas for improvement
Where we are at the end of 2024/25	We have worked hard to improve this metric and have ensured compliance on most of the processes. Whilst this is still being improved, we have ensured more enhanced care for children suffering with Type 1 Diabetes, care directly provided by WWL and also by the whole Wigan Borough

Objective:	Continue improvements in pressure ulcer reduction. System wide improvements for reducing pressure ulcers
Where we were in 2023/24	The increase in pressure ulcers acquired within the hospital is believed to be a symptom of a system under pressure – overcrowding in the ED leading to lack of skin inspections and off-loading of pressure points, reduced staffing levels in clinical areas to perform skin inspections and pressure ulcer prevention due to continued redeployment of staff
Where we are at the end of 2024/25	The work of the pressure ulcer panel continued within 2024/25 with good progress on control measures. Unfortunately, a small number of high harm pressure ulcers were identified and reported. On initial review, there were a number of issues and the Trust commissioned wide After-Action Reviews into these incidents that involved ward teams that were involved in the care of those patients as well as ward staff who were not to identify learning and implement immediate solutions. These have also been incorporated within the wider Trust pressure action plan that is being reviewed and monitored by the Harm Free Care Group

Objective:	To deliver Human Factors training to at least 900 members of staff
Where we were in 2023/24	Human Factors Training awareness training continued within 2023/24 with 640 members of staff being trained as at the end of March 2024 and so were short of the planned 700 staff trained. This was due to some sickness of trainers and operational pressures. However, we were nominated as one of 5 national finalists for a HSJ Patient Safety Award for our human factors training and commitment.
Where we are at the end of 2024/25	We continued training staff on human factors awareness and a number of sessions were run through the year at a variety of Trust locations. There was a short pause between Jan-March 2025 due to operational pressures and the availability of trainers during this time. As a result, we have now trained a total of 813 members of staff, which was an increase within this financial year of 173. We will continue this training day across 2025/26, recognising the importance of providing this key skill to our staff

Objective:	Continue and build upon the accreditation programme and to include escalated areas within the Emergency Department
Where we were in 2023/24	Within the financial year, inspections continued, and a number of wards and teams achieved silver status. The annual review of the content of the ASPIRE framework We developed and trialled an ASPIRE programme for the Emergency Village in February 2024, prior to the CQC unannounced inspection, we are also in the process of developing an ASPIRE visit indicators for Maternity services and Community services, which will be reviewed within 2024/25.
Where we are at the end of 2024/25	The Aspire programme was improved and strengthened across the financial year with a consultation to fundamentally overhaul the system to move forward for 2024/25. This will align more closely to the new CQC standards of inspections and other key inspection regimes to ensure that we are in compliance with national and local standards

Objective:	Deliver timely and high-quality responses to concerns raised by patients, friends and family
Where we were in 2022/23	The financial year was challenging, with a 24% increase in the numbers of complaints received. We did see a maintenance of a much higher response rate than in previous years, with a number of months exceeding 81% compliance. However, our overall financial year performance 72%.
Where we are at the end of 2023/24	This year continued to be challenging with the Trust not meeting the target set for responses. Changes this financial year have included introduction of a regular review of complaints by the Chief Nurse with the Divisional Directors of Nursing, targeted education programmes with teams to avoid complaints, a greater emphasis of matron on call and a drive to deescalate complaints by earlier conversations with complainants. Going into the next financial year this will be improved and logged within the Datix Complaints module to manage this further.

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	2022/23		2023/24		2024/25
Infection Control					
Clostridium difficile (C. *difficile*)	35 Threshold= 0	↓	23 Threshold = 0	↓	21
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	1	↓	0	↔	0

C.difficile:

In 2024/25 each case underwent a detailed individual patient to ascertain any lapses in care. Irrespective of this, comprehensive action plans were drawn up to address any learning that resulted from these investigations and progress is monitored at the Infection Prevention Control Group. There were 21 '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:

There were no cases logged as attributable to the Trust in 2023/24. This year saw the launch of the 'gloves off' campaign to promote good infection control and this campaign will continue in 2024/25.

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

Indicator	2022/23		2023/24		2024/25	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	4	↓	2	↑	6	

In 2024/25 we saw 6 incidents that were classified as 'never events' under the national framework definitions. This was concerning for us and, whilst each incident was investigated on it's merits, we also identified a theme around wrong site injection across the financial years of reports. This prompted a thematic analysis, and a key area of improvement is around the Local Safety Systems for invasive Procedures, LocSSIPS. A group has been established to review all processes to ensure they reflect the learning from these incidents, as well as ensuring that the latest safety systems are implemented. It is also noted that, whilst each incident is deeply concerning and has been investigated thoroughly, as compared

the number of procedures of this nature carried out every year, this number is thankfully small, however, we recognise the need to ensure that the best safety systems are in place.

Data Source: Datix Risk Management System. 'Never Events' are governed by standard national definitions.

Accident and Emergency (ED)	**2022/2023**		**2023/24**		**2024/25**
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	68.62%	↓	68.92%	↑	70.61%

WWL ED performance against the National 4-hour target of 95% has improved slightly in 2024/25, up to 70.61%.

The Trust again saw record attendances within 2024/25 and this has impacted on the Emergency Village, with a reduction of patients being discharged from wards. This has caused a significant delays within the department in being able to transfer those patients who require beds.

Attendances at the Walk in Centre increased and improvements in streaming continues and further work has been done to support longer opening of the Same Day Emergency Care (SDEC) unit to support further streaming at later times. The Trust Escalation Assurance Group continues to review all issues around escalation and has worked on development of an escalation app that triangulates key information so that this group can monitor wider issues and define changes as required.

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

Cancer Waits	**2021/22**		**2022/23**		**2023/24**
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	75.29%	↓* ↓**	74.54%	↓	73.53%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	87.37%	↓*	84.07%	↓	78.03%

WWL's overall performance for all standards related to the 62-day cancer waiting times in 2023/24 have been affected throughout the year by a number of factors within different services, however in certain specialties such as colorectal, there has been good performance. A number of specialties have seen capacity challenges and we continue to work with our GP colleagues to ensure that appropriate referrals are being made.

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

Data Source: NHS Digital, as governed by standard national definitions.

Complaints, Patient Advice and Liaison Service and the Parliamentary & Health Service 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 discussed at our weekly Learning from Patient Safety Events Group which was established in January 2024 in line with our launch of the Patient Safety Incident Response Framework. These have corporate and divisional representation from medical, nursing, midwifery and allied health professionals and gives an opportunity to review any complaint received with the more complex and serious complaints highlighted. Where appropriate, certain complaints may be escalated for further investigation via the Patient Safety Incident Response process. These meetings also provide the opportunity to triangulate information with 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) within quarterly reports to a variety of groups and the Quality & Safey Committee. 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.

We understand that every concern or complaint is an opportunity to learn and make improvements for our future patients, their relatives and carers. We also recognise that handling complaints and concerns effectively matters for people who use our services and explanations and apologies, if required, are provided. Feedback of any nature are welcomed to learn and reflect on how we work and to make the appropriate improvements. 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	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

families regarding the care and treatment provided to patients in hospital.	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 2023/24 the PHSO requested information regarding 7 complaints. Some of these relate to historical complaints as there has been a backlog of processing cases by the PHSO. On receipt of every outcome from the PHSO results in an action plan that is monitored within the Division

Part 3.2 Quality Initiatives

The Trust has 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 2024/25 is outlined below**.**

Ward Accreditation

The Trust's Ward Accreditation (ASPIRE) has continued througout 2024/2025 which was designed to support nurses and healthcare professional in practice to understand and measure how they deliver care. The ASPIRE accrediataion tool incorporates a number of quality indicators based on fundamental standards of clinical care. The standards reflect local, regional and national best practice, guidance and regulations that we would expect to have within all of our wards. The ASPIRE visits are conducted by a small team of collegues which is led by either the Associate Chief Nurse for Quality and Patient Experience or the Clinical Quality Lead for the organisation. Membership of the inspection team has included the

Corporate Nursing Team, Clinical Governance Team and collegues from the Intergated Care Board (Wigan Locality).

The Trust had 5 objectives relating to the AsPIRE program for 2024/2025 which included the following:

Trust objectives 24/25 relating to ASPIRE

1. Review and refresh the accreditation programme.
2. Increase the number of gold wards by 100%
3. Increase in Platinum wards by 100%
4. All wards and Departments to have had full ASPIRE review
5. ASPIRE Assurance Group to be commenced and established

A total review of the ASPIRE program has been undertaken across Q4 of 2024/25, with a number of stakeholders involoved in the review. The refreshed framework has been updated following feedback and now incorporates the CQC quality statements, the inspection process has also undergone a review to ensure that there are greater opportunities to share learning and good practice. The new accreditation tool will be launched across the organisation in Q1 of 2025/26.

The Trust is pleased to share that in 2024/25, three wards have achieved gold accreditation. This remarkable achievement is testament to the dedication and hard work of ward teams, leadership and the drive to improvement quality of care.

The Trust did not award any Platinum awards across 2024/25.

The Trust recognised that whilst good progress had been made with the current ASPIRE tool, and a number of wards have now achieved silver status. ASPIRE has created a culture of pride and accomplishment and helped frontline teams to understand the core standards, how these standards are measured and how well the ward is delivering care for our patients.

All wards and departments except for Maternity and Peadiatrics had an ASPIRE acrediation in 2024/25. An onjective for 2025/26 is to develop tailored acreditation tools for specialist areas including; theatres, paediatrics and maternity.

The ASPIRE program currently reports into the Trust's Quality and Safety Committee.

Clinical Quality Visits / Leadership Walkrounds- Observe, Watch, Listen and Learn "OWLL"

Until quarter 3 of 2024/25, the Trust continued clinical quality visits within several wards. These were designed to complement the ASPIRE ward accreditation process. The link between the two processes meant that wards could gain additional credits from the visits that could contribute towards their overall ASPIRE scores. The Quality Walkrounds ceased in August 2024, and an alternative Quality visit was implemented.

Leadership Walkrounds- Observe, Watch, Listen and Learn "OWLL"

Leadership Quality Walkrounds are recognised as a critical leadership intervention having been developed in America by the Institute of Healthcare Improvement (IHI) in the early 2000s. Walkrounds are intended to provide Executive and Non-Executive Directors (NEDs) with the opportunity to engage with patients, relatives, carers and colleagues. This informal method allows leaders to talk with front-line staff about safety and quality within the organisation and help to build a culture of safety within the organisation. Leadership visits aim to connect senior leaders with colleagues as a way both to inform senior leadership about issues, whilst demonstrating senior leaders' commitment to improving safety, and patient and staff experience.

The OWLL initiative is designed to be an informal reflective/ discussion based rather than inspection / accreditation focused and aims to provide space and time for conversations between patients and senior managers as well as staff and senior managers.

The clinical governance development initiative (HSE, 2014) identified the single most important obligation for any health system is service safety and improving the quality of care. The report of the initiative recommended that health service providers:

● Develop a mechanism for the board or community healthcare organisation to hear directly about patient, carers, service users and staff experiences
● Value, listen and engage with patients and service users in identifying and acting on suggestions to improve their experience of care as well as overall service improvements
● Value, listen and engage with staff in identifying and acting on suggestions for quality improvement including improving their work experience

Leadership Walkrounds can be conducted in any setting including wards, departments, clinics, corridors and community settings. They can also be carried out with groups of staff who affect the care and safety of the organisation for example portering or pathology.

The purpose of the Leadership Walkround is to:
● Demonstrate senior managers' commitment to quality and safety for service users, staff and the public
● Increase staff engagement and develop a culture of open communication
● Create opportunity for senior leaders to capture information about staff and patient experience which triangulates with information shared in formal forums
● Identify, acknowledge and share good practice
● Support a proactive approach to minimising risk, timely reporting and feedback
● Strengthen commitment and accountability for quality and safety
All staff involved in Leadership Walkrounds should be aware of the purpose of the walkabout and understand that this is not an inspection, but an opportunity for open discussion on quality and safety.

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. We have also continued to involve Non-Executive Directors and Governors as part of these teams and those that have participated have been valuable in identifying areas of good practice as well as possible areas for improvement.

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.

Findings from the OWLL visits will be reported biannually to the Patient Experience and Engagement group.

Fundamentals of care

The Fundamentals of Care Framework was launched in February 2025, following feedback from patients and staff, and learning from incidents. As a Trust, we are committed to ensuring that we provide excellent care every time, to all our patients, wherever they may be cared for. The framework has six key ambitions as part of the ‘We Care’ mission, and is patient and staff-focused, enabling WWL to be a great place to both receive treatment and to work.

Each month is a new focused topic of fundamental care, and every month we build on the previous month’s topic. Rather than a ‘top down’ approach, we have begun to challenge teams and wards to interpret the focused topic of the month, whether that be pressure ulcer management, patient experience, hospital acquired functional decline or falls, and how they can champion these topics that is meaningful to their area of practice. As this is in it’s early stages, more detail on outcomes will be able to be provided within the next year’s Quality Accounts.

This is alongside our 'Journey to Excellence', which sees us focusing on a key area every month over the year.

Conclusion

This Quality Account for 2024/25 reflects our continued dedication to delivering high-quality, patient-centred care. Over the past year, we have made significant strides in enhancing our services, embedding the new Patient Safety Incident Response Framework, and improving the quality of our responses to patient feedback and complaints. These efforts are a testament to the commitment and professionalism of our staff across all sites.

As we look ahead to 2025/26, our focus remains on continuous improvement, with clear priorities including the further integration of patient safety initiatives, strengthening our workforce culture, and progressing our ambition to become a university teaching organisation. We are proud to serve the people of Wrightington, Wigan, Leigh, and beyond, and we remain committed to transparency, accountability, and excellence in everything we do.

We welcome feedback from our patients, staff, and partners, and we look forward to working collaboratively

Appendix 1 – National Clinical Audits

Count	Programme / work stream	Provider organisation	Eligible to Participate	Participated
1	Breast and Cosmetic Implant Registry	NHS Digital	YES	NO
2	Case Mix Programme	Intensive Care National Audit & Research Centre	YES	YES
3	Child Health Clinical Outcome Review Programme 1 - Testicular Torsion	National Confidential Enquiry into Patient Outcome and Death	YES	YES
	Child Health Clinical Outcome Review Programme 1 - Transition from child to adult health services	National Confidential Enquiry into Patient Outcome and Death	YES	YES
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	YES	YES
Emergency Medicine QIPS: Workstream				
6	Assessing cognitive impairment in older People	Royal College of Emergency Medicine	YES	NO
	Infection Preventions & Control		YES	NO
	Mental Health self-harm		YES	NO
	Pain in Children		YES	NO
7	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	YES	YES
Falls and Fragility Fracture Audit Programme Workstream				
8	Fracture Liaison Service Database	Royal College of Physicians	YES	YES
	National Audit of Inpatient Falls		YES	YES

	National Hip Fracture Database		YES	YES
Gastro-intestinal Cancer Programme Workstream				
9	National Bowel Cancer Audit	NHS Digital	YES	YES
	National oesphago-gastric cancer		YES	YES
10	Inflammatory Bowel Disease Audit	IBD Registry	YES	NO
11	LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	NHS England and NHS Improvement	YES	YES
Maternal and Newborn Infant Clinical Outcome Review Programme				
12	Maternal mortality surveillance and confidential enquiry. (confidential enquiry includes morbidity data)	University of Oxford / MBRRACE-UK collaborative	YES	YES
	Perinatal confidential enquiries		YES	YES
	Perinatal mortality surveillance		YES	YES
13	Medical and Surgical Clinical Outcome Review Programme 1 - Community Acquired Pneumonia	National Confidential Enquiry into Patient Outcome and Death	YES	YES
	Medical and Surgical Clinical Outcome Review Programme Endometriosis		YES	YES
	Medical and Surgical Clinical Outcome Review Programme 1 - End of Life Care		YES	YES
14	Mental Health Clinical Outcome Review Programme	University of Manchester / NCISH	NO	N/A
15	Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	The British Association of Urological Surgeons	YES	YES

National Adult Diabetes Audit Workstream				
16	National Diabetes Core Audit	NHS Digital	YES	YES
	National Pregnancy in Diabetes Audit		YES	YES
	National Diabetes Footcare Audit		YES	YES
	National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms		YES	YES
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme Workstream				
17	Paediatric Asthma Secondary Care	Royal College of Physicians	YES	YES
	Adult Asthma Secondary Care		YES	YES
	Chronic Obstructive Pulmonary Disease Secondary Care		YES	YES
	Pulmonary Rehabilitation-Organisational and Clinical Audit		YES	YES
18	National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	YES	YES
19	National Audit of Cardiac Rehabilitation	University of York	YES	YES
20	National Audit of Cardiovascular Disease Prevention	NHS Benchmarking Network	NO	N/A
21	National Audit of Care at the End of Life	NHS Benchmarking Network	YES	YES
22	National Audit of Dementia	Royal College of Psychiatrists	YES	YES
23	National Audit of Pulmonary Hypertension	NHS Digital	NO	N/A
24	National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	NO	N/A

25	National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK	YES	YES
National Cardiac Audit Programme Workstream				
26	National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	YES	YES
	Myocardial Ischaemia National Audit Project		YES	YES
	National Adult Cardiac Surgery Audit		NO	N/A
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)		YES	YES
	National Heart Failure Audit		YES	YES
	National Congenital Heart Disease		NO	N/A
27	National Child Mortality Database	University of Bristol	NO	N/A
28	National Clinical Audit of Psychosis	Royal College of Psychiatrists	NO	N/A
29	National Early Inflammatory Arthritis Audit	British Society of Rheumatology	YES	YES
30	National Emergency Laparotomy Audit	Royal College of Anaesthetists	YES	YES
31	National Joint Registry	Healthcare Quality Improvement Partnership	YES	YES
32	National Lung Cancer Audit	Royal College of Surgeons of England	YES	YES
33	National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	YES	YES
34	National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	YES	YES

35	National Ophthalmology Database Audit	The Royal College of Ophthalmologists	YES	YES
36	National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	YES	YES
37	National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative	YES	YES
38	National Prostate Cancer Audit	Royal College of Surgeons	YES	YES
39	National Vascular Registry	Royal College of Surgeons	YES	YES
40	Neurosurgical National Audit Programme	The Society of British Neurological Surgeons	NO	N/A
41	Out-of-Hospital Cardiac Arrest Outcomes Registry	University of Warwick	NO	N/A
42	Paediatric Intensive Care Audit	University of Leeds / University of Leicester	NO	N/A
43	Perioperative Quality Improvement Programme	Royal College of Anaesthetists	YES	YES
Prescribing Observatory for Mental Health Workstream				
44	Improving the quality of valproate prescribing in adult mental health services	Royal College of Psychiatrists	NO	N/A
	The use of melatonin.		NO	N/A
Renal Audits: Workstream				
45	National Acute Kidney Injury Audit	UK Kidney Association	NO	N/A
	UK Renal Registry Chronic Kidney Disease Audit		NO	N/A
Respiratory Audits: Workstream				
46	Adult Respiratory Support Audit	British Thoracic Society	YES	YES
	Smoking Cessation Audit- Maternity and Mental Health Services		YES	NO

				(Currently on Hold by Provider)
47	Sentinel Stroke National Audit Programme	King's College London	YES	YES
48	Serious Hazards of Transfusion National Hemovigilance Scheme	Serious Hazards of Transfusion	YES	YES
49	Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	YES	YES
50	Trauma Audit & Research Network	The Trauma Audit & Research Network	YES	YES
51	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	YES	YES
52	UK Parkinson's Audit	Parkinson's UK	YES	YES

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: 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 and subsequent amendments 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 2024/25 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 2024 to March 2025
  - Papers relating to Quality reported to the Board over the period April 2024 to March 2025
  - Feedback from commissioners
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2024 national patient survey
  - The 2024 national staff survey
  - CQC inspection reports received during the financial year 2024/25
- 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 2025 *Chairman*

30 June 2025 *Chief Executive*

Annex B: 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 Trust Freephone Number 0800 073 1477 or by emailing: foundationstrust@wwl.nhs.uk