Safe & Effective | Kind & Caring | Exceeding Expectation

Quality Account 2017-18

The Royal Wolverhampton NHS Trust

CONTENTS

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.[1]

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.

[1] *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

The Royal Wolverhampton NHS Trust

New Cross Hospital

Wednesfield Road

Wolverhampton

WV10 0QP

Email: rwh-tr.patientexperienceteam@nhs.net

Statement on Quality from the Chief Executive

INTRODUCTION

All of us working at The Royal Wolverhampton NHS Trust (RWT) are committed to driving improvements in patient experience and a culture of excellence throughout the organisation. We want our patients to continue to have access to top quality services when they need them; we want our staff to feel valued and supported at all times, working in an environment in which they can thrive, and we want our local community and partner organisations to be confident in The Royal Wolverhampton NHS Trust as provider of excellent care and an employer of choice.

In the current financial climate, all public sector services are grappling with how to meet the increasing, and multi complex needs of the population within the limitations of available resources. We recognise that we have to make brave decisions and continue to develop innovative solutions to ensure that our patients and wider communities continue to receive the highest standards of care.

A lot of fantastic work and discussion is going on as we continue to build an 'Integrated Care System', with the aim of expanding and improving care and services for patients on this journey. We continue to engage with our local GP's, Commissioners and the Local Authority about working better together at a local level. As this new model continues to grow and develop we are starting to see the benefits of these changes for our communities.

Our greatest challenge over the last 12 months has been the continued growth in activity as well as the financial pressures within the system; this has had an impact on our ability to deliver some of our targets, for example, the 4 hour assess and discharge standard in ED. We recognise that this can adversely impact on the quality and experience some of our patients receive, and for this we apologise. We know our staff continue to work extremely hard when faced with these real pressures and we recognise their ongoing dedication during these difficult times.

The Trust is committed to improving patient's experiences and outcomes, and we are embarking on initiatives we know are already making a difference. The Trust has participated in a number of National Collaboratives, which allow sharing of best and innovative practices, which have already led to a reduction in Falls and Pressure injuries sustained during inpatient stays. We were a pilot site for the Nursing Associate programme and developers of a Clinical Fellowship Programme which have seen the Trust benefit from new and innovative roles supporting clinical care.

The Trust underwent an announced CQC inspection February - March 2018, CQC published it's report findings on the 27th June 2018 of which provided the Trust with an overall rating of 'good'. I would like to take this opportunity to recognise the hard work and commitment of our staff in this achievement. The Trust recognises that there is still the potential to improve on our achievements to date.

The Trust's priority remains to ensure patient safety as its overarching principle and we continue to strengthen our learning from incidents, complaints and feedback with a focus on the following priorities:

- Ensuring safer care by reducing the instances of harm caused
- Improving the experience of patients who use our service
- Maintaining Nurse staffing levels and enhancing the workforce with new roles

This report provides information on progress against the above quality priorities and key performance indicators for the past year and sets out quality improvement priorities and plans for 2018/19.

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

Signed:

David Loughton CBE

Chief Executive

Date: 28th June 2018

‘An organisation striving continuously to improve patient experience and outcomes. We pledge that we will always strive to be safe and effective, kind and caring and exceeding expectation.’

Our Visions & Values

Safe & Effective	Kind & Caring	Exceeding Expectation
• We will work collaboratively to prioritise the safety of all within our care environment	• We will always demonstrate a person centred approach	• We will always look for ways to improve our evidenced based practice and performance
• We will always communicate clearly	• We will always act in a way that is respectful to others, our profession and ourselves	• We will always provide a learning and supportive culture
• We will always raise concerns immediately and constructively	• We will act in the best interest of others at all times	• We will demonstrate positive attitudes to inspire others to achieve outstanding experiences
• We will be open and candid with persons in our care and with colleagues	• We will always make time to listen	• We will not accept mediocrity
• We will always work within our sphere of competence and maintain our knowledge and skills	• We will go out of our way to make others feel valued for their efforts and achievements	• We will grow a reputation for excellence as our norm

Looking back 2017/18

PRIORITIES

for Improvement

Safe Nurse Staffing Levels

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.

Safer Care

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.

Priority 1: Safe Nurse Staffing Levels

What we set out to achieve: The focus was based on the Nurse Recruitment and Retention Strategy (2016-2020) which embraces the concepts of 'Enable', 'Attract' and 'Retain'. In addition the team have reviewed pipelines into registration, the development of new and existing roles and new ways of working.

How have we performed against 2017/18 plans?

How we have performed: -

Enabling Staff:-

We have developed career pathways from unregistered to registered careers; In support of these pathways, education programmes have been implemented to develop staff to prepare for their career progression. This supports both the retention and attraction agendas for the Trust.

As part of the skill mix review, we took the opportunity to introduce new roles e.g.

- Nursing Associates
- Assistant Practitioners
- Advanced Clinical Practitioners.

The Trust took part in the national 'first wave' of the Trainee Nursing Associate which commenced January 2017, of whom are due to qualify in 2019.

The Trust is also one of 20 health care providers supporting curriculum delivery at the Health Futures University Technical College.

Attract Staff:-

We have updated and relaunched the internal transfer scheme, of which offers flexibility for staff to move within the organisation regarding career development or personal requirements.

Development opportunities are offered to all levels of staff, from the care certificate for unregistered staff through to preceptorship for newly qualified staff, to aspiring Senior Sisters and a 'Making the leap' programme for those new to a Senior Sister role. All programmes have been positively received and well attended with staff commenting on the benefits regarding their role.

International recruitment - NMC Pathway

The Objective Structured Clinical Examination (OSCE) programme for international recruitment has been exceptionally successful (see table below). The Nurse Education team have presented at several national conferences including the RCN conference in March 2017.

Timeframe	NMC report 1st attempt pass rate	RWT 1st attempt pass rate	NMC report 2nd attempt pass rate	RWT 2nd attempt pass rate	NMC combined 1st and 2nd	RWT combined 1st and 2nd
April 2017 – June 2017	41%	82%	71%	100%	51%	100%
July 2017 – September 2017	48%	88%	75%	33%	57%	78%
October 2017 – December 2017	49%	22%	65%	100%	55%	100%

The Nurse Education Department coordinates student placements, within an Educational Standards Framework, in partnership with local universities. Over 50,000 placement days were accessed by students during 2017/18 with 96 students gaining employment in our Trust as a registered nurse.

Recruitment processes have been reviewed and have expanded to incorporate the use of multiple social media platforms to reach out to a wider population.

Retain

As part of our framework to support excellence and recognise effective team working, the Trust has utilised the Process Communication Model (PCM) which further supports our Sign up to Safety initiative, the main benefits for staff and patients include :-

- How to manage people effectively.
- Communicate with patients more effectively.
- Provide quality care.
- Promote a positive patient experience.
- Provides motivation and effective communication
- Utilising the benefits of 'how' we communicate to ensure enhanced communication with staff, patients, relatives and visitors.
- Promotes a positive clinical and learning environment.

As part of workforce development Health Education England West Midlands (HEEWM) provided funding for :-

Course title	Number funded
Advanced Clinical Practitioner course	10
18 Month Midwifery course	3
Practice Nursing	2
District Nursing	4
Health Visitor	1

In addition Learning Beyond Registration (LBR) funding supported 66 mentorship courses for qualified nurses to support students.

Priority 2: Safer Care

Number and Themes of Serious Incidents

The Trust has a robust reporting mechanism communicated through policy, training and management lines. There remains timely reporting and completion of investigations.

In the financial year April 2017 to March 2018 the Trust has reported 106 serious incidents and 198 reportable incidents through the serious and reportable incident system (STEIS), this does not include incidents that have since been agreed for removal. This is a reduction from previous year of 124 serious incidents and 263 reportable incidents through the serious and reportable incident system (STEIS).

Serious incidents are reported in a timely manner and robustly investigated to ensure that the organisation learns from them to reduce the likelihood of recurrence and prevent harm to patients.

There has been an overall reduction in the number of serious incidents reported in 17/18, with significant reductions in Pressure Injuries (from 208 to 175), falls with harm (from 47 to 23) and Information Governance incidents (from 41 to 12).

Progress with the serious incident process is monitored via the Divisions at their Governance meetings and also via QSIG (Quality and Safety Intelligence Group previously the Patient Safety Improvement Group or PSIG) and Trust Board.

Row Labels	Count of Type
Confidential Leak	12
Diagnostic	29
Infection	25
Maternity	5
Medical Equipment	1
Medication	1
Wrong Site Surgery	4
Retained Foreign Object	2
Pressure Ulcer	175
Slip/Trip/Fall	23
Sub Optimal Care	1
Surgical/Invasive Procedure	6
Treatment Delay	10
Unexpected Death	7
Unexpected Injury	1
VTE	2
Grand Total	**304**

* New Overall Total = 305, These figures are a true reflection as of this date and time. They do not include incidents that have since been agreed for removal by the CCG.

Category	01/04/17 to 30/03/18
Confidential Breach	12
Diagnostic	30
Infection	25
(C.Diff)	(5)
(Infection)	(15)
(MRSA)	(5)
Medical Equipment	1
Medication	1
Never Event	6
(Retained Foreign Object)	(2)
(Wrong Site Surgery)	(4)
Sub Optimal Care	1
Surgical/Invasive Procedure	6
Treatment Delay	11
Unexpected Death	6
Unexpected Injury	1
VTE	2
TOTAL	**102**

Category	01/04/17 to 30/03/18
Maternity	5
Pressure Injuries (grade 3 and 4)	175
Slip/Trip/Fall (with serious harm)	23
TOTAL	**203**

Numbers and Themes of Never Events

There have been 6 reported Never Events reported in the financial year April 2017 to March 2018.

Date	Location	Category	Level of Harm	Progress
April 2017	ED	Retained foreign object	Moderate	Investigation completed
July 2017	Radiology	Wrong Site Surgery	Low	Investigation completed
August 2017	Obstetrics	Wrong Site Surgery	Severe	Investigation completed
October 2017	Gynaecology	Retained foreign object post-procedure	None	Investigation completed
November 2017	Dental	Wrong Site Surgery	None	Investigation completed
November 2017	T&O	Wrong Site Surgery	None	Investigation completed and request made to the CCG re: de-escalation. Outcome is awaited.

During the financial year April 2017 to March 2018, 6 Never Event incidents have been reported. Of these incidents 3 (50%) did not cause patient harm and 1 incident has been identified to have caused low patient harm, 1 incident has been identified to have caused moderate patient harm and 1 incident caused severe harm however we acknowledge the distress that can be caused regardless of the level of harm graded.

For the 6 investigations completed the following lessons have been learnt, please view summary as listed below:

- Consideration given to whether procedures at the end of shift are urgent or whether they can/should be handed over to incoming staff, therefore the area has introduced guidance on the timing and location of procedures to include human factor considerations
- NatSSIP (National Safety Standards for Invasive Procedures) to be implemented in Emergency Department for chest drains
- Introduction of a system for signing off procedural competencies for locum doctors in Emergency Department.
- The “stop before you block” check must take place immediately before the block, if delays are encountered then “stop before you block” must be re-done and the “stop before you block” checks read out loud.
- For every procedure list, the whole theatre team must focus on all elements of the WHO checks, particularly the Time-out.
- The consultant surgeon in charge of the list must see patients preoperatively by doing a preoperative ward round or by seeing the patient at the time of the WHO sign-in.

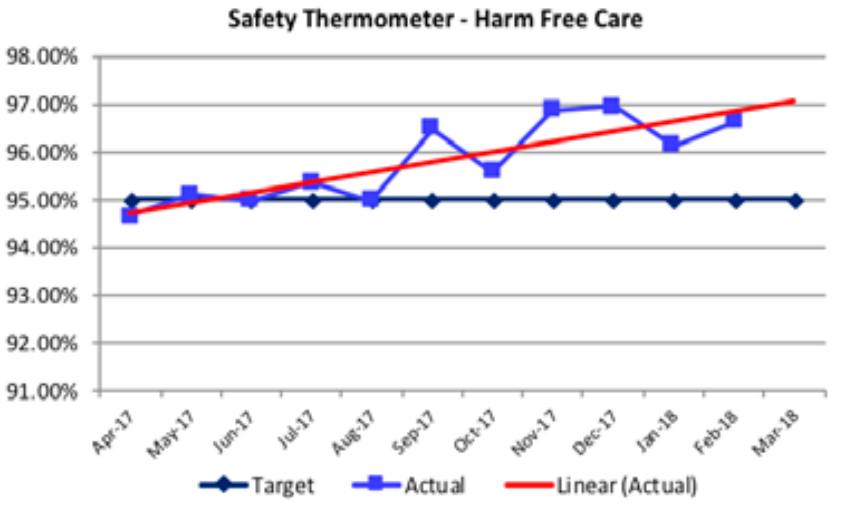
- The surgeon is to read the relevant entries in the electronic patient record and not rely on what has been printed in the “skinny” file that is the only paper record available during a patient’s admission.
- All swabs, tampons and needles to be checked and recorded even if not used.
- Consent must be in line with Trust policy in that abbreviations used must be explained in plain English.
- Staff must escalate to their line manager if they are aware that a Never Event has occurred.
- Site marking for unilateral procedures is essential and must be implemented.
- Waiting list cards must not have abbreviations to describe the surgical procedure.
- New members of theatre teams must have a Team Briefing.
- No person should work alone – the surgeon should always be accompanied by a responsible team member (even if not scrubbed).
- The WHO Safer Surgery Checklist must be filled in accurately.

The Trust is looking to engage the national body Association for Perioperative Practitioners (AfPP) to review surgical practices across the Trust and work with disciplines and teams with regards to standardise practices with the aim of reducing potential for never events and serious incidents.

The Trust reports monthly on the national ‘Safety Thermometer’ tool, which captures point prevalence data regarding the 4 harms, which are:

- Falls
- Urine infections in patients with a catheter
- Venous Thromboembolism
- Pressure injuries

It is captured on a given day each month.



(Safety thermometer data 2017/18)

How have we performed against 2017/18 plans?

Falls

The Trust joined the National Falls collaborative in January 2017, which has provided significant success in reducing the number of falls in the Trust (see table 1). The main contributory factor has been the multi-disciplinary approach to ensuring that staff are present in the bays and that patient's identified 'at risk' of falls are observable. The Trust Falls steering group continues to review and analyse data regards falls, further interrogation regards times of falls is currently underway and this information is being considered when reviewing shift patterns to support safety of patient's at key times where possible.

The Trust participated in the National Falls audit which sampled records of patient's during February 2017, the results (see table 2) were extremely disappointing and a significant focus has been placed on actions to improve the results with a re-audit planned.

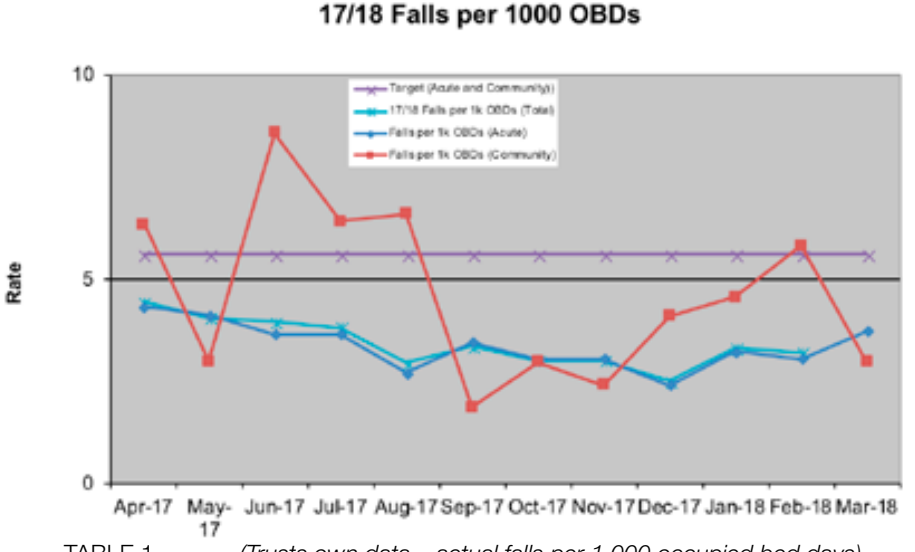


TABLE 1 *(Trusts own data – actual falls per 1,000 occupied bed days)*

Indicator	Percentage
Assessed for Delirium	35%
Continence Care Plan	44%
BP (lying and standing measured)	32%
Medication (assessed to identify drugs that increase risk of falls)	20%
Vision Assessment	39%
Call bell (could see it and within reach)	61%
Mobility Aid (and could reach it)	78%

Table 2 - National Fall Audit

Changes that have occurred during 2017/18 are:

- Revision of Trust policy to reflect changes in practice as a result of work from the National Falls Collaborative
- Falls training for Medical staff as part of their induction programme
- Revised accountability process regards falls and lesson learnt
- Revision of the Falls Prevention team referral form to expedite contact in the community
- Launch of a new 'Delirium' standard operating procedure
- Education of Nursing staff regards safe issue and use of walking frames, visual assessment and lying standing blood pressures

Preventing Infection

Infection Prevention remains a high priority for the Trust; and this is echoed by Wolverhampton CCG and City of Wolverhampton Council Public Health Service which is demonstrated by a continued collaborative working approach throughout 2017/18.

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 across the city.

We have very proudly forged close links with care homes, very sheltered housing accommodations, local authority and independent contractors (including GP's and Dentists) and we have been working on several projects within these settings to further build on the successes of previous quality improvement work undertaken.

Increased risk factors for Healthcare Acquired Infections (HCAI) are acknowledged in the ageing population, alongside the changes in use of health services and the rising threat of highly resistant organisms, and this is recognised as part of the strategy for preventing HCAI. 2017/18 has been a productive, yet challenging year, across Wolverhampton in relation to HCAI.

The challenge of acute and community incidence of Carbapenemase Producing Enterbacteriaceae (CPE) meant that new approaches were required in order to improve patient safety. These included developing a risk assessment to ensure that we identified positive patients, isolation and standard precautions introduced in a timely manner to reduce transmission. Clostridium difficile has remained within trajectory this year however there have been 2 MRSA Bacteraemia which were attributed to RWT and deemed avoidable. Environmental controls have been a top priority in our approach in tackling HCAI; the deep clean schedule has been completed with great effect and there has been a good compliance with monthly environmental audits in in patient areas.

Antimicrobial stewardship, innovation in design and ensuring clinical practice such as hand hygiene is optimal has been key to the control of familiar organisms.

A care home infection prevalence project has been delivered during 2017/18 regarding antimicrobial use and infection being treated in nursing and residential care, also assurance data is held on care home standards for Infection Prevention which supports CQC registration.

GP's have been supported to further improve their environments and practice, again building on improvements that have been achieved over the last 10 years of collaborative working. This will be strengthened with further GP's joining the Vertical Integration Project; which will not only improve patient safety but patient satisfaction also.

What we set out to achieve:

The Trust acknowledges the current challenges surrounding infection prevention. By working in partnership with colleagues across the health economy to deliver nine agreed strategic objectives, delivered through a health-economy Infection Prevention 5 year Strategy. Strategic objectives focus on consistent high standards, collaborative working and innovation to sustain and further reduce avoidable infection in healthcare.

The strategic objectives underpin the health economy Annual Programme of Work and the ambition for the year was to fully deliver this programme.

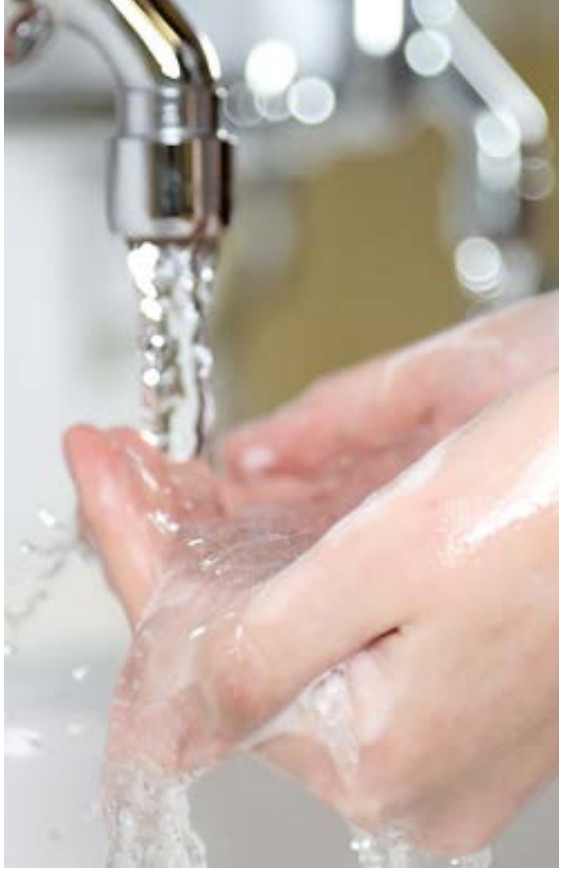
Specific achievements against last year's objectives include the following:

Clostridium difficile has remained within trajectory this year. At the end of month 12 RWT is 8 cases under an annual trajectory of 35.

- An increased focus on Standard Precautions, to include splash and sharps awareness to support a reduction in associated incidents and sharps claims
- Improved liaison with TB services with the outcome of the service being managed by Infection Prevention from February 2018
- Implementation of specific risk assessment and screening protocols to detect carriage of Carbapenemase Producing Enterbacteriaceae on admission
- The Intravenous Resource Team continues 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 is shared with Consultant Surgeons via a monthly Dashboard; this will continue into 2018/19 to further support with a reduction in SSI. MSSA screening and decolonisation for patients undergoing cardiac surgery trial and was evaluated
- Device related bacteraemia in the Trust is once again at its lowest and continued communication of community acquired related device related bacteraemia cases
- Catheter usage has remained the same but more robust management and surveillance continues
- Delivery of a care home prevalence of infection and antimicrobial usage project
- Continued 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
- The Infection Prevention Scrutiny process continues, which involves clinical areas presenting their investigations for each incidence of infection, to identify themes, risk, lessons learnt and to support with strengthening Governance processes in relation to HCAI
- Partnership working with Walsall Healthcare Trust to develop electronic sharing of infection risks
- Influenza testing now takes place on site thus reducing bed days lost with results being available within 2 – 3 hours
- Outbreak management for Influenza included dedicated bays to prevent further movement of patients and ward closures
- A process for flu outbreak management and treatment/prophylaxis in care homes was introduced in December to prevent admissions to hospital. This was joint working between the Infection Prevention team and the Rapid Interventions team (RIT)
- A gram-negative bloodstream infection action plan was devised to support RWT, CCG and PH to reduce these infections by 50% by 2021



Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) prevention and management remains a high priority for the Trust and since the last audit a significant revamp of reporting structures has been underway. There have been multiple changes to pathways and guidance and a drive to improve outcomes whilst ensuring robust reporting process.

Through the course of the past year we have undertaken a complete overhaul of guideline Trust Policy CP58, revised all key VTE related patient information leaflets, conducted ongoing trust-wide audits, implemented a successful transition trust-wide switch to biosimilar enoxaparin, disseminated key learning from critical incidents and changes both trust-wide and within individual directorates and teams and general advocated for safer care in relation to VTE prevention and management. The process for conducting Root Cause Analysis (RCA's) has been strengthened. The VTE Clinical Nurse Specialist (CNS) role now is aligned to anti-coagulation services which now encompasses the whole pathway from prevention to management and makes for more streamlined governance.

What we set out to achieve:

- More local involvement in VTE pathways
- More local ownership,
- Redesign of VTE curriculum and agreement to repeat 2 yearly and retention of mandatory status
- Improved awareness of prescribing guidelines both for weight and renal based dosing and for use of NOACs in general
- Links with E-prescribing.

We have continued to perform consistently with regards to VTE related measures. Local involvement is better in many areas such as gynaecology, trauma and orthopaedics, surgery and acute medicine. Guidelines and patient information leaflets have been revised and so has the training module for VTE mandatory training. A new VTE RCA process was devised and implemented.

Trust-wide switch over to a biosimilar enoxaparin was concluded safely with no significant incidents through leadership from the VTE group and pharmacy services. Ward pharmacists are more involved in day to day monitoring of appropriate VTE management. A Pulmonary Embolism and Deep Vein Thrombosis treatment study day which was held for World Thrombosis Day (of which we are a partner organisation) received excellent feedback and will be part of our educational programme for 2018/19. Awareness and educational initiatives have also been conducted within specific directorates by the VTE CNS and clinical lead.

We have reviewed VTE resources and hope to have additional support for administration allowing increased support to clinical areas which will aid education, awareness, improved safety and also translate into better targets.

We have worked with the EPMA (electronic prescribing) team by the VTE lead to ensure VTE prophylaxis and treatment is carefully considered in implementation. Unfortunately full electronic integration of assessment and prescribing is not possible currently but maybe available in the future. Alternative measures for safe and effective prescribing have been mooted.

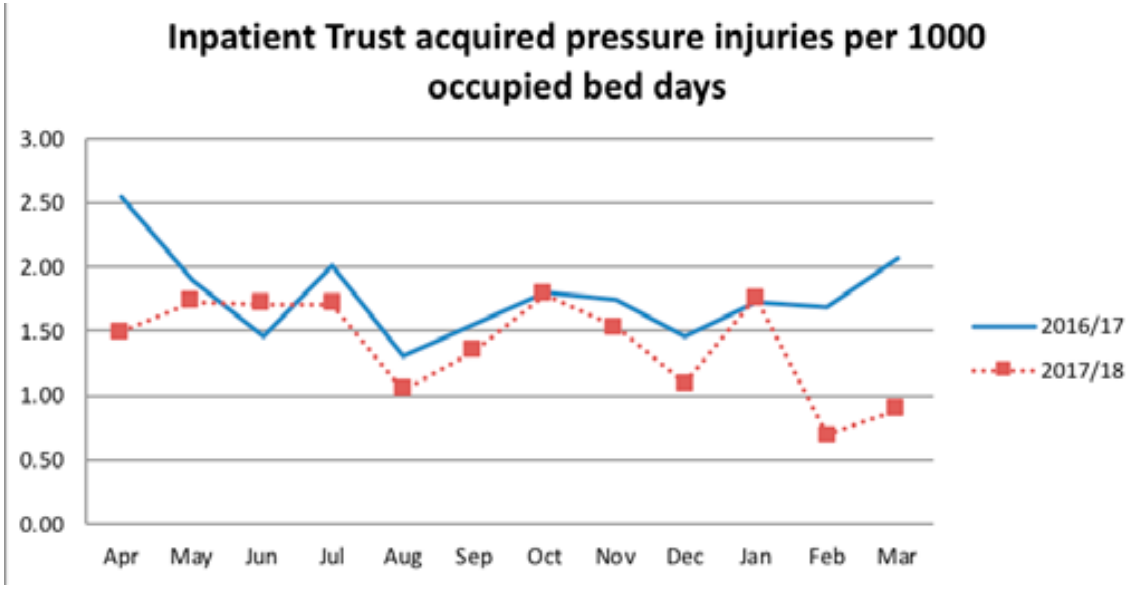
Monitoring: Minimum target >95% and aiming close to 100% (Figures based on percentage of adult patients admitted in the month who were assessed for risk of VTE on admission to hospital).

2017/18 Q1	95.59%
2017/18 Q2	95.37%
2017/18 Q3	95.72%
2017/18 Q4	95.88%

Pressure injuries

The Tissue Viability team produced a tissue viability strategy in 2016. This is a 3 year plan to develop systems and processes to prevent avoidable wounds and aid wound healing. Many pathways have been designed to help support carers, nurses, allied health care professional and doctors on recommended practices to care for patients' skin and wounds.

The Trust continues to move forward positively to prevent pressure injuries and has seen a significant reduction in incident numbers during the winter pressure time. Pressure injuries are reported if a patient is found to have them on admission or during their admission to our services. If the pressure injury is developed during their admission, the incident is investigated and processes are modified from any lessons that are learnt. Other wounds are not reported in this way but the Trust has started to monitor the number of patients with wounds managed by our Adult Community Services.



This year we have developed many pathways to help develop the wound formulary. The pathways include:

- Simple wound and exudate
- Moisture associated dermatitis prevention pathway
- Think heal pathway for leg ulcer management with compression bandaging
- Well leg pathway to prevent leg ulcers
- Honey pathway
- Skin tear
- Paediatric burns pathway.
- We have also invested in new machine called a 'Mesi', to help test patients' blood flow before planning compression therapy when they have a leg ulcer.

A new wound assessment tool has been piloted in Adult Community Services, which considers all elements required to understand the patients' health and social needs, possible barriers to healing and effects on their quality of life. These details are essential to help plan the appropriate individualised care.

The Trust took part in the NHS Improvements pressure ulcer collaborative and achieved an impressive reduction of incidents on the pilot wards in the trauma and orthopaedic directorates. The ward areas revisited the basics to prevent pressure injuries and introduced additional moving and handling aids, disposable female urinals that prevent back flow of urine and applied a cream to heels to help prevent dry skin. These actions have contributed to the reduction of the wards incidents and have been shared with other areas.

The Trust continues to follow ASSKINE to prevent pressure injuries A = assessment, S = skin inspection, S = surface, K = keep moving, I = incontinence and moisture and E= escalation and communication

The Trust set out to achieve zero avoidable pressure injury incidents. We are also aiming for a reduction of patients with chronic wounds in the community.

Both inpatient and community areas have experienced a significant reduction of pressure injury incidents. Chronic wound data has been collated for the first time as a baseline for the trust to case manage, monitor trends and monitor improvements.

Incidents are monitored by ward staff and the tissue viability team. They are validated to ensure there is as accurate reporting as possible.

All audits, quality improvement plans and incident data is reported into the Tissue Viability Steering Group and Patient Safety Information Group (now Clinical Oversight Group).

Sign up to Safety

The Sign up to Safety (SU2S) Project aimed at reducing harm and improving safety outcomes has continued to roll out targeted interventions that address safety culture, team effectiveness and performance and human factors including communication, relationship and interaction between healthcare staff.

The focus has been within the 3 SU2S areas (Emergency Dept. (ED), Obstetrics and Gynaecology (O&G) and Trauma and Orthopaedics (T&O)) incorporating the promotion of Process Communication Model (PCM) as a method to improve communication, self-management and relational interaction with healthcare colleagues.

During 2017/18 the uptake of PCM by staff in the SU2S areas (ED, O&G and T&O) continues to steadily grow with the total number of staff from the 3 areas currently signed for PCM at the end of February 2018 is 279 and across the Trust is 1321 staff.

Date	Spaces used by SU2S			Spaces used by wider trust	Total
	Emergency Department	Maternity	Trauma & Orthopaedics		
2014	3	0	1	50	54
2015	3	4	2	193	202
2016	8	56	22	364	450
2017	33	32	53	308	426
2018	10	27	25	127	189
TOTAL	**57**	**119**	**103**	**1042**	**1321**

During 2017/18 the Team Optimisation Model (TOM) has also been implemented, starting within Obstetrics & Gynaecology (May 17) and moving onto Trauma and Orthopaedic (Dec 17). The TOM is also being trialled within a non-clinical team to augment team effectiveness and to inform the model further. The TOM is planned to be rolled out to ED in April 2018.

The TOM is developed from research evidence on team effectiveness in healthcare and its impact on safety. The TOM programme is organised under four core headings: Goals, Roles, Processes and Relationships, with a number of interventions under each section of the programme. It contains a combination of data reviews, diagnostic surveys, workshops, exercises, delivered session topics and team discussion which all seek to introduce effective team ingredients (based on research from West et al 2004[2]) and/or allows these to be uncovered. The programme instils and strengthens the basic foundations of team and makes links between staff and patient satisfaction and outcomes.

The project set out to improve safety culture and team performance thereby improving quality and safety, reducing adverse events and harm linked to issues relating to teamwork, communication, culture, climate, morale and staff well-being. The model takes an individual and team approach. It uses PCM to raise awareness of self and others, recognising distress and its impact on self, colleagues and patients and how to give/receive support. Through the TOM programme workshop sessions are used to build cohesive vision and unity within team, data review, team assessments feedback and exercises are used to identify areas of strength and development at the same time facilitating communication, building trust and psychological safety across team members.

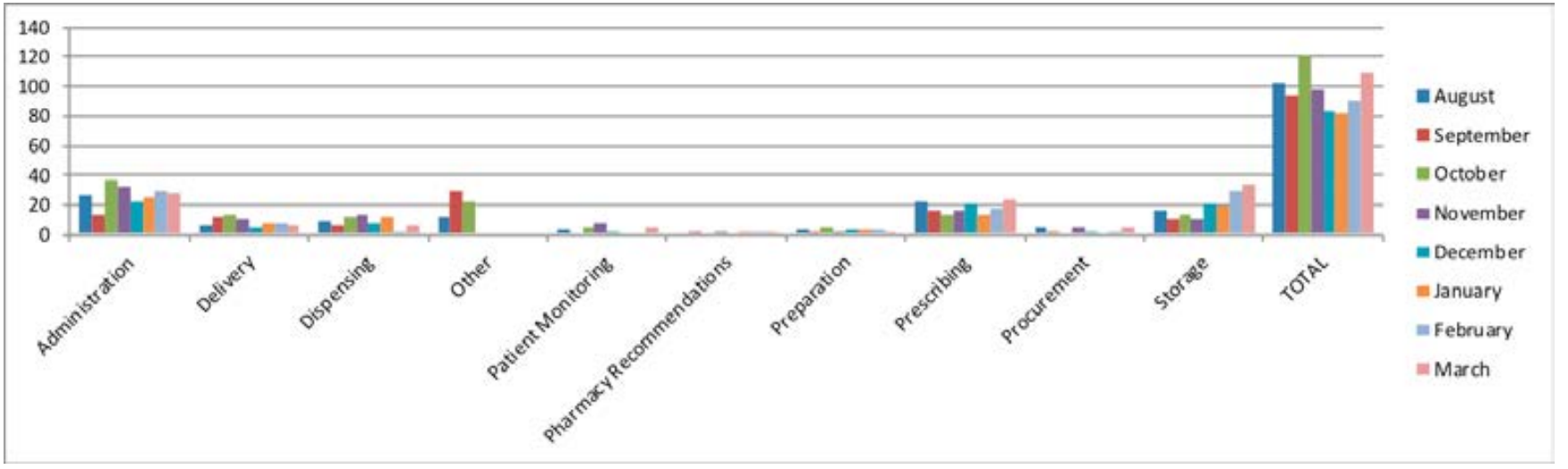
There are key outcome measures identified for the project, some are immediate and others longer term. In terms of PCM we conduct a 6 monthly evaluation around the use and impact of the model, the last report showed the training to be positive and beneficial to staff both at work and in their home lives. Further to evaluation feedback step up programmes are being developed and ongoing support for staff that aid the translation of PCM from principles to practice. Within the Tom programme, KPIs identified include reduced adverse incidents and complaints relating to communication and team work, sickness and attrition rates, staff morale, staff and wellbeing. These are too early to measure. So far from the TOM programme the initial feedback from participants is constructively positive evidenced by a culture enhancement, progressive service development and post survey results. The work continues through the collaborative efforts of local leaders and team members.

[2] *West, M.A., & Markiewicz, L. (2004). Building Team-Based Working. A practical guide to organizational transformation. Oxford: Blackwell/British Psychological Society.*

Medication errors

The Royal Wolverhampton NHS Trust dispenses more than 400,000 items per year to patients under our care. We encourage staff to report all incidents involving medication, not only those which have resulted in an error at the point of patient care. Incidents are monitored across the trust to identify learning and directorates are encouraged to share good practice through governance meetings, update sessions and regular training events. We make sure that all medicinal products bought by the Trust meet UK quality standards, are stored safely, used appropriately and disposed of properly.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Medication Incidents Reported in line with Trust Policy (i.e. within 5 days)	108	109	72	117	98	94	121	98	83	82	90	109
Level of Harm Caused (impact assessed using trust risk matrix)	101	107	69	113	93	91	116	92	79	78	89	107
	7	1	2	3	4	2	5	5	4	4	0	1
	0	1	1	1	1	1	0	1	0	0	1	1
	0	0	0	0	0	0	0	0	0	0	0	0
Number of Admissions	12359	13875	13797	13568	13435	10930	11406	11924	10050	11247	10090	10808
Rate of Medication Error (%)	0.87	0.79	0.52	0.86	0.73	0.86	1.06	0.82	0.79	0.73	0.89	1.01



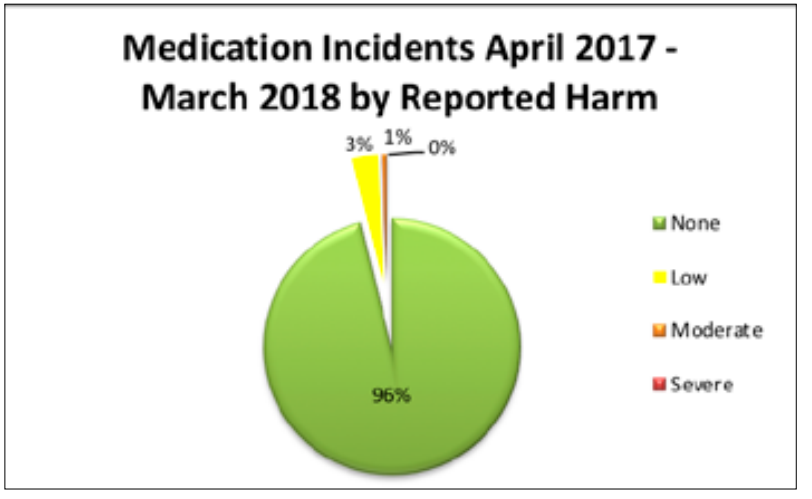
Medication Safety Initiatives 2017-2018

Medication reporting fields have been reviewed to allow ease and clarity of reporting, and more meaningful trend analysis.

A new 30 day treatment chart was launched on 1st February 2018 with the aim of reducing the time spent rewriting treatment charts by doctors, therefore also reducing prescribing errors made during transcription.

As part of our continuous medicines safety review process, any Patient Safety Alerts issued by NHS England (and previously the National Patient Safety Agency) more than 3 years ago are being revisited to ensure that actions are still relevant and effective.

March 2018 saw the launch of our new Electronic Prescribing and Medicines Administration System (ePMA) on an incremental plan across the Trust. It is recognised as being one of the most effective safety interventions in reducing harm and increasing effective use of medication.



Data sources: National Reporting Learning Systems (NRLS)

Sepsis

Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration. It is estimated by the Sepsis trust that sepsis claims at least 46,000 lives every year and may be as high as 67,000. Reducing deaths from sepsis is a priority for the NHS and the Royal Wolverhampton Hospitals NHS Trust.

- As part of the Trust's promotion of sepsis awareness drive in 2017/18, standardised pathways for detecting, recognising and managing patients with sepsis were developed. We also set out to develop the training, educational and service needs to improve sepsis management within the first year.
- In June/July 2017, there was a campaign to improve sepsis awareness across the organisation involving all staff and the public. There was a co-ordinated trust-wide introduction of three new sepsis screening tools with further educational activities to enable implementation.
- As part of the campaign there were several presentations at the medical grand round, shows of the Sepsis Trust supported Starfish movie, sepsis promotional campaigns and sepsis ward rounds in different clinical areas.
- Sepsis management has become incorporated as part of mandatory induction for the clinical staff and Sepsis study days for nurses organised by the education team have had a surge in attendance.
- Overall there has been a positive and exciting response to this drive with measurable improvements in sepsis screening, as indicated in quarterly CQUIN audits (Commissioning for Quality and Innovation) conducted by the Emergency Department.
- This is a continuing journey and future efforts are focused on building and developing the existing systems; and exploring new technological solutions to improve data gathering and real time reporting of sepsis management. Further focus is to maintain the momentum through continuing sepsis education and awareness to drive further improvement in our performance and to save more lives

Responding to Safety Alerts

The Trust is moving towards the Health Assure Central Alert System to better manage safety alerts.

Safety alerts continue to be monitored by external bodies and the Trust works to ensure compliance within the tight time frames. Although at the time of writing there were no alerts outstanding, throughout the year 2017/18 two alerts were late in being responded to, 1 Medical Device Alert and 1 Estates Facilities Notice (EFN) both due to administrative oversight.

The Patient Safety Alerts (NHS/PSA's) fall into 3 categories:

Stage 1 = Warning
Stage 2 = Requires Resource
Stage 3 = Directive giving instruction on implementation of protocols

In the main the alerts require an action plan for implementation of the alert actions; the Trust is then required to monitor the action plans to completion. Action plans are monitored at the relevant local Governance meeting until it is agreed all actions are complete.

Health & Safety Steering Group also monitors the alerts and response times and this is reported to the Quality Standards Action Group.

2017/18 has been a busy year particularly for Estates Facilities alerts, however many of them are for information enabling a swift response.

The Trust continues to work towards full and prompt compliance.

All NHS organisations receive safety alerts these come under several headings each described below:

MDA (medical device alerts)	These relate to equipment or sundries used in patient care.
EFN (Estates Facilities Notice)	Inform Trusts of problems highlighted following incidents relating to Plant and Equipment.
EFA (Estates Facilities Alert)	Relate to procedures undertaken regarding Estates Facilities services/equipment.
NHS/PSA/W	Stage 1 – Issued in response to a new or under-recognised patient safety issue with the potential to cause death or severe harm.
NHS/PSA/Re	Stage 2 – Issued in response to a patient safety issue that is already well-known, either because an earlier warning alert has been issued or because they address a widespread patient safety issue.
NHS/PSA/D	Stage 3 - Issued because a specific, defined action to reduce harm has been developed and tested to the point where it can be universally adopted, or when an improvement to patient safety relies on standardisation
FSN (Field Safety Notice)	Issued by suppliers/manufacturers to inform users of issues identified with their products.
SDA (Supply Disruption Alert)	Issued to inform organisations of major disruption to supply of equipment/sundries.

Table 1 provides the number and type of alerts received and responded to within the financial year 2017/18.

12 months April to March 2017/18:

The table below provides the number /type of alerts received within the last financial year 2017/18, RWT responses and any overdue.

YTD received (financial year)	
MDA's	43
EFN's	45
NHS/PSA/	6
EFA	5
NHSI	1
CHT	1
Total	101

YTD Closed	
MDA's	37
EFN's	45
NHS/PSA/	5
EFA	5
NHSI	1
CHT	1
Total	94

YTD Open	
MDA's	6
EFN's	0
NHS/PSA/	1
EFA	0
NHSI	0
CHT	0
Total	7

Open (YTD & Previous years still open)	
MDA's	6
EFN's	0
NHS/PSA/	1
EFA	0
NHSI	0
CHT	0
Total	7

Overdue Alerts x NHS PSA	0

Priority 3: Patient Experience

The Royal Wolverhampton NHS Trust is committed to working in partnership with patients, the public and local communities to ensure that its services are both relevant and responsive to local needs. We have established a variety of ways to gain feedback and seek patient opinion.

This includes local and national surveys, Friends and Family Tests, PALS concerns, formal complaints, compliments and social media forums such as Patient Opinions and NHS Direct.

By effective analysis and use of patient and family feedback we will improve our services to ensure we meet their needs.

We know that the patients' experience is formed through every contact they have with our 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 us provide the kind of care that we all want to deliver and would like to receive.

We know that staff can only provide the quality of care we expect if they work in an environment where they feel respected and valued, and are supported to deliver excellent care. The Trusts visions and values should be evident in everything we do, towards each other as colleagues/employees and to the patients and public we serve.

How have we performed in 2017/18?

This year, the Trust has focused on the holistic approach to patient experience recognising that a positive patient experience is not solely reliant on a good clinical outcome.

Several initiatives have been implemented which focus on improved processes and communication not only between Trust departments but also with stakeholders and patients and their carers.

These have included:

- Increased patient and user engagement by the introduction of a patient voice through the establishment of a Council of Members, and delivering local bespoke surveys in conjunction with partnering stakeholders.
- Reviewed how the Trust supports the organisation on how it handles complaints and other forms of patient feedback effectively and efficiently by the creation of designated Patient Experience Advisors, specifically aligned to specialities.
- Progression through goal 2 of the EDS2 – Improved Patient Access and Experience.
- Publication of the Trust's Equality, Diversity and Inclusion report. [3] in addition to the Trust's Patient Experience Report.
- Introduction of mandatory training on Equality, Diversity and Inclusion.
- Redesign of the Trustwide Patient Feedback Posters containing several patient experience metrics for public information.

[3] *http://www.royalwolverhampton.nhs.uk/patients-and-visitors/patient-experience-team/equality-diversity-and-inclusion/equalities-information/*

- Refining the complaints policy further to enhance how the Trust responds to complaints and other forms of patient feedback and included a further level of scrutiny for cases where complainants remain dissatisfied and incorporated this into the complaints management process.
- The introduction of enhanced technology to support the overall patient experience feedback mechanism by the review and implementation of a new telephony system resulting in improved average response time for PALS queries.
- The introduction of extended visiting hours where friends and family will be able to visit their loved ones from 12pm until 7pm, recognising that visits and support from family and friends can help aid a patient's recovery. Flexible visiting promotes family involvement in the care of patients such as mealtimes, encouraging visitors to assist the patient they are visiting. Exceptions to this are the children's ward, neonatal unit and maternity. Visiting times will also differ for surgical wards and day case surgery to ensure adequate provision of rest time for patients post-surgery.
- A new innovative menu for patients with swallowing difficulties - The Trust has developed a special 'thick pureed' and 'soft/fork-mashable' menu to improve the choices made available to patients who have problems swallowing. The menu was developed by the catering department working in partnership with speech and language therapy specialists and through sampling sessions held with patients.
- A reminiscence room at New Cross Hospital to support the rehabilitation of patients with dementia. Decorated in a 1960s-style design which harks back to days gone by, and provides memory aids to help patients recall details and happy memories from their past. It hosts weekly events such as bingo, board games and hairdressing, and features nostalgic photography and 'memory boxes' with trinkets from times gone by.
- A new 'red bag scheme' is currently being piloted in Wolverhampton to help reduce an elderly patient's stay in hospital. The red bag keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff. The bag includes medication, belongings, paperwork and personal and clinical information about the resident, which will assist ambulance and trust staff to speed up the transfer process. When an elderly person arrives at hospital, a nurse should receive the red bag from the ambulance crew. It could reduce an elderly patient's stay in hospital by up to four days. It could also save nursing staff up to 40 minutes per shift which would otherwise be spent chasing documents, personal items and toiletries.
- Red and Green Bed Days - The Trust has introduced Red and Green bed day methodology this year. This is a management system to assist in the identification of wasted time in a patient's journey (Emergency Care Improvement Programme). It is applicable to inpatient wards in acute hospitals; this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. A Red day is when a patient receives little or no value adding acute care. A green day is when a patient receives value adding acute care that progresses them towards their discharge. At the centre of the health care is a person receiving acute care whose experience should be one of involvement and personal control, with an expectation of what will be happening. As part of the Red and Green work staff are encouraging patients, carers and families to ask 4 questions.

1. Do I know what is wrong with me or what is being excluded?
2. What is going to happen now, later today and tomorrow to get me sorted out?
3. What do I need to do to get home?
4. If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?

Working in partnership with our patients our aim is to drive out the no value added experience and reduce length of stay in hospital.

Complaints' Management

As a result of amendments to the policy, the Trust has experienced a positive year in relation to its complaints' management, In particular:

- Following external review and investigations by the Parliamentary Health Service Ombudsman (PHSO) there has been no complaints upheld or partially upheld for a six month period.
- Recognising the need for thorough and consistent approaches to investigations for safeguarding concerns not meeting section 42 criteria, resulting in the investigative process being undertaken in line with the Trust's formal complaint process.
- Consideration of all new complaints ensuring resolution is timely and proportionate.
- Delivery of complaints awareness training.

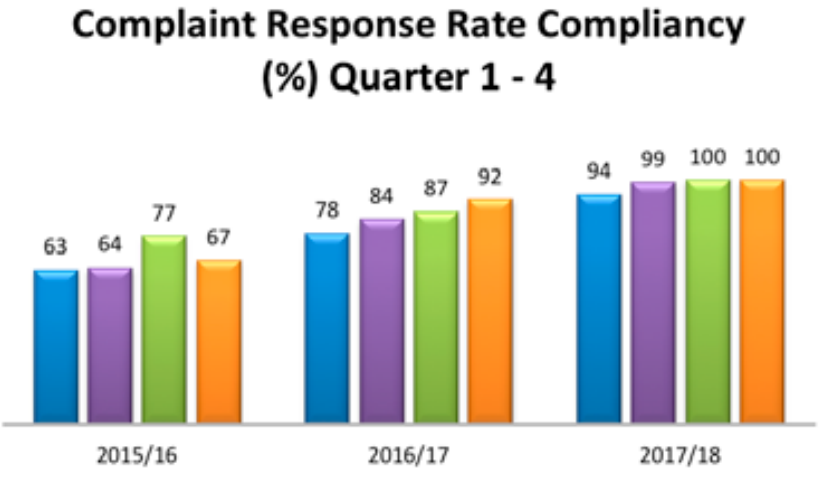
Formal complaints are managed in accordance with the relevant statutory regulations[4]. With the amendments made to the Complaints' Management Policy in August 2017 and, and following bespoke training, we have again seen a dramatic improvement in the timeliness of complaint handling and informing the complainants of the progress of their complaint.

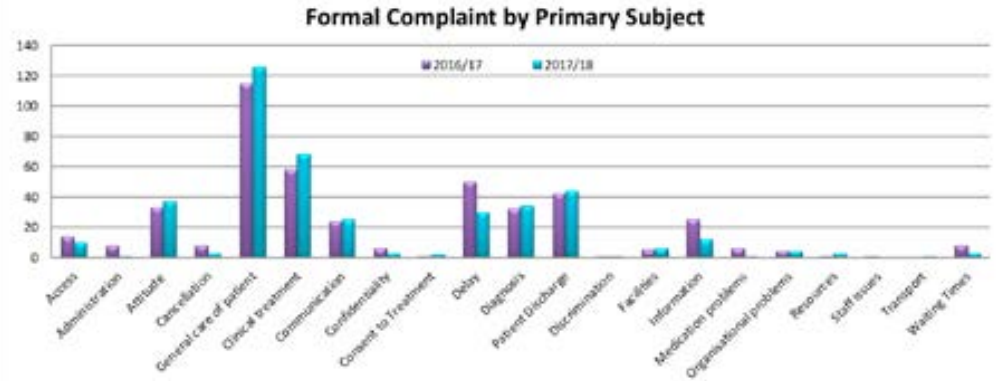
Over the last three years there has been continual improvement with the compliancy rising from 63% to 100%. For six months of year 2017/18, 100% of complaints were closed either within the organisational timeframe of 30 working days or were given consent to breach due to extenuating circumstances or complexity. This is reinforced by putting the complainant at the heart of the process and ensuring that they are communicated to and involved in how their complaint is handled.

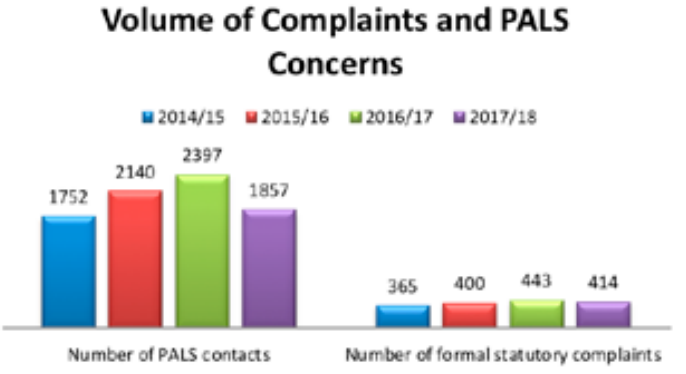
In terms of volume, 2017/18 has seen a 6.5% decrease in comparison to the previous year for formal complaints made through the statutory process, and 22.53% decrease in the volume of PALS concerns raised.

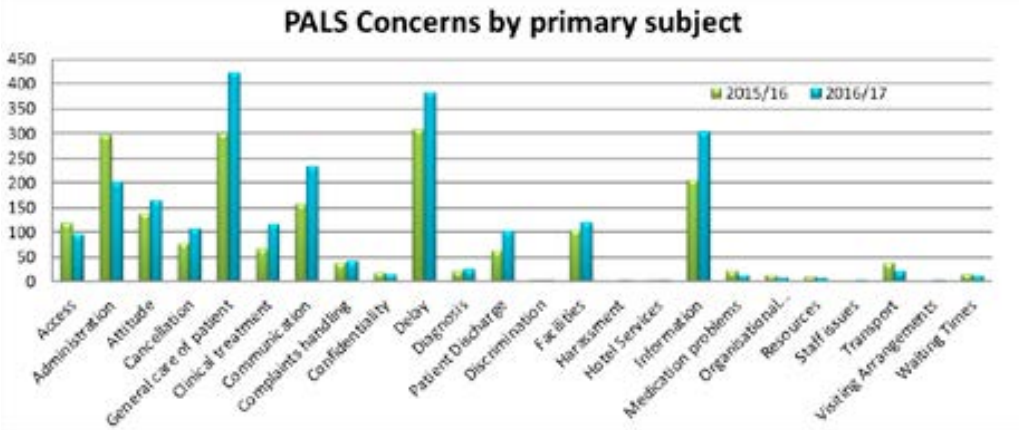
There is little variation between the key themes of complaints year on year, with the highest subjects being General Care of Patient and Clinical Treatment. However there is a strong association between the Trust's initiatives over the last year relating to information giving and delay, where it is noted that there has been decreases in these subject matters.

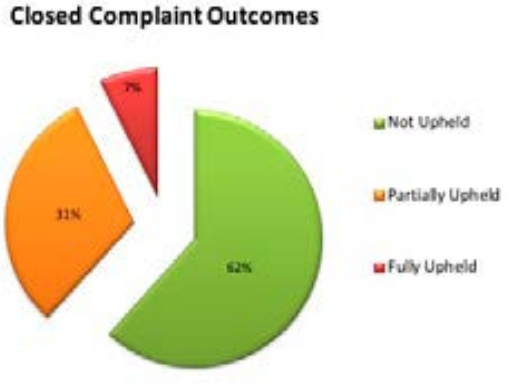
[4] *http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf*




Formal Complaint by Primary Subject
2016/17
2017/18
140
120
100
80
60
40
20
0
Access
Administration
Attitude
Cancellation
General care of patient
Clinical treatment
Communication
Confidentiality
Consent to Treatment
Delay
Diagnosis
Patient Discharge
Discrimination
Facilities
Information
Medication problems
Organisational problems
Resources
Staff issues
Transport
Waiting Times


Volume of Complaints and PALS Concerns
2014/15
2015/16
2016/17
2017/18
1752
2140
2397
1857
365
400
443
414
Number of PALS contacts
Number of formal statutory complaints


PALS Concerns by primary subject
2015/16
2016/17
450
400
350
300
250
200
150
100
50
0
Access
Administration
Attitude
Cancellation
General care of patient
Clinical treatment
Communication
Complaints handling
Confidentiality
Delay
Diagnosis
Patient Discharge
Discrimination
Facilities
Harassment
Hotel Services
Information
Medication problems
Organisational...
Resources
Staff issues
Transport
Visiting Arrangements
Waiting Times


Closed Complaint Outcomes
7%
31%
62%
Not Upheld
Partially Upheld
Fully Upheld

During 2017/18, 15 complainants referred their complaints to the Parliamentary Health Service Ombudsman (PHSO) for their consideration and were subsequently accepted for investigation. This represents 3.6% of the total of complaints received. Pleasingly this is an indication of the thoroughness of the response letters provided and of the remedial work undertaken by directorates to bring complaints to a resolution satisfactory.

In terms of outcomes of PHSO investigations closed during the year, it is noted that no cases were fully upheld and 57% of cases considered were not upheld.

The volume of complaints received for the year (414) represent 0.03% of the total volume of admissions, emergency activity, outpatient attendances and community contacts for the year of £1,726,025.

The Friends and Family Test (FFT)

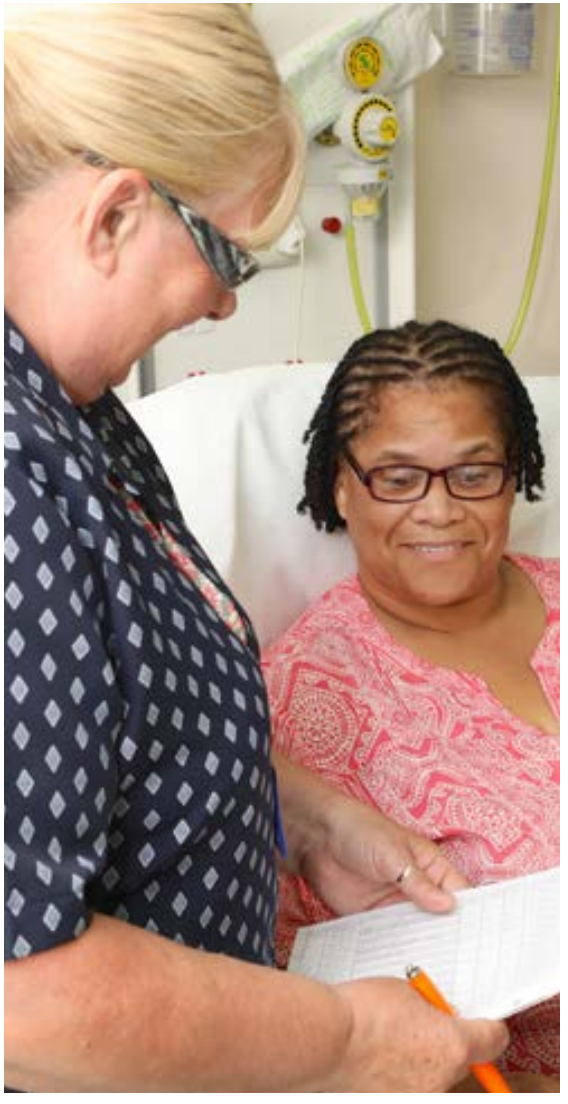
The Friends and Family Test (FFT) gives patients the opportunity to submit feedback to the Trust by using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care 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 have considered where there are gaps in surveying patients and worked with the provider to improve the feedback for those areas.

Improvements have included:

- 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 ability to capture survey responses to ascertain the level of satisfaction/dissatisfaction dependent upon the day of admission, supporting the work undertaken by the Trust as an implementer of 7 day services.
- A comprehensive review of paediatrics services, including the review and amendment of bespoke surveys in a variety of formats ensuring age specific and accessibility. Ensuring the key principles given by NHS England on making the test inclusive has been adopted.[5]
- Continuation of hand held devices used to capture FFT responses in real time on wards.
- Monthly metrics are analysed and the lowest five performing areas for response and recommendation rate are targeted with direct work for improvement.

https://www.england.nhs.uk/ourwork/pe/fft/fft-inclusive/



Patient and Public Engagement

Patient and public engagement (or involvement) is a continual process of working with patients, carers and other stakeholders (including relatives and advocates) to design, shape and develop services to improve services for its patients and their representatives. The Trust has a rolling 3 year strategy for Patient and Public Engagement which identifies the benefits of local engagement, and provides us with a framework to achieve our objectives.

Initiatives for the year have included:

- The creation of The Council of Members, established in 2017 and is a group of committed individuals from our local community with a wealth of different experiences to offer the Trust. All members have been recruited as they wish to support the Trust make improvements and provide a link between the work that we do and patient and public engagement, and be our 'critical friend'. A work plan has been compiled for the forthcoming six months and some has involved collaboration working with stakeholders to consider the patient views and the reviewing of performance monitoring data.
- Representatives from the Trust, including from the Patient Experience Department attends regular meetings with the Vertical Integration. (Primary Care) Patient Participation Group to extend our engagement with GP surgeries and their patients.
- The Trust has continued to be pro-active in attending local events to seek local views on the way Trust delivers care.
- Patients and carers are encouraged to express how it feels to receive care from RWT by the sharing of their 'Patient Stories'. Such stories provide us with an opportunity to learn as an organisation, bringing experiences to life and make 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.

Volunteering

The last 12 months have again shown a busy period for Volunteer Services in recruitment, widening the types of opportunities we have on offer, and working in partnership with our existing and new stakeholders. As always 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.

We currently have 24 different volunteer roles and opportunities within the Trust. Many of these roles are well established, however in the last 12 months we have also developed the following new opportunities in partnership with staff:

- Ophthalmology volunteers - volunteers who can support the uptake of patient satisfaction surveys and also support patients waiting to be admitted on to the ward
- Reminiscence Room (Elderly Care) - Volunteers who help provide reminiscence type activities from our patient's Reminiscence Room
- Outpatients One - Wayfinders who operate specifically from OPD1 to help patients be signposted on to other departments
- Discharge Lounge - Volunteers who support patients waiting to be discharged
- Hairdressing (Elderly Care) - Volunteers on placement from a local training provider, who provide hairdressing to inpatients
- Dementia Outreach - Volunteers who support our Dementia Outreach team with visiting patients who have dementia and offering companionship and distraction activities

Volunteer Services also supports several other charities and groups who run volunteer services throughout the Trust, with recruitment of their volunteers, and other key administrative functions.

These include:

- BLISS Neo Natal Charity
- Breastfeeding Peer Support Group (In collaboration with Wolverhampton Breastfeeding Network)
- Hospital Radio Stafford
- League of Friends of Stafford and Cannock Hospitals
- League of Friends of Wolverhampton Eye Infirmary
- Macmillan
- Pets as Therapy
- Radio Wulfrun
- Wolverhampton Coronary Aftercare Support Group
- Wolverhampton Hearing Services Volunteer Group

Equality, Diversity and Inclusion

The Trust has a commitment to equality, diversity and inclusion. We understand that our diverse workforce is our greatest asset, so we strive to create working environments in which people are valued, able to reach their full potential and flourish, this in turn will help us deliver high quality accessible services that are truly inclusive.

Services that treat people fairly, with respect, care, dignity, compassion and that are flexible, should improve the overall patient experience and health outcomes of the diverse population that we serve. Everyone should feel confident when accessing our services or joining our workforce that we are committed to eliminating discrimination, bullying, harassment, victimisation and that we promote equality, diversity, inclusion and fairness.

We are committed to creating a culture of openness and transparency. As a requirement of the Public Sector Equality Duty, the Trust must capture a range of equality related information and report on it. By analysing this information the Trust is able to identify possible issues of inequality and to seek to address them; specifically for people who have personal protected characteristics as defined by the Equality Act 2010.

A range of equality information is available within various reports which are published on the Trust's website and the Trust publish an Annual Equality, Diversity and Inclusion Report however key initiatives for this year include:

- The purchase and implementation of Browsealoud which gives website visitors a better experience by improving accessibility. The Trust's Accessibility page has a link to My Computer, My Way, a website which shows the user how to adjust settings on their computer to make it easier to use. The free tool explains all the accessibility features built into common desktop computers, laptops, tablets and smartphones, and how the user can enable them on their device. For further information go to: https://mcmw.abilitynet.org.uk/.
- Employment Data Cleanse: Information gathered from the data cleanse exercise was completed in May 2017, information has been updated within the ESR (electronic staff record). The overall response rate was 62.72%, however, if rotational doctors are excluded, the overall response rate was 64.40%.
- Equality, Diversity and Inclusion training package: This mandatory e-learning package called 'A brief introduction into Equality, Diversity and Inclusion Level 1 (including Bullying and Harassment)' was launched in November 2017. As at 31st March 2018 - 4574 employees (linked to an employee record) completed this package. NB Some people may have accessed this package more than once.
- Trust Induction: This is a mandatory session at Trust Induction and was implemented in June 2017. The session is entitled 'Brief Introduction into Equality, diversity and Inclusion (including Bullying and Harassment)'. As at 31st March 2018 - 664 Employees (linked to an employee record) have completed this training.
- Learning Disabilities (LD): The Trust's All Age LD strategy was launched in January 2018. The strategy will support staff who have contact with patients with learning disabilities, to enable them to deliver care appropriate to the individual needs of the patient. To support this, the learning disability core care plan has been ratified and is now in use in addition to the LD Hospital Passport which is routinely offered in some areas for pre-op assessments. The Children's Health Passport is currently being piloted.
- Dispute Resolution in the Workplace Policy has been launched, pulling together an approach to deal with grievances, discrimination, bullying, harassment or victimisation complaints, with the aim of early resolution.

- Adopting and promoting NHS Personal, Fair and Diverse Champions campaign
- Every Voice Matters Campaign is being used as an 'umbrella' under which all the initiatives to encourage and support Employee Voice and Patient Voice are presented
- With the RCN, we have appointed a team of cultural ambassadors
- EDS2 - Goals 3 and 4 relate to the workforce and have been self-assessed and reported to CQC (via CQRM) - all outcomes are incorporated into the Trust Annual Equality Report . The Trust will formally submit and publish its self-assessment outcomes once Goal 2 (Patient Experience) consultation and self-assessed grading has been agreed.
- Signing of the Armed Forces Covenant
- We have a year-long programme of Equality and Raising awareness events in place to further develop a culture of inclusivity
- Collaborative working with the Trust Communications Team has led to greater visibility of RWT's EDI events and achievements, utilising more forms of media e.g. Twitter, press, Facebook.
- Engagement in local and regional networks, eg. Wolverhampton City Council Covenant Board, network events with Health Education England, Inclusion and Leadership events, presentation at regional Freedom To Speak Up event on the Trust's Every Voice Matters campaign.

Equality Delivery System (EDS) – Goal 2 Improved patient access and experience

NHS England's Equality Delivery System (EDS) main purpose is to help NHS organisations, review and improve their performance for people with protected characteristics (as defined under the Equality Act 2010).

The Trust worked on goal 2, improved patient access and experience for the financial year 2017-18. Evidence was gathered and submitted for local people and/or stakeholders to assess and grade our equality performance. This collaboration enabled the Trust to agree its final grade for each of goal 2's outcomes. The results of the assessment and grading session are shown below:

Goal 2 Outcomes : Improved Patient Access and Experience	Overall grade
2.1 : People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	 Developing
2.2 : People are informed and supported to be as involved as they wish to be in decisions about their care	 Developing
2.3 : People report positive experiences of the NHS	 Achieving
2.4 : People's complaints about services are handled respectfully and efficiently	 Excelling

From this assessment and grading process a range of actions were identified, these will be reviewed and will form part of the Trust's equality actions and/or objectives (where relevant). This will ensure that the EDS process is embedded within current work streams, monitoring and reporting processes.

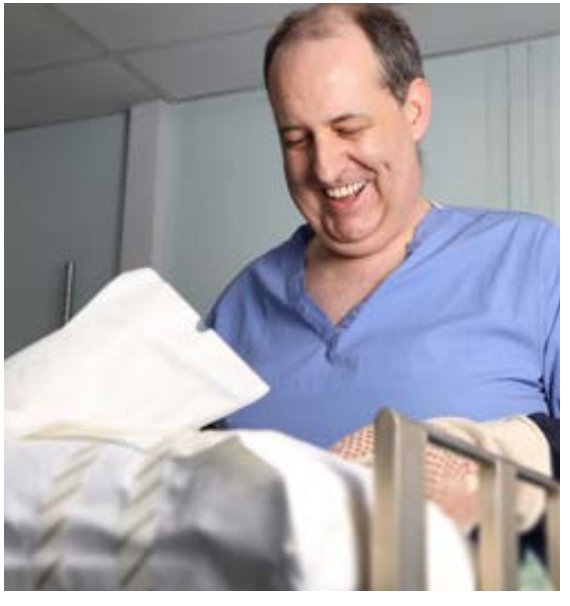
The Trust understands that it has some challenges ahead, but has started its journey towards inclusion. We are totally committed to making a difference to our workforce and to the people we serve.

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 inspection process were as follows;

Site	Date	No. of Patient Assessors	Number of Staff	Number of Wards Inspected	Number of Outpatient Areas Inspected	Number of Food Assessments Undertaken
New Cross	5th & 8th May 2017	13	8	10	10	5
West Park	11th May 2017	5	4	3	2	3
CCH	28th February 2017	6	5	2	6	1

The inspection 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 inspection and it was made clear that it was their opinion, and not the staff members, that would be documented and submitted.

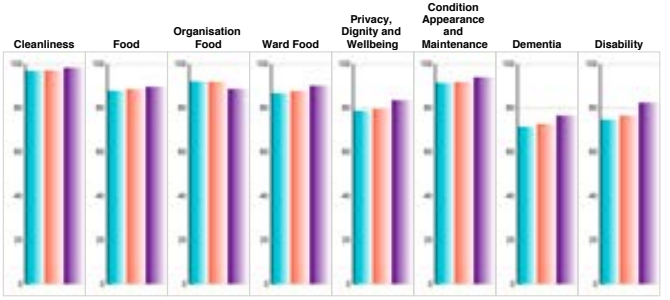
The inspection process was not a technical audit; this is the patient's perception of the environment based on the training given to them.

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 site score is in blue; National average is in purple and organisational average in red.

Results - New Cross

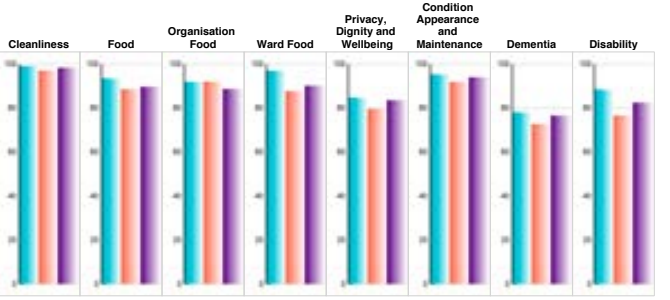
NEW CROSS HOSPITAL- Collection: 2017



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3537.0000	465.9493	107.3485	358.6008	420.4999	1779.0000	793.8991	587.9243
Available Score (Actual)	3648.0000	529.8148	116.5880	413.2268	534.0000	1946.0000	1110.8571	786.3697
Site Score	96.96%	87.95%	92.08%	86.78%	78.75%	91.42%	71.47%	74.76%
Organisation Average	97.18%	88.63%	92.07%	87.86%	79.64%	91.84%	72.88%	76.69%
National Average	98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%

Results - Cannock Chase Hospital

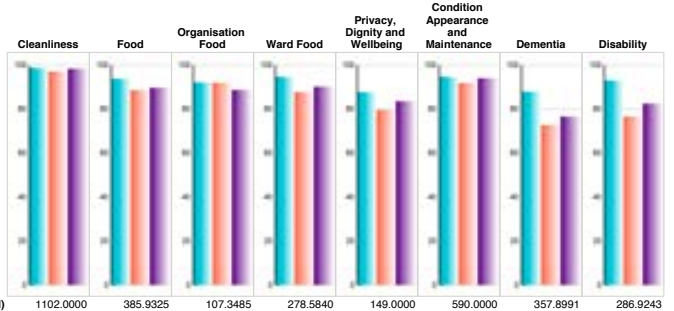
CANNOCK CHASE HOSPITAL- Collection: 2017



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1297.0000	157.2225	107.1595	50.0630	186.3333	801.0000	437.8991	369.9243
Available Score (Actual)	1308.0000	168.1510	116.5880	51.5630	220.0000	840.0000	560.8571	418.3697
Site Score	99.16%	93.50%	91.91%	97.09%	84.70%	95.36%	78.08%	88.42%
Organisation Average	97.18%	88.63%	92.07%	87.86%	79.64%	91.84%	72.88%	76.69%
National Average	98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%

Results - West Park

WEST PARK HOSPITAL- Collection: 2017



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1102.0000	385.9325	107.3485	278.5840	149.0000	590.0000	357.8991	286.9243
Available Score (Actual)	1118.0000	411.3442	116.5880	294.7562	170.0000	624.0000	406.8571	308.3697
Site Score	98.57%	93.82%	92.08%	94.51%	87.65%	94.55%	87.97%	93.05%
Organisation Average	97.18%	88.63%	92.07%	87.86%	79.64%	91.84%	72.88%	76.69%
National Average	98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%

Of the 24 assessment scores carried out across all three hospital sites, 17 (71%) achieved above the national average score.

On the West Park Hospital site and Cannock Chase Hospital site, all 8 areas of assessment exceeded the national average score.

All three hospital sites achieved above the national average for organisational food.

The New Cross site has improved the assessment results across 4 areas against the 2016 results.

Vertical Integration (VI)

In 2016 the Trust commenced the journey of Vertical Integration (VI) by initially integrating with three GP Practices. As of 1 April 2018, eight GP Practices are integrated with the Trust which through a subcontracting arrangement delegates the Trust to be directly responsible for the delivery of Primary Care Services. The vertical integration (VI) Programme offers a unique opportunity to redesign services from initial patient contact through on-going management and end of life care.

As a single organisation the issues of scope of responsibility, funding, differing objectives and drivers will be removed and clinicians are in a position to design effective, high quality clinical pathways which will improve appropriate access and positively impact on patient outcomes.

There have been a number of key challenges to date that have been identified across the VI practices as single entities. Whilst they remain challenging as we have integrated we have been able to develop and implement de fragmented processes and procedures and develop plans for the future to be able to provide the best care possible for our patients.

As of the 1st April 2018 Primary Care Services will be embedded as business as usual within the Trust and will be part of the newly formed Division 3. This demonstrates the Trust's commitment to the integration of Primary Care and will ensure that the service is able to flourish and build on the success to date.

From the very outset of the VI programme, the objectives were to have:

- Better Patient quality, outcomes & satisfaction
- Better access to GP services for patient services
- Better communication between GP Practices and the hospital to help enable better care
- Better use of integrated data and systems to help enable better care to be provided

It can be identified from the results of the GP Patient survey below that VI practices show an improvement in 21 out of the 23 patient questions / outcomes when comparing results from the July 17 survey to July 16. There are noticeable improvements in relation to feedback on nurse appointment experience (e.g. nurses involving patients in making decisions).

Practice	GP Appointments		Other Appointments		All Appointments		
	Pre VI	Post VI	Pre VI	Post VI	Pre VI	Post VI	
	Per 1,000 Appointments per week (Target = 45)	Per 1,000 Appointments per week (Target = 45)	Per 1,000 Appointments per week (Target = 27)	Per 1,000 Appointments per week (Target = 27)	Per 1,000 Appointments per week (Target = 72)	Per 1,000 Appointments per week (Target = 72)	Variance
Total	42.26	47.49	31.09	33.71	73.35	81.20	7.85

In addition to increased patient satisfaction for VI practices in the latest GP patient survey, the overall performance summary of the VI programme shown in Figure 5 illustrates that:

- There has been an 11% reduction in emergency admissions for patients from VI practices
- There has been an 8% reduction in emergency readmissions within 30 days for patients from VI practices
- Better access to GP services for patient services
- Better communication with the development of integrated systems between GP practices and the hospital

In terms of measuring appointments against the national standard, the table below calculates appointments per 1,000 patients for each VI practice compared to national guideline weekly targets for GPs (45), Other (27) and all practice appointments (72). It can be seen that GP appointments pre – VI did not meet the national target of 45 per 1,000 per week, however, with additional capacity invested by the VI programme, the practices are now achieving this target.

In actual terms, there has been a net increase of circa 30,000 patient appointments since the VI programme started. Additional appointment capacity has been created not only with practices increasing operational hours from 4.5 to 5 days but also the addition of Saturday and bank holiday appointments soon to include Sunday clinics from April 2018.

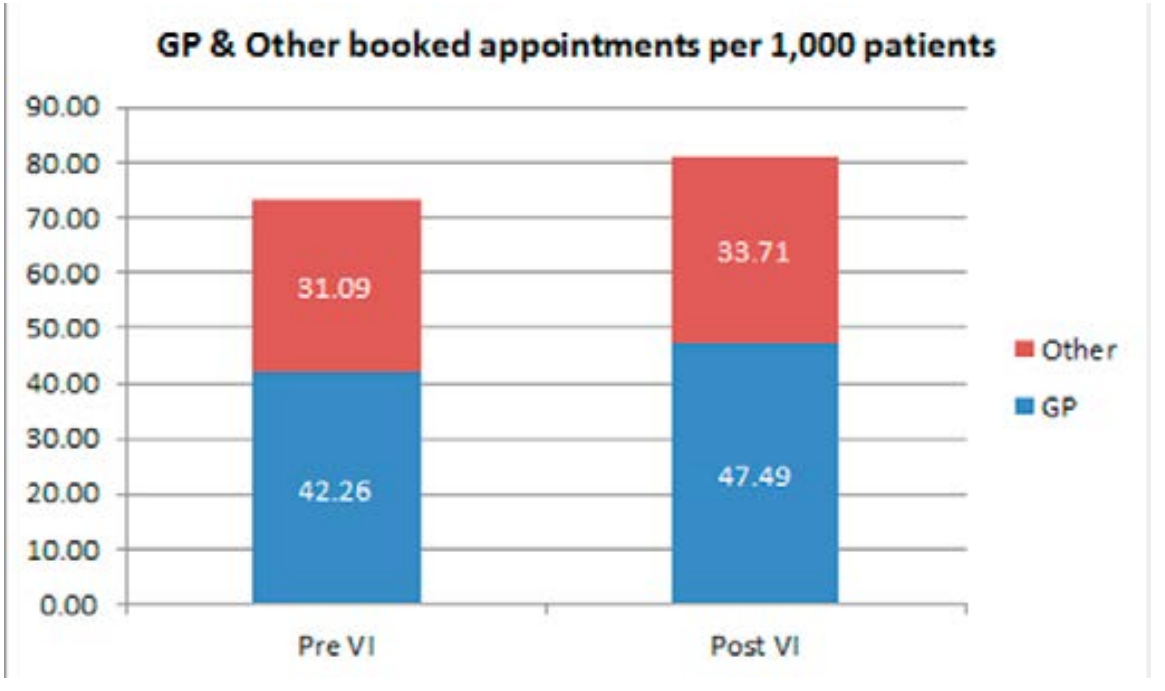
	Jul-16	Jul-17	Diff
Question	**Total VI**	**Total VI**	**+/-**
Through to surgery phone	71.00%	76.40%	5.40%
Receptionists are helpful	86.60%	89.40%	2.80%
Speak/See preferred GP	53.60%	57.60%	4.00%
Got an appointment the last time they tried contacting the surgery	82.60%	84.20%	1.60%
Last appointment was convenient	90.20%	80.40%	-9.80%
Experience of making an appointment was good	73.80%	76.40%	2.60%
Wait 15 mins or less for an appointment	64.40%	67.80%	3.40%
Feel they do not need to wait to long to be seen	60.80%	62.80%	2.00%
Last GP saw or spoke to gave them enough time	90.80%	92.80%	2.00%
Last GP they saw was good at listening to them	92.80%	94.00%	1.20%
Last GP was good at explaining tests and treatments	86.80%	92.60%	5.80%
The last GP involved them in decisions about care	80.80%	88.40%	7.60%
Last GP was good at treating them with care	86.00%	91.00%	5.00%
Confidence in the last GP they saw	93.40%	97.20%	3.80%
The last nurse gave them enough time	81.40%	93.20%	11.80%
Last nurse was good at listening to them	81.80%	93.80%	12.00%
Last nurse was good at explaining tests	79.20%	91.60%	12.40%
Last nurse was good at involving them in discussions around care	70.80%	90.00%	19.20%
Last nurse treated them with care and concern	79.40%	91.80%	12.40%
Confidence and trust in the last nurse	85.80%	98.80%	13.00%
Satisfied with surgery's opening hours	79.00%	80.80%	1.80%
Overall experience as good	90.80%	92.20%	1.40%

Figure 1 – GP Patient Survey Comparison results

Following workshops with GP's and the hospital, it was recognised that we need to make better use of the many disparate systems that are used when treating patients. There is a wealth of data and information available which we need to use in a more integrated fashion which enables clinicians to utilise this data in a more timely and intelligent manner.

To help deliver this, a live GP data dashboard has been developed and implemented which is accessible to GP's on a daily basis. The purpose of this dashboard is to visually highlight the stats of the population for each practice – e.g. how many patients are currently admitted, how many patients are high risk etc.

Utilisation of this dashboard and the data held within it can support GP's to make informed decisions and help introduce patient interventions earlier. This reporting system is constantly evolving in order to provide enhanced intelligence for clinicians.



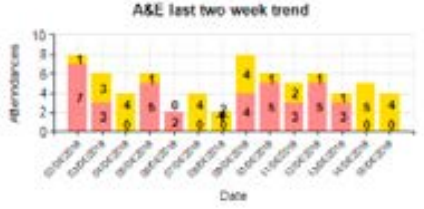
Practice Overall Summary

Current Inpatient Status	No. of patients	3 or more emergency admissions in last 12 months	3 or more A&E attendances in last 12 months	3 or more comorbidities	Watch List	Population Health
Not Admitted	6,584	37	64	621	635	
Currently Admitted	13	2	2	5	5	
Total	6,597	39	66	626	640	

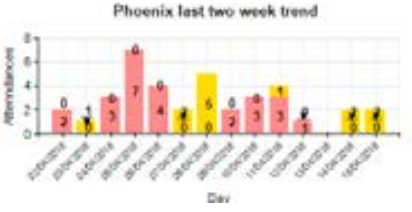
Quality & Safety Checks

Patient's with potential missing LTC coding	Child Safeguarding Differences	MDT Patient Basket	Diabetes HbA1c Check
403	5	0	2
403	5	0	2

Yesterday's A&E Attendances: (4)



Yesterday's Phoenix Walk in Centre Attendances: (2)



List of Current Inpatients: (13)

Patient Name	Ward Specialty	Age	Adm Type	NHS Number	Current inpatient ward	Current LoS	Delayed Transfer of Care?	Readmission within 30 days?	Days since Last GP Visit Date	A&E Attendances last 12 months	Emerg admissions last 12 months	Patient Journey	MDT Basket Add	Emergency Activity Trend last 3 months	PARR-30 * Score
*****	Rehab	88	NEL	*****	W1	47	No	Y	138	3	3				84%
*****	Orthopaedics	61	NEL	*****	A5W	14	No	N	167	1	1				74%
*****	Other		NEL	*****	TCUNIT	14	No	N	365						0%
*****	Other	21	NEL	*****	TCLODGE	12	No	Y	365						1%
*****	General Medicine	92	NEL	*****	C2MW	11	No	N	277	3	2				68%
*****	General Medicine	60	NEL	*****	C4flW	10	No	N	108	65	8				99%

Continuous Quality Improvement 2017/18

Use of the CQUIN payment framework

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals through the CQUIN Payment Framework.

CQUINs enable the organisation to focus on the quality of the services delivered, ensuring that we continuously improve and drive 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, with central support who develop SMART action plans 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 2017/18:

For the first time, NHS England published two year schemes which aim to provide greater certainty and stability on the CQUIN goals, leaving more time for health communities to focus on implementing the initiatives. The CQUIN schemes are intended to deliver clinical quality improvements and drive transformational change. With these objectives in mind the scheme is designed to support the ambitions of the Five Year Forward View and directly link to the NHS Mandate.

What we set out to achieve:

CQUIN schemes for 2017-2019 are detailed in the table below:

Commissioner	CQUIN Indicator Name 2017-19	Description	2018 Compliance
CCG	Introduction of health and wellbeing (Staff Survey)	The NHS England Five Year Forward View made a commitment 'to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy'. A key part of 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. National achievement is monitored via the NHS Staff Survey.	0% Risk assessment completed, action plan developed, Quarterly monitoring to be commenced
	Healthy food for NHS Staff, visitors and patients	Providers are expected 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.	Awaiting commissioner approval
	Improving uptake of Flu Vaccinations for Front line clinical staff	The CQUIN aims to achieve 70% uptake of Flu Vaccinations of frontline staff.	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%
	Reduction in Antibiotic Consumption	Following on from 2016-17 the aim is a further 1% reduction in the use of antibiotics across the Trust.	Notification expected July/August 2018
	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%
	E Referrals	To support the move away from paper based referrals providers are to publish via the E-Referral Service, for all appointments by GP referrals into Consultant led clinics by 31 March 2018	60%
	Supporting Proactive & Safe Discharge	This CQUIN builds upon the 2016/17 A&E Plan streamline discharge pathways, embed and strengthen the discharge to assess pathway, and to understand capacity within community services to support improved discharge.	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%

	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%
NHSE Public Health	Secondary Dental	This required an audit of oral surgery procedures to ensure that activity undertaken in an appropriate hospital setting.	100%
	Bowel Cancer and Bowel Scope Screening	Improve access and uptake through patient and public engagement.	100%
Specialised Services	Haemophilia Haemtrack Patient Home Reporting	The Haemtrack system, an electronic patient-reported record of self-managed episodes and usage of blood factor products, has been demonstrated to be effective in maintaining treatment compliance, optimising home therapy and home stock control. There is high variation in the adoption of the system, and in the timeliness and accuracy of its use. The CQUIN is aimed at improving adherence, timeliness, and accuracy of patient data submissions to the system.	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%
	Medicines Optimisation	This CQUIN has been designed to support Trusts and commissioners to realise this benefit 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%
	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 workstreams 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%
	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%

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 also monitored via the Finance and Performance Committee.

Each of the Service Leads is required to submit a quarterly report via the Contracts Team providing relevant data and any additional evidence which provides assurance that the goals outlined within the CQUIN have been achieved.

These reports are collated and submitted to each of the three Commissioning bodies. 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 2018/19

PRIORITIES

for Improvement

Workforce

Patient Safety

Patient Experience

Priority 1 – Workforce

Nationally there remains a shortage of nurses and applications to nurse training have started to decrease. With the withdrawal of bursary from September 2017 the Trust continues to work in partnership with Higher Educational Establishments to recruit the right students with the right attitude, retain students on the training programme by providing high quality placements, employ students upon completion of the course, demonstrating commitment to 'home grown' and invest and offer educational opportunities and career progression to retain the skills within the Trust to provide safe and effective care to patients. However as at the end of March 2018 there has been a 20% decrease in applications.

Supplying a workforce which is capable of meeting the changing needs of the population is one of the NHS's biggest challenges. Investing in skills training and nurturing talent is central to supporting the growth of the economy. Apprenticeships at all levels can help to form part of an effective workforce supply, supporting the development of a pipeline of talent.

Our intention is to utilise the apprenticeship programme as a core nursing recruitment initiative to support our pipeline, as these will provide career pathways for development, add diversity to our workforce, which reflects the communities we serve and provide a further entry route into a challenged nursing profession. In line with the national agenda to increase Nursing Associates the trust has already commenced our first cohort of Apprentice Nursing associate in March 2018.

Clinical supervision is a valuable learning tool for staff. The process enable's staff to reflect up on practice and promotes a 'resilience approach' to their practice.

Exploring opportunities for new role development, enhancement service delivery and engagement through pre and post registration education/ development to meet the changing needs of our diverse population.

As part of the Trust's Nurse Recruitment and Retention Strategy (2016-2020) the following workstreams are in progress:

Enabling staff:

- The Trust's Education and Training Strategy is due for its tri-anneal review will be undertaken.
- The Trust will continue to explore and develop new roles and opportunities for existing staff.

Attract staff

- A communications plan is currently being developed to support the Trust's recruitment agenda.
- A recruitment event calendar has been developed to ensure attendance at both local and national events.
- Promotion of innovative practices and service development at a range of national conferences aimed at raising the profile of nursing at the Trust.

Retain

- The Nurse Education Strategy is currently being reviewed to ensure an effective range of educational and development opportunities for staff are available.
- A greater analysis of exit data is required to inform workforce development and areas for improvement and retention.
- A commitment to review and expand the range of employee benefits.

Priority 2 – Safer Care

The Trust will continue to identify learning from incidents following robust investigation processes and disseminate this learning through tried and tested measures throughout the organisation.

The mortality review group will look to develop processes to ensure that structured judgement reviews are carried out for deaths within the organisation as part of its mortality review process and publish this data in line with national guidance recently issued.

Falls

Work of the National Falls collaborative will continue to be embedded across the Trust, with continued engagement in the National Falls prevention network to share and learn. Bespoke elements of work will see:

- Revision of Medical assessment documentation in the admitting areas to reflect best practice and avoid unnecessary duplication
- Continued collaboration with the CCG regards the falls specification for community care
- Re-audit of the elements from the National Falls audit where noncompliance was found
- Further Development of the frailty pathways
- Relaunch of the upgraded reminiscence therapy software
- Review of the current accountability meetings where all falls with harm will be scrutinised.

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.

A detailed annual programme of work has been developed, which includes the specific projects below:

- A strategy for reduction in gram negative bacteraemia (in particular E.coli) through a range of measures.
- Robust prevention and management of MRSA, MSSA and Carbapenemase Producing Enterbacteriaceae.
- Continued focus on the environment and sustaining improvements made during 2017/18
- Influenza preparedness and prevention for patients and staff.
- Development of the Surgical Site Infection Surveillance Team to include assurance of adherence to NICE guidance
- Strengthened education delivery to include forging links with the University of Wolverhampton
- Increased awareness of antimicrobial resistance through delivery of an Antimicrobial Stewardship Programme.
- Further reduction in device related bacteraemia both in the Acute and Community settings
- A strategy for reducing the use of urinary catheters
- Health and social care systems will work jointly to identify and reduce the risk of spread of tuberculosis

Venous Thromboembolism (VTE)

Having reflected on the recommendations of the external auditors report for 2016/17 and having consulted with UNIFY (DOH), we have worked with information services to fully review our reporting processes to enable full audit trail back to source data. Monthly sample audits have been undertaken to check the accuracy of the electronic record back to the patient record. The new data extraction process will be implemented from April 2018 which will see a move to only reporting those risk assessments completed on admission (within 24 hours). This will ensure all risk assessments have been completed in a timely manner in line with trust policy and UNIFY. Full Implementation of an electronic system within Maternity services (expected completion of roll-out by end of 2nd quarter of 2018/19) will enhance these processes further.

Pressure Injuries

In the coming year, the Tissue Viability team plan to:

- Continue to work on the pressure injury collaborative, to reduce the incidence of pressure injuries
- A pressure ulcer consensus report is expected from NHS improvements, the Trust will analyse the recommendations and modify any processes if they need to be changed.

- Launch a new wound formulary
- Develop a post operation wound pathway
- Communicate education via social media
- Work collaboratively with the CCG to design a wound care centre of excellence
- Continue to support staff with education and training to prevent and heal wounds.
- Review the tissue Viability Strategy and plan the next steps.
- Plan a wound prevention conference.

Sign up to Safety (SU2S)

The work of the SU2S project will continue in 2018/19 with the aim of refining the programme from evaluation feedback and observing measures and KPIs for initial change. The project will compliment work that falls from the Trust People and OD Strategy and related work streams.

A formal evaluation of the Team Optimisation Model (TOM) will commence in 2018/19 to assess the individual and team experience, impact, sustainability etc. along with learning that can be applied Trust wide.

Further plans for 2018/19 are to:

- Complete roll out of TOM to priority areas
- Conduct further evaluation(s) of PCM and the impact on staff personally and professionally
- Continue sharing written quotes/staff testimonials amongst staff
- Develop the E- learning package to encourage better uptake and interest in PCM by medical staff
- Develop SU2S/PCM video testimonials to share some the benefits of attending PCM
- Share the benefits and impact of PCM training and TOM programme as a human factors/ culture transformation tool
- Consider new routes to celebrate success and share learning

Medication Errors

The Trust will continue to monitor medication incidents and share learning. The electronic Prescribing and Medicines Administration (ePMA) system being implemented in 2018/19 will help us in reducing errors, as well as provide more detailed information on what errors are being made by who and when.

It will also improve the recording of allergy status to prevent harm. The further rollout of automated ward storage will help in the reduction of missed doses. Development of a Medicines Management link nurse role for wards and departments will support the effective and safe administration of medicines.

Sepsis

All healthcare professionals at The Royal Wolverhampton NHS Trust have a responsibility and are accountable for ensuring patients with sepsis receive high quality and timely care.

Our aim is to reduce harm or death from sepsis through:

1. **Implement actions to meet nationally recognised standards and recommendations.**
   There has been standardisation of screening tools across the organisation for maternity, paediatrics and adults. These have replaced local sepsis screening tools. We are aware that UK Sepsis Trust and NICE are jointly working to produce a new screening tool for sepsis, based on NEWS 2 published by the Royal College of Physicians (RCP) in 2017. Moving forward we will be implementing actions to continue to meet nationally recognised standards and recommendations.
2. **Implement intelligence gathering to examine performance and outcomes**
   We will be working with the Emergency Department (ED) as the main admission portal to develop robust process of screening and management of sepsis. An alert for sepsis has been put in place in ED triage to enable earlier identification of septic patients. We will be closely monitoring compliance with a quarterly sepsis screening audit in ED, trust-wide Early Warning Score, Sepsis screening and management, and antimicrobial prescribing audits.
3. **Develop further actions to deliver targeted improvement in sepsis management.**
   With sepsis, Early Warning Score and antimicrobial audits information we are capturing data for wards across the hospital. Using this intelligence data we are able to identify areas that need targeted improvement at a trust-wide and local level.
4. **Establish technological solutions to improve data gathering and real time reporting**
   We intend to use technology to improve the screening and reporting of sepsis. There are plans to implement sepsis screening tools as part of the electronic observation system, and to explore the use of the newly implemented electronic prescribing system to capture antimicrobial prescribing. We believe with these technological tools we would be able to establish robust solutions to improve data gathering and real time reporting.
5. **Implement a structured system to ensure an ongoing programme of education and training.**
   To increase awareness and recognition of sepsis by healthcare professionals and public, there are plans in place to strengthen the ongoing programme of education and training. Sepsis study days run by the education team over the calendar year are attended by nursing staff. It has been acknowledged that further training in addition to IP level 2 is necessary in portals of admission and higher risk areas with directorates mandating this training.
   The education team will provide information concerning attendance and completion of Infection prevention level 2 training, Sepsis e-learning and Sepsis study day to provide assurance of training.

Priority 3 – Patient Experience

1. Strengthening relationships with patient communities including Increased Patient and User Engagement.

Whilst the Trust has made some significant improvements with increasing patient and user engagement, in particular the creation of a Council of Members, ensuring that the voice of the patient is embedded throughout the organisation at a strategic level, the Trust aim to build on key relationships with the community and empower patients from every background to embrace and engage in the process.

Our aim during 2018/19 is to increase public and patient engagement, in particular to:

- Have a patient voice heard at Trust Policy Group for every policy change ensuring that the patient is always at the centre of service change.
- To undertake public consultations on key issues before service delivery change. The Trust are keen to involve local people in decisions which will determine how healthcare is provided.
- Increase membership of the Council of Members ensuring that members reflect the diverse population of the patients we serve.
- To undertake a series of engagement sessions to community groups specifically to gain views of patients accessing services for protected characteristic groups.
- Continue to implement a broad range of initiatives to encourage patient involvement and utilising various methods and platforms to ensure inclusivity.

2. To review and enhance the use of volunteers to aid a positive patient experience

This will include:

- To undertake a comprehensive audit of the volunteer base.
- Working with stakeholders, community groups and education facilities to promote the benefits of volunteering to a younger audience.
- Devise an audit tool in order to measure the effectiveness of volunteers in correlation to a positive patient experience.
- Explore different software packages to assist in the administration of recording of volunteer base

3. To be amongst the highest performing Trust's regionally and nationally in relation to the Friends and Family Test.

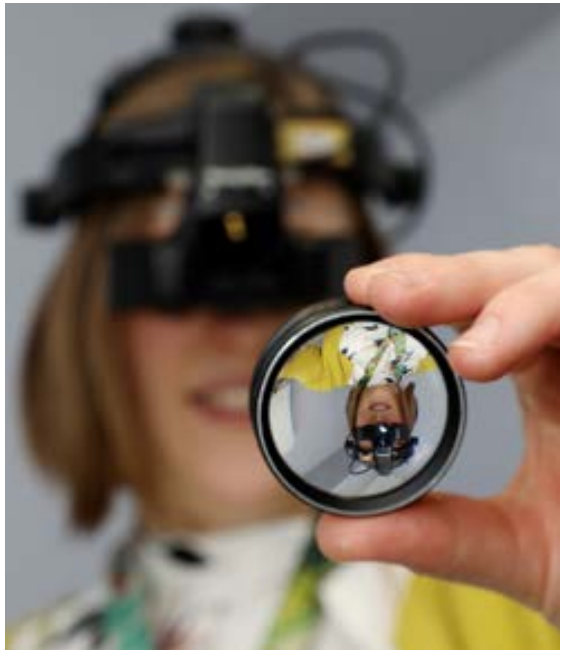
This will include:

- Benchmarking ourselves against our peers with aim to show continual improvements and narrowing the gap
- Robust systems in place to evidence actions and improvements for lower performing areas
- The recruitment of a data analyst to undertake more detailed analysis of the FFT metrics at divisional level

Vertical Integration

The objectives going forward are very much to build on what has been achieved so far and improve patient experience and outcomes further. To support this, the following objectives are planned within the next year:

- Collaborative working with Public health to understand our patient population and working together to improve the areas such as Obesity, teenage pregnancy, smoking status and general health inequalities in which Wolverhampton are an outlier when compared to national figures. Key to these improvements will be data analysis of primary, secondary and community care data to monitor performance and implement strategies to help improve these areas.
- Joint working with the National Gold Standards Framework Team by utilising data analytics to not only identify end of life patients earlier but also to implement policy and procedures for best practice when treating end of life patients.
- The Trust wants to work closer with patients to hear their views and learn from their experiences.
- Patients are encouraged to actively participate in Patient Participation Groups (PPG) meetings held at the Trust to share their ideas and experiences – this is for all VI practices. We have had excellent feedback from patients – both positive and constructive. This helps us greatly in identifying early indications of areas which may require change – an example being that patients have stated that there needs to be better education for patients about when to use the Emergency Department and when not to.
- Active Signposting: Up skilling first point of contact staff whether face to face or on the phone, raising awareness of services available for signposting and the use of social prescribers for practices to help with social needs.
- New Consultation types: Standardisation of appointments (face to face, home visits and telephone) across practices, implementation of 20 minute appointment slots for high risk / complex cases. Use of software to support online use, reduction of DNAs and improvement in clinics such as Flu uptake.
- Develop the team: Introduction of physician associates, clinical pharmacists, expanding social prescribing presence in all practices. Also the development of HCAs and increasing the use and consistency of MDT meetings
- Partnership working: Implement new innovative ways of working across primary, community and secondary care
- Self-care: To develop self-help videos, applications and utilise the practice / RWT website.
- Productive workflows: centralised call and recall systems for long term conditions and clinical pharmacists to deal with repeat prescription issues
- Personal productivity: Pooled resource where necessary and support from central team of managers and administrative duties to be taken away from clinicians freeing up capacity.
- Improving access and Working at scale: Implementation of extended access in the form of bank holiday and regular weekend access across VI practices and working collaboratively across the healthcare to realise the 7 day access objective.



Statements of Assurance

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

Overall 39 services are provided and/or subcontracted by the Trust. There are a significant number of sub specialties and contracts in place which deliver these overarching services.

The Royal Wolverhampton NHS Trust has reviewed all the data available to them on the quality of care from all 39 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 85% of the total income generated from the provision of relevant health services by The Royal Wolverhampton NHS Trust for 2017/18.

The Trust has reviewed the data against the dimensions of quality, 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.

Participation in Clinical Audits

During 2017/18 there were 57 applicable national audit projects and 2 national confidential enquiries covering relevant health services that The Royal Wolverhampton NHS Trust provides.

During 2017/18 The Royal Wolverhampton NHS Trust participated in 88% (50) of these national clinical audit projects and 100% (2) of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Royal Wolverhampton NHS Trust were eligible to participate in, and for which data collection was completed during 2017/18 are shown in the tables below.

The Trust has submitted 100% of the required number of cases for all national audit projects. Please note that some audits do not have a set number of required cases and instead criteria must be met in order for a case to be audited and therefore submitted to the audit project.

The National Confidential Enquiries that The Royal Wolverhampton NHS Trust participated in during 2017/18 are as follows:

National Confidential Enquiries	Participated
Young People's Mental Health (3518)	Yes – In Progress
Perioperative diabetes (3610)	Yes – Awaiting Report

The 7 national clinical audits that The Royal Wolverhampton NHS Trust **did not** participate in during 2017/18 are as follows, including rationale as to why the Trust did not participate:

National Clinical Audit & Enquiry Project name	Work stream	Directorate	Rationale
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	N/A	Gynaecology	Not participating - the Gynaecologists will have to subscribe to BAUS and the fees are high.
Congenital Heart Disease (CHD)	Adult	Cardiology	No longer participating in this audit as RWT were only submitting data for PFO closures, which has now been stopped.
National Audit of Intermediate Care (NAIC)		Care of the Elderly	Wolverhampton CCG are not participating in this audit and so the Trust cannot participate. Both parties must be registered in order to take part.
National Cardiac Arrest Audit (NCAA)	N/A	Resuscitation Team	The data captured by this audit would be of extremely limited value to the Trust. Assurance found via local audit.
National Ophthalmology Audit	Adult Cataract surgery	Ophthalmology	Medisoft software to be available by July 2018 with subsequent 6 month bedding in period (for staff to be familiarised with the system). Participation in this audit will continue during 2019/20.
National Vascular Registry	N/A	General Surgery	Audit relates to major vascular interventions which do not take place at any of the Royal Wolverhampton NHS Trust sites.
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)	N/A	Neurology	Due to the audit lead leaving the trust, the Neurology team missed their registration deadline. Audit provider has confirmed that no new trusts can be added onto this audit. In the previous audit the department scored well in most domains and the service provided was rated as good. The teams involved will use this time to further improve Parkinson's Care locally through national audit recommendations.

The national clinical audits that The Royal Wolverhampton NHS Trust did participate in during 2017/18 are shown in Appendix 1.

The national clinical audits that The Royal Wolverhampton NHS Trust continues to participate in since 2017/18 (remain in progress) are shown in Appendix 2.

The reports of 7 completed National clinical audits projects that were reviewed by the provider in 2017/18 are shown in Appendix 3 with the action the Trust intends to take to improve the quality of healthcare provided:

Clinical Audit Activity

In total 435 clinical audits were conducted across the Trust, 80% of which were completed by the end of the financial year. The adjusted completion rate for 2017/18 (excluding national audits) was 91%.

Clinical Audit Outcomes

The reports of 347 clinical audits (completed to date) were reviewed by the provider and a compliance rating against the standards audited agreed.

51 (15%) 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 re-audit against these standards in 2018/19. Details of these actions are shown at Appendix 4.

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 RWT 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.

The Trusts 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, has continued to be developed during the year.

The Trust is measured against a range of national performance indicators covering recruitment into studies, increasing access to commercially sponsored research and reducing the time to set-up studies. The Trust has worked hard to improve its performance in these key areas, whilst ensuring that the high quality of care experienced by research patients is maintained.

The number of patients receiving health services provided or sub-contracted by The Royal Wolverhampton NHS Trust in 2017/18 recruited to participate in research approved by a research ethics committee was in excess of 2,300. Over 200 studies have been active during the past year. The majority of these patients (96%) were recruited into studies adopted onto the National Institute of Health Research (NIHR) Clinical Research Network (CRN) Portfolio. This exceeds the Trust target of 2000 recruits set at the beginning of the year and 75% of the stretch target set by the CRN West Midlands.

There were 19 new NIHR adopted industry-sponsored clinical research studies opened at RWT during 2017/18.

The Trusts research teams have this year received national recognition for their recruitment into studies within a number of clinical areas including Cardiology, Rheumatology, Diabetes and Antenatal. In addition, the Trust received a CRN WM award in October 17 for the best performing Trust in recruiting patients to time and target for commercial studies.

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

Our most recent patient experience questionnaire, completed by 195 participants of research during 2017/18, showed that 96% of them felt research is important to improve healthcare services.

The following levels of satisfaction were reported:

Statements from the Care Quality Commission

The Royal Wolverhampton NHS Trust is required to register with the Care Quality Commission and its current registration status is registered with no conditions.

The Care Quality Commission has not taken enforcement action against The Royal Wolverhampton NHS Trust during 2017/18.

The Royal Wolverhampton NHS Trust has participated in an unannounced inspection of some of it's core services, announced 'use of resources' and a well led review as part of the CQC inspection process during Q4 2017/18. The Trust's detailed report was published on 27th June 2018 providing an overall outcome grade of 'good'. This has been an improvement on the previous 2015 inspection outcome of 'requires improvement'. The Trust is currently developing an action plan which will look to capitalise on the 'good' and 'outstanding' practices identified to ensure consistency and address some of the findings where performance fell short of what we would expect.

The Trust has had two inspections by the Health and Safety Executive, 1 in Pathology which was a planned inspection of which no contraventions were received, and 1 for a RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reportable incident with no contravention notice issued.

Ratings	
Overall rating for this trust	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

1 The Royal Wolverhampton NHS Trust Inspection report 27/06/2018

Information taken from CQC website - 28.06.18

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

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

- Conducts regular audit cycles
- Performs monthly Completeness and Validity checks across inpatient, outpatient, ED and waiting list data sets
- Monitor activity variances
- Use external/internal data quality reports
- Use standardised and itemised data quality processes in SUS data submissions monthly
- Hold bi-monthly meetings with a set agenda to discuss data quality items
- Hold bi-monthly Trust Data Quality Meetings to manage / review practices and standards

NHS Number and General Medical Practice Code Validity

Clinical Coding Error Rate

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

Clinical Coding Audits were conducted and conformed to Information Governance Standards Level 3. The area Audited for this was Admitted Patient Care for All Specialties.

The error rates reported in the latest audit for that period are detailed below and were based on a small sample of 200 Finished Consultant Episodes.

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

Primary Diagnoses Incorrect 3%

Primary Procedures Incorrect 3%

The overall Healthcare Resource Group error rate for the audit was 6.2% of the total number of episodes, which is a change of 3.1% absolute and 2.5% net.

All recommendations following the audit have been completed.

NHS Number and General Medical Practice Code Validity Updated as per Month 12 2017/18.

The Royal Wolverhampton NHS Trust submitted records during 2017/18 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 shows an improvement in every area against the 2017/18 submission, which included the patient's valid NHS number:

99.8% for admitted patient care;

99.9% for outpatient care; and

98.8% for accident and emergency care.

Which included the patient's valid General Practitioner Registration Code was:

100% for admitted patient care;

100% for outpatient care; and

100% for accident and ED

Information Governance Toolkit

Information Governance Toolkit Return 2017/ 2018

The annual self-assessment submission (V14.1) on the Information Governance Toolkit to the Department of Health for 2017/18, the overall scores are as follows:

- The Royal Wolverhampton NHS Trust — RL4 - 77% Satisfactory (45 requirements)
- Alfred Squire — M92002 - 89% Satisfactory (13 Requirements)
- MGS medical practice — M92654 - 71% Satisfactory (13 Requirements)
- Lea Road — M92007 - 66% Satisfactory (13 Requirements)
- West Park — M92042 - 66% Satisfactory (13 Requirements)
- Warstones — M92044 - 76% Satisfactory (13 Requirements)
- Ettingshall MC — Y02735 - 100% Satisfactory (13 Requirements)
- Thornley Street — M92028 - 82% Satisfactory (13 Requirements)
- Penn Manor — M92011 - 97% Satisfactory (13 Requirements)

Looking forward to 2017/18 for Information Governance and General Data Protection Regulation 2018

The Trust continues to monitor patterns and trends of Information Governance incidents, implementing measures to reduce these, where practically possible. The Trust's information governance strategy is currently being reviewed in light of revised general data protection regulation issued in 2016 which is currently awaiting statutory ratification.

In order to support a revised information governance strategy, a programme of work is currently underway to ensure compliance with the new General Data protection regulation 2016 (GDPR), in readiness for May 2018 when the regulation comes into force. The Trust is also working closely with GP Partnerships that have joined the organisation to align practices and share good practice.

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 2017/18;

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

The Royal Wolverhampton NHS Trust (RWT) has a robust, established mortality governance system and is continuously striving to improve processes to help minimise avoidable in-hospital mortality. The Trust promotes an open culture of facilitating learning from care provided to patients who die whilst in the hospital or shortly after discharge.

The Trust uses a variety of mortality monitoring measures such as unadjusted mortality rates, standardised mortality rates (Summary Hospital Level Mortality Indicator – SHMI*) and qualitative information from deceased patient case note reviews to inform the mortality review processes. The Trust has implemented a revised Learning from Deaths policy in 2017, aligned with the National Guidance on Learning from Deaths released at the beginning of the year.

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

The SHMI for RWT has increased and was published as higher than expected from April 2016 - March 2017; the values are presented in the table below.

	Reporting Period	
Indicator	April 2016 – March 2017	July 2016 - June 2017
SHMI RWT	1.15 (higher than expected)	1.16 (higher than expected)
SHMI England	1	1

SHMI data source NHS Digital.

**The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.*

***This is an indicator designed to accompany the SHMI. The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between trusts in the way that palliative care codes are used. Using the same spell level data as the SHMI, this indicator presents crude percentage rates of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level.*

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

Action was taken throughout 2017 to investigate the potential causes of the increased SHMI and to provide assurance that the care deceased patients received was appropriate.

It is well known that the mortality statistics are very sensitive to data quality and variation in data between acute Trusts in England. The Royal Wolverhampton Trust commissioned a number of audits of which concluded that the higher than expected SHMI was due to a data collation issue, more specifically due to variation in data and practice across England, there was no evidence of an actual higher mortality at this Trust. The statistically calculated expected mortality rate was lower from the second half of 2015-16, which resulted in a higher SHMI. Some of the changes in data can be explained by the introduction of a new admissions model following the opening of the new Emergency Department (ED). Whilst the number of deaths has not changed significantly, the revised model aimed at admission avoidance in ED has meant that significantly fewer admissions of certain patient categories have been

observed. At the same time, in England, admissions for the same patient diagnoses has also increased leading to a lower expected mortality rate. Whilst we cannot influence the variation in data across England, we have identified areas where we can potentially improve our data, which could lead to a correction in our expected mortality; actions are implemented to address these.

In addition to the internal case note reviews the Trust commissioned two external independent clinical audits to seek further assurance in relation to the quality of care provided to deceased patients and identify aspects of care which could be improved. The conclusions of these audits correlated well with findings from internal audits. The findings were generally positive and no systemic failures in care provided to deceased patients were identified. Opportunities for improvement were identified; some of those had already been addressed with changes implemented. Further actions were agreed to drive change and support learning.

Core Quality Indicators – Summary of Patient Death with Palliative Care

The data made to the Trust by the information centre with regard to the percentage of patient deaths with palliative care coded 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:

This contextual indicator shows the percentage of discharges and deaths reported in the SHMI dataset, where the patients received specialist palliative care as identified by the clinical coding. The Trust had seen a decline in the overall palliative care coding rate when compared to the national rate following the introduction of the new end of life care pathway. The variation could be explained by different recording and coding practices for specialist palliative care employed across England. During 2017 action was taken to improve the documentation and coding of the specialist palliative care to ensure this activity is more accurately reflected in the clinical coding.

	Reporting Period	
Indicator	April 2016 – March 2017	July 2016 - June 2017
Percentage of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level – RWT**	22.2	22.8
Percentage of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level – England**	30.7	31.1

Data Source NHS Digital2018

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 by:

- The Trust will continue to monitor the accuracy of palliative care coding by cross referencing with the Somerset database
- The palliative care directorate are currently reviewing the skill mix in line with the levels of activity within the service
- The Trust have sighted it's interest in joining a national collaborative looking at end of life care
- The Trust will continue with its commitment to achieving gold standards framework aims

Core Quality Indicators – Learning from Deaths

The Trust has adopted a revised Learning from Deaths policy incorporating the national guidance released in 2017. The new policy sets out the following principles for adult deaths:

a) All deaths will continue to have an initial consultant led mortality review (peer review within directorate) called stage 1 review

b) The evidence-based methodology developed by the Royal College of Physicians for reviewing deaths, the Structured Judgement Review (SJR), was adopted by the Trust and implemented since June 2017 as a pilot in 9 specialties, and across the Trust since August 2017.

c) A stage 2 review will be implemented for cases meeting a list of criteria which were determined in the policy, taking into account the national guidance. This will be a review undertaken independently by a medic and a non-medic (peer review across the division) with involvement from multidisciplinary professionals as appropriate.

The Mortality Review Group (MRG), a largely clinical group is monitoring the compliance with the new process across specialties. The work of this group is scrutinised by an executive Mortality Assurance Group and the Trust Board.

The organisation has made the decision to publish the avoidable mortality identified through agreed methodology on a quarterly basis in the Quality and Performance report presented to the Trust Board. These data are in the public domain.

Consideration is being given to the early implementation of the Medical Examiner role. It is likely that if this model is adopted the process for undertaking stage one reviews will change. It is envisaged that this model will allow specialties to undertake more in depth reviews therefore facilitating better learning opportunities.

During 2017-18 (April to March) 2077* of RWT's patients died in hospital. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

Q1	464
Q2	420
Q3	562
Q4	631
Total	2077

*all deaths including still births

As of 23 May 2018, 1415 cases of adult deaths have been subjected to a case record review and had the data entered on the central repository; the quarterly figures are as follows:

Q1	375
Q2	311
Q3	396
Q4	333

(These figures refer to reviews entered on the SharePoint repository both using the old method and the SJR method)

Avoidable Deaths

Q1 & Q2 2017/18

Four potentially avoidable deaths were noted, all of which were investigated using a root cause analysis. For all cases reviewed Likert scale recommended by *Hogan et al was used. Of the 4 cases:

1 was due to omission of venous thrombo-prophylaxis treatment.

2 were due to delays in treatment.

1 was due to misdiagnosis.

Q3 & Q4 2017/18

Four potentially avoidable deaths were noted, all of which were investigated using a root cause analysis.

Of the 4 cases:

1 was procedure related (haemothorax)

1 intra-operative complication

1 failure to diagnose Myocardial Infarction

1 intrauterine death

**BMJ 2015; 351 doi: https://doi.org/10.1136/bmj.h3239[accessed online 19/6/18]*

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

The data made 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 four surgical interventions using pre and post-operative survey questionnaires:

- Groin Hernia surgery
- Varicose vein surgery
- Hip replacement surgery
- Knee replacement surgery

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

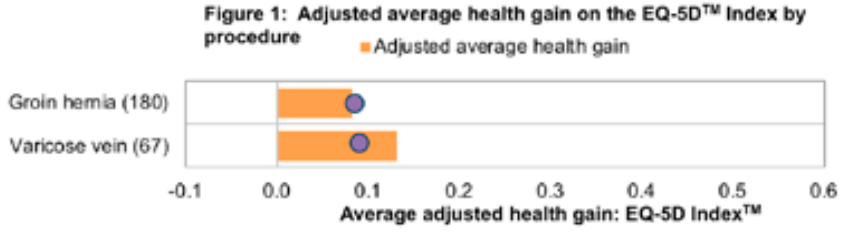


Fig 1 Data Source NHS Digital 2018

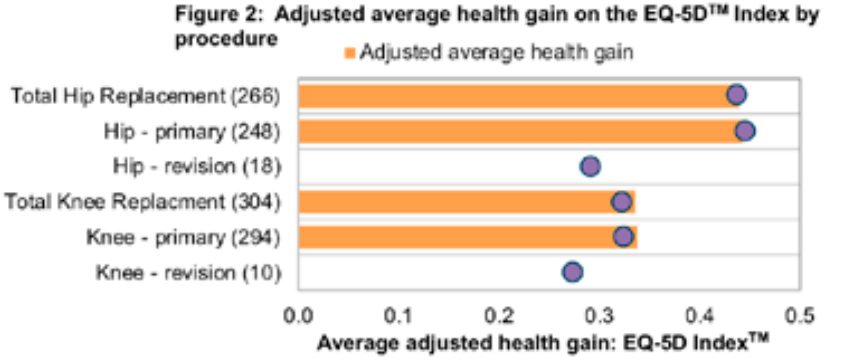


Fig 2 Data Source NHS Digital 2018 Provisional Data

	Varicose Veins		Groin Hernia	
Post-Surgery	RWT Outcomes	National Outcomes	RWT Outcomes	National Outcomes
Patients reporting improvement	79%	55%	52%	53%
Patient reporting no change	12%	30%	36%	29%
Patient reporting worse symptoms	8%	15%	12%	18%

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

Data relating to groin hernia and varicose veins represents the period April to September 2017. With effect from October 2017, the NHS contract no longer requires PROMs collection for groin hernia or varicose vein surgery; this is potentially due to the limited clinical value of these procedures. The only mandated collections that will continue are for hip and knee surgery.

PROMS data is shared via the directorate governance meetings, data indicates that performance is in line with national average for three of the four procedures, varicose veins has exceeded health gains compared to the national average. Upon comparison with previous year's figures there has been an improvement in all of the PROM outcomes for expected health gain. The Trust do not perform revisions for hips or knees therefore there is no Trust data included.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 by:

PROMS data will continue to be reviewed via the relevant directorate governance meetings. With the following actions identified:

- Education for patients continues to be provided pre operatively and the PROMS questionnaire explained and provided to patients at preoperative appointments.
- The Trust will continue to audit consent compliance as part of its ongoing audit programme, any issues identified will be discussed via local governance meetings and with individual clinicians as required

Core Quality Indicators - Readmission Rates

The data made available to the Trust from its internal PAS system with regard to Re-admission Rates

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

Readmissions				**Grand Total**
Age	**2015/16**	**2016/17**	**2017/18**	
Aged 4-15	440	505	423	**1368**
16yrs and over	5966	5443	5165	**16574**
Grand Total	6406	5948	5588	**17942**

Total Admissions				**Grand Total**
Age	**2015/16**	**2016/17**	**2017/18**	
Aged 4-15	5288	5429	5117	**15834**
16yrs and over	115288	118585	117355	**351228**
Grand Total	120576	124014	122472	**367062**

Percentage Readmissions				**Grand Total**
Age	**2015/16**	**2016/17**	**2017/18**	
Aged 4-15	8%	9%	8%	**8%**
16yrs and over	5%	5%	4%	**5%**
Grand Total	5%	5%	5%	**5%**

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

HSCIC (NHS Digital) no longer publish readmission data and therefore the Trust's internal data has been used, however this does not provide opportunities to allow benchmarking.

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

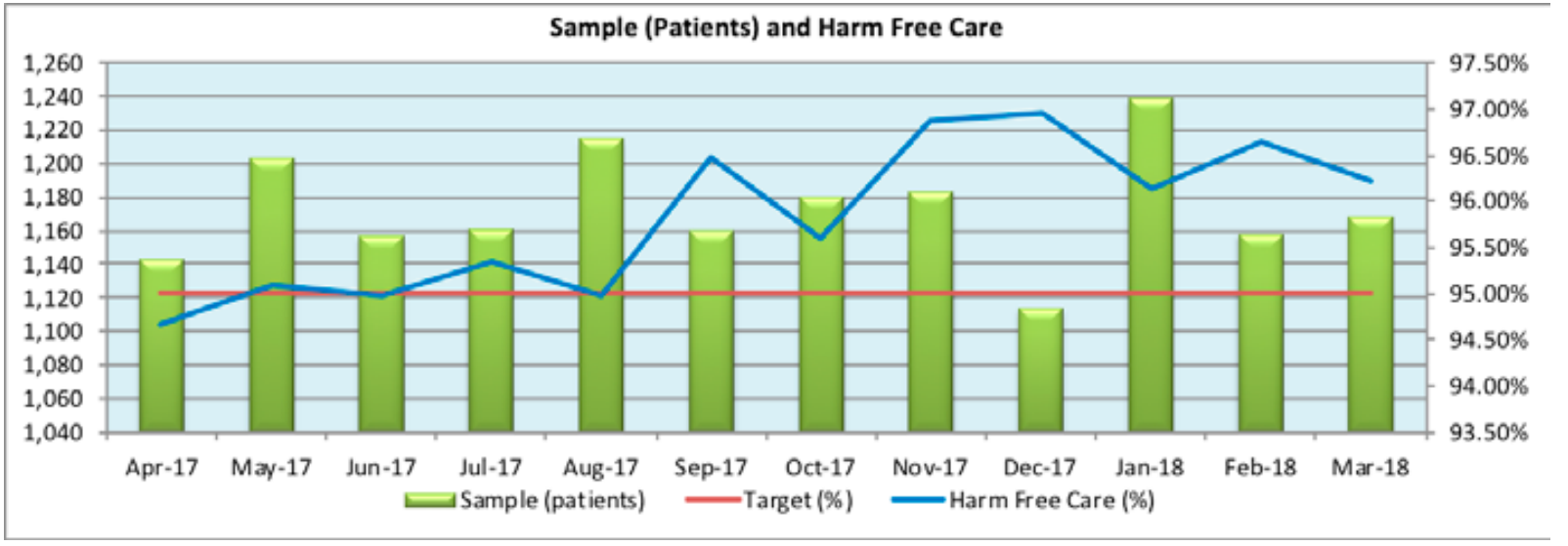
The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so he quality of its services in 2018/19 by:

- Adherence to the Red to Green day protocols regards discharge
- Improved information regards discharge
- Working with local residential and nursing homes regards transfer of patients back to their care
- Discharge planning at pre-operative assessment
- Discharge planning at the point of admission

All of the above is aimed at comprehensive discharge planning at the point of admission involving patients, families and/or carers to ensure a collaborative approach and that the patient remains at the centre of decision making.

Core Quality Indicators - Safety Thermometer

The data made available 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 Trust to analyse and triangulate performance.
- Data for each of the 4 harms is triangulated with that of internal incidence data reported via the Trust's datix system.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 by:

- The Senior Nursing Team will continue to promote the awareness of the prevalence of harm and associated learning in the Trust.
- Pressure injuries and falls are scrutinised using an accountability model, whereby root cause analyses are reviewed together with our commissioners for those with serious harm, this thereby ensures root causes are evidenced and lessons learnt explicit for communicating in to the Trust.
- Training regarding specific developments and learning for the 4 individual harms will be delivered through a range of forums and methods to ensure current evidence is used in practice
- The Trust will continue to work with its stakeholders to ensure that a city wide approach is taken.

(The NHS Safety Thermometer "Classic" allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism This is a point of care survey that is carried out on 100% of patient on one day each month.)

Core Quality Indicators - VTE Prevention

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

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
RWT	95.54%	95.29%	96.73%	96.60%	95.59%	95.37%	95.72%	95.87%
National Average	95.73%	95.51%	95.57%	95.53%	95.11%	95.25%	95.36%	95.21%
Trust with highest score	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Trust with lowest score	80.61%	72.14%	76.48%	63.02%	51.38%	71.88%	76.08%	73.15%

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); and
- The denominator is the number of adult inpatients (including surgical, acute medical illness, trauma, long term rehabilitation and day case etc).

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 by:

The VTE leads have the support of the Executive team to assist in promoting the importance of undertaking VTE assessments across the organization. The Trust is consistently meeting national targets and exceeding previous figures.

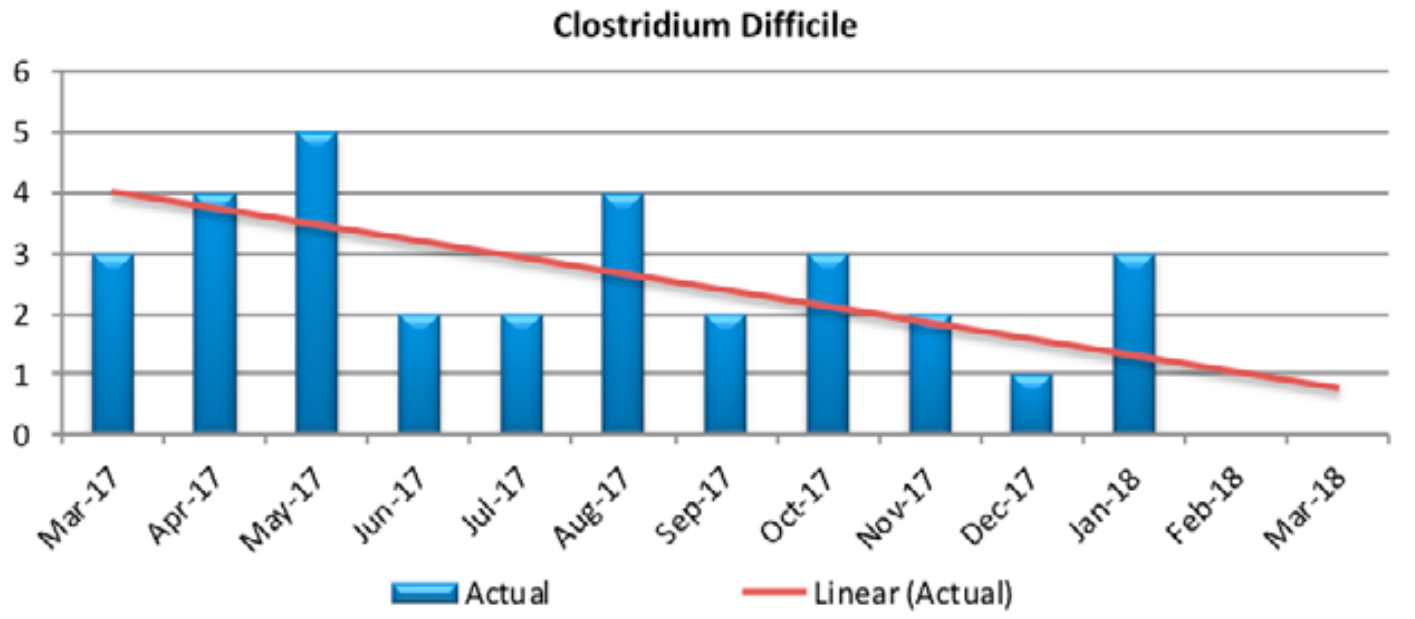
Multiple measures have been put in place to increase awareness of VTE prevention and management amongst all healthcare staff and some of the measures include:

- The new data extraction process will be implemented from April 2018 which will see a move to only reporting those risk assessments completed on admission (within 24 hours)
- Trust-wide audits for a minimum of twice a year are now in place in addition to the focused rolling monthly audits both of which serve to inform and assure the Trust regarding not only completion of VTE assessments but the actual care provided at individual patient level with respect to VTE management.
- Rolling RCA process to identify errors and disseminate the learning derived to the Trust.

The Royal Wolverhampton NHS Trust intends to continue its efforts to become a VTE exemplar site and to maintain its percentage as close to 100% and seek on-going assurance not only regarding completed VTE assessments but also appropriate prescribing and use of VTE prevention measures and to reduce patient harm. Measures are currently underway to improve clinical pathways and guidance and tighten up on other aspects of VTE prevention and anti-coagulation including the use of newer oral anti-coagulants.

Core Quality Indicators - Clostridium difficile

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



Data sources: Trust's internal reporting systems

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Totals
The Royal Wolverhampton Trust	4	5	2	2	4	2	3	2	1	3	0	0	28

	2014/15	2015/16	2016/17	2017/18
RWT	17.5	25.0	15.5	9.6
National Average	14.7	15.0	13.1	13.3
Trust with highest score	62.6	64.1	77.8	87.9
Trust with lowest score	0.00	0.00	0.00	0.00

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, to include:

- NHS 'Safety Thermometer'
- Nursing quality metrics
- Laboratory data
- Domestic monitoring
- Mortality information
- National HCAI data capture system Monitoring
- Trust Infection Prevention and Control Group
- Environment Group
- Health and Safety Steering Group
- Clinical Quality Review Meetings
- Contract Monitoring Meetings

The Infection Prevention Team feed data, assurance and risks into various reporting structures, to include but is not limited to; Patient Safety Improvement Group, Quality Standards Action Group, Environment Group, Health and Safety Steering Group, Decontamination Committee, Trust Management Committee and Trust Board.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

The challenge of acute and community incidence of Clostridium difficile meant that new approaches were required in order to improve patient safety. These included:

- Novel treatment therapies; Fidaxomicin, a new antibiotic choice for Clostridium difficile
- Human Probiotic Infusion (HPI) has been used more frequently during the year. These have been incorporated into the treatment algorithm which ensures they are used more often with recurrent disease for improved outcomes.
- Environmental controls have been a top priority in our approach in tackling Clostridium difficile; the deep clean schedule has been completed with great effect, disposable mop heads have been introduced in the last year and a new wipe for decontamination of the environment and equipment was introduced within inpatient and health centre settings.
- 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, to include care agencies and hospice settings
- Zero tolerance to avoidable health care associated infection
- Expand research activity of the Infection Prevention Team
- Sustain the Trusts' excellent reputation for Infection Prevention through team members' participation in national groups and projects.
- Sustain Clostridium difficile reduction with a lower tolerance of individual cases

Core Quality Indicators - Incident Reporting

The data made available to the Trust by the internal systems with regard to Incident Reporting

2016/17 (Full Year Data)			2017/18 (April - September)		
Incidents	**% resulting in death**	**% resulting in severe harm**	**Incidents**	**% resulting in death**	**% resulting in severe harm**
9324	0.2% (14)	0.2% (15)	4718	0.1% (5)	0.2% (10)

Data source – Trust Data at present 2018

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 and healthy 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 to the National Patient Safety Agency.

The Royal Wolverhampton NHS Trust intends to take/ has taken the following actions to improve this, and the quality of its services in 2018/19 by:

- The Trust has reviewed its policy and training to facilitate swift reporting and management review of incidents (including serious incidents)
- The Trust will continue to communicate lessons learnt via risky business newsletter
- Governance officers will continue to share Route Cause Analysis summaries across all directorate governance meetings where applicable
- The Trust Quality, Safety and Patient Experience Strategy will be reviewed to ensure it reflects current themes and shared learning

Core Quality Indicators - National Inpatient Survey

The data made to the Trust by the information centre with regard to National Inpatient Survey regards the Trusts' responsiveness to the personal needs of its patients

The National Inpatient Survey for 2017 surveyed patients who were discharged from hospital during July 2017.

Summary and analysis of the results data (mean rating scores base)

- With 444 surveys returned completed, the Trust had a response rate of 37.2% which was a reduction compared to the previous year.
- The Trust scored in the top 20% of Trusts on 9 questions and in the bottom 20% of Trusts on 3 questions.
- Compared with 2016, the Trust showed an improvement a 5% or greater improvement on 6 question scores and a 5% or greater reduction in score on 1 question. In the 2016 survey results the Trust showed an improvement of 2.5% or greater improvement on 1 question score and a 2.5% or greater reduction in score on 19 questions.
- The Trust scored an average score of 76%

About our strengths

- A&E Department – information giving and privacy
- Keeping to planned admission dates and waiting for a bed
- Enabling patients to take their own medicines
- Information giving – before operations/ procedures, after operations/procedures, before leaving hospital

The results showed that we compared well (in the top 20% of all Trusts) in the following questions:

- While you were in the A&E Department, how much information about your condition or treatment was given to you?
- Were you given enough privacy when being examined or treated in the A&E Department?
- Was your admission date changed by the hospital?
- From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?
- If you brought your own medication with you to hospital, were you able to take it when you needed to?
- Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?
- Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

Our areas for improvement – the results showed we need to do more in some areas as we scored in the bottom 20% of Trusts for the following questions:

- Did nurses talk in front of you as if you weren't there?
- During your hospital stay, were you ever asked to give your views on the quality of your care?
- Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

Areas for further consideration and potential improvement include:

- Nurses talking to patients as if they weren't there
- Enabling patients to give feedback on care or make complaints
- Review of questions scoring in the middle 60% to identify areas where performance can be brought into the top 20%

The table below sets out our performance for the three questions in the National Inpatient Survey.

	2013/14	2014/15	2015/16	2016/17	2017/18	2016/17
Involved as much as want to be in decisions about care definitely/to some extent	88%	89%	91%	92%	88%	92%
Treated with respect and dignity always/sometimes	98%**	97%	98%	98%	97%	98%

** This is an amendment to a figure of 96% quoted in the previous years' report.

	2013/14	2014/15	2015/16	2016/17	2017/18	2016/17
Overall care rated as excellent/ very good/good	94%	94%	95%	95%	93%	95%

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

Please note that 2017/18 figures shown are yet to be confirmed by NHS England and are based on the survey provider results only, however full details are publicised nationally by the Care Quality Commission.

The Royal Wolverhampton NHS Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 by:

- An action plan is currently being developed 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 - Friends & Family Test

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
- Analysis undertaken regards low performing areas and improvement plans implemented

Friends and Family Test Survey Response Rate

	Q1 2017/18				Q2 2017/18				Q3 2017/18				Q4 2017/18				2017/18 Average				2016/17 Average			
	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest
Emergency Department	17%	13%	45%	0%	13%	13%	47%	1%	12%	12%	45%	0%	14%	13%	45.1%	0%	11%	9%	34%	0%	17%	13%	44%	0%
Inpatients	28%	25%	100%	4%	27%	25%	100%	3%	28%	21%	100%	3%	30%	23%	100%	0.2%	21%	18%	75%	3%	27%	25%	87%	5%
Maternity	8%	24%	100%	0%	8%	22%	100%	0%	7%	19%	100%	0%	-	-	100%	0%	6%	16%	75%	0%	13%	24%	70%	0%
Outpatients	19%	6%	78%	0%	19%	6%	66%	0%	18%	5%	81%	0%	19%	6%	91.7%	0%	14%	4%	56%	0%	19%	7%	63%	0%

Percentage of Patients who would recommend the Trust

	Q1 2017/18				Q2 2017/18				Q3 2017/18				Q4 2017/18				2017/18 Average				2016/17 Average			
	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest
Emergency Department	85%	87%	99%	48%	84%	87%	100%	55%	82%	85%	100%	57%	81%	85%	100%	64%	63%	65%	75%	40%	83%	86%	99%	48%
Inpatients	93%	96%	100%	77%	92%	96%	100%	72%	92%	96%	100%	64%	91%	96%	100%	81%	69%	72%	75%	53%	94%	96%	99%	77%
Maternity	95%	96%	100%	69%	91%	96%	100%	48%	95%	97%	100%	80%	96%	96%	100%	91%	70%	72%	75%	49%	95%	96%	100%	82%
Outpatients	94%	93%	100%	80%	94%	93%	100%	81%	94%	94%	100%	71%	94%	94%	100%	67%	70%	70%	75%	58%	93%	93%	100%	73%

Percentage of Patients who would not recommend the Trust

	Q1 2017/18				Q2 2017/18				Q3 2017/18				Q4 2017/18				2017/18 Average				2016/17 Average			
	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest
Emergency Department	9%	7%	32%	0%	9%	7%	31%	0%	11%	8%	32%	0%	11%	9%	25%	0%	7%	6%	24%	0%	10%	7%	34%	0%
Inpatients	3%	1%	18%	0%	4%	2%	12%	0%	4%	2%	26%	0%	4%	2%	9%	0%	3%	1%	14%	0%	3%	1%	9%	0%
Maternity	3%	1%	19%	0%	5%	2%	30%	0%	2%	1%	10%	0%	2%	1%	3%	0%	3%	1%	15%	0%	2%	1%	11%	0%
Outpatients	3%	3%	20%	0%	3%	3%	14%	0%	3%	3%	16%	0%	3%	3%	21%	0%	2%	2%	13%	0%	3%	3%	20%	0%

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 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
- The recruitment of a data analyst to undertake more detailed analysis of the FFT metrics at divisional level

Core Quality Indicators - Supporting Our Staff

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

(Staff FFT, National NHS Survey and Chatback)

The Trust is one of the largest employers in its local community, employing over 8000 people. The detailed workforce profile is shown in section 1 of the Annual Report.

The Trust follows a number of established ways of engaging with staff in order to improve employee engagement and to support staff to continuously strive for excellence in patient care. These include 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 Q 1 2016/17 to Q 4 2017/18.

Staff Friends and Family Test
Recommendation Rates - Work

	Q1 2016/17	Q2 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q4 2017/18
RWT	70%	72%	70%	73%	70%	77%
England	64%	63%	64%	64%	63%	63%
Highest	89%	97%	85%	97%	96%	98%
Lowest	30%	29%	20%	29%	25%	23%

Recommendation Rates - Care

	Q1 2016/17	Q2 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q4 2017/18
RWT	79%	86%	82%	82%	82%	86%
England	80%	80%	79%	81%	80%	80%
Highest	100%	100%	98%	100%	100%	100%
Lowest	50%	44%	44%	55%	43%	36%

Not Recommended - Work

	Q1 2016/17	Q2 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q4 2017/18
RWT	13%	12%	14%	10%	14%	10%
England	18%	18%	18%	17%	19%	18%
Highest	57%	57%	78%	57%	64%	59%
Lowest	1%	0%	4%	1%	0%	1%

Not Recommended - Care

	Q1 2016/17	Q2 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q4 2017/18
RWT	5%	5%	7%	4%	7%	4%
England	6%	6%	7%	6%	6%	6%
Highest	28%	41%	27%	20%	29%	34%
Lowest	1%	0%	0%	0%	0%	0%

(b) National NHS Survey

Our staff engagement rate for 2017 was 3.82 and remains above average in relation to comparator Trusts. This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7.

In 2017 the Trust made a decision to carry out a census, therefore instead of the random sample of 1250 staff receiving a survey, all staff received an invitation to participate.

In addition to enabling the Trust to understand the view of staff, the national staff survey enables the Trust to benchmark performance against other combined acute and community Trusts. The response rate for the Trust in 2017 was 40%, despite this being 3% lower than comparator Trusts, the 2017 response rate was 8% higher than 2016 response rate of 32%.

Overall, the results are similar to 2016, except for Key Finding 4 – Staff motivation at work, which has seen a decrease in score, however still remains above the national average for comparator Trusts.

Top 5 ranking scores (i.e. where the Trust compares most favourably with other combined acute and community trusts in England)	KF2. Staff satisfaction with the quality of work and care they are able to deliver.
	KF27. % of staff/colleagues reporting most recent experience of harassment, bullying or abuse.
	KF14. Staff satisfaction with resourcing and support.
	KF28. % of staff witnessing potentially harmful errors, near misses or incidents in the last month.
	KF6. % of staff reporting good communication between senior management and staff.

Bottom 5 ranking scores (i.e. where the Trust compared least favourably with other combined acute and community trusts in England)	KF31. Staff confidence and security in reporting unsafe clinical practice.
	KF20. % of staff experiencing discrimination at work in the last 12 months.
	KF23. % of staff experiencing physical violence in the last 12 months.
	KF7. % of staff able to contribute towards improvements at work.
	KF9. Effective team working.

Where staff experience has deteriorated	KF4. Staff motivation at work

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

- Results are communicated by the management structure to all local areas
- Results are discussed at monthly governance meetings
- Analysis of results resulting in action plans are being formulated
- The action plans are monitored through divisional governance structures

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 by:

- Occupational health and wellbeing piloted a number of activities for staff relating to holistic therapies
- A programme of staff benefits is being developed engaging local businesses
- A range of flexible working options are available and these continue to be expanded
- Maternity workshops have been developed to allow staff to fully understand their options and entitlements
- Adopting and promoting NHS Personal, Fair and Diverse Champions campaign
- Every Voice Matters Campaign is being used as an 'umbrella' under which all the initiatives to encourage and support Employee Voice and Patient Voice are presented
- With the RCN, appointed a team of cultural ambassadors


Free NHS
WiFi
here
Every

Review of Quality

OUR PERFORMANCE IN 2017/18

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 2017/18	Performance 2017/18	Performance 2016/17	Performance 2015/16
*Cancer two week wait from referral to first seen date	93%	92.74%	93.59%	94.71%
*Cancer two week wait for breast symptomatic patients	93%	92.31%	95.39%	95.77%
*Cancer 31 day wait for first treatment	96%	97.20%	96.52%	96.75%
*Cancer 31 day for second or subsequent treatment - Surgery	94%	88.45%	86.49%	92.80%
*Cancer 31 day for second or subsequent treatment - Anti cancer drug	98%	100.00%	99.72%	99.85%
*Cancer 31 day for second or subsequent treatment - Radiotherapy	94%	97.75%	98.04%	99.76%
*Cancer 62 day wait for first treatment	85%	74.87%	77.84%	75.89%
*Cancer 62 day wait for treatment from Consultant screening service	90%	82.01%	86.97%	86.45%
*Cancer 62 day wait - Consultant upgrade (local target)	88%	90.69%	91.07%	91.50%
Emergency Department - total time in ED	95%	89.97%	90.66%	91.76%
Referral to treatment - incomplete pathways	92%	90.81%	90.89%	93.07%
Cancelled operations on the day of surgery as a % of electives	<0.8%	0.53%	0.42%	0.69%
Mixed sex accommodation breaches	0	0	1	0
Diagnostic tests longer than 6 weeks	<1%	0.8%	1.1%	0.0%

*forecast final performance as final figures are not finalised at the time of publication.

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

Performance against other National and Local Quality Requirements:

Indicator	Target 2017/18	Performance 2017/18	Performance 2016/17	Performance 2015/16
Clostridium Difficile	35	28	45	73
MRSA	0	2	0	0
Referral to treatment - no one waiting longer than 52 weeks	0	10	10	0
Trolley waits in A&E not longer than 12 hours	0	4	0	1
VTE Risk Assessment	95%	95.62%	96.00%	96.20%
Duty of Candour - failure to notify the relevant person of a suspected or actual harm	0	1	3	1
Stroke - 90% of time spent on stroke ward	80%	85.39%	89.16%	84.00%
Maternity - bookings by 12 weeks 6 days	>90%	91.50%	90.40%	89.10%
Maternity - breast feeding initiated	>64%	64.50%	65.20%	64.60%

ENGAGEMENT IN THE DEVELOPING OF THE QUALITY ACCOUNT

Prior to the publication of the 2017/18 Quality Account, we have shared this document with the following:

- Our Trust Board, including combination of Non-Executive and Executive Directors
- City of Wolverhampton Council Health Scrutiny Board
- Wolverhampton & Staffordshire CCG,
- Trust staff
- Healthwatch

In 2018/19 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

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

CITY OF WOLVERHAMPTON COUNCIL

Statement from City of Wolverhampton Council Health Scrutiny Panel

City of Wolverhampton Council Health Scrutiny Panel welcomes the opportunity to comment on The Royal Wolverhampton NHS Trust (RWHT) 2017/18 Draft Quality Accounts.

Overall the Quality Account report 2017/18 report is comprehensive and shows evidence that RWHT is continuing to perform at a high standard, while accepting the challenges facing the organisation in being able to continue delivering quality health care services in the future. The panel look forward to further progress being made to reduce staff vacancies and other priority areas detailed in the draft report.

The panel welcome the reported success of vertical integration initiative and look forward to seeing further progress in this and other areas to deliver high quality care to the residents of Wolverhampton.

The following is a summary of the panel comments on the draft quality account:

1. **Does the draft Quality Account reflect people's real experiences as reported to the Health Scrutiny Panel during the period 2017/18 by witness evidence?**

The panel considers that the Quality Account report provides an accurate assessment about performance of the hospital in terms of patient experience, patient safety and clinical effectiveness.

The panel received detailed reports on progress against areas detailed in previous quality accounts to provide evidence and reassurance that the current draft both reflects people real experiences and the work being done to deliver safe and effective services.

The panel is aware of the continued pressure on accident and emergency service and is satisfied that the range of activities led by staff at all levels is aimed at responding to these and other challenges detailed in report. The panel has received regular evidence from Wolverhampton Healthwatch which has been helpful in informing this view.

The panel has monitored progress against priority areas detailed in the previous Quality Accounts through the reports and presentations during the year. The panel received a review report on 16 November 2017 from Deputy Chief Nurse, RWHT, detailing progress against the key priorities detailed in the Quality Accounts 2016/17.

2. **From what people have told the Health Scrutiny Panel, is there evidence that any of the basic things are not being done well by the provider?**

The panel has not received any evidence during the year to suggest that the RWHT are not providing a quality service to the residents of Wolverhampton or that basic things are not being done well. The panel acknowledge the challenges facing the hospital as result of increasing patient demand with complex care needs and reduced resources across the health and social care sector.

Representatives of RWHT regularly attend health scrutiny panel meetings to present reports and respond to questions about the quality of the service offered to the residents of Wolverhampton. The panel welcome the frank assessment by representatives of the hospital of the work being done to improve performance against national and local performance targets.

The panel has representatives from Wolverhampton CCG, Wolverhampton Public Health, Wolverhampton Healthwatch who regularly attend health scrutiny meetings. The panel is not aware that representatives from these organisations have any major concerns about the accuracy of the evidence used as a basis for evidence to support conclusions in the quality accounts report.

Furthermore, there is no concern from the panel of the unwillingness of RWHT to respond to issues raised during meetings about the performance or quality of the care provided.

The issue of delays in patient discharge is a concern but the panel welcome the commitment of RWHT to work with other agencies to ensure that patients can be safely discharged at the earliest opportunity.

The panel welcome the continued focus on delivering equability of patient care at the weekend and note that all acute trusts are expected to meet 10 national

standards by 2020. The panel have been reassured that the necessary progress is being made to achieve this and will continue to monitor the situation during the year.

3. **Is it clear from the draft Quality Account that there is a learning culture within the provider organisation that allows people's real experiences to be captured and used to enable the provider to get better at what it does year on year?**

There is good evidence presented to the panel that RWHT is a learning organisation and making great effort to encourage service users and their carers to share their experiences. The active involvement of the public has led to improvements in the quality of the health services offered and helped to identify areas for improvement.

The panel welcome the regular attendance by the Chair and Chief Executive of the RWHT and senior staff to present reports. Reports have been presented in timely manner and have provided details of progress but also an acknowledgement of where services changes have not delivered the expected improvements in the delivery of patient care. The panel is satisfied that the RWHT is focused on collecting patient experience and using data to make changes to improve the quality of services.

The panel note the agreement of the hospital agreed to be filmed for the BBC tv series Junior Doctors as a clear example of work done to explain to the wider public about the service it provides and challenges it is trying to manage.

The panel was presented with evidence of the effectiveness of the Winter Planning 2017/18 – this is another example of RHWT willingness to share findings and learning from the experience and use it to improve future practice.

4. **Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?**

The panel support the areas below identified as priority areas for improvement for RWHT in the quality accounts.

The panel agree that the priorities are challenging enough to drive improvement and help identify areas where further action is needed to show the required progress is being made. The panel support the decision for the continued focus on these priority areas and based on evidence in reports considers that there is clear process for measuring improvement in the past and in the future.

The panel would like a user-friendly version that is aimed at explaining the progress made included either as a summary so that members of the public can be engaged in the process and be encouraged to share their views on the reported progress made.

The panel would welcome the addition in the Quality Account draft a section setting out milestones against which progress can be assessed and clarity about responsibility for delivering the improvements.

The panel have considered the findings of the Hospital Mortality Statistics report which provide an important indicator of both the quality of care and evidence of a willingness of RWHT to learn from the causes from unexpected deaths to improve future practice.

The panel would like a future document to include specific reference to the work being done by RWT to support efforts with other partner to tackle the top six causes of years of life lost 2012-2014 as reported in Wolverhampton Public Health Annual Report 2015/16; as part of its wider patient and public engagement strategy when reviewing progress against key priorities for 2017/18.

The health scrutiny panel will continue to foster an open and positive working relationship with RWHT. The panel will review progress against three priorities listed for improvement detailed in the Quality Account during the year to provide public reassurance that progress is being made to deliver high quality care to the residents of Wolverhampton.

Councillor Jasbir Jaspal
Chair of the Health Scrutiny Panel
20 June 2018

Councillor Paul Singh
Vice Chair Health Scrutiny Panel
City of Wolverhampton Council
20 June 2018

NHS
Wolverhampton
Clinical Commissioning Group

Statement from Wolverhampton & Staffordshire Clinical Commissioning Groups

As lead commissioner Wolverhampton Clinical Commissioning Group (CCG) welcomes the opportunity to provide this statement for The Royal Wolverhampton Trust quality account for 2017/2018. Wolverhampton Clinical Commissioning Group is committed to ensuring that the services it commissions provide the very highest standards in respect of clinical quality, patient safety, patient experience and clinical effectiveness. During the year we have reviewed information, held monthly Clinical Quality Review meetings and have carried out a number of visits to clinical areas to gain assurance around the standards of care being provided for our population. We have also provided challenge and scrutiny when performance has not met the expected standards.

In the quality accounts for 2017/18 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 2017/2018 to improve its services and the quality of care that it provides.

The Trust has addressed key areas to improve patient safety and have continued to strengthen learning from incidents, complaints and feedback with a focus on the following priorities:

- Ensuring safer care by reducing the instances of harm caused
- Improving the experience of patients
- Maintaining Nurse staffing levels and enhancing the workforce with new roles

During the year, as evidenced in the quality account, the Urgent Care system has provided many challenges due to continued growth in activity and thus impacting on delivering some key targets. The impact is felt further with staff recruitment and the Trust should be congratulated for its success with recruiting international nurses.

Safer Nursing Staff Levels

The quality account commits to continue to embrace the concept of attracting and retaining staff by reviewing pipelines into registration, the development of new and existing roles and new ways of working, to ensure that the right staff are in the right place, at the right time. During 2017/2018 the trust has developed career pathways from unregistered to registered to support the workforce of the future. The pilot for the trainee Nursing Associate programme is one the CCG has participated in and it is positive to read about the 19 trainees that commenced in January last year, we look forward to reading about their success in January 2019.

Safer Care

In 2017/2018 commissioners invited the Trust to participate in the CCG's Serious Incident Scrutiny Group; this has further helped learning from themes and embedding of the lessons learnt from serious incidents and never events. It is pleasing to see the overall significant reduction in the number of serious incidents reported by the trust for year 2017/2018. We would however, like to see further plans to embed overarching actions from the incidents, particularly the recent never events and diagnostic delay serious incidents.

It is encouraging to see that the Trust joined the National NHSI Falls collaborative and have achieved significant success in reducing the overall number of falls. Hopefully consolidation of these actions will impact positively on the national falls audit results for next year.

It is pleasing to see that the trust has achieved significant reduction in inpatient and community pressure injury incidents. We will continue our joint venture to impact the wider health economy to further reduce pressure injuries occurring.

The CCG welcome the Trust's continuous commitment to 'Sign up to Safety' to improve safety culture and team performance thereby impacting on the quality and safety of patient care.

Patient experience

The CCG acknowledge the continued patient and public engagement work that has positively impacted on the expansion in the volunteer services and the commitment to the equality, diversity and inclusion objectives. Equality requires commitment at every level and is not just a legal obligation, the Trust recognise this in their quality accounts and include the moral and social responsibilities, treating people fairly is the right thing to do.

Looking forward

Going into 2018/19 the CCG will continue to work collaboratively with the Trust and will seek further improvements in all areas of clinical quality, including cancer performance, mortality, never events, and sepsis. We fully support the Trusts commitment to review and refine the harm review process relating to the challenging cancer performance and welcome the particular focus on reducing 104 day cancer waits for our population.

The quality account is comprehensive and the report reflects an accurate picture of the Trust based. The CCG 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 CCG. The information presented within the quality accounts is consistent with information supplied to the commissioner throughout the year. We can confirm that we have no reason to believe this Quality Account is not an accurate representation of the performance of the organisation during 2017/18.

There are notable areas of success as well as areas that continue to require focus and improvement. 2018/19 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.

Yours sincerely

Dr Helen Hibbs

Chief Officer

Wolverhampton Clinical Commissioning Group

8th June 2018

Statement from Wolverhampton Healthwatch

Healthwatch Wolverhampton response to the Royal Wolverhampton NHS Trust Quality Accounts Priorities 2018/2019

"Healthwatch Wolverhampton is pleased to have been invited to comment on the Quality Priorities for the Trust.

We recognise the changes and improvements that have taken place over the past 12 months and with the constant landscape challenges that currently exists we welcome the Trust's focus on listening to its service users, their families and also its staff to ensure that it can continue to improve and sustain its service provision.

Healthwatch Wolverhampton will continue to work with the Trust to focus on improving patient experience and patient engagement especially being more visible in the community. Healthwatch have participated in PLACE Assessments and carried out a number of Enter and View visits within the Trust. The Council of Members that replaced the Patient Experience Forum is an opportunity for patients to be more involved in a strategic role, however Healthwatch staff and volunteers have been excluded from this.

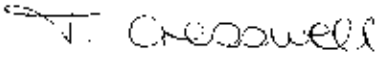
The Trust has a challenge ahead with the shortage of nurses and Healthwatch understand that this is a national shortage; however, it is assuring that the Trust have got a plan to recruit and retain staff. I believe staff that are recruited from overseas have to have English assessments, however, the patients are struggling to understand them.

Healthwatch welcomes the continued focus on Safer Care and is reassured that the Trust is identifying learning from their incidents, even though more evidence is required to how this is being used to prevent these incidents from occurring again.

Healthwatch welcomes the opportunity to work with the Trust to ensure there is ongoing and meaningful conversations and engagement with patients and members of the public around the future service models to sustain and improve its service provision.

Healthwatch Wolverhampton looks forward to reviewing progress against the forthcoming years priorities and to reviewing outcomes measured in the 2019/20 Quality Report to be able to assess how the quality initiatives have impacted on the residents of Wolverhampton".

Yours sincerely



Tracy Cresswell

Wolverhampton Healthwatch Manager

11th June 2018

Statement of Directors Responsibilities in respect of the Quality Account 2017/18

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

28th June 2018

Jeremy Vanes

Chairman

28th June 2018

Statement of Limited Assurance from the Independent Auditors

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF THE ROYAL WOLVERHAMPTON NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of The Royal Wolverhampton NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Venous thromboembolism risk assessment (VTE indicator)
- Healthcare acquired infection (HCAI) measure clostridium difficile infections (C-Diff)

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

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 Regulations).

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

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to March 2018;
- feedback from the Commissioners dated 08/06/2018;
- feedback from the Healthwatch Wolverhampton dated 11/06/2018;
- feedback from the City of Wolverhampton Council Health Scrutiny Panel dated 20/06/2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018;
- the annual governance statement dated 01/06/2018;
- the Care Quality Commission's Inspection Report dated 13/12/2016; and
- any other relevant information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of The Royal Wolverhampton NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Royal Wolverhampton NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Royal Wolverhampton NHS Trust.

Basis for adverse conclusion

Our testing of the Trust's VTE indicator found that:

- the Trust's processes to identify instances of VTE from its database did not identify all VTE instances; and
- when we compared the Trust's Unify submission to the VTE database reports we were unable to agree records to the source data from the supporting systems.

We therefore, cannot conclude that we have sufficient assurance as to the accuracy or completeness of the indicator. For this reason we are unable to issue a limited assurance opinion on this indicator included in the Quality Report for the year ended 31 March 2018.

Adverse conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for the adverse conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the C-Diff indicator in the Quality Account subject to limited assurance has not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

One Snowhill

Snowhill Queensway

Birmingham B4 6GH

27 June 2018

Actions following the Statement of Limited Assurance from the Independent Auditors

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
1	1	**VTE Indicator: VTE Database** During 2017/18, the Trust's VTE Group addressed the findings of our work from 2016/17 and the implementation of a new system. Since 1 April 2018 the Trust has operated its replacement VTE database to support reporting from 2018/19 and to strengthen associated control processes. Following the 2016/17 audit, the Trust wrote to the NHS Improvement Analytics Hub to clarify the meaning of 'on admission'. On 20 September 2017 they confirmed that the 'on admission' criteria means within 24 hours and not per admission. The Trust has not been able to generate a figure for 2017/18 based on within 24 hours as a result of the VTE database in calculating length of time from admission to VTE assessment. All figures were reported to UNIFY on a 'per admission' basis. Our work was focussed on the 1 April 2017 to 31 March 2018 period and as a result of the timing of these two developments outlined above, we found similar issues to those in 2017/18. We found that the current VTE database and its reports used to generate the UNIFY submission had a number of weaknesses: • No reconciliation maintained from source data to feeder systems; • Errors in automated cohort coding (1 of 6 cohort assessed patients in our sample of 25 had been automatically coded as a cohort assessed by the database in error); • Errors in recording of the number of VTE assessments completed. The Trust's own testing found instances where Vitalpac software showed assessments were completed but for unidentified reasons the database records did not match this; • Inconsistently calculating the time between admission and VTE assessment (in 2 of the 3 cases we reviewed, the time as per patient records and Vitalpac was different from the database). **Recommendation** In replacing the current VTE database, the Trust should review the findings from the 2016/17 and 2017/18 audits and ensure that their IT infrastructure and reporting processes are robust enough to ensure timely and reliable recording of VTE performance.	Action had already been taken and implemented prior to this financial year VTE testing, however data was not available for the auditors due to the timescale of testing.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
2	1	**VTE indicator: VTE Assessment Monitoring of Breaches After 24 hours** As part of our risk based approach to the sample of 25, we selected breaches where no VTE assessment was completed in 24 hours. We found three cases where a VTE assessment was not completed for 5 days or more during the patient's hospital stay. We also found that current reporting from both the VTE database and Vitalpac, whilst identifying breaches at 24 hours, was not used to monitor and flag those breaches that were continuing for these longer periods. **Recommendation** As part of the establishment of a new database and the review of their VTE reporting facilities, the Trust should ensure that there are reports to track cases that have breached at 24 hours and ensure they are promptly VTE assessed after that point.	The Trust are currently reviewing its process of escalation with regards to delays in assessment after 24 hours.
3	3	**VTE Indicator: Strengthening documentation and review** The Trust has not fully documented its data validation and submission process. It plans to do this as part of its review of processes with the introduction of a new VTE database and reporting facility. At the time of our work we found that the person responsible for making manual amendments to VTE database reports was also responsible for signing off the UNIFY submissions. A separation of duties between making amendments and signing off the submission would mitigate against the risk of accidental or deliberate errors. We also found that the VTE Group had incorporated data quality into its terms of reference but had yet to agree how this role would be implemented in practice as part of its work plan. **Recommendation** Following the introduction of the new VTE database and updated reporting facilities, the Trust should document fully its data validation process including the quality review arrangements. The Trust should maintain an accurate record of all manual changes made and of its formal review and approval process for these changes. This should ensure an appropriate segregation of duties. The VTE Group should seek to be clear on how in practice it intends to fulfil its role in terms of data quality.	The Trust has already developed a standard operating procedure to support the new system which was implemented in April 2018.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
4	2	**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. For2017-18, 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.	The Trust are compliant with the reporting of those cases tested for C.diff as per national guidance.
5	3	**C-Difficile Indicator: Data extraction and checking process** The data extraction process and checks are not documented. **Recommendation** The Trust should agree and document the parameters used for extracting data from the TDNexLab software application into the C-Diff spreadsheet. As part of Trust's approval of the monthly data submission to Public Health England, the officer submitting the return should evidence confirmation that the correct parameters have been used and all positive C-Diff cases have been included.	As per number four above.

We have also followed up the recommendations from the previous years audit, in summary:

Total number of recommendations	Number of recommendations implemented	Number outstanding (repreated below):
4	4	0

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:

Alison Dowling

Head of Patient Experience & Public Involvement

The Royal Wolverhampton NHS Trust

New Cross Hospital

Wednesfield Road

Wolverhampton

WV10 0QP

Email: rwh-tr.patientexperienceteam@nhs.net

Appendix 1 – National Clinical Audits that RWT participated during 2017/18

National Clinical Audit & Enquiry Project name of audit	Workstream	Directorate	Status
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	N/A	Cardiology	Awaiting Report
Adult Cardiac Surgery	N/A	Cardiothoracic	Awaiting Report
BAUS Urology Audits - Cystectomy	N/A	Urology	Completed
BAUS Urology Audits - Radical Prostatectomy Audit	N/A	Urology	Completed
Bowel Cancer (NBOCAP)	N/A	Oncology & Haematology	Awaiting Report
Cardiac Rhythm Management (CRM)	N/A	Cardiology	Awaiting Report
Case Mix Programme (CMP)	Intensive Care Audit	Critical Care	Completed
Elective Surgery (National PROMs Programme)	N/A	T&O	Awaiting Report
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	Rheumatology	Awaiting Report
Falls and Fragility Fractures Audit programme (FFFAP)	National Hip Fracture Database	T&O	Awaiting Report
Head and Neck Cancer Audit	N/A	Oncology & Haematology	Awaiting Report
Audit will cease to be part of NCAPOP from end of May 2017.	N/A	Oncology & Haematology	Awaiting Report
National Audit of Dementia	Dementia care in general hospitals	Care of the Elderly	Completed
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	N/A	Cardiology	Awaiting Report
National Comparative Audit of Blood Transfusion programme	Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Pathology	Awaiting Report

National Diabetes Audit - Adults	National Core Diabetes Audit	Diabetes	Completed
National Diabetes Audit - Adults	National Diabetes Foot Care Audit	Diabetes	Awaiting Report
National Diabetes Audit - Adults	National Diabetes Inpatient Audit (NaDia)	Diabetes	Completed
National Heart Failure Audit	N/A	Cardiology	Awaiting Report
National Joint Registry (NJR)	Hip replacement	T&O	Awaiting Report
National Joint Registry (NJR)	Knee replacement	T&O	Awaiting Report
National Maternity and Perinatal Audit (NMPA)	N/A	Obstetrics	Awaiting Report
National Prostate Cancer Audit	N/A	Urology	Completed
Oesophago-gastric Cancer (NAOGC)	N/A	Oncology & Haematology	Awaiting Report

Appendix 2 – National clinical Audits that RWT continues to participate in and which remain in progress since 2017/18

National Clinical Audit, Enquiry or Programme	Workstream/ Component	Directorate	Status of audit
BAUS Urology Audits - Nephrectomy audit	N/A	Urology	In Progress
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	N/A	Urology	In Progress
Diabetes (Paediatric) (NPDA)	N/A	Paediatrics	In Progress
Endocrine and Thyroid National Audit BAETS operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	N/A	General Surgery	In Progress
Falls and Fragility Fractures Audit programme (FFFAP)	Inpatient Falls	Care of the Elderly	In Progress
Fractured Neck of Femur (care in emergency departments)	N/A	ED	In Progress
Inflammatory Bowel Disease (IBD) programme / IBD Registry	N/A	Gastroeneterology	In Progress
Learning Disability Mortality Review Programme (LeDeR)	N/A	Trustwide	In Progress
Major Trauma Audit	N/A	ED	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential enquiry into serious maternal morbidity	Obstetrics	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	Obstetrics	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Obstetrics	In Progress

Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance	Obstetrics	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Obstetrics	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	Obstetrics	In Progress
National Audit of Breast Cancer in Older People (NABCOP)	N/A	General Surgery	In Progress
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	Respiratory	In Progress
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Secondary Care	Respiratory	In Progress
National Comparative Audit of Blood Transfusion programme	National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Pathology	In Progress
National Diabetes Audit - Adults	National Pregnancy in Diabetes Audit	Obstetrics	In Progress
National Emergency Laparotomy Audit (NELA)	N/A	Critical Care	In Progress
National Lung Cancer Audit (NLCA)	Lung Cancer Clinical Outcomes Publication	Respiratory	In Progress
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	N/A	Neonates	In Progress
Pain in Children			
(care in emergency departments)	N/A	ED	In Progress
Procedural Sedation in Adults (care in emergency departments)	N/A	ED	In Progress
Sentinel Stroke National Audit programme (SSNAP)	N/A	Stroke	In Progress
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	Trustwide - Lead by Pathology	In Progress

Appendix 3 – National Clinical Audits reviewed by RWT in 2017/18 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 2018/19 audit plan for subsequent re-audit.

The reports of 7 completed National clinical audit projects have been reviewed by the provider to date. The Trust intends to take the following actions to improve the quality of healthcare provided:

2017/18 Audit ID	National Clinical Audit, Enquiry, Project name & Worksteam	Lead Directorate	Compliance Rating	Actions identified to improve the quality of healthcare provided
3514	BAUS Urology Audits - Radical Prostatectomy Audit	Urology	All standards met	Not applicable.
3464	BAUS Urology Audits - Cystectomy	Urology	Fully compliant	Not applicable.
3214	Case Mix Programme (CMP) - Intensive Care Audit	Critical Care	Fully compliant	Not applicable.
2946	National Audit of Dementia - Dementia care in general hospitals	Care of the Elderly	Minor non-compliance	We have addressed all of the issues raised by the audit findings. In addition we have given the national team ideas on how to improve data collection and interpretation.
3440	National Diabetes Audit – Adults - National Core Diabetes Audit	Diabetes	Minor non-compliance	Continued review of all patients with diabetes to ensure all care processes are checked to improve identification of at risk patients
3438	National Diabetes Audit – Adults - National Diabetes Inpatient Audit (NaDia) -reporting data on services in England and Wales	Diabetes	Minor non-compliance	Development and implementation of foot assessment. Use of electronic prescribing will reduced wrong prescriptions of insulin type.
3466	National Prostate Cancer Audit	Urology	All standards met	Not applicable

Appendix 4 – Local clinical Audits reviewed by RWT in 2017/18 with actions intended to improve the quality of healthcare provided

The following 51 (15%) audits 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 will re-audit against these standards in 2018/19.

Directorate	Audit Title	Compliance Rating	Actions identified to improve the quality of healthcare provided
Accident & Emergency	Local documentation audit - completion of safeguarding stamp within Paediatric documentation	Moderate Non-Compliance	Documentation to be amended to ensure that concerns can be clearly documented and audited to assess whether the 'safeguarding stamp' is an effective measure and that concerns were acted upon accordingly.
Accident & Emergency	Local prescribing of Co-amoxiclav in the Emergency Department (re-audit)	Moderate Non-Compliance	Findings discussed at Doctors local induction. Ensure other specialties are aware of the correct management of soft tissue injuries. Consider adding a pop-up window on Mediwell to advise clinicians to check if co-amoxiclav is really indicated.
Audiology	Pure Tone Audiometry (PTA) (Service Evaluation)	Moderate Non-Compliance	To enhance awareness amongst relevant staff on the importance of good and accurate record keeping.
Cardiology	An audit into maternal planning around pacemaker and advanced devices implants (service evaluation)	Moderate Non-Compliance	Clinical Director to email colleagues to highlight the importance of taking a full history from patients concerning their past pregnancies and plans for any future pregnancies. Device pathway requires review.
Cardiology	Lipid measurement and referral after admission with a myocardial infarction (NICE Audit)	Moderate Non-Compliance	Not fully compliant against the gold-standard of measuring lipids on acute admission. Lipid service provision to be implemented (pharmacy template). Following the audit a full lipid profile is now requested at admission.

Cardiology	Local audit on the safe use of NOAC's	Moderate Non-Compliance	Discussions with pharmacy to support the revision of the patient leaflet produced by pharmacy. As the safe use of NOACs encompasses several areas (risk/ benefit, patient education, safe discharge), a tool in the form of a checklist could incorporate these and help improve safe prescribing Although a checklist is helpful, education in the safe prescribing of NOACs and use of the safety checklist also form an important aspect. (Junior doctor presentation at the start of the rotation/ Nurse + Pharmacist awareness checklist)
Cardiology	Local ECG Training and standards at RWT (re-audit)	Moderate Non-Compliance	Awareness of the E learning package and supporting documentation to be heightened. An ECG video to be devised and available to staff. A simplified ECG machine stocklist to be produced. Staff to be made aware of audit results. A SOP to be devised to assist staff who undertake ECG.
Cardiology	Pacemaker box change - local audit	Moderate Non-Compliance	A local guideline is being created as guidance for optimum replacement times of pacemaker, to be attached at the pacing clinic room. The audit was presented to the Cardiac physiologists, to inform them of discrepancy between time left on the battery of pacemaker and listing for a box change procedure. A local guideline is being created as guidance for optimum replacement times of pacemaker according to different makes.
Cardiothoracic Surgery	Implementation of a Structured Handover Form for Cardiothoracic Patients on Transfer from Theatre to Critical Care Unit: First Audit (local audit)	Significant Non-Compliance	The 'Handover Template' form should be included in the patient's folder on arrival to the operating room. The 'Handover Template' form should be filled in the operating room before patient leave the theatre and hand over to ITU team. Actions have been put in place to ensure a more effective handover is in operation.
Cardiothoracic Surgery	Local re-audit. Assessment of image quality in peri-operative TOE	Moderate Non-Compliance	Local standard / data set for targeted perioperative TOE are being developed. This audit has enabled a new local standard to be introduced and will enable further more detailed audits to be conducted to make further improvements to the service.

Care of the Elderly	Communication of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions to Primary Care (local audit)	Significant Non-Compliance	Approximately a quarter of our patients are having DNACPRs completed but only a quarter are being communicated to GPs. We will be working with Division to ensure that the DNACPR commencement is part of the template for Discharge Notifications.
Care of the Elderly	Correct documentation on Warfarin prescription on in patients on Care of the Elderly wards (local audit)	Moderate Non-Compliance	The directorate are going to ensure that every member of clinical staff is aware of their responsibilities with this group of patients. This will be done through teaching sessions, safety huddles and changes to the e-discharge letters.
Care of the Elderly	Local Antibiotics Audit	Moderate Non-Compliance	Local induction in April for new junior doctors - antibiotic stewardship and sepsis (bundle). Update in weekly departmental meeting - audit results and education. Education about antibiotics and importance of communication about type of antibiotic, review date and length of course of antibiotic. Sepsis bundle needs to be completed (when antibiotic used for sepsis).
Care of the Elderly	Peri-operative analgesia in patients with fractured neck of femur (local audit)	Moderate Non-Compliance	Project to be presented at the T&O Directorate governance meeting. Audit team recommends that analgesia prescriptions should be standardised. Regular paracetamol and 5 microgram/ hour buprenorphine patch. PRN oral morphine solution. This recommendation to be discussed at T&O governance meeting. Findings of project to be highlighted at the T&O junior induction to emphasise the importance of adequate analgesia especially in the cognitively impaired. Need to improve recognition of pain in cognitively impaired by ensuring it is assess on movement as well as at rest.
Critical Care	Anaesthetic Record keeping - 2018 (local audit)	Moderate Non-Compliance	In order to encourage better documentation of the delivery of better care, there needs to be good leadership both of encouragement and of correction. This data has been presented to the department and the audit will be repeated annually. The new anaesthetic chart has prompts which will hopefully increase compliance with completing the data set.
Critical Care	Audit of the use of the central venous catheter insertion checklist and record (NICE Audit)	Moderate Non-Compliance	Education in and awareness of the CVC checklist and reasons for its implementation.

Critical Care	Audit of Theatre Controlled Drug record-keeping (local audit)	Moderate Non-Compliance	Medical staff and Theatre staff have been briefed on the results of the audit at team meetings and at our Quality Improvement Forum. We have produced an educational video to reinforce the correct process and this will be made available to our staff. We will ask that all relevant staff watch the video and will record compliance with this using signature sheets. Results highlighted a necessity for improvement in our record-keeping and via presentation/ discussion we have raised the potential implications for not doing this correctly.
Critical Care	NELA - National Emergency Laparotomy Audit (NELA) - 2015/16 data	Moderate Non-Compliance	Modification of booking form for theatre to include P-possum score as standard. Modification of anaesthetic chart to include P-possum as standard.
Critical Care	Prevention of perioperative hypothermia; an audit of current practice against NICE CG65	Moderate Non-Compliance	Communication about use of warming devices and regular monitoring has been re-circulated. There is a new anaesthetic chart being agreed, which has on it a 'prompt' for temperature check every 30 minutes. Consider review of guidelines to include pre-op warming.
Dermatology	Local re-audit: Recommended Pre-treatment and Monitoring Investigation for Biological Treatment	Moderate Non-Compliance	New Cross to begin to using BAD proforma (UK biologics checklist). Both sites to adopt 2017 BAD guidelines. Spot audit to check compliance after three months. Cannock Chase Hospital site to undertake the same audit.
Dermatology	WHO Checklist - Local re-audit	Moderate Non-Compliance	More HCAs to be put in to clinics, so that nurses and doctors are available to carry out the WHO checklist process appropriately. We also agreed to carry out a spot audit before the next main audit to pick up changes sooner.
Dietetics	Nutrition support on the ICCU (local audit)	Moderate Non-Compliance	All patients admitted to the ICCU are MUST screened within 24 hours of admission (if not already done on the ward). All ICCU staff are aware of the ICCU NG feeding protocol (and adhere to it unless contraindicated) and dietetic referral criteria. Improve delivery of calories/protein to enterally fed critically ill patients towards gold standard of 80%. Use of micronutrient supplementation in select high risk patients ICCU patients.

Gastroenterology	Confirming correct placement of nasogastric feeding tubes (local audit)	Significant Non-Compliance	All Matrons and ward managers to be re-informed of the introduction of NG/ NJ Confirmation Sheet on the reverse of the Enteral feeding Regime. Communication to be sent to all matrons and ward managers regarding NG Feeding Tube Insertion Confirmation sticker. MUST to be completed each time a nasogastric tube is inserted. All Matrons and ward managers to be informed of availability of Monthly Key trainer and Introductory sessions for NG training by Nutrition Nurses. All Matrons and ward managers and ward staff to be informed of availability of E-learning package. IMTG informed of need for training to be Mandatory. IMTG to put as a Mandatory package.
General Surgery	Audit of contents of consent form (local audit)	Moderate Non-Compliance	Ensure that the teaching provided at induction will highlight these issues. There is a consideration of using standardised pre-printed consent forms for the common surgical procedures conducted. Improvements required around legibility, avoid abbreviations and to ensure 'removal of tissues' section is completed.
General Surgery	NICE CG174 IV Fluid Management in Acute Surgical Patients	Moderate Non-Compliance	Education in the form of tutorials has taken place. Dedicated session in the formal nursing teaching on IV fluid balance charts.
General Surgery	Oxygen Administration & Prescription (local audit)	Moderate Non-Compliance	Create a leaflet highlighting audit findings to be circulated to the surgical house officers and ward sisters.
General Surgery	Venous Thrombo-embolism Prophylaxis in Acute Surgical patients (local audit)	Moderate Non-Compliance	1st and 2nd VTE assessments columns added to the doctors Handover sheet. VTE assessments discussed at doctors handover (8am & 8pm). VTE rounds at 7:30 done by the on-call team - TEDS & Clexane. TEDS boxes on the drug chart for timing of prescription and application. Laminated papers in the ward about the TEDS importance. Adding TEDS application column in nursing hand-over sheets. Adding TEDS as part of the nursing safety handover. Highlight the importance of adding Wt to vital PAC on initial assessment or later by nursing staff. VTE champion (Junior doctors) to raise awareness.
Head & Neck	Re-audit Antibiotic prophylaxis in day case dentoalveolar surgery (local audit)	Significant Non-Compliance	Education of team. Poster in theatres with guidelines. Communication to all new team members. Create consensus with regard clinical care of day case dentoalveolar cases.

Head & Neck	Re-audit Seven day working : Review of acute ENT patient admissions (service evaluation)	Moderate Non-Compliance	Addressed at audit meeting, Consultants now provide daily ward rounds in the week. Additionally, a H&N Consultant ward round occurs every Wednesday. On-call consultant is responsible for reviewing patients at other times.
Obstetrics	Enhanced Maternity Care Audit (local audit)	Moderate Non-Compliance	Formalise ward rounds with the Anaesthetists. Ensure Consultant review debrief on wards. Improvements to documentation.
Oncology & Haematology	An Audit on the Management of Confirmed Neutropenic Sepsis (NICE Audit)	Moderate Non-Compliance	To be presented at academic meeting with Trust Sepsis Lead. Agreed to use Sepsis 6 screening tool across the Trust. Working group set up to move project across the trust to ensure all staff aware.
Oncology & Haematology	Audit of Acute Oncology Service (AOS) Activity (local audit)	Moderate Non-Compliance	Complete AOS audits in June 2018. Educational drive to support ED over the forthcoming months – Sepsis Awareness training to be completed. Directorate Managers to acknowledge increased service activity and initiate a projection plan (systems of identifying all patients for the on-call service. Seven-day nursing service implementation).
Oncology & Haematology	CG151 Neutropenic sepsis	Moderate Non-Compliance	To share these findings with Sepsis Working group and continue to meet monthly Continue to audit data on a two monthly basis (feed back to the group). Continue to work collaboratively with ED on this issue. Audit findings need to remain on Risk Register. Consider ways to support ED where prescribing is concerned. Promote the use of Sepsis Screening Tool in all areas. Re-evaluate the current practice of blood culture taking. Train nursing staff in Durnall Unit to take blood cultures.
Paediatrics Acute	A Local Audit on Anaphylaxis and use of Epipen	Moderate Non-Compliance	Manager for school nurses informed her team that on-going training needed to be delivered. EPIPEN packs now sent to schools by the company. GP advised about dose changes via clinic/emergency plan.

Paediatrics Community	Health Visiting Did Not Attend Appointment Documentation Audit (local audit)	Moderate Non-Compliance	The DNA Trust policy has been re-circulated to the entire health visiting team. Each team now holds a daily handover meeting, whereby practitioners discuss the visits/contacts of the previous day. The meeting is chaired by the Team Leader and promotes peer review, ensuring policy is followed.
Paediatrics Community	Health Visiting Domestic Violence Records Audit (Safeguarding) - 2017 (local audit)	Moderate Non-Compliance	Develop a training package for staff regarding safeguarding record keeping. Develop a form with the safeguarding team to be placed in the records evidencing discussion of the case during safeguarding supervision and any information sharing that may be required. Advise the Safeguarding Supervisor to always discuss any issues identified with the relevant professional and follow up to ensure staff have made appropriate changes as required.
Pharmacy	A re-audit assessing Warfarin prescribing in medical and surgical patients following the introduction of the new anticoagulant prescription chart (local audit)	Significant Non-Compliance	The team will raise awareness through educational support meetings and update their Standard Operating Procedures to improve their current practice.
Pharmacy	Missed and delayed doses of Parkinson's medicines at The Royal Wolverhampton Hospitals NHS Trust (local audit)	Moderate Non-Compliance	Yellow stickers from Parkinson's UK will be recommended, and it will be recommended to make rotigotine patches of formulary status. Rotigotine patches are now available in the dispensary robot.
Pharmacy	Trust Wide NHSLA Prescription Chart Audit 2017/18 (Re-audit)	Moderate Non-Compliance	The audit highlights that there is still scope for all clinical areas within the Trust to improve their prescribing practice against those standards outlined in MP01; this will in turn lead to fewer prescribing errors and an overall improvement in medication safety. The final report will be presented at specialty governance meetings. Each team is to develop action plans to address areas of non-compliance.
Radiology	Emergency Department CT Head Reporting Audit (local audit)	Moderate Non-Compliance	Recruit more Registrars. Undertake risk assessment. Delivery of training to ED Consultants (provided by Radiology Consultants).
Radiology	Justification criteria of referral of CT pulmonary angiogram requests (NICE Audit)	Significant Non-Compliance	Information to be disseminated to IRMER practitioners and referrers. Review of CTPA protocol.

Radiology	Percutaneous nephrostomy tube exchange: are we doing enough? (local audit)	Moderate Non-Compliance	Develop Interventional Radiology Department database for patients with long term nephrostomies, highlighting high risk patients. Remind Interventional radiologists to include drain type used for each patient in their procedure reports at the audit meeting.
Renal medicine	Quality of Documentation on E-Discharge, prescribing and follow up (local audit)	Moderate Non-Compliance	Amend the layout of the discharge summary. Suitable mechanism of training- As part of FY1 training, a CBD should be conducted on completion and summarising a patient's discharge. Encourage consultants as part of their ward round to help summarise the working/main diagnosis and potential follow ups. Incorporate as part of the junior doctor trust induction a template on writing discharge summaries. Aim to re-audit in 1 years' time following the above recommendations. Look into weekend discharges and discharge drugs.
Rheumatology	Audit of the ICE / DAWN system following implementation of the ICE Pathology results system at New Cross November 2017 (local audit)	Moderate Non-Compliance	Feedback audit findings to clinical staff re: improving registration and updating of DAWN database. Feedback to ICT team re: discrepancies in blood tests to inform DAWN development and pathology lab systems. Feedback to clinical managers re: DAWN resourcing implications and to refine the use of DAWN and proactively identify and act on problems. Re-audit by new DAWN administrator team to confirm improvement/ progress with the system.
Rheumatology	Cardiovascular risk monitoring in the rheumatology department (local audit)	Significant Non-Compliance	To educate team members on the importance of assessing cardiovascular risk factors in patients with RA. To use the QRISK2 CVD calculator yearly to assess patients (in a template form that can be attached to notes).
Rheumatology	National Fracture Liaison Service Database	Moderate Non-Compliance	Rheumatology now running a full FLS service from Cannock Chase Hospital.

Sexual Health	Audit of STI testing in HIV positive MSM within our service (local audit)	Moderate Non-Compliance	Educate staff on screening guidelines and this will encourage staff to offer screening to patients. Also, patient education will help to promote issues about HIV, sexual health screening and practicing safer sex. The team will need to develop and implement a new pro-forma to allow medics to easily access data such as high-risk behaviour and overdue screening.
Stroke	Psychology Provision on Inpatient Stroke Units within Royal Wolverhampton NHS Trust (service evaluation)	Moderate Non-Compliance	Staff training programme is being developed and rolled out at end of May 2018. MDT proforma developed.
Trauma & Orthopaedics	Assessing VTE risk in a hospital setting (local audit)	Significant Non-Compliance	A more stringent approach to ensuring VTE assessments are completed will be taken by Registrar B as part of afternoon duties and by the on-call Reg for overnight admissions. The importance of VTE assessment completion will be enforced at the local junior doctor induction. Continue to discuss the compliance rating of VTE assessment completion at monthly governance meetings.
Trauma & Orthopaedics	Audit of NOF Integrated Pathway, BPT and NOF Clinical Coding (local audit)	Moderate Non-Compliance	A more stringent approach to ensuring VTE assessments are completed will be taken by Registrar B as part of afternoon duties and by the on-call Reg for overnight admissions. The importance of VTE assessment completion, NOF pathway, Surgical coding and clinical coding forms will be enforced at the local junior doctor induction. Continue to discuss the compliance rating of VTE assessment completion at monthly governance meetings. NOF pathway is being re-written and consideration will be given to include the clinical coding forms.
Urology	G&S Blood Testing during Pre-Operative Assessment for Elective Urological surgery: A retrospective local audit	Moderate Non-Compliance	New protocol designed, distributed and implemented.

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

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

Punjabi

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

Polish

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

Russian

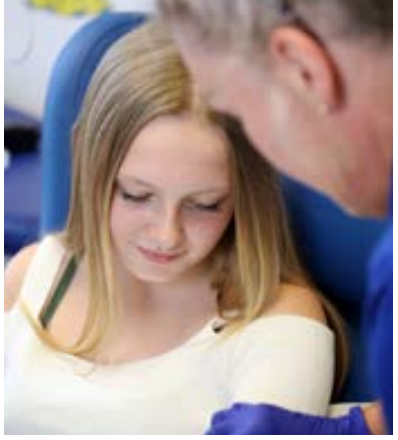
Если данный документ требуется Вам в альтернативном формате, например крупным шрифтом, на другом языке и т.п., просьба сообщить об этом одному из сотрудников здравоохранения.

Lithuanian

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

Kurdish

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



Safe & Effective | Kind & Caring | Exceeding Expectation

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

Mi 4298914 28.06.18 v0.5