NHS

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust Quality Accounts 2023-24

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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 us. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence-based quality improvement and to explain progress to the public.

Part 1: Statement from the Chief Executive

I am delighted to present the 2023/24 Quality Report for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

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

The Trust has continued to strengthen its focus on quality and continuous improvement, and we welcome this opportunity to outline our performance during 2023/24. We have continued to progress improvements and enhance our services for our patients, colleagues, and the public. Therefore, this Quality Account demonstrates the significant work that has been undertaken to develop and enhance our services, progress against key performance indicators and improve the quality of our services; highlighting some of the work we have undertaken during 2023/24. Finally, the Quality Account details key areas for continuous improvement during 2023/24.

We continue to build on our status as a teaching hospital and continue work towards becoming a university teaching organisation within the next few years. We already have a good relationship with our university partners, and we will further develop this for the benefit of our patients and our staff.

We recognise that delivery of quality is dependent on several factors, the most significant of which is our workforce. We believe in the importance of fostering and maintaining a positive culture and we aim to be the employer of choice in the borough and beyond. I would like to take this opportunity to place on record my thanks to all staff, both clinical and non-clinical, who work tirelessly to provide excellent care to our patients. Every interaction with patients, relatives, carers and beyond by our staff contributes to the excellent patient care we provide.

We also recognise the importance of learning lessons when things do not go as planned and during the year, we have focused on improving the quality of responses to any complaints we receive. This focus continues as we strive to deliver continuous improvement in this important area. Within the financial year 2023/24, we launched the new Patient Safety Incident Response Framework and this will continue to be embedded in 2024/25. This systematic change in the way manage and investigate incidents will allow us to learn better and more efficiently in the future, as well as learning from the excellent work that happens on a daily basis in all areas of our organisation.

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

Mary Fleming

Chief Executive and Accounting Officer

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

Part 2.1: Our priorities for Improvement in 2024/25

Quality Priorities for 2024/25

We are proud of the work that has been done over the last financial year to progress all of our objectives under pressures that the NHS as a whole has been facing during and since the pandemic. In addition to this, the Trust financial position has been incredibly challenging and, as such, resources for public services within the Borough will be constrained for some time. As such, our integrated approach to managing health an d care will become much more challenging. In the face of these challenges, safety must be seen as our top priority and quality is an integral part of this drive.

Part 3.1 of this account details the quality initiatives for the last financial year and what we have been able to achieve. Successes within safety and quality are detailed within that section, however, some of the highlights are:

- Successful implementation and launch of the Patient Safety Incident Response Framework – this is a new national framework that all providers of healthcare services must implement. It is a significant shift in the way we respond to patient safety incidents and allows us to be considered and proportionate in the way we respond to patient safety incidents, whilst maintaining the high standards of compassionate engagement with those who have been affected by adverse events. The implementation phase of this framework is now underway and is reflected within the 2024/25 corporate objectives
- Improvements in the effective management of Sepsis by showing significant improvements in areas such as early antibiotic prescribing, obtaining of blood cultures to assess infections and care scoring, all contributing to the early detection and treatment of sepsis. These have all led to the safety of patients and has contributed to the mortality within our acute services
- Reductions in the number of pressure ulcers acquired whilst under the caseload of our Community Services. There has been significant work in education, support and leadership around the early detection and management of ulcers which has reduced the risk of any pressure damage occurring, or where it has, deteriorating further.
- More wards and teams reaching the silver status within the Ward accreditation programme, ASPIRE. We have been proud of our teams who have been challenged over the last few years via ASPIRE to lead on quality improvement and have risen to these challenges with improvements over the last year.
- Huma Factors awareness education programme that has increased the number of staff who are now educated in how human factors can influence safety. We were also honoured to be shortlisted for a HSJ Patient Safety Award for the work that we have done in relation to the embedding of this programme. This will carry on and develop within 2024/25 to show our commitment to safety.

For this financial year WWL has four strategic priorities that builds on this quality work and ensures that we further embed safety within everything that we do. We aim to deliver these through a suite of annual objectives which we have refreshed for this financial year, taking into consideration the challenges mentioned earlier, the wider NHS and the needs of the local community that we serve. This section outlines the improvements we plan to take over the next year.

All quality priorities are monitored by our Quality and Safety Committee and a Board Executive is charged with leading on the successful implementation.

Patient Safety & Quality Improvement Our priority remains on delivery of safe patient care in the face of significant demand pressures and the requirement to deliver financial improvements. Key to this is developing our safety culture; listening to our patients when concerns are raised and learning from incidents. Our quality improvement priorities are: reducing pressure ulcers; sepsis care; paediatric diabetes care; and supporting people to be safely cared for at home, through working with partners and using technology.		
Objective purpose	**Focus of objective**	**Lead Executive**
To improve the safety and quality of clinical services	✓ To enhance patient care through digital transformation	**Medical Director**
To improve the safety and quality of clinical services	✓ To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.	**Medical Director**
To improve diabetes care for our paediatric population (up to age 19)	✓ To improve the care of paediatric patients with type 1 diabetes up to age 19 focussing on 5 care processes.	**Medical Director**
To improve the delivery of harm-free care	✓ Continue improvements Pressure Ulcer Reduction ✓ System wide improvement for reducing pressure ulcers	**Chief Nurse**
To promote a strong safety culture within the organisation	✓ Continue to strengthen a patient safety culture through embedding Human Factor awareness ✓ Continue to increase staff psychological safety	**Chief Nurse & Medical Director**
To improve the quality of care for our patients	✓ Continue and build upon the accreditation programme	**Chief Nurse**
Listening to our patients to improve their experience	✓ Deliver timely and high-quality responses to concerns raised by patients, friends and families	**Chief Nurse**

People & Inclusivity We will not tolerate discrimination. We want to have an inclusive and representative workforce that allows all staff to flourish, listen to each other and turn understanding into positive actions.		
Objective purpose	**Focus of objective**	**Lead Executive**
To enable better access to care by having the right people, in the right place, in the right number at the right time.	✓ Produce a workforce plan that outlines the future demand of our workforce and how we will meet that demand, setting out how we will integrate new ways of working and new roles into our teams, particularly those that experience workforce supply challenges.	**Chief People Officer**
To ensure we improve experience at work by actively listening to our people, and turning understanding into positive action	✓ Recognising the valuable role our Leaders play in staff experience, we will roll out a single programme that develops our leaders to operate with compassion and inclusivity and supports improvement of their own wellbeing. ✓ Support our staff to work flexibly. ✓ Gather feedback from staff who may chose to leave, or those who are thinking of leaving. ✓ Develop a robust local "self-service" approach to recognition as well as an efficient scheme that recognises service with the NHS. ✓ Meet the conditions outlined within the NHS Sexual Safety Charter. ✓ Embed the new arrangements for Freedom to Speak Up, including a review against the NHS Board Self-Assessment framework. ✓ Implement a streamlined and supportive approach to line manager and staff conversations. ✓ Undertake a self-assessment against the NHS Health & Wellbeing Framework and put strategies in place that meets gaps.	**Chief People Officer**
We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.	✓ Establish formal governance mechanisms that will drive forward commitments outlined within the WWL EDI Strategy. ✓ Deliver actions as outlined within the six high impact actions as set out in the NHS EDI Improvement Plan. ✓ Improve experience of our black, Asian, minority ethnic workforce. ✓ Improve the experience of our disabled workforce. ✓ Increase the demographic of our workforce Band 7 and above. ✓ Continue to grow and develop our Staff Networks	

Financial Sustainability & Performance Reducing the money we spend on delivering our services, without adversely impacting on safety or quality is important to ensure the sustainability of the services we provide. We all have a role in reducing unnecessary spend and using the resources we have as productively as possible.		
Objective purpose	**Focus of objective**	**Lead Executive**
To deliver our financial plan, providing value for money services	✓ Delivery of the agreed revenue and capital plans for 2024/25 ✓ Delivery of a medium to long term financial strategy focused on sustainability, positive value and success within a financially constrained environment.	**Chief Finance Officer**
To minimise harm to patients through delivery of our elective recovery plan	✓ Delivery of more elective care to reduce elective backlog, long waits and improve performance against cancer waiting times standards, working in partnership with providers across Greater Manchester to maximise our collective assets and ensure equity of access and with locality partners to manage demand effectively.	**Chief Operating Officer**
To improve the responsiveness of urgent and emergency care	✓ Working with our partners across the Borough, we will continue reforms to community and urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay. ✓ We will work collaboratively with partners to keep people independent at home, through developing and expanding new models of care, making use of technology where appropriate (e.g. virtual wards) and ensuring sufficient community capacity is in place.	**Chief Operating Officer**

Partnerships: **To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester**		
Objective purpose	**Focus of objective**	**Lead Executive**
To improve the health and wellbeing of the population we serve	✓ As an Anchor Institution we will work with partners to improve the health of the whole population we serve, supporting development of a thriving local economy and reducing health inequalities. ✓ Playing an active role in the Healthier Wigan Partnership to develop and deliver programmes which reduce health inequalities	**Director of Strategy & Planning**
To develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable	✓ Work with partners across GM to develop and implement plans which deliver efficient corporate services ✓ Work with partners across GM to develop and implement clinical service strategies which deliver services that are clinically and financially sustainable. ✓ Work with our partners across the Wigan locality to deliver system transformation programmes aligned to agreed priorities.	**Director of Strategy & Planning**
To make progress towards becoming a Net Zero healthcare provider	✓ Implementation of priority actions following completion of carbon footprint analyst and heat decarbonisation plan.	**Director of Strategy & Planning**
To increase our research activities delivering high quality research with patients and partners across the Wigan Borough, strengthening our research capability and making progress towards our ambition to be a University Teaching Hospital.	✓ Increase research taking place across the Trust and Primary Care. ✓ Increase number of commercial trials delivered with high performance meeting national KPIs. ✓ Increase research knowledge and capability to deliver research. ✓ Increasing NIHR funded research studies/programmes led by WWL. ✓ Increasing the number of WWL honorary clinical academics employed substantively with EHU.	**Director of Strategy & Planning**

Part 2.2: Statements of Assurances from the Board

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

2.2.1 Participation in Clinical Audits

The Trust is committed to ensuring that a robust clinical audit programme is maintained and is responsive to the safety and quality challenges of the organisation. Within this financial year, our Clinical Audit Team were also honoured to be awarded "Clinical Audit Team of the Year" by the National Clinical Audit Support Centre which recognised the work that we have done over the last few years in embedding audit as part of everyday practice and as a force for change.

During 2023/24, WWL participated in 46 National Clinical Audits and 8 National Confidential Enquiries covering relevant health services that WWL is eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that WWL participated in and for which data collection was completed during 2023/24 is listed in **Appendix 1.**

The reports of National Clinical Audits were reviewed by the provider in 2023/24 and WWL intends to take the following actions to improve the quality of healthcare provided. Other national reports will be presented once published.

National Audit	Reported Outcomes
National Paediatric Diabetes Audit NPDA 2021-2022	For completion of health checks, the Trust are 99.3% compliant in HbA1c. This is following an improvement plan to increase compliance. The Trust are 100% compliant in offering additional appointments/advice /training, screening at diagnosis.
National Paediatric Diabetes Audit of PREMS 2021 - 2022	90% of patients would recommend clinic to friends or family if they had diabetes. Our results are higher than England and Wales who scored 89%. Most of the comments from parents/carers were positive. Both parents/carers and children felt face to face appointments were better.
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Plans are in place to improve on appropriate first paediatric assessment, to ensure ECG is done in all children presenting with convulsive seizures and to adhere to NICE recommendation that children and young people presenting with suspected seizure are seen by a specialist in the diagnosis and management of epilepsies within 2 weeks of presentation (Quality statement 1).

National Audit	Reported Outcomes
National Neonatal Audit Programme (NNAP)	When giving antenatal steroids to mothers who deliver babies between 24-34 weeks we achieved a rate of 65% compared to 57% in the NW and 52% nationally in 2022. Improvement has been seen in 2022 in the number of babies <32/40 who had their temperature taken within an hour after birth; the result of which was in target range of 36.5-37.5. In 2022 we were 9% higher than the national and regional rate. There are improvement projects underway, including a ward care bundle.
The National Asthma and COPD (chronic obstructive pulmonary disease) Audit Programme	The COPD national audit showed WWL to have a low number of patients who received the discharge bundle. An improvement plan was put in place which has shown an improvement.
TARN audit (Trauma Audit and Research Network) now NMTR (National Major Trauma Registry)	Data showed that WWL did not have good case ascertainment, an improvement plan has been put in place to increase the number of patients submitted, however, results will not be evident for a while due to the changes made to the national audit.
Child Health Clinical Outcome Review Programme 1 - Transition from child to adult health services	Report shared at Divisional Quality Meeting and improvement plan implemented to meet the recommendations of the report.

The reports of 280 Local Clinical Audits were reviewed by the provider in 2023/24. A selection of these audits outlined below show improvements which have taken place from previous audits.

Speciality	Title	Success
Community	Diagnosis & Treatment of Community Acquired Pneumonia within the Community React Team	Improvement from 55% to 100% in patients prescribed the correct dosage and duration of doxycycline following improvement work to highlight awareness of NICE guidance and latest practice.
Audiology	Implementation of Hearing Aid Verification – community audiology paediatric	Improvement from 44% to 92% in patients receiving real ear measurements following improvement work to ensure patients receive new ear moulds prior to annual review.
Orthopaedic	Assessing bone health referral in acute vertebral fractures under Orthopaedic care	New referral pathway instigated for patients with osteoporosis. Teaching and awareness sessions implemented. IT changes to electronic patient record to allow recording of scoring, resulting in improvement in the number of patients attending specialist clinics (11% to 56%), patients initiated on bone protection (28% to 80) resulting in improved care with the potential to reduce fractures.
Urology	Audit of documentation of bladder cancer diagnostic information at flexible cystoscopy	A change in pathway and introduction of bespoke proforma led to improvement from 71% to 97% for documentation of stratification located tumours.
Neonatal	Shoulder Dystocia Audit	Documentation of anterior shoulder / occipital position was only recorded for 56% of cases, improvement plan instigated to include an IT solution to promote improvement documentation, seeing an increase to 100%.
Endocrinology	Inpatient audit on use of IV insulin	Only 65% of patients had insulin prescribed and correctly administered. Extensive bespoke training, and generalised training to around 200 staff saw an improvement to 85%. The remaining 15% was in one area, which has now had bespoke intensive training.
Gynaecology	VTE Audit	VTE reassessment had markedly declined to 6%, improvement work put in place including VTE champion. Subsequent audit showed an improvement to 98%.

Speciality	Title	Success
Orthopaedic	Pre-operative hydration of patients undergoing elective orthopaedic surgeries	Only 64% of patients had a fluid plan in theatre, improvement work including creating designated staff role and standardised proforma saw an improvement to 78%.
General Medicine	AKI Mortality Improvement Plan	Mortality rates for AKI were higher than expected (SHMI value over 100). Improvement work regarding care of patients with AKI alongside work around documentation and coding led to a decrease in mortality relative risk of 32 which is markedly below average.
Ophthalmology	Glaucoma Follow up Appointments	Only 47% of patients were being seen in the required time period. Improvement plan initiated including local database of high risk patients. Re-audit showed an improvement to 71%, improvement work is still on-going and further re-audits planned.
Anaesthetics (Pain Team)	Care of Patients with Fractured Ribs	Standards for patients with fractured ribs needed to improve, improvement plan including change of culture, increased education, change of practice and cohesive MDT working led to a pronounced improvement in all metrics, including rib fracture score completed in A&E from 10% to 61%, completed during admission 20% to 96% and admitted directly to surgical ward 50% to 85%.
Care of the Elderly	Improving Advanced Care Planning in Severe Frailty – Two Year Summary.	An initial audit had shown that no patients with a Clinical Frailty Score of 7 or over had an element of an Advanced Care Plan completed as recorded on the discharge letter. An improvement plan including education, awareness, MDT working, IT solutions and prompts led to an overall improvement to 56%. Work is still ongoing.
Orthopaedic	Reducing Length of Stay in Hip Replacement	Length of Stay following hip replacement was 3 days. An improvement plan using GIRFT recommendations was instigated involving an MDT approach, improving mobilisation and pain relief, which saw an improvement to 1.9 days.

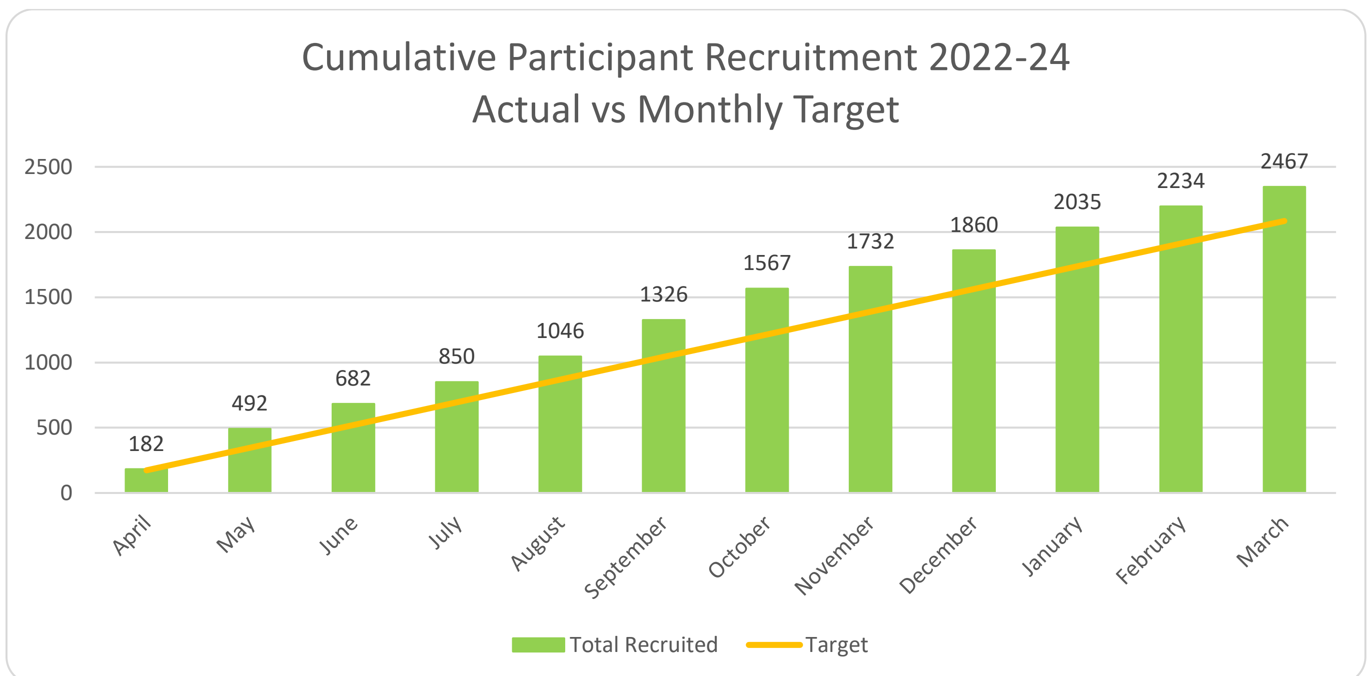
Speciality	Title	Success
Corporate	Improving Sepsis Care at WWL using AQ (Advancing Quality)	The Trust recognised a need to improve care of sepsis and an improvement plan agreed to improve compliance of the sepsis 6 bundle. This saw an improvement in all areas, most notably an increase in blood cultures from 8.7% to 50%.

2.2.2 Research

The number of WWL patients that were recruited to participate in research during 2022-2023 (approved by the HRA and adopted onto the NIHR CRN Portfolio) was 2467, an average of 196 patients per month. The Trust target agreed with the NIHR CRN was 2085 recruits (an average of 173 per month). We have therefore exceeded the set target.

Patient Recruitment 2022/23

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



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

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

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

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

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

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

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

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

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

The Research Team provide expert support and advice to all colleagues ensuring the safe care of patients when they are recruited to research at WWL, and ensure adherence to the European Directive, Good

Clinical Practice guidelines and data protection and all relevant laws. As a result of this expert support, the larger clinical community within the Trust is enabled to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

2.2.3 What others say about WWL

Feedback from the Care Quality Commission (CQC)

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

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2023/24.

Within 2023/24, WWL was subject to 2 published onsite inspections; 1 announced visit within the Antenatal Maternity Services in May 2023, and 1 unannounced visit within the Emergency Village in March 2024.

Maternity Services – Royal Albert Edward Infirmary
This was an announced focused inspection as part of our national maternity inspection programme. The programme aims to give an up to date view of hospital maternity care across the country. Following a 1-day onsite inspection process and pre and post data gathering, the CQC assessed the maternity services at our Royal Albery Edward Infirmary site as **GOOD**.

Emergency Village – Royal Albert Edward Infirmary
This was an unannounced focused inspection within the Emergency Village at Royal Albert Edward Infirmary in March 2024. At the time of writing, the Trust has not yet received a draft report and does not expect to have a finalised report by the time this Quality Account is due for publication. This will therefore be reported on within the next Quality Accounts for 2024/25.

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

100% of our services and locations are now rated either **OUTSTANDING** or **GOOD** by the CQC, the two highest ratings possible. The Trust has continues to carry out a schedule of internal inspections through our ASPIRE ward accreditation process and we therefore believe that is still reasonable to expect that these ratings are valid.

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

2.2.4 NHS Number and General Medical Practice Code Validity

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

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

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

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

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

2.2.5 Information Governance Toolkit Attainment Levels

WWL’s Data Security Protection Toolkit was submitted in June 2023. The assessment was scored as Standards Met/Not Met however an action plan has been submitted and agreed with NHS Digital. The Data Security Protection Toolkit is based on the National Data Guardian’s ten data security standards.

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

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Over the last 12 months the Trust has continued it’s programme of work for the development and improvement of the Data Quality.

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

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

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

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

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

2.2.7 Learning from Deaths

During 2023/2024 1424 patients died in WWL. This comprised the following number of deaths which occurred in each quarter of that reporting period. These figures also include deaths in the Emergency Department

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

By the end of March 2023, 741 deaths were reviewed and 11 were identified as potentially preventable deaths (representing 0.77% deaths recorded) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These reviews use a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance.

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

- The demographic change of our population is having an ever greater effect on attendance, admission and death. Patients are increasingly frail and the numbers of patients reaching the average age of death is increasing. This societal change is an important part of planning for the future.
- Overload of systems is a major theme. Systems within the organisation, but also those we rely on for transferring patients, are overloaded. For a hospital looking to transfer patients for tertiary care, that means additional waits and capacity problems. Sometimes those complex systems fail to provide appropriate care.
- Exceeding the capacity of the organisation is evident. This is most obvious in the Emergency Village. Whilst the numbers of patients dying within the Emergency Village has reduced from last year, 30% of the deaths reviewed occurred within this department.

Weekly reviews take place of deaths and within this themes become evident from the weekly reviews and whilst they can be part of the big picture noted in the Annual Review, they can also be more specific and indicate more specific issues in the care of an individual. A number of issues raised below also feature within incidence reporting and, as a result, have improvement plans associated with them to ensure better quality of care

- Covert bleeding
- Diabetic foot and opportunities to manage prior to the terminal event
- IV fluids, both too much and too little
- Capacity overload

- Medications
- Diagnosis or the opportunity to escalate deterioration

Good practice identified has also been evident from the deaths reviews conducted and it should be noted that 55% of deaths reviewed showed that patients had good sepsis care, with delivery of antibiotics within 1 hour increasing to 89%. 78% of patients who had a diagnosis of AKI also had good care

2.2.8 Seven Day Services

This was Suspended for 2023/24

2.2.9 Speaking up

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

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

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

2.2.10 NHS Doctors in Training

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

High level data

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

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

Annual data summary

Specialty	Grade	Exception Report Raised			

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

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

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

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

Issues arising:

Increased educational exception reports

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

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

Actions taken

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

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

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

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

Surgical F1 exception reports for hours and rest

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

Action taken to resolve the issue

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

General Medicine exception reports for hours and rest

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

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

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

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

Generic actions taken

Overseas recruitment to help with the vacancies:

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

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

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

Part 2.3: Reporting against core indicators

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

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

Please note that not all data included within this report is for 2023/24, this is due to publishing timescales from national data collection agencies

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
Mortality				
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	January 2022 - December 2022	Value: 1.1195, Banding : 2	Value: 0.9999	Best: CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.7117, Banding: 3
				Worst: NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RM1) - Value: 1.2186, Banding: 1
	January 2023 - December 2023	Value: 1.065, Banding : 2	Value: 1.0034	Best: CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.7202, Banding: 3
				Worst: EAST CHESHIRE NHS TRUST (RJN) - Value: 1.2548, 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.	January 2022 - December 2022	48.0%	40.0%	Best: ISLE OF WIGHT NHS TRUST (R1F) & UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST (RRV) - Value: 65.0%
				Worst: SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST (RK5) - Value : 12.0%
	January 2023 - December 2023	48.0%	42.0%	Best: UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST (RRV) - Value: 67.0%
				Worst: SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST (RK5) - Value : 16.0%
Patient Reported Outcome Measures Scores (PROMS)				

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
i) Groin Hernia Surgery	*April 2016 - March 2017*	*0.060*	*0.086*	*Best: NEW HALL HOSPITAL (NVC09) & POOLE HOSPITAL NHS FOUNDATION TRUST () - Value: 0.135*
				Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 0.006
	April 2017 - March 2018	*0.058*	*0.089*	*Best: CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.137*
				Worst: SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST (RXK) - Value: 0.029
ii) Varicose Vein Surgery	*April 2016 - March 2017*	*N\A*	*0.092*	*Best: TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (RMP) - Value: 0.155*
				Worst: ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST (RBN) - Value: 0.010
	April 2017 - March 2018	*N\A*	*0.096*	*Best: THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Value: 0.134*
				Worst: BUCKINGHAMSHIRE HEALTHCARE NHS TRUST (RXQ) - Value: 0.035
iii) Hip Replacement Surgery	April 2021 - March 2022		22.515	Best: SPIRE WASHINGTON HOSPITAL (NT333) - Value: 26.6038
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 6.95254
	April 2022 - March 2023		21.744	Best: EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST (RVR) - Value: 23.5717
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 7.4951
iv) Knee Replacement Surgery	April 2021 - March 2022		17.482	Best: AIREDALE NHS FOUNDATION TRUST (RCF) - Value: 20.4879
				Worst: ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST (RAN) - Value: 13.8526
	April 2020 - March 2021		17.483	Best: UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST (RTG) - Value: 18.793
				Worst: TGUY'S AND ST THOMAS' NHS FOUNDATION TRUST (RJ1) - Value: 11.7243
Hospital Readmission				
The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2021 - March 2022	10.1	12.5	Best: THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RL1) & THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RRJ) - Value: 3.3
				Worst: BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST (RWX) - Value: 46.9

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
	April 2022 - March 2023	7.5	12.8	Best: THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST (RL1) - Value: 3.7 Worst: ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST (RGM) - Value: 302.9
The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	April 2021 - March 2022	15.1	14.7	Best: BMI - THE HAMPSHIRE CLINIC (NT418) - Value: 2.1 Worst: TEDDINGTON MEMORIAL HOSPITAL (NNV2J) - Value: 142.0
	April 2022 - March 2023	15.8	14.4	Best: HUMBER TEACHING NHS FOUNDATION TRUST (RV9) - Value: 2.5 Worst: ORTHOPAEDICS & SPINE SPECIALIST HOSPITAL SITE (NQM01) - Value: 46.8

Responsiveness to Personal Needs

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
The Trust's responsiveness to the personal needs of its patients during the reporting period	*National Inpatient Survey 2019 - 2020*	*66.2%*	*67.1%*	*Best: The Royal Marsden NHS Foundation Trust (RPY) - Value: 84.2%* *Worst: Lewisham and Greenwich NHS Trust (RJ2) - Value: 59.5%*
	National Inpatient Survey 2020 - 2021	*72.5%*	*74.5%*	*Best: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RL1) & Queen Victoria Hospital NHS Foundation Trust (RPC) - Value: 85.4%* *Worst: Medway NHS Foundation Trust (RPA) - Value: 67.3%*

Friends and Family Test (Staff)

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
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 2022	62.43%	62.95%	Best: Alder Hey Children's NHS Foundation Trust (RBS) Value - 86.38% Worst: The Shrewsbury and Telford Hospital NHS Trust (RXW) - Value: 39.27%
	National NHS Staff Survey 2023	62.47%	64.97%	Best: Alder Hey Children's NHS Foundation Trust (RBS) Value - 88.82% Worst: United Lincolnshire Hospitals NHS Trust (RWD) - Value: 44.31%

Venous Thomboembolism

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	*July 2019 - September 2019*	*96.64%*	*95.40%*	*Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) & LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (RY5) - Value: 100%* *Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 71.72%*
	October 2019 - December 2019	*96.40%*	*95.25%*	*Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) & LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (RY5) - Value: 100%* *Worst: NORTHERN DEVON HEALTHCARE NHS TRUST (RBZ) - Value: 71.59%*

ClostridiumDifficile (C. difficile)

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
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 2021 - March 2022	23.74	18.61	Best: Liverpool Womens (REP) & Moorfields Eye Hospital (RP6) - Value: 0.00
				Worst: Wye Valley (RLQ) - Value: 59.03
	April 2022 - March 2023	30.49	20.29	Best: Liverpool Womens (REP), Moorfields Eye Hospital (RP6) & Birmingham Women's and Children's (RQ3) - Value: 0.00
				Worst: Wye Valley (RLQ) - Value: 59.03
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 if such patient safety incidents that resulted in severe harm or death.	April 2020 - March 2021	8333 Incidents Reported (Rate per 1000 Bed Days 61.9) / 8 Serious Incidents (0.10%)	1550533 Incidents Reported / 6767 Serious Incidents (0.44%)	Best: MEDWAY NHS FOUNDATION TRUST (RPA): Incidents Reported 3169 (Rate per 1000 bed days 27.2) / 56 Serious Incidents (1.77%)
				Worst: NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RM1): Incidents Reported 32917 (Rate per 1000 bed days 118.7) / 67 Serious Incidents (0.20%)
	April 2021 - March 2022	7428 Incidents Reported (Rate per 1000 Bed Days 47.67) / 17 Serious Incidents (0.23%)	1767264 Incidents Reported / 7116 Serious Incidents (0.40%)	Best: MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RD8): Incidents Reported 3839 (Rate per 1000 bed days 23.67) / 18 Serious Incidents (0.47%)
				Worst: PENNINE ACUTE HOSPITALS NHS TRUST (RW6): Incidents Reported 11903 (Rate per 1000 bed days 205.52) / 49 Serious Incidents (0.41%)

Part 3: Other Information

Part 3.1: Review of Quality Performance

This section of the Quality Account provides information on our quality performance during 2022/23. Performance against the priorities identified in our previous quality account and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of several initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2022/23

We agreed several priorities for improvement in 2022/23 published in last year's Quality Account. These were selected following a review of risks faced by the organisation, and local priorities in conjunction with internal and external stakeholders.

Patient Safety

Objective:	To improve the compliance of Sepsis-6 care bundles as per Advancing Quality Audit, with the aim to reduce mortality from sepsis
Where we were in 2022/23	During the financial year, the sepsis improvement plan was updated and monitored via a number of routes including mortality meetings, Deteriorating Patient Group and the Patient Safety Group. The ED Sepsis Group was re energised and explored aspects of care that previously had prevented adherence to administering antibiotics within one hour of Time Zero
Where we are at the end of 2023/24	Sepsis AQ data now shows that we are on target with the metric and, whilst some areas are still outwith of some AQ measures, we have significantly improved indicators including blood cultures, administration of IV antibiotics, serum lactate and appropriate care scores. Sepsis training has also been increased and is now included within induction, face to face sessions and specific training within the Emergency Village and during deteriorating patient training. An ED sepsis quality improvement programme to trial a sepsis nurse bleep for suspected sepsis to support the pathway. Coding meetings have also been established monthly to ensure that deaths and discharges are coded accurately as sepsis

	The improvement plan continues to be monitored and will be updated within 2024/5. We have also submitted an application to the HSJ Patient Safety Awards for the improvement work that has been done within the financial year.

Objective:	**To reduce the number of patients admitted to the hospital on end of life pathway**
Where we were in 2022/23	The previous objective was to ensure that there was an increase in the number of patients having a preferred place of death registered. This was achieved and the figure increased to 89% within the financial year.
Where we are at the end of 2023/24	The 2023/24 objective built on the previous financial year's objective to increase the number of patients referred to the District Nursing Service. Between November 2023 and March 2024, we have increased from 76% of patients who died under the care of the District Nurses with a listed Preferred Place of Death to 82% compliance in January 2024 Out of this number who had a Preferred Place of Death, 94% died at home or the hospice in January 2024 Therefore we are pleased to report that we achieved this target and ensured that we have made a difference for those patients who are at end of life to ensure they have the dignity of being in a place of their choosing during the last hours of life. District Nursing teams have received many compliments from families with regards to palliative and end of life care during the financial year and we will continue to support the single point of access system to ensure patients at end stage life have the best care possible

Objective:	**Continue improvements in pressure ulcer reduction. System wide improvements for reducing pressure ulcers**
Where we were in 2022/23	The reduction target was not achieved in the financial year, although we finished in a much better position than noted at the start of our journey in April 2022 and we have much to celebrate, focused work will continue to improve the position through the 2023/24 corporate objective setting process to articulate our commitment to the continuous improvement journey in reducing PU incidence.
Where we are at the end of 2023/24	During 2023/2024 we saw a 45% decrease in total pressure ulcers across WWL services, compared with 2022/2023, unfortunately due to the marked increase in hospital acquired pressure ulcers in Q4, we did not meet the Trust objective of Zero category 3, 4 and unstageable pressure ulcers. Despite this, Community teams have achieved a 67% reduction in category 3,4 and unstageable pressure ulcers this year. We are also celebrating our community teams for achieving the Trust objective of a '10% reduction in category 2 and DTI pressure ulcers' with a 25% reduction in

	2023/2024 and the inpatient teams working towards this for 2024/2025 and a 6% overall decrease in hospital acquired pressure ulcers. The increase in pressure ulcers acquired within the hospital is believed to be a symptom of a system under pressure – overcrowding in the ED leading to lack of skin inspections and off-loading of pressure points, reduced staffing levels in clinical areas to perform skin inspections and pressure ulcer prevention due to continued redeployment of staff. Part of the work in 2024/25 will be to move to a per 1000 bed days data capture, to allow a benchmarking exercise to review how other Trusts perform in the winter months; to explore good practice sharing with the Trusts who can maintain compliance during Q4s. A high number of the pressure ulcer cases were seen in patients who were receiving end of life care. The Tissue Viability service are recording and monitoring the patients who are receiving end of life care both in the hospital and community and who develop a pressure ulcer in the last days of their lives to identify if there is a correlation with end of life skin changes; as the skin is an organ and there is reduced circulation at the end of life, and the development of a pressure ulcer.

Objective:	**Continue and build upon the accreditation programme and to include escalated areas within the Emergency Department**
Where we were in 2022/23	Work continued on strengthening the whole accreditation process and developing the next stages of the programme including, review of using a similar tool within community, maternity and the Emergency Department. A new ASPIRE Quality Standards group was established to review the results of visits and work on quality for wards and teams.
Where we are at the end of 2022/23	Within the financial year, inspections continued and a number of wards and teams achieved silver status. The annual review of the content of the ASPIRE framework and SOP was completed in Q3 and allowed the electronic audit system, Tendable, to build our accreditation framework within their App. This will speed up the accreditation process, provide greater visibility of results and allow the team to increase the number of areas visited. We developed and trialled an ASPIRE programme for the Emergency Village in February 2024, prior to the CQC unannounced inspection, we are also in the process of developing an ASPIRE visit indicators for Maternity services and Community services, which will be reviewed within 2024/25.

Objective:	**To deliver Human Factors training to at least 700 members of staff**
Where we were in 2022/23	Human Factors Training awareness training continued within 2022/23 with 430 members of staff being trained as at the end of March 2023, thereby achieving this corporate objective.
Where we are at the end of 2023/24	The programme of training has continued, with a number of sessions per month. These courses are always well attended and take place within Wigan, Wrightington and Leigh regularly. Whilst we had a target of 700 staff to be trained by the end of the financial year, due to some sickness of trainers and operational pressures, we were not able to achieve 700 trained staff, achieving 640 instead. We are continuing

Objective:	Deliver timely and high quality responses to concerns raised by patients, friends and family
Where we were in 2022/23	Whilst the final overall rate did not achieve 85%, significant work was done by Divisions and the Central Patient Relations team to bring the response rate to 68% The importance of learning from patient experience via the complaints process for partially and fully upheld complaints was identified as a key priority. The Patient Relation team also rolled out training to support staff on responding to concerns and have invested in the Datix system to
Where we are at the end of 2023/24	This financial year has been challenging, with a 24% increase in the numbers of complaints received. We did see a maintenance of a much higher response rate than in previous years, with a number of months exceeding 81% compliance. However, our overall financial year performance 72%. For the financial year 2024/25, we will work on improving timely responses and increase the number of de escalations so that people who raise concerns are listened to and responded to in a more timely fashion

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

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

Key

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

Indicator	2021/22		2022/23		2023/24
Infection Control					
Clostridium difficile (C. *difficile*)	15 Threshold= 0	↑	35 Threshold = 0	↓	23 Threshold = 0
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	1	↔	1	↓	0
C.difficile:					

In 2023/24 each case underwent a detailed individual patient to ascertain any lapses in care. Irrespective of this, comprehensive action plans were drawn up to address any learning that resulted from these RCAs and progress is monitored at the Infection Prevention Control Group. There have been 23 'Lapses in Care' identified; the most common reason was related to samples being taken later than they should have been, followed by inappropriate use of antibiotics. Actions are ongoing to remind staff of the importance of timely sampling and the Consultant Microbiologists and Antibiotic Pharmacist continue to promote and monitor antibiotic use.

MRSA Bacteraemia:

There were no cases logged as attributable to the Trust in 2023/24. This year saw the launch of the 'gloves off' campaign to promote good infection control and this campaign will continue in 2024/25.

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

Indicator	2021/22		2022/23		2023/24	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	2	↑	4	↓	3	

In 2023/24 in the Trust saw a reduction in the number of Never Events reported. The three incidents reported related to two wrong area anaesthetic injection and one misplaced naso gastric tube. Improvements have been made in relation to time to pause for safety within surgery and further improvements are being made in relation to appropriate radiologically guided insertion of naso and oro gastric tubes.

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

Accident and Emergency (ED)	**2021/2022**		**2022/23**		**2023/24**
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	76.53% *	↓	68.62%	↑	68.92%

WWL ED performance against the National 4-hour target of 95% has improved slightly in 2023/24, up to 68.92%.

The Trust saw record attendances within 2023/24 and this has impacted on the Emergency Village, with a reduction of patients being discharged from wards. This has caused a significant delays within the department in being able to transfer those patients who require beds.

Attendances at the Walk in Centre increased and improvements in streaming continues. The Trust implemented a new escalation protocol within 2023/24 to ensure safe management of patients within the Emergency Village during periods of high attendances and an Escalation Assurance Group has been established to review the implementation of this process, along with areas for improvement.

Regionally, WWL was ranked 13th within the Greater Manchester Area for attendances, although it should be noted that we are beginning to show an increase within 2024/25

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

Cancer Waits	**2021/22**		**2022/23**		**2023/24**
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	75.29%	↓* ↓**	74.54%	↓	73.53%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	87.37%	↓*	84.07%	↓	78.03%

WWL's overall performance for all standards related to the 62-day cancer waiting times in 2023/24 have been affected throughout the year by a number of factors within different services, however in certain specialties such as colorectal, there has been good performance. A number of specialties have seen capacity challenges and we continue to work with our GP colleagues to ensure that appropriate referrals are being made.

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

Data Source: TrustBoard Performance reporting, as governed by standard national definitions.

Complaints, Patient Advice and Liaison Service and the Ombudsman

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

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

All complaints and concerns are discussed at our weekly Learning from Patient Safety Events Group which was established in January 2024 in line with our launch of the Patient Safety Incident Response Framework. These are held weekly and have corporate and Divisional representation from medical, nursing and allied health professionals. 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 further investigation via the Patient Safety Incident Response process. These meetings also provide the opportunity to triangulate information with previous incidents, possible claims or HM Coroner Inquests.

Statistical information in respect of complaints and concerns is collected and monitored to identify trends. We continue to share statistical information from formal complaints nationally (KO41a) which is required

on a quarterly basis. This includes information on the Subject of Complaint, the Services Area (in-patient; out-patient; ED and Maternity), amongst other information for each individual site under our responsibility.

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

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

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

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

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

During 2023/24 the PHSO requested information regarding 7 complaints. Some of these relate to historical complaints as there has been a backlog of processing cases by the PHSO. On receipt of every outcome from the PHSO results in an action plan that is monitored within the Division

Part 3.2 Quality Initiatives

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

Ward Accreditation

Ward Accreditation has continued through the financial year which drew in indicators on fundamental clinical care and reflects local, regional and national standards that we would expect to have within all of our wards and teams.

This has shown good progress in standards and a number of wards have now achieved silver status.

Wards and teams are proud to be awarded with accreditation and has begun to foster a culture of improvments within all wards and teams. Work to link improvments with the Quality Champions programme of improvmenets has continued and we will be looking to re focus our inspection programme so that it better aligns with the CQC single assessment framework.

Clinical Quality Walkrounds

During 2023/24, the Trust continued clinical quality walkrounds within a number of wards. These have been designed to compliment the ASPIRE ward and team so that wards and teams can gain credits from the walkrounds that contribute towards their overall ASPIRE scores.

Each visit is unannounced and conducted by a varied team of staff not connected to that ward or area. This allows for a more independent review of the area and can offer different perspectives on quality and safety. We have also continued to involve Non-Executive Directors and Governors as part of these teams and those that have participated have been valuable in identifying areas of good practice as well as possible areas for improvement.

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

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

Staff feedback was also generally positive with good relationships within the teams and a common theme has been improvements made within the communications between teams and with other teams.

Appendix 1 – National Clinical Audits

Count	Programme / work stream	Provider organisation	Eligible to Participate	Participated
1	Breast and Cosmetic Implant Registry	NHS Digital	YES	NO
2	Case Mix Programme	Intensive Care National Audit & Research Centre	YES	YES
3	Child Health Clinical Outcome Review Programme 1 - Testicular Torsion	National Confidential Enquiry into Patient Outcome and Death	YES	YES
	Child Health Clinical Outcome Review Programme 1 - Transition from child to adult health services	National Confidential Enquiry into Patient Outcome and Death	YES	YES
4	Cleft Registry and Audit Network Database	Royal College of Surgeons - Clinical Effectiveness Unit	NO	N/A
5	Elective Surgery (National PROMs Programme)	NHS Digital	YES	YES
Emergency Medicine QIPS: Workstream				
6	Assessing cognitive impairment in older People		YES	NO

	Infection Preventions & Control	Royal College of Emergency Medicine	YES	NO
	Mental Health self harm		YES	NO
	Pain in Children		YES	NO
7	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	YES	YES
Falls and Fragility Fracture Audit Programme Workstream				
8	Fracture Liaison Service Database	Royal College of Physicians	YES	YES
	National Audit of Inpatient Falls		YES	YES
	National Hip Fracture Database		YES	YES
Gastro-intestinal Cancer Programme Workstream				
9	National Bowel Cancer Audit	NHS Digital	YES	YES
	National oesphago-gastric cancer		YES	YES
10	Inflammatory Bowel Disease Audit	IBD Registry	YES	NO
11	LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	NHS England and NHS Improvement	YES	YES
Maternal and Newborn Infant Clinical Outcome Review Programme				
12	Maternal mortality surveillance and	University of Oxford /	YES	YES

	confidential enquiry. (confidential enquiry includes morbidity data)	MBRRACE-UK collaborative		
	Perinatal confidential enquiries		YES	YES
	Perinatal mortality surveillance		YES	YES
13	Medical and Surgical Clinical Outcome Review Programme 1 - Community Acquired Pneumonia	National Confidential Enquiry into Patient Outcome and Death	YES	YES
	Medical and Surgical Clinical Outcome Review Programme Endometriosis		YES	YES
	Medical and Surgical Clinical Outcome Review Programme 1 - End of Life Care		YES	YES
14	Mental Health Clinical Outcome Review Programme	University of Manchester / NCISH	NO	N/A
15	Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	The British Association of Urological Surgeons	YES	YES
National Adult Diabetes Audit Workstream				
16	National Diabetes Core Audit	NHS Digital	YES	YES
	National Pregnancy in Diabetes Audit		YES	YES
	National Diabetes Footcare Audit		YES	YES
	National Inpatient Diabetes Audit, including		YES	YES

	National Diabetes In-patient Audit – Harms			
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme Workstream				
17	Paediatric Asthma Secondary Care	Royal College of Physicians	YES	YES
	Adult Asthma Secondary Care		YES	YES
	Chronic Obstructive Pulmonary Disease Secondary Care		YES	YES
	Pulmonary Rehabilitation-Organisational and Clinical Audit		YES	YES
18	National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	YES	YES
19	National Audit of Cardiac Rehabilitation	University of York	YES	YES
20	National Audit of Cardiovascular Disease Prevention	NHS Benchmarking Network	NO	N/A
21	National Audit of Care at the End of Life	NHS Benchmarking Network	YES	YES
22	National Audit of Dementia	Royal College of Psychiatrists	YES	YES
23	National Audit of Pulmonary Hypertension	NHS Digital	NO	N/A
24	National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	NO	N/A
25	National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre /	YES	YES

		Resuscitation Council UK		
National Cardiac Audit Programme Workstream				
26	National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	YES	YES
	Myocardial Ischaemia National Audit Project		YES	YES
	National Adult Cardiac Surgery Audit		NO	N/A
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)		YES	YES
	National Heart Failure Audit		YES	YES
	National Congenital Heart Disease		NO	N/A
27	National Child Mortality Database	University of Bristol	NO	N/A
28	National Clinical Audit of Psychosis	Royal College of Psychiatrists	NO	N/A
29	National Early Inflammatory Arthritis Audit	British Society of Rheumatology	YES	YES
30	National Emergency Laparotomy Audit	Royal College of Anaesthetists	YES	YES
31	National Joint Registry	Healthcare Quality Improvement Partnership	YES	YES
32	National Lung Cancer Audit	Royal College of Surgeons of England	YES	YES

33	National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	YES	YES
34	National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	YES	YES
35	National Ophthalmology Database Audit	The Royal College of Ophthalmologists	YES	YES
36	National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	YES	YES
37	National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative	YES	YES
38	National Prostate Cancer Audit	Royal College of Surgeons	YES	YES
39	National Vascular Registry	Royal College of Surgeons	YES	YES
40	Neurosurgical National Audit Programme	The Society of British Neurological Surgeons	NO	N/A
41	Out-of-Hospital Cardiac Arrest Outcomes Registry	University of Warwick	NO	N/A
42	Paediatric Intensive Care Audit	University of Leeds / University of Leicester	NO	N/A
43	Perioperative Quality Improvement Programme	Royal College of Anaesthetists	YES	YES
Prescribing Observatory for Mental Health Workstream				
44	Improving the quality of valproate prescribing in adult mental health services	Royal College of Psychiatrists	NO	N/A

	The use of melatonin.		NO	N/A
Renal Audits: Workstream				
45	National Acute Kidney Injury Audit	UK Kidney Association	NO	N/A
	UK Renal Registry Chronic Kidney Disease Audit		NO	N/A
Respiratory Audits: Workstream				
46	Adult Respiratory Support Audit	British Thoracic Society	YES	YES
	Smoking Cessation Audit- Maternity and Mental Health Services		YES	NO (Currently on Hold by Provider)
47	Sentinel Stroke National Audit Programme	King's College London	YES	YES
48	Serious Hazards of Transfusion National Hemovigilance Scheme	Serious Hazards of Transfusion	YES	YES
49	Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	YES	YES
50	Trauma Audit & Research Network	The Trauma Audit & Research Network	YES	YES
51	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	YES	YES
52	UK Parkinson’s Audit	Parkinson’s UK	YES	YES

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

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

Annex A:

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

ADDED FOLLOWING FEEDBACK

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 and subsequent amendments to prepare Quality Accounts for each financial year.

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/24 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 2023 to March 2024
  - Papers relating to Quality reported to the Board over the period April 2023 to March 2024
  - Feedback from commissioners
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2023 national patient survey
  - The 2023 national staff survey
  - CQC inspection reports received during the financial year 2023/4
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

30 June 2024 Chairman

30 June 2024 Chief Executive

Annex C: How to provide feedback on the account

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