



**Wrightington,
Wigan and Leigh**
NHS Foundation Trust



Quality account
2017 - 2018





14 Jun 17
Dr. Sargent

Your stay with us

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QUALITY REPORT





What is a Quality Account?

- > All providers of NHS Services in England are required to produce an annual Quality Account.

The purpose of a Quality Account is to inform the public about the quality of services delivered by us. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence based quality improvement and to explain progress to the public.

This is our tenth Quality Account.



> Part 1:

Statement from the Chief Executive

> This year is something of a milestone as we publish our tenth Quality Account. It is a critically important document for us as it was ten years ago that we chose to pursue Quality as the overarching strategy for our services. We have always used the Darzi definition of Quality - Safe, Effective and Caring - as the basis of our corporate and divisional plans and as the basis for measuring and reporting on our progress in reducing avoidable harm and improving quality.

This is also the seventh year that we have used the WWL Wheel as a simple, visual reminder to strengthen awareness of 'Safe, Effective and Caring' and of our quality strategy amongst staff. The WWL has been updated this year (see page 9 of our Annual Report 2017-18) but quality remains at its centre. Our behaviours are now focused on being compassionate, respectful, accountable, collaborative and forward thinking. At the foundation of our new wheel sits the WWL 4Ps which are patients, people, performance and partnerships. All that we do falls under one of the 4Ps.

We continue to actively participate as a member of NHS QUEST. This is a network of foundation trusts, working collaboratively to reduce avoidable harms in hospital, to stimulate innovation and to improve staff satisfaction. We also continue to work with our partners in Greater Manchester and the Wigan Borough to drive improvements in healthcare.

As with previous Quality Accounts, we have given considerable priority to collecting and reporting facts and data to monitor our progress. These show that 2017-18 was a year of mixed results with continued improvement in some areas but modest deterioration in others, despite the enormous efforts of so many excellent staff. Why is this? In my opinion there are two major contributory factors. Firstly we have now had seven years of austerity in the public sector and the effects of repeated annual savings have begun to bite. Secondly, we see continued rise in demand for our services with greater numbers of sicker and older patients using our systems. This sometimes leads to overcrowding and extended waiting, both of which are a significant risk to patient safety and patient experience.

On infection control for example, we have reduced from 2 cases last year to just 1 case of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infection and not had a case for 11 months now. By contrast the number of Clostridium difficile rose from 22 last year to 25 and the number that were the result of lapses of care was six compared to three last year. We saw reductions elsewhere with 12 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) and 23 E Coli bacteraemia compared to 14 and 36 respectively in 2016-17.

Another key quality measure is Hospital Standardised Mortality Ratio (HSMR) and this has improved after disappointing figures the previous year. The most up to date year to date HSMR figure for 2017-18 is 101.9 to December 2017 compared to 115.9 for the whole of 2016-17. The absolute numbers of deaths in hospital has risen from 1340 in 2016-17 to 1363 in 2017-18, a rise of 1 per cent.

This report contains many more facts and figures and I encourage you to study the range of quality initiatives and measures that are in place to improve quality and reduce avoidable harm. Here are some headlines:

Safe

- > We had 7 serious falls in hospital, compared to 2 the previous year
- > There were zero Central Line infections, and 1 the previous year
- > There have been four incidents that met the criteria for a Never Event in 2017-18 and one the previous year.
- > There were no cases of Ventilator Associated Pneumonia compared to one in 2016-17
- > The total number of avoidable serious harms to patients was 74 compared to 96 last year

Effective

- > We continued our implementation of the new £13m Hospital Information System which is very highly regarded by users. However the roll-out to A&E had to be paused when, coinciding with the worst winter pressures, we saw a sharp deterioration in performance. This will be resumed in the Spring.
- > We won major national awards for our Procurement Team (rated as number 1 in the NHS in the PEPPA score), our pioneering software system to support Staff Engagement and the Finance Team (Finance Team of the Year at the Public Finance Innovation Awards 2018).



- > We successfully achieved all the national targets except for four hour waits in A&E and were in the top ten performers in the NHS for cancer and 18 weeks.

Caring

- > Our annual national Picker patient survey results showed notable improvements, with those scoring 7/10 or better improving from 86%

to 90%. The proportion reporting that they were "always well looked after" rose from 85% to 90%. Compared to other Trusts we scored significantly better on 17 questions and significantly worse on two.

- > In the annual Patient Led Assessments of the Care Environment (PLACE) survey our overall ranking across all Acute Trusts in the NHS in England is 4th which sees a slight improvement from previous year. The overall average score has increased to 96.94% from 95.81% and we have improved scores in all but one of the 8 categories.
- > Our national staff survey results also showed modest improvement and a very good performance compared to other Trusts. The proportion of staff who would recommend us as a place to work rose from 71% to 72% whilst the national average slipped from 62% to 61%.
- > This year we grew the number of Quality Champions to 365, each being trained in techniques of quality improvement before taking on leadership of 198 tasks or projects since the programme started.



In March 2018 the Care Quality Commission (CQC) published the results of its unannounced inspection and Well-Led review, both conducted in November 2017. The Trust scored 'Good' overall, for each of the main domains (Safe, Effective, Caring, Responsive, Well-Led) and for each of the Hospital sites. From the 2015 inspection, the Thomas Linacre Centre retains its 'Outstanding' rating as does End of Life Care. Each of the inspected services was rated as 'Good' except for Maternity Services who were rated as 'Requires Improvement'. At the same time, NHSI's rating for Use of Resources was also announced as 'Good'. In the context of the challenging

situation throughout the NHS, particularly as these inspections took place during the winter months, we are delighted that the quality of our services and our staff have been recognised in being rated 'Good' across the board.

We reported 34 serious incidents in 2017-18, two were subsequently downgraded bringing a year-end total of 32; this equals 32 in 2016-17. We received 464 formal complaints in 2017-18 compared to 453 in 2016-17, a small 3% increase. We were pleased to note a significant increase in incident reporting with a total of 11,101 datix reports in 2017-18 placing us in the top 25%, demonstrating an open and transparent reporting culture.

Over the years that we have been publishing Quality Accounts, we have aimed to build a strong safety culture all the way from the board to the level of our front line staff who deal directly with patients. We want strong leaders and managers at every level in the organisation, who are committed to quality and safety and who promote a strong and vibrant energy and sense of belonging. Culture is one of the hardest things to change and also one of the most difficult to measure but three of our programmes – Harm-Free Wards, Quality Champions and Always Events, seem to be making a clear and noticeable difference.

Two of our consultants were also recipients of Clinical Excellence Awards in December 2016; Professor Peter Kay had his Gold Award renewed and Professor Raj Murali received a new Gold Award.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate.

A handwritten signature in black ink, appearing to read 'Andrew Foster'.

ANDREW FOSTER CBE

> Chief Executive

22 May 2018



> Part 2:

Priorities for improvement and statements of assurances from the board

> Part 2.1:

Priorities for Improvement in 2018-19

This is the 'look forward' section of our Quality Account. In April 2017 we were delighted to publish our Quality Strategy 2017/21 outlining the framework to improve quality over the next four years. This section introduces our Quality Strategy 2017/21, provides an update on the national Sign Up to Safety Campaign and outlines the improvements we plan to take over the next year.

Quality Strategy 2017/21

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

“To move towards zero avoidable harm by 2021 through continual reduction”

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

1. Excellence in clinical care
2. Engagement and networking
3. Quality improvement
4. Measuring and monitoring of safety
5. Culture

Participation in the National Sign Up to Safety Campaign



The aim of the Sign Up to safety campaign launched in 2014 is to deliver harm-free care for every patient, every time, everywhere. The Campaign champions openness and honesty, and supports everyone to improve the safety of patients.

The campaign is focusing its attention on connecting organisations and people who can then support each other to make improvements.

We 'Signed up to Safety' in August 2014. We have built elements of the national campaign into our quality and quality improvement strategies to enable sharing of best practice by working with partners but also working together to resolve common problems, often across systems.

Quality Priorities for 2018-19

We have agreed our annual priorities for 2018-19 which support our Quality Strategy 2017/21 and consider some of our challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors, Wigan Borough Clinical Commissioners Group and Healthwatch. The quality priorities, the rationale for their selection and how we plan to monitor and report progress are outlined below. All quality priorities have a timescale for achievement by 31 March 2019 and progress to achieve them is monitored by our Quality and Safety Committee.

> Patient Safety (Safe)

Priority 1:	To complete a venous thromboembolism (VTE) risk assessment for 95% of patients admitted to hospital.
Rationale:	Our compliance for the completion of VTE assessments for 2017-18 is 84.89%. The inclusion of this indicator was supported by all stakeholders to ensure that compliance continues to improve to 95%.
Monitoring:	Thrombosis Committee is responsible for monitoring compliance to achieve this priority.
Reporting:	Quality and Safety Committee weighted dashboard; Board of Directors Performance Report.
Priority 2:	To achieve 95% of patients found to have sepsis receiving IV antibiotics within 1 hour in Accident and Emergency (A&E).
Rationale:	Our compliance for patients found to have sepsis receiving IV antibiotics within 1 hour in A&E was 69.70% in quarter 4 2017-18. We achieved 96.20% in March 2018. The inclusion of this priority was supported by all stakeholders to ensure that compliance continues to improve to 95%.
Monitoring:	Quality and Safety Committee is responsible for monitoring compliance to achieve this priority.
Reporting:	Quality and Safety Committee weighted dashboard.
Priority 3:	To reduce the numbers of falls resulting in serious harm and death.
Rationale:	We had 7 serious falls in hospital during 2017-18, compared to 2 the previous year. We have achieved significant improvements to reduce the number of multiple fallers by 50% and the total number of falls has decreased by 19%. Our focus in 2018-19 is to continue to reduce the level of harm resulting from a fall in hospital. This priority was supported by Governors.
Monitoring:	Harm Free Care Board is responsible for monitoring the work undertaken by the Falls Improvement Group and progress to reduce harm from falls.
Reporting:	Quality and Safety Committee weighted dashboard; Board of Directors Performance Report
Priority 4:	To achieve an overall Hospital Standardised Mortality Ratio (HSMR) of 95 and a Band 2 Summary Hospital Level Mortality Indicator (SHMI)
Rationale:	This indicator was proposed by Wigan Borough Clinical Commissioning Group. The Trust has achieved an improvement in the benchmarked position for HSMR. The most up to date HSMR figure for 2017-18 is 101.9 to December 2017 compared to 115.9 for the whole of 2016-17. We hope that SHMI will also improve as the data time periods published catch up with HSMR. The most up to date SHMI figure for 2017-18 is 120.3 for a rolling 12 months from September 2016 to September 2016. The Trust is currently in Band 3 (Band 1 is the best performing).
Monitoring:	Mortality Group is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Quality and Safety Committee weighted dashboard; Board of Directors Performance Report

> **Clinical Effectiveness (Effective)**

PRIORITY 1:	To achieve 95% compliance for the escalation of the deteriorating patient (triggering on MEWS)
Rationale:	The inclusion of this priority was supported by all stakeholders to ensure that compliance continues to improve to 95%. A review of the data quality behind the compliance data has been undertaken following the selection of the priority by Governors as their Locally Determined Indicator (LDI).
Monitoring:	Harm Free Care Board is responsible for monitoring the work undertaken by the Falls Improvement Group and progress to reduce harm from falls.
Reporting:	Quality and Safety Committee weighted dashboard;
PRIORITY 2:	To achieve 95% of patients prescribed warfarin having the correct dose prescribed
Rationale:	Anticoagulation is a high risk medicine that can result in patient harm if not administered correctly. During 2017-18 our Clinical Lead for VTE undertook an audit to review the prescribing accuracy of two anticoagulants (Dalteparin and Apixaban). 100% compliance was achieved regarding correct dosing and administration for these prescriptions. Our focus for 2018-19 is Warfarin.
Monitoring:	Medicines Management Committee is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Clinical Audit to Medicines Management Committee.
PRIORITY 3	To improve Fractured Neck of Femur Time to Appropriate Bed
Rationale:	The inclusion of this priority relating to the pathway to ensure appropriate treatment for patients admitted with a Fractured Neck of Femur was proposed by our Quality and Safety Committee. One of the best practice standards to achieve optimal care for patients with fractured neck of femur is to be transferred to an orthopaedic bed within 4 hours of admission (National Hip Fracture Database). The Trauma Orthopaedic Group meets bi-monthly and is responsible for monitoring this. Year to date average for 2017-18 was 42.3%. The Division is working collaboratively with the 'Right Patient, Right Ward' project led by the Deputy Director of Nursing to achieve this and in keeping fractured neck of femur beds available for these types of patients to assist with improved outcomes.
Monitoring:	Trauma Orthopaedic Clinical Group is responsible for progressing and monitoring the actions in relation to this priority.
Reporting:	Trauma Orthopaedic Clinical Group to Specialist Services Divisional Quality Executive Committee
PRIORITY 4:	To achieve a 20% reduction in patients experiencing harm as a consequence of lack of fluids
Rationale:	Management of IV fluids was a theme identified in our annual review of deaths as an area for improvement.
Monitoring:	Harm Free Care Committee is responsible for monitoring the actions and initiatives associated with this priority.
Reporting:	Harm Free Care Committee reports to Quality and Safety Committee.

> Patient Experience (Caring)

PRIORITY 1:	To achieve 90% of patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital.
Rationale:	Our annual national Picker patient survey results showed notable improvement by 8% to 50% for patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital. Our real time patient experience data collected monthly demonstrates that 62.21% of patients asked during 2017-18 reported that they were involved as much as they wanted to be in decisions about discharge from hospital. We will continue to focus on improving communication with patients about their discharge. Discharge 'Always Events' have just been launched which should assist with communication.
Monitoring:	Discharge Improvement Group is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Board of Directors Performance Report
PRIORITY 2:	To achieve 90% of patients reporting that they received information on medicines at discharge.
Rationale:	This was an area identified for improvement following the publication of benchmarking information against other NHS Trusts who utilise the organisation Picker to co-ordinate their inpatient surveys. The National Inpatient Survey Results are due for publication in June 2018.
Monitoring:	Harm Free Care Board is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Picker and National Inpatient Survey Results
PRIORITY 3:	To achieve an improved position regarding mothers reporting that they were given a choice about where to have their baby.
Rationale:	Our Maternity Services performed well in the national maternity survey 2017. This priority has been selected by Maternity Services and is being monitored by the 'Better Births' process. Stakeholders noted the importance of the inclusion of a Maternity Services priority for 2018-19. The personalised maternity care budget pilot was commenced in April 2017 and of the 230 eligible women 100 % were offered choice of place of birth. However, 10.4% declined to be part of the pilot. This pilot has now been rolled out across the whole of the Maternity service with the aim to continue to achieve 100% compliance for eligible women. The Better Births National Maternity Review recommends that women receive personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information. Women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget.
Monitoring:	This will be monitored through the current maternity information system and data submission to national bodies such as NHS Digital who compile the Maternity Service Data Set (MSDS). The percentage of eligible women who have been offered choice of place of birth will included within the Maternity Dashboard
Reporting:	The Maternity Dashboard is monitored at Obstetrics and Gynaecology Clinical Cabinet and Divisional Quality Executive Committee in addition to Monthly data submission to National Maternity Pioneer Information Group (NMPIG).

> 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 2017-18 Wrightington Wigan and Leigh NHS Foundation Trust ("WWL") provided and/or sub-contracted 67 relevant health services.

WWL has reviewed all the data available to them on the quality of care in all 67 of these relevant health services.

The income generated by the relevant health services reviewed in 2017-18 represents 93% of the total income generated from the provision of relevant health services by WWL for 2017-18.

>2.2.2: Participation in Clinical Audits

During 2017-18, 3 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that WWL provides. During that period WWL participated in 21 National Clinical Audits and 4 National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in. In addition WWL participated in a further 4 National Audits (Non-NCAPOP) recommended by HQIP.

The National Clinical Audits and National Confidential Enquiries that WWL was eligible to participate in during 2017-18 listed in Appendix A.

The National Clinical Audits and National Confidential Enquiries that WWL participated in, and for which data collection was completed during 2017-18 are listed in Appendix A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

> The reports of 6 National Clinical Audits were reviewed by the provider in 2017-18 and WWL intends to take the following actions to improve the quality of healthcare provided

Audit	Trust Actions
Acute Pancreatitis National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Actions taken following the publication of this report include the implementation of High Blood Pressure Guidelines, the development of a Transfer Policy, a review of the planned list for surgeons and an audit on the use of antibiotic prophylaxis in acute pancreatitis.
Paediatric Asthma	Further audits are to be undertaken related to readmissions, chest x-ray and antibiotic use.
Adult Asthma	The majority of the criteria are being met by services at Royal Albert Edward Infirmary. Follow-up rates are higher than the national average. Recommendations focus on the improving documentation in patient records.
Paediatric Pneumonia	The report has been reviewed and actions are under discussion.
National Cardiac Arrest Audit (NCAA)	Quarterly reports are received and regular reviews are undertaken by Resuscitation Officers. Reports are distributed to all Trust staff and periodic updates are given at audit meetings to create awareness amongst staff.
National Joint Registry (NJR)	Regular updates are provided at Audit meetings where areas for improvement are highlighted.

> The reports of 180 Local Clinical Audits were reviewed by the provider in 2017-18. A selection of these audits is outlined below and WWL has taken or intends to take the following actions to improve the quality of healthcare provided:

Audit	Trust Actions
Non-ST-Segment Myocardial Infarction (Acute Coronary Syndrome -NSTEMI)	<p>Following the first cycle of audit actions taken included the identification of all acute coronary syndrome (ACS) patients with positive troponin, improved communication with the cardiology team and prioritisation of patients according to GRACE score (a scoring system to risk stratify patients with diagnosed ACS to estimate their in-hospital and 6-month to 3-year mortality).</p> <p>Following the second cycle of audit demonstrated a significant improvement for patients who had a coronary angiography within 72 hours. A structured system approach has led to an improved 'admission to angio' rate at WWL which is higher than the national average.</p>
Early Arthritis Clinic	<p>The existing clinic at Wrightington Hospital has been re-structured to form a dedicated multidisciplinary one-stop early arthritis clinic. An evidence based early arthritis pathway was developed. Referrals are now faxed to the Rheumatology Department on an early arthritis pro-forma to be triaged. The action taken following this audit has improved the service for patients and we are meeting the recommended standards.</p>
Improving practice via a new Morbidity and Mortality (M & M) Analysis Tool	<p>Following the first cycle of audit, an Ear Nose and Throat (ENT) Quality Improvement Programme was introduced that enables simple assessment of each complication using grading tools and charts. A further audit was undertaken which showed that the tool provides clinicians with the ability to quickly grade and assess complications but more importantly, to create action plans to prevent recurrence and change practice.</p>
Management of Anaphylaxis; Assessment, referral after emergency treatment	<p>The first cycle of audit demonstrated discrepancies in treatment. Following the audit an Anaphylaxis pro-forma was introduced and highlighted at education sessions for all post-graduate staff.</p> <p>The second cycle of audit demonstrated some improvement in many areas. A further audit is to be undertaken following further awareness sessions.</p>
Visual acuity of children at discharge after amblyopia therapy	<p>Following the audit amendments were made to procedure. Further audits were undertaken to review the revised protocol. Results demonstrated that closing the audit loop has led to a successful redesign of amblyopia management. Audit data had improved from 48% to 96.8%. Results are demonstrating the best available visual acuity figures for the management of childhood amblyopia.</p>

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

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

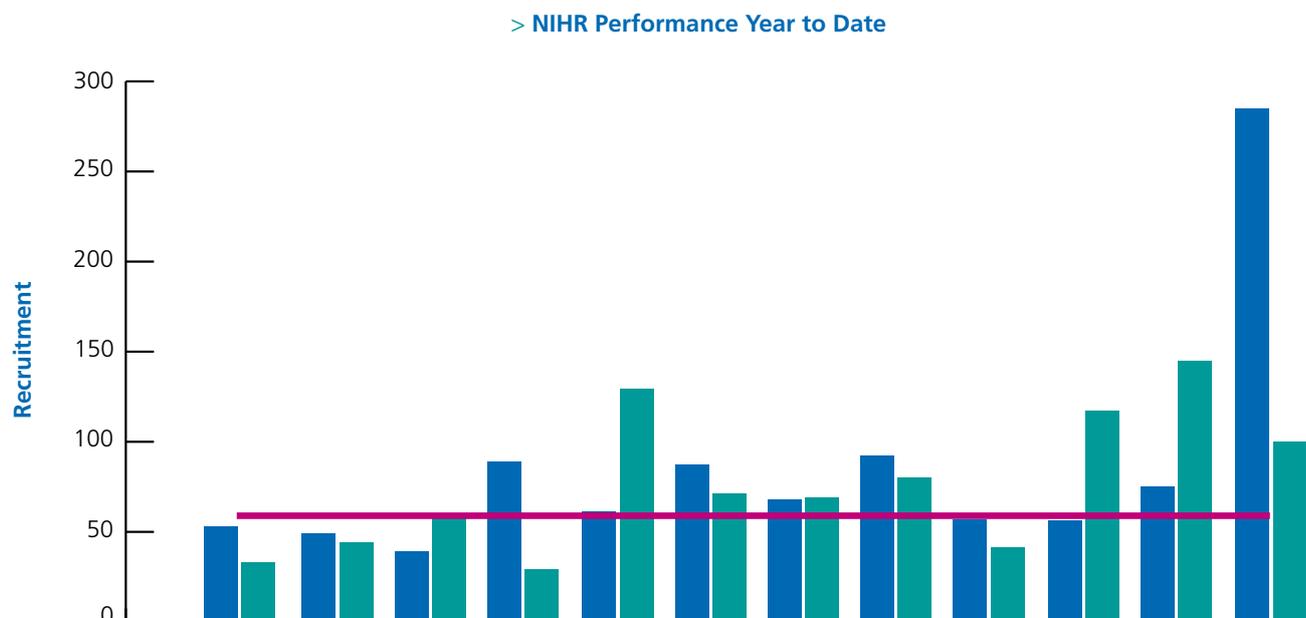
> 2.2.3: Research

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by WWL in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio' was 940, an average of 78 patients per month. The Trust target agreed with the National Institute for Health Research (NIHR) was 834 recruits.

Patient Recruitment 2017-18

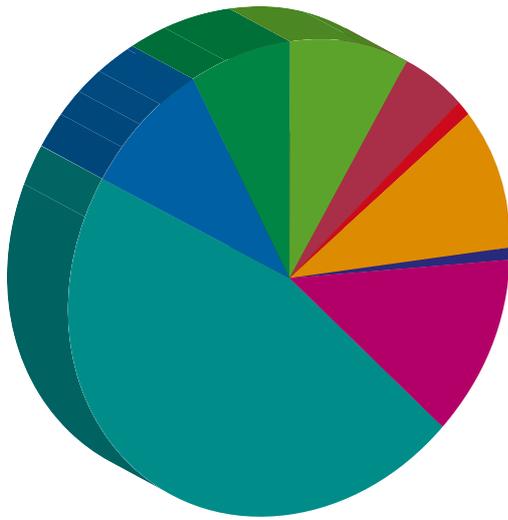
The following chart illustrates target recruitment versus actual recruitment to research studies in 2017-18.



	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
2016-2017	53	49	39	89	61	87	68	92	57	56	75	285
2017-2018	33	44	59	29	129	71	69	80	41	117	145	100
TARGET	60	60	60	60	60	60	60	60	60	60	60	60

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are continually updated about the latest treatments. We were involved in conducting 92 NIHR Portfolio clinical research studies and 89 Non Portfolio studies in a variety of specialities during the year 2017-18. The chart below illustrates recruitment into National Institute for Health Research registered studies between 1 April 2017 and 31 March 2018.

> Contribution by Speciality 2017-18



- Orthopaedics **9%**
- Rheumatology **5%**
- ENT **1%**
- Medical **10%**
- Dermatology **1%**
- Paediatrics **12%**
- Gastroenterology **46%**
- Oncology **9%**
- Reproductive Health **7%**

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

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

Our Research Strategy aims to include all clinical staff in research. Every year the Research Department identifies a clinical area for promoting and supporting research. This has proved successful and areas of interest have greatly increased with strong recruitment in the following clinical specialities:

Rheumatology, Cardiology, Diabetes, Surgery, Respiratory, Paediatrics, Obstetrics, Cancer, Ear Nose and Throat (ENT), Gastroenterology, Dermatology, Musculo-skeletal and Infection Control, Fertility and Ophthalmology.

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

The development of our Research Patient Public Involvement (PPI) group influences the way that research is planned. They help to identify which research questions are important.

By influencing the way research is carried out we aim to improve the experience of people who take part in research.

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

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

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

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

> 2.2.4: Goals agreed with Commissioners

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

A proportion of WWL's income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between WWL and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2017-18 and for the following 12 month period are available electronically at www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

WWL is estimated to receive £5.457 million in relation to CQUINS for 2017-18, in comparison with £5,66m in 2016-17. We had 6 national CQUIN schemes in 2017-18 which were as follows:

1. Staff and patient health and well-being
2. Sepsis screening and treatment and reductions in antibiotic consumption
3. Safe and proactive discharge
4. Improving services for patients attending A&E with mental health conditions
5. Introducing advice and guidance
6. Expanding the electronic referral system

There were significant achievements against a number of the schemes during 2017-18; firstly, in relation to reducing mental health related attendances at the emergency department there was a 55% reduction in attendances for patients who were identified as presenting regularly during 2016-17. This was achieved through close working between WWL and North West Boroughs Healthcare NHS Foundation Trust ensuring that effective individual strategies were put in place for each patient. During 2016-17 the identified cohort of patients accounted for 302 attendances but in 2017-18 this fell to 135. During 2017-18 these patients will continue to be monitored and a new cohort will be identified and it is hoped a similar impact can be made. Secondly, there was an improvement in the proportion of patients over 65 admitted non-electively who were discharged to their normal place of residence within 7 days. The national target was a 2.5% improvement but the Trust achieved 6%. This was achieved through close working with Wigan Council and the Trust's work in the Age Well Unit. This scheme does not continue in 2018-19 although the work itself will go on. Thirdly, the Trust achieved the healthy food and drink comfortably during the year and in fact has already met the requirements due at the end of March 2018. The Trust is one of the few to have achieved this during 2017-18. As part of the same scheme the Trust vaccinated over 74% of its frontline staff against flu against the target of 70%. The target for

2018-19 is 75% so this is expected to be achieved. The advice and guidance and e-referral service (ERS) schemes were included within the separate Paper Switch Off Programme which is linked to the contractual requirement to receive all GP referrals via ERS by 1 October 2018. The Trust achieved its local implementation date of 31st March 2018.

The main challenge was in relation to the sepsis scheme which requires all appropriate patients are screened for sepsis and that those who are found to have sepsis had antibiotics administered within one hour. Despite some early issues the screening targets were met throughout quarters three and four. However, the Trust did not achieve the 90% standard for antibiotic administration within an hour in any quarter (although it was achieved in several individual months). This was in part due to changes in the way the data was collected but also reflected the sustained pressure on unscheduled care. Each patient is now reviewed by the clinical leads for sepsis and learning points shared. This audit has also identified that most patients did receive their antibiotics within 3 hours which is the NICE standard. The sepsis scheme continues in 2018-19 and improving care for these patients is part of the Trust's Quality Strategy.

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.

> 2.2.5: What others say about WWL

Statements from the Care Quality Commission (CQC)

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2017-18, is registration without compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2017-18.

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

We were inspected by the CQC, as part of their responsive inspection programme in March 2017. The report was published by the CQC in September 2017. The CQC inspected Urgent and Emergency Services as well as services for Children and Young People. By the end of 2017-18, all of the must do and should do actions have been completed and a detailed update provided to the CQC around the improvements taken by the Trust.

When inspecting the Children's Ward (Rainbow Ward), the CQC noted significant progress since the previous inspection

in December 2015, including improved staffing levels, greater numbers of staff trained to deliver Advanced Paediatric Life Support (APLS), including care for children with tracheostomies, and an escalation process for staffing. Further actions have been completed in relation to the Paediatric Early Warning Score (PEWS) guidance and monitoring of fridge temperatures.

In relation to the Paediatric Emergency Care Centre (PECC) and Accident and Emergency (A&E), the CQC positively noted the electronic system for medicine storage and requisition which helps ensure staff had a safe and effective process in place to assist in reducing medicine errors. Controlled drugs are stored and checked correctly and staff escalate clinical concerns to medical staff efficiently. Further actions have been completed in relation to the Paediatric Early Warning Score (PEWS) guidance and availability of a paediatric nurse 24 hours 7 days a week in A&E particularly after PECC is closed at 1 am.

The CQC commented positively, advising the Trust “We were treated really well by the staff, who welcomed us in without question and wholeheartedly answered the many questions we put forward to them with a friendly and professional approach. This must have been challenging given that they had no time to prepare or source extra staff to assist us. They helped us despite having to manage and care for their patients. It really was very much noted and appreciated by us all. I hope you will pass on our thanks”.

We were also inspected by the CQC in November 2017. The CQC undertook an unannounced inspection to review Urgent and Emergency Services, Maternity Services, Services for Children and Young People and Medical Care. The CQC also undertook a well-led inspection. The reports were published in March 2018.

We are proud to have maintained our “Good” provider rating overall and achieved a “Good” rating for the announced well-led Inspection. All of our hospital sites are rated as “Good” or “Outstanding”, a significant achievement given the pressures that we have experienced over the winter period. Royal Albert Edward Infirmary is now rated as a “Good” hospital (an improvement from the previous rating “Requires Improvement”). Urgent and Emergency Services, Services for Children and Young People and Medical Care have made significant improvements since the last inspections and are all rated “Good” overall.

Some positive comments noted by the CQC include:

“Staff work together to benefit patients; Staff care for patients compassionately”

“Feedback from patients confirmed that staff treated them well and with kindness; Staff involved patients and those close to them in

decisions about their care and treatment and provided emotional support to patients to minimise distress”

“Managers promoted a positive culture that supported and valued staff and engaged effectively. They collaborated with partner organisations effectively”

“Local systems and processes reflected a culture of improvement”

“Staff described the culture within the service as open and transparent”

“The wards were clean and equipment was well maintained. Staff followed infection control policies that managers monitored to improve practice”

“There was a cohesive and thorough multidisciplinary approach to assessing the range of people’s needs, setting individual goals and providing patient-centred care”

“Staff treated patients with compassion, dignity and respect. Staff involved patients and those close to them in decisions about their care and treatment. They made sure patients were aware of their goals and plan of care”

We welcomed the constructive feedback from the CQC and inevitably the inspection did identify some areas where we can improve. Improvement plans are in place to address these and actions commenced immediately after the inspection. Maternity Services are undertaking a number of improvements following the CQC inspection which include a systematic evidence based process to calculate midwifery staffing establishment, a review of the availability of medicines and regular audits of risk assessments. Completing the actions in response to the CQC recommendations is a priority for 2018-19.

The full reports can be accessed here
www.cqc.org.uk/provider/RRF/reports

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

> 2.2.6: NHS Number and General Medical Practice Code Validity

WWL submitted records during 2017-18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:

- > 99.9% for admitted patient care.
- > 99.9% for outpatient care, and
- > 99.4% for accident and emergency care.

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

- > 100.0% for admitted patient care,
- > 100.0% for outpatient care, and
- > 100.0% for accident and emergency care.

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

> 2.2.7: Information Governance Toolkit Attainment Levels

WWL's Information Governance Assessment Report overall score for 2017-18 was 83% and was graded green, a satisfactory submission.

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance 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 presents them in one place as a set of Information Governance requirements.

> 2.2.8: Clinical Coding Error Rate

WWL was not subject to the Payment by Results clinical coding audit during 2017-18 by the Audit Commission. The Audit Commission has closed.

WWL commissioned an external audit in November 2017 for assurance of the clinical coding quality:

- > Primary Diagnosis Incorrect 4%
- > Secondary Diagnosis Incorrect 7%
- > Primary Procedures Incorrect 5%
- > Secondary Procedures Incorrect 7%

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

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

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

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Although the Trust already had good data quality it recognises that there are always improvements that can be taken.

Over the previous twelve months the Trust has developed

its own Data Quality (DQ) app. The app provides the Trust's frontline services with clear visibility on where there are issues or areas of concern. This allows the individuals and services entering the data to investigate and remedy any issues, as well as learning for the future. This supports the NHS Get It Right First Time (GIRFT) approach and is aligned to Article 5 of the General Data Protection Regulation (GDPR).

WWL will be taking the following actions to improve data quality: Due to the success the DQ app the Trust plans to continue its development over the next twelve months adding even more checks and Key Performance Indicators (KPIs) in order to provide more assurance and even better 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.

> 2.2.10: Learning from Deaths

During 2017-18 1337 of WWL patients died (data to 27th March 2018). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- > 328 in the first quarter;
- > 298 in the second quarter;
- > 359 in the third quarter;
- > 352 in the fourth quarter.

WWL has had a process for reviewing deaths for over eight years. WWL commenced the review of deaths in a structured way that met the Learning from Deaths Guidance published in March 2017, from October 2017 (quarter 3 2017-18) and therefore will be reporting data for two quarters.

By March 2018, 213 case record reviews and 213 investigations have been carried out in accordance with the Learning from Deaths Guidance (in quarter 3 and quarter 4 2017-18) in relation to 711 of the deaths referenced in the introduction. In 213 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was;

94 in the third quarter; 119 in the fourth quarter

4 representing, 0.6% of 711 deaths in quarter 3 and quarter 4 2017-18, of the patient deaths during the reporting period are

judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 2 representing, % of 359 of deaths which occurred for the third
- 2 representing, % of 352 deaths which occurred for the fourth quarter

These numbers have been estimated using a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance. A summary of what WWL has learnt from case record reviews and investigations conducted in relation to deaths identified above.

A dominant theme, particularly during quarter 4 2017-18 has been hospital pressures. That is witnessed most easily by visiting A&E, but is also seen in missed components of care (such as VTE venous thromboembolism, wrong ward or missed medicines) and standard of note keeping. At the busiest times patients were initially seen by the A&E team and their next review would often be on the Post Take Ward Round having missed the medical team's first review. Slow provision of transfusion and late ERCP (a procedure that combines upper gastrointestinal (GI) endoscopy and x-rays to treat problems of the bile and pancreatic ducts) noted in other cases are also linked to the pressures the Trust has experienced. Post-operative bleeding and harm from falls, particularly for patients on warfarin, were highlighted.

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

- > Additional ERCP sessions;
- > Amendments to the documentation for recording VTE risk assessments;
- > Task and Finish Group established for right patient right ward;
- > A review of pre-operative management of patients on Warfarin and highlighting the risk of patients on warfarin on a healthcare economy scale with Wigan Borough Clinical Commissioning Group leading work with GPs to reduce the number of frail patients who are on Warfarin.

An assessment of the impact of the actions described above which were taken by WWL during the reporting period.

The Trust's Hospital Standardised Mortality Ratio (HSMR) has started to reduce during 2017-18. The actions taken above continue to be monitored. Quality priorities for the prescribing of warfarin, VTE and reducing harm from falls have been agreed for 2018-19. The Mortality Committee, chaired by our Medical Director will continue to review actions taken.

The following statements are not applicable to the Trust:

- > 0 case record reviews and 0 investigations completed after quarter 3 which related to deaths which took place before the start of the reporting period.
- > 0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.
- > 0 representing 0% of the patient deaths during the previous reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

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



> 2.2.11: Seven Day Services

The latest available data for compliance against the priority clinical standards for seven days services was published in 2017:

- > **Standard 2:** Time to first consultant review **82%**
The Trust has performed better than the national average overall for two consecutive surveys.
- > **Standard 5:** Access to diagnostic tests **84%**
The Trust has performed better than the national average for weekdays; however, the Trust is worse than the national average for weekends. The Trust's focus for improvement is timely referrals to other hospitals, for example, interventional radiology at Preston. The development of a six day echocardiography service is in progress.
- > **Standard 6:** Access to consultant-directed interventions **94%**
- > **Standard 8:** Ongoing review by consultant twice daily if high dependency patients, daily for others **88%**

The Trust has performed better than the national average overall and for weekdays and slightly worse than the national average at weekends for standard 6 and standard 8. Workforce shortages have contributed to the Trust's compliance with these standards.

The time period for the next round of data collection commenced in April 2018.

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

> 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:

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

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

Mortality

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	October 2015 - September 2016	Value: 1.1419, Banding : 1	Value: 1.0034	Best: THE WHITTINGTON HOSPITAL NHS TRUST (RKE) - Value: 0.6897, Banding: 3 Worst: WYE VALLEY NHS TRUST (RLQ) - Value: 1.1638, Banding: 1
	October 2016 - September 2017	Value: 1.2028, Banding : 1	Value: 1.0037	Best: THE WHITTINGTON HOSPITAL NHS TRUST (RKE) - Value: 0.7270, Banding: 3 Worst: WYE VALLEY NHS TRUST (RLQ) - Value: 1.2473, Banding: 1
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	October 2015 - September 2016	31.0%	29.7%	Best: THE WHITTINGTON HOSPITAL NHS TRUST (RKE) - Value: 0.4% Worst: GEORGE ELIOT HOSPITAL NHS TRUST (RLT) - Value: 56.3%
	October 2016 - September 2017	29.9%	31.5%	Best: THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST (RCX) - Value : 11.5% Worst: ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST (RA2) - Value: 59.8%

Assurance Statement

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

The Summary Hospital-Level Mortality Indicator ("SHMI") includes deaths out of hospital. The Trust recognises the benchmarked position for SHMI and is undertaking a number of actions to understand this position.

WWL intends to take the following actions to improve these indicators and, so the quality of its services, by:

Mortality remains a principal risk for the Trust. The Trust has been undertaken a joint project with Wigan Borough Clinical Commissioning Group to review deaths within 30 days of discharge. Actions were agreed and monitored by the Trust's Mortality Committee. This project is being repeated. The Mortality Committee is chaired by the Medical Director and attended by external organisations including Wigan Borough Clinical Commissioning Group, Public Health and the AQUA (an NHS health and care quality improvement organisation at the forefront of transforming the safety and quality of healthcare) to support collaborative working to address SHMI in the Wigan Borough.

Patient Reported Outcome Measures Scores (PROMs)

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

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
i) Groin Hernia Surgery	April 2015 - March 2016	0.080	0.088	Best: BMI - THE SOMERFIELD HOSPITAL (NT438) - Value: 0.157 Worst: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (RVW) - Value: 0.021
	April 2016 - March 2017 (Final)	0.060	0.086	Best: NEW HALL HOSPITAL (NVC09) - Value: 0.135 Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 0.006
ii) Varicose Vein Surgery	April 2015 - March 2016	N/A	0.096	Best: NORTHAMPTON GENERAL HOSPITAL NHS TRUST (RNS) - Value: 0.150 Worst: SURREY AND SUSSEX HEALTHCARE NHS TRUST (RTP) - Value: 0.018
	April 2016 - March 2017 (Final)	N/A	0.092	Best: TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (RMP) - Value: 0.155 Worst: ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST (RBN) - Value: 0.010
iii) Hip Replacement Surgery	April 2015 - March 2016	0.444	0.438	Best: NORTH DOWNS HOSPITAL (NVC11) - Value: 0.512 Worst: WALSALL HEALTHCARE NHS TRUST (RBK) - Value: 0.320
	April 2016 - March 2017 (Provisional)	0.442	0.445	Best: NUFFIELD HEALTH, CAMBRIDGE HOSPITAL (NT209) - Value: 0.537 Worst: NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST (RAP) - Value: 0.310
iv) Knee Replacement Surgery	April 2015 - March 2016	0.315	0.320	Best: SHEPTON MALLET NHS TREATMENT CENTRE (NTPH1) - Value: 0.398 Worst: HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RQX) - Value: 0.198
	April 2016 - March 2017 (Provisional)	0.328	0.324	Best: SPIRE WASHINGTON HOSPITAL (NT333) - Value: 0.404 Worst: THE SPENCER WING (RAMSGATE ROAD) (NN801) - Value: 0.242

Assurance Statement

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

Audit and data validation to ensure completeness and accuracy of information is being undertaken.

WWL intends to take the following actions to improve these indicators and, so the quality of its services, by:

Continuing to ensure quality of data by liaising with pre-op and out-patient departments and reviewing audit figures.

Hospital Readmission:

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2010 - March 2011	7.73	10.31	Best: EPSOM AND ST HELIER UNIVERSITY NHS TRUST (RVR) - Value: 6.41 Worst: ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST (RL4) - Value: 14.11
	April 2011 - March 2012	7.95	10.23	Best: EPSOM AND ST HELIER UNIVERSITY NHS TRUST (RVR) - Value: 6.4 Worst: ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST (RL4) - Value: 14.94
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 2010 - March 2011	12.71	11.55	Best: SHREWSBURY AND TELFORD NHS TRUST (RXW) - Value: 9.20 Worst: HEART OF ENGLAND NHS FOUNDATION TRUST (RR1) - Value: 14.06
	April 2011 - March 2012	12.40	11.56	Best: NORFOLK AND NORWICH UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RM1) - Value: 9:34 Worst: EPSOM AND ST HELIER UNIVERSITY NHS TRUST (RVR) - Value: 13.80

Comments:

Large Acute Trusts Only. No New data - Future releases suspended pending review

Assurance Statement

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

The data made available by NHS Digital is out of date. The Trust continues to monitor readmissions internally.

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

As the Wigan Health economy has a large proportion of elderly population (especially 75+) then avoidance of readmissions has focussed on working closely with the community teams and in Care Homes to manage conditions out of the acute site. This includes the ICS (Integrated Community Services) and Social care teams focussing on the local provision of services. Other teams such as the Alcohol Service, has acute nursing teams working in A&E and picking up the frequent attenders before they are admitted to an acute bed.

Responsiveness to Personal Needs

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The Trust's responsiveness to the personal needs of its patients during the reporting period	National Inpatient Survey 2015 - 2016	69.20%	69.60%	Best: THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 86.2% Worst: CROYDON HEALTH SERVICES NHS TRUST (RJ6) - Value: 58.9%
	National Inpatient Survey 2016 - 2017	65.50%	68.10%	Best: (RPY) THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 85.2% Worst: LEWISHAM AND GREENWICH NHS TRUST (RJ2) - Value: 60.0%

Assurance Statement

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

We performed below national average for our responsiveness to the personal needs of its patients in the 2016 National Patient Survey. We hope this has improved in the 2017 National Patient Survey due to be published in June 2018. We acknowledge that when systems are under pressure we may not be as responsiveness to personal needs as we would wish to be for our patients.

WWL has taken the following actions to improve this score to the quality of its services by:

During the previous twelve months there have been a number of improvements following a focus on continued development of the Integrated Discharge Team. The team are supported by third sector organisations, charity organisations and local programmes to support the armed forces both currently serving personnel and families and veterans. All patients continue to receive an Expected Date of Discharge on admission. There has been a further focus on Grand Rounds during the weekends to support patients by providing a seven day service. The Discharge Always Events have recently been launched and are being communicated to all areas with patients and families opinions and options forming the essential part of these Always Events.

Friends and Family Test (Staff)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends (Acute Trusts only)	National NHS Staff Survey 2016	76.00%	70.00%	Best: ROYAL DEVON AND EXETER NHS FOUNDATION TRUST (RH8), WEST SUFFOLK NHS FOUNDATION TRUST (RGR) Value: 85% Worst: ISLE OF WIGHT NHS TRUST (acute sector) (R1F1) : Value: 49%
	National NHS Staff Survey 2017	77.00%	70.00%	Best: WEST SUFFOLK NHS FOUNDATION TRUST (RGR) Value - 86% Worst: ISE OF WIGHT NHS TRUST (acute sector) (R1F1), NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST (RJL) - Value: 47%

Assurance Statement

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

We have performed better than the national average for staff recommending us to friends and family as a place to be treated. We have also scored above average for staff recommending us as a place to work. The results for both measures have improved by 1% since 2016.

We continue to seek out and act upon staff feedback. A Staff Engagement Pulse Survey is distributed quarterly to a sample of staff. The responses to these are an invaluable source of information for us in highlighting any newly emerging issues and enabling timely action to support staff. The quarterly pulse surveys and associated actions are integral to shaping the organisational culture.

The results of the quarterly pulse survey from April 2017 highlighted a decline on 2016 results in enablers of staff engagement such as clarity, mind-set, personal development, influence, perceived fairness and recognition. There was similarly a decline in engagement feelings of dedication, focus and energy, and the engagement behaviour of advocacy.

Throughout the remainder of 2017, results have plateaued although there has been some improvement in relation to the enabler of clarity (Pulse Survey July 2017) and behaviour of adaptability (Pulse Survey October 2017). The improvements in clarity can be directly linked to the restructuring and realignment of resource to ensure that internal communications are more aligned to the strategy and the launch of the WWL Way 4Wards. Whilst this is positive progress, there haven't been any corresponding improvements in the enabler of mind-set but it is hoped that this will be seen in 2018.

Overall results remain moderate to positive and the majority of staff would recommend us as a place to be treated.

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

The pulse survey identifies that most of the factors that enable staff engagement have plateaued during 2017.

We will act on this information responsively to drive further improvements in engagement levels. There will be continued investment in health and well-being initiatives (via the Steps 4 Wellness Programme) with the aim to improve staff wellbeing, morale, resilience and energy levels. Initiatives will focus on mental, physical and social wellbeing, and creating awareness of healthy choices. Other key areas of focus will be to develop and implement a new behavioural framework, the implementation and further development of the new intranet site, to continue to review the staff engagement offering and to consider new opportunities and initiatives around Leadership training and development. Work will continue to embed the WWL Way 4Wards.

Venous Thromboembolism

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	July - September 2017	84.75%	95.25%	Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) - Value: 100% Worst: MID ESSEX HOSPITAL SERVICES NHS TRUST (RQ8) - Value: 71.88%
	October - December 2017	84.85%	95.36%	Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) - Value: 100% Worst: MID ESSEX HOSPITAL SERVICES NHS TRUST (RQ8) - Value: 76.08%

Assurance Statement

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

In 2016 we moved from one electronic patient record system to another. This led to issues collecting accurate data regarding VTE assessments.

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

The concerns regarding accurate data have now been resolved following the development of a new monitoring app. This has provided us with very specific data regarding ward areas and specialties and the VTE assessments for patients in those areas. This enables us to target particular areas where compliance is below the target and work with staff there to improve compliance.

Clostridium difficile (C. difficile)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	April 2015 - March 2016	7.9	14.9	Best: LIVERPOOL WOMENS HOSPITAL (REP), MOORFIELDS EYE HOSPITAL (RP6) & THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL (RL1): 0.00 Worst: THE ROYAL MARSDEN (RPY) :67.2
	April 2016 – March 2017	14.2	13.2	Best: LIVERPOOL WOMENS HOSPITAL (REP), MOORFIELDS EYE HOSPITAL (RP6), THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL (RL1): 0.00 Worst: THE ROYAL MARSDEN (RPY): 82.7

Assurance Statement

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

We performed less well in 2016-17 compared to 2015-16 in relation to C.difficile with 22 cases and rate of 14.2 per 100,000 bed days which was higher than the national average. There were 25 cases in 2017-18 giving a rate of 16.4. The increase in numbers for 2017-18 was the result of a large number of cases occurring in July and August 2017. Factors likely to have contributed to the increase were identified but there was no evidence of direct cross infection and the number of 'lapses in care' remains low. The numbers of C.difficile cases in quarter 4 was below trajectory. Additional actions have been taken to strengthen the pathway for C.difficile and raise staff awareness.

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

We intend to continue with the current actions to improve on this rate and support the quality of services by continuing to undertake individual detailed C. difficile investigations, which assist to identify any learning to prevent future C.difficile cases.

Patient Safety Incidents

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	April - September 2016	4209 Incidents Reported (Rate per 1000 Bed Days 55.3) / 21 Serious Incidents (0.50%)	673,865 Incidents Reported (Rate per 1000 Bed Days 39.9) / 2516 Serious Incidents (0.37%)	Best: LUTON AND DUNSTABLE NHS FOUNDATION TRUST (RC9): Incidents Reported 2305 (Rate per 1000 bed days 21.1) / 6 Serious Incidents (0.26%) Worst: NORTHERN DEVON HEALTHCARE NHS TRUST (RBZ): Incidents Reported 3620 (Rate per 1000 bed days 71.8) / 30 Serious Incidents (0.83%)
	October 2016 - March 2017	4280 Incidents Reported (Rate per 1000 Bed Days 51.5) / 7 Serious Incidents (0.16%)	696,643 Incidents Reported (Rate per 1000 Bed Days 40.5) / 2623 Serious Incidents (0.38%)	Best: MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST (RWF): Incidents Reported 3219 (Rate per 1000 bed days 23.1) / 47 Serious Incidents (1.46%) Worst: WYE VALLEY NHS TRUST (RLQ): Incidents Reported 3300 (Rate per 1000 bed days 75.9) / 6 Serious Incidents (0.18%)

Assurance Statement

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

We have reported more incidents in the second reporting period above in comparison with the first reporting period. We have a much higher rate of incidents reported per 1000 bed days than the national average. We also have a lower rate of serious harm and death incidents than the national average. We aim to promote a just culture to ensure that staff feel confident to report incidents. This is reflective in the numbers of incidents reported, particularly near misses and incidents resulting in low harm.

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

We continue to consider ways to improve our incident reporting processes to ensure staff feel confident and able to report incidents. Our National Staff Survey 2017 results for fairness and effectiveness of incident reporting processes were in the top 20%.



> Part 3:

Other information

> Part 3.1: Review of Quality Performance

This section of the Quality Account provides information on our quality performance during 2017-18. 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 Risk Assessment Framework and Single Oversight Framework are outlined. We are proud of a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2017-18

We agreed a number of priorities for improvement in 2017-18 published in last year’s Quality Account. These were selected following the development of our Quality Strategy 2017/21 in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1: To improve our benchmarked position for mortality [HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-Level Mortality Indicator)]

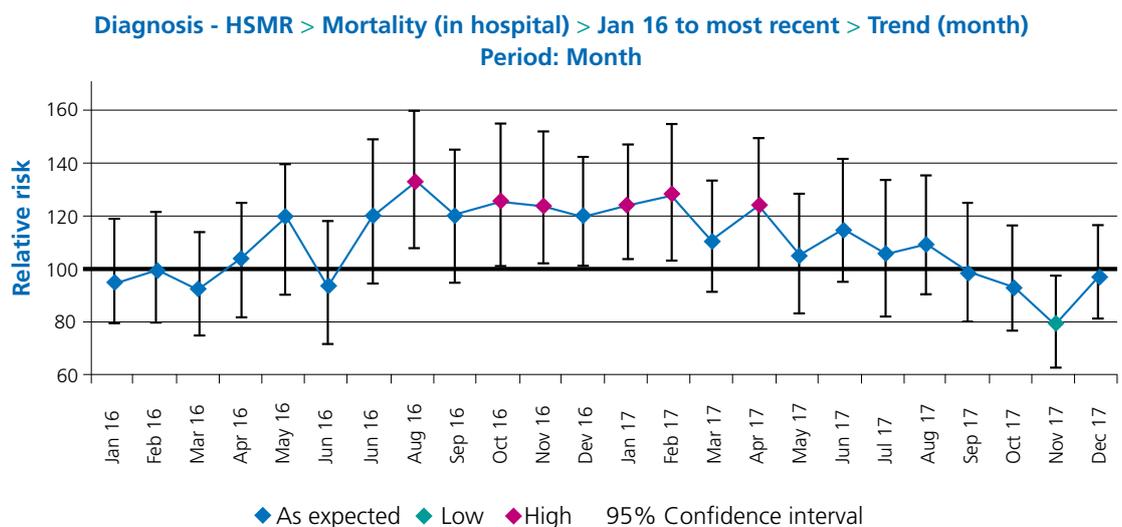
Where we were in 2016-17 Our HSMR for 2016-17 to March 2018 was 115.9. We had the 7th highest HSMR out of the eight acute NHS Trusts in Greater Manchester. Our SHMI is 114 for a rolling 12 months from October 2015 to September 2016. The Trust has the highest SHMI in comparison with peers in Greater Manchester.

Mortality will continue to be a Trust priority for 2017-18. A number of initiatives are underway which include a joint project with Wigan Borough Clinical Commissioning Group to review deaths within 30 days of discharge and benchmarking against national guidance on learning from deaths, published by the National Quality Board in March 2017.

Where we are at the end of 2017-18 HSMR: The most up to date HSMR figure for 2017-18 is 101.9 to December 2017 compared to 115.9 for the whole of 2016-17. In November and December 2017 the Trust’s benchmarked position for HSMR against the eight acute NHS Trusts in Greater Manchester had improved.

HSMR
Achieved ✓

SHMI
Not Achieved x



Priority 1: Contd.

From September 2016 - September 2017 our SHMI was 120.3 which was an improvement from the rolling twelve month period from July 2016 - July 2017.

In June 2017 we established a Mortality Committee chaired by the Medical Director and attended by representatives from Public Health, Wigan Borough Clinical Commissioning Group (CCG) and AQUA (Advancing Quality Alliance). A number of work-streams have reported into this committee, for example, joint work with CCG to review deaths within 30 days of discharge, case reviews of sepsis and lung cancer, and review of AQUA's quarterly reports on mortality. Work-streams continue to be identified. We published our Mortality Review Process at the end of September 2017 and commenced the submission of quarterly mortality reports to the Board of Directors (from January 2018 presented 2017-18 Q3 data) as required by the National Learning from Deaths guidance.

We are continuing to focus on reducing HSMR and SHMI during 2018-19

Priority 2: To complete a venous thromboembolism (VTE) risk assessment for 95% of patients admitted to hospital.

Where we were in 2016-17 At the end of March 2017 compliance for VTE risk assessments being completed on admission was 89%. Our Governors selected this indicator as their Locally Determined Indicator for 2016-17 meaning that the indicator was subject to an external review of data quality.

Where we are at the end of 2017-18 In March 2018 compliance for VTE risk assessments being completed on admission to hospital was 86.94%. Year to date compliance is 84.87%. VTE risk assessment compliance is continuing as a priority in 2018-19.

Not Achieved x

Priority 3: To reduce the numbers of falls resulting in moderate harm and serious harm.

Where we were in 2016-17 At the end of March 2017 there had been two falls resulting in serious harm and 14 falls resulting in moderate harm.

Where we are at the end of 2017-18 At the end of March 2018 there had been seven serious falls and 14 falls resulting in moderate harm. We are disappointed that we have not been able to reduce harm from falls; however, the actions undertaken during 2017-18 have reduced the number of multiple fallers by 50% and the total number of falls occurring by 19%.

Not Achieved x

We are continuing to focus on the reduction of harm from falls during 2018-19.

**However, ↓
in total number
of falls and
multiple fallers:
Achieved ✓**

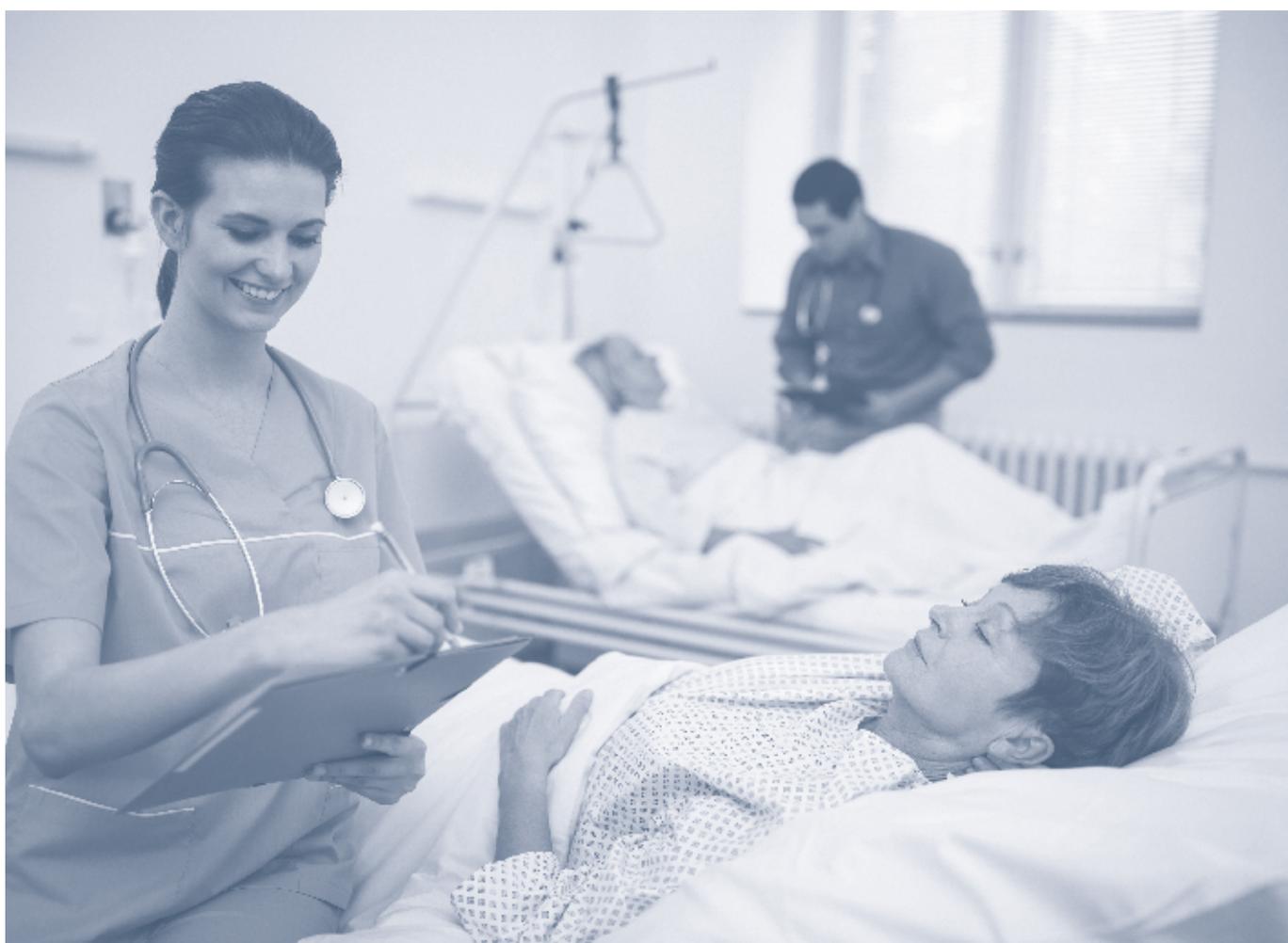
Clinical Effectiveness (Effective)

Priority 1:	95% of patients prescribed treatment dose anticoagulation have the correct dose prescribed and have it administered appropriately.
Where we were in 2016-17	Anticoagulation is a high risk medicine that can result in patient harm if not administered correctly. An NHS QUEST 'Clinical Community' had been established to improve anticoagulation management which we hoped would provide us with some support to more move forward. NHS QUEST is a network for Foundation Trusts who wish to focus on improving Quality and Safety.
Where we are at the end of 2017-18	The NHS QUEST Medicines Safety Community has unfortunately been inactive over this calendar year. There was a lack of engagement from organisations due to clinical pressures. The Clinical Lead for VTE has undertaken an audit to review the prescribing accuracy of two anticoagulants (Dalteparin and Apixaban). 100% compliance was achieved regarding correct dosing and administration for these prescriptions.
Achieved ✓	We have a priority for 2018-19 specifically related to the prescribing and administration of warfarin.
Priority 2:	To achieve 100% compliance with the identification of a deteriorating patient, appropriate frequency of observations and escalation of the deteriorating patient.
Where we were in 2016-17	A Task and Finish Group was established during 2016-17, chaired by the Director of Nursing. Despite achieving 100% compliance for MEWS (Modified Early Warning Score) during selected months during the year, the group continued to monitor the audit results and aimed to achieve consistent achievement of compliance.
Where we are at the end of 2017-18	<p>The final end of year audit results for compliance with the MEWS algorithm was 78%.</p> <p>The Task and Finish Group has focused raising awareness and achieving stated goals. The MEWS (Modified Early Warning Score) dashboard and reports have been reviewed, and sub groups have been identified.</p> <p>These groups are:</p> <ul style="list-style-type: none">> IT Systems: This group will collaborate with the teams responsible for our electronic patient record and business intelligence to develop ease of accessing audits, reports and what alerts can be configured and developed.> Education: This group will focus on mandating of courses, attendance and increasing access to education.> Handover: This group will standardise handover to enable clear communication and identification of MEWS and escalation.
Priority 3:	To achieve an improvement in the results of an audit reviewing the compliance with requirements for Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)
Where we were in 2016-17	A Task and Finish Group had been established, chaired by our Director of Nursing, to agree actions following a clinical audit of DNACPR.
Where we are at the end of 2017-18	We commissioned an external review of DNACPR practice from Merseyside Internal Audit. The results of this were similar to the clinical audit undertaken by the Trust. Actions were implemented and a further clinical audit was undertaken. This audit demonstrated a number of improvements. We are now undertaking some targeted work to ensure that every element of the DNACPR process is completed accurately.
Partially achieved	

Patient Experience (Caring)

Priority 1:	To achieve improved benchmarked position for patients being given notice of when discharge would be.
Where we were in 2016-17	The National Patient Survey 2016 results highlighted many positive elements of patient experience. Unfortunately one question with declining results related to patients being given notice of when discharge would be.
Where we are at the end of 2017-18	We will review the results from the National Patient Survey 2017, due for publication in June 2018, to understand whether the actions we have improved our benchmarked position. Our annual national Picker patient survey results (which provide a comparison against all Trusts utilising Picker for their surveys) showed some improvement. Implementation of the nursing discharge folders on all wards, including in Accident and Emergency, has occurred, which are discussed with patients, families and carers. The Integrated Discharge Team discuss planned and complex planned discharges with patients and families early into the patient's admission so a clear plan for the discharge date can be achieved. All third party agencies are contacted at the start of the patient journey to ensure early intervention is completed if required, this is discussed with the patient and carers. Patients and their named representative are provided with twenty four hours' notice of potential discharge. On the day of discharge both the patient and their representative are advised of discharge and this continues to be maintained at two hourly intervals.
Picker patient survey results: Achieved ✓ Awaiting National Patient Survey results.	
Priority 2:	To achieve 90% of patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital.
Where we were in 2016-17	Each month the volunteers and governors undertake the real time patient experience survey. On average 160 patients take part in the survey. In 2016-17 63.8% of patients asked reported that they were involved as much as they wanted to be in decisions about discharge from hospital.
Where we are at the end of 2017-18	Our annual national Picker patient survey results (which provide a comparison against all Trusts utilising Picker for their surveys) showed notable improvement by 8% to 50% for patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital. Our real time patient experience data collected monthly demonstrates that 62.21% of patients asked during 2017-18 reported that they were involved as much as they wanted to be in decisions about discharge from hospital.
Internal patient surveys: Not Achieved x However, an improvement in the Picker patient survey results: Achieved ✓	The multi-disciplinary team (MDT) and Integrated Discharge Team (IDT) discuss with patients, families and carers plans for discharge, ensuring preference and choice is provided if the patient is not returning to their home address. Discharge planning meetings include both the patients and their named representative to ensure all are clear of plans to ensure safe and effective discharge. Nursing staff provide patients and their representatives with the opportunity to discuss their discharge with the clinician during ward rounds to ensure there is a clear understanding of the plans. The Head of Quality is undertaking very early discussions with AQUA regarding the possibility of partnership working to consider how shared decision making and person centred care might impact on discharge and patient experience. We will continue to focus on improving communication with patients about their discharge.

Priority 3:	To develop a ward accreditation scheme.
Where we were in 2016-17	We did not have a ward accreditation programme. The aim of an accreditation programme was to provide a kite mark of high quality and performance.
Where we are at the end of 2017-18	The ASPIRE (Accreditation System providing improvement and recognition in the care environment) framework has been designed and piloted. The pilot has been evaluated and some changes have been made to the framework. Three wards have piloted the scheme, Ward A at Wrightington hospital, Acute Stroke Unit, RAEI and Ward 3, Leigh Infirmary.
Achieved ✓	<p>There is a programme of accreditation visits planned for 2018 - 2019. An education pack and coaching support will be provided to each area to assist with making improvements. Good practice will also be celebrated.</p> <p>A ward app (Caring Responsive Effective Well led Safe-CREWS) is currently being developed to support the ASPIRE.</p>



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. The Single Oversight Framework replaced the Risk Assessment Framework in November 2016. Please note Summary Hospital-level Mortality Indicator (SHMI) and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.

Key

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

Indicator	2015-16		2016-17		2017-18	
Infection Control						
Clostridium difficile (C.difficile)	12 Threshold= 19		22 Threshold= 19		25 Threshold= 19	
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	0		3		1	

C.difficile

Our C. difficile trajectory set by the Department of Health was 19 for 2017-18 but the Trust had 25 cases. We continue to undertake detailed individual patient reviews collaboratively with our commissioners to identify potential 'Lapses in Care' and key learning or trends. This year 6 'Lapses in Care' were identified; these related to:

- > Delayed patient isolation.
- > Delay in specimen collection and delayed isolation.
- > Prescribing outside Antibiotic Policy and poorly labelled sample.
- > Delayed use of Bristol Stool chart, prescribing outside Antibiotic Policy and delay in sample reaching the lab.
- > Delayed use of Bristol Stool chart, poor documentation, delay in sampling and delay between specimen being taken to lab and result being reported.
- > Antibiotic prescribing was not reviewed according to microbiology lab results.

MRSA Bacteraemia

We had 1 MRSA Bacteraemia during 2017-18 in April 2017. There have been no apparent care issues but the Trust took the opportunity to reiterate the importance of the ANTT principles in relation to Vessel Health and introduced a standard competency form for staff use.

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

Indicator	2015-16		2016-17		2017-18	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	0	↑	1	↓	4	↑

There were four incidents reported as Never Events at WWL during 2017-18. It is important to note (with the caveat that they remain serious incidents) that patients have not experienced serious harm directly related to these Never Events. We reported the following:

- > Two wrong site surgery incidents
- > One misplaced nasogastric tube incident;
- > One retained foreign object incident.

We sincerely apologise to the patients involved in these Never Events. We are liaising with NHS Improvement for some support to further progress the development of LocSSIPs (local safety standards for invasive procedures) outside of Theatre. The action plans developed following the investigations are monitored by our SIRI Panel, chaired by an Executive Director. Membership of the SIRI Panel includes representatives from Wigan Borough Clinical Commissioning Group and WWL Lead Governor.

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

Indicator	2015-16		2016-17		2017-18	
Accident and Emergency (A&E)						
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	95.10%	↑	87.61%	↓	80.89%	↓

Our overall performance against the 4 hour target has declined over the last 12 months. This is in line with a declining trend both regionally and nationally. Though the overall number of attendances has not increased we did note an increase in the acuity of patients presenting in A&E who required specialist input and admission. This was further evidenced by the increase in patients presenting over the aged of 65 and patients from Nursing Homes.

In line with the national picture, we experienced extreme pressures throughout the extended winter period. The Trust has worked with system partners to formulate a system wide action plan to improve our A&E performance in 2018-19 in line with our agreed trajectory. Areas of focus in 2018-19 are improving access and availability of community services, admission avoidance and the implementation of a system wide frailty strategy.

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

Indicator	2015-16		2016-17		2017-18	
Cancer Waits						
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	88.85%	↓*	90.59%	↑*	92.58%	↑*
	91.3%	↓**	93.21%	↑**	94.28%	↑**
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	97.25	↓*	100%	↑*	98.75%	↓*
	97.01%	↓**	99.75%	↑**	98.5%	↓**

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. Before repatriation are nationally reported figures. Greater Manchester has an integrated cancer system. A breach re-allocation policy has been agreed by all Trusts. When a breach has occurred and the pathway has involved more than one Trust, rather than sharing the breach, the whole breach can be re-allocated to one Trust if the agreed timescales for transfer or treatment have not been met.

We have continued to achieve all performance indicators for cancer care throughout 2017-18 despite a very challenging year for Cancer Services nationally. More patients are being treated within 62 days and WWL is consistently in the top ten performing trusts for this target. There has been a 9.7% increase in suspected cancer referrals from GPs; however, we have maintained performance against the 2 week wait for first appointment target. We continue to work closely with partner organisations in Greater Manchester and the Greater Manchester Cancer pathway boards. We have clinical representation from consultants and specialist cancer nurses on all the pathway boards working collaboratively with colleagues in the tertiary centres to improve patient outcomes and their experience.

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

Indicator	2015-16		2016-17		2017-18	
Referral to Treatment (RTT)						
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway (Threshold= 92%)	96.9%	↓	95.75%	↓	94.80%	↓

From October 2015 Trusts are monitored on incomplete pathways for RTT (RTT waiting times for patients whose RTT clock is running at the end of the month).

We have continued to achieve the national 18 week access targets and remains one of the highest performing Trusts in the country. We did see a slight drop in performance in 2017-18 as a result of the national directive to cancel elective activity to support unscheduled care pressures however we remained comfortably above the target of 92% which is representative of the Trust focus to provide the best possible care to our patients through low access times.

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

Indicator	2015-16		2016-17		2017-18	
Diagnostic Procedures						
Maximum 6-week wait for diagnostic procedures (Threshold=99%)	99.69%	↑	99.37%	↓	99.0%	↓

The Trust has achieved the maximum 6-week wait for diagnostic procedures. Radiology continues to perform extremely well against this standard and easily achieves the 99% threshold. This is despite rising numbers of referrals and increasing complexity of examinations. The standard does not measure all Radiology examinations, but a specific selection of key examinations such as MR, CT and DEXA. For WWL that represents about 10,000 examinations per month that we are measured against (we undertake around 330,000 examinations per year).



Complaints, Patient Advice and Liaison Service and the Ombudsman

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

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

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

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

We welcome complaints to learn and reflect on how we work and to make the appropriate improvements. The following outlines actions taken and lessons learned from a sample of complaints received.

Complaints Theme and Brief Summary	Actions Taken and Lessons Learned
<p>Communication Patient informed three members of staff before procedure they could not tolerate a particular medication; however on discharge the patient was prescribed the medication.</p>	<p>To ensure that clear and concise prescription requirements are documented appropriately. Process is in place for clear prescribing and checking to take place in relation to patient requests and allergies. To ensure that documentation is dealt with appropriately ensuring that any changes to patient demographic details are noted and actioned. Process in place to ensure any old labels are removed and disposed of appropriately and new labels added to avoid incorrect details being placed on patient records.</p>
<p>Clinical Treatment Patient insulin dependent diabetic, admitted with suspected appendicitis; following a scan patient informed by a doctor that this was not the case and a different diagnosis was advised. This was subsequently changed again.</p>	<p>A consultant met with the patient to apologise and to discuss the doctor's comments, actions and lessons learned. The individual involved has reflected and will use this case as a learning experience, to look at ways in the future on how this type of consultation can be improved.</p>
<p>Values and Behaviours Patient attended for removal of a drain and was unhappy with attitude of the staff member undertaking this procedure.</p>	<p>The staff member has written a reflective piece. An assessment of the technique used was observed to ensure compliance and to provide development and support.</p>
<p>Communication Patient was advised to fast for a local anaesthetic, and waited for 9 ½ hours to have surgery. There was no communication following the initial consultant review, and concerns were raised relating to the lack of communication from Theatres. Patient decided to leave the ward and has been since been referred to the local Podiatry Service.</p>	<p>A review of the Theatre list management has been undertaken; where there is change to a theatre list the printed version must be communicated to admission ward to ensure effective communication with the patients. There is currently a review to develop the scheduling and look at staggered admissions which will reduce the likelihood of this happening.</p>
<p>Waiting time Husband of patient unhappy at delay of operation and wife has received 3 questionnaires with questions that relate to after procedure has taken place.</p>	<p>Managers of the pre-operative and admissions team are to ensure they communicate clearly in regards to patient pathways changes. Staff made aware of the delay in the MDT (multidisciplinary team) discussion resulted in delays in decisions being made. Asked all staff to ensure attendance at MDT and if they are unable to attend they ask their Registrar to take the case to the MDT. Secretarial staff to keep a log of patient pathways status to ensure they are tracked and this would have been flagged.</p>
<p>Clinical treatment Mother of child felt doctor did not examine her son thoroughly enough and did not seem bothered (attitude). Patient taken to another Trust where she feels he got a thorough examination and diagnosis.</p>	<p>Investigations show that clinical care was appropriate at the time of presentation (referring to National Institute of Health and Care Excellence guidance); however, the doctor apologised for not communicating fully in respect of reassurance of the illness diagnosed at the time, and has reflected on this case for their own learning.</p>

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 2017-18 the PHSO requested information regarding 5 complaints. Decisions have been received for 2 cases which have not been upheld and 3 remain under investigation. These cases relate to 2014, 2015, 2016 and 2017.

Final reports for 5 cases sent in previous years have been received; one was upheld, 2 were partially upheld and 3 were not upheld. No financial redress has been awarded in respect of these cases.

Patient Experience

We have continually achieved excellent scores for cleanliness throughout the hospitals placing us in the top 20% of Trusts in this area of assessment in the National Inpatient Survey 2017.

The Patient and Public Engagement Team continue to obtain feedback from inpatients using the Real Time Patient Experience Survey. The surveys are undertaken by our hospital volunteers and governors. The results are presented to the Board of Directors every month to monitor the corporate objective of over 90% of a positive patient experience. As a result of this monitoring there has been significant improvement in "If a family or someone close to you wanted to talk to a doctor, did they have enough opportunity to do so?" Results of the outcome of the real times surveys are located in the patient engagement section of our annual report.

Patient and Public Engagement

Patients, Carers and Governors attended two Experience Based Design events to assist with the redesign of the Rheumatology Service. Rheumatology 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 implemented in response to feedback include improvement to the information both written and verbally about certain drugs and more education around Rheumatology for GPs.

The Patient and Public Engagement Team along with the Equality and Diversity Project Lead engaged with the women for the Support for Wigan Arrivals Project to explore their experience of accessing Women's and Children's Services. The

majority of the women said the services they received were excellent. Only one lady commented that she hadn't had an interpreter on her visit to the hospital. This was raised with the Quality and Safety Matron and improvements were put in place by putting on awareness raising sessions for the staff around interpreters.

The patient and public engagement campaign on "Shared Decision Making - Ask 3 Questions" continues to be successful by engaging with patients, public and staff through various touch points. The touch points include all patient information leaflets including information on Ask 3 Questions, Events and internal posters. The campaign informs and empowers patients to be involved in decisions about their care and treatment

We value the contribution of lay representatives who attend the Divisional Quality Executive Committees, Quality Champion Committee, Discharge Improvement Committee, Children's Clinical Cabinet, Infection Control Committee, Quality Champion Patient Flow Project and Patient-Led Assessments of the Care environment (PLACE) assessment, to give the patients' perspective.

We have a Patient and Public Engagement Committee. The Committee's remit is to ensure that patient and public engagement remains integral to us. The Committee is chaired by the Lead Governor with representation from Governor's key local stakeholder agencies.

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

We have continually achieved excellent scores for cleanliness throughout the hospitals placing us in the top 20% of Trusts in this area of assessment in the National Inpatient Survey 2017.



Consultation with Local Groups and Partnerships

The CCG, Healthwatch Wigan and Leigh, local voluntary groups such as Think Ahead and the Local Authority work in partnership with us on the Improving Discharge Committee. Some of the improvement work implemented as part of the group is the establishment of the Integrated Discharge Team, Introduction of the Discharge Wallet and improvements to discharge letters and the launch of the Discharge Always Events. Some examples how the CCG has listened to our patient feedback and making improvements:

Service	You said	We listened
Pain management	GP education is very important (continuity, sympathy, understanding of chronic pain conditions). There were mixed experiences and feelings about primary care.	A programme of GP education has been put in place for the GPs and this will be reviewed when the programme is complete.
Rheumatology	Some patients experience difficulty getting an appointment at their own practice. It was queried whether there was enough staff in practices to make this work.	We are working with our primary care colleagues to address the issues. These comments are being addressed in the context of a wider piece of work across all providers of care in Wigan to work closer together and provide greater accessibility to patients. This means that we are now working to ensure that services provided in the community and those provided in hospitals work better together and services support each other to deliver better care to patients.
Respiratory	This report identifies a number of key findings when considering access to respiratory services. 81% of the patients responding to the survey found the patient experience of being seen by a GP before being referred to hospital excellent or good.	As part of this ongoing redesign the Healthier Wigan Partnership are recruiting members of the public living with respiratory conditions into a Lived Experience Panel.

The Patient and Public Engagement Team have worked in partnership with Wigan Borough Clinical Commissioning Group to improve outpatient pathways as a part of the Locality Plan. We engaged with patient's carers and relatives from Respiratory, Ear Nose and Throat, Ophthalmology and Cardiology Services.

> 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 2017-18 is outlined below.



Staff Engagement the WWL Way

The year began with lower levels of staff engagement than seen at the beginning of 2016. The April 2017 Pulse Survey highlighted a decline in engagement measures including enablers for clarity, mind-set, personal development, influence, perceived fairness and recognition, feelings of dedication, energy levels and focus and behaviours of advocacy. Survey results for the remainder of 2017 plateaued with some improvement seen in enablers of clarity and behaviours of adaptability. Overall scores remained moderate to positive.

The staff engagement pulse survey assisted to pre-empt the outcomes of the National Staff Survey which took place from October to December 2017. The results published in March 2018 indicated some declines, particularly in relation to staff recognition and health and wellbeing at work, reducing the gap between our scores and the national average for some elements. However, in contrast to this, there was an improved or maintained score for 63% of the relevant questions and better performance against the national average on 90% of the relevant questions. WWL now ranks joint second out of 93 acute Trusts for overall staff engagement within the NHS, compared to a ranking of 10th in 2016.

Staff engagement activity continued to be delivered at full momentum in 2017 and included the following initiatives:

- > The continuance of the “Steps 4 Wellness” health and wellbeing programme/campaign with a number of activities including mental health awareness, mindfulness programmes, Lose Weight Feel Great, Happy Backs and Time to Talk.
- > Delivery of staff events such as the Recognising Excellence Awards and the WWL Way 4Wards Launch Event, followed up with an Interactive Experience.
- > Staff engagement and organisational development work to support organisational and cultural change (e.g. implementation of the new health information system (HIS) in A&E, The development of WWL Solutions Ltd, the WWL Way 4Wards and WWL Route Planner)
- > Staff engagement listening events and forums to gather staff ideas, feedback, contributions and influence
- > Delivery of Cohort 6 and Cohort 7 Pioneer Teams Programme

- > Review of all internal communications methods and a rebranding exercise – delivery against the strategy
- > Development and implementation of a new staff intranet (Wally) and app, transforming internal communications.
- > Provision of Leadership Masterclasses for senior staff
- > The launch of the Apprenticeship Scheme
- > Events held for careers and careers ambassadors

We continue to share our in-house developed staff engagement programme, “Go Engage”, with external organisations, which includes a licence to an online “Xopa” platform that surveys staff and statistically analyses data for trends and hot spots. Managers are also able to receive training in access to “Xopa” to enable them to stay connected to staff engagement results each quarter.

We have seen a number of challenges this year in the form of organisational change (internal and external), increased patient demands and financial pressure, which have added to pressure on staff and, as a result, impacted culture. The pulse survey has enabled us to identify areas for improvement ahead of the national staff survey results, which has meant engagement plans and initiatives are continually developed and implemented. The aim is to ensure that engagement does not decline further and begins to improve, leading us from a place of “good” results to “great” results once again by the end of 2018. We will continue to build on staff engagement and wellbeing plans to ensure the delivery of positive outcomes for staff, organisational performance and ultimately the quality of care provided to patients.

Continued Recruitment and Development of the Quality Faculty

Our Quality Faculty has continued to grow during 2017-18 and there are now over 400 Quality Champions representing a wide range of disciplines and departments, working on or have completed 200 improvement projects.

All Quality Champions who complete the training programme and commence an improvement project are awarded a bronze badge. Silver and gold badges are awarded to those Champions who sustain their improvements and disseminate them to other organisations. In 2018-19 we will be adding further criteria for a gold badge to support people who have undertaken sustained improvement work but are not able to disseminate it to other organisations. In 2017, 13 silver and 6 gold awards were awarded, taking the total to 60 silver champions and 19 gold champions.

Four courses of training in quality improvement methods have been delivered during 2017/2018. In July 2017 we held an unconference to look at how the programme needed to evolve to provide for the needs of staff. These changes have been incorporated into the new Quality Improvement Strategy.

During 2017-18 the programme continues to engage with a range of disciplines including Business Intelligence, Information Technology and a wide range of clinical disciplines. Finance and understanding the cost benefits of improving quality has become an integral part of the programme. To date, cost benefits have been realised in excess of £3.4 million. These have been realised through decreased length of stay, reduced financial penalties and achievement of best practice tariff.

We held our Quality Champions Conference in September 2017 where the new silver and gold quality champions were awarded their badges. At this event quality champions were invited to present their work in a presentation or poster display. A number of individuals external to the organisation attended the event with nationally recognised key note speakers. Speakers from NWS and the Countess of Chester NHS Foundation trust were invited to present their quality improvement journey.

During 2018-19 four further cohorts are planned in addition to supporting a further programme for junior doctors.

Leadership Quality and Safety Rounds

During 2017-18 six leadership safety rounds took place. Executive and Non-Executive members of the Board of Directors and Trust Governors visited wards and departments and held conversations with groups of staff about safety using an "appreciative inquiry" approach. Areas visited included Ince Ward, the Palliative Care Team, Community Services, Swinley Ward, Medical Records and the Estates Department. Forty four safety rounds have taken place using this approach since 2012, involving many different disciplines across four sites. During 2018-19 a further twelve visits are planned. One visit a month is planned; however, they are sometimes unable to go ahead for operational reasons, if the areas are unable to accommodate the visit.

Always Events

The Always Events are our commitment to improving the delivery of patient and family centred care. The first 10 Always Events were launched in January 2014. The Always Events are embedded within our Safe, Effective and Caring culture. Staff, patients and carers contributed to the development of the 'Always Events', identifying ten essentials of patient care that are fundamental to improving patient experience and should always happen for every patient. Their implementation has led to a positive improvement for our patients and staff. The regular weekly snap shot audits and the quarterly whole hospital site audits have continued to demonstrate stability and improvement. Discharge Always Events were introduced in 2017-18.

The HELPLine

The HELPLine continues to be a useful method of communication for families and loved ones to be able to contact a senior nurse when they need to discuss aspects of their loved one's care.

It is intended to be a way of escalating concerns that families may feel have not been addressed adequately by ward or department staff. HELPLine is a mobile phone that is carried on a rota basis between all operational divisions. The number of calls has remained fairly constant, and the majority of calls are resolved either during that point of contact or very soon afterwards.

Commissioner Quality Visits

NHS Wigan Borough Clinical Commissioning Group (CCG) has undertaken one unannounced Commissioner Quality Visit in 2017-18 to determine the experiences and views of the patients, relatives, carers and staff on services provided by Maternity Services. The Commissioner's reports following their visits are reviewed by our Quality and Safety Committee. Agreed actions are monitored by Commissioners at the joint Quality Safety and Safeguarding Committee attended by representatives from the Trust and the CCG.

The Trust welcomes the unannounced visits by the CCG and the collaborative approach taken by the CCG to improve patient and staff experience.

TalkSafe



TalkSafe is a programme that is focused on changing the safety culture of an organisation through structured conversations. TalkSafe has a twenty year proven history within the aviation, chemical engineering and engineering sectors.

Conversations focus on safety (safe and unsafe practice), and the potential consequences of these actions. TalkSafe uses a coaching style focused on behaviour, actions and consequences. It is designed to focus on practice prior to incidents or near misses, and focuses on organisational and system factors in addition to individual behaviours. The programme is a gateway to human factors and is focused at all levels of staff.

The Board of Directors have supported the deployment of Talksafe across the organisation. It was recognised that this would be a significant undertaking and unlikely to succeed using the current method of face to face training. Therefore the decision was taken to review the training and build a bespoke training package that will serve our needs. This training has taken the form of virtual reality with augmented face to face coaching and support from TalkSafe Champion Coaches. The films are in their final post production. The programme will be ready to launch in April 2018 with a staged deployment in conjunction with the ASPIRE programme.

> Appendix A:

National Clinical Audits and National Confidential Enquiries

The National Clinical Audits and National Confidential Enquiries that WWL has participated in during 2017-18 are as follows:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible to partnership Y/N	Participated	Number eligible	Actual submissions
Child Health Clinical Outcome Review Programme (Chronic Neuro-disability)	Yes	Yes	5	100%
Child Health Clinical Outcome Review Programme (Young People's mental health)	Yes	Yes	4	100%
Medical and Surgical Clinical Outcome Review Programme (Acute Heart Failure)	Yes	Yes	3	67%
Medical and Surgical Clinical Outcome Review Programme (Peri-operative Diabetes)	Yes	Yes	8	Project ongoing

National Audits (NCAPOP – n = 20)	Eligible	Participated	Number eligible	Actual submissions %
Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	Yes	703	100%
Coronary Angioplasty/ Percutaneous Coronary Intervention (National Institute for Cardiovascular Outcomes Research - NICOR)	Yes	Yes	Data collection complete	Information not available until June 2018
Cardiac Rhythm Management (NICOR)	Yes	Yes	Data collection complete	Information not available until June 2018
National Heart Failure	Yes	Yes	330	Validated figures not yet available
Bowel Cancer	Yes	Yes	All cancer audits reported by Oncology Department services Feedback report submitted to Audit Chairs meeting showed that all relevant submissions were complete	
Head and Neck Cancer	Yes	Yes		
Lung Cancer	Yes	Yes		
National Prostate Cancer	Yes	Yes		
National Oesophago-Gastric Cancer Audit (NAOGC)	Yes	Yes		
National Diabetes Inpatient Audit (Adult) (NaDIA)	Yes	Yes	61	100%
Diabetes Pregnancy in Diabetes	Yes	No	Figures not currently available	Figures not currently available
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	147 to date	100%

National Audits (NCAPOP – n = 20)	Eligible	Participated	Number eligible	Actual submissions %
Falls and Fragility Fracture Audit Programme (FFAP) Inpatient falls	Yes	No	31	100%
National Hip Fracture Database	Yes	yes	364	100%
Inflammatory Bowel Disease (IBD)	Yes	No	Not participated due to increased workload and lack of resources.	
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	No	The Trust has reviewed its participation in this programme to meet national requirements.	
Maternal, Newborn and Infant Clinical Outcome Programme (MBRRACE)	Yes	Yes	12 (Jan to Dec)	100%
National Audit of Dementia	Yes	Yes	52	100%
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	2800	100%
National Emergency Laparotomy audit (NELA)	Yes	Yes	154	100%
National Joint Registry (NJR)	Yes	Yes	Ankles – 72 Elbow – 36 Hip – 1592 Knee – 1332 Shoulder - 215	Validated figures not available to date
National Ophthalmology Audit	Yes	Yes	1397	100%
Neonatal Intensive Care (NNAP)	Yes	Yes	310 to date	Figures not currently available
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	No data collection during this period	
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	372	98.6%

Non-NCAPOP commissioned	Eligible	Participated	Number eligible	Actual Audit Submissions %
Female Stress Incontinence (The British Association of Urological Surgeons)	Yes	Yes	Continuous data collection	Validated data not available until June 2018 (AT)
Cystectomy (The British Association of Urological Surgeons)	Yes	Yes	Continuous data collection	Validated data not available until June 2018 (AT)
Case Mix Programme (Intensive Care National Audit and Research Centre)	Yes	Yes	527 to date	100%
Elective Surgery (National Patient Reported Outcome Measures Programme)	Yes	Yes	See section 2.3 Reporting against core indicators.	
Endocrine and Thyroid National Audit	Yes	Yes	Voluntary by individual Surgeon	

Non-NCAPOP commissioned	Eligible	Participated	Number eligible	Actual Audit Submissions %
Fractured Neck of Femur (Care in emergency departments)	Yes	Yes	52	100%
Inflammatory Bowel Disease (IBD) Registry	Yes	No	Trust not participated due to limited resource (intention to participate in next round)	
Major Trauma Audit (TARN)	Yes	Yes	Figures not currently available	Figures not currently available
National Audit of Intermediate Care	Yes	No	Did not participate	
National Cardiac Arrest Audit	Yes	Yes	88 (to Dec 17) Acute site only	100% (to Dec 17 – Q4 figures not yet available)
National Chronic Obstructive Pulmonary Disease (COPD)	Yes	Yes	931	100%
National Comparative Audit of Blood transfusion	Yes	Yes	Figures not currently available	Figures not currently available
Pain in children (Care in Emergency Department)	Yes	Yes	38	100%
Procedural Sedation in Adults (Care in Emergency Department)	Yes	Yes	33	100%
Serious Hazards of Transfusion (SHOT)	Yes	No	Did not participate due to limited resources.	
UK Parkinson's Audit	Yes	Yes	22	100%

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

*Trust provides services but audit currently includes selected Trusts only

> Annex A:

Statements from Healthwatch, Overview and Scrutiny Committee and Clinical Commissioning Group

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

Wigan Borough Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group Response to Wrightington Wigan and Leigh NHS Foundation Trust Quality Account 2017-18

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

The CCG has worked closely with the Trust throughout 2017-18 in what has been a challenging year for the Trust and the wider NHS to gain assurances that services are safe, effective and caring.

The CCG is pleased to note the Care Quality Commission (CQC) Inspection Report, published on 9th March 2018 rated the Trust as 'Good' overall and that all the Trust's hospital sites are now rated as 'Good' or 'Outstanding'. Maternity Services received a rating of 'Requires Improvement' and the CCG has supported improvement work in this area by undertaking a Commissioner Quality Visit to the service in January 2018.

In respect of the 2017-18 quality priorities, the CCG notes that a number of objectives were not achieved. However, progress was made in some of areas including a reduction in the overall number of inpatient falls and the development of a ward accreditation scheme. Other positives in year include the delivery of a comprehensive clinical audit and research programme and continued recruitment and development of the Quality Faculty.

The publication of the Trust's Quality Strategy 2017-21 in April 2017 is welcomed. The strategy identifies the quality priorities for the next four years.

Challenges in year have included A&E performance, staffing levels, Clostridium difficile rates, venous thromboembolism risk assessments, sepsis management, issues related to implementation of the Hospital Information System (HIS), a persistently high Summary Hospital Level Mortality Indicator (SHMI) and an increase the number of Never Events. The CCG has and continues to work with the Trust to make improvements in these areas.

The CCG supports the quality priorities identified for 2018-19 and welcomes the continued focus on reducing mortality rates and increasing the number of patients who receive a venous thromboembolism risk assessment. New priorities aimed at improving the management of patients with sepsis, identifying deteriorating patients and improving the care patients with a fractured neck of femur are also welcomed.

The CCG looks forward to working in partnership with the Trust and other stakeholders during 2018-19 to ensure the continuous focus upon improvement in order to provide the best possible care for our patients.

DR TIM DALTON

> Chairman,
Wigan Borough Clinical Commissioning Group

10 May 2018

> Healthwatch Wigan and Leigh:

The Trust received the following statement from Healthwatch Wigan and Leigh on the 16th May 2018:

All local Healthwatch within Greater Manchester are currently undergoing a full review to develop a standardised framework for involvement in the Quality Account process. Therefore we are unable to provide comment at this point.

> Health and Social Care Scrutiny Committee:

Comments were sought from Overview and Scrutiny Committee; however, none were received, most likely due to local elections.



> 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 2017-18 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 2017 to May 2018
 - Papers relating to Quality reported to the Board over the period April 2017 to May 2018
 - Feedback from commissioners dated 10th May 2018
 - Feedback from governors dated March 2018
 - Feedback from local HealthWatch dated 16th May 2018
 - Feedback from Overview and Scrutiny Committee (not received)
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2016-17
 - The 2017 national patient survey (not due for publication until June 2018 therefore the Trust has been unable to reference in this report)
 - The 2017 national staff survey 6th March 2018
 - The Head of Internal Audit's annual opinion over the Trust's control environment dated 2017-18
 - CQC inspection report dated 9th March 2018

- > 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; and;
- > 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



ROBERT ARMSTRONG

> Chairman

22 May 2018



ANDREW FOSTER CBE

> Chief Executive

22 May 2018

> Annex C:

How to provide feedback on the account

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

Independent auditor's report to the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust on the quality report

- > We have been engaged by the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust to perform an independent assurance engagement in respect of Wrightington, Wigan and Leigh NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust as a body, in reporting Wrightington, Wigan and Leigh NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Wrightington, Wigan and Leigh NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- > Accident and Emergency 4 hour wait times
- > 18 week Referral to Treatment times

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS foundation trust annual reporting manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- > the quality report is not prepared in all material respects in line with the criteria set out in the NHS foundation trust annual reporting manual and supporting guidance
- > the quality report is not consistent in all material respects with the sources specified below and
- > the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the NHS foundation trust annual reporting manual and supporting guidance and the six dimensions of data quality set out in the detailed requirements for external assurance on quality reports.

We read the quality report and consider whether it addresses the content requirements of the NHS foundation trust annual reporting manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- > board minutes for the period April 2017 to 22 May 2018;
- > papers relating to quality reported to the board over the period April 2017 to 22 May 2018;
- > feedback from commissioners, dated 16 May 2018;
- > feedback from governors, dated 16 May 2018;
- > the trust's quarterly complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for Q1, Q2, Q3 and Q4 of 2017-18;
- > the latest national patient survey, dated 31 May 2018;
- > the latest national staff survey, dated 6 March 2018;
- > the report arising from the Care Quality Commission inspection on 6-8 and 28-30 November 2017, published 9 March 2018; and
- > the Head of Internal Audit's annual opinion over the trust's control environment, dated April 2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) Assurance Engagements other than Audits or Reviews of Historical Financial Information, issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- > evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- > making enquiries of management
- > testing key management controls
- > limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation
- > comparing the content requirements of the NHS foundation trust annual reporting manual to the categories reported in the quality report
- > reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS foundation trust annual reporting manual and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- > the quality report is not prepared in all material respects in line with the criteria set out in the NHS foundation trust annual reporting manual and supporting guidance
- > the quality report is not consistent in all material respects with the sources specified above and
- > the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS foundation trust annual reporting manual and supporting guidance.

Deloitte LLP

DELOITTE LLP

> Leeds

24 May 2018



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NHS Foundation Trust

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GLOSSARY OF TERMS



Acute

Having or experiencing a rapid onset of short but severe pain or illness.

A&E

Accident and Emergency Department, also known as Emergency Department, based on the Royal Albert Edward Infirmary site.

Acute Care

Necessary treatment, usually in hospital, for only a short period of time in which a patient is treated for a brief but severe episode of illness, injury or recovery from surgery.

Age Well Unit

Launched in November 2016, this is a new service providing quick and effective care aimed at reducing the time spent in hospital for patients who may benefit from a more personalised multi-disciplinary assessment. The Age Well unit, which consists of 14 beds, seven male and seven female is based at RAEI.

Always Event

The Always Events are the Trust's commitment to improving the delivery of patient and family centred care. The first 10 Always Events were launched in January 2014 following concerns raised by complaints and incidents. The Always Events are embedded within our Safe, Effective, Caring culture. 'Goodnight' Always Events and Do Not Attempt Cardio-Pulmonary Resuscitation Always Events have also been introduced. Always events are everybody's responsibility and should always happen 100% of the time.

Annual Governance Statement

This is a key feature of the organisation's annual report and accounts. It demonstrates publicly the management and control of resources and the extent to which the Trust complies with its own governance requirements, including how we have monitored and evaluated the effectiveness of our governance arrangements. It is intended to bring together into one place in the annual report all disclosures relating to governance, risk and control.

Arterial

This is of or relating to an artery or arteries.

Board of Directors

The Board of Directors at WWL: sets the overall strategic direction of the Trust; monitors our performance against objectives; provides financial stewardship financial control and financial planning; through clinical governance, ensures that we provide high quality, effective and patient-focused services; ensures high standards of corporate governance and personal conduct.

The Board is made up of:

- > Non-Executive Directors (NEDs). These are paid part time appointments. NEDs bring independence, external perspectives and skills to strategy development. They help to hold the executive to account and offer scrutiny and challenge.

- > Executive Team / Executive Directors. These are full time Directors of the Trust. The executive team takes the lead role in developing and implementing strategic proposals, monitoring performance and feeding back to the wider Board of Directors.

Board Assurance Framework (BAF)

Is an essential tool for the Board of WWL and is reviewed at every meeting of the Trust Board. The BAF brings together in one place all of the relevant information on the risks to the board's strategic objectives.

Cardiology

The medical study of the structure, function, and disorders of the heart.

Chemotherapy

This is the treatment of disease by the use of chemical substances, especially the treatment of cancer by cytotoxic and other drugs.

CIP (Cost Improvement Programme)

These are a vital part of NHS Trust finances to deliver savings and reduce costs.

Clostridium difficile (C diff / CDT)

A bacterium that is recognised as the major cause of antibiotic associated colitis and diarrhoea. Mostly affects elderly patients with other underlying diseases.

Clinical Commissioning Groups (CCGs)

These are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. For WWL, Wigan Borough Clinical Commissioning Group (WBCCG) is the main commissioner of services.

Council of Governors

There are three types of Governors: public, staff and partner. The main role of the Governors is to represent the communities the Trust serves and our stakeholders, and to champion the Trust and its services. The Council of Governors do not "run" the Trust or get involved in operational issues as that is the job of the Trust Board. However, it has a key role in advising the Board and ultimately holding the Board to account for the decisions it makes.

Governors provide the link between the Trust and the local community enabling the Trust to gather views from local people and feedback what is happening in the Trust. This predominantly elected body represents service users, carers, the public, staff and other interested parties. People on this council are called Governors.

Together, they:

- > Represent the interests of our members and partner organisations
- > Give recommendations on our long-term strategy
- > Provide advice and support to the Board of Directors, which is responsible for the overall management of the Trust.

- > Appoint the Chair and the Non-Executive Directors of the Board of Directors.

CQC

The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health. It was established in 2009 to regulate and inspect health and social care services in England.

CQUIN

The Commissioning for Quality and Innovation (CQUIN) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

Dermatology

This is the branch of medicine concerned with the diagnosis and treatment of skin disorders.

Diabetes

This is a metabolic disease in which the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood.

Discharge to Assess

Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'.

Duty of Candour

Introduced as part of the Health and Social Care Act 2008 this regulation aims to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment.

The regulation also sets out some specific requirements that providers such as WWL must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Freedom of Information (FOI)

The Freedom of Information Act deals with access to official information and gives individuals or organisations the right to request information from any public authority.

Friends and Family Test

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The test helps service providers, such as the Trust, and

commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give views after receiving care or treatment across the NHS.

General Surgery

General surgery is a surgical specialty that focuses on abdominal contents including oesophagus, stomach, small bowel, colon, liver, pancreas, gallbladder and bile ducts.

Greater Manchester Devolution

Devolution is the transfer of certain powers and responsibilities from national government to a particular geographical region i.e. Greater Manchester. In 2016 Greater Manchester was the first region in the country to take control of its combined health and social care budgets – a sum of more than £6 billion. The Trust is one of 37 members of the Greater Manchester Health and Social Care Strategic Partnership – along with all NHS and Local Authority organisations across the region.

Gynaecology

This is the branch of physiology and medicine that deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system.

Healthier Together

Healthier Together has been looking at how patients will receive health and care in the future. The Healthier Together programme is a key part of the wider programme for health and social care reform across Greater Manchester. Clinically led by health and social care professionals, the programme aims to provide the best health and care for the people of Greater Manchester.

HIS

Hospital Information System.

Hospital Standardised Mortality Ratio (HSMR)

This is an important measure that can help support efforts to improve patient safety and quality of care in hospitals. The HSMR compares the actual number of deaths in a hospital with the average patient experience, after adjusting for several factors that may affect in-hospital mortality rates, such as the age, sex, diagnoses and admission status of patients. The ratio provides a starting point to assess mortality rates and identify areas for improvement, which may help to reduce hospital deaths from adverse events.

IM&T

Information Management and Technology

Integrated Community Services / Integrated Community Nursing and Therapy

Community based nurses, other health professionals and social workers are now working together as part of a new, single team across Wigan, Ashton and Leigh to improve care and support for patients.

The Integrated Community Service (ICS) brings together NHS staff based in the community with local council health and adult

social care staff to provide support to patients in their place of residence.

When under development, this service was known as Integrated Community Nursing and Therapy.

Integrated Discharge Team

The Integrated Discharge Team is made up of a group of professionals from both Social Care and Health who are co-located at Wigan Hospital and collaboratively work together to ensure the safe and timely discharge of patients from the Trust.

Information Governance

Information Governance is a framework for handling information in a confidential and secure manner to appropriate ethical and quality standards.

Locality Plans/Wigan Borough Locality Plan

A core element of Greater Manchester Devolution; each Borough in Greater Manchester is required to have a plan that details how the health and care system will be transformed to deliver improved health outcomes within a financially sustainable resource base.

Wigan's Locality Plan is called "Further, Faster Towards 2020"

Maxillo-facial (Max-Fax)

Oral and Maxillofacial Surgery is a specialty that deals with conditions affecting the head and neck.

MDT (Multi-Disciplinary Team)

This is a meeting of a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

Methicillin-resistant Staphylococcus aureus (MRSA)

Staphylococcus aureus (SA) is a common type of bacteria that live harmlessly, as a colonisation, in the nose or on the skin of around 25-30% of people. It is important to remember that MRSA rarely causes problems for fit and healthy people. Many people carry MRSA without knowing it and never experience any ill effects. These people are said to be colonised with MRSA rather than being infected with it.

In most cases, MRSA only poses a threat when it has the opportunity to get inside the body and cause an infection; this is called a bacteraemia.

National Inpatient Survey

NHS Inpatient Survey was developed by the Picker Institute in 2002 and forms part of the CQC National Survey Programme. The survey asks patients about their experiences of communications with doctors and nurses, hospital cleanliness, hospital food and discharge arrangements.

Never events

Never Events are a particular type of serious incident that meet all the following criteria: wholly preventable; has the potential to cause serious patient harm or death; There is evidence that the category of Never Event has occurred in the past;

occurrence of the Never Event is easily recognised and clearly defined.

NHS England (NHSE)

NHS England leads the National Health Service (NHS) in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

NHS Improvement (NHSI)

NHS Improvement is the independent regulator of NHS Foundation Trusts. The organisation was established in January 2004 to authorise and regulate NHS Foundation Trusts. It is independent of central government and directly accountable to Parliament.

There are three main strands to NHS Improvement's work:

- > Determining whether NHS Trusts are ready to become NHS Foundation Trusts
- > Ensuring that NHS Foundation Trusts comply with the conditions they signed up to and that they are well-led and financially robust
- > Supporting NHS Foundation Trust development.

NHS Foundation Trusts

NHS Foundation Trusts are a key part of the reform programme in the NHS. They are autonomous organisations, free from central Government control. They decide how to improve their services and can retain any surpluses they generate or borrow money to support these investments. They establish strong connections with their communities; local people can become members and governors. These freedoms mean NHS Foundation Trusts can better shape their healthcare services around local needs and priorities. NHS Foundation Trusts remain providers of healthcare according to core NHS principles: free care, based on need and not ability to pay.

Wrightington, Wigan and Leigh is an NHS Foundation Trust, and so are close partners such as Bolton NHS Foundation Trust and Salford Royal NHS Foundation Trust.

NICE

National Institute for Health Care Excellence is a statutory agency which provides national guidance and advice to improve health and social care

Obstetrics

This is the branch of medicine and surgery concerned with childbirth and the care of women giving birth.

Oncology

This is the study and treatment of tumours.

Ophthalmology

This is the branch of medicine concerned with the study and treatment of disorders and diseases of the eye.

Orthopaedics

The diagnosis and treatment, including surgery, of diseases and disorders of the musculo-skeletal system, including bones, joints, tendons, ligaments, muscles and nerves.

Paediatrics

This is the branch of medicine dealing with children and their diseases.

PAWS

This stands for Pathology at Wigan and Salford, a joint service between the two organisations.

Performance Development Reviews (PDR)

The purpose of a PDR is to review periodically the work, development needs and career aspirations of members of staff in relation to the requirements of their department and the Trust's plans and to take appropriate steps to realise their potential. It facilitates communication, clarity of tasks and responsibilities, recognition of achievements, motivation, training and development to the mutual benefit of employer and employees.

Radiology

This is the medical speciality that uses radioactive substances in the diagnosis and treatment of disease, especially the use of X-rays.

RCOG

This is the Royal College of Obstetricians and Gynaecologists.

Real Time Patient Experience Survey

The Real Time Survey is a regular survey of inpatients on our medical, surgical and postnatal wards. It runs alongside the Friends and Family Test as one of the main ways for the Trust to gather regular patient feedback. WWL has a dedicated team of volunteers who visit the wards each week to interview patients. The volunteers carry out face to face interviews with patients.

Rheumatology

This is the study of rheumatism, arthritis, and other disorders of the joints, muscles, and ligaments.

Secondary Care

The term secondary care is a service provided by medical specialists who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists.

Seven Day Services

This is an initiative to make routine hospital services available 7 days a week.

SPR (Specialist Registrar)

A Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.

Specialist Orthopaedic Alliance

Is a partnership of five hospital trusts that have specialisms within Orthopaedics. The Specialist Orthopaedic Alliance is leading the vanguard activity to establish a National Orthopaedic Alliance

Summary Hospital-level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which reports mortality at trust level across the NHS in England using standard and transparent methodology. This indicator is being produced and published quarterly by the Health and Social Care Information Centre.

Surgical Assessment Lounge (SAL)

SAL is the elective admissions lounge for all surgical patients at WWL. Patients admitted for day case surgery will also return to SAL after their operation before being discharged.

Surgical Assessment Unit (SAU)

This is an 8 bed unit on the Orrell Ward at RAEI. Patients are transferred to this unit for assessment by doctors from the Surgical team. The unit is run by a senior nurse and a care support worker.

Sustainability and Transformation plans (STP)

The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

Wigan is part of the Greater Manchester area where Greater Manchester Health and Social Care Devolution is responsible for the Greater Manchester Strategic Plan.

Ultrasound

This is sound or other vibrations having an ultrasonic frequency, particularly as used in medical imaging.

Urology

The branch of medicine concerned with the study of the anatomy, physiology, and pathology of the urinary tract, with the care of the urinary tract of men and women, and with the care of the male genital tract.

Vascular

This is relating to, affecting, or consisting of a vessel or vessels, especially those that carry blood.

Vanguard

In 2015 NHS England announced a programme for new models of care focussing on integration, this scheme is called Vanguard. WWL successfully applied with SRFT to be a vanguard project.

Venous Thromboembolism (VTE)

This is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE.



Wrightington, Wigan and Leigh NHS Foundation Trust

If you have any queries regarding this report,
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