The Royal Wolverhampton
NHS Trust

Quality Account 2019-20

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The Quality Account

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, taking into account 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.

Quality Account (2009) Health Act

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:

Patient Experience Team

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Statement on Quality from the Chief Executive

Introduction

During 2019/20, the Trust has continued to build upon its successful integrated care model in order to provide seamless care for our patients, at the right time and in the right place. The Trust has worked collaboratively with its partners, including Clinical Commissioning Group, Local Authority and General Practices to capitalise on our strengths and reduce care variation. Our vertical integration model has further expanded and we welcomed two new General Practices, Dr Bilas and Dr Fowler.

Workforce has continued to be one of our greatest challenges. However, persistent focus on recruiting to the nursing workforce has resulted in a significant reduction in nursing vacancies across the board. Our nationally recognised Clinical Fellowship programme for doctors has been successfully expanded to the nursing profession and subsequently the Trust won a national award for the Best Workplace for Learning and Development at the Nursing Times Awards. The Trust has also continued to invest in enriching its workforce by embedding specialist roles.

The Continuous Quality Improvement (CQI) model has continued to embed, with 143 staff having attended the Quality Service Improvement and Re-design (QSIR) fundamental training, 9 staff becoming QSIR trainers and 10 staff becoming QSIR practitioners. Having embedded the model of key trainers and practitioners, the Trust is now cascading this training across the organisation to ensure that the CQI approach is part of the culture, improvement and innovation across the organisation.

The Trust has continued to drive improvements with regards to a variety of safety indicators such as infection prevention, patient falls, sepsis, response to the deteriorating patient and pressure ulcers and these will remain as the areas of focus for 2020/21. The mortality improvement agenda has continued to be progressed, with the Trust working collaboratively with our Clinical Commissioning Group, to ensure that any learning is addressed across the system. As a result of this work, the Trust has seen the Summary Hospital-level Mortality Indicator (SHMI) reduce to an expected range. During 2019/20, the Trust scored, for the first time, above the national average for all categories of the Patient-Led Assessment of the Care Environment at New Cross Hospital, West Park Hospital and Cannock Chase Hospital, which is highly commendable.

The Trust welcomed the Care Quality Commission (CQC) during the summer 2019/20 to undertake a well-led and core services inspection. As well as the Use of Resources and well-led inspections, seven core services were inspected and the Trust received an overall rating of Good. I am delighted with this outcome and the Trust will continue to build upon its achievements and address all of the areas we need to improve. In addition, the CQC conducted an Ionising Radiation (Medical Exposure) Regulations IR(ME)R inspection, which resulted in a positive outcome. Coalway Road Medical Practice and Penn Manor Medical Practice were also inspected and their overall rating was Good.

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

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

Signed:

David Loughton CBE, Chief Executive

13th July 2020

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

Achieving Our Vision - Strategic Objectives

Our Values

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

Trust Strategic Objectives 2018-2021

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

Looking back 2019/20

Priorities

for Improvement

Workforce

We aim to deliver safe patient care and good patient experience. Our wards and departments need to have the right levels of staff and skill mix for the acuity of the patients for which they are caring.

Patient Safety

We aim to be the safest NHS Trust by "always providing safe & effective care, being kind & caring and exceeding expectation" (Trust Vision & Values September 2015) by making safe quality care a whole-system approach for every patient that accesses the Trust and its services.

Patient Experience

We are committed to providing high quality clinical care and aim to provide an excellent experience for patients, their relatives and carers.

The above priorities have supported the following Trust strategic objectives 2018-2021:

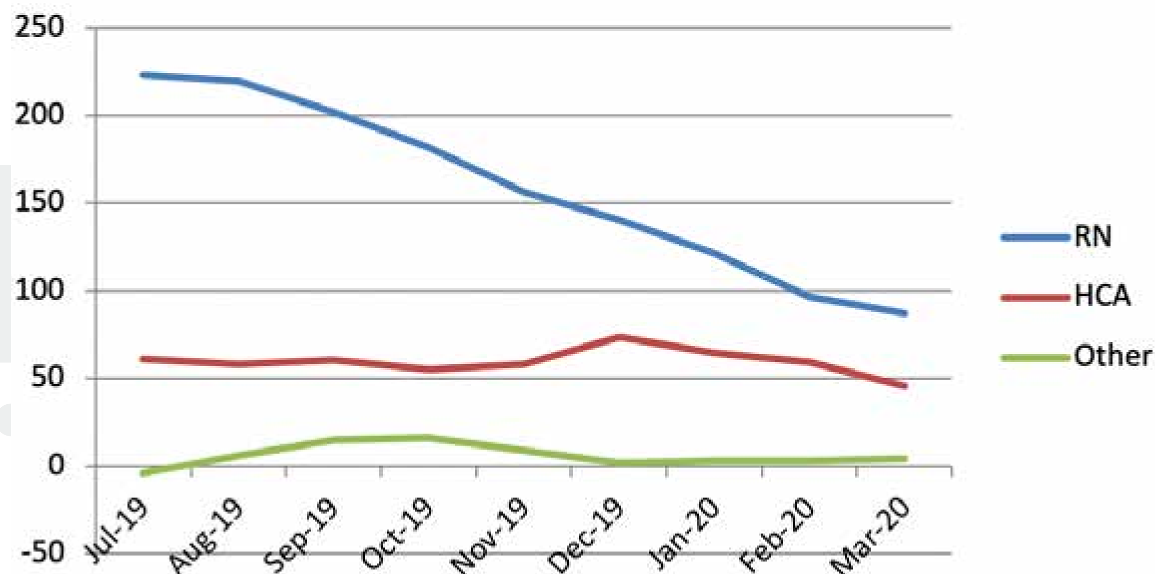
- To have an effective and well integrated health and care system that operates efficiently
- Proactively seek opportunities to develop our services
- Create a culture of compassion, quality and safety
- Attract, retain and develop our staff and improve employee engagement
- Be in the top 25% for key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

Priority 1: Workforce

Nursing, Midwifery and Health Visiting Workforce

During the financial year 2019/20, the Trust has continued its relentless efforts to recruit into the vacant nursing, midwifery and health visiting staff (registered and unregistered) vacancies. The Trust has further developed its nursing, midwifery and health visiting vacancy report and ensured that all key posts have been included, which provides a much more accurate status of vacancies.

The graph below illustrates the new reporting baseline since the change in June 2019 for registered nurses, midwives, healthcare support workers and other support staff.



Our key achievements during 2019/20 included:

- Extensive efforts were made to recruit into the vacant nursing, midwifery and health visiting posts, which included United Kingdom and international staff
- To support the increased number of staff into the organisation, the Trust invested into additional Practice Education Facilitator posts to provide pastoral and educational support to our new recruits and the existing staff
- Significantly increased the number of student placements offered to students from the Staffordshire, Wolverhampton and Birmingham universities
- Successfully utilised apprenticeships for registered and unregistered staff. This particularly supported people in the local community
- Forged strong links with the Prince's Trust to

enable young people in the local community to spend time in the health service to observe and understand future career opportunities. This resulted in some of these young people completing an apprenticeship programme and gaining employment within the Trust

- A retention strategy was developed, which included flexible working initiatives, retire and return options and development of a career framework. The framework provides guidance for staff to choose educational packages to support their career development. This is further underpinned by the Clinical Fellowship Programme for internal staff, which enables the staff to either complete a top up degree programme or masters programme. This strengthened approach resulted in 0.5% improvement in our retention rate for nursing, midwifery and health visiting staff
- The overall nursing, midwifery and health visiting leadership structure was reviewed and strengthened to embed the quality agenda and ensure robust senior oversight across the organisation
- The nursing, midwifery and health visiting education offer was reviewed to ensure it meets the future requirements of our workforce. This includes, for example, our 12 month preceptorship programme for all registered nurses, midwives and allied health professional recruits
- The Trust won a national award for the Best Workplace for Learning and Development at the Nursing Times Awards.

Medical Workforce

The key areas of focus included:

Senior (consultant) medical staff

- Continued focus on prioritising high quality appointments and ensuring the Trust is a preferred employer for those applying
- Strengthened the induction process and support for new consultants
- Identification of areas where consultant staffing is nationally challenged and development of links with other organisations/networks (e.g. oncology) and also planned development of fellows through Certificate of Eligibility for Specialist Registration (CESR) to consultant level in these specialties (oncology, radiology, ED)
- Robust job planning being implemented and plan to introduce rostering to maximise efficiency of consultant workforce.

Junior medical staff

- Deanery trainees – focus on maintaining high satisfaction levels in Job Evaluation Survey Tool (JEST) surveys, which are recognised as important in attracting trainees to work at the Trust as consultants in the future
- Strengthened support team for deanery trainees both academically and pastorally

- Fellowship programme – this award winning programme has increased in size with >140 fellows now employed at the Trust. The Trust has liaised with Health Education England (HEE) and the programme has now been approved as a HEE recognised training programme.

Allied Health Professionals

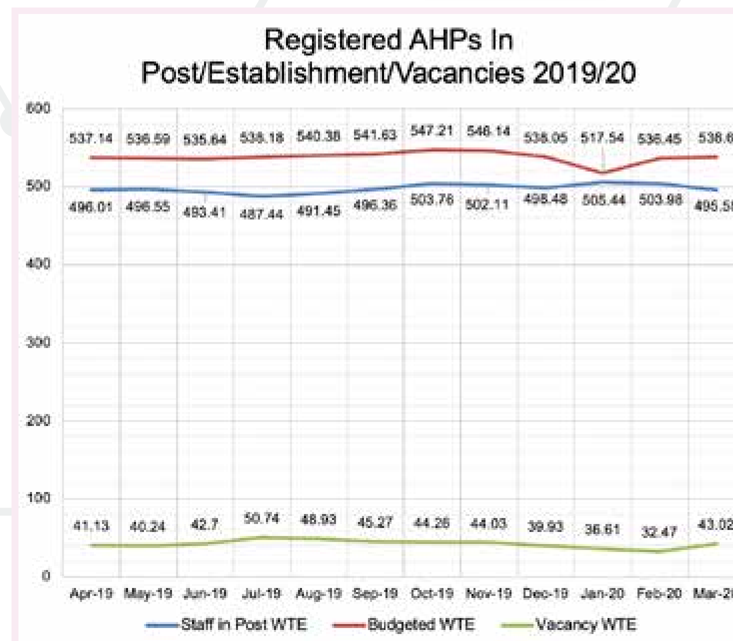
Registered Health Care Professionals form an integral part of the workforce across the Trust. As such professional leads are responsible for ensuring that they have an appropriate team structure and consistent and robust processes for communication and management within the teams. There must be sufficient and appropriate staffing capacity and capability to provide safe, high-quality and cost-effective care to patients at all times. Staffing decisions must be aligned to operational planning processes so that high quality care can be provided now and on a sustainable basis.

Nationally the focus on safe staffing has remained high and will continue to be so for the foreseeable future in light of the shortages of some Registered Health Care Professional groups. The Standard Operating Procedure (SOP) for Registered Health Care Professionals (non-nursing/medical) – Ensuring Safe Staffing Levels in Departments/Services has been developed and details relevant national guidelines that underpin safe registered Health Care Professional (non-nursing/medical) staffing for the areas. The SOP outlines the following:

- The methodology undertaken to agree funded Registered Health Care Professional establishments and skill mix
- How the establishments and skill mix are monitored to ensure that they remain fit for purpose, specifically to ensure appropriate staffing levels are provided to meet the dependency, acuity and complexity of patients in our care
- The process for regular and responsive staffing review
- The escalation process and steps to be followed to meet the demands of short term and long term staffing problems
- The expected outcomes and impact of safe staffing.

The following graph illustrates the establishment and vacancy data for Registered Allied Health Professionals (AHPs) for 2019/20.

Ongoing efforts continued to recruit into these vacancies during 2019/20. However, some are associated with national shortages for these professions.



The overall AHP vacancy rate has increased, with approximately 8% of vacancies unfilled in M12.

The vacancy rate ranged from <1% to 19% across the professions as follows:

Podiatry = 19.4%

Dietetics = 12.8%

Orthoptics/Optics = 14.89%

Physiotherapy = 11.41%

Diagnostic Radiography = 8.9%

Priority 2: Safe Care

Number and Themes of Serious Incidents

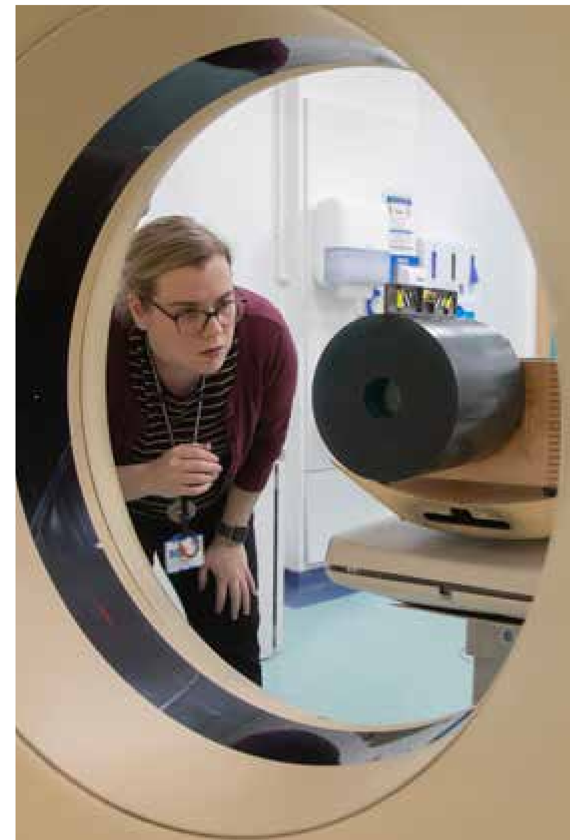
The Trust has a robust incident reporting mechanism communicated through policy, training and management lines. The arrangements include processes for the timely reporting, investigation and management of serious incidents.

In the financial year 2019/20, the Trust reported 89 serious incidents (13 less than in 2018/19) via the national serious and incident system (STEIS). The most significant changes being a reduction in the numbers of confidential breaches from 13 reported in 2018/19 to 3 in 2019/20. In contrary, the number of treatment delay incidents has increased from 4 reported in 2018/19 to 13 in 2019/20 and diagnostic incidents increasing from 12 reported in 2018/19 to 18 in 2019/20. The reduction of the numbers of Slip/Trips/Falls (with serious harm) noted last year continued with a 50% reduction in the numbers reported this year (5 incidents) when compared to the numbers reported in 2018/19 (10 incidents). Other reductions in incident types included maternity incidents and never events (50% reduction in the numbers of never events reported).

All serious incidents are reported in a timely manner and undergo robust investigation to ensure the Trust learns from these incidents to reduce the likelihood of recurrence and prevent further harm to patients. In addition, the Trust ensures that duty or candour requirements are met for all serious incident investigations.

During 2019/20, the Trust conducted a review of the serious incident themes reported and the following actions were identified to address causal themes:

- Strengthening local procedural arrangements – good progress has been made and work is ongoing
- Provision of specific training and education sessions both face to face and e-learning – work is ongoing
- Review the impact of Human Factors, for example, communication, handover practice, non- technical skills – scoping of handover practice has been completed and the Process Communication Model training continues
- Communication of shared learning throughout the Trust – development of shared learning intranet page and learning log
- Trust wide improvement initiatives, for example, patient falls reduction programme and a variety of continuous quality improvement (CQI) projects – CQI projects are ongoing and reporting into the Trust Governance structure.



The following serious and STEIS reportable incident data is a true reflection of events based on the data analysed on the 9th April 2020. The table does not include those incidents that have since been agreed for removal by the CCG.

Category	01/04/19 to 31/03/20
Accident	1
Actual Self Inflicted Harm	2
Confidential Breach	3
Diagnostic	18
Infection	10
(C.Diff)	(3)
(CPE)	(1)
(MRSA)	(5)
(Norovirus)	(1)
Major Incident	1
Maternity	5
Never Event	2
(Retained Foreign Object)	(1)
(Wrong Site Surgery)	(1)
Pressure Ulcers	15
(Community)	(2)
(Hospital)	(13)
Slip/Trip/Fall (with serious harm)	5
Sub Optimal Care	6
Surgical/Invasive Procedure	4
Treatment Delay	13
Unexpected Death (coded as pending at this time)	3
VTE	1
TOTAL	**89**

New Overall Total = 89
The figures above do not include any agreed removals and are a true reflection as of this time

During 2019/20, the Trust referred 10 maternity investigations to the Healthcare Safety Investigation Branch (HSIB) for investigation in line with the national process. From this number, 4 investigations have been completed. Learning from these incidents will be taken forward via the established governance processes.

N.B: Due to the coronavirus (COVID-19) pandemic pressures and the resulting impact on clinical staff and services, some of the data provided could be subject to delayed update and subsequent refresh. This data could include incident reports and clinical audit figures that may be subject to update/refresh from clinical staff who are currently unable to update the respective systems.

Numbers and Themes of Never Events

During the financial year 2019/20, there were 2 never events reported causing low harm. This is a reduction from the previous year when 4 never events were reported. Their details are as follows:

Date	Location	Category	Level of Harm	Progress
June 2019	Anaesthetics	Wrong Site Surgery (This related to a wrong side anesthetic block)	Low	Investigation completed
March 2020	Maternity	Retained foreign object (This related to a retained tampon)	Low	Investigation in progress

Never Events are reported in a timely manner and robustly investigated to ensure that the organisation learns from them to reduce the likelihood of recurrence and/or prevent never events occurring.

Progress with never events is monitored in line with the established serious incident process. This involves the Divisional Management Team at their Divisional Governance meetings and also via the Quality and Safety Intelligence Group (QSIG) and Trust Board.

The key lessons which have been learnt from the completed investigation are as follows:

- Staff must ensure that they follow the 'Stop Before You Block' procedure
- Discussion with regards to this requirement have taken place within all Directorates that use the WHO checklist for interventional procedures
- All members of staff must be engaged and present in all aspects of the WHO checklist to avoid communication errors
- The person [trainee or consultant] who assesses the patient must be present at the WHO team brief.

A reminder has been issued to all staff involved in performing invasive procedures stating they all have a responsibility to ensure that established safety procedures are followed. As part of the further work to be undertaken with the Association for Perioperative Practice, empowerment of staff to challenge non-adherence will be encouraged

How have we performed against 2019/20 plans?

Harm Free Care

Falls

During 2019/20, the Trust's Falls Prevention Group continued to maintain oversight of the falls prevention agenda and associated quality improvement projects. In addition, falls accountability meetings have continued to be held, to review and learn from falls incidents whether harm is resulting or not.

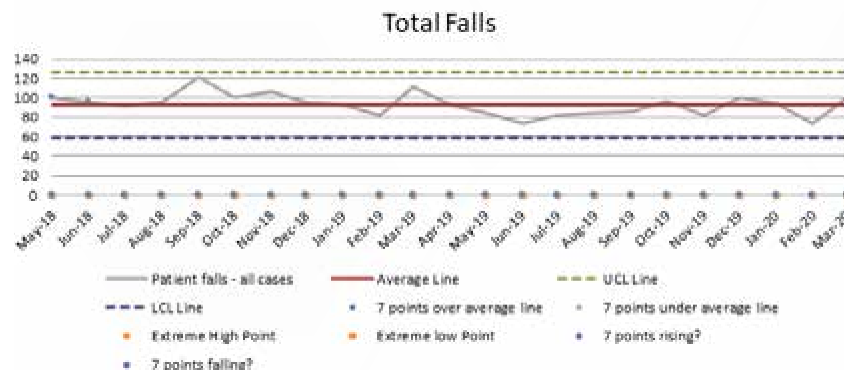
Key areas of focus in 2019/20 included:

- Falls assessment and identification of patients at risk in the Emergency Department
- Enhancing falls education for both staff and patients
- Improved access to walking aids
- Introduction of annual audit of assessment of falls risk on admission using the Royal College of Physician audit tool
- Review of the Falls Policy and processes
- Improved falls prevention in older adults, including lower leg assessment.

With this ongoing focus and oversight in place, the rate of falls per 1,000 occupied bed days remained below 5.6, averaging 3.62 (range 2.99-4.43) and falls numbers had reduced by 14% when compared to 2018/19. Falls with severe harm had reduced by 44% from 9 in 2018/19 to 5 in 2019/20 and falls with moderate harm had reduced by 12% from 26 in 2018/19 to 23 in 2019/20.

The following graphs illustrate the Trust's performance with regards to falls during 2019/20 and comparison of falls with serious harm with the previous year:

Trust Inpatient Falls Data May 2018-March 2020 illustrating improvement



Trust Inpatient Falls with Serious Harm 2018/19 compared to 2019/20

The audit of falls risk assessment on admission demonstrated a need to improve the documentation of advice provided and medicines reviewed.

Preventing Infection

Increased risk factors for healthcare acquired infections (HCAIs) are acknowledged in the ageing population, alongside the changes in the use of health services and the rising threat of highly resistant organisms. This has therefore been recognised as part of the Trust's plan for preventing HCAIs.

The work of the Infection Prevention Team includes education, research and development, standard and policy setting, establishing assurance processes and, most importantly, ensuring patient safety in the prevention of spread and acquisition of new infections.

Specific achievements against 2019/20 objectives include the following:

- The challenge of acute and community incidence of Carbapenemase Producing Enterbacteriaceae (CPE) has continued as the Trust has seen an increase in CPE colonised patients. As of the end of month 12 of 2019/20, 56 cases were identified whereas in 2018/19 the total was 20. A new more sensitive testing process was introduced in April 2019/20, which will have been a major contributory factor for this increase. All apart from 3 cases, were identified by screening as opposed to clinical samples
- The number of Clostridium Difficile cases was 43 in total which was above the agreed trajectory of 40 case
- Zero MRSA Bacteraemias were attributed to the Trust
- Environmental controls have been a top priority in our approach in tackling HCAs and the deep clean schedule has been completed with great effect
- General Practitioners (GPs) have been supported to further improve their environments and practice, building on improvements that have been achieved over many years of collaborative working
- A Wolverhampton Health Economy gram negative bacteraemia reduction working group has been established
- Influenza preparedness and prevention for patients and staff, achieving 64% uptake of vaccine for frontline staff
- Implementing the OneTogether audit tool in general surgery theatre environments to include assurance of adherence to the relevant National Institute for Health and Excellence (NICE) guidance
- Increased awareness of antimicrobial resistance through delivery of an Antimicrobial Stewardship Programme
- A plan developed for reducing the use of urinary catheters
- An additional sepsis nurse recruited to

complete the existing team to help drive early recognition and management of sepsis at ward level and support a cultural shift across the organisation and contribute towards reducing the number of preventable deaths due to sepsis

- Proactive latent tuberculosis (TB) case find has continued through contact screening and through collaborative working with the City of Wolverhampton Council and the Refugee and Migrant Centre
- The Intravenous Resource Team has continued to deliver a high standard of line care with increasing numbers of patients discharged on Outpatient Parenteral Antibiotic Therapy
- Surgical Site Infection (SSI) surveillance data has continued to be shared with consultant surgeons via a monthly dashboard. This will continue into 2020/21 to further support a reduction in SSIs
- Device related bacteraemia in the Trust has remained within the internal trajectory. At the end of month 12 of 2019/20 there were 39 cases, with an annual trajectory of 40
- Continued outbreak management support to care homes and very sheltered housing establishments across the Wolverhampton health economy, ensuring a seamless service across healthcare facilities throughout the city and reducing norovirus-related hospital admissions to acute services
- Outbreak management for influenza and norovirus, included identification of dedicated bays to prevent further movement of patients and ward closures
- A process for flu outbreak management and treatment/prophylaxis in care homes has continued to prevent admissions to hospital. This has been through joint working between the Infection Prevention Team and the Rapid Interventions Team (RIT)
- Successful Infection Prevention national Conference held in October 2019
- Significant planning and efforts made to deal with the challenges of the coronavirus (Covid-19) pandemic.

Venous Thromboembolism (VTE)

The Trust has continued to move forward in reporting risk assessments completed within 24 hours of admission achieving 95% for 5 months of this year. Further progress has been a challenge due to issues with IT systems following a system upgrade in December 2019. The external supplier has continued to work on rectifying these issues.

An overall improvement plan for VTE assessment was developed and implemented through the year. The majority of actions have been completed, with some to be continued in 2020/21.

Notable improvements were seen in areas which worked on quality improvement projects to make local changes to improve VTE assessments and prescribing, for example, General Surgery and Acute Medicine.

Re-launch of the E-learning package for mandatory training on VTE prevention and treatment which is now 2 yearly for all permanent staff and completed at least once for rotating staff. The training compliance for this package is now over 95%.

Trust guidance on VTE prevention and management has been updated in line with NICE guidance and new pathways for standardised management of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) have been ratified for use. The VTE group has worked to standardise guidance for use of DOACs (Directly Acting Oral Anticoagulants) including its use in primary care.

Increased training has been provided for nursing colleagues in several areas across the Trust to facilitate use of VTE prevention measures and equipment. The VTE group has monitored incidents and themes to ensure learning and provide assurance and support.

The anti-coagulation in-reach service was introduced in September 2019 to facilitate safe use of anti-coagulants, support safe discharges, and provide assurance around appropriate follow-up in key areas of the Trust. The team have also continued to aid timely audit of VTE prevention practices and support with identification of confirmed VTE.

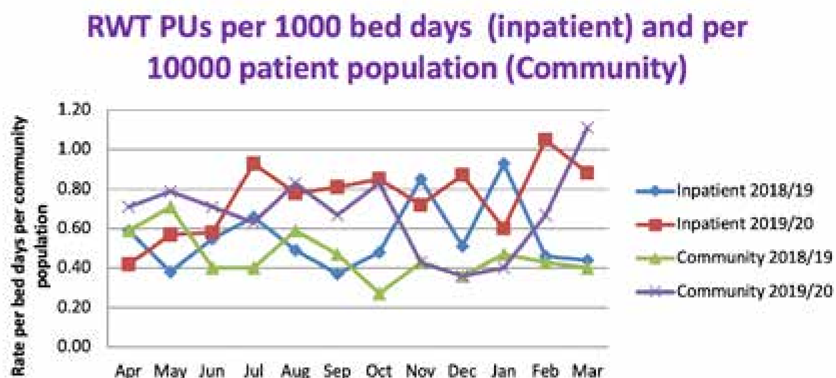
The VTE group has supported the Trust with the safe roll-out of electronic prescribing and with business continuity planning, including implementation of VTE related matters. The VTE group has aimed to link VTE risk assessment to prescribing. An alternative VTE risk assessment tool within the electronic prescribing system has been tested and the VTE group has continued to work with the software providers to create a suitable product. The VTE group have also explored the reporting functionality within the electronic prescribing system that would enhance the prescribing of VTE prevention methods and monitor its administration.

Pressure Ulcers

The Trust has continued its improvement work during 2019/20 to reduce pressure ulcer occurrence and ensure they are reported in line with the NHS England/Improvement's framework, which was fully launched in April 2019. Specific improvement plans were developed and implemented, based on learning from incidents, national and international evidence. Key learning points were associated with human factors and complex patient needs. Examples of the factors that have contributed to the increase in pressure ulcer incidents included, seasonal variations affected by temperature changes, carer changes and staff workloads. The accountability review model for incidents has continued, which enabled cross organisational learning. In addition, the Tissue Viability Steering Group continued to maintain oversight of the pressure ulcer prevention and reduction agenda.

In terms of staff education, there is a mandatory training package for specific care groups that has continued to be delivered on a minimum of weekly basis, but often more frequently across the health economy, including nursing homes and bespoke training for specialist areas. Learning has also been shared via the 'Making It Better' alerts and the Trust's Tissue Viability social media page. In addition, the tissue viability competency documents have been re-launched. The Tissue Viability Team and Professional Education Facilitators have provided bespoke support for all clinical areas where improvement has been required.

In terms of the pressure ulcer data, this has been translated in to the Statistical Process Control (SPC) chart format, to better understand trends and variations, in order to inform future improvements.



Sign up to Safety

The Sign up to Safety (SU2S) project completed in October 2018 continues as business as usual with areas continuing to access the scheduled Process Communication Model (PCM) training programme. Areas (Emergency Department, Trauma and Orthopaedics, Maternity Emergency Pregnancy Assessment Unit (EPAU)) that were subject to the Team Optimisation Model (TOM) workshops as part of the SU2S project, have completed and closed many actions including developing staff recognition schemes, reviewed their communication forums and sustained other actions such as monitoring team objectives via their regular team meetings and engagement forums. The Trust continues to utilise the team effectiveness tools and interventions developed as part of TOM in other areas of the Trust where team support is identified. The Trust will consider the provision of a more regular team effectiveness support programme as part of its considerations to develop in-house human factors resources for the Trust.

Medication Incidents

The Trust has continued to ensure that incidents involving medicines are reported in a timely manner and all incidents which have been associated with patient harm, have been discussed monthly at the Trust Medication Safety Group. Learning from these incidents has been widely shared across the Trust through the established governance processes.

Examples of actions taken during 2019/20 include:

- The Cold Chain Policy was approved and published for Trustwide use in May 2019. The policy provides comprehensive detail in relation to receipt, storage and temperature monitoring of medicines which require refrigerated storage
- The Transdermal Patch Application Form was designed following a number of incidents involving medication patches. The form was approved for use and launched in July 2019. An audit is planned for the coming financial year to confirm the form is being used correctly
- Extravasation is a known side effect associated with the administration of many medicines, and is frequently reported within the Trust. The IV team have reviewed incidents reported between September 2018 and September 2019, and identified a number of areas where changes in practice may result in a reduction of extravasation incidents. The team is providing advice and training, and incidents will be reviewed again during the coming financial year
- During November 2019, the Trust participated in a worldwide 'Medication Safety Week'. The week promoted the reporting of side effects of medicines using the MHRA Yellow Card Reporting scheme. The team presented posters, and provided leaflets to raise awareness to staff and patients in locations around the Trust.

	Apr 19	May 19	Jun19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Total No. of medication incidents reported	176	180	204	218	198	195	205	199	217	179	204	119
No Harm	172	170	190	205	196	187	199	184	212	172	189	114
Low Harm	3	5	12	9	2	8	6	14	5	7	13	5
Moderate Harm	1	5	2	4	0	0	0	1	0	0	0	0
Severe Harm	0	0	0	0	0	0	0	0	0	0	2	0
Number of Admissions	12534	12916	12423	13311	12010	12558	13698	12901	12269	13181	12582	9950
Rate of Medication Incident	1.40	1.39	1.64	1.64	1.65	1.55	1.50	1.54	1.77	1.36	1.62	1.20

Sepsis

The Trust has continued to focus its efforts on further strengthening sepsis recognition and management. This included ongoing provision of a dedicated Sepsis Team to provide organisational steer and oversight of sepsis matters. This team has been further strengthened during 2019/20 by appointing an additional sepsis nurse.

An improvement plan was developed during early 2019/20 to enable focus and delivery of key actions. This included, for example, increasing sepsis awareness across the Trust; introduction of sepsis ward rounds by the Sepsis Team; strengthening the education and training aspects; provision and delivery of specific Continuous Quality Improvement projects to support improvement; introduction of a more comprehensive audit programme and development of a patient information leaflet. The majority of actions in this plan have been delivered, with some being ongoing actions as part of the Continuous Quality Improvement approach.

The Trust had started to use the Vitals Operational Reporting (VOR) functionality, however due to the concerns with data accuracy this was discontinued and there is work in progress to rectify this. In the meantime, prevalence audits within the Emergency Department, other Emergency Portals and Inpatient areas have continued to maintain oversight of sepsis performance. This data has continued to be reported within the Trust's Integrated Quality and Performance Report.

Responding to Safety Alerts

Patient safety alerts are issued by NHS England/Improvement (NHSE/I) to warn the healthcare system of risks and provide guidance on preventing incidents that may lead to harm or death. The way safety alerts are being issued by NHSE/I had changed in 2019/20. There is now a clear requirement for executive oversight of the action plans and their implementation and this is being ensured via the Quality Safety Intelligence Group (QSIG). There are formal structures to receive and disseminate the alerts which has led to improvements in the reporting and monitoring of responses. Alerts received and responded to during the financial year 2019/20 included:

YTD received (financial year)	
MDA's	37
EFN's	1
NHS/PSA/	1
EFA	3
NHSI	1
SDA	19
CHT	2
NatPSA	4
Total	**68**

YTD Closed	
MDA's	30
EFN's	1
NHS/PSA/	1
EFA	1
NHSI	1
SDA	15
CHT	2
NatPSA	0
Total	**51**

YTD Open	
MDA's	7
EFN's	0
NHS/PSA/	0
EFA	2
NHSI	0
SDA	4
CHT	0
NatPSA	4
Total	**17**

Open (YTD & Previous years still open)	
MDA's	7
EFN's	0
NHS/PSA/	1
EFA	2
NHSI	0
SDA	4
CHT	0
NatPSA	4
Total	**18**

At the time of providing this data for the Quality Account, 91% of the alerts received were responded to within the timeframes set by MHRA and 1 NHS/PSA remains overdue. There is a robust action plan in place which is progressing well with weekly meetings monitoring the implementation of this overdue alert. In addition, 3 Supply Disruption Alerts (SDAs), 1 Estates and Facilities Alert (EFA) and 1 Patient Safety Alert (PSA) were responded to after the compliance date (no more than 2 days). Safety alerts continue to be monitored by external bodies and internally via Health and Safety Steering Group (HSSG) and Divisional Governance Groups. The Trust works to ensure compliance within mandated time-frames and there are well established reporting processes to ensure robust governance.

For 2020/21, the Trust will focus on the following aspects:

- To achieve 100% response rate within the given compliance timescales
- To further improve the quality of assurance provided, developing the continuation of monitoring of safety alerts implemented
- To improve the process of audit and monitoring following implementation of safety alerts.

Getting it Right First Time (GIRFT) Programme

The Getting It Right First Time (GIRFT) programme is a national initiative designed to improve the quality of care within the NHS by reducing unwarranted variations.

GIRFT is led by frontline clinicians, who are experts in the areas that they review, and it focusses on tackling variations and identifying opportunities for improvement. By sharing best practice between trusts, teams are able to identify potential enhancements in the delivery of care and ultimately patient outcomes. The programme also identifies ways to deliver operational efficiencies; such as the reduction of unnecessary procedures and cost savings.

The Trust has participated in 23 GIRFT visits to date across all 3 clinical divisions with each visit resulting in a subsequent action plan that is owned and developed with the individual directorates and specialities.

Attendance at GIRFT reviews at the Trust has remained impressive, with multi-disciplinary engagement to ensure shared learning.

This has been noted by the regional GIRFT partners and they are keen to use some of the practices identified at the Trust's visits to showcase as good practice. Examples of key achievements from these visits include:

- Implementation of professional led discharge within Radiology and ED
- Improvements within clinical pathways
- Pathway reviews across all divisions
- Reviewing workforce models to support clinical redesign.

Allied Health Professionals

Speech and Language Therapy (SLT)

During 2019/20 the service has:

- Undertaken a Multidisciplinary Team (MDT) audit to look at International Dysphagia Diet Standardisation Initiative (IDDSI) compliance across the wards
- Undertaken a benchmarking exercise for SLT provision to Head & Neck and Ear, Nose and Throat comparing our services to other local providers and some key national providers
- Developed their 2 year service plan
- Been an integral part of the Black Country Early Outcomes Fund project with partners in Health and Education across Wolverhampton, Walsall, Sandwell and Dudley at both operational and strategic levels
- Developed and presented a business case to increase SLT staffing across the wards. This is a 3 phase business case and phase 1 has been agreed in principle.

Physiotherapy - First Contact Physiotherapy

Approximately one in five people book in to the see their doctor with a Musculoskeletal (MSK) problem. MSK conditions are characterised by pain, loss of movement and function which impacts on individuals' quality of life, family and social relationships and capacity to work. Delayed treatment risks patients developing a range of significant co-morbidities. Physiotherapists are able to assess, advise on self-management and where appropriate request further investigation and referrals to other services. This approach to service delivery puts physiotherapy expertise at the beginning of the patients' experience, where they can most benefit from prompt specialist input, in the place where they are most likely to seek help first. This workforce initiative has been shown to reduce workload pressures for GPs enabling them to lead, manage and spend more time with patients with other problems including those with complex and multiple care requirements.

A pilot project was initiated, which enabled the service to explore the development of the MSK first contact physiotherapist role in partnership with our GPs, troubleshooting any issues and highlighting and optimising the benefits of First Contact Physiotherapy (FCPs) in our local vertical integration primary care GP practices. Five additional first contact physiotherapists have been recruited to support further rollout across the Primary Care Network. They are a fundamental local resource in preparation for the planned expansion of diverse roles within general practice to support GPs, enhance how patient care is delivered and build sustainability, capacity and diversity in our primary care services.

Research

Strengthening interdisciplinary research has remained an area of focus for the AHP workforce, with a variety of initiatives completed during 2019/20. This will remain the case for 2020/21 in order to further strengthen and develop the research portfolio and positively influence care provide to our patients.

Therapeutic Radiography

2019/20 saw the introduction of 2 new Consultant Radiographers: 1 Consultant Therapeutic Radiographer for Head and Neck and 1 Consultant Therapeutic Radiographer for Breast. In 2020/21, the service will be recruiting a Consultant Therapeutic Radiographer for Urology (predominately prostate), and is hopeful to recruit a Consultant Therapeutic Radiographer in Radiotherapy Late Effects. The service is currently the only centre in the West Midlands with Consultant Therapeutic Radiographers. The aim is to eventually have 5 in total. The Consultant in Late Effects would be only one of a few in the country, but essential in supporting cancer patients after treatment as many of these patients suffer in silence. It is suggested there could be over a million patients suffering late effects by 2030. The other Consultant Radiographers will each be taking a cohort of patients from MDT through the whole patient pathway for Radiotherapy; seeing new patients, consenting , planning radiotherapy, prescribing radiotherapy, reviewing patients on treatment and discharging patients (a full end to end service, improving the patient journey and avoiding patient breaches).

Priority 3: Patient Experience

Providing the best possible experience means getting the basics right, making sure our patients feel safe and cared for, that they have trust and confidence in the staff caring for them, and that they receive excellent quality of care in a clean and pleasant environment.

Involving patients, carers and their loved ones in all that we do has become an integral part of the Trust's culture and everyday decision making and thinking. This ensures that where possible, the services are both relevant and responsive to local needs. The Trust is committed to improving patient experience by using feedback to better understand the areas where it performs well and those areas where it needs to do better. Capturing service user and carer experiences and considering any learning resulting from experiences allows the Trust to drive forward service improvements.

There are a variety of established ways to gain feedback and seek patient opinion. This includes local and national surveys, Friends and Family Test, PALS concerns, formal complaints, compliments and social media forums such as Patient Opinions and NHS Direct.

In order to embrace a broad perspective, the Trust actively listens to people from all parts of the community and equality and diversity is the golden thread woven throughout the patient and carer experience agenda. Due to the large range of diverse services the Trust provides, there is an immense wealth of knowledge that can be accessed from our patients, service users and carers to assist with the Trust's transformation plans and improvement agenda.

The Trust knows that the experience of its patients is formed through every contact they have with the organisation, from the porter who helps them find the right ward, to the consultant who talks them through the next steps in their treatment. That means every member of staff has a responsibility to help provide the kind of care that the patients should expect.

An efficient and effective Patient Experience function is important in keeping the public's faith and trust in services, and is an essential building block of a high performing organisation. It can also provide the Trust with assurance about the safety and quality of service provision. A good Patient Advice and Liaison Service needs to be accessible, positive and professional in its approach.

How we performed in 2019/20

During 2019/20, the Trust had focused on continuous improvement and this began with the publication of the Patient Experience, Engagement and Public Involvement Strategy 2019-2022 in June 2019. This strategy sets out how the Trust would aspire to further improve patient experience, engagement and public involvement.

Putting patients first is at the centre of the Trust's overall objective and ambition to become an Integrated Care System with the aim of working in partnership with local councils and others, to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population served.

Several initiatives had been implemented as part of the strategy which focused on improved processes, co-production and continuous improvement.

Examples include:

- Introduction of the Observe and Act initiative within Division 3, including self-assessment and delivery of formal training
- Piloted the NHS England Initiative of 'Always Events' within Paediatrics and designed key always events as part of a co-production approach with patients
- Undertaken a self-assessment against the NHSI Patient Experience Improvement Framework to identify areas for improvement
- Ensured that patient experience is a standing agenda item on Directorate and Divisional governance meetings
- Ensured triangulation of patient experience with wider quality, safety, workforce and performance metrics
- Implemented the Complaints Survey Toolkit to enhance feedback mechanisms and patient satisfaction
- Established a formal complaints review panel with Council of Members as external reviewers
- Reviewed the Council of Member role and appointed a Chair and Vice Chair. The Council of Member role was continued to be promoted and the Trust has appointed further members throughout the year. Members have had training needs analysis undertaken and where appropriate, attended relevant and mandatory training
- Included stakeholders, patients and/or their carers to contribute and co-produce documents and initiatives to improve the patient experience
- Scoped the potential for involving families in the learning from deaths process and developed an implementation plan
- In terms of complaint outcomes, the Trust has continued to demonstrate a notable % increase on closed complaints not upheld and same notable reduction for closed complaints partially or fully upheld, when compared nationally. This data is supported by subsequent low numbers of our own complaint investigations being successfully appealed and upheld by PHSO
- Increased the ways and means of how patient feedback is obtained by ability to complete Friends and Family Surveys electronically and by scanning onto a QR Code
- Undertook an analysis of patient experience data to better understand patient experience across week day and weekend and set up a process for this analysis to be undertaken and reported going forward
- Implemented a specific volunteer services improvement plan including the development of clear objectives for recruitment and retention of volunteers.

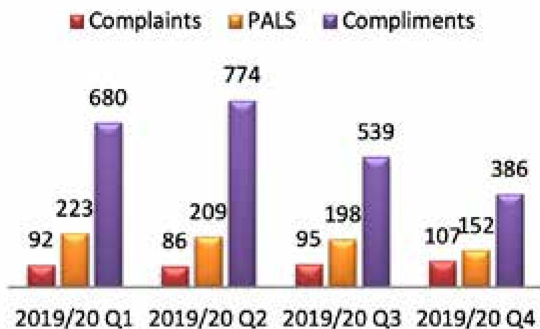
Complaints Management

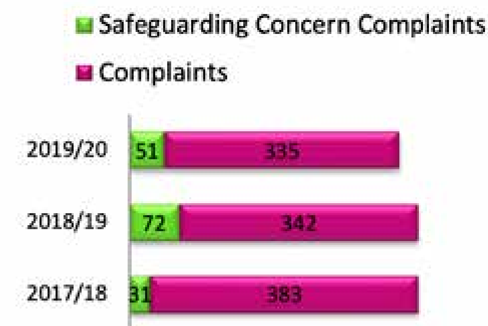
The Trust recognises how important it is to listen to feedback and provide an effective, and accessible complaints process with candour, openness and transparency. Staff are encouraged to try and resolve complaints at ward or local departmental level and annual training is provided with on-going support throughout the year.

The Trust continues to annually review its approach to complaints management to ensure that complaints are handled with sensitivity, timeliness and subject to a robust and thorough investigation and response. Formal complaints are managed in accordance with the relevant statutory regulations. The Trust has continued to see improvement in the timeliness of complaint handling, informing the complainants of the progress of their complaint and positive outcomes following external review from the Parliamentary Health Service Ombudsman (PHSO).

Key points for 2019/20 include:

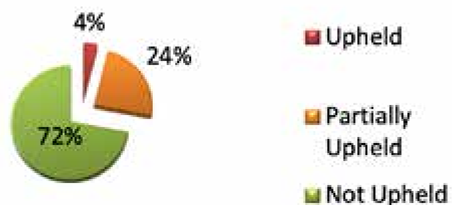
- Moved towards paper light system of working and increased use of our electronic systems
- Aiming to resolve all complaints speedily and efficiently whilst during investigation, keeping the complainant informed, as far as reasonably practicable, as to the progress of the investigation and any delays
- Compliancy against policy with response times reaching an average of 99% for the year, and ensured that complaints resolution was timely and proportionate, where possible, offering the complainant the option for early resolution through meetings and mediation
- The volume of complaints received for the year (386) represents 0.04% of the total volume of inpatient episodes, inpatient attendances and outpatient's attendances contacts for the year of 103,711
- The volume of PALS concerns has reduced from 1011 cases to 770, which is a reduction of 24%. This means that the Trust has experienced a reduction of 69% in the last two years. It is pleasing to see a year on year reduction and this provides assurance that staff members are being more proactive in their approach to concerns and embracing the ethos of PALS
- The delivery of complaints management training by PHSO and empowering front line staff to be more actively involved in early resolution of concerns
- During the year there were 51 complaints which did not meet the safeguarding criteria section 42 and were subject to a complaint investigation, compared to 72 for year 2018/19. There were however 54 safeguarding complaints investigated and closed within this period. 37 were not upheld, 13 were partially upheld and 4 fully upheld.
- 10 complaints were subject a full PHSO investigation during 2019/20 in comparison to 23 in 2018/19. This represents 2.6% of the total of complaints received. This provides assurance to the PHSO around the thoroughness of the Trust's investigation and response letters and of the remedial work undertaken to bring complaints to a satisfactory resolution
- In terms of the outcomes of PHSO investigations closed during the year (8 cases), it is noted that no cases were fully upheld and 5 cases were partially upheld. A financial redress of £1350 in total was noted in relation to two complaints partly upheld. No other financial redress was awarded during the year. This is a positive improvement on the outcomes from the previous year where the financial redress was £1750. The total financial redress for two financial years was £3100.





There is little variation between the key themes of complaints year on year, with the highest subjects being, general care of patient, clinical treatment and diagnosis. A deep dive into the highest volume category (general care of patient) shows that the largest volume of sub-subject category is general lack of care and features consistently across all divisions as in 2018/19. The table above illustrates the top 3 categories.

A deep-dive approach was undertaken with regards to actions taken and learning from those complaints where the outcome was fully or partially upheld. The learning was predominantly associated with the working practice of individuals (which necessitates supervision) and communication as opposed to a requirement for service or policy procedure change.



The Friends and Family Test (FFT)

The FFT provides patients the opportunity to submit feedback to the Trust by using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they would recommend the service to their friends and family if they needed similar care or treatment. Results of these surveys are received monthly and shared at directorate, divisional and Trust Board level in the form of divisional dashboards.

Throughout the year, the Trust had considered where there are gaps in surveying patients and worked with the provider to improve the feedback for those areas.

Improvements included:

- Continuation of the analysis of monthly metrics and the lowest five performing areas for response and recommendation rate were targeted with direct work for improvement
- Timely and accurate real time feedback direct to ward level automatically, providing the ability to consider the feedback and make instant actions to improve the patient experience
- The full implementation of electronic surveys for the maternity services ‘touch points’ for survey reporting.

Patient and Public Engagement and Co-production

During 2019/20, the Trust published a three year strategy for Patient Experience, Engagement and Public Involvement, which outlined the benefits of local engagement and provided a framework to achieve our objectives. The Patient Experience Team review progress on a monthly basis and report quarterly on achieving milestones within the strategy, to demonstrate their accountability with delivering the strategy.

The Trust is committed to the people of Wolverhampton, Cannock and the Black Country in them being involved at the heart of our work and decision making. The Trust will continue to listen and act upon individual and carer feedback to help inform and shape the services we provide and the experiences and aspirations of our patients.

Key initiatives during 2019/20 included:

Engagement Champions

This included the development of Patient Experience and Engagement Champions at divisional level and the implementation of a training programme and toolkit for engagement activities.

Bereavement Hub

The Trust has worked in collaboration with Compton Hospice to introduce a bereavement hub on site at New Cross Hospital. This invaluable service is run by volunteers with support from both stakeholders to offer support to those who have lost their loved ones.

Patient Stories

Patients and carers were again encouraged to express how it feels to receive care from the Trust by the sharing their ‘Patient Stories’. Such stories provided the Trust with an opportunity to learn as an organisation, bringing experiences to life and making them accessible to other people. They can, and do, encourage the Trust to focus on the patient as a whole person rather than just a clinical condition or as an outcome. Patient stories are shown at Senior Managers Briefings and Trust Board sessions. During 2019/20, the stories shared included experiences of accessing hospital services for patients who are deaf; a child’s experience of accessing speech and language therapy; a patient of maternity services with ongoing mental health issues and a mother’s experience of having a child on the neonatal unit.

Council of Members

The Council of Members, established in 2017, has continued to make strides by working together more effectively as a group and as individuals contributing to initiatives and meetings at the Trust. This group of committed individuals from our local community, have provided a patient perspective to the Trust on a range of important topics.

During 2019/20, the Chair and Vice Chair took up their appointment and the Council held 6 meetings. Members have also been active outside of the Council meetings. The overall activity is summarised as follows:

1. Key Topics Covered by Council Meetings:

- Roma Community and Health
- Vertical Integration
- ICT Digital Strategy
- Patient Engagement Consultation
- Governance
- Continuous Quality Improvement
- Macmillan Information Service.

In relation to some of these topics, the Council received a number of presentations, followed by discussion and feedback to lead officers. Whilst these were the major items for consideration, the Council was routinely approached for its views on a whole range of day to day service delivery issues such as revision of patient appointment letters.

Member Involvement in Trust Work streams

Council members have participated in a range of Trust work groups and initiatives to provide a patient perspective in areas such as:

- Equality , Diversity and Inclusion Steering Group
- Complaints Review Panel
- Recruitment and Selection and this included the appointment of the Trust Chair and some consultants
- Trust Research and Development Projects
- Undertaking PLACE assessment
- New design of ward placemat project group meetings
- Trust Policy Group meetings
- Transgender policy review
- Supporting the hospital with the design of a new Bereavement Centre.

Member representation on External Forums

Throughout the year, members have acted as ambassadors for the Trust and the Council by attending various events. These events were seen as opportunities to recruit more members and adding diversity to the Council.

Examples of these events include, community engagement events and a CCG public consultation event.

In addition to the above, members have also been active in promoting the Council through writing articles in Trust magazines and producing their own newsletter and as well as attending Trust induction market place sessions. A number of members have also taken part in training sessions provided by the Trust such as the NHS Operating Game, Induction and the NHS Introduction to Leadership Course.

Volunteering

The Trust is fortunate to have the support of volunteers, who are unpaid members of our local community who offer their time willingly to help. We hold provision of a positive patient experience at the forefront of our volunteering activity and we aim to place volunteers into roles which complement, but do not replace, paid members of staff. Volunteers add an important ‘extra’ factor to helping us provide a positive patient and visitors experience at the Trust.

Volunteer services have seen a successful year achieving its objectives and again, a busy period for volunteer recruitment with new volunteers joining the organisation this year in a variety of roles.

A three year volunteer plan was produced in 2019, which outlined key priority areas for recruitment within the Trust. The plan has been focusing heavily on recruitment of volunteers primarily into patient and ward support type roles. The Trust has also continued to recruit new volunteers into other well established services such as Chaplaincy, hospital radio, breastfeeding peer support, community services and charities which are aligned to the Trust.

- Number of volunteers interviewed in the Trust 2019/20: 136
- Number of volunteers started 2019/20: 70
- Number of volunteer who have left the Trust 2019/20: 14
- Total number of volunteers in place at end of financial year 2019/20: 357
- Breakdown of roles (services) new starters commenced into 2019/20:

Service/ Role	Number of volunteers employed
Breastfeeding peer support (maternity services)	11
Cancer Services (Information Assistants)	3
Chaplaincy	8
Dementia Outreach	3
Hospital ward / patient support	24
Hospital Radio	2
League Of Friends	6
Miscellaneous	5
Therapy Services	5
Patient Experience (Friends and Family test, scooter service, wayfinding)	3

Volunteer Activity during the Covid-19 (Coronavirus) Pandemic

As the Covid-19 pandemic reached the United Kingdom (UK) in March 2020, clear guidance was issued by the UK Government recommending that those who were more vulnerable due to health and age, were recommended to stay at home as much as possible and in some cases, shield entirely for 12 weeks. In addition, many volunteers wished to take a more cautious approach in terms of their volunteering and chose to suspend their volunteer placements during the pandemic.

This meant that the Trust's volunteer numbers reduced dramatically to very minimal numbers. At the same time, the Trust was being contacted by members of the public keen to provide their assistance. This ran parallel with many schools and colleges closing and students wishing to find something helpful to do and workers having non-essential work suspended meaning that they also had time to offer.

The Trust have therefore taken forward recruitment of new volunteers and at the end of March 2020, it received 350 applications from members of the public wishing to volunteer. As part of the recruitment process, as well as ensuring that

all essential statutory recruitment requirements were adhered to, these new volunteers received generic training to prepare them for the role.

Equality, Diversity and Inclusion

The Trust's commitment towards equality and diversity is evident through its value framework, its culture of openness and transparency and the range of activities across the Trust to improve services.

Key initiatives during 2019/20 included:

- Publication of the Trust Annual Equality, Diversity and Inclusion Report. The report provides an in-depth analysis of the equality related information collected across the Trust. Follow up actions have been created in order to address imbalances in diversity and to improve accessibility for the communities that the Trust serves
- Change in interpreting and translations services. Following the end of contract and new procurement and tendering process, the Trust changed its interpretation and translation services to a new provider. This was implemented in December 2019 with guidance being issued and staff being trained on how to use the new system
- Review of Accessible Information Standard (AIS) Action Plan and Progress. The Trust AIS working group has undertaken a fundamental review of the action plan which has been in place since 2016. The action plan has been streamlined and will concentrate on a small number of key actions. Efforts have been made to raise awareness of the standards and staff have been encouraged to complete an external e-learning training package
- Hearing Loss. Following the production of a patient story depicting the experiences of D/deaf patients, a D/deaf service user's liaison group has been established. Regular sessions of basic British Sign Language (BSL) training have been delivered for some front line staff and senior managers. Executive members have also received this training as part of their Board Development activity
- Publication of the 2018/19 Schedule of the Equality Impact Assessments. A new more proactive approach was also introduced for reviewing and monitoring equality impacts assessments related to policy and strategy updates.

PLACE Inspections

Patient Led Assessments of the Care Environment (PLACE) offer a non-technical view of buildings and non-clinical services. It is based on a visual assessment by patient assessors.

The assessment falls into 6 broad categories:

- Cleanliness
- Condition, appearance, maintenance
- Food
- Privacy, dignity and wellbeing
- Dementia
- Disability.

The details for the assessment process during 2019/20 were as follows:

Site	Date	No of Patient Assessors	No of Staff	No of Wards inspected	No of Outpatients inspected	No of food tastings
New Cross	16th October 2019	6	6	11	10	5
	30th October 2019	2	2			
West Park	17th October 2019	5	3	3	2	2
CCH	10th October 2019	4	4	2	6	2

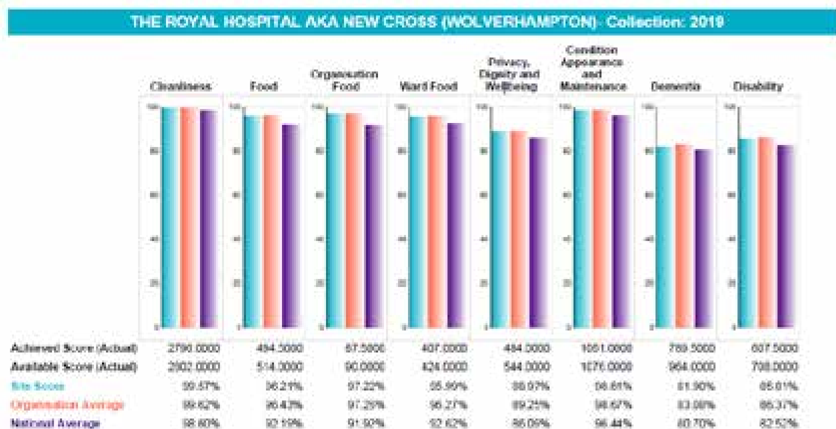
In addition, all sites had an external and internal assessment of general areas.

The assessment process was led by the patient assessors supported by a staff member acting as scribe. Each team comprised of 50% patient assessors as a minimum. The patient assessors had received training on how to conduct the assessment and it was made clear that it was their opinion that would be documented and submitted. The assessment process was not a technical audit, but the patient's perception of the environment based on the training provided to them.

The scoring is clear and in most cases was either a pass (2 points), a qualified pass (1 point) or a fail (no points).

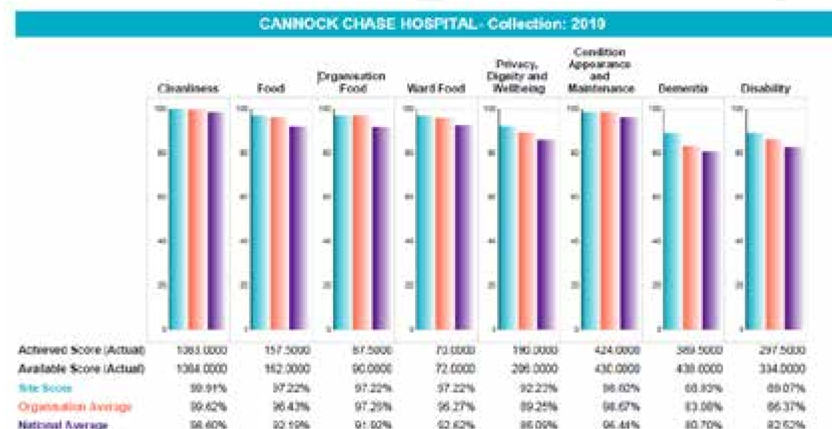
The assessment questions were revised and this is the first set of results following the revision, therefore, the results cannot be compared against previous years.

Results - New Cross



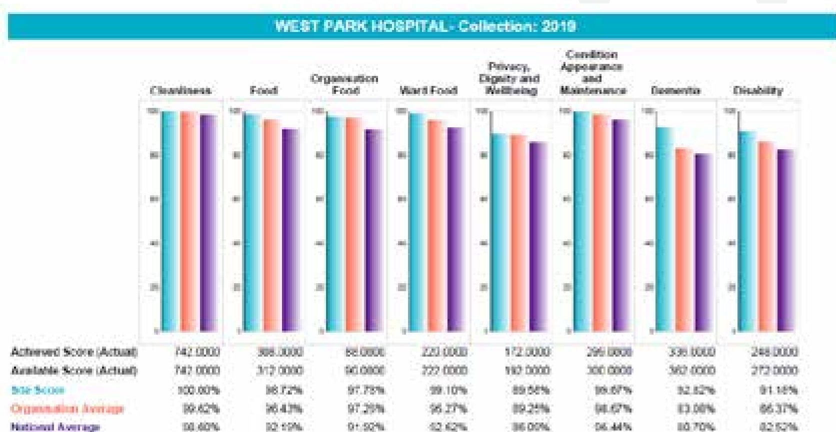
	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2790.0000	494.5000	87.5000	407.0000	484.0000	1061.0000	789.5000	607.5000
Available Score (Actual)	2802.0000	514.0000	90.0000	424.0000	544.0000	1076.0000	964.0000	708.0000
Site Score	99.57%	96.21%	97.22%	95.99%	88.97%	98.61%	81.90%	85.81%
Organisation Average	99.62%	96.43%	97.29%	96.27%	89.25%	98.67%	83.08%	86.37%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

Results - Cannock Chase Hospital



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1383.0000	157.5000	87.5000	70.0000	190.0000	424.0000	389.5000	297.5000
Available Score (Actual)	1384.0000	162.0000	90.0000	72.0000	206.0000	430.0000	438.0000	334.0000
Site Score	99.93%	97.22%	97.22%	97.22%	92.23%	98.60%	88.93%	89.07%
Organisation Average	99.62%	96.43%	97.29%	96.27%	89.25%	98.67%	83.08%	86.37%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

Results - West Park



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	742.0000	308.0000	88.0000	220.0000	172.0000	299.0000	336.0000	248.0000
Available Score (Actual)	742.0000	312.0000	90.0000	222.0000	192.0000	300.0000	362.0000	272.0000
Site Score	100.00%	98.72%	97.78%	99.10%	89.58%	99.67%	92.82%	91.18%
Organisation Average	99.62%	96.43%	97.29%	96.27%	89.25%	98.67%	83.08%	86.37%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

This is an outstanding set of results for the Trust and in summary:

- All areas, across all sites, have scored higher than the national average
- The Trust organisational score for cleanliness across the sites was 99.62%, against the national average of 98.60%
- The organisational score across all elements of the food service is 96.65%, which is approximately 4% higher than the national average score of 92.24%
- Condition, Appearance and Maintenance remains high scoring at 98.67% against the national average of 96.44%
- The Environment Group has completed a lot of work over the past two years to improve Dementia and Disability scores and whilst the scores are higher than the national average, there is further work to be completed to improve these areas.

Looking forward, in order to improve disability access to Trust's buildings and ensure the Trust is Dementia Friendly, the Trust will plan to:

- Have an independent review of access across all three sites to ensure we make the right changes
- Continue to address environmental issues which will ensure the Trust supports patients and visitors with dementia, by making the environment as welcoming as possible.

Chaplaincy Services

The Multi Faith Chaplaincy Team exist to meet the spiritual, pastoral and religious needs of those of faith and none within the Trust, irrespective of age, gender, ability, race, religion or belief or sexual orientation. This service is accessible to all patients, their families and friends, staff and volunteers throughout the Trust and, is available throughout the 24 hour period, each and every day of the week, throughout the year. The Team also responds to emergency call-outs across all three sites.

The Team currently comprises representatives from the Christian, Hindu, Muslim and Sikh faith traditions and, representatives from other faiths may be available upon request. The Chaplains regularly visit wards at each of the three Trust sites and, patients who require support, are visited at the bedside for pastoral and spiritual support, faith rites and sacramental care.

Prayer resources are available on all wards or may be obtained by contacting the Chaplaincy Team directly. Multi faith prayer facilities are available at New Cross and Cannock Chase Hospitals and, weekly Christian, Hindu, Muslim and Sikh prayers are offered at these sites.

The Chaplaincy Team delivers annual services on behalf of the Trust, some of which include the Annual Babies Memorial Service, Babies Christmas Act of Remembrance and Service of Thanksgiving to Celebrate International Nurses Day and Day of the Midwife. In addition, the Team organise events to celebrate Christian, Hindu, Muslim and Sikh festivals and is looking to further develop this across the three Trust sites.

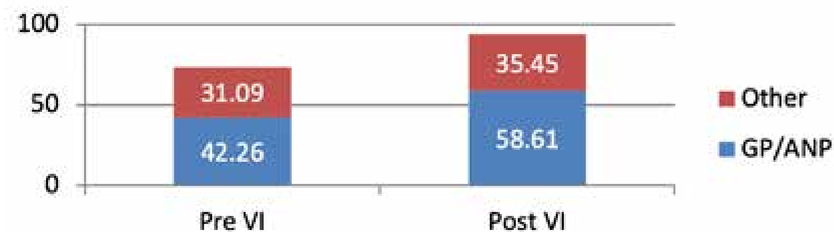
The Team respond to local, national and worldwide events and incidents, providing prayer and support to all, who may have been affected in any way. The Team continue to proactively develop, by increasing their involvement and collaborative working with the Palliative Care, Dementia Outreach and Critical Care Team. The development of quiet reflective spaces, accessible to all staff, is currently in the exploratory phase.

Primary Care Network (PCN)

The Trust has continued to expand its Primary Care services and there are now ten GP practices that are part of the Trust. This model of delivery of care offers a unique opportunity to re-design services from initial patient contact through to on-going management and end of life care. As a single organisation, the challenges associated with the scope of responsibility, funding, differing objectives and drivers are reviewed, which enables clinicians to design more effective, high quality clinical pathways to improve access and positively impact on patient outcomes.

Appointment access data

Improving access to patients is important to the Trust, and we strive to ensure that patients have the access they require at the right time with the right clinical staff. The information below demonstrates continued improvement in booked appointments for our patients.



The table below outlines booked appointments by practice per thousand patients per financial year:

	2018/19			2019/20		
	GP	Other	All	GP/ANP	Other	All
Alfred Squire	52.97	60.38	113.35	61.23	32.58	93.81
Coalway Road Joined the Trust during 2018/19: data starts May	46.88	19.85	66.73	50.84	26.72	77.56
Dr Bilas (Griffiths Drive) Joined the Trust during 2018/19: data starts June				33.26	24.48	57.74
Dr Fowler (Oxley) Joined the Trust during 2018/19: data starts February				17.95	12.63	30.58
Ettingshall No longer part of the Trust	47.16	30.55	77.71			
Lakeside	37.27	74.51	111.78	46.22	35.48	81.70
Lea Road	54.3	39.37	93.67	82.49	26.28	108.77
Penn Manor	48.88	41.93	90.81	74.32	124.52	198.84
Thornley	35.77	17.51	53.28	43.08	10.47	53.55
Warstones	72	39.58	86.55	96.92	32.59	129.51
West Park	68.44	29.46	97.9	67.38	28.78	96.16
	51.52	**39.24**	**87.98**	**58.61**	**35.45**	**84.65**

Health checks

The diagram on the right illustrates the Trust's completed health checks for our patients. The number of appointments has been doubled and has improved the Trust's national score, which is excellent demonstration of our success.

GP Patient Survey results

N.B: The content of the GP patient survey has been changed significantly to reflect changes in the delivery of primary care services in England. In addition, the sample frame has been extended to include 16-17 year olds to improve the inclusivity of the survey. These changes mean that it was necessary to consider the likely impact on comparison on survey estimates when looking at trend data. Following the assessment of the impact, the analyses suggests that comparison with previous years would be unreliable for the majority of questions at national level (and for all questions at CCG and practice level) even where question wording remained similar, and have informed the decision not to present trend data in the GP patient survey outputs for the 2018 publication. This information is based on the NHS England's narrative pertaining to this survey.

VI Averages	Jul-17	Jul-18	Jul-19	Local CCG Avg.	National avg.
Through to surgery phone	76.40%	72.56%	77.00%	66.00%	68.00%
Receptionists are helpful	89.40%	89.44%	92.00%	87.00%	89.00%
Patients satisfied with GP appointment times available		66.44%	68.50%	66.00%	65.00%
Speak/See preferred GP	57.60%	44.67%	45.33%	49.00%	48.00%
Patients offered choice of appointment		57.11%	61.40%	59.00%	62.00%
Patient satisfied with type of appointment offered		73.56%	75.30%	71.00%	74.00%
Patient took the appointment they were offered		91.89%	93.30%	71.00%	74.00%
Experience of making an appointment was good	76.40%	65.56%	69.50%	65.00%	67.00%
Wait 15 mins or less for an appointment	67.80%	69.67%	71.30%	69.00%	69.00%
Last Healthcare Professional they saw or spoke to gave them enough time		85.56%	84.80%	84.00%	87.00%
Last Healthcare Professional they saw was good at listening to them		87.00%	86.50%	86.00%	89.00%
Last Healthcare Professional they saw was good at treating them with care and concern		84.67%	86.40%	84.00%	87.00%
Last Healthcare Professional they saw involved them in decisions about care		91.33%	94.00%	91.00%	93.00%
Confidence and trust in the last Healthcare Professional seen		95.44%	94.60%	95.00%	96.00%
Healthcare professional recognised or understood any mental health needs		85.44%	84.60%	84.00%	86.00%
Felt their needs were met during their last general practice appointment		94.89%	94.10%	93.00%	95.00%
Enough support from local services or organisations in the last 12 months for LTC		87.11%	79.56%	77.00%	78.00%
Overall experience as good	92.20%	84.11%	85.40%	81.00%	83.00%

The Trust continues to monitor performance and quality through, for example, audits, scorecards, regular meetings, datix. This enables the Trust to identify key themes and trends to encourage innovation and improvement.

As part of the Trust's commitment to transparency, key information is shared with our teams, directorate and division through the performance and governance meeting structures to provide quality assurance.

Notable achievements during 2019/20 include:

- Governance structures implemented for all practices
- The work all of the practices had carried out with regards to the carers register
- Positive recognition from the CQC with respect of the:
  - scorecard and the information it provides to the practices
  - links between the Trust and practices and the making it better alerts which the practices received
  - safeguarding alert processes
  - medicines management and associated Standard Operating Procedure
  - International Normalised Ratio (INR) process and all practices now having access to INR star.

The Trust continues to work closely with colleagues and partners to deliver integrated working and new pathways and processes as they emerge from the Integrated Care Alliance (ICA) Clinical Groups and the emerging Primary Care Networks to continually improve the care and treatment of patients and the public we serve.

Continuous Quality Improvement

To support the realisation of the Trust's vision, there is recognition of the need to continuously improve the quality of its services and embed a culture to support this. One of the means to achieving this has been the establishment of a Continuous Quality Improvement (CQI) Team. The team was established in April 2019 and consists of programme partners aligned to the clinical divisions of the Trust and clinical leadership.

The CQI Team organise their work around the following key priorities:

1. Building CQI capability and capacity
2. Patient safety
3. Patient journey

The themes align with, and support, the overall quality priorities of the organisation.

- **The building capacity and capacity work stream** revolves around teaching staff the methodology of quality improvement to equip them with the skills to apply this in their working lives. Having been successfully accredited as a QSIR (Quality, Service Improvement and Redesign) Academy, it allows the Trust to train its staff in the methodology of quality improvement. The CQI Team has begun training staff in CQI with all new starters now receiving QSIR fundamentals sessions on induction and existing staff receiving the QSIR practitioner course. This is a significant milestone in the Trust's ambition to build capability in CQI across the organisation and embed this approach with the staff at the start of their career at the Trust.
- **The patient safety work stream** focuses on continually improving the safety of the Trust's services. Work with clinical teams has focussed on sepsis, stroke, heart failure, pneumonia, renal failure and liver disease. Additionally, through the use of Plan, Do, Study, Act (PDSA) cycles, the CQI Team has worked with ward teams to further reduce the number of patient falls being experienced under our care.
- **Finally, the patient journey theme work stream** focuses on improving the experience of a patient visits throughout the hospital by minimising delays. To support this, the team has rolled out a 'huddle' tool across all of the medical wards. This tool provides accurate and unique data in a timely fashion about the constraints in the system and clear targets for improvement work internally and with our partners. In addition to this, 'long length of stay reviews' now take place routinely on patients who have been in the Trust for an extended period of time to explore the reasons for their delay (if any) and swift action to minimise this.

- During 2020/21, the Trust will continue to further embed its CQI agenda and progress a variety of projects to support the overall CQI priorities, Trust vision and values.

Use of the CQUIN payment framework

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) Payment Framework. CQUINs enable the organisation to focus on the quality of the services delivered, ensuring that the Trust continuously improves and drives transformational change with the creation of new, improved patterns of care. These will impact on reducing inequalities in access to services, improve patient experiences and the outcomes achieved. CQUIN initiatives are owned by identified service leads, who develop action plans with support from the contracts team to ensure the required changes are delivered.

CQUINs are agreed during the contract negotiation rounds with input from clinical leads and Executive Directors including the Chief Operating Officer and the Deputy Chief Nurse. Any areas of clarification or concern are highlighted to commissioners during this negotiation period to ensure the CQUIN requirements are relevant and achievable to the organisation.

Review of 2018/19:

For the first time, NHS England published a number of two year schemes (2017-19) with the aim of providing greater certainty and stability on the CQUIN goals, leaving more time for health communities to focus on implementing the initiatives.

N.B. The 2018/19 financial year is the most recent finalised reporting period. At the time of producing this Quality Account, the 2019/20 CQUIN schemes remained in progress.

What we set out to achieve:

The 2017/18 and 2018/19 schemes are outlined below and performance against these requirements has been provided.

CQUIN Indicator Name 2017-19	Description	Achievement of Payment 2017/18	Achievement of Payment 2018/19
Introduction of health and wellbeing (Staff Survey)	Improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. Outcomes are monitored via the National NHS Staff Survey.	0%	0%
Healthy food for NHS Staff, visitors and patients	Providers are expected to maintain the step-change in the healthy food provision required in 2016-17 and to introduce additional changes to continue the reduction in high sugar, salt and fat food content.	100%	100%
Improving uptake of Flu Vaccinations for Front line clinical staff	The CQUIN aims to achieve 70% uptake of Flu Vaccinations of frontline staff.	50%	50%
Timely identification and treatment for sepsis in ED and acute inpatient settings	This CQUIN assesses timely identification of patients who present with severe sepsis, red flag sepsis or septic shock and were administered intravenous antibiotics within the appropriate time-frame.	67.5%	ED – 62.5% Acute – 37.5%
Reduction in Antibiotic Consumption	Following on from 2016-17 the aim is a further 1% reduction in the use of antibiotics across the Trust.	66%	33%
Empiric review of antibiotic prescriptions	This monitors the percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours. Ensuring appropriate monitoring of antibiotics usage and supporting the reduction antibiotic usage.	100%	100%
Improving Assessment of Wounds	The aims to increase the number of full wound assessments undertaken in patients who have wounds which have failed to heal after 4 weeks.	100%	100%
Personalised Care and Support Planning	The purpose of this CQUIN is to embed personalised care and support planning for people with long-term conditions. This will support people to develop the knowledge, skills and confidence to manage their own health and wellbeing.	100%	100%

Secondary Dental Electronic Referral Management System (2018-19 only)	Implementation of Dental Electronic Referral Management System. This system allows General Dental Practitioners to refer all patients electronically into secondary care.	N/A	100%
Bowel Cancer and Bowel Scope Screening	Improve access and uptake through patient and public engagement.	100%	100%
Cost Effective prescribing of Recombinant Factor VIII Products for Haemophilia A patients (2018-19 only)	Optimising the use and management of medicines is a significant and realisable opportunity within the NHS and the Carter Review highlighted a high level of variation in use and medicines management costs which could be re-invested to support sustainable service delivery. This CQUIN relates specifically to Factor VIII blood products for Haemophilia A patients	N/A	100%
Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)	It is intended that all NHS England commissioned providers of chemotherapy move to prescribing a range of drugs in accordance with a nationally approved set of dose tables.	100%	100%
Medicines Optimisation	This CQUIN has been designed to support Trusts and commissioners to realise benefits through a series of modules that improve productivity and performance related to medicines. The expectation is that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions.	91.5%	100%
Paediatric Networked Care	This scheme aligns to both the national Paediatric Intensive Care Unit service review and the West Midlands review of Paediatric Critical Care services. Both work streams require delivery of robust information in order to understand the existing flows of care and meaningfully scope potential for change. In order to ensure delivery nationally it is expected that providers within a region should form a network of care, with Paediatric Intensive Care Unit providers taking on leadership.	100%	100%
Neonatal Community Outreach	To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for Neonatal critical care beds and to enable reduction in occupancy levels.	100%	100%

Progress of the CQUIN programme is monitored via the Contracting and Commissioning Forum chaired by the Director of Strategic Planning and Performance. Any areas of concern or risk are discussed at this forum and actions identified for mitigating or escalating the risks. Financial progress is monitored via the Finance and Performance Committee.

Quarterly submissions are made to Commissioners via the Contracts Team which includes the data as specified within the CQUIN milestones and any additional evidence which provides assurance that the goals outlined within the CQUIN have been achieved.

These reports are collated and submitted to all commissioning bodies where CQUIN schemes have been agreed. These reports are scrutinised and where needed additional clarification is requested from the Trust before the Commissioners provide feedback as to levels of achievement.

Looking forward 2020/21

Priorities

for Improvement

Workforce

Safe Care

Patient Experience

The priorities outlined in the looking forward section will contribute to the achievement of the following Trust strategic objectives 2018-2021:

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

Priority 1 – Workforce

Nursing, Midwifery and Health Visiting Workforce

Key areas of focus for 2020/21 will include:

- Continue to build upon our successful recruitment programme into the nursing, midwifery and health visiting posts, through our award winning Clinical Fellowship Programme and United Kingdom and international recruitment
- Continue to work with universities to offer an increased number of placements and attract students as our future workforce
- Further strengthen our focus on retaining our nursing, midwifery and health visiting workforce
- Focus on developing new roles and career progressions opportunities for our existing nursing, midwifery and health visiting workforce
- Ensure provision of attractive development programmes
- Continue to strengthen our governance arrangements, by further embedding our daily oversight reports via the Safe Care Module and other governance reports
- Ensure the Trust is fully compliant with the Developing Workforce Safeguards requirements
- Expand our apprenticeship offer to the diverse population and continue to work with the Prince's Trust, to widen potential future employment opportunities within healthcare for the young people in our local community.

Medical Workforce

Key areas of focus for 2020/21 will include:

Consultants

- Continue to develop internally trained consultant staff from fellowship programme
- Aim to strengthen links with neighbouring organisations where the national consultant resource is limited.

Junior medical staff / fellowship

- Ongoing development and expansion of fellowship programme.

Medical students

- Integrate Aston Medical School students into the Trust and recognise this will be an important future source of junior and senior medical staff
- Continue to provide high quality training for University of Birmingham medical students

Allied Health Professionals

The vision of the Interim People Plan is to deliver an effective supply of AHPs, ensuring robust deployment and development of staff, whilst placing a focus on the retention of the workforce, across professions and geography, to ensure the system has the right workforce with the right skills in the right place to deliver high quality care by 2024. As a result of our combined interventions there will be fewer AHP vacancies nationally with an ambition to improve aggregate AHP vacancy rates to an operational position of 5%. To support this vision we will support the following projects/workstreams:

- Reducing Pre-registration Attrition and Improving Retention (RePAIR). Health Education England (HEE) launched the output from RePAIR in October 2018. It enabled HEE to gain an in-depth understanding of the factors impacting on healthcare student attrition and the retention of the newly qualified workforce in the early stages of their careers. Covering the four fields of nursing (adult, children's, learning disabilities and mental health), midwifery and therapeutic radiography, RePAIR explored effective interventions to improve retention across the student journey - from pre-enrolment to two-years post-qualification. Subsequently, six small individual projects made up the RePAIR Legacy projects covering the four fields of nursing and midwifery. HEE has now commenced the new national RePAIR Implementation Plan programme. This programme is a partnership between the Council of Deans of Health and HEE and is being delivered through four regional teams, including a regional RePAIR Fellow for HEE. The aim of the RePAIR Implementation Programme is to improve nursing, midwifery and AHP student retention by 15% and the number who take up employment by 15% over a five year period 2019/20-2023/24.
- The majority of new AHPs qualify through pre-registration education, therefore ensuring growth in this route is therefore central to achieving our aims. HEIs have highlighted placement capacity as a barrier to increasing current intake levels and initial discussions suggest expansion could be achieved with better coordination and alignment between HEIs and NHS providers, supported by a continued focus on increasing applications to AHP courses. It has also been identified that there is significant variation with regards to system architecture to support the AHP workforce with regard to professional development, education and research, including coordination of AHP clinical placements. Sustainable growth in the AHP workforce is vital to delivering the ambitions of the Long Term Plan. Therefore the Black Country Sustainability and Transformation Partnership AHP council will work collaboratively to support the operational delivery of increased placements utilising new placement models with a sound governance framework.
- We recognise that apprenticeships provide career ladders for staff to develop their skills, expand the contribution they can make to patient care and strengthen their commitment to continue working for the NHS. As an organisation we shall support the development of the infrastructure required to deliver apprenticeships and will provide training and education and explore opportunities for apprenticeship developments in the organisation.

Other AHP initiatives:

An AHP System Framework has been developed and is aligned to the Trust's Nursing System Framework. This Framework recognises the importance of all staff, including registered and support staff, in service delivery. It provides an opportunity to create a vision for 2020-2023, which progresses the development of current practice and ensures quality is embedded in all patient related interventions. There are specific outcomes for the AHP services to achieve which will be monitored within the governance framework.

In terms of SALT, the team will focus on the following initiatives:

- Complete our work with the Black Country Early Outcomes Fund project with our partner organisations and enact sustainability plans for the future
- Develop plans to modernise and expand services in partnership with Head & Neck and ENT
- Begin the move to paper-light working.

Health and Wellbeing

The Trust's commitment to delivering high quality patient care is dependent on having healthy staff who feel supported. The Trust believes that supporting staff wellbeing in the workplace is an important shared responsibility and to enable this, the Trust agreed its strategic approach to workplace health and wellbeing in 2019. This approach is based around 5 pillars of health and wellbeing: Career Wellbeing, Mental and Emotional Wellbeing, Physical Wellbeing, Financial Wellbeing, Community and Social Wellbeing. This approach includes a high level action plan with a number of key priorities particularly in relation to physical and emotional wellbeing. As key achievements, the Trust has put in place over 60 mental health first aiders, embedded Remploy's mental health support programme and made a number of improvements in line with the fatigue and facilities charter.

A health and wellbeing page has been developed on the Trust's intranet to provide information, tools and resources with the aim of supporting our staff by:

- letting them know what the Trust has put in place to assist them with wellbeing issues at work
- signposting them to what is available generally so that staff can take action on their personal health and wellbeing both in and outside of work.

The health and wellbeing page have a number of themes where staff can find tailored information on the following aspects:

- Mental wellbeing, physical wellbeing, a healthy body, work/ life balance, workplace health and welfare, smoke-free you and staff benefits.

The Trust has currently 25 volunteer Health & Wellbeing Champions who have offered their time to help promote health campaigns and encourage a healthy culture within their workplace, signpost others to local services and act as a communicator during team meetings to promote health events and initiatives across the Trust.

All our champions are approachable with an enthusiasm and an interest/qualification in health and wellbeing and wish to contribute to a positive culture in the workplace and by supporting staff engagement.

During 2020/21, the Trust will continue to further embed its health and wellbeing agenda and progress a variety of approaches to support the health and wellbeing of our workforce. Additional support and resources will also be provided as part of maintaining staff wellbeing during the coronavirus (Covid-19) pandemic period.

Priority 2 – Safe Care

The Trust will continue to focus on driving improvements in safe care and maximise learning opportunities to continuously improve patient care and experience. During 2020/21, the focus will be on the following specific areas:

Quality and Safety Strategy Priorities

The Trust's Patient Quality and Safety Strategy was launched during the summer 2019/20, which is aligned with the NHS Patient Safety Strategy (NHS England/Improvement, 2019). The Trust's strategy describes key aspect that the Trust will focus on over the next 3 years, which includes:

- Embedding a culture of safety
- Facilitating innovation and delivering safe and effective quality
- Protecting patients from unintended or unexpected harm.

This will be achieved by strengthening our approach to measuring and monitoring performance; learning continuous quality improvement skills; innovating, sharing best and spreading best practice, adopting new guidance and investing in leaders and teams. The strategy has 16 priority areas for 2019/20, associated outcome measures and milestones.

Positive progress has been made to date pertaining to these areas as the majority are part of existing work streams. Examples include:

- Learning from deaths programme – this extensive work programme has seen examples of positive impact on patient outcomes and a reduction of the Trust's SHMI to 'within the expected range'
- Embedding continuous quality improvement (CQI) – substantial activity has taken place and a CQI plan launched across the organisation, including staff training. In total, 143 staff have attended the Quality Service Improvement and Re-design (QSIR) fundamental training, 9 staff have become QSIR trainers and 10 staff have become QSIR practitioners. A variety of CQI projects have been supported and delivered during 2019/20. Please refer to the CQI section for more details
- Enhancing and retaining our workforce – extensive focus has remained in place to recruit and retain staff within the Trust. Please refer to the workforce section for more details
- Reducing harm – the Trust has continued to focus on reducing patient falls, VTE, infection, pressure ulcers and key achievements are described in the looking back section of the Quality Account.

The next step will be to evaluate the priority areas for 2019/20 during the summer 2020 and develop more detailed milestones and outcome measures for 2020/21.

In addition, the current governance structure associated with deteriorating patient oversight will be reviewed during 2020/21.

Harm Free Care

Falls

Preventing falls and learning from these incidents will remain a priority area and the Trust's focus will include:

- Identify further continuous quality improvement projects for specific aspects of care, or in specific clinical areas, and share our learning across the Trust
- Address concerns of audit undertaken in 2019/20 pertaining to documentation
- Further strengthen staff knowledge and education
- Undertake the annual audit and evaluate results in order to identify areas of good practice and where improvements are required

- Continue to hold the established accountability meetings with clinical leaders to review falls incidents, promoting shared accountability, learning and ownership.

Venous Thromboembolism (VTE)

The VTE group will continue its work and focus on the following areas:

- Work on consistently meeting and exceeding the Key Performance Indicators (KPIs) for VTE assessments. An updated Quality Improvement Plan (QIP) is in place to achieve this and other aims related to VTE prevention
- Undertake a full review of the Trust's VTE prevention and management policy by July 2020
- Implement the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) knowing the score for Pulmonary Embolism (PE) diagnosis and management
- Implement comprehensive assessment and management of VTE prevention measures for patients in lower limb casts as per the most recent NICE guidance NG89
- Given the success of the anti-coagulation in-reach team, the aim is to expand the team to provide the service across other areas of the Trust
- Continue to work with the electronic prescribing team to link VTE risk assessment and prescription
- Finalise a reporting system using electronic data for prescriptions and administration and trial its use in a clinical area.

In addition, the Trust anticipates further updates to clinical guidance (CG144) in the coming year, which might lead to changes in practice.

Pressure Ulcers

The key priorities for 2020/21 will include:

- To agree and launch an ambulatory wound services for patients with complex wounds such as leg ulcers and non-healing wounds
- To access the patients' wound care at a clinic managed by experienced wound care nurses
- The Trust plans to develop processes and will provide assurance for community leg ulcer management, in accordance with the national CQUIN guidance
- The pressure ulcer overarching action plans, to direct continued improvement to prevent preventable pressure ulcers and moisture associated skin damage
- The wound formulary and relevant pathways will be reviewed and launched.

Preventing Infection

The Trust will continue to work effectively with colleagues in primary, secondary and social care to develop work streams and individual projects that will deliver the values of the Trust and our CCG and improve patient safety and quality of care.

Key areas of focus for 2020/21 will include:

- A significant part of the Infection Prevention and Control Team's focus in Q1 and Q2 2020/21, will be managing the significant challenges and impact of COVID-19 (coronavirus) pandemic
- Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data
- Develop an infection prevention system in the wider healthcare community setting
- Zero tolerance to avoidable health care associated infections
- Expand research activity of the Infection Prevention Team
- Sustain the Trust's excellent reputation for infection prevention through team members' participation in national groups and projects
- Progress the plan for reducing the use of urinary catheters
- Continued robust prevention and management of Methicillin Resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA) and Carbapenemase Producing Enterobacteriaceae (CPE).

Human Factor and Team Optimisation

Human Factors

Human factors (HF) are widely used in safety-critical industries, with healthcare being a relative late-comer to the field. Being human by its very nature, makes us all fallible. The additional titles we hold, for example, doctor, nurse, midwife, pharmacist, dentist, chief executive, non-executive director, as a result of our education, training and technical ability, will never change the fundamental imperfections found among humans. This reality builds a stronger argument for the need to understand the impact of human factors within our healthcare setting.

Developing expertise in human factors analysis and principles will enable this learning and is expected to benefit patient outcomes, experience and patient safety as a whole. Other external benefits include meeting the requirements of external regulatory and oversight bodies and a reputation of improvement for the Trust.

A proposal for delivering in-house HF training and expertise has been drafted and consulted and is to be developed into a business case for Trust consideration. A Service Model for introducing human factor principles and expertise into the Trust has been developed and includes training and the application of HF expertise to Trust processes, including incident management and investigation, procurement, policy and process development, medical device and IT system usability testing.

The Trust reviews incidents to identify where human factors are featured. This may feature in the form of communication, policy/processes compliance, situational awareness, clinical judgement/decision-making. The Trust has already invested in buying-in bespoke HF training for some areas. These include, an in house Clinical Simulation Lab, training courses on emotional intelligence, process communication and leadership and will develop its resources and capacity further to address the HF issues that arise.

Team Optimisation

The effective functioning of a team is an important aspect of human factors and well recognised in research as key to patient safety, experience and outcomes. Taking on the challenge the Trust developed the Team Optimisation Model (TOM) aimed at improving the safety culture and team effectiveness through a number of co-complimentary interventions which dealt with human factors, staff and team communication, team function and teamwork, emotional intelligence and staff wellbeing. The intended benefits of rolling out Team Optimisation is to provide the team with a clearer understanding and plan of its overall goals, roles, processes, and working relationships (as well as inter team working and behaviours); so that staff can work more effectively, cohesively, efficiently and safely to reduce avoidable harm, recurring incidents and improve team culture and working climate.

The TOM model and its various interventions are arranged under the heading of Goals, Roles, Process and Relationships, it is based on research findings that charts the core components, interactions and functions of effective teams. The TOM programme is delivered via a programme of 4 workshops and are also available as a menu of bespoke interventions that can be applied to specific issues within a team.

In developing and using such a programme, the Trust is proactively seeking out opportunities and areas to improve and learn from its own intelligence and experience.

During 2020/21, the plan would be to develop a HF and TOM resource in a complimentary framework for implementation in the Trust. A proposal and service model is to be developed into a business case which the Trust will review through its approval processes. The Trust remains committed to continuous improvement and considers its work on human factors, team optimisation and safety culture to be a key parts of its improvement journey.

Medication Management and Safety

The Trust will continue to monitor medication incidents and share learning during 2020/21.

The Trust's priorities for 2020/21 will include:

- Insulin Task and Finish Group: A task and finish group has been set up to review all incidents which have involved insulin. The group will review the observations made by Care Quality Commission (CQC) and formulate a Trust wide plan for improvement
- The Medication Safety Team has identified that incidents involving enoxaparin and gentamicin are commonly reported. During the new financial year, incidents involving these medications will be collated, areas for improvement identified and an action plan for each drawn up and delivered.

Getting it Right First Time (GIRFT) Programme

The Trust's priorities for 2020/21 will include:

Continue to maintain links with the regional GIRFT Team to maximise the benefits that the GIRFT programme offers

Increase shared learning from other organisations, utilising the network that the GIRFT programme offers

Continue with the planned GIRFT visits and revisits and formulation of actions in conjunction with directorates

Maintain a multi-disciplinary approach to the programme to encourage learning across teams

Continue to embed GIRFT as a key component of the Continuous Quality Improvement agenda

Mental Health

During the summer 2019, the Trust has launched a comprehensive work stream focusing on improving care of the patients with mental health conditions and strengthen the associated governance processes. This was as a result of some gaps identified as part of the well-led framework assessment and feedback from Care Quality Commission. The strengthened approach includes a detailed action plan, which is being overseen by a multi-stakeholder oversight group.

Key aspects the Trust has focussed on include:

- Implementation of a robust governance structure for mental health from Ward to Board
- Staff training and competence with regards to mental health, including Mental Health Act
- Development of a Mental Health Policy and other associated documents
- Strengthening the provision of mental health care for patients attending our Emergency Department and those admitted to inpatient wards
- Access to mental health advocacy for patients
- Introduction of audits to monitor compliance associated with the mental health provision
- Ensuring that environments are safe for mental health patients
- The risks associated with mental health and learning disability patients are effectively mitigated
- Patients with learning disabilities are receiving safe and high quality care, meeting their needs
- Access to mental health support and resources for the staff.

During 2020/21, the Mental Health Operational Oversight Group will continue to progress actions outlined in the operational plan, with the Board receiving regular updates throughout the year.

Safeguarding

Safeguarding children, young people and adults from abuse and harm is everybody's business and an important part of everyday healthcare practice and patient care. The Trust has a dedicated Safeguarding Team of nurses / health professionals and administration staff to provide advice, support and training to the Trust's staff and other care providers within Wolverhampton.

All staff working within the Trust who have a responsibility for the care, support and protection of children and vulnerable adults should ensure that those at risk are safe. If staff witness or have suspicions of abuse or neglect, they are under an obligation to report it without delay even if they have not witnessed the abuse or neglect themselves. The Safeguarding Service seeks to protect children, young people and adults through training, supervision and advice.

The Safeguarding Service promotes a 'Think Family' focus throughout all child and adult safeguarding work to promote the importance of listening to the voice of children and young people so that their experience is heard and for the adult to ensure that safeguarding is made personal.

Trust and Safeguarding Key Legislation

The Children's Act 2004 (Section 10 and 11) requires each local authority to make arrangements to promote cooperation between the authority, relevant partners and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are made with a view to improving the well-being of all children in the authority's area, which includes the need to safeguard and protect from harm and neglect.

The 'Working Together to Safeguard Children' (2018) continues to be the guidance which covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children and provides a clear framework for Wolverhampton Safeguarding Together partnership to monitor the effectiveness of local services.

The Care Act (2014) continues to direct the statutory duties of all agencies in relation to safeguarding adults to ensure that services are reactive, proactive and responsive. There is now increased importance on making safeguarding personal for individuals who require safeguarding advice and support. To achieve this professionals and agencies must work in partnership and be able to promote the well-being of both individuals and their families/carers to reduce inequalities, risk and harm from abuse.

Quality Assurance

The overall safeguarding agenda is monitored through the regular completion of the Wolverhampton Clinical Commissioning Group (WCCG) Assurance Framework for Safeguarding Children and Adults with Care and Support Needs (2017). This provides evidence of the Trust's continued commitment to good safeguarding measures and is aligned to national and local safeguarding standards including the requirements from CQC and the Wolverhampton Safeguarding Together Partnership (WST) formerly Wolverhampton Safeguarding Children and Adult Board.

External Visits

The Wolverhampton Safeguarding Together Partnership (as part of their partnership function) visited the Trust in October and November 2019 to review the safeguarding arrangements for RWT 0-19 Children Service and Sexual Health Service. In summary, they were assured that:

- Overall practitioners were fully understanding of safeguarding
- The Wolverhampton Safeguarding Team's remit and thresholds for support were good
- There was good evidence of multi-agency working to safeguard children, families and adults.

The NHS England and Improvement Safeguarding Lead carried out a peer review of safeguarding in February 2020 and concluded that:

- The investment in safeguarding at the Trust was evident and commendable
- Safeguarding could be seen as central to the quality of care for patients and wider citizens who access the Trust.

Safeguarding Training

The Trust's Safeguarding Team deliver training to all staff who have contact with patients and volunteers. The level of training required is described within the Intercollegiate Document for Safeguarding Children and Young People (January 2019) and Intercollegiate Document for Safeguarding Adults (August 2018).

Training compliance 2019/20

Safeguarding Children Level 1	97.2%
Safeguarding Children Level 2	95.4%
Safeguarding Children Level 3	90.1%
Safeguarding Children Level 3s	87.0%
Safeguarding Adult Level 1	96.9%
Safeguarding Adult Level 2	94.5%
Safeguarding Adult Level 3	89.0%
Prevent Training	88.2%
MCA/DoLS Training	97.7%

Priority 3 – Patient Experience

The key priorities for the Patient Experience Team during 2020/21 will be to review milestones and outcomes for year 1 of the Patient Experience, Engagement and Public Involvement Strategy and progress year 2 milestones. Examples of these milestones include:

- A further roll out of the Observe and Act Initiative and Always Events
- Embed the concept of Patient Experience Champions
- Progress a variety of actions to strengthen community engagement
- Achieve key milestones associated with complaints management
- Develop new easy read patient surveys for FFT, PALS and complaints leaflets/posters
- Review themes from Friends and Family Test pertaining to groups with protected characteristics to identify potential improvements
- Take further actions to grow the co-production approach across the Trust
- Further expand the Council of Members
- Progress key milestones in the volunteer plan.

Office

Statements of Assurance from the Board

Mandatory Quality Statements

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

Review of services

During 2019/20, the Royal Wolverhampton NHS Trust provided and/or subcontracted nine categories of service; those being:

1. Accident and Emergency Services
2. Acute Services
3. Cancer Services
4. Continuing Healthcare Services
5. Community Services
6. Diagnostic, Screening and/or Pathology Services
7. End of Life Care Services
8. Radiotherapy Services
9. Urgent Treatment Centre Services

The Trust has reviewed all the data available to us on the quality of care in these categories of services.

The income generated by the NHS services reviewed in 2019/20 represents 79% of the total income generated from the provision of NHS services by the Royal Wolverhampton NHS Trust for 2019/20.

The Trust has reviewed the data against the three dimensions of quality including patient safety, clinical effectiveness and patient experience. The amount of data available for review has not impeded this objective. The data reviewed included:

- Performance against national targets and standards, including those relating to the quality and safety of the services
- Clinical outcomes as published in local and national clinical audits, including data relating to mortality and measures related to patient experience as published in local and national patient survey, complaints and compliments.

Doctors and Dentists in Training – Statement on Rota Gaps and Plan for Improvement

There are approximately 370 doctors in training who rotate throughout the Trust at any one time.

In accordance with the Terms and Conditions of Service for doctors and dentists in training (England) 2018, each trainee is issued with a work schedule which sets out the intended learning outcomes mapped to the educational curriculum, scheduled duties, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted. However, there are circumstances under which trainee doctors may work more hours than they are contracted for and there is a formal exception reporting procedure for reporting hours or educational issues that arise which should be discussed with the doctors educational or clinical supervisor to agree an outcome.

All trainee work rotas at the Trust are compliant with the requirements of the new junior doctor contract. The Guardian of Safe Working (GoSW) reports for 2019-20 highlight a limited number of exception reports submitted by doctors in training. One area that has been identified for improvement is to provide more guidance to trainees and supervisors regarding the exception reporting process. As a result the Exception Reporting Procedure has been updated and additional guidance produced. The full GoSW annual report for 2019/20 will be available in quarter two 2020/21.

In July 2019, the doctors and dentist contract was refreshed with a framework of agreement that sets out additional pay investments, improvement in safe working hours, more support for education and a modernised pay system.

A detailed project implementation plan that sets out activities to track and monitor has been completed. One challenge with progressing the recommendation was adhering to the safety limits for moving away from 1:2 weekend frequencies. This was not possible to implement in Emergency Medicine and risk assessments were put in place to maintain the 1:2 weekend working arrangement until August 2020. Implementing this recommendation sooner would have required recruiting additional Emergency Medicine Doctors from a labour market where these skills are short in supply. Despite the 1:2 weekend rotas in place, there have been no exception reports or safety concerns raised by doctors and dentist in training in Emergency Medicine.

The Trust has a Clinical Fellowship Programme (CFP) which was initiated as a method to attract and retain Junior Doctors with the aim of supporting clinical areas by enhancing junior doctor numbers and ensuring vacancies in trainee numbers were backfilled, thereby maintaining quality and safety of service provision. The CFP also helps to reduce temporary staffing spend (Agency and Locum) on Junior Doctors and the CFP has been a considerable success, recognised nationally. Whilst the CFP has been successful in filling vacancies in other specialties, this has only been partly successful in Emergency Medicine for reasons relating to lack of specific UK Emergency Medicine experience and familiarity.

A quarterly Trust wide junior doctor forum remains in place, attended by the Chief Executive and Medical Director, which provides a regular opportunity for feedback in respect of the trainee experience at the Trust

Participation in Clinical Audits

The aim of clinical audit is for the Trust to use it as a process to embed clinical quality, implement improvements in patient care, create a culture that is committed to learning and continual development, and a mechanism for providing evidence of assurance about the quality of services.

During 2019/20 there were 73 applicable national audit projects/ national confidential enquiries covering relevant health services that the Trust provides.

During 2019/20, the Trust participated in 93% of these national clinical audit projects/ national confidential enquiries, which it was eligible to participate in.

The National Confidential Enquiries that the Trust was eligible to participate in and actively collected data for are outlined in the table below. The national reports are currently awaited.

National Confidential Enquiries	Participated
Perinatal Mortality and Morbidity confidential enquiries	Yes – Awaiting Report
Maternal Mortality surveillance and mortality confidential enquiries	Yes – Awaiting Report
Maternal morbidity confidential enquiries	Yes – Awaiting Report

There were 5 national clinical audits that were applicable, but the Trust did not participate in during 2019/20 and these are listed in the table below, including the rationale for non-participation:

National Clinical Audit & Enquiry Project name	Work stream	Directorate	Rationale
BAUS Urology Audits	Female Stress Urinary Incontinence Audit	Gynaecology	Fees to subscribe to BAUS are too high to warrant participation
Child Health Clinical Outcome Review Programme	Long-term ventilation in children, young people and young adults	Children's services (Acute)	The directorate does not have any long term ventilated children and these patients are primarily under tertiary centre care
Endocrine and Thyroid National Audit	N.A	General Surgery	Directorate does not meet the audits inclusion criteria that staff to be members of BAETS society in order to participate
National Cardiac Arrest Audit (NCAA)	N.A	Resuscitation team	Financial cost of participating in audit outweighs any impact upon safety or quality on service, however this has been re-considered for 2020/21
National Ophthalmology Audit (NOD)	Adult Cataract surgery	Ophthalmology	Directorate does not have the electronic patient record Open Eyes system installed

The national clinical audits that the Trust participated in during 2019/20 and remain in progress are shown in **Appendix 1.**

The reports of 54 completed national clinical audits projects that were reviewed by the provider in 2019/20 are shown in **Appendix 2**, with the actions The Royal Wolverhampton NHS Trust intends to take to improve the quality of healthcare provided.

Clinical Audit Activity

In total, 466 clinical audits were registered on the Clinical Audit Database across the Trust, 292 (63%) of which were completed by the 31st March 2020. The adjusted completion rate (excluding national audits) was 73%.

Clinical Audit Outcomes

The reports of 292 clinical audits were reviewed by the provider and a compliance rating against the standards audited agreed. However, 46 local audits demonstrated moderate or significant non-compliance against the standards audited. The Royal Wolverhampton NHS Trust intends to take actions to improve the quality of healthcare provided and will consider re-audit against these standards once actions have been appropriately embedded. Details of these actions are outlined in **Appendix 3**.

N.B: Due to the coronavirus (COVID-19) pandemic pressures and the resulting impact on clinical staff and services, some of the data provided could be subject to delayed update and subsequent refresh. This data could include incident reports and clinical audit figures that may be subject to update/refresh from clinical staff who are currently unable to update the respective systems.

Participation in Clinical Research

National studies have shown that patients cared for in research active NHS trusts have better clinical outcomes. The availability of research across clinical services at the Trust provides a number of complementary additions to existing patient care and treatment. 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.

Review of 2019/20:

The Trust's performance in research continues to be on a par with the large acute trusts within the West Midlands region. The research culture, enhanced through the Trust's hosting of the West Midlands Clinical Research Network (CRNWM), has continued to be developed during the year.

The number of patients receiving health services provided or sub-contracted by the Trust in 2019/20 recruited to participate in research approved by a research ethics committee was in excess of 4200. Over 120 studies have been active during the past year. 4172 patients were recruited into studies adopted onto the National Institute of Health Research (NIHR) Clinical Research Network (CRN) portfolio, exceeding the target of 3236 participants set by the CRN West Midlands for recruits at the Trust in 2019/20.

The Trust's research teams have this year received national recognition for their recruitment into studies within a number of clinical areas including Cardiology, Rheumatology, Gastroenterology, Oncology and Paediatrics.

In addition, the Trust received the 'Best Overall Performance' Award in recognition of our achievements at the 2019 CRN WM Annual Network Awards.

The R&D Directorate at the Trust seeks feedback from research participants on their experiences of being involved in research. The results indicate how well the research team display the Trust values and behaviours of providing safe and effective care, being kind and caring and exceeding expectations.

The 2019/20 patient experience survey, completed by 329 participants of research, showed that 98% of them felt research is important to improve healthcare services.

74% reported the care provided was of the highest standard

81% felt communication from the research team was excellent

94% felt research staff maintained their privacy and dignity

91% felt fully informed about the study prior to taking part

79% felt comfortable in being able to withdraw from the study

“A positive experience which I have been happy to participate in.”

Participant in Stroke study

“Research is important and I was receiving a very expensive 4xbypass, so participation in the study was my limited way of saying ‘thank you’”

Participant in Cardiology study.

“Brilliant 5 star treatment, so blessed to be offered all the support and help.”

Participant in Rheumatology

The Trust’s priorities for 2020/21 will include:

- Continue to ensure that patients are given the opportunity to participate in clinically appropriate research trials
- Meet the National Institute of Health Research High Level Objectives for research delivery and performance
- Develop the Patient Research Champions role at the Trust to enhance the involvement of patients and the public as partners in research design and delivery
- Development of Chief Investigators, focused on research that reflects the health needs of the local population, through collaborations with academic and industry partners
- Increased involvement of non-medics in leading research at the Trust
- Raising the impact and profile of research – part of clinical care **not** an ‘add on’.

Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration statement is registered with no conditions.

The following service and Trust inspections took place during 2019/20:

Inspection date	Inspection type	Service	Date report published	Overall Outcome Rating	Requirement notices
18th July 2019	Ionising Radiation (Medical Exposure) Regulation Inspection	Interventional Radiology and Radiography	Not published	No official rating received. However, this inspection resulted in a positive outcome.	No requirement notices were issued. The following recommendations were received: 3 for Interventional Radiology 4 for Radiotherapy Actions associated with these recommendations were confirmed to the CQC in August 2019. The CQC subsequently confirmed that they were satisfied with the Trust's response and closed the inspection file.
20th August 2019	Primary Care Inspection	Coalway Road Medical Practice	29th October 2019	Good	The following requirement notice was issued: Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
July – September 2019	Well-Led, Core Services and Use of Resources Inspections	Trust wide focus as part of the Well-Led and Use of Resources Inspections The following Core Services were inspected: Medical Care, Urgent and Emergency Care, Critical Care, Outpatients, Children and Young People Services, Community Adults and Community Inpatients	14th February 2020	Good	The following requirement notices were issued: Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 18 HSCA (RA) Regulations 2014 Staffing
5th March 2020	Primary Care Inspection	Penn Manor Medical Practice	Publication date awaited	Good	The following requirement notices were issued: Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The Care Quality Commission had not taken enforcement actions against the Trust during 2019/20. The requirement notices issued are outlined in the table above, which all have associated action plans in place.

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

The Trust is taking the following actions to improve data quality in accordance with the relevant information governance toolkit standards.

- Conducting regular audit cycles
- Performing monthly Completeness and Validity checks across inpatients, outpatients, Emergency Department and waiting list data sets
- Monitoring activity variances and trends to spot outliers and erroneous numbers for investigation
- Using external/internal data quality reports to benchmark against peers and assess performance
- Using standardised and itemised data quality processes in Secondary Uses Service (SUS) data submissions monthly
- Holding bi-monthly meetings with a set agenda to discuss data quality items
- Holding bi-monthly Trust Data Quality meetings to manage / review practices and standards
- Reviewing Standard Operating Procedures for data collection to ensure consistency and standardisation across the Trust
- Forums in place to discuss data systems and data capture, with nominated 'Champions' disseminating key information across the Trust
- Recently employed additional resource into the Trusts' Data Quality Team to provide training and support, ensuring data is entered correctly at source.

NHS Number and General Medical Practice Code Validity

Clinical Coding Error Rate

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. Clinical coding audits were conducted and conformed to the Data Security & Protection Standards Advisory Level. The area audited as part of this was Admitted Patient Care for General Medicine & General Surgery.

The error rates reported in the latest audit for that period are detailed below, and were based on a small sample of 100 finished consultant episodes for each specialty, total audited 200 finished consultant episodes.

Admitted Patient Care diagnoses and procedure coding (clinical coding) were:

General Medicine Specialty	General Surgery Specialty
Primary Diagnoses correct 98%	Primary Diagnoses correct 91%
Primary Procedures correct 92.86%	Primary Procedures correct 97.70%

General Medicine

The overall Healthcare Resource Group error rate for the audit was 6% of the total number of episodes, which is a change of 2.3% absolute and 0.9% net. All recommendations following the audit have been completed.

NHS Number and General Medical Practice Code Validity Updated as per Month 12 - 2019/20. (Data extracted on 21/4/2020)

The Trust submitted records during 2019/20 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 demonstrates an improvement in every area against the 2019/20 submission, which included the patient's valid NHS number:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 97.2% for accident and emergency care.

This included the patient's valid General Practitioner Registration Code as follows:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 97.0% for accident and ED..

Information Governance Toolkit

Due to the coronavirus (COVID-19) pandemic, NHSX has recognised that it will be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. NHSX has therefore taken the decision to postpone the final deadline for DSPT submissions to the 30th September 2020. Therefore the following toolkit submissions will be delayed until such date:

The Royal Wolverhampton NHS Trust	RL4
Alfred Squire	M92002
West Park Surgery	M92042
Thornley Street	M92028
Lea Road	M92007
Penn Manor	M92011
Coalway Road	M92006
Warstones	M92044
Lakeside	M83132
Dr Bilas Surgery	M92026

Looking forward to 2020/21 Data security and Protection

Due to the COVID-19 challenges, the implementation of the national data opt out had also been delayed until the 30th September 2020. However, The Trust will continue to work towards achieving compliance with the national data opt-out for later in 2020.

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 which the Trust is aiming to improve with digital innovation and improvements in IT systems.

The Trust is continuing to embed the requirements of the General Data Protection Regulation 2016 (GDPR) into Trust practices, monitored via the GDPR implementation group ensuring data privacy is at the forefront of the care that we provide and the information that is captured. The Trust is also working closely with GP practices that have joined the organisation to align practices and share good practice.

The Trust remains focused on areas of business continuity in relation to data security, assurance around access to key information assets and how this is monitored as well as how data flows are mapped and monitored. This programme of work will be monitored though the following committees:

The Trust has several committees dedicated to reviewing assurance in relation to DSPT and GDPR, chaired by senior board members

The Medical Director is the Trust's trained Caldicott guardian, and is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that the Trust satisfies the highest practical standards for handling patient identifiable information, and Chairs the IG Steering Group and GDPR Implementation 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 the Trust has 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 appointed a 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 establishing clear responsibilities for Information Asset Owners across the Trust to facilitate robust and timely escalation of information risk escalation to the SIRO

Regular reports are provided to the Trust Board during the year to ensure that they are sighted on and support the Trust's plans in relation to data security and protection. To support this, each toolkit assertion is aligned to a director responsible on the Board

All Trust Board members received NHS Digital approved GCHQ cyber and data security training, and will receive updates and briefings in relation to the Trust performance in this area

Seven Day Services

The Trust is currently compliant against national 7 day service priority standards for 2019/20.

The four priority standards are:

- Standard 2: Patients admitted as an emergency to be reviewed by an appropriate consultant within 14 hours of admission. The compliance at audit October 2019 was 92.1%
- Standard 5: Seven day access to consultant directed and reported diagnostics
- Standard 6: Twenty-four hour access to consultant directed interventions e.g. endoscopy, emergency surgery
- Standard 8: Patients to be reviewed daily via a consultant delivered ward round and those who meet level 2 and 3 ICU criteria to be seen twice daily. The Trust's compliance during an audit carried out in October 2019 was 90.2%. This is an improvement on 2018/19 where the compliance target of over 90% for standard 8 was not achieved.

Areas of focus during 2020/21 will include, gathering both patient and staff experiences on care provision and working environments across the 7 days and also seeking assurance of the quality of medical handovers following the publication of policy in 2019/20.

Further areas of improvement will include the re-design of consultant rotas within Ear Nose and Throat (ENT) with the aim of introducing a daily ward round rota. This will require a system change across neighboring organisations.

The Trust will continue to seek opportunities to expand services across 7 days where this could have a positive impact on patient safety and quality of care. Examples include the intention to increase the provision of both specialist palliative care and acute kidney services from 5 day to 7 days.

A further case note review will take place during March-April 2020, to monitor compliance against standards 2 and 8. The Trust continues to submit reports on progress and actions to Trust Board.

The Learning Disability Improvement Standards

The Trust now has three learning disability (LD) nurses providing support across the whole organisation. The LD outreach team ensures that all patients with a LD are seen by an LD nurse during periods of admission. The team support staff to make reasonable adjustments where they are required, support with communications and advice on matters in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People with learning disabilities, autism or both their families and carers should be able to expect high quality care across all services provided by the NHS.

The Trust has engaged with the NHS England/ Improvement's benchmarking programme focusing on the learning disability improvement standards for all NHS Trusts.

The improvements focused on the Trust's performance against the three key standards outlined below. There was an additional 4th standard, which was for specialist learning disability services only).

Standard 1: Respecting and protecting rights

Standard 2: Inclusion and engagement

Standard 3: Workforce

Dementia

Dementia training at level 1, in line with Health Education England requirements, is mandatory for all disciplines of Trust staff with options for face-to-face and e-learning available. Face-to face dementia training at level 2 is provided on a monthly basis and is open to all disciplines of Trust staff.

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

The data made available to the Trust by the Information Centre with regard to the value and branding of the Summary Hospital-Level Mortality Indicator ("SHMI") for the Trust for the reporting period 2019/20:

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 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.

	Reporting Period	
Indicator	September 2018 - August 2019	October 2018 - September 2019
SHMI RWT	1.097 (within expected range)	1.097 (within expected range)
SHMI England	1	1

SHMI data and banding are public data made available by NHS Digital.

The SHMI has improved compared to previous months and is now categorised as 'as expected', within the control limit. The improvement in SHMI is as a result of both an increase in expected deaths, decrease in the observed deaths and a significant programme of improvement work taken place during 2019/20.

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

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

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

This programme of work has developed over the last 12 months and included, for example:

- Scrutiny and review of deaths in hospital via the medical examiner and mortality reviewer processes
- Focus on specific diagnostic groups including assurance of clinical pathways and developments of resultant action plans
- Improving the quality of coding and documentation
- Learning from deaths, including listening to the bereaved families and carers and involving them in key processes
- Provision of end of life care in patients' homes and care homes with an emphasis on admission avoidance where appropriate
- Invited External Reviews and development of resultant action plans
- A variety of audits.

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

Core Quality Indicators – Summary of Patient Death with Palliative Care

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

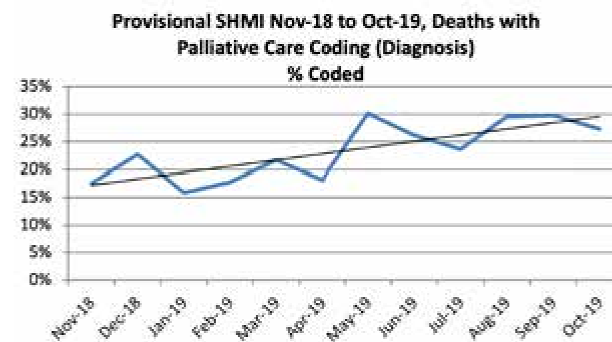
The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

	Current Period Oct 18 – Sept 19	Previous Period Oct 17- Sept 18	National Performance		
			Average	Lowest	Highest
Percentage of Deaths with palliative care diagnosis coding	22	22.1	36	12	58

Data Source NHS Digital 2018

The following is the latest available data on the NHS Digital (HSCIC) web site.

Compared to the same period last year, the number of deaths where palliative care diagnosis coding was recorded, has remained the same. However, this figure appears to be improving monthly as a result of various initiatives taking place, in particular the expansion of the palliative care team which continues to be further progressed.



During 2019/20, the Trust has established a medical examiner and mortality reviewer service so that all deaths are scrutinised and a significant selection undergo a Structured Judgement Review (SJR). This means that learning from deaths is now an established part of the Trust's governance process and has provided important information on the care of patients who were in the last months and weeks of life. This information has contributed to improving the Trust's ability to identify key areas of focus.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

- Continued expansion of the palliative care team, with full establishment expected by July 2020.
- Continuing to improve awareness of palliative and end of life pathways, using quality improvement initiatives to roll out gold framework standards
- Development of end of life services for specific diagnostic groups e.g. chronic kidney disease, focusing on community support and promotion of achieving care in the patients' preferred place
- Continued expansion of educational events for Trust staff (nursing, medical, acute and community), including development of joint education provision with local hospice providers
- Take forward an NHS England/Improvement project focusing on increasing identification of patients from South Asia with the intention of improving advance care planning.

Core Quality Indicators – Learning from Deaths

Actions taken by The Royal Wolverhampton NHS Trust in relation to mortality 2019/20:

The Trust continued to work on implementing the Learning from Deaths guidance to ensure that we promote learning from mortality reviews and improve how we support and engage with the families and carers of those who die in our care. The Trust has an established Mortality Review Group (MRG), chaired by one of the Divisional Medical Directors. The group meets every month to oversee progress with the implementation of the Trust's Learning from Deaths Policy, quality improvement plan for mortality and the associated work streams. Reports are provided from this group to the Trust's Quality Governance Assurance Committee and Trust Board.

In 2019/20, there have been several streams of work to enable the Trust to learn from deaths which are detailed below.

1. Scrutiny and review of deaths in hospital

The introduction of the Medical Examiner role in 2018/19 has meant that over 50% of in hospital deaths are scrutinised by an independent medical colleague within days of the death. The aim is to improve this further to achieve scrutiny in over 90% of cases.

The Trust's policy, in line with national guidance, is that where potential areas of concern with care are identified at the scrutiny stage, the Medical Examiner refers these cases for a more detailed review by one of the members of the mortality reviewers team. This process is called a Structured Judgement Review (SJR) and is a standard national process. SJR reviews will include cases where relatives have raised concerns as well as a group of conditions were mandatory referral is required. In addition, a random selection of 10% of cases are chosen for review.

2. Focus on specific diagnostic groups including assurance of clinical pathways

During 2019/20, in response to alerts of high SHMI for specific diagnostic groups, the Trust reviewed a cohort of cases and clinical pathways related to the following: Cerebrovascular disease (CVD), Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Disease, Sepsis, Senility and organic mental health disorders, Iron deficiency and other anaemia and Skin and subcutaneous tissue infections.

There was specific learning in each diagnostic group and the common themes included:

- Requirement for improvement in quality of documentation that would support accurate recording of primary diagnosis
- Requirement to improve recording of co-morbidities
- Requirement for improved support for patients to allow end of life care to occur in their own homes (or nursing homes) rather than reliance on admission to hospital
- Requirement to reduce mortality risk associated with long length of stay.

3. Quality of coding and documentation

It is important that the clinical data documented throughout a patient's stay in hospital, and particularly at admission, is accurate and complete as this data feeds the algorithm which produces the deaths that are expected within the Trust over a given period and this in turn affects the SHMI. The Trust has previously demonstrated that the depth of coding produced was good, however specific morbidity scores (Charlson comorbidity) were not captured as completely as required, especially during the admission episode which contributes to the calculation of expected mortality rates. This has led to a number of initiatives including re-design of the Trust's coding protocol, education of clinicians, regular

meetings between coding and emergency portal clinical teams and retrospective case note reviews.

4. Learning from Deaths including engagement with families

Through the medical examiner process, the Trust is now proactively speaking with families within days of bereavement to hear their experience of care provided to their loved ones. The discussions will have included requests for clarity about treatment as well as potential concerns in care. An action plan has been developed during 2019/20, to take forward and implement recommendations from the national Involving Families in the Learning from Deaths Process guidance.

5. Provision of end of life care in community settings

A variety of initiatives have commenced between the Trust's community teams, Wolverhampton Clinical Commissioning Group (CCG) and other community providers e.g. Compton Care and nursing homes, in an attempt to support an increase the use of advanced care planning with the intention of avoiding admission to hospital for end of life care. The Trust intends to measure the impact of ongoing interventions working collaboratively with our partners, including Wolverhampton CCG and Public Health.

6. External Reviews

Throughout the last year the Trust has used external, independent review and opinion to assure the Board of the progress against the mortality improvement agenda. This has included working with Price Waterhouse Cooper, who have reviewed the data collection systems and identified areas for change in addition to receiving an audit of the learning from death processes via the Trust auditors Grant Thornton UK. In addition, an independent invited review by an external medical consultant was conducted to provide assurance on the work being undertaken and identify areas of improvement and focus.

Plans for 2020/21

The MRG will continue to progress the Trust's mortality improvement programme and associated plan, underpinned by the Mortality Strategy.

Key areas of focus will include:

Monitoring of SHMI

Despite the Trust's SHMI improving and now being within expected range, the Trust will continue to monitor the mortality rates in specific diagnostic groups and where a rising trend is seen will instigate case note and clinical pathway review.

End of Life Care

Provision of end of life care in community settings rather than in hospital has been a constant theme in case note reviews. Through the Integrated Care Alliance, the partners will continue the ongoing work in an effort to identify and provide services for those people at the end of life and in their preferred place of care.

Review of Out-of-Hospital Deaths

Most primary care providers currently review the care of patients who subsequently die in their population. However, there is no systematic methodology which allows for recording of outcome or learning across organisations. The Trust has begun discussion across the Primary Care Networks and will pilot a system in the Trust's primary care practices during 2020/21.

(NB the following statements are mandatory for the Quality Account)

	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 2019 and March 2020, 1986 adult patient hospital deaths were recorded at the Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period: [464] in the first quarter [445] in the second quarter [477] in the third quarter [600] in the fourth quarter
B	The number of deaths included in item A which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By the 31st March 2020, [1638] case record reviews and [24] investigations have been carried out in relation to [1986] of the deaths included in item A. In [6] cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: [462] in the first quarter [377] in the second quarter [443] in the third quarter [356] in the fourth quarter Please note: 50 Structured Judgement Reviews stage 1 (SJR1) remain outstanding across Q4 2019/20 which are actively being progressed. It is also important to note that cases that have been through Medical Examiner (ME) process are included in the above figures.
C	An estimate of the number of deaths during the reporting period included in item B for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	A total of 2 cases [0.11%] representing [number as percentage of number in item A]% 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: [0.06%] for the first quarter [0.06%] for the second quarter [0%] for the third quarter [0%] for the fourth quarter These numbers have been determined using evidence from the Root Cause Analysis (RCA) investigations involving deaths that were subject to review under the serious incident framework. (The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated).

D	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C.	Case 1 – Summary only Death from bilateral cerebral haematoma resulting from an unwitnessed fall. Learning identified: The importance of timely completion of the falls competency risk assessment and vital signs. Assurance of staff compliance on falls competency document and Falls prevention e-learning through audit and monitoring of training compliance. Importance of effective communication within the team, outside the immediate team and family. Case 2 – Summary only Death resulting from explosion in patients home on long term oxygen therapy. Learning identified: The processes communicating with the hospital team regarding patient's non-concordance unclear. Initial Home Oxygen Risk Mitigation (IHORM) form incomplete. Escalation process for community teams with any concerns regarding patients with oxygen at home unclear. Communication to be strengthened to enable suppliers to raise any concerns following provision.

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).	Case 1 Education: Practice Education Facilitator delivered re-education and training on falls prevention/risk assessment and documentation. Focus of reinforcement of falls policy to night staff and inclusion in the unit's local induction pack. Monitoring: Daily falls audits implemented. CQI project commenced to support improvement. Policy/process change: Development of a Standard Operating Procedure (SOP) requesting emergency scans (communicated to ward/junior doctors and all medical staff) that includes the necessity for a referral and telephone call to the radiology department. Ward staff (doctors/nurses) to escalate any emergency diagnostic investigations to senior members of the team to avoid delays during safety briefings and multidisciplinary daily huddles. Sharing/Learning: Share learning from the incident with ward staff and 'Making it Better' Alert for wider trust learning. Discuss learning from the incident and actions taken as part of nursing training and development programmes. Case 2 Policy/Process change: Review and update local policy to include requirement to undertake Oxygen risk assessment (IHORM) for unstable patients at initial discharge and any subsequent discharge. Develop a clearly defined pathway for the removal of Oxygen from patients (to be used by acute and community). Reinforce single point of contact to HOSA team for escalation of any concerns with community staff. Patient contract to include provision for removal of equipment if non-compliant. Learning/sharing: Present this incident and the subsequent learning at the respiratory medical training session. Undertake pilot on respiratory ward whereby HOSA team review patients and undertake risk assessments. Communication: Communication to oxygen provider that at the point that Oxygen is being installed, any concerns must be escalated to the ward/clinical staff.

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 for the Trust is to continue full implementation of the mortality improvement programme and the associated plan which is underpinned by the Mortality Strategy. In addition, the focus will remain on ensuring that the learning identified though the Trust's mortality review process is systematically implemented. The Trust is working towards assessing the impact of actions identified through specific RCAs.
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.	[20] case record reviews (SJRs) and [3] investigations completed after 31st March 2019 which related to deaths which took place before the start of the reporting period.
H	An estimate of the number of deaths included in item G which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	3 of the patient deaths reported during the previous reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. The methodology used was through the Root Cause Analysis (RCA) investigations involving deaths that were subject to review under the serious incident framework. The determination whether they were more likely than not to have been due to problems in care is undertaken as part of the RCA process and reviewed/agreed through the Trust Executive Significant Event Review Group (ESERG) group. (The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated).
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.	0.23% of the patient deaths during 2018/19 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)

The data made available to the Trust by the information centre with regard to Patient Reported Outcome Measures (PROMS):

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 below outlines the adjusted post-operative score by procedure based on the EQ-5D Index.

Topic	April 17-March 18	April 18-March 19	National Average 18-19
Hip Replacement Surgery	0.81	0.78	0.80
Knee Replacement Surgery	0.76	0.75	0.75

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

For hip replacement, 288 patients completed the questionnaire. 88.9% of these patients reported improvement, for 4.2% the situation remained unchanged and for 6.9% the situation worsened

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

For knee replacement, 366 patients completed the questionnaire. 81.4% of these patients reported improvement, for 7.9% the situation unchanged and for 10.7% the situation worsened

This has resulted in a score for the reporting period equaling the national average

For both hip and knee surgery, the data demonstrated that the Trust's score is broadly in line with the national average with a slight decline on the previous year's performance.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

A PROMs audit to be undertaken as part of the Trust's audit programme in 2020/21

Education for patients will continue to be provided pre-operatively, and the PROMS questionnaire explained and provided to patients at their pre-operative appointment

Alongside commissioners, the Trust will continue to review its orthopaedic pathways to ensure optimum care is provided to patients post operatively through follow-up

Core Quality Indicators – Re-admission Rates

The data made available from the Trust's internal system with regard to re-admission rates.

All data is from the Trust's Patient Administration System (PAS) using the national definition of a re-admission.

Readmissions				**Grand Total**
Age	**2017/18**	**2018/19**	**2019/20**	
Aged 4-15	423	359	428	**2,155**
16yrs and over	5,165	5,677	6,018	**28,269**
Grand Total	5,588	6,036	6,446	**30,424**

Total Admissions				**Grand Total**
Age	**2017/18**	**2018/19**	**2019/20**	
Aged 4-15	5117	4,668	4,813	**25315**
16yrs and over	117355	117,669	120,049	**588946**
Grand Total	122472	122,337	124,862	**489399**

Percentage Readmissions				**Grand Total**
Age	**2017/18**	**2018/19**	**2019/20**	
Aged 4-15	8%	8%	9%	**9%**
16yrs and over	4%	5%	5%	**5%**
Grand Total	5%	5%	5%	**6%**

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

NHS Digital no longer publish readmission data and therefore the Trust's internal data has been used, however the Trust has provided the previous historical data collected by NHS Digital for benchmarking purposes.

This data forms part of the Chief Operating Officer's report to the Trust Board and Trust Management Team on a monthly basis.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

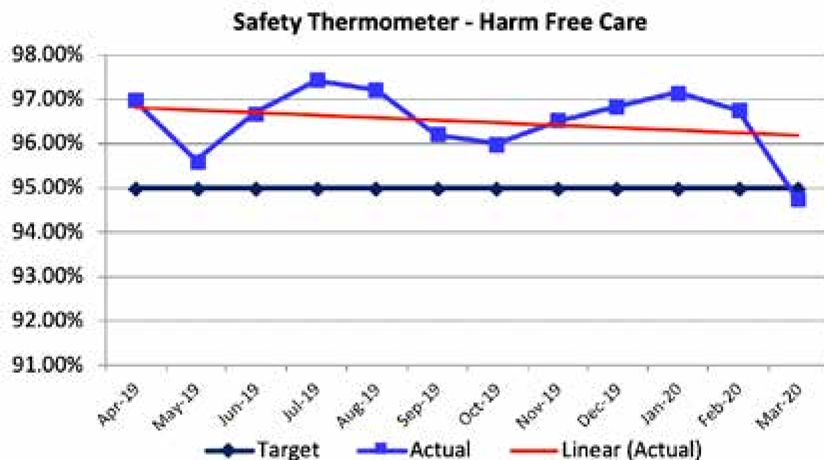
- Consistent adherence to the Red to Green day protocols and improved information with regards to discharge
- Continuing to work with local residential and nursing homes with regards transfer of patients back to their care
- Strengthening discharge planning at pre-operative assessment and at the point of admission
- Continuing to undertake reviews of 'stranded patients' to facilitate their discharge
- Undertake Multi Agency Discharge Events (MADE)
- Embed the principles of criteria led discharge.

Core Quality Indicators – Safety Thermometer

The data made to the Trust by the information centre with regard to Safety Thermometer.

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

- The data is collected monthly by each inpatient area and verified by the Senior Sister and Matron upon submission
- Safety Thermometer data is distributed and discussed on a monthly basis as part of a suite of key performance metrics used by the Trusts to analyses and triangulate performance
- Data for each of the four harms is triangulated with that of internal incidence data and reported via the Trust's incident reporting system
- Data is validated through by specialty services relating to each harm.



The Trust maintained its performance above the 95% ambition of harm free care for the whole 2019/20.

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

- The senior nursing and midwifery team will continue to promote the awareness of harm and associated learning in the Trust
- Falls and pressure ulcer incidents will continue to be reviewed using an accountability model
- A city-wide plan for the reduction of catheter-associated urinary tract infection will continue to be implemented
- Actions associated with the Nursing System Framework will continue to be implemented across the organisation.

Core Quality Indicators – VTE Prevention

The data made available to the Trust by the information centre with regard to VTE Prevention:

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	19/20 Year End
RWT	92.05%	93.48%	93.75%	93.70%	94.92%	95.17%	94.70%	93.08%	94.48%
National Average	95.63%	95.49%	95.65%	95.74%	95.63%	95.47%	95.33%		
Trust with Highest Score	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
Trust with Lowest Score	75.84%	68.67%	54.86%	74.03%	69.76%	71.72%	71.59%		

Trusts were notified at the end of March 2020 by NHS England and Improvement to temporarily suspend national reporting during the COVID-19 pandemic and that there would, therefore, be no data submission (including Q4 data) or publication until further notice later in the year. As a consequence there is no national benchmarking available. The Trust's Q4 data is available for illustration purposes.

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

- The numerator is the number of adult in-patients that have received a VTE assessment upon admission to the Trust using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with published guidance)
- The denominator is the number of adult inpatients (including for example surgical, acute medical illness, trauma, long term rehabilitation and day case).

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

Development and implementation of an improvement plan during 2019/20 and a new plan for 2020/21 in order to achieve 95% and above compliance

Development and implementation of clinical area specific continuous quality improvement plans

Review of associated policies, to ensure compliance with national guidance and best practice

Implementation of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) knowing the score for Pulmonary Embolism (PE) diagnosis and management

Implementation of comprehensive assessment and management of VTE prevention measures for patients in lower limb casts as per the most recent NICE guidance NG89

Given the success of the anti-coagulation in-reach team, the aim is to expand the team to cover other areas of the Trust

Continuation of the work with the electronic prescribing team to link VTE risk assessment and prescription

Finalise a reporting system using electronic data for prescriptions and administration and trial its use in a clinical area

Core Quality Indicators – Clostridium difficile

The data made available to the Trust by the information centre with regard to Clostridium difficile:

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Target	3	4	3	3	4	3	3	3	3	4	3	4
Actual cases	4	4	3	4	7	5	3	1	4	2	4	2

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

There are robust governance structures for monitoring delivery of the infection prevention annual programme of work, and this is supported by surveillance and indicator data including:

- NHS 'Safety Thermometer'
- Nursing quality metrics
- Laboratory data
- Domestic monitoring
- Mortality information
- National HCAI data capture system monitoring.

The Infection Prevention Team provide data, assurance and the risks into various reporting structures, to include but is not limited to:

- Compliance Oversight Group
- Quality and Safety Intelligence Group
- Environment Group
- Health and Safety Steering Group
- Decontamination Committee
- Trust Management Committee
- Trust Board
- Clinical Quality Review meetings
- Contract Monitoring meetings.

The Trust's Infection Prevention Group continues to provide strategic direction, monitor performance, identify risks, and ensure a culture of openness and accountability is fostered throughout the organisation in relation to infection prevention. This is re-inforced in the community by working closely with Public Health and Commissioners to manage risks within independently contracted services and care homes.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

The Clostridium difficile incidence was above the agreed trajectory during 2019/20. Focusses efforts were made to address the Trust's performance and focus on the key areas to drive improvements. Examples of these efforts included:

- Environmental controls have continued to be a top priority in the Trust's approach in tackling Clostridium difficile. The deep clean schedule has been completed with great effect and regular environment audits undertaken, results of which continued to be monitored through the Environment Group which reports to the Trust Infection Prevention Group
- Human Probiotic Infusion (HPI) has continued to be available for appropriate cases. This is incorporated into the treatment algorithm which ensures they are used more often with recurrent disease for improved outcomes
- Follow up of cases in the community has continued to ensure treatment is completed and to facilitate appropriate intervention and advice if symptoms return.

During 2020/21 the Trust will focus on the following aspects:

- Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data
- Sustain Clostridium difficile reduction with a lower tolerance of individual cases.

Core Quality Indicators – Incident Reporting

N.B: Due to the coronavirus (COVID-19) pandemic pressures and the resulting impact on clinical staff and services, some of the data provided could be subject to delayed update and subsequent refresh. This data could include incident reports and clinical audit figures that may be subject to update/refresh from clinical staff who are currently unable to update the respective systems.

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

2018/19 (Full Year Data)			2019/20 (April - September)		
Incidents	% resulting in death	% resulting in severe harm	Incidents	% resulting in death	% resulting in severe harm
10750	0.1% (12)	0.1% (12)	5233	0.1% (6)	0.1% (5)

Data source – Trust Data at present 2019

The Trust defines severe or permanent harm as detailed below:

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

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

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

The Trust has a well embedded reporting culture and promotes the reporting of near miss incidents to enable learning and improvement

The Trust undertakes data quality checks to ensure that all patient safety incidents are captured and appropriately categorised in order to submit a complete data set as per the national requirement

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

The Trust will continue to train staff to facilitate prompt reporting and management review of incidents (including serious incidents)

The Trust will continue to communicate lessons learnt via risky business newsletter, making it better alerts and through the Integrated Governance Reports (IGRs)

Governance officers will continue to share Root Cause Analysis (RCA) summaries across all directorate governance meetings where applicable

Core Quality Indicators – CQC National Inpatient Survey 2019

The data made available to the Trust by the information centre with regard to the National Inpatient Survey results:

The 2019 Inpatient Survey was part of a national survey programme run by Care Quality Commission (CQC) to collect feedback on the experiences of inpatients using the NHS services across the country. The results contribute to the CQC's assessment of NHS performance as well as ongoing monitoring and inspections. The programme also provides valuable feedback for NHS trusts, which they can then use to improve patient experience.

During 2019, a questionnaire was sent to all inpatients that used the service in July 2019. Results were published by the CQC on 2nd July 2020.

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.

Analysis of the results data

- A total of 519 patients returned (with total eligible of 1,188) response rate of 44% in 2019 compared to previous year of 515 returned (with total eligible of 1,173) response rate of 44% in 2018
- Pleasingly, the Trust has experienced a shift of double the volume of questions previously in the top 20% nationally when comparing 2018 to 2019 scores and a reduction from 4 questions to 2 in the bottom 20%
- No question showed at least 5% improvement on the 2018 score, and 2 questions showed a 5% or more worsening of score (out of 62 questions 2019). The remaining questions showed less than 5% in change in score since 2018
- The categories for improvements relate to leaving hospital, and the themes are related to discharge and delays.

Group	Count of National Comparison 2018 (60 questions)	Count of National Comparison 2019 (62 questions)
Top 20%	5	10
Middle 60%	51	48
Bottom 20%	4	2
No Comparison	0	2

The following questions were in the middle 60% in 2018 but have now moved into the top 20% in the 2019 survey.

Number	Question
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?
Q11	While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?
Q16	In your opinion, how clean was the hospital room or ward that you were in?
Q27	Did you have confidence and trust in the nurses treating you?
Q35	Did you have confidence in the decisions made about your condition or treatment?
Q36	How much information about your condition or treatment was given to you?
Q45	Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?
Q56	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?

The following questions were in the top 20% in 2018 but have now dropped into the middle 20% for 2019. The scores are shown below.

Number	Question	2018	2019
Q7	Was your admission date changed by the hospital?	93.5%	92.3%
Q8	In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	92.9%	91.2%
Q14	Were you ever bothered by noise at night from other patients?	67.3%	63.7%
Q49	Were you given enough notice about when you were going to be discharged?	74.7%	69.2%

Areas where there has been a reduction of 5% in score or the scores feature in the bottom 20% for national comparisons (4 questions in total) predominately relate to a category of leaving hospital. Communication was the key theme for these.

Questions which have been flagged as Bottom 20% in the National Comparison 2019:

Number	Question Group	Question	2018	2019	Diff
Q65	Leaving hospital	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	76.7%	75.6%	-1.1%
Q70	Overall views of care and services	During your hospital stay, were you ever asked to give your views on the quality of your care?	6.2%	5.6%	-0.6%

Questions showing at least 5% reduction since last survey:

Number	Question Group	Question	2018	2019	Diff
Q49	Leaving hospital	Were you given enough notice about when you were going to be discharged?	74.7%	69.2%	-5.5%
Q52	Leaving hospital	How long was the delay?	32.5%	27.4%	-5.1%

An analysis of written comments made by patients completing the survey was undertaken. Each comment was read and coded against a standard coding proforma which looked at different aspects of the pathway of care, staff and the hospital environment and facilities.

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

- Participation in the survey is mandatory, and part of a nationwide programme of surveys organised by CQC.

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

- The development of an action plan to address the key findings of the report which are yet to be agreed. This will be reported on in due course and monitored through the Trust's governance arrangements to ensure that appropriate improvements are made.

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

The data made available to the Trust by the information centre with regard to Patient Friends and Family Test:

The Friends and Family Test (FFT) is a nationwide initiative which is a simple, single question survey which asks patients to what extent they would recommend the service they have received at a hospital department to family or friends who need similar treatment.

The tool is used for providing a simple, headline metric, which when combined with a follow up question and triangulated with other forms of feedback, can be used across services to drive a culture of change and of recognising and sharing good practice. The overall aim of the process is to identify ways of improving the quality of care and experience of the patients and carers using NHS services in England.

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

- FFT data is published monthly
- FFT data is published nationally
- FFT data forms part of nursing metrics and is monitored against key performance indicators set as part of the Nursing System Framework
- Analysis undertaken regards low performing areas and improvement plans implemented.

Survey Response Rate

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	2019/20 Average			
RWT	RWT	RWT	RWT	RWT	RWT	England	Highest	Lowest
Emergency Department	14%	15%	14%	15%	15%	9%	30%	0%
Inpatients	30%	32%	34%	30%	32%	18%	75%	1%
Maternity	7%	13%	14%	15%	12%	15%	61%	0%
Outpatients	20%	20%	17%	18%	19%	5%	61%	0%

Percentage of Patients who would recommend the Trust

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	2019/20 Average			
RWT	RWT	RWT	RWT	RWT	RWT	England	Highest	Lowest
Emergency Department	85%	87%	85%	86%	86%	64%	75%	37%
Inpatients	94%	94%	93%	94%	94%	72%	75%	60%
Maternity	99%	99%	96%	95%	97%	73%	75%	51%
Outpatients	94%	95%	95%	95%	95%	70%	75%	57%

Percentage of Patients who would not recommend the Trust

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	2019/20 Average			
RWT	RWT	RWT	RWT	RWT	RWT	England	Highest	Lowest
Emergency Department	10%	8%	9%	9%	9%	7%	28%	0%
Inpatients	3%	3%	4%	3%	3%	2%	8%	0%
Maternity	1%	1%	1%	4%	2%	1%	17%	0%
Outpatients	2%	2%	2%	2%	2%	2%	12%	0%

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2020/21 by:

- Benchmarking ourselves against our peers with aim to show continual improvements
- Robust systems in place to evidence actions and improvements for under-performing areas
- Embedding of the new national FFT guidance.

Trusts were notified at the end of March 2020 by NHS England and Improvement to temporarily suspend national reporting during the COVID-19 pandemic and that there would, therefore, be no data submission (including Q4 data) or publication until further notice later in the year. As a consequence there is no national benchmarking available. The Trust's Q4 data is available for illustration purposes. The national averages shown do not include Q4 data.

Core Quality Indicators – Supporting Our Staff

The data made available to the Trust by the information centre with regard to Supporting Our Staff:

The Trust is one of the largest employers in its local community, employing over 9000 people.

The Trust has a number of ways of engaging with staff in order to improve employee engagement and to support staff to continuously strive for excellence in patient care. The efficacy of the Trust's staff engagement approach is measured principally through the annual national NHS Staff Survey and the quarterly national Friends and Family Test.

The data below is collected nationally each quarter and shows the percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends. In addition, the percentage of staff who would recommend the Trust as a place to work is shown for quarters.

Recommendation Rates - Work		
	Q1 2019/20	Q2 2019/20
RWT	79%	81%
England	66%	66%
Highest	91%	97%
Lowest	31%	33%

Not Recommended - Work		
	Q1 2019/20	Q2 2019/20
RWT	8%	6%
England	16%	16%
Highest	49%	50%
Lowest	0%	0%

Recommendation Rates - Care		
	Q1 2019/20	Q2 2019/20
RWT	87%	90%
England	81%	81%
Highest	98%	100%
Lowest	51%	50%

Not Recommendation Rates - Care		
	Q1 2019/20	Q2 2019/20
RWT	4%	2%
England	6%	6%
Highest	26%	38%
Lowest	0%	0%

Trusts were notified at the end of March 2020 by NHS England and Improvement to temporarily suspend carrying out the Staff FFT during the COVID-19 pandemic and that there would, therefore, be no data submission (including Q4 data) or publication until further notice later in the year.

National NHS Staff Survey

The Trust continues to undertake a census of all staff as part of the National Staff Survey such that all staff have the opportunity to provide feedback on their work. As in 2018, the benchmark data was published with responses being assessed against themes rather than the previous 32 Key Findings. Those themes are:

- Equality, Diversity & Inclusion
- Health and wellbeing
- Immediate Managers
- Morale
- Quality of Appraisals
- Quality of Care
- Safe Environment – Bullying and Harassment
- Safe Environment – Violence
- Safety Culture
- Staff Engagement
- Team Working (additional theme included in the 2019 survey).

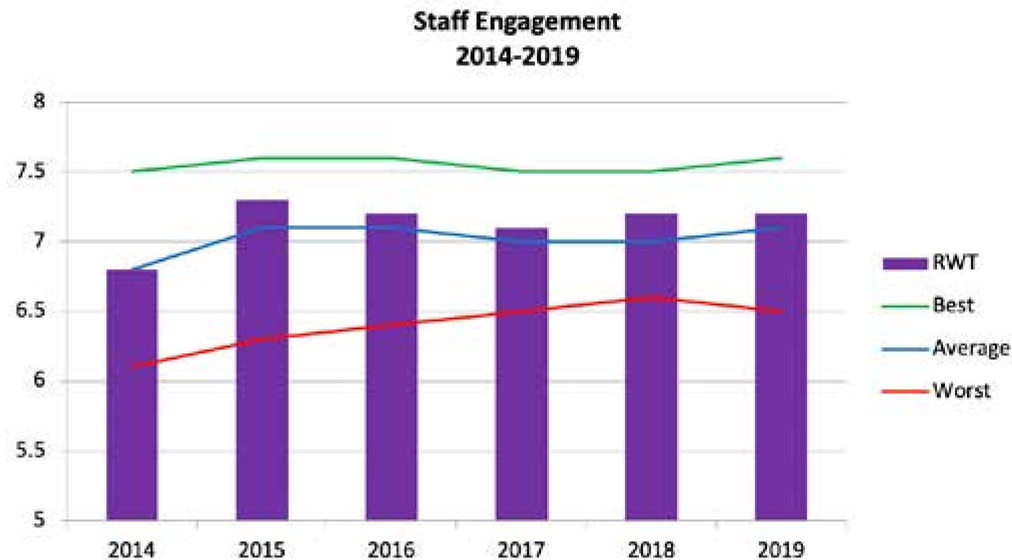
The Trust's results are outlined in the table below:

Theme	2018 Score	2018 respondents	2019 score	2019 respondents	Statistically significant change?*
Equality, Diversity and Inclusion	9.1	3078	9.2	3303	Not significant
Health and Wellbeing	6.1	3099	6.2	3340	
Immediate Managers	6.9	3103	7.0	3340	
Morale	6.3	3053	6.4	3286	Not significant
Quality of Appraisals	5.6	2613	5.7	2880	Not significant
Quality of Care	7.6	2607	7.8	2837	
Safe environment – Bullying & Harassment	8.2	3067	8.3	3306	Not significant
Safe environment – Violence	9.5	3065	9.6	3315	Not significant
Safety Culture	6.8	3082	6.9	3308	
Staff Engagement	7.2	3125	7.2	3357	Not significant
Team Working	6.6	3083	6.7	3306	

**Statistical significance is tested using a two-tailed t-test with a 95% level of confidence*

Year on year comparisons are shown in the table above for each of the themes (the scores are out of a maximum of 10). As can be seen, there had been statistically significant improvements in scores for five of the eleven themes, which include: health & wellbeing, immediate managers, quality of care, safety culture and team working. In relation to the remaining six themes, five have seen an improvement, including: equality, diversity and inclusion, morale, quality of appraisals, safe environment – bullying and harassment, safe environment – violence, albeit not such that it can be regarded as statistically significant.

Staff engagement has remained unchanged and steady since 2015 and above that of the average of comparator Trusts. This is illustrated in the chart below:



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

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

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

- Holding staff engagement sessions in each division and focus groups in relation to specific themes from the NHS staff survey
- Compile local / divisional / corporate actions plans to drive further improvements in the NHS staff survey results
- Re-introduce a local quarterly 'pulse survey', whereby additional questions linked to chosen NHS staff survey themes will be added to staff FFT survey.

Supporting Staff through Speaking Up

The Trust Board's vision to enable staff to speak up, together with 5 key objectives, was launched in 2019. As a result, the Trust has created a safe environment for staff to speak up and be supported when they raise concerns.

There are number of ways in which staff can speak up in confidence, including speaking up to their managers, colleagues, their teams and in their departments. In addition, the Trust has revised its Freedom to Speak Up (FTSU) Policy and put in place 13 Contact Links (staff volunteers) across the organisation within multiple sites and a Freedom to Speak Up Guardian providing a safe and confident environment for staff to speak up. Furthermore, there is an online reporting system (contained in DATIX) that enables staff to raise concerns anonymously should they wish to do so.

The Trust takes providing feedback as key to ensuring staff are kept informed and updated about their speaking up concerns. The Trust's FTSU training programme encourages managers to ensure feedback is given and ways in which feedback can be provided. The Trust's FSTU Policy includes a template to help provide feedback and where possible, feedback is encouraged via the DATIX system. If anonymous concerns are submitted, the FTSU Guardian works closely with the relevant HR Teams and Divisional Managers to agree when it would be appropriate to feedback to the department on actions the Trust has taken. The Trust's FTSU Guardian also feeds back to the Trust Board and through Trust wide newsletters on themes and areas of concerns. In 2019, the Trust held its first FTSU Conference; where themed feedback was provided on staff speak up concerns.

The FTSU process is taken very seriously and the Trust is fully committed to providing a safe and confident place for staff to speak up without fear of detriment. The Trust's policies and processed are designed to protect staff and enable them to speak up without fear of detriment. The FTSU Guardian has a responsibility to escalate concerns raised to the senior leadership team and has begun to report to the Trust Board on all cases where staff feel they suffered a detriment.

Review of Quality

Our performance in 2019/20

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 on a monthly basis.

Performance against the National Operational Standards:

Indicator	Target 2019/20	Performance 2019/20	Performance 2018/19
Cancer two week wait from referral to first seen date	93%	**82.11%**	83.18%
Cancer two week wait for breast symptomatic patients	93%	**35.19%**	51.12%
Cancer 31 day wait for first treatment	96%	**87.14%**	90.15%
Cancer 31 day for second or subsequent treatment - Surgery	94%	**84.84%**	76.02%
Cancer 31 day for second or subsequent treatment - Anti cancer drug	98%	**99.66%**	100.00%
Cancer 31 day for second or subsequent treatment - Radiotherapy	94%	**90.87%**	87.95%
Cancer 62 day wait for first treatment	85%	**58.07%**	62.78%
Cancer 62 day wait for treatment from Consultant screening service	90%	**60.18%**	78.48%
Cancer 62 day wait - Consultant upgrade (local target)	88%	**74.49%**	81.90%
Emergency Department - total time in ED	95%	**85.91%**	91.12%
Referral to treatment - incomplete pathways	92%	**84.31%**	90.44%
Cancelled operations on the day of surgery as a % of electives	<0.8%	**0.65%**	0.47%
Mixed sex accommodation breaches	0	**0**	0
Diagnostic tests longer than 6 weeks	<1%	**3.16%**	1.5%

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.

Similar to 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 2019/20	Performance 2019/20	Performance 2018/19
Clostridium Difficile	40	43	31
MRSA	0	0	2
Referral to treatment - no one waiting longer than 52 weeks	0	0	0
Trolley waits in A&E longer than 12 hours	0	38	7
VTE Risk Assessment	95%	94.48%	93.26%
Duty of Candour - failure to notify the relevant person of a suspected or actual harm	0	0	1
Stroke - 90% of time spent on stroke ward	80%	94.08%	93.55%
Maternity - bookings by 12 weeks 6 days	>90%	90.60%	90.80%
Maternity - breast feeding initiated	>64%	69.90%	64.90%

Congratulations on the birth of your baby
For the Lockdown Babies

Engagement in the developing of the quality account

Prior to the publication of the 2019/20 Quality Account, we have shared this document with the following:

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

NHS
Wolverhampton
Clinical Commissioning Group

Statement from Wolverhampton Clinical Commissioning Group

As lead commissioner, Wolverhampton Clinical Commissioning Group (WCCG) welcomes the opportunity to provide this statement for The Royal Wolverhampton Trust quality account for 2019/2020. In doing so, the WCCG reviewed the Quality Account in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Quality Review Meetings (CQRM) attended by commissioners. This evidence is triangulated with information and further informed through Quality Assurance visits to the Trust to gain assurance around the standards of care being provided for our population.

The WCCG supports the Trusts' identified quality priorities for 2020/21. To the best of our knowledge, the report appears to be factually correct. In the quality accounts for 2019/2020 the Trust has demonstrated its passion and determination to continually improve the quality of care it delivers across the healthcare economy, following their common goal "to make sure that patients are at the centre of all we do".

Whilst reviewing the Quality Account we were pleased to note many of the specific actions that the Trust has taken during 2019/2020 to improve its services and the quality of care that it provides.

The Trust has addressed key areas to improve patient safety and has continued to strengthen learning from incidents, complaints and feedback; however, the WCCG would like to congratulate the trust for the following key achievements achieved during 2019/2020:

- For achieving a significant reduction in nursing vacancies across the board and for winning a national award for the Best Workplace for Learning and Development at the Nursing Times Awards
- For achieving a significant reduction in the number of serious incidents which includes Slips, Trips & Falls, Confidential Breaches, Maternity incidents and most importantly for achieving 50% reduction in the numbers of never events incidents reported
- For achieving Zero MRSA Bacteraemias attribution to the Trust
- For strengthening trust sepsis team capacity to help drive early recognition and management of sepsis at ward level and support a cultural shift across the organisation and contribute towards reducing the number of preventable deaths due to sepsis
- For achieving a significant reduction in Summary Hospital-level Mortality Indicator (SHMI) to an expected range. It is positive to see that Trust is working collaboratively with the WCCG to ensure that any learning is addressed across the system and that they continue to achieve further reduction of the SHMI. This is a credit to all the staffs hard work and resilience in mortality review and shared learning
- For achieving a reduction in PALS concerns by 24% and in addition, including stakeholders, patients and/or their carers to contribute and co-produce documents and initiatives to improve the overall patient experience
- For achieving overall CQC rating of Good with a rating of Outstanding for Caring. Whilst this is significant achievement commissioners recognise the importance that the Trust maintains a continued focus on their improvement journey to achieve good quality care

As a CCG, we understand that trust has faced some significant challenges throughout the last year. Cancer performance is an area of significant challenge and whilst demand has outstripped capacity in some clinical pathways the relentless focus on improving the productivity of every clinical pathway has resulted in significant time reduction for those patients waiting for diagnosis and treatment.

Again the WCCG has worked in partnership with the Trust to adopt a local system approach to improvement; this includes working with local primary care colleagues to ensure referral pathways are robust and commissioning additional diagnostic capacity to support the increased demand. It should be noted that the trust achieved significant improvements for 2 week wait breast symptomatic patients

due to a collaborative system response i.e. cancer referral diversion pathway and also by introducing super clinics, additional staffing capacity and streamlining the cancer pathways.

VTE (Venous Thromboembolism) also remains a challenge and it is good to see that the trust recognises the need for continuing to drive improvements and a new 2020/21 improvement plan has been developed to support this. We recognise and are encouraged by the good work that has gone into many areas within the trust in relation to Sepsis and deteriorating patient recognition and management at ward level, and we will look forward to seeing further improvements made by the trust to reduce the number of preventable deaths across the trust.

Looking forward

WCCG fully endorse the three key priorities Workforce, Safe Care and Patient Experience to achieve improvements for year 2020/21 and will contribute to the achievement of the Trust strategic objectives. It is recognised that the focused areas for improvement in clinical quality have the potential to have a significant impact on improving safety, effectiveness and experience.

Going into 2020/2021 the WCCG will continue to work collaboratively with the Trust and will seek further improvements in all areas of clinical quality, including cancer performance, mortality, VTE and sepsis. We fully support the Trusts commitment to achieve continuous improvements for patients in both their experience and outcomes and welcome the particular focus on the overall reduction in mortality and reducing all cancer performance targets for our population.

The quality account is comprehensive and the report reflects an accurate picture of the Trust based. The WCCG has been working closely with the Trust during the year, gaining assurance of the delivery of safe and effective services. A range of indicators in relation to quality, safety and performance is presented and discussed at regular meetings between the Trust and WCCG. The information presented within the Quality Accounts is consistent with information supplied to the commissioners throughout the year.

There are notable areas of success as well as areas that continue to require focus and improvement. 2020/21 will be a year that will bring further change and challenge for the Trust, as commissioners we believe that the Trust's values will drive forward the objectives and they will continue to improve quality across the breadth of services we commission, their continuous improvement will benefit our patients in the care they receive.

The Wolverhampton Clinical Commissioning Group would like to thank The Royal Wolverhampton NHS Trust for the opportunity to review and provide a response to the 2019/2020 Quality Account. It is encouraging to see from this Quality Account that the Trust is clear that providing high quality and safe care is their number one priority. This is clearly evident through the progress with the quality priorities for 2019/2020 and the selection of new priorities for the year 2020/21.

Sally Roberts

Chief Nurse, Director of Quality – Wolverhampton CCG

Date: May 2020

CITY OF WOLVERHAMPTON COUNCIL

Statement from City of Wolverhampton Council Health Scrutiny Panel

Writing in late April 2020, it is hard to imagine the long-term impact of the Covid-19 crisis on health systems, but we are in no doubt that it will be profound. In some respects, the tragic circumstances of Covid-19, will stimulate change and in particular in the use of digital services for residents. We have already seen the widespread use of GP appointments, now conducted in the virtual world during the early stages of the Covid-19 pandemic. We are obviously concerned about the demand on health services once the immediate crisis begins to end and we are acutely aware the Trust is already planning for the future.

The Health Scrutiny Panel wishes to pay tribute to all staff working in the health sector for their ongoing commitment during the Covid-19 pandemic.

Looking back over the last year, the Health Scrutiny Panel would like to commend the Royal Wolverhampton NHS Trust for their excellent work on the mortality improvement agenda. As a result of this work, the Trust has seen the Summary Hospital-Level Mortality Indicator (SHMI) reduced to an expected range. The Panel is aware that in large part the drop in the indicator was down to better hospital coding and end of life care in the community, rather than a certain change in care quality in the hospital.

The Panel also congratulates the Trust on the significant progress made on their independent scrutiny of all hospital deaths, through their Learning from Deaths programme. This involved Medical Examiners and clinical peer reviews, which has always been a transparent process where health partners have been fully involved, and where RWT have set a benchmark for other Trusts. The Health Scrutiny Panel has received several reports and presentations on mortality over the last two years and we are pleased that there has been positive change.

It is clear that there has been some excellent work completed on the management of complaints at the Trust. The Health Scrutiny Panel reviewed this area earlier in the Municipal year. It is an important service and we know that organisations that take complaints seriously and learn from them will be a step closer to becoming leaders in their field.

The Health Scrutiny Panel are particularly pleased to see the introduction of the Bereavement Hub and the improvements this has led to in the efficient legally required registration of deaths and supporting people who have lost loved ones.

The Health Scrutiny Panel wishes to congratulate the Trust on receiving an overall good rating from the CQC inspections that took place during the Summer. We note that there were a few requirement notices issued and we are pleased to see that action plans have been put in place. The progress against these action plans is an area the Panel will wish to monitor moving forward.

A particular area that the Health Scrutiny Panel would like to see improvement, is on the management of sepsis in the acute setting, which was only at 37.5%, for timely identification and treatment in this setting. It is an area that the Panel will hold the Trust to account moving forward. We are aware of new methods being trialled in some Trusts, regarding the digital monitoring of sepsis and we think this shows promise for the future.

The Health Scrutiny Panel notes that 46 local audits demonstrated moderate or significant non-compliance against the standards audited. Audits are an excellent way of ensuring compliance and taking steps to make improvements thereafter. The Panel will wish to keep an oversight against the areas of non-compliance found as a consequence of these audits.

The Health Scrutiny Panel is grateful to all the witnesses from the Trust that have come before the Panel over the last Municipal year, their evidence has led to a high standard of governance.

We will continue to ask staff from the front line at the Trust to give evidence to the Panel and we thank the Chairman, the Chief Executive and the Deputy Chief Nurse (Scrutiny Panel Liaison Officer) of the Trust for their co-operation, openness and transparency. The Health Scrutiny Panel working in partnership with all health partners leads to better services. Asking the right questions can open up whole new ideas, concepts and stimulate creative thinking. This is ever more important with the changing arena of healthcare systems and during the Covid-19 crisis and its aftermath.

Cllr Phil Page

Chair of Health Scrutiny Panel

City of Wolverhampton Council

30th April 2020

Engaging Communities

healthwatch Wolverhampton

Statement from Healthwatch

Due to the pressures associated with Covid-19 pandemic, our local Healthwatch colleagues have advised that they will not be providing their statement in the Trust's 2019/20 Quality Account. This is based on the communication they have received via their national office, advising that these statements are optional for this year.

Statement of Director Responsibilities in respect of the Quality Account 2019/20

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012)). In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Accounts presents a balanced picture of the Trust's performance over the period covered;

The performance information reported in the Quality Account is reliable and accurate;

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

David Loughton, CBE

Chief Executive

13th July 2020

Professor Steve Field, CBE

Chairman

13th July 2020

Statement of Limited Assurance from the Independent Auditors

Due to the coronavirus (Covid-19) pandemic, a decision was made nationally in March 2020 to suspend the assurance audit element of the Quality Account 2019/20. However, the table below provides an update on actions agreed following the previous Quality Account audits for completeness.

#	Risk	Issue, Impact and Recommendation	Trusts Response
Quality Account 2018/19			
1	1	**PSI: Strengthening the timely reporting of Patient Safety Incidents** The Trust's policy sets a target of 48 hours for reporting any incident. As part of our testing, we found that 10 out of 25 incidents sampled were reported after 5 days of the incidents occurred and 13 out of 25 incidents were uploaded to NRLS system after 30 days of the incidents added to the Datix system. The timely capture of incidents and their submission is important for serious incident investigation and resolution by the Trust's Quality and Safety Intelligence Group as well as identifying and addressing any potential gaps in understanding. **Recommendation** The Trust should evaluate options to upload its data to NRLS more frequently and develop agreed performance measures for timeliness. Some trusts upload their data weekly. The Trust should establish a process of reporting and escalation through to the Quality Assurance Governance Committee where adverse performance is experienced on agreed timeliness measures.	The Trust has agreed to: • Implement weekly uploads to NRLS. (2020 update: Action completed). • Establish monitoring process for the weekly uploads to NRLS. (2020 update: Action completed). • Re-inforce the requirement of reporting incidents within 48 hours of their occurrence as stipulated by the Trust's policy. (2020 update: On review of this recommendation, the 48 working hour requirement is for an initial RCA in relation to STEIS incidents. This is already monitored via STEIS reports). • Develop a process for targeting those clinical areas where a delay in reporting of incidents within the 48 hour timescale has occurred. (2020 update: A process in in place via the Datix User Group). • Commence reporting of NRLS uploads via the Quality Safety Intelligence Group and the Quality Governance Assurance Committee. (2020 update: Reporting process agreed via the NRLS report submitted to QGAC).

2	2	**PSI: Maintaining a NLRS submission** We found differences across the indicator calculated based on the data provided for the audit, the figures used for internal reporting and the data submitted to the NRLS. Recommendation The Trust should undertake a reconciliation of the PSI figures between those reported to the NLRS and the underlying systems prior to creating the dataset for the audit.	The Trust has agreed to develop a Standard Operating Procedure for undertaking reconciliation of the PSI figures between those reported to NRLS and the underlying systems prior to creating the dataset for the audit. (2020 update: SOP developed and implemented).
3	2	**VTE: Improving the segregation of duties between manual input and submission sign-off** The same Trust officer is responsible for the manual input of data from the paper risk assessment forms into the database, the manual amendments to the VTE database reports and for signing off the SDCS submissions. A separation of duties between these tasks would mitigate against the risk of accidental or deliberate errors and protect the individual from any unwarranted criticism or suspicion of manipulation. The Trust has sought to refine its compilation of records prior to submission. However, it remains complex and prone to the occasional error. From our testing we found 4/25 instances where the VTE assessment date was either before the admission date or after the discharge date. The Trust's own testing, undertaken in response to our findings, also found instances where the Vitalpac software showed that VTE assessments were completed that the database records for the audit did not reflect. **Recommendation** The Trust should appraise options to better segregate duties for the formal review and approval process for manual changes and input of data from paper assessment forms. In addition, the Trust should evaluate options to clarify and share responsibilities among Information Services and VTE staff over future data validation procedures.	The Trust has agreed to: Information services to review process to ensure accuracy of data submission to Strategic Data Collection Services. (2020 update: Action completed). Appraise options to better segregate duties for the formal review and approval process for manual changes and input of data from paper assessment forms. Explore options to ensure greater clarity and sharing of responsibilities for future data validation procedures. (2020 update for the above two bullet points: A new process implemented whereby another clinician (part of the anticoagulation team) randomly selects a minimum of 20 patient notes each month to undertake checks and validation. Evidence of this is held by the anticoagulation service).

4	3	**PSI: Gaining assurance over 'No' harm and 'Low' harm incidents** Our testing found evidence that incidents were reviewed and approved by a local management level. Only 'moderate' harm or above incidents were systematically validated by the Governance team. There remains a small risk that inconsistencies across the Trust may permeate over time and that low or no harm incidents might be more serious incidents on review. **Recommendation** The Trust should devise a systematic approach to reviewing a periodic sample of lower harm rated incidents. Any learnings should be fed back to frontline staff through the normal mechanisms.	The Trust has agreed to review governance team resources in order to develop a systematic approach to reviewing a periodic sample of lower harm rated incidents and ensure any learning is fed back to frontline staff. (2020 update: SOP for quality assurance checks for low harm incidents implemented. All changes made are being captured and these will be reviewed to inform whether any staff education is required. A process for quality assuring 10% of 'no harm' incidents has been agreed).

#	Risk	Issue, Impact and Recommendation	Trust's response
Quality Account 2017/18			
1	2	**Quality Account -C-Difficile Indicator: Data entry omissions** When faecal samples are received in the microbiology laboratory they undergo a screening process and review against the prescribed criteria to determine if a C-Diff test is required. For 2017-18, the system recorded 4,361 samples with an acceptable exclusion result or reason. However, we found 3,993cases in which there were blank or undetermined fields and so the exclusion reason could not be immediately identified. A similar issue was reported in 2016/17 where the respective figures were 4,492 and 4,136 respectively. Using other fields or searches of source records it was possible for laboratory staff to identify the reason for no test being performed, with the exception of 13 cases, where tests for C-diff should have been completed but were not, and of these there were two cases that if tested and C-diff was identified could have been attributable to the Trust. In the unlikely event that both were positive cases, it would not make a difference to the overall achievement of the C-diff target. **Recommendation** Where the decision to exclude a sample from C-Diff testing is taken, the Trust should enforce mandatory recording of the reason in the system.	In order to implement this action fully, the Trust has agreed to develop a new laboratory system with the aim to use the new system to reduce the risk of human error and to avoid samples not being tested in line with Department of Health recommendations. (2020 update: The new LIMS is not currently live and its implementation date is to be confirmed. However, the details of the action are not exactly the process followed in microbiology. The current agreed process is that if the patient fits into the 'C-Diff testing criteria' then microbiology make a comment on the consistency of the sample received. This then determines whether it is tested for C-Diff of not. A comment is always sent out if testing is not completed. If the patient does not fit within the criteria then no comment is made. This process has been replicated in the new LIMS, therefore at this time there will be no change.

Appendix 1 – National Clinical Audits that the Trust participated in during 2019/20 and remain in progress

The 68 national Clinical Audits the Trust collected data for in for 2019/20 are as follows. The reports for the 2019/20 data will be reviewed and presented locally as and when they are made available to the Trust by the relevant Coordinating Centre.

National Clinical Audit, Enquiry or Programme	Work Stream/ Component	Lead Directorate
Antenatal and newborn national audit protocol 2019 to 2022	PHE Screening- antenatal and newborn screening	Obstetrics
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	N/A	ED
BAUS Urology Audits	BAUS Bladder Outflow Obstruction Audit	Urology
BAUS Urology Audits	BAUS Cytoreductive Radical Nephrectomy Audit	Urology
BAUS Urology Audits	Radical Prostatectomy Audit	Urology
BAUS Urology Audits	Cystectomy	Urology
BAUS Urology Audits	Nephrectomy Audit	Urology
BAUS Urology Audits	Percutaneous Nephrolithotomy (PCNL)	Urology
Breast and Cosmetic Implant Registry (BCIR)	Breast Implant – cosmetic augmentation and breast reconstruction with implant including revision and removal	General Surgery
Care of Children (Care in Emergency Departments)	N/A	ED
Case Mix Programme (CMP)	N/A	Critical Care

Elective Surgery (National PROMs Programme)	N/A	T&O
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	Rheumatology
Falls and Fragility Fractures Audit programme (FFFAP)	National Audit Inpatient Falls	T&O
Falls and Fragility Fractures Audit programme (FFFAP)	National Hip Fracture Database	T&O
Head and Neck Cancer Audit	N/A	Head and Neck
Inflammatory Bowel Disease (IBD) Audit	Inflammatory Bowel Disease (IBD) Biological Therapies Audit & Service Standards	Gastro
Learning Disabilities Mortality Review Programme (LeDeR)	N/A	Trustwide
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	N/A	Infection Prevention
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	Obs and Gynae
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal morbidity and mortality confidential enquiries	Obs and Gynae
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal Mortality surveillance and mortality confidential enquiries	Obs and Gynae
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity confidential enquiries	Obs and Gynae
Medical and Surgical Clinical Outcome Review Programme	Dysphagia in Parkinson's Disease	Neurology
Medical and Surgical Clinical Outcome Review Programme	In-hospital management of out-of-hospital cardiac arrest	ICCU
Mental Health (Care in Emergency Departments)	N/A	ED
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Children's Services Acute

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Adult Asthma Secondary Care	Respiratory
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Respiratory
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Pulmonary rehabilitation- organisational and clinical audit	Respiratory
National Audit of Breast Cancer in Older People (NABCOP)	N/A	General Surgery
National Audit of Cardiac Rehabilitation	N/A	Cardiology
National Audit of Care at the End of Life (NACEL)	N/A	Oncology/Palliative Care Team
National Audit of Dementia (care in general hospitals)	Dementia care in general hospitals	CoE
National Audit of Seizure management in Hospitals (NASH)	Emergency Departments	Neurology/ED
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	N/A	Children’s Services Acute
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Cardiology
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Cardiology
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	Cardiothoracic
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Cardiology
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Cardiology
National Child Mortality Database	N/A	Children’s Services Acute
National Comparative Audit of Blood Transfusion programme	2019 Re-audit of the Medical Use of Blood	Pathology

National Diabetes Audit – Adults	National Diabetes Foot Care Audit	Diabetes
National Diabetes Audit – Adults	National Diabetes Inpatient Audit (NaDIA) -reporting data on services in England and Wales	Diabetes
National Diabetes Audit – Adults	NaDIA-Harms - reporting on diabetic inpatient harms in England	Diabetes
National Diabetes Audit – Adults	National Core Diabetes Audit	Diabetes
National Diabetes Audit - Adults	National Pregnancy in Diabetes Audit	Obstetrics
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	Rheumatology
National Emergency Laparotomy Audit (NELA)	N/A	Critical Care
National Gastro-intestinal Cancer Programme	National Oesophago-gastric Cancer (NOGCA)	Gastro
National Gastro-intestinal Cancer Programme	National Bowel Cancer Audit (NBOCA)	Gastro
National Joint Registry (NJR)	8 workstreams; Hip, knee, ankle, elbow & shoulder replacement and Implant, hospital & surgeon performance.	T&O
National Lung Cancer Audit (NLCA)	N/A	Respiratory
National Maternity and Perinatal Audit (NMPA)	N/A	Obs and Gynae
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	N/A	Neonates
National Paediatric Diabetes Audit (NPDA)	N/A	Children’s Services Acute
National Prostate Cancer Audit	N/A	Urology

National Smoking Cessation Audit 2019	N/A	Respiratory
Perinatal Mortality Review Tool (funded by DH)	The PMRT is a tool to support high quality local reviews of care when a perinatal death has occurred; it is not a data collection tool.	Obstetrics
Sentinel Stroke National Audit programme (SSNAP)	N/A	Stroke
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	Pathology
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Acute Internal Medicine / General Internal Medicine	Acute Medicine
Surgical Site Infection Surveillance Service	N/A	Infection Prevention
Trauma Audit & Research Network (TARN)	N/A	ED
UK Cystic Fibrosis Registry	N/A	Respiratory
UK Parkinson's Audit	N/A	Neurology
UK Renal Registry	N/A	Renal

Appendix 2 – National Clinical Audits reviewed by the Trust in 2019/20 with actions intended to improve the quality of healthcare provided

Completed audits are reviewed by the provider to identify the outcomes of audits and confirm the compliance rating against the standards audited. It is crucial that where audits have identified moderate or significant non-compliance that actions are taken to address gaps and implement changes to improve the quality of healthcare provided. All audits identified as moderate or significant non-compliance were (where appropriate) added to the 2019/20 audit plan for subsequent re-audit.

The reports of 54 completed National Clinical audit projects have been reviewed in 2019/20 by the provider to date and the actions being taken to continue improvement are below.

2019/20 Audit ID	National Clinical Audit, Enquiry, Project name & Work-stream	Lead Directorate	Compliance rating	Actions identified to improve the quality of healthcare provided
5188	National Maternity and Perinatal Audit	Gynaecology	Not Applicable	13 national recommendations have been made and the directorate have completed a gap analysis to ensure all are being considered.
5186	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2015-17	Gynaecology	Not Applicable	National recommendations have been made and the directorate have completed a gap analysis to ensure all are being considered.
5185	MBRACCE - UK Perinatal Confidential Enquiry	Gynaecology	Not Applicable	National recommendations have been made and the directorate have completed a gap analysis to ensure all are being considered.
5183	MBRRACE-UK Maternal Report 2017	Gynaecology	Not Applicable	Review of audit recommendations and discussion in governance meetings.
5070	RCR National Audit: Evaluating Radiological Reporting of Fragility Fractures	Radiology	Significant Non-Compliance	Presentation to consultants. Rheumatology engagement to establish referral criteria and pathway.
5057	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Pathology	Not Applicable	Not applicable
4996	UTI treatment in Walk in Centre Phoenix Health Centre	Acute medicine	Minor Non-Compliance	Education through peer review and audit is being repeated in 1 years' time.

4961	2018/19: MBRRACE-UK: UK Perinatal Mortality Surveillance report for births in 2016	Gynaecology	Not Applicable	Gap analysis based on national recommendations in order to identify where improvements/changes are required.
4948	Each Baby Counts	Obstetrics	Not Applicable	Gap analysis based on national recommendations to identify areas of improvement/learning.
4939	2017 - Five years of cerebral palsy claims	Gynaecology	Not Applicable	Gap analysis of released national recommendations.
4892	National Audit of Breast Cancer in Older People 2019	General surgery	Not Applicable	Not applicable.
4887	SAMBA 2019/20 - Society for Acute Medicine Benchmarking	Acute medicine	Minor Non-Compliance	A review of time from DTA to consultant review in the next samba audit.
4852	2019/20 BAUS National Complex Surgery Audits - Prostate Cancer (2018 data)	Urology	Not Applicable	Not applicable.
4822	2019/20 National Audit: BAUS Urology - Cystectomy	Urology	Not Applicable	A review of the national findings will aid discussions to help improve patient care and service delivery.
4790	Patient Satisfaction Audit 19/20	Gastroenterology	Not Applicable	Plan to design a poster to be displayed across both sites, visible to all patients and staff with recommendations. Survey to be repeated in 2020. Positive comments to be circulated to all Endoscopy staff across both sites. Discuss areas of improvement around delays and communication of these delays to patients and those attending with them. Continued emphasis on the Consent process, information giving, privacy and dignity. To explore why some patients felt they did not receive adequate information about their personalised follow-up plan.

4760	NELA - National Emergency Laparotomy Audit (relates to 2017/18 submission of data) 2019/2020	Critical Care	Moderate Non-Compliance	We will continue to collate and distribute the data/ outcomes from this National Audit. The surgeons are being reminded to complete the pre op risk assessment tool to assess risk. Will be re-audited as part of national program.
4752	Management of Paediatric Supracondylar Humeral Fractures Regional Audit Protocol	Trauma & Orthopaedics	Minor Non-Compliance	Continue good practice, as compared to previous audit.
4720	The efficacy and safety of long term EEG monitoring in the outpatient setting. A national service evaluation. 2019/20	Neurology	Fully Compliant	Fully compliant already achieving standards and guidelines.
4607	PATHS - Perioperative administration of tranexamic acid in hip fracture surgery	Trauma & Orthopaedics	Fully Compliant	Not applicable
4590	AUDIT OF ASSESSMENT AND RECOGNITION OF DELIRIUM AMONG HOSPITALISED OLDER ADULTS IN UK HOSPITALS Protocol for Round 3 – Full re-audit (2019/2020)	Care of the elderly	Fully Compliant	Not applicable
4567	West Midlands Regional Audit on Orthodontic Treatment Outcomes in secondary care using the PAR index Jan 2017- Dec 2017	Head & Neck	Not Applicable	Not applicable
4532	2018: National Audit- National Epilepsy 12 Audit (Dr Sastry)- Re audit	Children's Services – Acute	Minor Non-Compliance	Establish Tertiary Outreach clinic
4449	AcUte manaGeMEnt of aNkle fracTures (AUGMENT) - A prospective multi-centre observational audit assessing the initial management of ankle fractures.	Trauma & Orthopaedics	Minor Non-Compliance	Continue to adhere to BOAST guidelines.

4440	Vital Signs In Adults (Care in Emergency Dept) 2018/2019	Accident & Emergency	Moderate Non-Compliance	Share the audit findings via emails and teaching sessions (Nurses and doctors). Raise awareness regarding early recognition and management of seriously ill patients. Re audit next year in 1st or 2nd Quarter
4433	CQUIN 2c: Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours meeting the following three criteria:(originally registered 2018/2019) 2019-2020	Pharmacy	Not Applicable	Not applicable
4432	2018-19 CQUIN Indicator 2d: Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption	Pharmacy	Not Applicable	Not applicable
4340	DRAFFT IMPACT STUDY	Trauma & Orthopaedics	Fully Compliant	Not applicable
4291	2018 National Diabetes in Pregnancy Audit	Gynaecology	Minor Non-Compliance	Continue to produce local audit and review national audit with the in house diabetic teams.
4264	2018 National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Neonatal	Not Applicable	Continue to encourage mothers to breast feed or express milk to feed to their preterm babies. Ensure that parents on ward round are entered correctly and consultant lead identified.
4231	Sentinel Stroke National Audit programme (SSNAP) 2018/2019	Stroke	Minor Non-Compliance	QI project being initiated to improve 1st CT scan times and stroke pathway with CQI team. This will help improve pathway for Stroke patients. Workforce review in progress for nursing and SALT.
4195	National Comparative Audit of Blood Transfusion Programme - O Neg use	Pathology	Fully Compliant	Not applicable
4164	The National Epistaxis Audit (Originally registered 2016/17 3124)	Head & Neck	Not Applicable	Not applicable

4131	2018/19: A National Audit: PCNL	Urology	Not Applicable	Not applicable
4130	2018/19: NATIONAL: Nephrectomy	Urology	Not Applicable	Not applicable
4128	2018/19 National: BAUS Audit - Radical prostatectomy (RALP Audit)	Urology	Minor Non-Compliance	The surgeon will plan all cases of surgery carefully and aim to avoid nerve spanning.
4121	Cancer Services National Audit RCR - Radical Lung	Oncology	Moderate Non-Compliance	Develop a pathway re: brain scanning. Develop a pathway for TF.
4120	Cancer Services National Lung Cancer Audit (NLCA)	Oncology	Minor Non-Compliance	Rapid alert small cell pathway to alert clinicians to a diagnosis resulting in swift OPA for diagnosis and treatment. WILD project to reduce pathway length in accordance with the National Pathway. Pathway meeting (pre diagnostic MDT) to start.
4058	National Joint Registry 2018 /19	Trauma & Orthopaedics	Minor Non-Compliance	Continue to submit data and monitor results.
4026	National Trans Catheter Aortic Valve implantation (TAVI) 2018 data	Cardiology	Fully Compliant	Not applicable
3909	National (re)Audit of Dementia Care (Fourth Round)	Care of the elderly	Minor Non-Compliance	Re-audit 2020/21
3808	Learning Disability Mortality Review Programme (LeDeR) 18-19	Trustwide	Not Applicable	All necessary actions are being monitored via the Mortality Review Group.
3603	PROMS (Patient Reported Outcome Measures) Audit 2017-18 data	Trauma & Orthopaedics	Fully Compliant	Not applicable
3602	PROMS (Patient Reported Outcome Measures) Audit 2016-17 data	Trauma & Orthopaedics	Fully Compliant	Not applicable
3601	National Joint Registry 2017/18 data	Trauma & Orthopaedics	Fully Compliant	Not applicable
3600	National Hip Fracture Audit- 2018 data	Trauma & Orthopaedics	Moderate Non-Compliance	To continue to monitor and improve on compliance for all categories of the National Hip Fracture Best Practice Tariff.

3599	National Adult Cardiac Surgery Audit 2018/ 19.	Cardiothoracic Surgery	Fully Compliant	Not applicable
3597	National Thoracic Surgery Audit (data2018/19) 2019/2020	Cardiothoracic Surgery	Fully Compliant	Not applicable
3594	National Audit of Cardiac Rehabilitation (2016-2017 data) 2019/2020	Cardiology	Fully Compliant	Not applicable
3593	Heart failure (HF) - (2017 /18 data.) 2019/2020	Cardiology	Moderate Non-Compliance	Work closely with audit team to expose areas of audit that may have uncertainties. Identify patients that are failing the audit on a monthly basis and reviewing notes to check accuracy. Clearly write reviews in patient's notes, summarising medication plans. Look at improving documentation for HF in-reach.
3591	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) - 2017/18 data	Cardiology	Moderate Non-Compliance	Introduce clock on ward to time door to balloon time and re-focus team on importance of working against the clock. Audit monthly patients who fall outside 90 minute door to balloon time to identify areas of improvement and ensure the data are accurate before submission to national audit
3590	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) - 2016/17 data	Cardiology	Moderate Non-Compliance	Review Capacity on day case unit. National figures- 33% NSTEMIs have angio > 96 hrs after admission.

3589	Cardiac Arrhythmia / Heart Rhythm Management (HRM) - 2016/17 data.	Cardiology	Fully Compliant	Not applicable
3584	Coronary interventions / Coronary angioplasty (BCIS) - 2017 data.	Cardiology	Moderate Non-Compliance	Re-emphasis on the ward/in cath labs- start stopwatch when patient reaches hospital- this clock goes into lab with patient so that time can be seen easily. Audit monthly those patients who fall outside the time window so that deeper understanding of delays can be made as well as identifying incorrect data entry (which can then be corrected before data are submitted)
3531	National: Breast and Cosmetic Implant Registry (BCIR)	General surgery	Not Applicable	Not applicable

Appendix 3 – Local Clinical Audits reviewed by the Trust in 2019/20 with actions intended to improve the quality of healthcare provided

46 local audits that demonstrated moderate or significant non-compliance against the standards audited. The Royal Wolverhampton NHS Trust intends to take the following actions to improve the quality of healthcare provided and consider re-audit against these standards once actions have been appropriately embedded.

Directorate	Directorate	Compliance Rating	Actions identified to improve the quality of healthcare provided
Oncology	Management of Neutropenic Sepsis	Moderate Non-Compliance	Remains on Risk Register and is being managed through this process. Re-audit in 12 months.
Trauma & Orthopaedics	Spine POUR	Moderate Non-Compliance	Discussed at Clinical Governance meeting, consensus is for POUR guidelines to be incorporated in T&O Junior Doctors Intranet Guidelines.
Care of the elderly	Identifying frailty in patients seen by the rapid intervention team	Significant Non-Compliance	Established Education and Training programme for RITS nursing staff to provide confidence and ability in assessing and recording Frailty for patients who are reviewed.
Trauma & Orthopaedics	Assessment of children presenting with painful limp from August 2018 - July 2019	Moderate Non-Compliance	Presentation of results at T&O Governance meeting to discuss areas of non-compliance. Consideration of the following: Accessibility to pathway/ guidelines Pathways to be displayed in A&E and Children's wards. A&E, Children's Acute Services and Orthopaedics department coordination. Discussion about need and arrangement for follow-up.
Audiology	Audit of Calibration Compliance at West Park 23-27 Sept 2019	Moderate Non-Compliance	The requirements of Stage A equipment checks are to be reiterated to all staff at Team meeting.
Trauma & Orthopaedics	Are we correctly managing joint aspiration samples correctly?	Moderate Non-Compliance	Pathology trying to see if one sample can do both tests. To include in the Induction pack for juniors that any sample obtained from a swollen joint should be sent both for microbiology (to look for organisms) and for histology (to look for crystals).

Audiology	231168-E01300-300 Paediatric outcome audit	Significant Non-Compliance	Innovative plans have been put in place with the aim of improving the availability of speech materials and staff awareness and refresher training has been arranged to ensure all staff undertaking paediatric hearing aid evaluations are fully cognisant of requirements for validation and outcome measures. A business case has been written which includes the provision of new equipment. The inadequate IT/ equipment is also monitored and added to the Risk Register.
Cardiology	Audit of healthcare professionals knowledge of precordial lead placement in a resting 12 lead electrocardiogram	Moderate Non-Compliance	Trusts ECG video to be watched by anyone who needs to perform an ECG with their job role. Consideration to be given regarding incorporating ECG training into the BLS/ILS training in order to ensure that there is a consistent standard of teaching provided on a regular basis.
Ophthalmology	Audit of Ocular Oncology Referrals from Wolverhampton Eye Infirmary to Liverpool	Moderate Non-Compliance	The issue re lack of knowledge of the referral process was communicated to all the staff at the department at the Audit meeting. Reiterated the referral process and the need to ensure this is followed.
Stroke	Enteral Feeding of Acute Stroke Patients : A review of current practice at New Cross Hospital	Moderate Non-Compliance	Improve communication; from huddle, any patients having problems with nutrition (ie. not tolerating NGTs) or potential referrals for PEGs will be highlighted to Specialist Nutrition Nurses. Specialist Nutrition Nurses will attend the ward 3 times a week to discuss any issues and potential referrals. Decision-making needs MDT consideration.
Ophthalmology	Audit of suspected TIA diagnosis and management in the Eye Referral Unit 2019/2020	Moderate Non-Compliance	Reiterated to all via audit meeting the importance of History taking in recognising amaurosis fugax. Reinforced NICE guidelines to all. Reinforced All patients should be referred to TIA clinic. Advised that all clinicians should check up on Clinical Portal to make sure patient has been followed up within weeks.
Urology	Time to Treatment in Ureteric Stones: Are we meeting the new NICE guidelines? (NG118 Renal and ureteric stones: assessment and management)	Moderate Non-Compliance	To consider the expansion of shockwave lithotripsy by investigating whether resources are available for weekly or fortnightly lithotripsy.

Audiology	Audit of Direct Referrals (reaudit)	Moderate Non-Compliance	Conduct revaluation of appropriateness of referrals.
Safeguarding	Mental Capacity Act 2005 Compliance	Significant Non-Compliance	An action plan of interventions has been devised and shared with the Trust Safeguarding Group. This will aim to embed the practice of mental capacity assessments and compliance of the Mental Capacity Act Trust wide.
Critical Care	Anaesthetic management of patients with hip fracture 2019/2020	Moderate Non-Compliance	There is a plan to develop an anaesthetic guideline and publish it on the intranet; this will include with anaesthesia for patients undergoing hip fracture surgery.
Audiology	Assessment of Paediatric Real Ear Measurements (REM's)	Significant Non-Compliance	Raise in staff meeting, Paediatric Team meeting and at Directorate governance meeting the importance of completing REMs (Real ear Measurements) for all patients and to document where REMs are not performed.
Radiology	Traumatic ankle pain and ankle plain film request - Adequacy of clinical information with reference to the Ottawa ankle rules	Moderate Non-Compliance	More education for A&E referrers about the Ottawa rules and importance of following these rules and improved clinical information when requesting an ankle plain film for an acute ankle injury. Encourage the radiographer to challenge requests without clear clinical history and non-compliance with Ottawa rules. Encourage registrars and consultants to support radiographers when they encounter such improper ankle plain film requests. Presentation of results of the audit at radiology and the ED education and QI meeting highlighting areas for improvement needed. Re-audit after implementing the above recommendations.
Gynaecology	QIP (Cycle 1): Induction of Labour (IOL) Care Pathway Delays > 8 hours For Transfer of Women from Maternity Induction Unit to Delivery Suite	Moderate Non-Compliance	A 'Deep Dive Audit' has been completed into why inductions are delayed. The most common themes were high activity and sub optimal staffing. We will continue to monitor and identify any common themes in delayed transfers.
Oncology	Oncology RCR - Audit of the patient Local pathway in bladder cancer	Moderate Non-Compliance	Bladder cancer specific MDT proforma with defined target times from TURBT to start of treatment. Consider decision for definitive treatment (cystectomy or radical radiotherapy) to be made prior to initiating neo-adjuvant chemotherapy. Re-audit after 6 months.

Children's Services - Acute	Are we delivering antibiotics within an hour to children identified with sepsis in line with NG51 (2018 Data) (2019/2020)	Moderate Non-Compliance	Introduce cannulation and other sepsis equipment immediately available and stocked up regularly. Educate on earlier use of IO or IM injections if difficult cannulation Sepsis 6 proforma to be used for suspected sepsis. To be re-audited.
Dermatology	CP50 Review of Diagnostic Test Results from referral to diagnosis & Treatment	Moderate Non-Compliance	We are planning to introduce a phone clinic, a new service which will be run by our cancer nurse specialists/nurse specialists. Our admin staff will check whether patients have been provided with written information following their surgical procedures.
Radiology	IR(ME)R Audit : Compliance of Employers Procedure A. Identification (Reaudit)	Moderate Non-Compliance	Raise departmental awareness of poor compliance with evidencing: Completion of six point identification check as detailed in procedure has been undertaken and evidenced on Radiology Information System (Soliton) and ensuring any variation from method of identification as detailed in the procedure is documented. Raise awareness of individual poor compliance. Monthly audited data to be collated and forwarded to individual operators who consistently fail to comply.
Rheumatology	Re-Audit of the ICE / DAWN system following implementation of the ICE Pathology results system at New Cross November 2017	Moderate Non-Compliance	Clinicians and ICE/IT team to investigate findings further.
Respiratory medicine	QIP - Improving the follow up engagement and reducing 28 re-attendance of patients after attending ED with an exacerbation of asthma	Moderate Non-Compliance	Contact with CQi department locally to help facilitate planning meetings with key stakeholders. Continue with QIP cycles.
Diabetes	Re-audit of the Inpatient Management of Hypoglycaemia	Moderate Non-Compliance	Ongoing outreach to patients with hypoglycaemia by remote monitoring from DSNs.

Respiratory medicine	QIP - Oxygen Prescription and it's appropriate use	Moderate Non-Compliance	Oxygen wrist bands; patients will wear a colour coded wristband according to different oxygen saturations ranges. Microbiology approval has been received and is currently awaiting funding approval.
Critical Care	Waste Management Audit - Is waste (clinical and non-clinical) being placed in the correct bin in intensive care and theatre enviroments? 2019/2020	Significant Non-Compliance	Orange bins to be available in every theatre, anaesthetic room and ICCU Bed space by 2020.
Radiology	Audit of positivity rate and compliance with referral guidelines for CTPA over the past 5 years.	Moderate Non-Compliance	Change ICE requesting, make Wells Score and D-Dimer mandatory. Require IT/ICE team input. Vetting radiologists to reject referrals without prior CXR - to email all consultant radiologists. Educate referring clinician about the need to CXR prior to CTPA.
Diabetes	Quality improvement project - Does a ward round handover sheet help with the timely handover of tasks between the medical and nursing team and aid timely completion of important tasks in patient care?	Moderate Non-Compliance	Encourage continued use of handover book to ensure it is incorporated into the everyday workings of the ward. Findings were discussed at the local department induction at the start of the most recent rotation to familiarise new doctors in the department. Third cycle of data collection to monitor continued change (tasks completed and when).
Gynaecology	QIP Gynaecological operation notes not meeting mandatory RCS standards.	Moderate Non-Compliance	Implement a stamp with tick boxes (checklist) to use in all future operations.
Head & Neck	ENT emergency clinic referrals - Are they appropriate?	Moderate Non-Compliance	Raised awareness of the referral criteria. Staff have been provided with examples of appropriate and inappropriate referrals to raise awareness of the appropriate referral criteria.
Pharmacy	An audit to assess vancomycin prescribing and monitoring 2019/2020	Moderate Non-Compliance	Re-audit in 6 months. Present the findings from this audit in the antimicrobial stewardship meeting. Present the findings from this audit to pharmacists and pharmacy staff. Educate nurses, doctors and pharmacy staff. Amend the wording used on Microguide to facilitate understanding.

Radiology	Pre Uterine Artery Embolisation biopsy compliance	Significant Non-Compliance	Audit findings and new national guidelines to taken to gynaecology directorate for discussion and a re-audit to be conducted.
Pharmacy	Prescribing and management according to trust hyperemesis guidelines (2019/2020)	Significant Non-Compliance	Amend guidelines to reflect practice Consider ondansetron as second line in place of metoclopramide.
Children's Services - Acute	Newly Diagnosed Juvenile idiopathic Arthritis (JIA) (2018-2019)	Moderate Non-Compliance	Increased capacity in paediatric rheumatology clinics so that patients can be seen earlier. Business plan submitted. Results shared with head of orthoptics.
Pharmacy	An audit on the use and monitoring of Teicoplanin in bone and joint infections. (2019/2020)	Moderate Non-Compliance	Encourage strict adherence to guidance on the prescribing of teicoplanin for long term OPAT patients. OPAT team to consider rewording guidelines and making teicoplanin level monitoring more formal, rather than just advisory, in patients who are likely candidates for OPAT (i.e. longer duration of therapy). As well as an update to guidance, all pharmacists should be updated on this. Re-audit due to the limitations detailed within this audit, and to ascertain whether recommendations have impacted practice.
Safeguarding	Documentation audit within the Emergency Department	Significant Non-Compliance	Disseminate audit to emergency department staff, safeguarding checklist to be completed in full, safeguarding documentation training to be delivered to staff, feedback forms to be used and review audit to be undertaken in 6 months to reassess compliance.
Dietetics	To assess the compliance and accuracy of MUST assessment on the Clinical Haematology Unit (2019-2020)	Moderate Non-Compliance	MUST Training to be completed and Nursing completion of MUST competencies.
Therapy Services	Patient information leaflet audit (Women's Health) (2019-2020)	Moderate Non-Compliance	Revise ordering quantities. Introduce annual check of all leaflets, to ensure all leaflets go through the appropriate governance processes and a program is developed to ensure all documents are reviewed according to process

Therapy Services	Patient information leaflet audit (Hands Team) (2019-2020)	Moderate Non-Compliance	Review all leaflets; delete any no longer applicable & remove from libraries Prioritise remaining leaflets for review and review/edit all needing amendments. Repeat audit once actions have been implemented and set up alert system to advise authors when their leaflets are approaching their 3 year review date.
Accident & Emergency	Do rapid antigen throat swabs reduce antibiotic therapy in children <15years with tonsillitis in ED	Significant Non-Compliance	Conduct 3 month prospective audit Dec-January using clinical decision rules to streamline diagnosis and antibiotic treatment for tonsillitis in children <15yrs.
Rheumatology	NICE NG100 Telephone Advice Line	Moderate Non-Compliance	Introduce group education sessions to all patients. All patients to be provided with a blood monitoring passport, this will hold all current information for adverse effects and up to date blood results. Prepare business case to fully commission the advice line service.
Pharmacy	Re-audit to assess missed and delayed doses of Parkinson's medicines at The Royal Wolverhampton Hospitals NHS Trust (2018/2019)	Significant Non-Compliance	Create a Parkinson's Passport which the patient carries with them at all times. This will include drug, strength, frequency and target time of administration. Improve identification of Parkinson's Patients for all members of the MDT. Raise awareness of audit findings and provide education to members of the MDT.
Gynaecology	Laparoscopy in Endometrial Cancer Audit (re-audit)	Moderate Non-Compliance	To forward the audit results to gynaecological care committee in order to make them aware and make adequate interventions to improve. To feedback to clinicians to ensure all patients have had post-operative FBC taken.
Renal medicine	QIP Re-Audit of eDischarge - completeness 2018/19	Moderate Non-Compliance	Incorporate teaching session 'How to write e-Discharge summary' for Junior Doctors on Trust / Local Induction. Create a poster 'How to write a good e-Discharge.' Encourage Consultants as part of their ward round to help summarise the working / main diagnosis and potential follow up's.
Rheumatology	CG146 (updated Feb) Osteoporosis: assessing the risk of fragility fracture	Moderate Non-Compliance	Re-audit mainly focusing on risk factors relevant to secondary care which will be true reflection of departmental practice.

How to give comments

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

Please contact us as indicated below:

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Glossary

For those readers who are not familiar with some of the terminology used in this document, the table below offers some explanation of abbreviations that have been used:

A&E	Accident and Emergency Department	MSSA	Methicillin Sensitive Staphylococcus Aureus
ACPs	Advanced Clinical Practitioners	MUST	Malnutrition Universal Screening Tool
CCS	Clinical Classification System	NCDAH	National Care of the Dying Audit – Hospitals
C-Diff	Clostridium Difficile	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
CICT	Community Intermediate Care Team	NCI/NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
CQC	Care Quality Commission	NHS	National Health Service
CQUIN	Commissioning for Quality and Innovation	NHSLA	NHS Litigation Authority
CMACH	Confidential Enquiry into Maternal and Child Health	NICE	National Institute of Clinical Excellence
CNO	Chief Nursing Officer	NIHR	National Institute for Health Research
DNA	Did Not Attend	NPSA	National Patient Safety Agency
DRHABs	Device related hospital acquired bacteraemia (blood infections)	NRLS	National Reporting and Learning Service
EAU	Emergency Assessment Unit	NSSC	Nutrition Support Steering Committee
ED	Emergency Department	ONS	Office for National Statistics
ENT	Ear, Nose & Throat	OSC	Overview & Scrutiny Committee
EOLC	End of Life Care	OWL	Outpatient Waiting List
GP	General Practitioner	PALS	Patient Advice & Liaison Service
GMCRN	Greater Midlands Cancer Research Network	PEAT	Patient Environment Action Team
HCAs	Health Care Assistants	PHSO	Parliamentary and Health Services Ombudsman
HRG	Healthcare Resource Group	PSIs	Patient Safety Incidents
HSMR	Hospital Standardised Mortality Ratio	PCT	Primary Care Trust
IHI	Institute for Healthcare Improvement	RRR	Rapid Response Report
IT	Information Technology	RWT	The Royal Wolverhampton NHS Trust
KITE	Knowledge, Information, Training and Education	SHA	Strategic Health Authority
KPI	Key Performance Indicator	SHMI	Summary Hospital Level Mortality
KSF	Knowledge and Skills Framework	UTI	Urinary Tract Infection
LCP	Liverpool Care Pathway	VTE	Venous Thrombo-embolism
LINk	Local Involvement Network	WHO	World Health Organisation
MLU	Midwifery Led Unit	WMNCLRN	West Midlands (North) Comprehensive Local Research Network
MRSA	Methicillin Resistant Staphylococcus Aureus	WMQRS	West Midlands Quality Review Service

English

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Punjabi

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