







The Royal Wolverhampton NHS Trust

Quality Accounts 2022/23

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Why are we producing a quality account? 1

Statement on Quality from the Chief Executive 2

Achieving our Vision: Strategic objectives 4

Looking back 2022/23 – Priorities for Improvement 5

Priority One: Patient Safety 6

PS 1: COVID-19 minimising impact 6

PS 2 - Reduce harm by assessing, recognising, and responding to minimise patient deterioration 8

PS 3 - Promote equality out of outcomes by routinely reporting user outcomes (reducing health inequalities) 9

PS 4 - We will aim to improve mental health care and treatment for all ages 10

PS 5 - We aim to review our services, working with our partners to deliver a flexible service to meet the needs of mental health patients 10

PS 6 - As a registered provider of mental health, we aim to adhere to the legislation within the Mental Health Act 1983 and to ensure all patients are treated in a person-centred way 10

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 or dementia 10

PS 8 - We aim to deliver parity of esteem by having embedded mental health services and skills across the workforce 10

Priority Two: Clinical Effectiveness 12

CE1: Nursing Workforce 12

CE1: Allied health professionals 13

CE1: Medical workforce - Consultants 14

CE1: Medical workforce - Junior medical staff / fellowship 15

CE1: Medical workforce - Medical students 15

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 16

Priority Three: Patient experience 17

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 17

PE 2 - To continue to improve complaints responses to patients and ensure learning is identified and areas are provided with e-learning 18

PE 3 - To build on the success of volunteer services ... 18

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 19

Looking forward 2023/24 – Our Priorities for Improvement: How we choose our priorities 20

Priority One: Patient safety 22

Priority Two: Clinical effectiveness 23

Priority Three: Patient experience 24

Statements of assurance from the Board. Mandatory Quality Statements 25

Participation in clinical research 33

Use of the CQUIN payment framework 33

Statements from the Care Quality Commission 34

Statement on relevance of Data Quality and your actions to improve your Data Quality 34

NHS Number and General Medical Practice Code Validity 35

Data security and protection toolkit 36

Seven Day Services 37

Core Quality Indicators - Summary Hospital Level Mortality Indicator (SHMI) 39

Core Quality Indicators - Summary of patient death with palliative care 39

Core Quality Indicators - Learning from Deaths 40

Core Quality Indicators - Summary of Patient Reported Outcome Measures (PROMS) 43

Core Quality Indicators - Re-admission Rates 44

Core Quality Indicators - Venous Thromboembolism (VTE) 45

Core Quality Indicators - Clostridium difficile 46

Core Quality Indicators - Incident Reporting 47

Core Quality Indicators - National Inpatient Survey 48

Core quality Indicators - Patient Friends and Family Test (FFT) 50

Core Quality Indicators - Supporting our staff 52

Supporting staff through speaking up 54

Review of Quality - Our performance in 2021/22. Overview of the quality of care based on trust performance 55

Engagement in the developing of the quality account 58

Statement from Black Country Integrated Care Board (BCICB) 59

Statement from the City of Wolverhampton Council Health Scrutiny Panel 61

Statements of director responsibilities in respect of the Quality Account 2022/23 62

Statement of Limited Assurance from the Independent Auditors 63

Appendices 64

How to give comments 72

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:

The Communications Team
The Royal Wolverhampton NHS Trust
New Cross Hospital
Wolverhampton Road
Wolverhampton
WV10 0QP

Email:
rwh-tr.communicationsdept@nhs.net

Statement on Quality from the Chief Executive

I am delighted to present the Quality Accounts for the year 2022/23, which represent our commitment to transparency, accountability, and the delivery of exceptional healthcare services to the people and communities we serve. This document outlines the work undertaken during the past financial year to deliver on the objectives we set for ourselves last year, which support our aim to foster a culture of continuous quality improvement across our organisations.

This has been an important year for us, with the launch of our joint Trust strategy. This formalises the strategic collaboration between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust and sets out our vision for what we will achieve together. Working collaboratively with staff, partners and service users, we have agreed four overarching strategic aims, which we refer to as the "four Cs":

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

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

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

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

These four Cs are aligned to our overall vision, which is **"To deliver exceptional care together to improve the health and wellbeing of our communities"**. This year, everything we do across both organisations will contribute to achieving goals within at least one of these priority areas. You can read our strategy in full on our website.

Statement on Quality from the Chief Executive

The closer ways of working across Walsall and Wolverhampton have already delivered many benefits for our local communities – enabling us to use services more efficiently, share learning and best practice, and offer patients more choice and flexibility in how they receive care.

Our shared vision and strategy have informed the creation of our new shared Quality Framework. This plan sets out in detail, with milestones, the actions we will take over the next two years to put quality at the forefront of all we do – further developing and enhancing our workforce, their skills and knowledge, and ultimately the care that we provide. This document is also published on our website.

This year, we will celebrate and look back on 75 years of the NHS. The very fact that our two Trusts can look to the future and set ourselves such ambitious shared goals, is entirely down to the hard work of our staff. In my years as an NHS chief executive, I have witnessed many changes within our health service, but what never changes is how humbled I am by the dedication and passion displayed by all those on the front line, and all who support them behind the scenes, on a daily basis.

We saw the very best of our services during the height of the pandemic, when our resilience was tested to its foundations. But though the immediate pressures placed on us by COVID-19 may have lessened this year, a whole new set of challenges has emerged. This year has been about the need to restore services to pre-pandemic levels and renew our focus on diagnostics, timely access to treatment, and bringing down waiting lists for elective procedures.

As can be seen in this report, we have achieved a great deal. We have been able to eliminate 104-week waits, and as I write we have the next target of 78 weeks firmly in our sights. Our upward trajectory even continued during what was arguably the NHS's most challenging winter on record, with staff pulling together to not only keep urgent and emergency care services running safely, but to consistently deliver some of the fastest ambulance turnaround times in the region.

This report is not just about what we have done well though. It underlines our commitment to transparency and accountability, and the importance of learning not just from successes but from challenges too. This means that as well as charting the progress made across our three key areas of patient safety, clinical effectiveness and patient experience, we include here the steps taken to address areas for improvement from last year, and we identify where there is still work to be done.

We are clear that the pursuit of quality never stops. We remain committed to promoting continuous learning, evidence-based practice, and patient-centred care. We have comprehensive governance systems and quality assurance processes in place, as well as robust feedback and involvement mechanisms to ensure we are responding to the needs of our patients and their families, and that their voices will be at the forefront as we develop and evolve our services in future.

I extend my sincere thanks to every individual who has contributed to the delivery of safe and high-quality care across our organisation this year. You have made a real impact on the lives of so many. Together, we will continue to drive positive change and deliver better health outcomes for the people of Walsall and Wolverhampton.

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

Signed:

Professor David Loughton CBE, Chief Executive

May 2023

Vision and Values

'Our vision is:
"To deliver exceptional care together to improve the health and wellbeing of our communities". Our vision has been updated to reflect the closer working of our organisation with local partners and to focus on our core purpose of improving the health and wellbeing of our communities. A vision is more than a few words – it reflects our aspirations and helps to guide our planning, support our decision making, prioritise our resources and attract new colleagues.

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

Looking back 2022/23 Priorities for Improvement

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

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

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

Priority 1: Patient safety

Priority and why priority identified

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 a pre-pandemic position.

Reduce indirect harm caused by COVID-19 by establishing systems to identify and monitor learning from related incidents.

What we said we would do

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.

How did we do?

Looking back Infection Prevention 2022/23

This year has been extremely busy with the ongoing COVID-19 pandemic but also returning to pre-COVID business as usual. During this period the Infection Prevention team (IPT) has, however, been able to complete both reactive and proactive work.

The IPT has continued to work effectively with Wolverhampton Public Health to ensure COVID-19 guidance and all COVID, flu and norovirus outbreaks are managed in a timely manner, thus ensuring patient safety in care homes and other high-risk settings. A new contract has been agreed from April 2023.

In the acute Trust:

- Carbapenemase producing enterobacterales (CPE) colonisation has continued to increase with 53 cases
- Clostridioides difficile is over trajectory with 72 cases (14 over trajectory)
- 2 MRSA bacteraemia attributed to RWT
- Environmental controls continue to be a top priority, however not all areas have received a deep clean due to lack of decant facilities. All inpatient areas have, however, received an enhanced level of cleaning throughout
- The bed cleaning service has resumed, whereby empty beds are taken to an area and cleaned using steam and hydrogen peroxide vapour (HPV). A clean bed is delivered to the ward ready for a new patient
- The Intravenous Resource Team continues to deliver a high standard of line care with patients discharged on outpatient parenteral antibiotic therapy (OPAT)
- Surgical site infection surveillance (SSIS) data is shared with consultant surgeons via a monthly dashboard
- Device related bacteraemia (DRHAB) has increased. This is an internal trajectory of 48 and there were 58 identified
- Outbreak management included COVID-19 x 87, norovirus x 2, influenza x 2

Ward based education has been completed, including Clostridioides difficile awareness week, different wards each week, and back to basics.

Looking back COVID-19 2022/2023

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. Outbreaks continue to be managed according to national guidance, however there have been many variables which have impacted the number of outbreaks, such as visiting and the removal of all COVID-19 guidelines for the general public. Outbreaks are reported and escalated to ensure learning is identified and corrective actions taken.

Several changes in guidance occurred throughout the year such as patients wearing face masks and a reduction in inpatient screening. Asymptomatic screening ceased and only patients who presented in the emergency department (ED), or in an inpatient setting with symptoms, were screened. All patients identified as clinically extremely vulnerable (CEV) or were admitted to intensive care or were being discharged to a care home were also screened for COVID-19.

Patients who had a positive result were isolated in a side room or nursed in a bay with other positive patients (cohort bay/ward).

All COVID-19 HCAI deaths are reviewed by an individual case analysis and structured judgement review (SJR) with a full root cause analysis (RCA) completed where indicated. Themes identified were ventilation of the ward environment and patient/staff compliance with face masks.

The Trust undertakes 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.

Looking back 2022/23

Priority and why priority identified
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.
What we said we would do
Maintain a 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.
How did we do?
Dashboard development is ongoing. With input from the Information Team, an "observations on time" dashboard was developed and implemented. The dashboard provides real time data that clinical areas can interrogate to evaluate performance and support improvement. There has been an incremental improvement in the compliance with "observations on time" which is a key safety metric. A similar approach will be used to develop other elements of the dashboard and we have plans to share it with Walsall Healthcare NHS Trust colleagues and work collaboratively on the deteriorating patient agenda. The Trust is committed to delivering the Commissioning for Quality and Innovation (CQUIN) relating to deteriorating patients and unplanned admissions to the critical care unit. It measures the recording of the National Early Warning Score (NEWS2), escalation time and response time for unplanned critical care admissions. The CQUIN goal is 20-60% and the Trust has performed consistently well, above the national target (overall compliance was 83% for the last quarter of 2022/23). The associated audit has demonstrated an improvement in escalation but challenges with documentation of the response time. Feedback is provided to ward teams when delay in escalation/response is identified. We have continued to contribute to the national cardiac arrest audit. An improvement has been noted in the "risk adjusted" parameters such as ROSC (Return of Spontaneous Circulation) >20 minutes and survival to hospital discharge. The overall 28-days in-hospital survival is similar to peer group and the national average. The Resuscitation Committee has set up a focus group to undertake further analysis of factors that impact on the risk-adjusted metrics and determine interventions to support improvement. Case ascertainment and data completion is also being explored and discussions are ongoing with the Information Technology Team to develop an electronic form to improve data capture post event. Unexpected deaths following cardiac arrest is now an additional criterion to identify any missed opportunities regarding prompt escalation or whether Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) should have been in place.

Priority and why priority identified
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.
What we said we would do
Ensure our current patient safety workstreams are dovetailed and support outcomes in line with health inequalities programme to maximise impact.
How did we do?

The Royal Wolverhampton NHS Trust has undertaken the following actions as part of the health inequalities agenda:
Governance and Education
• Introduced a health inequalities steering group which has representation from a wide range of stakeholders internal and external to the organisation, including local authority, public health and One Wolverhampton
• Trust Board reports and development sessions
• Business case templates have a dedicated section which includes consideration of inequalities
• Equalities Impact Assessment (legal duty) now also includes consideration of other inequalities e.g., deprivation
• Successful bids for developing educational packages for the workforce to improve understanding of health inequalities within the population we serve.
Five national themes and our initial action plan
1. Inclusive services – breaking down data by deprivation and ethnicity
  • Maternity and early years data development and dashboards to steer focus
  • Equity audit of elective pathways and pilot work on DNAs
2. Mitigating against digital exclusion
  • Considering data protection concerns, equipment and data availability, and digital skills in access to information and services; monitoring uptake
3. Ensuring datasets are complete and timely
  • Meeting ethnicity completion target of 95%, flags for learning disability in place
4. Accelerating prevention programmes
  • Introduction of tobacco dependency service for inpatients, expansion of the Drug and Alcohol Liaison Team, primary care workstreams, recruitment of EDI midwife
5. Strengthening leadership and accountability
  • Board level buy-in, working towards distributed leadership through education and changing business-as-usual processes
Assessing Equity
• Analysis and qualitative data gathering to identify disparities, focusing on patients that "did not attend" (DNA), and a review of current processes focusing on a deep dive in high volume specialities in the first instance to establish the inequalities faced. An equitable recovery programme pilot is currently underway in the ophthalmology department to proactively contact patients with outpatient appointments to identify any barriers they may face to attending their appointments.
• Updating the patient access policy to ensure services are available to all patients and easily accessible.

Looking back 2022/23

Priority and why priority identified
PS 4 - We will aim to improve mental health care and treatment for all ages **PS 5 - We aim to review our services, working 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, we aim to adhere to the legislation within the Mental Health Act 1983 and to ensure all patients are treated in a person-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 or dementia** **PS 8 - We aim to deliver parity of esteem by having embedded mental health services and skills across the workforce** This priority supports 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 mental ill health.
What we said we would do
• 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 • Deliver a mental health steering group that will enable a Trust-wide approach to reviewing mental health care standards and share experiences. The group will be a supportive forum 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 • Develop a process to support the Use of Force Act 2018 and improve governance processes for auding mental health data
How did we do?
PS4 – The Trust has developed systems where incidents and complaints can now be systematically reviewed to allow the organisation to have oversight. Regular data is available to support clinical areas to access appropriate care and treatment and support patient care. Systems and processes have been developed to support adherence to the Mental Health Act (MHA) and are able to support quality of care for patients who are detained under the Act, ensuring their patient rights are adhered to and they have access to independent mental health advocates when required. The Trust continues to work with partner organisations who support our patients on admission.
PS5 – The Trust liaises with partner organisations to agree pathways and services for our patients. The mental health team engages in transformational projects to develop the services available to patients whilst in the care of the organisation. The executive team is working with partner organisations to develop clear service standards.
PS6 – A process has been embedded where the Trust is aware of all mental health activity that takes place within the organisation. With this oversight, assurance has been gained that all patients have access to the correct legal process supporting MHA. The Trust adheres to the Mental Health Act 1983 and Mental Health Code of Practice to support our patients who are detained to the organisation. MHA administrators are in post who support the process and education for the workforce. Enhanced MHS training has been developed for the workforce to support their knowledge and understanding of the Act, to improve quality of care delivered to patients.

PS7 – Over the last year the mental health team has been able to learn and understand the services that are in place, working across the organisation to support all ages of mental health presentations. New working groups have begun to develop services to support areas for improvement, such as paediatrics, inpatient wards and for older adults who may be presenting with dementia.

Close working is taking place with the learning disability team to support sharing of information to enable a joint approach and support the quality of care patients receive. The Trust is working with our partner organisations to benchmark best practice and work in collaboration with regional workstreams that are taking place.

PS8 – The mental health team continues to advocate for parity of esteem and is working with our partner organisations to fully embed this practice, understanding that there are challenges to ensure parity of esteem from the front door throughout the patient journey. Therefore, work continues in collaboration to ensure pathways are robust and services are delivered to meet the complex needs of the patients that attend the Trust.

It is envisaged that with the completion of the ongoing workstreams, regional work and collaboration, we will achieve parity of esteem in the future.

Priority 2: Clinical Effectiveness

Priority and why priority identified
Nursing Workforce **CE 1 - To ensure we improve and continue to have an appropriate workforce to support clinical effectiveness, patient safety and a positive patient experience**
What we said we would do
• Continue our recruitment programme, using our lead recruiter clinical fellowship programme to attract and onboard international recruits • Continue to increase placement opportunities for student nurses, 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 organisation's 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 affect 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.
How did we do?
• Continued our recruitment programme, utilising our lead recruiter clinical fellowship programme to attract and onboard international recruits • Continued to increase placement opportunities for student nurses, supporting our local universities ability to educate more nursing students • Improved 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. We have also relaunched the internal transfer programme with good results • Continued 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. Introduction of STAY events for registered staff and nuanced events for unregistered staff • We improve opportunities for all by supporting local recruitment programmes in partnership with local government, charities, and associations to address local inequalities that affect employment within our communities. Success with recruiting through the Prince's Trust "Get Into" programme for 18-30-year-olds • Completed 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 and report daily • Improved the systematic review of staffing in the organisation using the new Safer Nursing Care Tool (SNCT). Completed an external review from NHSE/I to ensure we are using the SNCT appropriately, which we are fully compliant with. We have also intorducted robust training for staff around using the tool to ensure accurate data capture.

Priority and why priority identified
Allied health professionals **CE 1 - To ensure we improve and continue to have an appropriate workforce to support clinical effectiveness, patient safety and a positive patient experience**
What we said we would do
• Continue to build upon our Health Education England-funded workforce programmes, supporting AHPs to return to practice • Progress international recruitment into AHP posts through RWT's award-winning clinical fellowship pProgramme • 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 progression 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 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.
How did we do?
The Chief Nurse has oversight for AHP recruitment and retention thorough monthly reports. Working with colleagues across the Black Country Integrated Care System (ICS), we promoted return to practice (RtP) across the ICS. The campaign resulted in 481 views on the RWT RtP website. This represents an increase in views of approximately 250% compared to previous months. International recruitment (IR) is ongoing – through the NHSE ICS programme, for which RWT is the lead recruiter. Diagnostic radiography has done particularly well, with 13 radiographers appointed to date. Two offers have been made for internationally recruited podiatrists. Our first four operating department practitioner (ODP) apprentices became registered ODPs in 2022, with a further six theatre assistant practitioners starting their Level 6 apprenticeship in 2022. Within the Physiotherapy and Occupational Therapy (OT) Department there are currently three physiotherapy and four OT apprentices, with a further five apprentices due to start in 2023. New apprenticeship opportunities for 2023 include radiography, dietetics and speech and language therapy. We are also exploring level 3 and level 5 apprenticeships for our AHP support workforce as well as level 7 opportunities for those already educated to level 6. We are hopeful that links developed with several universities during our clinical placement expansion programme 2021/22 project will lead to increased retention of local students recruited as new graduates. To support retention, during 2022 we saw the launch of our new ICS AHP preceptorship programme. A positive preceptorship experience is reported to result in newly registered graduates and international recruits having increased confidence and feeling valued by their employer. This, in turn, is linked to improved recruitment and retention. Other initiatives implemented to improve retention include "stay and grow" conversations, the updated AHP career map and supporting flexible working. Temporary staffing arrangements are in place for vacancies where necessary to ensure services are appropriately staffed and targeted recruitment continues to proactively recruit into hard to fill posts. AHP vacancy levels overall are now meeting the Trust target over the last nine months, the first time since April 2020.

Looking back 2022/23

Priority and why priority identified
Medical workforce - Consultants **CE 1 - To ensure we improve and continue to have an appropriate workforce to support clinical effectiveness, patient safety and a positive patient experience**
What we said we would do
• Continue to develop internally trained senior medical staff from our fellowship programme • Aim to strengthen links with neighbouring organisations where the national consultant resource is limited • Develop a pathway for long term locum consultants to be employed and supported to progress through CESR to a substantive appointment
How did we do?
The Clinical Fellowship Programme (CFP) CESR Faculty is an initiative that supports doctors across The Royal Wolverhampton, Walsall Healthcare NHS Trust and Black Country Healthcare NHS Foundation Trust. The Certificate of Eligibility Specialist Register (CESR) Programme is the alternative training pathway for doctors to join the GMCs Specialist Register to become UK consultants. CESR is a lengthy process and requires a high level of commitment from the doctor, combined with support from the CESR faculty and a doctor's respective directorate to progress toward a successful application with the GMC. The Trust currently has: • 16 CESR successes since 2018 • 44 currently committed to the pathway • 18 anticipated submissions within the next 12 months • Developed CESR fellow posts, linked to "hard to fill" consultant vacancies with a view to attracting doctors from within the UK

Priority and why priority identified

Medical workforce - Junior medical staff / fellowship

CE 1 - To ensure we improve and continue to have an appropriate workforce to support clinical effectiveness, patient safety and a positive patient experience

What we said we would do

- Ongoing development and expansion of the clinical fellowship programme
- Embrace and adopt required changes to training structure and supervision requirements
- Explore options for digital fellowship programmes in collaboration with external stakeholders

How did we do?

Clinical fellowship education and enhanced support Services

- Implementation of a three-tier weekly teaching programme – aimed to support all levels of fellows.
- SIMS training sessions
- Educational support meetings during initial six months into tenure (running parallel to educational supervision)
- Group supervision sessions with trained educational supervisor for initial six months into tenure
- Peer-led enhanced support services sessions for portfolio, IT training and on-call induction training
- Peer-led pastoral programme - leads for academic, socio-cultural and early support aiding our international fellows with an easier transition into working in the NHS and adjusting to life in the UK

Priority and why priority identified

Medical workforce - Medical students

CE 1 - To ensure we improve and continue to have an appropriate workforce to support clinical effectiveness, patient safety and a positive patient experience

What we said we would do

- 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 student

How did we do?

- Aston Medical School (AMS) students have been well integrated into the organisation. The AMS inception cohort (intake 2018) will graduate this academic year, with every student having the entirety of their medical final clinical examination at RWT
- A quality visit from the GMC assessing AMS and their provision for OSCEs (Objective Structured Clinical Examinations) was excellent. The successful partnership between RWT and AMS resulted in an "impressive and well-organised" OSCE. (Source: General Medical Council team, 7 March 2023).

Quality metrics for University of Birmingham Medical School students remains high with the latest quality visit in September 2022. The feedback from the visit stated: "throughout the visit it was evident to the panel that the Trust has a genuine commitment to education. This was equally reflected within the student feedback whereby students perceived the RWT to be an excellent placement."

Looking back 2022/23

Priority and why priority identified
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
What we said we would do
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
How did we do?
During 2022/23, the Trust continued to progress the priorities and milestones outlined in the Clinical System Framework for Nurses, Midwives, Health Visitors and Allied Health Professionals (AHPs), which was launched during 2021/22 as Version 2. The Framework consisted of six pillars: Right Workforce, Excellent Care, Culture and Organisational Structure, Communication, Education, and Research and Innovation. In total, there were 36 specific work-streams and 222 associated objectives for the two-year period. Progress with delivering the agreed objectives was reported on a three-monthly basis and shared with senior leaders via the key forums, and with Trust Board via the chief nursing officer report. From the 222 set objectives, 157 were achieved, 73 were not achieved and two objectives were not reported against. Overall, the were many positive achievements, despite the extreme operational pressure caused by the COVID-19 pandemic. Examples include: • Recruitment/training of professional nurse advocates (PNAs). A total of 49 staff are now accredited as PNAs within the Trust • Recruitment of smoking cessation specialist midwife to support smoking cessation • Nurses, midwives, health visitors and AHPs published 113 peer reviewed articles in 2022, as opposed to 39 in 2021, overperforming on the CSF objective set for both years • The Care to Share magazine continued to be published to celebrate achievements as well as being a helpful communication tool • 100% Care Certification was achieved for healthcare support workers (HCSWs) • Progress with internal transfer process was achieved with a CNO fellow appointed to progress the workstream in 2022 • International nurse retention was positive and for 85 staff recruited during 2020, 85-90% remained at the Trust • The 30, 60 and 90-day conversations were introduced to proactively monitor staff wellbeing and job satisfaction • Success with the apprenticeship programme was achieved through proactive community scoping and collaborative working with the Prince's Trust and Health Education England • The target of expanding AHP representation on Trust committees was met • Co-production, clinician and patient workshops commenced and are now embedded In terms of the objectives that were not achieved, this was due to a variety of reasons. For example, some of the national reporting mechanisms had changed which meant that some metrics were no longer collected or relevant. In addition, the extreme operational pressures caused by the COVID-19 pandemic and the need for re-prioritisation of key activities had negatively impacted our ability to achieve all the objectives.
A new framework for nurses, midwives, health visitors and AHPs, renamed as the "Quality Framework", was launched in April 2023, following extensive consultation across both the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. Some of the objectives not achieved during 2022/23 are included in this version. The Framework outlines key areas of focus for the next two years and includes focus on the same pillars as outlined in previous iterations, but now includes five separate plans for the following services: paediatrics, maternity, acute adult, allied health professionals and community. Quarterly progress updates will be provided via the chief nursing officer/director of nursing reports.

Priority 3: Patient Experience

Priority and why priority identified
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
What we said we would do
With our colleagues at Walsall Healthcare NHS Trust (WHT), we will publish an enabling framework for 2022-2025.This will reinforce our collaborative working across both trusts.
How did we do?
A variety of workstreams have been ongoing throughout the year to improve patient engagement and involvement and ensure this is at the heart of decision making. We have an active Council of Members (patient participation group) where meetings are held bi-monthly. Active group members have been involved in a variety of projects and initiatives including assessment of standards against the "15 Steps" challenge and "Observe and Act" initiatives. This group has been rebranded and the members are now called patient involvement partners (PIPs), which gives more clarity to the role. The terms of reference were also agreed, plus new branding which will be going live in early 2023. The enabling strategy has been written following consultation with the patient groups and is currently being ratified. The Trust has trialled a feedback initiative called "mystery patients" in our paediatric areas. The model uses QR codes from posters displayed in clinical areas to collect anonymous feedback on the services accessed. In January 2023, our PIPs helped co-design the RWT model of the initiative to prepare for wider roll out. The PIPs group chose to call the RWT model "Feedback Friend" and discussed the logo and what information needs to go onto the poster and be on the online form which is accessed by the patient. The end co-designed result was due to be rolled out in a phased approach across further clinical areas in RWT from April 2023. RWT has been working on co-designing the ward welcome information boards within this reporting period, with final designs expected to be ready to go live in April 2023. We have worked with the following groups to identify what information patients and carers would like to see on the welcome boards: • Patient involvement partners (for adult wards) • Service users with learning disability in a specific focus group for both adult and paediatric wards • A local primary school for the paediatric ward The Patient Experience Team has met with the LD nursing team to begin scoping methods of feedback for patients with a learning disability. A video will be put together in the new financial year. **Patient involvement in quality improvement** The first task and finish group meeting was held in this reporting period, to develop a framework within RWT and WHT of involving patients and carers within all quality improvement workstreams. **15 Steps patient observation initiative** During this reporting period PIPs have been involved with supporting 15 Steps assessments in various clinical locations.

Looking back 2022/23

Priority and why priority identified
PE 2 - To continue to improve complaints responses to patients and ensure learning is identified and areas are provided with e-learning
What we said we would do
Embed the PHSO Complaints Standards and, with our colleagues at WHT, continue to develop and implement the standards including e-learning training modules and tracking progress against each trust's self-assessment.
How did we do?
The Trust has implemented the Parliamentary Health Service Ombudsman (PHSO) Complaint Standards for complaint handling and became an early adopter of the initiative. The early implementation was successful, and this initiative has now been suggested to be used nationally by the PHSO. A self-assessment was undertaken as part of the requirements for the PHSO for being an early adopter. A module has been written jointly between both The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust, and will be available shortly for wider access. This incorporates the principles of the PHSO standards, however, local training has been delivered for bespoke groups as and when required. There is an ambition to make this module mandatory for all those whose responsibilities are to deal with formal complaints. The PHSO standards include a focus on the customer care element, and a project has been implemented over the last 12 months focusing on de-escalation of complaints resulting from aggression between the public and staff. This was piloted within ED, mainly for receptionists, however has been widened out to clinical staff. The ambition for the forthcoming year is to deliver this training to other directorates. We have undertaken assessments of our complaint handling periodically throughout the year, with an independent panel. The current results are favourable about our compliance with processes.

Priority and why priority identified
PE 3 - To build on the success of volunteer services
What we said we would do
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

How did we do?

We are still trying to align volunteer roles with the strategic Trust priorities. During the last year, many new roles were requested of volunteers, including in the endoscopy waiting room, ED and ambulance receiving centre, discharge lounge and surgery wards, which we have been able to fulfil thanks to our adaptable approach with use of an app for volunteer rostering. To plan effectively for winter pressures 2023, we will be recruiting again in late summer, and will meet with workforce leads to understand where volunteers could most effectively support in clinical areas.

The recruitment of volunteers has increased; we continue to hold quarterly recruitment projects with a minimum target of 50, and in addition we attend the trust-wide recruitment events and a wide range of community engagement events. We also spend quality time on volunteer retention initiatives, to hold the numbers of volunteers in place for longer.

We continue to support volunteers with career explorations in the NHS, and to build upon their own skill development and to pursue job applications within the Trust if this is their choice. We have signed a partnership agreement with NHS Cadets, which is managed by NHSE and St John Ambulance, and trains and educates young people on NHS career opportunities alongside a volunteer placement. Since forming the partnership, we have supported nine young people through this route. We regularly collect case studies for use in social media and reports, and a case study of a volunteer who gained a bank HCA position has been featured in two national NHSE campaigns promoting HCA careers. The deputy head of patient experience with portfolio responsibility for volunteering also led a monthly NHS volunteer managers forum on recruitment of the clinical volunteers for Helpforce, which was live streamed on LinkedIn.

Finally, we will explore volunteer opportunities within the community fully in 2023, as we have been awarded funding by NHS Charities Together, for a two year volunteer programme aiming to ease social isolation.

Priority and why priority identified

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

What we said we would do

- 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 ongoing 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 use virtual clinics where appropriate to ensure maximum capacity is available
- We will continue to work collaboratively with other local trusts to offer and use mutual aid where appropriate to ensure the best outcomes for patients.

How did we do?

We have continued to prioritise the treatment of patients on a cancer pathway. There was a 22.7% increase in referrals in 2022/23 compared to pre-COVID which has impacted on all stages of the cancer pathway. Additional diagnostic capacity is in place to improve timeliness of diagnostics and mutual aid has been sought to increase treatment capacity further.

The Trust has significantly reduced the number of patients waiting over 78 weeks, reducing the number of breaches to 85 at the end of March. Industrial action in March (which continued into 2023/24) impacted on the improvements the Trust could make beyond this.

The Trust eliminated all waits over 104 weeks.

Looking forward 2023/24

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 2023/24 were agreed by the Trust Board.

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

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

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

Looking forward 2023/24

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

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

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

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

Our people

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

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

- Priority area – Quality improvement
- Priority area – Patient safety
- Priority area – Patient involvement

Prioritise the treatment of cancer patients, focusing on improving outcomes for those diagnosed with the disease

- Priority area – Cancer treatment

Deliver safe and responsive urgent and emergency care in the community and in hospital

- Priority area – Urgent and emergency care and patient flow

Deliver the priorities of the National Elective Care Strategy

- Priority area – National Elective Care Strategy

Looking forward 2023/24

Priority 1 – Patient Safety	
Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority area – Patient safety**	**Key actions we will take:** • Transition to the Patient Safety Incident Response Framework (PSIRF) • Transition to Learn from Patient Safety Events (LfPSE) • Increase uptake of Level 2 syllabus training **The aim for 2023/24** • Transition to PSIRF achieved by the national deadline • 100% of incidents uploaded to LfPSE by the national deadline

Deliver safe and responsive urgent and emergency care in the community and in hospital.
 	
Priority area –
Urgent and emergency care and patient flow
	Key actions we will take:
	• Working with partners from across the system, we will support the flow of patients through UEC, by:
	  • expanding and maintaining the use of same day emergency care (SDEC) services to avoid unnecessary hospital stays
	  • expanding virtual wards, allowing people to be safely monitored from the comfort of their own homes
	  • working with partners to speed up discharge from hospital and reduce the number of patients without criteria to reside
	The aim for 2023/24
	• Year on year improvement in the percentage of patients seen within four hours in A&E
	• Reduce adult general and acute bed occupancy to 92%
	• Consistently meet the 70% two-hour urgent community response time

Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority area – Quality improvement**	**Key actions we will take:** • Produce a gap analysis on how both trusts (RWT/WHT) rank against the four components of a quality management system (quality planning, quality control, quality improvement and quality assurance), and review how we triangulate data to understand priorities • All members of divisional and care group/directorate leadership teams to attend one day quality service improvement and redesign fundamentals (sessions scheduled from January 2023) • Year-on-year roll-out plan for QI huddle boards across both trusts to targeted areas e.g., low evidence of improvement work, non-clinical areas **The aim for 2023/24** • Completed gap analysis by end of 2023/24 • Increase in the number of staff trained following triumvirate training • Introduction of 10 QI huddle boards per site/annum

Priority 2 – Clinical Effectiveness

The right workforce with the right skills, in the right place at the right time **Priority area – Our people**	**Key actions we will take:** • Recruit and retain staff using targeted interventions for different career stages • Improve retention using bundles of recommended high impact actions • Develop and deliver the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models **The aim for 2023/24** • To improve staff turnover by the end of 2023/24
Prioritise the treatment of cancer patients, focusing on improving outcomes for those diagnosed with the disease **Priority area – Cancer treatment**	**Key actions we will take:** • Maintain focus on operational performance, prioritising capacity for cancer patients to support the reduction in patients waiting over 62 days • Increase and prioritise diagnostic and treatment capacity for suspected cancer, including prioritising new community diagnostic centre capacity • Implement priority pathway changes for lower gastrointestinal (GI), skin, and prostate cancer **The aim for 2023/24** • Reduction in the number of patients waiting more than 62 days for treatment, and meeting the cancer faster diagnosis standard by March 2024 • 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed, or have cancer ruled out, within 28 days
Deliver the priorities of the National Elective Care Strategy **Priority area – National Elective Care Strategy**	**Key actions we will take.** • Deliver an increase in capacity through the community diagnostic centre and theatre expansion programme • Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients • Increase productivity using the GIRFT (Getting it Right First Time) programme and improving theatre productivity **The aim for 2023/24** • Eliminate waits of over 65 weeks by the end of 2023/24 • Meet the 85% theatre utilisation expectation
Review of GIRFT[i] and Model health system data[ii]	**Key actions we will take.** • Review model health system and Getting It Right First Time (GIRFT) data to guide relevant aspects of activity, quality, and safety

i Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

ii The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity.

Priority 3 – Patient Experience

Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority area – Patient involvement**	**Key actions we will take:** • The key priorities are outlined within the joint Patient Experience Enabling Strategy (2022-2025). These include: **Pillar one – Involvement** • We will involve patients and families in decisions about their treatment, care, and discharge plans. **Pillar two – Engagement** • We will develop our Patient Partner programme and use patient input to inform service change and improvements across the organisation **Pillar three – Experience** • We will support our staff to develop a culture of learning to improve care and experience for every patient.

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

Fundamentals – based on internal and external priorities:

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

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

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

- Priority Area – Financial sustainability

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

Statements of assurance from the Board: Mandatory quality statements

During the period April 2022 to March 2023, 60 national clinical audits and seven national confidential enquiries covered relevant health services that The Royal Wolverhampton NHS Trust provides.

During that period The Royal Wolverhampton NHS Trust participated in 93% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that The Royal Wolverhampton NHS Trust was eligible to participate in during April 2022 to March 2023 are listed in Tables 1 and 2. The tables also note those audits and enquiries in which The Royal Wolverhampton NHS Trust participated, and for which data collection was completed during April 2022 to March 2023. The entries include 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.

The reports of 22 national clinical audits were reviewed by the provider in April 2022 to March 2023 and the actions that The Royal Wolverhampton NHS Trust intends to take to improve the quality of healthcare provided are detailed in Table 3.

The reports of 117 local clinical audits were reviewed by The Royal Wolverhampton NHS Trust during April 2022 to March 2023. Of these, 76 demonstrated areas where actions could be taken to improve the quality of healthcare. Details are at Appendix 1.

Statements of Assurance

National programme name	Work stream / Topic name	Participating 22/23	Data collection completed during period	% Submission rate / comments
Breast and Cosmetic Implant Registry	–	Yes	Yes	100%
Case Mix Programme (CMP)	–	Yes	Yes	–
Elective Surgery (National PROMs Programme)	–	Yes	Yes	–
Emergency Medicine QIPs	Care of Older People (COP)	Yes	Yes	100%
Emergency Medicine QIPs	Mental Health self harm	No	–	–
Emergency Medicine QIPs	Pain in Children	Yes	Yes	100%
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	Yes	Yes	–
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	Yes	–
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Yes	Yes	100%
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes	–	No minimum dataset
Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	–	No minimum dataset
Inflammatory Bowel Disease Audit	–	Yes	Yes	100%
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	–	Yes	–	–
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	Yes	–

National programme name	Work stream / Topic name	Participating 22/23	Data collection completed during period	% Submission rate / comments
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	Yes	Yes	–
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal mortality surveillance	Yes	Yes	–
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	Yes	Yes	–
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	Data collection still in progress	–
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Yes	–	–
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	Yes	Data collection still in progress	TBC
National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	Yes	–
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes	Data collection still in progress	–
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Data collection still in progress	–
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Yes	Yes	–
National Asthma and COPD Audit Programme (NACAP)	Pulmonary Rehabilitation Organisational and Clinical Audit	Yes	Yes	–
National Audit of Breast Cancer in Older Patients	–	Yes	–	–
National Audit of Cardiac Rehabilitation	–	Yes	Data collection still in progress	–
National Audit of Cardiovascular Disease Prevention Primary care	–	Yes	–	Data automatically extracted from GP records
National Audit of Care at the End of Life (NACEL)	–	Yes	Yes	–

Statements of Assurance

National programme name	Work stream / Topic name	Participating 22/23	Data collection completed during period	% Submission rate / comments
National Audit of Dementia	Care in general hospitals	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	–	Yes	Yes	–
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Congenital Heart Disease Audit (NCHDA)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	Data collection still in progress	–
National Child Mortality Database (NCMD)	–	Yes	Yes	–
National Early Inflammatory Arthritis Audit	–	Yes	Yes	100%
National Emergency Laparotomy Audit (NELA)	–	Yes	Yes	100%
National Joint Registry	–	Yes	Yes	100%
National Lung Cancer Audit	–	Yes	Data collection still in progress	–
National Maternity and Perinatal Audit (NMPA)	–	Yes	Yes	–
National Neonatal Audit Programme (NNAP)	–	Yes	Yes	–
National Ophthalmology Database Audit (NOD)	Adult Cataract Surgery Audit	No	–	–
National Paediatric Diabetes Audit	–	Yes	Yes	100%

National programme name	Work stream / Topic name	Participating 22/23	Data collection completed during period	% Submission rate / comments
National Perinatal Mortality Review Tool	–	Yes	Yes	–
National Prostate Cancer Audit (NPCA)	–	Yes	Yes	–
Perioperative Quality Improvement Programme (PQIP)	–	Yes	–	–
Renal Audits	National Acute Kidney Injury Audit	Yes	Yes	100%
Renal Audits	UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	100%
Respiratory Audits	Adult Respiratory Support Audit	No	–	–
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	No	–	–
Sentinel Stroke National Audit Programme (SSNAP)	–	Yes	Data collection still in progress	–
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	–	Yes	Yes	□
Society for Acute Medicine Benchmarking Audit (SAMBA)	–	Yes	Yes	100%
Trauma Audit & Research Network (TARN)	–	Yes	Yes	100%
UK Cystic Fibrosis Registry	–	Yes	Yes	100%
UK Parkinson's Audit	–	Yes	Yes	–

Statements of Assurance

National programme name	Work stream / Topic name	Participating 22/23	Data collection completed during period	% Submission rate / comments
Child Health Clinical Outcome Review Programme	Testicular torsion	Yes	Data collection still in progress	–
	Transition from child to adult health services	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Yes	Yes	100%
	Crohn's disease	Yes	Yes	100%
	End of Life Care	Yes	Data collection still in progress	–
	Endometriosis	Yes	Data collection still in progress	–
	Epilepsy Study	Yes	–	–

Based on information available at time of publication.

National Audit Title	Actions to be taken by RWT
National Cardiac Rehabilitation Audit 2021/22 (2022/23)	Fully compliant - no local actions.
Audit on Device Complications 2022/2023	No local actions - consistent growth of device implantations (except during the COVID period in line with national and international trends). RWT complications rates are lower compared to other centres in Europe. There was no significant perforation or pericardial effusion or tamponade. There was no fatality related to the procedure
National Cardiac Audit Programme (NCAP) 2021/22 data (2021/22)	Cardiac surgical mortality data is fully compliant with national standards with no identified local actions.
National Thoracic Surgery Audit (2021/22 DATA) 2021/22	No local actions - statistics for RWT continue to identify us as one of the top cardiac surgical centres for thoracic surgery in terms of measured outcomes.
National Emergency Laparotomy Audit (relates to 2020/21 submission of data). 2022/23	Consider direct admission to critical care for high-risk patients and promote multidisciplinary decision making.
National audit - Use of Negative pressure dressing in breast surgery (17/18)	This was a national study rather than a clinical audit and therefore no audit standards. There was no non-compliance to address. The study has highlighted that prophylactic use of negative pressure dressing in high-risk patients undergoing breast oncoplastic and reconstructive surgery is being used in routine practice at the Trust.
REspiratory COmplications after abdominal Surgery (RECON) (18/19)	This was a study to determine the impact of pulmonary complications on death after surgery both before and during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic. This study has helped understand the detriment of surgery taking place during the pandemic and that we must do our utmost to protect surgical patient from contracting COVID-19
IbRAnet localisation study: SAVI SCOUT	This was a project to assess the use of the novel technology to see if this improves localisation of non-palpable lesions and improve the excision rate of these lesions. The study concludes that it is a safe and acceptable technique, provides flexibility in preoperative planning but introduces a significant cost.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) (2021/2022) 2022/2023	Overall 97.8% compliant with standard, however some improvement actions have been taken in certain areas. This includes differed cord clamping, temperature management and monitoring of newborn babies <32 weeks, parental consultation, additional funding for neonatal staffing, support and training around breastfeeding.

Statements of Assurance

National Audit Title	Actions to be taken by RWT
National Audit: National Maternity and Perinatal Audit (NMPA) (2018/2019) 2022/2023	Maternity and neonatal services at RWT are developing an overarching action and improvement plan incorporating recommendations from several national requirements including 'Single Delivery Plan', Ockenden Immediate essential actions, CNST maternity incentive scheme, ICB / LMNS workstreams, Saving Babies Lives Care Bundle V3, MBRRACE, The East Kent Report, CQC, and Baby Friendly Initiative standards (among others). Local improvement actions have been split into key objectives around personalised care, equity, working with services users to improve care, growing and retaining workforce, investment in skills, patient safety culture, learning, support and oversight, standards to support best practice, data and use of digital technology.
MBRRACE (Maternal, Newborn and Infant Clinical Outcome Review) Audit – Perinatal Mortality Surveillance Report-UK Perinatal Deaths for Births (2020/2021) 2022/2023	
National Audit – Perinatal Mortality Review Tool (PMRT) (2021/2022) 2022/2023	
MBBRACE-UK (Maternal, Newborn and Infant Clinical Outcome Review Programme)- Perinatal Confidential Enquiry- Stillbirths and neonatal deaths in twin pregnancies (2018/2019) 2022/2023	
MBBRACE (Maternal, Newborn and Infant Clinical Outcome Review) Saving Lives Improving Mothers' Care – Maternal mortality surveillance and confidential enquiry (2018-2020) 2022/2023	
National Joint Registry (NJR) Annual Report (2020/2021) 2022/2023	The service is meeting or exceeding the national average in all areas. However, some improvements have been applied locally including compliance with consent and linkability for neck of femur total hip arthroplasty patients. This has been added to the patient information booklet.
Corona Virus in Hip Fracture - CHIP2 National Study: Is vitamin D associated with increased mortality from COVID-19 infection in a hip fracture population? - National Observational Study 2020 data (2022/2023)	National data only - none of the recommendations were applicable to RWT.
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Hip Fracture Database (2021) 2022/2023	Service is meeting or exceeding the national average in all areas including all the requirements of Best Practice Tariff. No local actions.
National Joint Registry (NJR) Annual Report (2021)) 2022/2023	RWT performed well above national average - no local actions.
National Audit British Spine Registry (2021) 2022/2023	National data only - none of the recommendations were applicable to RWT.
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Inpatient Falls (2021/2022) 2022/2023	There has been increased education and teaching regarding tagging to help prevent falls. Embedded to all staff including therapy teams, junior doctors, flow coordinators and pharmacy staff. Practice education facilitator providing training and support.
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder (MITRE) Audit (2022/2023)	RWT performed well above national average - no local actions.
National Prostate Cancer Audit (2020/2021) 2022/2023	National data only - none of the recommendations were applicable to RWT.

Participation in clinical research

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

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

The Research and Development Directorate team has focused on delivering the recovery, resilience and growth programme for research following the disruption caused by the pandemic. A total of 42 new studies were opened during 2022/23. Participants have taken part in research projects across a range of services provided by the Trust including oncologyh Haematology, rheumatology, cardiology/cardiothoracic, obstetrics, surgery, paediatrics, gastroenterology, respiratory, diabetes, ophthalmology, renal, stroke/neurology and primary care.

Our 2022/23 research experience survey, completed by 133 participants, showed:

- 94% felt fully informed about the study prior to taking part
- 84% felt valued for taking part in the research study
- 90% felt they were always treated with courtesy and respect
- 86% would consider taking part in research again

For consideration:

Providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven-day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement. Further information can be found at https://improvement.nhs.uk/resources/seven-day-services/

Use of the CQUIN payment framework

A proportion of Royal Wolverhampton NHS Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for April 2022-March 2023, and for the following 12-month period, are available electronically at NHS England » 2022/23 CQUIN.

Statements from the Care Quality Commission

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

The CQC has not taken enforcement action against The Royal Wolverhampton NHS Trust during 2022/23.

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 2022/23, (current data available up to Month 11: April 2022-February 2023) to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99.8% for admitted patient care
- 99.9% for outpatient care and
- 99.2% for accident and emergency care

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

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

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

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

The corporate Data Quality Team continues to provide assurance to support improvement of data quality within the Trust, which helps to underpin the provision of excellent services to patients and other customers:

- First point of call, answering and resolving thousands of queries and helping to support teams in ensuring all data is recorded accurately, timely, completely, and meeting all standards
- Support for IT projects continued with testing, validation and systems expertise provided by the team
- Promote data quality compliance Trustand getting the data right at point of entry
- Creating new data quality dashboards to show both compliance and areas of improvement
- Encourage good data quality beyond our usual KPIs; this includes audits into additional information such as ethnicity

- A data quality forum was established in 2017. There are terms of reference for this group and the chair is the head of clinical coding and data quality
- The Data Quality Department is responsible for monitoring and recording data quality issues identified in the organisation and for ensuring action plans are in place to address these. The department reviews the issues and prioritises them on an issues log, holds action plans for issues and manages progress against these
- Compliance is checked against indicators to assess the quality of the information on our Patient administration system (PAS) in relation to patients
- The Trust's data quality policy is in place and was reviewed in October 2022.

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 2022/23 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 2022/23, achieving an overall "Standards Exceeded" rating in all areas of the audit.

A programme of continuous improvement audits on clinical coding is in place and audits take place monthly. 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 2022/23:

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

Clinical coding/data quality reports are in place to ensure quality of coding is maintained and continually improved – examples include HED Report, SHMI and DQMI.

Data security and protection toolkit

Summary of serious incident requiring investigations involving personal data, as reported to the Information Commissioner's Office in 2022/23.

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

Date incident occurred (Month)	Nature of incident	Number of data subjects	Description/ nature of data involved	Further action on information risk
August 2022	Cyber incident	None affected	Ransomware attack against Advanced Health and Care Limited (Advanced). Advanced act as a data processor for Royal Wolverhampton NHS Trust and provide services to the Trust which were impacted. No data is known to be compromised but the systems were unavailable for a period of time while the supplier was investigating.	Technical remediation was put in place before system was made available again. During this time business continuity plans were enacted to maintain service provision.

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

Summary of other personal data related incidents		
Category	**Breach type**	**Total**
A	Corruption or inability to recover electronic data	5
B	Disclosed in error	107
C	Lost in transit	3
D	Lost or stolen hardware	1
E	Lost or stolen paperwork	16
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	5
H	Uploaded to website in error	1
I	Technical security failing (including hacking)	2
J	Unauthorised access/disclosure	12
	Total	**152**

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

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

An internal audit of the DSP toolkit in March 2023 had provided adequate assurance of the processes and evidence that is in place to support the DSP toolkit submission.

Looking forward to 2023/24 data security and protection

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

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

- The Trust has several committees dedicated to reviewing assurance in relation to DSPT and GDPR, chaired by senior board members.
- The chief medical officer is the Trust's trained Caldicott Guardian and is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. The Guardian plays a key role in ensuring the Trust satisfies the highest practical standards for handling patient identifiable information, and chairs the Information Governance (IG) Steering Group.
- The chief financial officer is the Trust's Senior Information Risk Officer (SIRO) and is responsible for monitoring the Trust's overall information risk, ensuring we have a robust incident reporting process for information risks. The SIRO reports to the Trust Board and provides advice on the matter of information risk. The SIRO is also a member of the IG Steering Group and co-chair of the GDPR Implementation Group.
- The Trust has an assigned data protection officer who acts independently to ensure compliance with the GDPR as well as monitoring its application across the Trust. The DPO has a reporting line into the Caldicott Guardian through to the Trust Board.
- The Trust is in the process of implementating a robust asset management system and defining clear responsibilities for information asset owners across the Trust to facilitate robust and timely escalation of information risk to the SIRO.
- All Trust staff receive appropriate annual training on data security and protection principles.

Seven Day Services

The Clinical Audit Team is now picking up the seven day service audit as part of the clinical audit programme at the Royal Wolverhampton NHS Trust. The audit is currently ongoing.

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

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

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

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 2021 to August 2022	October 2021 to September 2022	November 2021 to October 2022
SHMI RWT	0.938	0.935	0.928
SHMI England	1	1	1

The SHMI is lower compared to 2021/22. The Trust has been categorised as being "within the expected" range for the past year. The improvement in SHMI is a result of both an increase in expected deaths and a decrease in the observed deaths.

The Royal Wolverhampton NHS Trust has a robust mortality governance process underpinned by the Learning from Deaths Programme:

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

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

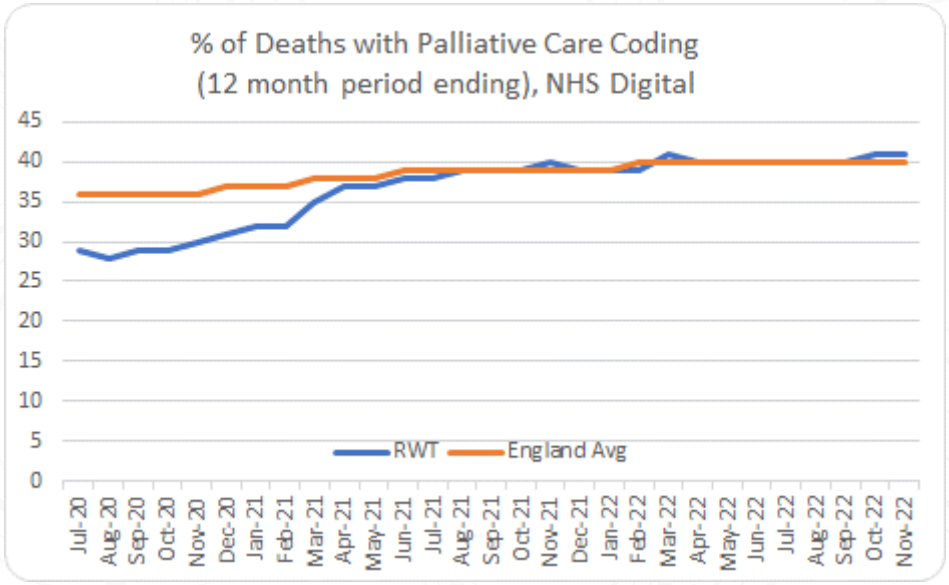
- Further strengthening the process of scrutiny and review of deaths in hospital via the medical examiner and mortality reviewer processes
- Successful expansion of the medical examiner service to undertake reviews of deaths in the non-acute (community) setting
- Expansion of the mortality reviewer process to the vertically integrated primary care network (PCN) – RWT PCN to capture learning across the entire patient pathway
- 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
- A programme of continuous quality improvement

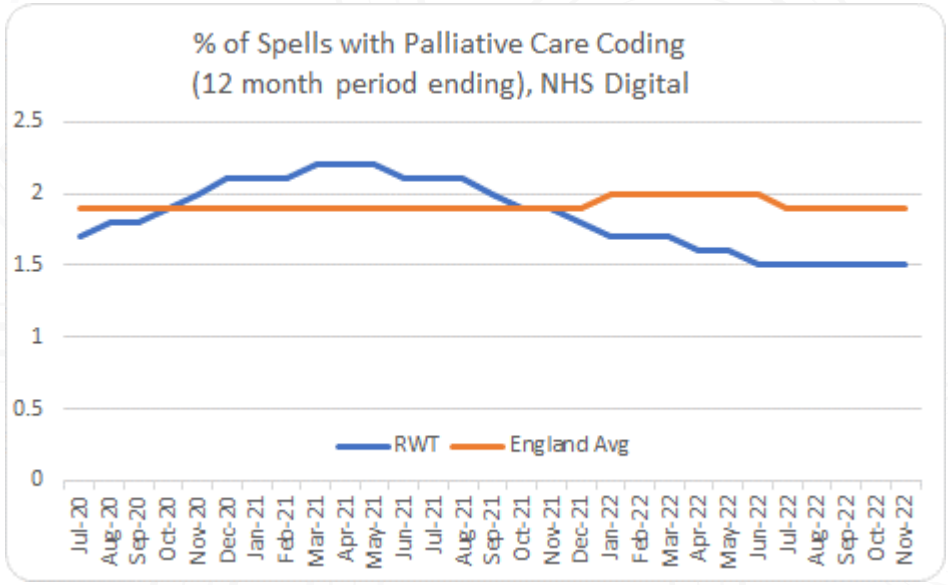
Progress against the agreed actions and the mortality improvement plan is monitored by the relevant quality boards. In addition, mortality associated reports are regularly presented to the Trust Board.

Core Quality Indicators – Summary of patient death with palliative care

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

	RWT	England Avg
% of spells (stays in hospital from admission to discharge) with palliative care coding	1.5	1.9
% of deaths with palliative care coding	41	40
% of spells with COVID-19 coding	3.8	4.8





The Royal Wolverhampton NHS Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2023/24, by:

- Business case submission for expansion of the Specialist Palliative Care Team in view of increased referrals
- Ongoing development and expansion of supportive care virtual ward, to include amber and red patients in partnership with community services and Compton Care
- 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.

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 2022 and March 2023, 2,157 adult patient hospital deaths were recorded at the Trust. This comprised the following, in each quarter of that reporting period: • 520 in the first quarter • 489 in the second quarter • 579 in the third quarter • 569 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 31 March 2023, 2,074 case record reviews (medical examiner [ME]) assessments followed by Structured Judgment Reviews (SJRs) in selected cases based on the criteria) and 14 root cause analysis investigations (RCA) have been conducted in relation to 2,157 of the deaths included in item A. In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was conducted was: • 500 ME assessments/SJRs + 1 RCAs in the first quarter • 458 ME assessments/SJRs + 5 RCAs in the second quarter • 553 ME assessments/SJRs + 3 RCAs in the third quarter • 563 ME assessments/SJRs + 5 RCAs in the fourth quarter Please note: 19 Structured Judgement Reviews stage 1 (SJR1) remain outstanding across 2022/23, which are actively being progressed. It is also important to note that cases that have been through 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 0.14% 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%] 0 cases for the first quarter • [0.61%] 3 cases for the second quarter • [0%] 0 cases for the third quarter • [0%] 0 cases for the fourth quarter These numbers have been determined using evidence from the RCA investigations involving deaths that were subject to review under the serious incident framework. (The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated).

D	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C.	Themes that have emerged from reviews of deaths at the Trust include. • Delay in treatment • Communication.
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: **Delay in treatment** Action completed: • To make the process of acting on abnormal results telephoned from clinical chemistry more robust and auditable • The need for clinicians to be systematic in all aspects of their review of patients • Dropping hemoglobin levels should prompt investigation and management for gastrointestinal hemorrhage including proton pump inhibitor prescription • In-reach gastro team attend to assess patients' needs before bringing them up to the ward. • Communication **Action completed:** • RCA should be discussed at governance meetings for acute medicine and cardiology. Wider dissemination to all medical governance meetings • Escalation of treatment should be based on clinical findings and the management plan needs to be clearly communicated to nursing staff on the ward with information regarding the timings and expectations for review of the patient • To continue with the implementation of the "push" model to ensure that patients from ED and AMU are transferred at set times in the day (10am and 12pm). • Staff on receiving ward to review risk assessments to ensure that patients' safety needs are being met.
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 through 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.	24 case record reviews and 10 investigations completed after 1 April 2022 related to deaths which took place before the start of the reporting period.

Statements of Assurance

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.	0.18% 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.	0.18% of the patient deaths during 2021/22 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	April 2021 – March 2022
Hip Replacement Surgery	0.79	0.84	
Knee Replacement Surgery	0.75	0.73	

Statement from NHS Digital regarding missing data:

"In 2021 significant changes were made to the processing of hospital episode statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

"We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known."

Core Quality Indicators – Re-admission Rates

Adult readmission rates remain largely unchanged from previous years.

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

- Work to deliver same day emergency care within medicine, frailty, gynecology, head and neck, and surgery
- Further development and use of virtual wards
- Ongoing expansion of the huddle tool to support timely discharge
- Flow initiatives including criteria led handover and criteria led discharge

Readmissions in RWT

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

Readmissions									Grand Total
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	
Aged 4-15	440	505	423	359	428	269	348	443	**3,215**
16yrs and over	5,966	5,443	5,165	5,677	6,018	4,051	7,967	8,659	**48,946**
Grand Total	**6,406**	**5,948**	**5,588**	**6,036**	**6,446**	**4,320**	**8,315**	**9,102**	**52,161**

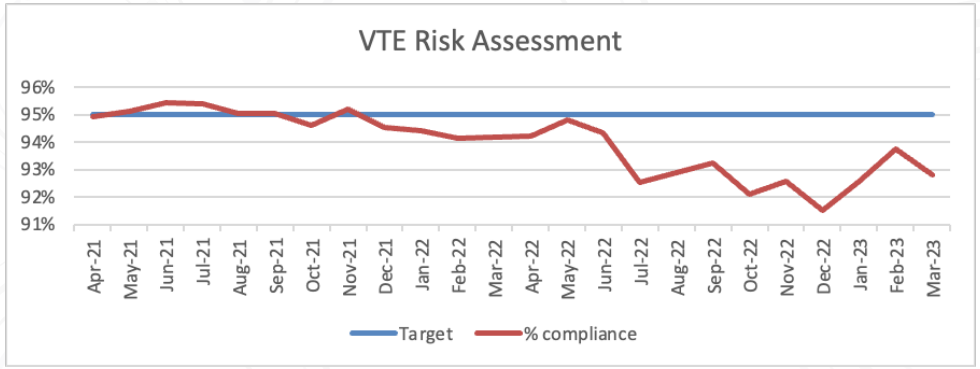
Total Admissions									Grand Total
Age	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	
Aged 4-15	5288	5429	5117	4,668	4,813	2,899	4,078	4,592	**36,884**
16yrs and over	115,288	118,585	117,355	117,669	120,049	90,876	136,824	147,554	**964,200**
Grand Total	**120,576**	**124,014**	**122,472**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

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

Core Quality Indicators – Venous Thromboembolism (VTE)

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

The graph below illustrates the Trust's compliance over time.



National data submissions to NHS digital have remained suspended since March 2020 due to the COVID-19 pandemic, therefore there is no national data currently available for benchmarking purposes.

We believe our performance:

- Demonstrates that the Trust has a robust process in place for collating data on venous thromboembolism risk assessments completed within 24 hours of admission
- Reflects the challenges of increased activity and impact on our compliance as a result of the COVID-19 pandemic and associated recovery plans.

Despite the challenges of the last two years and the pause in national data submission, we have continued to internally monitor our VTE risk assessment compliance. The timeliness of VTE risk assessment has been below our expected criteria and we continue to work with clinical areas to identify service improvement opportunities. Patient safety and effective care remain our priority and improving VTE risk assessment completions within 24 hours is our key target for the coming year, as is ensuring that patients receive care ein line their VTE risk assessment and individual needs. We continue to explore ways to improve compliance, including digital solutions and are currently preparing to apply for a VTE exemplar buddy which will allow us to work with an organistaion with exemplar status in order to learn and share best practice.

Core Quality Indicators – Clostridium difficile

	2018-19	2019-20	2020-21	2021-22	2022-23
Trust apportioned cases (hospital and community onset cases)	45	43	46	57	72
Trust apportioned cases hospital onset only (excludes community onset cases)	37	33	35	44	58
Trust bed days (calculated using hospital onset cases and rate)	289,063	289,728	289,017	289,093	269,777
Rate per 100,000 bed days (hospital onset cases only)	12.80	11.39	12.11	15.22	21.5
National average (hospital onset cases only)	14.00	15.38	14.09	17.30	22.21
Best performing Trust (hospital onset cases only)	0	0	0	0	0
Worst performing Trust (hospital onset cases only)	90.04	66.47	69.27	79.43	79.43

** These bed days have been calculated using C.difficile number and rate (data supplied by UKHSA). These numbers do not match those that are held by RWT information department for the same time periods. A query has been submitted to UKHSA on 25 May 2023 regarding this and a response is awaited.*

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

The Trust collates numbers monthly and submits to UKHSA. Figures for apportioned cases, apportioned cases (hospital onset only), rate per 100,000 bed days and national figures have all been taken from the UKHSA Healthcare Associated Infection Mandatory Surveillance Data Capture System. Bed days have been calculated using the apportioned cases (hospital onset only) and the rate per 100,000 bed days.

The Royal Wolverhampton NHS Trust has 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:

2021/22 (full year data)			2022/23 (full year sata)		
Incidents	**% resulting in death**	**% resulting in severe harm**	**Incidents**	**% resulting in death**	**% resulting in severe harm**
12,538	0.4% (45)	0.3% (35)	**16,356**	**0.2% (29)**	**0.2% (36)**

The Trust defines severe or permanent harm as follows:

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

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

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

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

Core Quality Indicators – National Inpatient Survey

CQC National Adult Inpatient Survey 2021 published results from CQC September 2022

The 2021 Inpatient Survey was part of a national survey programme run by the Care Quality Commission (CQC) to collect feedback on the experiences of inpatients using 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.

Patients were eligible to take the survey if they were 16 years or older, had spent one night in hospital during November 2021 and were not admitted to maternity or psychiatric services. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January and May 2022.

The survey is spilt into eight categories: ED, waiting list and planned admissions, the hospital and ward, doctors, nurses, care and treatment, operations and procedures, leaving hospital.

There are five questions highlighted as "CQC questions" – areas of focus that the CQC were particularly interested in. The results of these questions and comparable results between 2020 and 2021 are shown in the table below:

Category	Question	2020	2021	% increase/ decrease from 2020
The hospital and ward	Did the hospital staff explain the reasons for being moved in a way you could understand?	59.0%	62.0%	+3%
The hospital and ward	If you brought your own medication with you to hospital, were you able to take it when you needed to?	79.0%	76.0%	-3%
The hospital and ward	Were you offered food that met any dietary needs or requirements you had? This could include religious, medical or allergy requirements, vegetarian/ vegan options, or different food formats such as liquified or pureed food.	80.0%	79.0%	-1%
Leaving hospital	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	60.0%	63.0%	+3%
Overall views of care and services	During your hospital stay, were you ever asked to give your views on the quality of your care?	9.0%	7.0%	-2%

Nationally, gaining views on quality of care is always a low scoring question. The Trust has revisited its various posters for patient feedback. Place mats have been amended to seek views.

Most improved scores

The table details those questions that saw a more than five per cent increase. Both questions relate to leaving hospital:

Category	Question	2020	2021	% increase/ decrease from 2020
Leaving hospital	Did a member of staff explain the purpose of the medicines you were to take home in a way you could understand?	48%	54%	+6%
Leaving hospital	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	74%	81%	+7%

Medication features in a couple of questions although there was a reduction in score which was worse than expected from 79% to 74% for the question: *"If you brought medication with you into hospital, were you able to take it when you needed to?"*

Deteriorating scores

The table below details those questions where there was a statistically significant change in score.

Communication, as always, features as a common theme and for this survey, specifically about the patient not being able to understand. This applied to communication by both doctors and nurses.

The Trust can see that the other two questions specifically relate to capacity issues. In particular, waiting to get a bed on a ward and also notice when being discharged:

Category	Question	2020	2021	% increase/ decrease from 2020
Waiting to get a bed on a ward	From the time you arrived at the hospital, did you feel that you had to wait a long time to get a bed on a ward?	74%	67%	-7%
Doctors	When you asked doctors questions, did you get answers you could understand?	89%	84%	-5%
Nurses	**When you asked nurses questions, did you get answers you could understand?**	88%	84%	-4%
Leaving hospital	**Were you given enough notice about when you were going to leave hospital?**	72%	66%	-7%

Obtaining feedback from patients is vital for bringing about improvements in the quality of care and this is an excellent way for inpatients to directly influence services locally. Heads of nursing have been compiling an action plan to address areas where improvements can be made.

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

The Adult Inpatient Survey 2022 provisional results are due to be received Trust in June 2023. However, the official CQC results will not be released until September 2023 (date to be confirmed) and will feature in next year's Quality Account.

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

Patient recommendation to friends and family

The Friends and Family Test (FFT) is a nationwide initiative which is a simple, single question survey which asks patients to what extent they would recommend the service they received at a hospital department to family or friends who need similar treatment. The tool provides 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 on a monthly basis to the Department of Health and Social Care
- data is compared to our own previous performance, as set out in the table below.

The friends and family test recommendation scores are illustrated in the tables below. These include percentage changes on 2021/22 and the 2022/23 response rates. The Trust's overall average recommendation score for 2022/23 was 83%. When looking at the different touch points, there is a fluctuation of 8% with scores ranging between 77% and 85%. The Trust's overall response rate has varied between 15% and 20%.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust overall recommendation score	83%	84%	83%	84%	84%	85%	82%	82%	77%	85%	86%	84%

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust overall score - response rate	18%	18%	18%	18%	18%	19%	20%	18%	16%	18%	18%	15%

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*
2022/23	92%	92%	91%	92%	93%	93%	94%	94%	71%	71%	65%	72%	90%	87%	90%	91%
2022/23 comparison against 2021/22	-1	=	-1	+1	+12	+17	+12	+24%	-4%	+3%	-3%	=	-3%	-3%	-2%	=

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*
2022/23	77%	89%	78%	86%	91%	95%	90%	93%	80%	82%	84%	87%	86%	82%	83%	82%
2022/23 comparison against 2021/22	-19%	+22%	-3%	+5%	-5%	+1%	-3%	=	-6%	=	-1%	+4%	+3%	-3%	-3%	-2%

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

The below table illustrates the percentage difference between the Trust's recommendation score for each touchpoint and the local system and national results. The Trust scores higher for all the touchpoints for the (then)Black Country and West Birmingham Integrated Care System, except for Community. Comparisons with national scores indicate that Outpatients and Birth are above national scores.

	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
Trust overall	94%	69%	73%	92%	88%	95%	88%	77%
Compared to STP*	+3%	+4%	+2	-2%	+1%	+6%	+4%	+5%
Compared to National*	-4%	+3%	-5	-3%	-7%	+3%	-1%	-6%

* The Black Country and West Birmingham ICS and national scores as at 28 February 2022.

Core Quality Indicators – Supporting our staff

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

National NHS Staff Survey

The Trust has again undertaken a full census of the national NHS Staff Survey, in which all staff were invited to provide feedback on their workplace experience. The results have, for the second time, been measured against the seven people promise elements and two themes of staff engagement and morale. The specific words that make up the NHS People Promise have come from people in different healthcare roles – all making it clear what matters most to them and what would make the greatest difference in improving their experience in the workplace. These 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

The Trust response rate was 34%, a 5% decrease, although this was proportionate to the increase in the workforce establishment. For the first time, bank workers were also invited to participate in the national NHS Staff Survey, and this yielded a 12% response rate (out of 1,195) people.

The Trust scored higher than average for acute and community trusts in four of the People Promises:

- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We work flexibly

We also scored higher than average in the two themes:

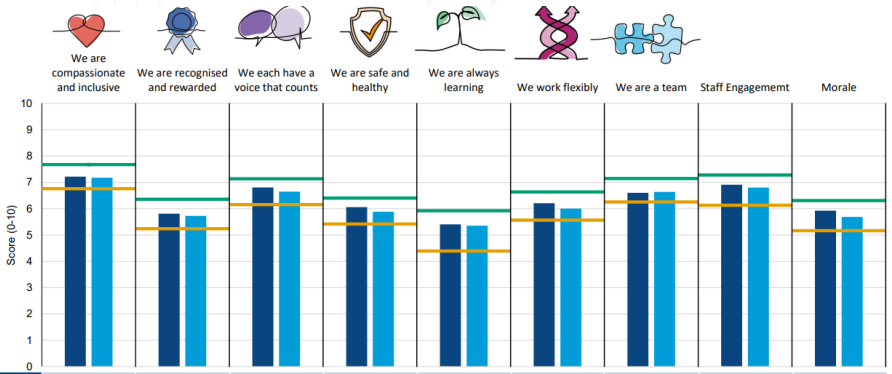
- Staff engagement
- Morale

Our scores are in line with the average for three People Promises:

- We are compassionate and inclusive
- We are always learning
- We are a team

Whilst all scores are above or in line with the sector average, they do show a decline from our 2021 Staff Survey results, with the exception of "we work flexibly", which has remained the same. This is likely in response to the Trust continuing to support agile and flexible working.

The table below shows the results for 2022 for each of the seven People Promise elements and the two themes and are scored on a 0-10 point scale, where 10 is the best score attainable. 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 Engagememt	Morale
Your org	7.2	5.8	6.8	6.1	5.4	6.2	6.6	6.9	5.9
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	3619	3619	3547	3563	3442	3592	3612	3623	3625

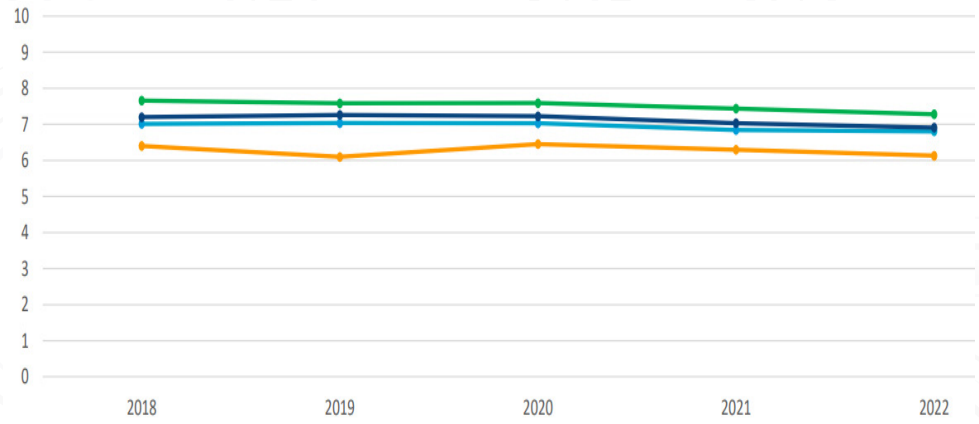
The Quarterly Pulse Survey response rate has shown a steady increase during 2022:

Q4 - 2021/22	Q1 - 2022/23	Q2 - 2022/23	Q4 - 2022/23
150	81	225	576

	Q4 - 2021/22	Q1 - 2022/23	Q2 - 2022/23	Q4 - 2022/23
Engagement	7.00	7.23	6.71	6.20
Advocacy	7.30	7.49	6.99	6.33
Involvement	6.60	6.91	6.54	6.02
Motivation	7.10	7.27	6.60	6.26

Staff Engagement

The graph below provides a comparison for each year from 2017 to 2022. Staff engagement levels within RWT have remained consistent over the last five years and are above average for the comparator group:



	2018	2019	2020	2021	2022
Your org	7.2	7.3	7.2	7.0	6.9
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	3125	3357	3275	3920	3623

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 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 the following actions to improve this, and so the quality of its services, in 2023/2024 by:

The key objective 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 2023/24 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 underperforming areas.

Supporting staff through speaking up

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, speak to a trade union representative or contact the Freedom to Speak Up Guardians. Two types of referral are available, identified and anonymous.

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/action points, which includes how any issues that have been raised will be addressed. Staff are given the opportunity to feedback and have a follow-up call. Any agreed actions are monitored by the Guardian and feedback is given to the staff member as 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 2022/23

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 2022/23 is shown below. The COVID-19 pandemic clearly had a significant impact on our performance: large elements of the Trust's 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

Performance against the National Operational Standards:

Indicator	Target 2022/23	Performance 2022/23	Performance 2021/22	Performance 2020/21
Cancer two week wait from referral to first seen date	93%	80.91%	81.87%	86.85%
Cancer two week wait for breast symptomatic patients	93%	84.29%	36.66%	51.42%
Cancer 31 day wait for first treatment	96%	75.83%	83.25%	86.03%
Cancer 31 day for second or subsequent treatment - Surgery	94%	54.67%	63.80%	76.02%
Cancer 31 day for second or subsequent treatment - Anti cancer drug	98%	82.36%	96.56%	97.92%
Cancer 31 day for second or subsequent treatment - Radiotherapy	94%	82.32%	84.96%	92.61%
Cancer 62 day wait for first treatment	85%	38.22%	47.36%	55.49%
Cancer 62 day wait for treatment from consultant screening service	90%	37.17%	48.66%	58.33%
Cancer 62 day wait - Consultant upgrade (local target)	88%	54.96%	67.07%	68.87%
28 Day Fast Diagnosis	75%	69.16%	71.42%	
Emergency Department - total time in ED	95%	76.51%	81.55%	85.56%
Referral to treatment - incomplete pathways	92%	59.85%	68.42%	65.26%
Cancelled operations on the day of surgery as a % of electives	<0.8%	0.29%	0.43%	0.34%
Mixed sex accommodation breaches	0	0	0	0
Diagnostic tests longer than 6 weeks	<1%	45.93%	31.76%	45.27%

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.

Indicator	Target 2022/23	Performance 2022/23	Performance 2021/22	Performance 2020/21
Clostridium Difficile	58	72	57	46
MRSA	0	2	1	2
Referral to treatment - no one waiting longer than 52 weeks	0	3,653	1,697	2,404
Trolley waits in A&E longer than 12 hours	0		523	169
ED waits >12 hours	<2%	7.82%		
VTE Risk Assessment	95%		94.84%	93.57%
Duty of Candour - failure to notify the relevant person of a suspected or actual harm	0	0	0	1
Stroke - 90% of time spent on stroke ward	80%	88.99%	83.30%	91.88%
Maternity - bookings by 12 weeks 6 days	>90%	86.90%	89.60%	92.00%
Maternity - breast feeding initiated	>64%	77.80%	75.90%	71.50%

Engagement in developing the quality account

Prior to the publication of the 2022/23 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

In 2023/24 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

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

NHS
Black Country
Integrated Care Board

Statement from Black Country Integrated Care Board (BCICB)

Black Country Integrated Care Board (BCICB) statement on The Royal Wolverhampton NHS Trust (RWT) Quality Account 2022/2023

BCICB welcomes the opportunity to review and provide the statement for The Royal Wolverhampton NHS Trust Quality Account for 2022/23. RWT Quality Account is materially accurate and in line with the information presented to the ICB via contractual/ quality monitoring and quality visits. The ICB recognises that 2022/2023 has continued to be a challenging year for RWT to deliver services with unprecedented demands outstripping capacity.

We genuinely recognise the Trust's efforts to maintain quality whilst acknowledging the uncertainties and the challenges faced throughout the year. The ICB would like to thank all staff and volunteers working at RWT for their commitment, remaining resilient throughout these challenging times, ensuring patient care is safe and of the highest standard.

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

We are proud of our effective working relationship with the Trust, and we recognise the Trust's achievements against the quality priorities and their individual and collective engagement with the commissioners.

The ICB are pleased to note that Quality remains a top priority for the Trust, focusing on three main areas: Patient Safety, Clinical Effectiveness and Patient Experience. We will continually monitor trust progress against the delivery of the quality priorities and look forward to seeing the positive impact and outcomes.

The ICB would particularly like to note the following key achievements for 2022/2023:

- Incremental improvement in compliance with "patient observations on time", an essential safety metric.
- Trust has embedded a process where the Trust is aware of all mental health activity within the organisation. With this oversight, assurance has been gained that all patients have access to the correct legal process supporting MHA.
- Initiatives taken by the Trust to improve the work/life balance of their nursing staff by offering flexible working will enhance the organisation's attractiveness to new staff and retention of current staff. In addition, we note that the Trust also relaunched the internal transfer programme with good results.
- Implementation of peer-led pastoral programme - leads for academic, socio-cultural, and early support aiding our international fellows with an easier transition into working in the NHS and adjusting to life in the UK.
- International nurse retention at the Trust was positive, and for 85 staff recruited during 2020, 85-90% remained at the Trust.
- Trust achieved 100% Care Certification for healthcare support workers (HCSWs).
- Trust has been successfully able to eliminate 104-week waits.
- Implementation of safe care and safe staffing policy to fully realise the benefits of a responsive, acuity-led staffing allocation and the governance of red flag alerts and reports daily.
- It is commendable that the Trust continues to be a strong performer concerning SHMI, and the values are continued to be reported within the `as expected' range and below the national average.
- Trust participation in 93% of national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.
- The ICB recognises that the Trust has worked collaboratively with system partners on services for patients who present to the Trust with significant mental health challenges alongside their physical ill health, and we are aware that this work is continuing.

Engagement

Whilst we recognise these achievements, we would value delivery of sustainable improvements in the following areas for 2023/2024:

- 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 expect to see a reduction in hospital-onset C.Diff infection cases for the year ahead.
- The Trust's intention to continue improving VTE risk assessment compliance is noted, and we look forward to seeing a further improved picture of VTE compliance and the positive impact of this work over the coming year.
- Members of the system elective and cancer board, we expect the Trust to work with our system partners to achieve three key performance deliverables and metrics set nationally as elective care priorities for 2023/24, which means:
    - Virtually eliminate waits of >65 weeks by March 2024.
    - Continue to reduce the number of cancer patients waiting over 62 days.
    - Meet the 75% cancer FDS ambition by March 2024.
- ICB acknowledges the impact that COVID-19 has had on Cancer, Diagnostic
- Performance and RTT waiting times. We recognise the Trust has a robust cancer harm review process in place, but we expect the Trust to conduct harm reviews for any patient where these delays have impacted clinical outcomes or resulted in patient harm. In addition, we expect that any learning identified from these harm reviews is shared across the organisation and wider system.
- We expect to see some further improvements in the trust staff survey and build on current staff survey results, which will allow fresh ideas, team building, cooperation, and positivity and make the Trust a place where the staff wants to work and attracts others for future employment.
- We look forward to seeing the Trust approach to the transition to PSIRF, which will replace the existing National Serious Incident Framework (2015) by Autumn 2023.

The ICB confirms that the Annual Quality Account information accurately reflects the Trust's performance for 2022/2023. It is presented in the format required and contains information that accurately represents the Trust's quality profile and reflects quality activity and aspirations across the organisation for the forthcoming year. We commend the Trust on its commitment to working with the ICB collaboratively and transparently in 2022/2023 and look forward to working in collaboration and partnership over the next year.

Sally Roberts

Chief Nursing Officer/Deputy Chief Executive Officer

Black Country Integrated Care Board

June 2023

CITY OF WOLVERHAMPTON COUNCIL

Statement from City of Wolverhampton Council Health Scrutiny Panel

City of Wolverhampton Council – Health Scrutiny Panel. Statement on The Royal Wolverhampton NHS Trust, Quality Accounts 2022-2023

We join in with the Trust celebrating 75 years of the NHS and extend our thanks to the staff, without whose efforts and resilience, we would not have the healthcare service we have today.

We are pleased the Trust is reducing cancer treatment waiting times for patients and endorse their commitment to further waiting time reductions, however, we note this has been raised previously by the Health Scrutiny Panel and we will continue to scrutinise this area to help ensure reductions continue. The creation of a Health Inequalities Steering Group is a positive step towards achieving equity in healthcare for our local population. We have noted the Trust is producing educational packages for staff to increase knowledge about health inequality and we will seek to bring this to our Panel in a timely fashion.

We note that Infection Prevention remains a challenge, with increasing cases above trajectory of various bacteria forms in Trust sites; we would like to see a stronger focus in staff training, site deep cleans and adherence to Infection Prevention & Outbreak Management protocols.

We support the Trust's goal in reducing adult general and acute bed occupancy to 92% and recognise that the digital wards plan should contribute to this aim; this will however require valuable Scrutiny to ensure that the roll out of this works for all patients and provides them with the same necessary and valuable care they would receive prior to the digital roll out. Ensuring this is done in a manner which is effective and sensitive to the needs of patients is paramount.

Health Scrutiny would like to see improvements made to public parking on New Cross Hospital grounds so better accessibility for patients and relatives can be provided. Space availability and ease of payment methods considering all people would significantly contribute to an improved service for our citizens.

We support the Trusts commitment to and increasing focus on enabling employment pathways and learning for its staff, as well as its volunteer placement schemes. Staff retention is a key area in maintaining a quality service for the population. We are pleased to read International Nurse Retention rates remain high since 2020 with a reported 85-90 percent staying, this is a testament to the internationalism of the NHS and the principles of universal healthcare, providing valuable skills and knowledge to specialists.

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
23 June 2023

Statement of director responsibilities in respect of the Quality Account 2022/23

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 2022 to March 2023
    - Papers relating to quality reported to the board over the period April 2022 to March 2023
    - Feedback from commissioners dated June 2023
    - Feedback from overview and scrutiny committee dated 23 June 2023
    - The 2022 national staff survey
- the quality report presents a balanced picture of the trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

Professor David Loughton, CBE
Chief Executive
30 June 2023

Sir David Nicholson, CBE
Chairman
30 June 2023

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement have confirmed in the Quality Accounts requirements for 2022/23 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 2022/23 with actions intended to improve the quality of healthcare

Local Audit Title	Actions to be taken by RWT
Audit of Calibration Compliance at West Park (20/21)	Raise awareness with staff and address documentation errors with calibration sheets
Audit of Compliance with Visual Reinforcement Audiometry Guidelines and procedures (22/23)	Reminder to clinical staff re documentation and cross checks of journal entries.
Evaluation on the effectiveness of BAHA service (22/23)	Provide training to improve and ensure the process that patients are seen in MDT and then referred for surgery, plus need to fully complete post-fitting questionnaires.
Audit of New Paediatric Hearing Therapy (PHT) Appointments (Tinnitus/ Hyperacusis) (22/23)	Communication to PHT team and relaxation therapist to request that the specific leaflet handed out is recorded. Develop a new hot key for appointments to improve continuity of care when the child is seen by other team members.
Melatonin ABR (22/23)	MDT meetings introduced and current pathway altered for difficult to assess patients (complex needs patients)
Audit of Completed ABRs (Re-audit) (22/23)	Reminders to staff to: Ensure that Peer review requirements are added to the system and reviewed within timeframes. Check flags, parameters, risks, codes and outcomes and update accordingly. Give appropriate literature at appointments.
Audit of Paediatric Hearing Aid fittings and Reviews 2022 (22/23)	Consider options to use hotkeys as reminder to record when REM is under target at high frequencies. Reminder to all staff to check new parameters and update on each visit.
Use of PPI with DAPT in patients with acute coronary syndrome - (Re-Audit) 2022/23	New ACS ward guideline to improve prescribing. Potential area to to create posters for the cardiology ward for cardiology SHOs on-call especially during clerking. Education re ACS treatment to the non-cardiology trained juniors/ new juniors rotating on cardiology regarding order-sets.
LocSSIp- Chest Drains (2020/21 DATA) 2022/23	Minor non-compliance so reminders to staff re importance of checklist completion.
Audit of diabetic patients having operations in June 2021 (covering New Cross and Cannock) 2021/22 (2022/2023)	Theatre list to document diabetes and allocate patient first on list unless other patient takes clinical priority.

Local Audit Title	Actions to be taken by RWT
Improving communication between physicians and patients' relatives in the Intensive Care Unit (ICU) 2022/23	Informing doctors and ACCPs in ICU to update their patients' relatives at least twice a week.
Posters on ICU and plan to include relative updates as part of the ward round plan.	
Arterial Line 2022/23	Disseminate results and recirculate sticker information. Designated drawer for all compulsory stickers. All stickers mentioned in Doctors-intraining induction pack. Checking of relevant prescriptions on ward rounds. Education for new nurses regarding site monitoring. Propose flush-bag change to be 48 hourly.
A Quality Improvement Project to understudy the difficult intravenous access service provided by the Directorate of Intensive and Critical Care 2022/2023 (Part 1)	Organisational training in USS guided IV cannulation for hospital doctors, and designing a protocol for borrowing USS machines from theatre.
HTM01-05 - Infection Prevention (21/22)	Business case for refurbishment is awaiting approval at the time of this audit. Temporary repairs in meantime and risk managed via risk register.
RADQA reaudit (21/22)	In-house training of staff in new grading guidance and introduction of RINN holders, create new log book and risk assess the likely doses received and liaise with radiation advisor.
RADQA reaudit (22/23)	In-house training of staff and introduction of RINN holders
HTM01-05 - Infection Prevention Reaudit (22/23)	Refurbishment planned. On Directorate risk register.
Improving the surgical ward round: a quality improvement project	Creation of ward round proforma and education of the team via clinical governance meeting.
Do we follow GMC guidelines for intimate examination and chaperone use? (22/23)	Posters in surgical ward areas about guidelines for intimate examination, consent and chaperoning and exploring introducing a stamp to meet the RCS standards of documentation on intimate examination, consent and chaperoning.
Evaluation of General surgical Operations Notes according to the Royal college Guideline and Good Surgical Practice (22/23)	Development of a new proforma for operation notes, consideration of including general standards for documentation in the induction for new starters.

Appendices

Local Audit Title	Actions to be taken by RWT
National Audit - Project assessing the Management of Endometrial Hyperplasia - pre and post 2016 Green Top Guideline (2021/22) 2022/2023	Developing Trust guideline with clear algorithm for the management of EH and AEH. Explore feasibility of developing database and recall system to maintain timeline for biopsy follow up. AEH should be discussed with MDT / ? MRI before medical treatment. Adopting holistic approach in the management of EH and addressing high BMI and weight reduction measures.
Audit of ovarian cancer investigation and management over a 5 year time period (2022/2023)	Documentation of RMI at initial review Recommend BRCA testing and document as routine at initial oncology review.
Retrospective review of management of Endometrial Hyperplasia (2022/2023)	Developing Trust guideline with clear algorithm for the management of EH and AEH Explore feasibility of developing database and recall system to maintain timeline for biopsy follow up. AEH should be discussed with MDT / ? MRI before medical treatment. Adopting holistic approach in the management of EH and addressing high BMI and weight reduction measures.
QIP- E-Discharge in Gynae Oncology (2022/2023)	Raise awareness via discussion at Gynae Care Group re importance of specifying follow-up, duration of hospital supplied medications and whether the patient had a procedure/diagnosis/ plan discussed with them during their inpatient stay.
QIP- Post Coital Bleeding (2022/2023)	This project delivered further teaching and learning to junior doctors around the subject.
Improving the safety and effectiveness of the gynaecology emergency handover Audit (2022/2023)	Improvements to handover including ensuring all relevant staff attend, that it is completed face to face, covering all aspects of care and takes place at a specific location.
QIP-'Gynaecology post op Ward Round Audit (to review attendance to see elective gynaecology patients daily) (2022/2023)	Develop a simple department guideline for post-op rounds and develop and expand on standards. Emphasise/feedback on detailed documentation. Survey - record of discussions with nurse in charge after rounds.
Minimal access rate for patients under the age of 50 undergoing hysterectomy for benign reasons Service Evaluation (2022/2023)	Plan to offer women minimal access hysterectomy i.e., either vaginal or laparoscopic route wherever feasible. Training clinicians to use morcellation technique to perform hysterectomy of a large fibroid uterus laparoscopically. Encouraging consultants to refer patients to their colleagues if they have surgical skills to perform the procedure through minimal access route.

Local Audit Title	Actions to be taken by RWT
Re-audit Antibiotic prophylaxis in daycase dentoalveolar surgery (22/23)	Update induction pack and produce poster for anaesthetic room.
An Audit of Time to CEPOD Theatre for Patients admitted under OMFS with Acute Cervicofacial Infections. (22/23)	Review of CEPOD theatre lists to aim to reduce the time to theatre and reduce any delays, leading to reduced length of stay and improved patient care.
Assessing the effectiveness of a new analgesia protocol on re-presentations amongst paediatric post-tonsillectomy patients (22/23)	Ensure clear communication and documentation between surgical team, anaesthetic team, nursing staff and parents regarding optimal use of analgesia prior to and post-tonsillectomy. Ensure adherence to prescription using proposed proforma for all components of the analgesia protocol. Encourage use of tonsillectomy pain management home diary to ensure optimal analgesia is delivered.
A quality improvement project for post-operative pain management of osteotomy patients (22/23)	Implementing a standardised post-operative pain management protocol for inpatient and outpatient medication and to complete a post-operative pain review at the follow up appointment.
Black Country Head and Neck Cancer Pathway - an Audit and a Service Evaluation (22/23)	Further discussion of findings at the head and neck cancer MDT meeting.
Thyroidectomy Audit (22/23)	To improve clinician education on BAETS guidelines relating to the peri-operative care of patients undergoing Thyroidectomy.
ENT Handover sheet audit (22/23)	The audit has reminded clinicians on safe and adequate handover and reinforced the need for a more robust system which will be introduced with the rolling out of Careflow Connect.
Compliance with glandular fever screening in patients admitted with acute tonsillitis (22/23)	Further data is being collected on differential white cell count. If this is predictive of acute glandular fever infection, the Trust guidelines will be reviewed so that glandular fever screening should be considered but is not mandatory.
Operation Notes Audit (22/23)	Clinicians were reminded of the Royal College of Surgeons "Good Surgical Practice" guidelines for documentation of operation notes via presentation of the audit results and email circulation.
Hypoglycemia QIP	Ensure that haemolysed samples are repeated and send urine sample as per guidance
Low Cord PH Audit (2022/2023)	Education of junior doctors and midwives.
NICE CG129 & QS46 Multiple Pregnancy Audit- Caearean Sections (2021/2022) 2022/2023	Good compliance with NICE guidance – improvement actions around documentation on mode of delivery (MOD) discussion.

Appendices

Local Audit Title	Actions to be taken by RWT
Saving Babies Lives Element 4- Intrapartum care for healthy women and babies- CTG Compliance (2022/2023)	Consultant fetal monitoring lead and fetal monitoring midwife will ensure all medical and new midwifery staff have been allocated to a fetal monitoring study day and reallocate non-attenders.
Major Obstetric Haemorrhage (MOH)/ Post partum haemorrhage (PPH) (primary and secondary) Audit (2021/2022) 2022/2023	Improve documentation from theatre cases / recovery area, risk discussion in the briefing of elective cases and prophylactic measures. Low threshold for use of TXA. Encourage PPH proformas
Consent in Obstetrics Audit (2021/2022) 2022/2023	To introduce standardised procedure specific pre-printed consent forms with risks outlined as per RCOG advice. Antenatal counselling: to provide information about operative vaginal delivery to women on BadgerNet app ,so the women can go through it and get background information about instrumental delivery in the antenatal period. Intrapartum Counselling: to develop patient information sheets/infographics in partnership with patients and midwifery staff to be available for intrapartum counselling of women on labour ward.
Saving Babies Lives: Element 3- Reduced Fetal Movement Monitoring Audit (2022/2023) 2022/2023	Ensure awareness amongst all maternity staff including midwives and doctors regarding the importance of RFM at the induction. Ensuring all maternity/medical staff have recorded given/discussed the Tommy's leaflet recorded on the BadgerNet. Ensure that the RFM checklist is completed fully prior to discharge home.
NG25 and Saving Babies Lives Element 5: Preterm Labour and Birth (to include data on MSU) (2022/2023)	Learning for staff re: UTI positive growth must be treated according to the culture and sensitivity in a timely fashion. Good practice to document the name of the antibiotic prescribed. Results of MSU must be reviewed and filed in the system by all doctors as evidence that the results were acknowledged and acted accordingly. A repeat MSU must be sent after completing treatment to confirm the clearance of infection
Saving Babies Lives: Element 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR) (2022/2023) - incorporating requirement of CNST quarter audit of a minimum of 10 cases delivered <3rd centile after 37*6 weeks	Include data on SBL dashboard Raise awareness amongst staff to update each patient's risk assessment following review.

Local Audit Title	Actions to be taken by RWT
Ockenden Report Audit: Intrapartum Risk Assessment Re-Audit (2022/2023)	Reminder to all staff by using visual aid with an additional column on Induction unit and Delivery Suite white board ensuring continuous intrapartum RA is being done. Highlight need for risk assessment during mandatory EFM training.
Ockenden Audit: Audit of Handover process on Delivery Suite (2022/2023)	Re-audit results demonstrates considerable improvement in hand over-process. Increase awareness of handover times and the hospital guideline.
Ockenden Audit: Audit of Maternity Inpatient Review by Consultants (2022/2023)	Consultant buddy teams to have rota for ward cover Reg/SHOs have been clustered into teams to improve ward cover. More direct contact with registrars during week through texts / emails to discuss cover for the week. Use of blue spots for visual reminder of who hasn't been seen. Agreed escalation plan for patients not seen.
Saving Babies Lives Element 4- CNST- 4.2 - Are all staff who care for women in labour required to undertake annual training and competency assessment on and use of auscultation every 12 months? February 22 (2022/2023)	Improve documentation of reasons why maternal pulse or auscultation may be missed or delayed.
Saving Babies Lives: Element 1- Reducing smoking in pregnancy (2022/2023)	Outcomes are above threshold required but not yet at 100%. Ongoing work aided by the Smoking Cessation Team alongside continued efforts of midwifery and support staff at each stage of the woman's journey.
MLU audit 3rd/4thDegree Tears Audit (2022/2023)	Ensuring documentation is more detailed in birth position, particularly in water Ensuring new midwives to are supported at time of birth (where possible) for a number of births before supporting women independently
Saving Babies Lives Element 4- CNST- 4.2 - Re-Audit- Are all staff who care for women in labour required to undertake annual training and competency assessment on and use of auscultation every 12 months? February 2023 (2022/2023)	Staff learning around need to document reason why auscultations are delayed/omitted, also to ensure that maternal pulse is palpated and documented hourly in 1st stage and quarter hourly in 2nd. Ensure time on BadgerNet is adjusted to reflect time of auscultation rather than time of entry to avoid appearance of delayed auscultation.
CNST Safety Action 4: Roles & Responsibilities of the Obstetric Consultant Compliance Monitoring (2022/2023)	Continue to follow the Consultant attendance monitoring process.
Local ECV Service Evaluation (2022/2023)	Updating ECV leaflet in line with RCOG leaflet
Efficacy of WHO Surgical Safety Checklist for Cataract Surgery 2022/23	Set local guidelines for documentation in biometry sheet and patient notes.

Appendices

Local Audit Title	Actions to be taken by RWT
'Going green' in Ophthalmic theatres (22/23)	A table has been created with the help of the waste management team to raise awareness for theatre staff of which bags different waste gets placed in.
Assessment and Management of Paediatric Supracondylar Humeral Fractures at New Cross Hospital, Wolverhampton (2022/2023)	Proforma for easy documentation of assessments (pre-op and post-op). Updated operation note template. Discharging clinician to ensure all patients have a documented post-op assessment before discharge. Continue the excellent compliance with x-ray post op, long term follow up and wires removal.
Door-to-clexane time in trauma patients (2022/2023)	Changes and improvement around clexane plan including on electronic prescribing system, clerking and handover documentation. Reviewing ED and ward doctor involvement.
Effect of pre-operative dexamethasone on post op pain relief, PONV and length of stay in lower limb arthroplasty patients (2021/2022) 2022/2023	Results inconclusive due to small numbers, but having an agreed recommendation and protocol for the Trust may help to standardize as per best practice.
Re-audit of compliance with surgeon operated mini c-arm standards (2022/2023)	Electronic form - prompts user to complete all pertinent sections. Negates issue of missing radiology request forms and allows for better analysis. Standardised font makes information more legible.
VTE Re-audit (2022/2023)	Document diagnosis clearly, including the anatomical side of pathology. Whilst patients may already be on VTE prophylaxis when presenting for cast modification, indicate this clearly – this is also an opportunity to catch any initially missed cases. Document weight bearing status. Emphasise the importance of doing and documenting a VTE risk assessment on the plaster room sheet.
Assessment of the workload assigned to General Practices within one month of discharge post elective orthopaedic surgery (2022/2023)	Clinic for clip removal +/- BP check / blood samples / wound review. Proforma given to patient to give to GP i.e., with BP documented. GP can then make further decisions about medications etc. GP can also action results of blood tests in community.
Bone bank transportation- from consent to green freezer re-audit (2022/2023)	Improvements around flagging patients who are rescheduled to have fresh set of pre-op bloods, improve documentation where bone graft not taken for donation, measures to minimize contamination of samples, improved labelling and documentation of entry time to freezer.
Safe use of Intra-operative tourniquets in Trauma and Orthopaedics (2022/2023)	Improvements in documentation of exsanguination, padding and method of isolation, compliance with tourniquet pressure. Raising awareness of guidance via posters in theatres.

Local Audit Title	Actions to be taken by RWT
Emergency Spinal MRI Services QIP(2022/2023)	Aiming for improved access to MRI services for cauda equina syndrome, and implementing a local pathway for cases of back pain with suspected cauda equina syndrome.
Re-Audit of Documentation in Medical Records-consent form 4 for neck of femer patients (2022/2023)	Include next of kin discussion in medical clerking checklist Involve NOF nurses Prompt underneath the AMTS
Post-operative urinary retention (POUR) in lower limb arthroplasty patients (2022/2023)	Improve compliance with bladder scan protocol
Outcomes of Platelet Rich Plasma Injections In Early arthritis of The Knee. Comparison between a single injection Vs Course of Three Injections	Consider establishing PRP clinics once a month to improve theatre efficiency.
QIP: Improving Discharge Summaries for Arthroscopic Procedures (2022/2023)	Poster will be included in induction pack for junior doctors. Awareness raised for discharge summaries of all day case procedures.
An audit of the investigation and management of shoulder dislocation in New Cross Hospital against BESS guidelines (2022/2023)	Improved awareness via presentation of audit findings and posters in fracture clinic. Gatekeeping of slots on acute shoulder instability clinic lists.
Re-Audit of Compliance of Antimicrobial prophylaxis in Trauma and Orthopedic surgery (2022/2023)	Learning incorporated into junior doctor induction and nurse teaching around antibiotics to be given to maintain optimal plasma level for 24 hours, per Trust guidelines.
NICE-related audit: Review of the outcomes for patients with fast track referrals for possible testicular cancer (2022/2023)	Results highlighted the importance of reviewing the ultrasound scan before fast-track referrals. Considering whether primary care could access USS results prior to fast-track referrals. Two fast-track USS slots to be allocated every week.
QIP: Day Case TURBT Project (2022/2023)	Development of TURBT stickers to distinguish day case suitability easily and drive decisions re suitability at time of booking, aiming to reduce default position of overnight stay.
CEPOP Theatre Utilisation pre and post merger of Walsall and New Cross Emergency Urology (2022/2023)	Continued monitoring of CEPOD use and if necesssary to procure extra radiographer support in theatre.
Group & Save Samples for Robotic-Assisted Laparoscopic Prostatectomy Service Evaluation (2022/2023)	Routine pre-operative G&S samples is likely unnecessary and stopping this may lead to increased efficiency and sustainability. To be sampled and cross-matched on a case-by-case basis.

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:

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

Tel: 01902 695368
Email: rwh-tr.pals@nhs.net

English

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

Punjabi

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

Polish

Aby uzyskać niniejszy dokument w innym języku lub formacie, np. pisany dużą czcionką, itp., prosimy skontaktować się z przedstawicielem personelu medycznego.

Russian

Если данный документ требуется Вам в альтернативном формате, например крупным шрифтом, на другом языке и т.п., просьба сообщить об этом одному из сотрудников здравоохранения.

Lithuanian

Jei pageidaujate šį dokumentą gauti kitu formatu, pvz., padidintu šriftu, išverstą į kitą kalbą ir t. t., praneškite apie tai sveikatos priežiūros darbuotojui.

Kurdish

ئەگەر ئەم بەڵگەنامەیە بە شێوازێکی دیکە دەخوازیت بۆ نموونە چاپی گەورەتر، زمانێکی دیکە هتد. تکایە پەیوەندی بە کارمەندانی سەرپەرشتی تەندروستی ئاگادار بکەرەوە.

Designed and produced by the Department of Clinical Illustration, New Cross Hospital, Wolverhampton WV10 0QP

MI_11820214_30.06.23_V_1