NHS
The Royal Wolverhampton
NHS Trust

Quality Accounts
2024-25

Care Colleagues
Collaboration Communities

Quality Account 2024/25

The Quality Account

Why are we producing a Quality Account?

In line with NHS Trusts across the country, The Royal Wolverhampton NHS Trust produces an annual Quality Account to provide information on the quality of services delivered to patients.

This gives the Trust an opportunity to be open and accountable and demonstrate how well the organisation is performing and considers the views of patients, their families and carers, our staff and the public.

The Trust also uses this information and ongoing engagement to shape services and improvements.

Statement on Quality from the Chief Executive Officer

Welcome to the Annual Quality Account for 2024/25, detailing the progress we've made in our efforts to deliver high-quality care to patients across all of our communities, working with our partners across the borough.

I am a relative newcomer to The Royal Wolverhampton NHS Trust (RWT), joining the organisation, and Walsall Healthcare NHS Trust as Group Chief Executive in January 2025, taking the reins from interim Caroline Walker.

This document gives us an opportunity to pause and reflect on our performance against last year's objectives as we continue our collective efforts to promote a culture of continuous improvement, underpinned by the five-year strategy and Quality Framework that we share with Walsall Healthcare.

We are halfway through the joint strategy we launched back in 2022 where we agreed four strategic aims, referred to as the four Cs.

These are:

Excel in the delivery of Care

We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.

Support our Colleagues

We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting diversity of our populations.

Improve the health of our Communities

We will positively contribute to the health and wellbeing of the communities we serve.

Effective Collaboration

We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.

We pledged that everything we do across both organisations should contribute towards achieving goals within at least one of these priority areas. They also align to our overall vision which is to 'To deliver exceptional care together to improve the health and wellbeing of our communities'.

At the time of writing, we were awaiting publication of the government's 10 Year Health Plan which we know will focus on delivering three big shifts in healthcare:

- hospital to community
- analogue to digital
- sickness to prevention

A lot of hard work and innovation has been taking place here in Wolverhampton over the last 12 months – particularly around that switch from hospital to community. We have a Community First programme of work that is focused on ensuring our patients can manage their conditions at home where they feel happiest, if appropriate, rather than be in hospital. Equally important is the support given to our teams of dedicated community staff to be able to provide the type of services to best support our patients in this way.

We are also concentrating on transformational programmes in Outpatients and Elective Care.

Work continues on further improvements to strengthen cancer services. Engagement with our communities around preventative measures as well as raising awareness of potential signs and symptoms remains an important element of this work.

I have joined the Trust at a time that is extremely challenging for the NHS nationally and locally. But I have seen some fantastic examples of innovation and resilience that will help us make our organisation as sustainable and effective as possible.

Our commitment to quality will not waver as we go into 2025/26 and I thank our patients, staff and partners for the part they will all play in this focus.

Vision and Values

In the autumn of 2022, the Trust launched its new, five-year strategy. This is a joint strategy with Walsall Healthcare NHS Trust which recognises the closer working taking place between the two organisations.

The development of the new strategy encompassed a new set of strategic objectives as well as a new vision.

Our vision, chosen by our colleagues, is to **'To deliver exceptional care together to improve the health and wellbeing of our communities'**.

RWT's values remain unchanged:

- **Safe and Effective** – We will work collaboratively to prioritise the safety of all within our care environment
- **Kind and Caring** – We will act in the best interest of others at all times
- **Exceeding Expectation** – We will grow a reputation for excellence as our norm

Strategic Aims and Objectives 2022/27

The Trust has four strategic aims, collectively known as the 'Four Cs' – Care, Colleagues, Collaboration and Communities. Extensive engagement across a wide range of stakeholders identified these areas as those which need prioritising if we are to achieve our vision.

Underpinning each of these aims, is a set of more specific strategic objectives. These are the practical steps we will take to achieving our strategic aims and will be used to measure our success.

Excel in the delivery of Care

We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.

- We will embed a culture of learning and continuous improvement at all levels of the organisation
- We will prioritise the treatment of cancer patients, focused on improving the outcomes of those diagnosed with the disease
- We will deliver safe and responsive urgent and emergency care in the community and in hospital
- We will deliver the priorities within the National Elective Care Strategy
- We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations

Support our Colleagues

We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations.

- Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff
- Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing
- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged
- Deliver year on year improvement in Workforce Equality Standard performance

Improve the health of our Communities

We will positively contribute to the health and wellbeing of the communities we serve.

- Develop a strategy to understand and deliver action on health inequalities
- Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025
- Work together with PLACE based partners to deliver improvements to the health of our immediate communities

Effective Collaboration

We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.

- Work as part of the provider collaborative to improve population health outcomes
- Improve clinical service sustainability by implementing new models of care through the provider collaborative
- Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital
- Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes
- Facilitate research that establishes new knowledge and improves the quality of care of patients

Our Values

Safe and Effective	Kind and Caring	Exceeding Expectation
We will work collaboratively to prioritise the safety of all within our care environment.	We will act in the best interest of others at all times.	We will grow a reputation for excellence as our norm.

Looking back 2024/25

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 was monitored by reporting to the relevant Quality Groups at the Trust.

Priority 1 **1.1 Priority area – Patient safety**	Embed a culture of learning and continuous improvement at all levels of the organisation.	Transition to the Patient Safety Incident Response Framework (PSIRF) The aims for 2024/25 were: • Training Needs Analysis (TNA) by March 2024 • Level 1 & 2 – 50% of **priority staff** identified in TNA to be completed in 2024/25 • 3 PSIRF roles – minimum of 30% of need of TNA met by 31 Dec 2024 • Implement LfPSE in year	The Trust transitioned to the Patient Safety Incident Response Framework starting in November 2023 and this continues to evolve as it is being embedded. An updated single group policy and plan is in place, reflecting feedback and learning from the first year of implementation and role-specific training. The plan for National Patient Safety Syllabus Level 1 and 2 training was postponed in response to the introduction of a revised approach to PSIRF which resulted in a refresh of the training needs analysis and delivery of PSIRF role specific training to meet the updated need. The minimum of 30% of staff from the TNA were trained by October 2024. The Trust transitioned to LfPSE in February 2024. All patient safety events are reported to the new national database.
Priority 1 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.	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 aims for 2024/25 were:** • Year on year improvement in the percentage of patients seen within four hours in A&E • Consistently meet the 70% two-hour urgent community response time • Reduce number of patients waiting in ED >12hrs following decision to admit	During 2024/25, the Trust has delivered a sustained improvement in 4 hour ED performance overall, achieving 80.9%. This has resulted in the Trust being one of the best performing organisations in the country. This was despite continued growth in overall attendances through the Trust's UEC services of more than 250,000 attendances (5% growth compared to 2023/24, totalling more than 257,509 attendances). Type 1 ED activity totalled 152,118 for the year. Emergency Service Teams have worked collaboratively with WMAS and Black Country ICB colleagues to implement the 45-Minute Handover resulting in significant improvements in average ambulance handover performance. This has facilitated ambulances responding to patients in a more timely manner within the community. Improvements in the delay in transferring patients from Emergency Department (ED) to an inpatient ward have not been delivered. This will be a focus

		• Revise the process of Discharge Ready date (without criteria to reside)	for 2025/26. The Trust has well established streaming pathways to all Same Day Emergency Care (SDEC) including specialty SDECs such as Medical, Frailty, Surgical, ENT and Gynae. In 2025/26 there are plans to further develop an Integrated Medical SDEC and Infusion Centre to enhance the Same Day Emergency Care offer and reduce the pressure within the Emergency Department. In addition, the organisation's Virtual Wards continue to expand and develop seeing 4,194 patients last year and supporting patients to stay well and be treated in their own home, either avoiding admission or facilitating an early discharge. Work continues within OneWolverhampton to further reduce the time patients are waiting to be discharged with a package of care or to a placement. Whilst the Trust's rolling average number of patients without a Criteria to Reside has stabilised, there are still improvements to be delivered in 2025/26.
Priority 1 **1.3 Priority area – Quality improvement**	Embed a culture of learning and continuous improvement at all levels of the organisation.	• 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 Quality Improvement (QI) huddle boards across both Trusts to targeted areas e.g., low evidence of improvement work, non-clinical areas.	Progress against our aims for 2024/25: • The Trust's Strategic Priorities Framework for 2024/25 became a core part of the work of the QI Team, with QI projects that were clearly aligned to the Framework receiving dedicated support. This was evidenced in positive outcomes in specific workstreams, particularly in productivity and efficiencies in length of stay. • QI training for leadership teams (triumvirates) will remain an objective for 2025/26. More than 10% of staff have received QI training. • Huddle boards have increased with 27 in situ, surpassing our target of 15.

		The aims for 2024/25 were: • Build actions/recommendations against gap analysis 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.	• A recent report on huddle board use has highlighted inconsistencies in its application although, when used, good improvement ideas are being implemented as a result. This was evidenced recently when the Portering Team presented its successes in improving Radiology turnaround times. The huddle board and its consistent use will be an objective for 2025/26 and has been included within the recently released Quality Framework. • We will undertake the NHS Impact self-assessment in July 2025.
Clinical Effectiveness			
Priority	**Quality & Safety Enabling Strategy**	**What we said we would do**	**How we did**
Priority 2 **2.1 - Clinical Effectiveness - Priority area – Our people**	The right workforce with the right skills, in the right place at the right time.	• 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 rollout of Virtual Wards and discharge to assess models. **The aims for 2024/25 were:** To work with system partners to ensure we have appropriate staffing in key areas to facilitate safe, effective patient care.”	**Retention** The Trust continues to run successful employability programmes across Nursing, support and administration staff groups. The work-based placements offer valuable knowledge and experience to all participants with the aim of securing bank or substantive employment upon successful completion. **Exit interviews** Resourcing developed and launched a new ‘Exit Interview’ resource with the aim of supporting managers and add value to a potentially difficult conversation. Coupled with ‘Stay Conversation’ this important tool provides all staff with the opportunity for their voice to be heard and insight into their role and potential reasons for leaving. Whilst in its infancy, the new online questionnaire has received more submissions than the previous iterations. Q2-Q4 – 124.

			Workforce Expansion of Virtual Ward clinical pathways has required us to recruit to new roles within frailty and heart failure pathways and develop staff competence within this. We introduced the Advanced Clinical Practitioner (ACP) roles into the Virtual Ward to enable us to deliver more complex care in a place they call home. We now also have dedicated Medical leadership for the Virtual Ward and a prescribing Pharmacist for Community services. As a Black Country system, we have aligned the commitment to Safer Staffing with an agreed annual schedule of Workforce skill mix reviews for all Nursing and Midwifery Services.
Priority 2 **2.2 - Clinical Effectiveness - Priority area – Cancer treatment**	Prioritise the treatment of cancer patients, focusing on improving outcomes for those diagnosed with the disease.	• 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 aims for 2024/25 were:** • Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% 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%). • Maintain focus on performance against 31-day decision to treat standard (96%).	RWT was escalated into Tier 1 status for national scrutiny in May 2024, however by successfully reducing our backlogs and improving 62-day performance the Trust was de-escalated to Tier 2 in January 2025. The aspiration to be removed from tiering at the next review in April 2025 was confirmed in May 2025. This means that RWT is now on the lowest level of escalation for cancer performance. The Trust continues to perform to the national standard for the 28 Faster Diagnosis Standard and is ahead of its plan for 2025/26. Surgical treatments continue to be the area of challenge for achieving the 31-day decision to treat standard, however successful outsourcing some Urology demand in 2024/25 saw some improvements to the overall 31-day performance metric. Referrals for Lower GI for FIT positive continue to deliver against the national standard.

			In May 2024 RWT successfully introduced the new skin cancer pathway, which saw the introduction of an image capture element to the pathway.
Priority 2 **2.3 - Clinical Effectiveness - Priority area – National Elective Care Strategy**	Deliver the priorities of the National Elective Care Strategy.	• 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 aims for 2024/25 were: • 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.	The Trust has largely eradicated waits of over 65 weeks with only three patients remaining at the end of March 2025. The focus now turns to reducing the cohort of patients waiting over 52 weeks. The Trust achieved the above through an increase in activity alongside continued productivity improvements. The Trust's capped Theatre utilisation remains within the top quartile of Trusts within the country and frequently within the Top 10 Trusts. The Trust continues to focus on dropped list uptake. The Community Diagnostic Centre at Cannock continues to provide support to diagnostic pathways and is on course to complete c120,000 diagnostic tests in 2024/25. The Trust has ambitions for another CDC as well as an Elective Hub, however, this is dependent on national capital funding, which is yet to be confirmed.

Priority 2 **2.4 - Clinical Effectiveness - 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.	• Review model health system and Getting It Right First Time (GIRFT) data to guide relevant aspects of activity, quality, and safety. **The aims for 2024/25 were:** 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, b) work together with our national clinical leadership to build on that guidance further. • Embed GIRFT/Model Health metrics into Directorate and Divisions' review processes. • Regular benchmarking of GIRFT data and alignment with Quality Improvement plans.	All Further Faster handbooks and guidelines have been shared with the relevant Directorates. GIRFT visits have been undertaken in a number of Directorates including Dermatology, Diabetes and Surgery and action plans have been distributed. The Surgical Division continues to benchmark performance against GIRFT data. This has resulted in a number of initiatives. Subsequently there has been a reduction in the Length of stay (LOS) of patients in Orthopaedics and an increase in day case activity in Urology and Gynaecology. Additionally, a process has been introduced that has reduced the number of overnight stays in General Surgery. Getting it right first time (GIRFT) data and recommendations have been embedded in the Trust Outpatient Transformation programme. Monthly meetings are held with the GIRFT Lead and the RWT Service Efficiency Lead to share learning and good practice.
Patient Experience			
Priority	**Quality & Safety Enabling Strategy**	**What we said we would do**	**How we did**
Priority 3 **Patient Experience - Priority area – Patient involvement**	Embed a culture of learning and continuous improvement at all levels of the organisation.	• The key priorities are outlined within the joint Patient Experience Enabling Strategy (2022/25). 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	In line with the **Patient Experience Enabling Strategy (2022–2025)**, several key developments have been introduced across our three pillars of **Involvement, Engagement, and Experience** to meet the 2024/25 ambitions. **Pillar One – Involvement**, we have strengthened patient and family participation in treatment, care, and discharge planning through programmes such as *Mealtime Mates*, *Patient Involvement Partners*, and targeted volunteer support. These roles help embed lived experience into care, encouraging better outcomes and shared decision-making.

		We will support our staff to develop a culture of learning to improve care and experience for every patient. **The aims for 2024/25 were:** • We will involve patients and families in decisions about their treatment, care, and discharge plans. • Ensure 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. • Reduce complaints, learning from them, and encouraging better attitudes and practice from employees. • Use 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.	**Pillar Two – Engagement** has seen the expansion of the *Patient Partner* programme and the formation of a *QI Working Group for Patient Involvement & Engagement*, enabling patient voice to be actively embedded in service transformation and quality improvement. The launch of *Mystery Patients* in April and regular *Patient Voice Reports & Dashboards* ensure real-time insights inform change. Our *Volunteer Role Database* has supported local recruitment, increasing community representation and participation across wards and services. Meanwhile, our *Volunteering for Health*, *VIP (Volunteering in Partnership)*, and *RWT Volunteer in Education* programmes support inclusive engagement across demographics, reinforcing our commitment to non-discriminatory, equitable services. **Pillar Three – Experience**, we continue to promote a culture of learning and service improvement through systematic use of *FFT hierarchy and scheduled reports*, complaint learning, and ward-level feedback. Our *Patient and Partner Experience Group* meets regularly to monitor, review, and provide assurance on experience-related workstreams. We are progressing implementation of a **real-time feedback dashboard** for directorates to proactively respond to concerns and celebrate positive practice. Together, these initiatives reinforce our commitment to reducing complaints, improving staff attitudes, and ensuring equitable, patient-centred care for all communities across our Trusts. 2024/25 Priorities achieved for Complaint Management. We have implemented a proactive early intervention approach, working with complainants to

			achieve local resolution on concerns. Resolutions negate the need to escalate to operational teams, whether this be for informal complaints (PALS Concerns) or formal complaints. We have engaged with the Parliamentary Health Service Ombudsman's mediation process. The aim is to navigate 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. More cases have been considered for mediation thus reducing the need for complex and lengthy investigation.

Formal complaints, Informal complaints (PALS concerns) and compliments

There were 563 complaints compared to 460 for year 2023/24. This represents an increase of 22%. The directorates where the greatest volume of complaints have been received when compared to the previous year are Older Adult Medicine (74% increase) and General Surgery (71% increase).

Safeguarding concerns which do not meet the criteria for a Section 42 investigation are processed through the complaints procedure and are included in the total number of complaints received. Safeguarding concerns have increased from 59 in 2023/24 to 79 in 2024/25. These numbers are included in the overall figures of 563 for the financial year.

During the year 2024/25, from 471 cases which were closed, the Trust determined that 32% of cases were not upheld, (an increase of 15%), 47% were partially upheld (an increase of 5%), and 18% (an increase of 6%) were upheld. As with the previous year, the Trust's performance measured for complaint outcomes for cases upheld was significantly lower than the national average of 26.4% (as recorded by NHS Digital for 2023/24).

The Patient Experience Team continues to adopt a proactive early intervention approach working with complainants to achieve local resolution on concerns. These cases are resolved negating the need to escalate to operational teams, whether this be for formal or informal complaints.

For this financial year, 1920 cases were assessed and resolved. This is a notable increase from 770 in the previous year. The main theme of these cases remains consistent and relates to communication and information. Not all cases are able to be considered for early resolution and are considered on an individual case basis. Several factors contribute to this decision including co-operation of the complainant and complexity of complaint or concern raised.

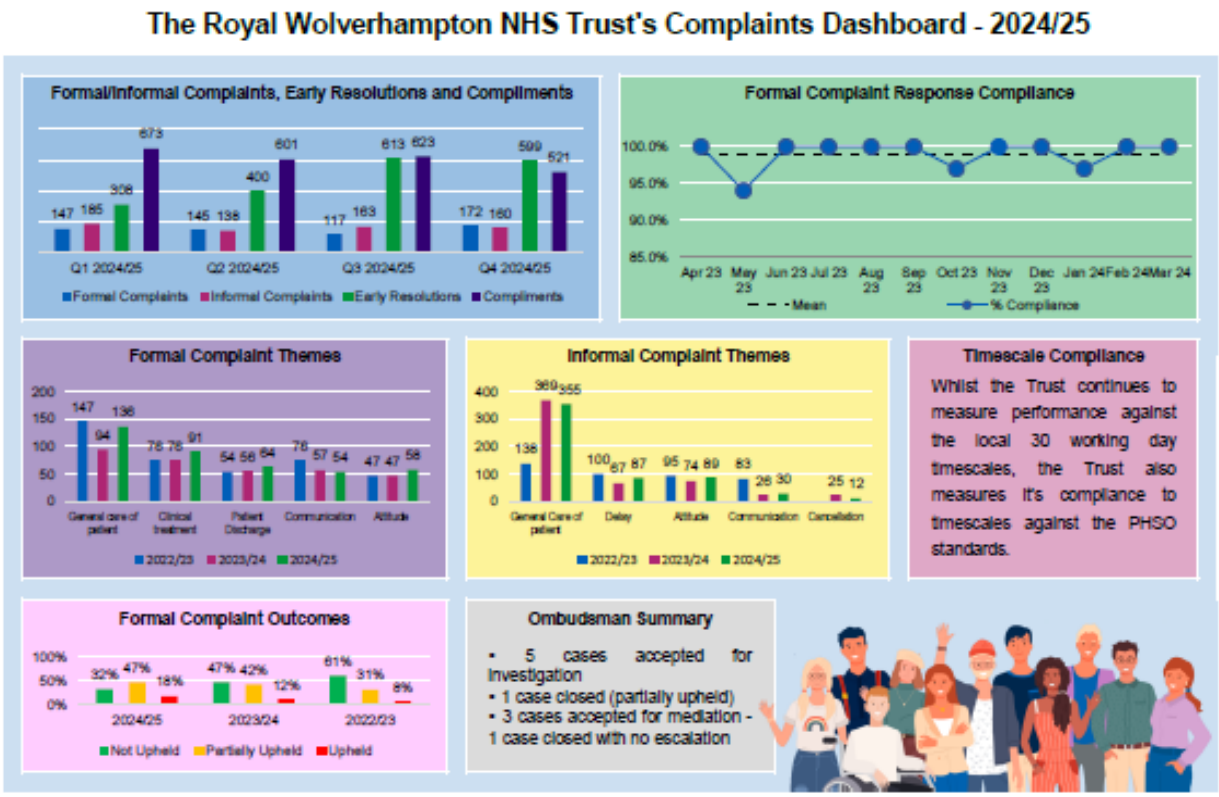
There is little variation between the key themes of complaints year on year. Clinical treatment, patient discharge, general care of patient, attitude and communication, feature highly for formal complaints with the last three featuring in informal complaints along with delay and cancellation.

Parliamentary Health Service Ombudsman (PHSO)

For this financial year a summary of PHSO activity is as follows:

- Five cases assessed with no escalation to formal investigation. One of which resulted in an apology and £100 financial remedy.
- Three cases accepted for mediation. One of which has been concluded with no requirement for escalation.
- Five cases subjected to full investigation. One outcome available, case partially upheld.

There were four cases accepted for investigation in 2022/23 so a slight increase a year later.



Measurable Outcomes:

Percentage of complaints resolved within the Parliamentary and Health Service Ombudsman (PHSO) response timeframe.

Evidence of service improvements resulting from complaint themes including triangulation against other patient experience metrics.

Increase in the number of shared learning cases from both complaints and compliments.

Percentage of staff trained in complaints handling and learning from excellence.

Improved patient and staff confidence in the complaints process (measured via surveys after complaint cases are closed and periodic feedback surveys).

Percentage of complaint responses that explicitly outline changes made because of patient feedback.

Higher percentage of wider data collection on complaints, such as gender, ethnicity and disability etc in line with protected characteristics groups as defined under equalities legislation.

Looking Forward 2025/26 Priorities for Improvement

How we chose our priorities

Each year the Trust is required to identify its quality priorities. We consulted on the quality framework (2023 /25) and the Quality and Patient Experience priorities. The draft priorities were shared with Commissioners, Healthwatch, The Trust Management Committee, Local Authority Public Health, Executive teams within the Divisions and Directorate Management Teams. The final priorities for 2025/26 were agreed by the Trust Board.

The chosen priorities support several quality 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:

KO41a Hospital and Community Health Services Complaints collection - NHS England Digital

Strategic Priority: Embedding the PHSO Complaint Standards and Learning from Excellence

Action 1: Ensure the PHSO Complaints Standards are fully embedded across all services, shifting from a reactive approach to one that prioritises learning from complaints, compliments, and excellence in care. Strengthen feedback loops to demonstrate transparency, accountability, and continuous improvement.

Action 2: Introduce improved performance indicators for complaint handling including the number of re-opened complaints, and the number of complaints referred to the Parliamentary Health Service Ombudsman (PHSO).

Action 3: Consider and implement recommendations from the Healthwatch report published January 2025 'A Pain to Complain'. This involves three distinct categories:

- Make the complaints process easier for patients and their families to navigate.
- Monitor and improve the performance of organisations that handle complaints.
- Develop a culture of listening and learning from complaints.

The priorities detailed below have been identified and agreed in reference to the following strategic documents:

- Quality Framework 2025-2028
- Quality and Safety Enabling Strategy 2023-2026
- Patient Experience Enabling Strategy 2022-2025
- Planning guidance: National priorities 2025/2026

The above Joint Strategies and Framework for The Royal Wolverhampton NHS Trust (RWT) and Walsall HealthCare NHS Trust (WHT) defines in detail how we will strive to excel in the delivery of care, which is one of the four strategic aims of the Joint Trust Strategy.

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

- The priorities taken from Quality and Patient Experience Actions within the Quality Framework 2025 /28
- Embedding Eat, Drink, Dress, Move to Improve (EDDMI)
- Full implementation of Saving Babies Lives to prevent avoidable harm
- Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach

The priorities taken from Patient Experience Enabling Strategy 2022/25:

- Strengthening Organisational Response to National Mandated Surveys
- Embedding the PHSO Complaint Standards and Learning from Excellence
- Integrating Volunteering to Enhance Patient Experience

The priorities taken from the Planning guidance: National priorities 2025/26:

- Reduce the time people wait for elective care
- Improve A&E waiting times and ambulance response times
- Live within the budget allocated, reducing waste and improving productivity

A more detailed breakdown of the aims and key actions are detailed in the table below:

Patient Safety

Section	Key Actions we will take	Aim for 2025/26
Prevention of avoidable hospital deconditioning.	• Monitoring of progress and actions through Safer Mobility Group, Tissue Viability Group, Mouth Care Group, Continence Steering Group, Nutrition Steering Group and Infection Prevention and Control Group. • Incorporating EDDMI status into Clinical Accreditation reports to influence local Quality Improvement.	• Implementation of a standard toolkit to embed principles of EDDMI across a variety of settings, including in the community – starting with an Inpatient focus for 2025/26 – to be expanded in the subsequent financial year. The prevention of patient deconditioning will be incorporated within the EDDMI initiative.
Mental Health	• Develop a policy that supports Medical Emergencies for Eating Disorders (MEED) in line with the • Royal College of Psychiatrist guidance and ensure that any patients who may be suffering from an • eating disorder are supported as per their individual needs. • Develop a training package that supports staff to deliver high quality care for mental health patients. • To develop a policy that supports an all age mental health patient journey, to support all clinical areas in accessing mental health support when required. • Ensure that both Trusts have a mental health risk assessment to support the requirements for patient safety and enhanced observations when required.	• Continue to meet and adhere to the CQC standards for providers of mental health care and treatment within the acute Trust. Ensure clear processes and policies to support mental health patients of all ages to receive excellent quality of care and treatment.
Safeguarding	• The Trust Safeguarding Group will oversee the delivery of safeguarding practice within the organisation and report to Trust Board. • The safeguarding service will develop co-ordinated workstreams in respect of the delivery of core duties. These will be shaped and reflect learning and good practice identified from	• To ensure the Trust discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004 and the Care Act 2014 set against the objectives detailed within the revised Black Country Integrated Care Board Safeguarding Assurance Framework for Commissioned Services.

	Safeguarding Adult Reviews (SAR), Child Safeguarding Practice Reviews (CSPR), Domestic Homicide related Death Reviews (DARDR) and internal incidents. • Safeguarding priorities will be reviewed and reflected in the Annual Report, to inform workstreams for the following year. • Safeguarding risks will be updated to give early warning of delivery issues, so that mitigation and solutions can be implemented and where risk remains significant, concerns are escalated.	
Safe Discharge	• Robust oversight of patient feedback, safeguarding referrals, quality concerns raised via external routes, incidents and excellence to drive continuous improvements. • Through the governance route, strengthen Divisional/Directorate/Care Group oversight and reporting of patient discharge-related concerns, including actions and wider learning. Summary of key themes, learning and actions to be captured in Divisional reports provided to QSAG and QPES.	• Ensure that all patients experience a safe and timely discharge and deliver on the discharge related priorities as outlined in the joint Patient Experience Enabling Strategy (2022/25).
Infection prevention	• Utilise NHS England's "Take your gloves off" campaign to support both rationalisation of glove use by our staff and sustainability objectives • Support the "Eat, Drink, Dress, Move to improve" (EDDMI) initiatives across both organisations • IPC staff will undertake Quality Improvement (QI) training • Work with areas utilising Quality Improvement methodology to support them to be able to do the right thing at the right time. The IPC teams will explore the application of behavioural science and human factors in interventions made • Explore interventions, working with industry partners to support improvement in hand hygiene compliance assurance, for example	• We will enable and empower our staff to be able to practice the fundamental elements of IPC on a consistent basis. This will be achieved through education, educational resources and information, employing innovative methods where appropriate, utilising quality improvement methodologies, aligned policies and IPC visibility. We will facilitate and influence the endeavour to meet and positively exceed nationally set objectives for C diff and Gram negative bacteraemia

	triangulate audit data with alcohol hand gel and soap consumption to establish expected metrics to clinical areas • Facilitate ownership of IPC across all areas • IPC policies will be aligned where possible between the two organisations and will incorporate the National IPC Manual • Audit programmes - alignment of templates/frequency/responsibilities for undertaking • Support and participate in initiatives to improve patient mouthcare • Explore and develop innovative methods of education delivery to ensure meaningful and interactive learning that will encourage and engage the workforce • We will actively support the Clinical Nurse Fellow (CNF) support network to ensure our colleagues are inducted with regard to IPC and provided with education and guidance	
Full implementation of Saving Babies Lives to prevent avoidable harm	• Overarching toolkit and monitoring via national database for Saving Babies Lives. • Monitoring of progress through Maternity Incentive Scheme Directorate surgeries, Local Maternity and Neonatal System (LMNS) Touch Point meetings, LMNS Quality Surveillance, Quality Committee and Trust Board. • Transition of Care Bundle Principles into clinical practice, education and training.	• Deliver the highest quality maternity services across both Trusts, by delivering the safest care options, offering personalised care and choice, and the optimal patient experience for mothers, babies and their families.
Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach	• Implementation of workstreams to Prevent, Identify, Escalate and Respond to patient deterioration across a variety of settings, including in the wider community.	• Develop a collaborative strategic approach focusing on the prevention of patient deterioration, including early recognition and treatment. The purpose will be to strengthen the safety culture and prevention of harm to patients in our care that is evidence based and current.

VTE compliance	Key actions for 2025/26: • Following the announcement of the chair step-down, appointment of new VTE chair to ensure drive and governance is maintained • trial of mandated VTE risk assessments through use of EPMA • development and distribution of VTE dashboard for live compliance monitoring • continual monitoring and sharing of monthly compliance	• Continuous improvement towards achieving the national operational standard of 95% set by the NHS Standard Contract.
Clinical Effectiveness		
Reduce the time people wait for elective care	• Improve 18 weeks RTT to 65% nationally by March 2026. • Improve 18 weeks RTT for a first appointment to 72% nationally by March 2026. • Over 52 weeks RTT to less than 1% of the total waiting list by March 2026. • Improve 28-day cancer Faster Diagnosis Standard to 80% by March 2026. • Improve cancer 62-day standard to 75% target by March 2026.	• Continue recovery of the backlog in elective care resulting from the pandemic, prioritising patients based on their clinical need and reducing the number of patients waiting for the longest time, in line with the priorities of the National Elective Care Strategy.
Improve A&E waiting times and ambulance response times	• 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.	• Improve A&E waiting times, minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours by March 2026 • a higher proportion within 12 hours DTA across 2025/26 compared to 2024/25.
Outpatient Transformation Patient Experience	• Ensure Outpatient services are accessible and efficient for all by: • reviewing pathways. • identifying digital opportunities to support efficiency • improving the interface between primary and secondary care.	• Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients.

Patient Experience		
Strengthening Organisational Response to National Mandated Surveys	**Measurable outcomes:** • Improvement in national patient survey scores over time. • Percentage of national survey feedback themes with clear action plans in place. • Evidence of tangible service improvements resulting from survey insights. • Staff and patient awareness of survey outcomes and resulting actions.	**Action:** Ensure that insights from national patient experience surveys (e.g., CQC Inpatient Survey, Maternity, Children and Young People, Urgent and Emergency Care and NCPES) are systematically reviewed, acted upon, and embedded into continuous improvement cycles. Each organisation should demonstrate clear ownership and accountability for addressing themes and trends.
Embedding the PHSO Complaint Standards and Learning from Excellence	**Measurable outcomes:** • Percentage of complaints resolved within the PHSO response timeframe. • Evidence of service improvements resulting from complaint themes including triangulation against other patient experience metrics. • Increase in the number of shared learning cases from both complaints and compliments. • Percentage of staff trained in complaints handling and learning from excellence. • Improved patient and staff confidence in the complaints process (measured via surveys after complaint cases are closed and periodic feedback surveys). • Percentage of complaint responses that explicitly outline changes made because of patient feedback. • Higher percentage of wider data collection on complaints, such as gender, ethnicity and disability etc in line with protected characteristics groups as defined under equalities legislation.	**Action 1:** Ensure the PHSO Complaints Standards are fully embedded across all services, shifting from a reactive approach to one that prioritises learning from complaints, compliments, and excellence in care. Strengthen feedback loops to demonstrate transparency, accountability, and continuous improvement. **Action 2:** Introduce improved performance indicators for complaint handling including the number of re-opened complaints, and the number of complaints referred to the Parliamentary Health Service Ombudsman (PHSO). **Action 3:** Consider and implement recommendations from the Healthwatch report published January 2025 'A Pain to Complain'. This involves three distinct categories: • Make the complaints process easier for patients and their families to navigate • Monitor and improve the performance of organisations that handle complaints • Develop a culture of listening and learning from complaints
Integrating volunteering to enhance patient experience	**Measurable outcomes:** • Increase in the number of active volunteers contributing to patient experience initiatives • Positive feedback from patients regarding volunteer interactions, measured through patient satisfaction surveys	**Action:** Continue to develop, innovate, and implement a comprehensive volunteering programme that aligns with patient experience goals. This includes recruiting, training, and supporting volunteers to assist in various capacities, such as patient navigation, companionship, and administrative support, thereby enriching the overall patient journey.

	• Improvement in patient flow and reduced waiting times attributed to volunteer support • Enhanced staff satisfaction due to volunteer contributions alleviating workload pressures	

Within the Quality and Safety Enabling strategy there are 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 Quality Account aims.

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

Financial investment can be an enabler to delivering high quality care. 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 and this is focusing on ensuring that we best utilise the finite resources available including, but not limited to, people, physical capacity and finances and maximise opportunities offered through collaborative working between RWT and WHT.

Statements of Assurance from the Board

Mandatory Quality Statements

5.1.1 - Participation in national clinical audits 2024/25 and

5.1.2 - Participation in national confidential enquiries 2024/25

During 2024/25, 38 national clinical audits and three national confidential enquiries covered relevant health services that the Royal Wolverhampton NHS Trust provides.

During that period the Trust participated in 32 (84%) national clinical audits and two (66%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries the Trust was eligible to participate in during 2024/25, and details of whether we did participate or not, are as follows:

National programme name	Directorate	Work stream / Topic name	Participating 24/25	Rationale for not participating 2024/25
BAUS Urology Audits	Urology	BAUS Nephrostomy Audit	Yes	
	Urology	Penile Fracture Audit	No	Missed for 2024/25 due to cross cover within Assurance Team and not identified by Directorate, the audit is on the 2025/26 plan.
	Urology	Environmental Lessons Learnt and Applied to the Bladder Cancer care pathway audit (ELLA)	Yes	
Breast and Cosmetic Implant Registry	General Surgery	–	Yes	
*British Hernia Society Registry	General Surgery		No	Confirmed not completed. General Surgery has not been approached to participate.
ICCU Case Mix Programme	ICCU	Intensive Care National Audit and Research	Yes	The data cut-off date is set by ICNARC each year and has

(CMP)		(ICNARC)		usually been around September to October of each year. The 2024/25 data is being submitted.
Confidential Enquiry Child Health Clinical Outcome Review Programme	Children's Acute	National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	Yes	
Emergency Medicine QIPs	ED	Care Of Older People	Yes	N/A
	ED	Adolescent Mental Health	No	The Directorate has completed local and national audits on adolescent mental health recently therefore, due to cost saving measures, the Directorate have decided not to pay to participate in this particular RCEM QIP this year.
	ED	Time Critical Medications	Yes	
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Children's Acute	–	Yes	
Falls and Fragility Fracture Audit Programme (FFFAP)	Rheumatology	Fracture Liaison Service Database (FLS-DB)	Yes	
	T&O	National Audit of Inpatient Falls	Yes	
	T&O	National Hip Fracture Database	Yes	

LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Trust wide	–	Yes	Learning from Deaths platform - RWT submits deaths of people with learning disabilities and deaths of autistic people to the central repository at NHS England. We cannot guarantee that we submit for everyone as we may not be aware of a person's diagnosis.
Confidential Enquiry Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Services	Perinatal confidential enquiries	Yes	
***Confidential Enquiry** Medical and Surgical Clinical Outcome Review Programme	Gastroenterology	National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	No	Abandoned audit not going ahead for RWT Criteria.
National Adult Diabetes Audit (NDA)	Diabetes	National Diabetes Foot Care Audit	Yes	
	Diabetes	National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms	Yes	
	*Diabetes	Diabetes Prevention Programme (DPP) Audit	No	Directorate was not approached with this audit. Not participated in them previously. The diabetes prevention would be primary care.
	Diabetes	Transition (Adolescents and Young Adults) and	Yes	This has been integrated as part of the National Diabetes Core Audit.

		Young Type 2 Audit		
	Perinatal Services	National Diabetes in Pregnancy Audit	Yes	Now included as part of Saving Babies Lives programme element 6, data is submitted monthly and reviewed quarterly via new dashboards. These will no longer be registered as audits.
	Perinatal Services	Gestational Diabetes	Yes	Now included as part of Saving Babies Lives programme element 6, data is submitted monthly and reviewed quarterly via new dashboards. These will no longer be registered as audits.
	Diabetes	National Diabetes Core Audit	Yes	
National Audit of Cardiac Rehabilitation	Cardiology	−	Yes	
National Audit of Cardiovascular Disease Prevention Primary care	Primary Care	−	Yes	
National Audit of Care at the End of Life (NACEL)	Palliative Care	−	Yes	Twenty case notes review /quarter (completed by the team with Consultant/CNS to ensure consistency).
National Audit of Dementia (NAD)	Older Adult Medicine/Neurology	−	No	Trust does not have a Dementia Team or any resource.
National Cancer Audit Collaborating Centre - Natcan	General Surgery	National Audit of Metastatic Breast Cancer- (NAoME)	Yes	

	General Surgery	National Audit of Primary Breast Cancer (NAoPri)	Yes	
	General Surgery	National Bowel Cancer Audit (NBOCA)	Yes	
	Respiratory	National Lung Cancer Audit (NLCA)	Yes	
	Renal	National Kidney Cancer Audit	Yes	
	Haematology	National Non-Hodgkin Lymphoma Audit (NLHLA)	Yes	
	Gastroenterology	National Oesophago Gastric Cancer (NOGCA)	Yes	
	Gynaecology	National Ovarian Cancer Audit (NOCA)	Yes	
	Gastroenterology	National Pancreatic Cancer Audit (NPaCA)	Yes	
	Urology	National Prostate Cancer Audit (NPCA)	Yes	
National Cardiac Arrest Audit (NCAA)	Resuscitation		Yes	
National Cardiac Audit Programme (NCAP)	Cardiology	National Adult Cardiac Surgery Audit	Yes	
		National Congenital Heart Disease (NCHDA)	Yes	
		National Heart Failure Audit	Yes	

		National Audit of Cardiac Rhythm Management (CRM)	Yes	
		Myocardial Ischaemia National Audit Project (MINAP)	Yes	
		National Audit of Percutaneous Coronary Interventions (NAPCI)	Yes	
		The UK Transcatheter Aortic Valve implantation (TAVI Registry)	Yes	
		Left Atrial Appendage Occlusion (LAAO) Registry	No	Directorate advised that it did not participate, possibly due to capacity.
		Patent Foreman Ovale Closure (PFOC) Registry	Yes	
		Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	The National body (NICOR) has confirmed that MVLR is included in TMTV.
National Child Mortality Database (NCMD)	ED	–	Yes	
National Comparative Audit of Blood Transfusion	Pathology	Audit of NICE Quality Standard QS138	Yes	
		Bedside Transfusion Audit	Yes	
National Early Inflammatory Arthritis Audit	Rheumatology	–	Yes	

National Emergency Laparotomy Audit (NELA) a) Laporotomy	ICCU Theatres	–	Yes	
National Emergency Laparotomy Audit (NELA) b) No Laporotomy	ICCU Theatres	–	Yes	
National Joint Registry	T&O	–	Yes	
National Major Trauma Registry	ED	Previously TARN	Yes	N/A
National Maternity and Perinatal Audit (NMPA)	Perinatal Services	–	Yes	Now include MBRACE and part of CNST reported via Inphase performance dashboards. These will no longer be registered as audits.
National Neonatal Audit Programme (NNAP)	Neonatal	–	Yes	
*National Ophthalmology Database Audit (NOD)	Ophthalmology	Adult Cataract Surgery Audit	No	Department awaiting EPR to be installed in order to submit data. Expected installation Dec 2025.
		Age Related Macular Degeneration Audit	No	Department awaiting EPR to be installed in order to submit data. Expected installation Dec 2025.
National Paediatric Diabetes Audit	Children's Acute	–	Yes	
National Perinatal Mortality Review Tool	Perinatal Services	–	Yes	Now included as MBRRACE and part of CNST reported via Inphase performance dashboards. These will no longer be registered as audits.

National Pulomary Hypertension Audit	Cardiology		No	Missed for20 24/25 due to cross cover within Assurance Team and not identified by Directorate, the audit is on the 2025/26 plan.
National Respiratory Audit Programme (NRAP) Previously known as Asthma and COPD Audit Programme	Respiratory	COPD Secondary Care	Yes	
	Physiotherapy	Pulmonary Rehabilitation	Yes	
	Respiratory	Adult Asthma Secondary Care	Yes	
	Children's Services	Children Young Peoples Asthma Secondary Care	Yes	
Perioperative Quality Improvement Programme (PQIP)	ICCU Theatres	–	No	Did not complete due to capacity Issues (Amber (9) risk 5961) on Directorate Risk Register.
*Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Head & Neck	Oncology & Reconstruction	No	Only 16 Trusts participated, RWT was not approached.
		Trauma	No	Only 16 Trusts participated, RWT was not approached.
		Orthognative Surgery	No	Only 16 Trusts participated, RWT was not approached.
		Non-melanoma skin Cancers	No	Only 16 Trusts participated, RWT was not approached.
		Oral and Dentoalveolar Surgery	No	Only 16 Trusts participated, RWT was not approached.
Sentinel Stroke National Audit Programme (SSNAP)	Stroke	–	Yes	
Serious Hazards of Transfusion	Pathology	–	Yes	

(SHOT): UK National haemovigilance scheme				
Society for Acute Medicine Benchmarking Audit (SAMBA)	Acute Medicine	–	Yes	
UK Cystic Fibrosis Registry	Respiratory	–	Yes	
UK Renal Registry Chronic Kidney Disease Audit	Renal	–	Yes	
National Acute Kidney Injury Audit	Renal	–	Yes	

*National Audits the Royal Wolverhampton NHS Trust was eligible to participate in, but where the Trust was either not approached to participate, the Directorate is awaiting a new system to be installed or the element relevant to the Trust was withdrawn from the audit.

The national clinical audits and national confidential enquiries that the Royal Wolverhampton NHS Trust participated in are listed below, 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, where that information is available.

National programme name	Directorate	Work stream / Topic name	% of cases submitted	Data collection completed during reporting period? Yes/No?
BAUS Urology Audits	Urology	BAUS Nephrostomy Audit	Extracted from Registry - Audit In progress	No
	Urology	Environmental Lessons Learnt and Applied to the Bladder Cancer care pathway audit (ELLA)	Extracted from Registry - Audit In progress	No
Breast and Cosmetic Implant Registry	General Surgery	–	In Progress	No
ICCU Case Mix Programme (CMP)	ICCU	Intensive Care National Audit and	In Progress	No

		Research (ICNARC)		
Confidential Enquiry Child Health Clinical Outcome Review Programme	Children's Acute	National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	In Progress	No
Emergency Medicine QIPs	ED	Care Of Older People	100%	Yes
	ED	Time Critical Medications	100%	Yes
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Children's Acute	–	100%	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)	Rheumatology	Fracture Liaison Service Database (FLS-DB)	100%	Yes
	T&O	National Audit of Inpatient Falls	Extracted from Registry - Audit In progress	No
	T&O	National Hip Fracture Database	Extracted from Registry - Audit In progress	No
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Trustwide	–	Unable to confirm	No
Confidential Enquiry Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Services	Perinatal confidential enquiries	Extracted from Registry - Audit In progress	No
National Adult Diabetes Audit (NDA)	Diabetes	National Diabetes Foot Care Audit	Extracted from Registry - Audit In progress	No
	Diabetes	National Diabetes Inpatient Safety Audit	Extracted from	No

		(NDISA) Previously NaDIA-Harms	Registry - Audit In progress	
	Diabetes	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Extracted from Registry - Audit In progress	No
	Perinatal Services	National Diabetes in Pregnancy Audit	100%	Yes
	Perinatal Services	Gestational Diabetes	100%	Yes
	Diabetes	National Diabetes Core Audit	Extracted from Registry - Audit In progress	No
National Audit of Cardiac Rehabilitation	Cardiology	−	Extracted from Registry - Audit In progress	No
National Audit of Cardiovascular Disease Prevention Primary care	Primary Care	−	Extracted from Registry - Audit In progress	No
National Audit of Care at the End of Life (NACEL)	Palliative Care	−	100%	Yes
National Cancer Audit Collaborating Centre - Natcan	General Surgery	National Audit of Metastatic Breast Cancer-(NAoME)	Extracted from Registry - Audit In progress	No
	General Surgery	National Audit of Primary Breast Cancer (NAoPri)	Extracted from Registry - Audit In progress	No
	General Surgery	National Bowel Cancer Audit (NBOCA)	Extracted from Registry - Audit In	No

			progress	
	Respiratory	National Lung Cancer Audit (NLCA)	Extracted from Registry - Audit In progress	No
	Renal	National Kidney Cancer Audit	Extracted from Registry - Audit In progress	No
	Haematology	National Non-Hodgkin Lymphoma Audit (NLHLA)	Extracted from Registry - Audit In progress	No
	Gastroenterology	National Oesophago Gastric Cancer (NOGCA)	Extracted from Registry - Audit In progress	No
	Gynaecology	National Ovarian Cancer Audit (NOCA)	Extracted from Registry - Audit In progress	No
	Gastroenterology	National Pancreatic Cancer Audit (NPaCA)	Extracted from Registry - Audit In progress	No
	Urology	National Prostate Cancer Audit (NPCA)	Extracted from Registry - Audit In progress	No
National Cardiac Arrest Audit (NCAA)	Resuscitation		Extracted from Registry - Audit In progress	No
National Cardiac Audit Programme (NCAP)	Cardiology	National Adult Cardiac Surgery Audit	Extracted from Registry -	No

			Audit in Progress	
		National Congenital Heart Disease (NCHDA)	Extracted from Registry - Audit in Progress	No
		National Heart Failure Audit	Extracted from Registry - Audit in Progress	No
		National Audit of Cardiac Rhythm Management (CRM)	Extracted from Registry - Audit in Progress	No
		Myocardial Ischaemia National Audit Project (MINAP)	Extracted from Registry - Audit in Progress	No
		National Audit of Percutaneous Coronary Interventions (NAPCI)	Extracted from Registry - Audit in Progress	No
		The UK Transcatheter Aortic Valve implantation (TAVI Registry)	Extracted from Registry - Audit in Progress	No
		Patent Foreman Ovale Closure (PFOC) Registry	Extracted from Registry - Audit in Progress	No
		Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Extracted from Registry - Audit in Progress	No
National Child Mortality Database (NCMD)	ED	–	Extracted from	No

			Registry - Audit In progress	
National Comparative Audit of Blood Transfusion	Pathology	Audit of NICE Quality Standard QS138	100%	Yes
		Bedside Transfusion Audit	100%	Yes
National Early Inflammatory Arthritis Audit	Rheumatology	–	Extracted from Registry - Audit in Progress	No
National Emergency Laparotomy Audit (NELA) a) Laporotomy	ICCU Theatres	–	100%	Yes
National Emergency Laparotomy Audit (NELA) b) No Laporotomy	ICCU Theatres	–	100%	Yes
National Joint Registry	T&O	–	100%	Yes
National Major Trauma Registry	ED	Previously TARN	100%	Yes
National Maternity and Perinatal Audit (NMPA)	Perinatal Services	–	100%	Yes
National Neonatal Audit Programme (NNAP)	Neonatal	–	Extracted from Registry - Audit in Progress	No
National Paediatric Diabetes Audit	Children's Acute	–	100%	Yes
National Perinatal Mortality Review Tool	Perinatal Services	–	100%	Yes
National Respiratory Audit Programme (NRAP) Previously known as Asthma and COPD Audit Programme	Respiratory	COPD Secondary Care	Extracted from Registry - Audit in Progress	No
	Physiotherapy	Pulmonary Rehabilitation	In Progress	No

	Respiratory	Adult Asthma Secondary Care	Extracted from Registry - Audit in Progress	No
	Children's Services	Children Young Peoples Asthma Secondary Care	100%	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Stroke	–	100%	yes
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Pathology	–	In Progress	No
Society for Acute Medicine Benchmarking Audit (SAMBA)	Acute Medicine	–	100%	Yes
UK Cystic Fibrosis Registry	Respiratory	–	Extracted from Registry - Audit in Progress	No
UK Renal Registry Chronic Kidney Disease Audit	Renal	–	Extracted from Registry - Audit In progress	No
National Acute Kidney Injury Audit	Renal	–	Extracted from Registry - Audit In progress	No

The reports of 42 national clinical audits were reviewed by the provider in 2024/25 and the Royal Wolverhampton NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Actions Taken
BHIVA National clinical Audit 2024 is Documentation of Co-medications and provision of vaccinations	No further action required by RWT.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary	To ensure that there is adequate assessment time for patients to complete an exercise test in line with ERS recommendations.

Rehab (2024/25)	
(Dietetics) Neonatal Audit - Time To Reach 150ml/kg/g (24/25)	Referral criteria developed for review of nutritionally at risk babies. Presence at ward times weekly to encourage advancement of feeds To discuss audits at national dieticians meeting.
The National Audit of Cardiac Rhythm Management (NACRM) 2023/24 data (2024/25)	No further action required by RWT.
The National Heart Failure Audit (NHFA) 2023/24 data (2024/25)	Directorate currently developing a Heart Failure in reach proforma to further improve the referral process for cardiac rehab.
The National Audit of Percutaneous Coronary Interventions (NAPCI) (procedures between 1 April 2022 to 31 March 2023) (2024/25)	No further action required by RWT.
The Myocardial Ischaemia National Audit Project (MINAP) 2022/23 data (2024/25)	No further action required by RWT.
National Audit of Cardiovascular Disease Prevention in Primary Care (CVD Prevent) 2023/24 data (24/25)	Overall, nationally, further work is needed to investigate the reasons behind these inequalities.
National Lung Cancer Audit 2023 Data (24/25)	Regular data review with Cancer Service Team to ensure data input is as accurate as possible as small variance likely to be due to data entry.
BAUS: Snapshot Audit Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard Care Practices (I-DUNC) Audit (2024/2025)	Results not specific to RWT. The national recommendations are: Units are encouraged to look carefully at their indications for diagnostic URS and their median times from diagnosis to nephroureterectomy. Urology will devise an action plan based on this recommendation.
National SAMBA Audit (2024/2025)	Directorate seeks to improve clerking times as this is proved crucial to timely interventions to improve patient care and outcomes.
RCEM - National QIP- Time Critical Medications (Year 1) (2024/2025)	The Emergency Services Group will plan to implement the following actions: Display posters around departments and work collaboratively with Pharmacists to improve patient care through education resources and teaching sessions.
Get it right the first time- National Service Evaluation- Paediatric hallux valgus surgery (2024/2025)	No further action required by RWT.

Safety and effectiveness audit of JAK inhibition in IBD (2023/2024)	No further action required by RWT.
Regional Residual Limb Quality Audit (VARICS - Vascular Research and Innovation Consortium (VARICS) (23/24)	RWT to share with The Vascular Team that it should continue to make timely pre-amputation referrals to limb absence MDT.
HASTE National Collaborative Audit "The effect of oral anticoagulant use on surgical delay and mortality in older hip and femoral fracture patients" (2023/2024)	No further action required by RWT.
2023 National Comparative Audit of Quality Standard QS 138 (Blood Transfusion)	Directorate to issue a communication to relevant departments on the results of this audit and the importance of the standards of QS138.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary Rehab (2023/24)	Department to review clinic times to ensure that there is adequate assessment time for patients to complete an exercise test in line with ERS recommendations.
The 2023 National Respiratory Support Audit	Directorate developing business case to include enhanced Nursing staff: Patient ratio, with additional ACP support to provide 24-hour cover. Policy to be reviewed for ring fencing from Capacity Team. Regular, bi-monthly education for the JDs and Nursing Team.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) COPD Secondary Care (Adults) Asthma- 2022 data	No further action required by RWT.
National Diabetes Audit - Adults (National Core Diabetes Audit) 2023/24	No further action required by RWT.
National Diabetes Foot Care Audit - 2023 data	National requirement to improve education – ICB wide.

BAUS: National Nephrostomy Audit (2023/2024)	National Recommendations are as follows: prompt assessment in ED increasing awareness of the possibility of obstruction in patients being treated for pyelonephritis (on Urology and Medical wards) with early imaging improved access to out of hours imaging early review by senior decision makers improved access to IR in and out of hours appropriate application of sepsis pathways ensuring blood, urine and nephrostomy cultures are sent early review by ITU outreach teams where appropriate increased awareness in high risk groups such as the immunosuppressed or elderly careful consideration of options to minimise delays in anticoagulated patients consideration of stent insertion as an alternative to minimise delays where appropriate arrangements for patient transfer where needed minimising delays in nephrostomy re-insertion where previous nephrostomy has been dislodged
National Cardiac Rehabilitation Audit data 2023/24 (2024/25)	No further action required by RWT.
National Trans Catheter Aortic Valve implantation (TAVI) 2023/24 data (2024/25)	No further action required by RWT.
National Adult Cardiac Surgery Audit (NACSA) (2023/24 data)	No further action required by RWT.
National Thoracic Surgery Audit 2023/24 DATA (2024/25)	No further action required by RWT.
National ICNARC Case Mix Audit & Research Programme for Critical Care (2023/24 Data)	No further action required by RWT.
National Clinical Outcome Review Programme: Endometriosis (2022/2023)	Trusts to further improve awareness training and recognition of endometriosis symptoms, patient engagement to help manage their symptoms and medicine management to treat patients effectively with endometriosis and improve quality of care.
NHSBT: Audit for Acute Upper Gastrointestinal Bleeding 2022	AUGIB bundle to be incorporated to Trust GIB guidelines. This audit has been superseded by up-to-date annual JAG Bundle and GI bleed audits, so this is old data and most of the recommendations are already incorporated.
National Diabetes Audit - Adults (National Core Diabetes Audit) 2022/23	No further action required by RWT.

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Asthma (2022/23)	No further action required by RWT.
National ICNARC Case Mix Audit & Research Programme for Critical Care (2022/23 Data)	No further action required by RWT.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) (2022/2023)	No further action required by RWT.
National Joint Registry (NJR) Annual Report (2022/2023)	The Trust continues to perform well and is not an outlier. The implant selection for total hip replacement and total knee replacement is in accordance with the national standards as per the national joint registry.
MBRRACE (Maternal, Newborn and Infant Clinical Outcome Review) Audit- Perinatal Mortality Surveillance Report- UK Perinatal Deaths for Births (2022/2023)	There are no recommendations within the report in relation to hospital acute Trusts- all recommendations are for commissioners, RCGOG and Government.
National ICNARC Case Mix Audit & Research Programme for Critical Care (2021/22 data)	No further action required by RWT.
(Theatres) NAP7: Perioperative Cardiac Arrest (2021/22 Data) (carried over from 2023/24)	Directorate has displayed posters in key areas to share the results of the NAP7.
NCEPOD Medical and Surgical Clinical outcome review programme Crohn's disease 21/22	Management Team to write a business case for psychological and dietetic support. Review rota demands/list availability and hold discussions with Clinical Directors. Department to develop a database for all surgical patients, including relevant pre-operative therapy, surgical operation performed and post operative complication, referral back to IBD medical team for follow up and, where necessary, follow on therapy started.
Improving Quality in Liver Services (IQILS) National accreditation (20/21)	National recommendation for all Directorates to review their own practice to identify areas where they can improve performance.
National ICNARC Case Mix Audit & Research Programme for Critical Care (relates to 2020/21 data cycle).	No further action required by RWT.
National ICNARC Case Mix Audit & Research Programme for Critical Care (relates to 2019/20 data cycle).	No further action required by RWT.

An additional 18 national audits were closed on the Clinical Audit Database in 2024/25 as the Trust had not received a published report for more than two years. It has been agreed by the Trust Clinical Audit Lead that when the final reports are published, Directorates will re-open the audits on Clinical Audit database and record the results. Those results will be collated and will feature in the next Quality Accounts report.

5.1.3 - Local Clinical Audits 2024/25

A total of 212 local clinical audits were registered by The Royal Wolverhampton NHS Trust between 1 April 2024 and 31 March 2025 (data excludes audits pending, declined and abandoned). A total of 149 audits were completed by the Trust and of these, 115 demonstrated some areas where improvements could be made. The Trust intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Actions Taken
Adequacy of (a) documentation of patients reviewed and (b) Handover of ITU patients on the cardiothoracic ward (2024/25)	The team has developed a new handover form between ICCU and the Cardiothoracic Ward. The new handover form includes a box for the Registrar to sign when the patient has been reviewed post transfer.
(SLT) Time to oral intake for patients in the ICU setting	Team to explore additional parameters such as: Non-oral feeding requirements IDDSI recommendations during bedside assessments to explore cost savings with dysphagia diet modifications and non-oral feeding requirements Collection of the Functional Oral Intake Scale (FOIS) at the start and end of SLT input to add additional information to the changes made by swallowing interventions
Audit of Completed ABRs July 2024	Clinical Lead to discuss audit results of sedation audit and documentation errors that require addressing at ABR team meeting and implement ideas raised by Paediatric and ENT Governance team meetings.
Peripheral Venous Cannula (PVC) Audit Date: September 2024	IPC Team will undertake a targeted approach to ensure entering all devices on to Vitals system at insertion which would be a positive change, increasing assurance for accuracy of device dwell times. Continued education and reinforcement from clinical leads to maintain devices correctly and promote removal of unnecessary devices. Education to encourage referral to the IV resource team where patients have poor venous access or require longer term therapy.
Annual Sharps Audit November 2024	The IPC Team will continue to undertake regular spot checks and increase education for areas where non-compliance was identified, focusing on the importance of completing labels correctly, temporary closure mechanism and appropriate items to dispose of into sharps containers.

Appropriateness of usage of computed tomography pulmonary angiography (CTPA) investigation of suspected pulmonary embolism	Clinical Lead to disseminate the results to Radiology Registrars, Radiographers and Consultants as a reminder to vet the referrals accurately and reaudit in six to 12 months. Key focus on additional training or reinforcement of D-dimer and CXR in clinical settings could help improve the rate of positive findings on CTPA. Integrate clinical decision support tools within the electronic medical records system i.e. ICE to automatically prompt Wells score assessments and D-Dimer testing when PE is suspected. This may help streamline the decision-making process and improve both adherence and diagnostic accuracy.
Transplant Audit - Living Donor update 2024/25	Quarterly transplant meetings to be held with CKD team to review process focusing on pre-emptive transplants and involvement in Pre-transplant clinic MDTs to ensure less patients missed. This will also help to identify any barriers to transplantation for individual patients/patient groups. Include as agenda item in local governance meeting - plan to start transplant work up at eGFR 20 and early referral to transplant team for patient education/identification of live donors. Plan quarterly meetings with the local transplant centre to follow up on all referrals to transplant centres/outcomes and live donor progress.
Trust wide Linen Audit	Wards to ensure that no inappropriate items are stored within linen rooms and linen is stored correctly. Infection prevention to undertake regular walkarounds to ensure compliance with linen policy.
Isolation Audit	Ensure all clinical areas are aware of and adhere to IP10 Isolation Policy for infectious diseases (including the isolation matrix) Infection Prevention and Control to support clinical areas and the Capacity Team to improve compliance and provide education on how to prioritise side rooms dependent on the patient's risk.
Trust wide Audit To assess the cleanliness and integrity of the commodes	Ensure that an adequate supply of chlorine-based wipes are ordered and available for use for the decontamination of all commodes. I am clean" stickers to be used when commodes are cleaned. Carry out spot checks of commodes for damage or rust. IPC to provide education to support wards to achieve improvement IPC to continue to complete the C. diff enhanced, environmental audits PECC team to buy four commodes funded by the Divisions to support a cycle of enhanced cleaning Current poster to be reviewed to ensure it shows all parts of the commode are decontaminated.

	Managers to ensure that all staff are trained on how to clean a commode including a practical demonstration.
Re-audit on Prophylactic Antibiotics post (assisted) delivery - Nov 2024 Previous audit reference number 16761	Doctors encouraged to undertake the assisted delivery procedure in Theatre. The October LocSSips (submitted in November 2024, showed that the majority of assisted births did take place in Theatre showing increased number in Theatre over two months Sept/Oct 24.
(SLT) Repeat review of compliance to national standards for ICCU SLT service (2024/25)	New Band 7 role established to enhance training of staff in verbal and non-verbal communication methods to include communication training on the use of augmentative and alternative communication (AAC). This will provide the staff with knowledge and awareness of AAC and how best to facilitate communication with their patients.
Audit of Documentation of Pacing charts for Cardiac surgery patients (2024/25)	Introduce teaching sessions for clinical teams on the standards required for pacing chart documentation and to raise awareness on importance of documentation of pacing charts.
Audit of practices for patients with Coeliac Disease	Directorate will collaborate with Dietetic Services within the region. Introduction of coeliac checklist and creation of a coeliac information leaflet.
Prescription compliance according to controlled drug SOP (2024/25)	Management Team to reinforce recommendations regarding all CD prescriptions to have all required information.
NICE Audit: Appropriate use of antibiotics in patients presenting with uncomplicated UTI with local formulary (2024/25)	Clinical Lead to communicate the need for appropriate antibiotics to be provided when prescribing for UTIs across the wider team.
Re-audit: Pregnancy of unknown location (2024/2025)	Audit Lead to present findings at departmental teaching to ensure all Doctors dealing with PUL understand importance of following Trust guidance. Improvements in Weekend Beta HCG chasing and further actioning has already been implemented.
Theatres - Fasting times among patients coming for trauma surgery (2024/25)	Discussion at Orthopaedic governance meeting to Initiate campaign in trauma wards by involving trauma Nurses to implement sip till send.
Audit of ERCP Timing for Patients With CBD Stones	Plan for early identification of patients who fit criteria for emergency ERCP after USS confirmation (guided by BSG ERCP Working Party guidelines) • Improve access to emergency imaging (including MRCP) for patients who may require emergency ERCP.

Adherence of patient operation notes to the Royal College of Surgeons of England, good surgical practice guidelines (2024/25), Re-audit	Directorate to create a pre-designed electronic specific operation note proforma for thoracic surgery to include the applicable domains as recommended by RCS.
Paeds Prescribing Audit	Directorate to advise wider team of further improvements on documentation of charts through dedicated education forums.
Retrospective Quality Audit Chest X-ray - Bases (2024/25)	Radiology Lead to present findings to wider team, highlighting the awareness of bigger field of view for bases or to repeat the whole chest imaging.
Ankle Re-audit 2023 (2024/25) Re-audit	Feedback to Radiology plain imaging team to further improve imaging quality.
Annual Audit Review Reporting Radiographers (September 2022/23) (2024/25)	Continue to discuss error in learning meetings to promote open and blame free culture and support learning. Radiographers to give a short presentation/case study on pathology/plain film appearance of their choice lasting approximately 10- 30mins– rolling programme (learning meetings).
Monitoring of Cardiac Risk in CML patients	Clinical Team to ensure every cml patient has risk score correctly documented.
Audit of Stage A Calibration Compliance at Gem Centre (2024/25)	All staff have been reminded to continue with ensuring eCalibration sheets are appropriately completed.
Investigating Diabetes in patients with Acute Coronary Events in Cardiology Ward (2024/25)	Directorate will continue pre-operative Hba1c testing in diabetic patients prior to cardiac surgery. To review HbA1c results and refer to the specialist diabetes team where HbA1c is above 69. To not stop long-acting insulin prior to surgery.
Opioid prescription practice for chronic kidney disease patients as per standard guidelines - cycle 1 and Cycle 2	Directorate Team plans to incorporate the following actions: Cycle 1. To provide Renal drug handbooks for all Junior Doctors. This will be included in the Renal Induction Programme. Cycle 2. Ward Consultant/Registrar/Pharmacist to double check opioid doses. Also, authors to devise posters.
Vision Screening Audit	Team to Identify number of correct referrals to the Orthoptics Department. Develop a process to obtain feedback of the percentage of correct referrals to opticians.
(SLT) Peer review clinical supervision (2024/25)	The team will ensure that information sharing at a service meeting is done every 12 months.

Patient notes audit (2024/25)	Clinical Lead to disseminate the audit presentation to team leads for cascade to the wider staff for information and raise in general meetings/PT/OT newsletters and bulletin. Clinical leads and team leads to inform staff without stamps/lost stamps to contact staff base to order/replace.
Acute PT and OT team audit - Implementation and effectiveness of dedicated input to patients on the inpatient rehabilitation waiting list (2024/25)	Ensure focused intervention and implement “Home First” approach for all discharges.
Staff compliance of using the modified Nottingham Sensory Assessment Tool in patients that have sensory deficits following an acute stroke (2024/25).	Directorate to establish a focus group to identify barriers to completing the tool.
Staff Stress Audit (2024/25)	Adding a health and wellbeing section to department bulletin and induction pack including information on health and wellbeing and access if needed.
Planned Care (RASC) - Re-audit of compliance of Medication Administration	E-community code RASC- Administration of Medication T16 to be used for all patients on the RASC medication service. Medication detail to include reasons why medication support is required. MAR Chart training to be included in new starters’ induction.
Re-Audit PGDs across Ophthalmology (2024/25)	Stamps have been circulated around areas to ensure that questions are compliant with healthcare advice. Date and time given drug requires improvement and possible training if this does not improve on the next audit.
An audit of use of Guslkkumab for treating active psoriatic arthritis after inadequate response to DMARDS as per NICE guidelines (TA815) (2024/25)	Clinicians will be informed via Directorate Governance meetings and reiterate the importance of the documentation with a request to use biologic proforma now available.
Recommendation for herpes Zoster vaccination in immunosuppressed individuals with autoimmune rheumatic disease aged 70 to 79 years - a review of the departmental practice as per "The Green Book" guidelines (2024/25)	There will be effective communication to GPs regarding new guidelines recommending GPs to offer vaccination to all eligible patients.
An audit of the timing of Zoledronic acid infusion as per locally agreed standards (2024/25)	Demand and capacity mapping is being done within the service for Zoledronate. Impact on 20%, however, noted to be related to COVID-19.

A review of continuation of Denosumab on timely manner in the community following discharge from the hospital (2024/25)	Department to consider further studies to understand the circumstances beyond the delay with the GP as the data collection does not provide sufficient information to understand the reasons and to develop an action plan for improvements to the service.
Non-Medical Prescribing (NMP) Audit	Disseminate results to NMP lead, Pharmacy lead, NMP team and at local governance meeting. Ensure the list of NMPs is up to date. Request line management team includes NMP as part of its reviews for staff annual appraisals.
Dietetics: Compliance with CP50 (2024/25)	To review CP50 and update dietetic guidance with input from gastroenterology and Paediatricians. To further discuss with gastroenterology regarding reporting abnormal bloods and supplementation advice to GP.
(Dietetics) Dietetic Record Keeping (2024/25)	**Actions include:** To circulate inpatient documentation SOP to all dietitians as a reminder of dietetic entry requirements To include a discussion of this SOP in induction of new staff Highlight in dept meeting to all team members that dietitians must stamp their entry, or if one is not available must write out, full name, designation and DT number. Highlight in dept meeting to all team members to ensure colleagues provide a bleep or other contact number to their entries. Provide all dietitians with a learning resource on writing PASS statements.
(Dietetics) Parenteral Nutrition (2024/25)	Audit findings to be presented to Gastroenterology Governance meeting, further discussion around recommended updates required to guidelines.
(Dietetics) In Patient snack Availability (2024/25)	Audit results to be shared at Catering Ops and NSSG and ensure newly created posters are circulated to all wards.
Cancer Pathway SOP: To audit the effectiveness of SOP (LocSSIPs) (2024/25)	This is being addressed as part of a bigger scope and no specific actions determined from this specific audit. Recommendations for increasing clinic capacity, re-audit and investigating the delays have been agreed, however.
An audit assessing whether the patients referred for ambulatory EEG meet the selection criteria for an ambulatory EEG at the time they are offered and at the time of the appointment (2024/2025)	List of criteria developed for this investigation. Patients contacted and history taken, plus a thorough explanation of the investigation and how it works plus when the patient needs to return. If no longer meet the criteria the appointment is cancelled and the referrer contacted. Standard questions should be asked of every patient so that an adequate history is taken for all patients.
(Foot Health) Local Safety Standards for Invasive Procedures (LocSSIP)	Consent training implemented within the department to help reinforce that staff should never use abbreviations on the

Nail Surgery Annual Audit (2024/25)	consent form.
Orthotics: Use of Pressure Integrity Tool for In-patients (2024-25)	Management Team to implement further teaching sessions to wider team to ensure that staff are aware of how and when to complete the skin integrity proforma.
Asymptomatic Testing for Chlamydia and Gonorrhoea in Men who have sex with Men (MSM)	Incorporate changes in the electronic templates to specify FCU for male urine chlamydia and gonorrhoea testing in the relevant EPR templates. Also, to incorporate changes in the electronic template so that if three sites are not tested for CT/GC, then the reasons and justifications for this decision could be recorded and appropriately documented.
NPSA Steroid Card Audit (2024/25)	Action plan developed to improve guideline. Team will implement training and awareness on steroid management and use of steroid cards Trust wide and re-audit in one year to assess efficacy of action plan.
Saving Babies Lives: Element 6 – Diabetes in Pregnancy Audit (2024/25)	Directorate to liaise with Dietetics to create a joint ANCs and MDT for women with pre-existing DM.
Saving Babies Live: CTG in Labour Audit: Element 4 – Intrapartum care for healthy women and babies, to include CTG Documentation audit; Risk Assessment; Fresh Eyes (2024/25)	• Monthly Infographic to be launched for shared learning. • Monthly Infographic to be shared on social media pages. • Continue with Teach and Treat on the third floor. • Ad Hoc Tea Trolley Training. • FM Teaching Board to be updated monthly. • Follow up staff who are non-compliant with required standards. • Monthly FMSD. • Monthly teaching on the PrOMPT day.
Saving Babies Lives: Element 5 – Reducing Preterm Birth Audit (2024/25)	Perinatal Services continue to utilise the Badgernet checklist and periprem passport in managing extreme preterm birth, to identify patients who will benefit from an offer for joint Neonatal/Obstetrics counselling in extreme preterm cases. Further improvements are also required to documentation and cases of IUT to have a clear management plan included in their discharge summary.
Newborn and Infant Physical Examination (NIPE) (2024/25)	Clinical Leads have completed the action regarding staff education. This is now embedded into the Midwifery training programme nationally.
PSD/PGD Validity	Directorate to formulate a PSD Guidance document, with a re-audit in September 2025 to measure the success following education.
Medicines Storage (2024/25)	Plans in place to work with department leads and audit individual practices that did not achieve 100% every six

	months to focus on improvement.
Orientation of MRI shoulder planes: are discrepancies linked to scanning sites?	West Park MRI scanner is no longer being used. We now have two in-house MR scanners at the Cannock CDC.
Audit of the Quality of Discharge Information	To further improve compliance, Pharmacy will work with specific wards through their Directorate Governance meetings and highlight areas for improvement around patient medication discharge information.
Ambulatory - Re-audit of Personal Management Plans for Clinic Patients (2024/25)	Personalised Care Plan completion compliance increased since last report. Communication to all staff via Trust Brief and team meetings around expectations of care plan completion.
Planned Care - Professional Bag and Car Boot Audit (2024/25)	Secretaries to ensure specimen transportation boxes and relevant documentation are made available to staff when required? Re-audit 2025/26.
Supportive Care - Excellence in Care - Quality Assurance of Patient Pathways (2024/25) Re-Audit	Peer reviews to be undertaken to ensure mandatory fields are not missed within the telephone triage process.
Adequacy of Pre-Operative Diabetic Assessment and Management in Patients Undergoing Cardiac Surgery (2024/25)	To continue pre-operative Hba1c testing in diabetic patients prior to cardiac surgery. To review HbA1c results and refer to the specialist diabetes team where HbA1c is above 69. Continue long-acting insulin prior to surgery.
CP50 Policy for the Management of Risks Associated with Pathology and Radiology Diagnostic and Screening Tests -	Directorate to ensure all results are reviewed, actioned and filed within the appropriate timeframe and ensure robust process are in place to cover annual leave and sickness leave.
NICE NG195: Implementation of Kaiser Permanente Sepsis Risk Calculator (KP-SRC) audit (2024/25)	There will be ongoing Quality Improvement work before the re audit which will include: Verbalise decision to treat time to the team Work as a team – one person cannulates, one prescribes, Nursing team prepares drugs required as per prescription
An audit of compliance with the BSH guideline for the laboratory diagnosis of G6PD deficiency in haematology patients	Directorate to ensure testing for G6PD should be included in baseline work-up for all sickle and thalassemia patients. Patients likely to need rasburicase, such as those with leukaemia, lymphoma or other malignancies should be screened for G6PD.
West Park - Audit on Malnutrition Universal Screening Tool (MUST) in NRU (CG32) (2024/25) Re-Audit (Divisional approval granted 21/6/24 to add this audit to the Plan)	To continue to comply for the patients who are able to get on the weight scales.

(Theatres) Re Audit of diabetic patients having operations (covering New Cross and Cannock)	Educational material (poster) for Theatre staff. Communication to pre-op team and discussion at pre-op meeting highlighting the need for checking HbA1c values for all patients with diabetes.
Re-Audit- Door-to-clexane time in trauma patients (2024/25)	VTE team has amended Foundation Year Induction to include 14 hours assessment and prescribing targets. Closer scrutiny will be completed daily by Consultant B on Trauma & Orthopaedic ward round.
Re-Audit Taking blood cultures in patients with who have temperature spikes following elective orthopedic surgery (2024/25)	Clinical Leads will continue to educate all the staff, especially the rotating Resident Doctors with regards to blood cultures taken, as recommended by the audit standard.
Brain Metastasis audit	The Directorate to develop local guidelines for the Trust for ED or AMU to follow which will help physicians to take certain decisions in the acute settings for recommended dose of the steroids. There should be an imaging recommendation as per the NICE for follow up and request Neuro Onc MDT outcomes should be uploaded in the MDT section in the CWP.
Review of Use of Sepsis 6 Tool for Neutropenic Sepsis.	To assess and ensure the timely implementation of the Sepsis 6 bundle within one hour of the initial diagnosis of neutropenic fever through dedicated teaching sessions that are held for the staff and Junior Doctors within the department.
Audit of Paediatric Hearing Aid Fittings and Reviews - Reaudit (2024/25)	Meeting has taken place to educate clinical team to allocate time for speech testing/aided testing in the Hearing Aid Fitting/Review appointment and to update and record parameters if any changes i.e. an aid is fitted or removed.
Cardio-Renal Audit	Plans in place to increase the number of referrals for patients presenting with CKD and heart failure to the Cardio-renal MDT for optimisation of heart failure treatment.
Oxygen Prescription in Paediatric Acute Ward	Pharmacy team has been informed to note when oxygen is administered to patients without a prescription.
Sickle Cell Pain Audit	Education around Sickle Cell Disease and pain management is ongoing with in-service training days and lunch and learn presentations. Further education is planned and will be focused on PAU staff to ensure children with Sickle Cell Disease have their pain controlled quickly. Development of paperwork specific to Sickle Cell pain management is being considered. Further education is needed to ensure both Nursing and medical staff are aware of the importance of prescribing laxatives. End of stay questionnaire has been rolled out.

CP50 Audit	Clinical Lead to amend the proforma to include a section on information given to parents to further improve documentation of discussions with patients and their families. Education awareness will be shared through department local induction processes.
Newly diagnosed JIA Audit	Re-establish meetings with wider MDT to plan going forward Cannock referral system review – communication with GPs Undertake a service review and formulate an action plan. Communicate with Primary Care in Cannock catchment area to raise awareness of the route of referral into Paediatric Rheumatology. Update Paediatric Rheumatology risk Undertake a service review and formulate an action plan.
Service Provision for Unaccompanied Asylum-seeking Children within CYPIC	The department leads plan to Improve the processes in blood checking and six week follow ups through additional department education and training sessions.
CYPiC NICE Guidance (NG205) Audit	Review of previous care plan. To include sexual health in 16-18 care plans. Discussions around transitions. Improvements to documentation around wishes for family time to be included. RHAs to be completed by same healthcare professional.
Record-keeping Audit - CYPiC (IHA RHA Documentation Audit)	The Directorate Team will continue to deliver training to all staff who see children and young people in care for health assessments. Including the importance of inclusion of mental health screening tools during health assessments. Local authority to send requests for health assessments in a timely manner, ensure paperwork is completed in full and supporting information is available for assessments.
PGD Audit	Recommendations have been generated to improve compliance to the PGD guidance: Pharmacist to ensure signed PDF copies are sent to the team Senior Sisters to ensure that the signature list is printed double-sided so there is a prompt for the senior responsible person's signature. All staff to be educated on the documentation requirements of PGDs. To complete new PGD training on My Academy to aid education and training.
Management of Syphilis Audit (2024/25)	Directorate to implement updated guidelines and implement a new clinical pathway for neurosyphilis and disseminate this to the Trust which will reinforce the importance of serological follow-up, particularly the requirement for repeat RPR six months post treatment. Provide teaching sessions for Junior Doctors and health advisors.

An Audit on Pre-operative Fasting Protocols for Trauma Patients: Insights from New Cross Hospital (2024/25)	Raise awareness of fasting times to the Nursing and medical team. Devise a poster to display on the wards.
Audit on antiplatelet prescription in TIA & minor stroke (2024/25)	Clinical Lead to update local Trust guideline and share the information through governance, learning through academic meetings. Plans in place to implement QI on improvement of the TIA referral and review pathway.
Audit of Hydroxychloroquine Monitoring Service (2023/24)	Directorate plan to continue using RCOphth HCQ screening result form. Reject referrals not sent on pro forma and incorporate appropriate triage and clinic slots.
CP50 audit managing risks for pathology, radiology and other screening investigations (2024/25)	Department plan to improve education, to improve the time disparity for neurology patients awaiting care plans across the region. Ensure that a clear plan for each patient is made following consultation.
Review of current Practice of Orthoptist Input to Stroke in-patient Service Delivery (2024/25)	Learning and updated NICE guideline shared through Directorate Governance meeting and sent to all relevant stakeholders. Ongoing liaison with Orthoptic Service to focus on service improvement within the limitations of resources.
Surveillance images following lung cancer resection surgery (2024/25)	Directorate are implementing the ASCO guidelines to New Cross Hospital as the standard of care follow up protocol post lung cancer surgery. Conveying this protocol to other hospitals to represent the surgical team at the MDTs including RHH and WMH.
An Audit of the Glaucoma Enhanced Referral Service pathway	Referrals should be vetted by Consultant for glaucoma screening clinics' feedback to Local Optometric Community (LOC) Encourage all referrals through GERS pathway. Clinical Lead to disseminate results to Local Optometric Community (LOC).
An evaluation of the quality of weekend discharges of patients in Ear Nose and throat- re audit (2024/25)	Clinical teams have been advised that eDischarges should be prepared in advance of the weekend where possible and particular care should be taken to enter relevant investigations undertaken.
The quality of weekend handover of Ear Nose and Throat (ENT) inpatients - re-audit (24/25)	Department will continue with the use of Careflow Connect to reduce illegibility and documentation errors.
HTM01-05 - Infection Prevention Reaudit (2024/25)	Mobile dental unit has been placed on the risk register. Directorate developed business case to replace current worktops on long term plan managed via the department risk register (risk ID 4372).

Audit of Compliance with Osteoporosis Prophylaxis guidelines In Elderly Trauma Patients (2024/25)	Continue education for Junior Doctors and other ward staff Ensure a standardised method of referring patients to ortho-geriatrics, for instance, team huddles in the morning Ensure the ordering of appropriate post operative bloods, including bone profile/vitamin D, to initiate treatment of fragility fractures Emphasise and educate Junior Doctors on the need to start treatment as per guidelines for fragility fractures. Including informing juniors regarding dosing regime.
Fracture Clinic Reducing Times & Improving Outcomes (2024/25)	Directorate to undertake further analysis the 40% of patients booked into red slots from ED to identify additional improvements that could be made to the service.
Adult & Paediatric cardiac arrest trolley annual audit (Aug 2023 – July 2024)	Departments identified as having missing/expired kit were advised to complete a datix report and identify actions to improve and maintain standards. Resuscitation group will continue to monitor audit results and datix completion bimonthly.
(Foot Health) Specialist Foot Health Services Skin Integrity Trigger Tool Re-Audit (2024/25)	Tissue Viability Team will continue to monitor reported pressure injuries and support ward teams with advice with how to manage pressure-related injuries to prevent further deterioration and improve patient care.
(Foot Health) Diabetic Foot Screening Re-Audit (2024/25)	Team meeting to report data and update staff on compliance.
HIV testing in ITU admissions (2023/24) (carried over to 2024/25)	Clinical Lead currently having active discussions with GUM and Microbiology on implementing routine screening for HIV patients admitted to ICCU. There are parallel plans to implement universal testing for all admissions to RWT which are awaiting financial approval.
(Theatres) Use of Neuromuscular Monitoring for Elective/Emergency Surgery (carried over from 2023/24)	Directorate to share through allocated team briefing sessions to explore suggestions to create additional columns for TOFR and TOFC in anaesthetic charts for quantitative neuromuscular monitoring.
LWG - Assurance of COVID Vaccine services covered by the Roving Team (2023/24)	Management Team to ensure stock book is used for clear audit trail PAT testing of fridge to be undertaken to ensure all temperature monitoring devices are calibrated Reiterate to team the information required to complete worksheets and logs correctly.
Re: audit CP50 Audit into the management of risks associated with pathology and radiology, diagnostic and screening investigations (2023/24)	The Directorate plans to reduce waiting times by referral triaging, Incorporating Waiting List Initiatives to reduce waiting times to six weeks.

SLT: Request for Review Audit for Children's Service (2023/24)	To continue to monitor the process.
(SLT) Audit of discharge documentation for patients discharged from New Cross Hospital on modified diet/fluids (2023/24)	The team will actively support Directorates to ensure that patients requiring thickened drinks (IDDSI levels 1-3) should have 'Thicken Up Clear' added to their drug charts to ensure this is included in the eDischarge. Also to be included within the discharge notification are speech and language therapy recommendations, additional discussions are taking place with IM&T to incorporate an annex to eDischarge that will provide access to eDischarge to ensure accurate and up to date diet and fluid recommendations are included.
(SLT) Audit of the IDDSI consistencies of breakfasts within the Acute Stroke Unit (2023/24)	IDDSI training for all catering and ward staff to be arranged. Catering to supply a range of level 4 breakfast choices and provide training for ward staff to heat meals as required.
NG198: Acne vulgaris: management.	No specific actions, however, recommendations to consider for improvement: Using BAD templates of Isotretinoin for improving prompting of testing Utilising specialist Nurses for Isotretinoin patients.
NG190: Secondary bacterial infection of eczema and other common skin conditions: antimicrobial prescribing.	The following recommendations have been discussed to improve patient care: refer all eczema patient to a Nurse education clinic record quantities of emollients record quality of life, psychosocial burden of disease, when disease significantly changes or significant treatment changes.
An Audit of the Paediatric Audiology Service (2024/25) (carried over from 2023/24)	Audiology and Children's Services will continue to review current processes with a view to secure additional resources to include a Paediatric service.
Factors affecting The length of hospital stay post appendectomy (carried over from 2023/24)	Revised GIRFT best practice pathway. The pathway will now be implemented across the Directorates.
Cervical Cytology (2023/24) - Re-Audit	Directorate has incorporated weekend clinics at Alfred Squire Road Surgery providing access to all patients across the PCN. Further looking at smear clinics at the hub during weekdays, depending on demand. Pre bookable slots were also added. Weekend clinics were set up for asylum seekers/underserved communities at Thornley Street Surgery but have been stopped due to poor uptake after four weeks. Dedicated information and videos being produced in various languages by local GPs within the RWT PCN Practices, although waiting to be collated and uploaded to PCN website as well as the process of linking smear invitation to appointment books enabling patients to book appointments at

	their convenience.
Re-Audit Taking blood cultures in patients with who have temperature spikes following elective orthopaedic surgery (2023/24)	Management Team to raise awareness of the guidelines to medical/Nursing colleagues within Older Adult Medicine and Rheumatology Doctors covering the wards.
Alcohol use Screening and Intervention (PH24) Use of the AUDIT-C screening tool at New Cross Hospital, pre and post introduction of the electronic screening tool on Vital Pac 2021 (2021/22)	Meetings to be held with Vitals team, informatics, ward managers and PEFs.
Supporting Adult Carers - Quality Standards 200 (2024/25)	To maintain compliance, actions have been devised - see action plan.
NG 88: Heavy Menstrual Bleeding - Assessment and Management (2023/24) -To include outcome of outpatient pipelle biopsy in patients with heavy menstrual bleeding	Department Leads to increase awareness of the guideline to change practice (Teaching on HMB in wed pm meeting) Flow chart on management in clinic Capacity issues with hysteroscopy – perhaps a deterrent Follow up on hysteroscopy to see if any significant findings to further support change in practice
CG102 (Updated) Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management	Clinical Lead to complete care plan for children admitted with meningitis/suspected meningitis to include one hourly observation and neuro-observation. To provide education at Directorate Governance meeting, through careflow connect and DiT sessions where appropriate.

Form of Statement as per Legislation

Please see last year's Quality Account for reference.

5.1.4 Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by The Royal Wolverhampton NHS Trust in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee is 1573 across 102 different studies.

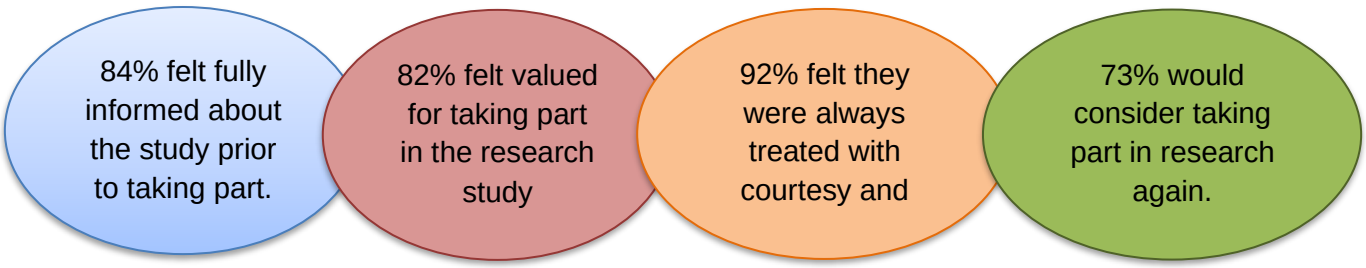
Nationally, the DHSC vision is to make the UK a world-leading hub for life sciences that delivers improved health outcomes for people and attracts investment, giving patients and service users access to the most cutting-edge treatments and technologies.

Studies show 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 priority and is identified by patients as an important clinical choice.

The Royal Wolverhampton NHS Trust has continued to perform well in research activity when benchmarked against the large acute Trusts within the West Midlands region. The Trust was second in the region for patient participation in commercial contract studies.

The Research and Development Directorate Team has focused on delivering its recovery and growth programme for healthcare research. Eighty three new studies were opened during 2024/25. Participants have taken part in research projects across a wide breadth of services provided by the Trust including Oncology, Haematology, Rheumatology, Neurology, Cardiology/Cardiothoracic, Obstetrics, Surgery, Orthopaedics, Critical Care, Paediatrics, Gastroenterology, Respiratory, Diabetes, Ophthalmology, Renal, Stroke/Neurology and Primary Care.

Our 2024/25 research participant survey, completed by 89 participants, showed the following:



5.1.5 Use of the CQUIN payment framework

"(b) The Royal Wolverhampton NHS Trust's income in 2024/25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because CQUINs have been suspended by NHS England."

5.1.6 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 the Trust during 2024/25.

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

Our current overall Trust rating is Good.

Key Question:

Safe - Requirements Improvement

Effective - Good

Caring - Outstanding

Responsive - Good

Well-led - Good

5.1.7 Our data quality

The Royal Wolverhampton NHS Trust submitted records during 2024/25, (current data available up to Month 10 April 2024 – January 2025) to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

which included the patient's valid NHS number was:

99.9% for admitted patient care

100% for outpatient care and

99.2% for accident and emergency care

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

98.7% for admitted patient care;

98.6% for outpatient care; and

99.2% for accident and emergency care

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 and completely, meeting all standards.
- Support for IT projects continued with testing, validation and systems expertise provided by the team.
- Promote 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.
- A Data Quality Forum was established in 2017. There are terms of reference for this group and the chair is 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 issues identified. The Department reviews the issues and prioritises them on the DQ issues log, holds action plans for DQ issues and manages progress against these action plans.
- Compliance is checked against indicators to assess the quality of the information on our PAS systems in relation to patients.
- The Trust Data Quality policy is in place and was reviewed in November 2022.

5.1.8 Clinical coding error rate

The Royal Wolverhampton NHS Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

The 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 2024/25, achieving an overall ‘Standards Exceeded’ rating in all areas of the audit.

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

Key Achievements in 2024/25:

- Achievement of ‘Standards Exceeding’ for DSPT
- CCAP Qualified Clinical Coding Auditor - after completing in-depth internal and external training program our trainee Clinical Coding Auditor has attained the CCAP Accredited Clinical Coder Auditor
- Increased number of Clinical Coders with accredited status within the department after completing the internal and external Clinical Coding Training programme and attaining ACC Qualification
- In depth specialty and clinical coder-based audits to maintain/improve quality from the previous year
- Continued engagement with Consultants and clinical teams
- Improved depth of coding

Clinical Coding/Data Quality reports are in place internally and externally to ensure quality of Clinical Coding is maintained and continually improved - examples include HED Report, SHMI and DQMI.

5.1.9 Data security and protection toolkit

SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2024/25.

The table below details the incidents **reported** on the NHS Digital incident reporting tool and to the Information Commissioners Office (ICO), within the financial year 2024/25. Any incidents that are still being investigated for the period 2024/25 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	No. of data subjects	Description / Nature of data involved	Further action on information risk
January 2025	Unauthorised access	1	Staff member is alleged to have accessed a patient's record 16 times with no valid reason. Patient is ex-partner of staff member's current partner.	Reported to regulator and investigation is underway.
November 2024	Unauthorised access	9	Staff member has admitted accessing medical records of staff that are known to them.	Reported to regulator and investigation is underway.
July 2024	Unauthorised access	1	Patient has raised concerns that they believe a family member of ex-partner has accessed their record.	Reported to regulator and investigation is underway.
June 2024	Unauthorised access	6	Following a routine audit on notes viewed it has been highlighted that a member of staff accessed notes on system for a number of patients when not directly involved in the patients' care, or the patient isn't an inpatient at the time of viewing.	Reported to regulator and investigation is underway.
May 2024	Unauthorised access	1	Patient contacted Trust to ascertain whether a member of their family had accessed their records as there was information that was known about a diagnosis that was not shared.	Audit of record revealed access had taken place. Patient informed that investigation is underway. ICO notified.

Overview of incidents classified at lower severity level - Incidents classified at severity level 1 or below are aggregated and provided in the table below. Please note this is not all incidents, just incidents scored level 1 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	0
B	Disclosed in Error	29
C	Lost in Transit	1
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	7
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	1
J	Unauthorised access/disclosure	7
		45

Data Protection and Security Toolkit Return 2023 - 2024 – final submission

RL4 submission currently has 108 completed mandatory elements with 0 outstanding. For GP practices 28 completed with 0 outstanding meaning that at this stage the Trust and G's will be submitting as '**Standards Met'** for the submission**.**

- The Royal Wolverhampton NHS Trust RL4
- Thornley Street M92028
- Coalway Road M92006
- Penn Manor M92011
- Alfred Squire
- West Park Surgery
- Lea Road
- Warstones
- Oxley Surgery
- Tettenhall Road Medical Practice

An internal audit of the DSP toolkit in 2023/24 detailed the overall assurance that was provided for the standards as an overall confidence rating of HIGH.

Looking forward to Data Protection and Security Toolkit (DPST) with Cyber Assessment Framework (CAF) overlay - submission 2024/25.

Background to the changes to the DSPT

In 2023 the health and care cyber security strategy committed to adopt the CAF as the principal cyber standard. This was with a view to:

Emphasise good decision-making over compliance, with better understanding and ownership of information risks at the local organisation level, where those risks can most effectively be managed

Support a culture of evaluation and improvement, as organisations will need to understand the effectiveness of their practices at meeting the desired outcomes – and expend effort on what works, not what ticks a compliance box

Create opportunities for better practice, by prompting and enabling organisations to remain current with new security measures to meet new threats and risks

The DSPT for 2024/25 has changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. NHS Trusts, CSUs, ALBs and ICBs will now be working to a more detailed set of prescriptive standards, which sets out CAF-aligned requirements in terms of Objectives, Principles and Outcomes.

The Trust will aim to self-assess its level of compliance against each outcome using the indicators of good practice as a guide. The process of submitting assessments to NHS England will not change. National assurance will continue to be based on organisations commissioning independent audits of their self-assessments, complemented by national sampling audits.

The indicators of good practice are not prescriptive, and in most cases, the Trust will have flexibility to determine how to meet each outcome. For a small number of outcomes, where we deem the national risk to be too great to permit that flexibility, we will constrain organisations by issuing directive national policy that requires them to take (or not to take) certain approaches as part of that outcome. The first submission of the new DSPT is due in June 2025 and results will be detailed in next year's Annual Report.

5.1.10 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.

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

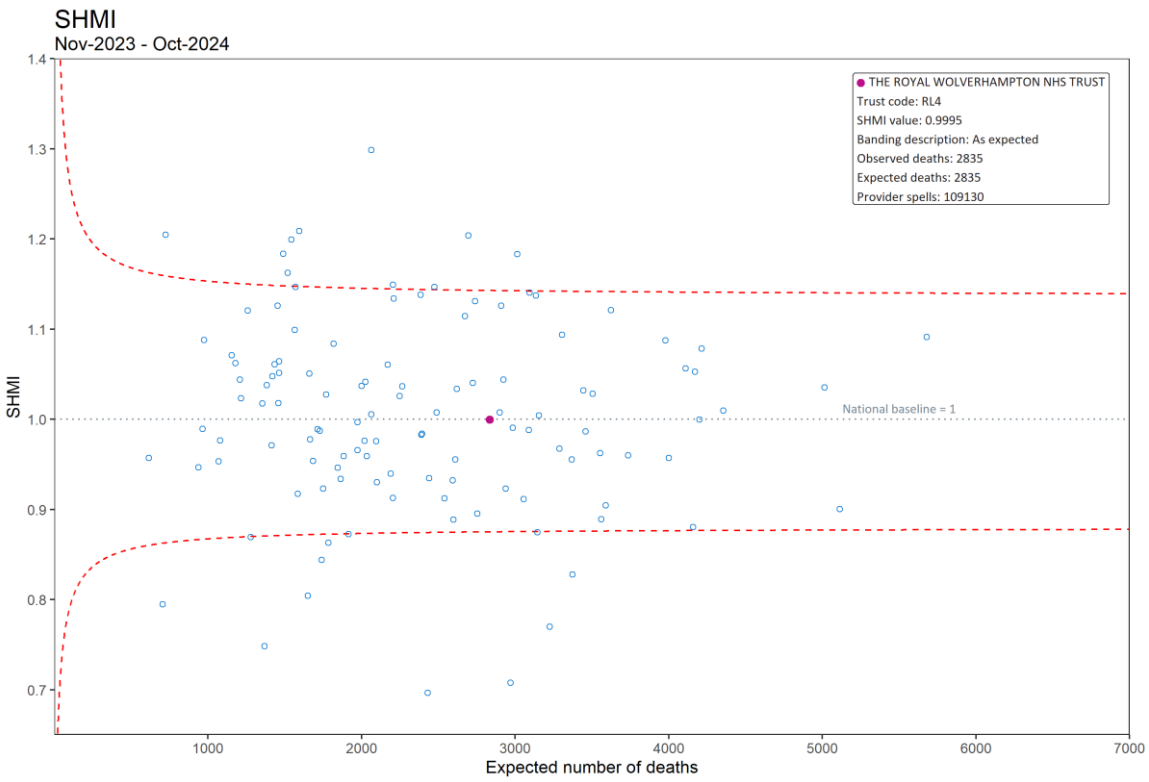
The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

(a) The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the Trust for the reporting period and
(b) the percentage of patient deaths with Palliative Care coded at either diagnosis or specialty level for the Trust for the reporting period.
(a) The Summary Hospital-Level Mortality Indicator (SHMI) is the most commonly used indicator to compare the number of deaths in the Trust with the number expected on the basis of average England figures, taking particular characteristics e.g. age, comorbidities and diagnosis profile into account. 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, a rapid review is undertaken to establish whether a further PSIRF Learning Response is required. This is reviewed by the Directorate and Division, and where necessary, the Learning Response Panel (Executive-led oversight panel) to agree whether there are further opportunities for learning. Where it is agreed there are further opportunities for learning, a decision is taken around which is the most appropriate PSIRF Learning response to undertake. Once complete, robust action plans are drawn up to address safety recommendations identified.

Indicator	September 2023 to August 2024	October 2023 to September 2024	November 2023-October 2024
SHMI RWT	1.0025	1.0032	0.9995
SHMI England	1	1	1



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

The Trust continues to use mechanisms to review and investigate the SHMI, overseen by the Mortality Surveillance Group and Mortality Review Group (MRG). Alerting diagnosis groups with a higher-than-expected SHMI are investigated by a data quality review followed by a case note review. The results of these reviews are presented at Clinical Pathway meeting where the focus is on quality improvement and is subsequently reported to MRG.

While the SHMI alone does not represent a quality metric, the Trust maintains a robust programme to scrutinise clinical care, ensure timely identification and action on care gaps, improve documentation quality, and develop care systems that benefit both individual patients and the wider population.

Over the past 12 months, this programme has developed to include a continuous quality improvement initiative, including:

- Improve clinical pathways for specific diagnostic groups through focused review and action planning
- Enhance patient safety by promptly evaluating mortality parameters and refining clinical pathways in response to identified alerts or signal
- Ensure comprehensive review of all hospital deaths via Medical Examiner and Mortality Reviewer processes to support continuous quality improvement
- Development of an action plan to address data quality issues
- Continue validation exercise for clinical coding and progress continues to be monitored through the Mortality Surveillance Group, highlighting the importance of capturing the correct priory diagnosis group on Mortality metrics
- Expansion of the Medical Examiner Service which became statutory on 9 September 2024, to now cover hospital deaths (New Cross, Cannock and West Park) Compton Hospital, Nuffield Hospital and also, all GP practices in Wolverhampton and five Primary care networks (PCN) in the South Staffordshire area (Seisdon, Cannock Village, Cannock North, Rugeley and Great Haywood Neighbourhood 1 and Neighbourhood 2)
- The Medical Examiner service now offers an out of hours service for hospital and community deaths to facilitate urgent faith burials, implemented on 17 August 2024.
- Actively learn from patient deaths by listening to bereaved families and carers and meaningfully involving them in relevant 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

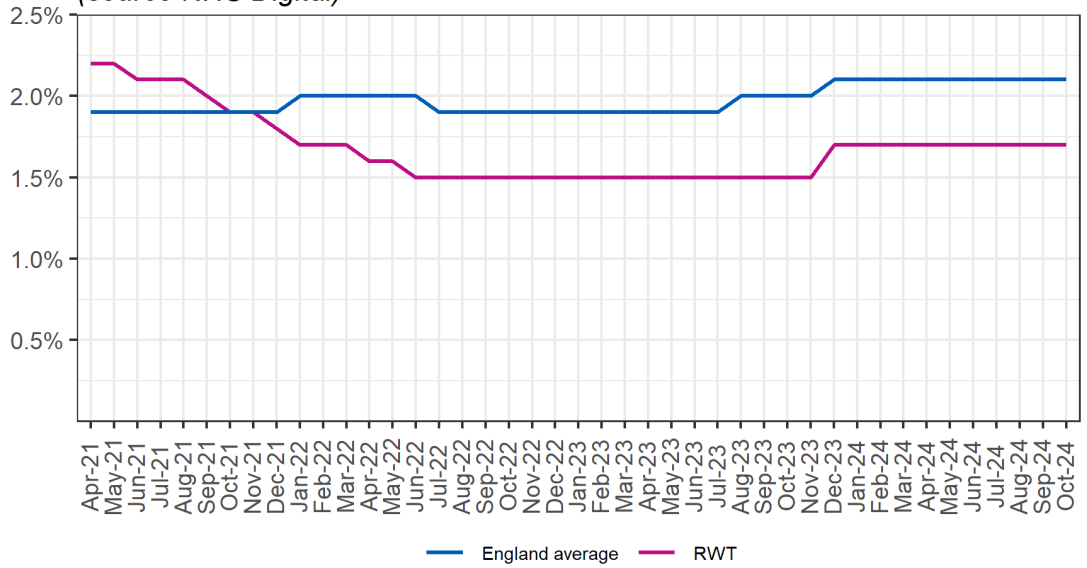
Progress against the agreed actions is monitored by the relevant quality groups and mortality associated reports are regularly presented to the Trust Board.

(b) the percentage of patient deaths with Palliative Care coded at either diagnosis or specialty level for the trust for the reporting period.

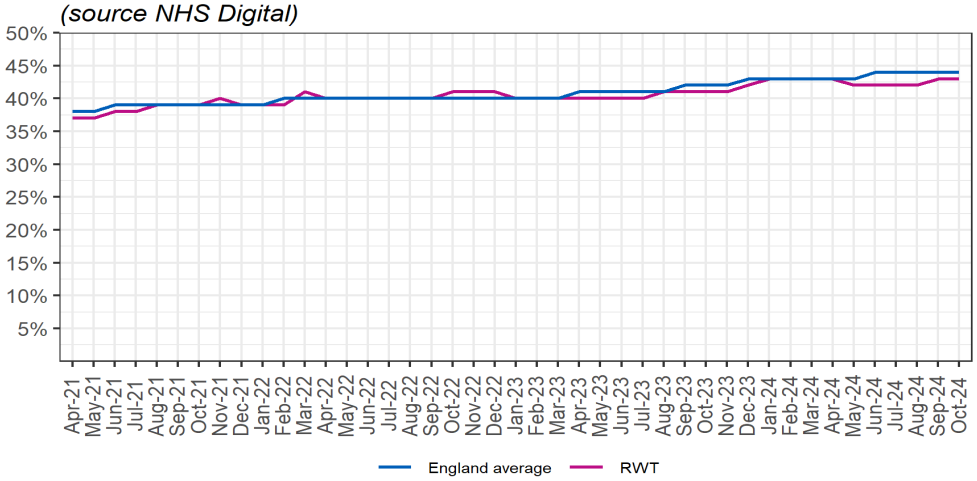
Table: The percentage of patient deaths with Palliative Care coded at either diagnosis or specialty level for the Trust for the reporting period. (November 2023 – October 2024).

	RWT	England Avg
% of Spells with Palliative Care Coding	1.7	2.1
% of Deaths with Palliative Care Coding	43	44

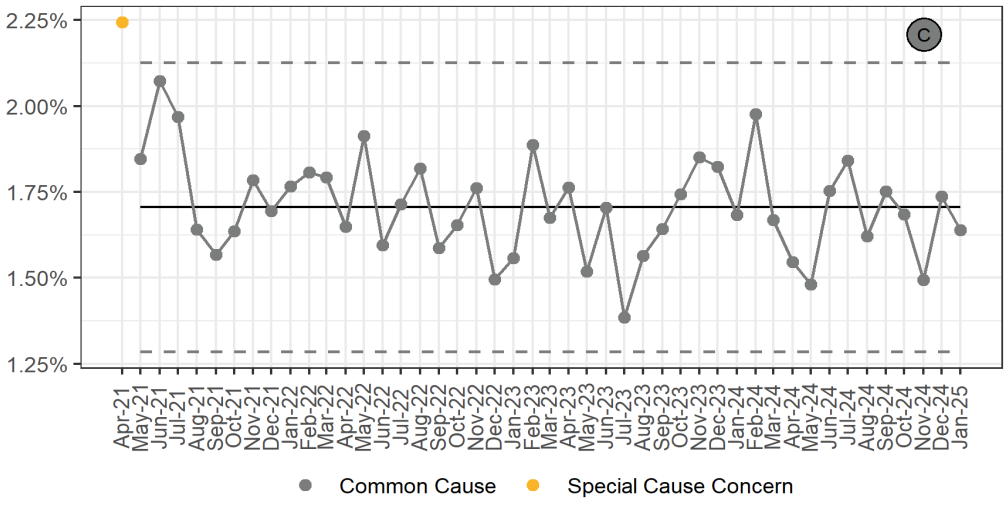
Percentage of Spells with Palliative Care Coding
(source NHS Digital)

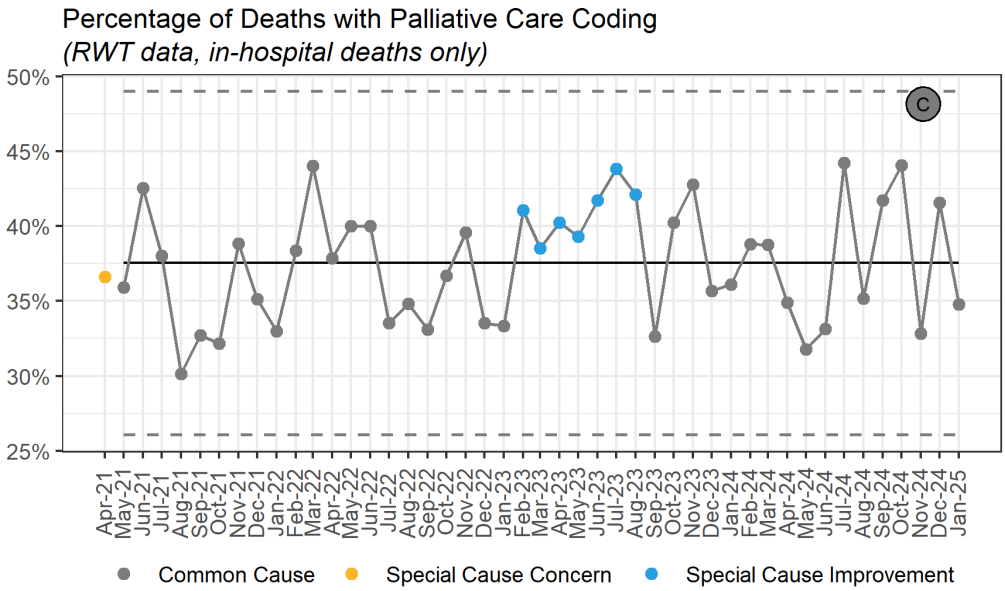


Percentage of Deaths with Palliative Care Coding
(source NHS Digital)



Percentage of Provider Spells with Palliative Care Coding
(RWT data)





The Royal Wolverhampton NHS Trust intends to take/has taken the following actions to support Palliative Care provision:

- 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 One Wolverhampton Palliative and End of Life Care Group
- Use of SWAN model of care across the organisation to support patients in the last days of life and introduction of monthly SWAN study days for staff education in relation to SWAN.

6.2 Core Quality Indicators – Learning from Deaths

	Prescribed information	Form of statement
A	The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During the reporting period April 2024 to March 2025, 2121 adult inpatient deaths were recorded at RWT. This is broken down into deaths which occurred in each quarter: • Q1 – 495 deaths • Q2 – 529 deaths • Q3 – 522 deaths • Q4 – 575 deaths
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 2025, of the 2121 deaths recorded there have been 458 structured judgement reviews (SJRs) and two PSIRF learning responses (Patient safety incident investigation (PSIIs) carried out. In two cases, a death was subjected to both a case record review and an investigation (RCA). The number of deaths in each quarter for which a case record review or an investigation was carried out was: • 483 Medical Examiner assessments + 127 SJRs + 0 RCAs in the first quarter. • 517 Medical Examiner assessments + 135 SJRs + 1 RCA in the second quarter. • 478 Medical Examiner assessments + 133 SJRs + 1 RCA in the third quarter. • 491 Medical Examiner assessments + 63 SJRs + 0 RCAs in the fourth quarter. Please note: Forty one Structured Judgement Reviews 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 2023/24. 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),	One case is undergoing a Patient Safety Individual Event Review (PSIER) and the outcome is awaited. There are no current cases (0% of the adult inpatient deaths) during the reporting period that have been judged to be 'more likely than not to have been due to problems in the care provided to the patient.' These numbers have been determined using evidence from the Root Cause Analysis (RCA) and PSIRF investigations involving deaths that were subject to review under the serious incident

	with an explanation of the methods used to assess this.	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 and learning which have emerged from reviews are detailed in bullet points below. • Communication - concerns raised by patients' next of kin should be addressed by clinical staff • Response to the deteriorating patient • Documentation • Management of long stay/"stranded" patients in ED • Over reliance on NEWS score and use of oxygen leading to missed patient deterioration • Medication (oxygen) administered without prescription
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 from C include: • Education around medication, Trust policies, mouth care, and use of oxygen arranged for Nursing staff and Resident Doctors • Quality Improvement Programme (QIP) now in progress to address communication issues between wards and set a standard practice for the Older Adult Medicine Directorate. • Plan to review current Emergency Department (ED) processes including the new long stay ED document to improve documentation • Clinicians submit 'urgent' referrals appropriately and proactively seek the results including discussion with clinical team • Focus to improve communication with relatives 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 in addition to the learning from deaths agenda, which is designed to scrutinise clinical care, provide assurance that gaps in care are identified and acted upon and systems of care provision are developed for the benefit of individual patients and the wider population. The Trust continues to have review 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	A total of 116 case record reviews and five investigations completed after 1 April 2024 which related to deaths which took place before the start of the reporting period.

	period but were not included in item B in the relevant document for that previous 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.	Two cases (0.09%) 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. One case was assessed following the completion of an RCA investigation as having a “Problem In Care score of 2 i.e. Strong evidence of being due to problems in healthcare”. One case was assessed following the completion of PSII as “more likely than not due to problems in care”.
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.	A total of 0.18% of the patient deaths during 2023/24 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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

There was an insufficient number of records submitted for data analysis during this period. The Directorate has since embedded a new process to capture this data to improve submissions and data for 2024/25.

6.4 Core Quality Indicators – Readmission rates

Readmissions. All data from PAS, using the national definition of a readmission.

2015/16 – 2024/2025.

Readmissions											Grand
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Aged 4-15	440	505	423	359	428	269	348	443	612	623	4,450
16yrs and over	5,966	5,443	5,165	5,677	6,018	4,051	7,967	8,659	9,816	9,901	68,663
Grand Total	6,406	5,948	5,588	6,036	6,446	4,320	8,315	9,102	10,428	10,524	73,113

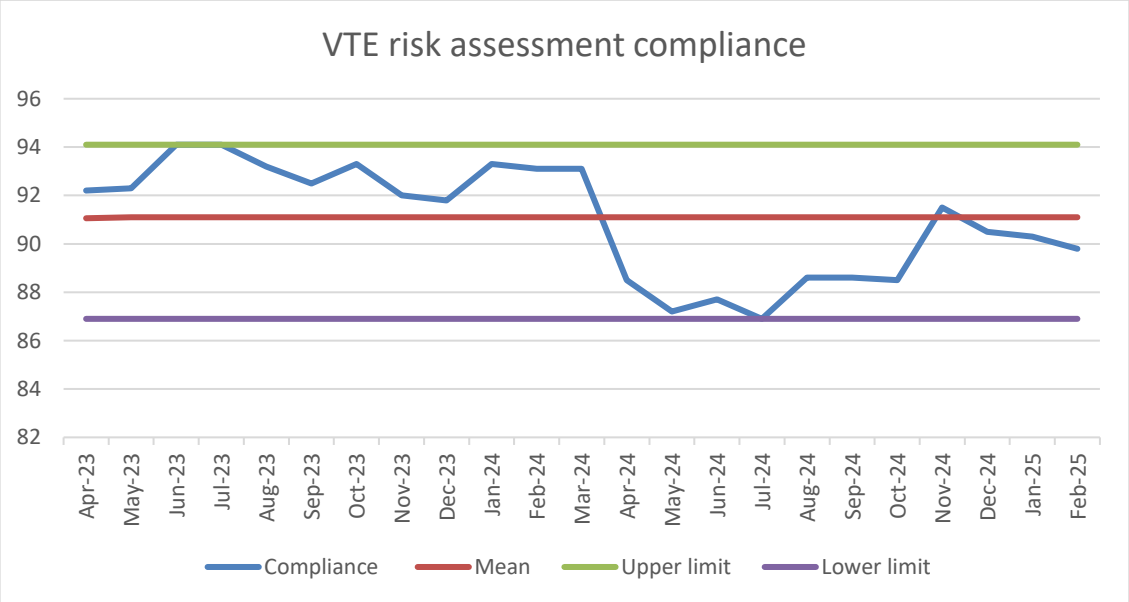
Total Admissions											Grand
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Aged 4-15	5,288	5,429	5,117	4,668	4,813	2,899	4,078	4,592	5,076	5,532	47492
16yrs and over	115,288	118,585	117,355	117,669	120,049	90,876	136,824	147,554	157,780	165,418	1287398
Grand Total	120,576	124,014	122,472	122,337	124,862	93,775	140,902	152,146	162,856	170,950	1334890

Percentage Readmissions											Grand
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Aged 4-15	8%	9%	8%	8%	9%	9%	9%	10%	12%	11%	9%
16yrs and over	5%	5%	4%	5%	5%	4%	6%	6%	6%	6%	5%
Grand Total	5%	5%	5%	5%	5%	5%	6%	6%	6%	6%	5%

6.5 Core Quality Indicators – Venous Thromboembolism (VTE)

2.3 Reporting against core indicators

Mandatory data collection to quantify the numbers and proportion of inpatient hospital admissons aged 16 and over who receive a risk assessment for venous thromboembolism (VTE) to allow for appripriate preventative measures to be given based on national NICE guidance. NHS Digital reinstated the VTE Risk Assessment Data Collection from April 2024. With this reinstatement, the target time for VTE risk assessment completion reduced from 24 hours of admission to 14 hours of admission. This change saw a reduction in VTE risk assessment compliance which is noted in the below chart from April 2024.



The data includes all inpatient activity carried out by Royal Wolverhampton NHS Trust across all locations.

National data submission was reinstated from April 2024 with quarters 1 and 2 national data available (Statistics » VTE risk assessment 2024/25). A summary has been provided below:

> England did not achieve the 95% NHS Standard Contract threshold – compliance 89% (NHS acute care providers) in quarters 1 and 2
> No regions achieved the 95% NHS Standard Contract threshold in quarters 1 and 2

Quarter 1

The data includes all inpatient activity carried out by the Trust across all locations.

National data submission was reinstated from April 2024 with quarter 1 and 2 national data available (Statistics » VTE risk assessment 2024/25). A summary has been provided below:

- England did not achieve the 95% NHS Standard Contract threshold – compliance 89% (NHS acute care providers) in quarters 1 and 2
- No regions achieved the 95% NHS Standard Contract threshold in quarters 1 and 2
-

Quarter 1

Table 1: Percentage of hospital admissions (aged 16 and over at the time of admission) risk assessed for VTE (Q1 2024/25, England)

	April 2024	May 2024	June 2024	Q1 2024/25
NHS acute care providers	88.9%	88.6%	88.2%	88.6%
Independent sector providers	87.7%	87.4%	88.2%	87.7%
All providers of NHS-funded acute care	88.9%	88.6%	88.2%	88.6%

No regions achieved the 95% NHS Standard Contract operational standard in Q1 2024/25 (see Table 2).

Quarter 2

Table 1: Percentage of hospital admissions (aged 16 and over at the time of admission) risk assessed for VTE (Q2 2024/25, England)

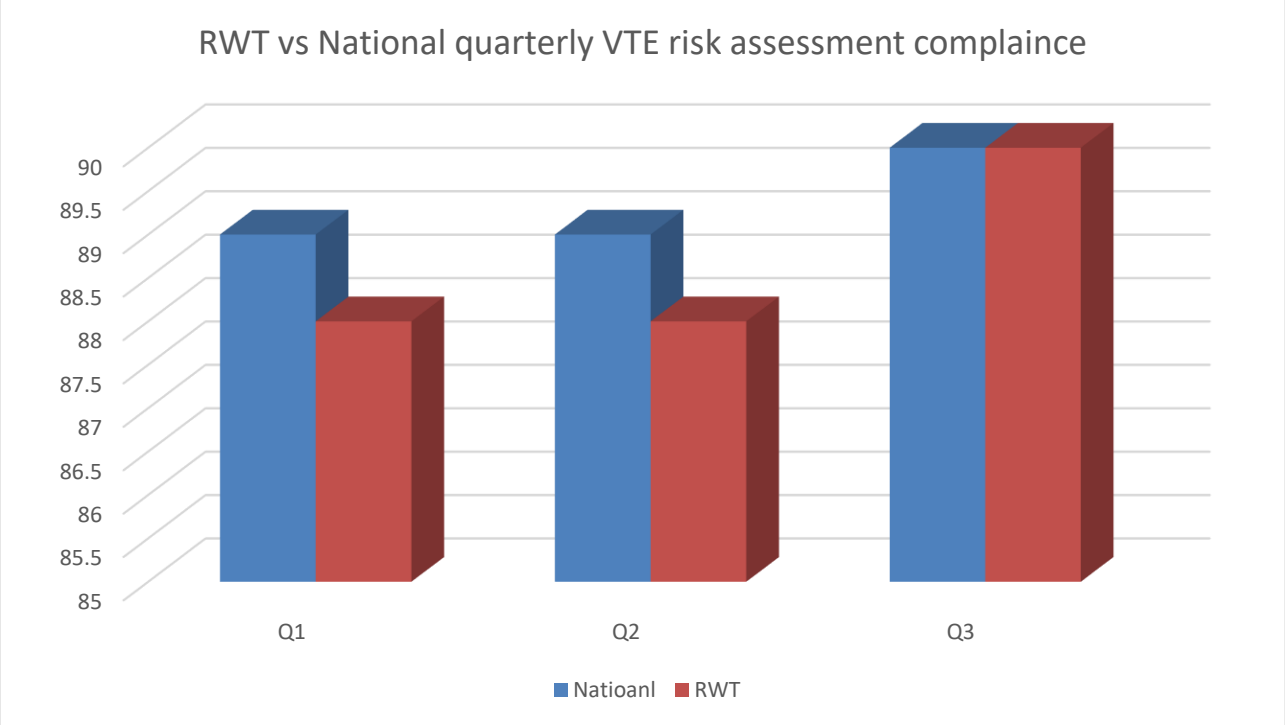
	July 2024	August 2024	September 2024	Q2 2024/25
NHS acute care providers	89.0%	89.2%	88.9%	89.0%
Independent sector providers	88.1%	88.6%	88.2%	88.3%
All providers of NHS-funded acute care	89.0%	89.2%	88.8%	89.0%

- No regions achieved the 95% NHS Standard Contract operational standard in Q2 2024/25 (see Table 2).

Quarter 3

Table 1: Percentage of hospital admissions (aged 16 and over at the time of admission) risk assessed for VTE in England by month (Q3 2024/25)

	October 2024	November 2024	December 2024
All providers of NHS-funded acute care	90.3%	90.6%	90.1%



Venous Thromboembolism (VTE), or blood clots, are 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, reason for admission and then administering preventative measures. The national target is that 95% of all patients over the age of 16 have a VTE risk assessment completed on admission. Our data reports all inpatients who received an individual VTE risk assessment within 14 hours of admission or met the criteria for a low risk COHORT group as approved by the Chief Medical Officer.

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 14 hours remains our key target for the coming year as is ensuring patients receive care as per their VTE risk assessment. The VTE group continues to explore new digital options to improve compliance. We continue to provide support o and work closely with clinical areas to delelop local improvement plans. We have been working with the governace and informatics teams to develop a Trust VTE dashboard which is anticipated to go live within quarter 1 2025/26.

Core Quality Indicators – Clostridium difficile

6.6 Reporting against core indicators 2024/25

Reporting against core indicators – guidance only

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Trust apportioned cases (hospital and community onset cases)	43	46	57	72	80	126
Trust apportioned cases hospital onset only (excludes community onset cases)	33	35	44	58	56	77
Trust bed days (calculated using hospital onset cases and rate) *	291777	230111	275517	275534	276270	275590
Rate per 100,000 bed days (hospital onset cases only)	11.31	15.21	15.97	21.05	20.27	27.94
National average (hospital onset cases only)	15.59	18.60	18.93	22.83	23.46	25.99
Best performing Trust (hospital onset cases only)	0	0	0	0	0	0
Worst performing Trust (hospital onset cases only)	64.61	80.65	59.03	81.3	67.28	88.22

*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, (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 has taken the following actions to improve this indicator, and the quality of its services, by implementing a *C. difficile* action plan. This includes 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. New commodes have been boughtto enable a rotating deep clean programme for commodes.

6.7 Core Quality Indicators – Incident Reporting

2024/25 (full year data)		
Incidents	% resulting in death	% resulting in severe harm
19886	0.1 (20)	0.1 (28)

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 incident reporting culture.
- 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 even

6.8 Core Quality Indicators – National Inpatient Survey

Published in August 2024, the Adult Inpatient Survey gathered responses from 454 patients at The Royal Wolverhampton NHS Trust, with a 39.31% response rate - closely aligning with the national average of 40.2%. Results showed the Trust performed *worse than most* on three questions, *somewhat worse* on three, and *in line* with others for 43 questions.

Key areas for improvement identified included enabling patients to share views about their care, better communication around nighttime ward moves, improving sleep quality during hospital stays, enhancing information for patients on Virtual Wards, and ensuring patients are included in conversations about their care.

Positive feedback was received on food quality and availability, cleanliness, consistency of staff information, and communication while on waiting lists.

To address areas for improvement, several actions have been taken:

- **Patient Feedback:** A new Voices in Care: Partnering in Excellence survey was conducted, and from April 2025, new feedback awareness posts with QR codes (Mystery Patients and FFT) were introduced.
- **Information Quality:** Online surveys now measure how effectively information is delivered. Staff communication training has been reinforced.
- **Noise at Night:** The Quiet Protocol has been revitalised, supported by staff and visitor awareness campaigns.
- **Staff Engagement:** The Learning from Excellence initiative recognises and shares positive experiences to spread best practices.
- **Inclusion:** The It's OK to Ask campaign is being embedded to empower patients to actively participate in their care discussions.

These actions will be continually reviewed for effectiveness, with future plans including expanding digital and in-person feedback opportunities, ongoing evaluation of environmental factors like noise, and deeper collaboration with clinical divisions to drive sustainable improvement in patient experience. To access our published CQC inpatient survey results click here [ON FINAL FORMATTING ADD LINK TO EMBEDDED DOCUMENT BELOW ON CQC INTERNET PAGE]

_RL4_The Royal Wolverhampton NH

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

The Friends and Family Test (FFT) is a mandatory patient feedback tool in the NHS in England. It was introduced in 2013 to help providers understand patients' experiences and drive improvement. Here's a summary of the mandated requirements as in the most recent NHS England guidance (April 2020 onwards).

The national NHS Staff survey collates data for staff employed at the trust and asks a variety of questions. One question asks about recommending the Trust as a provider of care for family and friends. The response rate of staff employed at the Trust for the whole survey was 34%. Of those that completed the survey, the percentage of staff recommending the Trust as a place to receive care is 60.84%, which has declined from the previous year and fallen below the sector average.

The FFT must be offered in all NHS-funded services, including:

- Acute inpatient and day case services
- Accident and Emergency (A&E)
- Maternity (antenatal, birth, postnatal)
- Community services
- GP practices
- Outpatients
- Mental Health services

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
A&E	71%	72%	72%	70%	78%	75%	75%	68%	66%	72%	69%	70%
Community	90%	91%	92%	93%	94%	92%	91%	90%	93%	95%	93%	92%
Inpatients and Daycases Combined	93%	94%	94%	94%	94%	95%	94%	94%	91%	92%	94%	81%
Maternity Antenatal	76%	69%	74%	90%	82%	62%	80%	62%	70%	63%	82%	82%
Maternity Births	95%	93%	91%	98%	85%	98%	92%	90%	96%	88%	95%	95%
Maternity Postnatal Ward	67%	88%	82%	89%	76%	85%	86%	85%	78%	93%	94%	88%
Maternity Postnatal Community	93%	94%	80%	82%	94%	87%	89%	83%	91%	76%	95%	74%
Outpatients	93%	93%	94%	93%	94%	94%	93%	93%	94%	95%	93%	93%

FFT Overview: April 2024 – March 2025

🔵 **A&E**
Range: 66% – 78%
Trend: Fluctuating performance, with a notable dip in December (66%) and a peak in August (78%). Results have not consistently exceeded 75%.

🟢 **Community Services**
Range: 90% – 95%
Trend: Consistently strong performance, peaking in January (95%). Community feedback remains positive, reflecting effective engagement and service continuity.

🟣 **Inpatients and Day Cases (Combined)**
Range: 81% – 95%
Trend: Stable high ratings until a sharp drop in March (81%).

🟠 **Maternity – Antenatal**
Range: 62% – 90%
Trend: Highly variable, with low points in September and November (62%), contrasting with a peak in July (90%). Indicates inconsistency in experience.

🟡 **Maternity – Birth**
Range: 85% – 98%
Trend: Strong and steady, with consistently high satisfaction and a peak in July (98%), demonstrating good care during delivery.

🔴 **Maternity – Postnatal Ward**
Range: 67% – 94%
Trend: Improving trajectory, rising significantly from 67% in April to 94% in February.

🟤 **Maternity – Postnatal Community**
Range: 74% – 95%
Trend: Generally strong, with a dip in March (74%) following a peak in February (95%).

🟣 **Outpatients**
Range: 93% – 95%
Trend: Exceptionally stable and high-performing throughout the year, with ratings never falling below 93%. Reflects consistently positive patient experience in Outpatient settings, underpinned by effective communication and streamlined care pathways.

6.11 Core Quality Indicators – Supporting Our Staff

NHS Staff Survey Results

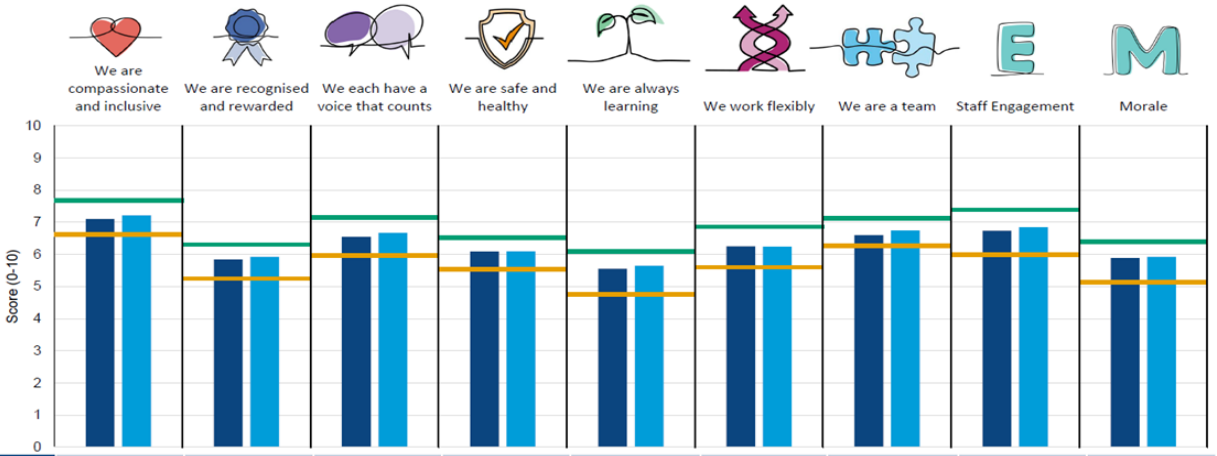
Staff engagement

The National Staff Survey provides an opportunity for organisations to understand the staff experience. The survey questions map to the NHS People Promise, which has seven key elements, and two themes of staff engagement and morale. The results for 2024 show we have improved our staff response rate by 7%, we have scored higher than the sector average for ‘we work flexibly,’ and we have remained the same as the sector average for ‘we are safe and healthy.’ All People Promise indicators have declined since 2023 and staff recommending the Trust as a place to work (60.14%) and to receive care (60.84%), have declined and fallen below the sector average.

We remain committed to creating a great staff experience and intend to address the scores decline by aligning priority actions to the People Enabling Strategy. This focuses on 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 developed a Joint Behavioural Framework: Caring for All, which has been embedded within our people processes and policies. In addition, the Trust has delivered a Managers’ Essentials Programme, which aims to support managers with their day-to-day activities and developing themselves and others. An additional cultural awareness programme will be introduced to help teams and departments across the Trust create a listening, kind, inclusive and professional organisation where staff can thrive.

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	7.10	5.84	6.54	6.09	5.55	6.25	6.59	6.73	5.89
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	3931	3937	3896	3899	3728	3913	3929	3936	3939

The Royal Wolverhampton NHS Trust Benchmark report

6.13 Supporting staff through Speaking Up

Here are details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

The Royal Wolverhampton NHS Trust has two full-time dedicated Freedom to Speak Up (FtSU) Guardians with ring-fenced time to support staff, along with an accompaniment of more 12 FtSU Champions. There are various avenues for staff to contact their Guardians, either through email, telephone calls, completion of an online form offering identified or anonymous reporting options or via referral from their FtSU Champions. FtSU posters are displayed throughout the Trust with all relevant QR codes and contact information. The FtSU team provides a psychologically safe space for mutual interaction.

There is an up-to-date FtSU policy, under the title HR16 and the Guardian team reports directly to the Chief Executive Officer. There are intranet pages with useful information for staff to access additional support and wellbeing information. The FtSU Guardians are involved in organisational change mandates and deliver presentations to multiple disciplinary teams across all specialties and services in order to raise awareness around the importance of speaking up and what they can support staff with. There are promotional events throughout the year, including Executive walk arounds and drop-in sessions for staff, as visibility and approachability is very important. October is the designated National Speak Up month in which we do events in collaboration with our colleagues at Walsall Healthcare NHS Trust.

The Guardians know how important it is for any reported challenges or complaints to be followed up by closing the loop. They are mindful of confidentiality in sharing themes around data collected and concerns that are reported. Where requested, the reporter anonymity is maintained. There is continuous collation of monthly, quarterly and annual data, which is then shared by the Guardian team across the trust. The CEO, Senior Leaders, Divisional Management Teams, HR Advisory teams, and Organisational Development Team members are all sighted on the themes only as it helps to facilitate learning opportunities. The staff who share their details with FtSU are contacted by the Guardian assigned to them and given an update verbally, followed by a written conclusion. In order to ensure information is communicated and transparency is maintained, there will be the launch of the quarterly Guardians and Champions update in the form of a newsletter for the purpose of information sharing.

Detriment, where a staff member is treated unfairly or negatively as a result of speaking up, is viewed as very serious and relevant action is taken. Cases of detriment are recorded separately and reported to the National Guardians Office as mandated. The Guardians support staff if there is report of detriment by following policies and procedures, as well as informing the senior leadership team for further support and input for the staff member experiencing detriment, helping to safeguard them and their wellbeing. HR16 policy also details guidelines for cases of detriment.

In its response to the Gosport Independent Panel Report, the government committed to legislation requiring all NHS Trusts and Foundation Trusts in England to report annually on staff who speak up (including whistleblowers). Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

Various routes for speaking up:

- Identified or unidentified referral form via online QR codes or Trust Intranet page or posters around Trust
- Email address for FtSU team
- Telephone access for FtSU team - both office landline or mobile numbers
- Champions >12 across different specialties across the Trust can be spoken with initially, they can then help staff members make a referral to FtSU Guardians

Staff then have options to:

- Be offered support that is impartial and objective
- Talk through their concern in a psychologically safe space
- Have their concerns kept confidential (within the set limits of confidentiality) unless there are safeguarding concerns
- Discuss the options of emotional and wellbeing support available to them
- Be signposted to other staff in the Trust if appropriate for additional support
- Receive practical and non-judgemental advice

- Receive closure if details of referrer shared with team

6.14 Reporting against core indicators

Guardian of Safe Working Statement

Doctors and Dentists across the organisation work rotas of varying shift patterns dependent on the needs of the specific clinical area. These rotas are checked against contractual safe working hour limits prior to rota implementation. For those Doctors and Dentists in training posts, variance from this rota pattern, for example finishing shifts late or missing breaks, can be highlighted by the individual by submitting an exception report. The number of exception reports rose from 42 last year to 79 this year, however this correlates with efforts to improve accessibility to exception reporting, thus possibly reflects increasing reporting practices rather than increased incidence of working outside of the scheduled pattern.

Currently, rotas are logged on individual documents making full oversight of medical workforce working patterns challenging. The Trust plans to migrate medical rotas to specialised software which will allow greater assurances and oversight. Additionally, work will be carried out this year aiming to reduce rota gaps and thus reliance on locum staffing through evaluating staffing requirements and optimising staff utilisation.

Review of Quality

Our performance in 2024/25

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 2024/25 is shown below.

Performance against the National Operational Standards:

Indicator	Target (2024/25)	2024/25	2023/24	2022/23
Cancer two week wait from referral to first seen date	93%	90.12%	81.39%	80.91%
Cancer two week wait for breast symptomatic patients	93%	79.51%	84.21%	84.29%
Cancer 31 day wait for first treatment	96%			75.83%
Cancer 31 day wait for second or subsequent treatment - Surgery	94%			54.67%
Cancer 31 day wait for second or subsequent treatment - Anti-cancer drug	98%			82.36%
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	94%			82.32%
Cancer 31 day Combined	96%	89.43%	84.40%	
Cancer 62 day wait for first treatment	85%			38.22%
Cancer 62 day wait for treatment from Consultant screening service	90%			37.17%
Cancer 62 day wait- Consultant upgrade (local target)	88%			54.96%
Cancer 62 day Combined	70%	60.58%	42.58%	
28 Day FDS (all routes)	77%	78.68%	74.37%	69.16%
Emergency Department - total time in ED	78%	80.86%	77.43%	76.51%
Referral to treatment - incomplete pathways	92%	52.62%	55.13%	59.85%
Cancelled operations on the day of surgery as a % of electives	<0.8%	0.56%	0.27%	0.29%
Mixed sex accomodation breaches	0	0	0	0

Diagnostic tests longer than 6 weeks	<5%	5.24%	40.55%	45.93%

Performance against other National and Local Quality Requirements		**Performance**		
Indicator	**Target (2024/25)**	**2024/25**	**2023/24**	**2022/23**
Clostridium Difficile	58	126	80	72
MRSA	0	4	3	2
Duty of Candour	0	6	0	0
Ambulance handover <15 minutes	>65%	44.67%	52.63%	40.05%
Ambulance handover <30 minutes	>95%	74.46%	82.91%	75.71%
Ambulance handover >60 minutes	0%	13.61%	7.57%	10.82%
ED waits >12 hours	<2%	10.86%	8.52%	7.82%
Referral to treatment - no one waiting longer than 52 weeks	0	2,090	2,570	3,653
Referral to treatment - no one waiting longer than 65 weeks	0	2		
Referral to treatment - no one waiting longer than 78 weeks	0	0	0	85

Engagement in the development of the Quality Account

Prior to the publication of the 2024/25 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
- ICB
- Trust staff
- Healthwatch Wolverhampton

In 2025/26 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 patients and community representatives for their feedback as well as members of staff who gave their time to help us select our priorities and ensure that the document is clear and accessible.

Black Country Integrated Care Board (BCICB) statement on The Royal Wolverhampton NHS Trust (RWT) Quality Account 2024/25

The Black Country Integrated Care Board welcomes the opportunity to review and provide feedback on The Royal Wolverhampton NHS Trust's Quality Account for 2024/25. The document is materially accurate and reflects the information shared with the ICB during contractual discussions, quality monitoring meetings, and quality assurance visits.

We acknowledge that 2024/25 has presented significant challenges for the Trust, with service demand consistently exceeding available capacity. Despite these pressures, the Trust has demonstrated commendable commitment to maintaining the quality and safety of care. The BCICB recognises and values these efforts in navigating operational uncertainty while upholding high standards.

The BCICB extends its sincere appreciation to all staff and volunteers at The Royal Wolverhampton NHS Trust for their ongoing dedication and resilience. Their contribution remains vital in ensuring that patient care is delivered safely and to the highest possible standard. We also fully support the strategic partnership between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. This collaborative approach represents a positive and progressive step towards a more integrated healthcare system that improves efficiency, sustainability, and the overall quality of care for the local population.

The BCICB is proud of its strong and constructive working relationship with the Trust. We commend the organisation for its engagement with commissioners and for its continued efforts in meeting established quality priorities. It is encouraging to note that the Trust maintains a clear focus on quality improvement, particularly in the areas of Patient Safety, Clinical Effectiveness, and Patient Experience.

Looking ahead, the ICB remains committed to supporting and monitoring the Trust's progress in delivering against its quality priorities for 2025/26. We look forward to the positive outcomes and system-wide benefits that will emerge from this ongoing work.

Key Achievements for 2024/25

The Integrated Care Board (ICB) would particularly like to highlight the following key achievements of The Royal Wolverhampton NHS Trust during 2024/25:

Emergency Department (ED) Performance: The Trust has achieved a sustained improvement in 4-hour ED performance, reaching an overall rate of 80.9%. As a result, it is now ranked among the best-performing organisations nationally.

Ambulance Handover Improvements: The Trust's Emergency Services teams have worked collaboratively with West Midlands Ambulance Service and Black Country ICB colleagues to implement the 45-Minute Handover initiative, leading to significant improvements in average ambulance handover times.

Cancer Performance and Tiering Status: In May 2024, RWT was elevated to Tier 1 status for national scrutiny. Following significant reductions in backlogs and improvements in 62-day performance, the Trust was de-escalated to Tier 2 in January 2025 and has since been removed from the national tiering system, reflecting the lowest level of escalation for cancer performance.

Elective Recovery: The Trust has made substantial progress in addressing long waits for treatment, having virtually eliminated waits exceeding 65 weeks. The current focus is now on reducing the number of patients waiting over 52 weeks.

Patient Experience Improvements: Aligned with the Patient Experience Enabling Strategy, the Trust has introduced significant developments across the areas of Involvement, Engagement, and Experience. Noteworthy programmes include Mealtime Mates, Patient Involvement Partners, Mystery Patients, and Patient Voice Reports. These initiatives provide real-time insights and reflect the Trust's ongoing commitment to reducing complaints, improving staff attitudes, and ensuring equitable, patient-centred care for all communities served.

Maternity Services Rating: The Trust's Maternity service received an overall rating of 'Good', with specific ratings of 'Good' for safety, effectiveness, and leadership. The 'Caring' domain was not inspected during this assessment and retains its previous rating of 'Outstanding', while the 'Responsive' domain maintains its previous rating of 'Good'.

Community First Programme: The Trust has taken an innovative approach in developing the Community First programme, which supports patients to manage their conditions at home, where they feel most comfortable, avoiding hospital admission when clinically appropriate.

Staff Survey Results: The results of the 2024 Staff Survey indicate a 7% increase in staff response rate. The Trust exceeded the sector average in the category "We work flexibly" and matched the sector average in "We are safe and healthy."

Areas for Continued Focus and Improvement in 2025/26

Whilst we recognise and commend the Trust's achievements, the ICB would value the delivery of sustainable improvements in the following areas over the coming year:

SSNAP Mortality Alert: The Trust has been identified as an outlier for the Sentinel Stroke National Audit Programme mortality alert for 2023/24. We acknowledge that an overarching improvement action plan has been developed, aligned with recommendations from both the external Royal College of Physicians (RCP) review visit and the internal quality review. However, we expect to see a sustained improvement in outcomes related to this alert during 2025/2026.

Patient Safety Incident Response Framework (PSIRF): We encourage the Trust to continue embedding PSIRF across the organisation, with a focus on learning from incidents and enhancing patient safety. We

are particularly interested in monitoring the positive cultural impact PSIRF is having on the Trust's safety ethos.

Clostridioides difficile (C. Difficile): We recognise the Trust's participation in the ICB's C. Difficile Task and Finish Group, aimed at implementing a system-wide approach to reducing infection rates across community and acute care settings. While continued efforts to improve clinical practices and infection prevention and control are welcomed, we expect to see a reduction in hospital-onset C. Difficile infections during 2025/26.

Staff Survey – People Promise Indicators: While we note some positive results from the 2024/25 Staff Survey, there has been a decline in the All People Promise indicators. We therefore expect the Trust to implement targeted actions aimed at improving the overall staff experience, with a particular focus on the areas highlighted by the People Promise framework indicators.

National Operational Targets: We expect the Trust to work collaboratively with system partners to meet key national performance targets, as outlined below:

Increase the proportion of patients waiting no more than 18 weeks for treatment to 65% nationally by March 2026, with each Trust expected to achieve a minimum of five percentage points improvement.

Improve the proportion of patients receiving their first outpatient appointment within 18 weeks to 72% nationally by March 2026, with a minimum of five percentage points improvement expected per Trust.

Reduce the proportion of patients waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026.

Improve performance against the 62-day cancer standard to 75% by March 2026.

Improve compliance with the 28-day Faster Diagnosis Standard for cancer to 80% by March 2026.

Reduce Category 2 ambulance response times to an average of 30 minutes across 2025/26.

Improve A&E performance, with a minimum of 78% of patients being admitted, discharged, or transferred within four hours by March 2026. Additionally, there should be an increase in the proportion of patients seen within 12 hours during 2025/26 compared to 2024/25.

The ICB confirms that the information presented in the Annual Quality Account accurately reflects the Trust's performance for 2024/25. The report is presented in the required format and provides a comprehensive and accurate representation of the Trust's quality profile, including its current activities and future aspirations. We commend the Trust for its ongoing commitment to working collaboratively and transparently with the ICB. We look forward to continuing our strong partnership throughout 2025/2026, supporting shared priorities and delivering high-quality care for our population.

Sally Roberts

Chief Nursing Officer/Deputy Chief Executive Officer

Black Country Integrated Care Board

Statement of Director Responsibilities in respect of the Quality Account 2024/25

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

- the content of the Quality Account meets the requirements set out in the annual reporting manual and supporting guidance Detailed requirements for Quality Acounts.
- the content of the Quality Account is not inconsistent with internal and external sources of information including:

– board minutes and papers for the period April 2024 to March 2025

– papers relating to quality reported to the board over the period April 2024 to March 2025

– feedback from commissioners

– feedback from local Healthwatch organisation

– feedback from overview and scrutiny committee

– the 2024 National Staff Survey

- the Quality Account presents a balanced picture of the Trust's performance over the period covered.
- the performance information reported in the Quality Account is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- the Quality Account 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 Account.

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

By order of the board

Sir David Nicholson KCB CBE

Chair

27 June 2025

Joe Chadwick-Bell

Chief Executive

27 June 2025

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement have confirmed in the Quality Accounts requirements for 2024/25 that there is no national requirement for NHS Trusts or Foundation Trusts to obtain external auditor assurance on the Quality Account.

How to give comments

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

Please contact us as indicated below:

Patient Experience Team
The Royal Wolverhampton NHS Trust
New Cross Hospital
Wednesfield Road
Wolverhampton
WV10 0QP