NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Quality Accounts


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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 the Trust. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence based quality improvement and to explain progress to the public. This is the Trust's ninth Quality Account.

Part 1:

Statement from the Chief Executive

Welcome to our ninth Quality Account. This is a critically important document for us as it was nine years ago that we chose to pursue Quality as the overarching strategy for our services. We use 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 sixth 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. We continue to actively participate as a member of NHS QUEST; (a network for Foundation Trusts who wish to focus on improving quality and safety) working collaboratively with other member organisations to reduce avoidable harms in hospital.

Welcome to our ninth Quality Account. This is a critically important document for us as it was nine years ago that we chose to pursue Quality as the overarching strategy for our services. We use 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 sixth 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. We continue to actively participate as a member of NHS QUEST; (a network for Foundation Trusts who wish to focus on improving quality and safety) working collaboratively with other member organisations to reduce avoidable harms in hospital.

As with previous Quality Accounts, we have given considerable priority to collecting and reporting facts and data to monitor our progress. These show that 2016/17 was the first year for some time that we have seen some results slip backwards, 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 six years of austerity in the public sector and the effects of repeated annual savings' plans in the NHS and reduced funding for Social Care have really begun to bite. Secondly, alongside funding pressures we see a continued rise in demand for our services with ever more and sicker patients using our systems. This leads to overcrowding and extended waiting, both of which are a significant risk to patient safety.

On infection control, for example, after 25 months with none, we have had three cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infection. And after many consecutive years of reduction we have seen a rise to 21 cases of Clostridium difficile compared to 12 the previous year. It must be pointed out though that only three of these cases were the result of lapses of care in the hospital, the rest being acquired outside hospital and diagnosed after admission. We also recorded 12 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) and 36 E Coli bacteraemia compared to 4 and 6 respectively in 2015/16.

Another key quality measure is Hospital Standardised Mortality Ratio (HSMR) and, again, this has slipped backwards for the first time in several years. The most up to date HSMR figure for 2016/17 is 112 to December 2016. To corroborate the data provided by Dr Foster, over the last eight years our absolute numbers of deaths in hospital has risen from 1122 in 2015/16 to 1340 in 2016/17, a rise of 19%.

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 15 serious and moderate falls in hospital, compared to 15 the previous year
- There was one Central Line infection, and zero the previous year
- There has been one incident that met the criteria for a Never Event in 2016/17 and none in 2015/16
- There were no cases of Ventilator Associated Pneumonia compared to one in 2015/16

Effective

- We concluded our £13m investment in the new Hospital Information System, which went live in the summer. Although there are still teething problems, the move to the new system was exceedingly smooth and will bring huge benefits in years to come
- As a joint venture with The Christie, a new PET (Positron Emission Tomography) scanner came into service at RAEI, further reducing the need for Wigan residents to travel across Manchester
- We successfully achieved all the national targets except for four hour waits in A&E, although we were still the best performing Trust in Greater Manchester.

Caring

- In the national patient survey we had 24 scores significantly better than other Trusts who utilise Picker for their national inpatient survey (87 Trusts) and none significantly worse
- In the annual Patient Led Assessments of the Care Environment (PLACE) survey we were the cleanest hospital in the NHS for the third year in a row and our overall scores were the sixth best in the NHS
- Our national staff survey results have fallen back a little from the high of 2015 but we are

still in the top 20% of Trusts for 20 of the 32 measures
- This year we increased the number of Quality Champions to 349, each being trained in techniques of quality improvement before taking on leadership of 143 tasks or projects since the programme started.

In June 2016, the Care Quality Commission (CQC) issued an overall 'Good' rating for the Trust following its inspection in December 2015. Whilst the Trust was particularly pleased with the 'Outstanding' rating for both End of Life Care and for services at the Thomas Linacre Centre, we were disappointed with some other ratings. The full table of ratings is shown in section 2.2 under "What others say about WWL".

The Trust reported 31 serious incidents in 2016/17, in comparison with 22 in 2015/16. The Trust received 457 formal complaints in 2016/17 compared to 362 in 2015/16. We were pleased to note an increase in incident reporting rates with 11,538 Datix incident reports submitted in 2016-17 in comparison with 10,546 in 2015/16. This increase enabled the Trust to maintain its position in the top 10% of Trusts reporting incidents to the National Learning and Reporting System.

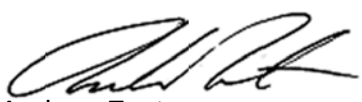
We continue to have one of the best A&E departments in the country and for several years it has been the top performer in Greater Manchester. However, we had a very difficult Christmas and January exacerbated by an outbreak of norovirus, both in the Trust and in many local care homes. Our system became overwhelmed for many weeks and our performance dipped to 87.61% for the 4-hour standard. We apologise to patients who experienced extensive waiting at that time.
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 deals 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.

It is pleasing to note that we won 10 national and regional awards in 2016/17. My congratulation go to the following teams and individuals:

- Maternity Services: Champions of the Year (NHS England Friends and Family Test Awards),
- Professor John Stanley, Hand Surgeon: Pioneer in Hand Surgery (International Federation of Societies for Surgery of the Hand Awards),
- Business Intelligence Team: Innovation Awards (E-Health Insider),
- Pharmacy Team: Patient Engagement Award (Improving Medicine Safety Awards),
- Wrightington Phase 1 Projects Team: Estates Award (Health Service Journal Value in Healthcare),
- Patient Safety Team: First Steps to Employment in Health and Social Care Award (Adult Learners Week North West Awards),
- Fertility Services – Best Debut Award (Greater Manchester Clinical Research Awards),
- Linzi Heaton, Clinical Research Administration Assistant: Outstanding Contribution Award (Greater Manchester Clinical Research Awards),
- Finance Team: Sue Rossen Prize for the North West (Healthcare Financial Management Association North West Awards);
- Janet Irvine, Lead Cancer Nurse: Henry Garnett Award (Macmillian Cancer Support).

Two of our consultants were also recipients of Clinical Excellence Awards in December 2016; Professor Nirmal Kumar, Consultant ENT Surgeon, received a Gold Award, while Dr Sanjay Arya, Medical Director, attained a Silver Award. Professor Nirmal Kumar has also been elected as President-Elect for ENT UK and will commence this role in 2019.

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



Andrew Foster

Chief Executive

31 May 2017


International Day
Of The Midwife 2017

Part 2:

Priorities for Improvement and Statements of Assurances from the Board

Part 2.1: Priorities for Improvement in 2017/18

This is the 'look forward' section of the Trust's Quality Account. In April 2017 we were delighted to launch our Quality Strategy 2017/21 outlining the framework to improve quality over the next three years. Additionally the Sign Up to Safety campaign was launched in 2014 and action is ongoing. Outlined below is information on the focus of our new Quality Strategy 2017/21, how this is directly linked to Sign Up to Safety and the improvements we plan to undertake over the next three years.

Quality Strategy 2017/21

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

WWL (Wrightington Wigan and Leigh NHS Foundation Trust) will move towards zero avoidable harm through continual reduction by April 2021, increasing staff and patient satisfaction

This strategy, although new, continues on the same direction as previous Quality Strategies by maintaining the focus on our overarching strategy to be safe, effective and caring.

Over the last three years there has been an improvement in our harm free care. We consistently achieve 99% harm free care measured by the NHS Safety Thermometer. There has also been reductions in harm from falls and hospital acquired pressure ulcers.
There are core themes that we will continue to work towards as well as new themes to ensure that the strategy fits into the wider local and national agenda of bringing care closer to home and ensuring care is co-designed with our patients. Our Quality Account will operationalise the strategy and will provide the necessary structure to ensure that the aim is being achieved.

Nationally and locally the landscape that we, and more widely the NHS and social care, are operating in has changed beyond recognition over the last three years with a focus on financially viable services, Greater Manchester Devolution and working in much closer partnerships as part of the Wigan locality plan.

To achieve the aim of moving towards zero avoidable harm by 2021 through continual reduction we will focus on 5 key primary drivers:

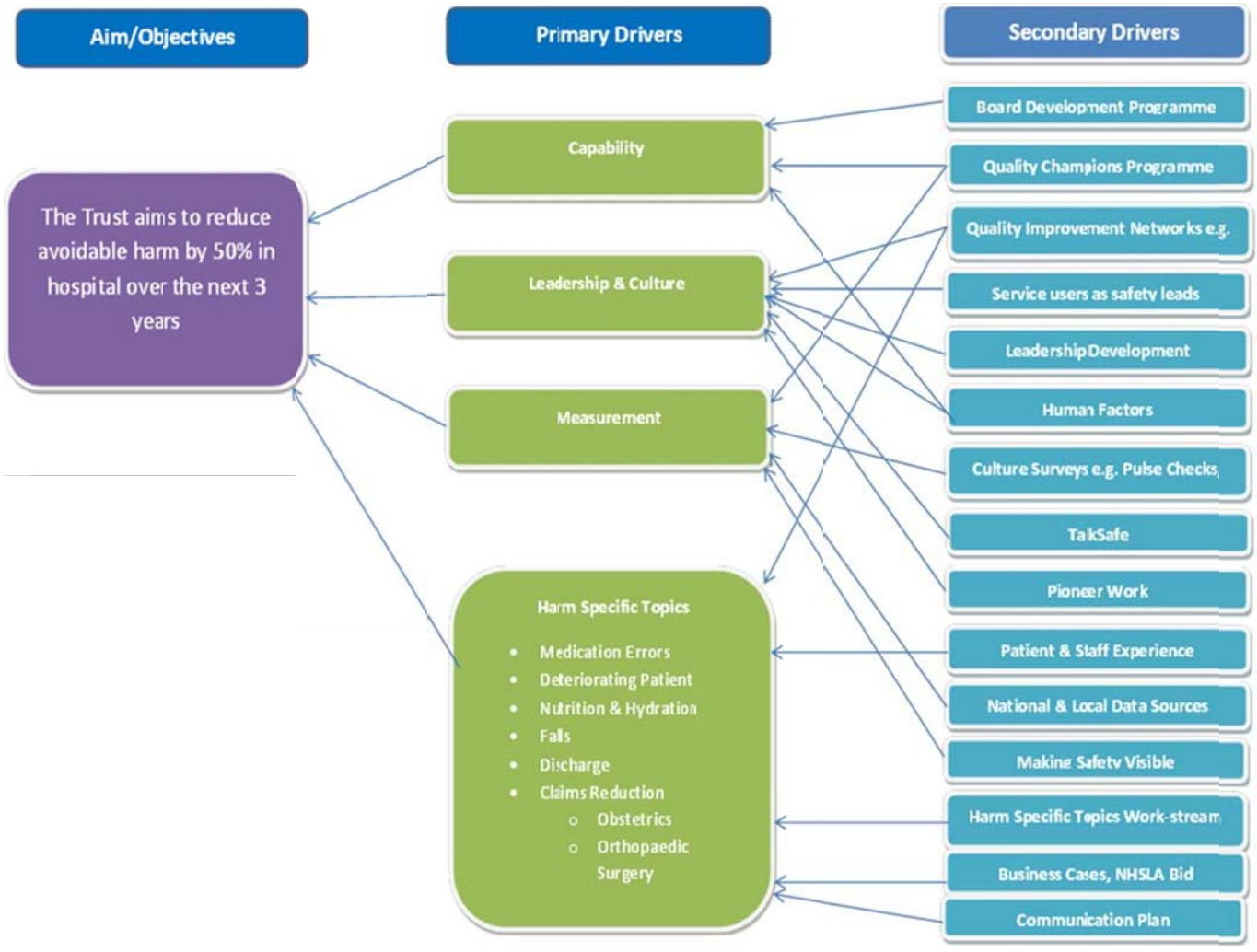
1. Excellence in Clinical Care,
2. Engagement and Networking,
3. Quality Improvement,
4. Measuring and Monitoring of Safety,
5. Culture.

Participation in the National Sign Up to Safety Campaign

The aim of the national Sign Up to Safety Campaign 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 has a three year objective to reduce avoidable harms by 50% and save 6,000 lives over three years.

We 'signed up to safety' in August 2014, committing to the development of an improvement plan which was submitted in January 2015. Our improvement p an built on the Trust's Quality Strategy 2014/17 and brought together existing quality and safety initiatives that are underway.

The diagram below summarises our Sign up to Safety Improvement Plan. Further detail in relation to a number of the initiatives included in the plan is described in this Quality Account. The Sign up to Safety aims and objectives are now embedded into the 2017/21 Quality Strategy to allow us to continue to pursue the aim of progressively moving towards zero avoidable harm.



Quality Priorities for 2017/18

Our safe, effective and caring strategy is the basis for the corporate and divisional plans, as well as being the basis for measuring and reporting on progress in reducing avoidable harm and improving quality. We have experienced local successes and challenges in achieving the Trust's safe, effective and caring strategy over the previous year which are outlined throughout this Quality Account.

We have agreed a number of annual priorities for 2017/18 which support the Trust's 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 Commissioning Group and Healthwatch.

The quality priorities, the rationale for selection and how we plan to monitor and report progress are outlined below. All quality priorities have a timescale for achievement by the 31st March 2017 and progress to achieve them is monitored by our Quality and Safety Committee.

Safe

Priority 1:	To improve our benchmarked position for mortality [HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-Level Mortality Indicator)].
Rationale:	A quality priority to reach a Hospital Standardised Mortality Ratio (HSMR) of no more than 85 before rebasing and Summary Hospital level Mortality Indicator (SHMI) of no more than 100 was not achieved in 2016/17. Our HSMR for 2016/17 to December 2016 is 112. HSMR just for the month of December 2016 was 110. This was an improvement in comparison to the proceeding five months; however 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.
Monitoring:	Mortality Group, chaired by the Medical Director is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Trust Board Performance Report; Team Brief.

Priority 2:	To complete a venous thromboembolism (VTE) risk assessment for 95% of patients admitted to hospital.
Rationale:	We did not achieve this priority during 2016/17; compliance has improved to 89% at the end of March 2017. Our Governors selected this indicator as their Locally Determined Indicator for 2016/17 meaning that the indicator is subject to an external review of data quality.
Monitoring:	Thrombosis Committee is responsible for monitoring compliance to achieve this priority.
Reporting:	Trust Board Performance Report; Team Brief.

Priority 3:	To reduce the numbers of falls resulting in moderate harm and serious harm.
Rationale:	At the end of March 2017 there had been 2 falls resulting in serious harm and 14 falls resulting in moderate harm. The Trust aims to reduce this by focussing on a number of initiatives which include work related to multiple fallers.
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:	Trust Board Performance Report; Ward Falls Dashboards.

Effective

Priority 1:	95% of patients prescribed treatment dose anticoagulation have the correct dose prescribed and have it administered appropriately
Rationale:	Anticoagulation is a high risk medicine that can result in patient harm if not administered correctly. We did not achieve this priority during 2016/17; however, the establishment of an NHS QUEST 'Clinical Community' to improve anticoagulation management will support us to move forward during 2017/18. NHS QUEST is a network for Foundation Trusts who wish to focus on improving quality and safety.
Monitoring:	The monitoring of this priority will be undertaken as part of the Trust's participation in the NHS QUEST 'Clinical Community'.
Reporting:	NHS QUEST 'Clinical Community' progress reports to Medicine Management Committee.

Priority 2:	To achieve 100% compliance with the identification of a deteriorating patient, appropriate frequency observations and escalation of the deteriorating patient.
Rationale:	We aim to identify on every occasion a patient whose condition is deteriorating, to observe and take every necessary action to attempt to alleviate the deterioration. Early recognition of the deteriorating patient reduces the patient's morbidity and mortality rate, allowing appropriate treatment to commence in a timely manner. We have demonstrated significant improvements for this priority during 2016/17; however, further work is required to consistently achieve 100% compliance.
Monitoring:	The Critical Care Outreach Team (CCOT) undertakes monthly audits of compliance. The results are monitored by the MEWS (Modified Early Warning Score) Task and Finish Group.
Reporting:	MEWS Dashboard.

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).
Rationale:	An audit of DNACPR documentation was undertaken in November 2016. A Task and Finish Group chaired by our Director of Nursing was established to renew the audit results and agree actions required.
Monitoring:	The DNACPR Task and Finish Group actions are monitored by Corporate Quality Executive Committee.
Reporting:	Clinical Audit Report.

Caring

Priority 1:	To achieve improved benchmarked position for patients being given notice of when discharge would be.
Rationale:	The National Patient Survey 2016 results have highlighted many positive elements of patient experience. Unfortunately one question with declining results relates to patients being given notice of when discharge would be. We will continue to focus on discharge in 2017/18 and improvements to patient experience.
Monitoring:	Real Time Patient Surveys are undertaken monthly by our lay auditors and the results are reported to Trust Board.
Reporting:	Trust Board.

Priority 2:	To achieve 90% of patients reporting that they were involved as much as they wanted to be in decisions about care, treatment and discharge from hospital.
Rationale:	We have demonstrated some improvement for this priority during 2016/17; however, further work is required to achieve 90% compliance by the end of 2017/18.
Monitoring:	Real Time Patient Surveys are undertaken monthly by lay auditors and the results are reported to Trust Board.
Reporting:	Trust Board Performance Report; Team Brief.

Priority 3:	To develop a ward accreditation scheme.
Rationale:	The ward accreditation scheme is part of developing the CREWS Quality Improvement Framework. It will address variations between wards to ensure Caring, Responsive, Effective, Well led and Safe Care (CREWS) is evidenced within inpatient ward areas and will provide a kite mark of high quality and performance for the ward.
Monitoring:	Corporate Quality Executive Committee (QEC) is responsible for monitoring the development and implementation of a ward accreditation scheme.
Reporting:	Corporate QEC

Part 2.2:

Statements of Assurances from the Board

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

Review of Services

During 2016/17 Wrightington, Wigan and Leigh NHS Foundation Trust provided and/or sub-contracted 67 relevant health services as defined in the Trust's Terms of Authorisation as a Foundation Trust.

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

The income generated by the relevant health services reviewed in 2016/17 represents 90.6% of the total income generated from the provision of relevant health services by the Trust for 2016/17.

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

Participation in Clinical Audits

During 2016/17, there were 20 National Clinical Audits and 6 National Confidential Enquiries covered relevant health services that the Trust provides.

During that period the Trust participated in 80% National Clinical Audits and 100% National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in. In addition, the Trust participated in a further 14 National Audits (Non-NCAPOP) recommended by HQIP.
The National Clinical Audits and National Confidential enquiries that the Trust was eligible to participate in during 2016/17 are listed in **Appendix A.**

The National Clinical Audits and National Confidential Enquiries that the Trust participated in, for which data collection was completed during 2016/17, 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 10 of National Clinical Audits were reviewed by the provider in 2016/17 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Trust Actions
National Rheumatoid Arthritis Audit	The Trust has set up an early Rheumatoid Arthritis clinic. This will be further audited to review its effectiveness.
Emergency Laparotomy Audit (NELA)	The report indicated that an assessment of mortality risk should be made explicit to the patient and recorded clearly on the consent form and in the notes. The Theatre booking form is being updated to include space for the P-Possum score (a risk prediction score). The service plan to introduce a no-score, no-booking policy.
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE UK)	The Trust reviews individual cases as they arise. This will continue on an ongoing basis.
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 Trust was more than 95% compliant this year.
National Heart Failure	This year the audit results demonstrated an improvement in comparison to previous reports.
End of Life Care	The Trust has taken or will take the following actions in response to this audit: • Four Palliative Care study days and an induction programme to be introduced, • A strategy will be developed and implemented for symptom control at end of life care, • Pro-active individual feedback to health care professionals on the completion of Individual Plan of Care (IPOC), • Review of IPOC documentation by Wigan Borough End of Life and Palliative Care Steering Group, • Implementation of documentation to support Advanced Care Planning, • Implementation of communication training programme.
Asthma (paediatric and adult) care in emergency departments	The Trust has taken the following actions: Education sessions have been provided on peak flow oxygen therapy and will be included in future teaching sessions.
National Paediatric Diabetes audit	Results have shown a significant improvement and the Trust is doing very well for the top target group. Sensor augmented pumps contribute to this. FY1 doctors to further audit sensor augmented pumps.
Cataract Surgery	All relevant Consultants regularly audit their own outcomes. When comparing to the figures from the National Audit, Surgeons within WWL are comparing well or have higher success rates than the National Average

The reports of 188 Local Clinical Audits were reviewed by the provider in 2016/17. A selection of these audits is outlined below and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

Audit	Trust Actions
Sepsis Improvement in the Emergency Care Centre	The Trust has undertaken the following actions in response to this audit: • Formation of sepsis improvement group, • Introduction of "STEPS for Sepsis" framework, • Identification of problems surrounding data capture and coding, • Real time monthly audits in Accident and Emergency (A&E), • Sepsis book in Resus and Pit Stop, • Identification of named Triage nurse, • Audit of patients who breached the one hour anti-biotic target, • Drive on education and improving awareness, • Allocation of Nurse for sepsis on each shift, • Promotion of education and screening in doctors' induction week, • Improved communication between medical and nursing staff in relation to administration of antibiotics, • Improved accessibility of screening tools, • Identification of Trust sepsis leads, • Development of sepsis dashboard.
Re-audit of Hyperglycaemia in Acute Coronary Syndrome (ACS)	The Trust has undertaken the following actions in response to this audit: • Present re-audit findings at appropriate teaching sessions to educate staff, • Encourage use of cardiac chest pain biochemistry bundle, • Enlist the help of ACS specialist nurse to identify hyperglycaemic patients, • The guidelines for hypoglycaemia in Acute Coronary Syndrome are being reviewed.
Safeguarding Adults – Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)	The Trust overall showed a good understanding of the principles of MCA and DoLS. However, some areas had demonstrated a reduction in compliance. The Trust's Safeguarding Team has carried out a number of training and awareness sessions across the Trust following the completion of this audit. Further unannounced audits have been undertaken and these have again showed a marked improvement in compliance.
Outcome Measure Audit of Patients Following Prosthetic Rehabilitation	The outcome measures used were specific to lower limb amputee patients and suitable for use in clinical practice. They demonstrated that prosthetic rehabilitation achieves improvements in prosthetic mobility and functional activities. These improvements benefit our patients' independence, physical health and psychological wellbeing.
Audit of Termination of Pregnancy (TOP) Service at Leigh Infirmary	The patient information leaflet in relation to TOP has been updated and documentation for use in the TOP clinic has been improved.

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 by the Trust 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.

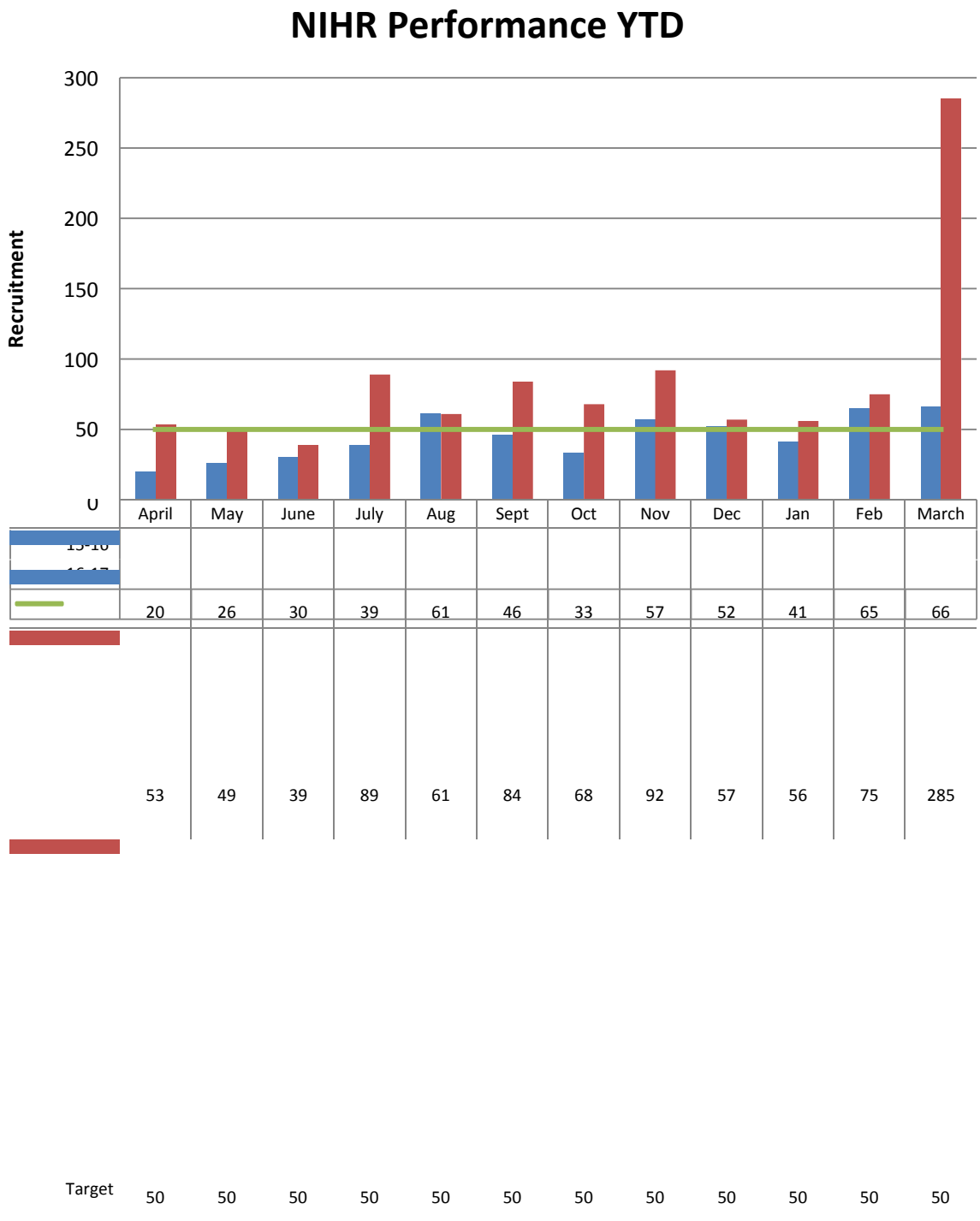
Research

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016/17 who were recruited during this period to participate in research (approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio') was 1,008; an average of 84 patients per month.

Patient Recruitment 2016/17

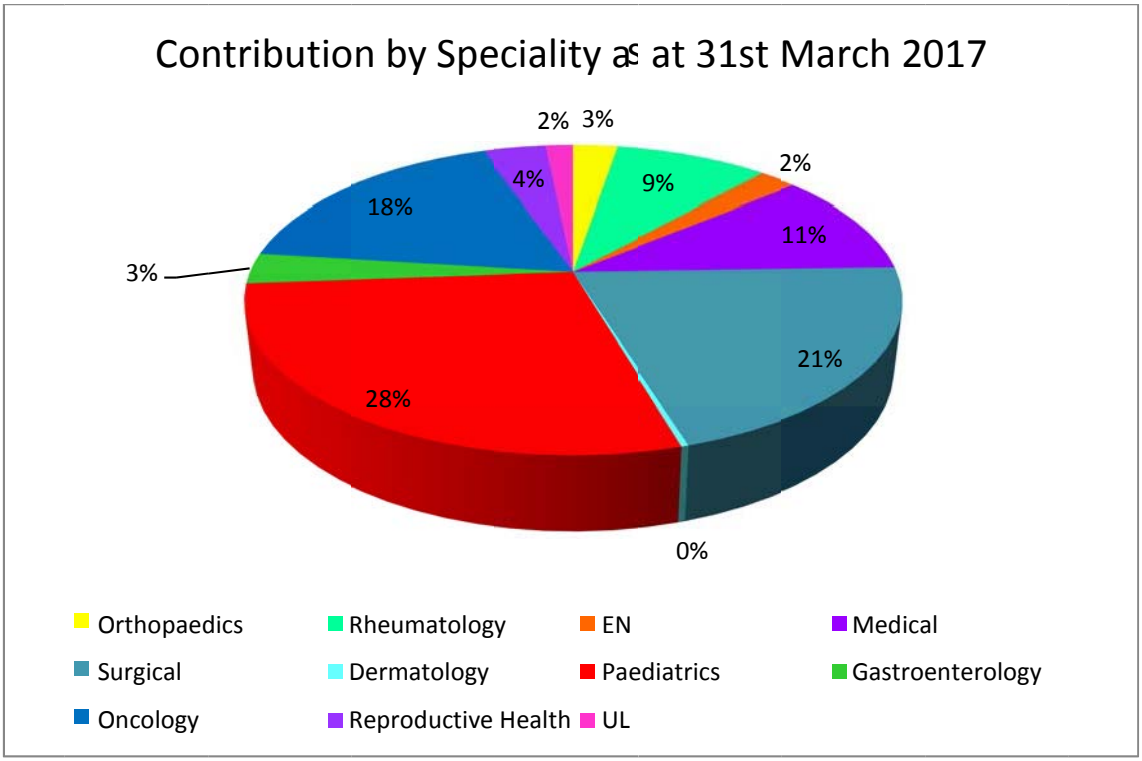
The following chart illustrates target recruitment versus actual recruitment to research studies in 2016/17.



Participation in clinical research demonstrates the Trust's 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. Active participation in research leads to improved patient outcomes.

The Trust was involved in conducting 103 NIHR Portfolio clinical research studies and 212 Non Portfolio studies in a variety of specialities during the year 2016/17. The chart below illustrates recruitment into National Institute for Health Research registered studies between 1st April 2016 and 31st March 2017.



It is globally recognised that a commitment to clinical research leads to better outcomes for patients. An example of this has been our growing involvement in research associated with fertility. The new fertility centre at Wrightington Hospital is attracting significant interest from both patients and innovators and the Trust has been recognised at a regional award ceremony for its success in attracting international research projects for the benefit of our patient population.

The Trust's five-year research strategy aims to include all clinical staff in research. Each year the Research Department has identified 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 research activity within the Trust 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 within the Trust 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.

Publications have resulted from both our engagement in NIHR Portfolio research and Trust supported research, which has secured Eth cal 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 studie , ensuring the safe care of patients and adherence to the European Directive, Good Clinic l Practice gui elines and data collection standards. As a result of this expert support, the larger clinical

community within the 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.

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

A proportion of the Trust's income for 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between Wrightington, Wigan and Leigh NHS Foundation Trust 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 2016/17 and the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

In 2016/17 the Trust received £5,666k in relation to CQUINS in comparison with £5,763k in 2015/16. The Trust had nine CQUIN schemes in 2016/17 which were as follows:

1. National Schemes
   a. Staff and patient health and well-being
   b. Sepsis Screening and treatment
   c. Reductions in antibiotic consumption

2. Local Schemes
   a. Discharge improvement
   b. Nutrition and hydration
   c. Falls
   d. Promoting healthy lifestyles
   e. Paediatric diabetes
   f. Cancer referral waiting times

Particular improvements are evident in relation to sepsis screening and treatment. Sustained work by the lead clinical staff produced significant and sustained improvements. This was achieved through on-going training, new systems, regular audit and feedback and closer working relationships across teams. In relation to staff health and well-being a large number of schemes were introduced including weight loss challenges, team sports events and access to a wide range of support services including physiotherapy and counselling.

In relation to the local schemes both the nutrition and hydration and falls schemes encompassed large amounts of work and were linked to wider improvement plans within the Trust. In relation to cancer referral waiting times there was a significant improvement for patients waiting less than 14 days for their first appointment.

In 2017/18 the Trust will have a new CQUIN requirement which will be linked to health and well-being, proactive and safe discharge, reducing the impact of serious infections, reducing mental health attendances at accident and emergency, introducing an advice and guidance service for GPs and ensuring all appropriate outpatient services can be accessed through the national e-referral system.

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

What others say about WWL

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission and its current registration status is registration without compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against the Trust during 2016/17.

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

Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) were inspected by the CQC, as part of their comprehensive inspection program, in December 2015. The reports were published by the CQC on 22 June 2016. The Trust is proud that 87% of its services received either 'outstanding' or 'good', the two highest ratings. This is a magnificent result and follows on from the Trust being named as the Health Service Journal's (HSJ) best provider Trust in the country in November 2014. It is thanks to the hard work, professionalism and dedication of all staff. The overall rating for WWL was 'good'.

In the inspection report, the CQC notes a positive caring culture throughout the organisation and praises staff for being not only caring but also committed, compassionate and proud of their services and of the Trust. The staff were noted to be open and friendly, going out of their way to help and support patients. The report also comments on the good standard of cleanliness throughout the Trust and the high level of compliance with regard to infection control standards.

The report highlighted the Trust's End of Life Care services and services at the Thomas Linacre Centre, both of which received the highest rating of 'outstanding'. It was also a great credit to staff at Wrightington Hospital and Boston House which were rated 'good' in every area reviewed by the CQC (Safe, Effective, Caring, Responsive and Well-led).

The Trust welcomes constructive criticism and inevitably the inspection did identify some areas where it can improve. Action plans are in place to address these. The majority of the actions are now complete.

Trust Chairman, Robert Armstrong said "I am really pleased to see that almost the entire Trust was rated as 'outstanding' or 'good'. This is a great tribute to our hard working staff."

Andrew Foster, Trust Chief Executive, said "We are pleased to see that the CQC rated the majority of our services as either 'good' or 'outstanding' but we truly believe as a Board that our Trust and our staff are outstanding. We will continue on our improvement journey, whose success is evidenced by numerous national indicators and benchmarks to ensure that our patients continue to receive safe, effective and compassionate care."

The CQC inspected our various sites and actions were required for all, with the exception of the Thomas Linacre Centre.

1. CQC Quality Report - (June 2016) Trust						
Core Service	Core Service Rating	1. Safe	2. Effective	3. Caring	4. Responsive	5. Well led
Trust-wide	Good	Requires Improvement	Good	Good	Good	Good

CQC Quality Report - (June 2016) Royal Albert Edward Infirmary						
Core Service	Core Service Rating	1. Safe	2. Effective	3. Caring	4. Responsive	5. Well led
Children & young people	Requires Improvement	Inadequate	Good	Good	Good	Requires Improvement
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Outstanding	Good	Good	Outstanding	Outstanding	Good
Maternity and gynaecology	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Medical care	Good	Requires Improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Not Assessed	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Urgent and emergency services	Good	Requires Improvement	Good	Good	Good	Good

CQC Quality Report - (June 2016) Leigh Infirmary						
Core Service	Core Service Rating	1. Safe	2. Effective	3. Caring	4. Responsive	5. Well led
Maternity and gynaecology	Good	Good	Requires Improvement	Good	Good	Good
Medical care	Good	Requires Improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Not Assessed	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good

CQC Quality Report - (June 2016) Thomas Linacre Centre						
Core Service	Core Service Rating	1. Safe	2. Effective	3. Caring	4. Responsive	5. Well led
Outpatients and diagnostic imaging	Outstanding	Good	Not Assessed	Good	Outstanding	Good

CQC Quality Report - (June 2016) Wigan Health Centre Boston House						
Core Service	Core Service Rating	1. Safe	2. Effective	3. Caring	4. Responsive	5. Well led
Outpatients and diagnostic imaging	Good	Good	Good	Good	Good	Good

CQC Quality Report - (June 2016) Wilmslow Health Centre						
Core Service	Core Service Rating	1. Safe	2. Effective	3. Caring	4. Responsive	5. Well led
Outpatients and diagnostic imaging	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed

CQC Quality Report - (June 2016) Wrightington Hospital						
Core Service	**Core Service Rating**	**1. Safe**	**2. Effective**	**3. Caring**	**4. Responsive**	**5. Well led**
Outpatients and diagnostic imaging	Good	Good	Not Assessed	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good

Detailed below is the progress being made with the actions included in the CQC reports:

CQC Quality Report	Must Action		Should Action	
	Completed	**In Progress - On Target**	**Completed**	**In Progress - On Target**
CQC Quality Report - (June 2016) Leigh Infirmary	3	1	7	0
CQC Quality Report - (June 2016) Royal Albert Edward Infirmary	8	2	40	3
CQC Quality Report - (June 2016) Wigan Health Centre Boston House	0	0	3	0
CQC Quality Report - (June 2016) Wrightington Hospital	0	0	4	0
Total	**11**	**3**	**54**	**3**
Total Percentage	**78.57 %**	**21.43 %**	**94.74 %**	**5.26 %**

Of the 71 actions, as at the end of 2016/17, 65 actions have been completed, making 91.5% of the actions completed. The Trust has a robust system for managing the CQC actions. Progress is overseen by the Trust's Quality and Safety Committee.

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.

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2016/17 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,*
- *98.5% for outpatient care, and*
- *99.0% for accident and emergency care.*

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

- *100% for admitted patient care,*
- *100% for outpatient care, and*
- *100% 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).

Information Governance Toolkit Attainment Levels

The Trust's Information Governance Assessment Report overall score for 2016/17 was 81% 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.

Clinical Coding Error Rate

The Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission. (The Audit Commission is no longer in existence). The Trust commissioned an external audit in November 2016 for assurance of the clinical coding quality. The error rates reported in the audit for diagnoses and treatments coding (clinical coding) were:

- Primary Diagnosis incorrect 2.5%
- Secondary Diagnosis incorrect 2.74%
- Primary Procedures Incorrect 3.68%
- Secondary Procedures Incorrect 2.8%

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.

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

The Trust will be taking the following actions to improve data quality:

The Trust has a Data Quality Policy outlining the roles and responsibilities for recording good quality data. In order to ensure that the policy is adhered to the Data Quality Committee oversee an annual audit programme whereby data is audited for accuracy, timeliness of data entry, confidence in the source of the data and validation of the use of the data. A kite mark is then applied to the appropriate reports where this data is displayed showing the data quality rating. Where the quality of data is identified as needing improvement an action plan is put in place to address the recommendations.

The Data Quality Team undertake regular service reviews within the Divisions to provide advice and guidance on the accurate recording of patient activity to ensure that any changes to service provision are accurately reflected contemporaneously.

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The Trust Board 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.

Part 2.3: Reporting against core indicators

We are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

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

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

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

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Mortality				
(a) *The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and*	October 2014 - September 2015	Value:1.115, Banding : 1	Value: 1.004	Best: THE WHITTINGTON HOSPITAL NHS TRUST (RKE): Value:0.690 , Banding: 3
				Worst: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (RVW) : Value: 1.177 , Banding: 1
	October 2015 - September 2016	Value:1.142, Banding : 1	Value: 1.003	Best: THE WHITTINGTON HOSPITAL NHS TRUST (RKE): Value:0.652 , Banding: 3
				Worst: WYE VALLEY NHS TRUST (RLQ) : Value: 1.164 , 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 2014 - September 2015	28.6%	26.6%	Best: THE WHITTINGTON HOSPITAL NHS TRUST (RKE) : Value:0.189%
				Worst: IMPERIAL COLLEGE HEALTHCARE NHS TRUST (RYJ) : Value: 53.5%
	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%

Assurance Statement

The Trust 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.

The Trust 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 undertaking a joint project with Wigan Borough Clinical Commissioning Group to review deaths within 30 days of discharge. A Mortality Group has been established, chaired by the Medical Director and attended by external organisations to support collaborative working to address SHMI in the Wigan Borough. One responsibility of the group will be to analyse the Trust's mortality data and seek meaningful comparisons.

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Patient Reported Outcome Measures Scores (PROMs)				
The Trust's patient reported outcome measures scores during the reporting period for - *i) groin hernia surgery;*	April 2014 - March 2015	0.074	0.084	Best: POOLE HOSPITAL NHS FOUNDATION TRUST (RD3): Value: 1.54
				Worst: LEWISHAM AND GREENWICH NHS TRUST (RJ2): Value: 0.00
	April 2015 - March 2016 (Provisional)	0.079	0.087	Best: BMI - THE SOMERFIELD HOSPITAL (NT438): Value: 0.157
				Worst: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (RVW): Value: 0.021
i) varicose vein surgery;	April 2014 - March 2015	n/a	0.094	Best: BUCKINGHAMSHIRE HEALTHCARE NHS TRUST (RXQ): Value: 0.15
				Worst: ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RJ7) : Value: -0.009
	April 2015 - March 2016 (Provisional)	n/a	0.095	Best: MID YORKSHIRE HOSPITALS NHS TRUST (RXF): Value: 0.149
				Worst: SURREY AND SUSSEX HEALTHCARE NHS TRUST (RTP) : Value: 0.018
ii) hip replacement surgery;	April 2014 - March 2015	0.453	0.436	Best: SPIRE CLARE PARK HOSPITAL (NT345): Value: 0.52
				Worst: WALSALL HEALTHCARE NHS TRUST (RBK) : Value: 0.33
	April 2015 - March 2016 (Provisional)	0.443	0.438	Best: NORTH DOWNS HOSPITAL (NVC11): Value: 0.510
				Worst: WALSALL HEALTHCARE NHS TRUST (RBK) : Value: 0.32
iii) knee replacement surgery	April 2014 - March 2015	0.305	0.314	Best: NUFFIELD HEALTH, CAMBRIDGE HOSPITAL (NT209) :

				Value: 0.42
				Worst: SOUTH TYNESIDE NHS FOUNDATION TRUST (RE9) : Value: 0.204
	April 2015 - March 2016 (Provisional)	0.314	0.320	Best: SHEPTON MALLET NHS TREATMENT CENTRE (NTPH1) : Value: 0.398
				Worst: HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST(RQX) : Value: 0.198

Assurance Statement
The Trust considers that this data is as described for the following reasons:

The data is validated and published by Patient Related Outcome Measures (PROM's).

The Trust has taken the following actions to improve this indicator and, so the quality of its services, by:
A new system has been implemented in pre-op and has improved the participation for the Hip and Knee PROMs.

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Hospital Readmission				
The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2010 - March 2011	7.73	10.31	Best: Epsom & St Helier University Hospitals NHS Trust (RVR): 6.41
				Worst: Royal Wolverhampton Hospitals NHS Trust (RL4): 14.11
	April 2011 - March 2012	7.95	10.23	Best: Epsom & St Helier University Hospitals NHS Trust (RVR): 6.4
				Worst: Royal Wolverhampton Hospitals NHS Trust (RL4): 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 Hospital NHS Trust (RXW): 9.20
				Worst: Heart of England NHS Foundation Trust (RR1): 14.06
	April 2011 - March 2012	12.40	11.56	Best: Norfolk and Norwich University Hospital NHS Foundation Trust (RM1): 9:34
				Worst: Epsom & St Helier University Hospitals NHS Trust (RVR): 13.80
	Comments: Large Acute Trusts Only. No New data - Future releases suspended pending review			

Assurance Statement

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

Readmission rates in children reduced slightly this year, but remained broadly static and significantly better than the national average. Over the past 12 months focus on community clinics has supported this reduction. The adult rates increased slightly this year, but remained static and were better than the national average. It has been noted that attendances from patient over the age of 75 years old to Accident and Emergency has increased by 9% and this cohort often require multiple attendances.

The Trust 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.

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Responsiveness to Personal Needs				
The Trust's responsiveness to the personal needs of its patients during the reporting period	National Inpatient Survey 2014 - 2015	66.90%	68.90%	Best: The Royal Marsden NHS Foundation Trust (RPY) : Value: 86.1% Worst: Croydon Health Services NHS Trust (RJ6): Value: 59.1%
	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%

Assurance Statement

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

The Trust has performed slightly below national average for patients reporting that their personal needs are responded to

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

The Trust continues to respond to the National Survey by making improvements in patient care based on the results. There have been a number of improvements made during the last 12 months including some detailed work around patient discharge by integration of Health and Social Care and the development of the Integrated Discharge Team (IDT), who work across all areas in the Trust at the point of admission. All patients are provided with an Expected Date of Discharge, and the IDT provide support and advice during Consultant and Grand Ward Rounds. All patients are advised of the Consultant who is providing their treatment and care. Following the introduction of the admission pack an additional discharge wallet has been introduced to all inpatient areas which provides specific information regarding discharge and community services. Both theses information resources are provided to the patient at admission. There will be continued focused work ensuring that the Always Events and the Goodnight Always Events continue to be embedded and provided reinforcement across the organisation. There will also be the development of the always discharge events which will be launched later this year

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

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Friends and Family Test (Staff)				
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	National NHS Staff Survey 2015	79%	69%	Best: Northumbria Healthcare NHS Foundation Trust (RTF) : Value: 85%
				Worst: Worst: Isle of Wight NHS Trust (acute sector) (R1F1) : Value: 46%
	National NHS Staff Survey 2016	76%	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%

Assurance Statement

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

The Trust has performed better than the national average for staff recommending the Trust to friends and family as a place to be treated. The Trust has also scored above average for staff recommending the Trust as a place to work. The results have declined marginally by 3% since 2015; however, this is a statically insignificant change.

The Trust has been able to achieve this position by regularly acting on staff feedback. The Trust distributes its own staff engagement Pulse Survey which is issued to a quarter of staff every quarter of the year.
The quarterly pulse survey has been of significant value to WWL over the last three years. It has enabled the Trust to act quickly on the issues identified, ensuring that we are always aware of trends and new issues. The quarterly pulse surveys and associated actions have been integral to shaping the organisational culture.

Whilst the staff Friends and Family Test has shown an insignificant decline, the results of the quarterly Pulse Survey over the last year do indicate a decline in the results for a number of enabling factors such as staff recognition, trust, work relationships, resources, mindset, personal development and perceived fairness. Staff feelings around dedication, focus and energy levels and behaviours around persistence, discretionary effort and adaptability have also declined in this period.
Despite these shifts in staff engagement, results are still moderate to positive and the majority of staff still recommend the Trust as a place to be treated.

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

The Pulse Survey identifies that a number of factors that enable engagement have declined during 2016. The Trust will act on these areas responsively. Further investment in health and well-being initiatives (via the Steps 4 Wellness Programme) aims to improve staff wellbeing, morale, resilience and energy levels and includes a number of initiatives associated with mental, physical and social wellbeing, and healthy choices. Other key areas of focus will be to fully embed WWL's "People Promise", investing in engagement tools such as a new intranet and staff app, internal communications, focus groups, staff forums, recognition programmes, leadership development, staff events and driving engagement locally through the pioneer teams programme.

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Venous Thromboembolism				
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	April to June 2016	96.22%	95.73%	Best: BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST (RY2), CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST (RT1), SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (RWN) : Value: 100%
				Worst: HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST (RWA) : Value: 80.61%
	July to September 2016	86.15%	95.51%	Best: BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST (RY2), CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST (RT1), SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (RWN) : Value: 100%
				Worst: IPSWICH HOSPITAL NHS TRUST (RGQ) : Value: 72.14%

Assurance Statement

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

A new Trust Electronic Patient Record system was introduced in July 2016 changing the way data was recorded. There were issues around completion of the correct medical forms by medical staff and problems with data analysis. Compliance from April 2016 to March 2017 is 87.17%.

The Trust has taken the following actions to improve this percentage and so the quality of its services by:
There has been a Trust-wide initiative to highlight the correct documents that doctors are required to complete when patients are admitted as inpatients. We have reviewed ward areas to make sure that day case wards and paediatric units are not incorrectly counted in our target figures. We have also corrected errors in the retrieval of VTE data from the electronic system.

Our figures have improved on recent audits and we are above 90% across the three divisions. However there is still room for improvement and we continue with staff education to try and achieve our target.

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Clostridium *difficile (C. difficile)*				
The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	April 2014 - March 2015	16.3	15.1	Best: Alder Hey Children's (RBS), Birmingham Children's Hospital (RQ3), Birmingham Women's (RLU), Moorfields Eye Hospital (RP6): 0.00 Worst: The Royal Marsden (RPY) :62.2
	April 2015 - March 2016	7.9	14.9	Best: Birmingham Children's Hospital (RQ3), Birmingham Women's (RLU), Liverpool Womens (REP), Moorfields Eye Hospital (RP6), The Robert Jones and Agnes Hunt Orthopaedic Hospital (RL1): 0.00 Worst: The Royal Marsden (RPY) :66.0

Assurance Statement

The Trust considers that this data is as described for the following reasons:
The Trust has performed well against other Trusts in relation to C. *difficile* per 1,000,000 bed days within the Greater Manchester region in 2016/17 and was second best performer with a rate of 14.2. (N.B. National comparison data at time of printing was not available)

The Trust has continued to make clinical assurances to avert any 'Lapse's in Care' regarding CDT cases and has continued to reduce the number of "Lapse's in Care". This has been supported with improvement in technology, methodology and data collection, resulting in a more accurate reflection of activity.

The Trust intends to take the following actions to improve this percentage and so the quality of its services by:
The Trust intends to continue with the current actions to improve on this rate and support the quality of services by continuing to undertake individual C. *difficile* "Post Infection Reviews- PIR's", which will assist to identify any learning points to prevent future C.*difficile* cases.

Indicator	Reporting Periods	Trust Performance	National Average	Benchmarking
Patient Safety Incidents				
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death.	October 2015 - March 2016	3990 Incidents Reported (Rate per 1000 bed days 52.32%) / 64 serious incidents (1.6%)	655,193 Incidents Reported (Median national reporting rate per 1000 bed days 39.31%) / 2642 serious incidents (0.4%)	Best acute non-specialist Trust: Wye Valley NHS Trust (RLQ) Incidents Reported (Rate per 1000 bed days 75.91%) / 7 serious incidents (0.2%)
				Worst acute non-specialist Trust: Medway NHS Foundation Trust (RPA) 1499 Incidents Reported (Rate per 1000 bed days 14.77%) / 26 serious incidents (1.8%)
	April 2016-September 2016	4209 Incidents Reported (Rate per 1000 bed days 55.29%)/ 21 serious incidents (0.5%)	673,865 Incidents Reported (Median national reporting rate per 1000 bed days 40.02%) / 2516 serious incidents (0.5%)	Best acute non-specialist Trust Northern Devon Healthcare Trust (PBZ) 3620 Incidents Reported (Rate per 1000 bed days 71.81%) / 30 serious incidents (0.8%)
				Worst acute non-specialist Trust Luton and Dunstable University Hospital NHS Foundation Trust (RC9) 2305 Incidents Reported (Rate per 1000 bed days 21.15%) / 6 serious incidents (0.3%)

Assurance Statement

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

In relation to reporting Patient Safety Incidents to the National Reporting and Learning System (NRLS), the Trust has made significant progress in year.

Previously the Trust benchmarked 137th out of 140 acute Trusts, improving to 37th out of 137 acute non-specialist Trusts in 2015/16. The NRLS reports published in April 2016 identified the Trust as 26th out of 136 acute non-specialist Trusts in April 2016 (top 25%). By the October 2016 report, the Trust had made further improvements, becoming 13th out of 136 acute non-specialist Trusts, (top 10% of reporters.) The latest NRLS report published in April 2017 demonstrated that the Trust remains in the top 10% of reporters for the period from the 1st April 2016 to the 30th September 2016 at 14th out of 136 acute non-specialist Trusts.

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

The Trust is currently below the national average for reporting to submission timescales. Actions to ensure daily uploads to NRLS have commenced and were tested with success during March 2017.
The Trust was proud to be a finalist for the Health Service Journal (HSJ) Awards 2016 for "Reporting, Escalation and Learning from Reported Incidents". The Trust has been shortlisted for two HSJ Patient Safety Awards; "Clinical Governance and Risk Management" and "Best Organisation". The awards are due to be announced in July 2017.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AWARDS

Part 3:

Other Information

Part 3.1:
Review of Quality Performance

This section of the Quality Account provides information on our quality performance during 2016/17. 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 2016/17

We agreed a number of priorities for improvement in 2016/17 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.

Safe

Priority 1:	To reduce the number of falls by 10%.
Where we were in 2015/16	This was a quality priority in 2015/16 and remained a priority for 2016/17. The Trust did not achieve the ambitious target to reduce falls by 10% by the end of 2015/16.
Where we are at the end of 2016/17	We have achieved a reduction in the number of falls in 2016/17 in comparison with 2015/16. There were 969 falls in 2015/16 and 960 falls in 2016/17. We achieved a reduction in falls resulting in serious harm from 5 in 2015/16 to 2 in 2016/17. We were delighted to successfully achieve the falls CQUIN in 2016/17. A ward level dashboard has been developed. The falls risk assessment has been updated to reflect current NICE guidance. A referral form to the clinical lead for falls for inpatients that have fallen twice or more is currently being trialled. A Falls Summit was held in September 2016 providing an opportunity for acute, community and primary care staff to come together and identify shared challenges. As a direct result of this summit, work has started with community partners to ensure that the communication flow for patients who attend hospital and those who are discharged is improved to provide correct information. The Falls Improvement Group continues to focus on the Trust-wide falls improvement plan. We have four volunteer patient companions. A new process to review patients care for those who have suffered moderate, serious or catastrophic harm has been developed. Ward staff present the investigation to the Director of Nursing to ensure that the ward/department owns any improvements that are required to decrease the risk of recurrence. The focus for 2017/18 is to continue to reduce the level of harm caused by inpatient falls.

Priority 2:	To complete a venous thromboembolism (VTE) risk assessment for 95% of patients admitted to hospital.
Where we were in 2015/16	An improvement in the completion of VTE risk assessments were identified as a priority at the end of 2015/16.
Where we are at the end of 2016/17	Benchmarking for VTE risk assessments is outlined in Section 2.3. We have not achieved 95% compliance due to unforeseen complications following the introduction of HIS (the Trust's Electronic Patient Record). We undertook a risk assessment that scored highly enough to be on the corporate risk register and was monitored at the Risk Environmental Management Committee (REMC). Issues have now been resolved. Our Governors selected this indicator as their Locally Determined Indicator for 2016/17 meaning that the indicator is subject to an external review of data quality. This priority remains one of our quality priorities for 2017/18 outlined in this Quality Account (Section 2). Compliance from April 2016 to March 2017 is 87.17%

Priority 3:	To reach a Hospital Standardised Mortality Ratio (HSMR) of no more than 85 before rebasing and Summary Hospital level Mortality Indicator (SHMI) of no more than 100.
Where we were in 2015/16	This was a quality priority for the Trust in 2015/16 and remained a priority for 2016/17. HSMR year to February 2016 (data is three months behind) was 92.3 and within expected range when benchmarked against other organisations. The latest SHMI data available at the end of 2015/16 was 111.45 (October 2014 – September 2015).

Where we are at the end of 2016/17	The Trust has not achieved this quality priority in 2016/17. Our HSMR for 2016/17 to December 2016 is 112. HSMR just for the month of December 2016 was 110. This was an improvement in comparison to the proceeding five months; however 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.

Effective

Priority 1:	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 2015/16	The Trust aims to identify on every occasion a patient whose condition is deteriorating, to observe and take every necessary action to attempt to alleviate the deterioration. Monthly audits of compliance were undertaken by the Critical Care Team (CCOT). In February 2016, the audit results demonstrated that completion of the Modified Early Warning Score (MEWS) algorithm was 94%; however, completion of observations was 62%.
Where we are at the end of 2016/17	A Task and Finish Group was established during 2016/17, chaired by the Director of Nursing. Despite achieving 100% compliance for MEWS during selected months during the year, the group continues to monitor the audit results and aims to achieve consistent achievement of compliance. This priority remains one of the Trusts quality priorities for 2017/18 outlined in this Quality Account (Section 2).

Priority 2:	To achieve 95% of patients who have correct anti-coagulation treatment prescribed and administered at the correct time, 24 hours after admission (NHS QUEST)
Where we were in 2015/16	This priority was identified at the end of 2015/16. Anticoagulation is a high risk medication that can result in patient harm if not administered correctly. The Trust had had a number of incidents related to anticoagulation.
Where we are at the end of 2016/17	The Trust has not achieved this priority in 2016/17. Monitoring of this priority is undertaken as part of the Trust's participation in the NHS QUEST 'Clinical Community' that has been established to improve anticoagulation management. NHS QUEST is a network for Foundation Trusts who wish to focus on improving quality and safety. The 'Clinical Community' has struggled to identify a joint aim and this has in part been due to engagement from all the trusts in the community. This priority remains one of the Trust's quality priorities for 2017/18 outlined in this Quality Account (Section 2).

Priority 3:	To achieve a 50% reduction in delays in discharge
Where we were in 2015/16	The Trust Board selected this priority at the end of 2015/16 as a corporate objective for 2016/17. The Trust's Business Intelligence Team then identified a framework to measure compliance. The indicators in this framework are outlined below.
Where we are at the end of 2016/17	The Corporate Objective states the following: "To reduce variation leading to unnecessary delay for patient admission to discharge by 50%." 10 key performance indicators have been established and progress monitored on a monthly basis in the "10 small steps to Big improvement" Team Forum. Progress against each indicator is as follows, according to available data: **1.** 16 A&E breaches per day: The number of patients in the past 3 months waiting beyond 4 hours in A&E for a decision has averaged 44.5 per day. Several improvement work streams aimed at reducing unnecessary waits improving patient outcomes and Staff experience are underway. **Not achieved** 2. 30 minutes from decision to admit from A&E to patient arriving on ward: This is not currently measured to an accurate level and is set as a target. **Not measurable.**

	3. 97% of patients on the right ward: An average of 93.5% of patients was admitted to their speciality specific ward in the last 3 months **Not achieved** **4.** 1.0 day between Assessment for being sent and Integrated Discharge Team assessment of patient: there has been a positive month on month reduction in delays. In the last 3 months the average wait was 1.67 days. **Not achieved** **5.** 1 hour between Request for Medicine and Medication being dispatched: Current performance 4.8 hours (data being checked for accuracy**)** **Not achieved** **6.** 15 medically optimised patients per day: There is currently no electronic means of measuring this data; therefore, it does not form part of the dashboard to date. Assurance is provided by WWL having the lowest number of reportable "Delayed Transfers of Care" in Greater Manchester. **Not achieved; however the Trust benchmarks positively for Delayed Transfers.** 7. 5 or fewer patients having their elective procedure cancelled on the day of the operation: On average 8.6 patients have been cancelled in the last 3 months, primarily due to bed pressures. **Not achieved**. **8.** 10 patients per day leaving the wards before 10.30am on their day of discharge. An average of 7.6 patients left a ward before 10.30am in the last 3 months. **Not achieved; however, the position has improved.** **9.** The number of patients discharged at weekends to be 80% of the weekly rate: This fluctuates; however, generally the numbers have marginally increased in December 2016 and January 2017 correlating with Consultant presence at the weekend. The average for the last 3 months is 77.1%. **Not achieved; however, the position has improved.** 10. Reduce spend on private patient transport to less than £25,000 per month: Average cost for private patient transport over the last 3 months is £11,750. **Achieved.**

Priority 4:	**To recruit a further 100 clinical staff as dementia champions.**
Where we were in 2015/16	At the end of 2015/16 the Trust had 250 trained Dementia Champions.
Where we are at the end of 2016/17	At the end of March 2017 70 Dementia Champions had been recruited and trained during the year taking the Trust total to 320. In April 2017 a further 40 were trained.

Priority 5:	**To create a comprehensive register of all of the Trust's electronic information assets with details of the name and role of the responsible individual.**
Where we were in 2015/16	This was a quality priority for 2015/16 and it was identified that further work was required during 2016/17. A simplified Information Asset Owner approach had been established. The Trust is required to have an information asset register that includes all assets that comprise or hold personal data, with a clearly identified accountable individual. The Trust had a register but it required a significant review.
Where we are at the end of 2016/17	We have made great progress with the Information Asset Owner programme in 2016/2017. The Trust currently has 25 Information Assets Owners and 44 Information Asset Administrators. 270 clinical systems have been identified and 121 of those have agreed ownership. The remaining 149 systems have identified owners however those individuals have yet to confirm that the system is their responsibility. The Trust anticipates that this piece of work will be completed by September 2017.

Caring

Priority 1:	To achieve an improved benchmarked position for patients reporting that they have been bothered by noise at night.
Where we were in 2015/16	The 2015 National Patient Survey results indicated that the Trust scored worse than other Trusts for patients reporting that they were bothered by noise at night (43.8%). 'Goodnight Always' events were introduced in late 2015 to reduce the unnecessary noise at night and promote a good night's sleep for patients.
Where we are at the end of 2016/17	We are delighted that this priority was achieved in 2016/17. The results of the National Inpatient Survey 2016 demonstrated that 34.2% of patients reported being bothered by noise at night. We continue to consider how to improve this further with initiatives such as posters to encourage patients to turn off or put their mobile devices to silent after 11pm and information about prevention of noise at night in the new Welcome Booklet available on all wards.

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 2015/16	During 2015/16 66.63% of patients reported that they were involved as much as they wanted to be about their discharge from hospital.
Where we are at the end of 2016/17	During 2016/17 63.8% of patients reported that they were involved as much as they wanted to be about their discharge from hospital. This priority has not been achieved; however, there has been an improvement. Work has been undertaken to address patients being involved in decisions about their discharge which includes the launch of a new discharge wallet and specific discharge assistants to support patients on the wards. 'Calling cards' provided to patients following discussions about their discharge have just been introduced. We were pleased to meet the requirements of a local CQUIN for 'expected date of discharge'.

Priority 3:	To achieve 90% of patients reporting that they were aware of which Consultant was treating them.
Where we were in 2015/16	During 2015/16 84.26% of patients reported that they were aware of which Consultant was treating them.
Where we are at the end of 2016/17	During 2016/17 87.2% of patients reporting that they were aware of which Consultant was treating them.

Priority 4:	To achieve 100% of notifiable patient safety incidents triggering Duty of Candour requirements acknowledged to relevant person (informing them that the incident has occurred or is suspected to have occurred) within 10 working days of the incident being reported.
Where we were in 2015/16	The Trust Board selected this as a corporate objective for 2016/17. A culture of openness is essential to improve patient safety, experience and service quality. The Trust aims to ensure that the responsibilities outlined in regulations for Duty of Candour are undertaken, enhanced and monitored at a senior level within the organisation. Implementation of Duty of Candour has been a priority since the introduction of the regulation in November 2014. The Trust had held a number of training sessions for staff, developed a 'resource page' on the Trust intranet and produced a video providing clarity on the requirements to meet the

	regulations.
Where we are at the end of 2016/17	The CQC stated in their inspection report published in June 2016 that 'the Trust had a strong process in place that met the requirements of the Duty of Candour Regulations'. However, an audit undertaken at the end of March 2017 highlighted inconsistencies regarding how this objective is evidenced. A look back exercise is now underway for 2016/17 and Duty of Candour is being reviewed by Internal Audit during 2017/18.


First
passion

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

The Trust selected a number of key indicators monitored under its strategy to be safe, effective and caring for the last three years and reported to the Trust Board within the monthly performance reports. These indicators include those set out in NHS Improvement's Risk Assessment Framework and Single Oversight Framework. The Single Oversight Framework replaced the Risk Assessment Framework in November 2016.

Safe

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	2014/15		2015/16		2016/17	
Infection Control						
Infection Control: Clostridium difficile (*C.difficile*)	25 Threshold 32	↑	12 Threshold 19	↑	22 Threshold 19	↓
Infection Control: Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia	1 Threshold 0	↔	0	↑	3	↓

C.difficile

Our C. difficile trajectory set by the Department of Health was 19 for 2016/17. We continue to undertake individual patient reviews collaboratively with our commissioners to identify potential 'Lapses in Care' and key learning or trends. This year 3 'Lapses in Care' were identified:

- Lack of patient isolation
- Lack of communication causing delayed isolation
- Prescribing outside Antibiotic Policy.

MRSA Bacteraemia

We had 3 MRSA Bacteraemia during 2016/17. We are reviewing vessel health care in line with the new National Institute of Clinical Excellence (NICE) guidelines.

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

Hospital Standardised Mortality Ratios (HSMR)

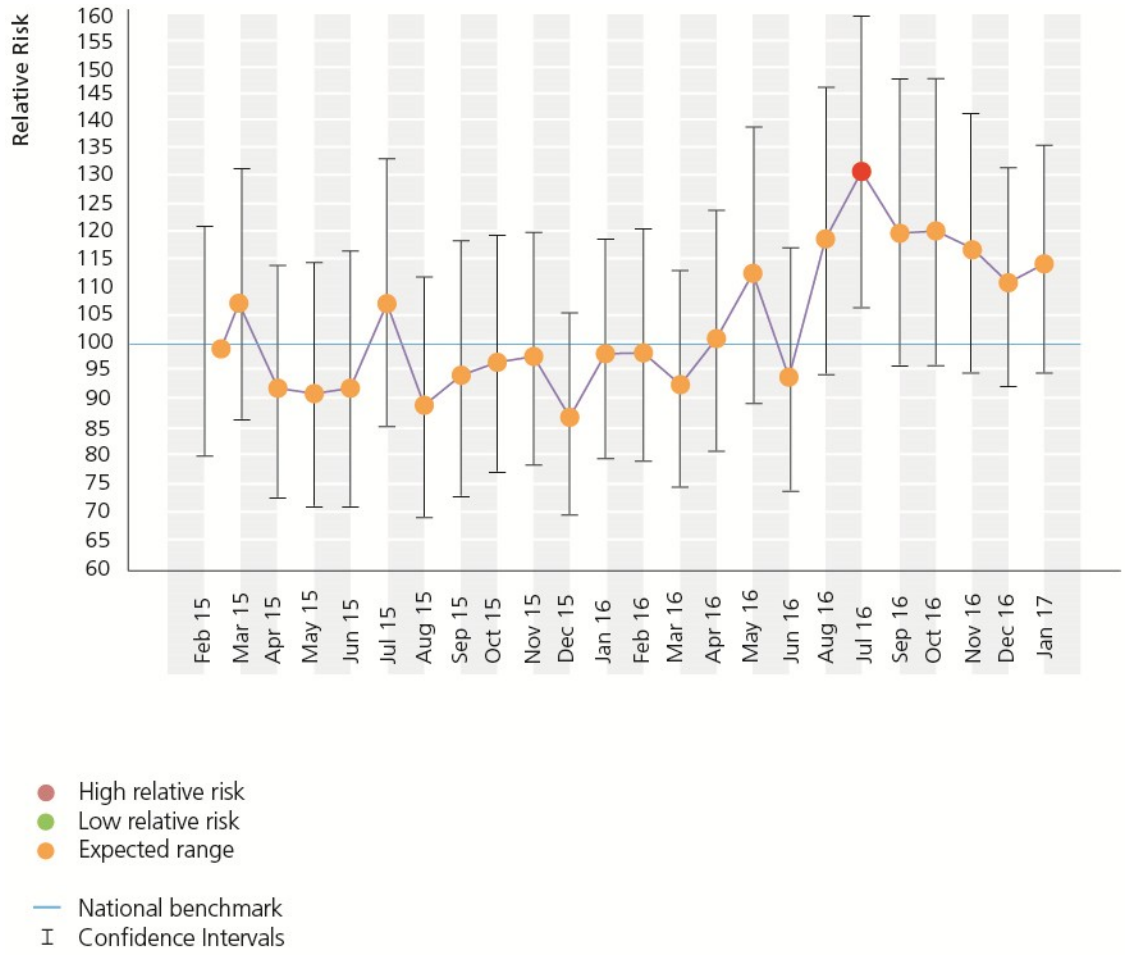

Table: HSMR from February 2015 to January 2017.

Hospital Standardised Mortality Ratios (HSMR) is a statistical way of comparing mortality ratios between hospitals. In order to compare hospitals in different areas with different populations and varying specialty work, the methodology looks at how many people are expected to die in hospital due to their condition and then compares this figure against how many people actually die. Mortality remains a principal risk for the Trust. A Mortality Group has been established, chaired by the Medical Director and attended by external organisations to support collaborative working. One responsibility of the group will be to analyse the Trust's mortality data and seek meaningful comparisons.

Data Source: Dr Foster intelligence sourced from national commissioning datasets as governed by standard national definitions.

Never Event

Number of Incidents Reported as Never Events (Threshold = 0)	6	↓	0	↑	1	↓

In 2016/17, one serious incident was categorised as a 'Never Event' under the definition "bed rails entrapment" which resulted in low harm to the patient. A comprehensive action plan was developed and is being monitored via the Trust's Serious Incidents Requiring Investigation (SIRI) Panel chaired by the Trust's Director of Nursing. Membership includes a Governor and representatives from Wigan Borough Clinical Commissioning Group (CCG).

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

Human Resources						
Temporary Staffing – Threshold N/A	14/15 £14,178,009	↑	15/16 £14,626,255	↑	16/17 £14,331,510	↓

Spend on Temporary Staffing year to date (April 2016 to March 2017) is £14,332k. The in-month spends for March 2017 increased by £276k from £1,068k in February 2017 to £1,344k in March 2017.

Agency spend continues to be a 'hot spot' and year to date spend at Month 12 stands at £5,972k. Our NHS Improvement (NHSI) Agency Ceiling was set at £5,482K and will remain at this level in 2017/18. Agency was the highest spend in Month 12 at £615k and accounted for 45.76% of spend. It is noted that Agency spend has increased by £248k from £367k in February 2017. The second highest spend in Month 12 was Bank NHS Professionals (NHSP) at £291k (21.65% of spend).

Compared to the 2015/16 financial year, total temporary spends have decreased from £14,626k to £14,332k (reduction of £294k). Agency spend has reduced from £7,162k to £5,972 (a decrease of £1,190k), however, this is offset by increases in 'Add Sessions' and Bank NHSP which have increased by £785k and £391k respectively.

We continue to examine temporary staffing costs on a monthly basis. A temporary staffing meeting is now established to convene on a monthly basis with executive oversight and attendance. Within this meeting both temporary and agency spend is considered and appropriate response and strategies are defined. An update is also provided to our Workforce Committee for further discussion and oversight. In response to NHSP use, the Senior Nurse Management Team have completed an examination of nurse staffing across the Trust and E-rostering assessment. A Standardisation of Nursing Hours and E-rostering consultation is underway which we hope will result in a reduction in temporary spend. 'Hard to fill' vacancies have continued, as in most Trusts, to cause the highest spend in relation to medical agency. This is inclusive of Emergency Medicine, Dermatology and Care of the Elderly. Recruitment strategies to reduce temporary/agency spend have included an assessment of alternative workforce models during 2016/17 with pilots progressed for Senior Allied Health Professionals (AHPs) and Pharmacists within Accident and Emergency (A&E) and consideration of nurse consultants. Gaps in Emergency Medicine middle grades have had some success as has Consultant recruitment with Care of the Elderly. We are launching a new Information Technology (IT) authorisation model for medical agency recruitment which will ensure stronger controls and appropriate senior oversight and authorisation.

An internal medical bank has also been launched. The large scale recruitment event in June 2016 was successful and is to be repeated in 2017. Over 70 offers of employment were made during the event with new recruits joining a talent pool. Throughout 2016/17 new starters commenced as vacancies were available or candidates obtained relevant qualifications.

We continue to respond to the requirements of NHSI and Agency Cap guidelines, the enforcement of the HMRC regulations in respect to IR35, and to explore within networks where best practice and workforce solutions have reduced spend in other Trusts.

Data source: Trust Oracle Ledger

Effective

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	2014/15		2015/16		2016/17	
Accident and Emergency (A&E)						
Total time in A&E: Less than 4hrs (Threshold- Monitor 95%)	94.7%	↓	95.08%	↑	87.61%	↓
A&E 4 hour performance has declined in this financial year in line with the national overall drop of 7%; however, we remained the top performing Type 1 A&E in Greater Manchester. Length of stay for our Medicine division at Royal Albert Edward Infirmary has increased by 2 days and is an indicator of the acuity of patients admitted to hospital. This was reflected in A&E attendances where there has been a 9% rise in patients over the age of 75 years old as the population demographics within the locality changes. This increasing elderly population has further stretched the community resources such as Care Homes, and coupled with reducing Nursing Homes beds. The location of our Integrated Discharge Team (IDT) on site and internal discharge processes resulted in us having the lowest DTOC (Delayed Transfer of Care) rates in Greater Manchester. During 2016/17 there was an increase in attendances from Preston post codes to Wigan which accounted for 3 to 4 beds being occupied by Preston patients throughout this period. From December 2016 to February 2017 outbreaks of Norovirus and Influenza resulted in bed closures both in hospital and in the community. At one stage in early January 2017, 3 wards and up to 10 Care Homes were closed. Future work to respond to the changes in A&E attendances includes co-location of GP practices on site and reviewing internal processes. Data Source: Management Systems Services (MSS), as governed by national standard definitions.						

Indicator	2014/15		2015/16		2016/17	
Cancer Waits						
Cancer 62-Day Waits for first treatment - from urgent GP referral (Threshold 85%)	91.25%* 92.13%**	↑* ↑**	88.85% 91.3%	↓* ↓**	90.59% 93.21%	↑* ↑**
Cancer 62-Day Waits for first treatment - from NHS Cancer Screening Service Referral (Threshold 90%)	99.54%* 99.54%**	↑* ↑**	97.25 97.01%	↓* ↓**	100% 99.75%	↑* ↑**
Cancer 31-Day Wait for second or subsequent treatment – surgery (Threshold 94%)	100%	↔	100%	↔	99.19%	↓
Cancer 31-Day Wait for second or subsequent treatment – drug treatments (Threshold 98%)	100%	↔	100%	↔	99.34%	↓

Cancer 31-Day Wait from diagnosis to treatment (Threshold 96%)	99.03%	↓	99.08%	↑	99.57%	↑
Cancer 2-week –all cancers (Threshold 93%)	98.28%	↓	98.14%	↓	98.16%	↑
Cancer 2-week - breast symptoms (Threshold 93%)	95.66%	↓	96.67%	↑	96.31%	↓

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 been re-allocated to one Trust if the agreed timescales for transfer or treatment have not been met.

The Trust has continued to achieve all performance indicators for cancer care throughout 2016/17 despite being a very challenging year for Cancer Services nationally. The Trust has increased compliance for all 62 day pathways. More patients are being treated within 62 days, just over 90% of GP referred patients which is 8% higher than the national average and 100% of patients that come through the national screening programmes. There has been a 15% increase in suspected cancer referrals from GPs; however, the Trust has maintained performance against the 2 week wait for first appointment target. The Trust continues to work closely with partner organisations in Greater Manchester, the Greater Manchester Cancer pathway boards and the Cancer Vanguard. The Trust has 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	2014/15		2015/16		2016/17	
Referral to Treatment (RTT)						
Referral to treatment time, 18 weeks in aggregate, incomplete pathways (Threshold 92%)	97.1%	↑	96.9%	↓	95.75	↓

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). The Trust continues to exceed the threshold.

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

Indicator	2014/15		2015/16		2016/17	
Access to Healthcare for People with a Learning Disability						
Compliance with requirements regarding access to healthcare for people with a learning difficulty	Achieved	↔	Achieved	↔	Achieved	↔

The Trust has continued to be compliant with requirements regarding access to healthcare for people with a learning disability

Indicator	2014/15		2015/16		2016/17	
Community Care						
Community care – referral to treatment information completeness (Threshold 50%)	66.69%	↑	67.1%	↑	66.7%	
Community care- referral information	95.57%	↑	95.1%	↓	95.7%	

completeness (Threshold 50%)						
Community care – activity information completeness (Threshold 50%)	97.91%	↓	97.8%	↓	97.0%	
The data above represents the Trusts year end position. The Trust has continued to consistently perform above the threshold for these indicators for the past three years. Data Source: Electronic Patient Record (EPR) system, as governed by standard national definitions.						

Caring

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	2014/15		2015/16		2016/17	
Selected Real Time Feedback Indicators						
Feedback scores – Real Time Patient Survey (Threshold >90%)	92.39%	↑	92.49	↑	92.17%	↓
Feedback scores – Real Time Patient Survey – Pain Control (Threshold >90%)	93.5%	↓	96.00	↑	95.75	↓
Feedback scores – Real Time Patient Survey – Worries and Fears (Threshold>90%)	90.5%	↑	92.75	↑	93.04%	↑
During 2016/17 the average score of the Real Time Survey is 92.17% (March 2017) which has shown a slight decrease of 0.32% in comparison with the average score for 2015/16. There has been a slight improvement of 0.29% in the score for the Worries and Fears question during 2016/17 and a slight decrease of 0.25% in the pain control question. Data Source: Real Time Patient Feedback Surveys as at March 2017.						

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 Trust 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 the Trust's 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 and possible claims.

Statistical information in respect of complaints and concerns is collected and monitored to identify trends. The Trust continues to share its 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 of the Trust.

As a Trust 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**
Patient Experience *The decision to close the Pharmacy at Thomas Linacre Centre (TLC)and the provision of inadequate information documented on the prescription causing problems with Community Pharmacies*	The closure of the TLC Pharmacy was a decision taken by the Trust to improve patient choice and enable the majority of medications to be obtained from a community based Pharmacy. Feedback has been provided to the medical staff on their prescribing. This is to ensure that prescriptions are legible and contain enough detail for other Pharmacies to supply medication without confusion.
Values and Behaviours *A patient was very unhappy with the attitude displayed by a member of staff when attending for clinic as they arrived on time for the running of the clinic but were refused to be seen as the clinic was closing within the hour.*	An explanation of the system used has been shared. An apology has been provided in relation to the lack of information available to explain clinic times and how they work. There has been a change in the system including the opening of an extra room to see patients to provide additional support and new notices have been displayed to provide patients with further information.
Clinical Treatment *Patient underwent a procedure but later was re-admitted with*	Following this complaint the Consultant in charge of the patient's care has written and published a case study to highlight a rare condition following this procedure to be used as part of an

complications.	education package.
Medication Error *Patient received medication that was not compliant with the current medication which led to the patient having a setback in treatment.*	The doctor concerned has discussed this complaint with their Consultant and has reflected on the error. They have provided a statement to the Consultant in charge of the patient's care and in future will liaise with the Pharmacy Department.
Protocols and Procedures *Failure in system for the Theatre schedules as patient was a 'short-notice' addition, which led to patient being cancelled, having fasted all day.*	Improvements for theatre scheduling are under consideration and processes are being reviewed to ensure that operating lists continue to be planned as far in advance as possible. Any changes within 24 hours must be communicated verbally through the respective operating team in order to support patient needs and amend any resource requirements. Efficiency and planning is now discussed and monitored daily at a communication cell.
Values and Behaviours *The manner in which information regarding the discharge from clinic was provided as per the Access Policy following missed appointments.*	Staff member invited is attending the Trust's 'Caring for our Customers' training course. Patients and relatives are now made aware of the process for discharging from clinic following missed appointments. Data pertaining to missed appointments is to be displayed within the clinic on a monthly basis and the process of discharge is to be highlighted to ensure this is clearer to patients.

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 2016/17 the PHSO requested information regarding 5 complaints. Of these, 3 were partially upheld, 1 was not upheld, and 1 remains under investigation. These cases relate to 2014, 2015 and 2016.

We are currently preparing action plans for 2 of the partially upheld complaints and 1 required no action plan in respect of the PHSO recommendations. No financial redress has been awarded in respect of these cases.

Patient Experience

The Trust has continually achieved excellent scores for cleanliness throughout placing the hospitals in the top 20% of Trusts who utilise Picker to co-ordinate their national inpatient surveys (87 Trusts). The latest National Inpatient Survey results are due for publication in early summer 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 Trust Board 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 "do you know which Consultants treating you?" Results of the outcome of the real times surveys are located in the patient engagement section of the Trust's Annual Report.

Patient and Public Engagement

Patients, Carers and Governors attended an event to assist with the redesign of Audiology Hearing Aid Service. They 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. Initiatives implemented in response to feedback include improvement to the information both written and verbally about the patients' first experience of having a hearing aid fitted and going outside with their hearing aids in.

The Patient and Public Engagement Team attended the first Wigan Pride Event in 2016 to engage with the LGBT (Lesbian, Gay Bisexual and Transgender) Community to explore their experience of accessing and using Trust Services. Overall, the majority of the public who completed a survey said that the services they received were excellent. The public commented that the staff were excellent, very friendly and very supportive and they were made to feel at ease. The public also spoke highly of how clean the hospital was. The community did comment that the seating in Accident and Emergency was uncomfortable. New seating in Accident and Emergency has been installed to meet certain criteria such as being bolted to the floor and meeting infection control standards.

The patient and public engagement campaign on "Shared Decision Making – Ask 3 Questions" continues to be successful engaging with over 180,000 patients, public and staff through various touch points. The campaign informs and empowers patients to be involved in decisions about their care and treatment.

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

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

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

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 the Trust 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.


Wrightington, Wigan and Leigh
Physical He
Getting
hearing
aids
PHONAK

Part 3.2 Quality Initiatives

The Trust has 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 2016/17 is outlined below.

Staff Engagement the WWL Way

In 2016 we were sustaining high levels of staff engagement for the first half of the year, until July 2016 when there were some significant declines on a number of engagement measures. Most notably these were the engagement enablers for trust, work relationships, resources, mind-set, personal development, perceived fairness and recognition, engagement feelings of dedication, focus and energy and engagement behaviours of persistence, discretionary effort and adaptability. This decline plateaued in October 2016, but despite this decline, the overall scores remained moderate to positive. The pulse survey assisted to pre-empt the outcomes of the National Staff Survey which took place from October to December 2016. The results, published in March 2017 also indicated a number of declines, particularly in relation to staff influence, recognition and development, reducing the gap between the Trust scores and the national average for the majority of items. WWL now ranks 10th out of 98 Acute Trusts for overall staff engagement within the NHS, compared to achieving the top 10% position in 2015.
Staff engagement activity had continued to be delivered at full momentum in 2016 and included the implementation of the following:

- "Steps 4 Wellness" health and wellbeing programme/campaign launched at "Wellfest" in September 2016 which included the introduction of mental health awareness training, resilience stress management open courses, six week mindfulness programmes, a critical incident stress management service to support staff following trauma, new staff societies such as a running club and book club and physical health programmes (WWL step challenge, lose weight feel great, body MOTs, slimming world);
- ☐ Delivery of staff events such as the Recognising Excellence Awards, WWL Euro five-a-side football tournament and NHS games;
- ☐ Staff engagement organisational development work to support organisational and cultural change (e.g. implementation of the new health information system (HIS), delivery of a wellbeing improvement plan in Accident and Emergency)
- ☐ Staff engagement listening events and forums to gather staff ideas, feedback, contributions and influence (such as junior doctors forums, admin and clerical focus group, HIS graffiti walls, bright ideas scheme)
- ☐ Initiation of the development of a new staff intranet and app, transforming internal communications within the Trust (to be delivered 2017)
- ☐ Launch of the WWL People Promise
- ☐ Sixth cohort of pioneer teams programme, with 58 teams participating to date.

We continue to share its 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. Trust 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 the Trust to identify this six months ahead of the national staff survey results, which has meant improvement plans have already been developed and continue to be implemented. The aim is to ensure that engagement does not continue to decline further and begins to make a recovery, leading the Trust from a place of "good" results to "great" results once again by the end of 2017. The Trust 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 2016/17 and there are now over 350 Quality Champions representing a wide range of disciplines and departments, working on or have completed 143 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 2016, 9 silver and 6 gold awards were awarded, taking the total to 47 silver champions and 13 gold champions.

Four courses of training in quality improvement methods have been delivered during 2016/17. Several other NHS organisations have shown interest in The Quality Champions' programme including the Countess of Chester Hospital NHS Foundation Trust who has delivered a version of Quality Champions for several years. They are seeking to understand how they can develop the culture to support and sustain the programme. Birmingham Community NHS Foundation Trust have adopted the programme.

During 2016/17 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 £2 million. These have been realised through decreased length of stay, reduced financial penalties and achievement of best practice tariff.

This year has been the first year that we have delivered a bespoke quality improvement methodology training programme for Foundation Year One Doctors. This has been evaluated well by attendees. A number of the Junior Doctors have been offered support from Consultants to progress their quality improvement projects.

We held our inaugural Quality Champions Conference in September 2016 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.

During 2017/18 four further cohorts are planned in addition to supporting a further programme for junior doctors.

Implementing Recommendations from the Kirkup Report

The Kirkup report was published March 2015 subsequent to an independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust. The report made 44 recommendations, 18 recommendations for Morecombe Bay Trust and 26 recommendations for the wider NHS, aimed at ensuring the failings were properly recognised and acted upon.

In light of these recommendations WWL maternity and neonatal services developed an action plan to provide the evidence and assurance in regard to the service provision for women, children and families.

A review of the Trust Kirkup action plan and supporting evidence was conducted by Mersey Internal audit agency (MIAA) to provide additional assurance in accordance with the requirements of the 2015/16 Internal Audit Plan, as approved by the Audit Committee. The overall objective of

the review was to confirm whether processes relating to the Kirkup action plan were sufficiently robust within WWL.

The action plan was monitored through the internal governance process of the Trust and scrutinised by the Quality and Safety Committee until completion and assurance against all of the recommendations had been achieved. This action plan will be revisited later in the year to ensure that all of the recommendations are still compliant and embedded within the organisation.

Leadership Quality and Safety Rounds

During 2016/17 nine leadership safety rounds took place. Executive and Non-Executive members of the Trust Board and Trust Governors visited wards and departments and held conversations with groups of staff about patient safety using an "appreciative inquiry" approach. Areas visited included Astley, Orrell, Taylor and Shevington Wards and the Thomas Linacre Centre. 23 staff participated in the visits in total. In all, 38 safety rounds have taken place using this approach since 2012, involving many different disciplines across four Trust sites. During 2017/18 a further 12 visits are planned.

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. The regular weekly snap shot audits and the quarterly whole hospital site audits have continued to demonstrate stability and improvement. 'Goodnight Always' events and 'Do Not Attempt Cardio-Pulmonary Resuscitation Always' events have also been introduced.

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 haven't 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 decreased significantly during this financial year, partly as a result of removing the contact number from outpatient documentation. The HELPline was established for inpatients and their relatives to contact a senior nurse with concerns to be addressed whilst the patient is in hospital.

Commissioner Quality Visits

NHS Wigan Borough Clinical Commissioning Group (CCG) has undertaken one unannounced Commissioner Quality Visit in 2016/17 to determine the experiences and views of the patients, relatives, carers and staff on services provided by Taylor Ward at Leigh Infirmary. The Commissioner's reports following their visits are reviewed by the Trust's 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.

In March 2017 the CCG held focus groups with Theatre staff at the Royal Albert Edward Infirmary and Wrightington Theatres to understand staff perception on the current position of safety in the Trust's operating theatres.

TalkSafe

TalkSafe is a programme that is focused on changing the safety culture of an organisation through structured conversations. TalkSafe has a 20 year proven history within the aviation, chemical engineering and engineering sectors.

Conversations focus on safety, both 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 act at the level 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.

TalkSafe was introduced into WWL in October 2014. The Trust's Medical Admission Unit (MAU) and Lowton Wards were chosen as the pilot areas. The programme has trained over 40 TalkSafe champions. There is continued evidence on MAU and Lowton that the safety culture is changing and that there is a reduction in moderate/severe harm incidents and an increase in no/low harm incidents, which demonstrates that a mature safety culture has been sustained.

The programme has been extended to wards A and B, Wrightington Hospital. Theatres at Wrightington Hospital have also begun to engage with the programme.


Ways WWL will help
you keep well

Appendix A

National Clinical Audits and National Confidential Enquiries

The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2016/17 are as follows:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible to participate Y/N	Participated	Number eligible	Actual submissions
Acute Pancreatitis	Yes	Yes	5	80%
Mental Health	Yes	Yes	5	100%
Chronic Neurodisability	Yes	Yes	5	40%
Young People's Mental Health	Yes	Yes	Study Still Open	N/A
Cancer in Children, Teens and Young Adults	Yes	Yes	Study Still Open	N/A
Non-Invasive Ventilation	Yes	Yes	5	60%
National Audits (NCAPOP – n = 20)	**Eligible**	**Participated**	**Number eligible**	**Actual submissions %**
Acute Coronary Syndrome (MINAP)	Yes	Yes	Figures not yet available	N/A
Coronary Angioplasty/Percutaneous Coronary Intervention	Yes	Yes	Figures not yet available	N/A
National Heart Failure	Yes	Yes	Figures not yet available.	100%
Bowel Cancer	Yes	Yes	All cancer audits reported by Oncology Department services	
Head and Neck Cancer	Yes	Yes		
Lung Cancer	Yes	Yes		
National Prostate Cancer	Yes	Yes		
Oesophago-gastric Cancer (NAOGC)	Yes	Yes		
Diabetes (Adult) (NADIA)	Yes	Yes	65	100%
Diabetes (Paediatric) NPDA	Yes	Yes	152	100%
Falls and Fragility Fractures (FFAP)	Yes	Yes	Audit has been deferred until April 2017	
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	Trust intends to begin participation	
Maternal, New-born and Infant Clinical Outcome Programme (MBRRACE)	Yes	Yes	17	100%
National Audit of Dementia	Yes	Yes	52	100%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	127	100%

National Joint Registry	Yes	Yes	3138	100%
National Ophthalmology Audit	Yes	Yes	Figures not yet available	
Neonatal Intensive Care (NNAP)	Yes	Yes	270	100%
Sentinel Stroke National Audit Programme	Yes	Yes	347	100%
Non-NCAPOP	**Eligible**	**Participated**	**Number eligible**	**Actual Audit Submissions %**
Adult Asthma	Yes		10	100%
Asthma (paediatric and adult) care in emergency departments	Yes		80	100%
Case Mix Programme (CMP) (ICNARC)	Yes	Yes	632	100%
Elective Surgery (National PROMS Programme)	Yes	Yes	Reported by other department	
Endocrine and Thyroid National Audit	Yes	Yes	Voluntary by individual Surgeon	
Major Trauma Audit	Yes	Yes	146	Figures not yet available
National Cardiac Arrest Audit	Yes	Yes	94	100%
National Chronic Obstructive Pulmonary Disease (COPD)	Yes*	No	Selected Trusts only for current year	
National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled surgery	Yes	Yes	27	100%
Paediatric Pneumonia	Yes	Yes	Data entry closes end of April 2017	N/A
Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	9	100%
Severe Sepsis and Septic Shock – Care in Emergency Departments	Yes	Yes	99	100%
Stress Urinary Incontinence Audit	Yes	Yes	26	100%
UK Cystic Fibrosis Registry	Yes	Yes	Young patients are transitioned to Wythenshawe Hospital – 26A other CF patients submitted	

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

Annex

Annex A:

Statements from 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 2016/17

Wigan Borough Clinical Commissioning Group (the CCG) welcomes the opportunity to comment on the 2016/17 Quality Account for Wrightington, Wigan and Leigh NHS Foundation Trust.

The CCG has worked closely with the Trust throughout 2016/17 in what has been a challenging year for the Trust and the wider NHS to gain assurances that services are safe, effective and personalised to patients.

The Care Quality Commission (CQC) Quality Report; published on the 22nd June 2016 rated the Trust overall as 'Good'. The report highlighted a number of areas of good practice; however it also identified areas where the Trust was required to make improvements; this included the Paediatric Inpatient Service. A comprehensive improvement plan was agreed with the CQC and continues to be monitored by both the CQC and the CCG.

In respect of the 2016/17 quality priorities the CCG notes that the majority of objectives were not achieved. However, progress was made in a number of areas including the recruitment of an additional 70 Dementia Champions, improvements to the discharge process and a reduction in the number of patients reporting they were disturbed by noise at night.

A significant concern for the CCG is the increase in the Hospital Standardised Morality Ratio and the Summary Hospital Mortality Index. The CCG continues to work closely with the Trust on this agenda; we are aware that the Trust has established a Mortality Review Group to oversee the implementation of the National Quality Boards '*National Guidance on Learning from Deaths'* (March 2017). The CCG will continue to support the Trust in its efforts to reduce mortality rates.

Despite the challenging climate there have been a number of successes in 2016/17. Examples include the continued recruitment and development of the Quality Faculty and significant progress in the reporting of Patient Safety Incidents to the National Reporting and Learning Service.

The CCG supports the quality priorities identified for 2017/18 and welcomes the continued focus on Venous Thromboembolism Prevention and Anticoagulation Treatment, Falls Prevention and Early Recognition and Escalation of the Deteriorating Patient. The proposed introduction of a ward accreditation scheme and initiatives to improve compliance with the Do Not Attempt Cardio Pulmonary Resuscitation guidance are also welcomed.

The CCG will continue to work with the Trust during the coming year to build on the progress made and to provide support to initiatives that will improve the quality of care and outcomes for the resident population of the Wigan Borough.

Dr Tim Dalton, Chairman, Wigan Borough Clinical Commissioning Group

Healthwatch Wigan and Leigh

Healthwatch Wigan and Leigh Response to WWL Quality Accounts

Healthwatch Wigan and Leigh welcomes the opportunity to comment on this Annual Quality Account *(*as seen in draft and with incomplete data*)*. We recognise that Quality Account reports are a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public for the quality of services they provide. We fully support these reports as a means for providers to review their services in an open and honest manner, acknowledging where services are working well and where there is room for improvement.

Healthwatch Wigan and Leigh share the aspiration of making the NHS more patient-focussed and placing the patient's experience at the centre of health and social care. An essential part of this is making sure the collective voice of the people of Wigan and Leigh is heard and given due regard, particularly when decisions are being made about quality of care and changes to service delivery and provision.

Therefore, our focus is that Healthwatch Wigan and Leigh works with its partners in the health and social care sector to engage patients and service users effectively and to ensure that their views are listened to and acted upon. We look forward to continuing to work alongside Wigan, Wrightington and Leigh Foundation Trust to ensure that the voice and experience of patients and the public is heard throughout the provision of services.

We congratulate the Trust on the awards it has gained through the hard work and dedication of teams and individuals over the last 12 months and it's increasing endeavours through research and clinical developments to be a learning organisation. We welcome the Trust's initiative for junior doctors to be involved in projects to improve quality of service.

Healthwatch Wigan and Leigh works closely with the Trust and commissioners in respect to the Improving Discharge Committee. Though hospital discharge is Caring Priority 1, the qualitative data and feedback from patients we have recorded illustrates this is still an area that requires improvement. Therefore, Healthwatch will be monitoring quality and safety issues related to this area of service and continue working with the Trust, particularly in relation to achieving 90% of patients reporting that they were involved in decisions about their care, treatment and discharge from hospital.

We recognise the value of benchmarking against other Trusts as means of monitoring progress. Though it would be useful for Wrightington, Wigan and Leigh to indicate which statistical quartile they are placed in with respect to services and delivery.

Healthwatch notes the new safe, effective and caring priorities for 2017/18 particularly falls reduction, development of a ward accreditation scheme and that the 'right patient is placed in the right ward'. We expect the Trust to achieve these and the priorities it set itself for 2016/17 which it has retained as a framework for improvement across the Trust.

Overall, Healthwatch Wigan and Leigh commends the Trust on the many areas where, through hard work and dedication of staff, quality improvements and outcomes have been demonstrated and a positive cultural change is evolving. However, from our qualitative data obtained through engagement with patients there are still areas for improvement and we will continue to work with the Trust to ensure patient-centred care remains at the core of everything it does.

Cynthia Horrocks, Chair, Healthwatch Wigan and Leigh

Health and Social Care Scrutiny Committee

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

Annex B:

Statement of Directors' Responsibilities in respect of the Quality Report

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 plac to support the data quality for the preparation of the Quality Report.

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

☐ The content of the Quality Report meet**s** the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 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 2016 to May 2017
- Papers relating to Quality reported to the Board over the period April 20**1**6 to May 2017
- Feedback from commissioners dated 03/05/2017
- Feedback from governors dated 07/03/2017
- Feedback from local Healthwatch dated 08/05/2017
- Feedback from Overview and Scrutiny Committee (not received)
- The Trust's complaints r**e**port published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations, dated 2015/2016
- The 2016 national patient survey (embargoed until end of May 2017 therefore the Trust has been unable to reference in this report)
- The 2016 national staff survey 07/03/2017
- The Head f Internal Audit's annual opinion over the Trust's control environment dated 2016/17
- CQC inspection report dated 22/06/2016

☐ 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 regu**l**ations) as well as the standards to support data qua ity for the preparation of the Qual**i**ty 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

31 May 2017

Andrew Foster
Chief Executive

31 May 2017

Annex C:

How to provide feedback on the account

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

Annex D:

External Auditors Limited Assurance Report

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 th·e 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 2017 (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, to assist the Council of Governors 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 2017, to enable the Council of Gov.ernors 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 2017 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Percentage of patients with a total discharge time in A&E of 4 hours or less from arrival to admission, transfer or d·1scharge.

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';

the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed requirements for external assurance for quality reports for Foundation Trusts; 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 the six dimensions of data quality set out in the 'Detailed Guidance 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 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 the documents listed below:

- Board minutes for the period April 2016 to March 2017;
- papers relating to quality reported to the Board over the period April 2016 to March 2017;
- feedback from Commissioners, dated 3 May 2017;
- feedback from local HealthWatch dated 08/05/2017;
- the 2016 national patient survey dated January 2017;
- the 2016 national staff survey dated 07/03/2017
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations dated 2015/16;
- Care Quality Commission inspection report dated 22/06/2016; and
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2017.

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 back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- 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 which 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'.

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

Basis for qualified conclusion

The annualised 18 week referral to treatment indicator is calculated as an average based on the percentage of incomplete pathways which are incomplete at-each month end, where the patient has been waiting less than the 18 week target. We have tested a sample of 50 pathways.

We identified the following errors:

- In 4 cases the start date recorded on the system was different to the start date recorded in the patient notes; ·
- For 10 of the pathways sampled we were unable to reconcile the case data to the reported performance data.

Our procedures included testing a risk based sample of cases, and so the error rates identified from that sample cannot directly be extrapolated to ihe population as a whole.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway". indicator for the year ended 31 March 2017. We are unable to quantify the effect of these errors on the reported indicator.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the Basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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';
- the quality report is not consistent in all material respects with the sources specified in the respective responsibilities of the directors and auditors section of this limtted assurance report; 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 Foundaf1on Trust Annual Reporting Manual'.

Deloitte LLP

Chartered Accountants
Leeds
31 May 2017

Annex E:

Glossary of Terms

AAGL
When established in 1971, AAGL was known as the American Association of Gynecologic Laparoscopists. The organization eventually dropped its full name, and became known simply as the AAGL, along with the phrase "Advancing Minimally Invasive Gynecology Worldwide."

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.

Assisted Conception
Assisted conception means using reproductive technology to increase the chances of pregnancy.

Being Open framework
Being open provides a best practice framework for all healthcare organisations to create an environment where patients, their carers, healthcare professionals and managers all feel supported when things go wrong and have the confidence to act appropriately.

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.

Carter / Carter Review / Carter Report
Lord Carter led a review into NHS productivity and efficiency, which reported in 2016. Implementing the recommendations could help end variations in quality of care and finances that cost the NHS billions.

Chemical Pathology
Chemical Pathology is the branch of pathology dealing with the biochemical basis of disease and the use of biochemical tests for screening, diagnosis, prognosis and management.

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.

Colorectal
This is relating to or affecting the colon and the rectum.

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.

CPE (Carbapenemase Producing Enterobacteriaceae)
Carbapenem-resistant enterobacteriaceae (CRE) or Carbapenemase-producing Enterobacteriaceae (CPE), are gram-negative bacteria that are nearly resistant to the carbapenem class of antibiotics, considered the "drug of last resort" for such infections. Enterobacteriaceae are common commensals and infectious agents.

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 (CQUINs) 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.

Devolution / Greater Manchester Devolution / Greater Manchester Health and Social Care Devolution / Devo Manc
Various forms of Devo, GM Devo etc are used throughout, see below for Greater Manchester Devolution.

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'.

http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

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.

FSRR
Financial Services Risk and Regulation

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.

Hot Clinics
The hot clinic is a consultant run surgical clinic where GP or A&E referrals are evaluated.

HSJ
This is Health Service Journal, a national health care publication.

Hyperemesis
This is severe or prolonged vomiting.

IM&T
Information Management and Technology

Integrated Care Organisation
An Integrated Care Organisation, combining acute and community services, will focus on excellent care, locally managed, for our populations. In Wigan, it will integrate some services that are currently run by WWL, Wigan Council, WBCCG, 5 Boroughs Partnership and Bridgewater.

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.

Kirkup action plan (Morecambe Bay)
Dr Bill Kirkup led the investigations into failings at the maternity unit of Morecambe Bay NHS Trust. The investigation made recommendations for all NHS providers, WWL have developed an action plan for the implementation of these recommendations.

Laparoscopy
Laparoscopy is a surgery that uses a thin, lighted tube put through a cut (incision) in the belly to look at the abdominal organs or the female pelvic organs. Laparoscopy is used to find problems such as cysts, adhesions, fibroids, and infection. Tissue samples can be taken for biopsy through the tube (laparoscope).

LEAN
Lean is an improvement approach to improve flow and eliminate waste that was developed by Toyota. Lean is basically about getting the right things to the right place, at the right time, in the right quantities, while minimising waste and being flexible and open to change.

Legionella
This is the bacterium which causes legionnaires' disease, flourishing in air conditioning and central heating systems.

League of Friends
A voluntary organisation which supports the work of the hospitals in the Trust. The League of Friends is able to provide much needed equipment and comforts for the benefit of patients and staff through the income raised by the work of volunteers.

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"

https://www.wiganleadership.com/storage/app/media/Wigan%20Council/Wigan%20Locality%20Plan%20Exec%20Summary.pdf

LUSCS
This is a lower uterine segment caesarean section.

Magnetic Resonance Scanning
This is a medical imaging technique used in radiology to image the anatomy and the physiological processes of the body in both health and disease.

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

Mch
The Master of Surgery (Latin: Magister Chirurgiae) is an advanced qualification in surgery.

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.

MSK CATS
Musculoskeletal Clinical Assessment / Treatment Service. The service assesses patients with disorders and injuries of the bones and muscles (orthopaedics).
The aim of the clinic is to assess patients and determine the most appropriate course of action to manage and improve their symptoms.

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 ask 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

North West Sector
Under Healthier Together proposals; hospitals in Bolton, Salford and Wigan will work together on transformation plans to reform emergency medicine and abdominal surgery. This geographical footprint is called the North West Sector.

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 Trusts.

PCR (Polymerase Chain Reaction)
The polymerase chain reaction (**PCR**) is a technology in molecular biology used to amplify a single copy or a few copies of a piece of DNA across several orders of magnitude, generating thousands to millions of copies of a particular DNA sequence.

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.

PLACE (Patient Led Assessments of the Care Environment)
This is the system for assessing the quality of the patient environment. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. The assessments enable local people to go into hospitals, as part of teams, to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.

Pseudomonas
This is a bacterium of a genus that occurs in soil and detritus, including a number that are pathogens of plants or animals.

Quality / Quality Strategy
In terms of quality improvement in healthcare, quality is about learning what you are doing and doing it better http://www.qihub.scot.nhs.uk/qi-basics/quality-improvement-glossary-of-terms.aspx#Q

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. VTE Assessment is an international patient safety issue and a clinical priority for the NHS in England. It has been selected by Governors as the Locally Determined Indicator in the 2016/17 Quality Account.

WWL Wheel
The Strategic framework for the Trust is represented by the WWL wheel; there are 7 strategic aims that are underpinned by the 6 core values contained in the NHS Constitution. Patients are at the centre of the wheel as they are at the heart of everything we do.