NHS
The Royal Wolverhampton
NHS Trust

Quality Account
2025/26

Care Colleagues
Collaboration Communities

Contents

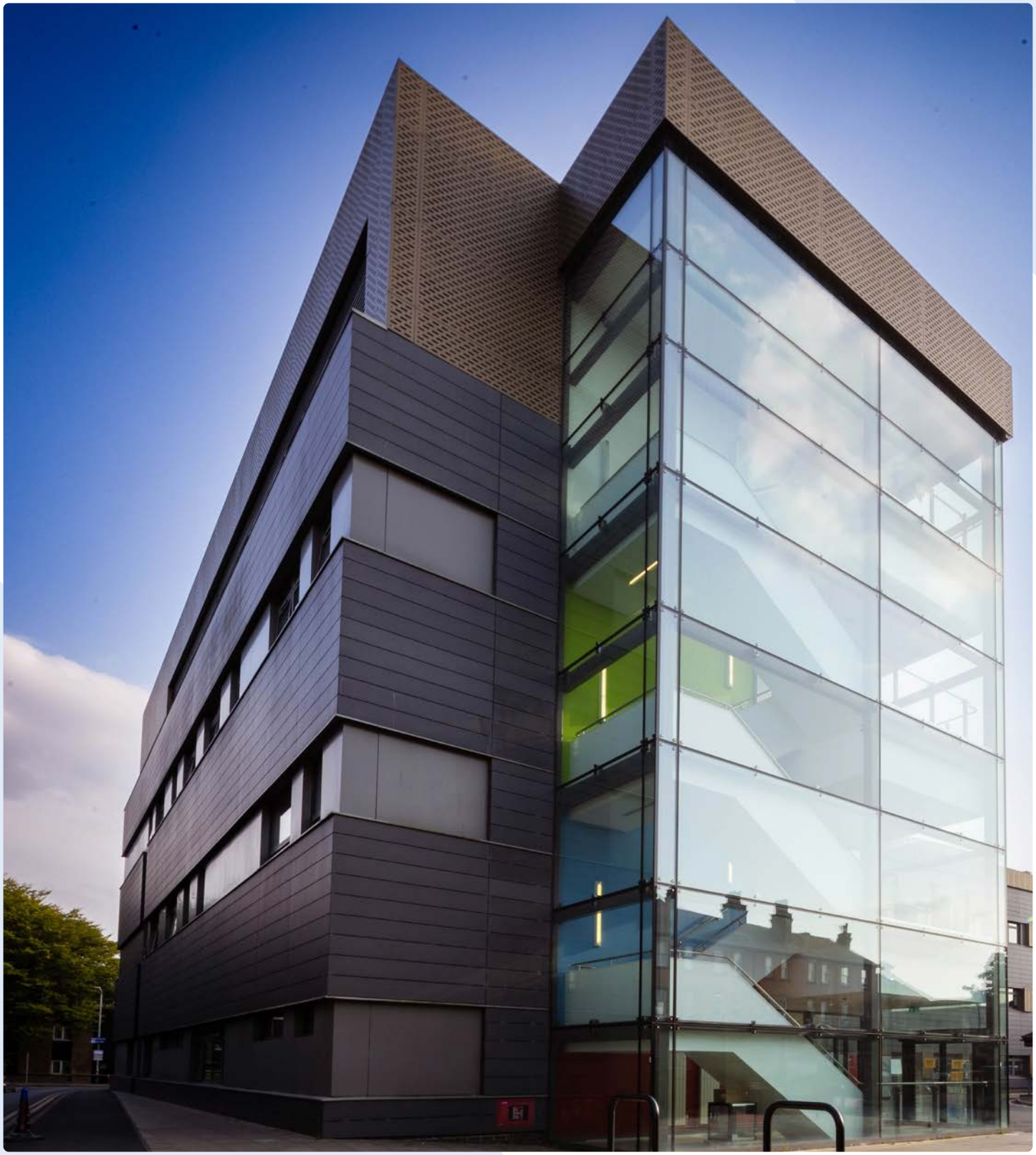
The Quality Account

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 provided to patients.

This gives the Trust an opportunity to be open and accountable and demonstrate how well the organisation is performing, 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.



Chair and Chief Executive's Welcome

Welcome to our annual Quality Account for 2025/26, which sets out our progress – working in collaboration with our partners - to deliver high-quality care to patients who access our services, both in our hospitals and in the community.

The past 12 months have once again presented challenges for the NHS as we all focus our efforts on the national priorities which include reducing the time people wait for elective care and improving A&E waiting times and ambulance response times.

Demand for acute services has continued to rise against a backdrop of unprecedented periods of industrial action while we try to meet the growing needs of our ageing population and address health inequalities. And managing our finite resources is an ongoing challenge.

All our patients deserve the highest standard of care, and this Quality Account shares areas of best practice, as well as areas where we need to make further improvements to ensure they receive this.

We monitor our safety, clinical effectiveness, and patient experience through a range of methods including audits, patient surveys and sub-committees that report to Board as well as regular reviews with the Black Country Integrated Care Board. Regulators and peer reviews externally assess our healthcare services.

Whilst appreciating there is always more to do, we're encouraged by the progress the Trust has made to significantly improve waiting times for patients across its services, for outpatient and inpatient / same day care treatments. The Trust was also in the top quartile for the most improvement in waiting times and the same is true for its diagnostic services.

And we continue to collaborate with patients, their families and carers and our stakeholders to co-design our services and ensure the patient voice is at the heart of all we do.

Around his time last year, we were all anticipating the content of the government's 10 Year Health Plan. It was released last summer and, as we expected, it focuses on three key shifts in healthcare:

- Hospital to community
- Analogue to digital
- Sickness to prevention

This direction aligns with our own vision for The Royal Wolverhampton NHS Trust and were drivers for us as we developed a refreshed joint strategy with Walsall Healthcare NHS Trust earlier this year.

We know the challenges that healthcare services face when meeting the varied – and often complex - needs of the people they serve are not going to suddenly reduce. Add into this the necessity of managing our finances efficiently and using our resources in the most effective way possible and it's clear the NHS cannot continue to operate in the way it traditionally has done for so many years.

We're proud that Transforming Care Together, our refreshed strategy, encourages a strengthening of community services, development of neighbourhood teams, expansion of elective capacity, modernised outpatient care, and improved access to diagnostics, ensuring patients receive timely, co-ordinated and convenient care.

Our pledge is that by 2031, patients will experience faster access to care in their communities, staff will work in a digitally enabled and supportive environment, our organisations are fit for the future, and patients will benefit from improved ways of communicating with our clinical teams.

The strategy is bold and brave, and it takes account of the fast-moving advancements being made through digital technology that will undoubtedly help us to innovate to become fit for the future.

In 2025, I had only recently joined the organisation. Now, after more than 12 months spent with committed, passionate teams who are striving to make a difference to all communities, I want to say how proud I am of what we have achieved so far. Thank you. I know we will go on to make an even greater impact while continuing to create supportive environments that prioritise our patients' needs whilst nurturing those who care for them.

Joe Chadwick-Bell

Chief Executive

Vision and Values

As our previous joint The Royal Wolverhampton and Walsall Healthcare and NHS Trusts' strategy was coming to an end, we have taken the opportunity to co-design a new five-year strategy.

This aligns with the NHS 10 Year Health Plan priorities:

- Analogue to digital
- Illness to prevention
- Acute to community

It also takes advantage of the opportunities of our integrated Group model and recognises the national challenges around productivity.

Our new strategy for 2026/31 is Transforming Care Together.

Our vision remains: To deliver exceptional care together to improve the health and wellbeing of our communities. And the four Cs from our previous strategy – Care, Colleagues, Collaboration and Communities – are still the strategic aims that guide us.

Our Values also remain:

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

At the heart of Transforming Care Together is our "wheel" which details our ten objectives.

We want every colleague to understand how their role contributes to our collective success, making us proud to be part of this organisation. To help, we have set three key priorities for this year:

- We want our colleagues to feel cared about
- We want to improve safety by reducing the time patients wait
- We want to deliver our services efficiently

By 2031, we will have transformed into digitally-enabled, community-focused organisations that deliver exceptional quality of care closer to home, where clinically appropriate. We will operate within our means and empower our staff to innovate and excel.

We will have transformed our services, so care is delivered in communities, hospitals focus on emergency and complex care, and digital innovation empowers both patients and staff to achieve better outcomes.

We will work effectively with primary care and our partners across integrated neighbourhood health teams to provide co-ordinated, person-centred care that keeps people healthy and independent in their communities.

Strategic Objectives

Looking back 2025/26

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	What we said we would do	How we did
1.1 Priority area – Patient safety Prevention of avoidable hospital deconditioning	• Monitoring of progress and actions through Safer Mobility Group, Tissue Viability Group, Mouth Care Group, Nutrition Steering Group and Infection Prevention and Control Group • Incorporating EDDMI (Eat, Drink, Dress, Move to Improve) status into Clinical Accreditation reports to influence local Quality Improvement **The aim for 2026/27** • 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	The Eat, Drink, Dress, Move to Improve programme is progressing in line with the Nursing, Midwifery and AHP Quality Framework, with increasing evidence of impact on avoidable deconditioning, falls prevention, pressure ulcer reduction and patient independence. The programme is gaining national and regional interest and supports wider sustainability objectives. The Trust introduced targeted quality improvement interventions focused on improving early nutritional screening and optimising patient flow out of the Emergency Department. Over recent months, a clear and encouraging correlation has emerged between strengthened MUST compliance across wards and a reduction in the number of pressure ulcers being reported. Wards demonstrating the highest levels of MUST compliance have consistently recorded the fewest pressure ulcers, reinforcing the clinical importance of early nutritional assessment in preventing skin breakdown. Activity and surveillance continue to be overseen by a variety of quality and safety oversight groups. Elements of EDDMI are incorporated into the InPhase Audit Programme and the revised Clinical Accreditation methodology. **Group Wide Progress and Shared Learning** • Consistent communication and engagement materials developed, including resources on Healthy Feet, Appropriate Footwear and What to Bring Into Hospital, supporting patient and family involvement • Reduction in inappropriate items (e.g. slipper socks) embedded through clear communication, with patients and families encouraged to bring well fitting footwear from home • Toolkit under development to support structured, consistent rollout across the Group, enabling shared learning and standardisation • Contribution to sustainability agenda, including reduced reliance on pulp products and adoption of reusable alternatives in pilot areas • External profile raised, including presentation at the Preventing Avoidable Deconditioning Conference (March 2026) and the development of a National upscale project based on the Trust's Bathroom First project • A showcase event for both Trusts is planned for 2026 to demonstrate local improvements and wide scale actions for 2026/27. Research is also in development to identify a metric to measure deconditioning

Priority 1	What we said we would do	How we did
1.2 Patient Safety 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 **The aim for 2026/27** • 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	• MEED unable to progress due to limited dietetic support • Training packages available on MyAcademy, including use of ligature cutters. IKON training rolled out • Policies available for all age groups which support best practice and current evidence • RCEM risk assessment ratified and in place in Emergency Department

Priority 1	What we said we would do	How we did
1.3 Patient Safety Safeguarding	**Key actions we will take:** • Robust oversight of patient feedback, safeguarding referrals, quality concerns raised via external routes, incidents and excellence to drive continuous improvements **The aim for 2026/27** • To ensure the Trust discharges its statutory duties and responsibilities in relation to Section 11 of the Children's 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 Service	**Governance and Compliance** • Strong safeguarding systems in place; statutory duties for adults and children met • 100% compliance with Black Country ICB Safeguarding Assurance Framework; no outstanding actions • Robust governance via monthly Safeguarding Group with good multidisciplinary engagement • Compliance achieved with MCA (2005), Care Act (2014), Children Act (2004 s.11), and CQC standards • All policies in date; updated to reflect national learning (e.g. Fuller Report) **Training and Workforce** • Training compliance consistently high (>95%) across most areas • Safeguarding Children Level 3 at 86%– actions in place to address • Strong Prevent assurance (policy, leadership, reporting, >95% training) **Practice and Supervision** • Supervision established but reduced (96% - 86%); recognised risk with mitigation in place • Maternity supervision strong position (93.5%) **Multi-Agency and Learning** • Active contributor to all statutory reviews (SARs, CSPRs, DARDRs, LeDeR) • Learning effectively tracked and embedded; new action tracker strengthens oversight **Demand and Activity** • Sustained high safeguarding demand; increased advice line use reflects improved visibility and confidence • Adult referrals and DoLS levels stable **Quality Improvement** • MCA audit shows significant improvement (+24% compliance) **Equality and Patient Voice** • Compliance with Accessible Information Standard (policy + Easy Read materials) • Person-centred safeguarding embedded; voice of child/adult prioritised

Priority 1	What we said we would do	How we did
1.4 Patient Safety Safe Discharge	**Key actions we will take:** • 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 **The aim for 2026/27** • To ensure 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)	Patient discharge priorities are being delivered in line with the Patient Experience Enabling Strategy (2022–2025). Both Trusts demonstrate improving oversight, multidisciplinary coordination and patient experience, supported by routine feedback, governance reporting and targeted service improvements. **Group Wide Assurance and Shared Progress** • Robust governance and feedback mechanisms in place, with routine oversight of patient feedback, complaints, safeguarding referrals and quality concerns • Positive patient experience trends demonstrated through national survey results at both Trusts, particularly around information, involvement in discharge decisions and post discharge support **Royal Wolverhampton NHS Trust** • Daily Trust wide discharge huddle held with multidisciplinary representation • Expanded Virtual Ward (Hospital at Home) capacity, enabling patients to recover at home with remote monitoring, home visits, and video consultations, supporting safety, flow and patient experience • Demonstrable improvement in patient feedback National Inpatient Survey (2024- results received November 2025) shows post discharge support cores improving from 7.5 (2020) to 8.3 (2024) Continued positive trends in patient involvement in discharge decisions and clarity of information

Priority 1	What we said we would do	How we did
1.5 Patient Safety Infection Prevention	**Key actions we will take:** • Utilise NHS England's 'Take your gloves off' campaign to support both rationalisation of glove use by our staff and sustainability objectives • Support the EDDMI initiative 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 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	• Worked collaboratively with the Quality Team and key stakeholders to support the implementation of EDDMI initiatives and Bathroom First, providing specialist IPC input and preventative strategies • To support reductions and appropriate use of gloves the IP Team has embedded this as part of IP fundamentals education and training. Led Trust activity as part of NHS England's 'Take your gloves off' campaign • IPC staff completed essential or full Quality Improvement training, with learning embedded into practice and aligned to the annual work plan • Maintained and regularly updated local policies in line with the latest evidence base and the National Infection Prevention and Control Manual • Continued to deliver service situated training, ad hoc surveillance to identify emerging trends and themes, supporting organisational learning and improvement • Actively engaged internal and external stakeholders to support initiatives aimed at reducing Gram negative bloodstream infections. Catheter Group moved to Optimising Continence shared decision making council (RWT and WHT membership), active participation in Trust Healthcare Associated Pneumonia (HAP) Group • Achieved improvement in Clostridioides difficile rates through an ongoing multi-factorial improvement programme, effective use of the Patient Equipment Cleaning Centre (PECC) and a modified deep clean programme. External visits from NHSE and ICB facilitated and Trust C. Diff action plan monitored through IPCG

Priority 1	What we said we would do	How we did
1.5 Patient Safety Infection Prevention	• 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 **The aim for 2026/27** • 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.	Infection prevention incident response process aligned to PSIRF. Implemented the PSIRF IPC Matrix for RWT. Incident reports are presented at the IPC Group reporting to the DIPC • Supported the Trust's green and sustainability agenda through specialist IPC expertise and advice • Supported the Trust seasonal influenza vaccination programme • All statutory IPC duties have been maintained. This summary is not exhaustive; full details of activity and deliverables are outlined within the RWT IPC Annual Report

Priority 1	What we said we would do	How we did
1.6 Patient Safety Full implementation of Saving Babies Lives to prevent avoidable harm	**Key actions we will take:** • 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 • Implementation of workstreams to Prevent, Identify, Escalate and Respond to patient deterioration across a variety of settings, including in the wider community **The aim for 2026/27** • 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	• Progress: RWT fully implemented care bundle (99% compliance) • One element outstanding which requires funding is Placental Growth Factor (PlGF) - business case developed and exploring ways within the Black Country in terms of how this is resourced and funded

Priority 1	What we said we would do	How we did
1.7 Patient Safety Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach	**Key actions we will take:** • Implementation of workstreams to Prevent, Identify, Escalate and Respond to patient deterioration across a variety of settings, including in the wider community **The aim for 2026/27** • 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	• Robust Trust wide governance for the deteriorating patient agenda is fully embedded through the multidisciplinary Deteriorating Patient Groups (DPG), providing routine oversight of deterioration, escalation, incidents, mortality review and patient feedback via established quality governance routes • Standardised policies, guidelines and escalation standards are aligned across both Trusts where operationally practicable, supporting consistent recognition and management of deterioration • NEWS2 CQUIN delivery achieved and sustained, with ongoing routine data submission and retrospective review continuing beyond the life of the incentive to maintain assurance against national KPIs • Live digital dashboards for observations completed on time, NEWS2 escalation (≥5/≥7) and sepsis screening are embedded at ward and Trust level, enabling real time visibility, targeted deep dives and responsive improvement where variation is identified • Sustained improvement in observations completed on time, in line with the Quality Framework trajectory, supported by continuous monitoring, targeted escalation reviews and local action planning • Early recognition and escalation pathways strengthened through close collaboration with the Critical Care Outreach Team and virtual review by specialist teams, ensuring timely senior clinical input for deteriorating patients

Priority 1	What we said we would do	How we did
1.7 Patient Safety Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach		• Martha's Rule Patient Wellness Rounds successfully implemented for adult inpatients, strengthening patient and family escalation and reinforcing a safety first culture. Call for Concern embedded and reported on via DPGs in combination of scrutiny of other deteriorating patient metrics. 2026/27 will be focusing on the next phase of implementation in Emergency Departments and Maternity Services • Education and workforce capability embedded as business as usual, with deteriorating patient training delivered through induction, mandatory training, simulation and targeted ward based support • Stable external benchmarking, including ICNARC outcome data across the 2023/26 strategy period, provides independent assurance of safe outcomes for critically unwell patients Agreed actions for timely sepsis recognition and treatment have been largely achieved, with standardised governance, NICE aligned pathways, digital oversight, MDT education and continuous learning embedded as business as usual. Both organisations demonstrate strong multidisciplinary working through shared Deteriorating Patient Group (DPG) governance, bi annual performance review and alignment of key policies and assurance mechanisms wherever operationally practicable. • Clinically led MDT governance embedded through the DPG, providing joint oversight of sepsis recognition, escalation, mortality, incidents, complaints and patient feedback

Priority	What we said we would do	How we did
1.7 Patient Safety Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach		• Standardised oversight and reporting of sepsis performance aligned across both Trusts by Q2 2024/25, enabling consistent assurance and shared learning • Demonstrated incremental improvement in key sepsis indicators from the 2023/24 baseline • Education and workforce capability strengthening, with induction and ongoing sepsis training programmes in place across both Trusts; >90% staff compliance remains • Evidence of improved patient outcomes, triangulated through sepsis metrics, deterioration data, unplanned critical care admissions and external benchmarking • Innovative digital sepsis dashboard, identifying patients with NEWS ≥5 or single parameter 3, providing Trust wide visibility of screening completion and escalation; this work was HSJ Awards shortlisted • Updated NICE aligned risk stratification implemented in Emergency Medicine, with clear escalation expectations for high risk sepsis (antibiotics, IV fluids and senior review within one hour) • 24 hour sepsis and Critical Care Outreach collaboration, following post COVID integration, strengthening MDT response and escalation • Focused work on mortality assurance, with SHMI trends monitored through DPG governance; current performance is broadly comparable with Black Country peers. Further work is underway with clinical coding to understand recent variation • Growing community and public engagement, including work with local MPs and councillors to explore wider sepsis education and awareness campaigns

Priority 1	What we said we would do	How we did
1.7 Patient Safety VTE Compliance	**Key actions we will take:** • 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 **The aim for 2026/27** • Continuous improvement towards achieving the national operational standard of 95% set by the NHS Standard Contract	• New VTE lead and VTE Chair appointed • Trial successfully completed - we identified the need for some collaborative working between epma and the Clinical Information Team to provide clear compliance outcomes. Second trial to take place in May • Awaiting Clinical Information Team manager to confirm go live date • VTE Team continues to monitor and share monthly compliance

Priority 2	What we said we would do	How we did
1.1 Clinical Effectiveness Reduce the time people wait for elective care.	**Key actions we will take:** • Improve 18 weeks RTT to 65% nationally by March 2026 • Improve 18 weeks RTT for a first appointment to 72% nationally by March 2026 • Reduce 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 2027 **The aim for 2026/27** • 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	• We continued to prioritise patients for elective care treatment based on their clinical need whilst also reducing the number of patients waiting for the longest time • Our 18 weeks RTT target was to achieve 60.6% by March 2026. We achieved 60.61% • We had no patients waiting over 65 weeks at the end of December 2025 • We achieved the 28-day cancer Faster Diagnosis Standard and narrowly missed the 62-day standard with 73% of patients receiving treatment within this timeframe

Priority 2	What we said we would do	How we did
1.2 Clinical Effectiveness Improve A & E waiting times and ambulance response times	**Key actions we will take:** • Expanding and maintaining the use of Same Day Emergency Care (SDEC) services to avoid unnecessary hospital stays • Expanding Virtual Wards, allowing people to be safely monitored from the comfort of their own homes. • Working with partners to speed up discharge from hospital and reduce the number of patients without criteria to reside **The aim for 2026/27** • Improve A & E waiting times, minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours by March 2026 • Achieve a higher proportion within 12 hours DTA across 2025/26 compared to 2024/25	• We continued our work to further improve access for patients with an immediate unplanned assessment, treatment and care need throughout the year • We expanded the use of our Frailty SDEC service to see more patients each day and implemented a dedicated Medical SDEC in March 2026 • Our Virtual Wards continue to see increasing numbers of patients with a wider range of needs – either avoiding their admission to hospital or facilitating an earlier discharge • We maintained our 4hour Urgent and Emergency care standard with over 80% of patients being seen and treated within 4 hours of arrival

Priority 2	What we said we would do	How we did

1.3 Clinical Effectiveness
Outpatient Transformation
Patient Experience
	Key actions we will take:
	• To 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
	The aim for 2026/27
	• Transform the delivery of Outpatient services with the aim of avoiding unnecessary travel and stress for patients
		• CAS is being introduced across directorates to improve efficiency
		• Phone clinics are being used judiciously where clinical assessment and discussion is not enhanced by the face-to-face experience
		• PIFU is being adopted where appropriate to avoid unnecessary follow-up appointments

Priority 3	What we said we would do	How we did
1.1 Patient Experience Strengthening Organisational Response to National Mandated Surveys.	**Key actions we will take:** • 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 **The aim for 2026/27** • To 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 these and trends	• Established a systematic survey insight process, ensuring that all national patient experience survey results (Inpatient, Maternity, CYP, UEC, and NCPES) were shared and reviewed at appropriate divisional and Trust-wide meetings within four weeks of publication • Introduced a new "Corporate Survey Tracker", enabling leaders to upload actions against specific trends over time, benchmark against national averages, and identify areas of improvement more rapidly. • Delivered staff engagement sessions and learning workshops to ensure teams understood survey results, patient comments, and how insight links to day-to-day practice Demonstrated some measurable impact, including early improvements in communication scores, enhanced discharge information processes, and updated patient-friendly materials co-designed with service users

Priority 3	What we said we would do	How we did
1.2 Patient Experience Embedding the PHSO Complaint Standards and Learning from Excellence	**Key actions we will take:** • 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	1. PHSO standards fully embedded in policy which was amended to reflect and ratified in 2025. Policy contains for the first time, a comprehensive toolkit as a stand alone document which further supports the standards by guidance and templates contained within 2. Performance indicators exist but in light of new 'Group' policy are being reviewed for consistency against Group Trust and new PHSO standards. New performance indicators effective from April 2026 3. Recommendations considered and featured alongside the new policy and implementation of PHSO standards. Complaint process accessible in variety of ways, email, telephone, face to face and via advocacy service Monthly monitoring performance undertaken based on metrics and published Trust wide in the implementation of dashboards which were implemented in 2025 **Other highlighted points** • **Implemented the 'Ask, Listen, Do'** approach to hearing and responding to concerns - designed to support organisations to listen, learn from and improve the experiences of children and adults who are autistic or have a learning disability, their families and carers and make it easier for people, families and paid carers to give feedback, raise concerns and complain

Priority 3	What we said we would do	How we did

1.2 Patient Experience
Embedding the PHSO Complaint Standards and Learning from Excellence
	The aim for 2026/27
	• To 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
	• Introduce improved performance indicators for complaint handling including the number of reopened complaints, and the number of complaints referred to the Parliamentary Health Service Ombudsman (PHSO)
	• 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.
		• Launched real-time Patient Voice Dashboards combining all modes of feedback in one place allowing for easier staff access to the data and themes arising
		
		Both RWT and WHT – redesigned dashboards for monthly real time overview of complaints compliancy. This included an introduction of an Executive-led dashboard with weekly data of activity at operational level.
		
		Introduced new risk matrix for determining complex complaints. Reviewed final complaint sign off process for more operational approval (specifically at RWT at present) based on risk matrix and methodology. Thus enabling more efficiency in complaint handling timescales providing a greater degree of patient satisfaction.
		
		At RWT – reviewed complaints management for Non-section 42 complaints and implemented a more proactive approach in collaboration with Local Authority and Quality Matters teams.

Priority 3	What we said we would do	How we did
1.3 Patient Experience Integrating volunteering to enhance patient experience	**Key actions we will take:** • Increase in the number of active volunteers contributing to patient experience initiatives. • Positive feedback from patients regarding volunteer interactions, measured through patient satisfaction surveys • Improvement in patient flow and reduced waiting times attributed to volunteer support • Enhanced staff satisfaction due to volunteer contributions alleviating workload pressures **The aim for 2025/26** • 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	• Held recruitment events to increase the volunteer workforce, recruiting new volunteers across both acute and community settings, with a focus on supporting patient navigation, wayfinding, and companionship roles • Launched a refreshed training and induction programme, including dementia awareness, communication skills, safeguarding, and cultural competency to ensure volunteers were confident and well-prepared • Integrated volunteers into patient flow initiatives, such as supporting discharge lounges, reception areas, Outpatient check-in points, and community children's clinics • Improved volunteer visibility through branded clothing, clearer role descriptions, and the introduction of volunteer hubs in high-footfall areas • Captured patient feedback on volunteer impact, with consistently positive comments about kindness, reassurance, and reduced anxiety for patients and families • Strengthened partnerships with VCSE organisations, particularly around joint roles, pathway support, and the emerging 50/50 Volunteer Programme across the Walsall–Wolverhampton footprint

Priority 3	What we said we would do	How we did
1.3 Patient Experience Integrating volunteering to enhance patient experience		• Introduced volunteer recognition and development pathways, increasing retention and promoting volunteers into more skilled patient-facing roles • Demonstrated improvements in staff experience, with clinical teams reporting reduced pressure in non-clinical tasks due to enhanced volunteer support • Commissioned HACT to conduct an independent social value evaluation, providing an external assessment of the impact created by the volunteering programme across Walsall and Wolverhampton. HACT's report identified £2.4 million in measurable social value, demonstrating the significant contribution volunteers make to patient experience, staff wellbeing, community connection, and organisational resilience

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

Fundamentals – based on internal and external priorities:

- Priority Area – Prevention and management of patient deterioration
- Priority Area – Timely sepsis recognition and treatment
- Priority Area – Medicines management
- Priority Area – Adult and children safeguarding
- Priority Area – Infection prevention and control
- Priority Area – Eat, Drink, Dress, Move to Improve
- Priority Area – Patient discharge
- Priority Area – Maternity and neonates
- Priority Area – Mental health
- Priority Area – Digitalisation
- The Quality and Safety Enabling Strategy also includes the following priority area, which is part of the
- "Care" strategic aim of the Trust Strategy:
- Deliver financial sustainability by focussing investment on the areas that will have the biggest impact on our communities and populations
- Priority Area – Financial Sustainability
- This will focus on ensuring that we best use the finite resources available to us, which include, (but are not limited to), people, physical capacity and finances, as well as maximising opportunities offered through collaborative working between WHT and RWT.

Formal complaints, informal complaints (PALS concerns) and compliments

There were 847 formal complaints received compared to 563 for 2024/25. This represents an increase of 50%. The directorates where the greatest volume of complaints have been received when compared to the previous year are Emergency Department (58% increase) and General Surgery (38% increase). It is noted that although General Surgery features highly, when compared to the previous year it has been subject to a 46% decrease in volume.

Safeguarding concerns which do not meet the criteria for a Section 42 investigation are processed through the complaints procedure if submitted by a member of the public and are included in the total number of complaints received for the financial year. Those cases which are from professionals (e.g. Ambulance Service, care home, social workers) will be subject to investigation and response by the Quality Matters Team.

Safeguarding concerns have decreased from to 79 in 2024/25 to 61 in 2025/26. A review of the criteria and management of these complaints is a contributory factor for the decrease.

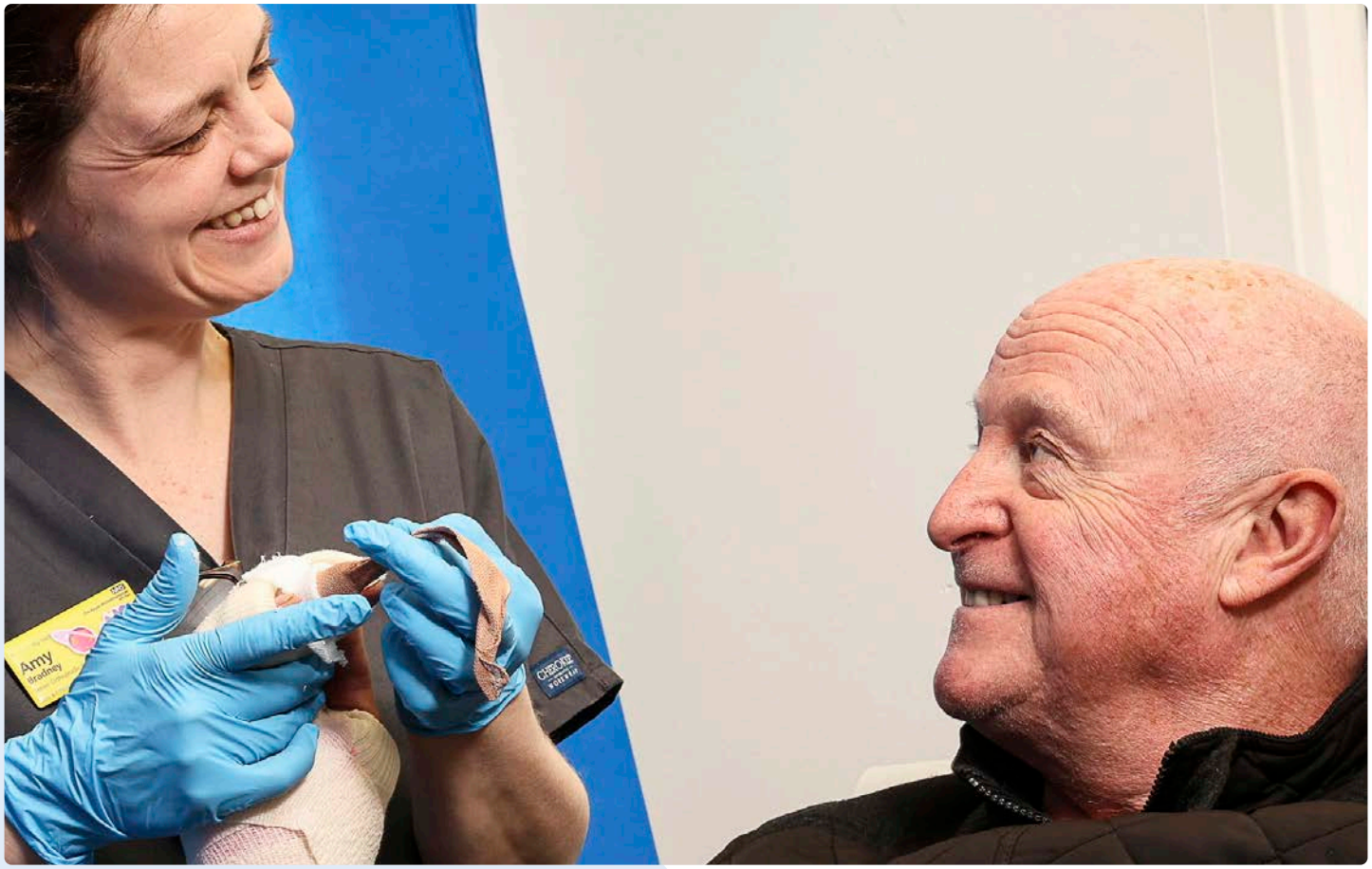
The Patient Relations Team continues to adopt a proactive early intervention approach working with complainants to achieve local resolution on concerns. These cases are resolved negating the need to escalate to operational teams, whether this be for formal or informal complaints.

Complaint compliancy is measured on the adherence to policy (30 working days) and gaining consent for an extension for completion. The Trust has seen a decrease in compliance with this timeframe, only attaining 100% for two months.

The non-compliance of 43 cases throughout the year was the contributory factor in the decrease in performance and failure to achieve 100%. The increase in volume and amended Quality Assurance process are noted as contributory factors.

Whilst the Trust continues to measure performance against the local 30 working day timescales, it also measures its compliance to timescales against the PHSO standards.

In line with these standards, for the year 2025/26, the Trust achieved 86% completed within three months in comparison to 96% during 2024/25 and 99% within six months for both 2024/25 and 2025/26. There were six cases in 2025/26 which exceeded the six-month completion timeframe. The average response rate within an agreed timeframe during 2025/26 was 94%.



Complaint outcomes

During 2025/26, from 762 cases which were closed, the Trust determined 28% of cases were not upheld, (a decrease of 4%), 60% were partially upheld (an increase of 13%), and 9% were upheld (a decrease of 9%).

As with the previous year, the Trust's performance measured for complaint outcomes for cases upheld was significantly lower than the national average of 25% (as recorded by NHS Digital [1] for 2024/25).

Parliamentary Health Service Ombudsman (PHSO)

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

- Six cases assessed with no escalation to formal investigation, one of which resulted in an apology and £1000 financial remedy
- A further 11 cases currently being assessed for possible escalation to detailed investigation
- No cases accepted for mediation
- Five cases subjected to full investigation
  - One case was upheld; recommendations included a letter of apology and action plan
  - One case was not upheld
  - The other three cases are still under investigation and awaiting final outcome

The cases closed during the period may not necessarily correlate with the cases received due to the receipt date or completion dates falling outside of the respective reporting periods.

Patient Relations & Experience

Complaints Dashboard - 2025-26

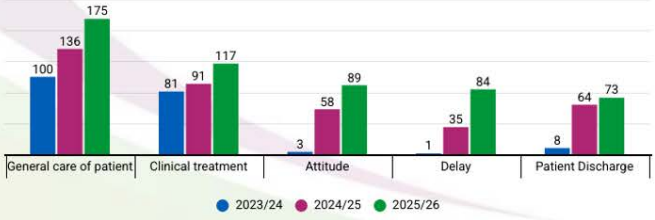
NHS The Royal Wolverhampton NHS Trust

Complaints & Contacts Volume

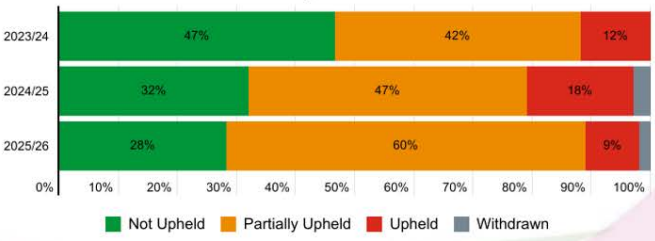
Contact Type	2023/24	2024/25	2025/26
Formal Complaint	460	563	847
Escalated From a PALS Concern	23	26	21
Informal Complaints, Queries & Early Resolutions	1412	2571	4775
Comments	24	24	12
Compliments	2549	2418	1880
NHS Choices 'Patient Opinion/Feedback'	289	305	173
Totals:	4757	5907	7708

Formal Complaint Response Compliance

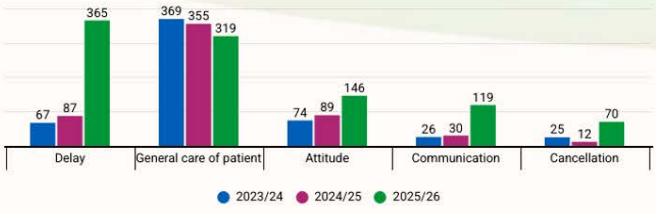
Top 5 Formal Complaint Themes



Formal Complaint Outcomes



Top 5 Informal Complaint Themes



Ombudsman Summary

- 6 cases assessed with no escalation to formal investigation. One of which resulted in an apology and £1000 financial remedy.
- A further 11 cases currently being assessed for possible escalation to detailed investigation.
- 5 cases subjected to full investigation of which; one case was upheld, one not upheld and three are awaiting final outcome.

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

Key achievements for complaint management

We have produced an updated joint Group Complaint Handling Policy to ensure standardisation and consistency across both Walsall Healthcare and The Royal Wolverhampton NHS Trusts.

We have updated our literature to ensure our complaints and PALS process is accessible.

In addition, we have:

- Launched several E-learning packages across both organisations, including formal complaint investigation and language services modules
- Developed an updated formal complaint investigation toolkit for complaint handlers
- Promoted early contact as a standard approach within the formal complaints process, thus providing the opportunity for early resolution and resulting in the downgrading of formal complaints
- Implemented a real time weekly dashboard in addition to the monthly dashboards for directorates to support a more proactive approach to patient feedback
- Increased the use of virtual interpreting services Trust wide, including launching video interpreting throughout the Outpatients Department. This allows equal access to services and ensures patients have better understanding of care delivery and clinical interaction
- Piloted and expanded the use of virtual interpreting services Trust wide
- Designed a Complaints Forecasting tool which is proving to be insightful in workforce planning. This has been 'peer reviewed' by data analysists for accuracy and methodology
- Redesigned real time interactive dashboards for monthly real time overview of complaints compliancy. This included an introduction of an Executive-led dashboard with weekly data of activity at operational level
- Introduced new risk matrix for determining complex complaints. Reviewed final complaint sign off process for more operational approval based on risk matrix and methodology, thus enabling more efficiency in complaint handling timescales providing a greater degree of patient satisfaction
- Reviewed complaints management for Non-section 42 complaints and implemented a more proactive approach in collaboration with Local Authority and Quality Matters teams

Looking Forward 2026/27

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 and the Quality and Patient Experience priorities. The draft priorities were shared with Commissioners, Healthwatch, The Trust Management Committee Local Authority Public Health, the Executive Teams within the divisions and Directorate Management Teams. The final priorities for 2026/27 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:

Patient Safety

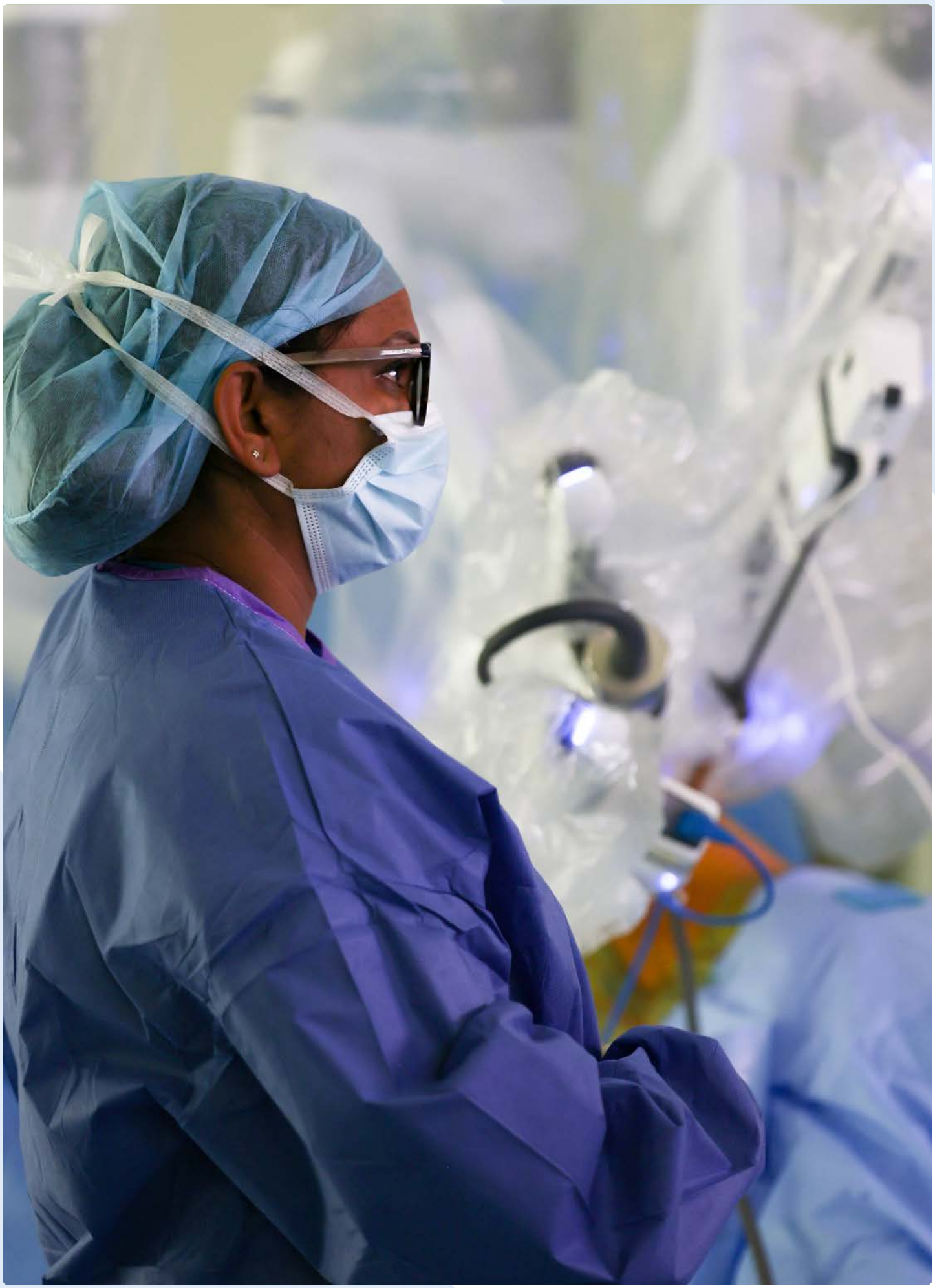
Section	Key Actions we will take	Aim for 2026/27
Reducing avoidable harm through quality improvement	• Strengthen initiatives associated with the Eat, Drink, Dress, Move to improve implementation across all care pathways • Deliver an updated Clinical Accreditation programme to span different care pathways • Monitor implementation of patient safety initiatives through a suite of deteriorating patient metrics • We will triangulate audit and Clinical Accreditation data in combination with Nursing Sensitive Indicators and operational metrics to identify areas for improvement in process • We will revise clinical documentation to optimise holistic assessments • We will implement targeted interventions to prevent healthcare-associated infections in accordance with our Infection Prevention Annual Programme • We will improve Maternity safety and outcomes through implementation of national Saving Babies' Lives initiatives and local improvement actions	• To reduce avoidable harm across care settings and services through the systematic implementation of evidence-based quality improvement initiatives, measurable reductions in harm indicators, and strengthened clinical governance processes • Enhance quality assurance and continuous improvement through our quality improvement actions • To reduce unwarranted variation in clinical outcomes by improving performance against key outcome measures, including Summary Hospital-Level Mortality Indicator (SHMI), 14-day and 30-day readmission rates and timely follow-up after discharge • To improve patient flow and continuity of care by ensuring safe, timely discharge processes and effective follow-up, including reducing avoidable readmissions and improving responsiveness to urgent community and crisis care needs • To sustain reductions in healthcare-associated infections including Clostridioidies difficile, MRSA and Gram-negative bacteraemias • Reducing delays in planned inductions, improving monitoring and response to fetal wellbeing, reducing perinatal harm and variation in outcomes

Patient Experience		
We will deliver care that is consistently person-centred, responsive, and compassionate by embedding the patient and community voice across all services.	• Strengthen mechanisms to routinely capture, analyse, and act on patient, carer, and community feedback across all services • Ensure that learning from feedback, complaints, compliments, and surveys is systematically translated into service improvement • Implement actions in response to survey findings, with clear ownership and measurable improvement trajectories • Embed Advice and Liaison Service (PALS) and complaints learning into divisional governance and quality improvement cycles, in line with PHSO standards • Further develop and expand the Trust volunteering programme to support patient experience priorities	• Improved performance in the CQC Inpatient Survey satisfaction measures • Reduction in the average number of days from discharge ready to actual discharge • Increased evidence of learning from patient feedback, complaints, and compliments translating into measurable service improvements • Enhanced patient involvement in care decisions and improved communication across all care settings

Clinical Effectiveness		
We want to improve safety through reducing the time patients wait	• Deliver sustained improvements in referral-to-treatment (RTT) pathways to reduce waiting times and minimise delays to diagnosis and treatment • Improve access to diagnostics and cancer pathways to support earlier diagnosis and intervention • Use benchmarking data, national guidance, and best practice to identify variation and target improvement efforts in priority pathways • We will maintain regular reviews of staffing levels and skill mix aligned to service demand and patient acuity • Strengthen Same Day Emergency Care, admission avoidance, and system co-ordination to improve outcomes and experience • Expand the use of digital solutions to support pathway optimisation, real-time decision making, and improved access to care • Strengthen community-based models of care to reduce unnecessary hospital attendance and admission • Optimise inpatient pathways to reduce length of stay, particularly for older adults and those with complex needs	• Increased proportion of patients treated within 18 weeks (RTT) across acute and community pathways • Reduction in 52-week waits in both acute and community services • Improved performance against diagnostic waiting time standards (≤6 weeks) • Improved cancer pathway performance. • Improved urgent and emergency care performance including reductions in long waits in the Emergency Department and Urgent Community Response performance • Reduction in average length of stay for older adult patients • Improved alignment between planned and actual performance across key access standards

Workforce

We want our colleagues to feel cared about	• Promote a culture where colleagues feel cared for, valued, and able to speak up safely. This will include continued access to Freedom to Speak Up services and embedding learning from concerns raised • Supporting staff health, wellbeing, and experience through a comprehensive health and wellbeing offer to support physical and psychological wellbeing. • Maintained oversight of Professional Advocates and peer support networks across the organisation. • We will identify and address variation in staff experience through targeted, data-driven interventions • Embed coaching leadership approaches to support compassionate, inclusive leadership at all levels. Support teams to develop local improvement plans reflecting their specific needs and challenges. Strengthen appraisal processes to ensure meaningful conversations, clear objectives, and personalised development plans • Strengthen education, training, and competency frameworks to support safe and effective care • Enhance career development pathways, including leadership development, healthcare support worker (HCSW) progression, and preparation for advanced and new roles • Supporting Recruitment, Retention, and Workforce Sustainability • Reduce reliance on temporary staffing through improved workforce planning and retention strategies • Embed Quality Improvement skills and methodologies across the workforce to empower staff to lead and sustain improvements. Ensure staff are equipped to support new models of care, including virtual care, neighbourhood working, and integrated services	• Improvement in NHS Staff Survey engagement and experience scores • Improvement in raising concerns (speaking up) sub-score • Improvements in workforce metrics including sickness absence rates • Sustained improvements in National Education and Training Survey satisfaction • Increased staff seasonal vaccination uptake • Reduction in temporary staffing costs as a proportion of total pay bill • Reduced variation in staff experience across teams and staff groups



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 2025/26
5.1.2 - Participation in national confidential enquiries 2025/26

During 2025/26, 42 national clinical audits, which includes six national confidential enquiries, covered relevant health services that the Royal Wolverhampton NHS Trust provides.

During that period, the Trust participated in 38 (90%) national clinical audits and six (100%) 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 2025/26, and details of whether we did participate or not, are as follows:

National programme name	Directorate	Work stream / Topic name	Participating 25/26	Rational for not participating 2025/26
BAUS Urology Audits	Urology	a) British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Yes	
BAUS Urology Audits	Urology	b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Yes	
Breast and Cosmetic Implant Registry	General Surgery	–	No	Pending update from NHS England
British Spine Registry	T&O	–	Yes	
ICCU Case Mix Programme (CMP)	ICCU	Intensive Care National Audit and Research (ICNARC)	Yes	
Child Health Clinical Outcome Review Programme	Children's Services	National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	Yes	
Child Health Clinical Outcome Review Programme	Children's Services	National Confidential Enquiry into Patient Outcome & Death (NCEPOD) Emergency surgery in children and young people	Yes	
Child Health Clinical Outcome Review Programme	Children's Services	National Confidential Enquiry into Patient Outcome & Death (NCEPOD) Stabilisation of the critically ill child	Yes	

Emergency Medicine QIPs	ED	Care Of Older People	Yes	
		Mental Health Self Harm	No	RWT did not participate, completed local and national audits in a same topic
		Adolescent Mental Health	Yes	
		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)	T&O / Rheumatology	Fracture Liaison Service Database (FLS-DB)	Yes	
		National Audit of Inpatient Falls	Yes	
		National Hip Fracture Database	Yes	
		National Confidential Enquiry into Patient Outcome & Death (NCEPOD) Rib Fracture	Yes	
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Trust wide	–	Yes	
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Maternity Services	Perinatal Confidential Enquiries	yes	
Medical and Surgical Clinical Outcome Review Programme	Respiratory	National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	Yes	
National Adult Diabetes Audit (NDA)	Diabetes	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications and Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	Yes	

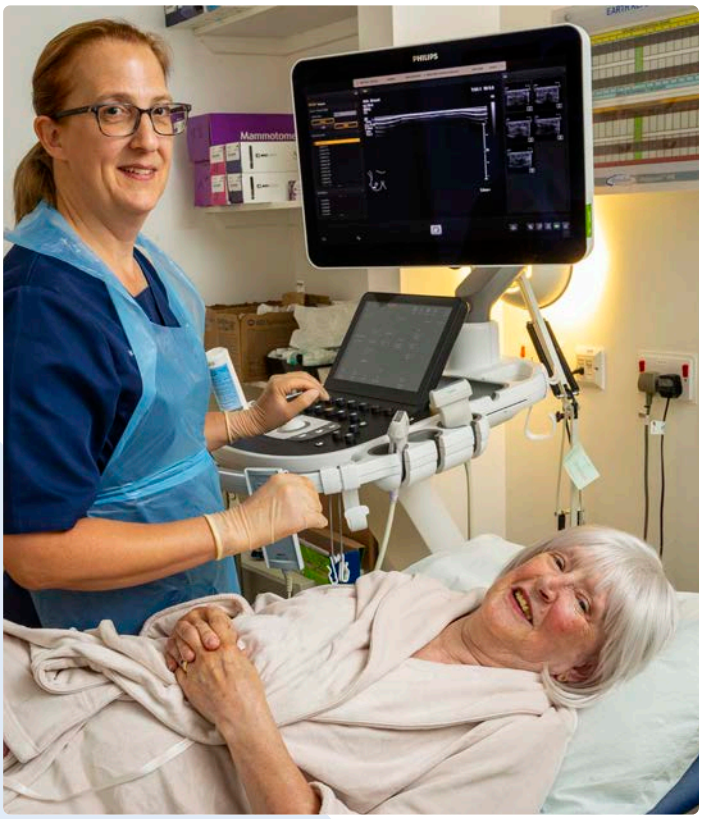
	Diabetes	National Diabetes Foot Care Audit	Yes	
	Diabetes	National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms	Yes	
	Primary Care	Diabetes Prevention Programme (DPP) Audit	No	Primary Care was unaware of this audit as listed under Diabetes on HQIP List, Directorate has included on 2026/27 audit plan for review
	Diabetes	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	
	Perinatal Maternity Services	National Diabetes in Pregnancy Audit	Yes	
National Audit of Cardiac Rehabilitation	Cardiology	–	Yes	
National Audit of Cardiovascular Disease Prevention Primary care	Cardiology	–	Yes	
National Audit of Care at the End of Life (NACEL)	Palliative Care	–	Yes	
National Audit of Dementia (NAD)	Older Adult Medicine/ Neurology	–	No	Trust does not have a Dementia Team or any resources for the team - this audit will not be completed.

National Cancer Audit Collaborating Centre - Natcan	Oncology / Cancer Services	National Audit of Metestatic Breast Cancer-(NAoME)	Yes	
	Oncology / Cancer Services	National Audit of Primary Breast Cancer (NAoPri)	Yes	
	General Surgery / Cancer Services	National Bowel Cancer Audit (NBOCA)	Yes	
	Oncology / Cancer Services	National Kidney Cancer Audit (NKCA)1	Yes	
	Oncology / Respiratory	National Lung Cancer Audit (NLCA)	Yes	
	Cancer Services	National Non-Hodgkin Lymphoma Audit (NLHLA)	Yes	
	Cancer Services	National Oesophago Gastric Cancer (NOGCA)	Yes	
	Oncology / Gynaecology	National Ovarian Cancer Audit (NOCA)	Yes	
	Oncology / General Surgery	National Pancreatic Cancer Audit (NPaCA)	Yes	
	Oncology / Urology	National Prostate Cancer Audit (NPCA)	Yes	
National Cardiac Arrest Audit (NCAA)	Clinical Skills Resuscitation Team	Intensive Care National Audit and Research (ICNARC)	Yes	
National Cardiac Audit Programme (NCAP)	Cardiology	National Adult Cardiac Surgery Audit	Yes	
	Cardiology	National Congenital Heart Disease (NCHDA)	Yes	
	Cardiology	National Heart Failure Audit	Yes	
	Cardiology	National Audit of Cardiac Rhythm Management (CRM)	Yes	
	Cardiology	Myocardial Ischaemia National Audit Project (MINAP)	Yes	
	Cardiology	National Audit of Percutaneous Coronary Interventions (NAPCI)	Yes	
	Cardiology	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	
	Cardiology	Left Atrial Appendage Occlusion (LAAO) Registry	Yes	
	Cardiology	Patent Foreman Ovale Closure (PFOC) Registry	Yes	
	Cardiology	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	
National Child Mortality Database (NCMD)	ED	Audit of NICE Quality Standard QS138	Yes	
National Comparative Audit of Blood Transfusion	Pathology	2025 Major Haemorrhage Audit	Yes	
		Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	

National Early Inflammatory Arthritis Audit	Rheumatology	–	Yes	
National Emergency Laparotomy Audit (NELA)	Critical Care (APPM)	Laparotomy	Yes	
		No Laparotomy	Yes	
National Joint Registry	ED/T&O	Previously TARN	yes	
National Major Trauma Registry	ED	–	Yes	
National Maternity and Perinatal Audit (NMPA)	Perinatal Maternity Services	–	Yes	
National Neonatal Audit Programme (NNAP)	Neonatal	–	Yes	
National Ophthalmology Database Audit (NOD)	Ophthalmology	Adult Cataract Surgery Audit	No	Department was awaiting EPR to be installed in order to submit data, however, unable to obtain funding to implement, Department Risk 5633
		Age Related Macular Degeneration Audit	No	Department was awaiting EPR to be installed in order to submit data, however, unable to obtain funding to implement, Department Risk 5633
National Paediatric Diabetes Audit	Children's Acute / Diabetes	–	Yes	
National Perinatal Mortality Review Tool	Perinatal Maternity Services	–	Yes	
National Pulomary Hypertension Audit	Respiratory	COPD Secondary Care	Yes	
National Respiratory Audit Programme (NRAP) Previously known as Asthma and COPD Audit Programme	Physio & OT	Pulmonary Rehabilitation	Yes	
	Respiratory	Adult Asthma Secondary Care	Yes	
	Children's Services	Children Young People's Asthma Secondary Care	Yes	

Perioperative Quality Improvement Programme (PQIP)	General Surgery	Rapid tranquillisation in the context of Pharmacological Management of acute disturbed behaviour	No	Participation in this audit is optional and Trusts are invited to show "expressions of interest". RWT has not participated
Sentinel Stroke National Audit Programme (SSNAP)	Stroke/Neurology	–	Yes	
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Pathology	–	Yes	
UK Cystic Fibrosis Registry	Respiratory	Cystic Fibrosis - Adults	Yes	
UK Parkinson's Audit	Neurology	–	Yes	
UK Renal Registry Chronic Kidney Disease Audit	Renal	–	Yes	
National Acute Kidney Injury Audit	Renal	–	Yes	

The national clinical audits and national confidential enquiries 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	a) British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	100% Extracted from Registry	Yes
BAUS Urology Audits	Urology	b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	100% Extracted from Registry	Yes
British Spine Registry	T&O	–	100% Extracted from Registry	Yes
ICCU Case Mix Programme (CMP)	ICCU	Intensive Care National Audit and Research (ICNARC)	In Progress	No
Child Health Clinical Outcome Review Programme	Children's Services	National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	In Progress	No
Child Health Clinical Outcome Review Programme	Children's Services	National Confidential Enquiry into Patient Outcome & Death (NCEPOD) Emergency surgery in children and young people	67%	Yes
Child Health Clinical Outcome Review Programme	Children's Services	National Confidential Enquiry into Patient Outcome & Death (NCEPOD) Stabilisation of the critically ill child	In Progress	No
Emergency Medicine QIPs	ED	Care Of Older People	100%	Yes
		Adolescent Mental Health	In Progress	No
		Time Critical Medications	100%	Yes
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Children's Acute	–	In Progress	No
Falls and Fragility Fracture Audit Programme (FFFAP)	T&O / Rheumatology	Fracture Liaison Service Database (FLS-DB)	100% Extracted from Registry	Yes
		National Audit of Inpatient Falls	In Progress	No
		National Hip Fracture Database	100% Extracted from Registry	Yes

		National Confidential Enquiry into Patient Outcome & Death (NCEPOD) Rib Fracture	100% Extracted from Registry	Yes
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Trust wide	–	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Maternity Services	Perinatal Confidential Enquiries	100% Extracted from Registry	Yes
Medical and Surgical Clinical Outcome Review Programme	Respiratory	National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	In Progress	No
National Adult Diabetes Audit (NDA)	Diabetes	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	100% Extracted from Registry	Yes
	Diabetes	National Diabetes Foot Care Audit	100% Extracted from Registry	Yes
	Diabetes	National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms	100% Extracted from Registry	Yes
	Diabetes	Transition (Adolescents and Young Adults) and Young Type 2 Audit	100% Extracted from Registry	Yes
	Perinatal Maternity Services	National Diabetes in Pregnancy Audit	100% Extracted from Registry	Yes
National Audit of Cardiac Rehabilitation	Cardiology	–	100% Extracted from Registry	Yes
National Audit of Cardiovascular Disease Prevention Primary care	Cardiology	–	100% Extracted from Registry	Yes
National Audit of Care at the End of Life (NACEL)	Palliative Care	–	In Progress	No

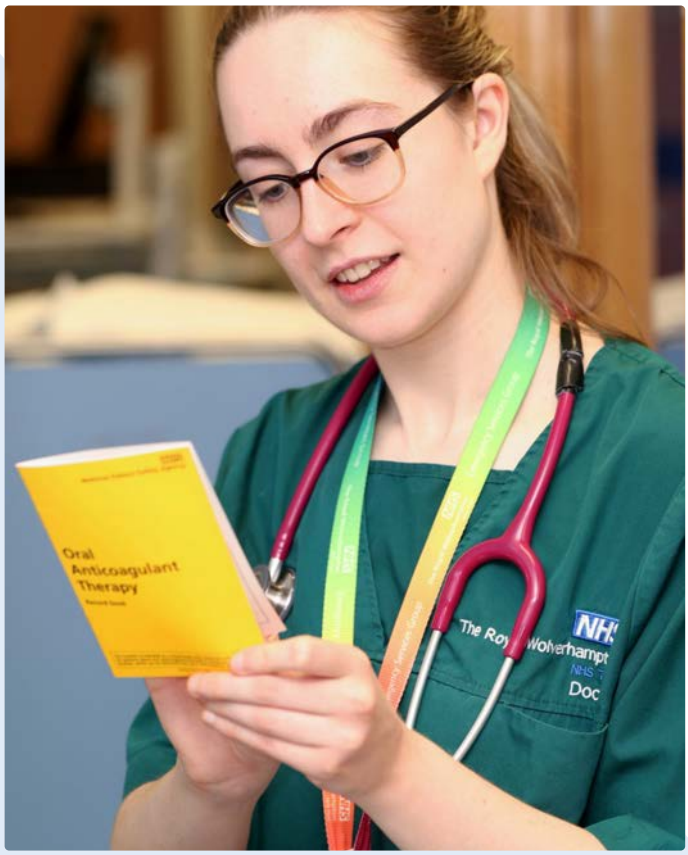
National Cancer Audit Collaborating Centre - Natcan	Oncology / Cancer Services	National Audit of Metestatic Breast Cancer-(NAoME)	100% Extracted from Registry	Yes
	Oncology / Cancer Services	National Audit of Primary Breast Cancer (NAoPri)	100% Extracted from Registry	Yes
	General Surgery / Cancer Services	National Bowel Cancer Audit (NBOCA)	100% Extracted from Registry	Yes
	Oncology / Cancer Services	National Kidney Cancer Audit (NKCA)1	100% Extracted from Registry	Yes
	Oncology / Respiratory	National Lung Cancer Audit (NLCA)	100% Extracted from Registry	Yes
	Cancer Services	National Non-Hodgkin Lymphoma Audit (NLHLA)	100% Extracted from Registry	Yes
	Cancer Services	National Oesophago Gastric Cancer (NOGCA)	100% Extracted from Registry	Yes
	Oncology / Gynaecology	National Ovarian Cancer Audit (NOCA)	100% Extracted from Registry	Yes
	Oncology / General Surgery	National Pancreatic Cancer Audit (NPaCA)	100% Extracted from Registry	Yes
	Oncology / Urology	National Prostate Cancer Audit (NPCA)	100% Extracted from Registry	Yes
National Cardiac Arrest Audit (NCAA)	Clinical Skills Resuscitation Team	Intensive Care National Audit and Research (ICNARC)	In Progress	No
National Cardiac Audit Programme (NCAP)	Cardiology	National Adult Cardiac Surgery Audit	100% Extracted from Registry	Yes
	Cardiology	National Congenital Heart Disease (NCHDA)	100% Extracted from Registry	Yes
	Cardiology	National Heart Failure Audit	100% Extracted from Registry	Yes
	Cardiology	National Audit of Cardiac Rhythm Management (CRM)	100% Extracted from Registry	Yes
	Cardiology	Myocardial Ischaemia National Audit Project (MINAP)	100% Extracted from Registry	Yes

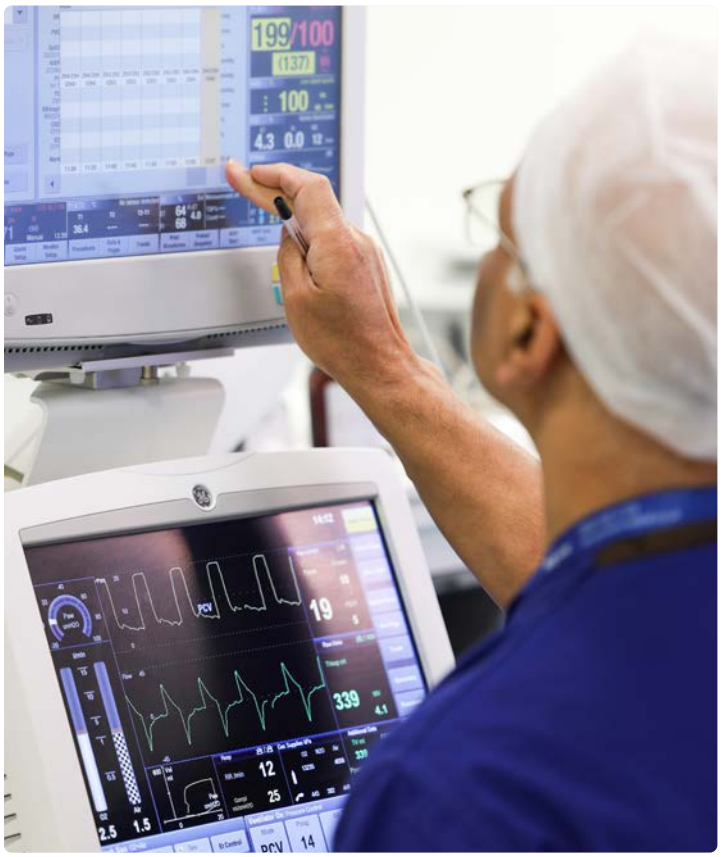
	Cardiology	National Audit of Percutaneous Coronary Interventions (NAPCI)	100% Extracted from Registry	Yes
	Cardiology	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	100% Extracted from Registry	Yes
	Cardiology	Left Atrial Appendage Occlusion (LAAO) Registry	100% Extracted from Registry	Yes
	Cardiology	Patent Foreman Ovale Closure (PFOC) Registry	100% Extracted from Registry	Yes
	Cardiology	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	100% Extracted from Registry	Yes
National Child Mortality Database (NCMD)	ED	Audit of NICE Quality Standard QS138	100% Extracted from Registry	Yes
National Comparative Audit of Blood Transfusion	Pathology	2025 Major Haemorrhage Audit	In Progress	No
		Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	In Progress	No
National Early Inflammatory Arthritis Audit	Rheumatology	–	100% Extracted from Registry	Yes
National Emergency Laparotomy Audit (NELA)	Critical Care (APPM)	Laparotomy	In Progress	No
		No Laparotomy	In Progress	No
National Joint Registry	ED/T&O	Previously TARN	In Progress	No
National Major Trauma Registry	ED	–	In Progress	No
National Maternity and Perinatal Audit (NMPA)	Perinatal Maternity Services	–	In Progress	No
National Neonatal Audit Programme (NNAP)	Neonatal	–	100% Extracted from Registry	yes
National Paediatric Diabetes Audit	Children's Acute / Diabetes	–	In Progress	No
National Perinatal Mortality Review Tool	Perinatal Maternity Services	–	In Progress	No
National Pulomary Hypertension Audit	Respiratory	COPD Secondary Care	100% Extracted from Registry	yes

National Respiratory Audit Programme (NRAP) Previously known as Asthma and COPD Audit Programme	Physio & OT	Pulmonary Rehabilitation	In Progress	No
	Respiratory	Adult Asthma Secondary Care	100% Extracted from Registry	yes
	Children's Services	Children Young People's Asthma Secondary Care	In Progress	No
Sentinel Stroke National Audit Programme (SSNAP)	Stroke/Neurology	–	In Progress	No
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Pathology	–	In Progress	No
UK Cystic Fibrosis Registry	Respiratory	Cystic Fibrosis - Adults	In Progress	No
UK Parkinson's Audit	Neurology	–	In Progress	No
UK Renal Registry Chronic Kidney Disease Audit	Renal	–	100% Extracted from Registry	Yes
National Acute Kidney Injury Audit	Renal	–	100% Extracted from Registry	Yes

The reports of 26 national clinical audits were reviewed by the provider in 2025/26. The sample provided below details actions The Royal Wolverhampton NHS Trust intends to take to improve the quality of healthcare provided.

Audit Title	Action Taken
RE-AUDIT on usage on pus culture and antibiotics In patients undergoing drainage of Perianal Abscess	The department has reduced the usage of pus swab cultures and oral antibiotics in patients undergoing uncomplicated perianal abscess drainage. Swab culture will only be reserved for complicated cases.
Audit on Documentation in Operative notes for laparoscopic appendicectomy according to RCS guidelines	Clinical Lead to Implement standardised procedure-specific operative note for appendicectomy to further improve compliance with the standards.
RCEM - National QIP- Time Critical Medications (2025/2026) (Year 2)	A poster will be developed and used to help identify TCM earlier in the patient journey. A small orange card will be developed and given to patients who were identified as requiring TCM which the patient will give to the Doctor or Nurse to ensure the medication is prescribed as soon as possible.
National RCEM - Care of Older People (2023/2024) (Year 2)	Efforts to be focused on engaging Doctors, ACPs, PAs and Nursing staff to complete delirium screen for the appropriate patients. Targeted teaching with Resident Doctors and AHPs at induction
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry (one report covering 23/24 and 21/22 data) (2024/25)	No non-compliance to address as this was not an audit. The only recommendations in the national report advised that all hospitals performing TMTV (Transcatheter Mitral and Tricuspid Valve) procedures should register and submit data within the scheduled data submission timeframes, as there were three other hospitals in the country known to perform TMTV procedures which did not submit data during 2023/24.
Improving Quality in Liver Services (IQILS) National Service Evaluation (2025/2026)	Management Team continues to explore initiatives to increase liver clinic capacity and clinician availability within the department





The Myocardial Ischaemia National Audit Project (MINAP) 2023/24 data (2024/25)	Although there are no Trust-specific recommendations in the national report, the Directorate is planning to increase capacity with an additional Cath Lab to enable more patients to be treated sooner and reduce waiting times and delays.
National Major Trauma Registry (2024/2025)	ED Management Team is currently holding discussions with Radiology to identify the reasons for delays with CT requests and further explore the feasibility of introducing dedicated CT slots for ED patients to improve compliance. Documentation issues around consultant presence will improve with the implementation of EPR CareFlow Connect
2024 National Comparative Audit of Quality Standard QS 138 (Blood Transfusion) (July, August and September 2024 data) (2024/25)	Management Team and Clinical Lead have further improved WHO checklist to address issues with minor non-compliance.
Bedside Transfusion Audit (March and April 2024 data)	Directorate continues to raise awareness of safe blood transfusion practice through the distribution of posters throughout the department, include training sessions and an exhibition stand
(Theatres) National Emergency Laparotomy Audit (NELA) (data period 1 December 2021- 31 March 2023) (24/25)	Management Team currently reviewing department capacity to identify if further improvements can be made to improve length of stay.

Further information below:

An additional 13 National audits were closed on the Clinical Audit Database in 2025/26 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 feature in the next Quality Accounts report.

5.1.3 - Local Clinical Audits 2025/26

2.7 The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.

2.8 A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.

241 Local clinical audits were registered by The Royal Wolverhampton NHS Trust between 1 April 2025 and 31 March 2026 (data excludes audits pending, declined and abandoned). A total of 146 audits were completed by the Trust and of these, the sample provided below demonstrates where improvements could be made. The Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Actions Taken
Injuries in Non-Mobile Children Presenting in ED	Management Team to re-share the updated protocol for Injuries in Non-Mobile Children Presenting in ED Review audit tool to ascertain data in line with revised protocol Disseminate this audit to provide feedback to all the team working within ED
Brachytherapy compliance audit	RWT interstitial brachytherapy implemented Oct 2025, aim is to reduce the number of patients transferred to alternative hospitals, allowing for more control of treatment dates, transport and insertions, if capacity allows.
Holmium laser enucleation of the prostate: 5-year Single-Centre outcomes (2025/26)	The department is in the process of reviewing the following recommendations to further improve the service: Further standardisation of LUTS clinic, especially regarding prostate size assessment Further standardisation of post-operative reviews
Foot Health: Nail Surgery LocSSIPs (Consent and WHO re-audit)	The team continues to review monthly and monitor trends. Issues with clinical system have been resolved by including additional training for staff.
EM LSCS Decision to delivery interval (DDI audit). 2025/26	Focused efforts to standardise documentation by implementing an electronic template, including compulsory explanation for reason of delay on BadgerNet Review theatre activation processes for emergency caesarean sections, particularly out-of-hours for category 1 cases Include specialist review at time of decision making Midwives to include documentation of delays alongside documentation of events as they unfold
Audit of Adherence to Gentamicin Prescribing and Monitoring Guidelines in General Surgery	Clinical Lead is taking steps which include assessing factors that affect clinician decision making, performing a teaching session to Resident Doctors (and associated healthcare staff where possible) and subsequently re-assessing gentamicin prescription guideline adherence.
Re-Audit -Adherence to acute asthma discharge guidelines and improving asthma follow-up (2025/26)	Clinical Leads will continue email and handover reminders to help standardise eDischarge template for asthma documentation. Continue to pilot asthma Nurse review model in ED and develop a real-time discharge checklist for asthma cases
Standard of electronic discharges	Education and training focused sessions delivered for Resident Doctors.
Management of Diabetes Ketoacidosis in Patients with Chronic Kidney Disease on Dialysis	Plan in progress to update the Trust protocol of DKA management including DKA management in CKD patients on dialysis. Raise awareness of DKA management in CKD patients on dialysis among all the Nurses and Doctors working in the acute medical department, diabetes and endocrinology ward

Re-Audit Distal Radius Fracture Assessment 2025/2026	Optimise surgical pathways to reduce delays by Implementing a regular day case bed allowance on Appleby suite for ambulatory trauma Improve scheduling for outpatient appointments to meet the 72-hour target by re-auditing traffic light system within fracture clinic to determine future direction Continue to monitor imaging protocols to ensure efficiency and reassess compliance
Post-op Anticoagulant Restart: An Audit of Surgical Documentation Practices."	Management team will continue to monitor compliance by SpR/SHO's (pre-op anticoagulation highlighted in post-op notes)
Planned Care (RASC) - Re-audit of compliance of Medication Administration (25/26) Re-audit	Annual update training in place for HCAs to avoid medication administration errors and incorrect documentation of administration on the MAR chart To share communication amongst team administering medication to ensure MAR chart is returned to base to be scanned onto portal.
CYPIC Record Keeping Audit	Training sessions delivered to Doctors (completing the IHAs) and to Nurses (completing the RHAs) and in departmental meetings and in quarterly Medical Advisors meeting. Training compliance reporting is captured in monthly and quarterly reports. CYPIC Management Team has regular meetings with the local authority to review processes to ensure the health needs of CYPIC continue to be met in a timely manner. Bimonthly health operational and steering group meetings will continue to be held for enhancing interagency collaborative working. CYPIC team to deliver sessions to social workers around health needs and assessments, next due in March 2026
NICE QS149: A service evaluation of osteoporosis treatments at New Cross Hospital	Clinicians to consider the need for a bone scan to further assess bone health in patients starting osteoporosis treatment at the initiation of corticosteroid therapy.
Cancer Pathway SOP: To audit the effectiveness of SOP (LocSSIPs)	Department Leads plan to Increase the availability of treatment at New Cross Hospital and refer to other hospitals, if necessary Improve communication with Plastics Department at Russells Hall Hospital and investigate and address other causes of delay in first and second treatments. Maintain capacity of fast-track clinics.
Virtual Ward and Hospital at Home - Virtual Ward - re-admission rate into ED within 30 days of a Virtual Ward referral - paeds and adults (2025/26)	The department will implement weekly teaching for clinical escalation and recognition of deteriorating patient Review of respect plans upon initial on boarding by suitably qualified clinician (further training and supervision to be provided to meet this) ACP/tACP reviews for paediatric patients pre hospital attendance/ admission Review self-referral process into PVW for respiratory patients (asthma/ wheeze) Redesign of leaflet to enhance patient education to call via care co-ordination to prevent inappropriate reattendance to A&E

Enhancing Diagnostic Productivity for Deep Vein Thrombosis: An Audit of Ultrasound Request Quality and Impact on Resource Efficiency.	Clinical Lead will continue to identify over-referrals and unjustified requests cards. Additional training will also be required to improve adherence to NICE guidelines. Better adherence will filter out those clinically deemed unlikely to have a DVT and therefore will not be referred for unnecessary ultrasound imaging. Filtered referrals will reduce waiting lists so patients will receive more prompt appointments for potential emergencies and suspected DVTs. It also will reduce the cost to the Radiology department/Trust due to the reallocation of resources to essential areas as opposed to the wastage seen in this audit.
Supportive Care - Excellence in Care - Quality Assurance of Patient Pathways 2025/26 Re-Audit	Consider implementing mandatory fields on CWP to support more accurate information received from the referrer.
A prospective audit of dental assessments and timing of dental extractions before radiotherapy for head and neck cancer patients 2025/26	Department Leads to Liaise with Capacity Co-ordinator to create additional protected slots for LA MOS appointments, specifically for the use for pre-radiotherapy head and neck patients, with an aim to have all dental extractions completed within seven days of assessment.
Asthma/Wheeze Integrated Pathway Audit	Highlight importance of discharge booklet and checklists. Trust will continue use of PRN pathway, however, and learning was shared at time of audit presentation.

5.1.4 Participation in clinical research

Research activity at The Royal Wolverhampton NHS Trust (RWT) during 2025/26 has continued to demonstrate a strong and increasingly diverse portfolio, with a notable shift towards higher-value and more complex research delivery. By the end of February 2026, 1,054 participants had been recruited, with a further 80 participants recruited in March, representing an overall 8% increase in-year. While overall recruitment is lower than 2024/25, this is largely attributable to participation in a large-scale observational study in the previous year, which significantly inflated recruitment figures. The current year therefore provides a more representative reflection of routine research activity and delivery capacity.

Importantly, the Trust has seen a substantial increase in commercial research activity, with 153 participants recruited to commercial studies and 981 to non-commercial studies. Commercial research now accounts for 13% of overall recruitment, compared to just 1% in the previous year, demonstrating clear progress in aligning with national priorities to increase commercial trial delivery. There are currently 34 open commercial studies and 110 non-commercial studies, reflecting a well-balanced and sustainable research portfolio.

Specialities involved in research

Research activity at RWT continues to be delivered across a broad and diverse range of clinical specialties, supporting equitable access to research opportunities for patients. Key areas contributing to recruitment include cancer (227 recruits), cardiovascular (224), gastroenterology and hepatology (151), and reproductive health and childbirth (143), demonstrating strong engagement from core clinical areas.

There are also encouraging signs of growth and diversification, particularly within dermatology and diabetes, metabolic and endocrine specialties, alongside continued activity in children's research, surgery, neurology, musculoskeletal and orthopaedics, stroke, trauma and emergency care, critical care, respiratory, renal, and ophthalmology.

Focus for 2026/27

The focus for 2026/27 is on building on the Trust's strong foundations to further enhance research delivery, efficiency, and impact. Key priorities include continuing the upward trajectory in commercial research, improving recruitment performance across the portfolio, and ensuring studies are delivered to time and target.

Performance against national study set-up benchmarks remains strong, with 68% of commercial studies and 85% of non-commercial studies confirmed within 60 days. Median time to first recruit is 27 days for commercial studies and 26 days for non-commercial studies, demonstrating efficient study activation processes.

The Trust will continue to focus on improving recruitment to time and target, while maintaining high standards of data quality (currently 97%) and patient experience, with 80 responses received through the 'My Research Experience' survey. There is also a strong emphasis on developing research leadership capacity, supported by 97 Principal Investigators and eight Associate Principal Investigators across the organisation.

5.1.5 Use of the CQUIN payment framework

"(b) The Royal Wolverhampton NHS Trust's income in 2025/26 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 Royal Wolverhampton NHS Trust during 2024/25.

The Royal Wolverhampton NHS 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 2025/26, (current data available up to Month nine April 2024 – December 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
- 99.4% for accident and emergency care

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

- 99.2% for admitted patient care
- 99% for outpatient care
- 99.3% 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 Trust which helps to underpin the provision of excellent services to patients and other customers.

- First point of call, answering and resolving thousands of queries and helping to support teams in ensuring all data is recorded accurately, timely, completely, meeting all standards
- Support for IT projects continued with testing, validation and systems expertise provided by the team
- 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's Data Quality policy is in place and was reviewed in February 2026

5.1.8 Clinical coding error rate

The Royal Wolverhampton NHS Trust was not subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

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

The annual external Data Security & Protection Toolkit (DSPT) clinical coding audit took place during 2025/26, achieving an overall 'Standards Exceeded' rating.

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 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 2025/26:

- Achievement of 'Standards Exceeding' for DSPT
- 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 speciality 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 2025-/26.

The table below details the incidents reported on the NHS England incident reporting tool and to the Information Commissioners Office (ICO), within the financial year 2025/26. Any incidents that are still being investigated for the period 2025/26 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
March 2026	Unauthorised access	1	Medic currently assigned to the Trust has accessed the records of relative who was receiving care at the Trust.	ICO reported investigation underway
March 2026	Unauthorised access	1	Concern raised from clinician that it appears a staff member who is a parent of a patient has been accessing the EPR.	Investigation underway
November 2025	Unauthorised access	6	Staff member when accessing patient record noticed that it was locked by someone with same surname. review of audit shows access and no legitimate reason.	ICO reported investigation underway
September 2025	Unauthorised access	1	Staff member has been looking at family members which was found by a review of audit logs.	ICO reported investigation underway
September 2025	Unauthorised access	1	Patient raised concerns that their sensitive health data has been accessed. Audit review showed one access attempt that was not authorised.	ICO reported investigation underway
April 2025	Unauthorised access	4	The NMC contacted the Trust seeking assurances following a complaint it received from someone with regards to a Nurse who had inappropriately accessed records. A review of a Staff Nurse audit shows that records of family members have been inappropriately accessed.	ICO reported. Trust provided NMC with audit data and NMC has taken forward the investigation.

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

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	132
C	Lost in Transit	1
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	16
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	5
H	Uploaded to website in error	1
I	Technical security failing (including hacking)	35
J	Unauthorised access/disclosure	18
		208

Data Protection and Security Toolkit Return 2025/26 – final submission from last year

The Royal Wolverhampton NHS Trust submission for RL4 against the new CAF aligned DSPT was - STANDARDS NOT MET – IMPROVEMENT PLAN AGREED. Out of the 47 mandated outcomes, 36 were achieved and 11 did not meet the expected standard. Action plans are in place and have been signed off by NHS England to ensure the Trust is managing any risk and working towards a compliant position.

For the RWT GP practices, all submitted against the 10 data standards and were all STANDARDS MET.

- Thornley Street M92028
- Coalway Road M92006
- Penn Manor M92011
- Alfred Squire M92011
- West Park Surgery M92011
- Lea Road M92011
- Warstones M92011
- Oxley Surgery M92011
- Tettenhall Road Medical Practice M92011

An internal audit of the DSP Toolkit in 2025/26 resulted in an overall High-Risk rating. Of the 12 outcomes assessed, three were found to be not meeting the required standard. Action plans have been put in place to address any gaps in assurance.

Looking forward to 2026/27 data security and protection work programme

The Trust continues to actively monitor patterns and trends in data security incidents and to implement proportionate measures to reduce these to the lowest level practicable. Current risks include a continued and increasing external cyber security threat, particularly relating to email based phishing attacks and other forms of social engineering. The Trust also recognises the growing cyber and information security risks associated with the supply chain, including reliance on third party systems and services, and continues to strengthen assurance and due diligence arrangements in this area.

Additional risks to data security include the potential for disclosure in error through a variety of means. These risks are influenced by the operational realities of healthcare delivery, including increased remote and hybrid working practices and greater use of digital tools.

In addition, the Trust is actively delivering the actions set out within the DSP Toolkit improvement plan, developed in response to areas of non compliance identified in the 2025/26 submission. This programme of work is focused on strengthening cyber resilience, incident response and recovery arrangements, and associated governance and assurance processes, in line with the CAF aligned DSPT requirements, including RL4.

Progress against the improvement plan is being closely monitored through established information governance and digital assurance forums, with clear ownership, defined milestones, and regular reporting to senior leadership and the Trust Board. Key actions include strengthening incident management processes, improving documentation and testing of response and recovery arrangements, enhancing assurance over third party and supply chain cyber risks, and embedding learning from incidents and exercises into operational practice.

This targeted work is designed to ensure that identified gaps are fully addressed and embedded ahead of the 2025/26 DSPT submission, with the aim of improving the Trust's overall assurance position, reducing residual information and cyber risk, and demonstrating sustained compliance with national data security and protection standards.

The Trust remains focused on embedding the principles of privacy by design and by default across all Trust processes, including procurement, digital innovation, and service redesign. This includes the increasing adoption of artificial intelligence (AI) and advanced digital solutions, with appropriate governance, risk assessment, and assurance mechanisms in place to ensure lawful, ethical, and secure use of data. AI initiatives are subject to proportionate assessment to ensure compliance with data protection, cyber security, and clinical safety requirements.

This programme of work continues to be monitored through established governance structures, including the committees outlined below.

- The Trust has several committees that provide assurance in relation to compliance with the Data Security and Protection Toolkit (DSPT) and UK GDPR, chaired by senior Board members
- The Chief Medical Officer, as the Trust's trained Caldicott Guardian, is responsible for protecting the confidentiality of patient and service user information while enabling appropriate information sharing, and chairs the Information Governance Steering Group
- The Chief Financial Officer, as Senior Information Risk Owner (SIRO), is accountable for overseeing the Trust's overall information risk profile, including cyber and supply chain risks, and for ensuring robust incident reporting and escalation to the Trust Board
- The Trust's Data Protection Officer (DPO) operates independently to monitor GDPR compliance and reports through the Caldicott Guardian to the Trust Board
- The Trust is progressing implementation of a robust information asset management system and clarifying responsibilities for Information Asset Owners (IAOs) to support effective identification, management, and escalation of information risks
- All Trust staff receive mandatory annual data security and information governance training, and the Trust continues to provide specialist and role based training to ensure awareness remains current and aligned with emerging threats and regulatory expectations
- Mandatory cyber security training, including phishing awareness, has been implemented for all staff and is kept under regular review to ensure ongoing relevance
- Members of the Trust Board and senior leaders continue to receive specialist cyber security briefings and training to maintain informed oversight, particularly in relation to emerging technologies, AI related risks, and supply chain dependencies.

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 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

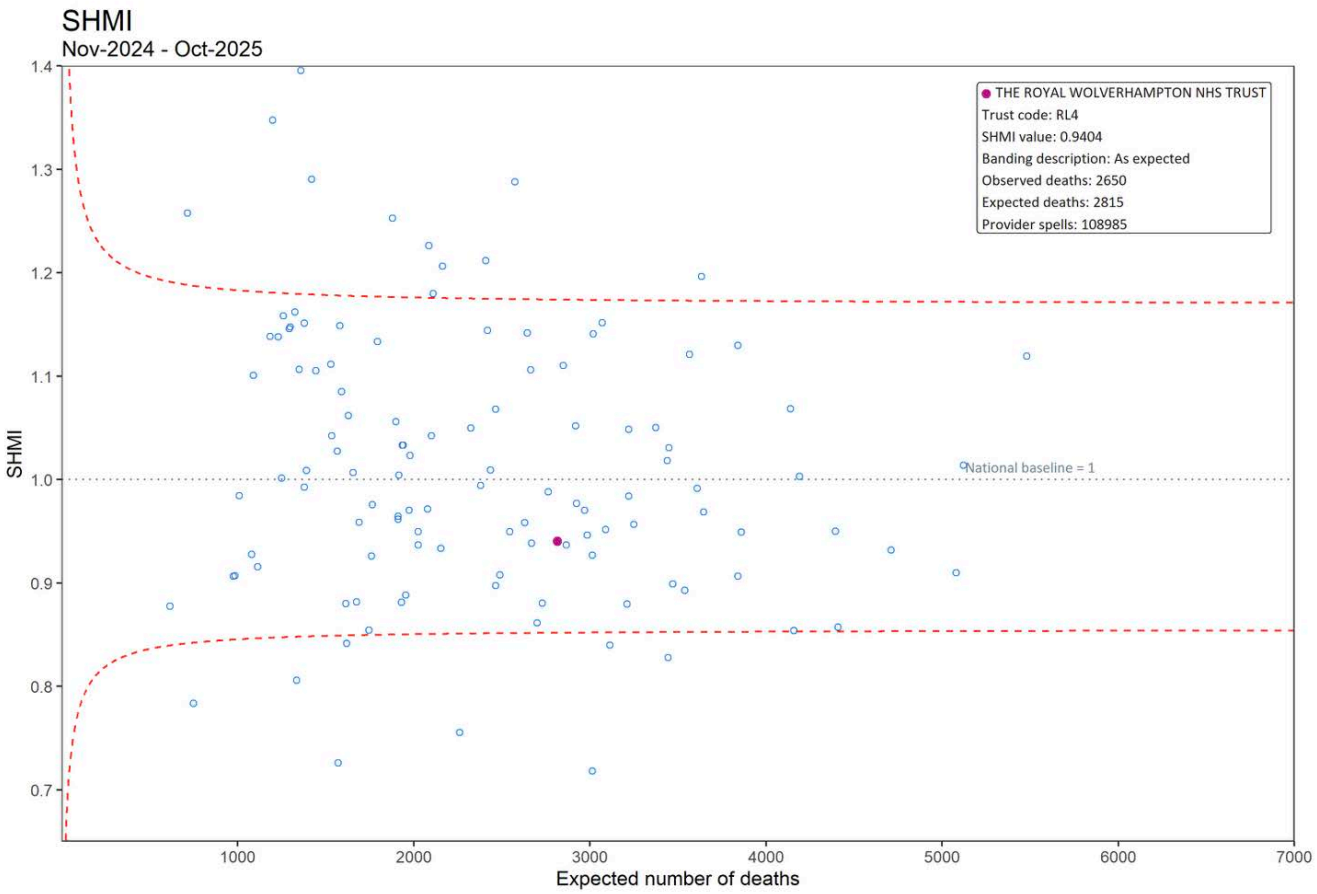
(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

(c) 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, co-morbidities 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 2024 to August 2025	October 2024 to September 2025	November 2024-October 2025
SHMI RWT	0.9489	0.9389	0.9404
SHMI England	1	1	1



The Trust has a robust mortality governance process underpinned by 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 meetings 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 signals
- 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
- 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

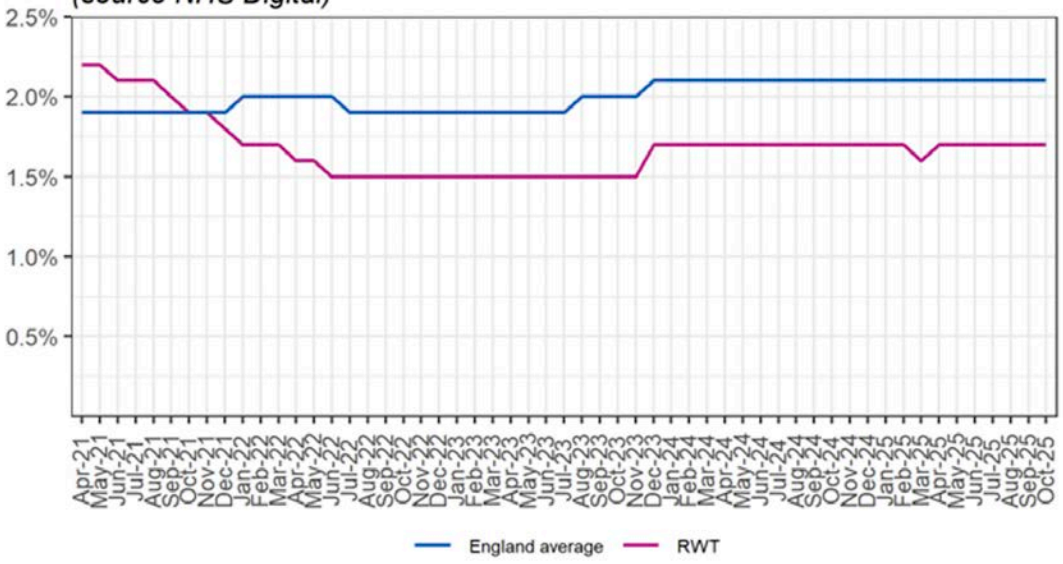
Progress against the agreed actions is monitored by the relevant quality groups and mortality associated reports are presented to Quality Committee.

(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

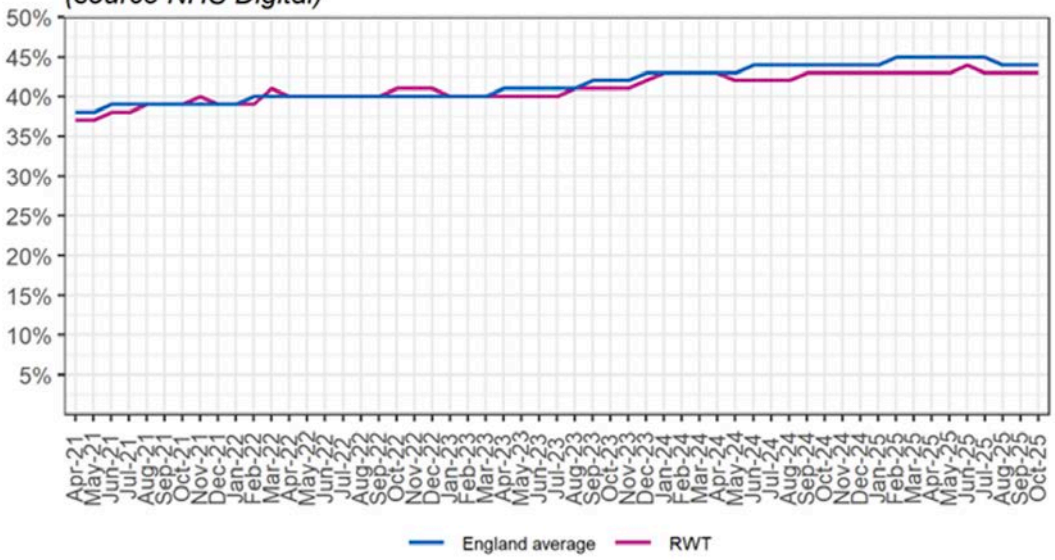
Table: The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. (November 2024 – October 2025).

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

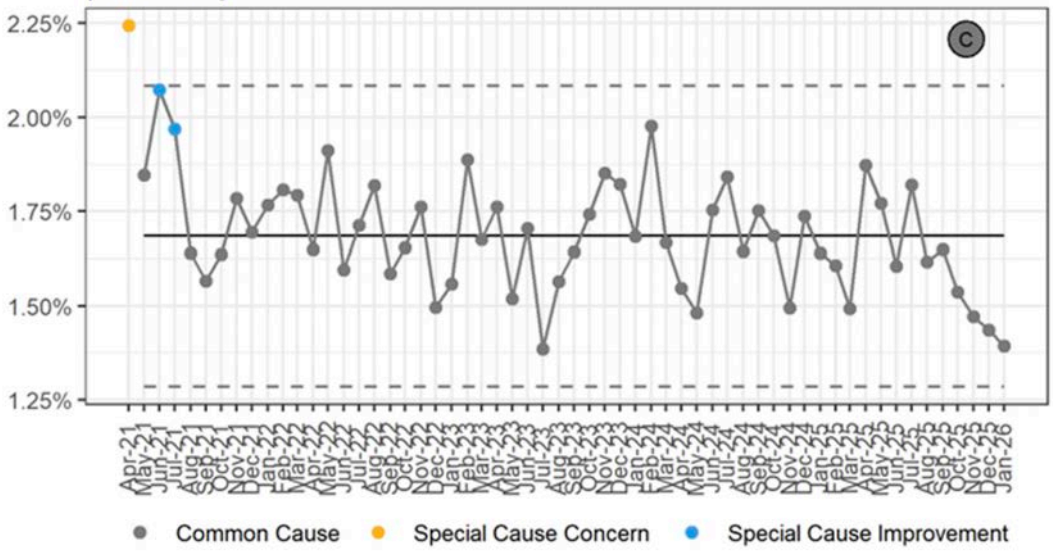
Percentage of Spells with Palliative Care Coding
(source NHS Digital)

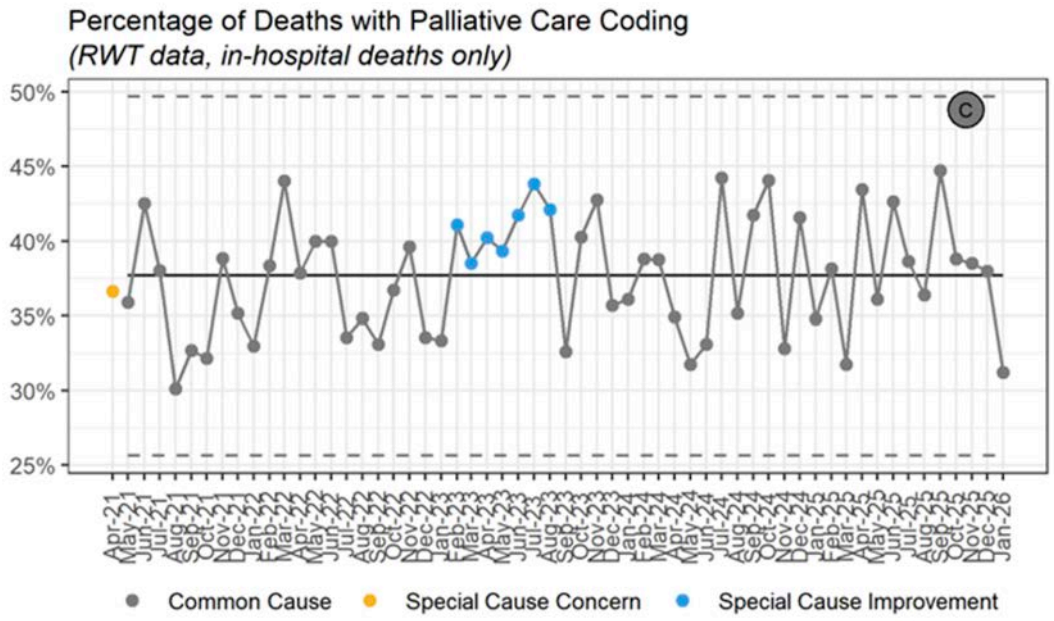


Percentage of Deaths with Palliative Care Coding
(source NHS Digital)



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





The Royal Wolverhampton NHS Trust intends to take/ have 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 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 2025 to March 2026, 1828 adult inpatient deaths were recorded at RWT. This is broken down into deaths which occurred in each quarter: Q1 – 481 deaths Q2 – 411 deaths Q3 – 445 deaths Q4 – 491 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 1 April 2026, of the 1828 deaths recorded there have been 361 case record reviews, structured judgement review (SJRs) and five PSIRF learning responses (Patient safety incident investigation (PSIIs)) carried out. In five cases a death was subjected to both a case record review and a PSIRF investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 451 Medical Examiner assessments + 102 SJRs + 1 PSII in the first quarter 377 Medical Examiner assessments + 111 SJRs + 1 PSII in the second quarter 417 Medical Examiner assessments + 94 SJRs + 3 PSII in the third quarter 453 Medical Examiner assessments + 54 SJRs + 0 PSII in the fourth quarter Please note: 32 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), with an explanation of the methods used to assess this.	Two cases are undergoing a Patient Safety Individual Event Review (PSIER) and the outcome is awaited. There were two cases [0.2% of the adult inpatient deaths] during the reporting period that have been judged to be 'Death thought more likely than not due to problems in care'. These numbers have been determined using evidence from PSIRF investigations involving deaths that were subject to review under the serious incident framework.

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 PSII reviews are detailed below: • Initial assessments were not sufficiently thorough, leading to missed clinical needs, incomplete examinations, and unsafe discharge decisions • Key investigations were not reviewed or repeated, including unacknowledged D dimer results and lack of ongoing blood gas/glucose monitoring • Clinical deterioration was not recognised or acted upon, with concerning signs (e.g., severe pain, hypotension, persistent unwellness) not prompting escalation • Escalation pathways were not followed, with delays or failures to involve senior clinicians, ITU, or relevant specialty teams • Documentation was incomplete, particularly regarding referrals, monitoring, decision making, and review of test results • System pressures and prolonged ED stays contributed to risk, affecting monitoring quality, escalation, and timely senior review
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: • Complete a gap analysis to identify required safety and quality improvements and confirm with the coroner whether the MCCD cause of death needs amendment • Review and clarify the ED re-attendance policy (including senior review requirements) for sharing with MRG and provide case feedback to the clinicians involved 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 to 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 the learning identified though the Trust's mortality review process is systematically implemented and fed into the PSIRF and QI processes.

G	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item B in the relevant document for that previous reporting period.	84 case record reviews and 0 investigations completed after 1 April 2025 which related to deaths which took place before the start of the reporting period.
H	An estimate of the number of deaths included in item G which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0% [0 cases] of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
I	A revised estimate of the number of deaths during the previous reporting period stated in item C of the relevant document for that previous reporting period, taking account of the deaths referred to in item H.	0.2% of the patient deaths during 2024/25 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)

Patient Reported Outcome Measures (PROMS) assess the quality of care delivered to NHS patients from their perspective, regarding the health gains for the following two surgical interventions using pre- and post-operative survey questionnaires:

- Hip replacement surgery
- Knee replacement surgery

The questionnaire does not differentiate between first time intervention or repeat surgery for the same procedure.

The table outlines the adjusted post-op score by procedure based and health gain on the EQ-5D Index

	Post-Op Score RWT April 24-March 25	Post-Op Score National Average April 24- March 25	Health Gain RWT April 24-March 25	Health Gain National Average April 24- March 25
Hip Replacement Surgery	0.730	0.780	0.453	0.447
Knee Replacement Surgery	0.720	0.740	0.311	0.320

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

For hip replacement, 172 patients completed the questionnaire - 87.8% of these patients reported improvement, 7% unchanged and 5.2% worsened.

This has resulted in a post-op score for the reporting period of 0.05 below the national average. Health gain is 0.006 higher, however..

For knee replacement, 143 patients completed the questionnaire - 81.1% of these patients reported improvement, 7% unchanged and 11.9% worsened.

This has resulted in a post-op score for the reporting period of 0.02 below the national average and health gain is 0.009 below national average.

For both hip and knee surgery, the data demonstrated the Trust score to be broadly in line with the national average. The number of patients completing the questionnaire has increased significantly due to a new Trust process in place which has ensured higher PROMS collection rates to ensure the Trust can monitor its quality of services.

4 Core Quality Indicators – Re-admission rates

Readmissions in RWT - All data from PAS, using the national definition of a re-admission.

2015/16 – 2025/26.

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

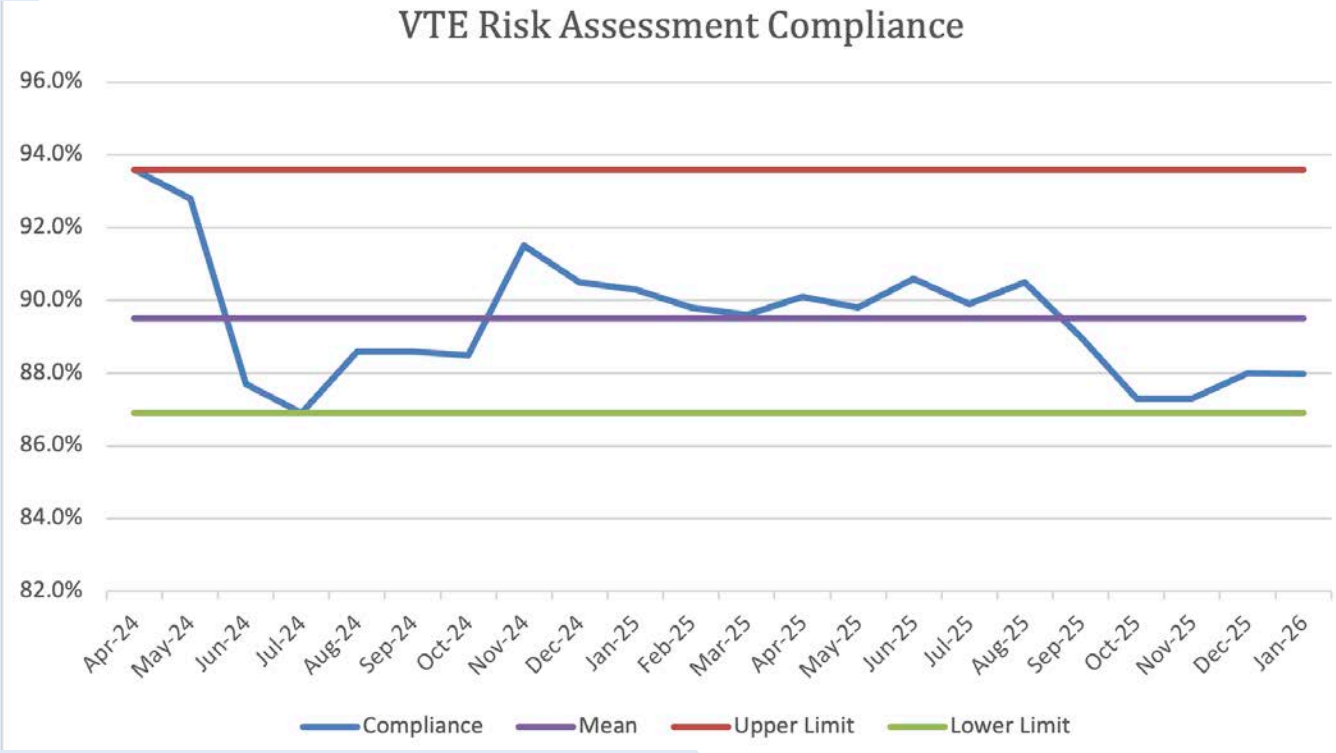
Total Admissions											Grand Total
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	
Aged 4-15	5,288	5,429	5,117	4,668	4,813	2,899	4,078	4,592	5,076	5,532	47492
16yrs and over	115,288	118,585	117,355	117,669	120,049	90,876	136,824	147,554	157,780	165,418	1287398
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 Total
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	
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) New for 2025/26

2.3 Reporting against core indicators

Mandatory data collection to quantify the numbers and proportion of inpatient hospital admissions aged 16 and over who receive a risk assessment for venous thromboembolism (VTE) to allow for appropriate preventative measures to be given based on national NICE guidance. Since the rollout of the EPR system, there have been delays and difficulties in obtaining the data required for monitoring. We are currently unable to determine whether the decline in compliance since September 2025 is coincidental with the rollout of the EPR system or the result of data loss. We are working closely with our data analysts and IT Team to ensure that the data are complete and accurate.



The data includes all inpatient activity carried out the Trust across all locations.
National data for quarters 1, 2 and 3 2025 is available from NHS England (Statistics » VTE risk assessment 2025/26), a summary has been provided below:

- England did not achieve the 95% NHS Standard Contract threshold – compliance (NHS acute care providers) 91% in quarter 1, 92% in quarters 2 and 3
- No regions achieved the 95% NHS Standard Contract threshold in quarters 1-3

Quarter 1

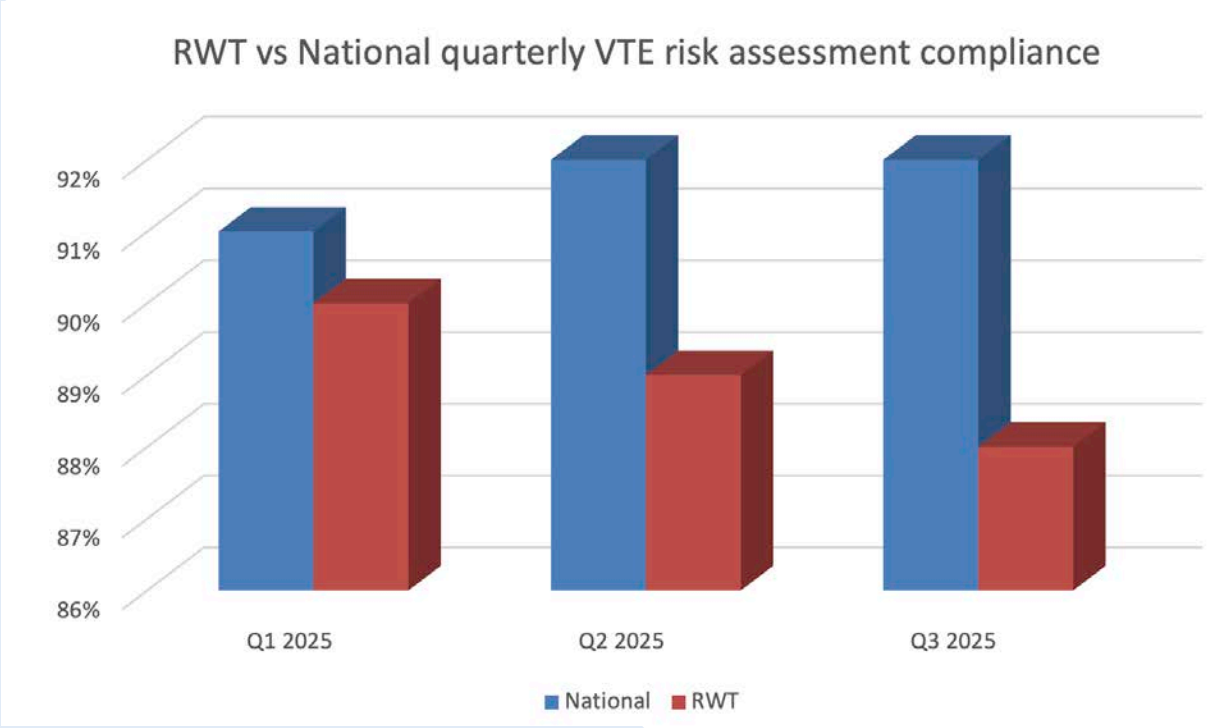
Table 1: Percentage of hospital admissions (aged 16 and over at the time of admission) risk assessed for VTE in England by month (Q1 2025/26)			
	April 2025	May 2025	June 2025
All providers of NHS-funded acute care	91.1%	91.0%	91.0%

Quarter 2

Table 1: Percentage of hospital admissions (aged 16 and over at the time of admission) risk assessed for VTE in England by month (Q2 2025/26)			
	July 2025	August 2025	September 2025
All providers of NHS-funded acute care	91.6%	91.6%	91.6%

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 2025/26)			
	October 2025	November 2025	December 2025
All providers of NHS-funded acute care	91.7%	91.5%	91.5%



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 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 on 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 Medical Director.

We have continued to monitor our VTE risk assessment compliance internally, despite operational pressures. Current performance shows that the timeliness of VTE risk assessments remains below the standards we expect. Patient safety and the delivery of effective, evidence based care continue to be our highest priorities. Improving the completion of VTE risk assessments within 14 hours will remain a key objective for the coming year, alongside ensuring that patients consistently receive care aligned with the outcomes of their assessments. The VTE Group is actively exploring enhanced digital solutions to strengthen compliance and streamline clinical workflows. We continue to work closely with clinical areas, offering targeted support and helping teams to develop and implement local improvement plans. We are also progressing trials to transition VTE assessments to the EPMA prescribing system. Making the assessment a mandatory first step within the prescribing process is expected to significantly improve completion rates and support achievement of national VTE compliance targets.

Core Quality Indicators – Clostridium *difficile*

6.6 Reporting against core indicators 2025/26

	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Trust apportioned cases (hospital and community onset cases)	46	57	72	80	126	74
Trust apportioned cases hospital onset only (excludes community onset cases)	35	44	58	56	78	57
Trust bed days (calculated using hospital onset cases and rate) *	230111	275517	305907	302702	300693	300632
Rate per 100,000 bed days (hospital onset cases only)	15.21	15.97	18.96	18.50	25.94	18.96
National average (hospital onset cases only)	18.30	1874	20.46	20.85	23.36	20.18
Best performing Trust (hospital onset cases only)	0	0	0	0	0	0
Worst performing Trust (hospital onset cases only)	80.65	59.03	76.6	63.12	80.97	51.08

The Royal Wolverhampton NHS Trust considers this data is as described for the following reasons:
The Trust collates numbers monthly and submits to UKHSA. Figures for apportioned cases, apportioned cases (hopsital 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 100,00 bed days.

The Trust has taken the following actions to improve this indicator, and the quality of its services, by continuing to implement the C.***dfficile*** action plan, including ongoing weekly C. ***difficile*** ward rounds, antimicrobial stewardship ward rounds and consistent use of the patient equipment cleaning centre (PECC) for cleaning of bedside equipment including commodes.

6.7 Core Quality Indicators – incident reporting

2025/26 (full year data)		
Incidents	% resulting in death	% resulting in severe harm
18314	0.1 (17)	0.2 (33)

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 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 events

6.8 Core Quality Indicators – National Inpatient Survey

(Updated: Adult Inpatient Survey 2024 – The Royal Wolverhampton NHS Trust)

The Adult Inpatient Survey 2024 invited 1,250 patients from The Royal Wolverhampton NHS Trust, with 483 responses, resulting in a 41% response rate, which is slightly above the national average.

This represents an improvement from 2023, where the Trust recorded 454 responses and a 39% response rate.

Overall performance

Compared with all other NHS Trusts in England, RWT performed:

- About the same on all benchmarked questions

(No questions rated better, somewhat better, worse, or much worse than expected)

- Year on year analysis for 2024 showed:
- 10 questions significantly improved
- 10 questions significantly worsened
- 28 questions showed no significant change

Interpretation

RWT's performance demonstrates high consistency, with no areas of exceptional outperforming or underperforming relative to other NHS Trusts. The equal balance of improvements and declines indicates a stable but mixed trajectory.

Key areas where patient experience could improve

The survey identifies the five lowest scoring areas relative to the national average for RWT:

- Who to contact after discharge
- Quality of information while on the waiting list
- Length of waiting list before admission
- Sleep disruption from other patients at night
- Discussion of home equipment needs prior to discharge

These areas remain important themes for improvement in 2024 and reflect several long standing issues previously identified in the 2023 results, particularly around waiting list communication and discharge preparation.

Additional recurring themes (based on section scores and trend data):

- Involving patients in decisions about care and treatment
- Improved significantly in 2024, but still lags behind stronger domains
- Involving families/carers in discharge planning
- Also improved yet remains one of the lowest-performing areas
- Information provision at discharge, particularly medicine related information
- Weak in 2023 and still requiring improvement in 2024
- Waiting list communication, which was also a major negative performance theme in 2023

Summary of improvement needs

Discharge, waiting list communication, and rest environment remain priority areas for the Trust.

Areas where patient experience is strongest

The Trust's five highest performing areas relative to the national average in 2024 were:

- Staff taking account of dietary needs
- Not being prevented from sleeping due to noise overall
- Being able to take own medicines when needed
- Information about medicines to take home
- Enough Nurses on duty

Additional indicators demonstrating consistently strong performance include:

- Kindness and compassion
- Respect and dignity
- Privacy during examinations/treatment

These strengths also align with 2023 findings, where dignity, kindness and privacy consistently scored at the upper end of RWT's results.

Actions to address areas for improvement

In response to the themes emerging from the 2024 survey, RWT is progressing a set of Trust wide improvement actions:

1. Strengthening communication and information provision

- Development of clearer waiting list updates, with improved written and digital information
- Redesign of discharge information packs, including improved guidance on who to contact after discharge
- Updated medicines safety leaflets and improved standardised discharge checklists.

(Addresses persistent waiting list and discharge communication issues highlighted in both 2023 and 2024).

2. Enhancing noise-at-night programmes

- Expanded implementation of night time Quiet Protocol measures
- Enhanced staff awareness campaigns on night-time behaviours
- Targeted ward-level audits focusing on patient to patient noise and environmental disruptions
- (Aligned to bottom five scoring questions on sleep environment)

3. Improving patient and family involvement

- Embedding patient empowerment tools to increase involvement in decisions about care and discharge
- Earlier involvement of families/carers in discharge planning, improving consistency across wards

(This directly addresses involvement themes significantly improved yet still low in 2024)

4. Supporting staff communication practices

- Targeted refresher training for staff to strengthen:
- Explanations for ward moves
- Consistency of clinical information shared
- Approaches to shared decision making
- Reinforcement of multi disciplinary roles in communication quality

(Reflects 2024 variability in clinical communication performance, including declines in Doctor clarity)

5. Enhancing real-time feedback loops

- Continued expansion of QR code enabled real time feedback solutions
- More visible FFT feedback loops and Ward to Board reporting

Future plans

To support sustained and long term improvement, RWT will:

- Further expand digital and in person patient insight mechanisms
- Work with Divisions on targeted improvement programmes for:
- Waiting list communication
- Discharge advice and post-discharge support
- Night-time noise interventions

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

The Friends and Family Test (FFT) is a nationally mandated patient feedback tool used across NHS services in England. Introduced in 2013 and updated in April 2020, it enables providers to capture patient experience in real time and use this insight to drive service improvement.

FFT is required across all NHS-funded services, including:

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

Patient recommendation to friends and family

FFT results for 2025/26 show variation across services:

- Inpatient and Outpatient services recorded lower recommendation scores compared to 2024/25, with a downward trend observed across most quarters
- Community Services maintained consistently high recommendation scores throughout the year, despite reduced data availability in Quarter 4
- Emergency Department performance fluctuated, although Quarter 4 showed improvement compared to Quarter 3
- Maternity Services demonstrated variation by care setting. Antenatal and birth services maintained higher recommendation scores, while Postnatal Ward and Postnatal Community Services saw lower scores in several quarters compared to the previous yea

A reduction in FFT response volumes was observed in Quarter 4, linked to the implementation of a new Patient Administration System (PAS) and associated technical issues, which affected the capture and submission of responses.

When benchmarked:

- The Trust performed below the national average across most services, with Community and birth services achieving or exceeding national benchmarks
- Against the Black Country ICB, performance was also below average in most areas; however, Community and birth services outperformed the ICB, and Antenatal services aligned with local performance

See table below: Friends and Family Test recommendations

Friends and Family Test	Inpatients				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2025-26	87	90	77	83	93	93	88	75	72	69	51	73	93	94	96	x
Difference	-7	-4	-16	-6	0	-1	-5	-19	0	-5	-19	3	2	1	5	x
2024-25	94	94	93	89	93	94	93	94	72	74	70	70	91	93	91	93
Number of responses	1709	2233	649	797	4820	4593	3348	610	6286	5967	2911	5111	953	977	422	0

Friends and Family Test	Antenatal				Birth				Postnatal Ward				Postnatal Community			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2025-26	90	81	89	82	94	95	95	96	86	82	81	84	89	83	84	88
Difference	17	3	18	6	1	1	2	3	7	-1	-2	-8	0	-5	-4	6
2024-25	73	78	71	76	93	94	93	93	79	83	83	92	89	88	88	82
Number of responses	58	52	60	64	133	119	116	132	73	112	75	88	106	83	81	43

Regional and National Comparison	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
National	-11	-7	-13	0	-6	3	-9	-7
Black Country ICB	-5	-3	-5	1	0	6	-2	-1

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 to the themes of staff engagement and morale. The results for 2025 show we have scored below the sector average and declined since 2024 across all People Promise indicators. We are committed to, and continuously strive to, provide the right conditions for our staff, so they in turn can deliver excellent care to our patients. Staff recommending the Trust as a place to work has declined to 49.82% and staff recommending the organisation as a place to receive care has also declined to 54.46%, which both score below the sector average.

We will address this notable decline by taking a new approach to staff engagement and involvement, aligned to the new Trust strategy. The Trust will continue to adopt a Caring for All approach, which underpins our standards of behaviour. This will help the Trust create a listening, kind, inclusive and professional organisation where staff can thrive and feel cared for.

6.13 Supporting Staff through speaking up

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 Trust has two full-time dedicated Freedom to Speak Up (FtSU) guardians with ring-fenced time to support staff, along with an accompaniment of 16 FtSU champions. There are various avenues for staff to contact their guardians, 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 both in the acute and community settings with all relevant QR codes and contact information. The FtSU team provides a psychologically safe space for mutual interaction.

Numbers of concerns received in 2025/26 (247) by quarter:

Q1	Q2	Q3	Q4
56	64	61	66

This is the same number of concerns that was reported during 2024/25.

There is an up-to-date FtSU policy, under the title HR16, and the guardian team reports directly to the People Director with regular data intelligence sharing with the Managing Director, Chief People Officer, and ultimately, Chief Executive Officer for completeness of data triangulation. There are intranet pages with both identified and anonymous reporting routes as well as useful information for staff to access additional support and wellbeing information.

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.

The guardians recognise how important it is for any reported challenges or complaints to be followed up for closure and always endeavour to close the loop by means of feeding back in a timely manner. Confidentiality is maintained in accordance with policy and procedures, this helps to reassure staff and provide them with the psychological safety they deserve. The FtSU guardians share data collected, and concerns that are reported in the form of thematic categories. Where requested, the reporter's anonymity is maintained. There is continuous collation of monthly, quarterly and annual data, which is then shared by the guardian team across the Trust by means of our Board reports and a quarterly staff newsletter. The Chief Executive, senior leaders, Divisional Management Teams, HR Advisory Teams, and Organisational Development Team s are all sighted on the themes only as it helps to facilitate learning opportunities.

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 be supported with impartially.

In the last year we have had 12 drop ins (177 attendees; 26 spoke up) and 40 awareness sessions reaching 1,042 staff from all activity. Activities range from 17 MDT inductions, forums, and ward/unit walkarounds and accreditation team visits (11 staff interviews).

Additionally, four Trust staff events were attended resulting in 151 staff attending to receive information.

Three Executive and EVG (BAME) Walkabouts took place in Speak Up Week 2025, attending eight clinical areas.

During 2025/26, the Bla ck Country ICB network also hosted two FtSU events. In June 2025, an in-person event was held for senior leaders and Executives. In October 2025, an online FtSU event called 'Not Just a Tick Box Exercise' was also held for all healthcare staff across the system as part of the national Speak Up week activities.

We saw a few high-profile events and collaborative ventures facilitated by the RWT FtSU guardians and champions.

The Trust has supported staff by exploring what detriment means and if it applied to them as per their own interpretation. Detriment is covered in our HR16 policy, i.e. where a staff member is treated unfairly or negatively as a result of speaking up. This is viewed as serious and relevant action is taken to safeguard staff and look after their wellbeing - the staff member experiencing detriment is supported.

In its response to the Gosport Independent Panel Report, the government committed to legislation requiring all NHS Trusts and NHS 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
- 16 champions across different specialties across theTrust 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-judgmental advice
- Receive closure if details of referrer shared with team

The guardian service regularly reviews FtSU specific staff satisfaction on the service offered via an anonymous 'Have your say" staff survey which colleagues are given the opportunity to complete once their case is concluded. This survey was introduced during 2025 and shows that a large majority of participants said they were 'extremely satisfied' and 'somewhat satisfied' with the support and intervention of FtSU with their concern. Staff have also expressed their desire for faster senior leadership feedback, this is something the FtSU team is currently reviewing with senior leaders. The RWT FtSU service remains committed and dedicated to delivering a service that allows all staff to speak up with voices that will be heard.

Additionally, four Trust staff events were attended resulting in 151 staff attending to receive information. Three Executive and EVG (BAME) Walkabouts took place in Speak Up Week 2025, attending eight clinical areas.

During 2025/26, the Bla ck Country ICB network also hosted two FtSU events. In June 2025, an in-person event was held for senior leaders and Executives. In October 2025, an online FtSU event called 'Not Just a Tick Box Exercise' was also held for all healthcare staff across the system as part of the national Speak Up week activities.

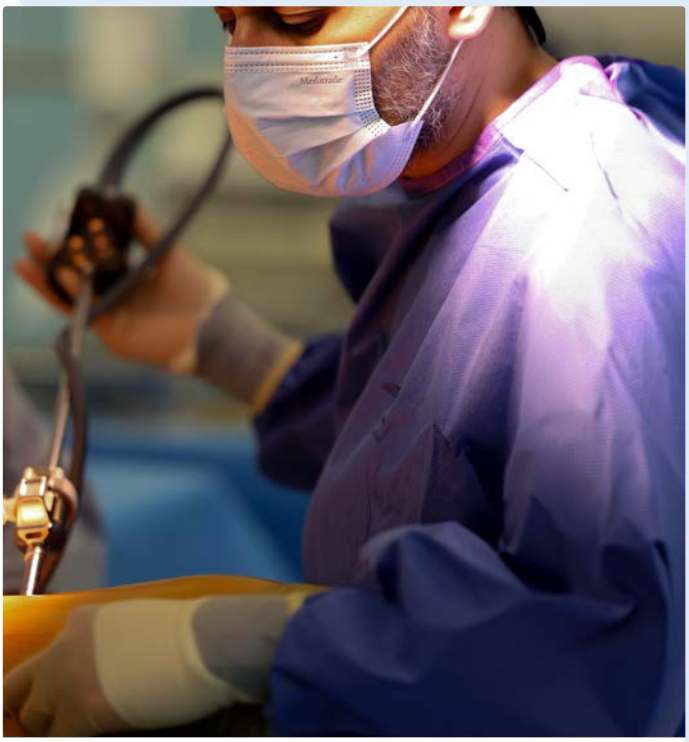
We saw a few high-profile events and collaborative ventures facilitated by the RWT FtSU guardians and champions.

The Trust has supported staff by exploring what detriment means and if it applied to them as per their own interpretation. Detriment is covered in our HR16 policy, i.e. where a staff member is treated unfairly or negatively as a result of speaking up. This is viewed as serious and relevant action is taken to safeguard staff and look after their wellbeing - the staff member experiencing detriment is supported.

In its response to the Gosport Independent Panel Report, the government committed to legislation requiring all NHS Trusts and NHS 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
- 16 champions across different specialties across theTrust 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-judgmental advice
- Receive closure if details of referrer shared with team

The guardian service regularly reviews FtSU specific staff satisfaction on the service offered via an anonymous 'Have your say" staff survey which colleagues are given the opportunity to complete once their case is concluded. This survey was introduced during 2025 and shows that a large majority of participants said they were 'extremely satisfied' and 'somewhat satisfied' with the support and intervention of FtSU with their concern. Staff have also expressed their desire for faster senior leadership feedback, this is something the FtSU team is currently reviewing with senior leaders. The RWT FtSU service remains committed and dedicated to delivering a service that allows all staff to speak up with voices that will be heard.

6.14 Reporting against core indicators

Guardian of Safe Working Statement

Doctors and Dentists across the organisation work a variety of rota patterns tailored to the operational requirements of their respective clinical areas. Fatigue, tiredness, and burnout are recognised contributors to poorer patient outcomes, including increased patient safety incidents, reduced patient satisfaction, and unprofessional behaviours. Regular exception reporting of missed breaks, late finishes, and inadequate rest periods therefore serves an important function in identifying issues relating to rota design, workload pressures, and insufficient staffing levels, all of which may adversely affect the quality and safety of patient care.

Version 13 of the Terms and Conditions of Service, published on 4 February 2026, introduced some of the most significant changes to exception reporting and the role of the Guardian of Safe Working since the contract was first implemented in 2016. These reforms include, amongst other measures, anonymisation of reports relating to periods of less than two hours, greater emphasis on ensuring access to exception reporting systems, the introduction of financial penalties for Trusts, and stricter timelines for report processing.

Between 1 May 2025 and 30 April 2026, a total of 139 exception reports were submitted, of which 53 were submitted following the introduction of February's revised Terms and Conditions of Service. This compares with 79 exception reports submitted during the preceding year. The increase may reflect improved accessibility to exception reporting systems and a positive cultural shift with reduced stigma associated with reporting. Alternatively, it may indicate an increased frequency of Doctors working beyond their scheduled rota commitments.

Work schedule reviews, rota redesign, and enhanced scrutiny of working patterns aim to reduce instances of overwork and fatigue amongst Doctors, thereby supporting both staff wellbeing and improvements in patient safety.

Review of Quality

Our performance in 2025/26

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 Performance Report (IPR).

Our performance for 2025/26 is shown below.

Performance against the National Operational Standards:

		Performance		
Indicator	**Target (2025-26)**	**2025/26**	**2024/25**	**2023/24**
Cancer 31 day Combined	96%	92.75%	89.43%	84.40%
Cancer 62 day Combined	75%	71.52%	60.58%	42.58%
28 Day FDS (all routes)	80%	80.15%	78.68%	74.37%
Emergency Department - total time in ED	78%	79.81%	80.86%	77.43%
Referral to treatment - incomplete pathways	60%	55.32%	52.62%	55.13%
Cancelled operations on the day of surgery as a % of electives	<0.8%	0.52%	0.56%	0.27%
Mixed sex accommodation breaches	0	0	0	0
Diagnostic tests longer than 6 weeks	<5%	3.94%	5.24%	40.55%

Performance against other National and Local Quality Requirements

		Performance		
Indicator	**Target (2025-26)**	**2025/26**	**2024/25**	**2023/24**
Clostridium Difficile	58	74	126	80
MRSA	0	8	4	3
Duty of Candour	0	16	6	0
Ambulance handover <15 minutes	>65%	43.12%	44.67%	52.63%
Ambulance handover <30 minutes	>95%	69.29%	74.46%	82.91%
Ambulance handover >60 minutes	0%	20.33%	13.61%	7.57%
ED waits >12 hours	<2%	12.44%	10.86%	8.52%
Referral to treatment - no one waiting longer than 52 weeks	0	1,642	2,090	2,570
Referral to treatment - no one waiting longer than 65 weeks	0	0	2	
Referral to treatment - no one waiting longer than 78 weeks	0	0	0	0

Engagement in the developing 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 a combination of Non-Executive and Executive Directors
- City of Wolverhampton Council
- ICB
- Healthwatch

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 the patients, community representatives and members of staff who gave their time to help us select our priorities and ensure that the document is clear and accessible.

Statement from Birmingham, Black Country and Solihull Integrated Care Board

NHS Birmingham and Solihull Integrated Care Board
Alpha Tower, 8th Floor
Suffolk Street
Queensway
Birmingham
B1 1TT
Telephone: 0121 203 3300

www.birminghamandsolihullicb.nhs.uk

The Royal Wolverhampton NHS Trust

Quality Account 2025/2026

Statement of Assurance from NHS Birmingham, Black Country and Solihull Integrated Care Board

June 2026

1.1 Birmingham, Black Country and Solihull Integrated Care Board (ICB) as co-ordinating commissioner for The Royal Wolverhampton NHS Trust, welcomes the opportunity to provide this statement for inclusion in the Trusts 2025/26 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 12 June 2026, and the review has been undertaken in accordance with the Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

1.3 The information provided within this account presents a balanced report of the healthcare services that The Royal Wolverhampton NHS Trust provides. The report demonstrates the progress made by the Trust against the 2025/26 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and priorities set for 2026/27.

1.4 During 2025/26, the ICB worked collaboratively with The Royal Wolverhampton NHS Trust to review progress against a range of quality improvement initiatives, including safeguarding assurance, infection prevention, maternity safety through the Saving Babies 'Lives Care Bundle, deteriorating patient programmes, and discharge transformation. Through regular quality surveillance, governance reviews and system-wide assurance processes, the ICB provided support and challenge to help drive continuous improvements in patient safety, clinical effectiveness and patient experience. We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2026/27.

1.5 The ICB welcomes the opportunities presented in the report to strengthen partnerships through Wolverhampton place arrangements, assuring alternative pathway arrangements through the neighbourhood models of care and reducing demand upon emergency services.

1.6 We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2026/27.

Yours sincerely,

Sally Roberts

Chief Nurse/Clinical & Quality Officer

Birmingham, Black Country and Solihull (Cluster) Integrated Care Board

Councillor Mary Bateman, Chair of Health Scrutiny, City of Wolverhampton Council's response to The Royal Wolverhampton NHS Trust Quality Account 2025/26

As Chair of the City of Wolverhampton's Health Scrutiny Committee, I welcome the opportunity to comment on this year's Quality Account and to reflect on the progress made by The Royal Wolverhampton NHS Trust.

CITY OF WOLVERHAMPTON COUNCIL

First, I am pleased to see the areas where the Trust has met or exceeded its targets, particularly in relation to elective recovery, diagnostics, cancer pathways and infection prevention. The significant improvement in Referral to Treatment performance, the achievement of the Faster Diagnosis Standard, and the reduction in Clostridioides difficile cases demonstrate a clear commitment to improving patient outcomes and operational performance. I also welcome the continued development of Same Day Emergency Care, the expansion of Virtual Wards, and the strengthened governance around deteriorating patients, all of which are positive steps in modernising care and improving patient experience.

However, I must also raise concern about the areas where performance has not met expectations. In particular, the continued challenges around ambulance handover delays are deeply worrying. The increase in handovers exceeding 60 minutes and the Trust's performance remaining well below the national standard for 15 minute handovers represent a significant risk to patient safety and system flow. This is an area that requires urgent and sustained focus, and the committee will continue to monitor progress closely. Other areas of concern include the rise in MRSA cases, the increase in Duty of Candour breaches, and the decline in staff survey results, particularly regarding staff experience and morale. These issues highlight the pressures facing the workforce and the need for continued investment in staff wellbeing, culture, and support. The increase in formal complaints and the challenges in meeting response times to those complaints also indicate that further work is needed to ensure patients feel heard and supported throughout their care journey.

Despite these challenges, I want to acknowledge the many areas where the Trust has made meaningful improvements. The strengthened patient experience governance, the expansion of volunteering, the progress in maternity safety, and the Trust's growing research portfolio all demonstrate a forward-looking organisation committed to learning, innovation and continuous improvement. The development of the Transforming Care Together strategy also provides a clear and ambitious vision for the future of health and care across Wolverhampton and the wider Black Country.

I would like to thank all staff across the Trust for their continued dedication during what remains a challenging period for the NHS. The Health Scrutiny Committee remains committed to working constructively and in partnership with The Royal Wolverhampton NHS Trust to improve the lives of all people in the City of Wolverhampton.

Healthwatch Wolverhampton response to The Royal Wolverhampton NHS Trust Quality Account 2025/26:

We are pleased to see the positive outcomes against the priorities set for 2025/26, especially those around patient experience and safety. Patient care remains at the heart of everything we do. We thank the staff team who over the last year have continued to work with commitment, compassion, and professionalism to provide safe, effective, and person-centred care across the hospitals and community services. We recognise that every patient's experience matters, whether they are attending for planned treatment, urgent and emergency care, diagnostics, cancer services, maternity care, mental health support, or care closer to home.

However, with the ongoing pressures across the NHS, including increasing demand and workforce challenges, some patients are still reporting to us experiences that fall short of good, therefore we would like the focus to remain on improving access, reducing delays and ensuring patients receive the right care, in the right place, at the right time. We hope the commitments and priorities set out for 2027 will improve on patient experiences and go toward achieving this. Healthwatch will continue to share patients' experiences to help with improvements. We were very pleased to see the progress made in reducing waiting times, strengthening urgent and emergency care performance, expanding virtual wards, improving diagnostic access, and supporting faster cancer diagnosis.

In addition, the account shows that the Trust has made strong progress in strengthening the identification, escalation, and response to deteriorating patients and we were pleased to see that Martha's Rule and Call for Concern have further strengthened patient and family escalation routes, reinforcing a safety-first culture. This further provides ongoing evidence that patients and their loved ones know best about their care concerns, and we will continue to promote Martha's Rule to patients and inform them of their right to be heard and be involved in their care.

Statement of Director Responsibilities in respect of the Quality Account 2025/26

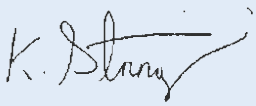
In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Account meets the requirements set out in the annual reporting manual and supporting guidance, Detailed requirements for quality reports.
- 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 2025 to March 2026
  - papers relating to quality reported to the Board over the period April 2025 to March 2026
  - feedback from commissioners dated 17 June 2026
  - feedback from local Healthwatch organisations dated 27 June 2026
  - feedback from overview and scrutiny committee dated 26 June 2026
  - the 2025 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 report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality 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

Joe Chadwick-Bell, Group Chief Executive
Date: 23 June 2026



Kevin Stringer, Group Chief Finance Officer

Date: 23 June 2026

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement has confirmed in the Quality Accounts requirements for 2025/26 that there is no national requirement for NHS Trusts or NHS 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

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

Designed and produced by The Department of Clinical Illustration and Graphic Design, RWT

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