

**Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust**

**Quality Accounts 2022-23**

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**Contents**

**Part 1: Statement from the Chief Executive**

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

Part 2.1 Priorities for Improvement in 2021/22

Part 2.2 Statements of Assurance from the Board

Part 2.3 Reporting against core indicators

**Part 3: Other Information**

Part 3.1 Review of Quality Performance

Part 3.2 Quality Initiatives

**Conclusion**

**Appendix 1 – National Clinical Audit**

**Annex A: Statement from Healthwatch, Overview and Scrutiny Committee and Clinical Commissioning Group**

**Annex B: Statement of Directors’ Responsibility in respect to the Quality Account**

**Annex C: How to provide feedback on the account**

**Annex D: External Auditors Limited Assurance Report**

**Annex E: Glossary of Terms**

**What is a Quality Account?**

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



**Part 1: Statement from the Chief Executive**

I am very happy to present the 2022/23 Quality Report for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

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

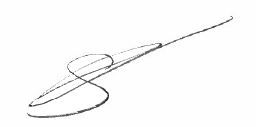
We recognise that delivery of quality is dependent on a number of factors, the most significant of which is our workforce. We believe in the importance of fostering and maintaining a positive culture and we aim to be the employer of choice in the borough and beyond. We have continued in 2022/23 to develop *Our Family, Our Future, Our Focus* – a programme of activities designed to maintain and further improve the support we provide. The programmes are promoted at every opportunity to develop a safe and effective workforce and this will continue into the next financial year.

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

We also recognise the importance of learning lessons when things do not go as planned and during the year, we have focused on improving the quality of responses to any complaints we receive. This focus continues as we strive to deliver continuous improvement in this important area. This financial year, 2022/23 we will be rolling out the national Patient Safety Incident Response Framework and this will allow us to learn better and more efficiently in the future from things that do not go the way we intend, as well as learning from the excellent work that happens on a daily basis in all areas of our organisation.

The Board of Directors are 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 2023/24**

**Quality Priorities for 2023/24**

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

All quality priorities have a timescale for achievement by the 31st of March 2024 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.

|  |  |
| --- | --- |
| **Patients**  **To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience** | |
| **Objective** | **Lead Executive** |
| To improve the compliance of Sepsis-6 care bundles as per Advancing Quality Audit, with the aim to reduce mortality from sepsis | **Dr Sanjay Arya** |
| To reduce the number of patients admitted to the hospital on end of life pathway through enhanced and expanding the excellent end of life care provided by the District Nursing Team (current audit shows that 89% of all patients referred to the team die at home or in hospice) | **Dr Sanjay Arya** |
| Work with our partners across primary care to deliver the diabetes transformation programme | **Dr Sanjay Arya** |
| Continue improvements in pressure ulcer reduction. System wide improvements for reducing pressure ulcers | **Rabina Tindale** |
| Continue to strengthen a patient safety culture through embedding Human Factors Awareness. Continue to increase staff psychological safety | **Rabina Tindale** |
| Continue and build upon the accreditation programme and to include escalated areas within the Emergency Department | **Rabina Tindale** |
| Deliver timely and high quality responses to concerns raised by patients, friends and family | **Rabina Tindale** |

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| **People:**  **To create an inclusive and people centred experience at work that enables our WWL family to flourish** | |
| **Objective** | **Lead Executive** |
| As part of our workforce sustainability agenda we will deliver the HR fundamentals brilliantly to:   * Reduce sickness absence from 6.58% to 5% * Reduce vacancy rate from 6.85% * Improve time to hire * Reduce employee relations cases * Improve employee relations timeline | **Tracey Boustead** |
| As part of Our Family, Our Future, Our Focus cultural development we will:   * Continue to prioritise our staff voice * Co design our just and learning culture * Improve the quality of meaningful conversations with our people * Create an inclusive, person centred experience * Showcase how we are acting on concerns raised by staff and patients | **Tracey Boustead** |
| The WWL leadership community will baseline where we are now, map where we wish to be, and bridge the gap to focus our collective effort.  We will regularly participate in leadership development events so that we:   * Continue to develop Inclusive and Compassionate leadership capability * Achieve higher levels of mutual trust and respect * Reduce demand by empowering our colleagues to Improve the discharge & patient flow for our residents | **Tracey Boustead** |

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| **Performance:**  **To consistently deliver efficient, effective and equitable patient care** | |
| **Objective** | **Lead Executive** |
| * Delivery of the agreed capital and revenue plans for 2023/24. * Proactive development of a long term sustainable financial strategy focused on positive value and success within a financially constrained environment. | **Ian Boyle** |
| * Delivery of more elective care to reduce elective backlog, long waits and improve performance against cancer waiting times standards, working in partnership with providers across Greater Manchester to maximise our collective assets and ensure equity of access and with locality partners to manage demand effectively. | **Mary Fleming** |
| * Working with our partners across the Borough, we will continue reforms to community and urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay. * We will work collaboratively with partners to keep people independent at home, through developing and expanding new models of care, making use of technology where appropriate (e.g. virtual wards) and ensuring sufficient community capacity is in place. | **Mary Fleming** |

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| **Partnerships:**  **To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester** | |
| **Objective** | **Lead Executive** |
| * As an Anchor Institution we will work with partners to improve the health of the whole population we serve, supporting development of a thriving local economy and reducing health inequalities. | **Richard Mundon** |
| * Develop effective relationships across the Wigan locality and the wider Greater Manchester Integrated Care Board, supporting delivery of our other corporate objectives. * Develop effective relationships across the Wigan locality and the wider Greater Manchester Integrated Care Board, supporting delivery of our other corporate objectives. * We will ensure that the effectiveness of our diabetic, children & young people and urgent and emergency care services are considered and acted upon in line with the locality transformation programmes. | **Richard Mundon** |
| * To make progress towards becoming a Net Zero healthcare provider | **Richard Mundon** |
| * Continuation of this three to five year strategic objective to: * Increase the NIHR Research Capability Funding to achieve an average of £200k/annum over 2 years in Year 4 and Year 5. * Progress joint clinical academic appointments between WWL and EHU to help meet the requirements of the University Hospitals Association i.e. achieving a minimum of 6% of the consultant workforce with substantive contracts of employment with EHU by Year 5). | **Dr Sanjay Arya** |

**Part 2.2: Statements of Assurances from the Board**

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

**2.2.1 Review of Services**

During 2022/23 Wrightington Wigan and Leigh NHS Foundation Trust (“WWL”) provided and/or sub-contracted 67 relevant health services detailed in the Trust’s mandated services.

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

**2.2.2 Participation in Clinical Audits**

During 2022/2023, WWL participated in 48 National Clinical Audits and 6 National Confidential Enquiries covering relevant health services that WWL is eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that WWL participated in and for which data collection was completed during 2022/23 is listed in **Appendix 1.**

The reports of National Clinical Audits were reviewed by the provider in 2022/23 and WWL intends to take the following actions to improve the quality of healthcare provided. Other national reports will be presented once published.

|  |  |
| --- | --- |
| **National Audit** | **Reported Outcomes** |
| NNAP 2018 – 2020 | When giving antenatal steroids to mothers who deliver babies between 24-34 weeks we achieved a rate of 95% compared to 93% in the NW and 92% nationally in 2020.  Improvement has been seen from 2018-2020 in the number of babies <32/40 who had their temperature taken within an hour after birth; the result of which was in target range of 36.5-37.5. In 2019 we were 14% higher than the national average and 7% higher than the regional average. In 2020 we were 3% higher than the national average and 10% higher than the NW average.  There has been a continuous high standard of documented consultation with parents by a senior member of the neonatal team within 24 hours of admission. From 2018-2020 we have had a higher average than both the NW and national average. 2018 99%, 2019 100%, and 2020 98%. |
| NACEL 2021 | Discussion with the patients (or reason why not) regarding their plan (IPOC). 100% of families had discussions that the patient may die, compared to 98% nationally.  The Trust provides a 7 day service compared to 60% nationally. |
| National Epilepsy 12 | 7/12 indicators – 100% achieved.  100% of children and young people diagnosed with epilepsy had been given AED during their first 12 months of care.  100% care planning was achieved in all parameters.  Time to first assessment – better than regional and national average. |
| National Paediatrics Diabetes – Audit of PREMS | Higher number of responses from both children/young people & parents/ carers compared to the previous PREMS report.  90% would recommend the clinic to friends / family if they had diabetes. |

The reports of 229 Local Clinical Audits were reviewed by the provider in 2022/23. A selection of these audits outlined below show improvements which have taken place from previous audits.

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| --- | --- | --- |
| **Speciality** | **Title** | **Success** |
| Obs & Gynae | VBAC Audit 2021  (Vaginal birth after c-section) | Increase in the rate of VBAC proforma being completed, increase in information leaflet being given to patients.  Increase in women who would like to try VBAC.  Increase in documentation during labour, regarding IV access, Bloods & Continuous EFM  Reduction in PPH risk |
| Obs & Gynae | Gynae VTE Audit | Improvement of Initial VTE assessment from 52% to 85% |
| Ophthalmology | Allergy Documentation Re-audit | Departmental stamp being used to document ID checks, MCA & Allergy status at Boston House appears to be working and an increase in compliance for checking & documenting allergies. |
| Community – District Nursing | Audit of End of Life with District Nursing Service – Cycle 6 | Changing the EOL care plan on SystmOne to mirror the IPOC paper document has shown a high compliance across all the standards. |
| Gastroenterology | Re-audit of Nasogastric Placement & Chest X-ray Interpretation. | Increase in using HIS insertions / reinsertion templates on HIS |
| Ophthalmology | Re-audit of New Retinal Vein Thrombosis Referrals to URC | All parameters have improved |
| Urology | Re-audit of Active Surveillance Prostate Cancer Compliance | All patients have been given a Key worker, DRE, MRI & information leaflets compared to the previous audit. |
| Accident & Emergency | Re-audit of the Quality of GP Letters from the Emergency Department | Percentage of letters that have been coded with an appropriate presenting complaint - 96%.  Percentage of letters that included a diagnosis - 80%. |
| Community – Childrens Audiology | Hearing Aid Verification – Cycle 3 | Improvements in compliance can be seen in standards 1 & 2. |
| Community – Childrens Audiology | Hearing Aid Verification – Cycle 4 | Further increase in Standard 2 from 81% - 91%. |
| Community – Adult Services | Falls Multifactorial Risk Assessment Re-Audit | Falls history being completed in 100% of cases audited. |
| Trauma & Orthopaedics | Re-audit of Mortality & Morbidity of Patients with #NOF with COVID-19 when Compared to those Without | The 30-day mortality had decreased from 35.2% in 2020 to 10.5% now and 90-day mortality decreased from 49.01% in 2020 to 36.8%  Getting back Aspull ward are major determinants causing decreased mortality now. |
| Trauma & Orthopaedics | Assessing Bone Health Referral in Acute Vertebral Fractures under Orthopaedic Care | Results showed improvements in all areas due to intervention of FRAX tool on HIS.  FRAX calculated and documented from 11% to 68%, DEXA from 11% to 63%, follow up 11% to 56%, bone protection from 22 to 80%, bone mineral bloods slight increase by 1% and vitamin D 50% to 72%. |

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

**2.2.3 Research**

The number of WWL patients that were recruited to participate in research during 2022-2023 (approved by the HRA and adopted onto the NIHR CRN Portfolio) was 2347, an average of 196 patients per month. The Trust target agreed with the NIHR CRN was 2085 recruits (an average of 173 per month). We have exceeded the set target.

**Patient Recruitment 2022/23**

The chart below illustrates target versus actual participant recruitment to research studies in 2022/23.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement and offering *Research for All*. Our clinical staff are continually invited to express interest in new CRN Portfolio studies and growth in research is a core Aim of WWL’s 5-year Research Strategy (*Research for All* 2022-26). Currently, there are 27 different specialities delivering CRN Portfolio adopted clinical research with 77 clinicians acting as Principal Investigators for these studies.

The chart below illustrates annual recruitment into NIHR CRN portfolio studies over 4 years.

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

The number of studies delivered decreased in the first year of the COVID-19 pandemic (2020-21) from 100 to 79 with a peak in the number of participants recruited to studies in 2020-21 and 2021-22 due to prioritisation of studies to treat COVID-19 in both years. The portfolio of studies in 2022-23 has now restored to pre-pandemic levels with an equal spread across specialties and shows a marked improvement in participants recruited (2347 recruits) compared to pre-pandemic year 2019-2020 (1478 recruits).

Our Research Strategy aims to increase the research capacity and capability, and the number of clinical staff involved in research has grown, with the number of clinicians acting as Principal Investigators increasing from 55 in 2019-20 to 77 in 2022-23. Specialties which have a robust research track record include: Rheumatology, Cardiology, Surgery, Respiratory, Reproductive Medicine, Cancer, Ear Nose and Throat (ENT), Gastroenterology, Orthopaedics and Infection. Areas of focus for improvement in research activity include: Dermatology, Diabetes, Paediatrics, ENT and Critical Care.

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

The ongoing development of our Research Patient Public Involvement (PPI) group influences the way that research is designed and to encourage more awareness and interest, we have undertaken engagement events during 2022-23 incorporating a recruitment drive to expand the diversity of the PPI group. Ten new members have joined the group and we will continue to expand the scope of this group this year and beyond. Members help to identify which research questions are important and help to influence the way research is carried out to help WWL improve the experience of people who take part in research.

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

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

The clinical research team supports all clinical teams conducting research studies across the Trust.

A new Community Clinical Research Hub has been established to make research more accessible to our patients, providing a unique facility for the local community to take part in research, and also to provide access to a facility for training and research to our healthcare partners across the Healthier Wigan Partnership.

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

**2.2.4 Goals agreed with Commissioners**

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

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

Within 2022/23, a number of

**2.2.5 What others say about WWL**

**Feedback from the Care Quality Commission (CQC)**

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2022/23, is registration without compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2022/23.

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

There were no on-site formal inspections by the CQC of our services in 2022/23. However, regular contact was maintained between the Trust and the CQC during the year as part of the CQC’s changing approach to regulation.

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

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

100% of our services and locations are now rated either **‘Outstanding’** or **‘Good’** by the CQC, the two highest ratings. Whilst the Trust has not been formally inspected within 2022/23, the Trust continues to carry out a number of internal inspections and we therefore believe that is still reasonable to expect that these ratings are valid.

Progress against actions required by the CQC from the latest inspections in 2019/20 have continued at pace during 2022/23, all actions identified as ‘must do’ were completed within 2021/22, with work being completed on those actions identified as ‘should do’ within 2022/23.

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

**2.2.6 NHS Number and General Medical Practice Code Validity**

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

WWL submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

* 100% for admitted patient care.
* 100% for outpatient care, and
* 98.25% for accident and emergency care.

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

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

**2.2.7 Information Governance Toolkit Attainment Levels**

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

WWL’s Data Security Protection Toolkit was submitted in June 2022. The assessment was scored as Standards Met/Not Met however an action plan has been submitted and agreed with NHS Digital**.** The Data Security Protection Toolkit is based on the National Data Guardian’s ten data security standards.

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

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

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

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

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

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

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

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

**2.2.10 Learning from Deaths**

During 2022/2023 1575 patients died in WWL. This comprised the following number of deaths which occurred in each quarter of that reporting period. These figures also include deaths in the Emergency Department:

* 351 in the first quarter.
* 383 in the second quarter.
* 439 in the third quarter.
* 402 in the fourth quarter.

WWL has had a process for reviewing deaths since 2008. WWL commenced the review of deaths in a structured way that met the Learning from Deaths Guidance published in March 2017.

By the end of March 2023, 1037 case record reviews and 1037 investigations have been carried out in accordance with the Learning from Deaths Guidance in relation to 66% of the deaths referenced in the introduction. In 1037 cases, a death was subjected to both a case record review and/or an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

* 191 in the first quarter
* 272 in the second quarter
* 310 in the third quarter.
* 264 in the fourth quarter

Seven (representing 0.4% of 1575 deaths in 2022/2023) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance.

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

* Annual review – each year the Learning from Deaths Team produce a review of learning from the deaths they have looked at. This enables a broad view of death within the organisation. Many of the themes are recurrent.
  + The demographic change of our population is having an ever greater effect on attendance, admission and death. Patients are increasingly frail and the numbers of patients reaching the average age of death is increasing. This societal change is an important part of planning for the future.
  + Overload of systems is a major theme. Systems within the organisation, but also those we rely on for transferring patients, are overloaded. For a hospital looking to transfer patients for tertiary care, that means additional waits and capacity problems. Sometimes those complex systems fail to provide appropriate care.
  + Exceeding the capacity of the organisation is evident. This is most obvious in the A/E corridor queues. Corridors now represent a common place to care for patients. The proportion of patients waiting in A/E over 24 is dramatically raised over pre-COVID levels. Because of the waits, A/E is now the commonest place of death for a Wigan Resident.
* Weekly reviews - Themes become evident from the weekly reviews and whilst they can be part of the big picture noted in the Annual Review, they can also be more specific and indicate more specific issues in the care of an individual.
  + Large oral cancer caused airway obstruction and wasn’t recognised to have the level of risk that existed.
  + Inadequate capacity of Nephrology / Dialysis in the tertiary referral system leaving patients waiting for transfer and occasionally dying whilst waiting.
  + Diabetic Foot cases have been seen where the existence of a diabetic foot MDT would potentially allow for earlier decisions with better outcomes. Setting up such an MDT is an agreed outcome for the organisation.
  + Late identification of patients deteriorating in A/E corridors. Whilst there are corridor nurses and reviews, the corridor is a very difficult place to provide appropriate care.

**2.2.11 Seven Day Services**

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

This was Suspended for 2022/23

**2.2.12 Speaking up**



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

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

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

**2.2.13 NHS Doctors in Training**

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

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

**High level data**

Number of doctors and dentists in training (total): 178

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

**Annual data summary**

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

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

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

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

**Issues arising:**

**Increased educational exception reports**

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

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

**Actions taken**

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

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

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

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

**Surgical F1 exception reports for hours and rest**

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

**Action taken to resolve the issue**

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

**General Medicine exception reports for hours and rest**

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

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

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

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

**Generic actions taken**

Overseas recruitment to help with the vacancies:

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

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

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

**Part 2.3: Reporting against core indicators**

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

1. National average for the same, and;
2. Those NHS Trusts with highest and lowest for the same.

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

| **Indicator** | **Reporting Periods** | **WWL**  **Performance** | | | **National Average** | **Benchmarking** |
| --- | --- | --- | --- | --- | --- | --- |
| **Mortality** | | | | | | |
| The value and banding of the summary hospital-level mortality indicator (“SHMI”) for the Trust for the reporting period | January 2021 – December 2021 | Value: 1.0616  Banding:2 | | Value: 0.9993 | | Best: CHELSEA & WESTMINSTER HOSPITAL NHS TRUST- Value: 0.7127 Banding :3 |
| Worst: NORFOLK AND NORWICH UNIVERSITY HOSPITAL NHS FOUNDATION TRUST 1.897 Banding:1 |
| January 2022 – December 2022 | Value: 1.1195, Banding : 2 | | Value: 0.9999 | | Best: CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.7117, Banding:  3 |
| Worst: NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RM1) - Value: 1.2186, Banding: 1 |
| **Assurance Statement**  SHMI for the organisation is high. It has been rising since the end of the COVID pandemic. The exclusion of COVID cases from the calculation of SHMI was advantageous to WWL. It reduced the total number of deaths included in the calculation and so broadened the confidence intervals. Now that few deaths are from COVID, that effect has evaporated.  There are widely accepted flaws in the methodology of SHMI calculation that will disadvantage organisations in poor areas with smaller numbers of beds per head of population. That is true for WWL.  The assurance the organisation needs to understand the hospital deaths comes from the regular reviews of deaths within the organisation. We are unusual in having a systematic weekly review method for deaths in hospital. The proportion of patients reviewed is exceptionally high in comparison to other organisations. The reviews are independent and widely shared for the purposes of learning. The team identify problems with care and will identify deaths where problems in care are potentially linked to the patient’s death. These deaths are referred to as Potentially Preventable Deaths. There is global experience of reviewing deaths in this way and publications of such reviews suggest that rates of Potentially Preventable Deaths should be under 3%. The rate for WWL was 0.4%. The methodology for finding such cases was the same here in WWL as it was for the published studies. This provides assurance that whilst there are problems with care, the standard of care in WWL is not leading to excessive numbers of Potentially Preventable Deaths. | | | | | | |
| **Patient Reported Outcome Measures Scores (PROMs)**  The Trust’s patient reported outcome measures scores during the reporting period for: | | | | | | |
| i) Groin Hernia Surgery | April 2017 - March 2018 | 0.058 | | 0.089 | | Best: CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.137 |
| Worst: SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST (RXK) - Value: 0.029 |
| ii) Varicose Vein Surgery | April 2017 - March 2018 | N\A | | 0.096 | | Best: THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Value: 0.134 |
| Worst: BUCKINGHAMSHIRE HEALTHCARE NHS TRUST (RXQ) - Value: 0.035 |
| iii) Hip Replacement Surgery | April 2020 - March 2021 | Not collected | | 0.453 | | Best: SPIRE SOUTHAMPTON HOSPITAL (NT304) - Value: 0.486 |
| Worst: SPIRE LITTLE ASTON HOSPITAL (NT321) - Value: 0.266 |
| iv) Knee Replacement Surgery | April 2020 - March 2021 | 0.405 | | 0.305 | | Best: SPIRE SOUTHAMPTON HOSPITAL (NT304) - Value: 0.405 |
| Worst: SPIRE LITTLE ASTON HOSPITAL (NT321) - Value: 0.266 |
| **Assurance Statement**  There have been some issues within the financial year in collection of PROMS, and it should be noted that data is released nationally with different reporting periods that the Trust does not have control over  Work is underway to develop dashboards locally so that the more live information can be reviewed internally. | | | | | | |
| **Hospital Readmission:** | | | | | | |
| The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15 | April 2017 - March 2018 | 10.1 | | 11.9 | | Best: SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST (RXX) - Value: 1.3 |
| Worst: BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RYW) - Value: 32.9 |
| The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over | April 2017 - March 2018 | 15.9 | | 14.1 | | Best: HATHAWAY MEDICAL CENTRE (NXP04) - Value: 2.6 |
| Worst: MERSEY CARE NHS FOUNDATION TRUST (RW4) - Value: 33.0 |
| **Assurance Statement**  WWL has taken the following actions to improve this indicator and so the quality of services by:   * Multi Agency Complex multi-disciplinary MDT to review high intensity users and provide community-based support is being re-stablished following COVID. * Community Response Team provide follow up calls for all patients discharged over 65 and over. * Ongoing word in respect of End-of-Life pathways.  Recent developments include integration of Hospice Staff in care planning within community and Primary Care. * Revised discharge pathway will see an improved discharge process with increased wrap around support and home-based assessments. | | | | | | |
| **Friends and Family Test (Staff)** | | | | | | |
| The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends (Acute Trusts only) | National NHS Staff Survey 2021 | 63.1% | | 77.9% | | Best: 91.7% Alder Hey Children's NHS Foundation Trust (RBS) |
| National NHS Staff Survey 2022 | 61.1% | | 75.2% | | Best: not published |
| Worst: not published |
| **Assurance Statement**  *WWL considers that this data is as described for the following reasons:*  *WWL intends to take the following actions to improve this percentage and, so the quality of its services, by:*  We recognise the importance of staff engagement and have committed to a strategic staff engagement reset, “Our family…Our future…Our focus, led and overseen by our Deputy Chief Executive and with leadership from all Executive Directors”. We continue to focus on key themes that have informed by our staff feedback and which evidence tells us has an impact on how our people will feel working in WWL and the positive impact that improved employee engagement has on patient care and outcomes. Our themes are culture, leadership & team development, well-being and communications & visibility. | | | | | | |
| **Venous Thromboembolism** | | | | | | |
| The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. | October 2020 - December 2021 | | 96.40% | 95.25% | | Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) & LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (RY5) - Value: 100% |
| Worst: NORTHERN DEVON HEALTHCARE NHS TRUST (RBZ) - Value: 71.59% |
| **Assurance Statement**  WWL is performing well against the national average. It is continuing to educate and raise awareness of the importance of VTE prophylaxis in increasing compliance even further and reducing patient harm. | | | | | | |
| **Clostridium difficile (C. *difficile*)** | | | | | | |
| The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period. | April 2020 – March 2021 | 31.3 | | National average 22  North West average 24.9 | | Best in NW: Liverpool Women’s 0, Alder Hey 8, East Cheshire 9 |
| Worst in NW: Christie 57, Blackpool 55, Lancashire 46 |
| Assurance Statement  *WWL considers that this data is as described for the following reasons:*  In 2021/22 there were 43 cases, compared to 48 in 2019/20., Incident investigations were completed, and the cases assessed at Divisional level and actions undertaken to help prevent reoccurrence where relevant.  Ribotyping was carried out on over half of the cases, especially where patient’s pathways crossed over with others who had *C. difficile*, but there were several strains in circulation and there was no evidence of direct cross infection. Again, due to the pandemic and a lack of ward to decant to, only a small number of wards received a Deep clean this year. There were also consistently high activity and acuity levels on the wards and an ongoing lack of side-rooms, which was exacerbated by COVID this year.  *WWL intends to take the following actions to improve this percentage and so the quality of its services by:*  Full RCAs continue to be carried out on each case and the Executive reviews with involvement of the CCG continue to take place. Comprehensive action plans are drawn up to address any learning that results from these RCAs and progress monitored by the Infection Prevention and Control Committee (IPC)  IPC continue to track patients with *C. difficile* through the hospital and will send samples for typing where cases crossover with one another to see if they have the same strain.  Despite the lack of Deep cleaning, IPC and Facilities continue to liaise closely to focus this team to carry out additional cleaning in higher risk areas and ensure rooms and bed spaces receive an infected terminal clean when patients with *C. difficile* are discharged.  The *C. difficle* risk assessment is being reviewed in line with the new Trust guidance and IPC will continue to carry out audits of commodes and stool charts on a regular basis to monitor compliance with policy.  The IPC team are looking to reinforce all standard IPC precautions this year through a series of high-profile initiatives, including having a month long IPC Awareness Campaign and identifying and training link nurses on the wards to help drive best practice. | | | | | | |

**Part 3: Other Information**

**Part 3.1: Review of Quality Performance**

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

**Performance against priorities identified for improvement in 2022/23**

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

**Patient Safety (Safe)**

|  |  |
| --- | --- |
| **Objective:** | **To achieve a Summary Hospital Level Mortality Indicator (SHMI) within the expected range** |
| **Where we were in 2021/22** | The Trust has significantly reduced the SHMI position and is now well within the normal range when compared to its peers. This was as a result of extensive work review all deaths, with identification of Potentially Preventable Deaths and workstreams to learn from areas where care falls short of the standards expected |
| **Where we are at the end of 2022/23** | The mortality improvement plan has been progressed through the financial year and have been continuing to implement improvements within key areas of potentially preventable deaths, including AKI and Sepsis. Whilst there are still challenges, significant work has been done to reduce the risk of these within WWL. However, within 2022/23 the Trust saw a slight decrease of the SHMI figure to go outside of the normal range. Significant work is being done to recover this position and this is being carried over to 2023/24 objectives |

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| **Objective:** | **25% reduction in mortality related to Sepsis** |
| **Where we were in 2021/22** | During the financial year the work on sepsis continued to ensure that link nurses were embedded within the Trust and were championing the appropriate management of sepsis. A project to introduce sepsis management within Electronic Medical Records was commenced and embedded. |
| **Where we are at the end of 2022/23** | The focus on this target has continued as reduction in mortality has a direct correlation on the speed of administering antibiotic medication.  The ED Sepsis group met explore, identify and address aspects of care that previously had prevented adherence to administering antibiotics within one hour of Time Zero.  A Sepsis improvement plan was updated through the financial year and was monitored via a number of routes including mortality meetings, deteriorating patient group and the Patient Safety Group.  Unfortunately, the lead Sepsis nurse post was vacant for a number of months due to vacancy and the post was not filled due to recruitment issues. Whilst link nurses were in place and sepsis was being managed through the electronc HIS system, there was a reduction in the sepsis compliance, however with this post now filled, there is a review of the management and recording of sepsis to ensure that this is supporting patient care |

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| **Objective:** | **To reduce category 3, category 4 and unstageable pressure ulcers contributed to by lapses in care by 50%** |
| **Where we were in 2021/22** | Trust reported 10 hospital acquired pressured ulcer incidents to StEIS in this financial year, which was a 67% reduction from the previous financial year and was an achievement of the aim to reduce category 2, 4 and unstageable pressure ulcers contributed to by lapses in care by 50%. |
| **Where we are at the end of 2022/23** | This target has not been achieved and although we are in a much better position than noted at the start of our journey in April 2021 and we have much to celebrate, focused work will continue to improve the position through the 2023/24 corporate objective setting process to articulate our commitment to the continuous improvement journey in reducing PU incidence. |

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| **Objective:** | **Improvement of the patient experience ensuring 7 inpatient wards progress to silver rating** |
| **Where we were in 2021/22** | This programme recommenced towards the second half of the financial year. The accreditation programme was revitalised to ensure that it could capture key information to reflect minimum clinical standards, as well as incorporating national standards such as the CQC key Lines of Enquiry. |
| **Where we are at the end of 2022/23** | Work continued on strengthening the whole accreditation process and developing the next stages of the programme including, review of using a similar tool within community, maternity and the Emergency Department. A new ASPIRE Quality Standards group was established to review the results of visits and work on quality for wards and teams. |

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| **Objective:** | **To deliver Human Factors training to at least 400 members of staff** |
| **Where we were in 2021/22** | The Trust invested in training up a number of its own staff as accredited trainers to enable a wider delivery of this training within 2021/22. This also allowed for local knowledge to be given and a human factors faculty to be developed, which will continue to be developed in 2022/23. Within this financial year, therefore, 71% of all ward managers undertook the human factors training. |
| **Where we are at the end of 2022/23** | Human Factors Training awareness training continued within 2022/23 with 430 members of staff being trained as at the end of March 2023, thereby achieving this corporate objective. The Trust intends to go further and bring this figure to 700 by the end of March 2024. |

**Patient Experience (Caring)**

|  |  |
| --- | --- |
| **Objective:** | **To improve compliance in response rates to 85%** |
| **Where we were in 2021/22** | 332 formal complaints were due to be responded to on time – 109 achieved this: with a Trust overall performance of 33%. |
| **Where we are at the end of 2022/23** | Whilst the final overall rate did not achieve 85%, significant work was done by Divisions and the Central Patient Relations team to bring the response rate to 68%  The importance of learning from patient experience via the complaints process for partially and fully upheld complaints was identified as a key priority.  The Patient Relation team also rolled out training to support staff on responding to concerns and have invested in the Datix system to |

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| **Objective:** | **To improve patients, experience of discharge** |
| **Where we were in 2021/22** | * Bi-monthly Discharge improvement meetings * Increasing Discharge related incidents * No standardised discharge checklist |
| **Where we are at the end of 2022/23** | * Monthly Discharge Improvement Group meetings commenced July 2020 with new chair (Chief AHP) and with multi-disciplinary and multi-agency representation * Discharge risk assessment with associated action plans devised and monitored by the group on a monthly basis * Paper discharge checklist implemented across all in-patient wards with plans to audit on a monthly basis commencing March 2021 * On-going work with the HIS team in relation to implementation of the Discharge Tracking Boards and creation of an electronic version of the paper discharge checklist |

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| --- | --- |
| **Objective:** | **To embed an organisational culture of psychological safety, civility and respect** |
| **Where we were in 2021/22** | At the end of 2019, WWL participated in a psychological safety survey, along with other Trusts in Greater Manchester. Outputs from this showed that WWL had a psychological safety score of 3.5 out of 5, which was amongst the lowest in Greater Manchester. This was also evidenced through the national staff survey results. |
| **Where we are at the end of 2022/23** | We have now implement our psychological safety programme of work within the Trust to support the improvements in safe culture.  The culture theme of work in “Our family, Our future, Our focus” prioritised psychological safety, civility at work and compassionate leadership. Teams have been identified to be part of a pilot, which will include education, experiential learning, action learning sets and reflective practice and we will refine the programme using participant feedback before wider roll out inn 2021/22. We have a Medical Consultant championing the programme and approach.  Our leadership and team development programmes will be built on compassionate leadership, psychological safety and human factors principles.  Our disciplinary policy was updated and published in March 2021, embedding the just culture ethos within conduct processes. During the year we also introduced an executive led review panel to consider all conduct matters. This uses the just culture decision tree and looks for informal resolution of issues where possible and appropriate. We intend to review all our People policies in 2022/23 to have a more person-centred focus. |

**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 |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | **2018/19** | | | **2019/20** | | **2021/22** | |
| **Infection Control** | | | | | | | |
| Clostridium difficile (C. *difficile*) | | 11  Threshold= 18 | ↓ | 48  Threshold = 20 | ↑ | 43  Threshold = 20 | ↓ |
| Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0) | | 2 | ↔ | 0 | ↓ | 2 | ↑ |
| **C.difficile:**  The rules governing how to identify Hospital Acquired Cases changed on 01/04/19, resulting in an increase in Hospital Reportable Cases. In addition, the threshold set by the Department of Health for 2019/20 was based on 2018/19 data, where WWL had the lowest ever number of cases.  In 2021/22 each case underwent a detailed individual patient review but due to COVID pressures only around half the cases were reviewed collaboratively with our commissioners. Irrespective of this, comprehensive action plans were drawn up to address any learning that resulted from these RCAs and progress monitored at the IPC Committee. There have been 12 ‘Lapses in Care’ identified; the most common reason was related to samples being taken later than they should have been, followed by inappropriate use of antibiotics. Actions are ongoing to remind staff of the importance of timely sampling and the Consultant Microbiologists and Antibiotic Pharmacist continue to promote and monitor antibiotic use.  **MRSA Bacteraemia:**  Cases in 2021/22; one was due to a delayed diagnosis of a pre-existing MRSA infection and could not have been prevented. The second appears to have been associated with a catheter associated urinary tract infection; there was poor documentation of the blood culture and the vascular access device so an action plan was put in place following this. Work to standardise the approach to ANTT (Aseptic Non-Touch Technique) stalled in 2021/22 due to COVID, but the aim is to make ANTT assessments part of the annual mandatory training schedule and put the blood culture documentation on to HIS, which should support compliance with the SOPs.  *Data Source: National Health Protection Agency data collection, as governed by standard national definitions.* | | | | | | | |

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| **Indicator** | **2020/21** | | **2021/22** | | **2022/23** | |
| **Never Events** | | | | | | |
| Number of Incidents Reported as Never Events (Threshold= 0) | 4 | ↓ | 1 | ↑ |  |  |
| In 2021/22 in the Trust has seen a reduction in the number of Never Events reported. In 2021/22 there was one incident reported relating to a wrong route medication. LOcSSIPs remain part of the annual audit programme.  *Data Source: Datix Risk Management System. ‘Never Events’ are governed by standard national definitions.* | | | | | | |

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| **Accident and Emergency (ED)** | **2019/20** | | | **2020/21** | | | **2021/22** | | | | | |
| Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%) | 87.48%  \* | ↓ | 76.53% | | ↑ | | 73.01% | | | | | ↑ |
| WWL ED performance against the National 4-hour target of 95% has started to improve since December 2020 after a low of 73.42% in November 2020. Performance in February 2021 reached 91.85%.  To aid recovery in ED the aim was that attendances should remain below 75% of pre-Covid levels; RAEI ED has exceeded this number from May onwards and increased month on month, peaking in August. Numbers have reduced since then, February 2021 being 7.4% lower than the previous February but remaining above the 75% pre-Covid levels.  Attendances at the Walk in Centre dropped dramatically during the Covid pandemic, April showing a 70% drop. Numbers did increase month on month, peaking in August, however, numbers started to decrease in September and remain below the 75% recovery target, February attendances being 32.8% lower than February last year.  Nationally in February, WWL ranked 14th out of 110 Acute Trusts with published data, at 91.9%, 2nd in the region for Quarter 4 and 1st in Greater Manchester  *Data Source: Management Systems Services (MSS), as governed by national standard definitions.* | | | | | | | | | | | | |
| **Cancer Waits** | **2018/19** | | | **2019/20** | | | | **2021/22** | | | | |
| All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%) | 88.04%  89.53% | ↓\*  ↓\*\* | 85.34%% | | ↓ | | | 74.58% | | ↓ | | |
| All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%) | 97.04%  97.52% | ↓\*  ↓\*\* | 92.92% | | ↓ | | | 91.98% | | ↓ | | |
| Please note where there are two percentages for one year, one represents \* after repatriation and one represents \*\* before repatriation. After repatriation are Greater Manchester agreed figures using the new national policy for allocation of breaches and compliances. From April 2019 the national system NHS digital  which all trusts are required to upload their data to will automatically re-allocate which should result in just one set of figures for 2019/20.  *Data Source: National Open Exeter System, as governed by standard national definitions.*  WWL’s overall performance for all standards related to the 62-day cancer waiting times in 2021/22 have been affected throughout the year by the ongoing COVID pandemic. Several months of the year experienced delays in Cancer pathways due to COVID which caused diagnostic delays and many patients wanting to wait or defer treatment due to the potential risk of catching the virus when attending hospital appointments – all of which had a significant impact on performance and subsequently caused a backlog of patients waiting for investigations. However, most of the cancer standards were still achieved despite being such a difficult year, only the 62-day cancer target was not achieved. We have worked hard to adapt to new ways of providing services and to deliver the best possible care for patients, we hope to see an improvement in performance over the coming months  We continue to collaborate with our partners across Greater Manchester to improve patient pathways and deliver the best possible outcomes for our patients. | | | | | | | | | | | | |
| **Referral to Treatment (RTT)** | **2018/19** | | | **2019/20** | | | | | **2021/22** | | | |
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway (Threshold= 92%) | 92.29% | ↓ | 85.70% | | | ↓ | | | 59.04% | | ↓ | |
| Achievement of the 18-week referral to treatment standard for all of our elective services has been extremely challenging throughout the last year due to the far-reaching impact of the COVID pandemic, not least due to the high numbers of medical, nursing, allied health professional and support staff that were redeployed into different roles to support the Trust’s response.  Non-urgent face to face outpatient activity was paused completely during the initial COVID surge, virtual clinic activity was quickly increased in response to this however waiting lists for both new and follow-up patients quickly grew. The increased access times to first appointment have negatively impacted on meeting the 18-week pathways.  The interruption to elective, non-urgent, surgery and huge reduction in theatre capacity for most of the last year has also negatively impacted on achievement of this standard. In line with NHSE and Royal College of Surgeons guidance all available capacity was used to treat patients in order of clinical priority, the number of patients waiting in excess of 52 weeks for their surgery are also being carefully managed and accommodated as more capacity becomes available.  Detailed recovery plans are in place for all services, progress against the trajectory is monitored through Greater Manchester and Nationally.  *Data Source: Patient Administration System (PAS), as governed by standard national definitions.* | | | | | | | | | | | | |
| **Diagnostic Procedures** | **2018/19** | | | **2019/20** | | | | | **2021/22** | | | |
| Maximum 6-week wait for diagnostic procedures (Threshold=99%) | 99.25% | ↓ | 93.40% | | | ↓ | | | 92.94% | | ↓ | |
| We failed to achieve the national standard of 99% of patients receiving diagnostics within 6-weeks. This was primarily due to backlogs generated throughout the Covid-19 pandemic because of social distancing and reduced capacity.  The largest volume of procedures is undertaken in imaging and Radiology performs extremely well against this standard; this is despite rising numbers of referrals and increasing complexity of examinations. The standard does not measure all Radiology examinations, but some of the main tests fall within Magnetic Resonance (MR), Computer Tomography (CT), Non Obstetric Ultrasound (NOUS) and DEXA which equates to about 10,200 examinations per month. Overall, we undertake approximately 330,000 examinations per year, although this was reduced last year because of Covid-19. Current imaging activity levels are higher than 2019/20 & 2021/22 attributable to recovery programmes and increasing demand in unscheduled care.  Patients receiving endoscopy within 6 weeks remains challenging due to high levels of demand and environment on the RAEI site which require investment to meet National accreditation standards, however, patients are prioritised from a patient safety perspective according to clinical need and with the input of senior clinicians.  We are engaged in the process to deliver a Community Diagnostic Hub (CDH) within the Wigan borough to expand diagnostic capacity on a non-acute site. This facility will host essential imaging procedures (CT, MR, NOUS and Projectional Radiography) physiological testing and has the potential to deliver endoscopy if a large scale CDH is developed. | | | | | | | | | | | | |

**Complaints, Patient Advice and Liaison Service and the Ombudsman**

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

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

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

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

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

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

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

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

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

During 2022/23 the PHSO requested information regarding 6 complaints. Decisions have been received for 2 cases which were: 2 closed and not investigating, with 4 remaining under investigation. These cases relate to the years, 2015, 2016, 2017, 2019 (x2), and 2020. A further 2 cases were updated in this year, 1 was suspended by the PHSO (relating to 2017), and 1 was not upheld, relating to year 2015.

Final reports for investigations concluded in 2021/22 have not required financial redress.

**Patient Experience**

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

We continue to obtain feedback on the patients experience through the Friends and Family Test. Overall 86% (March 2022) of patients expressing a good experience of the service they have used.

**Patient and Public Engagement**

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

A group of patients and the public attended our first socially distanced meeting since the pandemic to give feedback on the new development of the Jean Heyes Rehabilitation Unit. (JHRU) The group gave positive feedback on the colours and décor of the facilities. They particularly thought the dinning and social area would be of great benefit to the patients during their recovery. They did have concerns about the beds, chairs and seating and that their needs to be a variety of chairs and beds to support the patient needs and brought this to the attention of the estates and facilities team, designers and architects.

The estates and facilities team now involve the falls specialists and the moving and handling specialist in their design team to look at which type of chairs and beds any new facilities they design or build need in the future. We also have a lay representative and a governor representative on the JHRU programme board and the Model of Care task and finish group.

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

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

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

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

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

**Part 3.2 Quality Initiatives**

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

**Ward Accreditation**

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

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

**Staff Engagement – “Our Family…Our Future…Our Focus”**

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

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

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

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

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

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

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

**Continued development of the Quality Faculty**

**2022-23 Overview of Trust-Wide Continuous Improvement Training within the Transformation Team**

Training for quality champions have continued within the financial year with a good number from all divisions. Between April 2022 and March 31, 2023, 180 employees commenced the Continuous Improvement training. Of these, 97 achieved Bronze level accreditation, 38 achieved Silver level accreditation, 20 achieved Gold level accreditation and 2 achieved Platinum level accreditation

To date we have had 256 members of staff trained, with 147 at bronze level, 49 at silver level, 24 at gold level and 3 at gold level.

Within Q3 of 2022/23 a new Initiatives Streamlining Group was established with the purpose to review divisional programmes of work to support cross divisional working to achieve Trust priorities. Whilst the first few meetings were establishing the scope of the group, this will continue within 2023/24 to develop and triangulate QI programmes of work within the Trust to provide high level exposure and support.   
  
The Continuous Improvement Group has also continued to work, providing executive led support for Quality Champions and events were also held during the year to celebrate the work being done.

A number of QI projects are underway, led by medical, nursing, AHP and maternity colleagues within the Trust. Some of these include reduction in infections from long term feeding tubes, reductions in falls and management of vitamin D deficiency during admission.

**Clinical Quality Walkrounds**

During 2022/23, the Trust continued clinical quality walkrounds within a number of wards. These were designed utilising the CQC Key Lines of Enquiry as a baseline template to facilitate supportive discussions regarding quality and safety, as well as triangulating patient experience, staff experience and governance information about a particular ward. Each visit is unannounced and conducted by a varied team of staff not connected to that ward or area. This allows for a more independent review of the area and can offer different perspectives on quality and safety.

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

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

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

For 2022/23 we also introduced Non Executive Directors as part of the walkround team and this proved useful for awareness of staff, as well as the opportunity for Non-Executive Director colleagues to have one to one discussions with staff from a variety of disciplines.

**CONCLUSION**

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

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

**Appendix 1 – National Clinical Audits**

| **Count** | **Programme / work stream**  **(A-Z)** | **Provider organisation** | **Eligible to Participate** | **Participated** |
| --- | --- | --- | --- | --- |
| 1. | Case Mix Programme 4 | Intensive Care National Audit & Research Centre | YES | YES |
| 2. | Child Health Clinical Outcome Review Programme 1 | National Confidential Enquiry into Patient Outcome and Death | YES | YES |
| 3. | Chronic Kidney Disease registry | The Renal Association/The UK Renal Registry | NO | N/A |
| 4. | Cleft Registry and Audit NEtwork Database | Royal College of Surgeons - Clinical Effectiveness Unit | NO | N/A |
| 5. | Elective Surgery (National PROMs Programme) | NHS Digital | Reported on in section 2.3 of QA report | |
| 6. | Emergency Medicine QIPs | | | |
| a. | Pain in Children (care in Emergency Departments) | Royal College of Emergency Medicine | YES | Local data collection only |
| b. | Severe sepsis and septic shock (care in Emergency Departments) | Royal College of Emergency Medicine | YES | Local data collection only |
| 7. | Falls and Fragility Fracture Audit Programme | | | |
| a. | Fracture Liaison Service Database | Royal College of Physicians | YES | YES |
| b. | National Audit of Inpatient Falls | Royal College of Physicians | YES | YES |
| c. | National Hip Fracture Database | Royal College of Physicians | YES | YES |
| 8. | Inflammatory Bowel Disease Audit | IBD Registry | YES | NO - Waiting for a business case to be approved to appoint an IBD admin team member. |
| 9. | Learning Disabilities Mortality Review Programme | NHS England | YES | YES |
| 10. | Maternal and Newborn Infant Clinical Outcome Review Programme 1, 4 | University of Oxford / MBRRACE-UK collaborative | YES | YES |
| 11. | Medical and Surgical Clinical Outcome Review Programme | National Confidential Enquiry into Patient Outcome and Death | YES | YES |
| 12. | Mental Health Clinical Outcome Review Programme | University of Manchester / NCISH | YES | YES |
| 13. | National Adult Diabetes Audit | | | |
| a. | National Diabetes Core Audit | NHS Digital | YES | YES |
| b. | National Pregnancy in Diabetes Audit | NHS Digital | YES | YES |
| c. | National Diabetes Footcare Audit | NHS Digital | YES | YES |
| d. | National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms | NHS Digital | YES | YES |
| 14. | National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme | | | |
| a. | Paediatric Asthma Secondary Care | Royal College of Physicians | YES | YES |
| b. | Adult Asthma Secondary Care | Royal College of Physicians | YES | YES |
| c. | Chronic Obstructive Pulmonary Disease Secondary Care | Royal College of Physicians | YES | YES |
| d. | Pulmonary Rehabilitation-Organisational and Clinical Audit | Royal College of Physicians | YES | YES |
| 15. | National Audit of Breast Cancer in Older Patients 1, 2 | Royal College of Surgeons | YES | YES - Automatically collected via NCRAS, HES data |
| 16. | National Audit of Cardiac Rehabilitation | University of York | YES | YES |
| 17. | National Audit of Cardiovascular Disease Prevention | NHS Benchmarking Network | NO | N/A |
| 18. | National Audit of Care at the End of Life | NHS Benchmarking Network | YES | YES |
| 19. | National Audit of Dementia | Royal College of Psychiatrists | YES | Now delayed until 2022/2023 |
| 20. | National Audit of Pulmonary Hypertension | NHS Digital | NO | N/A |
| 21. | National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) | Royal College of Paediatrics and Child Health | YES | YES |
| 22. | National Cardiac Arrest Audit | Intensive Care National Audit and Research Centre / Resuscitation Council UK | YES | YES |
| 23. | National Cardiac Audit Programme | | | |
| a. | National Audit of Cardiac Rhythm Management | Barts Health NHS Trust | YES | YES |
| b. | Myocardial Ischaemia National Audit Project | Barts Health NHS Trust | YES | YES |
| c. | National Adult Cardiac Surgery Audit | Barts Health NHS Trust | NO | N/A |
| d. | National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) | Barts Health NHS Trust | YES | YES |
| e. | National Heart Failure Audit | Barts Health NHS Trust | YES | YES |
| f. | National Congenital Heart Disease | Barts Health NHS Trust | NO | N/A |
| 24. | National Child Mortality Database | University of Bristol | NO | N/A |
| 25. | National Clinical Audit of Psychosis | Royal College of Psychiatrists | NO | N/A |
| 26. | National Comparative Audit of Blood Transfusion | | | |
| a. | 2021 Audit of Patient Blood Management & NICE Guidelines | NHS Blood and Transplant | YES | NO |
| b. | 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery | NHS Blood and Transplant | NO | N/A |
| 27. | National Early Inflammatory Arthritis Audit | British Society of Rheumatology | YES | YES |
| 28. | National Emergency Laparotomy Audit | Royal College of Anaesthetists | YES | YES |
| 29. | National Gastro-intestinal Cancer Programme | | | |
| a. | National Oesophago-gastric Cancer | NHS Digital | YES | YES |
| b. | National Bowel Cancer Audit | NHS Digital | YES | YES |
| 30. | National Joint Registry | Healthcare Quality Improvement Partnership | YES | YES |
| 31. | National Lung Cancer Audit 1, | Royal College of Physicians | YES | YES |
| 32. | National Maternity and Perinatal Audit | Royal College of Obstetrics and Gynaecology | YES | YES |
| 33. | National Neonatal Audit Programme | Royal College of Paediatrics and Child Health | YES | YES |
| 34. | National Paediatric Diabetes Audit | Royal College of Paediatrics and Child Health | YES | YES |
| 35. | National Perinatal Mortality Review Tool | University of Oxford / MBRRACE-UK collaborative | NO | N/A |
| 36. | National Prostate Cancer Audit | Royal College of Surgeons | YES | YES |
| 37. | National Vascular Registry | Royal College of Surgeons | YES | YES |
| 38. | Neurosurgical National Audit Programme | The Society of British Neurological Surgeons | NO | N/A |
| 39. | Out-of-Hospital Cardiac Arrest Outcomes Registry | University of Warwick | NO | N/A |
| 40. | Paediatric Intensive Care Audit | University of Leeds / University of Leicester | NO | N/A |
| 41. | Prescribing Observatory for Mental Health | | | |
| a. | Prescribing for depression in adult mental health services | Royal College of Psychiatrists | NO | N/A |
| b. | Prescribing for substance misuse: alcohol detoxification | Royal College of Psychiatrists | NO | N/A |
| 42. | Respiratory Audits | | | |
| a. | National Outpatient Management of Pulmonary Embolism3 | British Thoracic Society | YES | YES |
| 43. | Sentinel Stroke National Audit Programme | King's College London | YES | YES |
| 44. | Serious Hazards of Transfusion | Serious Hazards of Transfusion | YES | YES |
| 45. | Society for Acute Medicine Benchmarking Audit | Society for Acute Medicine | YES | YES |
| 46. | Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment | BURST Collaborative / British Urology Researchers in Surgical Training | YES | YES |
| 47. | Trauma Audit & Research Network | The Trauma Audit & Research Network | YES | YES |
| 48. | UK Cystic Fibrosis Registry | Cystic Fibrosis Trust | YES | YES |
| 49. | Urology Audits | | | |
| a. | Cytoreductive Radical Nephrectomy Audit | British Association of Urological Surgeons | NO | N/A |
| b. | Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit) | British Association of Urological Surgeons | NO | N/A |

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

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

**Annex A:**

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

**TO BE ADDED**

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

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

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

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

* The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance.
* The content of the Quality Report is not inconsistent with internal and external sources of information including:
  + Board minutes and papers for the period April 2022 to March 2023
  + Papers relating to Quality reported to the Board over the period April 2022 to March 2023
  + Feedback from commissioners
  + The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  + The 2022 national patient survey
  + The 2022 national staff survey
  + CQC inspection report dated February 2020
* The Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered.
* The performance information reported in the Quality Account is reliable and accurate.
* There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice.
* The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
* The Quality Report has been prepared in accordance with NHS Improvement’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

*30 June 2023 Chairman*

*30 June 2023      Chief Executive*

**Annex C: How to provide feedback on the account**

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