







The Royal Wolverhampton NHS Trust

Quality Accounts 2021/22

Safe & Effective | Kind & Caring | Exceeding Expectation

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Why are we producing a quality account?

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

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

Getting involved

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

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Statement on Quality from the Chief Executive

During 2021/22, The Trust set out the next steps to further develop the strategic collaboration between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust within the wider Black Country and West Birmingham (BCWB) acute provider collaboration arrangements. The aim of this strategic collaboration is to ensure that our patients and the diverse communities we serve, experience the best possible care, and are supported to achieve improved health outcomes. It will do this by standardising on the best clinical practice, providing a safe, skilled, and sustainable workforce and supporting each trust to develop its place-based partnership.

One of the many focuses for this partnership is that all trusts are to develop a common approach to quality improvement (clinical and non-clinical). To enable this the Trust Board, at the meeting in February 2022, agreed to extend its overarching organisational strategy to August 2022. This will align the development of a new joint strategy with Walsall Healthcare NHS Trust. Subsequently it has been necessary to extend the Trust's Patient Experience and Quality enabling Strategy to November 2022 for review. Therefore, the key priorities for the Quality Account for 2022/23 have been based on external reviews/accreditations and have been built on last year's priorities which remain relevant. This also means that progress can be made for those priorities that were impacted by the COVID-19 pandemic. All these priorities are linked and support delivery of the current overarching Trust strategy.

The Trust has continued to manage the local impact of COVID-19. Despite the many challenges we have faced as an organisation, and as individuals, there have been many quality improvements. I am proud of the work that the Trust has commenced in identifying and tackling health inequalities and continuing this work will be a key priority for 2022/23.

Workforce across all professions in the NHS remains a challenge, the Trust is committed to meeting this challenge and continues to further develop the clinical fellowship scheme across nursing and medicine.

Statement on Quality from the Chief Executive

Despite the workforce challenges I am delighted to see the achievements of the staff and services in the following awards during 2021/22:

- Chief Midwifery Officer Awards: Chief Nurse received the Gold award and Trauma and Orthopaedics Matron earned the Silver award, which recognises major contributions to patients and the profession.
- Helpforce Champions Awards 2021: One of the Trust Volunteers was crowned 'Young Volunteer of the Year'.
- National Association for Healthcare Security (NAHS) Awards: The Security team at the Trust was awarded two awards, Healthcare Security Manager of the Year' and 'Patient Safety' award for a recent pilot of innovative CCTV software.
- Raising Awareness of Developmental Language Disorder (RADLD) International Certificate awarded to Wolverhampton's Children's Speech and Language Therapy (SLT) Service in recognition of the work they have undertaken about DLD.
- British Journal of Nursing Awards: A urology nurse, the Liver Nursing Team and the Gastroenterology Day Case Team at The Royal Wolverhampton NHS Trust are now the proud owners of national silver award for Urology Nurse of the Year and The Gastroenterology Day Case Team took home a silver award while bronze went to the Liver Nursing Team.
- British Medical Association's Outstanding Contribution to Equality and Diversity award from the British Association of Physicians of Indian Origin (BAPIO): The Trust's former Freedom to Speak Up (FTSU) Guardian was nominated and won this award for Outstanding Contribution to Equality and Diversity.
- Sepsis Lead Nurse at The Trust has been made the Trust's first Digital Nurse Fellow by NHSX (the Health Service's digital arm), NHS England and the Faculty of Clinical Informatics after being selected based on her experience as Sepsis Lead as part of the Sepsis Team.
- Black Country Chamber of Commerce Business Awards: The Trust Charity won in the 'Kindness in the Community' category (2021).
- Regional Black History Month Awards: Head of Governance for RWT, won in the 'Black African / Black Caribbean leadership award during COVID-19' category, 'International Nurse of the Year' went to a Staff Nurse within the Trust's Stroke service and the third and final award was secured by the BAME EVG in the category 'BAME Staff Network'.

Learning from our experiences throughout covid and in line with the NHS long term plan, we are investing in the capabilities of our virtual ward, which is receiving national recognition. As the anchor organisation in the One Wolverhampton Placed Based Partnership, we are committed to the development of services at a local level with other health, social, voluntary and social enterprise organisations.

Staff health and wellbeing continues to be a priority area, both in coping with the usual needs of a large organisation and the exceptional stresses that are still being felt following the pandemic.

This Quality Account provides information on progress against the agreed key priorities, which include workforce, safe care and patient experience and sets out our priorities and plans for the upcoming year.

To the best of my knowledge, the information contained within this Quality Account is accurate.

Signed:

David Loughton CBE, Chief Executive

May 2022

'Our vision is to be an NHS organisation that continually strives to improve the outcomes and experiences for the communities we serve'

Achieving our vision: Strategic objectives

Our values

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

Trust Strategic Objectives 2018-2021

To have an effective and well integrated health and care system that operates efficiently	Proactively seek opportunities to develop our services	Create a culture of compassion, safety and quality	Attract, retain and develop our staff and improve employee engagement	Maintain financial health - appropriate investment to patient services	Be in the top 25% for key performance measures
					








Looking back 2021/22 Priorities for Improvement

Patient Safety	We aim to be the safest NHS Trust by "always providing safe and effective care, being kind and caring and exceeding expectation" (Trust Vision and Values September 2015), by making safe quality care a whole-system approach for every patient that accesses the Trust and its services
Clinical Effectiveness	We aim to deliver safe patient care and good patient experience. Our wards and departments need to have the right levels of staff and skill mix for the acuity of the patients for which they are caring.
Patient Experience	Meeting our patients' emotional needs as well as their physical needs.

The above priorities have supported the following Trust strategic objectives:

- To have an effective and well-integrated health and care system that operates efficiently
- Proactively seek opportunities to develop our services
- Create a culture of compassion, quality, and safety
- Attract, retain, and develop our staff and improve employee engagement
- Be in the top 25% for key performance measures.

Priority 1: Patient safety
Preventing Infection - Minimising the impact of COVID-19

Managing the impact of Covid	What we said we would do	How we have done
1) Achieve best practice for the management of COVID-19 inpatients, preventing the spread of Infection and minimising the impact of COVID-19	• The emergence of COVID-19 has had a significant impact on the Trust and will continue to have influence on Trust plans moving forward. The organisation has, and will, continue to base actions related to COVID-19 on the best available evidence and aligned with local and national guidance • Bed management plans will need discussion and development to enable safe patient placement and management particularly if a rise in cases occurs. • Ensuring that the learning from COVID-19 incidents is implemented and embedded • Explore the expansion of COVID-19 point of care testing capacity in the organisation where appropriate • Increase the number of RWT staff receiving first vaccinations • Complete second vaccinations • Establish a process for vaccination of new starters • Be flexible to the currently unknown requirements for a future vaccination programme.	• The Trust continues to identify all COVID-19 Healthcare Associated Infections (HCAIs) in line with national definitions and to undertake investigations as indicated by national guidance • All COVID-19 HCAI deaths are reviewed by case analysis, structured judgement review and a full root cause analysis is completed where indicated • Serious incidents are escalated for external reporting and management to ensure learning is extracted and corrective actions are taken • The Trust has identified themes for attention such as ventilation, cohorting of patients, staff and patient screening compliance and patient wearing face masks and have taken appropriate redress action including standalone air filtering units, designed a compliance screening tool which is used for every patient, twice weekly LFT testing introduced, and results recorded on Infinity dashboard and monthly audit of patients wearing face masks • Twice weekly grand outbreak meetings are held to discuss incidents with external partners involved • The Trust has undertaken the Duty of Candour in a sensitive manner and in line with national guidance in all cases where moderate or severe harm or death has been caused by omissions in care.

Deteriorating Patient

Priority and why priority identified	What we said we would do	How have we done?
2) Reduce harm by assessing, recognising, and responding to prevent patient deterioration. The Trust has continued to focus on recognising and responding to deteriorating patients and strengthening the identification and management of sepsis. To further support this initiative, the Trust has amalgamated our Sepsis Team (CCOT) and Critical Care Outreach Team to work under the same umbrella with a goal to strive to continuously improve both sepsis compliance and management of deteriorating patients.	This dedicated collaborative team will provide structure to support early detection and treatment of both deterioration and sepsis throughout a 24 hour period. To facilitate the delivery of early identification and management of the septic patient within one hour, the Trust Sepsis Team and Critical Care Outreach Team will work towards a collaborative approach. Going forward for 2021/2022, as part of our overarching Clinical Service Framework, the strategy for the deteriorating patient and sepsis is to demonstrate further improvement in sepsis performance in both the Emergency Department and inpatients and work towards being compliant with the upcoming NICE sepsis recommendations. Other strategies are as follows: • Publication of a monthly "Vitals sepsis module screening compliance" report • Continue with sepsis ward rounds and campaign about the sepsis six highlighting the importance of senior clinician review • Whilst we continue to collaborate with the third-party provider for updates and version releases, we aim to build our own reports, ensure clinical validation, and develop a deeper understanding of data flow • Ensure real-time visibility of data for clinical staff.	The Trust has remained focused on improving the recognition and prevention of deteriorating patients. Achievements for 2021/2022 have included: • An amalgamated Critical Care Outreach service and the Sepsis Team have successfully employed a substantive Matron to lead the team • Sepsis performance for 2021 has been consistently good with screening and antibiotic delivery completed in more than 80% of the patients across the Trust. Our "door to needle" time for neutropenic patients with sepsis is approximately 24 minutes. A "significant assurance" was provided on the above data and our methodology by an external reviewer and our sepsis SHMI continues to be less than 100 • The Critical Care Outreach Team continues to provide a 24 hour – seven days a week service to strive to support staff in the identification in the early detection and management of the deteriorating patient. The readmission of the discharged ICU patients followed up by the Critical Care Outreach Team is less than 1% while an average of 7% of the patients were admitted to ICU following referral and subsequent review by CCOT in the last year. 40% of the total number of patients reviewed were out-of-hours referrals. Cardiac arrest calls have also decreased in the last year • The use of a robust web-based system utilised by the Critical Care Outreach Team enables paperless documentation of assessment in real-time data entry • Acute illness management (AIM) course was launched, with members of the Critical Care Outreach and Sepsis Team being part of the teaching faculty for the Trust • Focusing on data quality from electronic systems to drive improvement going forward, has led to an 'observations on time' report being established and validated with methodologies being approved during April 2022. With the aim to live by June 2022 to allow real-time visibility of the data • The current 'Observations on time performance' audit has mirrored COVID-19 activity during the last 12 months, at the time of writing currently over 95.8%.

	• An additional educational focus to support a relaunch of both training incorporating the use of the electronic Vital Pac system and the sepsis bundle for our health care assistants and registered practitioners, to ensure continuous quality improvement trust wide.	• As part of the CQINN for the deteriorating patient, a deteriorating patient concern sticker providing details of the concern, time of escalation, and time of medical review have been introduced to wards and departments • A focus for the coming year will be to increase the visibility of sepsis ward rounds and campaigns throughout the year on the prevention of deteriorating patients and sepsis • Deteriorating patient and sepsis eLearning modules on My Focus have been launched and are mandatory • Competency for our health care support workers is introduced as part of a structured program alongside an E-Learning program • Face-to-face training has been introduced on how to use devices to enter observations and screening • First-year student nurses, prior to commencing placements complete an eLearning program in relation to NEWS2 and escalation.

Health Inequalities

Priority and why priority identified	What we said we would do	How have we done?
3) Promote equality out of outcomes by routinely reporting user outcomes (reducing health inequalities) LD, Maternity, BAME, Continuity of care. Key areas of focus for 2021/22 included:	• Production of a maternity dashboard focusing on data relating to inequalities to enable areas for improvement to be identified and provide an ability to measure outcome from improvement initiatives commenced. • Continue to drive improvements in continuity of care and achieve determined objectives in relation to the number of BAME women receiving continuity of care during their pregnancy. • Continued participation in Learning Disability Mortality Review programme (LeDeR) and ensure learning is embedded. • Further improve the number of learning disability annual health checks conducted within our primary care GP practices.	• RWT now has a maternity inequalities dashboard generating a substantial about of data, which is been used to plan services to reflect the needs of service users. This will be key particularly in community maternity service design • We continue to work on the building blocks to achieving midwifery continuity of care, namely correct staffing, training, and commitment of staff in line with national guidance on implementation. RWT is appointing an equality, diversity, and inclusion lead midwife, with funds secured from the Local Maternity and Neonatal System, to target care and support to groups within our communities to ensure the most appropriate care is accessed • The Trust has representation at the LeDeR steering group and local governance panel • Using the electronic patient records flagging system, people with LD can be identified and a structured judgement review undertaken using the Royal College of Physicians methodology for each death. Identified learning from reviews is reported into the Trust Mortality Review group and disseminated across the Trust • There has been an improvement in compliance in the majority of PCN practices from last year. Going forward the PCN will be having a centralised call and recall process to ensure patients are captured and communicated to effectively, to ensure they are seen as part of any enhanced service or quality outcomes framework, which includes the learning disability health checks to continue to improve uptake across the PCN.

Mental Health

Key areas of focus for 2021/22	How have we done?
4) The Trust is registered by the Care Quality Commissioner for the Regulated Activity of Assessment or Medical Treatment for persons detained under the Mental Health Act 1983 (MHA). Mental health will remain an area of priority and is embedded in the Trust Quality and Safety Strategy. Key actions for 2021/22 are to: • Expand Level 2 mandatory training • Launch Level 3 mandatory training, application of the MHA • Audit of reports of MHA applications against the MHA administration policy • Review of emergency and urgent care environments and pathways for patients with Mental Health • Review provision of mental health care in the Trust.	• Level 2 mandatory training is embedded within the Trust. The training has been reported on the monthly compliance reports since April 2021. March 2022 Compliance is at 87.6% • Level 3 mandatory training is embedded within the Trust. The training has been reported on the monthly compliance reports since December 2021. March 2022 Compliance is at 68.6%. Following investment in a mental health team within RWT and feedback from the training, a new mental health training platform will be developed to further support staff across all areas of the trust. • RWT conducted a Mental Health Act (MHA) audit and acted upon the findings. RWT have employed a Mental Health Act administrator to support the MHA process. The policy is now under development to adhere to the recent changes in the MHA law. The Mental Health Act administrator will be working to develop training and regular audits as required under the CQC provider status • RWT have been collaborating with our partner agencies and reviewing the mental health service delivery. To improve patient care and treatment we will be working towards the delivery of CORE24 services. The mental health team employed by RWT will be supporting parallel assessments and parity of esteem. This will support the patient journey from ED through to discharge • A full audit was conducted of mental health. The findings from the audit will support all future developments of mental health care and treatment within RWT.

Safeguarding

Priority and why priority identified	What we said we would do	How have we done?
5) Safeguarding Safeguarding children, young people and adults from abuse and harm is everybody's business and an important part of everyday healthcare practice and patient care. The Trust has a dedicated safeguarding team of nurses / health professionals and administration staff to provide advice, support and training to the Trust's staff and other care providers within Wolverhampton. All staff working within the Trust who have a responsibility for the care, support and protection of children and vulnerable adults should ensure that those at risk are safe. If staff witness or have suspicions of abuse or neglect, they are under an obligation to report it without delay even if they have not witnessed the abuse or neglect themselves. The Safeguarding Service seeks to protect children, young people and adults through training, supervision, and advice. The Safeguarding Service promotes a 'Think Family' focus throughout all child and adult safeguarding work to promote the importance of listening to the voice of children and young people so that their experience is heard and for the adult to ensure that safeguarding is made personal.	**Key priorities** • Additional recruitment for maternity safeguarding posts • Review and update the safeguarding training programme to include learning disability • Refresh Safeguarding Children and Adult Policies on a regular basis (including Prevent and Safeguarding Supervision policy) • Progress with work around Mental Capacity Act assessments across the Trust • Continue to support staff with safeguarding cases by offering reflective supervision • Monitor Deprivation of Liberty Standards (DoLS) applications.	• Maternity have appointed a safeguarding midwife with an operations role as a secondment. Funding this post will happen in the next 12 months • The safeguarding training programme has been reviewed during 2021. Learning disability awareness training has been developed and subsequently rolled out to all staff • All safeguarding policies have been reviewed monthly. The Safeguarding Supervision and the Prevent policy were updated during 2021/22 • A MCA task group was convened during 2021 to progress with raising awareness of the act. Noteworthy progress has been made with staff identifying and recording mental capacity assessments for patients. This work will continue throughout 2022/23 • DoLs activity is monitored every month within the Trust, and we can see that with focused support offered by the safeguarding team that all ward areas are submitting applications • The Trust has reported and monitored safeguarding referral activity at the Trust Safeguarding Group which meets monthly.

Priority 2: Workforce
Nursing, midwifery and health visiting workforce including allied health professionals

What we said we would do	How we have done
• Continue to build upon our successful recruitment programme into the nursing, midwifery, and health visiting posts, through our award-winning Clinical Fellowship Programme and United Kingdom and international recruitment • Continue to work with universities to offer an increased number of placements and attract students as our future workforce • Further strengthen our focus on retaining our nursing, midwifery, and health visiting workforce • Focus on developing new roles and career progression opportunities for our existing nursing, midwifery, and health visiting workforce • Ensure provision of attractive development programmes • Continue to strengthen our governance arrangements, by further embedding our daily oversight reports via the Safe Care Module and other governance reports • Ensure the Trust is fully compliant with the Developing Workforce Safeguards requirements • Expand our apprenticeship offer to the diverse population and continue to collaborate with the Prince's Trust, to widen potential future employment opportunities within healthcare for the young people in our local community.	• The Clinical Fellowship Programme has continued to support recruitment to nursing, midwifery and health visiting posts and has additionally supported neighbouring Trusts within our ICS to support their staffing needs • We have increased the number of placements we provide to local universities; this enables us to ensure that students gain the positive experience needed to want to seek employment with us as they finish their training. Increasing numbers of newly qualified nurses continue to choose us as their first employer • The Flex Working group continues to work within an NHS Workforce plan to deliver on new flexible working practices to encourage retention of staff throughout their career whilst meeting their work/life balance • We continue to monitor our ongoing compliance with the Workforce Safeguards on a yearly review basis. Last year we undertook two skill mix reviews for all the inpatient wards and Critical Care and have a programme to cover the remaining key areas such as Theatres, Emergency Department, Outpatients and Community Services. • We have continued our work with the Prince's Trust to support employment experience and opportunities for young people within our community utilising apprenticeships and Kickstarter programmes • We have progressed our Advanced Clinical Practice agenda to ensure we are sighted on new roles and competencies for Clinical Specialists to Non-Medical Consultants – offering greater continuity of care and clinical career advancement for our Nursing and AHP colleagues.

Allied health professionals

What we said we would do	How we have done
• To continue to increase the availability of apprenticeships for AHPs, with physiotherapy and occupational therapy apprenticeships already embedded within the organisation • After the success with the Clinical Placement Expansion Programme for physiotherapy, we will share the learning across all the professions with a view to increasing student placements. • E-roster for AHPs and Pharmacy. E-Community where applicable and job planning for AHPs. Review of job descriptions • Further AHP recruitment events are planned, and we will be supporting a virtual AHP work experience event in May 2021.	• We continue to offer physiotherapy and occupational therapy Level 6 apprenticeships and are exploring opportunities for other allied health professions, particularly for radiography • There are currently no band 5 vacancies in physiotherapy, which we feel is a result of our successful Clinical Placement Expansion Programme (CPEP) last year. This academic year we had a second successful CPEP bid and are focusing on increasing student placements in dietetics, podiatry, paramedicine and diagnostic radiography • The e-roster project is ongoing, with waves one and two complete. Services are using e-community where applicable • A review has been undertaken to ensure that job titles match those used in the AHP career map, and generic person specifications have been agreed by the professional leads • AHPs continue to support work experience events. There have been two further AHP recruitment events plus a system-wide return to practice event.

Clinical System Framework (CSF)

What we said we would do	How have we done?
• Our new Clinical System Framework (CSF) was launched in March 2020. It has been the culmination of several months hard work, discussion and collaboration between the Trust's nurse, midwife and health visitor colleagues and the Trust is delighted that its allied health professional workforce has also collaborated to produce the CSF. The operational multi-functional framework produced provides a road map for priorities and improvement journey for the next 2 years. The milestones set will help the Trust to monitor, learn and drive improvement within the organisation. It will be fundamental in helping to deliver the absolute best care and most importantly help to achieve the best possible patient outcomes and experience • The contribution of allied health professionals to this CSF framework, which has replaced the Nursing System Framework, is a positive step forward for the Royal Wolverhampton NHS Trust and will create stronger links in practice which will enhance the care delivered. • Over the next two years we plan that the CSF will be integrated into all our work programmes and our day-to-day operational business. The CSF unites us all and it is the Trust's shared vision for continuous improvement providing safe, effective, and high-quality care for all our service users.	• We have integrated the CSF into all our work programmes and our day-to-day operational business. Regular reports are submitted to provide an update on progress against the agreed milestones to various groups and committees within the Trust.

Medical workforce

What we said we would do	How have we done?
Consultants • Continue to develop internally trained senior medical staff from fellowship programme. • Aim to strengthen links with neighbouring organisations where the national consultant resource is limited • Introduce the new SAS (Specialist and Associate Specialist) national contract.	• CESR support programme ongoing with CESR submissions/imminent submissions within next three months: 12 • Number of committed CESR doctors increasing • Eligible doctors contacted to express an interest to move to the 2021 national terms and conditions of service • Expressions of interest received from 12 doctors for the specialist grade and none for the associate specialist grade. Offers to be progressed • Now providing a shared service with Walsall Healthcare Trust with the number of fellows increasing across their medical workforce • Partnership with BCHFT extended with number of psychiatrists increasing from 10 to up to 40.
Junior medical staff / fellowship • Ongoing development and expansion of fellowship programme. • Embrace and adopt required changes to training structure and supervision requirements.	• Protected teaching for medicine and SIMS teaching in place • Royal College (RC) accredited supervisor course scheduled for May 2022 to expand number of educational supervisors (ES) across the organisation • Introduction of internal quality visits • Ongoing discussion with RCP/Compton Care to develop earn learn return scheme for Palliative Medicine and Medical Institute in Pakistan • Appointment of education and quality leads.
Medical students • Integrate Aston Medical School students into the Trust and recognise this will be an important future source of junior and senior medical staff. • Continue to provide high quality training for University of Birmingham medical students.	• RWT welcomed (for the first time) 20 year three students from Aston Medical School (AMS) in September 2021, with plans to accommodate students from year four and five in 2022, (the year five students will be earlier than previously planned). • There has been successful integration of RWT staff into the AMS faculty • A quality assurance visit from the University of Birmingham UOB was last conducted in November 2021 and was a positive visit. The visit highlighted three areas of notable practice including; the educational culture of the trust, the academy and leadership from the heads and deputy heads of academy and the undergraduate management structure • All areas identified for development have been completed, namely quality assurance for the incorporation of Aston students. • The National Education and Training Survey (NETS) highlighted that undergraduate education at RWT had higher scores for each of the four domains compared to the two largest comparator trusts in the region • A medical education quality dashboard has been created for each specialty which will be shared with divisions and directorates following feedback from NETS and the GMC National Training Survey (NTS), (which is for medical trainees' feedback). This dashboard will inform and drive quality improvements along with internal peer review of education and other initiatives • Both organisations (RWT and WHT) have appointed medical leads for medical leadership development and part of their role will focus on talent pipelines and talent management for medical staff. These individuals will both collaborate with the people development team to design and deliver a range of development programmes to support the talent plans and succession planning supporting recruitment and retention of medical staff, into and within the organisation.

Health and wellbeing

Why the priority was selected	What we said we would do	How have we done
The Royal Wolverhampton NHS Trust's people strategic aim is: *Attract, retain, and develop our staff and improve employee engagement.*	To support this aim, the following key objectives have been agreed for 2021/22: • Maintain the lowest vacancy levels in the Black Country - the target outcome is to ensure the Trust's vacancy rate remains the lowest of acute providers in the Black Country. • Increase the percentage of staff who deem the organisation has taken positive action on their health and wellbeing - The target outcome is to maintain the Trust's upper quartile position in the staff survey. During 2021/22, the Trust will continue to embed and progress its health and wellbeing approaches to support our workforce. • Improve overall employee engagement - this will be measured by benchmarking ourselves against our peers with the aim to show continual improvements in response to the nine staff engagement theme questions. • Reduce the gap in engagement scores for Black Asian and Minority Ethic (BAME) staff and improve Workforce Race Equality Standard (WRES) metrics - a detailed analysis will be undertaken to identify gaps against staff engagement theme metrics with 2020 staff survey data and 2021 WRES metrics. This objective is also supported by specific actions set out in the Trust's equality, diversity, and inclusion delivery plan and through engagement with the BAME employee voice group.	• Systems are in development for reporting of vacancies at an Integrated Care Board (ICB) provider level through the people board. Until then, it is not possible to compare vacancy rates from the Trust with the wider Black Country. The Trust's overall vacancy rate at the end of 2021/22 was 6.37% with an additional 312WTE employed over the course of the year. Vacancy rates for medical and nursing staff were 2.88% and 4.49% respectively at the end of the year. • Comparative data is not available for this staff survey indicator on health and wellbeing due to changes in the staff survey. The Trust has continued to embed the health and wellbeing offer and remains within the upper quartile with 62% of staff agreeing or strongly agreeing that the Trust acts on health and wellbeing. However, the Trust remains in upper quartile. • The Trust is above the median in eight out of the nine themes which make up the staff survey and above the upper quartile in three of the nine themes. The Trust has seen improvements to upper quartile performance in two areas, 'staff looking forward to going to work', and staff considering that care of patients/ service users is the organisation's top priority'; staff recommending the Trust as a place to work remains in the top quartile. Targeted improvements in relation to morale were also achieved. • The Trust has developed a robust EDI delivery plan in 2021/22, including the six high impact actions on recruitment. WRES metrics for 2021/22 will be published as part of the Equality, Diversity, and Inclusion annual report.

Priority 3: Patient experience

2021/2022 Priorities

One of the key priorities for the Patient Experience Team during the financial year of 2021/22 was to ensure that we put patient engagement and involvement at the heart of decision making and/or driving forward improvements in delivery of care. Some of these initiatives included:

- Collaborating with our stakeholders in the design and implementation of a co-design and co-production toolkit which is due for publication in the forthcoming weeks. This included key work streams from the following services: Learning disabilities, paediatrics and stroke services
- Gathering feedback from seldom heard communities by a range of mechanisms which included newly designed posters and videos for those whose first language is not English.
- Developed an online learning package for training on the observe and act, an initiative by Shropshire Community Health NHS Trust with equality and diversity input from RWT.
- A PALS training video highlighting the need to consider customer care and the potential impact on ineffective communication and how dissatisfaction escalates
- Placemats for inpatients reviewed and available in several other languages.

For complaint management:

- We have undertaken an assessment against the Parliamentary Health Service Ombudsman Complaint Handling Standards which will then involve a review of the Trust Complaint Management Policy (OP08) and early adoption of the standards. We have used complaints as a metric to identify performance issues and highlight and share learning and good practice
- Designed a complaints feedback analysis tool specifically adapted to look at end of life complaints with an emphasis on the qualitative feedback and the ability to specifically identify the stage of the patient's journey the dissatisfaction occurs.
- A compassionate/purposeful visiting guide was introduced to enable a supportive visiting approach for vulnerable patients. This was then followed by the 'welcome hub' which was established in mid-March 2022 to manage the visiting process following a period of restricted visiting.

Co-Design and Co-Production

Priority and why priority identified	What we said we would do	How have we done?
Co-Design and Co-Production The key priorities for the Patient Experience Team during the financial year of 2021/22 will be to look at putting patient engagement and involvement at the heart of decision making and driving forward improvements in delivery of care.	• Work with our stakeholders in the design and implementation of a co-design and co-production toolkit. • Involve patients and their loved ones in the co-design and co-production of several key work streams including: mental health, learning disabilities, maternity services, paediatrics and stroke services • To review milestones and outcomes for year two of the Patient Experience, Engagement and Public Involvement Strategy and refresh the strategy where applicable to focus on the emphasis of ensuring patient involvement in all we do • Gathering feedback from seldom heard communities by a range of mechanisms • To design and implement a robust system using a variety of patient experience metrics to identify areas for targeted improvement • To understand patient experience metrics for patient groups where inequalities exist and implement changes to improve experiences for these cohorts.	• Despite the impact of COVID-19 the Trust has continued to progress the deliverables within the three-year Patient Experience, Engagement and Public Involvement Strategy (2019-2022). Several initiatives have been implemented this year which focused on improved processes, co-production, and continuous improvement • The toolkit is in the latter stages of finalisation and several key workstreams have been identified for stroke services, paediatric and learning disabilities • Designed a complaints feedback analysis tool specifically adapted to look at end of life complaints with an emphasis on the qualitative feedback and the ability to specifically identify the stage of the patient's journey the dissatisfaction occurs • Embedded the NHS England initiative of 'Always Events' within paediatrics and designed key always events as part of a co-production approach with patients • Ensured triangulation of patient experience with wider quality, safety, workforce, and performance metrics • Included stakeholders, patients and/or their carers to contribute and co-produce documents and initiatives to improve the patient experience • We have worked in collaboration with the University of Wolverhampton on a project to embed co-design and production throughout the Trust • We recognise the need to engage with all the communities we serve and have increased the ways and means of how patient feedback is obtained by making more literature available in other languages and sought feedback by the release of videos in other languages. We recognise the need to engage with communities whose first language is not English • The Trust's maternity services are working with the University of Wolverhampton on a co-production approach to improving information to women both concerning induction of labour and care in latent phase of labour • Maternity research team have started a maternity patient and public involvement group to look at research priorities.

Complaint management

Priority and why priority identified	What we said we would do	How have we done?
Complaint management Actions to improve outcomes for the new financial year.	• A review of the formal complaints policy to ensure the process is clear and accessible to all • Joint Parliamentary Health Service Ombudsman (PHSO) and Patient Experience Team complaints training to be facilitated and delivered • Quarterly review of the complaints performance to be undertaken by the Council of Members • Complaints to be used as a metric to identify performance issues and highlight and share learning and good practice.	• The policy is reviewed each year to ensure it is accessible for all • Whilst PHSO training was not delivered due to restrictions relating to COVID-19, it is intended to review and deliver this within the new financial year • A structure has been implemented for a regular review of formal complaints by the Council of Members which is the Trust's Patient and Public Involvement Group.

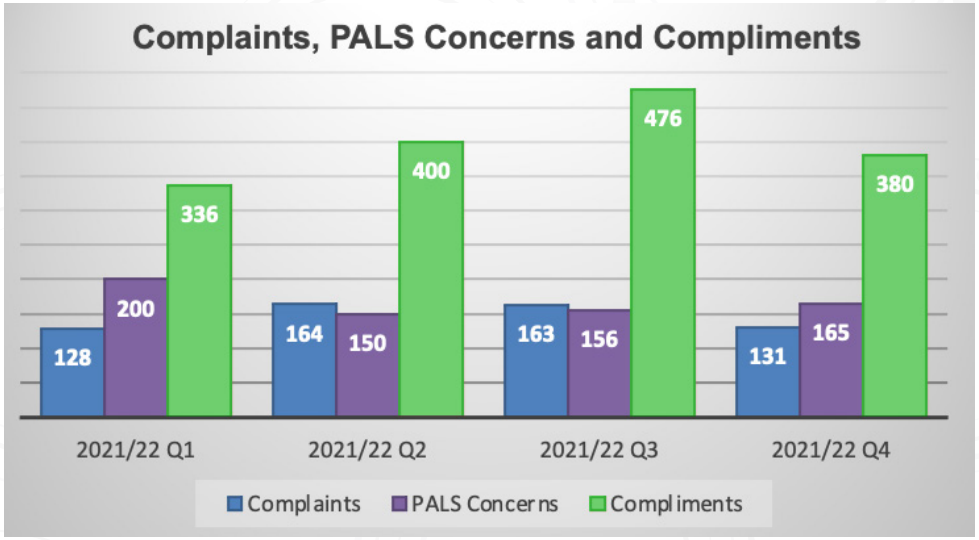
Complaints, concerns, comments, compliments & PALS queries

There were 562 complaints compared to 472 for year 2020/21. This represents an increase of 19%. The department where the greatest numbers of complaints have been received when compared to the previous years are ED (63% increase) and General Surgery (68% increase).

Safeguarding concerns which do not meet the criteria for a Section 42 investigation are processed through the complaints procedure and are included in the total number of complaints received. Safeguarding concerns have decreased from 61 in 2020/21 to 50 in 2021/22.

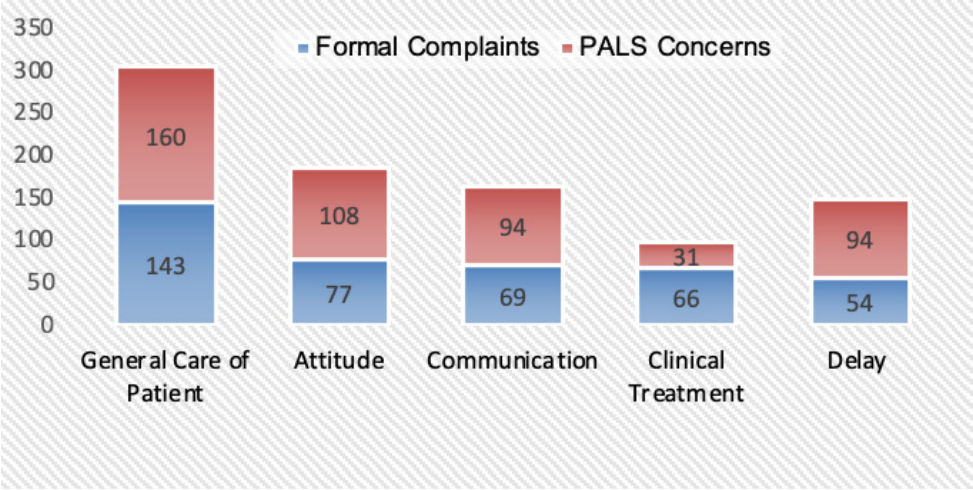
During the year 2021/22, from 553 formal complaint cases which were closed, the Trust determined that 69% of cases were not upheld, 25% were partially upheld and 5% were upheld. As with the previous year, the Trust's performance measured for complaint outcomes were significantly lower than the national average of 27.1% (as recorded by NHS Digital) for cases upheld. The volume of compliments received (1592) represents an increase of 23% on last year's total of 1286, and far exceeds the volume of formal complaints and PALS concerns recorded.

Quarter on quarter, there has been an increase in compliments received throughout the year although this is a reduction compared to the volume recorded in 2019/20.



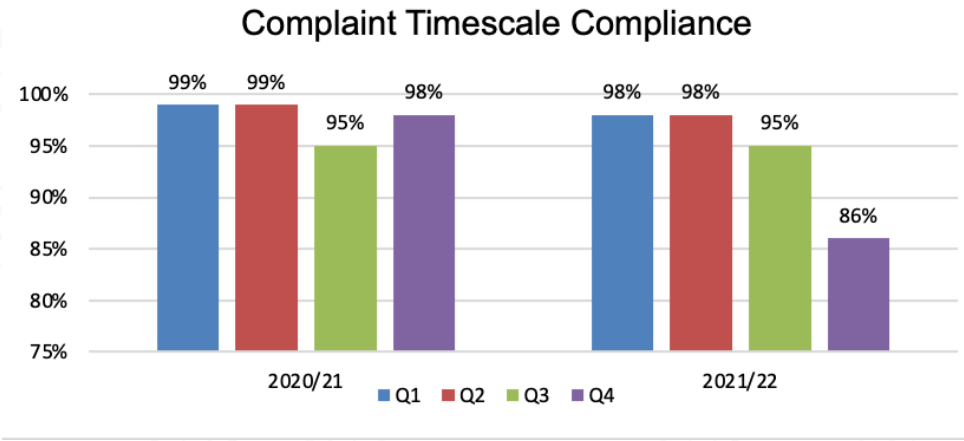
Themes of complaints and PALS queries (Concerns)

During 2021/2022, there were 586 complaints raised. There is little variation between the key themes of complaints year on year, with the highest subjects being, general care of patient, attitude, and communication. The table below illustrates the top five categories which are the same for both formal complaints and PALS Concerns.



Responding to complaints

Complaint compliancy is measured on the adherence to policy (30 working days) and gaining consent for an extension for completion. Compliance is shown below however during 2022/23 the Trust will also be measuring the average timescales for responses per division and directorate.



Parliamentary Health Service Ombudsman (PHSO)

In terms of the outcomes of PHSO investigations which were ongoing from the previous year and were closed during 2021/22, (six cases), it is noted that two cases were fully upheld with a financial redress total of £1350, and one case was partially upheld and three were not upheld. No other financial redress was awarded during the year.

It is noted that for the previous year (2020/21) three cases were subject to a full PHSO investigation in comparison to 16 for this year. This represents 3% of the total of complaints received. The PHSO suspended receipt of new cases for investigation during 2019/20 because of the peak of the COVID-19 pandemic and throughout this year have been considering new cases.

Themes emerging from those cases fully upheld related to care received and pain management during labour and in case two, medication received.

Patient access waiting times – focus on 62 day cancer performance

Priority and why priority identified	What we said we would do	How have we done?
Patient access waiting times A focus on waiting times to improve 62-day cancer performance, a reduction in the 52 week waits and RTT waiting times.	**Cancer diagnostics and treatments including:** • Improvement of the general patient experience – we recognise that our 62-day cancer performance is in the lowest quartile – to address this we are renewing our focus on improving all cancer pathways with the Trust cancer team and CQI team. We are establishing a Cancer Improvement Board which will be chaired by the chief medical officer with CEO oversight. • Improvement in nationally reported outcomes.	• Following the effects of the COVID-19 pandemic the organisation has continued to see an increased number of referrals, above and beyond the expected yearly growth. • The diagnostic element of the pathway has recently been supported with the opening of the Community Diagnostic Hub at Cannock Chase Hospital. • The focus remains to reduce the backlog with special attention being given to patients waiting over 104 days. • The number of patients waiting over 104 days for treatment has increased as a result of Covid, this has affected the Trusts performance against the national 62 day to treatment metric. • The organisation is working with the ICS on the review of the four focused pathways to deliver continuity of care across the ICS. • The Cancer Improvement board was delayed however is due to commence May-22.

Volunteering

Priority and why priority identified	What we said we would do	How have we done?
Volunteering	• To design and implement a comprehensive career pathway to assist our young volunteering workforce.	• We continued with recruitment into the clinical volunteer role, holding three recruitment events within this period and recruiting 183 new volunteers. • We appointed a youth volunteer co-ordinator to lead the young volunteers workstream and the role engaged with local community, facilitating presentations at schools, colleges, universities, The Way (youth provision), local authority youth services, and Black County Talent Match. Recruitment fairs were also attended in collaboration with other Trust representatives around employment from 'Wolves at Work.' As a result of this community engagement, of the 183 people that applied, 139 were aged 16-25 (75%). • We continued placing volunteers in ward areas, covid swab hub, and vaccination hub, plus ward activity programme in rehab areas. The volunteers undertook general holistic duties including bed making, distributing refreshments and facilitating video calls with loved ones to name a few. • We continued liaising with Trust staff bank team regarding volunteers joining the bank following completion of a satisfactory number of volunteering hours and having gained skills and confidence in their placement areas. • As a result, 11 young volunteers gained employment - either in permanent, temporary or apprenticeship roles. More reported the increased skills and confidence gained through the volunteering role has helped them gain positions elsewhere or progress academic study further. Through use of reflective logbook, reviews and peer mentoring we have been able to focus on the developmental aspect of the volunteering experience.

Looking forward 2022/23 Priorities for improvement: How we chose our priorities

Each year the Trust is required to identify its quality priorities. We consulted on both the quality strategy and annual quality priorities. The draft priorities were shared with commissioners, Healthwatch, our governors, the Trust management committee, the executive teams within the divisions and directorate management teams. The final priorities for 2022/23 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.

Priority 1: Patient safety

PS 1 - COVID-19 minimising impact This priority supports the delivery of our quality and patient safety strategy and builds on the work already undertaken to maintain best practice for the management of COVID-19 for inpatients, preventing the spread of infection and minimising the impact of COVID-19 to optimise service recovery to pre-COVID-19 position. Reduce indirect harm caused by COVID-19 by establishing systems to identify and monitor learning from related incidents.	**We will:** • Minimise and manage outbreaks within national/regional guidance to maintain safety of staff and patients with minimal impact on service provision • Aim to provide high quality, safe services to pre-covid rates to meet national targets.
PS 2 - Reduce harm by assessing, recognising, and responding to minimise patient deterioration This priority supports delivery of our quality strategic aim to deliver a safe and high-quality service and builds on the achievements of our 2021/22 quality and patient safety strategy priority to protect patients from unintended or unexpected harm.	**We will:** Continued focus on good governance processes for the deteriorating patient including: • Development of a dashboard for deteriorating patient and sepsis • Critical care reviews and themes for learning and quality improvement • Learning from mortality reviews in relation to the deteriorating patient • Further collaboration and close working with resuscitation committee • Achieve the CQUIN in relation to recognition and response to deterioration of patients.
PS 3 - Promote equality out of outcomes by routinely reporting user outcomes (reducing health inequalities) This priority supports the delivery of the national/regional (Integrated Care System - ICS) agenda to focus on access and health equity for underserved communities and our local quality and patient safety strategy to promote equality of outcomes for all, including hard to reach groups.	**We will:** • Ensure of our current patient safety workstreams are dovetailed and support outcomes in line with health inequalities programme to maximise impact.

Looking forward 2022/23

PS 4 - We will aim to improve mental health care and treatment for all ages **PS 5 - We aim to review our services, work with our partners to deliver a flexible service to meet the needs of mental health patients** **PS 6 - As a registered provider of mental health care, we aim to adhere to the law and legislation within the Mental Health Act 1983 and to ensure all patients are treated in a patient centred way** **PS 7 - We aim to support and deliver excellent care for some of our most vulnerable patients and their carers including children and those living with a learning disability, mental health issues and dementia** **PS 8 - We aim to deliver parity of esteem by having embedded mental health services and skills across the workforce** These priorities support the delivery of the national/regional (Integrated Care System - ICS) agenda to improve mental health services and services for people and our local quality and patient safety strategy to strengthen governance and care systems related to the care of those with ill mental health.	**We will:** • Ensure the workforce is knowledgeable and skilled in meeting the needs of our mental health patients • Embed a multidisciplinary approach to supporting mental health patients • We will deliver a mental health steering group that will enable a trust wide approach to reviewing mental health care standards and to share experiences. The group will be a supportive group that aims to improve mental health care and standards throughout the organisation • Work with partner agencies to support effective delivery of mental health care services that are delivered within the organisation • Develop a mental health strategy • We will develop a process to support the use of Force Act 2018 and improve governance processes for auding mental health data.

Priority 2 – Clinical effectiveness

CE 1 - To ensure we improve and continue to have an appropriate workforce to support clinical effectiveness, patient safety and a positive patient experience	**Nursing Workforce** **We will:** • Continue our recruitment programme, utilising our lead recruiter Clinical Fellowship programme to attract and onboard international recruits to our workforce • Continue to increase placement opportunities for nursing students, supporting our local universities ability to educate more nursing students • Improve the work/life balance of our nursing staff by offering flexible working which will improve the organisations attractiveness to new staff and retention of current staff • Continue to provide mechanisms to allow for personal and professional growth, whether from clinical support to nursing associate, nursing associate to registered nurse or registered nurse to advanced practice • Seek to improve opportunities for all by supporting local recruitment programmes in partnership with local government, charities, and associations to address local inequalities that effect employment within our communities • Complete the implementation of safecare and safe staffing policy to fully realise the benefits of a responsive, acuity led staffing allocation and the governance of red flag alerts • Improve the systematic review of staffing in the organisation using the new Safer Nursing Care Tool (SNCT) provided for both Emergency Departments and community in late 2021 and early 2022. **AHP** **We will:** • Continue to build upon our Health Education England-funded workforce programmes: supporting AHPs to return to practice; international recruitment into AHP posts through RWT's award-winning Clinical Fellowship Programme; increase attraction, reduce attrition, and improve retention of AHPs and the support workforce; enhance our resources to increase the number of AHPs undertaking apprenticeships at all levels; develop the AHP support workforce • Continue to work with universities to offer an increased number of placements and attract students as our future workforce • Focus on developing new roles and career progressions opportunities for our existing AHP workforce • Ensure provision of attractive development programmes. • Continue to strengthen our governance arrangements using our oversight reports to the chief nurse • Expand our apprenticeship offer to the diverse population to widen potential future employment opportunities within healthcare for the young people in our local communities • Continue to build a personalised plan to deliver more flexible working opportunities in all our roles and deliver on the promises made in the NHS People Plan.

Looking forward 2022/23

	Medical Workforce **We will:** **Consultants** • Continue to develop internally trained senior medical staff from fellowship programme. • Aim to strengthen links with neighbouring organisations where the national consultant resource is limited • Develop pathway for long term locum consultants to be employed and supported to progress through CESR to a substantive appointment. **Junior medical staff / fellowship** • Ongoing development and expansion of clinical fellowship programme. Embrace and adopt required changes to training structure and supervision requirements • Explore options for digital fellowship programmes in collaboration with external stakeholders. **Medical students** • Consolidate Aston Medical School students into the Trust and continue to recognise this will be an important future source of junior and senior medical staff • Continue to provide high quality training for University of Birmingham medical students.
CE 2 - To continue with our multi-professional Clinical Services Framework (CSF) to further enhance our ability to work as integrated teams and support our patient needs	**We will:** Continue to implement the Clinical Services Framework (CSF) and the elements outlined for 2022 under. • Right workforce • Excellence in care • Cultural and organisational structure • Communication • Education • Research

Priority 3 – Patient experience	
PE 1 - To maintain and improve patient engagement and to continue to place patient engagement and involvement at the heart of decision-making driving forward improvements in delivery of care	**We will:** • With our colleagues at WHT we will publish an enabling framework for 2022-2025. This will reinforce our collaborative working across both Trusts.
PE 2 - To continue to improve complaints responses to patients and ensure learning is identified and areas are provided with e-learning	• Embed the PHSO Complaints Standards, and with our colleagues at WHT, we will continue to develop and implement the new PHSO Complaints Standards including e-learning training modules and tracking progress against each Trust's self-assessment.
PE 3 - To build on the success of volunteer services	• Identify strategic priorities for volunteering opportunities aligned with strategic priorities of the Trust • Increase recruitment of volunteers • Continue to explore career pathways for volunteers within the Trust and evidence case studies/ good practice • Expand volunteer opportunities based within Trust community services.
PE 4 - Patient Access Waiting Times: A focus on waiting times to improve 62-day cancer performance, a reduction in long waiting patients (+78 weeks) and elimination of 104 week waits	• Focus on cancer capacity and pathway times. This year has seen a sharp increase in referrals, however, our 2ww performance is improving which will in turn help the 62-day pathway times. Work is on-going to improve diagnostic waiting times with the inclusion of mobile units to increase capacity • We recognise the need for capacity to be increased over and above pre-covid numbers to reduce waiting times. We continue to utilise virtual clinics where appropriate to ensure maximum capacity is available • We will continue to work collaboratively with other local Trusts to offer and utilise mutual aid where appropriate to ensure the best outcomes for patients.

Statements of assurance from the Board: Mandatory quality statements

All NHS providers must present the following statements in their quality account; this is to allow easy comparison between organisations.

Participation in Clinical Audits

During the period of April 2021 to March 2022, The Royal Wolverhampton NHS Trust participated in 98% of national clinical audits and 100% of national confidential enquiries it was eligible to participate in.

This equated to 45 national clinical audits and five national confidential enquiries covering relevant health services provided by The Royal Wolverhampton NHS Trust.

Please see Appendix One for a list of all local clinical audits reviewed by the Trust in 2021/22 with actions intended to improve the quality of healthcare provided

The following table details national clinical audits and national confidential enquiries that The Royal Wolverhampton NHS Trust contributed to during April 2021-March 2022. The number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are stated.

National programme name	Work stream / Topic name	Participating 21/22	% of cases submitted	Data collection completed during reporting period.
Child Health Clinical Outcome Review Programme	Transition from child to adult health services	Yes	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	Yes	-	-
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal mortality surveillance	Yes	-	-
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	-	-
Medical and Surgical Clinical Outcome Review Programme	Crohn's disease	Yes	-	-
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	100%	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	100%	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Yes	86%	Yes
National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	-	-
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	Yes	100%	Yes
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Audit	Yes	100%	Yes
National Asthma and COPD Audit Programme (NACAP)	Children and Young People's Asthma Audit	Yes	-	Yes
National Asthma and COPD Audit Programme (NACAP)	Pulmonary Rehabilitation	Yes	-	-
National Asthma and COPD Audit Programme (NACAP)	COPD	Yes	100%	Yes

Statements of Assurance

National programme name	Work stream / Topic name	Participating 21/22	% of cases submitted	Data collection completed during reporting period.
National Audit of Breast Cancer in Older People (NABCOP)	-	Yes	Audit is completed from data that is submitted to Public Health England monthly as part of the COSD dataset	Yes
National Audit of Cardiovascular Disease Prevention Primary care	-	Yes	Data is automatically extracted from GP held records	Yes
National Audit of Care at the End of Life (NACEL)	Acute and community hospital providers	Yes	100%	Yes
National Audit of Dementia (NAD)	Care in general hospitals	Yes	-	-
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	Yes	100%	Yes
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	-	No - data collection still in progress (Reporting deadline June 22)
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	Yes	-	No - data collection still in progress (Reporting deadline June 22)
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	-	No - data collection still in progress (Reporting deadline June 22)
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management Devices and Ablation	Yes	-	No - data collection still in progress (Reporting deadline June 22)
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	-	No - data collection still in progress (Reporting deadline June 22)

National programme name	Work stream / Topic name	Participating 21/22	% of cases submitted	Data collection completed during reporting period.
National Child Mortality Database (NCMD)	-	Yes	Reported via the child death review process	-
National Early Inflammatory Arthritis Audit	-	No (participation optional in 21/22 due to Covid-19 Pandemic)	-	-
National Emergency Laparotomy Audit (NELA)	-	Yes	100%	Yes
National Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes		
National Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit (NBOCA)	Yes		
National Lung Cancer Audit	-	Yes	100%	Yes
National Maternity and Perinatal Audit (NMPA)	-	Yes		
National Neonatal Audit Programme (NNAP)	-	Yes	100%	Yes
National Paediatric Diabetes Audit (NPDA)	-	Yes	100%	Yes
National Prostate Cancer Audit (NPCA)	-	Yes		Yes
Sentinel Stroke National Audit Programme (SSNAP)	-	Yes	100%	Yes
Case Mix Programme (CMP)	-	Yes		Yes
Elective Surgery (National PROMs Programme)	-	Yes	Information goes straight to the Department of Health	Yes
Emergency Medicine QIPs	Pain in Children	Yes	100%	Yes

Statements of Assurance

National programme name	Work stream / Topic name	Participating 21/22	% of cases submitted	Data collection completed during reporting period.
Inflammatory Bowel Disease (IBD) Audit	Inflammatory Bowel Disease (IBD) Biological Therapies Audit	Yes	-	-
LeDeR - Learning Disabilities Mortality Review	-	Yes	100%	Yes
National Audit of Cardiac Rehabilitation	-	Yes	-	No - data collection still in progress
National Cardiac Arrest Audit (NCAA)	-	Yes	-	
National Joint Registry	-	Yes	-	Yes
National Perinatal Mortality Review Tool	-	Yes	-	
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	-	Yes	100%	Yes
Society for Acute Medicine Benchmarking Audit	-	Yes	100%	Yes
Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	-	Yes	-	Yes
Trauma Audit & Research Network	-	Yes	100%	Yes
UK Cystic Fibrosis Registry	-	Yes	-	-
Chronic Kidney Disease Registry Previously listed under UK Renal Registry	-	Yes	100%	Yes

The reports of 22 national clinical audits were reviewed by the provider in April 2021-March 2022 and The Royal Wolverhampton NHS Trust intends to take the following actions to improve the quality of healthcare provided.

National Audit Title	Actions to be taken by RWT
MBBRACE (Maternal, Newborn and Infant Clinical Outcome Review) Saving Lives Improving Mothers Care- Maternal mortality surveillance and confidential enquiry (2017-2019)	All national recommendations are reviewed, and a local action plan is in place to address any areas of potentially improvement.
2021 National Comparative Audit of Quality Standard 138 (Blood Transfusion)	Areas of minor non-compliance to be addressed; staff to improve the documentation surrounding prescription of Iron.
National Acute Kidney Injury Audit	Areas of minor non-compliance will be addressed by conducting a quality improvement project.
National Audit of Breast Cancer in Older People 2021 data	Report reviewed and no areas of concern, no formal action plan required.
BAUS Renal Colic Audit (2020/21)	Report to be discussed at the governance meeting, any areas of potential improvement will be addressed.
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database Annual Report (2020/2021)	The Trust have performed very well compared to national averages, any national recommendations will be discussed in the governance meeting and taken forward as required.
PROMS (Patient Reported Outcome Measures) National Audit (2020/2021)	The Trust is performing better than the national average across the board, there is no change in practice required currently.
2020/21 BAUS National Complex Surgery Audits/ National Prostate Cancer	To continue to refine nerve sparing surgery. Participation in audit is on-going.
National Diabetes Foot Care Audit - 2019 data	Action plan aimed to tackle the following concerns will be implemented; reduce DNA rates & reduction in the length of time for referral. Increasing the amount co-working with other neighbouring hospitals will also be addressed.
BAUS Bladder Outflow Obstruction Audit (2019/2020)	Presentation and review of national data compared to local data to determine any variations in assessment and treatment whereby a local action plan will be determined.
National Diabetes in Pregnancy Audit (2019/2020)	The department will continue to conduct local audits and quality improvement projects and review the national audit data with the inhouse diabetic teams in order to continue to make improvements for our patients.
National Audit - Perinatal Mortality Review Tool (PMRT) (2019/2020)	The neonatologists and obstetricians will meet to ensure that all relevant parties are present at the reviews as highlighted as needed in the report.

Statements of Assurance

National Audit Title	Actions to be taken by RWT
National Adult Cardiac Surgery Audit 2019/20 (2021/22)	Report presented and reviewed; no formal actions are required as Trust is one of the best cardiac surgical centers in terms of the outcomes being measured.
NCA (Re-Audit) of the Medical Use of Red Cells (19/20)	Since the introduction of patient blood management strategies across the Trust there are proactive measures in place to ensure blood is transfused appropriately, e.g., challenging of requests that do not meet the national indicator codes.
2019/20 NNAP Audit	Minor non-compliance is being addressed regarding criterion relating to parents being involved with ward rounds.
National Audit: BAUS Percutaneous Nephrolithotomy (PCNL) (2017-2019)	Presentation and review of national data, no formal action plan required.
2019 BAUS National Radical Prostatectomy Outcomes Audit (2019/2020)	Presentation and review of national data, no formal action plan required.
2019 BAUS National Nephrectomy Outcomes Audit (2019/2020)	Presentation and review of national data, no formal action plan required.
MBBRACE (Maternal, Newborn and Infant Clinical Outcome Review) Audit- Perinatal Mortality Surveillance Report-UK Perinatal Deaths for Births (2019/2020)	Data was submitted onto the MBRACCE database, analysed, and reported upon nationally. Results showed that all standards were met by the Trust and therefore no formal action plan required.
National Audit: MBRRACE (Maternal, New-born and Infant Clinical Outcome Review Programme) Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births (2018/2019)	Data was submitted onto the MBRACCE database, analysed, and reported upon nationally. Results showed that all standards were met by the Trust and therefore no formal action plan required.
National Cardiac Arrhythmia/Heart Rhythm Management (HRM) - (2017/18 data) 2021/22	Have monitored compliance against National Standards and given access to national recommendations to further improve service given to patients
National Audit: MBRRACE (Maternal, Newborn and Infant Clinical Outcome Review Programme) Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births (2017/2018)	Presentation and review of national data, no formal action plan required.

Participation in clinical research

The total number of patients receiving relevant health services provided or subcontracted by The Royal Wolverhampton NHS Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee is 3271, across 82 different studies.

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

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

As part of the national response to the coronavirus outbreak, the Trust has continued to deliver research designated by the National Institute of Health Research as Urgent Public Health Research (NIHR UPHR). 1356 patients participated in six research projects during the past year which investigated the management and treatment of COVID-19.

In addition, research within other high priority clinical specialties has continued to grow during the year with the R&D Directorate team re-opening studies paused during the pandemic and opening 64 new studies as we work on our recovery, resilience, and growth programme.

Use of the CQUIN payment framework

All CQUINs were suspended in 2021/22 due to the COVID-19 pandemic. National guidance stated that the operation of CQUIN targets would remain suspended for all providers until 31 March 2022 and trusts were therefore not required to gather or submit performance data.

Statements from the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against The Royal Wolverhampton NHS Trust during 2021/22.

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

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

The Royal Wolverhampton NHS Trust submitted records during 2021-22, up to month 11 April 2021 – February 2022 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 99.9% for outpatient care and
- 98.8% for accident and emergency care.

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

- 99.9% for admitted patient care;
- 99.8% for outpatient care; and
- 100% for accident and emergency care.

The Trust continually monitors data quality via an internal Data Quality Dashboard and a reporting suite identifying any areas that may require further focus, externally via Secondary Uses Service (SUS) reporting and University Hospitals Birmingham Hospital Evaluation Data tool (HED).

- The corporate Data Quality team continued to provide assurance throughout the last year to support the improvement of Data Quality and the provision of excellent services to patients and other customers.
- The DQ team continued to support The Royal Wolverhampton Trust staff, answering, and resolving thousands of queries and helping to support teams undertaking unfamiliar roles in the Trust's response to the COVID-19 pandemic.
- Support for IT projects was also 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.
- Create 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.

NHS Number and General Medical Practice Code Validity

Clinical Coding Error Rate

The Royal Wolverhampton NHS Trust was not subject to the Payment by Results clinical coding audit during 2021-22 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 2021/22, achieving an overall 'mandatory' rating in all areas of the audit. The internal Staff Audit Programme continues for all coding staff and has been updated for 2022/23. The Trust has a robust two year training programme for trainee coders and existing staff undertake coding training workshops yearly. In addition, all mandatory national training is completed yearly, ensuring all coders are compliant with training requirements.

Key Achievements in 2021/22:

- Increase our capacity for audit within the department (+1 WTE) - We have successfully recruited a Trainee auditor which has expanded our audit capacity. During 2021/22 coder-based audits have increased by 50% thus further improving quality from the previous year.
- Increased number of coders with accredited status within the department.
- Continued engagement with consultants and clinical teams.
- Improved depth of coding.

Data security and protection toolkit

Data and Security Protection Toolkit (DSPT) submissions provide assurance that the Trust complies with national data protection standards to keep personal information about our patients and staff safe.

The assessment for 2020/21 was published and achieved a "Standards Met" grading.

The submission for 2021/22 is due at the end of June 2022.

Seven Day Services

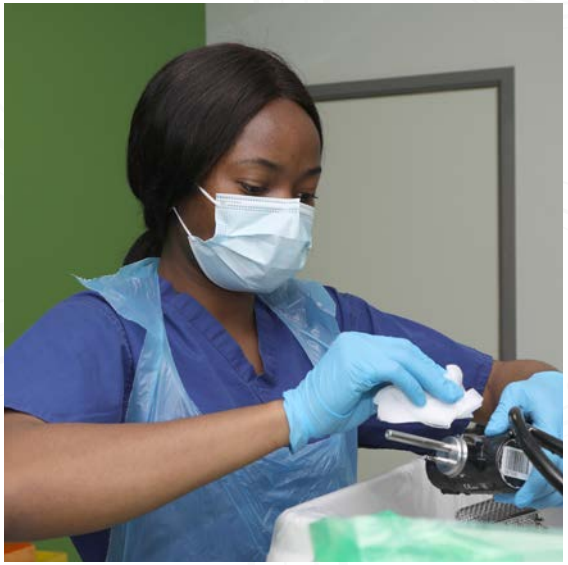
The Trust is currently compliant with all four priority standards:

- Clinical Standard 2 – All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
- Clinical Standard 5 – The availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales which is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.
- Clinical Standard 6 – Timely 24-hour access seven days a week to nine consultant-directed interventions.
- Clinical Standard 8 – Ongoing consultant-directed reviews received by patients admitted in an emergency once they have had an initial consultant assessment.

Following the review there have been some actions identified such as improvement of documentation and job planning.

The Trust has adopted the NHS England and Improvements Board Assurance Framework for Seven Day Hospital Services including submission of a report on progress and action to the Trust Board.

Areas of focus for 2022/23 include the implementation of an electronic handover system.



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

The Summary Hospital-Level Mortality Indicator (SHMI) is the most used indicator to compare the number of deaths in the Trust with the number expected based on average England figures, taking 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.

Where it is suspected that a death could have been prevented, an investigation is conducted via root cause analysis to understand the reasons and draw up robust action plans.

Indicator	September 2020 to August 2021	October 2020 to September 2021	November 2020 to October 2021
SHMI RWT	1.006	0.994	0.993
SHMI England	1	1	1

The SHMI has reduced compared to 2020/21. The Trust has been categorised as being within the "as expected" range for the past year. The improvement in SHMI is because of both an increase in expected deaths and a decrease in the observed deaths.

The Trust continues to have reporting and investigation mechanisms for the SHMI, overseen by the Mortality Review Group (MRG). All diagnosis groups with a higher-than-expected SHMI are investigated via a case note review with results reported at the MRG and action plans developed.

Despite the SHMI improving, the Trust continues with a key programme of work designed to scrutinise clinical care, provide assurance that gaps in care are identified and acted upon, gaps in quality of documentation are identified and corrected and systems of care provision are developed to the benefit of individual patients and the wider population.

This programme of work has developed over the last 12 months and included the following:

- Scrutiny and review of deaths in hospital via the medical examiner and mortality reviewer processes.
- Focus on specific diagnostic groups including assurance of clinical pathways and developments of resultant action plans.

- Improving the quality of coding and documentation.
- Learning from deaths, including listening to the bereaved families and carers, and involving them in key processes.
- Provision of end-of-life care in patients' homes and care homes with an emphasis on admission avoidance where appropriate.
- Independent External Reviews/Audit and development of resultant action plans.
- A programme of continuous quality improvement.
- The medical examiner and mortality reviewer process is now being rolled out to the RWT Primary Care Network.
- Following national guidance, the medical examiner service is currently in the process of rolling out the medical examiner service to scrutinise all Wolverhampton deaths.

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

Core Quality Indicators – Summary of patient death with palliative care

The data made available to the Trust by the information centre about the percentage of patient deaths with palliative care coding at either diagnosis or specialty level for the Trust for the reporting period:

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

Percentage of deaths with palliative care coding	August 2021	September 2021	October 2021
RWT	39	39	39
England Average	39	39	39

Data Source – https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2022-03

The Trust has an established medical examiner and mortality reviewer service so that all deaths are scrutinised, and a significant selection undergo a structured judgement review (SJR). This means that learning from deaths is now an established part of the Trust's governance process and has provided valuable information on the care of patients who were in the last months and weeks of life. This information has contributed to improving the Trust's ability to identify key areas of focus.

The Royal Wolverhampton Trust intends to take/ have taken the following actions to improve this, and so the quality of its services in 2021/22 by:

- Expansion of Specialist Palliative Care Team is now fully established thus far, however there may be need for further expansion with recent initiation of Virtual Ward.
- Development of Virtual Ward for palliative care patients who are coded green according to Gold Standards Framework. This will facilitate earlier discharge and prevent unnecessary hospital admissions.
- Education programme developed and is available across all disciplines including RWT community. There is the potential to offer education to Walsall etc.
- PRADA – proactive risk-based assessment tool to identify patients in last year of life facilitating earlier intervention and advance care planning.
- Collaboration with RWT community and Compton Care BAME support worker.

Core Quality Indicators – Learning from Deaths

	Prescribed information	Form of statement
A	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During April 2021 and March 2022, 1895, adult patient hospital deaths were recorded at the Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 393 in the first quarter • 479 in the second quarter • 529 in the third quarter • 494 in the fourth quarter
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.	By the 31 March 2022, 640 case record reviews (SJRs) and 15 investigations (RCA) have been conducted in relation to 2169 of the deaths included in item A In 26 a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was conducted was: • [415 ME assessments + 120 SJRs + 8 RCAs] in the first quarter • [491 ME assessments + 139 SJRs + 5 RCAs] in the second quarter • [569 ME assessments + 146 SJRs + 6 RCAs] in the third quarter • [526 ME assessments + 135 SJR + 9 RCAs] in the fourth quarter Please note: 17 Structured Judgement Reviews stage 1 (SJR1) remain outstanding across Q4 2021/22 which are actively being progressed. It is also important to note that cases that have been through Medical Examiner (ME) process are included in the above figures.
C	An estimate of the number of deaths during the reporting period included in item B for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	A total of four cases [representing 0.18% of the adult patient deaths] during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • [0.44%] 2 cases for the first quarter • [0.18%] 1 case for the second quarter • [0.16%] 1 case for the third quarter • [0%] for the fourth quarter These numbers have been determined using evidence from the root cause analysis (RCA) investigations involving deaths that were subject to review under the serious incident framework. (The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated).

D	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C.	Learning from the reviews/investigations of those adult patient identified in item C are as follows: • Themes that have emerged from reviews of deaths at the Trust include. • Over-Anticoagulation Risk - Concordant Prescription of Both Low Molecular Weight Heparin (LMWH) and Direct Oral Anticoagulants (DOAC) • Adherence to the National Early Warning Score (NEWS) protocol, • Communication (both within departments / external to departments)
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 to address the above thematic issues are as follows **Anticoagulation** Action completed: • Safety working group reviewed all cases communicated a making it better alert (MIBA) about the findings. This has been circulated across the Trust. • The BNF interaction risk for both these drug groups has been updated following contact from the Trust. • Develop local protocols for anticoagulation management and include this in training packages. **Escalation and adherence to NEWS protocol:** Action completed: • Deteriorating patient sticker launched. • Acute illness management (AIM) course launched, with members of the Critical Care Outreach and Sepsis Team being part of the teaching faculty for the Trust. • Nursing staff reminded that Critical Care outreach must be informed of patients who have a NEWS above 7. • Critical Care Outreach/Sepsis Team amalgamated providing 24/7 coverage. • Deteriorating patient and sepsis eLearning modules on My Focus have been launched and are mandatory. • Continue monitoring 'observations on time' performance. • Communication (internal and external) Action completed: • Sharing of learning from SJRs via Local Governance meetings (through use of Learning from Death platform, Making it Better Alerts, Specialist Groups). • Themes and learning from SJRs shared with Patient Safety team for triangulation with other relevant data (e.g., Anti-coagulation). • Learning/themes shared with relevant specialist groups for action (e.g., deteriorating patient group/end of life steering group).

Statements of Assurance

F	An assessment of the impact of the actions described in item E which were taken by the provider during the reporting period.	A key impact of the actions has been to continue full implementation of the mortality improvement programme and the associated plan which is underpinned by the Mortality Strategy. In addition, the focus will remain on ensuring that the learning identified though the Trust's mortality review process is systematically implemented.
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.	Seven case record reviews and 10 investigations completed after 31st March 2021 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% 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.	0.04% of the patient deaths during 2020/21 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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

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 post-op score by procedure based on the EQ-5D Index.

	April 2019 - March 2020	April 2020 - March 2021	National Average 2020 - 2021
Hip Replacement Surgery	0.79	0.84	0.79
Knee Replacement Surgery	0.75	0.73	0.75

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

For hip replacement, 27 patients completed the questionnaire. 96.3% of these patients reported improvement, 3.7% unchanged and 0% worsened.

This has resulted in a score for the reporting period of 0.05 above the national average.

For knee replacement, 43 patients completed the questionnaire. 86% of these patients reported improvement, 2.3% unchanged and 11.6% worsened.

This has resulted in a score for the reporting period of 0.02 below the national average.

For both hip and knee surgery, the data demonstrated the Trust score to be broadly in line with the national average with a slight increase on the previous year's performance. However, the number of patients completing the questionnaire did decline significantly. This was due to the fact elective activity was significantly reduced in 2020-21 due to the COVID-19 pandemic

The Royal Wolverhampton Trust has taken actions to improve this, and so the quality of its services by ensuring that clinicians review the data regularly and audits are undertaken as part of the Trusts audit plan to see if further improvements can be made.

Core Quality Indicators – Re-admission Rates

Readmissions								Grand Total
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	
Aged 4-15	440	505	423	359	428	269	348	**2,772**
16yrs and over	5,966	5,443	5,165	5,677	6,018	4,051	7,967	**40,287**
Grand Total	**6,406**	**5,948**	**5,588**	**6,036**	**6,446**	**4,320**	**8,315**	**43,059**

Total Admissions								Grand Total
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	
Aged 4-15	5288	5429	5117	4,668	4,813	2,899	4,078	**32292**
16yrs and over	115288	118585	117355	117,669	120,049	90,876	136,824	**816646**
Grand Total	**120576**	**124014**	**122472**	**122,337**	**124,862**	**93,775**	**140,902**	**848938**

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

All data from PAS using the national definition of a readmission

Adult readmission rates remain largely unchanged from previous years

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

- Cross Divisional work to deliver Same Day Emergency Care within Medicine, Frailty, Gynaecology, Head and Neck and Surgery
- Further development of Virtual Wards building on the success within Covid, COPD and Asthma
- Ongoing expansion of the huddle tool to support timely discharge
- Joint work with ECIST on pathways, capacity and patient flow.

Core Quality Indicators – Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) or blood clots, are a major cause of death in the UK. Some blood clots can be prevented through an individual patient risk assessment and administration of preventative measures. The national target is that 95% of all patients over the age of 16 have a VTE risk assessment completed on admission. Our data reports all patients who recieved a VTE risk assessment within 24 hours of admission.

National data submissions to NHS digital have been paused since March 2020 due to the COVID-19 pandemic. No national data is currently availble for comparision.

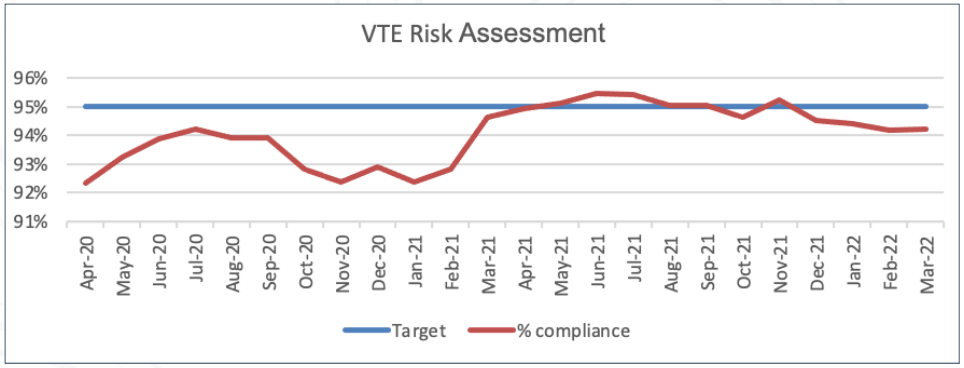
We believe our performance:

- Demonstrates that the trust has a robust and acurate process in place for collating data on venous thromboembolism risk assessments completed within 24 hours of admission
- Refects the challenges of COVID-19 .

Like may services the COVID -19 pandemic has stretched VTE resources as well as presented the clinical challenge of increased risk of VTE in patients with COVID-19. We have ensured that our VTE guidance has been frequently reviewed and updated in line with NICE guidance and emerging evidence.

Despite the challenges of the last 2 years we have continued to internally monitor our VTE risk assessment compliance and work with departments who have seen changes in activity and clinical workload. The timeliness of VTE risk assessment has been below our expected criteria and we continue to work with areas as part of wider recovery plans. We are reviewing our process for VTE related incidents and working towards thematic reviews as per the new national framework.

Patient safety and effective care remain our priority. Improving VTE risk assessment completions within 24 hours is our key target for the coming year as is ensuring patients receive care as per their VTE risk assessment. In order to achieve this we are hoping to secure additional recourses to support the work of the VTE group. We are also exploring new options for real time monitoring of VTE performance and directly linking electronic VTE risk assessment to our electronic prescribing system. This also includes the capability to identify patients who have missed doses of VTE preventative measures so prompt action can be taken.



Core Quality Indicators – Clostridium difficile

	2017-18	2018-19	2019-20	2020-21	2021-22
Trust apportioned cases (hospital and community onset cases)	47	45	43	46	57
Trust apportioned cases hospital onset only (excludes community onset cases)	35	37	33	35	44
Trust bed days (calculated using hospital onset cases and rate)	284784	289063	289728	289017	289093
Rate per 100,000 bed days (hospital onset cases only)	12.29	12.80	11.39	12.11	15.22
National average (hospital onset cases only)	15.71	14.00	15.38	14.09	17.30
Best performing Trust (hospital onset cases only)	0	0	0	0	0
Worst performing Trust (hospital onset cases only)	95.59	90.04	66.47	69.27	79.43

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

The Trust collates numbers monthly and submits to UKHSA. Figures for apportioned cases, apportioned cases (hopsital onset only), rate per 100,00 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 Royal Wolverhampton NHS Trust has implemented a C. difficile action plan, to include ongoing weekly C difficile and antimicrobial stewardship ward rounds, education of ward staff, C. difficile toolkits monthly to assess cases, thematic review of cases and the annual deep clean programme.

Core Quality Indicators – Incident Reporting

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

2020/21 (Full Year Data)			2021/22 (Full Year Data)		
Incidents	% Resulting in Death	% Resulting in severe harm	**Incidents**	**% Resulting in Death**	**% Resulting in severe harm**
9866	0.2% (15)	0.1% (11)	**12197**	**0.2% (25)**	**0.3% (33)**

Data source – Trust Data NRLS 2022

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

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

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

Core Quality Indicators – National Inpatient Survey

The 2020 Inpatient Survey was part of a national survey programme run by Care Quality Commission (CQC) to collect feedback on the experiences of inpatients using the NHS services across the country. The results contribute to the CQC's assessment of NHS performance as well as ongoing monitoring and inspections. The programme also provides valuable feedback for NHS trusts, which they can then use to improve patient experience.

The CQC National Inpatient Survey for 2020 was postponed during the peak of COVID-19 pandemic. However, during January 2021, the survey re-commenced, and patients were contacted to provide feedback, although results were not available until CQC release the official results late in 2021.

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care is 73.5% against a national score average of 74.5%. This is an improvement of 6% when compared to 2019-20.

Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month.

The Adult Inpatient 2021 benchmark reports (due in October 2022) will include an overview of the number of questions at which the trust's performance has significantly improved, significantly declined, or not significantly changed compared with the result from the previous year. These results will feature in next year's Quality Account.

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

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

Results of these surveys are received monthly and shared at directorate, divisional and Trust Board level in the form of divisional dashboards.

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

- the Trust has a process in place for collating data on the Friends and Family Test
- data is collated internally and then submitted monthly to the Department of Health & Social Care.

Data is compared to our own previous performance, as set out in the table below.

The friends and family test recommendation scores are illustrated in the tables below. These include percentage changes on 2020/21 and the 2021/22 response rates. The Trust average recommendation score for 2021/22 was 84%. When looking at the different touchpoints, there is a fluctuation of 20% with scores ranging between 96% and 68%.

Friends and Family Test	Inpatients and Day case (consolidated)				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2021/22	93%	92%	92%	91%	81%	76%	82%	70%	75%	68%	68%	72%	93%	90%	92%	91%
2021/22 Comparison against 2020/21	=	-1%	-1%	-1%	-13%	-17%	-12%	-24%	-14%	-14%	-16%	-12%	+8%	-3%	=	-1%
Response Rate 2021/22	30%	27%	28%	28%	17%	16%	15%	16%	17%	16%	16%	17%	4%	5%	7%	7%

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*
2021/22	96%	67%	81%	81%	96%	94%	93%	93%	86%	82%	85%	83%	83%	85%	86%	84%
2021/22 Comparison against 2020/21	+12%	-6%	-1%	-8%	-2%	+1%	-5%	-4%	-3%	-6%	+17%	-6%	-9%	=	+1%	-5%
Response Rate 2021/22	6%	5%	6%	5%	19%	18%	13%	17%	12%	11%	14%	11%	14%	13%	12%	11%

* Q4 data subject to change in line with March 2022 data submissions for FFT being after reporting date

The below table illustrates the percentage difference between the Trusts recommendation score for each touchpoint and the local STP and National results. The Trust scores higher for all the touchpoints for the Black Country and West Birmingham STP except for Community. Comparisons with national scores indicate that Outpatients and Birth are above national scores however all the other touchpoints are below.

	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
Trust overall	90%	94%	72%	91%	83%	97%	91%	85%
Compared to STP*	+3%	+4%	+2	-2%	+1%	+6%	+4%	+5%
Compared to National*	-4%	+3%	-5	-3%	-7%	+3%	-1%	-6%

Core Quality Indicators – Supporting our staff

The Trust is one of the largest employers in its local community, employing over 10,500 people.

The Trust has several ways of engaging with staff to improve employee engagement and to support staff to continuously strive for excellence in patient care. The efficacy of the Trust's staff engagement approach is measured principally through the annual national NHS Staff Survey and the quarterly National People Pulse Survey. The People Pulse was launched in Aril 2021; however, benchmark data has not been published to Trusts for this dataset due to the COVID-19 Pandemic.

National NHS Staff Survey

The Trust has again undertaken a full census of the national NHS Staff Survey, whereby all our staff have been invited to provide feedback on their workplace experience. The findings were grouped into nine themes, the seven themes of the People Promise together with 'Engagement' and 'Morale.' The People Promise themes are:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

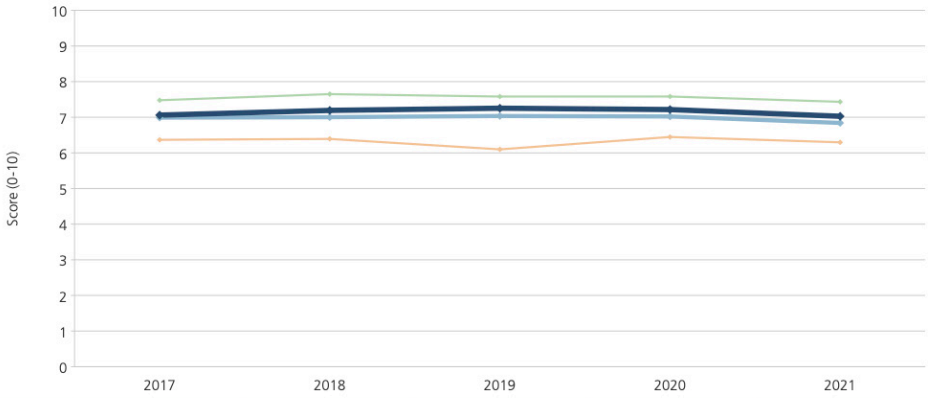
There was a 39% response rate, up 5% on the previous year. The Trust scores were better than average across all nine indicators and particularly positive in the 'We are safe and healthy,' 'We work flexibly' and 'Morale' domains. The result in relation to "We are safe and healthy' is particularly positive given the focus on health and wellbeing over the COVID-19 pandemic.

The table below shows the results for 2021 for each of the nine survey themes. Themes are on scored on a 0–10-point scale, where 10 is the best score attainable.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	6.0	6.9	6.2	5.5	6.2	6.7	7.0	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,920	3,920	3,838	3,850	3,508	3,877	3,908	3,920	3,927

Staff Engagement

The graph below provides a comparison for each year from 2017 to 2021 and Staff engagement levels within RWT have remained consistent over the last six years as well as above the average comparator group



	2017	2018	2019	2020	2021
Best	7.5	7.7	7.6	7.6	7.4
Your org	7.1	7.2	7.3	7.2	7.0
Average	7.0	7.0	7.0	7.0	6.8
Worst	6.4	6.4	6.1	6.4	6.3
Responses	3,257	3,125	3,357	3,275	3,920

The 2021 NHS staff survey included reporting experiences for the 10 themes by COVID-19 classification breakdown:

- Worked on COVID-19 specific ward or area
- Redeployed (to other areas within the Trust)
- Required to work remotely / from home

There were slightly higher levels of engagement recorded by staff 'required to work remotely', mirroring the national position. Engagement was higher than average in each of the groups listed above. The Trust's staff engagement approaches in this last year have focused on listening and learning sessions, surveys and focus groups, and engaging with our Employee Voice groups. In addition, there has been regular communication and updates provided across the organisation through daily/weekly communications bulletins, video messages and senior leadership briefings. Feedback from staff was included in designing and implementing several successful changes to many of the Trust's working practices, policies and processes.

The theme of slightly better results for those staff working remotely is mirrored across all thematic areas.

The Royal Wolverhampton NHS Trust takes the following steps to develop and oversee continuous improvements in the staff survey:

- The results are shared across the Trust through the management structure to all local areas.
- Results are discussed at monthly governance meetings.
- Themes are identified at a Trust, division and directorate level for priority action, and initial action plans developed. These action plans will be monitored through the organisational and divisional governance structures.
- Updates for assurance are provided at the Trust's People and Organisational Development Committee (PODC).

The Royal Wolverhampton Trust intends to take/ have taken the following actions to improve this, and so the quality of its services in 2022/23 by:

The key objective in this area for 2021/22 is to improve overall employee engagement. This will be measured by benchmarking ourselves against our peers with the aim to show continual improvements; in response to key questions related to staff engagement. Identified priorities for 2022/23 include:

- Compile local / divisional / corporate action plans to drive further improvements in the national staff survey results.
- Divisions utilising a range of methods to communicate with and engage and involve staff locally in implementing improvement actions.
- Engage with the Trust's Employee Voice groups in sharing and gaining feedback on survey results and plans.
- Robust systems in place to evidence actions and improvements for under-performing areas.

Supporting staff through speaking up

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).

Ahead of such legislation, NHS trusts and NHS foundation 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.

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

Identified Speaking Up Referral Form

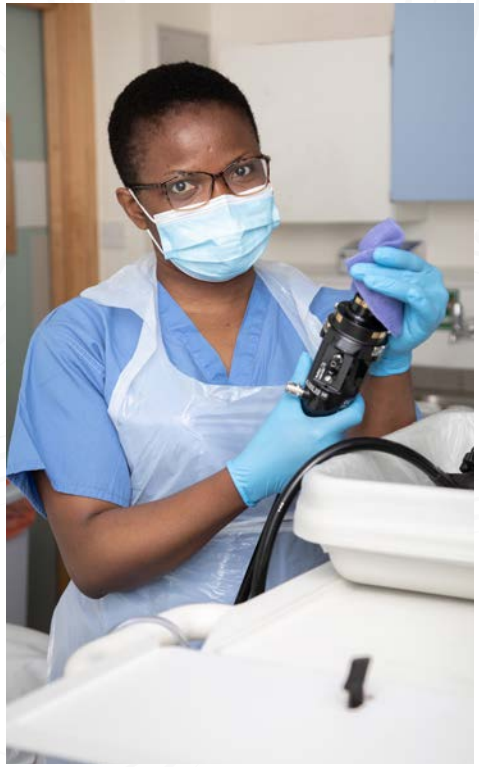
Anonymous Speaking Up Referral Form

Other enquiries are emailed to: rwh-tr.freedomtospeak@nhs.net

When staff request an appointment, they can expect to:

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

Staff are routinely sent an email following their first appointment with a summary of next steps / actions points, which includes how any issues that have been raised will be addressed. Staff are given the opportunity to feedback and have a follow-up call. Any agreed actions are monitored by the guardian and feedback is given to the staff member as and when appropriate. Within follow-up calls / discussions, the guardian will monitor the impact of raising concerns on the staff member, ensuring they do not feel at a disadvantage. If detriment is experienced, this is followed up by the guardian to explore further, and to prevent further detriment where possible.



Review of Quality Our performance in 2020/21

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 monthly.

Our performance for 2020/21 is shown below. The emergence of the COVID-19 pandemic has clearly had a significant impact on our performance. During the first and third waves of the virus, large elements of the Trusts planned programme were suspended or curtailed to care for the surge in COVID-19 patients. Even when these suspensions were not in place, the performance measures below reflect the loss in productivity from working within a COVID-19 environment.

Performance against the National Operational Standards:

Indicator	Target 2021/22	Performance 2021/22	Performance 2020/21	Performance 2019/20
Cancer two week wait from referral to first seen date	93%	81.87%	86.85%	82.11%
Cancer two week wait for breast symptomatic patients	93%	36.66%	51.42%	35.19%
Cancer 31 day wait for first treatment	96%	83.25%	86.03%	87.14%
Cancer 31 day for second or subsequent treatment - Surgery	94%	63.80%	76.02%	84.84%
Cancer 31 day for second or subsequent treatment - Anti cancer drug	98%	96.56%	97.92%	99.66%
Cancer 31 day for second or subsequent treatment - Radiotherapy	94%	84.96%	92.61%	90.87%
Cancer 62 day wait for first treatment	85%	47.36%	55.49%	58.07%
Cancer 62 day wait for treatment from consultant screening service	90%	48.66%	58.33%	60.18%
Cancer 62 day wait - Consultant upgrade (local target)	88%	67.07%	68.87%	74.49%
28 Day Fast Diagnosis	75%	71.42%		
Emergency Department - total time in ED	95%	81.55%	85.56%	85.91%
Referral to treatment - incomplete pathways	92%	68.42%	65.26%	84.31%
Cancelled operations on the day of surgery as a % of electives	<0.8%	0.43%	0.34%	0.65%
Mixed sex accommodation breaches	0	0	0	0
Diagnostic tests longer than 6 weeks	<1%	31.76%	45.27%	3.16%

NB. the cancer indicators are only provisional as we will not have the final year end data until mid-May.

Performance against other national and local requirements

There are a number of other quality indicators that the Trust uses to monitor and measure performance. Some of these are based on the National Quality Requirements and others are more locally derived and are more relevant to the city of Wolverhampton and the wider population we serve.

Like the National Standards, these metrics are also reported to the Trust Board alongside a range of other organisational efficiency metrics. This gives the Board an opportunity to have a wide-ranging overview of performance covering a number of areas.

Performance

Indicator	Target 2021/22	Performance 2021/22	Performance 2020/21	Performance 2019/20
Clostridium Difficile	48	57	46	43
MRSA	0	1	2	0
Referral to treatment - no one waiting longer than 52 weeks	0	1,697	2,404	0
Trolley waits in A&E longer than 12 hours	0	523	169	38
VTE Risk Assessment	95%	94.84%	93.57%	94.48%
Duty of Candour - failure to notify the relevant person of a suspected or actual harm	0	0	1	0
Stroke - 90% of time spent on stroke ward	80%	83.30%	91.88%	94.08%
Maternity - bookings by 12 weeks 6 days	>90%	89.60%	92.00%	90.60%
Maternity - breast feeding initiated	>64%	75.90%	71.50%	69.90%

Engagement in the developing of the quality account

Prior to the publication of the 2021/22 Quality Account, we have shared this document with the following:

- Our Trust Board, including combination of Non-Executive and Executive Directors
- City of Wolverhampton Council Health Scrutiny Panel
- Wolverhampton Clinical Commissioning Group
- Trust staff
- Healthwatch
- Council of Members

In 2022/23 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

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

NHS
Wolverhampton
Clinical Commissioning Group

Statement from Wolverhampton Clinical Commissioning Group

Black Country West Birmingham (BC&WB) Clinical Commissioning Group (CCG) statement on The Royal Wolverhampton NHS Trust (RWT) Quality Account 2021/22

BC&WB CCG welcomes the opportunity to provide this statement for The Royal Wolverhampton Trust Quality Account for 2021/2022. Like 2020/21, the Trust has experienced a challenging and pressured 2021/22, and we genuinely recognise the efforts made to maintain Quality whilst acknowledging the uncertainties and the challenges faced throughout the year. The CCG would like to thank all staff at RWT for their outstanding commitment to responding to the pandemic and restoring services to deliver different ways of working to ensure patient care is continuously delivered to a high standard. In addition, we commend the Trust for their exceptional contributions and their collaborative approach as a key system partner in our response to COVID-19.

We recognise and support the strategic collaboration between Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust, which is a positive step for system working collaboratively at scale to benefit local populations by improving efficiency, sustainability, and quality of care.

We are proud of the CCG's effective working relationship with the Trust across the quality and safety agenda, and we recognise the Trust's achievements against the quality priorities and their individual and collective engagement with the commissioners. Upon reviewing this Quality Account, we note that this Quality Account complies with national guidance and demonstrates a wide range of areas where there has been achievement and areas where improvement is required. Throughout 2021/2022, BC&WB CCG continued to hold regular Clinical Quality Review Meetings with the Trust, which were well attended and provided positive engagement for the monitoring, reviewing, and mitigating of any safety and quality issues, whilst restoration and recovery took place.

The CCG are pleased to note that clinical quality remains a priority for the Trust in 2022/23, focusing on three main areas: Patient safety, Clinical effectiveness, and patient experience. The CCG fully endorses the priorities outlined by the Trust for 2022/2023, as they are in line with the broad domains of Quality and Safety and focused on improving the patient experience by strengthening existing and future workforce arrangements.

The CCG would particularly like to note the following key achievements for 2021/2022:

- An amalgamation of Critical Care Outreach service and the Sepsis Team with a clear focus on improving the recognition and prevention of both deteriorating and sepsis patients throughout a twenty-four-hour period.
- An introduction of the maternity inequalities dashboard, which generates a substantial about of data, which has been used to plan services to reflect the needs of service users.
- Continue to build upon the successful recruitment programme into the nursing, midwifery, and health visiting posts through the award-winning Clinical Fellowship Programme and the United Kingdom and international recruitment programmes.
- Significant investments in Virtual Ward capabilities. This will help narrow the gap between demand and capacity and provide an alternative to admission and/or early discharge.
- Establishment of a Continuous Quality Improvement Team at the Trust to support a culture of Continuous Quality Improvement to improve organisational effectiveness and behaviours at the Trust.
- Trust continues to be a strong performer in relation to SHMI, and the values are continued to be reported within the `as expected' range and below the national average.
- Whilst we recognise these achievements, we would like to see the sustainable improvements in the following areas for 2022/23:
- We note the IPC performance for C.Diff cases over the annual threshold. We recognise that the Trust is currently working on a robust C.Diff action plan with continued efforts to improve clinical and IP practices. However, we would like to see a reduction in hospital-onset C.Diff infection cases for the year ahead.
- We fully endorse the trust intention to improve care for patients with deterioration and sepsis, particularly the introduction of amalgamated Critical Care and the sepsis team. However, we will continue to provide robust scrutiny and challenge in relation

to clinical outcomes for this cohort of patients during 2022/23 and will continue working with the Trust to identify opportunities for shared learning across the local and wider healthcare system.

- The Trust's intention to continue improving VTE risk assessment compliance is noted, and commissioners look forward to seeing a further improved picture of VTE compliance and the positive impact of this work over the coming year.
- CCG acknowledges the significant impact that COVID-19 has had on the Cancer Performance and RTT waiting times but are pleased to note that the Trust continues to work collaboratively with system partners to reduce the backlogs with particular attention to cancer patients. However, we continue to expect Trust to conduct harm reviews to determine if these delays have impacted clinical outcomes or have resulted in harm for these patients. In addition, we would expect that any learning identified from these harm reviews is shared across the organisation and wider system.

Throughout the COVID-19 pandemic, the Trust maintained the delivery of all emergency activity and many urgent and life-extending services. However, we recognise the long waits that routine patients may have had to endure as the system restores will have inevitably impacted the patient experience and potentially patient outcomes.

The decreased performance for many cancer targets has been a significant challenge for the Trust, acknowledging the increased volume of referrals overall and activity on some diagnostic services. The CCG is actively working with the Trust and the wider system to restore and recover services, drawing on wider system initiatives to improve overall performance.

The CCG confirms that the Annual Quality Account information is an accurate and fair reflection of the Trust's performance for 2021/2022. It is presented in the format required and contains information that accurately represents the Trust's quality profile and reflects quality activity and aspirations across the organisation for the forthcoming year. The CCG looks forward to working in partnership with the Trust to ensure the quality of services commissioned in 2022/23.

Sally Roberts

Chief Nursing Officer, Black Country and West Birmingham CCG and Black Country and West Birmingham ICS Lead Nurse

7th June 2022

CITY OF WOLVERHAMPTON COUNCIL

Statement from City of Wolverhampton Council Health Scrutiny Panel

We would like to congratulate the Trust on receiving a number of awards during 2021/22. We endorse the Trust's vision of being an NHS organisation that continually strives to improve the outcomes and experiences for the communities we serve. The overall three priorities of patient safety, workforce and patient experience are also commendable.

We are pleased to see the introduction of the maternity inequalities dashboard at the Trust. We note that the introduction of the Cancer Improvement Board has been delayed. The Health Scrutiny Panel hopes to learn more about the impact of this Board when it is fully operational and hopes to help shape its strategic direction. Clearly Cancer Services is a priority, reducing waiting times is important and the Health Scrutiny Panel will be scrutinising this during the Municipal year. We will also be requesting to look at Maternity Services and the Trust's wider Public Health work including its work on reducing inequalities throughout the City of Wolverhampton.

We would like the Trust to work on trying to achieve a better response rate to the staff survey, as we think this is a good way of helping to ensure staff health and wellbeing. Waiting times in Accident and Emergency are of obvious concern. More generally we will be asking for progress reports on the actions to be taken following the local audit reviews. We would like the Trust to work with neighbouring authorities on innovative methods in reducing delayed discharges. This will help free up beds and improve ambulance drop off waiting times at New Cross Hospital.

The Health Scrutiny Panel will be working with the Trust on its relationship in the new Integrated Care System which officially commences on 1 July 2022. We hope that a local place-based approach will flourish within the ICS system. Winter planning will be crucial this year, with an expected rise in Flu, Norovirus and spikes in Covid.

Cllr Susan Roberts MBE - Chair of Health Scrutiny Panel
Chair of Health Scrutiny Panel
City of Wolverhampton Council,
Civic Centre, St Peter's Square
Wolverhampton
WV1 1SH
28 June 2022

Statement from Healthwatch

Healthwatch Wolverhampton's Response to The Royal Wolverhampton NHS Trust's Quality Statement 2021/22

Healthwatch Wolverhampton welcomes the opportunity to comment on The Royal Wolverhampton NHS Trust's quality account for 2021/22. Healthwatch Wolverhampton exists to promote the voice of patients and the wider public with respect to health and social care services. As of April 1st, 2022, Healthwatch Wolverhampton came under a new provider and we are therefore unable to comment on the previous year's activity as it relates to work carried out under the previous Healthwatch Wolverhampton contract. However, we look forward to developing relationships with the Trust over the coming year and working with them to ensure the patient voice is heard.

It is good to see that the Trust has a clear focus on continuous quality improvement with a view to making life better for communities, service users and unpaid carers. In addition, the input of patient experience into the priorities for the coming year is welcomed and ensures that the Trust remain patient focused.

Work by the Healthwatch network has shown that people often find the complaints process stressful we are therefore pleased to see that the review of complaints processes and a better focus on analysing qualitative data will help to identify performance issues and highlight and share learning and good practice. Healthwatch Wolverhampton would be happy to support this important work stream.

Healthwatch Wolverhampton looks forward to developing robust and collaborative relationships with The Trust over the coming year and working with them to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Statement of director responsibilities in respect of the Quality Account 2021/22

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the annual reporting manual and supporting guidance Detailed requirements for quality reports.
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2021 to March 2022
    - Papers relating to quality reported to the board over the period April 2021 to March 2022
    - Feedback from commissioners dated 07/06/2022
    - Feedback from local Healthwatch organisations dated 07/06/2022
    - Feedback from overview and scrutiny committee dated 28/06/2022
    - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/06/2022
    - The 2021 national staff survey
    - Please note that the National Inpatient Survey for 2020 was postponed during the peak of COVID-19 Pandemic. January 2021 the survey re-commenced; results will become available from late 2021.
- the quality report presents a balanced picture of the trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

Professor David Loughton, CBE
Chief Executive
7 June 2022

Professor Steve Field, CBE
Chairman
7 June 2022

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement have confirmed in the Quality Accounts requirements for 2021/22 that there is no national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account.

Appendix 1 – Local Clinical Audits reviewed by the Trust in 2021/22 with actions intended to improve the quality of healthcare provided

The reports of 224 Local clinical audits were reviewed by The Royal Wolverhampton NHS Trust and of these, 171 demonstrated some areas where improvements could be made. The Royal Wolverhampton NHS Trust and intends to take the following actions to improve the quality of healthcare provided

Local Audit Title	Actions to be taken by RWT
Antibiotic Prophylaxis Audit for Patients undergoing Urological Surgery (2021/2022).	Education on current guidelines, increased use of Microguide App, encourage sole prescribing of antibiotics on EPMA & Re-audit.
Serious Untoward Incident (SUI) Actions Evidence Audit.	Reminder to departments to upload evidence of closure. Review partial compliance with directorates to identify learning. Directorates to ensure SMART actions are put in place.
Audit of Direct Referral/reassessments 2021 (21/22).	Local guidelines amended to state that the reason for not performing any part of the assessment is to be documented. Clinicians have been reminded to ensure appropriate assessment documentation in line with the BSA recommended guidance.
Audit of Calibration Compliance at Gem Centre May 2021 (21/22).	All staff have been reminded to ensure calibration sheets are appropriately filled out to reflect instances where calibration has not been performed.
An audit of proning - unproning of invasively ventilated patients in the critical care unit.	Introduction of a new proning checklist form. Teaching session for junior doctors and band six nursing staff.
Audit of Calibration Compliance at Gem Centre December 2021 (21/22).	Praise clinicians for high levels of compliance and reminders sent to staff to continue to complete calibration sheets accordingly.
High Risk Medicine Monitoring (re-audit) 2021/22.	Further improvements in data capture and process are to be implemented.
Assessing renal colic pathway in new cross hospital emergency department (2021/2022)	Update Renal Colic Proforma, add renal colic blood order set to ICE & continue education of staff.
An Audit evaluating Antibiotic prescribing practices on Care of Elderly Wards.	Antibiotic end date documentation to be discussed via e-learning, ward-based posters, and courses.
Deep Vein Thrombosis Prophylaxis from Emergency Department - Re audit (2022/2023)	To provide the fracture clinic with a risk assessment tool
Re-audit of the patient autonomy pathway - completion (Q4 21/22).	Discussed at Ward meeting and Safety Briefings & re-audit for assurance of increased compliance.
Surgical ward round documentation clinical audit (21/22).	A teaching session on correct documentation techniques. Communicate and promote the pilot of a new proforma. Also, in contact with the Documentation Committee to enquire on the feasibility of adding the ward round proforma into Trust policy.

Appendices

Local Audit Title	Actions to be taken by RWT
Adequately scanned and filled consent and WHO forms in breast interventional radiology procedures in New Cross Hospital.	Educate healthcare professionals involved in obtaining written consent and WHO forms & Educate healthcare assistants involved in scanning and attaching the written consent and WHO forms to the breast interventional radiology procedure.
Audit on the availability and usage of antimicrobial prescribing stickers for patients admitted under Oral and Maxillofacial Surgery at New Cross Hospital (21/22).	Audit's findings will be disseminated on ward round and at the Head and Neck Governance meeting. Actions will be put in place to ensure a supply of antimicrobial prescribing stickers are more accessibility and to increase awareness of the location of these stickers. Audit's findings on ward round and at the Head and Neck Governance meeting 18th February 2022.
'Appropriateness of usage of computed tomography pulmonary angiography (CTPA) investigation of suspected pulmonary embolism.	Ensuring the criteria are in keeping with a likely PE prior to vetting scans to reduce the number of inappropriate scans. This will be presented at the local governance meeting and re-audited in the coming months.
Improving the Weekend Handover: A Multi-Cycle QIP.	Shared drive access to ensure ease of access to the handover document to all juniors in the department and handover sheet to be updated by Juniors on Friday evening.
Is there a Role of angioplasty in SFA disease? (21/22).	Repeat audit in future and include external Hospitals Data.
Non-Organic Hearing Loss Clinic Audit (21/22).	Creation of a Non-organic hearing loss clinic report template.
Audit of Completed ABRs (21/22).	Review and update local guidelines, review journal requirements and to ensure flags and parameters are added to AB for patients.
Audit of Paediatric Hearing Aid fittings and Reviews 2021 (21/22).	Remind clinicians of importance of good record keeping and documentation for patient continuity of care. Investigate possibility of a reminder in patient information page as a reminder to ask whilst checking demographics.
Audit of Medical Air Outlets.	Contact manufacturer for replacement equipment.
Re-audit: Adequacy of Clinical Information on CT Head Request forms for patients with suspected Stroke.	The importance of providing full information on the request forms is being re-iterated to staff in the relevant departments.
QIP - Neurophysiology Referrals.	A new system is being designed to be able to triage patients more accurately for their tests.
A multidisciplinary audit of the orthognathic care pathway to assess effectiveness, clinical outcomes, and PROMS (21/22).	Education of team for record keeping including Re-enforcement of wisdom tooth removal date - ensure letters from GDPs scanned with date or patients to inform during assessment prior to surgery's planning.
ENT emergency/casualty clinic - departmental comparison.	Service evaluation completed; quality improvement project will be conducted if required.

Local Audit Title	Actions to be taken by RWT
An assessment of antibiotic prescribing in surgical patients that developed c. difficile (21/22).	Consider incorporating a stop date on ePMA for antibiotics. Education and reminder to clinical teams to document where patients are at high risk for C diff on admission.
Audit of EHCP Health Advice.	To produce an abridged EHCP report checklist to enable clinicians to add addendums to clinic letters or prospectively include key information in clinic letters in anticipation of EHCP.
Bone bank transportation re-audit.	A prospective audit could be considered to identify reasons for longer times.
Compliance of Antibiotic Prophylaxis in Trauma & Orthopaedics Surgery at New Cross Hospital (2021/2022).	To work with the relevant specialties to ensure appropriate prescribing and administration of antibiotic prophylaxis. Increase awareness about antibiotic prophylaxis among ward staff. Assess compliance after the implementation of interventions.
Transition from Child to Adult Health Services (NICE NG 43: Transition to adult services for CYP in special school and ADHD clinics).	To have a specific transition clinic appropriate children and young people and to develop a transition proforma.
Assessment of commutativity of parathyroid hormone (PTH) and adjusted calcium measured on Abbott, Roche, and Siemens assays in the diagnosis of normocalcaemic hyperparathyroidism (NCPHPT).	In view of audit findings and based on published PTH reference range studies, PTH reference range in the New Cross Hospital Laboratory (Abbott) has been updated to 2.7 to 11.1 pmol/L. Abbott has addressed negative bias observed in the calcium assay.
Cerebral Palsy Integrated Pathway (CPIP) Audit.	To design a CP proforma & ensure that a Tone Management/ Orthopaedic Clinic Review is undertaken within 3 months of CPIP assessment.
Duty of Candour Trust Wide Audit July 2021 (data from July- Dec 2020)..	All areas of non-compliance with policy, regulations or procedure will be discussed with the Directorates. Consider including in next audit further elements of assessment of guidance.
Antibiotic prescription in pneumonia patients.	Actions for Junior doctor/Registrar/Consultant; Documentation of CURB65 score on admission, Antibiotic champion to be allocated among the junior doctors weekly by the consultant, Posters with antibiotic guidance and review reminders to be posted at important points.
Audit of the Management of Sexual Assault Complainants at Wolverhampton Sexual Health Service.	Staff educated on the guidelines; review sexual assault proforma and template; a sexual assault local policy to be created, taking into consideration findings of the audit, and reducing visits to improve overall uptake; text message reminders for the window period for bloods and for vaccinations put in place.
Progression of PFT Clients 12 months after being transferred to the generic health visiting service.	Repeat audit looking at the progression of PFT clients 12 months after transfer to the generic health visiting service.
Baseline assessment tool for anaphylaxis: assessment and referral after emergency treatment (NICE CG134).	To educate and raise awareness of NICE recommendations; improve documentation quality and information discussed with the patient and family; provision of information leaflet on patient support groups as part of the discharge criteria.

Appendices

Local Audit Title	Actions to be taken by RWT
Indications for plain abdominal films from the Emergency Department.	Education via posters and informal educational sessions. Consult with Radiology with a view to include a drop-down list for indications when completing refers and for them to provide feedback on requests when inappropriate.
Audit into ureteric stone referrals at New Cross Hospital.	All the referrals from A+E should be seen, and a decision made, use of the ESWL slots. Consider a pan-network list & Patient choice ESWL v URS.
Evaluation of the use of Local Safety Standards for Invasive Procedures (LocSIPPs) for dental extractions over a 2-cycle audit in both the community dental setting (CDS) and hospital dental setting.	Staff training sessions on the use of SOE LocSIPPs-Dental Extractions template.
Assessment of Management of Epistaxis at New Cross Hospital (21/22).	Developing an acute epistaxis management protocol.
Re-Audit- QIP- Is there a role of Ciproflaxacin at the time of TWOC post-surgery? (2021/2022).	Discontinue routine administration of Ciprofloxacin to all patients at the time of TWOC following surgery. Document in post-operative plan whether Ciprofloxacin should be given at time of TWOC. Continue to safety net patients at the time of TWOC & to provide open access to SEU/ attend ED if unwell. Discuss who will decide whether patients will receive ciprofloxacin at TWOC following a non-urological procedure. Repeat audit if required.
Comparison of the Ultrasound and MRI of shoulder for rotator cuff tear - Audit and Quality improvement project.	Primary care clinicians to follow the appropriate pathways to assess and refer patients with shoulder pain and/or suspected rotator cuff tear. Feedback findings to the Integrated Care System.
Is there a role of Ciproflaxacin at the time of TWOC post-surgery? (2021/2022).	Consider discontinuation of routine administration of Ciprofloxacin. Repeat audit.
Vitamin D Assessment in Elderly Neck of Femur Fracture Patients.	Continue use of interventions placed on ICE pathology requesting system and introduce the importance of assessing vitamin D3 and prescribing appropriately in junior doctor induction.
Efficacy of WHO Surgical Safety Checklist for Cataract Surgery 2021/22.	Check mandatory compliance to WHO check, identify, and address any error during pre-operative round, identify patients awaiting cataract surgery with biometry error and republish the biometry, practice writing down on the biometry sheet all requirements, re-audit in 12 months.
NatSSIPs/LocSSIPs Safety clinical Audit/QIP for coronary angiogram and PCI 2021/22.	Following the audit report a review will now be undertaken to understand the reason for partial compliance.
Re-Audit of suspected TIA diagnosis and management In the Eye Referral Unit 2021.	TIA poster already placed in clinic rooms in ERU after first round of audit. To reinforce the message that 100% of patients seen with a diagnosis of TIA need to be started on 300mg aspirin and 100% patients with a diagnosis of TIA should be referred to TIA clinic.

Local Audit Title	Actions to be taken by RWT
Movement in and out of area audit (reaudit) (July 2021).	Team leaders to continue to communicate in team meetings the importance of contact being made with families new to area within five working days and the importance of contact being made with the forwarding trust for all children who have moved into area and are receiving universal plus or universal partnership plus services.
X-ray Audit (Part 2 - closing the loop) 2021/22.	Discuss with the team conducting the ongoing ward round proforma and implement the XR documentation within this proforma.
Analgesia prescribing in patients with cognitive impairment (21/22).	Introduce the use of this modified Abbey Pain Scale tool for patients with cognitive impairment. Information to be added in the Ward Round proforma.
SUI Action Evidence Audit - January to June 2021.	Governance to review internal processes to ensure sufficient evidence is received before an action is closed. Reminder to directorates that when they complete actions, they must upload evidence to support closure onto Datix. Directorates to review the reason for Partial assurance, to identify learning and to ensure actions are SMART.
Ockendon Report Audit: Audit of Women's Choices in Their Care and Respecting Their Decisions (2021/22).	To brief the Community Midwives on the importance of providing support or scheduling appointments.
NUTRITION AUDIT – Ward A21 and Paediatric Assessment Unit.	Directorate to raise a risk about areas of non-compliance if continuing issues are found. Bimonthly updates provide assurance/update back to Division. E-mail to be sent to all staff indicating expectations to comply with policy. Teaching sessions to all nursing staff to be undertaken with agreed outcomes. Practice to be observed and re-audited monthly and additionally spot check by Matron and all sisters. Poster to be placed in PAU/Ward areas to raise staff awareness of the need for compliance to policy. Review non-compliance and address with individual members of staff.
Sugammadex and contraception 2021/22.	Increase awareness of the drug's side effects and ensure patients fully understand the potential implications of the drug.
VTE Reaudit (2021/22).	To present and discuss findings and reiterate the importance of documentation to relevant staff.
X-ray Audit (2021/22).	To implement a standardised X-ray review form to improve consistency.
Pre-operative fasting times for elective surgical patients 2021/22.	More emphasis to the patients- verbal and written to adhere to the 6 and 2 rule of fasting. Theatre team to communicate the Post Briefing Agreed List Order to the ward. Anaesthetist should ensure that the patients and ward staff have clear fluid instructions once PBALO is confirmed. Posters in the admission lounge encouraging patients to keep hydrated.

Appendices

Local Audit Title	Actions to be taken by RWT
Movement in and out of area audit (reaudit) (2021/22).	Communication to practitioners to improve awareness of the importance of making contact within five working days and contacting the forwarding trust. Furthermore, completion of a records audit by the 0-19 service.
Cancer Pathway SOP: To audit the effectiveness of SOP (LocSSIPs).	To develop see and treat to avoid breach.
Re-Audit Written Consent Audit (21/22).	To re-audit 22/23.
NICE CG124: Audit of time to theatre for fractured neck of femur patients in March/April 2021 (2020/21).	Use of a trauma list template is advised. Breach time should be recorded for every case. On call teams should try to optimise patients early on to avoid delay. Ensure necessary imaging is requested and done on an urgent basis – speak to on call Radiologist if needed. Clear documentation of reasons behind delays or cancellation in notes.
Taking blood cultures in patients with who have temperature spikes following elective orthopaedic surgery (2021/2022).	Actions were implemented throughout the three cycles including meeting with staff to stress the importance of following the guidelines. The poster produced was tweaked so it was clearer and simpler to follow. The Directorate will re-audit again once recommendations are embedded.
Improving service delivery in Stroke – Improving access to urgent in-patient Carotid Doppler for patients admitted to Stroke Unit, New Cross Hospital (21/22).	Streamline pathway for in-patient carotid Doppler for in-patient strokes/TIAs with dedicated scanning slots. Select appropriate patients during ward round in liaison with therapy team to facilitate appropriate utilisation of available resources. Re-audit in 2 years to assess improvement.
Local Audit of Overnight Red Cell Transfusion.	Continue monitoring and reiterated through training. Audit findings shared with HTG members to take back to local governance for sharing.
NICE Psoriatic Arthritis Biologics.	To continue to ensure timely assessment of the patients who have recently started high-cost drugs. As the department has performed well, to encourage it to maintain these results.
Mycophenolate counselling - contraceptive advice/pregnancy test and documentation (QIP). (21/22).	Findings will be discussed in the governance meeting and will encourage the medical and nursing staff to follow correct recording procedures regarding documentation.
Audit of Neurorehabilitation Unit (NRU) Inpatient Referrals (21/22).	The Referral form should be made available on the Trust's intranet page, it should be electronic with mandatory fields and should ask for the Referring clinician's email address. The process for managing the referrals is to be communicated and agreed upon by the directorate.

Local Audit Title	Actions to be taken by RWT
2021/22: Local and National Safety Standards for Invasive Procedures (LocSSIPs). - Fetal Blood Sampling Water birth. - Normal Vaginal Births. - Forceps delivery. - Ventouse. - Caesarean Sections.	Staff member involved contacted. The sterile instrumental and suture packs have been reconfigured to remove the tampon from the pack. The Delivery Suite team/Intrapartum manager has produced a Standard Operating Procedure (SOP). A copy has been added to the documents page of this database file.
Smoking Cessation - Saving Babies Lives (SBL) (2021/22).	Ensure the clinics have adequate equipment. Correspondence to be sent to the relevant team expressing the importance of the 36-week CO monitoring.
Ockendon Report Audit: Intrapartum Risk Assessment (2021/2022).	Education of all staff on delivery suite about the importance of intrapartum risk assessment and keeping these updated as further risks become apparent ensuring continuous intrapartum RA is being done. Highlight need for risk assessment during mandatory EFM training. Re-audit in 3 months to see if there is any improvement.
Oxytocin use for Induction and Augmentation of Labour in Multiparous Women (2021/2022).	Correct process to be reiterated to staff, a new proforma to be introduced and a re-audit to assess any increase in compliance.
Ockendon Report Audit: Named Consultant for High-Risk Pregnancy and Labour (2021/22).	To share the results of the audit with the Delivery Suite (midwives) to improve compliance. Digital midwife may be able to help review the second stage CS to ensure adequate documentation.
Med-Track: accuracy of data collection 2021/22.	To consider a business case to implement CIS as recommended by the GPICS V2. The CIS should be able to collect and share electronically Critical Care Minimum Data Sets (CCMDS).
Emergency Caesarean Section Audit, including Caesarean Section in Second Stage of Labour Audit (2021/22).	Impacted fetal head training to be enhanced.
Audit of compliance with NG010 Violence and aggression: short-term management in mental health, health, and community settings.	Matron and Lead Nurse for Mental Health to create action plan to be monitored via Governance Meeting.
Re-audit of the patient autonomy pathway completion (21/22).	Reminder to staff to ensure patient autonomy document is uploaded to clinical web portal. Reminder to staff to ensure completion of demographics and to sign, stamp, designation, and date the patient autonomy document. Changes to be made to next audit to reflect the amendments required due to a change in local processes.
Deteriorating Patient Escalation audit (21/22).	Re-audit to be undertaken. Education, training, and interpretation of the NEWS2 score to be conducted.
Re-audit of Antimicrobial Prescribing by Non-Medical Prescribers (21/22).	Share the Audit and remind all staff to complete anti-microbial forms & re-audit.

Appendices

Local Audit Title	Actions to be taken by RWT
An audit assessing the clinical need for recording observations overnight for stable patients in an elderly care ward (21/22).	Box added to consultant ward sheet to be completed during ward round which will identify patients who do not need overnight observation
(Orthotics) use of pressure integrity Tool for in-patients (21-22).	Another audit will be conducted to review the number of skin integrity tools completed in the next 6-month period to re-assess compliance.
(Nutrition & Dietetics) Completeness of HETF database (21-22).	Update any missing data, identify any missed patients, and follow up with full nutritional reviews and record number of patients not triggered despite data being completed
Perioperative Use of Dmards and Biologic 'Drugs for Elective Orthopaedic Surgery. (LocSSIP) (21-22).	Share outcome of the audit with orthopaedic department. Update agreed guidelines with update date evidence.
Incidental vertebral fracture identification and new reporting pathway - is it working? (21-22).	Fully implement pathway to increase the identification of the incidental osteoporotic fractures.
Identifying frailty in patients seen by the rapid intervention team 21/22.	Two teaching sessions have been held with the RITS nursing team to discuss the results of the initial audit and teach the team how to use the clinical frailty scale. Are aim following this is for the clinical frailty scale to be documented for each patient on the RITS admission avoidance document. For the last stage of the quality improvement project, we will re-audit patients and consider a pathway for referral.
Deep Vein Thrombosis Prophylaxis from Emergency Department (2021/22).	Emergency Department has now started DVT prophylaxis assessment for patients having lower limb plaster slabs.
Is routine pre-operative G&S sampling necessary for elective laparoscopic cholecystectomy.	Stop routine G&S for elective LC patients.
Secondary Post-partum Haemorrhage/Retained Placental Tissue (Post-partum EVAC and Histology).	More specific mentioning of either presence or absence of chorionic tissue from histology department. To train more registrars to do manual vacuum aspiration (MVA).
Use of PPI with DAPT in patients with acute coronary syndrome (2021/22)	Further education for discharging doctors on other wards who may treat patients with ACS. Re audit 2022.
Audit of E-Discharge (SUI action from 240118) (21/22).	Wound care training for nurses. Medical Team to have training from Tissue Viability. Explore the feasibility of mandating wound care documentation on e-discharge and adding to discharge policy.
Glaucoma virtual clinics during covid-19 2021/22.	Recommendations from QIP included: Include disc photographs as part of the work up +/- OCT or fields, more clinics in the community, consider discharging the stable glaucoma's' into the community & explore ways to disentangle doctors' simultaneous presence – promote remote review of notes.

Local Audit Title	Actions to be taken by RWT
Audit of compliance with surgeon operated mini c-arm standards (2021/22).	Senior Consultant has informed all registrars and consultants to give filled forms to Matron and a future re-audit will be arranged with a current SHO to assess any change in compliance.
QIPof pre-operative ultrasound scan findings for shoulder rotator cuff tears (2021/2022).	Awareness to colleagues that Ultrasound scan is a cost effective and fast method of diagnosing rotator cuff pathology. Should be considered as first line for rotator cuff pathology.
Reducing inpatient fall among patients aged 65 and above.	Management Team utilising bank staff where appropriate to cover staff shortages. Also, staff on ward encouraged to sit in tag bays that are not nurses or Drs. On admission, identify aids patient used at home and ensure relatives bring those aids to the ward. Ensure ward is clutter free, medical devices that are not in use e.g., ECG machines, weighing chairs are removed from the bay.
Term NNU Admissions Audit (2021/22).	The Pyrexia guideline will be updated to remove paracetamol as first line management and CTG traces will be discussed in the webinar teaching.
Insulin prescriptions in diabetic mums with steroids (2021/2022).	The issues that were identified were problems with prescriptions, cannulation delays and handover issues. The proposed solutions are: Updated steroid proforma to be completed, aide memoire developed, ANC checklist to ensure both proforma and drug chart filled in prior to admission, Cannulation training for staff, clear management plan to be documented on Badgernet & Junior doctor teacher sessions.
Local Safety Standards for Invasive Procedures (LocSSIP) Nail Surgery Annual Audit 2020-21.	Continued monitoring and discussion and sharing of the outcomes with the team.
Effective use of Brain MRI in Transient ischemic attack (TIA) and acute non-disabling stroke (21/22).	Consideration of a daily slot to the stroke unit for brain MRI request.
Audit of Documentation in Medical Records (2021/2022).	Staff to be reminded of importance of completing the consent form in full. NOF red booklet to be altered to make it easier to include necessary information. Reaudit in 6 months to see if any improvements have been made.
Efficient prescribing of Insulin and warfarin.	Proposed 3rd Cycle with show emphasis on training new Jnr Doctors on local Induction to further improve result.
Safe Handovers in emergency admissions - A snapshot audit.	Update/standardise handover sheet, ensure formal update of nurse-in-charge at the end of the WR, include Resus and Covid status as well as frequency of obs per patient, consider using a Resus and Covid status sign & use minimum information on the patient boards.
CPAP compliance study: Pre-COVID vs. COVID pandemic period.	Continue with current hybrid clinic model of telephone and face-to-face, consider video consultation, set up 30 days follow up clinic post initiation of CPAP, selection of appropriate patients, continued utilisation of sleep MDT and virtual/CAS clinic to discharge patients without seeing them if they have normal sleep studies or mild (to moderate OSA) but no syndrome.

Appendices

Local Audit Title	Actions to be taken by RWT
CPAP management of COVID-19. Service evaluation audit.	Business plan in progress to adapt the ward for enhanced ventilation and to incorporate critical care spec bed spaces. Increase nursing numbers and ACPs to provide experienced support 24/7.
Compliance Against CP11 and the Mental Capacity Act 2005 when completing DNACPR (Reaudit) (2021/22).	Trust wide RESPECT audit will be commenced which will audit the DNACPR forms.
Mental Capacity Act (2005) Compliance (reaudit 21/22).	To pilot a virtual safeguarding drop-in clinic. To review current MCA/DoLS E-learning package to ensure that it is fit for purpose. To improve the quality of Mental Capacity Assessments and Deprivation of Liberty Safeguard applications. Local MCA / DoLS champions in each clinical area.
Assessing attitudes to - and educating staff about - environmentally friendly anaesthesia (2021/22) Part 1.	This audit has reminded the anaesthetic department of the environmental impact of their anaesthetic techniques. This will be re-audited to assess the impact of the presentation.
Impact of Covid Lockdown on Patient fitness for surgery 2021/22.	Translating the results (that some patients have frailty pre-op) into improved outcomes from prehab is the next step from this audit.
Assessing small bowel distension in MRI enterography.	Compare New Cross's MRI small bowel prep protocol with large GI centres nationally and implement any necessary improvements.
Assessment of the Mental Health and Quality of Life of patients with hyperthyroidism attending the Endocrine Clinic at WDEC.	To consult with psychiatry and set up the required service.
Audit of lower limb open fracture management against the British Orthopaedic Association Standards for Trauma (BOAST) guidance on open fracture management (2021/22).	To discuss with Clinical Illustration and IT to see if issues can be resolved.
Adherence to British Thoracic Society Guidance on follow up of Patients with a Clinic-radiological Diagnosis of COVID-19 pneumonia.	Look at the adherence with the guidance in non-respiratory areas, present audit to the trust board meeting & share the results with the ITU. Consider developing COVID specific clinics which could be Nurse based & Long COVID clinic, and a separate referral pathway developed in line with the national recommendations.
Robot-Assisted Radical Cystectomy: A Complete Audit Cycle of Our First 120 Cases.	Patient will be discussed at MDT and offered neobladder formation where appropriate & ongoing review of results with regular analysis and re-audit after next 100 cases.
Covid 19: Are we following the Trust guidelines?	Improve Oxygen prescription Prompts for Oxygen prescription in ePMA, oxygen champions in the ward, Oxygen prescription QIP & additional Oxygen assessment statement in the consultant ward round sheet.
Lower Gastrointestinal Bleeds - An Audit on the safe discharge of patients from the Emergency Department.	Incorporate this early assessment tool/score into a departmental guideline.

Local Audit Title	Actions to be taken by RWT
Audit of the Management of suspected C spine injury in the Emergency Department.	Radiology have circulated shared learning IRMER guidelines for appropriate requesting of scans to all Depts.
NICE Guidance - TA587 Lenalidomide plus dexamethasone for previously untreated multiple myeloma.	Discussion in consultants meeting to start using proformas again & email to all consultants.
QIP on improving VTE risk assessments in patients admitted on cardiology ward, New Cross Hospital.	Introduction of VTE cues onto ward to remind clerking doctors to complete VTE risk assessments - posters and VTE 'stamp.' Incorporate number of outstanding VTE risk assessments into morning board round. Appoint daily 'VTE marshal' to monitor outstanding VTE risk assessments and advise relevant doctors/ ANPs to complete assessments for their patients. 'VTE marshal' SOP developed and distributed.
Review of the outcomes for patients with fast-track referrals for possible penile cancer (2021/22).	Communication to GPs on audit findings, recommendations to include full history taking and examination and changes to referral form.
Cataract Telephone Post-Op Clinic Audit 2021/22.	Consider post-op clinics to move to community optometrists and/or continue to do telephone cataract post-op clinics, re-audit will be completed.
Adult and paediatric post-tonsillectomy pain and readmissions (21/22).	Consensus within ENT department regarding all audit recommendations. Discussion with anaesthetics/pharmacy for a standardised post-op pain protocol and discharge analgesia pack &trial of new intraoperative techniques locally.
Audit of the consent process for BAHA procedures to ascertain whether the manufacturer is named (21/22).	Pre-printed BAHA-specific consent forms to be created.
Audit of CP50- Results filing in rheumatology (based on the local SOP in this area; SOP 2. Rheumatology CP50 Compliance and ICE Results Review Policy).	All clinicians are being encouraged to file results on the system in a timely manner.
Multiple Sclerosis (MS) - Acute Inpatient Physiotherapy Provision.	To consider ways to improve the referral process of MS patients to the Neurological Physiotherapy team. Education to Acute therapy team & nursing ward staff. Improve direct links with Neurologists/MS nurse. Improve use of standardised outcome measures Use of PFMP consistently. Re-audit in the future.
Audit on Work Up for Profound Hyponatraemia in Acute Medical Unit.	Update guidelines & consider sending out making it better alert e mail.
Adequacy of Clinical Information on CT Head Request forms for patients with suspected Stroke.	Audit results to be disseminated to team members involved in imaging referral and vetting. Re-audit later (3-6 months) after changes are expected to have been implemented.
Staff compliance of using the modified Nottingham Sensory Assessment Tool in patients that have sensory deficits following an acute stroke.	To modify the stroke ICP document to include a space to document whether the patient requires a mNSA. Stroke Physiotherapy and Occupational Therapy team to be educated on this.

Appendices

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Service level audit (Blood podding) – A relook and review (2021/22).	To maintain the current practice and reaudit in four months' time.
NICE NG 118: COVID Stones: An observational multi-centre cohort study investigating the clinical management and outcomes of ureteric stones during the COVID-19 pandemic in the United Kingdom (2020/21).	To increase the capacity of ESWL.
HTM01-05 - Infection Prevention (20/21).	Refurbishment. Managed via the risk register.
An audit of time to CEPOD theatre OMFS trauma patients, including mandible fractures (carried forward from 20/21).	Utilisation of the dedicated maxillofacial trauma list.
Are GP Referrals to the Emergency Department Appropriate? (20/21).	To be presented to ED Management Team.
Audit into Neurophysiological referrals (20/21) and 21/22.	New e-referral system and the new system will be on the clinical web portal.
A retrospective audit into time of waits for pts to start first line DMT (20/21) and 21/22.	New pathway guidance, database needs to be completed accurately & will reaudit in 2 years post pandemic to see if figures have improved.
Prospective audit into compliance of Cancer waits in neurology (20/21) and 21/22.	More rigorous triaging of the referrals.
Hypothyroidism during pregnancy QIP (2020/21).	A patient information leaflet has been developed to give clearer instructions to the patient, awareness has been given to the community midwives regarding vANC and the findings of this audit will also benefit the Endocrinology team.
QIP (2020/21) Preterm Birth Clinic Performance: – Did we prevent preterm birth in those who had cerclage/progesterone group/ in the group where intervention was not needed?	The directorate to aim for steroid administration <7 days of delivery.
QIP: Management of Bartholin's Cysts - introducing word catheters Audit (2021/22).	Training sessions will be arranged for staff, to improve documentation a standard operation notes form will be developed for the procedure.
Gynaecology Operation Notes Audit/Review (QIP) 2020/2021.	Communication to staff to ensure- better legibility, more use of coloured paper / red ink, signatures, better compliance with the stamp filling until we move to electronic records.
PD (20/21)21/22.	Continue to monitor performance annually.
MacMillan Consultant Radiographer Service - Palliative treatments.	Compliance with the recommendations has improved over the last 2 years, a further re-audit in future to be considered.

Local Audit Title	Actions to be taken by RWT
Are we managing joint aspiration samples correctly? (2020/21).	Ensure these results and teaching goes out to all departments in New Cross Hospital rather than just the Orthopaedic department.
Laparoscopy in Endometrial Cancer Audit (re-audit) 2020/21.	Completion of further cycles of audits will help us monitor the department's performance in terms of mode of surgery, complication rates, lynch syndrome screening, and the 62-day-target achievement rates.
An audit looking at the reasons for in-patient CT and MRI scan rejections (20/21).	Recommendations are to be conveyed to referring Directorates to improve compliance.
(Speech & Language) Special Schools and Community dysphagia audit.	Further training for staff working on acute wards.
(Physio & OT) Patient information leaflet re-audit – Hands Team (20/21).	Review usual order quantities & aim for improved consistency across sites .
(Physio & OT) Patient information leaflet audit – Children's Therapies (20/21).	Revisit suite of leaflets and identify those which can be archived & compile a list of all currently used publications. Ensure staff are aware of Trust policy and process.
(Physio & OT) MSCC – compliance with NICE guidance (20/21).	Occupational therapy referral to be included in local policy.
Zoledronate for osteoporosis - Timing of the 2nd Zoledronate infusion in patient who had initial infusion outside rheumatology department but within the trust (20/21).	Audit findings will be disseminated to care of elderly team who manages bone health of inpatients.
Consent Audit of Breast Biopsies It was agreed that in terms of the process for Radiology to follow around checking consent forms been uploaded to Soliton etc. following RCA Datix 220491 Wire insertion. (20/21).	This audit will be made available to all staff and a further reminder to state where the documentation has been viewed will be given to all reporting radiographers.
High Risk Medicines (20/21).	Change in process for consideration; transfer process to PCN pharmacy technicians to identify and book the overdue blood tests.
Re-Audit Cervical cytology (20/21).	To re-iterate to staff, the importance of labelling samples correctly.
Re-Audit Written Consent Audit (20/21).	Recommendations include compulsory photography of all sites for biopsy & monthly audit of ten patients.
Re-Audit WHO Checklist (20/21).	To ensure all paperwork is completed appropriately and checked at end of session. To Re audit.
CG 143 – A NICE-related Audit on the Management of Sickle Cell (20/21).	To increase awareness on the appropriate management of sickle cell disease.

Appendices

Local Audit Title	Actions to be taken by RWT
Prophylactic antibiotic prescription (2020/21) 2021/22 PART 1.	Improve adherence of prophylactic antibiotic prescribing for elective surgery, inform relevant specialty leads & re-audit to be undertaken.
Audit of transplant outcomes for 2019 compared to 2018.	Continue with annual review and monitor 3 to 5 yearly trends were information available.
The Management of Patients presenting to ED with Haematuria.	To alter the ED haematuria pathway so that it is more efficient, to ensure that appropriate investigations have been done.
Re-audit of the Inpatient Management of Hypoglycaemia (20/21).	To strengthen training using the e learning for management of hypoglycemia in ward areas with poor compliance.
Does the current management of pregnant patients with suspected DVT/PE at New Cross Hospital adhere to current local and national guidance?	Communication to all ED staff to remind them that there is no indication for D-dimer in pregnancy and all patients with possible PE need CXR as part of their work-up. Maternity leads to discuss with radiology regarding the difference in time to scan for their patient group.
NG25 Preterm labour and birth - updated Aug 2019 (2021/22).	To increase awareness among junior doctors and midwives about management of preterm births & to ensure clearer documentation.
NICE DG036 Therapeutic monitoring of TNF-alpha inhibitors in rheumatoid arthritis.	To present findings in the governance/departmental meeting.
Audit to see if all CT scans are reviewed in 1 hour.	Consult with Radiology to identify and address issues leading to delays. Audit to see if referrals have been made in line with guidelines. Audit results to be shared with junior doctors during training. Re-audit in future.
Audit of DVT pathway 2019/20.	Consider as a potential risk, Junior dr induction to be reviewed to increase learning, AMU to review how VTE patients are managed when transferred from ED and to re-audit.
QIP: Saving Babies Lives: Element 2 - Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR) (2019/2020).	Share presentation with Community Midwives, Matron level review of cases missed by SFH measurement & update current pregnancy risk assessment.
IPG 356 Total Laparoscopic Hysterectomy (Benign Gynaecology) (2019-2020).	Recommendations include to introduce enhanced recovery pathway, Consultant Gynecologists should be encouraged and supported to undertake minimal access hysterectomy, dedicated teams including theatre staff/anesthetists & introduction of a pre-printed consent form and patient information leaflet.
Post-operative analgesics requirement for Robotic assisted laparoscopic radical prostatectomy with fixed anaesthetic technique (RARP).	Standardise pre/post operative data collection.
QS173 - Intermediate care including reablement (21/22).	Outcome measure review required & management plan added to patient held record.

Local Audit Title	Actions to be taken by RWT
NG073 and QS 172 Endometriosis: diagnosis and management (2021/22).	To create an Endometriosis pathway/proforma and the provision of patient leaflets and signposting to support groups.
NICE NG76 Child Abuse and Neglect.	Consider the lack of framework for staff to evidence neglect as a risk which is being addressed by RWT's safeguarding team involvement in the development of the WeCan toolkit.
QS149 - Osteoporosis (20/21).	Wider team meeting has been organised to produce the most appropriate and realistic way to address areas of non-compliance.
TA228 Multiple myeloma (first line) - bortezomib and thalidomide.	Updated guidance now available to be reviewed and followed.

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:

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English

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

Punjabi

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

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Kurdish

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Quality Accounts 2021-22

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