

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust Quality Accounts 2025-26



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Foreword

What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual Quality Account to the public about the quality of services they deliver. This includes the requirements of the NHS (Quality Accounts) Regulations and subsequent Amendment Regulations. This publication aims to increase public accountability and drive quality improvement within NHS organisations. Within this document we will review our performance on quality over the previous year, identify areas for improvement, and commit to new quality objectives for the new financial year.

Quality consists of three areas that are essential to the delivery of high-quality services:

- How safe the care is (patient safety)
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

Scope and Structure of the Quality Account

This report summarises how well the Wrightington, Wigan and Leigh NHS Teaching Hospitals Trust (WWL) did against the quality priorities and goals we set ourselves in 2025/2026. It also sets out the quality priorities we have agreed for 2026/27 and how we intend to achieve them.

The report is divided into three parts:

Part One: includes statements from our Chief Executive, Chairman and Chief Nurse.

Part Two: Looks at our performance in 2024/2025 against our quality priorities we set for the year and also sets out the quality priorities for 2025/2026. Part two also includes statements of assurance relating to the quality of services and describes how we review them.

Part Three: Looks at how we identify our own priorities for improvement and gives examples of how we have improved services to patients.

This document is available in an Easy Read version. If you would like this document in another language, large print or braille, please email:

Part 1: Statement from the Chief Executive on Quality

I am delighted to introduce the 2025/26 Quality Account 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 highlight our achievements over 2025/26 that includes the launch of our new Learning, Experimenting, Applying Perfecting, LEAP programme which replaced the previous continuous Improvement drive. More detail on this exciting new programme is contained within this Account and I am proud that this furthers our sustainable improvement capability model aligned to national best practice.

It is fair to say that there have been some challenges through the year, particularly due to the number of patients needing admission with seasonal illness such as flu, norovirus and COVID at peak times for these illnesses. Whilst this was a country wide issue, our teams have worked tirelessly to enhance patient outcomes, improve service accessibility and ensure that the care patients receive meets the highest standards. I want to recognise the hard work of our staff in ensuring safety, driving innovation, and adapting to changes. As a Board, we are clear that the use of escalation beds and temporary spaces is not to be normalised practice in our hospitals and are only used as a last resort and our teams have worked hard to restrict any uses of these escalation spaces to support good patient experience outcomes for those we treat.

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. Every interaction with patients, relatives, carers and beyond by our staff contributes to the excellent patient care we provide and I am proud of every team's effort in ensuring that these interactions are overwhelmingly positive.

I 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 2025/26, using the Patient Safety Incident Response Framework, and we have embraced this systematic change. 2025/26 marked the second year of implementation of this and we are able to see that incidents are investigated quicker and more efficiently, whilst ensuring that vital is still identified, which allows us to then 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

Our Values

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

Part 2.1: Our new priorities for Improvement in 2026/27

Quality Priorities for 2026/27

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 2027 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	Focus of objective	Lead Executive
To improve the quality of care for our patients and residents	✓ To reduce harm through the application of Internal Professional Standards – ensuring we get the right patients to the right ward/specialty, within the right time for patients presenting with heart attack, acute abdomen, stroke or fractured neck of femur	Medical Director
	✓ To improve outcomes and experience by strengthening frailty focused care in hospital and working with partners to develop neighbourhood plans which embed care for our frail elderly residents in the most appropriate setting – building on the Better Lives Programme	
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 care and about the design of services ✓ Developing a culture among our teams which empower our patients and their families ✓ Support patients to manage their own care, particularly making use of digital approaches (e.g. patient initiated follow ups, digital apps, self-booking)	Chief Nurse

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	✓ Improving our communication with patients and residents of the Borough, ensuring it is inclusive of population needs ✓ Review our estates through the eyes of our patients, staff including volunteers 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	
To promote early detection and intervention, preventing avoidable ill health	✓ Endorse the development of the Health Inequalities and Prevention Plan, recognising it as a strategic priority for the Trust and a key enabler of equitable care and improved population health. ✓ Support the establishment of a Health Inequalities and Prevention Group, with appropriate reporting lines and senior leadership chairing arrangements, to provide oversight and assurance on delivery. ✓ Endorse and enable activity against each of the priority areas outlined ✓ Ensure alignment with statutory duties and system-wide priorities, and advocate for the integration of health equity principles across Trust strategies and programmes	Chief Nurse



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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 2025/26, 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 2025/26 is listed in **Appendix 1**.

The reports of National Clinical Audits were reviewed by the provider in 2025/26 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

National Audit	Reported Outcomes
	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.
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 320 Local Clinical Audits were reviewed by the provider in 2025/26. 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	A change in pathway and introduction of bespoke proforma led to improvement from

Speciality	Title	Success
	information at flexible cystoscopy	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%.
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%

Speciality	Title	Success
		and admitted directly to surgical ward 50% to 85%.
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

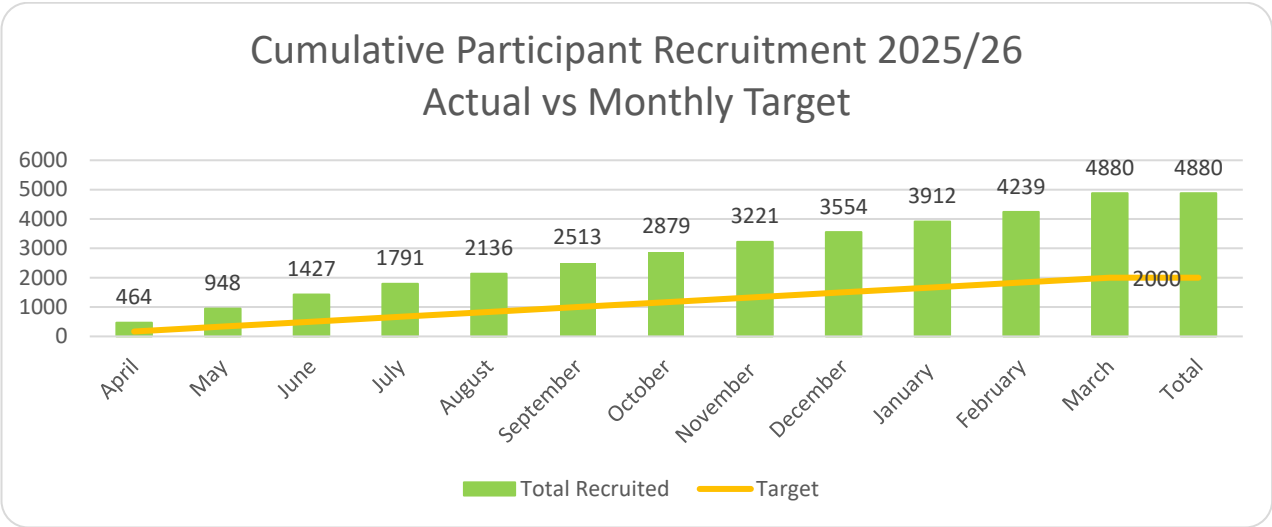
Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement and offering *Research for All*. Our clinical staff are continually invited to express interest in new NIHR Research Delivery Network (RDN) 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 2025/2026 (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 2025/26 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 2025/26.



The portfolio of studies continues to thrive in 2025/6 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.

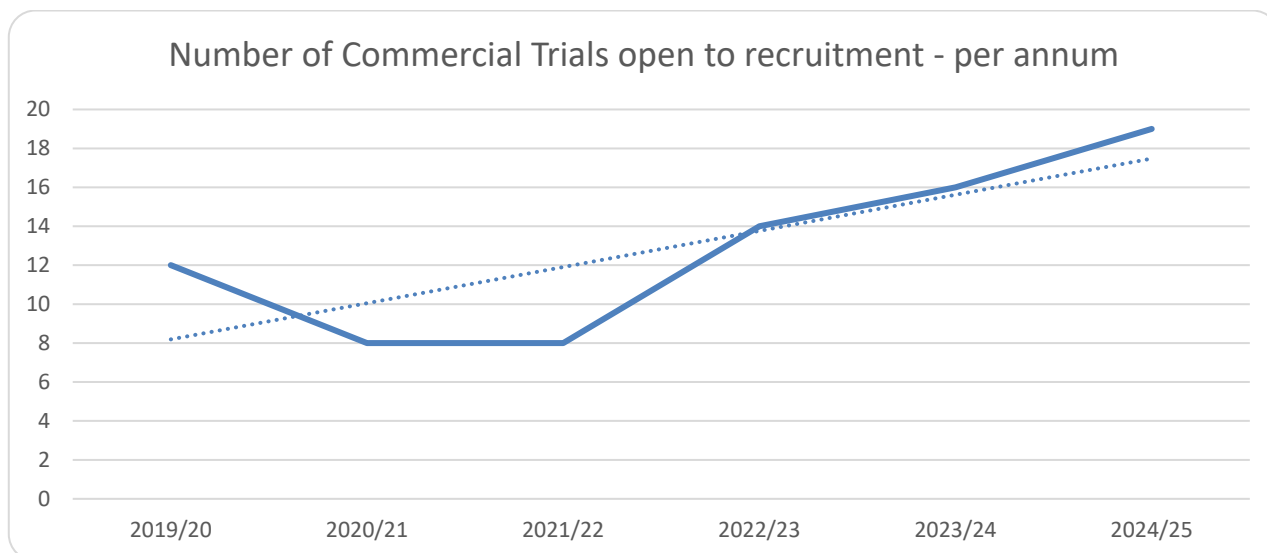
Research active specialties include: Ageing & Complex Needs, Cardiology, Cancer, Critical Care, Diabetes, Ear Nose and Throat (ENT), Emergency Medicine, Gastroenterology, Orthopaedics, Reproductive Medicine, Respiratory and Surgery. Areas of focus for improvement in research activity include: Dermatology,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

Primary Care - A strategic project was delivered in 2025 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, established in 2024 and continues 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.

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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.

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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 2025/26, is registration without any compliance conditions. The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2025/26.

Within 2025/26, WWL we had one any onsite inspection at the Tomas Linacre Centre underwent a comprehensive assessment of both the outpatient department and diagnostic imaging services. The assessment was unannounced and triggered due to the age rating from the previous inspection (2015). An inspection team crossed the threshold 6 January 2026 and spent two days on site. This was followed up with online well led interviews and an extensive request for information; the information was returned on time. There was high level feedback on 8 January 2026, this did not highlight any regulatory breaches from the assessment at that point. The full report is expected to be received during the first week of April 2026, the outcome has the potential to affect our overall Trust rating.

The Trust underwent a focused CQC inspection within our of Nuclear Medicine services under the Ionising Radiation (Medical Equipment) Regulations IR(ME)R assessment in December 2025, this report has been received and the action plan to mitigate gaps has been accepted. There were no enforcement or improvement notices issued from this assessment. Whilst this assessment does not influence our overall rating, we are pleased that our services are externally validated.

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**

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Safe	<u>Good</u> 
Effective	<u>Good</u> 
Caring	<u>Good</u> 
Responsive	<u>Good</u> 
Well-led	<u>Good</u> 
Use of resources	<u>Good</u> 
Combined Rating 	
	<u>Good</u> 

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. We are currently working through the areas of the sites not covered by ASPIRE to assess them against CQC standards and support staff in hosting an external assessment; these are predominantly consisting of outpatient and diagnostic imaging.

We continue 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. We work closely with our regulators and despite frequent changes in the CQC we have managed to maintain good relationships with our CQC Point of Contact with monthly point of contact meetings, in addition to quarterly relationship meetings. We work hard to be responsive to all enquires from the CQC and we are very timely to provide a quality response to each enquiry. We also have an open line of communication with the CQC Point of Contact, and we are proactive in raising any concerns as they occur. The positive working relationship we have with our regulators has streamlined the number of enquiries we manage; the CQC understand how we are managing our pressures, as well as having a good understand of what is going well.

We are expecting further CQC assessments over the next two years as many of our services have not been inspected since 2016, this is a national drive by the CQC to review services where the ratings are significantly old and do not always reflect any specific risks for inspection of a site or service.



2.2.5 Information Governance Toolkit Attainment Levels

WWL's Data Security Protection Toolkit was submitted in June 2025. The assessment was scored as Standards Met. For 2025/26 the Trust will be submitting an improvement plan on June 2026, 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.

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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 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 2025 there were 1339 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 696 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 7 deaths that were highlighted as being potentially preventable. This represents approximately 1% of the reviewed cases. It is significantly below the academically predicted 5% of cases considered to be predictable in similar retrospective case reviews.

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

- Whilst the population is aging, the number of deaths has remains surprisingly stable.
- In order to accommodate an increasingly dependent population the organisation has grown by about 1/3 in the last 10 years.
- Whilst 24 hour waits in A/E are always unacceptable, they have fallen a little in the last year.
- Long stay patients are important causes of the need for increased capacity, but most of the increase was caused by greater need for healthcare and increased provision in all areas.
- Elective clinical care is remarkably safe with all deaths after elective admission being reviewed. There were just 5 deaths from 18,000 operations.
- Problems with clinical care included issues raised with Chest Drain insertion, Corridor waits, Internal bleeding and capacity issues.

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:

- Chest Drain
- Deterioration
- Diabetes care
- Bladder perforation
- Internal bleeding
- Pericardial effusion

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. 69% of patients with sepsis were judged to have care that fulfilled all the components of good sepsis care. The commonest problem remains the failure to send blood cultures.

2.2.8 Seven Day Services

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals. The standards have been reviewed in 2021 by a clinical reference group that confirmed they remain relevant and important in the NHS today.

Clinical Standard 2-

This standard states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

- Summary of Standard 2:
 - 120/122 patients (98.4%) seen by a consultant within 14 hours of admission to the ward
 - 2/122 patients (1.6%) seen by a consultant over 14 hours after admission to the ward
 - 100% of patients were seen by a consultant
 - There were two patients who did not get seen within 14h of arrival to the ward by a consultant. However, both patients had appropriate review.

Clinical Standard 5-

This standard states that emergency and urgent access to appropriate consultant-led diagnostics tests and reported results should be available every day.

For all of the Emergency Diagnostic Tests all are available at weekends either directly or via a network, as in the case of Microbiology

Clinical Standard 6-

This standard states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

For all of the interventions it has been shown that they are available on site at weekends either directly or via a network as in the case of interventional radiology and interventional endoscopy.

Clinical Standard 8-

This standard states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

This has been determined by analysing the notes of each of the 122 patients and determining if they had been reviewed by a consultant or a delegate on each day of their admission, up to 7 days after admission. Day 2 has been taken on the day following arrival, rather than day following admission. Patients who were transferred to Jean Heyes Unit, Bryn Ward or Highfield Ward are not included.

Patients are considered to have been reviewed within the expected timeframe if they are seen within 14 hours of admission to the ward. Historically, most patients would leave the Emergency Department within four hours and then be admitted to a ward, meaning the total expected time from ED arrival to consultant review was effectively 18 hours (4 hours in ED plus 14 hours on the ward). As current practice shows that relatively few patients are admitted to a ward within four hours, an additional 18-hour ED-to-review standard has been introduced to reflect the full patient journey more accurately.

The average length of stay for patients in the emergency department prior to admission to the ward is 36 hours 2 minutes.

The average time to be seen from arrival is 18 hours 50 minutes. 51 patients were seen within 18 hours of arrival.

2.2.9 Speaking up

Who can you speak up to?



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

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- 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

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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 few doctors in training vacancies however there are vacancies for the non- training grade doctors who participate on the training grade rotas.

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.

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.

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:

- National average for the same, and;
- 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	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
	December 2024 – November 2025	1.0058	Value: 1	Best: Imperial College Healthcare NHS Trust – Value 0.7194
				Worst: Blackpool Teaching Hospitals NHS Trust – Value 1.3183
Patient Reported Outcome Measures Scores (PROMS)				
i) Groin Hernia Surgery	National PROMs benchmarking for groin hernia surgery ceased in 2018; however, procedural activity and outcomes continue to be monitored using HES data			
ii) Varicose Vein Surgery	National Patient Reported Outcome Measures (PROMs) data for varicose vein surgery were discontinued by NHS England from October 2017 following a national consultation. As a result, national comparative PROMs data are no longer available for inclusion in Quality Accounts			

iii) Hip Replacement Surgery	April 2023 - March 2024	24.381	22.303	Best: SPIRE WASHINGTON HOSPITAL (NT333) - Value: 26.6038
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 6.95254
	April 2024 – March 2025	24.381	22.189	Best: WINFIELD HOSPITAL (NVC22) - Value: 25.583
				Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 16.1743
iv) Knee Replacement Surgery	April 2023 - March 2024	23.412	16.815	Best: DROITWICH SPA HOSPITAL (NT412) - Value: 20.1149
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 11.445
	April 2024 - March 2025	17.375	16.666	Best: IMPERIAL COLLEGE HEALTHCARE NHS TRUST (RYJ) - Value: 21.5593
				Worst: SPIRE GATWICK PARK HOSPITAL (NT308) - Value: 12.4107
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 2023 - March 2024	7.9	13.2	Best: BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RYW) - Value: 1.6
				Worst: WORCESTERSHIRE HEALTH AND CARE NHS TRUST (R1A) - Value: 69.1
	April 2024 - March 2025	8.6	13.0	Best: BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RYW) - Value: 1.2
				Worst: THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 48.1
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 16 or over	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
	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	April 2023 - March 2024	18.0	15.1	Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) - Value: 1.7
				Worst: YOUR HEALTHCARE (HOLLYFIELD HOUSE) (NNV01) - Value: 99.6
	April 2024 - March 2025	15.8	14.9	Best: NUFFIELD HEALTH, BRIGHTON HOSPITAL (NT436) - Value: 0.6
				Worst: NUFFIELD HOSPITAL OXFORD (THE MANOR) (NT244) - Value: 40.3
Friends and Family Test (Staff)				

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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 Thromboembolism				
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	21.08	20.94	Best: LIVERPOOL WOMEN'S NHS FOUNDATION TRUST (REP), BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (RQ3) & QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST (RPC) - Value: 0.00
				Worst: THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 63.12
	April 2024 - March 2025	36.89	23.29	Best: BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (RQ3) - Value: 1.79
				Worst: THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 80.97
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. - Reported data paused for the implementation of LFPSE data	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%)



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Part 3: Other Information

Part 3.1: Review of performance against out Patient Safety Objectives from 2025/26

This section of the Quality Account provides information on our quality performance during 2025/26. 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 improve the quality of care for our patients and residents.
Where we are at the end of 2025/26	We always work hard to ensure we provide high quality for all. To do this we have worked on: ✓ 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 – we completed a successful annual programme of reviewing one quality metric per month over the financial year. Divisions and Teams rose to the challenge and launched a variety of programmes such reviewing nutrition and hydration, infection control and safeguarding ✓ Harm free Care work continued and we saw a reduction in the number of avoidable high harm falls over the year ✓ Introduction of Martha's Rule work has seen staff and families alike use the service to support our patients. The introduction of daily questionnaires has also helped in ensuring individualised care to all our patients

Objective:	To ensure that our residents and patients have the best possible experience of our care
Where we are at the end of 2025/26	✓ Putting patients and residents at the heart of decision making; about their own care and about design of services – in addition to having a healthy and number of hospital volunteers, we have introduced a Lived Experience Volunteers and partners who are beginning to provide essential inputs into our ✓ Developing a culture among our teams which gives patients the power – again, the introduction of Martha's Rule has helped in giving patients, relatives and carers more opportunity to identify deterioration ✓ 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

Objective:	To promote early detection and intervention, preventing avoidable ill-health.
Where we are at the end of 2025/26	✓ 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) by using the Better Lives Programmes of work to truly achieve a system approach to supporting our community ✓ 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

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

The following indicators are set out in NHS England's 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	2023/24		2024/25		2025/26
Infection Control					
Clostridium difficile (C. difficile)	56	↑	76	↑	77
	Threshold= 0		Threshold = 0		
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	0	↓	1	↔	1
C.difficile: In 2025/26 each case underwent a detailed review 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 was one cases logged as attributable to the Trust in 2025/26. <i>Data Source: National Health Protection Agency data collection, as governed by standard national definitions.</i>					

Indicator	2023/24		2024/25		2025/26
Never Events					
Number of Incidents Reported as Never Events (Threshold= 0)	5	↔	5	↓	2
In 2025/26 we saw 2 incidents that were classified as ‘never events’ under the national framework definitions. The first incident related to a wrong site nephrostomy and the second surrounded a wrong site carpal tunnel procedure. Whilst the first incident clearly aligned to the national framework, the second was not so clear, however, the Trust has taken the decision to report it as such to show its openness and honesty. Both incidents noted human factors and one reformatting issue in relation to the CT performed. Action plans for both have been completed and evidence on the implementation tested.					
Data Source: Datix Risk Management System. ‘Never Events’ are governed by standard national definitions.					

Accident and Emergency (ED)	2023/24		2024/25		2025/26
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	68.92%	↑	70.61%	↑	71.88%
Significant work has been undertaken in 2025/26 to ensure that the Trust performs to the standard and we are pleased that we have been identified as the most improved Trust in the Greater Manchester Area for our A&E performance <i>Data Source: Management Systems Services (MSS), as governed by national standard definitions.</i>					
Cancer Waits	2023/24		2024/25		2025/26
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	93.86%	↓* ↓**	85.56%	↓	81.66%
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 2025/26 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. All breaches have a harm review and if any harm has been identified to have occurred, an incident is raised to investigate this further. No harms have been identified within the breaches. We continue to collaborate with our partners across Greater Manchester to improve patient pathways and deliver the best possible outcomes for our patients. <i>Data Source: NHS Digital, as governed by standard national definitions.</i>					

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 & Safety 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

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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 2025/26 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 a robust cycle of continuous improvement and we built and launched an electronic management tool within our electronic Audit management system, AMaT that has allowed those undertaking continuous improvement projects to manage their work, as well as having a better overview of the programmes underway.

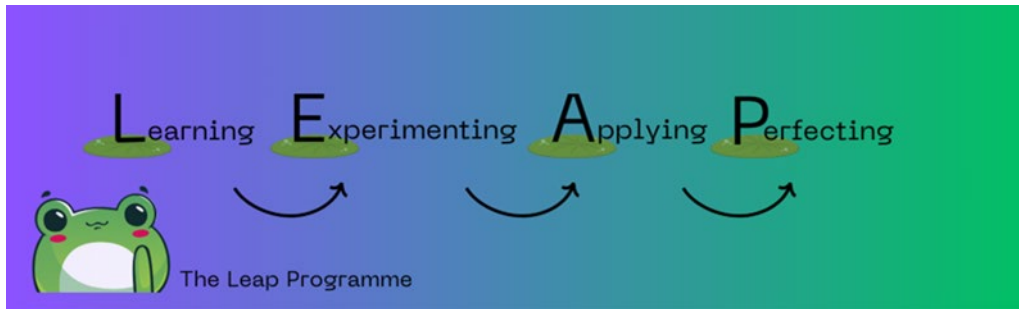
Continuous improvement at WWL

Over the last year, Continuous Improvement (CI) at WWL has focused on **building improvement capability**, **strengthening learning from patient safety incidents**, and **aligning improvement activity to Trust priorities** – supporting safer care, better outcomes and a more empowered workforce.



Building Improvement Capability: The LEAP Programme

A major milestone this year was the **launch of the LEAP improvement capability programme (November 2025)**, replacing the previous continuous improvement offer with a clearer, more inclusive pathway.



What we delivered

- A multi level programme:
 - **Level 1 - LEARN** and **Level 2 - Experiment**: online, interactive modules accessible to all staff
 - **Level 3 - APPLY**: face-to-face sessions focused on practical improvement delivery
 - **Level 4- PERFECT**: active delivery of improvement projects
- This provides a **clear progression route** that supports staff from first exposure to CI through to leading improvement work.

Why this matters

- Continuous improvement capability is no longer limited to a small cohort — it is now **embedded, scalable and accessible**.
- Teams are better equipped to lead change locally, rather than relying on central support.
- A consistent language and methodology for improvement across the Trust.
- The programme directly supports Trust priorities around **quality, safety and productivity**.

✅ **Reason to celebrate:** WWL now has its own, sustainable improvement capability model aligned to national best practice.

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Creating Momentum: CI Conference and Roadshows

To support the LEAP launch and build energy around improvement, we delivered a **Trust-wide conference and roadshow programme**.

Highlights

- Successful online conference, showcasing improvement in action and signalling strong organisational commitment.
- Roadshows across services, bringing improvement closer to frontline teams.
- External presentations to enable new ideas as well as internal speakers spreading learning and improvements to a wider audience.

Impact

- Raised awareness and visibility of Continuous Improvement.
- Reinforced the message that **improvement is everyone's business**.
- Created opportunities for teams to connect, share learning and feel recognised.

✅ **Reason to celebrate:** Improvement moved from something “done to teams” to something **owned by teams**.

Alignment to Trust Priorities

Across all activity, Continuous Improvement has been deliberately aligned to what matters most for WWL:

- **Patient safety and quality**
- **Staff capability and engagement**
- **System learning and reliability**

CI is increasingly seen as an **enabler of Trust strategy**, not a standalone function.

✅ **Reason to celebrate:** Improvement is becoming part of “how we do things here”, not an add-on.

What's Next: Embedding and Maturing Improvement

Building on the foundations laid over the last 12 months, the next phase of Continuous Improvement at WWL will focus on **greater system grip, assurance and sustainability**, particularly through **Board-level improvement oversight** and the development of a **Quality Management System (QMS)**.

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Board-level Improvement and Oversight

- Strengthening how improvement, learning and risk are **visible and assured at Board level**.
- Supporting clearer **lines of sight** from frontline learning (including PSIRF) through to strategic priorities and decision-making.
- Enabling the Board to have confidence not just in knowledge of issues, but in the **effectiveness of improvement actions** taken to address them.
-

Impact we are aiming for

- Improved strategic grip on quality and safety.
- Better prioritisation of improvement work.
- Stronger organisational learning and accountability.

Developing a Quality Management System (QMS)

- Designing and implementing a **coherent QMS** that brings together:
 - Improvement capability (LEAP)
 - Patient safety and PSIRF learning
 - Quality governance and assurance
- Moving from isolated improvement activity towards a **joined-up, repeatable system** for managing quality and improvement.
- Supporting consistency, clarity and sustainability across services.

Impact we are aiming for

- A shared understanding of how quality is planned, monitored and improved.
- Reduced duplication and greater alignment between teams.
- Improvement becoming part of everyday business, not additional work.

Conclusion

This Quality Account for 2025/26 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 2026/27, 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 Wroughtington, 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



Our Values

**People at
the Heart**

**Listen and
Involve**

**Kind and
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**One
Team**

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

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Community Acquired Pneumonia	YES	YES
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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 England 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 2025/26 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 2025 to March 2026
 - Papers relating to Quality reported to the Board over the period April 2025 to March 2026
 - Feedback from commissioners
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
 - The 2025 national patient survey
 - The 2025 national staff survey
 - CQC inspection reports published during the financial year 2025/26
- 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 2026 *Chairman*

30 June 2026 *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: foundationtrust@wwl.nhs.uk



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