







NHS

The Royal Wolverhampton NHS Trust

Quality Account 2023/24

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Why are we producing a quality account?

All NHS Trusts are required to produce an annual Quality Account, to provide information on the quality of the services it provides to patients and their families.

The Royal Wolverhampton NHS Trust (RWT) welcomes the opportunity to be transparent and able to demonstrate how well we are performing, considering the views of service users, carers, staff, and the public. We can use this information to make decisions about our services and to identify areas for improvement.

Getting involved

We would like to hear your views on our Quality Account. If you are interested in commenting or seeing how you can get involved in providing input into the Trust's future quality improvement priorities, please contact:

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Statement on Quality from the Chief Executive

I am pleased to present the Annual Quality Account for 2023/24, detailing our commitment to delivering the highest standard of care for patients of The Royal Wolverhampton NHS Trust. This document sets out how our teams have performed against last year's objectives and describes our collective efforts to promote a culture of continuous improvement, as underpinned by the five-year strategy and Quality Framework that we share with our group partner Trust, Walsall Healthcare NHS Trust.

I joined the Trust at the beginning of the current financial year, and it has been an absolute pleasure to familiarise myself with the many and varied initiatives that have contributed to a successful 2023/24 for the organisation. I want to express my gratitude to all the staff whose hard work has been instrumental to the Trust making sustained progress on patient care, amid the challenges of increased demand on services, periods of industrial action, and financial constraints in the NHS.

The Trust's highlights from the past year include:

1. **Patient Safety:** This remains our top priority. Over the past year, we have seen various successes including a timely and effective transition to the new Patient Safety Incident Response Framework, alongside mortality rates that remain among the lowest in the region, and lower than average rates of hospital acquired infection.
2. **Clinical Effectiveness:** Our focus on this area of delivery is reflected in our patient outcomes: notably, our increased diagnostic capacity – thanks in large part to our new Community Diagnostic Centre in Cannock – has delivered an above-target reduction to our 62-day cancer backlog, and an increase of 27 percentage points in the number of patients who received their diagnostic test within six weeks.

3. **Patient Experience:** We believe that patient experience is a critical component of healthcare quality. This year, the CQC National Inpatient Survey delivered stable results, with patients citing food quality and eating support, and being kept informed and involved in their discharge planning, as areas of positive experience. Feedback from the Friends and Family Test has been good overall, with a recommendation score of 84.75 per cent.
4. **Staff Engagement and Training:** Our staff are at the heart of everything we do, and we recognise the impact that good staff engagement can have on a patient's experience and outcomes – if they are cared for by motivated staff who feel valued. Our NHS Staff Survey results have been encouraging, with around two thirds of staff recommending us as a place to work or receive care – both above the sector average.
5. **Innovation and Improvement:** Innovation is key to our continued success, and we continue to invest in and promote improvement, gaining significant staff engagement in our Quality Improvement programme, which has delivered benefits ranging from front-line digital innovations to increased capacity for our Virtual Ward and Discharge to Assess pathways – supporting faster discharge and reducing readmission.
6. **Community Engagement and Integration:** We continue to work closely with our community partners to deliver integrated care services. As well as recruiting more Patient Involvement Partners to help shape our services, we have embraced new ways of working to improve patient flow, for example a "call before convey" project for the over-65s, which offers a community alternative to an ED visit.

Looking ahead

While we are proud of our achievements, there are areas for improvement, which are set out clearly in this report. Our ambition for a culture of continuous quality improvement depends on us learning from our successes and tackling our challenges too. In 2023/24 we saw an increase in the number of reported patient incidents, which is in fact positive – because it is only by encouraging open, transparent reporting with a focus on capturing learning, that we can get the best standards of data to help us identify where we can make things better. Informative and high-quality reporting will be a significant theme across this year's quality improvement activity.

Other areas of focus for the coming year include:

- **Improving patient flow in urgent and emergency care**, by expanding same day emergency care services and virtual wards, while working with partners to speed up discharge from hospital.
- **Reducing waiting times:** in cancer services this means increasing the percentage of early diagnoses and reducing the number of patients waiting more than 62 days, while eliminating the longest waits in elective services and working towards a return to pre-pandemic activity levels.
- **Further improving patient safety** by focusing on staff training and competency, to further embed a culture of continuous learning with the ambition of eliminating avoidable harm.

As I lead this Trust into 2024/25, I would like to reaffirm our commitments to quality, and to continually striving for excellence in all areas of patient care. I look forward to working with our patients, staff and partners to build on our successes and address the challenges ahead.

Thank you for your continued support.

Caroline Walker

Interim Chief Executive Officer

The Royal Wolverhampton NHS Trust

Looking back 2023/24 Priorities for Improvement

The chosen priorities supported several quality goals detailed in last year's quality strategy as well as three key indicators of quality:

Patient Safety	Having the right systems and staff in place to minimise the risk of harm to our patients and being open and honest and learning from mistakes if things do go wrong.
Clinical Effectiveness	Providing the highest quality care with world-class outcomes whilst also being efficient and cost effective.
Patient Experience	Meeting our patients' emotional needs as well as their physical needs.

Progress in achieving our quality priorities has been monitored by reporting to the relevant Quality Boards at the Trust.

Priority 1: Patient safety

Priority and why priority identified

1.1 Priority area – Patient safety

Embed a culture of learning and continuous improvement at all levels of the organisation.

What we said we would do

- Transition to the Patient Safety Incident Response Framework (PSIRF)
- Transition to Learning from Patient Safety Events (LfPSE)
- Increase uptake of Level 2 syllabus training
- Achieve transition to PSIRF by the national deadline
- Upload 100% of incidents to LfPSE by the national deadline

How did we do?

In preparation for the transition to Patient Safety Incident Response Framework (PSIRF), workstreams were set up to enable staff to help shape what PSIRF could look like in practice. These focused on building our patient safety profile and planning how to respond to incidents, exploring the structures and ways of working under PSIRF, reviewing the training that would be required for staff and developing the processes for engaging patients and staff following an incident. The Patient Safety Incident Response Policy and Plan was created during this time and the transition to PSIRF began in November 2023. The transition is expected to continue as we become more familiar with the new ways of working, and this is supported by a dedicated group to oversee and provide structure for implementation.

The transition to Learning from Patient Safety Events (LfPSE) is to be implemented in quarter one of 2024/25; there have been unforeseen national technological delays.

Looking back 2023/24

Priority and why priority identified
1.2 Priority area – Urgent and emergency care and patient flow Deliver safe and responsive urgent and emergency care in the community and in hospital.
What we said we would do
Working with partners from across the system, support the flow of patients through UEC, by: • Expanding and maintaining the use of same day emergency care (SDEC) services to avoid unnecessary hospital stays • Expanding virtual wards, allowing people to be safely monitored from the comfort of their own homes • Speed up discharge from hospital and reduce the number of patients without criteria to reside. **The aim for 2023/24:** • Year on year improvement in the percentage of patients seen within four hours in A&E • Reduce adult general and acute bed occupancy to 92% • Consistently meet the 70% two-hour urgent community response time
How did we do?
1. Over performance against 70% 2UCR compliance target on 10/12 months. Compliant in 8/9 dispositions with falls pathway going live at the end of 2023, and diabetes pathway in development due to go live quarter 2. Non-compliance of target under review, with some data quality issues to be addressed. 2. Adult and paediatric virtual wards continue to expand to meet demand (both step down and step up), consistent over performance against 98 beds and 80% bed occupancy. Working with acute colleagues to increase acuity of patients to support more step-down patients and working with NHSE behavioural scientist team to understand and improve number of referrals. 3. Actively involved in working with partners across the system to improve flow, one telephone number in place for West Midlands Ambulance Service for use by community services across the ICB and development of the Single Health Resilience Early Warning Database (SHREWD) to provide visibility of demand and capacity. 4. Call before convey project in place for over 65s, to offer community alternative to ED attendance/admission. 5. SDEC pathways in place via care coordination to help navigate patients to the right place.

Priority and why priority identified

1.3 Priority area – Quality improvement

Embed a culture of learning and continuous improvement at all levels of the organisation.

What we said we would do

- Produce a gap analysis on how both trusts (RWT/WHT) rank against the four components of a quality management system (quality planning, quality control, quality improvement and quality assurance), and review how we triangulate data to understand priorities
- All members of divisional and care group/directorate leadership teams to attend one day quality service improvement and redesign fundamentals (sessions scheduled from January 2023)
- Year-on-year roll-out plan for QI huddle boards across both trusts to targeted areas e.g., low evidence of improvement work, non-clinical areas

The aim for 2023/24:

- Completed gap analysis by end of 2023/24
- Increase in the number of staff trained following triumvirate training
- Introduction of 10 QI huddle boards per site/annum

How did we do?

NHS IMPACT (Improving Patient Care Together – NHSE national team) requested all trusts complete a maturity matrix (self-assessment) which was used to assess our state of readiness against the five domains for quality improvement which are part of a quality management system. We held a workshop in July attended by senior leaders, executives, and non-executive directors to undertake the self-assessment to produce a gap analysis against the following five domains:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability
5. Embedding into management and systems

With 5 being the highest rating (exemplar organisations), our average rating was 2.25. Improvement actions were identified during the workshop and have been incorporated into the Quality Improvement (QI) action plan. The QI teams have continued to work with Divisional teams to ensure their work is focused on Divisional and Trust priorities.

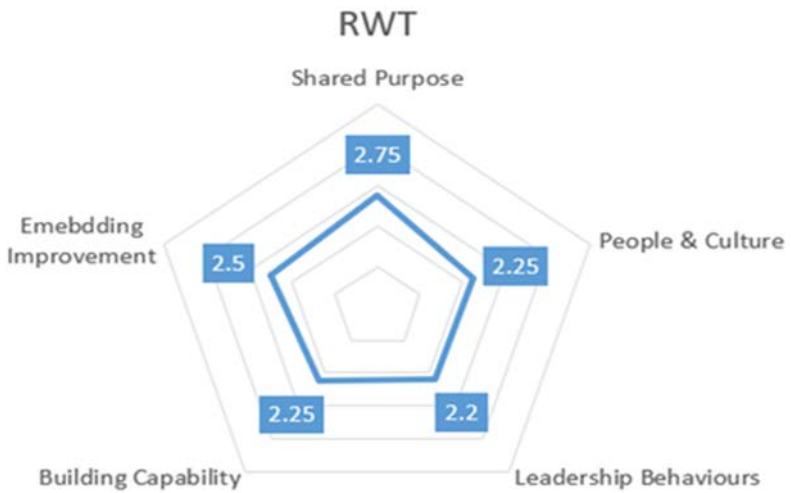
We have delivered training to 97 Managers, Heads of Departments and Leads over the past year, from all Divisions, including Corporate Services and Estates and Facilities. In addition, we have delivered several bespoke QI training sessions incorporating the leadership and wider divisional teams.

We have had great success with the roll-out of our huddle boards and particularly within Estates and Facilities where historically there has been low evidence of engagement in improvement. We currently have eight boards actively being used in both clinical and non-clinical areas with a further five in situ with training taking place. There are a further six requests for boards. In total we have delivered facilitator training to 48 individuals.

Summary	Totals
Boards active and in use	**8**
In progress (the next areas to be active)	**5**
Expressions of Interest	**6**

A training has video has been developed which highlights the great work in the Portering Department and how they have used the huddle board to best effect.

Below is the submitted gap analysis showing our self-assessment against the five domains of a Quality Management System as identified by NHS IMPACT .



We have seen a sustained increase in staff attending the QI training from most of the clinical and non-clinical areas with all our courses fully booked, and additional sessions provided during November and December to address the training waiting list.

Below is a summary of the huddle boards in situ in both clinical and non-clinical areas and across Divisions:

Summary	Totals
Boards active & in use	**8**
In progress (the next areas to be active)	**5**
Expressions Of Interest	**6**

Priority 2: Clinical Effectiveness

Priority and why priority identified
2.1 - Priority area: Our people The right workforce with the right skills, in the right place at the right time.
What we said we would do
• Recruit and retain staff using targeted interventions for different career stages • Improve retention using bundles of recommended high impact actions • Develop and deliver the workforce required to deliver multidisciplinary care closer to home, including supporting the roll-out of virtual wards and discharge to assess models **The aim for 2023/24** • To improve staff turnover by the end of 2023/24
How did we do?
The NHS England five high impact actions for retention have been implemented; this includes the use of the retention self-assessment tool, adoption of the National Preceptorship Framework, the introduction of a legacy nurse mentors pilot scheme, access to pension seminars and introduction of a menopause policy. Adult Community Services have seen significant growth in our Virtual Ward and Discharge to Assess (D2A) services, enabling us to positively support the health and wellbeing of patients while they are returning home from a stay in hospital or are already in the place they call home. To provide a safe and effective service the D2A team is welcoming new roles including a Senior Sister, Patient Flow Coordinator and Trusted Assessors, who will work collaboratively to provide excellent patient care when supporting discharges. Furthermore, the implementation of Digital Nurse roles in The Virtual Ward Team, along with development of an advanced practice led model will maximise our capacity to support even more patients at home, where we offer an alternative to hospital-based care with a variety of pathways. Our staff are enrolled onto an induction boot camp training programme, where we harness the potential of our future workforce to support the development of 'home first' discharge pathways and our innovative virtual ward model. The Trust is pleased to report it has a lower than three per cent vacancy rate and is in an improved position with both normalised turnover and 12-month retention rate.

Looking back 2023/24

Priority and why priority identified
2.2 – Priority area: Cancer treatment
What we said we would do
• Maintain focus on operational performance, prioritising capacity for cancer patients to support the reduction in patients waiting over 62 days • Increase and prioritise diagnostic and treatment capacity for suspected cancer, including prioritising new community diagnostic centre capacity • Implement priority pathway changes for lower gastrointestinal (GI), skin, and prostate cancer **The aim for 2023/24** • Reduction in the number of patients waiting more than 62 days for treatment, and meeting the cancer faster diagnosis standard by March 2024 • 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed, or have cancer ruled out, within 28 days
How did we do?
Throughout 2023/2024 there has been a reduction in 62-day backlog from 246 to 179 currently, with an expected end of year position to be 175. This means we have overachieved against our target of 195. This reduction has been seen across all 62-day pathways including screening and upgrades pathways. As the reduction has been greater than originally anticipated the Trust's overall 62-day performance has been lower than predicted as a reflection of this work. Increased diagnostic capacity and the introduction of the Community Diagnostic Centre has enabled us to achieve the end of year 28-day FDS target ahead of schedule and overachieve the 75% target. The prostate best practice timed pathway (BPTP) set out individual clinical stages; the organisation has adopted this pathway for all prostate patients, however the organisation is currently failing to achieve them within the targeted timescales. Therefore, there is ongoing work to review and improve compliance against this target. Expected end of year position for urology 28-day Faster Diagnosis Standard (FDS) to be 64.1%, which is above the recognised urology FDS expectation of 60%. The Trust has seen the benefit of the introduction of the FIT (faecal immunochemical testing) pathway with a high number of referrals containing a FIT result prompting further investigation. Whilst tele-dermatology was introduced into Wolverhampton in 23/24 the uptake has been slow and works continue to see an improvement in this. Staffordshire successfully rolled out tele-dermatology in January 2024 with all clinically appropriate referrals coming via this route.

Priority and why priority identified
2.3 – Priority area: National Elective Care Strategy Deliver the priorities of the National Elective Care Strategy
What we said we would do
• Deliver an increase in capacity through the community diagnostic centre and theatre expansion programme • Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients • Increase productivity using the GIRFT (Getting it Right First Time) programme and improving theatre productivity **The aim for 2023/24** • Eliminate waits of over 65 weeks by the end of 2023/24 • Meet the 85% theatre utilisation expectation
How did we do?
The Community Diagnostic Centre at Cannock Chase Hospital opened in 2022/23 and was open throughout 2023/24. Circa 77,000 diagnostic tests were undertaken in 2023/24, which has enabled the Trust to increase the percentage of patients having their diagnostic test within six weeks from 48 per cent at the start of 2023/24 to 75 per cent by the end of the year. The Trust has embarked on an outpatient transformation programme which focuses on increasing the use of 'Patient Initiated Follow Up' (PIFU), the use of advice and guidance and reducing the number of DNAs (do not attends). The Trust did not meet the ambition to clear 65-week waits by the end of 2023/24. This was due to the impact of industrial action taken by Junior Doctors and Consultants. The target for clearance of 65-week waits has subsequently been revised, nationally, to the end of September 2024. The Trust cleared its 78-week waits by the end of March 24, in line with the national target. The Trust consistently achieves more than 85 per cent theatre utilisation and is in the top quartile of trusts in the country for theatre utilisation.

Looking back 2023/24

Priority and why priority identified
2.4 - Review of GIRFT(i) and Model health system data(ii) (i) Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. (ii) The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity.
What we said we would do
• Ongoing development and expansion of the clinical fellowship programme • Embrace and adopt required changes to training structure and supervision requirements • Explore options for digital fellowship programmes in collaboration with external stakeholders
How did we do?
The benchmarking data which is available on the Model Hospital portal is utilised in monthly performance meetings held with the Surgical Division and facilitated by the Service Efficiency Team. Each Directorate provides actions and updates based on performance against the metrics. The meeting attendees include the Deputy Chief Operating Officer, Divisional Medical Officers, Divisional Head Nurse and the relevant Clinical Directors and Operational Managers. Areas of focus include day case rates, patient initiated follow ups (PIFU), missed appointments, lengths of stay, surgical readmissions and theatre utilisation. The purpose is to drive efficiencies and to continue to improve patient care whilst identifying opportunities for potential financial benefits. Trust representatives attend national and regional GIRFT meetings wherever possible. The Head of Service Efficiency now meets with the Regional GIRFT lead monthly to update on the Trust's progress and learn of any new initiatives, clinical pathways or guidelines, which are then disseminated to the relevant directorates. It is also an opportunity to discuss shared learning. Action going forward to extend the performance meetings to Division 2 and Division 3 where appropriate.

Priority 3: Patient Experience

Priority and why priority identified

Priority area: Patient involvement

What we said we would do

Focus on the key priorities outlined within the joint Patient Experience Enabling Strategy (2022-2025). These include:

Pillar one – Involvement

- We will involve patients and families in decisions about their treatment, care, and discharge plans.

Pillar two – Engagement

- We will develop our Patient Partner programme and use patient input to inform service change and improvements across the organisation.

Pillar three – Experience

- We will support our staff to develop a culture of learning to improve care and experience for every patient.

How did we do?

The key priority for the Patient Experience Team during 2023/24 was to embed the agreed strategic objectives from the patient experience strategy. This included ensuring that we listen to the patient voice and take meaningful action with a focus on learning from experiences. Putting patient engagement and involvement at the heart of decision making continued to be a priority to drive forward improvements in delivery of care. Some initiatives included:

- Volunteers placed in the discharge lounge to support discharge process. Materials have been created and patients are also signposted to Wolverhampton and South Staffordshire health and social care for additional discharge support – Wolverhampton Voluntary and Community Action now has a social prescriber based with the hospital discharge team.
- Increased visibility of patient representation at various committees and subgroups. More Patient Involvement Partners (PIPs) have been recruited, including community leaders. Engagement meeting held with interfaith leaders and chaplaincy to build links with community leaders. Several PIPs on committees including Policy Group, Environmental Committee and Research.
- Initiatives to promote respect, dignity, and compassion: monthly Bereavement Hub recommenced in partnership with Compton Care (since March 2023), with good and regular attendance. Volunteers are used to support this initiative.
- Patient Feedback Oversight (PFOG) group established with Divisions to discuss themes from all patient experience feedback including formal complaints and Patient Advisory and Liaison Service (PALS) concerns. Patients encouraged to join Patient Involvement Partners (PIPS) to share views. Regular meetings with Healthwatch continue.
- We have engaged with the Parliamentary Health Service Ombudsman's mediation process. The aim is to navigate the barriers which may have prevented explanations or learning from being accepted and to provide the opportunity for both complainants and the Trust to speak and listen to each other.

Looking forward 2024/25

Priorities for improvement: How we choose our priorities

Each year the Trust is required to identify its quality priorities. We consulted on both the quality strategy and annual quality priorities. The draft priorities were shared with commissioners, Healthwatch, our governors, the Trust Management Committee, the executive teams within the divisions, and directorate management teams. The final priorities for 2024/25 were agreed by the Trust Board.

The chosen priorities support several goals detailed in our quality strategy as well as three key indicators of quality:

Patient Safety	Having the right systems and staff in place to minimise the risk of harm to our patients and being open and honest and learning from mistakes if things do go wrong.
Clinical Effectiveness	Providing the highest quality care with world-class outcomes whilst also being efficient and cost effective.
Patient Experience	Meeting our patients' emotional needs as well as their physical needs..

Progress in achieving our quality priorities will be monitored by reporting to the relevant Quality Boards at the Trust.

Looking forward 2024/25

The priorities detailed below have been identified and agreed in the Quality and Safety Enabling Strategy and the Patient Experience Enabling Strategy. These are the first joint strategies for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). The strategies define in detail how we will strive to excel in delivery of care, which is one of the four strategic aims of the joint Trust strategy. These can be located at royalwolverhampton.nhs.uk/about-us/publications-and-documents/

Our key priority areas have been agreed based on information from various local, regional and national sources, including recent engagement with our staff, patients, partners, and the communities we serve.

The priorities identified below are specifically drawn from both the above strategies.

The priorities are captured in the overarching themes of the Quality & Safety Enabling Strategy.

Our People

- Priority Area – The right workforce with the right skills in the right place at the right time

Embed a culture of learning and continuous improvement at all levels of the organisation

- Priority Area – Quality Improvement
- Priority Area – Patient Safety
- Priority Area – Patient Involvement

Prioritise the treatment of cancer patients focused on improving the outcomes of those diagnosed with the disease

- Priority Area – Cancer treatment
- Deliver safe and responsive urgent and emergency care in the community and in hospital
- Priority Area – Urgent and Emergency Care and patient flow

Deliver the priorities of the National Elective Care Strategy

- Priority Area – National Elective Care Strategy

Looking forward 2024/25

Priority 1 – Patient Safety	
Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority area – Patient safety**	**Key actions we will take:** • Transition to the Patient Safety Incident Response Framework (PSIRF) **The aim for 2024/25** • Training Needs Analysis (TNA) completed by March 24 and training commenced • Level 1 & 2 – 50 per cent of priority staff identified in TNA to be completed in 24/25 • Three PSIRF roles – minimum of 30 per cent of need of TNA met by 31 Dec 24 • Implement LfPSE
Deliver safe and responsive urgent and emergency care in the community and in hospital. **Priority area –** **Urgent and emergency care and patient flow**	**Key actions we will take:** Working with partners from across the system, we will support the flow of patients through UEC, by: • Expanding and maintaining the use of same day emergency care (SDEC) services to avoid unnecessary hospital stays • Expanding virtual wards, allowing people to be safely monitored from the comfort of their own homes • Working with partners to speed up discharge from hospital and reduce the number of patients without criteria to reside. **The aim for 2024/25** • Year on year improvement in the percentage of patients seen within four hours in A&E • Consistently meet the 70 per cent two-hour urgent community response time • Reduce number of patients waiting in ED >12hrs following decision to admit • Revise the process of discharge ready date (without criteria to reside)
Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority area – Quality improvement**	**Key actions we will take:** • Produce a gap analysis on how both trusts (RWT/WHT) rank against the four components of a quality management system (quality planning, quality control, quality improvement and quality assurance), and review how we triangulate data to understand priorities • All members of divisional and care group/directorate leadership teams to attend one day quality service improvement and redesign fundamentals • Year-on-year roll-out plan for QI huddle boards across both trusts to targeted areas e.g., low evidence of improvement work, non-clinical areas **The aim for 2024/25** • Build actions/recommendations against gap analysis that was completed during 2023/24 • Increase in the number of staff trained following triumvirate training • Increase use of QI huddle boards per site • Build evidence of huddle board use and improvements identified • Aim to improve NHS Impact self-assessment score

Priority 2 – Clinical Effectiveness

The right workforce with the right skills, in the right place at the right time **Priority area – Our people**	**Key actions we will take:** • Recruit and retain staff using targeted interventions for different career stages • Improve retention using bundles of recommended high impact actions • Develop and deliver the workforce required to deliver multidisciplinary care closer to home, including supporting the roll-out of virtual wards and discharge to assess models **The aim for 2024/25** • To work with system partners to ensure we have appropriate staffing in key areas to facilitate safe, effective patient care
Prioritise the treatment of cancer patients, focusing on improving outcomes for those diagnosed with the disease **Priority area – Cancer treatment**	**Key actions we will take:** • Maintain focus on operational performance, prioritising capacity for cancer patients to support the reduction in patients waiting over 62 days • Increase and prioritise diagnostic and treatment capacity for suspected cancer, including prioritising new community diagnostic centre capacity • Implement priority pathway changes for lower gastrointestinal (GI), skin, and prostate cancer **The aim for 2024/25** • Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75 per cent early diagnosis ambition by 2028 • Maintain focus on performance to reduce, the number of patients waiting over 62 days • Maintain performance against 28-day Faster Diagnosis Standard (75 per cent) • Maintain focus on performance against 31-day decision to treat standard (96 per cent)

Looking forward 2024/25

Deliver the priorities of the National Elective Care Strategy **Priority area – National Elective Care Strategy**	**Key actions we will take.** • Deliver an increase in capacity through the community diagnostic centre and theatre expansion programme • Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients • Increase productivity using the GIRFT (Getting it Right First Time) programme and improving theatre productivity **The aim for 2024/25** • To continue to monitor (and eliminate) over 65 week waits and continue to increase elective activity through increased elective and diagnostic operating at our elective hub in Cannock • To comply with national standards to reduce long waiting times • Meet the 85% theatre utilisation expectation
(i) Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. (ii) The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity. **Review of GIRFT[i] and Model health system data[ii]**	**Key actions we will take.** • Review Model Health System and Getting It Right First Time (GIRFT) data to guide relevant aspects of activity, quality, and safety • Aim for 2024/25 • Through the Further Faster programme, deliver rapid clinical transformation with the aim of reducing 52-week waits in Cohort 1. • Map current pathways against the GIRFT Specialty Outpatient Guidance to identify the gaps and opportunities and implement plans • Engage with the specialty clinical groups to a) overcome barriers to adopting the best practice pathways and b) work together with our national clinical leadership to build on that guidance further • Embed GIRFT/Model Health metrics into directorate and division review processes • Regular benchmarking of GIRFT data and alignment with Quality Improvement plans

Priority 3 – Patient Experience

Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority area – Patient involvement**	**Key actions we will take:** Patient Experience Enabling Strategy (2022-2025). These include: **Pillar one – Involvement** • We will involve patients and families in decisions about their treatment, care, and discharge plans. **Pillar two – Engagement** • We will develop our Patient Partner programme and use patient input to inform service change and improvements across the organisation. **Pillar three – Experience** • We will support our staff to develop a culture of learning to improve care and experience for every patient. **The aim for 2024/25** • We will involve patients and families in decisions about their treatment, care, and discharge plans • Ensuring that people from minorities (ethnic minorities, disabilities, religious groups, LGBT+ groups) have services that do not discriminate and equally meet their needs alongside others • We will support our staff to develop a culture of learning to improve care and experience for every patient • Reducing complaints, learning from them, and encouraging better attitudes and practice from employees • Using our Patient and Partner Experience Group meeting to gain assurance, monitor and manage patient experience workstreams and initiatives • Implement a real time dashboard for directorates to encourage a more proactive approach to patient feedback

Within the Quality and Safety Enabling Strategy there are also several priority areas identified under the overarching theme of "fundamentals", which are based on internal and external priorities. The Trust will also be expected to deliver on the specific objectives linked to the strategy under this section.

Fundamentals – based on internal and external priorities:

- Priority Area – Prevention and management of patient deterioration
- Priority Area – Timely sepsis recognition and treatment
- Priority Area – Medicines management
- Priority Area – Adult and children safeguarding
- Priority Area – Infection prevention and control
- Priority Area – Eat, Drink, Dress, Move to Improve
- Priority Area – Patient discharge
- Priority Area – Maternity and neonates
- Priority Area – Mental health
- Priority Area – Digitalisation

The Quality and Safety Enabling Strategy also includes the following priority area, which is part of the "Care" strategic aim of the Trust Strategy:

Deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations.

- Priority Area – Financial sustainability. This will focus on ensuring that we best use the finite resources available to us, which include (but are not limited to) people, physical capacity and finances, as well as maximising opportunities offered through collaborative working between RWT and WHT.

Statements of assurance from the Board: Mandatory quality statements

During April 2023 to March 2024, 56 national clinical audits and five national confidential enquiries covered relevant health services that Royal Wolverhampton NHS Trust provides.

During that period The Royal Wolverhampton NHS Trust participated in 80 per cent of national clinical audits and 60 per cent of national confidential enquiries in which it was eligible to participate. The reports of 171 local clinical audits were reviewed by The Royal Wolverhampton NHS Trust during April 2023 to March 2024. Of these, 121 demonstrated areas where actions could be taken to improve the quality of healthcare. Details are at Appendix 1.

The national clinical audits and national confidential enquiries in which The Royal Wolverhampton NHS Trust was eligible to participate during April 2023 to March 2024, 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 that audit or enquiry, are as follows:

National programme name	Work stream / Topic name	Participating 23/24	% of cases submitted	Data collection completed during period? Yes / No?
Respiratory Audits	Adult Respiratory Support Audit	Yes	100%	Yes
BAUS Urology Audits	BAUS Nephrostomy Audit	Yes	100%	Yes
Breast and Cosmetic Implant Registry	–	Yes	100%	Yes
Case Mix Programme (CMP)	Intensive Care National Audit and Research (ICNARC)	Yes	Unable to confirm	Unable to confirm
Child Health Clinical Outcome Review Programme - JIA	–	Yes	Unable to confirm	No
Elective Surgery (National PROMs Programme)	Elective Surgery (National PROMs Programme)	Yes	100%	Yes
Emergency Medicine QIPs	Care Of Older People	No - Frailty team already undertaking a similar audit	–	–
	Mental Health (Self Harm)	No - Undertaken previous year, as well as audit of NICE guidance, along with limited capacity	–	–
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	–	No - Limited admin support meant we were unable to participate	–	–
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Yes	100%	Yes
	National Audit of Inpatient Falls	Yes	100%	Yes
	National Hip Fracture Database	Yes	100%	Yes

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National programme name	Work stream / Topic name	Participating 23/24	% of cases submitted	Data collection completed during period? Yes / No?
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	–	No - This is not an audit it is a continual data submission of relevant deaths	–	–
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	No - No report published since 2017, awaiting confirmation from National team around whether reports will be received	–	–
Medical and Surgical Clinical Outcome Review Programme	(NCEPOD) - End of Life	No - Audit undergoing redesign by the national team	–	–
	(NCEPOD) - Crohns	Yes	Unable to confirm	No
	(NCEPOD) - Epilepsy	Yes	Unable to confirm	No
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	100%	Yes
	National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms	Yes	100%	Yes
	National Diabetes in Pregnancy Audit	Yes	100%	Yes
	National Diabetes Core Audit	Yes	100%	Yes

National programme name	Work stream / Topic name	Participating 23/24	% of cases submitted	Data collection completed during period? Yes / No?
National Asthma and COPD Audit Programme (NACAP)	COPD Secondary Care	Yes	100%	Yes
	Pulmonary Rehabilitation Organisational and Clinical Audit	Yes	100%	Yes
	Adult Asthma Secondary Care	Yes	100%	Yes
	Paediatric Asthma Secondary Care	Yes	100%	Yes
National Audit of Cardiac Rehabilitation	–	Yes	Unable to confirm	No
National Audit of Cardiovascular Disease Prevention Primary care	–	No - Directorate decision not to participate	–	–
National Audit of Care at the End of Life (NACEL)	–	No - Audit undergoing redesign by the national team	–	–
National Audit of Dementia (NAD)	–	Yes	100%	Yes
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	–	No - Audits were still in the planning stage	–	–
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	–	No - Audits were still in the planning stage	–	–
National Cardiac Arrest Audit (NCAA)	–	Yes	100%	Yes

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National programme name	Work stream / Topic name	Participating 23/24	% of cases submitted	Data collection completed during period? Yes / No?
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	Yes	100%	Yes
	National Heart Failure Audit	Yes	100%	Yes
	National Audit of Cardiac Rhythm Management (CRM)	Yes	100%	Yes
	Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%	Yes
	National Audit of Percutaneous Coronary Interventions (NAPCI)	Yes	Unable to confirm	No
	National Audit of Mitral Valve leaflet repairs (MVLR)	Yes	Unable to confirm	Unable to Confirm
	The UK Transcatheter Aortic Valve implantation (TAVI Registry)	Yes	Unable to confirm	Unable to Confirm
National Child Mortality Database (NCMD)	–	Yes	100%	Yes
National Comparative Audit of Blood Transfusion	Audit of NICE Quality Standard QS138	Yes	100%	Yes
	Bedside Transfusion Audit	Yes	100%	Yes
National Early Inflammatory Arthritis Audit	–	Yes	100%	Yes
National Emergency Laparotomy Audit (NELA)	–	Yes	100%	Yes
National Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes	100%	Yes
National Joint Registry	–	Yes	100%	Yes
National Lung Cancer Audit	–	Yes	100%	Yes
National Maternity and Perinatal Audit (NMPA)	–	Yes	100%	Yes

National programme name	Work stream / Topic name	Participating 23/24	% of cases submitted	Data collection completed during period? Yes / No?
National Neonatal Audit Programme (NNAP)	–	Yes	100%	Yes
National Ophthalmology Database Audit (NOD)	Adult Cataract Surgery Audit	No - Directorate awaiting 'Open eyes' system to enable participation	–	–
National Paediatric Diabetes Audit	–	Yes	–	No - data collection still in progress
National Prostate Cancer Audit (NPCA)	–	Yes	100%	Yes
National Perinatal Mortality Review Tool	–	Yes	100%	Yes
Perioperative Quality Improvement Programme (PQIP)	–	No - Directorate decision not to participate	–	–
Sentinel Stroke National Audit Programme (SSNAP)	–	Yes	100%	Yes
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	–	Yes	100%	Yes
Society for Acute Medicine Benchmarking Audit (SAMBA)	–	No - Directorate decision not to participate	–	–
Trauma Audit & Research Network (TARN)	–	Yes	100%	Yes
UK Cystic Fibrosis Registry	–	Yes	100%	Yes
UK Renal Registry Chronic Kidney Disease Audit	–	Yes	100%	Yes
National Acute Kidney Injury Audit	–	Yes	100%	Yes

Based on information available at time of publication.

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The reports of 33 national clinical audits were reviewed by the provider in April 2023 to March 2024 and The Royal Wolverhampton NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Actions taken
National Cardiac Audit Program 2021/22 (2023/24)	Presentation and review of national data, no formal action plan required.
National Cardiac Rehabilitation Audit data 2022/23 (2023/24))	Presentation and review of national data, no formal action plan required.
National Adult Cardiac Surgery Audit (2022/23 data) 2022/23	Presentation and review of national data, no formal action plan required.
National Thoracic Surgery Audit 2022/23 DATA (2022/23)	Presentation and review of national data, no formal action plan required.
NCEPOD Acute Bowel Obstruction - Delay in Transit (21/22) (carried over to 23/24)	Presentation and review of national data, no formal action plan required.
UK COVID and Gynaecological Cancer Study (2020/2021)	Presentation and review of national data, no formal action plan required.
MBRRACE (Maternal, Newborn and Infant Clinical Outcome Review) Audit - Perinatal Mortality Surveillance Report-UK Perinatal Deaths for Births (2021/2022)	Areas of minor non-compliance to be addressed by: review local data entry to ensure accuracy and completeness. Ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths to assess care, identify and implement service improvements to prevent future similar deaths.
National Audit: Diabetes in Pregnancy Audit (2021/2022)	National guidelines adopted and used to inform care and practice
MBRRACE-UK (Maternal, Newborn and Infant Clinical Outcome Review Programme)- Perinatal Confidential Enquiry (2019-2021)	Presentation and review of national data, no formal action plan required.
National Service Evaluation- UK CoTS (COVID Trauma Surge) project (2020/2021)	Presentation and review of national data, no formal action plan required.
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Inpatient Falls (2022/2023)	Focused initiatives to improve the quality of MFRA to be implemented across trusts and HBs, these include reviewing data on lying and standing blood pressure measurement and implementing targeted improvement projects where indicated. Review admission assessment process for people who sustain inpatient femoral fractures to ensure effective delirium assessment and ongoing monitoring. Review training and competency requirements to ensure that post-fall checks for injury are effective. Ensure that processes are in place to hasten time to administration of analgesia after an injurious fall.

Audit Title	Actions taken
Re-audit of distal radius fracture management against BOA/BSSH guidelines (2023/2024)	Virtual clinic has been trialled. New pathway set up to improve patient journey. Slightly better times to fracture clinic. Fewer patients needing to have decision altered from presentation as to how to best manage their fracture.
TARN (Trauma Audit and Research Network) 2020/21 Re-Audit	Presentation and review of national data, no formal action plan required.
National Child Mortality Database (NCMD) - 2021/22	Presentation and review of national data, no formal action plan required.
National Child Mortality Database (NCMD) - 2022/23 REAUDIT	Presentation and review of national data, no formal action plan required.
National SAMBA Audit 2022	Areas of minor non-compliance to be addressed by: Adapting the consultant presence in ED and on AMU based on workload to achieve consultant review at the right time.
National Audit of Dementia (NAD)22/23	Areas of minor non-compliance to be addressed by: Improve patient/carer feedback. Simplify the 'About Me' documentation. Improve recording of info dementia on MSS
National Diabetes Foot Care Audit - 2022 data	Presentation and review of national data, no formal action plan required.
Hypoglycaemia audit	Areas of minor non-compliance to be addressed by: Continued review of inpatient glucose levels through COBAS with DSN monitoring weekdays. Target ward areas where education needs are greater with DSN monitoring weekday
Impact of Covid on Pancreatic cancer (CONTACT study) (21/22)	Presentation and review of national data, no formal action plan required.
Microscopic Colitis: A Regional Multi-Centre Audit (MCARMA) 2022	Areas of minor non-compliance to be addressed by: Continued review of inpatient glucose levels through COBAS with DSN monitoring weekdays. Target ward areas where education needs are greater with DSN monitoring weekday
A 'Flash-Mob' UK national audit of the use of Reversal Agents in Patients anticoagulated with Direct Oral anticoagulants (HaemSTAR RAPIDO)	Presentation and review of national data, no formal action plan required.
National Parkinsons audit (22/23) (23/24)	Areas of minor non-compliance to be addressed by: Sentence to be added to the template for the GP letter which lists potential side effects of medication, and nurses to obtain leaflets from PD UK to distribute to patients in clinic.
Tick box to be added to existing proforma to identify discussion regarding daytime sleepiness and if it impacts driving.	
National Lung Cancer Audit 2022	Areas of minor non-compliance to be addressed by: Meeting with cancer services and agree schedule for housekeeping data

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Audit Title	Actions taken
National Lung Cancer Audit 2021 Data	Areas of minor non-compliance to be addressed by the establishment of SBRT at RWH
Management of Community-Acquired Pneumonia (CAP) as per new BCWB Pneumonia guidelines	Areas of minor non-compliance to be addressed by: Regular communication with the ED/AMU teams. Regular educational sessions with the AMU and ED teams. Monthly WhatsApp messages to postgraduate groups/forum. Weekly pneumonia ward rounds
Sentinel Stroke National Audit programme (SSNAP) 2021/22	Data is analysed in Directorate SSNAP meetings and shared within the Team to focus on continual improvements.
Sentinel Stroke National Audit programme (SSNAP) 2022/23	Data is analysed in Directorate SSNAP meetings and shared within the Team to focus on continual improvements.
2021/2022: National Paediatric Diabetes Audit (NPDA)	Annual review checks to be put as a standard on clinic letters. Team education sessions on normalising discussion on weight/ BMI and how to sensitively approach weight issues. Increasing clinic capacity to accommodate for those cancelling appointments.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) (Paediatric) Audit Programme (NACAP) (2021/2022)	The directorate has appointed 2.6 WTE Asthma specialist nurses for children. There is a new team of virtual ward nurses for follow-ups and the directorate has approved the guidelines and is in the process of approving new documents for pathways.
Child Health Outcomes Review - Transition from Child to Adult Health Services (2022/23)	Presentation and review of national data, no formal action plan required.
(CNRT) Motor Neurone Disease Care Audit (22/23)	Areas of minor non-compliance to be addressed by: Continuing to ensure all patients are being weighed
(CNRT) Motor Neurone Disease Care Audit (23/24)	Areas of minor non-compliance to be addressed by: Development of MND specific assessment and review paperwork with built in outcome measure. Identify resources around literature already available for management of breathlessness techniques. Development of a condition companion / patient held document. Audit time taken by qualified staff on patient reviews and the cost effectiveness of this.

Participation in clinical research

National studies have shown that patients cared for in research active NHS Trusts have better clinical outcomes. Ensuring patients are given an option to participate in clinically appropriate research trials is a national and local target and identified by patients as an important clinical choice.

The Royal Wolverhampton NHS Trust's performance in research continues to be on a par with the large acute Trusts within the West Midlands region.

The R&D Directorate team has focused on delivering its recovery and growth programme for healthcare research. A total of 71 new studies were opened during 2023/24. Participants have taken part in research projects across a wide breath of services including Oncology, Haematology, Rheumatology, Neurology, Cardiology/ Cardiothoracic, Obstetrics, Surgery, Paediatrics, Gastroenterology, Respiratory, Diabetes, Ophthalmology, Renal, Stroke/Neurology and Primary Care.

Our 2023/24 research participant survey, completed by 119 participants, showed:

- **87% felt fully informed about the study prior to taking part**
- **88% felt valued for taking part in the research study**
- **92% felt they were always treated with courtesy and respect**
- **80% would consider taking part in research again**

Use of the CQUIN payment framework

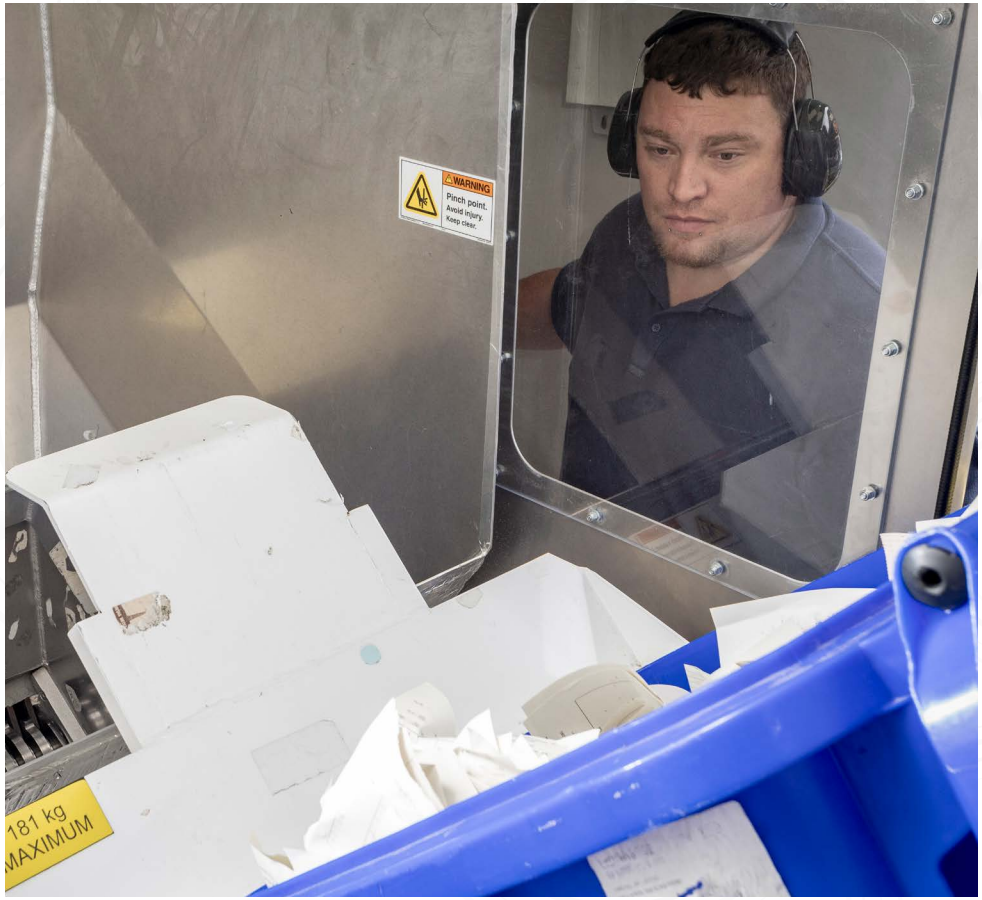
A proportion of The Royal Wolverhampton NHS Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between The Royal Wolverhampton NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Statements from the Care Quality Commission

The Royal Wolverhampton NHS Trust is required to register with the Care Quality Commission and its current registration status is registered 'without conditions or restrictions'.

The Care Quality Commission has not taken enforcement action against Royal Wolverhampton NHS Trust during 2023/24.

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



Our data quality

The Royal Wolverhampton NHS Trust submitted records during 2023/24, (current data available up to Month 10, April 2023-January 2024) 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:

- 99.8% for admitted patient care.
- 99.9% for outpatient care, and
- 99% for accident and emergency care.

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

- 99.6% for admitted patient care
- 99.7% for outpatient care, and
- 100% for accident and emergency care.

Clinical coding error rate

The Royal Wolverhampton NHS Trust was not subject to the Audit Commission Payment by Results clinical coding audit during 2023/24.

The Royal Wolverhampton NHS Trust has taken the following actions to improve data quality:

The annual external Data Security and Protection Toolkit (DSPT) clinical coding audit took place during 2023/24, achieving an overall 'Standards Exceeded' rating in all areas.

A programme of continuous improvement audits on clinical coding is in place and monthly audits take place. The Trust has a robust two-year training programme for trainee coders and existing staff undertake coding training workshops yearly. In addition, all mandatory national training is completed yearly, ensuring all coders are compliant with training requirements.

Key achievements in 2023/24:

- Achievement of 'Standards Exceeding' for DSPT
- In depth speciality and clinical coder-based audits improving quality from the previous year,
- Continued engagement with consultants and clinical teams
- Improved depth of coding

Clinical coding/data quality reports are in place to ensure quality of clinical coding is maintained and continually improved. Examples include Hospital Evaluation Data (HED) Report, SHMI and Data Quality Maturity Index (DQMI).

Further information

The Trust continually monitors data quality by external and internal data quality dashboards audits and reporting suites, identifying any areas that may require further focus.

External reports are used to monitor data quality within the organisation via Secondary Uses Service (SUS) Data Quality Dashboards, Data Quality Maturity Index (DQMI) and University Hospitals Birmingham Hospital Evaluation Data tool (HED).

The corporate Data Quality team continues to provide assurance to support the improvement of data quality within The Royal Wolverhampton NHS Trust, which helps to underpin the provision of excellent services to patients and other customers.

- First point of call, answering and resolving thousands of queries and helping to support teams in ensuring all data is recorded accurately, timely, Completely, meeting all standards
- Support for IT projects continued, with testing, validation and systems expertise provided by the team
- Promotes compliance to data quality within the Trust and getting the data right at point of entry
- Creation of new data quality dashboards to show both good compliance and areas of improvement
- Encourage good data quality beyond our usual KPIs; this includes audits into additional information such as ethnicity
- The Trust has a data quality forum with terms of reference, chaired by the Head of Clinical Coding and Data Quality
- The data quality department is responsible for monitoring and recording data quality issues identified in the organisation and for ensuring action plans are in place to address these. The department reviews the issues and prioritises them on the issues log, holds action plans for issues and manages progress against these.
- Compliance is checked against indicators to assess the quality of the patient information on our patient administration systems
- The Trust's Data Quality Policy is in place and was reviewed in October 2022.

Data security and protection toolkit

Summary of serious incident requiring investigations involving personal data, as reported to the Information Commissioner's Office in 2023/24.

The table below details the incidents reported on the NHS Digital incident reporting tool and to the Information Commissioner's Office (ICO), within the financial year 2022/2023. Any incidents that are still being investigated for the period 2022/23 are not included. The incidents listed below are for the Royal Wolverhampton NHS Trust and GP partnerships that have joined the Trust, as listed below.

Date incident occurred (Month)	Nature of incident	Number of data subjects	Description/nature of data involved	Further action on information risk
June 2023	Unauthorised access	<10	Staff member staff has accessed record pertaining to family members. Following a complaint received and audit of the records the access was seen to have occurred on numerous occasions without a clear justification. Staff member was questioned and confirmed unauthorised access.	HR investigation has been carried out
July 2023	Unauthorised disclosure	1	Staff member shared information about a patient with their family member and the family member happened to be a work colleague of the patient. Family member made direct contact with the patient regarding their health and discussed the patients' health with other work colleagues	HR investigation has been carried out

Overview of incidents classified at lower severity level - Incidents classified at severity level 1 or below are aggregated and provided in table below. Please note this is not all incidents, just level ones and below against the below listed categories:

Summary of other personal data related incidents in 2023-24		
Category	**Breach type**	**Total**
A	Corruption or inability to recover electronic data	1
B	Disclosed in Error	109
C	Lost in Transit	1
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	19
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	1
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	67
J	Unauthorised access/disclosure	2
	Total	**200**

Data Protection and Security Toolkit Return 2022/2023 – final submission

The Royal Wolverhampton NHS Trust	RL4	Standards Met
Alfred Squire	M92002	Standards Met
West Park Surgery	M92042	Standards Met
Thornley Street	M92028	Standards Met
Lea Road	M92007	Standards Met
Penn Manor	M92011	Standards Met
Coalway Road	M92006	Standards Met
Warstones	M92044	Standards Met
Oxley Surgery	M92014	Standards Met
Tettenhall Road Medical Practice	M92640	Standards Met

An internal audit of the DSP toolkit in March 2023 had provided substantial assurance of the processes and evidence for this year so far 2023/24, the final submission for which is due in June 2024.

Looking forward to 2024/25 data security and protection

The Trust continues to monitor patterns and trends of data security incidents and implementing measures to reduce these to the lowest level practicable. Current risks include continued and increasing risk of external threats in relation to cyber security, particularly via email phishing. Other risks to data security include disclosure in error via various means, and this is attributed to the ways of working in health, with increased remote working.

The Trust remains focused on embedding principles of privacy by design into Trust processes, from procurement to digital innovation and service redesign. This programme of work will be monitored though the committees below.

- The Trust has several committees dedicated to reviewing assurance in relation to DSPT and GDPR, chaired by senior board members.
- The Chief Medical Officer is the Trust's trained Caldicott Guardian and is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that Trust satisfies the highest practical standards for handling patient identifiable information and Chairs the Information Governance Steering group.
- The Chief Financial Officer is the Trust's Senior Information Risk Officer (SIRO) and is responsible for monitoring the Trust's overall information risk, ensuring we have a robust incident reporting process for information risks. The SIRO reports to the Trust Board and provides advice on the matter of information risk. The SIRO is also a member of the IG steering Group and co-chair of the GDPR implementation group.
- The Trust has an assigned Data Protection Officer (DPO) who acts independently to ensure compliance with the GDPR as well as monitoring its application across the Trust. The DPO has a reporting line into the Caldicott Guardian through to the Trust board.
- The Trust is in the process of implementation a robust asset management system and defining establishing clear responsibilities for Information Asset Owners across the Trust to facilitate robust and timely escalation of information risk escalation to the SIRO.
- All Trust staff receive appropriate annual training to ensure data security and protection principles are embedded within their understanding.
- This year the Trust has introduced a mandatory cyber training package for all staff.
- The Trust board and its members have also received specialist cyber training.

Seven Day Services

The Trust is assured that as in previous years we are compliant with the Seven Day Hospital Services Clinical Standards. There have been no changes to medical staffing cover and there is consultant cover within job plans seven days per week for all specialties.

Core Quality Indicators - Summary Hospital Level Mortality Indicator (SHMI)

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

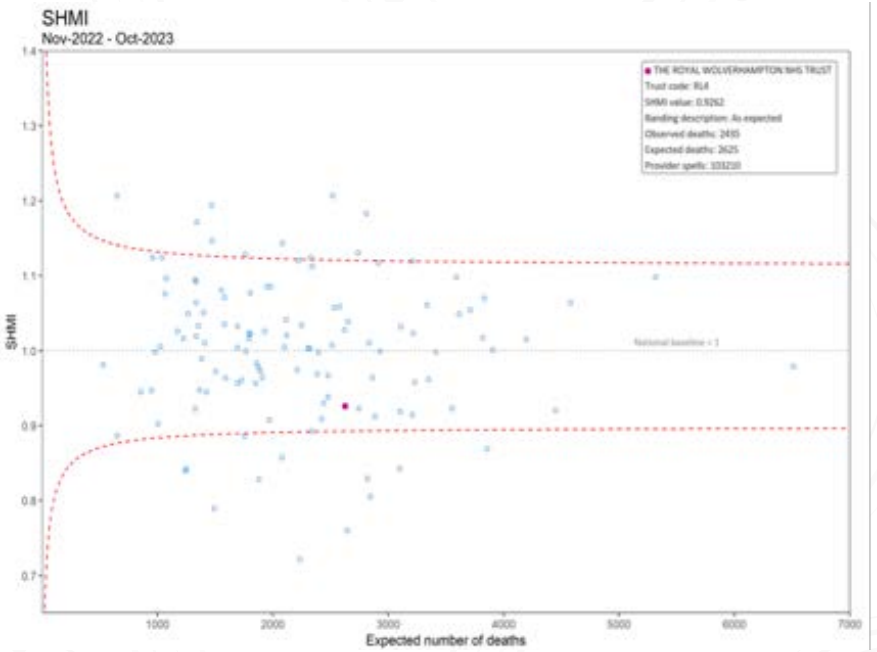
The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the trust for the reporting period and

The Summary Hospital-Level Mortality Indicator (SHMI) is the most used indicator to compare the number of deaths in the Trust with the number expected based on average England figures, taking into account particular characteristics, e.g., age, co-morbidities and diagnosis profile. The score includes the deaths in hospital as well as those that occur within 30 days of discharge over a rolling year.

The Trust has been categorised as being "within the expected" range for more than two years.

Where it is suspected that a death is more likely than not due to problems in care, an investigation is conducted via root cause analysis to understand the reasons and draw up robust action plans.

Indicator	September 2022 to August 2023	October 2022 to September 2023	November 2022 to October 2023
SHMI RWT	0.911	0.926	**0.926**
SHMI England	1	1	**1**



The Royal Wolverhampton Trust has a robust mortality governance process underpinned by the Learning from Deaths programme.

- The Trust continues to have reviewing and investigation mechanisms for the SHMI, overseen by the Mortality Surveillance Group and Mortality Review Group (MRG). Diagnosis groups with a higher-than-expected SHMI are investigated by a data quality review followed by a case note review were indicated with results presented at a clinical pathway meeting where the focus is on quality improvement, and it is subsequently reported to MRG.
- SHMI on its own is not a quality metric. The Trust continues with a key programme of work designed to scrutinise clinical care, provide assurance that gaps in care are identified and acted upon, gaps in quality of documentation are identified and corrected and systems of care provision are developed to the benefit of individual patients and the wider population.

This programme of work has developed over the last 12 months and include a programme of continuous quality improvement including:

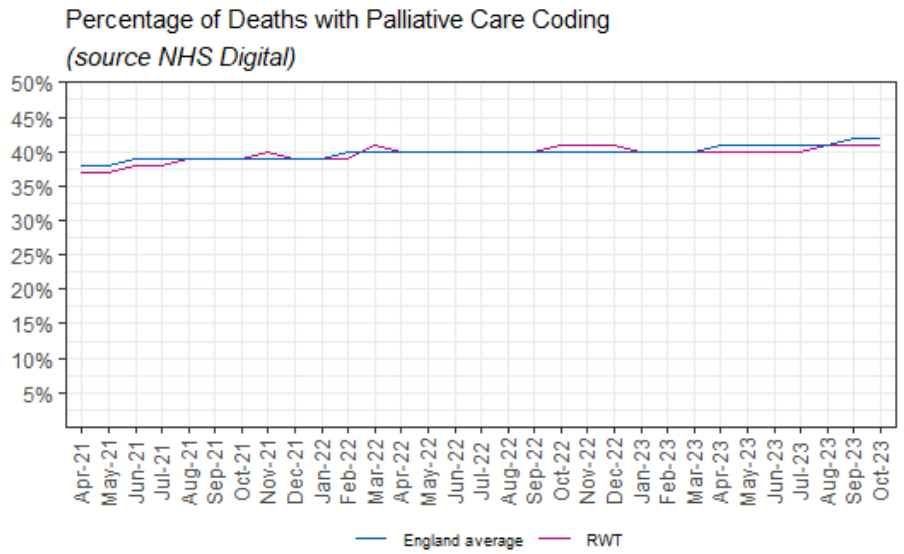
- Focus on specific diagnostic groups including assurance of clinical pathways and developments of resultant action plans.
- Review mortality parameters to ensure any potential alerts or signals are evaluated promptly along with review of clinical pathways when required to support quality improvement.
- Continue scrutiny and review of all deaths in hospital via the Medical Examiner and Mortality Reviewer processes.
- Expansion of the Medical Examiner Service to undertake reviews of deaths in the non-acute (community setting) for Wolverhampton and a catchment area within South Staffordshire.
- Expansion of the Mortality Reviewer process to the vertically integrated primary care network (PCN) – RWT PCN – to capture learning across the entire patient pathway.
- Continue to monitor and improve the quality of coding and documentation.
- Learning from deaths, including listening to the bereaved families and carers and involving them in key processes.
- Align the sharing of learning from deaths with the Trust Learning Framework.
- Provision of end-of-life care in patients' homes and care homes with an emphasis on admission avoidance where appropriate.

Progress against the agreed actions is monitored by the relevant quality boards and mortality associated reports are regularly presented to the Trust Board.

Core Quality Indicators – Summary of patient death with palliative care

Percentage of deaths with palliative care coding, recorded at diagnosis or specialty level:

	RWT	England Avg
% of Spells with Palliative Care Coding	1.5	1.9
% of Deaths with Palliative Care Coding	41	42



The Royal Wolverhampton Trust intends to take/has taken the following actions to support palliative care provision:

- Business case submitted for expansion of the Specialist Palliative Care Team in view of increased referrals and activity levels.
- Ongoing development of the Supportive Care Virtual Ward in conjunction with RWT adult community services.
- Use of PRADA – proactive risk-based assessment tool – to identify patients in last year of life, facilitating earlier intervention and advance care planning including the use of PRADA care plans.
- Ongoing collaborative working between RWT adult community services and Compton Care as part of OneWolverhampton Palliative and End of Life Care Group.
- Use of Signs, Words, Actions, Needs (SWAN) model of care across the organisation to support patients in the last days of life.

Core Quality Indicators – Learning from deaths

	Prescribed information	Form of statement
A	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During the reporting period April 2023 to March 2024, 2,185 adult inpatient deaths were recorded at RWT. This is broken down into deaths which occurred in each quarter: • 492 deaths in quarter one • 471 deaths in quarter two • 580 deaths in quarter three • 642 deaths in quarter four
B	The number of deaths included in item A which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	As of 2 April 2024, of the 2,185 deaths recorded, there have been 565 case record reviews (SJRs) and 12 investigations (RCAs) carried out. In 12 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: • 332 Medical Examiner assessments + 140 SJRs + 5 RCAs in the first quarter • 319 Medical Examiner assessments + 135 + 7 RCAs in the second quarter • 360 Medical Examiner assessments + 209 SJRs + 0 RCAs in the third quarter • 517 Medical Examiner assessments + 81 SJR + 0 RCAs] in the fourth quarter Please note: 83 Structured Judgement Reviews stage 1 (SJR1) remain outstanding across Q4. Cases that have been through Medical Examiner (ME) process are included in the above figures. Patient Safety Incident Response Framework (PSIRF) was implemented during 23/24 which will affect the number of RCAs going forward. Key themes through Learning from Deaths have been used to develop the Trust's Patent Safety Incident Profile

C	An estimate of the number of deaths during the reporting period included in item B for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	A total of two cases (representing 0.09% of the adult inpatient deaths) during the reporting period are judged "more likely than not to have been due to problems in the care provided to the patient". In relation to each quarter, this consisted of: • [0.02%] one case for the first quarter • [0.07%] one case for the second quarter • [0.0%] no cases for the third quarter • [0.0%] no cases for the fourth quarter These numbers have been determined using evidence from the Root Cause Analysis (RCA) investigations involving deaths that were subject to review under the serious incident framework. The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated.
D	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C.	Themes that have emerged from reviews of deaths at the Trust include: • Communication • Documentation • Consistent seven-day senior medical cover
E	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item D).	Actions identified from those adult patients identified in item C are as follows: • Focus to improve documentation ensuring all ward round entries are recorded contemporaneously in the presence of the senior medic • Improved communication between and within teams by focussing on safety brief, handover, and huddle • Provision of consistent seven-day senior medical cover and establish mechanism to manage complex patients including provision for MDT discussions • Training package to complement existing corporate training on unconscious bias as part of human factors training, and specifically targeted at healthcare practitioners. All learning shared via ward and divisional meetings, Governance meetings and Trust Groups.
F	An assessment of the impact of the actions described in item E which were taken by the provider during the reporting period.	The Trust continues with a key programme of work designed to scrutinise clinical care, provide assurance that gaps in care are identified and acted upon, gaps in quality of documentation are identified and corrected and systems of care provision are developed to the benefit of individual patients and the wider population. The Trust continues to have reviewing and investigation mechanisms overseen by the Mortality Surveillance Group and Mortality Review Group (MRG). In addition, the focus will remain on ensuring that the learning identified though the Trust's mortality review process is systematically implemented and fed into the PSIRF and QI processes.

G	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item B in the relevant document for that previous reporting period.	81 case record reviews and four investigations completed after 1 April 2023 which related to deaths which took place before the start of the reporting period.
H	An estimate of the number of deaths included in item G which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0.05% (one case) of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
I	A revised estimate of the number of deaths during the previous reporting period stated in item C of the relevant document for that previous reporting period, taking account of the deaths referred to in item H.	0.02% of the patient deaths during 2022/23 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Core Quality Indicators – Summary of Patient Reported Outcome Measures (PROMS)

There were an insufficient number of records submitted for data analysis and the directorate are now reviewing the process to capture this data to improve submissions and data for future years.

Core Quality Indicators – Re-admission rates

Adult readmission rates remain largely unchanged from previous years, with all initiatives continuing.

Work within the Trust to deliver the right care at the right time and the right location continues to be a focus. For a number of patients this means safely avoiding a patient's admission or facilitating an earlier discharge with ongoing support and monitoring at home.

Key areas of work include:

- Work to deliver Same Day Emergency Care within Medicine, Frailty, Gynaecology, Head and Neck and Surgery
- Further development and use of Virtual Wards including Paediatrics
- Ongoing expansion of the huddle tool to support timely discharge
- Flow initiatives including criteria led handover and criteria led discharge

Readmissions in RWT

All data from PAS, using the national definition of a readmission 2015/16-2022/23

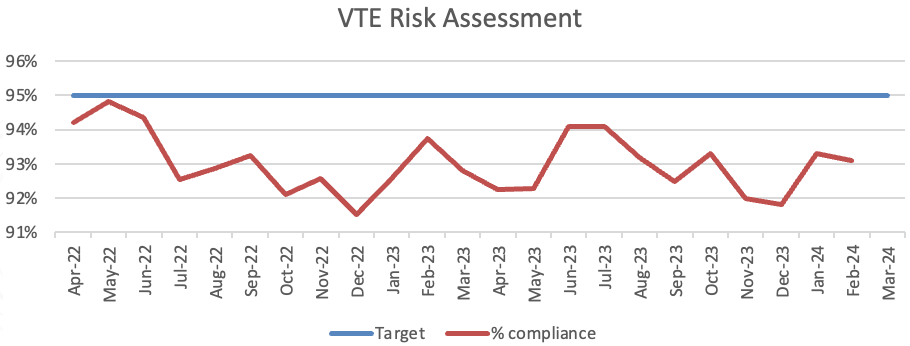
Readmissions										Grand Total
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	
Aged 4-15	440	505	423	359	428	269	348	443	**612**	**3,827**
16yrs and over	5,966	5,443	5,165	5,677	6,018	4,051	7,967	8,659	**9,816**	**58,762**
Grand Total	**6,406**	**5,948**	**5,588**	**6,036**	**6,446**	**4,320**	**8,315**	**9,102**	**10,428**	**62,589**

Total Admissions										Grand Total
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	
Aged 4-15	5288	5429	5117	4,668	4,813	2,899	4,078	4,592	**5,076**	**36,884**
16yrs and over	115,288	118,585	117,355	117,669	120,049	90,876	136,824	147,554	**157,780**	**964,200**
Grand Total	**120,576**	**124,014**	**122,472**	**122,337**	**124,862**	**93,775**	**140,902**	**152,146**	**162,856**	**1,001,084**

Percentage Readmissions										Grand Total
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	
Aged 4-15	8%	9%	8%	8%	9%	9%	9%	10%	**12%**	**10%**
16yrs and over	5%	5%	4%	5%	5%	4%	6%	6%	**6%**	**6%**
Grand Total	**5%**	**5%**	**5%**	**5%**	**5%**	**5%**	**6%**	**6%**	**6%**	**5%**

Core Quality Indicators – Venous thromboembolism (VTE)

Mandatory data collection to quantify the numbers and proportion of inpatient hospital admissions aged 16 and over who receive a risk assessment for venous thromboembolism (VTE) to allow for appropriate preventative measures to be given based on national NICE guidance.



National data submission has remained suspended since March 2020 due to COVID pandemic therefore there is no national data available for comparison.

Venous thromboembolism (VTE) or blood clots is a major cause of death in the UK. Hospitalisation on its own is a significant risk factor. The risk of hospital-associated blood clots can be reduced by assessing an individual's predisposing risk factors for blood clots and reason for admission, then administering preventative measures. The national target is that 95% of all patients over the age of 16 have a VTE risk assessment on admission. Our data reports all inpatients who received an individual VTE risk assessment within 24 hours of admission or met the criteria for a low risk COHORT group as approved by the medical director.

Despite the challenges of recent years we have continued to internally monitor our VTE risk assessment compliance. The timeliness of VTE risk assessment has been below our expected criteria. Patient safety and effective care remain our priority. Improving VTE risk assessment completions within 24 hours remains our key target for the coming year as is ensuring patients receive care as per their VTE risk assessment. VTE group continue to explore new digital options to improve compliance. We continue to provide support to and work closely with clinical areas to develop local improvement plans. We are currently working with the governance and informatics teams to develop a trust VTE dashboard.

NHS England resumed national data submission and publication as of 1 April 2024.

Core Quality Indicators – Clostridium difficile

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Trust apportioned cases (hospital and community onset cases)	45	43	46	57	72	**80**
Trust apportioned cases hospital onset only (excludes community onset cases)	37	33	35	44	58	**56**
Trust bed days (calculated using hospital onset cases and rate)	288836	291777	230111	275517	275534	**276270**
Rate per 100,000 bed days (hospital onset cases only)	12.81	11.31	15.21	15.97	21.05	**20.27**
National average (hospital onset cases only)	14.93	15.59	18.60	18.93	22.83	**23.46**
Best performing Trust (hospital onset cases only)	0	0	0	0	0	**0**
Worst performing Trust (hospital onset cases only)	90.22	64.61	80.65	59.03	81.3	**67.28**

**These bed days have been calculated using C. difficile number and rate (data supplied by UKHSA).*

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons: The Trust collates numbers monthly and submits to UKHSA. Figures for apportioned cases, apportioned cases (hospital onset healthcare associated cases only), rate per 100,000 bed days and national figures have all been taken from the UKHSA Healthcare Associated Infection Mandatory Surveillance Data Capture System. Bed days have been calculated using the apportioned cases (hospital onset only) and the rate per 100,000 bed days.

The Royal Wolverhampton NHS Trust continues to implement a C. difficile action plan, to include ongoing weekly C. difficile and antimicrobial stewardship ward rounds, education of ward staff, C. difficile toolkits monthly to assess cases, and thematic review of cases. Due to pressures across the hospital, it was not possible to complete a full deep clean in 2022/23, nor reliably perform weekly hydrogen peroxide vapour decontamination of side rooms.

Core Quality Indicators – Incident reporting

The data made available to the Trust by the information centre regarding Incident Reporting:

2022/23 (full year data)			2023/24 (full year sata)		
Incidents	**% resulting in death**	**% resulting in severe harm**	**Incidents**	**% resulting in death**	**% resulting in severe harm**
16681	0.2% (26)	0.2% (32)	**20147**	**0.1% (17)**	**0.2% (31)**

The Trust defines severe or permanent harm as detailed below:

Severe harm: a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

Permanent harm: permanent lessening of bodily functions; including sensory, motor, physiological or intellectual. It is harm directly related to the incident and not related to the natural course of a patient's illness or underlying condition.

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

- The Trust has a well embedded reporting culture as evidenced by benchmark comparisons within the National Learning and Reporting System (NRLS).
- It promotes the reporting of near miss incidents to enable learning and improvement and undertakes data quality checks to ensure that all patient safety incidents are captured and appropriately categorised to submit a complete data set and to enable wider learning from adverse events.

Core Quality Indicators – National Inpatient Survey 2022

National Inpatient Survey 2022 (published 12 September 2023)

The 2022 National Inpatient Survey is the third "mixed mode" national survey undertaken as part of the CQC patient experience survey programme. The survey used online completion, SMS reminders and paper questionnaires. Feedback was gathered from people who attended services in November 2022. The Trust's results can be accessed directly on the link below.

The Royal Wolverhampton NHS Trust - Care Quality Commission (cqc.org.uk)

Overall, some positive scores when comparing to other Trusts within the region: in terms of categories, the Trust featured in the top five regionally for "Hospital and Ward" and "Operations and Procedures". The Trust did not feature in the bottom five regionally in any category.

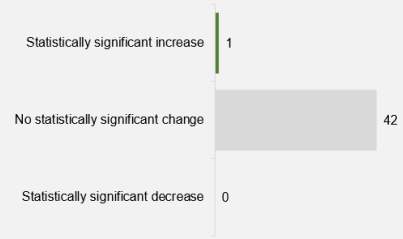
Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

Comparison with last year's results

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2021 results.



Where patient experience is best

- ✓ Quality of food: patients describing the hospital food as good
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed
- ✓ Noise from other patients: patients not being bothered by noise at night from other patients
- ✓ Involvement in decisions: patients being involved in decisions about leaving hospital, if they wanted to be
- ✓ Understanding information on discharge: patients understanding the information given about what they should or should not do after leaving hospital

Where patient experience could improve

- ○ Feedback on care: patients being asked to give their views on the quality of their care
- ○ Including patients: patients feeling included in nurses' conversations about their care
- ○ Answers to questions: doctors answering patients questions in a way they could understand
- ○ Answers to questions: nurses answering patients questions in a way they could understand
- ○ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night

Actions

Actions in place or underway to address areas of concern or where improvements can be made are:

- Friends and Family Test: A series of outreach activities to support inpatient areas to improve the Trust's overall response and recommendation rate, where there is notable month-on-month decline in performance for inpatient areas. This will help progress the Trust's ambition to achieve and maintain a recommendation rate of 92%
- Statutory complaint outcomes: High volume of cases not upheld. A review of determination made by investigating officers will be undertaken to provide assurance of accuracy of self-determination
- Increased volume of complaints: The triangulation of other feedback metrics indicative of trend to be undertaken at directorate level
- Complaint breaches: Positive improvement in July, however ambition to return to 100% compliancy. Additional measures to be implemented to support directorate compliance
- Volunteering: A further cohort to be recruited to assist in clinical areas during winter pressures
- DNA support project: To gain and evaluate measurable data of the direct impact of volunteer support.

Core Quality Indicators – Patient Friends and Family Test (FFT)

Patient recommendation to friends and family

The Friends and Family Test (FFT) is a nationwide initiative which is a simple, single question survey which asks patients to what extent they would recommend the service they have received at a hospital department to family or friends who need similar treatment. The tool is used for providing a headline metric which, when combined with a follow up question and triangulated with other forms of feedback, is used across services to drive a culture of change and of recognising and sharing good practice.

Results of these surveys are received monthly and shared at Directorate, Divisional and Trust Board level and updated onto the Trust-wide software Inphase.

We believe that patient recommendation to their friends and family is a key indicator of the quality of care we provide. We believe our performance reflects that:

- The Trust has a process in place for collating data on the Friends and Family Test
- Data is collated internally and then submitted monthly to the Department of Health and Social Care
- Data is compared to our own previous performance, as set out in the table below

The Friends and Family Test recommendation scores are illustrated in the tables below. The charts show the fluctuation in scores over the last financial year. The Trust's average recommendation score for 2022/23 was 84.75 per cent.

	30/04/2023	31/05/2023	30/06/2023	31/07/2023	31/08/2023	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024	29/02/2024	31/03/2024
Trust overall Response Rate (%)	14%	14%	14%	14%	16%	15%	15%	14%	13%	14%	13%	13%
Trust overall Would Recommend Rate (%)	86%	86%	83%	85%	87%	85%	86%	85%	84%	84%	83%	83%

Statements of Assurance

Friends and Family Test	Inpatients and Day case (consolidated)				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2023/24	93%	93%	92%	93%	94%	93%	94%	94%	71%	71%	69%	67%	93%	91%	92%	92%
2023/24 Comparison against 2022/23	1%	1%	1%	1%	1%						4%	5%	3%	4%	2%	1%
Response Rate 2023/24	22%	22%	20%	21%	15%	17%	14%	15%	16%	16%	15%	13%	6%	7%	6%	6%

Friends and Family Test	Antenatal				Birth				Postnatal Ward				Postnatal Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2023/24	77%	82%	83%	78%	90%	92%	93%	95%	88%	86%	77%	82%	84%	89%	80%	81%
2023/24 Comparison against 2022/23		-5%	5%	-8%	-1%	-3%	3%	2%	8%	4%	-7%	-5%	-2%	7%	-3%	-1%
Response Rate 2023/24	5%	5%	5%	4%	10%	13%	11%	12%	11%	11%	10%	11%	13%	16%	13%	14%

Q4 data subject to change in line with March 2023 data submissions for FFT being after reporting date

Core Quality Indicators – Supporting our staff

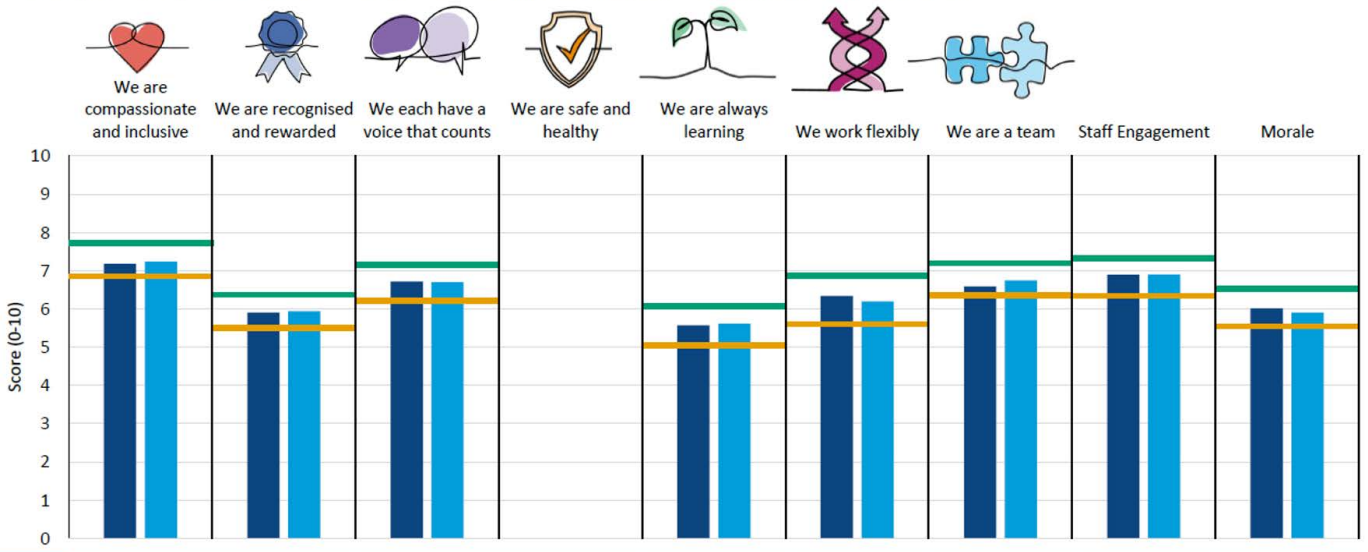
The Trust is one of the largest employers in its local community, employing 10,652 people. The Trust has several ways of engaging staff to improve employee engagement and to support staff to continuously strive for excellence in patient care. The efficacy of the Trust's staff engagement approach is measured principally through the annual national NHS Staff Survey and Quarterly Pulse Survey.

NHS Staff Survey Results

For 2023, the People Promise indicator of 'we are safe and healthy' has not been published with the results due to a data quality issue, therefore the results focus on eight indicators related to the People Promise elements and the themes of Staff Engagement and Morale.

In comparison to other acute and acute and community Trusts, we scored higher than average on we each have a voice that counts, we work flexibly and for morale. Our scores were below average on we are compassionate and inclusive, we are recognised and rewarded, we are always learning, we are a team, and for staff engagement.

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.17	5.91	6.72	-	5.57	6.34	6.59	6.89	6.01
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	2611	2609	2585	-	2467	2587	2606	2611	2613

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

The People Promise scores for RWT show an improvement from the 2022 results in the areas of we are recognised and rewarded and for the theme of morale, with a statistically significant improvement for we are always learning, and we work flexibly. We endeavour to continue to develop our staff to maximise their potential and offer flexible working policies to attract and retain staff.

The Royal Wolverhampton NHS Trust is committed to, and continuously strives to, provide the right conditions for our staff and in turn improve patient experience and outcomes. This is confirmed through staff responding that they would recommend the Trust as a place to work (65.66 per cent) and receive care (65.62 per cent), which both score above the sector average.

The Trust's staff engagement levels have dropped below the national average of comparator organisations. We have also seen a decline in our scores in relation to we are compassionate and inclusive, we each have a voice that counts, and we are a team. The Trust intends to address this through the priority areas of our new people and organisational development strategy: Leading by putting our people first, ensuring equality, diversity, and inclusion in all that we do, being a safe and healthy place to work and retaining and developing the workforce of today and for the future. The Trust has developed a new Joint Behavioural Framework: Caring for All, which outlines the standards of behaviour we expect from our staff. This will help the Trust to create a listening, kind, inclusive and professional organisation where staff can thrive.

Supporting staff through speaking up

The Royal Wolverhampton NHS Trust has been committed to its Freedom to Speak Up (FTSU) journey and the Guardian role since October 2016, following the recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). The FTSU Guardian is an independent role that focuses on creating an open and honest reporting culture, enabling staff to talk about anything that could compromise good patient care. The Trust Board has shown its full commitment and support to embed FTSU within the organisation, placing emphasis on creating a culture were speaking up becomes business as usual.

All staff have the option of raising concerns to their line manager in the first instance or to the next level of management if they feel unable to speak with their line manager. If staff feel unable to do this, for whatever reason, they can approach HR, a trade union representative, or the Freedom to Speak Up Guardians. Two types of referral are available: identified and anonymous.

When staff request an appointment, they can expect to:

- Talk through their concern in a safe space
- Have their concern kept confidential (within the set limits of confidentiality)
- Discuss the options of support available
- Be signposted to support from other staff in the Trust if appropriate
- Be offered support that is impartial and objective
- Receive practical and non-judgemental advice

Staff are routinely sent an email following their first appointment with a summary of next steps or action points, which includes how any issues that have been raised will be addressed. Staff are given the opportunity to feedback and have a follow-up call. Any agreed actions are monitored by the Guardian and feedback is given to the staff member as appropriate.

Within follow-up calls/discussions, the Guardian will monitor the impact of raising concerns on the staff member, ensuring they do not feel at a disadvantage. If detriment is experienced, this is followed up by the Guardian to explore further, and to prevent further detriment where possible.

Guardian of Safe Working

Safety is a high priority for the Trust. The 2016 Terms and Conditions for Doctors and Dentists in training posts safeguards their working hours in terms of total hours worked, breaks whilst at work, and rest periods between shifts. The Guardian of Safe Working monitors compliance with these hours through exception reports submitted by individual doctors where those hours conditions are breached. This is to prevent tiredness and fatigue and in turn support patient and staff safety.

Exception reporting software allows oversight of hours breaches, enabling the monitoring of trends such that underlying causes for these can be identified and addressed. A total of 42 exception reports were submitted in 2023/2024. Rostering for doctors is migrating to the same software, allowing greater oversight of rota gaps in order to further improve working hours safeguards.


PHILIPS


metos


Kolmi


PHILIPS

Review of Quality Our performance in 2023/24

Overview of the quality of care based on Trust performance

As part of the standard NHS contract, the Trust is required to monitor and report performance against a set of key metrics. These indicators are all reported to the Trust Board bi-monthly through our Integrated Quality and Performance Report (IQPR).

Our performance for 2023/24 is shown below. The Covid-19 pandemic continues to impact our performance with a number of national standards having changed since the pandemic and a number of new metrics being introduced.

Performance against the National Operational Standards:

Indicator	Target 2023/24	Performance		
		2023/24	2022/23	2022/22
Cancer two week wait from referral to first seen date	93%	Indicators removed from 1 October 2023 as part of review of cancer standards	80.9%	81.9%
Cancer two week wait for breast symptomatic patients	93%		84.3%	36.7%
Cancer 31 day for second or subsequent treatment - Surgery	94%		54.7%	63.8%
Cancer 31 day for second or subsequent treatment - Anti cancer drug	98%		82.4%	96.6%
Cancer 31 day for second or subsequent treatment - Radiotherapy	94%		82.3%	85.0%
Cancer 62 day wait for treatment from Consultant screening service	90%		37.2%	48.7%
Cancer 62 day wait - Consultant upgrade (local target)	88%		55.0%	67.1%
Cancer 62 day wait for first treatment	85%	42.6%	38.2%	47.4%
28 Day Fast Diagnosis	75%	74.4%	69.2%	71.4%
Cancer 31 day wait for treatment	96%	84.4%	75.8%	83.3%

* Target has subsequently been changed to the end of September 2024 because of the industrial action in 2023/24.

Engagement in developing the Quality Account

Prior to the publication of the 2023/24 Quality Account, we have shared this document with the following:

- Our Trust Board, including combination of Non-Executive and Executive Directors
- City of Wolverhampton Council Health Scrutiny Panel
- Black Country Integrated Care Board
- Trust staff
- Healthwatch

In 2024/25 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

We would like to thank all the patients, community representatives for their feedback and members of staff who gave their time to help us select our priorities and ensure that the document is clear and accessible.

NHS
Black Country
Integrated Care Board

Statement from Black Country Integrated Care Board

Black Country Integrated Care Board (BCICB) statement on The Royal Wolverhampton NHS Trust (RWT) Quality Account 2023/2024

BCICB welcomes the opportunity to review and provide the statement for The Royal Wolverhampton NHS Trust Quality Account for 2023/24. RWT Quality Account is materially accurate and in line with the information presented to the ICB via contractual/ quality monitoring meetings and quality visits. The ICB recognises that 2023/2024 has continued to be a challenging year for RWT to deliver services with unprecedented demands outstripping capacity. We genuinely recognise the Trust's efforts to maintain quality while acknowledging the uncertainties and challenges throughout the year.

The ICB would like to thank all staff and volunteers working at RWT for their commitment, resilience, and commitment to ensuring patient care is safe and of the highest standard. We recognise and strongly endorse the strategic collaboration between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. This collaboration is a significant step towards a system that works collaboratively at scale, ultimately benefiting local populations by enhancing efficiency, sustainability, and the quality of care. We are proud of our effective working relationship with the Trust and recognise its achievements against the quality priorities and its individual and collective engagement with the commissioners.

The ICB is pleased to observe that quality remains a top priority for the Trust, with a clear focus on three key areas: Patient Safety, Clinical Effectiveness, and Patient Experience. We are committed to monitoring the Trust's progress in delivering these quality priorities identified for 2024/25 and eagerly anticipate the positive impact and outcomes that will result from these efforts.

The ICB would particularly like to note the following key achievements for 2023/2024:

- Transition to the Patient Safety Incident Response Framework - It is a testament to our collective efforts that the Trust has successfully transitioned from a traditional SIF framework to the PSIRF methodology. This significant shift towards a system-based approach makes an essential and positive difference in patient safety, offering substantial benefits for patients and healthcare providers. During 2023/2024, the ICB, in close collaboration with local trusts and independent providers, supported the transition to PSIRF in line with National Guidance. As of April 2024, all NHS Trusts within the Black Country ICS footprint have successfully transitioned to PSIRF. The ICB continues to support PSIRF within Trusts via quarterly PSIRF workshops and will monitor the progression of local implementation via the ICB PSIRF Quality Framework.
- It is reassuring that the Trust has expanded and maintained the use of Same Day Emergency Care (SDEC) services. This commitment to SDEC has brought significant benefits such as better patient and staff satisfaction, reduced admission rates, and enhanced patient flow within the department, all of which contribute to the overall quality of our healthcare services.
- It is good to see that both RWT & WHT are working jointly and have produced a gap analysis on how both trusts rank against the four components of a quality management system (quality planning, quality control, quality improvement and quality assurance), and review how we triangulate data to understand priorities and the benefits this will bring to the local and wider population within the system.
- The ICB is pleased to see that the Trust has reported a lower than three per cent vacancy rate and is in an improved position with normalised turnover and a 12-month retention rate.
- It is commendable that the Trust continues to be a strong performer regarding SHMI, and the values are reported within the `as expected' range and below the national average.
- Incremental improvement in compliance with "patient observations on time", an essential safety metric.
- The ICB recognises that the Trust has worked collaboratively with system partners on services for patients who present to the Trust with significant mental health challenges alongside their physical ill health, and we are aware that this work is continuing.

Engagement

For the Elective and Non-Elective patient pathways, we recognise the Trust's continuous commitment to deliver against the Nationally agreed Elective and Non-Elective priorities and acknowledge the progress made so far, such as:

- The Trust consistently achieves more than 85% theatre utilisation and is in the top quartile of Trusts in the country for theatre utilisation.
- Increased diagnostic capacity by the new Community Diagnostic Centre in Cannock has delivered an above-target reduction to our 62-day cancer backlog and an increase of 27 percentage points in the number of patients who received their diagnostic test within six weeks.
- Over performance against 70% for Urgent Care Response (UCR) compliance target on10/12 months. Compliant in eight of nine dispositions with falls pathway going live at the end of 2023.
- The Trust cleared its 78-week waits by the end of March 2024, aligning with the national target.

Whilst we recognise these achievements, we would value the delivery of sustainable improvements in the following areas for 2024/2025:

- We recognise that the Trust is represented at the ICB C. Difficile Task and Finish Group to achieve a system approach in reducing C. Difficile harm between community and acute providers with continued efforts to improve clinical and infection, prevention, and control practices. However, we expect to see a reduction in hospital-onset C. Difficile infection cases for the year ahead.
- The Trust's intention to continue improving Venous thromboembolism (VTE) risk assessment compliance is noted, and we look forward to seeing a further improvement in VTE compliance and the positive impact of this work over the coming year.
- We look forward to the Trust achieving 100% compliance with uploading 100% of incidents to Learning from Patient Safety Events (LfPSE) by the national deadline.
- Continue to embed the Patient Safety Incident Response Framework (PSIRF) within the organisation to learn and improve patient safety and the positive impact PSIRF is having on Trust's patient safety culture.
- We expect the Trust to work with our system partners to achieve the key targets, which are set nationally, which means:
    - To eliminate 65-week breaches by the end of September 2024.
    - Meet the cancer 62-day target of 70% by March 2025.
    - Meet cancer faster diagnosis standard of 77% by March 2025.
    - Increase the percentage of patients that receive a diagnostic test within six weeks to 95% by the end of March 2025.
    - Expand the uptake of Patient Initiated Follow Up (PIFU) to all major specialities, discharging 5% of outpatient's attendances on PIFU.
    - To maximise planned activity undertaken, achieving a local target of 108.9% of the valued activity undertaken in 2019/2020.
- Over the last year, we have noticed a slight increase in reported patient discharge-related incidents. We acknowledge the Trust's efforts and commitments to ensure safe patient discharge processes and practices are followed for every patient discharged from the hospital. However, we will continuously monitor this position and expect the Trust to achieve a substantial reduction in any discharge-related patient incidents and quality concerns.

The ICB confirms that the Annual Quality Account information accurately reflects the Trust's performance for 2023/2024. It is presented in the format required and contains information that accurately represents the Trust's quality profile and reflects quality activity and aspirations across the organisation for the forthcoming year. We commend the Trust on its commitment to working with the ICB collaboratively and transparently in 2023/2024 and look forward to working in collaboration and partnership over the next year.

Sally Roberts

Chief Nursing Officer/Deputy Chief Executive Officer

Black Country Integrated Care Board

June 2024

CITY OF WOLVERHAMPTON COUNCIL

Statement from City of Wolverhampton Council Health Scrutiny Panel

City of Wolverhampton Council – Health Scrutiny Panel. Statement on the Royal Wolverhampton NHS Trust Quality Accounts 2023 – 2024

The Panel notes the contribution David Loughton, CBE, former Chief Executive has made to the Royal Wolverhampton Trust and wishes him well in his retirement. The Panel welcomes Caroline Walker as Interim Chief Executive and hopes to work in partnership with her to continue to improve the lives of local people.

We are pleased with the progress made on staff retention rates, and that the staff turnover rate is currently under 3%. We note positively the priority area – Urgent and emergency care and patient flow, which has seen the Trust over perform against its set targets, expand its virtual care ward service, reduce bed occupancy, and work closer with partners to improve pathways and response times.

We would like to see greater focus and improvement on the "State of Readiness", which the Trust self-assessment found that in all categories (Building a shared purpose and vision, investing in people and culture, developing leadership behaviours, building improvement capability, embedding into management and systems) they were rated on average at 2.5 out of 5; with 5 being the top score that can be achieved.

We recognise the progress the Trust is making in tackling cancer treatment backlogs, noting positive developments in reducing the 62-day backlog and their over achievement at hitting targets for the 28-day faster diagnosis standard. We, however, also recognise that the goal of returning to pre-pandemic performance levels remains a key focus, particularly cancer treatment waiting lists and note the Trust needs to improve its performance on the prostate best practice timed pathway.

The work the Trust is doing to improve patient involvement is promising. The use of volunteers for discharge signposting, further recruitment of Patient Involvement Partners and particularly the creation of a Patient Feedback Oversight Group are all positive steps to deliver better outcomes for patients.

We look forwards to our continued partnership with the Royal Wolverhampton Trust and hope for a positive 2024 – 2025.

Councillor Mary Bateman – Chair of Health Scrutiny
City of Wolverhampton Council,
Civic Centre, St Peter's Square
Wolverhampton
WV1 1SH
June 2024

Statement from Healthwatch

HealthWatch Wolverhampton (HWW) comments

Healthwatch Wolverhampton (HWW) welcome the RWT areas of focus for the coming year.

Locally we continue to hear of long waiting times which support Healthwatch England national research figures that in January, **only 62.3% of people started their first treatment within 2 months (62 days) of an urgent cancer referral.** The target is 85%. RWT needs to ensure that locally, alongside efforts to reduce waiting lists there should also be a focus on measuring and acting on the things that matter most to patients such as how quickly they are initially triaged, their access to food, water, and pain relief, and the quality of communication while waiting for care. Whilst we were pleased to see the CQC National Inpatient Survey delivered stable results, with patients citing food quality and eating support, and being kept informed and involved in their discharge planning, as areas of positive experience. Feedback from our own data has been largely about GP services (48%) but negative sentiments about hospital services featured strongly. As a result, HWW has identified a listening project about hospital services and care to be one of its two priorities for 2024/2025. We would welcome any opportunity to share our report with RWT and work with them to implement recommendations in their delivery plans.

Patient Experience - Pillar two – Engagement

- We will develop our Patient Partner programme and use patient input to inform service change and improvements across the organisation.

HWW core values are based on the involvement of patients' voices to be at the heart of service improvements and by working together we can show how listening to the voices of the public can lead to a system that works better for everyone. The report states various ways in which patients are involved and as your local health and social care champion we have established ourselves as a pivotal voice in not only identifying the issues, but in highlighting how to make real and lasting change. Therefore, we will look to establish further ways of being part of the various committees mentioned and to strengthen the meetings we already have with PALS.

Statement of Director Responsibilities in respect of the Quality Account 2023/24

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 annual reporting manual and supporting guidance Detailed requirements for quality reports.
- 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 dated June 2024
  - feedback from local Healthwatch organisations dated June 2024
  - feedback from overview and scrutiny committee dated June 2024
  - the 2023 national staff survey
- the quality report presents a balanced picture of the trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Caroline Walker
Interim Chief Executive Officer
28 June 2024

Sir David Nicholson, CBE
Chairman
28 June 2024

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement have confirmed in the Quality Accounts requirements for 2023/24 that there is no national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account.

Appendix 1 – Local clinical audits reviewed by the Trust in 2023/24 with actions intended to improve the quality of healthcare.

The reports of 171 Local clinical audits were reviewed by The Royal Wolverhampton NHS Trust and of these, 121 demonstrated some areas where improvements could be made. The Royal Wolverhampton NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Local Audit Title	Actions to be taken by RWT
Audit of Tinnitus service against NICE Guidance NG155 (carried over from 22/23 to 23/24).	Development of a tinnitus pack to include a questionnaire for the patient to complete prior to their appointment. Management team to raise awareness of the importance of full hearing assessment taking place prior to referral and discussions about hearing aids are documented in patients journal.
Audit of Calibration Compliance (re-audit) (23/24).	Clinical Lead to communicate to all staff via department meeting to document on the calibration sheet when equipment was not used or not present. Staff to record their clinic location to allow for equipment calibration.
Audit of Impressions Adult Service (23/24).	Staff to be reminded of the implementation of the new local guideline for Impression taking with additional quality checks developed and available training sessions.
Audit of Completed ABRs (Re-audit) (23/24).	Meeting with ABR Testing Team to discuss the importance of good documentation and journal writing, and listing reasons as to why any testing was not carried out.
Audit of Paediatric RECDS and Verification Measures (23/24).	Create a guideline for the Measurement of RECDS. Staff training on completion of RECDs to correct protocol. Amend 'Hotkey' to make RECD choice and verification choice more explicit. Audit results to be shared at Paediatric team meeting.
Audit of the echocardiographic assessment of left and right ventricular function in patients receiving trastuzumab and/or anthracycline chemotherapy against international societal recommendations (2023/24).	Potential Implementation of AI software which is currently under trial. Implementation of educational sessions to increase staff awareness of the advance echocardiographic techniques, right heart parameters, importance of stating reason of unsuccessful acquisition.
Does FFR CT reduce downstream testing & cost 2023/2024.	Downstream tests considered in context of CT FFR of exact value, vessel / segment, and education of the end users of CTCA report. Improvement in image quality by optimising heart rate, tailoring acquisition parameters may reduce rejected cases from Heart flow.
Routine chest radiography after primary PCI for STEMI: is it still clinically necessary?	Chest x-ray to be incorporated in the local guidelines for the management of the patients with STEMI.

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Local Audit Title	Actions to be taken by RWT
Surveillance imaging following lung cancer resection surgery.	Discussion at Directorate Governance Meeting to emphasise the importance of using preferred imaging modalities (CT imaging with contrast) in the first 24 months post-resection. Training session to clinicians as a reminder of outpatient clinic appointments ensuring timely imaging is performed.
Assessment of consent documentation for inter hospital transferred patients as per unit instructions.	Introduction of a checkbox in the patient notes to coincide with the Trust Consent to procedure proforma.
Adherence of patient operation notes to the royal college of surgeons of England, Good surgical practice guidelines.	Plan to introduce electronic performance and pre-designed template.
Perioperative Management of Hip Fractures 2023/2024.	Implement SHARP Protocol proforma.
Group & Save (G&S) Samples for Robotic-Assisted Laparoscopic Prostatectomy (RALP) Surgeries 2023/24.	Cease all routine G&S sampling on day of RALP surgery as well as at pre-operative assessment. Implement process of sample and crossmatch on a case-by-case basis. Plans to increase the scale of data collection for future audits to include other surgical procedures.
Documentation of femoral/fasciailiaca blocks in ED 2023/24.	New proforma developed to aid decision making for Anaesthetists in theatre to perform a block at induction of anaesthesia (either regional or GA). Clinical Lead to Improve education with regards to the importance of accurate documentation standards.
Paediatric perioperative temperature monitoring.	Staff training updated to reiterate the importance of: Anaesthetic time > 30 mins need active warming. Anaesthetic time > 30 mins need intermittent temperature monitoring. Turn up the temperature in theatre to >23 degrees
HTM01-05 - Infection Prevention Reaudit (23/24)	Business case in progress to refurbish clinics with new worktops - managed/monitored via the Directorates risk register.
Gallstone disease. Acute cholecystitis in elderly patients	Information disseminated amongst the surgical team to allow clinicians to make informed decisions on how to improve the quality of management to our patients
An Audit of the Key NASBO Recommendations for the Management of Small Bowel Obstruction (SBO)	Develop and promote a new Integrated SBO management pathway
Audit on the impact of weight recordings on VitalPac on VTE assessments (23/24)	Implementation of nurse teaching on timely recording of weights on VitalPac. This will be through multiple routes including during nursing safety brief, over multiple days, discussion with matrons and potentially teaching sessions
Re Audit: Do we follow GMC Guidelines for intimate examination and chaperon Use?	Chaperone stamps / stickers generated that can be easily used in the documentation section of the patients notes. Importance of following GMC guidelines for intimate examinations re-iterated to staff

Local Audit Title	Actions to be taken by RWT
Day case rate for HVLC (high volume low complexity) operative laparoscopy procedures (2023/2024)	Department to complete Education / Training / Awareness about HVLC / GIRFT Programme and Trust Targets to reach Benchmarks. To further improve method of listing the cases using GIRFT pathways/packs including patient selection, planning and admittance, anaesthesia, surgery, post op, requirements for discharge and post discharge.
Re-Audit Retrospective review of management of Endometrial Hyperplasia (2023/2024)	Plans to introduce a Data base with re-call system to prevent patients being lost to follow-up (FUOWL) Endometrial Hyperplasia Code. Patient information leaflet developed about EH and management options risks and benefits. Clinicians empowered to discuss implications of high BMI and lifestyle modifications
Audit of management of patients with pregnancy of unknown location (2023/2024)	Laminated copies of PUL flow charts to be displayed in the clinical rooms in EGAU and the Doctors office. Review and update (as required) the PUL guidance
Re-audit on the availability and usage of antimicrobial prescribing stickers for patients admitted under Oral and Maxillofacial Surgery and ENT at New Cross Hospital (23/24)	Improve accessibility of the anti-microbial prescribing stickers by re-locating them from the B7 clean room to the doctor's office. Inform new junior doctors joining the team during induction.
A retrospective audit on Midazolam dose and record keeping for IV sedation (23/24)	Clinical Lead to design proforma for IV sedation recording keeping (head & neck only)
Sleep Study Audit (23/24)	Introduction of sleep study proforma for trial and introduce teaching sessions re: requesting sleep studies
The quality of weekend handover of Ear Nose and Throat (ENT) inpatients (23/24)	Department to consider the Introduction of Careflow Connect.
An evaluation of the quality of weekend discharges of patients in Ear Nose and throat (ENT) (23/24)	Education and summary to be provided to junior doctors as part of their local induction programme.
Sleep Study Re-audit (23/24)	Creation of a sleep study proforma
ATAIN - Phototherapy at home for babies with Neonatal Jaundice 2022-2023 (2023/2024)	Education and training sessions to be implemented with the medics, ANNPs and community teams. Department to upload updated home phototherapy guideline to Trust web page.
NICE NG195: Implementation of Kaiser Permanente Sepsis Risk Calculator (KP-SRC) audit (2023/2024)	Directorate consideration to be given to reducing unnecessary antibiotics exposure and avoid antibiotics resistance in well newborn babies = 34 weeks' gestation. Reducing family anxiety about invasive and painful procedures (cannulation and blood sampling) and exposure of their babies to antibiotics
Neonatal Hypoglycaemia Re-audit (2023/2024)	Education to raise awareness of local guidelines on the use of prophylactic dextrose gel. Improved documentation quality of prophylactic dextrose gel on BadgerNet.

Appendices

Local Audit Title	Actions to be taken by RWT
Second Stage C Section Re- Audit (2022/2023)	Obstetric staff and midwives reminded of the need for antibiotic prescription for those underwent end stage CS. Deliver a standard way on BadgerNet to document VE before 2nd Stage CS. Update guidelines to define optimal management of 2nd stage CS
Antibiotic Prophylaxis in Obstetrics NICE & Local Audit (2023/2024) NG192	Junior doctors reminded that TTOs are not required for manual removal of placenta. Department Leads to discuss with Pharmacy regarding the anaesthetist to add the timing & dosage of antibiotics on their chart
Local and National Safety Standards for Invasive Procedures (LocSSIPs) Q1- Fetal Blood Sampling Water birth - Normal Vaginal Births - Forceps delivery - Ventouse - Caesarean Sections (2023/2024)	Teaching Consultant has circulated message to every member of medical staff and continues to monitor. Delivery Suite managers have contacted midwives where relevant. Added to shared learning document. Included in Delivery Suite Safety Brief
Ockenden Report Audit (IEA 5): Intrapartum Risk Assessment Re-Audit (2023/2024) 2023/2024	Continue to gather data from intrapartum ward (Delivery Suite) that risk assessments are completed for each patient in a timely manner.
Saving Babies Lives: Element 1- Reducing smoking in pregnancy (2023/2024) 2023/2024	Liaise with teams (out of area) from South Staffs re: pathway for women and birthing people. Ensure direct Supply of NRT (Nicotine Replacement Therapy). Staff education to include Referrals to be made according to guideline and stop smoking teams to connect to patients identified.
Saving Babies Lives: Element 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR) (2023/2024) 2023/2024 incorporating requirement of CNST quarter audit of a minimum of 10 cases delivered <3rd centile after 37*6 weeks and 3rd & 10th centile- IOL to be offered at 39 weeks (Ockenden Report IEA 4)	Liaise with the Community Matron to cascade information via the CMW team leaders to all community staff at RWT. Meet with Digital Midwife to make Vitamin D supplementation as a visible field on BadgerNet at the Antenatal Booking History. Monitor and collect data monthly to ascertain RWT compliance with Vitamin D supplementation by utilising the NEW SBL Report launched in January 2024.
Saving Babies Lives: Element 3- Reduced Fetal Movement Monitoring Audit (2023/2024) 2023/2024	Adapt RFM definition as outlined in SBLCB tool kit. Ensure RFM Guideline is up to date and complies with SBL toolkit definition. Promote guideline at QSM study day and relevant forums to increase staff awareness of the latest guidance on RFM. Submit Divergence re scan capacity data to NHS England. Look into alternative way of working: recruitment to vacant posts - manage via Directorate Risk Register
Saving Babies Lives Element 5- Reducing Preterm Birth Audit- Audit on Cervical Cerclage (2023/2024)	Staff reminded to record use of progesterone as part of ANC plans and early referral of women to the clinic (ideally 12-14 weeks)
MBRRACE Audit (potential element 6 for SBL)- Diabetes in Pregnancy Audit (2023/2024)	Promotion of clear communication re: folic acid importance and to seeking prescription from GP/ANC. Add folic acid to the BadgerNet page as a mandatory field for completion.
BSOTS- Birmingham, Standardised Obstetric Triage Score Audit (2023/2024) 2023/2024 (To include patient wait times on meeting the 15-minute target and appropriate escalation)	Improve staffing levels within department. Continual monitoring using SPC (Statistical Process Control Tool)

Local Audit Title	Actions to be taken by RWT
NIPE Assessment - Managing and responding to risks issues and concerns Audit (2023/2024) 2023/2024	From 2024 (data from NMC and NHSE) all midwives will have the NIPE as part of their qualification requirements as it will be embedded in midwifery training. Current community midwives team leaders will be notified and to share with area midwifery teams.
Midwifery SBARD Audit (Handover Audit) (Quarterly data) (2023/2024) 2023/2024	Department will continue to report SBARDs at Intrapartum meetings.
Saving Babies Lives CTG in Labour Audit: Element 4- Intrapartum care for healthy women and babies, to include CTG Documentation audit- Fresh Eyes (2023/2024)	Raise awareness of measurement and expected standard: Added to the safety brief and emailed to all midwives on DS. Planned relaunch new board on DS. Target/ measurement on display
Local and National Safety Standards for Invasive Procedures (LocSSIPs) Q2- Fetal Blood Sampling Water birth - Normal Vaginal Births - Forceps delivery - Ventouse - Caesarean Sections (2023/2024)	Each member of staff contacted when non-compliance is identified. Reminder communicated through monthly department shared learning
Uncontrolled Chronic Hypertension in Pregnancy (2023/2024)	All staff to have access to equipment and be competent in use of Blood pressure monitoring. Share results with care providers
Prophylactic antibiotics post assisted delivery (Antibiotics in Pregnancy).	Posters on delivery suite and instrumental delivery trolley as reminders for staff.
(OASI) Reducing Obstetric Anal Sphincter Injury (2023/2024)	Recruitment of additional staff will support additional work required to monitor these patients
New outpatient appointments DNA (did not attend) in the Wolverhampton and Midland Counties Eye Infirmary in September	Introduction of SMS messages to all applicable ophthalmology clinics. Implementation of failsafe officers and CNS Teams to manage DNA patients in clinically appropriate areas
PGDs across Ophthalmology (23/24)	Staff issued with stamps to document counselling has taken place. Audit presented to MMG for assurance and monitoring
Bone bank transportation- from consent to green freezer re-audit (2023/2024) 2023/2024	Explore the need for patients to be flagged for repeat bloods who have been rescheduled. Improve documentation regarding donation for bone grafts by liaising with Pre-Assessment to re: training staff to obtain patients consent for bone donation. Explore ways to minimise sample contamination and improve 6 monthly screening of patients.
Re-Audit of Documentation in Medical Records-consent form 4 for neck of femur patients (2023/2024)	Reinforcement with clinical staff the need to file clinical notes in order. Consider NOF booklet redesign to include removal of blank continuation sheets at the back of booklet. Purchase file dividers and organise notes.
Re-Audit- Door-to-clexane time in trauma patients (2023/2024)	Distribute educational poster on the ward to raise awareness of the guidelines. Raise awareness to the Rheumatology and Care of Elderly doctors covering the ward.

Appendices

Local Audit Title	Actions to be taken by RWT
Distal Radius Fracture Assessment (2023/2024)	Virtual fracture clinic trial underway. The team will review pilot study to measure timeline for patients seen in Fracture clinic following referral from A&E and if further improvements can be made to the service.
Auditing back pain patients admitted onto the Trauma & Orthopaedics wards (2023/2024)	Implementation of suspected to CES Checklist at ED before referral. Usage of interactive website by the T&O on-call team. Liaise with Radiology to reach target of 4h MRIs in cases with high suspicion decided by the GIRFT pathway. Standardise referral to regional spinal team/ spinal MDT for further management in high suspicion
Re-Audit: Safe use of Intra-operative tourniquets in Trauma and Orthopaedics (2023/2024)	Department have distributed copies of the guideline to be displayed in all theatres and anaesthetic rooms Trustwide.
NICE audit NG38: Surgically treated ankle fracture before and after COVID - 19 (2023/2024)	Directorate to facilitate ways in which ankle fractures can be operated on as soon as they are ready for surgery
Can new technology improve the bladder cancer management pathway? (2023/2024)	Discuss the possibility of replacing TURBT with TULA
Re-Audit - Invasive Procedures LocSSIPs - Chest drains 2023/24	Clinician Education regarding the importance of comprehensive documentation as well as the availability of the proforma. Improved ease of access: Printed copies of the form will be kept near the Chest drain kits.
Introduction of Idiopathic Intracranial Hypertension (IIH) pathway 2022/2023	Continued use of the pathway and collaborative work with other department (ED, radiology, ophthalmology, neurology)
Review of Documentation of RESPECT / DNACPR in community visits by the RITS team.22/23	Amend standard writing practices to include photographs of the RESPECT form on the tablet used by the RITS team member on review of a patient. Dissemination of this change via team brief meetings
CP50 Policy for the Management of Risks associated with Pathology and Radiology Clinical Diagnostic and Screening tests 22/23	Presentation to the Departmental meeting for Junior Doctors. Education session on audit findings and teaching sessions to improve outcomes
CT Brain imaging in patients aged over 65 presenting to ED (23/24) (CG176)	NICE guidance was updated after completion of this audit. Audit to be undertaken against new standards
Audit on Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Process	Education of nursing and medical staff to highlight RESPECT documents that are due for a review. Review of RESPECT and MCA documents when patient arrives to West Park hospital
CP50 Policy for the Management of Risks Associated with Pathology and Radiology Diagnostic and Screening Tests	Job planning to be undertaken to schedule in opportunities to review results.

Local Audit Title	Actions to be taken by RWT
Implementation of cardiovascular Q2 risk score in CML patients on TKI'	Clinical teams reminded of the need to document the cardiac risk of CML patients.
Audit on Malnutrition Universal Screening Tool (MUST) in NRU (CG32)	Raise awareness of staff of the need to complete nutrition screening. Staff training around nutrition screening
NICE Guidance - NG71 Parkinson's disease in adult's 22/23	Update template letter to GP to list potential side effects of medication. Obtain leaflets from PD UK to distribute to patients in clinic. Update proforma to record discussion regarding daytime sleepiness and impact on driving.
Re: audit CP50 Audit into the management of risks associated with pathology and radiology, diagnostic and screening investigations	Work required to reduce waiting times and ensure working practices are standardised across the board
Category 1 Head & Neck Radiotherapy Audit	Implementation of AI for radiotherapy outlining. Review of medical physics planning days. Audit the number of head and neck re-scan/re-plans considering dietitian issues and delays in PEG/RIG insertions.
Auditing antibiotic stewardship on Deanesly Ward 1st-14th January 2023	Reminders sent to junior doctor team of the neutropenic guideline's pathways. Posters put up in ward areas. Audit findings presented to local department to raise awareness.
Cancer of Unknown Primary Audit for 2022	Review of HNA and allocation of Key Worker process. Reminder sent to all other MDTs to refer MUO patients without an identified primary site to the CUP MDT
Management of Neutropenic sepsis 2023 re-audit of 5167	Implementation of: Post Systemic Anti – Cancer Treatment (SACT) Sepsis Pathway and Antibiotic Patient Group Directive (PGD), this will be supported in the Emergency Department by the Oncology team. Continue Neutropenic Sepsis training on study day for trained nurses & commence training with F1 doctors joining ED
A quality improvement project on appropriate administration of prescribed drugs (2023/24)	Provision of education and training sessions for the healthcare professionals who are involved with prescribing and administration of the drugs.
LocSSIPs Audit (2023/24)	Reiteration, during induction sessions, of the importance of proper documentation around each procedure, after care and discharge for renal patients
Non-Invasive Ventilation Audit	Provision of regular teaching sessions for registrars and the 2 doctors involved in decision-making for NIV. Facilitation and streamlining the transfer of patients to avoid delays. Facilitation of decision making and early transfer. Development of a poster on NIV pathway and distribution to all wards
Enteral Feeding of Acute Stroke Patients: A review of current practice at New Cross Hospital 22/23 23/24 - NICE CG32	Presentation of results in Governance Meeting and share with stake holders. Improved MDT working to ensure handover, prognostication, and early discussion about PEG with necessary information sharing with patients and families

Appendices

Local Audit Title	Actions to be taken by RWT
Review of timely completion of cardiac Investigations in TIA/Stroke patients attending TIA Clinic in New Cross Hospital, Wolverhampton - a retrospective review of service delivery (23/24) (NG127)	Directorate reviewing alternative strategies around outsourcing of cardiac investigations, particularly prolonged monitors
VTE prevention on the Stroke Unit (23/24)	Include awareness of the role of the Responsible Doctor/ PA to ensure VTEs are complete in Directorate Junior Doctor Induction. Identification of outstanding VTE's by the VTE champion in morning huddles. VTE sticker to be added to the Hyper acute stroke pathway.
Quality assurance of patient pathways - Care co-ordination/SDEC (23/24)	Peer review to be undertaken to modify referral proforma and templates, to include prompts for Safeguarding, Staff designations, NOK, and Relationships
Re-Audit of Personal management plan for clinic patients (23/24) (QS123)	Training for staff with the development of prompt cards to improve communication with regards to completion of care plans
Re-Audit of waiting times for Doppler (23/24) Re-Audit	Clinics have been restructured allowing more time to complete ABPI's at initial assessment. Business plan in progress to enhance workforce. Recruitment drive was successful which resulted in 5 new posts appointed.
Audit of compliance of medication administration (RASC)	Implement training for patient flow coordinators around TOC form and improve training to mitigate errors and Improve communication to nursing teams and acute wards.
Deteriorating Patient Escalation Audit (23/24)	Increase awareness to staff with regards to the completion of NEWS2 on the initial visit and to ensure the NEWS2 scores are recorded accurately.
RASC Medication Pilot - Referral Outcome Review for Care Coordination	Findings reported to RASC management team and ESERG. RASC to review capacity management within the team.
VW Paediatric Referrals via Care Coordination	Directorate to amend the Paeds Virtual Ward inclusion / exclusion criteria to improve referral pathway.
Local Safety Standards for Invasive Procedures (LocSSIPs) 2019-2020	Directorate to develop pro-forma for lumbar puncture and poster to further improve documentation and awareness for all staff
CP50: Review of Diagnostic Test Results (2023/24)	Communication to clinicians reiterating the importance of complying with CP50. Directorate to consider development of a proforma and review training at local induction
Non-Medical Prescribing (NMP) Audit (2023/24)	Communication to staff the importance of accurate documentation with regards to approved drug names, designations, and location.
Door to Needle (D2N) Paediatric Audit (NG 51: Audit on Antibiotic Usage in Paediatric Sepsis) (2023/24)	Directorate to continue to develop personalised care plans for febrile oncology patient's presenting to PAU. Nursing rota to be amended to include one senior member of the nursing staff in PAU/A21 who is central line-trained and competent to facilitate quick access to central line for sampling and administration of antibiotics.
Re-audit: Newly diagnosed Juvenile Idiopathic Arthritis (JIA) 2021/22	Service review to be undertaken. Immediate changes implemented to incorporate a second triage through paediatric Rheumatology Consultant, to prioritise inflammatory disease.

Local Audit Title	Actions to be taken by RWT
Two-stage Consent in Paeds Acute	Nursing staff to liaise with medical teams to ensure consent is taken appropriately. Medical teams to be advised that consent is taken prior to the date of an elective procedure.
Enuresis Audit (2022/23)	Review and update pathway to reflect current 2-tier service ensuring the documentation of 'explanation of reward systems' are captured on the Enuresis proforma and documents are scanned. Recommendation to purchase a selection of bed and body alarms suitable for children and YP.
Child Protection Medical Audit (2023/24)	Information leaflet/website to be provided to families. Amend the proforma incorporating consent for skeletal survey and recording of strategy meeting time requests for CP medicals.
Advance Care Plan Audit (2023/24)	Launch service to assist with CYPACP formation. Implementation of CYPACP training for acute and community teams. Amend audit tool to reflect variety of different versions of CYPACP in circulation
Cancer Pathway SOP: To audit the effectiveness of SOP (LocSSIPs)(22/23)	Directorate to review the Triage process for 2ww referrals incorporating the use of Tele-dermatology to further streamline referral pathway
Eczema Treatment Plans (23/24)	Directorate to consider the use of Physicians Global Assessment (PGA) for eczema and record eczema as generally mild/ moderate/ severe/ very severe, if unable to complete an Eczema Area Severity Score (EASI) score.
Audit of the Quality of Discharge Information	Shared learning to be disseminated Trustwide with regards to accurate drug documentation when completing patient discharge summaries focussing on duration, reason stated, the number of drugs stopped / changes documenting the reason.
NPSA Steroid Card Alert	Pharmacy to develop steroid questionnaire to be completed by prescribers to identify educational needs to be addressed and publish a summary of key changes through Risky Business. Further increased awareness for prescribers across the trust to incorporate steroid safety measures into local implementation plans
Prescription Chart Audit	Pharmacy and ePMA digital team to provide educational material to upskill prescribers, including training videos and information mail shots with bullet point guidance. Lead clinical divisional pharmacists to undertake updates at the daily pharmacy huddle and in-house training sessions to raise the awareness of reviewing all prescription charts. Undertake 'Back to the floor' audits to identify where pharmacy endorsement is not occurring
COVID-19 rapid guideline: managing the long-term effects of COVID-19 (23/24)	Directorate to liaise with Secondary Care to review referral form
WHO lists and consent forms - are these being appropriately completed and scanned for ultrasound guided liver biopsies? (2023/24)	Assisting nurse/HCA to ensure that all documents are uploaded on the system before transferring the patient back to the ward. Reporting radiologist to ensure that consent form/ WHO checklist is available on the system before authorising a report.
Audit of CP50- Results filing in Rheumatology (based on the local SOP in this area; SOP 2. Rheumatology CP50 Compliance and ICE Results Review Policy) (23/24)	All clinicians are being encouraged to file results on the system in a timely manner.

Appendices

Local Audit Title	Actions to be taken by RWT
NG219: Gout Diagnosis and management -	Reiterate to clinical staff the need to ensure gout leaflet are given to patients. Discussion at departmental meeting around how to improve "Treat to target approach".
PGD-related Audit (2022/23)	Education for staff on the documentation requirements of PGDs.
Epidemiological Treatment for Sexual Contacts of Gonorrhoea (2023/24)	Directorate to consider updates to proforma to enable Clinicians to identify the correct management pathway
A retrospective audit on the commencement of Antiretroviral Therapy (ART) in newly diagnosed HIV-1 patients in 2021 (2023/24)	Directorate have increased their staffing and clinic capacity which has enabled patients to be seen in a timely manner following diagnosis
(Nutrition & Dietetics) Nutrition support on the ICCU (22/23)	Dietitians to regularly meet with senior nurses/managers/matron to identify strengths and actions to support improving the quality of MUST assessments on the unit. Consider introducing/signing off on 'MUST on Vitals competencies' to be completed by our 'nutrition champion' nursing colleagues and the Education team.
(Nutrition & Dietetics) • CP50 Review of Diagnostic Test Results (22/23)	Protected time to be allocated to complete daily upload of clinical letters to the portal
(Orthotics) use of pressure integrity Tool for in-patients (23-24)	Directorate to review the current proforma to evaluate the information and identify training required to improve compliance
(Orthotics) Clinical note audit (23/24)	Findings to be shared with the team and discuss individual results with each member of staff. Reiterate the importance of good record keeping
(Foot Health) Diabetic Foot Screening Re-Audit (23/24)	The service continues to develop the automated GP letter to auto populate and send completed risk assessments
(SLT) Peer review clinical supervision. (23/24)	Plans to create a Link up recording of peer supervision with job planning document in secure personal area of Trust /w/ drive will enable staff to have a clear understanding of what comprises supervision, sessions are recorded accurately.
(Dietetics) In Patient snack Availability (23/24)	Poster created to highlight importance / benefits of snacks to be offered to patients on the ward
Staff compliance of using the modified Nottingham Sensory Assessment Tool in patients that have sensory deficits following an acute stroke.	To implement regular IST and training for new starters and establish a focus group to identify barriers to completion. Consider In house 'database' to identify those patients needing the mNSA and the date when completed/ data sheet changed to reflect.
Compliance of out of bed activities on the acute stroke unit, and links to aspiration pneumonia	Implementation of laminated transfer cards that can travel with patients when they move bed space
Compliance with splint regime prescription across the stroke and neuro inpatient pathway	Produce clear laminated signage indicating the regime to follow. Documentation to be developed to ensure clear documentation of splint application and removal.

Local Audit Title	Actions to be taken by RWT
Re-Audit of Multiple Sclerosis Therapy Pathway (23/24)	Continue with wider Education to MDT members on appropriate referrals. Improve direct links with Neurologists / MS nurses. Improve use of standardized outcome measures
Staff stress audit (23/24)	Results to be discussed at team away day, this will then feed into the departmental mandatory stress risk assessment.
Documentation Audit (23/24)	Findings will be cascaded to all participating Directorates to address areas of non-compliance to improve documentation at their local Governance meetings.

How to give comments

We welcome your feedback on this Quality Account and any suggestions you may have for future reports.

Please contact us at the following address:

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English

If you require this document in an alternative format e.g., larger print, different language etc., please inform one of the healthcare staff.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਰੂਪ ਉਦਾਹਰਨ ਵੱਜੋਂ ਵੱਡੀ ਛਪਾਈ, ਵੱਖਰੀ ਭਾਸ਼ਾ ਆਇਦ ਵਿੱਚ ਚਾਹੀਦਾ ਹੋਵੇ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਸਿਹਤਸੰਭਾਲ ਕਰਮਚਾਰੀ ਨੂੰ ਬੇਨਤੀ ਕਰੋ।

Polish

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