Wrightington, Wigan and Leigh Teaching Hospitals

NHS Foundation Trust

Quality Report
2019/20





WELCOME TO OUR
2019/20 QUALITY REPORT





WHAT IS A **QUALITY REPORT?**

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

PART 1:
STATEMENT FROM THE CHIEF EXECUTIVE

I am pleased to present the 2019/20 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 that we do at WWL and informs our most strategic decision-making. By way of example, in April 2020 we became a teaching hospital which is the first step in our longer-term ambition to become a university teaching hospital. For us, the move to become a teaching hospital and ultimately obtaining university hospital status is synonymous with the delivery of the highest standards of patient care and in our soon-to-be-released ten-year strategy we will set ourselves the aim of being outstanding in everything we do. 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 of 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 a number of 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.

During the year we have continued to follow our Quality Strategy 2017-21 and our quality priorities for the coming year have been set out later in this report as part of our aim to move towards zero avoidable harm by 2021. Over the next twelve months we will be developing the next iteration of our Quality Strategy which will be linked to our overall organisational strategy.





"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 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 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 not only serves to improve the experience of those who make contact with 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

This is the 'look forward' section of our Quality Report. In April 2017 we were delighted to publish our Quality Strategy 2017/21 outlining the framework to improve quality over the next four years. This section outlines the improvements we plan to take over the next year. Over the next twelve months we will be developing the next iteration of our Quality Strategy which will be linked to our overall organisational strategy.

Quality Strategy 2017/21

Our Quality Strategy 2017/21, published in April 2017, set the direction of travel for the next four years. The aim of the strategy is:

"To move towards zero avoidable harm by 2021 through continual reduction"

The Quality Strategy maintains our values to provide safe, effective and compassionate care. The strategy focuses on five primary drivers:

Quality Priorities for 2020/21

We have agreed our annual priorities for 2020/21 which support our Quality Strategy 2017/21 and consider some of our challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors, Wigan Borough Clinical Commissioners Group and Healthwatch Wigan and Leigh. The quality priorities, the rationale for their selection and how we plan to monitor and report progress are outlined opposite.

All quality priorities have a timescale for achievement by the 31st March 2021 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.

Patient Safety (Safe)

Priority 1:	95% of patients with Red Flag sepsis will receive antibiotic treatment within 1 hour in both Accident and Emergency (A&E) and on wards
Rationale:	Red Flag sepsis requires treatment within an hour of diagnosis, and patients should receive antibiotics during within an hour. If sepsis is not treated early, it can become life threatening.
Monitoring:	Quarterly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • % of patients who received antibiotics within 1 hour in A&E; • % of patients who received antibiotics within 1 hour on wards.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 2:	95% of patients with an elevated NEWS2 score (5 in total or 3 in one domain) will be screened for Sepsis in A&E and on the wards
Rationale:	Sepsis screening is associated with a decreased mortality rate. The surviving sepsis campaign (SSC) guidelines emphasise routine screening of potentially infected patients who are likely to be septic to improve the early identification and treatment of sepsis
Monitoring:	Quarterly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • % of patients who received a sepsis screen within 1 hour in A&E; • % of patients who received a sepsis screen within 1 hour on wards.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 3:	To reduce grade 3, grade 4 and unstageable pressure ulcers contributed to by lapses in care by 50%
Rationale:	WWL wants to continue the work that has been already undertaken to reduce grade 3, grade 4, and unstageable pressure ulcers occurring both within the acute setting and within the community due to lapses in care.
Monitoring:	Monthly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • Number of pressure ulcers as described that have developed due to lapses in care
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 4:	To reduce the number of CDT infections by 20% where there have been lapses in care
Rationale:	Infection with Clostridium difficile - (CDT) is the most common cause of hospital-acquired diarrhoea in the developed world. Prudent prescribing of antibiotics, correct hand hygiene, the use of personal protective equipment, environmental decontamination and isolation can prevent infection.
Monitoring:	Monthly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • Number of CDT infections that have developed due to lapses in care
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Clinical Effectiveness (Effective)

Priority 1:	**To achieve a Summary Hospital Level Mortality Indicator (SHMI) within the expected range**
Rationale:	WWL's SHMI has increased in recent months following a period of improvement. The Trust is currently in Band 1 (worse than expected) with a SHMI of 1.17 for the rolling 12 month period March 2019 – February 2020. Further work is required to improve WWL's position to move into Band 2 (as expected).
Monitoring:	Monthly SHMI reviews Monitoring of Divisional Pathway SHMI including Trauma and Orthopaedics, to be included in Divisional reporting to the Quality and Safety Committee.
Reporting:	Monthly mortality meetings Quality and Safety Committee

Priority 2:	**Compliance with the National Patient Safety Strategy (NPSS)**
Rationale:	To deliver improvements in patient care and experience in line with NPSS requirements. The following improvements are required within the organisation: • 87% of patients to benefit from the use of the emergency laparotomy care bundle; • Increase the use of the COPD discharge bundle by 50% over baseline; • Increase the use of the ED Checklist by 50% over baseline.
Monitoring:	Quarterly monitoring Reported in Divisional Quality and Safety reports as the metrics below: • % of patients who receive the emergency laparotomy care bundle; • % of patients who receive the COPD discharge bundle; • % of patients who have the ED checklist completed.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee





Patient Experience (Caring)

Priority 1:	To ensure all complaint responses are timely and have learning identified and demonstrable action is taken
Rationale:	To improve our patients experience of care and ensure learning from patient feedback is embedded into practice
Monitoring:	Quarterly monitoring Reported in Divisional Quality and Safety reports as the metrics below: • 90% of complaints responded to on time; • 100% of complaints with an improvement plan to address learning where it is identified (i.e. for all fully and partially upheld complaints).
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 2:	To improve patients experience of discharge
Rationale:	Improving discharge from hospital is one of the Trust's key patient experience priorities.
Monitoring:	Monthly monitoring Reported in Divisional Quality and Safety reports the metrics below: • 100% of discharge checklists completed; • 100 % of discharge summaries provided to the patient (and GP); • 50% reduction of upheld complaints and incidents relating to discharge.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 3:	To embed an organisational culture of psychological safety, civility and respect
Rationale:	It is essential that staff are provided with civility, respect and psychological safety as it is recognised that this is a key enabler to safe and effective care.
Monitoring:	Quarterly monitoring • Your Voice Survey: score above 3.6 or an improvement of >0.1 on each of the areas (Working Relationships, Psychological Safety, Influence, Clarity); • National Staff Survey: score of 7, or an improvement >0.2 on each of the identified areas (Immediate Managers, Team Working, Health and Wellbeing at Work, Staff Engagement and Morale); • Psychological Safety: scores above 3.6, or an improvement >0.1 for the three areas (Conditions, Beliefs and Behaviours).
Reporting:	People Committee Quality and Safety Committee

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 Reports.

2.2.1 Review of Services

During 2019/20 Wrightington Wigan and Leigh NHS Foundation Trust ("WWL") provided and/or sub-contracted 68 relevant health services detailed in the Trust's mandated services including the Wigan Community Adults and Children's services which transferred from Bridgewater Community NHS Trust in April 2019.

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

The income generated by the relevant health services reviewed in 2019/20 represents 93% of the total income generated from the provision of health services by WWL for 2019/20.

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.

2.2.2 Participation in Clinical Audits

During 2019/20, WWL participated in 27 National Clinical Audits and 6 National Confidential Enquiries covering relevant health services that WWL provides. In addition WWL participated in a further 16 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 2019/20 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 2019/20 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
Sentinel Stroke National Audit programme (SSNAP)	The SSNAP audit data is reviewed regularly and discussed at all Operational Delivery Network (ODN) Meetings. It is used to highlight areas that need improvement both locally and within Greater Manchester, and ideas identified on how the ODN can support WWL to improve areas when needed.
National Paediatric Diabetes Audit (NPDA)	The national audit showed case-mix adjusted mean HbA1c (mmol/mol) was 76.2 which is a negative outlier compared to national aggregate of 67.5. Quality Improvement (QI) sessions were held monthly with implementation of a pathway which continues to show improvements.
National Emergency Laparotomy Audit (NELA)	The Trust now has a NELA Nurse Practitioner who drives forward quality improvement initiatives from yearly reports, sharing best practice and benchmarking care delivery against national standards which aims to improve mortality and morbidity in emergency laparotomy patients.
National Joint Registry (NJR)	Regular updates are provided at audit meetings and areas for improvement highlighted. **The Information from the 2017/18 Audit is as follows:** **Wrightington site:** Total number of Hip/Knee replacements was 3098. There were 3078 operations (99.4%) that matched the NJR and 20 unmatched operations (0.6%) of which 12 had not been submitted to the NJR, 4 had an incorrect operation date and 4 had an incorrect operation surgeon. There were a further 13 operations that had been correctly submitted to the NJR that did not match with what had been coded. **Wigan site:** Total number of Hip/Knee replacements was 111. There were 93 operations (83.8%) that matched the NJR and 18 unmatched operations (16.2%) of which 10 had not been submitted to the NJR, 4 coded as operation being performed at Wrightington and 3 had an incorrect operating surgeon There were a further 16 operations that had been correctly submitted but did not match with what had been coded.

The reports of 155 (to the end of Q3) 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
Termination of Pregnancy (TOP)	Improvement in documentation and since provided following the introduction of a pathway and check list. Documentation is now almost 100% in all areas.
Outcome Form Audit in Ophthalmology	Improvement of outcome forms in outpatients to 97% completion compared to previous outcome of 47% as a result of a training session to educate staff on how to complete forms.
Pre-operative Airway Assessment	Improvement in documented airway assessment in 80% of patients (previously 73% in 2017 and 48% in 2015) and improvement in airway assessment by anaesthetising anaesthetist has improved to 100% (91% in 2017 and 80% in 2015) as a result of adhering to 4 National Audit Project (NAP) standards. This is the largest study of major complications of airway management every performed, and following previous audit recommendations.
Audit of Low Grade Smears	Improvement in offer of appointments within 6 weeks (99.8% vs 91% in previous audit). Improvement in achieving suitable biopsy for histopathology (98.6% vs 96% in previous audit). Improvement for communication of results to patient; (87.5% within 4 weeks (best practice) compared to average of 46% last year). This was achieved following lengthy discussion and raised awareness at the audit meeting regarding the recommendations.
uDNACPR 2019	Improvement in overall compliance as a result of actions taken by the Task and Finish Group following MIAA Internal Audit Results.

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.

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 Report. 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.

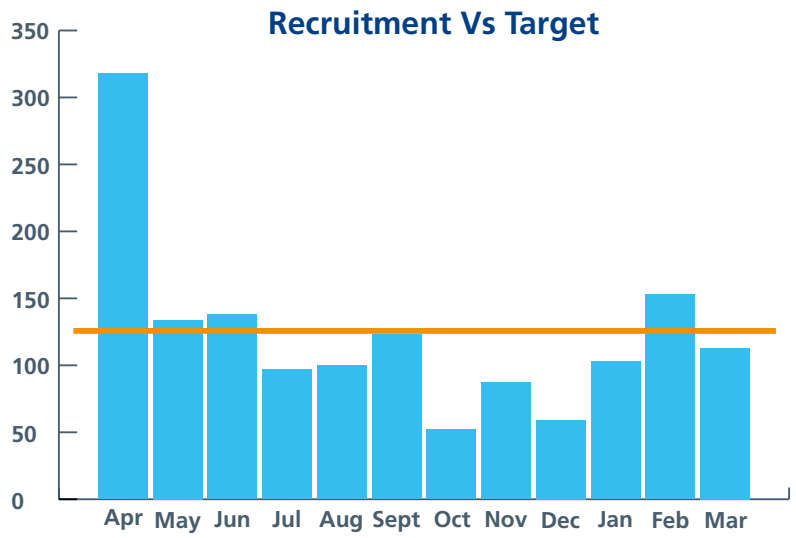
2.2.3 Research

Participation in Clinical Research

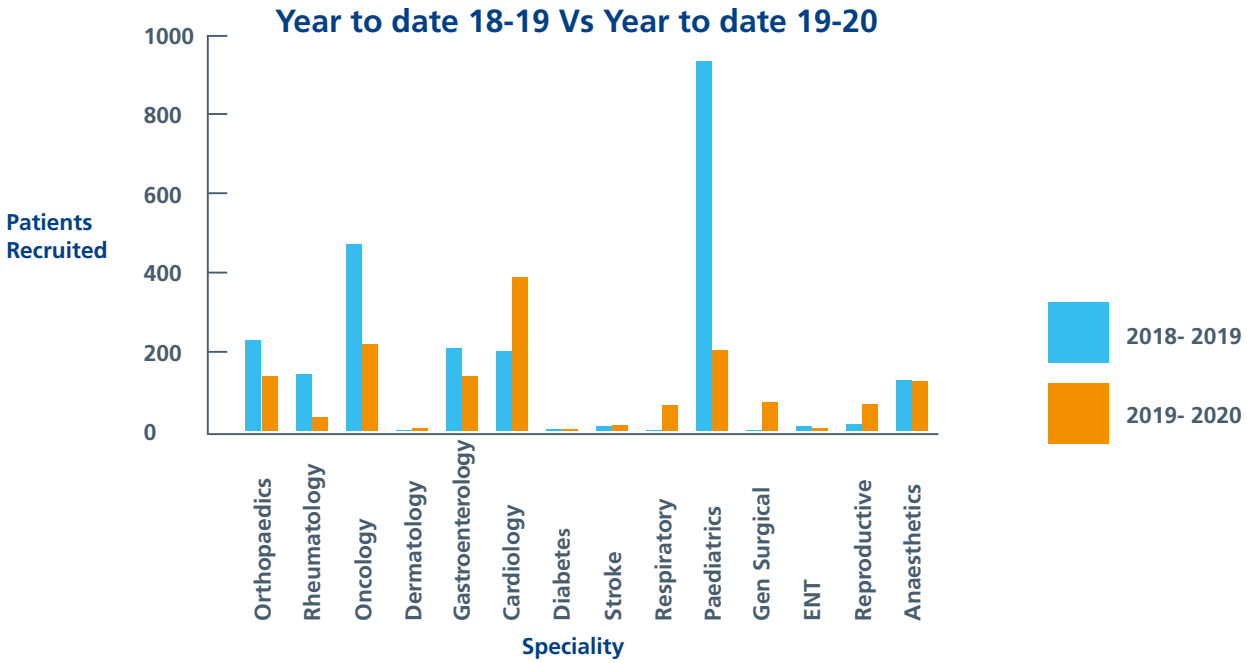
The number of patients receiving relevant health services provided or sub-contracted by WWL in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio') was 1477 an average of 123 patients per month. The Trust target agreed with the National Institute for Health Research (NIHR) was 1455 recruits (an average of 122 per month).

Patient Recruitment 2019/20

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

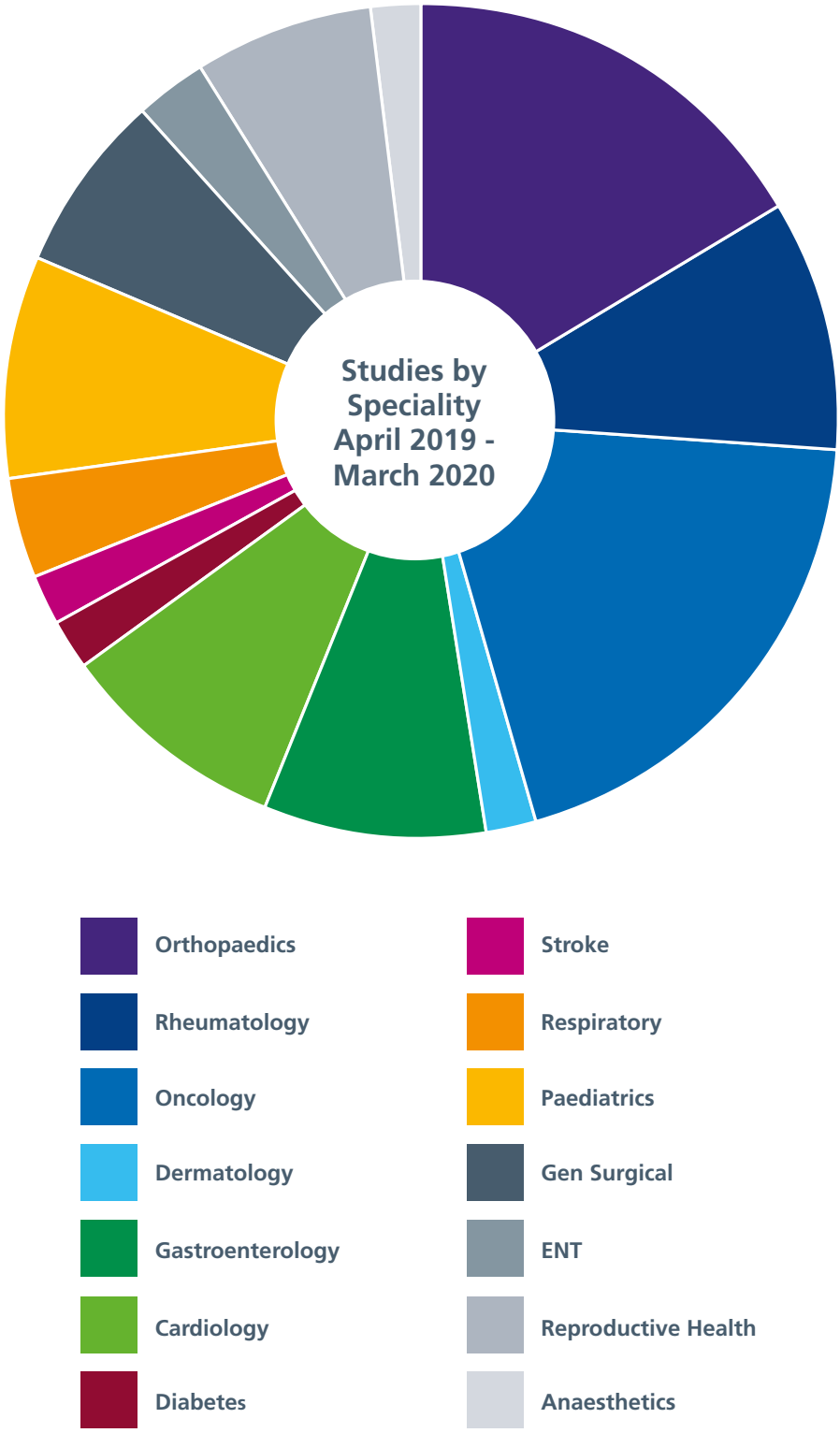


Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are continually updated about the latest treatments. We were involved in conducting 102 NIHR Portfolio clinical research studies in addition to Non Portfolio studies in a variety of specialities during the year 2019/20.
The chart below illustrates the recruitment by speciality.



2019/20 saw the successful application for funding via the National Institute for Health Research (NIHR). Two Orthopaedic Surgeons received substantial funding awards totalling more than £2million.

The chart below illustrates the variety of disease areas where the Trust has participated in National Institute for Health Research registered studies between 1st April 2019 and 31st March 2020.



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 absolutely 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."

Once again the Trust has been recognised at a regional awards ceremony in a number of categories. This includes engagement with our Patient Public team led by Dr Jane Martindale.

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.
The Trust was one of the first in the country to set up an interventional

trial for finding a suitable treatment for COVID-19 and we are continuing to support the fight going into year 2020/2021.

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 in a position to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

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.

2.2.4 Goals agreed with Commissioners

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

A proportion of WWL's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between WWL and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

WWL received £3.3m in relation to CQUINS for 2019/20, in comparison with £5.5 million in 2018/19 although it should be noted that the total available reduced and therefore this is not a fair comparison. In addition due to the Covid-19 pandemic quarter 4 activities were suspended resulting in an estimate of the final position.

For acute services all of the schemes in 2019/20 were nationally mandated and covered the following areas:

1. Antimicrobial Resistance – Lower Urinary Tract Infections in Older People
2. Antimicrobial Resistance - Antibiotic Prophylaxis in Colorectal Surgery
3. Staff Flu Vaccinations
4. Alcohol and Tobacco Screening
5. Tobacco Brief Advice
6. Alcohol Brief Advice and Onward Referral
7. Three High Impact Actions to Prevent Hospital Falls
8. Same Day Emergency Care for the following conditions
    a. Pulmonary Embolus
    b. Tachycardia
    c. Community Acquired Pneumonia

Whilst the schemes were suspended during quarter 4 significant progress was made in a number of areas during the year particularly in relation to antibiotic prophylaxis in colorectal surgery and high impact actions to prevent hospital falls. Throughout the year the Trust reported full compliance with alcohol and tobacco screening, alcohol brief advice and onward referral and same day emergency care.

For community services the schemes were locally agreed and were as follows:

1. Reducing Deterioration of Pressure Ulcers (PURA Form) – District Nursing Service
2. Preventing ill health by Risky Behaviours – 0-5's Health Visiting Service
3. Implementing Specialist Falls Prevention Training – Community Response & Falls Teams
4. Reducing the Impact of Serious Infections: Timely Identification of Patients with Sepsis by District Nursing Services

As with the acute service schemes, good progress was made until much of the activity was suspended during quarter 4. Progress in relation to the sepsis scheme was slow due to the lack of some key equipment in the community but this was resolved in quarter allowing for some work to be done during that period.

Schemes for 2020/21 were launched during March 2020 but all work on them was suspended as the pandemic took hold in the UK.

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.





> "The CQC notes how both leaders and staff are proud of their services and to work for the Trust and staff are praised on their dedication, patient focus and the way in which staff treat patients with compassion and kindness."

2.2.5 What others say about WWL

Statements from the Care Quality Commission (CQC)

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2019/20, is registration without conditions on the registration.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2019/20.

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

During 2019/20 the CQC undertook a core service inspection between 22 and 24 October 2020. The CQC inspected the Surgery, Maternity and Critical Care Core Services and visited Leigh Infirmary, Wrightington Hospital and the Royal Albert Edward Infirmary sites.

The Use of Resources Inspection occurred on 11 November 2019 and the Well-Led Inspection between 26 and 28 November 2019.

The CQC subsequently published a combined quality and resource rating report 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 overall CQC rating for WWL was 'Good' and WWL has maintained a rating of 'Good' for every domain (safe, effective, caring, responsive and well-led). Our Use of Resources was 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 is a reflection of the hard work, compassion and professionalism of all our staff.

The CQC notes how both leaders and staff are proud of their services and to work for the Trust and staff are praised on their dedication, patient focus and the way in which staff treat patients with compassion and kindness.

The CQC inspected three core services across the RAEI, Wrightington and Leigh hospital sites including; Surgery, Maternity and Critical Care, all of which were rated 'Good' overall.

The CQC highlighted examples of outstanding practice in all three services including:-

Maternity:

The CQC highlighted an "Emergency Response Station" developed by one of our senior midwives, improving the quality of care in an obstetric or neonatal emergency, and the support the service provides to women who had delivered and were being cared for in the critical care unit.

Maternity services improved in three of the five domains (safe, effective and well-led) and is now rated 'Good' overall, an improvement from the 2017 CQC inspection and a credit to our staff that work in and support this service.

Critical Care:

The CQC highlighted the "TEA-ching" training programme developed by our practice educators, involving a 10 minute teaching break each day, and also the critical care patient acuity and staffing risk assessment tool the service has designed, helping to ensure that nurse staffing on the unit was safe and adequate for the patient and unit's needs. The Critical Care service maintained a rating of 'Good' overall and in all five domains.

Surgery:

At the RAEI site the CQC highlighted the use of innovative approaches within the service to ensure the highest quality of care we provide to our patients, including alarm clocks for those patients who require time sensitive and critical medicines. They also highlighted the innovation seen by the 10 successful 'Dragons Den' bids within the service to help deliver improvements in patient care, staff experience and financial benefits. This includes the Wrightington Hospital which was praised on their work around piloting the day case hip replacement surgery and Leigh Infirmary with the successful funding for Holmium laser equipment to provide day case treatment for patients with prostate cancer. Both of these initiatives have a positive impact on patient care through less invasive surgery and less time in hospital.

Our Surgery core service maintained a rating of 'Good' overall at all three locations (RAEI, Leigh Infirmary and Wrightington). However, we were rated 'Requires Improvement' for the 'safe' domain at RAEI and Wrightington. The Trust acknowledges and recognises the commitment and dedication of staff working within this service, both for WWL and the quality of patient care you provide.

WWL always welcomes feedback and inevitably the inspection did identify some areas for improvement. Action plans are already in place to address these, with some already underway following the initial feedback. These include; a Trust-wide review of the storage of cleaning products, addressing a number of issues identified by the CQC regarding the Theatre environment, consistency of risk management processes, storage of patient records, paediatric resuscitation training compliance and the visibility of senior leaders.

The Trust continues on 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.

Below are some of the highlighted CQC comments included in the final report:

- "Leaders and staff were patient focussed and proud to work for the Trust";
- "The trust had a culture of openness and honesty and processes to support people speaking up";
- "The trust had transparent, collaborative and open relationships with all relevant stakeholders, particularly in the Wigan borough";
- "The trust had an integrated governance structure with processes to support ward to board assurances. Structures, processes and systems of accountability were clear and understood by staff, and were going to be reviewed shortly";
- "The trust had a strong track record of financial performance and delivery of most national performance standards";
- "The trust's performance reporting gave a holistic understanding of quality, performance and finance and incorporated the views of patients";
- "The trust had a track record of using improvement methods and skills which is used at all levels of the organisation".

A review of how the Trust uses its resources concluded that the Trust has been able to demonstrate an improvement across a range of metrics together with an increase in collaborative working, both across the local health economy and wider systems, and in particular a greater use of technology to drive efficiencies and provide high quality care.

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.

2.2.6 NHS Number and General Medical Practice Code Validity

WWL submitted records during 2019/20 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:

- 99.9% for admitted patient care,
- 100% for outpatient care, and
- 99.5% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care,
- 100% for outpatient care, and
- 99.8% for accident and emergency care.

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).

2.2.7 Data Security Protection Toolkit

In 2019/20 submission of the Data Security and Protection Toolkit was delayed due to the COVID response. This is based on the National Data Guardian's ten data security standards. In 2019/20 the Trust did not meet all of the Data Security Plans; however an action plan has been submitted and agreed with NHS Digital.

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.

2.2.8 Clinical Coding Error Rate

WWL was not subject to the Payment by Results clinical coding audit during 2019/20 by NHS Improvement. WWL commissioned an external audit by Blackpool Teaching Hospitals NHS foundation Trust to comply with Data Security and Protection. The audit was conducted in December 2019 for assurance of clinical coding quality.

- Primary Diagnosis incorrect 4.0%
- Secondary Diagnosis incorrect 5.66%
- Primary Procedures incorrect 1.43%
- Secondary Procedures incorrect 5.08%

The Trust achieved the advisory assertion levels for both Clinical Coding Standards of

- Data Security Standard 1 Audit and
- Data Security Standard 3 Training

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

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.

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

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Although the Trust already has historically had good Data Quality however 2019/2020 has seen a notable reduction in this from the top 7th percentile to the bottom 23rd percentile with the Model Hospital, which in part is a result of taking on the Community Service provision in April 2019. The Trust recognises this and will always acknowledge where improvements can be made.

Over the last 12 months the Trust has a continuing programme of work for the development and improvement of the Data Quality. The Trust is getting ready to release the latest iteration of the (DQ) app with in the Acute setting with a view to include the Community Division in the coming months. 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.

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 interation 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.

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.

2.2.10 Learning from Deaths

During 2019/20 (1.2%) (Q1, Q2, Q3, Q4) of WWL patients died (1222). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 312 in the first quarter;
- 270 in the second quarter;
- 330 in the third quarter;
- 310 in the fourth quarter.

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

By March 2020, 627 case record reviews and 627 investigations have been carried out in accordance with the Learning from Deaths Guidance in relation to 51% of the deaths referenced in the introduction. In 627 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was;

- 108 in the first quarter;
- 174 in the second quarter;
- 226 in the third quarter;
- 209 in the fourth quarter.

7 representing 0.5% of 1222 deaths in 2019/20, 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. In relation to each quarter, this consisted of:

- 1 representing 0.3% of deaths which occurred for the first quarter;
- 2 representing 0.3% of deaths which occurred for the second quarter;
- 2 representing 0.6% of deaths which occurred for the third quarter;

- 3 representing 0.9% of deaths which occurred for the fourth quarter,

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:

- Concerns were highlighted regarding Vascular access.
- Drug omissions are a known area for improvement. There are continued episodes of drug omissions despite the evidence of improvement from previous interventions.
- Care of sepsis remains a priority for the Trust and includes escalation as well as response to sepsis where it occurs.
- Non Invasive Ventilation (NIV) and overnight Continuous Positive Airway Pressure (CPAP) has been omitted in some cases.
- Bleeding where the source is hidden. This has been noted previously and is usually related to Gastrointestinal Bleeding or intra-abdominal bleeding.
- Problems with discharge have become increasingly evident.
- Complex system failure is a recognised problem. Difficulties with transfer across organisations is typically present. Significant examples are in Dialysis, PPCI, Vascular Surgery, Neurosurgery and Stroke.
- Complications of surgery are well recognised, but there were significant complications. Perforation of oesophagus required further investigation. There was a death related to surgery that was considered to be of limited benefit.
- Overload is a significant theme to the cases that have been noted. It is typically present as a contributory factor rather than the only issue. It links to NIV beds, to recognition of pelvic bleeds and to extended stay in A/E. Its also linked to omitted drugs and to sepsis care. When considered across organisations its also linked to complex system failure where beds are too full to receive transfers.

A description of the actions WWL has taken in the reporting period and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period: Some of the actions taken include the following:

- To address issues with vascular access, the Trust has extended the Vascular Access Team to include two whole time equivalents. Along with other services the COVID pandemic has brought changes and alterations to the clinical needs of patients. Reassessment will be needed.
- The recent COVID pandemic has altered the landscape for ventilatory support across the organisation. Significant increases in non ventilatory support (in the form of CPAP) were needed in order to manage the outbreak. Reassessment of the service provision will be needed in the light of changed clinical landscape.
- There are initiatives being implemented throughout the Trust to support staff in clinical areas with timely administration of medications. Pharmacy technicians are now assisting with medication rounds on assessment areas and also Practice Educators are based on wards to support staff in medication administration training. These initiatives should result in a reduction of drug commissions which will be monitored during 2020/21.
- There is on-going work with sepsis care with the implementation of an electronic pathway.
- To ensure safe care of patients in A&E, the emergency care bundle has been implemented.
- The Trust held a themed SIRI panel focusing on patient discharge. This event identified areas of learning. A task and finish group has been established and actions taken from this event are progressing. The Trust's Chief AHP will lead these actions during 2020/21.

In the time since the work was done the landscape of clinical care in hospitals has been immeasurably changed by the COVID outbreak. There are different models of care and different expectations. It is unlikely that the clinical landscape will return to its previous normal. Rather a new normal will evolve and require new understanding and new clinical developments. The work will be similar but its outcomes likely to be different.

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.

2.2.11 Seven Day Services

The latest available data for compliance against the priority clinical standards for seven days services was published in November 2019 although comparator data is no longer available so it is not possible to undertake a peer comparison. The November submission measured performance against the 4 four priority standards listed below and a self-assessment against the other six standards for continuous improvement.

- Standard 2: Time to first consultant review
- Standard 5: Access to diagnostic tests
- Standard 6: Access to consultant-directed interventions
- Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others

The performance since March 2016 is shown below (gaps are where the data wasn't part of the national data collection tool)

WWL Results	Weekday Results				Weekend Results			
	Standard 2	Standard 5	Standard 6	Standard 8	Standard 2	Standard 5	Standard 6	Standard 8
Mar-16	61%			100%	58%			97%
Sep-16	74%				59%			
Mar-17	81%	100%	100%	98%	84%	68%	89%	64%
Sep-17	82%				94%			
Jun-18	89%	100%	100%	100%	71%	83%	100%	100%
Jun-19	96%	100%	100%	100%	95%	83%	100%	100%
Nov-19	91%	100%	100%	100%	82%	83%	100%	100%

In relation to Standard 2 at the weekend it should be noted that this is based on a small sample of patients (28), 5 of whom did not see a Consultant within 14 hours. All patients have been reviewed by the Medical Director and no harm was identified. The sample was too small to identify themes and a wider audit was planned but this was put on hold due to the Covid-19 pandemic.

In relation to standard 5 access to echocardiography remains available via informal arrangement only at the weekend. Patients who need this test urgently will have it carried out but the standard requires there to be a formal agreement to be in place. There are no plans to change the Trust approach at present.

The Trust is compliant with all six of the standards for continuous improvement. Reporting on Seven Day Service standards has now been suspended indefinitely and there is no indication that this will be reinstated.

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 on the basis of 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.

"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."

2.2.12 Speaking up

#SpeakUp ToMe

WHO CAN YOU SPEAK UP TO?

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

If staff do not feel able to raise concerns with their managers or they are unsatisfied with any feedback they have been given there are other routes available to staff. Staff can raise concerns with their Union, Human Resources or with the Trust's 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. In 2019/20 the Trust appointed a fulltime Freedom to Speak Up Guardian.

In its response to the Gosport Independent Panel Report, the Government 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.

2.2.13 NHS Doctors in Training

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

High level data

Number of doctors and dentists in training (total):	**176**
Number of doctors and dentists in training on 2016 Terms and Conditions of Service (total):	**156**
Annual vacancy rate among this staff group:	**6.41%**

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)
		Quarter 1	Quarter 2	Quarter 3	Quarter 4			
General Surgery	FY1	11	42	27	13	0	4	0.5
General Surgery	FY2/ST1-2	1	1	4	1	2	42	43
General Medicine								
	FY1	25	99	45	66	1	11	1
General Medicine	FY2/ ST1-2	1	23	15	3	2	536	79
Orthopaedics	FY1	0	5	4	4	0	0	0
Orthopaedics	Fy1	0	30	7	0	0	0	0
Paediatrics	ST1-2		1	0	0	2	8	2
Obstetrics and Gynecology	FY2/ ST1-3	1	2	0	0	0	154	30
Psychiatry	Fy2/ST1-2	2	0	1	0	0	3	0.5
Palliative Care	FY2/ST1-2	2	23	10	0	0	0	0
Total	FY2	0	0	1		0	0	0
		41	**226**	**114**	**87**	**5**	**758**	**156**

For this report we have the results of two quarters work of Exception Report data and some comments from face to face meetings with Junior Doctor representatives for the BMA.

For General Medicine many of the issues related to understaffing, deteriorated patients and heavy workloads. Most Exception Reports were a mixture of all of these. In General Surgery during this quarter it was clear that there were delays due to handovers but also issues with staff shortages and issues with weekend cover.

The bulk of Surgical Exception Reports in this quarter were by FY1's and lack of support was the common theme.

In Trauma and Orthopaedic in this quarter all Exception Reports were by FY1's and the bulk of these were due to staffing issues and high workload due to ward work.

In contrast on the 8th January 2020 the next quarterly report showed a substantial reduction in Exception Reports with 60 in General Medicine, 27 in General Surgery and Trauma and Orthopaedics having 7. This was encouraging to see, however, we would caution against an assumption that problems have been fixed as we think it is wise to make judgments over a much longer period of time than to react to results from one individual quarter.

Issues arising

In General Medicine the bulk of Exception Reports were due to late finishes and these are best illustrated by example. Stayed an hour late on Monday evening due to a scan returning at 4 pm showing a patient having an acute stroke. Due to the patients age this needed escalating to Salford to discuss management plan and then putting this plan in place. This was again urgent and inappropriate for the On Call F1 to take the jobs because the jobs were urgent and I had to complete them in order to ensure patient safety and quality of care. I stayed 1 hour and 30 minutes late due to having to finish ward jobs. There was an unforeseeable work load with patient's family members turning up after 4 pm and thus prioritising patient care. Additionally the scan reports returned at 4 pm with results needing actioning and was too urgent to hand over to the F1 on call.

From these examples one can see clearly the difficulty that Junior Doctors are having leaving on time particularly with the results of tests returning quite late in the afternoon. The often complex medical action which is required to respond to this takes time and is difficult to hand over to an On Call Clinician due to the complexity of medical intervention. It is not always clear and easy to do a simple handover and the interventions are best done by the day referring clinicians. The actions of these Doctors were therefore commendable however they do therefore result in delays in going home which therefore contributes to Exception Reports and puts Junior Doctors at risk of burn out.

Looking at General Surgery this quarter again the Exception Reports were predominantly with either late finishes or early starts or inability to take breaks. In this quarter there appear to be some variation in the starting times of some of the most Senior Doctors and Middle Grade Doctors particularly at weekends and there also appear to be a lack of post take ward round support. Also during the last quarter a meeting was held with the Junior Doctors BMA reps and with FY1's from Shevington Ward and also for General Surgery.

The main issues expressed by the FY1 Doctors are that the ward can have up to 40 patients on a round with a Registrar often having to finish late and excessive workload leading to the concerns from the FY1's. There have also been concerns about variation in the starting times of the middle grade surgical doctors covering the wards at weekends. This view was backed up by the Exception Reports submitted in the quarter leading to the January report.

Concerns from Shevington:

The Shevington rota looks good on paper however in practice often some of the medical staff down to cover the wards are not available for very legitimate reasons but this is not reflected on the paper rota. Some of these reasons are Senior Doctors being in Endoscopy or Clinics which may be off site. The main concern for the FY1's is that they are often left without support.

Nearly all ERs are by Foundation Trainees. I do not see any from core trainees or higher trainees from other spaecialities.

Actions taken to resolve issues

The actions taken to resolve these issues were as follows:

Meetings between the Clinical Director in Surgery and BMA reps to address rota needs for General Surgery

Active interaction and meetings between the Divisional Medical Director for Medicine and BMA reps to look at the issues behind Shevington Ward

Request for increased staffing levels (FY3 / IMTs) by the Medical Director to strengthen staff numbers for medicine, surgery and emergency medicine.

Meetings with FY1s and FPD Alison Quinn to examine issues and look at coping strategies and resilience of Foundation Trainees. Further engagement with core and higher trainees – opportunities are at induction and during teaching sessions (eg CMT teaching)

Summary

We have seen a drop in Exception Reports over one quarter. General Medicine has the most reports followed by surgery. The reports are about late arrival of results, sudden worsening of patients on word rounds and inconsistencies in staffing levels. Exception Reporting is almost exclusively performed by Foundation Trainees.

Active involvement from the Clinical Director of General Surgery, Divisional Medical Director of Medicine and Medical Director (with regards to rota restructuring and additional medical recruitment) is taking place. Foundation Programme Directors are actively engaging with Foundation Trainees with regards to resilience and safe handover technique.

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.

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.

Mortality

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	October 2017 - September 2018	Value: 1.1025, Banding : 2	Value: 1.0034	**Best:** HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RQX) - Value: 0.6917, Banding: 3 **Worst:** SOUTH TYNESIDE NHS FOUNDATION TRUST (RE9) - Value: 1.2681, Banding: 1
	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 2017 - September 2018	36.6%	33.6%	**Best:** THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST (RCX) - Value : 14.3% **Worst:** ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST (RA2) - Value: 59.5%
	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

Mortality data from the year follows the pattern of years past. SHMI has been higher than average. Palliative care coding is more relevant to HSMR and is monitored because it was used as a way of reducing HSMR values. It is in clinical terms better to have more palliative care. There has been extensive work on mortality once again this year. That has included the weekly deaths audits and various areas of deeper investigation to seek areas for improvement. The role of Medical Examiner has been developed and was implemented toward the end of the data time period. This allows for further examination of cases where patient have died. The system supports the Learning From Deaths programme that already runs in the Trust. The role of "total bed numbers" has been discussed within the organisation. Mathematically, the lower the number of beds per head of population served, the higher the SHMI value across Greater Manchester. There are multiple reasons that greater capacity would be linked to a lower SHMI, but the increase in capacity for the organisation is a clinical necessity given the pressure on beds and A/E flow problems. Plans for increased capacity were made and accelerated by the arrival of COVID-19.

The data time period for this report ends just as the COVID-19 pandemic arrived. Mortality data is significantly altered by COVID-19. There is uncertainty about future reporting of SHMI, but it is unlikely to include COVID-19 deaths.

Patient Reported Outcome Measures Scores (PROMs)

The Trust's patient reported outcome measures scores during the reporting period for:

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
i) Groin Hernia Surgery	April 2016 - March 2017	0.060	0.086	**Best:** NEW HALL HOSPITAL (NVC09) & POOLE HOSPITAL NHS FOUNDATION TRUST () - Value: 0.135 **Worst:** BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 0.006
	April 2017 - March 2018	0.058	0.089	**Best:** CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.137 **Worst:** SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST (RXK) - Value: 0.029
ii) Varicose Vein Surgery	April 2016 - March 2017	N\A	0.092	**Best:** TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (RMP) - Value: 0.155 **Worst:** ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST (RBN) - Value: 0.010
	April 2017 - March 2018	N\A	0.096	**Best:** THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Value: 0.134 **Worst:** BUCKINGHAMSHIRE HEALTHCARE NHS TRUST (RXQ) - Value: 0.035
iii) Hip Replacement Surgery	April 2017 - March 2018	0.470	0.468	**Best:** SHEPTON MALLET NHS TREATMENT CENTRE (NTPH1) - Value: 0.566 **Worst:** ONE HEALTH GROUP CLINIC - THORNBURY (NTX11) - Value: 0.376
	April 2018 - March 2019	0.460	0.465	**Best:** HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RQX) - Value: 0.557 **Worst:** SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST (RVY) - Value: 0.348
iv) Knee Replacement Surgery	April 2017 - March 2018	0.350	0.338	**Best:** NUFFIELD HEALTH, CAMBRIDGE HOSPITAL (NT209) - Value: 0.417 **Worst:** LEWISHAM AND GREENWICH NHS TRUST (RJ2) - Value: 0.234
	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

WWL considers that this data is as described for the following reasons:
The hip and knee PROMs compliance rate has been 99% again this year, once again passing the target for best practice tariff. However it does look like our patient improvement in general has dipped slightly.

WWL intends to take the following actions to improve these indicators and, so the quality of its services, by:
We have non to little control over the national PROMs however we are working towards developing/ updating our own system in order to provide better data then we can compare that against what is collected nationally.

Hospital Readmission

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2016 - March 2017	9.0	11.6	**Best:** SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST (RXX) - Value: 1.6 **Worst:** WEST LONDON NHS TRUST (RKL) - Value: 68.4
	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 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 to 75	April 2016 - March 2017	14.1	13.6	**Best:** NUFFIELD HEALTH, WARWICKSHIRE HOSPITAL (NT224) - Value: 0.9 **Worst:** SPIRE YALE HOSPITAL (NT338) - Value: 121.5
	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 considers that this data is as described for the following reasons:
The data displayed above is out of date.

WWL continues to work with system partners to reduce Hospital Readmissions which include the following programs of work:

- Multi Agency complex multi-disciplinary MDT to review high intensity users and provide community based support.
- Community Response Team provide a follow up for all patients discharged aged 65 and over.
- Ongoing work 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.

Responsiveness to Personal Needs

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The Trust's responsiveness to the personal needs of its patients during the reporting period	National Inpatient Survey 2017 - 2018	66.9%	68.6%	**Best:** The Royal Marsden NHS Foundation Trust (RPY) - Value: 85.0% **Worst:** Barts Health NHS Trust (R1H) - Value: 60.5%
	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

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

- Continuous monthly scrutiny of the monthly internal real time patient survey programme to drive improvements based on patient feedback. The survey which asks 12 key questions of patients' experience of person centred, compassionate care. The results have been consistently improving and positive.
- 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.

Friends and Family Test (Staff)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
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 2018	71.00%	70.00%	**Best:** St Helens and Knowsley Teaching Hospitals NHS Trust (RBN) Value - 87% **Worst:** Isle of Wight NHS Trust (acute sector) (R1F1) - Value: 41%
	National NHS Staff Survey 2019	77.00%	71.00%	**Best:** The Newcastle upon Tyne Hospitals NHS Foundation Trust (RTD) Value - 90% **Worst:** Walsall Healthcare NHS Trust (RBK) - Value: 49%

Assurance Statement

WWL considers that this data is as described for the following reasons:
We have triangulated the data with our internal survey, where we asked the same question at a similar time point. These results were comparable (78.43%). Furthermore, this result has remained relatively stable (within 3%) 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 have again performed better than the national average for staff recommending us to friends and family as a place to be treated. We have also scored above average for staff recommending us as a place to work (71.7% against the sector average of 64.0%). Results for both measures have increased since 2018.

This is a positive result not only because we are above the National sector average, but also because our results have increased significantly since last year in both metrics (up from 2018 scores of 70.7% recommending the Trust as a place to receive care, and 63.6% recommending as a place to work). We have continued to invest in three main areas of staff experience: engagement, health and wellbeing, and learning and development. Key activities to improve staff experience over the next 12 months include:

- Redevelopment of the annual appraisal system (My Route Plan)
- The launch of training for line managers
- Broadening the health and wellbeing offer to staff
- A relaunch of the intranet site to make it more user-friendly
- Re-aligning the way staff surveys are fed back to local areas to maximise usefulness

Venous Thromboembolism

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	July 2019 - September 2019	96.64%	95.40%	**Best:** Essex Partnership University NHS Foundation Trust (R1L) & Lincolnshire Community Health Services NHS Trust (RY5) - Value: 100% **Worst:** Blackpool Teaching Hospitals NHS Foundation Trust (RXL) - Value: 71.72%
	October 2019 - December 2019	96.40%	95.25%	**Best:** Essex Partnership University NHS Foundation Trust (R1L) & Lincolnshire Community Health Services NHS Trust (RY5) - Value: 100% **Worst:** Northern Devon Healthcare NHS Trust (RBZ) - Value: 71.59%

Assurance Statement

WWL considers that this data is as described for the following reasons:
I am confident that the figures are correct as they are obtained from our VTE app that pulls data directly from HIS in real-time.

WWL has taken the following actions to improve this percentage and so the quality of its services by:
We are always trying to improve our assessment scores through staff education in particular promotion of the Medical/Surgical Assessment Documents and Trust Inductions where I inform new medical staff of the importance of VTE assessments.

Clostridium difficile (C. difficile)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
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 2017 – March 2018	16.1	13.7	**Best:**Liverpool Women's (REP), Moorfields Eye Hospital (RP6) & Queen Victoria Hospital (RPC) - Value: 0.00 **Worst:** The Royal Marsden (RPY) - Value: 91.0
	April 2018 - March 2019	7.3	12.2	**Best:** Liverpool Womens (REP), Moorfields Eye Hospital (RP6) & Queen Victoria Hospital (RPC) - Value: 0.00 **Worst:** The Royal Marsden (RPY) - Value: 79.7
	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 2018/19 WWL had the lowest ever numbers of C.diff cases (11) and just 4 lapses in care.

In 2019/20 the national definition changed; the number of days to identify hospital associated cases reduced from ≥3 to ≥2 days after admission and also included cases that occurred in the community when the patient had been an inpatient in the previous 4 weeks. Therefore, rates have increased for most hospitals this year and the national average has increased from 12 to 22.

WWL have however, seen a greater number of cases than expected with peak levels in December 2019. In total there were 48 cases in 2019/20 but only 11 resulted in Lapses in care (awaiting confirmation from CCG).

Ribotyping was carried out on every specimen to help identify any linked cases; there could have been some cross infection in July in the stroke ward so an outbreak was declared and a StEIS report submitted. A number of changes were made to improve the environment and practice on the ward. There have been no cases of cross infection in the Trust since then.

The reasons for the higher C.diff rates are unclear but are likely to be multi-factorial and include not being able to give the general wards a full Deep clean this year, high activity and acuity levels on the wards and an ongoing lack of side rooms which was exacerbated in December due to caring for high numbers of patients with Flu that month.

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 C.diff case but there have been no obvious similarities or conclusions with regards location, speciality and antibiotic use identified to date but in 4 cases staff were late to send a sample so actions are being taken to raise awareness about this. Comprehensive action plans are drawn up to address any learning that results from these RCAs and progress is monitored at the IPC Committee.

The risk assessment score on C.diff was increased to 20, a C.diff reduction plan put in to place and an external review was undertaken by NHSI in September 2019 who did not identify any significant additional actions.

IPC continue to reinforce standard IPC precautions including hand hygiene, use of PPE and ensuring equipment and beds are fully decontaminated between patients. A new e-learning programme for level 2 went live in December and compliance with cleaning of commodes and completion of stool charts improved.

A full IPC audit was carried out in January on the 8 wards with the highest numbers of C.diff cases and a number of recommendations taken forward. A training day for Housekeepers took place in December; 41 attended with excellent evaluations; the importance of cleaning and hand hygiene for staff and patients was emphasised. A plan is being drawn up to ensure all general wards receive a full Deep clean in 2020.

The rate of C.diff cases has dropped since December; there were just 8 cases in the whole of Q4. .

Patient Safety Incidents

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
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	April 2018 - September 2018	4236 Incidents Reported (Rate per 1000 Bed Days 56.7) / 11 Serious Incidents (0.26%)	731348 Incidents Reported (Rate per 1000 Bed Days 44.1) / 2488 Serious Incidents (0.34%)	**Best:** Weston Area Health NHS Trust (RA3): Incidents Reported 566 (Rate per 1000 bed days 13.1) / 3 Serious Incidents (0.53%) **Worst:** Croydon Health Services NHS Trust (RJ6): Incidents Reported 9467 (Rate per 1000 bed days 107.4) / 14 Serious Incidents (0.15%)
	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 reported a higher number of patient safety incidents in the first reporting period in comparison with the second reporting period. Our rate of incidents reported per 1000 bed days does not show any evidence for under reporting and our rate is higher than the national average. Patient Safety has reviewed the data to better understand why there has been a drop in the number of incidents uploaded during the second period. This is mainly related to the time it takes for the incidents to be reviewed, investigated and shut down. 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 now monitored via the Datix Quality Improvement Group. Performance reports are distributed monthly to the Divisions for their information / action, this performance is also detailed within the Quarterly Safe Effective Caring report. 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 be trying to 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:
STATEMENTS OF ASSURANCES FROM THE BOARD

"We are proud of a number of initiatives which contribute to strengthening quality governance systems."

Part 3: Other Information

PART 3.1:
REVIEW OF QUALITY PERFORMANCE

This section of the Quality Report provides information on our quality performance during 2019/20. Performance against the priorities identified in our previous quality report 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 2019/20

We agreed a number of priorities for improvement in 2019/20 published in last year's Quality Report. These were selected following the development of our Quality Strategy 2017/21 in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1:	**To achieve an overall Hospital Standardised Mortality Ratio (HSMR) of 95 and a Band 2 Summary Hospital Level / Mortality Indicator (SHMI)**
Where we were in 2018/19	Our benchmarked position for mortality had improved during 2018/19; however, learning from deaths and analysis of mortality data remained a quality priority for the Trust.
Where we are at the end of 2019/20 ✘ **HSMR: Not Achieved** ✘ **SHMI: Not Achieved**	Regulators are increasing their emphasis on SHMI, particular since NHS Digital has moved to monthly reporting. The Trust is now scrutinising the NHS Digital data regularly for clinical pathways requiring further review. At the end of March 2020 the Trusts SHMI was 119.6 to November 2019 (latest data available). HSMR for the same time period is 101.1. Actions to improve mortality data are ongoing and include: • The Medical Director has sought a GP Fellow who is reviewing deaths within 30 days of discharge to include primary and community care provision; • The establishment of a Medical Examiner role as required for all Trusts by April 2020. This will impact on how the Trust reviews deaths and identifies learning. • The Trust is shortly implementing the sepsis triggering component on HIS which should bring a step change in the way the Trust is able to monitor and manage sepsis. The Medical Director has scheduled a meeting with Public Health and the Trust clinicians in relation to Alcoholic Liver Disease, highlighted as an 'outlier' for SHMI.

Priority 2:	**To reduce grade 3 and 4 pressure ulcers contributed to by lapses in care**
Where we were in 2018/19	WWL became an integrated acute and community NHS Trust, following the transfer of Wigan Borough Community services from April 2019. We wanted to continue the work that has been commenced to reduce grade 3 and 4 pressure ulcers occurring in the community that may be the result of lapses in care.
Where we are at the end of 2019/20 ✘ **Not Achieved**	A Task and Finish Group was established in July 2019 to develop a pressure ulcer reduction plan, monitored via Harm Free Care Committee. A Themed SIRI Panel was held in November 2019 and was well attended by staff from across all clinical areas. A pressure ulcer review panel was commenced in December 2019 chaired by the Deputy Chief Nurse to review all **Hospital Acquired Pressure Ulcers (HAPU's)** regardless of grade. This replicates a forum established within the community division. This forum has identified further areas for improvement in practice, process and equipment availability which have been incorporated in to the Trusts improvement plan. There were 0 category 3 and 4 HAPU's reported to StEIS in December 2019 and January 2020, 1 in February 2020 and 0 in March 2020. Three wards where the majority of pressure ulcers have been reported have moved, on a trial basis, back to paper records for the SSKIN bundle. Audits of practice are being undertaken monthly and a report on the trial with subsequent recommendations is scheduled to be presented in March 2020 to Harm Free Care Committee. 25 HAPU's were reported to STEIS in 2019/20. It should be noted for **Community Hospital Acquired Pressure Ulcers (CAPUs)** that this year, it is difficult to benchmark this with data with Bridgewater Community Health Care NHS Trust data for the same time period last year as their reporting would include all localities and the criteria for reporting to STEIS was different at WWL. 20 CAPU's were reported to STEIS in 2019/20.

Priority 3:	To reduce the numbers of falls resulting in serious harm or death.
Where we were in 2018/19	From April 2018 – March 2019 there were 7 serious falls, the same number as we had in 2017/18. Further work was required to reduce this number.
Where we are at the end of 2019/20 ✔ **Achieved**	**Q4** 2019/20 there were 2 serious falls, so in comparison to the same period last year there has been a **66.6 %** reduction in the number of falls reported which resulted moderate severe or catastrophic harms on the wards or adjacent areas. Comparing the financial years 2018-19 and 2019-20 we have had a **45.8%** reduction in moderate, severe and catastrophic harms from falls, which significantly exceeds the WWL goal of reducing the level of said harms by 15%. This significant reduction in harms has been achieved through excellent team working of the Falls Improvement Group (FIG), along with the trust's commitment and support of the Clinical Quality Team as it strives to reduce harms from falls. Work has continued to be undertaken during Q4 by the Quality and Governance Team in conjunction with the FIG which has supported the reduction in falls resulting in serious harms. This includes: • Weekly emails to ward manager reminding them of the importance of checking that staff have completed the lying & standing BP on all appropriate patients. • Raising awareness of falls by teaching on the Clinical Induction and Cavendish course, highlighting the importance of a lying and standing BP • Working with the HIS team to add the lying and standing BP to the tracking board, to make it easier for the ward managers to monitor. • Falls Improvement Group members are monitoring for compliance in their own areas and offering support to staff in completing the lying and standing BP for all appropriate patients. Compliance with the Falls Improvement CQUIN in Q4 is **62%** which is a significant improvement from Q1 which was just 14%. Future work: a trial of innovative falls technology, relaunching of the falls champions, campaign to keep patients hydrated to reduce orthostatic hypotension, review of hourly rounding tool, and training/ awareness with junior doctors on wards to highlight medications that can cause an increase in falls and working with the Chief AHP to launch the next PJ paralysis campaign.

Patient Safety (Safe) contd.

Priority 4:	**To achieve 95% of patients found to have sepsis receiving IV antibiotics within 1 hour in Accident and Emergency (A&E)**	
Where we were in 2018/19	Compliance for patients with sepsis receiving IV antibiotics within 1 hour in A&E was 39.70% in Q4 2017-18. This initially improved significantly up to the end of Q2 2018-19; however, compliance declined during Q3 to 79.8%. This quality priority was selected due to this decline in compliance and the further work required to improve this.	
Where we are at the end of 2019/20 ✘ **A&E: Not Achieved**	**A&E/Inpatient** A&E: The percentage of patients who present with suspected sepsis to emergency departments, and were administered intravenous antibiotics within 1 hour.	**Q4 2019-20 data** Jan 2020 – 80% compliant Feb 2020 – 87.5% compliant March 2020 – 93.75 compliant = 87.1% compliant for Q4
	It is important that the Trust progresses the development of the sepsis pathway on the Trust's electronic patient record (HIS). This has been delayed due to pressures related to the COVID-19 pandemic; however this remains a priority for the Trust. There continues to be variability in A&E for patients being administered antibiotics within 1 hour of suspected sepsis, however Q3 data (73.3%) shows an improvement on Q1 (65.8%). Inpatient time to antibiotic continues to be sustained over 95%. QI methodology is being considered to improve these measures with realistic trajectories in place and regular evaluation.	

Clinical Effectiveness (Effective)

Priority 1:	To improve Fractured Neck of Femur (#NOF) Time to Appropriate Bed
Where we were in 2018/19	It is best practice to support optimal care for patients with fractured neck of femur (NOF) and that they are transferred to an orthopaedic bed within 4 hours of admission. In 2018 WWL achieved 45.8% for NOF orthopaedic patients to access and orthopaedic bed in 4 hours. There had been no significant improvement despite the work that had been undertaken to improve this
Where we are at the end of 2019/20 ✘ **Not Achieved**	A review of the #NOF ring fenced beds SOP has been undertaken and implemented. Time to Aspull Ward (appropriate bed) within 4 hours for January 2020 is 15%, a decrease from 25% however, the average time to Aspull which is calculated manually was 5.5 hours in December 2019 and 6 hours in January 2020. It was over 18 hours prior to November 2019. In January 2020 there were 40 #NOF patients, compared to a previous monthly average of 30 patients. Other metrics have demonstrated improvement. Achievement of Best Practice Tariff YTD is 54.2%. Since November 2019 (when the ring fenced #NOF beds were allocated) it is 77.7%.Time to Theatre % within 36 hours YTD is 66.42%. Since November 2019 this has improved 80.8%.

Priority 2:	To achieve 95% compliance with the triggering on NEWS2 (National Early Warning Score) escalation of the deteriorating patient.
Where we were in 2018/19	The Trust completed the actions required to meet the patient safety alert issued in relation to the implementation of NEWS2 (replacing MEWS – Modified Early Warning Score) by the end of March 2019. NEWS2 had been implemented on the Trusts electronic patient record (HIS). The first audit conducted for NEWS2 following its implementation unfortunately resulted in a deterioration in compliance. Further work was required to improve this.
Where we are at the end of 2019/20 ✘ **Not Achieved**	Audits results are now produced by an app utilising data directly inputted by clinical staff into HIS. Overall compliance with recording all elements of NEWS2 for Q3 2019-20 is **91%**. Compliance with escalation and recording of observations in a timely manner in accordance with the algorithm is **71%**; however it should be noted that a request has been made to the HIS Team to amend NEWS2 to reflect medically led exemptions to completion of NEWS2 (for example, if a patient is at end of life) and the frequency that observations are performed. This will then permit the App to pull through accurate data to provide assurance of compliance with escalation. This change will be implemented following the upgrade of the HIS system. It is also recognised that the App only gives cold data therefore it has been agreed that the Lead for Critical Care Outreach will audit 50 patients quarterly to ensure quality and identify themes that will be reported back at the Harm Free Care Committee.

Clinical Effectiveness (Effective) contd.

Priority 3:	**To embed actions required in response to recommendations from NHS Improvements review of reported Never Events.**
Where we were in 2018/19	We reported 5 Never Events in 2018/19 and commissioned a review by NHS Improvement. We were committed to responding to the findings from this review and ensuring that actions are embedded across the Trust. This commitment had been reinforced by the selection of this quality priority in our Quality Reports.
Where we are at the end of 2019/20 ✔ **Achieved**	We end the year on 4 Never Events. To date there is one outstanding action from NHS Improvements review and this relates to the audit of LOCCSIP's. There have been 17/19 LocSSIPs audited. This was on track to be completed but due to the COVID Pandemic this action remains outstanding. The completion of these audits will be rescheduled and undertaken during 2020/21.

Priority 4:	**To reduce the number of sharps incidents by increased usage of safer sharps devices and improved clinical practice.**
Where we were in 2018/19	Staff incidents related to injuries from sharps had been high in number during 2018/19. We commissioned an audit from Mersey Internal Audit Agency (MIAA) and received 'limited assurance'. Actions were required to reduce the number of sharps incidents and therefore this quality priority was selected.
Where we are at the end of 2019/20 ✘ **Not Achieved**	We end the year on 4 Never Events. To date there is one outstanding action from NHS Improvements review and this relates to the audit of LOCCSIP's. There have been 17/19 LocSSIPs audited. This was on track to be completed but due to the COVID Pandemic this action remains outstanding. The completion of these audits will be rescheduled and undertaken during 2020/21. The number of sharps related incidents continued to rise throughout the current financial year and as at the end of Q3 2019-20 the numbers in the current financial year were comparable to those for the entire previous financial year; however actions recently taken following the MIAA audit should now begin to have a positive impact on the number of sharps injuries reported. An Audit of compliance with European Directive on Prevention from Sharps Injuries (2010/32/EU) was undertaken by MIAA in 2018/19. This demonstrated "limited assurance". A detailed action plan was developed to improve compliance which included actions to replace non-safe sharps where possible. The number of sharps-related incidents has continued to be closely monitored and reported in the quarterly SEC report. The Trust's Health and Safety Manager chairs the Medical Sharps Management Meeting which is overseeing this improvement work. The Trust now has a Medical Sharps Management Policy and flowchart on the actions to take following a contaminated sharps incident. An investigation proforma is issued to an employee who completes it with their line manager. This proforma is a reflective exercise designed also as a training tool to improve practice where this is possible. The proforma is also reviewed by a multi-disciplinary team and where potential for learning is identified or where retraining is required, this is acted upon. A database of non-safe sharps is now available and being used to swap unsafe varieties to safe ones where possible. It is hoped that the introduction of safer varieties will assist in reducing the number of incidents and this is a focus of the meeting. A campaign is planned for the new financial year, which is hoped will raise awareness of the personal impact of poor practices that result in a sharps incident and contribute to a decrease in the number of sharps incidents.

Patient Experience (Caring)

Priority 1:	To achieve 90% of patients reporting that they received information on medicines at discharge.
Where we were in 2018/19	The patient survey results for Trust's using an organisation called Picker for their national surveys had demonstrated that we had further work to do to improve this indicator.
Where we are at the end of 2019/20 ✔ **Achieved**	This metric has been monitored via feedback from patients who have participated in the Discharge Always Events Audits. For the current financial year compliance with this measure is as follows: • RAEI: **92.6%** • Wrightington: **92.6%** The Trust has recently introduced Pharmacy Technicians onto the assessment wards who have a specific role regarding medicines administration and education of patients to improve concordance with treatment regimes. The pilot is to be expanded to other areas of the Trust.

Priority 2:	To achieve an improvement in patients reporting that they were treated with kindness and understanding during the care received in hospital after the birth of their baby.
Where we were in 2018/19	The results of our National Patient Survey 2018 for Maternity Services were very good; however, patients reporting that they were treated with kindness and understanding during the care received in hospital after the birth of their baby was one of areas requiring improvement.
Where we are at the end of 2019/20 ✔ **Achieved**	In October 2019 it was reported that the Trust had received the 2019 Maternity Survey results for Trusts that utilise Picker for their patient surveys. The results demonstrated that the Trust has achieved an improvement. In 2018 93% reported that they were treated with kindness and understanding. In 2019 this has improved to 97% which is in line with the national average. The full national maternity survey results were published in January 2020 which also identified an improvement for WWL to **97%** which is in line with the national average

Priority 3:	To achieve a reduction in the number of complaints related to discharge.
Where we were in 2018/19	There was an increase in the number of formal complaints during 2018/19, in comparison with the previous year. We wanted to focus on a reduction of complaints related to discharge.
Where we are at the end of 2019/20 ✔ **Achieved**	Figures to the end of January 2020 demonstrate a reduction in the number of complaints related to discharge by **73%**. This demonstrates the collaborative work undertaken by stakeholders.

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	2017-18		2018-19		2019-20	
Infection Control						
Clostridium difficile (C. difficile): variance from plan	25 Threshold = 19	↑	11 Threshold = 18	↓	**48 Threshold = 20**	↑
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	12	↓	2	↔	**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.

We continue to undertake a detailed individual patient review collaboratively with our commissioners on each case. Comprehensive action plans are drawn up to address any learning that results from these RCAs and progress is monitored at the IPC Committee. There were 11 'Lapses in Care' identified, 4 of these were related to samples being taken later than they should have been, the other reasons for lapses were all different. Actions are ongoing to remind staff of the importance of timely sampling.

MRSA Bacteraemia.
There were no MRSA bacteraemias in 2019/20. Work to standardise the approach to ANTT (Aseptic Non-Touch Technique) across the Trust is ongoing and the new teaching package and assessment documentation was rolled out. There are now over 115 staff trained to carry out assessments with monthly training sessions continuing until the COVID outbreak. The aim in 2020/21 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	2017-18		2018-19		2019-20	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	4	↑	5	↑	**4**	↓

The Trust has reported 4 Never Events during 2019/20. Previously Never Events have occurred in various locations, sites and specialties; however, 3 of the most recent incidents did occur within the theatre setting.

Following the review of all our Never Events by NHSI the report and actions were shared via CQEC / Quality and Safety Committee. To date there is one outstanding action from this review and this relates to the audit of LOCCSIP's. There have been 17/19 LocSSIPs audited. This action was on track to be completed but due to the COVID Pandemic this action remains outstanding. Our action for 2020/2021 is to ensure that the learning from the NHSI review is embedded in practice through both qualitative and quantitative audits of the Trusts LocSSIPs.

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

Indicator	2017-18		2018-19		2019-20	
Accident and Emergency (A&E)						
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	80.57%* 86.04%**	↓	82.11% * 87.48%**	↑	**84.00%**	↑

Attendances to Accident & Emergency Department rose by 4% compared with the previous year, this is an increase of over 3,000 patients. Following the successful implementation of the Frailty at the Front door pathway in collaboration with AQUA and Same Day Emergency Care pathways we say a reduction in the number of Admissions through A&E which reduced by 3% compared with 18/19. We also treated and discharged in excess of 99% of patients within four hours in our Type 3 Walk in Centre. Despite the overall increase in demand within A&E, WWL was the highest performing unscheduled care system in Greater Manchester. We also saw a notable improvement in Ambulance Handover Times following collaboration with NWAS as part of the 'Super 6 programme'. We also saw improvements to our Urgent Treatment Centre with the integration of GP Out of Hours services and the introduction of a Mental Health Suite on the Acute Hospital site in collaboration with North West Boroughs Healthcare NHS Foundation Trust to improve services for patients presenting to Urgent care Services with Mental Health related conditions

As we move into 20/21 WWL is looking forward to the expansion of the A&E unit which will provide increased capacity for the expansion of the Initial Senior Assessment Triage (ISAT). The continued roll out the ED safety checklist and continued collaboration with local and regional partners as we work meet the increased challenges of COVID 19, maintaining safe services for patients and staff and meeting the national objective to reduce A&E attendances to 75% of 19/20 demand

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

Indicator	2017-18		2018-19		2019-20	
Cancer Waits						
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	92.58% 94.28%	↑* ↑**	88.08% 89.53%	↓* ↓**	**85.34%**	↓
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	98.75% 98.5%	↓* ↓**	97.04% 97.52%	↓* ↓**	**92.92%**	↓

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.

WWL's overall performance for all standards related to the 62 day cancer waiting times in 2019/20 were maintained above the national threshold. This year has again been challenging, with more complex pathways and greater demand for diagnostics. We continue to collaborate with our partners across Greater Manchester to improve patient pathways and deliver the best possible outcomes for our patients.

In April 2020 we have the introduction of the 28-day diagnosis standard. This standard requires that patients are informed of either a cancer diagnosis or the ruling out of cancer by day 28 from a GP suspected cancer referral or referral from a national screening programme. It has been mandatory to collect this data from April 2019, performance to be reported from April 2020. To help deliver this standard there have been 4 National best-timed pathways introduced, mapping the various milestones within the pathway to achieve a diagnosis or ruling out by day 28.

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

Indicator	2017-18		2018-19		2019-20	
Referral to Treatment (RTT)						
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway (Threshold= 92%)	94.80%	↓	93.25%	↓	**90.53%**	↓

While WWL continues to perform well in comparison with Greater Manchester ending the year as the 2nd top performing Trust, the organisation failed to achieve the 18 week referral to treatment time for the first time in 19/20. The number of patients receiving their first definitive treatment within 18 weeks of GP referral continues to fall year on year primarily within specialties where demand for both elective and non-elective care exceeds capacity within an organisation which has the lowest bed base in Greater Manchester. However, specialties primarily outpatient focused or operating out of the Trust's elective treatment sites consistently perform within the top quartile in the country. The last time England achieved the standard was February 2016.

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

Indicator	2017-18		2018-19		2019-20	
Diagnostic Procedures						
Maximum 6-week wait for diagnostic procedures (Threshold=99%)	98.99%	↓	99.21%	↑	**98.83%**	↓

We continue to maintain the national standard of 99% of patients receiving diagnostics within 6-weeks.

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.

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.

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 department continues to work closely with the Divisions to promote a positive patient experience and to actively encourage a swift response to concerns which may be received by letter, e-mail, telephone or visitor to PALS, providing resolution in real time.

All complaints and concerns are shared at our Executive Scrutiny 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; A&E and Maternity), amongst other information for each individual site under our responsibility.

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. Below are the lessons identified from complaints closed within the period of Q4

In light of the Covid-19 pandemic, the Trust suspended responding to formal complaints received from mid-March 2020; this was consistent with national guidance.

Complaints Theme and Brief Summary	Actions Taken and Lessons Learned
Appointments Patient is unhappy with referral delays concerning her baby being referred to the tongue tie service which meant it was too late to start breast feeding. She would also like to know the outcome of the discussion with the midwife who falsely recorded observations.	To help improve the referral system it has been agreed with breastfeeding together peer support services that it would be beneficial for the infant feeding team to confirm they have received any future referrals. If they have not heard confirmation within 72 hours they would then follow up the referral to ensure the email had been received. It will also be requested that if a tongue tie is noted at any point that the midwives inform the infant feeding team so that are able to offer additional support should this be required.
Clinical treatment History of patient having orthopaedic surgery had a fall at home; attended A&E and a x-ray but did not reveal fracture, however some time later it was discovered there was a fracture and the patient had to undergo revision surgery.	A full review of systems and processes undertaken of how reporting of radiological findings are done in A&E.
Clinical treatment Mum not happy with misdiagnosis when her daughter attended leigh walk in centre.	Department to communicate that consideration to wider differentials during clinical assessments in patients with symptoms suggestive of PE, and information on PE recognition cascaded to the whole team. Patients presenting with symptoms suspicious of PE must be discussed with the A&E consultant
Patient Care Patient unhappy with the events which happened whilst waiting for a bed on the ward. Patient was then sent to delivery suite, whilst suffering a miscarriage which cause upset and distress.	Division to review a protected area within the Ward were women in the same situation can be cared for more appropriately.
Communication Complainant is unhappy with the lack of communication and believes that there has been conflicting information given to family.	Consultant has reflected thoroughly on what and how he communicates with families to try to ensure them and their loved one have as full a picture as possible.
Communication Patient is not happy with the amount of time it takes for the pharmacy to have the prescribed drugs delivered to the PIU ward, which she attends regularly.	Pharmacy and PIU undertaking a review of the process of dealing with prescriptions for these presentations.





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 2019/20 the PHSO requested information regarding 5 complaints. Decisions have been received within this period for 8 cases which were: 4 partially upheld, and 2 not upheld, 2 not investigating. These cases relate to 2015 through to 2018. 4 remain with the PHSO with no further correspondence received to date.

In addition the Trust received notification from the PHSO that they are re-investigating one of their own investigation, and the Trust awaits any instructions.

Final reports for investigations concluded in 2019/20 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 Inpatient Survey 2019.

The Patient and Public Engagement Team continue to obtain feedback from inpatients using the Real Time Patient Experience Survey. The surveys are undertaken by our hospital volunteers and governors. The results are presented to the Board of Directors every month to monitor the corporate objective of over 90% of a positive patient experience.

As a result of this monitoring there has been significant improvement in patients being involved in decisions about their care and treatment and patients being offered a choice of food during their stay, leading to a much improved experience for our patients. Overall we have scored slightly lower than the previous year in the Real Time Patient Experience Survey. In 2018-19 we scored an average 92.78% and in 2019-20 we scored an average 92.71% so a slight drop in the overall score of 0.08%.

This year we have struggled to improve the question "Do you know which consultant is currently treating you". We introduced this question in 2013. During this time the scores have struggled to achieve the 90% benchmark score. The trust has only achieved the 90% benchmark on seven occasions during the six years. Discussion have taken place with patients on many occasions about them knowing what their doctors name is and many respond that they are not bothered about the doctors name, they just want to get better. Our proposal to change the question to "Do you have confidence and trust in the Consultant/ Doctor treating you" we feel this is a more appropriate question for our patients and in line with national patient surveys.

Following the National Cancer Survey 2019 results the report again tells us that Black and Minority Ethnic (BME) cancer patients have poorer experiences of cancer services than their White British patients. Following this we undertook our second yearly survey BME Cancer Survey to engage with our BME community. Overall our patients reported that they had a good experience of our cancer services. They felt respected and cared for and had trust in our staff.

Patient and Public Engagement

Patients and carers attended an 'Experience Based Design'(EBD) event to assist with the design of the new Community Assessment Unit. The public were asked what they wanted the environment and facilities to look like in the new unit. The results of the EBD group work demonstrated some really good ideas and thoughts for the environment and facilities for the new Community Assessment Unit. To enable the unit to be of a gold standard and service to our patients we should consider those ideas and recommendations that members of the public have put forward to us today.

Some of those key gold standards are below:

- The names of the doors to be themed either with names of local areas, nature, garden themes or flowers.
- Good accessibility, wheelchair access.
- The colours to be calming. Water or garden scenes. Landscape artwork. A tropical fish tank.
- Lowery prints, Flat screen TV, Local Landmarks, mural, clean colours, black and white pictures.
- Old shop, pub, sweet shop, bus stop scenes, reminiscence memorabilia.
- Bedside lights, Trial Alexa so it reminds us when to take our medication or get up out of our chair to exercise, dimmer switches so the patient can control the lighting.
- Chairs to have arm rests which will aid weakened elderly patients to lift themselves out or to move to a more comfortable position. NB not too low of a seat. Assisted reclining chairs. Durable clean chairs but not plastic.
- Windows with good ventilation but must be secure. Clocks, leisure activities, menus designed like

you get in a restaurant, TVs in the rooms, access to books and magazines, information board.

- Polite helpful friendly staff.

Members of the public also attended an event to assist with the development of the Trusts new 2030 Strategy. One idea suggested for the new strategy was to have more patients self-managing their own health.

We have worked in partnership with Wigan Borough Clinical Commissioning Group on the Maternity Voices Partnership. We have increased the awareness of skin to skin contact. We have done this by midwives emphasising the importance of skin to skin at the antenatal appointments along with the infant feeding team who are working with families. Skin to skin information is included in information packs for partners.

The Patient and Public Involvement Team worked with members of the Support for Wigan Arrivals Project (SWAP) for refugees and asylum seekers asking their views on receiving their appointment letter via a mobile phone or device. Some of the members thought it was a good idea to receive the letters by a mobile device but what if we have no money for phones? Reassurance was given that if the letter is not accessed a paper copy of the letter would be posted to them automatically.

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 points include 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 Divisional Quality Executive Committees, Quality Champion Committee, Discharge Improvement Committee, Children's Clinical Cabinet, Infection Control Committee, and PLACE assessment, to give the patients' perspective.

We have reviewed the Trusts Patient Engagement Committee and formed a new Patient Experience and Improvement Committee. The Committee's remit is to ensure that Patient and Public Involvement remain integral to us and all Trust activity. A lay representative attends the committee. Achieving a positive patient experience and improving services for our patients remains a key priority for us.

"We have continually achieved excellent scores for cleanliness throughout the hospitals placing us in the top 20% of Trusts in this area."

Consultation with Local Groups and Partnerships

Wigan Borough Clinical Commissioning Group (CCG), Healthwatch Wigan and Leigh, local voluntary groups such as Healthwatch, Think Ahead and the Local Authority work in partnership with us on the Improving Discharge Committee. Some of the improvement work implemented includes discharge prescribing for the Re-enablement Team, pharmacy information leaflet and signposting of the service on discharge medication, introduction of extra pharmacy resource at weekends to ensure that patients receive a safe, effective and caring provision of medication for discharge on Saturdays and Sundays.

Some examples of how the Trust has listened to our patient feedback/comments and made improvements are as follows:

SERVICE	YOU SAID	WE LISTENED
Accident and Emergency Department	I was not told when I could resume normal activities (Type 1).	At each contact opportunity the dedicated member of staff providing care and treatment or any form of support will discuss with the patient when they can resume normal activities. The relevant staff member will support the patient.
Inpatient - Discharge	I was not told who to contact if worried.	We reviewed the discharge booklets. We reviewed external websites for information and added this to discharge information. We reviewed the Clinical Nurse Specialist answerphone message and the quality of information provided.
Cancer Services	I did not have all the information needed about chemotherapy treatment before it commenced.	We ensured all information is given at a pre chemotherapy talk and available in Macmillan Information Centres.
General	I feel like I received an excellent level of care. Thanks to all involved.	We welcome your comments. Thank you.
General	I feel the nurse that dealt with me on most visits has been extremely pleasant and helpful and I would highly recommend her to anybody.	We are delighted you have had such a positive experience.

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 2019/20 is outlined below.

Ward Accreditation

WWL's ward accreditation system ASPIRE (Accreditation System Providing Improvement and Recognition in the care Environment) continues to provide assurance that the care provided by the Trust is of a high standard. ASPIRE also continues to act as an early warning system to highlight any area of concern in a ward or department.

During 2019/20 the Clinical Quality Team have continued to support wards to maintain their bronze awards, prepare for silver awards and most importantly support the white wards in their efforts to achieve bronze. 20 areas have met the standard for bronze; most of the areas which did not achieve bronze on the first visit were successful on the revisit. One ward remains identified as white, and as such, a number of different support mechanisms have been employed. The Clinical Quality team have provided the ward with a suggested improvement plan, which is monitored by the division.

The progress of ASPIRE is monitored by the Harm Free Care Board, which receives its quarterly reports. These reports are also shared via the Senior Nurse Meetings and Corporate Quality and Safety, which allows the learning from ASPIRE visits to be shared across the organisation. The reports highlight any emerging themes

across wards and departments; this allows the trust to make appropriate focused improvements. This reporting process also allows the ward teams to celebrate their successes and share good ways of working and new ideas across the organisation.

Accreditation visits can be used to aid preparation for CQC inspections, with each element of the framework now aligned to a Key Line of Enquiry (KLOE). The ASPIRE visits have seen an increase in staff confidence in showcasing their good work, much of which may have been previously accepted as 'just what we do'. ASPIRE has given direction and support to drive improvements within areas. The use of Appreciative Inquiry during ASPIRE visits has seen staff embrace improvement work, as has the healthy competition to see who will be the first to achieve silver ASPIRE!

A period of reflection allows the team to review the ASPIRE process and the framework and make improvements required. A significant amount of work was undertaken to adapt the framework to work within an App, however, it was decided to continue the accreditation process on paper at present due to challenges experienced during the initial trials.

Measures for silver are currently being trialled to ensure that the targets set are a suitable 'stretch' to drive improvement further. The framework will continue to change over time through lessons learnt and in order to reflect quality improvements required.

2019/20 has seen the development of the matron's audit. This audit was developed out of ASPIRE, focusing on themes or trends which required monitoring for improvement. This audit sits within the Perfect Ward App and is completed monthly, providing further assurance that standards of care are being monitored for improvement. High level reports may be produced and they themselves are used as an improvement measure feeding back into ASPIRE.

2019/20 saw the Clinical Quality Team expand, with the employment of a Clinical Quality Practitioner (CQP) and most recently a Clinical Quality officer (CQO). The CQP provides more 1:1 support to the clinical teams. This support includes using the Ward Performance App, which has been developed by the trust to support teams to monitor their team's performance. The CQO will collect pre visit intelligence and help to collate post visit reports, which will speed up the accreditation process and see it expand to other areas.

Accreditation at WWL is still relatively new, and it continues to be developed to ensure that it is a truly multidisciplinary (MDT) improvement system, which recognises the quality of care provided by all at WWL. ASPIRE results are now proudly displayed in the main entrance on the acute site, and includes images of some of the MDT leaders for the areas visited. This makes a very prominent and positive statement about how the Trust assesses and recognises excellence on the wards and other clinical areas.

Staff Engagement the WWL Way

Staff engagement and experience continues to be high on the agenda at WWL. The 2019 National Staff Survey highlighted a slight improvement in staff engagement since 2018, however the picture overall remains mixed – the scores remain lower than pre-2018, and overall we are within the average range, below our ambitions to be the best for staff engagement.

We measure staff engagement using both the National Staff Survey and a quarterly 'pulse' survey – 'Your Voice'.

Looking at the available data in more detail, the indication is that we have a number of areas of strength regarding staff experience:

- Working relationships within teams are generally positive.
- Staff generally feel trusted to do their jobs with autonomy.
- Staff generally look forward to coming to work at the Trust.

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

- Quality of appraisals.
- Equality, diversity and inclusion.
- Enabling of development via non-mandatory training.
- Line managers.

Ongoing and upcoming activities to improve these areas, as well as staff experience more generally, include:

- The quarterly staff pulse survey, 'Your Voice', to accurately identify organisational and divisional trends in staff engagement and the factors which enable and hinder this. This leads to both organisational and local plans to tackle issues raised.
- A revision and redesign of the annual appraisal system (My Route Plan).
- Formation of a work stream dedicated to improving equality, diversity and inclusion within the workplace, particularly with regards to opportunities for progression and development opportunities.
- Development of training and of the support available for line managers, as well as continuation of previous offers such as the day Leadership and Management Modules, and Leadership Masterclasses (with the latter being available to all staff).
- Realignment of the training budgets.
- Expansion of the wellbeing offer to staff (Steps for Wellness), with activities including the mindful living programme, roll-out of physical 'health checks', and of the 'power pause', as well as resilience offers.

- Ongoing close local partnerships, such as the Healthier Wigan Partnership.
- Debriefing offers to increase, with an expansion of the Critical Incident Stress Management (CISM) programme.
- Delivery of staff recognition programmes such as Going the Extra Mile, Employee/Team of the Month, and the Recognising Excellence Awards.
- The re-launch of the staff intranet platform, in response to staff feedback.
- Delivery of targeted support and intervention within areas identified as potentially benefitting from OD support.
- 'Focus' magazine, the staff magazine which is produced and distributed quarterly.
- The celebration of national and local initiatives such, as national awareness days, by walkabouts, giveaways and promotion.
- Bespoke learning and development learning opportunities in addition to the corporate offer.
- Delivery of the highly successful Pre-employment and Apprenticeship programmes.
- Partnership working with local schools and colleges to promote careers in the NHS.

Our locally-developed staff engagement programme, Go Engage, continues to be utilised by other organisations, with 14 organisations currently using the system. A dedicated team continues to work on developing and growing this as a commercial product, as well as supporting the internal staff engagement team with engagement within the Trust.

Continued Recruitment and Development of the Quality Faculty

2019-20 Overview of Trust-Wide Quality Improvement Training within the Transformation Team

The Transformation Team visited each of the Trust's three sites at the end of summer 2019 and undertook a survey to seek feedback from current and past Quality Champions (QC) regarding the Quality Champion course content, delivery method and support provided. Findings from this fact-finding exercise indicated the need to provide more structured training around managing the project life-cycle, including Quality Improvement (QI) project sponsor sign-off, project scoping, stakeholder management, data collection and analysis, problem solving, root cause analysis, process mapping, future state improvements using action plans and sustaining achievements. The feedback was taking on board and improvements made to the Quality Champion programme. The newly designed programme was tested, refined and rolled-out in January 2020. In addition to this, the Transformation Team now runs regular 'drop-in' coaching sessions to provide on-going support as needed for those completing their first or subsequent QI projects.

The new QC training programme is now modular based. A new format and delivery method has been developed and rolled out during January 2020 This has been extended by an extra day, to three days, to include new advanced QI tools and techniques missing from the condensed two day programme to ensure projects fully deliver their goals. The new programme has been designed to walk employees through their sponsor signed-off Quality Improvement project, from project improvement idea through to project completion and close-out.

Benefits and impact of the changes made to the new QC training programme:

- QI Projects now require sponsor 'sign-off' from their senior manager to ensure project objectives are aligned to WWLs strategic priorities
- An A3 Project Charter (one page) is now used to clearly define and communicate project objectives, thus reducing future conflict between key stakeholders and team members
- The data collection and analysis process provides more focus on establishing baseline metrics to demonstrate performance improvement
- Ensures correct use of mapping activities clearly identifying customer driven value streams
- Using an action plan to manage future state process improvement, ensuring projects deliver sustainable results over time
- Modular based training (each module can be delivered independently of each other to meet specific needs e.g. Value Stream Mapping a departments current state processes)
- More emphasis and 'hands-on' use of QI tools and techniques resulting in better project outcomes and success

The Quality Champions Training Programme has continued to attract increasing numbers of Quality Champions from both clinical and non-clinical divisions. In summary for 2019-2020:

- Three Quality Champions training courses completed
- Two QC courses in progress
- Two QC course pending
- 84 employees undertaking the QC training course
- There is now no waiting list for QC training
- There are now 450 Quality Champions who have completed the QC training programme
- There are 343 completed QI projects from Quality Champions to date

All Quality Champions who complete the training programme and commence an improvement project are awarded a bronze badge. Silver and gold badges are awarded to those Quality Champions who sustain their improvements and disseminate them to other organisations.

In 2019-20 the awards have now increased to:

433
Bronze awards,

89
Silver awards,

31
Gold awards across the Trust.

In the year there were 15 Silver and 4 Gold badges awarded.

The Quality Champions conference took place in October 2019 attracting both Trust and external delegates to experience and share best practise on Quality Improvement. Key note speakers were Helen Bevan, NHS Horizon, and Roy Lily from the Fab Academy. Quality Champions led and delivered their projects and badges were awarded to the Gold and Silver project team leads. We also had fourteen Quality Champion posters displayed around the conference room highlighting specific Quality Champion projects for delegates to view throughout the day.

The Transformation Team have introduced 'lunch and learn' one hour introductory QI sessions at all three Trust sites. These have been designed to introduce employees to methodologies and tools they could use in improving their workplace environment. In addition to this, as a member of Advancing Quality Alliance (AQuA), we have taken advantage of three one day 'Essential Quality Improvement Planning' (EQuIP) training sessions offered to Trust employees. Offering these two additional options to Trust employees, it is expected to attract more interest onto the QC training programme throughout 2020-21.

The Transformation Team have provided assistance to Astley Ward (Wigan), Upper Limb Ward 1 and Orthopaedic Wards 1 and 2 at Wrightington set up and manage the introduction of weekly Quality Improvement MyQ Boards. These are designed to identify 'day-to-day' quality improvement opportunities, address these problems and record outcomes on a weekly tracker. To date MyQ boards have identified and made over 56 small scale improvements during a six months period.

The Transformation Team continue to provide QI training and support on SAVI Schemes e.g. MSK, GP Out of Hours and Estates. The support ranged from Idea for Improvement generating sessions to leading teams as they map out their service pathways to developing improvement action plans.

The Quality Champions training programme and support programmes will continue to adapt and evolve to meet our diverse and changing stakeholder needs throughout 2020-21 and improved alignment in enabling the achievement of corporate priorities and objectives.

Leadership Walkrounds

There have been scheduled Leadership Quality and Safety Rounds throughout 2019/20. These involve Executive Directors, Non-Executive Directors and Governors. Visits took place in the following areas: Maternity Ward, Leigh Walk in Centre, Dermatology, Endoscopy Wigan, Theatre Wigan, Paediatric Out Patients, Theatres Leigh, Accident and Emergency, Planned Investigation Unit and John Charnley Wing.

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 remained fairly constant, and the majority of calls are resolved either during that point of contact or very soon afterwards.





APPENDIX A:
NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

The National Clinical Audits and National Confidential Enquiries that WWL has participated in during 2019/20 are as follows:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible to partnership Y/N	Participated	Number eligible	Actual submissions
Pulmonary embolism	Y	Y	4	3 (75%)
Acute bowel obstruction	Y	Y	5	4 (80%)
Long term ventilation	Y	Y	2	2 (100%)
Young people's mental health study	Y	Y	None eligible	NA
Dysphagia in Parkinson's Disease	Y	Y	8	8 (100%)
In Hospital Management of Out of Hospital Cardiac Arrests	Y	Y	5	3 (60%)

National Audits (NCAPOP)	Eligible	Participated	Number submitted	Actual submissions %
Falls and Fragility Fractures Audit programme (FFFAP) (Comprises 3 audits, as below):				
• Fracture Liaison Service Database (FLS-DB)	Y	Y	140	100%
• National Hip Fracture Database (NHFD)	Y	Y	346	100%
• National Audit of Inpatient Falls (NAIF)	Y	Y	5	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	Ongoing data collection Up to date	Ongoing
National Asthma and Chronic Audit Programme (NACAP) Comprises following 3 audits below:				
• COPD	-	-	536	Ongoing
• Asthma	-	-	124	Ongoing
• Paediatric Data	Y	Y	34	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Y	Y	Ongoing data collection Up to date	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	41	100%
National Audit of Dementia (Care in general hospitals)	Y	N	-	-
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Y	Y	73	100%
National Cardiac Audit Programme (NCAP) Comprises the following audits below:				
• Heart Failure (Heart Failure audit)	Y	Y	308	Ongoing
• Adult Percutaneous Coronary Interventions (Angioplasty audit)	Y	Y	614	Ongoing
• Cardiac Rhythm Management (Arrhythmia audit)	-	-	347	100%
• Myocardial Ischaemia/MINAP (Heart Attack audit)	Y	Y	530	Ongoing
National Diabetes Audit – Adults	Y	Y	Data collection ongoing	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	75	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	153 (2019 data)	100%
National Gastro-intestinal Cancer Programme	Y	Y	Ongoing data collection Up to date	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Ongoing data collection Up to date	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing data collection Up to date	Ongoing
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Y	Y	Ongoing data collection Up to date	Ongoing
National Ophthalmology Audit (NOD)	Y	Y	1176	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	154	Ongoing
National Prostate Cancer Audit	Y	Y	Ongoing data collection Up to date	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	275	92%

Non-NCAPOP commissioned	Eligible	Participated	Number submitted	Actual Audit Submissions %
BAUS Urology Audit - Female Stress Urinary Incontinence	Y	Y	13	100%
BAUS Urology Audit - Percutaneous Nephrolithotomy	Y	Y	12	100%
Case Mix Programme (CMP)	Y	Y	469	100%
Elective Surgery - National PROMs Programme	Y	Y	See part 2.3: Reporting against core indicators	-
Endocrine and Thyroid National Audit	Y	N	-	-
Head and Neck Audit (HANA)	Y	N	-	-
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Y	N	-	-
Major Trauma Audit	Y	Y	153	72%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Y	Y	Ongoing data collection	Ongoing
National Audit of Seizure Management in Hospitals (NASH3)	Y	Y	Data not available	-
National Cardiac Arrest Audit (NCAA)	Y	Y	124	100% (awaiting validation)
National Joint Registry (NJR)	Y	Y	3700	99%
Perioperative Quality Improvement Programme (PQIP)	Y	Y	34	-
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Y	Y	Ongoing data collection	Ongoing
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Y	Y	3	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Y	Y	Submission of audit	100%
Surgical Site Infection Surveillance Service	Y	Y	Ongoing data collection	Ongoing
UK Cystic Fibrosis Registry	Y	Y	22	100%
UK Parkinson's Audit	Y	Y	Ongoing data collection	-

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:

Statements from Wigan Borough Clinical Commissioning Group, Healthwatch Wigan and Leigh and Wigan Health and Social Care Scrutiny Committee

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

Wigan Borough Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group Response to Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust Quality Account 2019/20

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

The CCG acknowledges the level of partnership working that has been undertaken by WWLFT during 2019/20 to improve the quality, safety and experience of care for our residents and more latterly to support the Boroughs response to the COVID-19 pandemic.

In respect of the 2019/20 quality priorities, the CCG acknowledges progress has been made in a number of areas; of particular note is:

- A reduction in the number of falls reported which resulted moderate, severe or catastrophic harms on the wards or adjacent areas
- An increase in the number of patients reporting that they received information on medicines at discharge
- An increase in the number of patients reporting that they were treated with kindness and understanding during the care received in hospital after the birth of their baby
- A reduction in the number of complaints related to discharge

The CCG notes some of the objectives for 2019/20 were not achieved including a reduction in the number of sharps incidents and improving the time to appropriate bed for patients with a fractured neck of femur and although these objectives have not been carried over into 2020/21 the CCG does not want the Trust to lose sight of these targets.

Challenges in year have included an increase in:

- Hospital acquired pressure ulcers
- Summary Hospital Level Mortality Indicator (SHMI)
- Clostridium difficile cases
- Serious incidents

The CCG supports the quality priorities identified for 2020/21 and welcomes the focus on:

- Increasing to 95%, the percentage of patients with Red Flag sepsis receiving antibiotic treatment within 1 hour in both Accident and Emergency (A&E) and on wards
- Reducing the number of category 3, 4 and unstageable pressure ulcers contributed to by lapses in care by 50%
- Reducing the number of Clostridium difficile infections by 20% where there have been lapses in care
- Achieving a SHMI within the expected range. This will be supported by a review of pathways across the system
- Improving patients experience of discharge

In recognising the Trust's exceptional response to the first wave of the COVID-19 pandemic the CCG would ask the Trust to concert its efforts to meet the needs of all other patients during 2020/21, in order to reduce unmet need and tackle health inequalities. Undertaking harm reviews for all long waiters must also be a priority for 2020/21.

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 during 2020/21 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
23 September 2020

Healthwatch Wigan and Leigh

Healthwatch thanked the Trust for giving them sight of the draft Quality Accounts and the opportunity to comment. Unfortunately, on this occasion Healthwatch would not be providing feedback on the Accounts, however will work with the Trust going forwards to ensure future involvement.

Health and Social Care Scrutiny Committee

Comments were sought from Overview and Scrutiny Committee; however, none were received.

ANNEX B:
STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

Silas Nicholls
Chief Executive and Accounting Officer

Robert Armstrong
Chair

The Directors of Wrightington, Wigan and Leigh Teaching Hospitals 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 Detailed requirements for quality reports 2019/20;
- 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 2019 to March 2020.
  - Papers relating to Quality reported to the Board over the period April 2019 to March 2020.
  - Feedback from commissioners dated 29 September 2020.
  - Feedback from local Health Watch dated 2 October 2020.
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2020.
  - The 2019 national patient survey July 2020.
  - The 2019 national staff survey dated 30 January 2020.
  - CQC inspection report dated 26 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 Report 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; and;
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting 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

Silas Nicholls
Chief Executive and Accounting Officer
25 November 2020

Robert Armstrong
Chair
25 November 2020

ANNEX C:
HOW TO PROVIDE FEEDBACK ON THIS REPORT

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: foundationtrust@wwl.nhs.uk

Visit our website

View our Quality Report 2019/20 online:

www.wwl.nhs.uk

ANNEX D:
EXTERNAL AUDITORS LIMITED ASSURANCE REPORT

We have been advised by our External Auditors that there is no requirement for the Trust's Quality Accounts to be audited this year, as NHSE/NHSI removed the requirement as part of the changes they made in response to COVID.





THANK YOU
NHS

NHS

Wrightington, Wigan and
Leigh Teaching Hospitals

NHS Foundation Trust