Wrightington, Wigan and
Leigh Teaching Hospitals
NHS Foundation Trust

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust Quality Accounts 2020-21 v0.09

Page Intentionally Blank

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. This is our eleventh Quality Account.

Part 1: Statement from the Chief Executive

I am delighted to present the 2020/21 Quality Report for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

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

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

During our last inspection, which took place in October and November 2019, we were rated as 'Good' overall by the Care Quality Commission, as well as being rated 'Good' across each of the five key domains – safe, effective, caring, responsive and well led. Our use of resources was similarly determined to be 'Good' by NHS Improvement. All our acute sites have individually been rated as 'Good' with the Thomas Linacre Centre being rated as 'Outstanding'.

In its inspection report, the CQC highlighted several areas of outstanding practice, including:

- The establishment of an independent domestic violence advocacy service for patients and staff.
- Our dedicated innovation investment fund and our dragon's den style approach to allocation of the funding.
- The use of Holmium laser equipment to provide day case treatment for patients with prostate cancer which limits the need for admission and for more invasive surgery.
- The piloting of hip replacement surgery as a day case procedure which significantly reduces the time spent in hospital for patients undergoing hip surgery.
- The development of a critical care patient acuity and staffing risk assessment tool within critical care to ensure that nurse staffing is safe and appropriate to the needs of the patients and the unit; and
- The approach to management of emergencies within our maternity department.

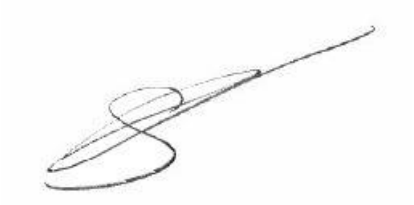
We recognise that delivery of quality is dependent on a number of factors, the most significant of which is our workforce. We believe in the importance of fostering and maintaining a positive culture and we aim to be the employer of choice in the borough and beyond. We have recently launched *Our Family, Our Future, Our Focus* – a programme of activities designed to maintain and further improve the support we provide.

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

We also recognise the importance of learning lessons when things do not go as planned and during the year, we have focused on improving the quality of responses to any complaints we receive. This focus continues as we strive to deliver continuous improvement in this important area. This not only serves to improve the experience of those who contact us to share their concerns but also allows us to undertake a more systematic review of lessons so that these can be shared across the organisation.

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

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



Silas Nicholls

Chief Executive and Accounting Officer

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

Part 2.1: Priorities for Improvement in 2020/21

Quality Strategy [2020/21]

Patient Safety (Safe)

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

Clinical Effectiveness (Effective)

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

Patient Experience (Caring)

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

Quality Priorities for 2021/22

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

All quality priorities have a timescale for achievement by the 31st of March 2022 and progress to achieve them is monitored by our Quality and Safety Committee. The Trust is committed to driving forward these quality priorities and the improvements required. It should be noted that the management of the COVID-19 pandemic and associated actions remains one of the Trust's greatest priorities.

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

Objective	**Lead Executive**
We will reduce preventable death demonstrated by bringing the Trust's Summary Hospital Level Mortality Indicator (SHMI) within the expected range by the 31st of March 2022	**Dr Sanjay Arya**
We will improve the safety and quality of our clinical services by achieving the following by the 31st of March 2022: • 25% reduction in mortality related to Sepsis • 25% reduction in mortality related to Acute Kidney Injury	**Dr Sanjay Arya**
We will improve the safety and delivery of Harm Free Care by achieving the following by the 31st of March 2022: • 50% reduction in Hospital Acquired Category 3 and 4 pressures ulcers • 20% reduction in serious incidents related to deteriorating patients	**Rabina Tindale**
We will improve the patient experience and the quality of care by ensuring all clinical areas participating in the ward accreditation programme achieve a bronze rating by the 31st of March 2022.	**Rabina Tindale**
We will improve our safety culture by introducing Human Factors Awareness Training, ensuring delivery to 50% of our ward managers by the 31st of March 2022	**Rabina Tindale**

Strategic Priority Two

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

Objective	Lead Executive
We will support the physical health and mental well-being of our WWL family by ensuring we have a comprehensive range of wellbeing activities and services that are accessible to our colleagues. By the 31st of March 2022, we will have achieved: • Well-being score of 3.75 in Your Voice Survey • Positive evaluation of Steps 4 Wellness services	**Alison Balson**
We will improve nursing, AHP and midwifery recruitment and retention so that by the 31st of March 2022 have will have achieved: • A reduction in the clinical vacancy rate to under 5% • 95% of our people having a prioritised personal development plan that is supported by the Trust • Talent mapping and succession plans for Nursing, AHP and midwifery leadership roles • A personal development score of 3.75 in Your Voice Survey • A 5% reduction in leavers with less than 12 months service	**Rabina Tindale**
We will make the WWL experience at work positive and fulfilling by creating an environment where our people feel safe to be themselves, to make suggestions and to call out concerns, knowing that we always look for learning and ways to improve. By 31st March 2022, we will have achieved: • Implementation of the civility and just culture programmes of work • Engagement and psychological safety score of 3.75 in Your Voice Survey • 30% of people leaders will have undertaken or have completed (with modular top up requirement) an accredited leadership development programme	**Alison Balson**
We will place fairness and compassion at the centre of our people policies, always respecting the needs and diversity of our colleagues. By 31st March 2022, we will have achieved: • Reduced our gender pay gap by at least 5% and improved our WRES and WDES outcomes • Compassionate leadership score of 3.75 from Your Voice Survey • Re-designed key WWL Employment Policies (Disciplinary, Grievance, Dignity at Work, Attendance Management, Performance Management and Raising Concerns)	**Alison Balson**

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

Objective	Lead Executive
*We will minimise harm to patients and staff in recovering and restoring our elective services in line with national recommendations by identifying and treating patients most at risk to: • Reduce the number of patients waiting over 52 weeks • See and treat priority 2 patients within Royal College timescales • Improve against national minimum standards for cancer services	**Mary Fleming**
**We will improve the Trust's financial sustainability by a focus on productivity in all areas, demonstrated through meeting the expectations of NHSE/I for 2021/22	**Ian Boyle**
We will have created and communicated our Digital Strategy to drive excellence in digital healthcare for patients by the 1st of October 2021, and by the end of March 2022 have modernised key elements of our IT infrastructure demonstrated through: • 100% of staff being provided with the latest versions of Microsoft Office and MS Teams • The deployment of a new, modern Telephony solution throughout the Trust • Implementation of the first clinical pathway in HIS • Increase critical system availability from a year-end FY2020/21 position of 95% to a FY2021/22 year-end position of 98% through conforming to NHS Digital's Data Security and Protection toolkit resulting in the reduction of unplanned outages	**Mary Fleming**
We will have refreshed the Estate Strategy by the 1st of January 2022, exploring and leveraging the benefit of locality working under the One Public Estate initiative with Wigan CCG and Wigan Council, whilst supporting the Trust Service Strategy and incorporating the longer-term implications and benefits of remote working.	**Ian Boyle**

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

Objective	Lead Executive
We will become an elective recovery hub at Wrightington to contribute to reducing inequality of access across Greater Manchester and beyond for patients waiting for elective orthopaedic procedures. By the end of March 2022, we will have: • seen an increase in our OOA referrals to 10,000 • restored and recovered to pre-COVID capacity of 20 orthopaedic sessions per working day	**Richard Mundon**
** We will create and agree our development and delivery plan for achieving the criteria required to become a University Hospitals Trust in a maximum of 5 years' time by the end of Q1, and then deliver the 2021/22 elements of this plan by the end of March 2022	**Dr Sanjay Arya**
We will continue to work side by side with our HWP partners in the development and provision of integrated and placed-based services and pathways to improve the health and wellbeing of Wigan residents, whilst also actively shaping the emerging new locality construct during 2021/22 and ensuring we contribute to community wealth building in Wigan in keeping with our anchor institution role	**Richard Mundon**

**The level of reduction / improvement across the three outcomes to be achieved by March 2022 to be included in the objective once the planning guidance is received and the elective recovery modelling is complete in Q1.*
*** Corporate objective to be updated in 2021/22 when year 1 deliverables can be confirmed / planning guidance confirmed.*

Part 2.2: Statements of Assurances from the Board

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

2.2.1 Review of Services

NHS Trusts are required to include this statement in their Quality Account to demonstrate that they have considered the quality of care across all the services delivered across WWL for inclusion in this Quality Account, rather than focusing on just one or two areas.

During 2020/21 Wrightington Wigan and Leigh NHS Foundation Trust ("WWL") provided and/or sub-contracted 67 relevant health services detailed in the Trust's mandated services.

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

Due to the nature of funding the Trust received during the Covid-19 Pandemic it is not possible to identify the income generated by the relevant health services reviewed in 2020/21 in relation to the total income generated from the provision of health services by WWL for 2020/21.

2.2.2 Participation in Clinical Audits

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

During 2020/21, WWL participated in 22 National Clinical Audits and 4 National Confidential Enquiries covering relevant health services that WWL is eligible to participate in. In addition, WWL participated in a further 13 National Audits (Non-NCAPOP) recommended by HQIP.

The National Clinical Audits and National Confidential Enquiries that WWL participated in and for which data collection was completed during 2020/21 is listed in **Appendix A** alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

The reports of National Clinical Audits were reviewed by the provider in 2020/21 and WWL intends to take the following actions to improve the quality of healthcare provided. Other national reports will be presented once published.

Audit	Trust Actions
National Diabetes Audit 2018/19	The Trust was an outlier for 'Case mix adjusted mean HbA1c'. The Trust now has a high HBA1c pathway in place and continue to make progress.
NELA Report National Emergency Laparotomy Audit	As a result of the patient feedback where patients felt there was a lack of information on discharge, we have implemented SOS cards which are sent home with the patient that includes contact details.
TARN (Trauma Audit Research Network)	Using TARN data, we were able to identify that self-presenting major trauma cases and cases not pre-alerted by NWAS were not being reliably identified as necessitating a major trauma response. Through analysis of TARN data, able to identify susceptible patient groups and target training to the identification, and escalation of care for this demographic. Training is currently on-going.
NICOR: Heart Failure	NICOR data is reviewed on a regular basis to allow the heart failure specialist nurses to monitor their progress against national benchmarking. This has ensured that they maintain a high standard of care for our patients.
NJR – National Joint Registry	The NJR showed the Trust to high a high 90-day mortality rate in knee replacements. A focus group was established to review the data and the cases and review any learning
Lung Cancer Audit	We were shown to be an outlier for "Case mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy" in the 2018 audit results. An audit is to be undertaken to understand the reasons for the late presentation of these patients and meetings are being arranged for discussions between the Medical Director and the Cancer Care Lead in primary care.
NEIAA	WWL were shown as an outlier against quality statement two of the NICE quality standard 33 (2013 version) – patients referred with suspected persistent synovitis should be seen within three weeks of referral. As a result, we have made improvements in data collection by involving the clinical audit team, increased the number of early arthritis clinics by conversion of other clinics, have created a triage system so all new patients are referred to appropriate clinics and are linking with the radiology team to provide further radiology support.
MINAP	MINAP is used to examine the episode of care during the hospital admission, focussing on 'door to angio' times for eligible patients & standards of care for ACS patients. These are reviewed monthly at a local level which ensures we are achieving best practice of care. Data is exported regularly from NICOR and we are able to complete local audits from the datasets. During 2020-2021 AEI provided a PPCI service during the COVID pandemic & we were able to show timely 'door to balloon' times for these patients suffering a STEMI. Our aim is to continue to provide accurate data for the management of ACS patients & utilise it within clinical practice

The reports of 174 Local Clinical Audits were reviewed by the provider in 2019/20. A selection of these audits is outlined below and WWL has taken or intends to take the following actions to improve the quality of healthcare provided:

Audit	Trust Actions
Surgical Post-Take Ward Round Documentation Audit	Since the introduction of a formal checklist there has been an improvement. The most improved area was risk assessments
Improving VTE Risk Assessment and Prescribing Prophylaxis in Acute Surgical Admissions	A leaflet to re-enforce the importance of VTE was displayed and further discussions with colleagues on why prophylaxis may be withheld.
Faints/Syncope Following Orthopaedic Surgery	Proforma for use pre-op when patients attend clinic detailing fasting instructions
Long term health complications of COVID 19 among staff	An audit of post-COVID symptoms in WWL staff led to a Post Covid clinic set up for WWL staff which was a joint service between respiratory department, fatigue service, ENT and occupational medicine. Staff could self-refer via email and were offered appropriate follow up.
CVC Checklist audit	An audit in CVC checklist insertion has led to numerous ongoing measures being implemented. We began with starting a 'topic of the week' board in theatre, with the first subject being central line insertion, including mandatory documentation, completed by the anaesthetic trainees. We have also added invasive procedures/guidewire step to the WHO Theatre Checklist sign out, as another point to stop and check for guidewire removal. Finally, we have designed and had approval for a "CVC insertion document" to be added to our electronic patient record which includes LOCSIPP compliance. Further cycles of audit are planned for 2021/22.

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

2.2.3 Research

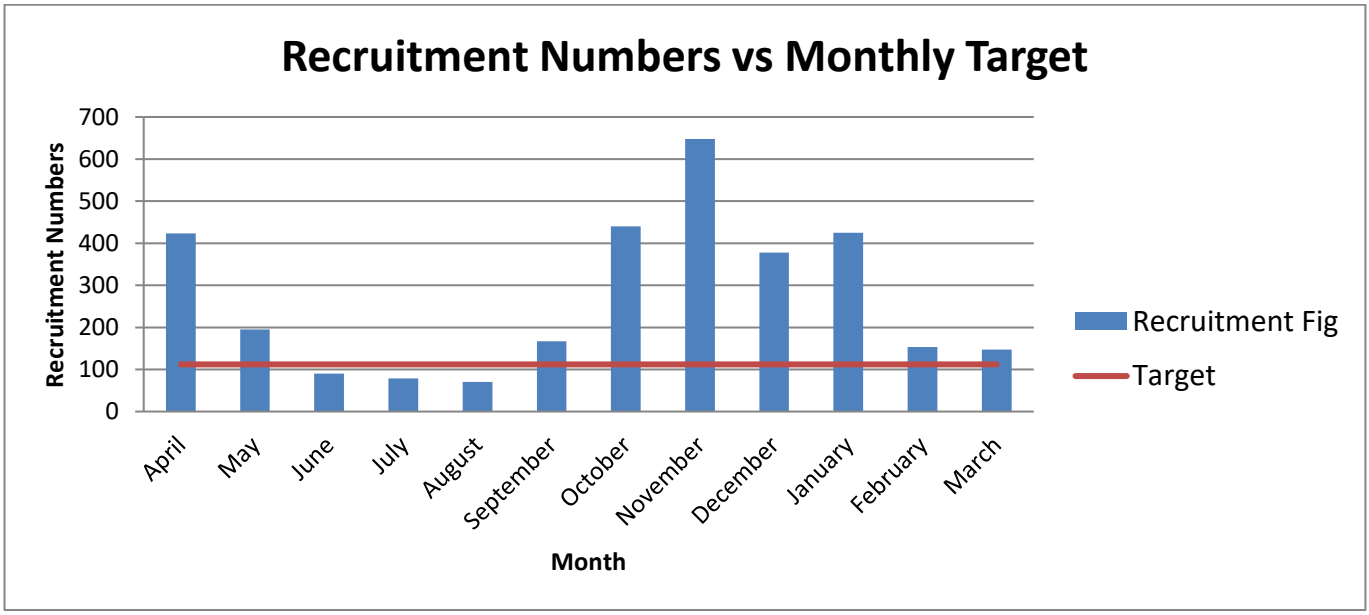
Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' refers to research that has received a favourable opinion from a Research Ethics Committee within the National Research Ethics Service (NRES). Trusts must keep a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

Participation in Clinical Research

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

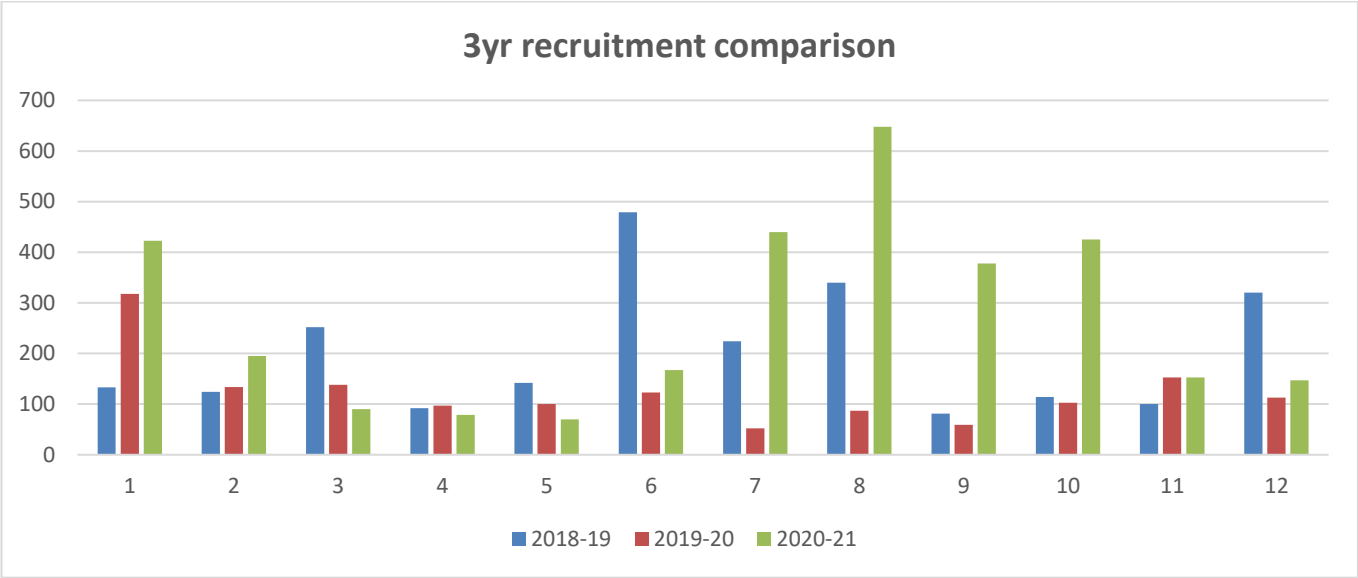
Patient Recruitment 2020/21

The following chart illustrates target recruitment versus actual recruitment to research studies in 2019/20.



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

The chart below illustrates recruitment into National Institute for Health Research registered studies between 1st April 2020 and 31st March 2021 [compared to the year 2018/19 and 2019/20.]



It is globally recognised that a commitment to clinical research leads to better outcomes for patients. We are continuously scrutinised, and the data provided is monitored by recognised, expert teams who ensure that confidentiality and the conduct of every trial meets European Legislation. An example of the esteem held for our work at WWL is illustrated in the comment below: ***"****I just wanted to give you a little bit of feedback on the study after I've spent the day here monitoring. The patient notes and source data for the study are brilliant – the worksheets that you have created for every visit are invaluable too – every data point can be verified, and this makes the patient notes so much easier to monitor. I honestly wish that I could use your site as an example to other sites because you have achieved a level of attention to detail for the trial data that we are constantly asking sites to strive towards".*

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

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

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

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

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

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

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

2.2.4 Goals agreed with Commissioners

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

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

CQUIN schemes were suspended for 2020-21

2.2.5 What others say about WWL

Statements from the Care Quality Commission (CQC)

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

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2020/21, is registration without compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2020/21.

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

During 2020/21, the Trust expanded its registration with the CQC to include newly constructed areas on the Royal Albert Edward Infirmary site. This included Bryn North and Bryn South; these were constructed during 2020/21 to assist in the Trust's response to the Covid-19 pandemic. Additionally, during 2020/21 the Trust also expanded its registration to include the newly constructed Community Assessment Unit; this is also on the Royal Albert Edward Infirmary site.

There were no on-site formal inspections by the CQC of our services in 2020/21. However, regular contact was maintained between the Trust and the CQC during the year as part of the CQC's changing approach to regulation known as Transitional Monitoring Arrangements.

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

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

An astonishing 100% of our services and locations are now rated either **'Outstanding'** or **'Good'** by the CQC, the two highest ratings. We are immensely proud of this and it reflects the hard work, compassion and professionalism of all our staff over recent years.

Progress against actions required by the CQC from the latest inspections in 2019/20 have continued at pace during 2020/21.

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

2.2.6 NHS Number and General Medical Practice Code Validity

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

WWL submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 100% for admitted patient care.
- 100% for outpatient care, and
- 99.6% for accident and emergency care.

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

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

2.2.7 Information Governance Toolkit Attainment Levels

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

WWL's Data Security Protection Toolkit was submitted in June 2020. The assessment was scored as Standards Met/Not Met however an action plan has been submitted and agreed with NHS Digital**.** The Data Security Protection Toolkit is based on the National Data Guardian's ten data security standards.

2.2.8 Clinical Coding Error Rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

WWL was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. The Audit Commission has closed.

WWL commissioned an external audit in December 2020 for assurance of the clinical coding quality:

- Primary Diagnosis Incorrect 9.5%
- Secondary Diagnosis Incorrect 8.07%
- Primary Procedures Incorrect 5.07%
- Secondary Procedures Incorrect 3.93%

The results should not be extrapolated further than the actual sample audited. 200 finished consultant episodes (FCEs) were selected by the auditor across the range of specialties and these cases were reviewed in terms of clinical coding accuracy.

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

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

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Although the Trust already has historically had good Data Quality 2020/2021 has been a challenging year and that is reflected by the Trust's position within the Model Hospital. Over the last 12 months the Trust has a continuing programme of work for the development and improvement of the Data Quality, however this has been impacted by the pandemic.

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

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

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

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

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

2.2.10 Learning from Deaths

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

During 2020/21 1641 (2.8%) of WWL in- patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period. These figures also include deaths in the Emergency Department, which gives a total of 1790

- 484 in the first quarter.
- 284 in the second quarter.
- 596 in the third quarter.
- 426 in the fourth quarter.

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

By March 2021, 1687 case record reviews and 1687 investigations have been carried out in accordance with the Learning from Deaths Guidance in relation to 94% of the deaths referenced in the introduction. In 1687 cases, a death was subjected to both a case record review and/or an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was.

- 469 in the first quarter
- 237 in the second quarter
- 560 in the third quarter.
- 421 in the fourth quarter

Three, representing 0.1% of 1790 deaths in 2020/21, of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance.

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

COVID:

- Patients acquiring COVID in hospital
- Patients with COVID negative swab but treated as COVID indicating a significant level of limitations of COVID PCR test
- Dramatic rise in care home admissions due to COVID and the potential spread of COVID via Nursing Homes
- Overlap of COVID vs sepsis such that sepsis screening tools became less effective
- Post-operative deaths related to COVID, where the risk of death of COVID patients after emergency surgery was higher.
- Thrombosis related death following vaccine. Reported as appropriate to vaccine monitoring
- Potential re-infection with COVID and also following COVID vaccine in a minority of cases
- Patients remaining positive with COVID for many months
- Severe hypoxia at presentation
- Inadequate treatment of DKA after giving dexamethasone and resulting hyperglycaemia

Non COVID:

- CT abdomen provided false reassurance in a patient with small bowel obstruction
- Patient with tonsillar cancer and potentially preventable airway obstruction
- Patient with and fall and fracture neck of femur with a missed intracranial bleed and head injury
- Late presentation of severe diseases, including heart failure, various cancers and CVA
- Deaths related to social deprivation
- Patient who died from coning after lumbar puncture
- Anti-coagulation associated intracranial bleeding
- Late diagnosis of Parkinson’s and inadequate management
- DNACPR and unrealistic expectations from families with conflict over decisions – ethical dilemma
- Patient who dies with bradycardia having been started on drugs which cause bradycardia
- Aortic Stenosis patient with possible delay in referral for TAVI.
- Aminophylline in a patient already on theophylline
- Omitted drugs (issues with NG tubes/Nil by mouth)
- Patient with radiotherapy and possible failure of follow up post treatment
- Patient with vascular bleed from coeliac artery and problems with transfers of care
- Patients who were brought in to die

2.2.11 Seven Day Services

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

This was Suspended for 2020/21

2.2.12 Speaking up

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

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

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

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

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

2.2.13 NHS Doctors in Training

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

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

High level data

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

Annual data summary

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

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

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

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

Issues arising:

Increased educational exception reports

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

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

Actions taken

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

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

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

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

Surgical F1 exception reports for hours and rest

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

Action taken to resolve the issue

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

General Medicine exception reports for hours and rest

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

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

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

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

Generic actions taken

Overseas recruitment to help with the vacancies:

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

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

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

Part 2.3: Reporting against core indicators

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

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

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

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Mortality				
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	October 2018 - September 2019	Value: 1.1649, Banding : 1	Value: 1.0026	Best: IMPERIAL COLLEGE HEALTHCARE NHS TRUST (RYJ) - Value: 0.6979, Banding: 3 Worst: DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST (RBD) - Value: 1.1877, Banding: 1
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	October 2018 - September 2019	42.0%	36.0%	Best: SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST (RK5) - Value : 14.3% Worst: ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST (RA2) - Value: 59.0%

Assurance Statement

SHMI for this time period at WWL is high. That has remained through most of the last 5 years. There is extensive work to review all deaths, with identification of Potentially Preventable Deaths and work to learn from areas where care falls short of the standards expected. The proportion of Potentially Preventable Deaths identified was 1.3%, which is low in comparison to previous years and the standards established by similar retrospective reviews internationally (typically reported at 3%). There are significant issues related to the calculation of SHMI and these are widely accepted. One issue of particular significance to WWL is the low bed base. This is potentially helpful to a well-run, efficient organisation, but within the calculation of SHMI it means that the number of deaths is concentrated into a lower number of admissions and so the death rate artificially appears raised. WWL is increasing its bed base, with significant change during the last year (2020). That will to some extent mitigate the problem, but it will remain an issue until the bed base approximates levels more typical across the NHS. The increase in the WWL bed base is also essential given the patterns of frailty and dependence we are experiencing. The pattern of older, more frail patients arriving in hospital is set to increase as the demographic bulge known as "baby boomers" reach old age and require increasing healthcare.

The proportion of deaths with palliative care coding is used in the calculation of HSMR but is not included in the calculation of SHMI. Within WWL it indicates that there are good, active services provided to patients who are dying. The extensive involvement of the palliative care team with patients in the hospital recognises the severity of illness and high levels of predictability of dying that we recognise within our patients. In this regard, a high level of palliative care involvement offers no statistical benefit to the organisation but offers a compassionate care for our sickest patients.

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

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

Assurance Statement

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

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

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

Assurance Statement

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

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

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

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

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

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

Assurance Statement

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

In 2020/21 there were 43 cases, compared to 48 in 2019/20. Due to the pandemic, it was not possible to do a full review with the CCG and Executive team on all cases, but root cause analysis (RCA) was still completed, and the cases assessed at Divisional level and actions undertaken to help prevent reoccurrence where relevant.

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

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

Full RCAs continue to be carried out on each case and the Executive reviews with involvement of the CCG have now recommenced for all cases. Comprehensive action plans will be drawn up to address any learning that results from these RCAs and progress monitored by the IPC Committee.

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

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

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

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

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
Patient Safety Incidents				
The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	October 2018 - March 2019	3674 Incidents Reported (Rate per 1000 Bed Days 48.2) / 14 Serious Incidents (0.38%)	765221 Incidents Reported (Rate per 1000 Bed Days 45.2) / 2458 Serious Incidents (0.32%)	Best: North Tees and Hartlepool NHS Foundation Trust (RVW): Incidents Reported 1580 (Rate per 1000 bed days 16.9) / 15 Serious Incidents (0.95%) Worst: Croydon Health Services NHS Trust (RJ6): Incidents Reported 8289 (Rate per 1000 bed days 95.9) / 28 Serious Incidents (0.34%)

Assurance Statement

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

We continue to report a high number of patient safety incidents during 2020/21. The data just show a slight decrease in reporting in Q1, evidence suggests there was a decrease in the number of patients admitted into hospital during this period, which may account for the downward trend. Our rate of incidents reported per 1000 bed days does not show any evidence for under reporting and our rate remains in the top 25% of all Trusts. We aim to promote a just culture to ensure that staff feel confident to report incidents. This is reflective in the numbers of incidents reported, particularly near misses and incidents resulting in low harm

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

Performance in the investigation and closure of incident is monitored via the Datix Quality Improvement Group. Performance reports continue to be distributed monthly to the Divisions. We continue to consider ways to improve our incident reporting processes to ensure staff feel confident and able to report incidents. This year we will continue to try and improve the timeliness of our incident investigation so to enable a more robust learning process and subsequently improve the quality of our uploaded incidents to NRLS.

Part 3: Other Information

Part 3.1: Review of Quality Performance

This section of the Quality Account provides information on our quality performance during 2020/21. 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 a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2020/21

We agreed a number of priorities for improvement in 2020/21 published in last year's Quality Account. These were selected following the development of our Quality Strategy 2017/21 in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1:	**95% of patients with Red Flag sepsis will receive antibiotic treatment within 1 hour in both the Emergency Department (ED) and on wards**
Where we were in 2019/20	We achieved 76.9% within ED We achieved 96% within our wards
Where we are at the end of 2020/21	We improved our position for ED achieving 95% Figures have demonstrated an increase in compliance in the administration of antibiotics within one hour from 76.9% to 95%. ED Sepsis Task Force was introduced in August 2020 to explore, identify and address aspects of care that previously had prevented adherence to administering antibiotics within one hour of Time Zero. During the pandemic it was difficult to meet the target as we had planned. However, the department was committed to driving this forward and smaller projects continued throughout 2020 to help achieve this improvement. Work that is currently ongoing to continue to drive this improvement include: ❖ PGDs are being introduced in ED for antibiotics and IV fluids ❖ Blood Cultures education, training and competency is ongoing and we are looking to improve the numbers of train-the-trainers across the Trust to support the Sepsis Nurse. ❖ Sepsis on HIS – having the sepsis tool embedded within our HIS system will significantly support evidence of recognition, screening and management of patients with Sepsis. The 'GO -live' date for this initiative is 6/7/2021

	We improved our position within the Wards achieving 100% Work is ongoing to try and continue to maintain this compliance. There are plans for all Divisions to have a Sepsis Task Force that will involve both clinicians and nurses to continue in driving the sepsis improvement work.

Priority 2:	**95% of patients with an elevated NEWS2 score (5 in total or 3 in one domain) will be screened for Sepsis in the Emergency Department (ED) and on the wards**
Where we were in 2019/20	Not audited during this period.
Where we are at the end of 2020/21	Audited from October 2020 in collaboration with Business Intelligence using the first episode of elevated NEWS 2 scores Within the Emergency Department we achieved 100% Compliance remains over 100% of the patients who have presented with elevated NEWS2 score. This result evidence that patients are being correctly identified and treated for sepsis at triage. Within our inpatient wards we achieved 16.2% There has been little change in compliance to health care professionals utilising the Acute Sepsis Assessment Tool in response to an elevated NEWS2 score. In response to this the following initiatives have been implemented: • re-energising of Sepsis recognition, screening and management at WWL – known as #sepsisready. • All wards have the most recent sepsis screening tool, up-to-date literature of Sepsis, and red sepsis response / orange sepsis trolleys. • Sepsis Nurse has met with senior nurses to support and strengthen leadership on our wards at WWL • Moving forward will be the introduction of Sepsis on HIS early July 2021 and this will alert the user when Sepsis threshold (Elevated NEWS2 of 5 in total and 3 in one domain) has been exceeded.

Priority 3:	To reduce category 3, category 4 and unstageable pressure ulcers contributed to by lapses in care by 50%
Where we were in 2019/20	In 2019/20 the Trust reported an increase in healthcare acquired pressure ulcers. These included categories 3,4 and unstageable which were contributed to by lapses in care. In July 2019, to address this increase, a pressure ulcer reduction plan was developed, this improvement plan was monitored at Patient Safety Quality Improvement Group. In 2019/20 41 healthcare acquired pressure ulcers were reported, this included 21 HAPUs and 20 CAPUs.
Where we are at the end of 2020/21	The Trust continues to see an increase in reportable pressure ulcers, the Pressure Ulcer Review Panel continues to meet weekly to review all incidents of pressure ulcer development in the hospital and community. In 2020/21 the Trust has reported 36 pressure ulcers to StEIS these comprised of 5 CAPU and 31 HAPU. Community have seen a 75% reduction, disappointingly there has been a 48% increase in hospital acquired pressure ulcers. Overall, the Trust has seen a 24% decrease in reportable pressure ulcers contributed to by lapse in care. The pressure ulcer improvement plan has been reviewed and updated to ensure that all themes and trends are captured and to ensure that all actions are measurable and provide assurance that learning has occurred and embedded in practice. Due to the continued increase in pressure ulcers the Trust has established a task and finish group to review the entire process in which pressure ulcers are both prevented and managed and remains committed to reducing this harm.

Priority 4:	To reduce the number of CDT infections by 20% where there have been lapses in care
Where we were in 2019/20	In 2019/20 the Trust reported a total of 48 CDT's against a threshold of 20
Where we are at the end of 2020/21	This year we reported 43 CDT's against a threshold of 20, although this is a reduction from last year by five, we were disappointed with our results as we failed to achieve our 20% reduction target. Of these, twelve lapses of care were identified, of which seven were related to late sampling and four to inappropriate use of antibiotics. We are currently developing a reduction plan, with an increased focus on timely sample taking and appropriate use of antibiotic therapy.

Clinical Effectiveness (Effective)

Priority 1:	To achieve a Summary Hospital Level Mortality Indicator (SHMI) within the expected range
Where we were in 2019/20	Trust's SHMI for this time period was high. That has remained true through most of the last 5 years. At the end of 2019/20 WWLs SHMI ratio was 118.4 This is marginally better than the previous update of 1.20.
Where we are at the end of 2020/21	There is extensive work ongoing to review all deaths, with identification of Potentially Preventable Deaths and workstreams to learn from areas where care falls short of the standards expected. In addition, the CCG have part funded a Quality Lead post which is delivering focussed improvement work to reduce our SHMI ratio. A Mortality improvement plan has been developed and these actions are looking at outlier areas such as sepsis, acute kidney injury and congestive cardiac failure. The Trust has implemented the following additional control measures to reduce SHMI: • Working with AQuA to investigate reasons for Trust's persistently high SHMI rate. • Review of issues with coded data extraction to secondary user service. • Wigan wide Mortality Improvement Group. • Quality Improvement Lead to monitor themes and trends identified from WWL SHMI • Develop specific improvement work streams in relation to the diagnosis groups highlighted as being significantly higher than the National average for SHMI • Network with other Trusts to identify good practice and share knowledge where changes have impacted positively on SHMI WWL are networking with other Trusts to identify good practice and share knowledge where changes have impacted positively on SHMI. At the end of 2020/21 the Trust has seen a decrease in the SHMI ratio to 112.77, which is within the expected range. **12 Month Overview** Source: Dr Foster/NHS Digital Target Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb 100.0 SHMI 118.14 117.68 115.98 114.65 114.82 115.40 115.43 115.28 112.84 112.77 100.0 HSMR (12 month rolling) 102.96 104.20 103.47 100.85 99.72 99.55 101.01 101.73 101.49 102.61 104.08 104.59 100.0 Monthly HSMR 113.69 118.28 107.70 87.25 79.99 108.81 124.74 114.07 104.63 103.95 93.79 97.23 100.0 SMR (12 month rolling) 100.69 102.97 101.79 99.32 98.64 99.03 100.06 101.24 101.90 104.32 107.79 109.26 100.0 95% Confidence Limit (Local Data)

Priority 2:	Compliance with the National Patient Safety Strategy (NPSS)
Where we were in 2019/20	Following the release of the National Patient Safety Strategy in July 2019, the Trust developed an action plan to monitor the progress of each priority; this is monitored via Corporate Quality Executive Committee. It was acknowledged that most of the recommendations were dependent upon National progress and therefore could not be implemented locally until the National objectives had been implemented. There were, however, several recommendations that were immediately considered by WWL to ensure that the Trust met the local deadlines (defined in the strategy).
Where we are at the end of 2020/21	In February 2021 NHS England released a document highlighting updates to the National Patient Safety Strategy. The Trusts action plan now includes all the new updates to the original recommendations outlined in the strategy. Progress is monitored at Corporate Quality Executive Group and Quality Safety Committee. It is acknowledged that some of these recommendations/improvement programmes are dependent on national progress and therefore cannot be implemented locally until the national objectives have been implemented. There are several actions that have been considered and progressed by WWL to date the Trust is on track to meet the local deadlines (defined within the strategy).

Patient Experience (Caring)

Priority 1:	To ensure all complaint responses are timely and have learning identified and demonstrable action is taken
Where we were in 2019/20	497 formal complaints were due to be responded to on time – 266 achieved this: with a Trust overall performance rate of 54% Quality Priorities 2020/2021 was identified as above
Where we are at the end of 2020/21	332 formal complaints were due to be responded to on time – 109 achieved this: with a Trust overall performance of 33%. The above priority was affected by the Complaints Procedure being formally put on hold in March 2020 until 1 July 2020. PRD re-introduced the back log of complaints on the 1 July 2020, alongside the daily formal complaints being received by the department. As clinical staff were still prioritising treatment and care of our patients, as well staff still shielding investigations were difficult to complete. The importance of learning from patient experience via the complaints process for partially and fully upheld complaints was identified as a key priority. The Patient Relations and PALS Annual Report for 2020/21 includes some examples of lessons learned/actions taken in response to feedback from patients and their loved ones who made a formal complaint.

Priority 2:	To improve patients, experience of discharge
Where we were in 2019/20	• Bi-monthly Discharge improvement meetings • Increasing Discharge related incidents • No standardised discharge checklist
Where we are at the end of 2020/21	• Monthly Discharge Improvement Group meetings commenced July 2020 with new chair (Chief AHP) and with multi-disciplinary and multi-agency representation • Discharge risk assessment with associated action plans devised and monitored by the group on a monthly basis • Paper discharge checklist implemented across all in-patient wards with plans to audit on a monthly basis commencing March 2021 • Themed SIRI panel focussing on Discharge (March 2021) highlighted downward trend in relation to discharge incidents • On-going work with the HIS team in relation to implementation of the Discharge Tracking Boards and creation of an electronic version of the paper discharge checklist

Priority 3:	To embed an organisational culture of psychological safety, civility and respect
Where we were in 2019/20	At the end of 2019, WWL participated in a psychological safety survey, along with other Trusts in Greater Manchester. Outputs from this showed that WWL had a psychological safety score of 3.5 out of 5, which was amongst the lowest in Greater Manchester. This was also evidenced through the national staff survey results.

Where we are at the end of 2020/21	We haven't been able to implement our psychological safety programme of work as initially planned, due to operational pressures in managing the Covid-19 pandemic. We have however, made some key strategic decisions to progress and prioritise this work in 2021/22. The culture theme of work in "Our family, Our future, Our focus" will prioritise psychological safety, civility at work and compassionate leadership. Teams have been identified to be part of a pilot, which will include education, experiential learning, action learning sets and reflective practice and we will refine the programme using participant feedback before wider roll out inn 2021/22. We have a Medical Consultant championing the programme and approach. Our leadership and team development programmes will be built on compassionate leadership, psychological safety and human factors principles. Our disciplinary policy was updated and published in March 2021, embedding the just culture ethos within conduct processes. During the year we also introduced an executive led review panel to consider all conduct matters. This uses the just culture decision tree and looks for informal resolution of issues where possible and appropriate. We intend to review all our People policies in 2021/22 to have a more person-centred focus. Freedom to speak up Guardian services have been reviewed in 2020/21 and a strategic decision has been taken to commission an external and fully independent service provider to provide additional assurance and encouragement to staff to raise any concerns. The independence of the service provider will also help to ensure that appropriate actions are taken in response to concerns and that this is done in a timely manner.

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

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

Key

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

Indicator	2018/19		2019/20		2020/21	
Infection Control						
Clostridium difficile (C. *difficile*)	11 Threshold= 18	↓	48 Threshold = 20	↑	43 Threshold = 20	↓
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	2	↔	0	↓	2	↑

C.difficile:

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

In 2020/21 each case underwent a detailed individual patient review but due to COVID pressures only around half the cases were reviewed collaboratively with our commissioners. Irrespective of this, comprehensive action plans were drawn up to address any learning that resulted from these RCAs and progress monitored at the IPC Committee. There have been 12 'Lapses in Care' identified; the most common reason was related to samples being taken later than they should have been, followed by inappropriate use of antibiotics. Actions are ongoing to remind staff of the importance of timely sampling and the Consultant Microbiologists and Antibiotic Pharmacist continue to promote and monitor antibiotic use.

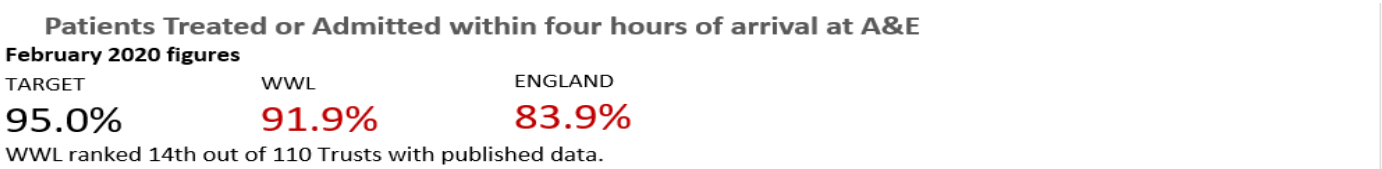
MRSA Bacteraemia:

Cases in 2020/21; one was due to a delayed diagnosis of a pre-existing MRSA infection and could not have been prevented. The second appears to have been associated with a catheter associated urinary tract infection; there was poor documentation of the blood culture and the vascular access device so an action plan was put in place following this. Work to standardise the approach to ANTT (Aseptic Non-Touch Technique) stalled in 2020/21 due to COVID, but the aim is to make ANTT assessments part of the annual mandatory training schedule and put the blood culture documentation on to HIS, which should support compliance with the SOPs.

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

Indicator	2018/19		2019/20		2020/21	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	5	↑	4	↓	1	
In 2020/21 in the Trust has seen a reduction in the number of Never Events reported. In 2020/21 there was one incident reported relating to a wrong route medication. LOcSSIPs remain part of the annual audit programme. *Data Source: Datix Risk Management System. 'Never Events' are governed by standard national definitions.*						

Accident and Emergency (ED)	**2018/19**		**2019/20**		**2020/21**	
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	82.11% *	↓	84.00%	↑	87.48%	↑



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

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

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

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

Cancer Waits	**2018/19**		**2019/20**		**2020/21**	
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	88.04% 89.53%	↓* ↓**	85.34%%	↓	74.58%	↓
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	97.04% 97.52%	↓* ↓**	92.92%	↓	91.98%	↓

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

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

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

WWL's overall performance for all standards related to the 62-day cancer waiting times in 2020/21 have been affected throughout the year by the ongoing COVID pandemic. Several months of the year experienced delays in Cancer pathways due to COVID which caused diagnostic delays and many patients wanting to wait or defer treatment due to the potential risk of catching the virus when attending hospital appointments – all of which had a significant impact on performance and subsequently caused a backlog of patients waiting for investigations. However, most of the cancer standards were still achieved despite being such a difficult year, only the 62-day cancer target was not achieved. We have worked hard to adapt to new ways of providing services and to deliver the best possible care for patients, we hope to see an improvement in performance over the coming months

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

Referral to Treatment (RTT)	**2018/19**		**2019/20**		**2020/21**	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway (Threshold= 92%)	92.29%	↓	85.70%	↓	59.04%	↓

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

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

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

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

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

Diagnostic Procedures	2018/19		2019/20		2020/21	
Maximum 6-week wait for diagnostic procedures (Threshold=99%)	99.25%	↓	93.40%	↓	92.94%	↓

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

The largest volume of procedures is undertaken in imaging and Radiology performs extremely well against this standard; this is despite rising numbers of referrals and increasing complexity of examinations. The standard does not measure all Radiology examinations, but some of the main tests fall within Magnetic Resonance (MR), Computer Tomography (CT), Non Obstetric Ultrasound (NOUS) and DEXA which equates to about 10,200 examinations per month. Overall, we undertake approximately 330,000 examinations per year, although this was reduced last year because of Covid-19. Current imaging activity levels are higher than 2019/20 & 2020/21 attributable to recovery programmes and increasing demand in unscheduled care.

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

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

Complaints, Patient Advice and Liaison Service and the Ombudsman

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

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

During this reporting period, nationally the NHS Complaints Procedure was paused in March 2020, due to the COVID-19 pandemic; any new complaints received were held on file and not investigated until after 1 July 2020 due to the involvement of clinical staff in the complaints process. The formal complaints process was re-started on 1 July 2020 and the paused complaints were reinstated were indicated by the complainant. During this period the PALS team continued to act on all concerns received seeking resolution and advice.

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

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

The team understand that every concern or complaint is an opportunity to learn and make improvements for our future patients, their relatives and carers. The team recognise that handling complaints and concerns effectively matters for people who use our services and explanations and apologies, if required, are provided. We welcome complaints to learn and reflect on how we work and to make the appropriate improvements. Whilst we provide an apology to our complainants, the following outlines actions taken, and lessons learned from a sample of complaints received.

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

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

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

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

During 2020/21 the PHSO requested information regarding 6 complaints. Decisions have been received for 2 cases which were: 2 closed and not investigating, with 4 remaining under investigation. These cases relate to the years, 2015, 2016, 2017, 2019 (x2), and 2020. A further 2 cases were updated in this year, 1 was suspended by the PHSO (relating to 2017), and 1 was not upheld, relating to year 2015.
Final reports for investigations concluded in 2020/21 have not required financial redress.

Patient Experience

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

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

Patient and Public Engagement

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

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

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

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

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

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

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

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

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

Consultation with Local Groups and Partnerships

The CCG, Healthwatch Wigan and Leigh and Pensioners Link have worked in partnership with the Trust on the Discharge Improvement Group. We have made changes to the discharge checklist by looking at Steis discharge incidents and seeing if we have assurance against the discharge checklist and discharge risk assessment. The changes made to the checklist were to make sure we have patients have gone home with their equipment added to the checklist and that the Reablement Team have been notified of the patients discharge or if there are any delays in the discharge. This should now improve the patients experience of going home with their equipment as it has been an issue in the past.

Part 3.2 Quality Initiatives

We have introduced a number of initiatives to strengthen quality governance systems and improve the care, treatment and support provided to patients across the organisation. A summary of progress during 2020/21 is outlined below**.**

Ward Accreditation

Ward Accreditation process was halted throughout the pandemic. This accreditation programme is being revised and will be supported by a suite of audits undertaken through the Perfect Ward App. Although the accrediation process was paused, Monthly Quality Assurance Audits were continously undertaken in order to provide continued quality assurance. There will be a renewed focus on the ward accreditation programe during 2021/22 and the trust is committed to supporting all areas within scope of the programme to achieve a minimum rating of Bronze.

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

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

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

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

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

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

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

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

Continued Recruitment and Development of the Quality Faculty

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

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

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

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

- Three additional online Zoom Workshops covering: The A3 Project Charter and PDSA Improvement Cycle; Problem Solving Techniques; and Value Stream Mapping
- Support and guidance for all Quality Champions provided through online coaching and check-in sessions
- Additional content and learning material including exercises and practical use of templates incorporated into the online learning system
- A Learning Guide providing ‘step-by-step’ instructions on using the video lessons that support the learning journey through the programme
- A new combined Celebration Event and Quality Champions Committee Bronze Badge recorded presentations introduced, for employees completing the training programme during the pandemic

Intake of New Candidates

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

Bronze Badge Awards

Despite current Covid-19 pressures, 6 employees attended and presented their Quality Champion Project Update at a combined Celebration and Quality Champions Committee presentations on Zoom and are awaiting their Bronze Badge Award.

Silver and Gold Awards

No members of staff have been put forward or nominated for either Silver or Gold Awards during 2020-21.

Quality Champions Conference

The Quality Champions Conference Webinar took place in October 2020 and this was the first virtual event held to celebrate the work of the Quality Champions. The Keynote Speaker was Dr Adrian Richardson, Director of Continuous Quality Improvement at Frimley Health NHS Foundation Trust, who spoke about his experience in using continuous improvement in healthcare. The event providing a forum for reflecting on the excellent work delivered throughout the past year and set out the new direction for the blended-learning Quality Champions training programme.

The next 12 months

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

Leadership Quality and Safety Rounds

Due to the COVID Pandemic the Leadership Quality and Safety Rounds have not taken place. The process for these is currently being revised and are expected to due to recommence in Summer 2021.

The HELPline

The HELPline continues to be a useful method of communication for families and carers to be able to contact a senior nurse when they need to discuss aspects of their loved one's care. It is intended to be a way of escalating concerns that families may feel have not been addressed adequately by ward or department staff.

HELPline is a mobile phone that is carried on a rota basis between all operational divisions. The number of calls has been sporadic over the last 12 months due to issues with the mobile phone system and a new phone and logging system is currently under review.

Appendix A: National Clinical Audits and National Confidential Enquiries

The National Clinical Audits and National Confidential Enquiries that WWL has participated in during 2020/21 are as follows:

NCEPOD National Confidential Enquiry into Patient Outcome and Death
Long term ventilation
Dysphagia in Parkinson's Disease
In Hospital Management of Out of Hospital Cardiac Arrests
Physical Healthcare in mental health hospitals

National Clinical Audits	Participated	Number submitted	Actual audit submissions %
Antenatal and newborn national audit protocol 2019 to 2022	Yes	Ongoing data collection	Ongoing data collection
BAUS Urology Audits 2, 3	Suspended due to Pandemic	-	-
Case Mix Programme (CMP) 2	Yes	344	100%
Child Health Clinical Outcome Review Programme 1	Yes	Ongoing data collection	Ongoing data collection
Elective Surgery (National PROMs Programme)	Information provided in part 2.3	-	-
Emergency Medicine QIPs 3	Local data collection	-	-
Falls and Fragility Fracture Audit Programme (FFFAP) 1, 2, 3			
Fracture Liaison Service Database (FLS-DB)	Suspended due to pandemic	-	-
National Hip Fracture Database (NHFD)	Yes	384	100%
National Audit of Inpatient falls (NAIF)	Yes	4	100%
Inflammatory Bowel Disease (IBD) Audit 3	Suspended due to pandemic	-	-
Learning Disabilities Mortality Review Programme (LeDeR) 1	Yes	21	100%
Mandatory Surveillance of HCAI	Yes	325	100%
Maternal and Newborn Infant Clinical Outcome Review Programme 1	Yes	Ongoing data collection	Ongoing data collection
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) 1, 2, 3			

National Clinical Audits	Participated	Number submitted	Actual audit submissions %
Asthma	Yes	60	100%
COPD	Yes	156	100%
Paediatric Asthma	Yes	Data collection 1st February 2020 – 31st March 2021 36	100%
National Audit of Breast Cancer in Older Patients (NABCOP) 1, 2	TBC	TBC	TBC
National Audit of Cardiac Rehabilitation	Yes	102	100%
National Audit of Care at the End of Life (NACEL) 1	Suspended due to Pandemic	-	-
National Audit of Dementia (NAD) 1, 2	Suspended due to Pandemic	-	-
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) 1	Yes	175	100%
National Cardiac Arrest Audit (NCAA)	Yes	39	23%
National Cardiac Audit Programme (NCAP) 1, 2, 3	Yes		
Heart Failure (Heart Failure audit)	Yes	410	100%
Adult Percutaneous Coronary Interventions	Yes	752	100%
Cardiac Rhythm Management (Arrhythmia audit)	Yes	TBC	100%
Myocardial Ischaemia/MINAP (Heart Attack audit)	Yes	655	100%
National Diabetes Audit – Adults 1, 2, 3	Yes	Ongoing data collection	Ongoing data collection
National Early Inflammatory Arthritis Audit (NEIAA) 1	Yes	28	-
National Emergency Laparotomy Audit (NELA) 1, 2	Yes	1st Dec 2019 – 30th Nov 2020 124	100%
National Gastro-intestinal Cancer Programme 1, 2, 3	Yes	Ongoing data collection	Ongoing data collection
National Joint Registry 2, 3	Yes	1285 Elective surgery part-suspended throughout the pandemic	100%
National Lung Cancer Audit (NLCA) 1, 2	Yes	Ongoing data collection	Ongoing data collection
National Maternity and Perinatal Audit 1	Yes	Ongoing data collection	Ongoing data collection
National Neonatal Audit Programme (NNAP)	Yes	Ongoing data collection	Ongoing data collection

National Clinical Audits	Participated	Number submitted	Actual audit submissions %
National Ophthalmology Database Audit 2	Yes	Ongoing data collection, however, elective surgery postponed throughout the pandemic	Ongoing data collection
National Paediatric Diabetes Audit (NPDA) 1, 2	Yes	170	100%
National Prostate Cancer Audit (NPCA) 1, 2	Yes	Ongoing data collection	Ongoing data collection
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections.	No	-	-
Perioperative Quality Improvement Programme (PQIP)	TBC		
Sentinel Stroke National Audit Programme (SSNAP) 1, 2	Yes	273	90%
Serious Hazards of Transfusion Scheme (SHOT)	TBC		
Society for Acute Medicine Benchmarking Audit	Suspended due to Pandemic	-	-
Surgical Site Infection Surveillance	Yes	Ongoing data collection	100%
The Trauma Audit & Research Network (TARN) 2	Yes	Data input partially suspended due to pandemic. 349	100%+
UK Cystic Fibrosis Registry	Yes	22	100%
UK Registry of Endocrine and Thyroid Surgery 2	Suspended due to pandemic.	-	-

[1] National Clinical Audit and Patient Outcomes Programme (NCAPOP) project

[2] Project participates in the Clinical Outcomes Publication (COP)

[3] Projects with multiple work streams are reflected in the HQIP National Clinical Audit and Enquiries Directory (The Directory)

Note: The figures above represent the information provided to the Clinical Audit Department by the relevant audit leads/departments. Data collection for some of the audits extends beyond the date of this report therefore the figures contained within the report may not correspond with the actual validated figures published in the final audit reports.

Annex A:

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

Wigan Borough Clinical Commissioning Group Response to Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust Quality Account 2020/21

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

The CCG acknowledges the level of partnership working that has been undertaken by WWLFT during 2020/21 to improve the quality, safety and experience of care for our residents and to support the Boroughs response to the COVID-19 pandemic.

In respect of the quality priorities identified in the 2019/20 Quality Account, rolled forward to 2020/2021 the CCG acknowledges progress has been made in a number of areas; of particular note is:

- Discharge improvement activity, including the establishment of a multidisciplinary Discharge Improvement Group, the development of a Trust wide Discharge Risk Assessment and the implementation of Discharge Checklist across all in-patient wards

- The development of an action plan to ensure compliance with the NHS National Patient Safety Strategy

The CCG notes some of the objectives from 2020/21 were not achieved including a reduction in hospital acquired pressure ulcers, an improvement in complaint response times and an increase in the number of patients with an elevated National Early Warning Score being screened in ward areas, however the CCG accepts the COVID-19 pandemic has impacted on the delivery of a number of quality priorities.

The CCG supports the quality priorities identified for 2021/22 and particularly welcomes the focus on the following areas which the CCG has also identified as priority areas for improvement:

- Reducing the number of category 3 and 4 pressure ulcers by 50%

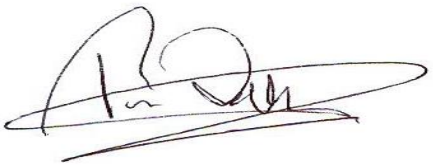
- Minimising harm to patients and staff in recovering and restoring elective services in line with national recommendations by identifying and treating patients most at risk. This includes:

    - Reducing the number of patients waiting over 52 weeks
    - Seeing and treating priority 2 patients within Royal College timescales
    - Improving against national minimum standards for cancer services

- Achieving a 25% reduction in mortality related to sepsis and acute kidney injury
- Improving nursing, AHP and midwifery recruitment and retention

During 2021/22 the CCG will continue to work closely with the Trust to support the Wigan Borough response to the COVID-19 pandemic and the delivery of the Wigan Borough Recovery Plan.

The CCG looks forward to working in partnership with the Trust and other stakeholders to ensure the continuous focus upon quality improvement in both acute and community services in order to provide the best possible care for our residents.



Dr Tim Dalton, Chairman, Wigan Borough Clinical Commissioning Group

28 June 2021

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

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

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

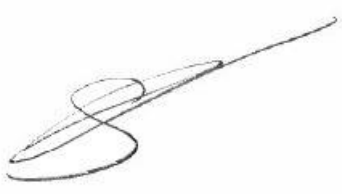
In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

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

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

By order of the Board

30 June 2021 *Chairman*



30 June 2021 *Chief Executive*

Annex C: How to provide feedback on the account

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