# Quality Account 2020/21

# 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, considering the views of service users, carers, staff and the public. We can use this information to make decisions about our services and to identify areas for improvement.

## Statement on Quality from the Chief Executive

*During 2020/21, the Trust has had an exceptional year, coping with the local impact of COVID-19. Despite the many challenges we have faced as an organisation, and as individuals, there have been many quality improvements. I am proud that within 9 weeks, 2 wards and an 8 bedded intensive care unit were opened to support and provide additional services for our population in response to COVID-19.*

*Workforce remains an ongoing national challenge to prevent key shortages, particularly in medical positions, allied health professionals and nursing and midwifery. Despite this, the Trust has continued its improvement journey, and within nursing and midwifery this has led to less than 10 vacancies. I am delighted that this has led to two Nursing Times Workforce Awards in 2020, they were 'Best Diversity and Inclusion Practice Award for the Clinical Fellowship Programme' and 'Best UK Employer of the Year for Nursing Staff' as well as recognition from the Chief Nursing Officer for England.*

*Our journey through integration of care services has continued and has seen the expansion of roles such as pharmacists, advanced nurse practitioners, social prescribers and physicians associates in the RWT Primary Care Network, providing a variety of patient interventions. New technology has supported this approach such as a partnership with Babylon to develop a virtual care assistant, as well as shared services with other teams in the Trust. It is extremely pleasing to see improvements in services to those at risk of inequality of care, such as the improvement in health checks for those with a learning disability.*

[1] Quality Account (2009) Health Act

*Staff health and wellbeing has been a priority area, both in coping with the usual needs of a large organisation and the exceptional stresses that the COVID-19 pandemic created on our teams. We have worked with partners and the workforce to develop a new intranet site signposting staff to a wealth of resources, multiple routes for access to psychology services, bespoke support packages to specialist areas such as the intensive care unit, wobble and serenity rooms for staff to take time out and recover from incidents or manage their emotions, as well as listening events and many more. I have been impressed at the resilience of our workforce and have kept in touch through frequent communications and opportunities to recognise the exceptional contributions of both teams and individuals.*

*In January the Trust opened the Hospital Vaccination Hub as part of the Trusts contribution to gaining control of the COVID-19 virus. We were able to vaccinate over 7,000 of our staff and more than 1,000 local health and social care workers, in partnership with the Public Health Team with the allocated vaccines. This provided a significant boost to morale and staff came from many disciplines and corners of the Trust to support the vaccine administration. At the same time the RWT Primary Care Network administered over 15,000 doses of vaccine to residents of Wolverhampton and beyond.*

*The Trust once again welcomed the Care Quality Commission (CQC) through its Transitional Monitoring Arrangements to undertake virtual reviews of infection prevention and control, the Emergency Department and a well-led review, and I am delighted that there were no significant concerns raised from these calls.*

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

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

*Signed:*

*David Loughton CBE, Chief Executive*

*18 May 2021*

# Vision and Values

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

# Looking back 2020/21

# Priorities for Improvement

| Workforce | Patient Safety | Patient Experience |
|---|---|---|
| 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. | 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. | We are committed to providing high quality clinical care and aim to provide an excellent experience for patients, their relatives and carers. |

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

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

# Priority 1: Workforce

## Nursing, Midwifery and Health Visiting Workforce including Allied Health Professionals

### Recruitment

Throughout 2020 the successful recruitment programme for nursing continued despite the impact of the COVID-19 pandemic. An interview team made up of clinical staff who were unable to work in patient facing roles actively recruited on a weekly basis to all vacant nursing posts. 166 international nurses were able to enter the country during this time and they completed the cultural transition and OSCE programme which enabled them to join the NMC register and now have permanent registered nurse posts within the Trust. Health Education England introduced paid placements for Student Nurses and Midwives, the Trust deployed over 180 students to support clinical areas for 6 months during the pandemic, many of these were subsequently recruited into permanent posts.

The Trust won two Nursing Times Workforce Awards in 2020, they were, Best Diversity and Inclusion Practice Award for the Clinical Fellowship Programme and Best UK Employer of the Year for Nursing Staff.

### Expanding placements

The Trust has successfully secured additional funding to support the expansion of placements in Nursing, Midwifery and Allied Health Professionals (AHPs) for pre-registration students. We have continued to increase the number of student nurses and midwives on placement within the Trust.

### Attractive development programmes

A virtual learning platform is now in place to support the delivery of online learning tailored to meet the needs of all staff within the Trust and will help with the recruitment and retention of nurses, midwives and AHPs.

### Professional Advocate role

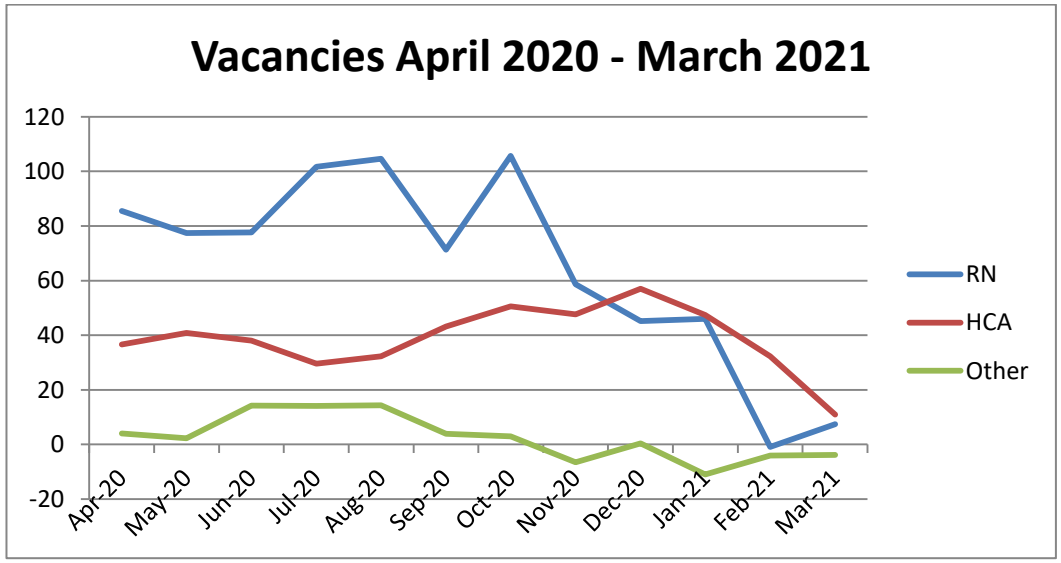
Following the success of the Professional Midwifery Advocate roles we have extended the role into nursing. These posts will help support the health and wellbeing of nurses and midwives, the quality agenda and support retention. Thirteen members of staff have attended an MSc module at Worcester University, supported by their line managers, they will have one day per month to commit to the role of Professional Advocate to support their nursing colleagues and associated teams.

**Safe Care**

The use of the SafeCare software provided the basis of our daily staffing toolkit, which matches staffing levels with patient acuity. It was utilised during the pandemic to compare staff numbers and skill mix alongside actual patient demand in real time, allowing the senior nursing team to make informed decisions and create acuity driven staffing.

During the financial year 2020/21, the Trust has successfully continued its efforts to recruit into the vacant nursing, midwifery and health visiting staff (registered and unregistered) vacancies. The Trust has further developed its nursing, midwifery and health visiting vacancy report and ensured that all key posts have been included, which provides a much more accurate status of vacancies.

The graph below illustrates the vacancy position since April 2020 for registered nurses, midwives, healthcare support workers and other support staff.




The Trust has increased the number of Registered Nurses undertaking Degrees and Masters Degrees in line with providing a knowledgeable workforce to deliver the best possible patient care.

During 2020/21, workforce turnover rate has considerably decreased. In 19/20 the normalised nursing and midwifery turnover rate was an average of 9.8%. The Trust has managed to improve its retention rate over the last 12 months and for 20/21 the average normalised turnover rate was down to 8.9%.

Other workforce achievements during the financial year of 2020-2021 include:

- Continued international nurse recruitment, navigating the COVID-19 pandemic, providing quarantine arrangements and virtual online learning.
- OSCE Bootcamp for international recruits continues to have a 100% pass rate.
- The Trust won a Health Education England clinical placement expansion fund to support the increase in student nurses.
- Attainment of Degrees and Masters Degrees within the nursing workforce continues to increase with the internal clinical fellowship offer support.
- A successful response to NHS England /Improvement Health Care Support worker recruitment campaign and an offer of education support is in place for those new to care.
- Purchase of a learner management system to support the quality of education.
- Provision of infection prevention education to local Care Home employees.
- Provision of intensive care nursing education to our reservist workforce, including military personnel.
- Provision of vaccination competency training to build a COVID-19 vaccinator workforce.
- Expansion of the number Advanced Clinical Practitioners employed within the Trust and across numerous specialties.
- 30 of our Health Care Assistants (Registered Nurses in their own country) have been supported to complete the International English Language Testing System (ILETS) and the Occupational English Test (OET) in the first steps towards UK registration.
- Significantly increased the number of student placements offered to students from the Staffordshire, Wolverhampton and Birmingham Universities.
- Improved governance structures.

## Allied Health Professionals

Allied Health Professionals (AHPs) are registered with the Health and Care Professions Council (HCPC) and are the third largest workforce in the NHS. They are graduate level professions, and are professionally autonomous practitioners making them central to meeting the changing demands faced by the NHS. As leaders and practitioners, AHPs are instrumental in delivering person-centred, evidence-based care and are vital to ensuring the sustainability of future services. This breadth of skills makes AHPs ideally placed to lead and support improvement. AHPs make a crucial contribution in supporting patients as first-point of-contact practitioners and bridge the historic divide between primary and community health services.

Our Allied Health Professionals (AHPs) adapted their services during the COVID-19 pandemic. These roles include dietitians, occupational therapists, operating department practitioners, orthoptists, physiotherapists, podiatrists, orthotists, radiographers and speech and language therapists. Many AHPs working in outpatient areas had to significantly change their ways of working from a literal ‘hands-on’ approach, which ended in March 2020 when lockdown started, to what we are now calling ‘a virtual service’.

Some of the key changes and achievements during this period include:

- Over 80 additional physiotherapy student placements have been offered to Keele and Wolverhampton University.
- Telephone and video consultations in the majority of cases, using smart phones between staff and patients have enabled some face-to-face contact ensuring assessments have continued.
- Cardiac Rehabilitation Exercise team have been particularly innovative by the creation of an exercise workout for patients which has attracted over 1,000 views on YouTube. Two more similar videos have subsequently been uploaded to the social media channel, all of which are to become part of the new Cardiac Rehabilitation Exercise programme model.
- The Team have also provided workouts through an online exercise software resource for physiotherapy, rehabilitation and fitness. For those without internet access, staff can print off PDFs of personalised workouts to post to patients.
- The Clinical System Framework (CSF) has superseded the Nursing System Framework (NSF) and the AHP Strategic Framework.
- Speech and Language Therapy have successfully implemented paper-light working and other AHP services are now working towards it.

These new ways of working presented numerous challenges to AHPs as they continued to try to maintain the same levels of care and professionalism, but staff embraced the changes that were imposed upon them by the restrictions of COVID-19. Several members of staff reported that their telephone assessment skills had improved as a result of these changes and they had positive feedback from patients. Patients now have a greater choice of how they receive their treatment. The greater flexibility has been welcomed by patients, some of whom are still nervous about attending hospital for clinic appointments, or having someone visit them at home. All of this benefits the patient experience.

**Long COVID**

We recognise that COVID-19 will have a prolonged impact on many, particularly for those who have been ill with the virus and are experiencing further health complications, weeks or months after the event. Between two and ten percent of COVID-19 patients suffer from what is commonly known as ‘long covid syndrome’, with varying symptoms including a high temperature, fatigue, ‘brain fog’, anxiety, breathlessness and generalised pain.

In October 2020, NHS England /Improvement announced a plan to create new ‘Long COVID Clinics’ in an effort to provide physical, cognitive and psychological assessments for these patients, and we are pleased to say we now have such clinics at our New Cross Hospital site.

Patients with ongoing symptoms (12 weeks after COVID-19 diagnosis) and no other explanation for their illness are seen by a Respiratory Physiotherapist Specialist in one of the three-weekly clinics, run alongside a clinic held by the Trust’s Respiratory Team who support patients with on-going chest problems. Many of the patients referred to the clinic are patients that have been struggling for months, not knowing what was wrong with them, and are extremely grateful for the help being offered. They are often not back at work

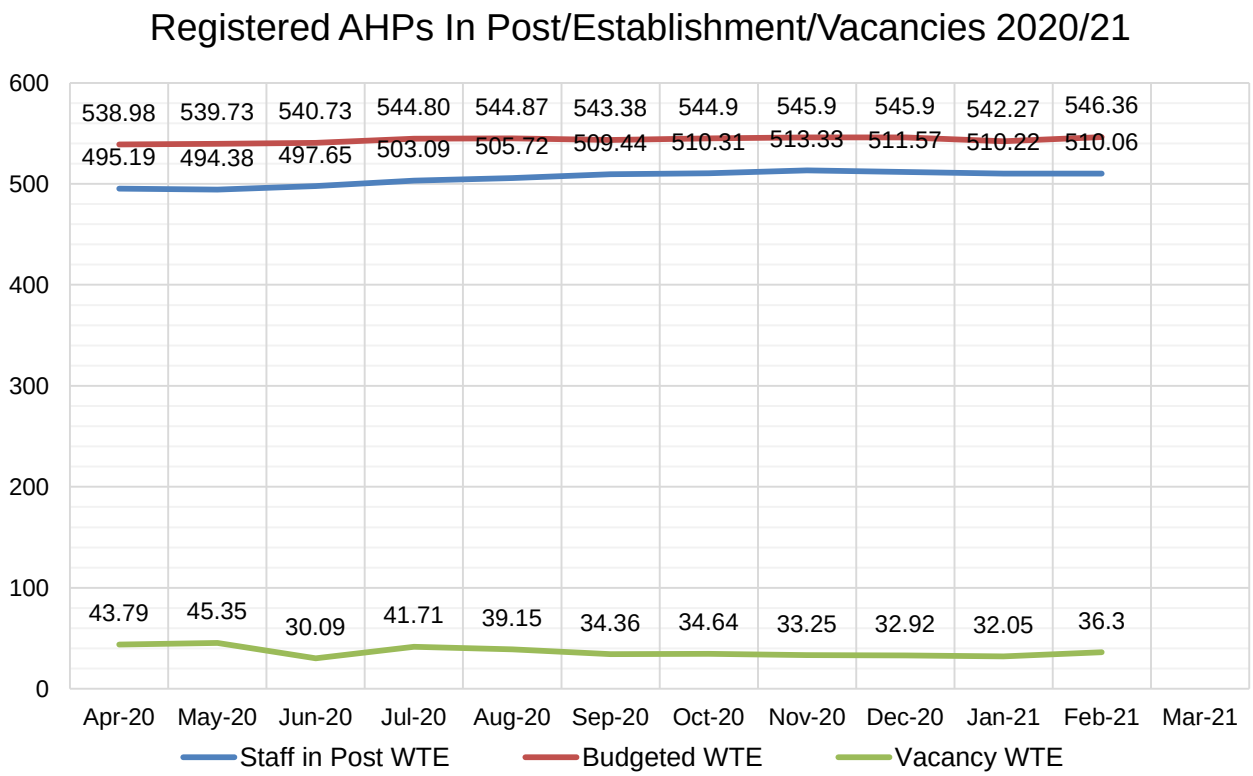
and are experiencing regular fatigue, breathing problems and cognitive impairments. Following an assessment, the Physiotherapist signposts patients to the relevant services. Often this means working with therapy colleagues, the Psychology Team and other disciplines to support both their physical and mental wellbeing. It is a great example of collaborative working.

Setting up the Long COVID Clinics has been a challenge and we are all still learning about the virus and its impact, but there are already a number of resources to help people, including online literature and support groups.

The Chartered Society of Physiotherapy has recently updated their COVID-19 Rehabilitation Standards: Rehabilitation of adults who are hospitalised due to acute COVID-19 or Long COVID: physiotherapy service delivery.

The document lays out the key principles of delivering physiotherapy/rehabilitation for people with acute COVID-19 and Long COVID in a hospital setting. Version 1 focused on critical care and rehabilitation for people with acute COVID-19, but version 2 is expanded to include people with Long COVID and any episode of hospital care. The new guidelines are underpinned by the latest national guidance, government regulations, emerging evidence, expert opinion and lived experiences of people with COVID-19. The document includes a definition and description of Acute and Long COVID, different classifications and the latest data on prevalence. The Trust will self-assess against the 6 standards outlined in the document.

The following graph illustrates the establishment and vacancy data for Registered Allied Health Professionals (AHPs) for 2020/21




The overall AHP vacancy rate has decreased, with approximately 6.6% of vacancies unfilled in February 2020.

The vacancy rate ranged from 1.3% to 13.8% across all of the professions.

The professions currently with a vacancy rate higher than the average value include:

- Podiatry 10.8%
- Occupational Therapy 13.8%
- Orthoptics/Optics 7.9%

Ongoing efforts continued to recruit into these vacancies during the financial year of 2020/21. However, some are associated with national shortages for these professions.

## Medical Workforce

The key areas of focus included:

**Senior (consultant) medical staff**

- Continued focus on prioritising high quality appointments and ensuring the Trust is a preferred employer for those applying.

- Embedded induction and mentoring programme to support new senior medical staff.
- Established a senior medical staff development programme.
- Identification of areas where consultant staffing is nationally challenged and development of links with other organisations/ networks (e.g. oncology) and also planned development of fellows through Certificate of Eligibility for Specialist Registration (CESR) to consultant level in these specialties (Oncology, Radiology, Emergency Department).
- Robust job planning established and rostering for senior medical staff being implemented to maximise efficiency of senior medical staff workforce.
- The Senior Medical Staff Committee is now run online with improved attendance and engagement.

**Junior medical staff**

- Investment into rest facilities for junior medical staff, including enhanced health and wellbeing support.
- Deanery trainees – focus on maintaining high satisfaction levels in Job Evaluation Survey Tool (JEST) surveys, which are recognised as important in attracting trainees to work at the Trust as consultants in the future.
- Strengthened support team for all trainees both academically and pastorally.
- Fellowship programme – this award winning programme has increased in size with >200 fellows now employed at the Trust. The Trust has liaised with Health Education England (HEE) and the programme has now been approved as a HEE recognised training programme.
- Increased numbers of junior medical staff have facilitated compliant, enhanced and robust 24/7 rotas during the COVID-19 pandemic.

## Health and Wellbeing

The Trust's commitment to delivering high quality patient care is dependent on having healthy staff who feel supported. We believe that supporting staff wellbeing in the workplace is an important shared responsibility, which is enabled through the Trust's strategic approach to workplace health and wellbeing and covers the following 5 Wellbeing themes: Career, Mental and Emotional Wellbeing, Physical, Financial, and Community and Social Wellbeing. This is underpinned by a high-level action plan with a number of key priorities particularly in relation to physical and emotional wellbeing.

The health and wellbeing of our staff has always been paramount at the Trust and never more so than over the past 12 months when the demands on staff have taken us into extraordinary territory.

Reflecting back, we recognise that the wellbeing needs of staff were different through the waves of the pandemic. During the first wave we were able to quickly establish pop-up shops on site so that staff were able to access basic provisions without having to worry about being able to get food and toiletries; we extended the hours of our fresh fruit and vegetable stall so that staff ending and starting shift

were able to buy supplies at times that worked for them and our cafes were open into the early hours of the morning every day.

Initially we created and developed a set of wellbeing web pages that were accessible to staff on any device at any location and at any time, recognising that many staff have limited access during their working day to email and the Trust intranet.

The wellbeing webpages aimed to provide support at 4 levels as shown in the model below:

During the subsequent waves, access to groceries and toiletries has been less of a priority however we are still ready to put this extra support in place if needed.

Wobble Rooms and a Serenity Room were created to ensure staff had a quiet safe space to go when they needed time to reflect or have some quiet time away from their immediate work areas. This is an investment the Trust will continue to support.

Waves two and three have offered different wellbeing challenges that have focused more on facilitated support and psychological interventions as resilience has been severely impacted not only for those who have been on the front line of COVID-19, but also for those who have been shielding and working remotely for long periods of time.

We have communicated widely and frequently the resources available through the national wellbeing offer which offers support for individuals as well as tools for managers and leaders to help them navigate through the challenges the pandemic has brought with relationships and team dynamics.

Readily accessible support from colleagues in the Black Country Healthcare Partnership has been welcomed and the establishment of the Black Country Mental Healthcare Hub as part of the national initiative to support staff through Our NHS People continues to be utilised.

The key objective during the financial year of 2020/21 was to continue to further embed the Trust's health and wellbeing agenda and progress a variety of approaches. Protecting the health and wellbeing of our staff has been a top priority throughout the COVID-19 pandemic, during which everyone has been continuingly challenged and tested - both physically and emotionally. Our 2020 staff survey results have shown a further increase in the number of staff members who have stated that the Trust takes positive action on health and wellbeing (a 4% increase compared to 2019).

In supporting our staff wellbeing, the Trust put in place a dedicated website accessible for all staff with a variety of information and resources to help individuals at work and at home. This includes enhanced access to packages for physical activities and health management, mental wellbeing (including access to mental health first aid and the Remploy support programme) and increased psychological support provision, staff benefits such as access to financial support and guidance. Additionally, a suite of information for managers/leaders providing techniques and guidance on how to best support their teams was implemented.

Our trained Mental Health First Aiders and Health and Wellbeing Champions continue to be a crucial resource across the organisation.

The Trust has offered COVID-19 Vaccinations to Trust staff since their availability in line with Black Country & West Birmingham CCG direction as detailed in the table below.

| | | |
|---|---|---|
| Walsall Hospital Hub | 1st December 2020 to present | 1st and 2nd doses |
| RWT Hospital Hub | 5th January 2021 - 2nd February 2021<br>1st March 2021 – present<br><br>22nd March 2021 – 18th April 2021 | 1st doses (Pfizer)<br>1st doses (Oxford AstraZeneca, Limited supply)<br>2nd doses (Pfizer) and 1st doses (Pfizer Oxford AstraZeneca) |

Trust staff uptake was 74.17% (7610) by 30th March 2021. The Trust was stood down as Hospital Hub from 1st February until 2nd doses commenced on 22nd March, however, from 1st March the Trust did get a small allocation of vaccine which enabled vaccination in addition to the provision at Walsall Hospital Hub.

The Trust Hospital Hub has also supported the vaccination of health and social care staff across the catchment area and those supporting the extremely clinically vulnerable in Wolverhampton and Cannock. The Hospital Hub has also vaccinated a small number of patients.

# Priority 2: Safe Care

## Number and Themes of Serious Incidents

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

As a result of the COVID-19 Pandemic the Trust has adapted its incident reporting and investigation processes to meet National guidance changes during the financial year of 2020/21. This includes the reporting and review of all COVID-19 healthcare associated infections and appropriate application of the Duty of Candour.

In the financial year 2020/21, the Trust reported 129 serious incidents (89 in 2019/20) via the National Serious and Incident Management System (STEIS). The most significant change being an increase in reported incidents related to COVID-19 infections (59) during the pandemic. Diagnostic incidents were reduced from 18 in 2019/20 to 9 in 2020/21.

Some incident categories have seen less change for example treatment Delay incidents - 13 were reported in 2019/20 and 14 in 2020/21 and the same number of incidents were reported in 2019/20 and 2020/21 for Slip/Trips/Falls (with serious harm) (5), Never Events (1) and Confidential breaches (4).

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

As an ongoing area of work the Trust reviews serious incident themes and causes, in order to identify issues for quality and safety improvement, audit, monitoring and learning.

The following serious and STEIS reportable incident data is a true reflection of events based on the data analysed on the 9th April 2021.

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

**Serious Incidents (including Never Events) – Reported to Steis within stated date range**

**New Overall Total = 129**

The figures above do not include any agreed removals and are a true reflection as of this time

| Category | 01/04/2020 to 31/03/2021 |
|---|---|
| Confidential Breach | 4 |
| Consent | 1 |
| Diagnostic | 9 |
| Infection | |
| (C.Diff) | 5 |
| (COVID-19 related) | 59 |
| (CPE) | 1 |
| (MRSA) | 2 |
| (MSSA) | 1 |
| Maternity | 4 |
| Never Event | |
| (Oxygen related) | 1 |
| Pressure Ulcers | |
| (Community acquired) | 3 |
| (Hospital acquired) | 12 |
| (Corporate acquired) | 1 |
| (Trust acquired) | 2 |
| Slip/Trip/Fall (resulted in serious harm) | 5 |

| | |
|---|---|
| Sub Optimal Care | 3 |
| Treatment Delay | 14 |
| Unexpected Death<br>(coded as pending at this time) | 1 |
| VTE | 1 |
| **TOTAL** | **129** |

## Numbers and Themes of Never Events

During the financial year April 2020 to March 2021, there has been one Never Event incident reported and this is currently under investigation. This number of never events reported is the same as in 2019/2020. N.B last year's quality account reported two never events however following publication it was noted that one case had been de-escalated.

| Date | Location | Category | Level of Harm | Progress |
|---|---|---|---|---|
| February 2021 | Care of Elderly | Unintentional connection of a patient requiring oxygen to an airflow meter | None | Investigation underway |

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

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

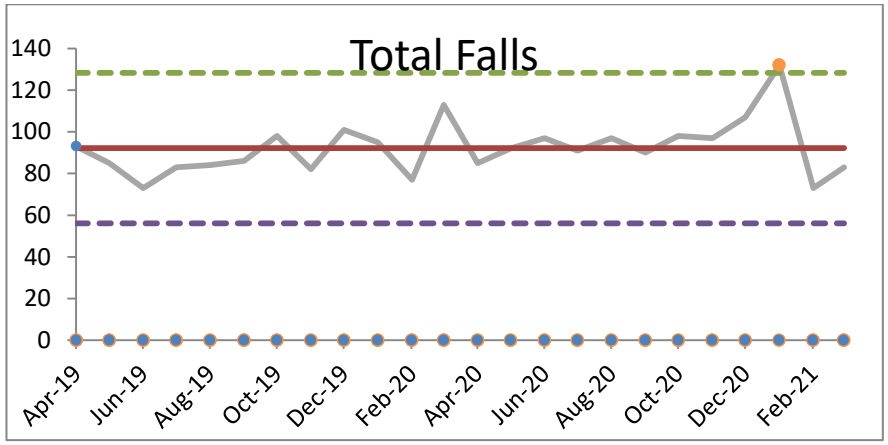
## Falls

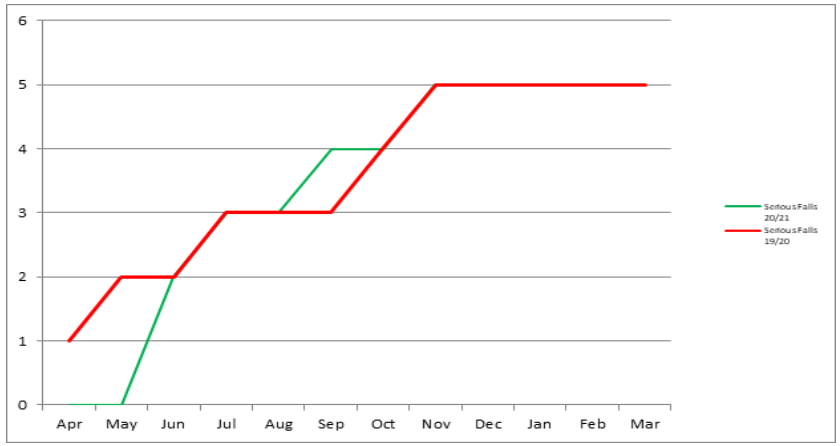
During the financial year of 2020/21, the Trust's Falls Prevention Group continued to maintain oversight of the falls prevention agenda and associated quality improvement projects. Some of which included:

- A full review of falls risk assessment and launch across the Trust in March 2021. This includes a new comprehensive, patient centred assessment tool and care pathway to ensure patient safety in relation to falls is its main focus. The new risk assessment document addresses the areas for improvement highlighted in last year's audit data around patient information and medication review.
- Further updates to policy and processes go hand in hand with these changes.
- Falls audit questions have been reviewed and strengthened.

- In addition, weekly falls accountability meetings have continued to be held, to review and learn from falls incidents, which enhances falls education for both staff and patients.
- The number of falls per 1,000 occupied bed days has remained below 5.6, averaging 4.46 (range 3.6-5.7) but **total** falls numbers increased by 6.7% when compared to 2019/20, this was in line with increased bed occupancy.
- The number of falls resulting in severe harm in the financial year 2020/21 was 5, the same as in the previous year (2019/20), despite increased bed occupancy during 2020/21.
- The number of falls resulting in moderate harm in 2020/21 was 23, also the same as in the previous year (2019/20).

**Trust Inpatient Falls Data May 2018 - March 2021**
**illustrating improvement**




**Trust Inpatient Falls with Serious Harm 2018/19 compared to 2020/21**

As part of our Excellence in Care pillar within the Clinical System Framework, preventing falls and learning from these incidents remains a priority area and the Trust's focus will include:

- Continue to strengthen our timely assessments of patients who are at risk of falling.
- Further strengthen staff knowledge with a dedicated falls training and competency package.
- Address any concerns from our more detailed monthly falls audits undertaken in 2021/2022 pertaining to documentation, specifically assessing a patients' falls risk and planning care around that risk.
- Undertake further continuous quality improvement projects for specific aspects of care, or in specific clinical areas, and share our

learning across the Trust.
- Continue to hold the established accountability meetings with clinical leaders to review falls incidents, promoting shared accountability, learning and ownership whilst also identifying areas of good clinical practice.

## Preventing Infection

The financial year of 2020/21 has been an unprecedented year within the Infection Prevention Team. The first case of COVID-19 was identified in early March 2020 and admissions continued to rise throughout until a peak in April 2020. June – September 2020 saw a low rate within the hospital however the second wave started in October 2020 and did not subside until March 2021. During this period the Infection Prevention team (IPT) were reactive rather than proactive so the key objectives set in March 2020 were not met.

The IPT continued to work effectively with Public Health and the multi-disciplinary teams to ensure that COVID-19 guidance was implemented across the City. This included education, standard and policy setting, establishing assurance processes and, most importantly, ensuring patient and staff safety in the prevention of spread of COVID-19.

Key Infection Prevention updates for 2020-2021 include:

- Caprbapenamase resistant enterococcus (CPE) colonisation has been low in numbers due to reduced overseas travel – 18.
- *Clostridiodes difficile* (C. difficile) is over trajectory this year with 46 cases, 6 over internally agreed trajectory.
- 2 MRSA bacteraemia attributed to the Trust.
- Environmental controls have been a top priority in our approach in tackling Health Care Acquired Infection*;* this has been more important this year due to the Pandemic although the deep clean schedule has not been completed entirely, wards have received partial deep cleans throughout the year.
- Influenza preparedness and prevention for patients and staff, achieving 70.23% uptake of vaccine for frontline staff and 75.45% of all staff.
- 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.
- Device related hospital acquired bacteraemia (DRHAB) was above the internal trajectory with 67 being identified against a trajectory of 48.
- COVID-19 outbreak management within Care Homes was a challenge as this became part of the workload with a substantive 2 year contract being agreed, ensuring a seamless service across healthcare facilities throughout the City.
- Outbreak management for COVID-19 included dedicated wards/bays to prevent further movement of patients and ward closures – 59 outbreaks occurred.

The team has worked tirelessly throughout the COVID-19 Pandemic and a successful business case was agreed to ensure 7 day working, 9 – 5 and ensuring that proactive work will take priority in the years to come.

A new Matron has been appointed to develop Education and Innovation within Infection Prevention. 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.

Looking forward the Annual Work Programme includes:

1. Re-launching Infection Prevention and going back to basics. Over the last 12 months COVID-19 has been at the forefront of the Trust and other organisms have not been so prevalent so the IP Team will be regularly providing education for new staff who have joined in 2020 and updating existing staff.
2. Maintaining environment scores above 95%. With the IP education this will support:
   - Reduction in MRSA Acquisition
   - Reduction in *Clostridiodes difficile*
   - Reduction in DRHABs
3. A strategy for reducing the use of urinary catheters across the City, explore alternative products, develop a protocol for identifying Catheter Associated Urinary Tract Infections (CAUTI) and develop a Root Cause Analysis (RCA) tool.
4. Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data.
5. Sustain the Trusts' excellent reputation for Infection Prevention through team members' participation in national groups and projects.
6. COVID-19 will continue to be identified, therefore Infection Prevention will maintain and update protocols accordingly and will form part of routine workload.
7. Identifying the prevalence of Hospital Acquired Pneumonia (HAP) and Ventilator Associated Pneumonia (VAP) cases and developing a strategy to reduce these numbers.

## Venous Thromboembolism (VTE)

The financial year of 2020/21 has been the VTE group's most challenging year. Resources were stretched as consultants worked to support COVID-19 areas.

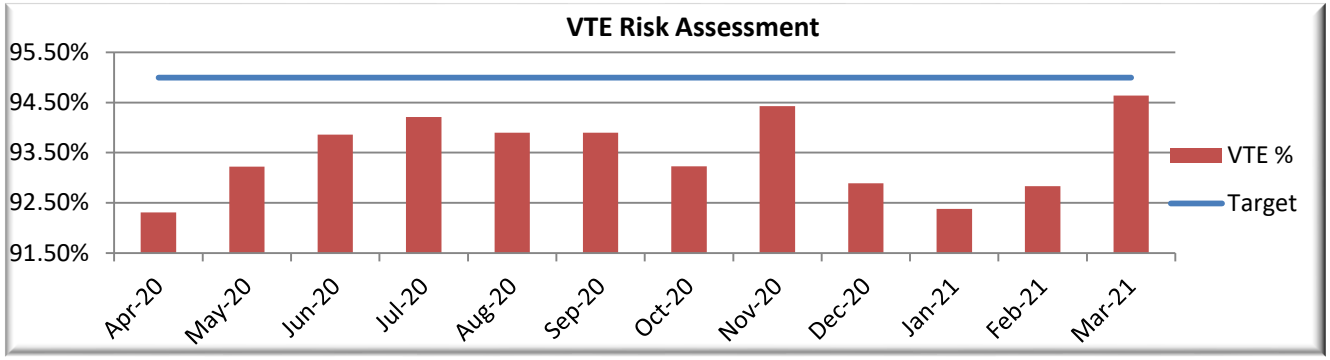
Anticoagulation in reach and VTE support hours were used to facilitate the increased requirement for home visits to clinically vulnerable and shielding patients under the care of the Community Anticoagulation Service. Logistically we moved all induction training on line to ensure that staff still were able to receive a full medical and nursing induction. As new clinical areas opened and other areas changed

function we supported re-deployed staff, re-configured equipment allocations and worked with other providers to ensure that safer care was a priority. Due to infection prevention measures and reduced resources VTE live ward audits had to be scaled back during the year.

COVID-19 also presented clinical challenges. A complication of COVID-19 was the increased risk of patients developing Venous Thromboembolism. In response to this VTE group issued guidance for enhanced care of patients with COVID-19, this guidance was based on best evidence available and later updated to reflect guidance issued by NICE in November 2020. During the year we have seen the incidence of deep vein thrombosis and pulmonary embolism increase with COVID-19 as the main contributory factor, these case numbers peaked in January 2021. We have continued to monitor all cases of VTE, completing case reviews to ensure patients have received safe and effective care.

We have continued to monitor VTE risk assessment compliance. The timeliness of risk assessments has been below our expected criteria. We have continued to work with departments to improve performance and compliance with this indicator.

Due to the challenges of the year we have not completed some of the work we had set out to achieve. Work has continued with the Emergency Department to introduce VTE risk assessment for patients in lower limb casts, setting up a VTE multi-disciplinary review team to optimise planned care for patients with VTE as per the NCEPOD report, VTE policy has had a partial review which has been approved, and we have continued to look at linking VTE risk assessment to prescribing and ways of improving administration/patient compliance with these prescriptions.




## Pressure Ulcers

Pressure ulcer prevention has remained very important through this challenging year. There were many new challenges the staff faced that increased the risk of pressure ulcers. However, teamwork and collaborative actions has helped us achieve a reduction of incidents. The data shows the Trust has sustained an improvement, but has learnt where there were significant spikes in the data.

The challenges we faced were:

- Unknown effects of Coronavirus and the effects on a person's skin. COVID-19 related skin changes can look like pressure ulcers and it is very difficult to differentiate between the two.
- Teams faced daily workforce challenges of experience and capacity due to the pandemic and required on-going training and support to develop new skills.
- Patients managed in a prone position (lying on their front) for prolonged periods as they were too unstable to move, therefore new pressure points were affected by gravitational oedema.
- Steroid medication and noradrenaline have significant effects on the skin, therefore increasing the risks of pressure ulcers.
- The sedentary life, limited access to family or support networks had an impact on community incidents initially.
- Serious incidents were reported and investigated to learn and take action. The Trust experienced a 20% reduction of pressure ulcer serious incidents in 2020/21.

Specific achievements in 2020/21 were:

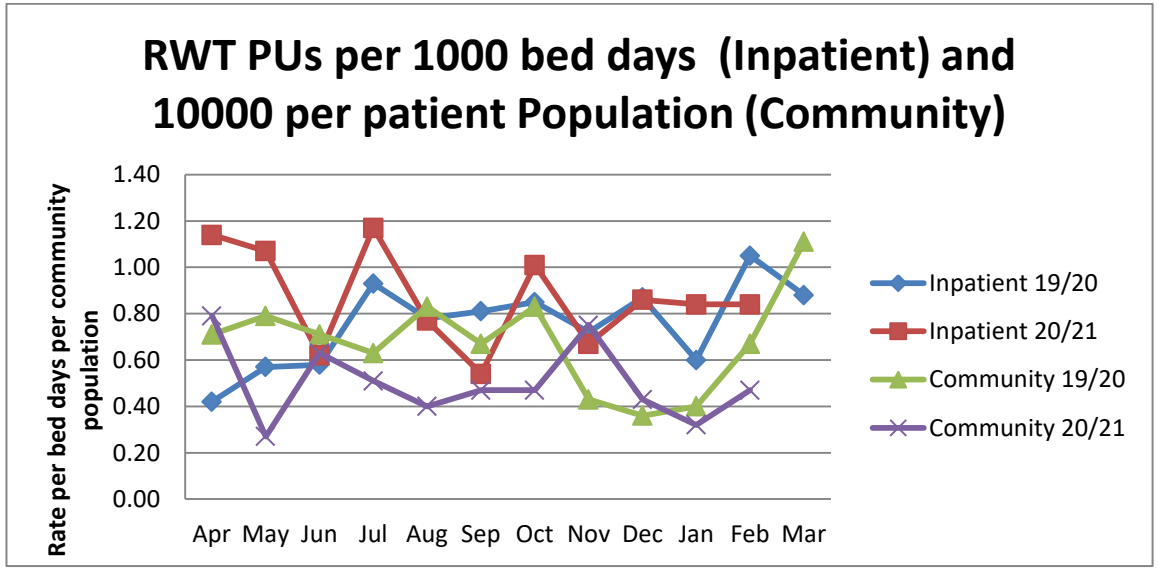
- An e-learning pressure ulcer prevention education session for staff to learn the fundamental elements of pressure ulcer prevention and management.
- Tissue Viability Nurse and Practice Education Facilitators supported education at the bedside.
- All care homes were issued a moisture lesion and skin tear box to manage simple wounds early to prevent pressure ulcers and potential hospital admission.
- Invested in very high specification mattresses for Integrated Critical Care Unit.
- Continually achieved a reduction of moisture associated skin damage incidents.
- A sustained reduction of the more serious type of pressure ulcers (Category 3, 4, and unstageable).
- A reduction of total number of incidents.
- Developed a new admission risk assessment document which includes a new risk assessment tool called PURPOSE T and a continence assessment tool.
- Videos and pathways implemented to protect staff skin were implemented to prevent skin damage from sustained use of personal protective equipment (PPE).

Future plans:

- The Trust has a Clinical Service Strategy with an aim to reduce serious incidents further.
- Exploration of new innovations to help prevent pressure ulcers.
- Continual education and competency development.

The pressure ulcer data has been translated in to the Statistical Process Control (SPC) chart format, to better understand trends and

variations, in order to inform future improvements.




## Medication Incidents

The Trust values include safety and effectiveness. The Trust aims to work collaboratively to prioritise the safety of all within our care environment. Staff are encouraged to report all incidents involving medication. A high level of reporting with a low level of patient harm is seen as a positive outcome.

The incidents are a valuable tool to direct learning and policy improvements within the Trust. Incidents are analysed monthly by the Medication Safety Team for trends and areas for escalation. The Medication Safety Group (MSG) reviews all incidents which have been associated with harm and ensures that they have been graded correctly and appropriate actions have been taken. Learning identified is widely shared across the Trust through governance processes and publications.

In addition to incident review, the MSG focuses on improvement actions. A dashboard has been produced for medication incidents and this enables the group to have oversight and identify trends.

Completed actions within medication safety for financial year 2020/21 include:

- Quarterly reporting of manual missed doses audits to Medicines Management Group (MMG).
- Approval of a critical medicines list and missed doses procedure.

- Insulin templates within ePMA updated to improve timely administration.
- Deep dive review of extravasation incidents, and actions taken to reduce reported numbers.
- Production of prescribing and administration quick reference guides for use in the Integrated Critical Care Unit, to support staff working with unfamiliar medicines in a high-pressure environment.

The MSG will continue to have oversight of medication incidents within the Trust, with a close focus on improvements progressed by the task and finish groups, examples include:

- Monthly insulin prescribing and administration audit.
- Publication of a new insulin prescription chart.
- Use of ePMA to produce automated missed doses reports.
- Use of the quarterly missed doses audit to identify focus areas.
- Collaboration with the Trust VTE group to reduce harm from VTE incidents.
- The Trust will implement the NHS England National Patient Safety Alert: Steroid Emergency Card with a coordinated plan across both primary and secondary care.

The table below indicates reported medication incidents and levels of harm for the financial year 2020-2021

| | Apr 20 | May 20 | Jun 20 | Jul 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total No. of medication incidents reported | 101 | 104 | 166 | 175 | 178 | 161 | 172 | 139 | 153 | 117 | 130 | 129 |
| No Harm | 96 | 99 | 159 | 164 | 163 | 152 | 168 | 131 | 149 | 114 | 130 | 128 |
| Low Harm | 4 | 5 | 6 | 8 | 14 | 8 | 3 | 8 | 4 | 3 | 0 | 1 |
| Moderate Harm | 1 | 0 | 1 | 3 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| Severe Harm | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of Admissions | 4858 | 6196 | 7355 | 9087 | 8780 | 9598 | 10341 | 9744 | 9424 | 7935 | 7797 | 10226 |
| Rate of Medication Incident | 2.08 | 1.69 | 2.26 | 1.93 | 2.03 | 1.68 | 1.66 | 1.43 | 1.62 | 1.47 | 2.62 | 1.26 |
| Rate of Incident Associated With Harm | 0.10 | 0.08 | 0.10 | 0.12 | 0.17 | 0.09 | 0.04 | 0.08 | 0.04 | 0.04 | 0.00 | 0.01 |

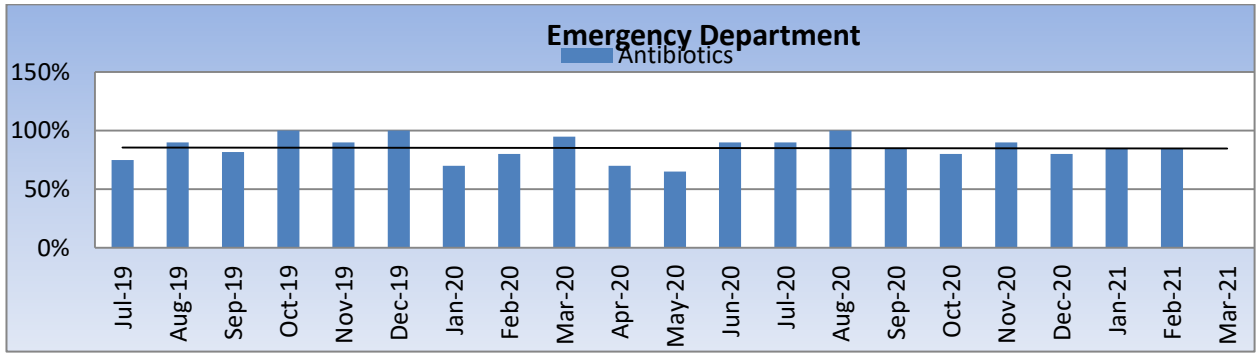
# Sepsis

Despite the Sepsis Team's redeployment during the COVID-19 pandemic, the Trust has continued to focus its effort on increasing sepsis awareness by re-enforcing education and training further including the use of virtual platforms. With the delivery of specific continuous quality improvement projects to support improvement, implementation of a comprehensive audit programme and regular ward rounds by the Sepsis Team, the Trust has been able to achieve above eighty per cent consistently across all quarters in sepsis screening and antibiotic administration within an hour of clinician review, both in the Emergency Department and acute inpatient settings. This data has continued to be reported within the Trust's Integrated Quality and Performance Report. Due to concerns with data accuracy using vitals operational reporting, manual audit data for the last three quarters was reviewed by an external auditor with no concerns identified, confirming our robust and effective audit methodology. This improvement in Trust's sepsis performance has also been reflected in the significant drop in septicaemia related Standardised Hospital Mortality Index (SHMI).

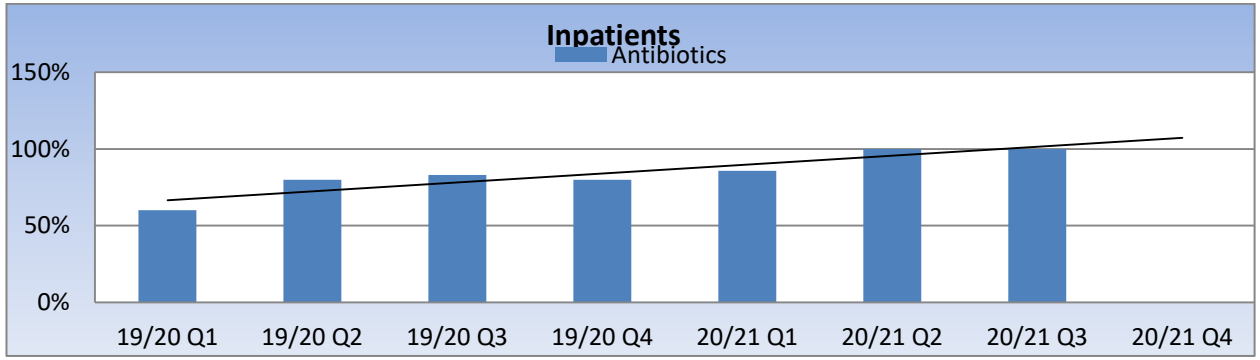
Please see below graphs showing consistency and improvement in administration of IV antibiotics within 1 hour of identifying sepsis in:

1. Emergency department (please see graph 1)
2. Other emergency portals and in-patient areas (please see graph 2).

Graph 1



Graph 2




## Mental Health

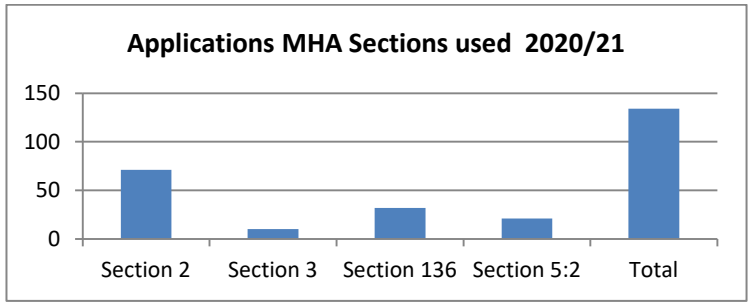
Having previously made a commitment to substantially review the approach to the safety and quality of the provision of mental health care within the organisation, some of the achievements for 2020/21 have been:

- Implementation of a robust governance structure - The Trust has a Mental Health Operational Oversight Group which oversees major developments and governance of Mental Health. The Group reports to the Compliance Oversight Group biannually and has representation from the Mental Health Trust and Social Services, as well as Trust wide representatives across adult and children's services. The group acts on a suite of information including applications of the Mental Health Act (MHA), restraint, self-harm attempts, violence and aggression incidents, training, complaints and deprivation of liberty standards use.
- Staff training - In August 2020 a mandatory training programme was launched in the Trust to provide all trust staff with awareness of mental health issues, including what encompasses mental illness and the link between mental and physical health diagnoses. It also provides some simple guidance on how best to care for someone with mental health difficulties. Levels 2-4 provides service specific training including Trust Board training.
- Development of the Mental Health Policy - The Mental Health Act (1983) Administration Policy has been published in the Trust and contains guidance, links and a suite of processes in order to safely govern the use of the MHA. This policy has been written in partnership with Black Country Healthcare Mental Health Trust and is supported by a new service level agreement. It includes access arrangements to mental health advocacy services. The Policy sets out the board reporting arrangements which includes the reporting of inequalities relating to applications of the MHA.
- Introduction of compliance monitoring associated with the mental health provision - A simple reporting system has been introduced to enable the reporting of patients detained under the MHA. This enables assurance that papers have been appropriately registered with the mental health trusts and the detention is safe.

- Ensuring that environments are safe for mental health patients - The Trust Ligature Policy risk assessments have been reviewed in 2020/21. The Emergency Department has benchmarked its environment against the CQC brief guide: assessing mental health care in the emergency department. A programme of review of pathways of patients with Mental Health needs through the organisation has commenced.

Applications of the MHA in the Trust in 2020/21

The below table shows the number of patients reported as cared for under the MHA in 20/21 by RWT. This data includes care in the Emergency Department.




# Priority 3: Patient Experience

Providing a positive patient experience during the COVID-19 Pandemic has certainly been challenging.

Whilst we always try to ensure that we get the basics right, making sure our patients feel safe and cared for, that they have trust and confidence in the staff caring for them, and that they receive excellent quality of care in a clean and pleasant environment, for 2020/21 this has not been without its difficulties.

During such unprecedented times, our patients and their loved ones were understanding and whilst clearly worried about the circumstances we all found ourselves in, continued to be appreciative and trusted us to deliver first class clinical care.

Delivering first class clinical care is always our aspiration and what should be expected, however, after that, it is the ‘added factor’ which gives a positive patient experience. Getting communication right, spending time with patients and their families to talk about treatment pathways are amongst many added factors. During the peak of the pandemic visiting was suspended to protect everyone and this added to the distress felt by some families whilst we cared for their loved ones during these difficult times.

The Trust invested in the purchase of new technology to enable families to be involved in decision making about their loved ones and part of discussions during ward rounds. The same technology was used to assist patients to have 'virtual' visiting on iPads.

In an attempt to help clinical colleagues, we recruited community clinical volunteers to help with some of those 'unseen' actions which take place behind the scenes, keeping communication open and transparent and helping to undertake the non-clinical duties required in clinical areas.

The introduction of communication hours and messages to a loved one was instrumental. The Patient and Advice and Liaison service continued to run, albeit, remotely at some times and offered support and reassurance where possible, sometimes, becoming the intermediate between the clinical areas and families at home.

A comprehensive communication strategy was implemented to also assist in keeping the families of our loved ones up to date on key changes as a result of the pandemic.

## Patient and Public Engagement and Co-Production

Despite the impact of COVID-19 throughout 2020/21 the Trust has continued to progress the three-year Patient Experience, Engagement and Public Involvement Strategy (2019-2022). This strategy sets out how the Trust would aspire to further improve patient experience, engagement and public involvement. Several initiatives had been implemented this year which focused on improved processes, co-production and continuous improvement.

Examples include:

- The ability to receive real-time patient experience feedback and monitoring across all Trust areas including in community/acute settings.
- The publication of a quarterly newsletter 'Listen, Learn, Share' which provides information of actions taken and learning outcomes as a result of feedback received.
- The development and maintenance of a community stakeholder database.
- A refresh of the self-assessment against the NHS Improvement Patient Experience Improvement Framework to identify areas for improvement.
- Piloted the NHS England Initiative of 'Always Events' within Paediatrics and designed key always events as part of a co-production approach with patients.
- Ensured triangulation of patient experience with wider quality, safety, workforce and performance metrics – now visible on ward entrances of all inpatient areas.
- Included stakeholders, patients and/or their carers to contribute and co-produce documents and initiatives to improve the patient experience.

- Increased the ways and means of how patient feedback is obtained by ability to complete Friends and Family Surveys electronically and by scanning onto a QR Code.
- Observe and Act - A critical-friend service improvement tool involving non-medical supporters, has been revised. The introduction of the Observe and Act initiative has been implemented as an e-learning package.
- In terms of complaint outcomes, the Trust has continued to demonstrate a notable percentage increase on closed complaints not upheld and same notable reduction for closed complaints partially or fully upheld, when compared nationally. This data is supported by subsequent low numbers of our own complaint investigations being successfully appealed and upheld by Parliamentary Health Service Ombudsman (PHSO).
- Following the implementation of a specific volunteer services improvement plan, cohorts of community clinical volunteers supported the Trust throughout the year, some gaining paid employment as a result of volunteering.
- The Patient Engagement Toolkit has been reviewed and updated to make it more accessible and visually engaging. Co-Production has been given more emphasis and a new appendix has been added on to digital engagement which has become a key tool in the COVID-19 environment. The Engagement Champions have continued to meet virtually.
- Always Events - A co-production and design framework, have now been introduced to a second team at West Park with others planned.

The Patient Experience Team has continued work on EDS2 (Equality and Diversity Systems). Information has been collated from across the Trust about the engagement that has taken place. Examples of this are:

- The Neuro-Rehab Team at West Park: Worked with patients to run an ‘inclusivity’ programme to ensure that patients’ specific needs across all protected categories are being met.
- The Accessible Information Working Group: Similarly examined communication protocols to ensure that communication barriers to engagement are minimised to maximise patient and public participation.
- The Sexual Health Team: Following patient comments the Sexual Health Team has desegregated patient waiting areas and adapted forms to be more reflective of the wide range of gender identities.
- Learning Disability Team: Now offers an open referral system to patients and carers to access the team more readily.
- Colorectoral Team: Responded to stated patient sensitivities around awareness of their ‘stoma’ status. This resulted in procedures, policies and protocols being changed to ensure even greater confidentiality and ‘sensitive signposting’ contacts being identified.
- Children’s Services: Introduced a ‘Health Passport’ to enable patients to participate in and contribute to greater care planning, with the passport informing the full range of health professionals to enable them to provide patient-centred care.
- Trust magazine entitled ‘Engagement Under Lockdown’ to guide staff to explore alternative ways engaging with patients and community groups.

## Patient Stories

Patients and carers were again encouraged to express how it feels to receive care from the Trust by sharing their 'Patient Stories'. Such stories provided the Trust with an opportunity to learn as an organisation, bringing experiences to life and making them accessible to other people. They can, and do, encourage the Trust to focus on the patient as a whole person rather than just a clinical condition or as an outcome. Patient stories are shown at Senior Managers Briefings and Trust Board sessions. During 2020/21, the stories shared included experiences of accessing stroke services, participating in a clinical trial for breast cancer and long-term recovery following treatment for ulcerative colitis.

## Council of Members

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

During 2020/21, the impact of COVID-19 meant that progress of the Council was paused and the level of active involvement in Trust work streams and external events was limited, although members have been active where possible, however we are happy to say that from July 2020 onwards we were able to pick up work again and resume meetings virtually.

Due to the COVID-19 situation we decided to also pause new elections for this year and are glad to say the existing Chair and Vice Chair were happy to stay in their roles to support us re-establishing the important work of the Council. Members have also been active outside of the Council meetings. The overall activity is summarised as follows:

1. **Key Topics Covered by Council Meetings**

- Sexual Health Services and patient engagement.
- Trust response to COVID-19.
- Equality Delivery System 2.
- Trust Dementia Services.

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

1. **Member Involvement in Trust Work streams**

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

- Equality, Diversity and Inclusion Steering Group
- Complaints Review Panel
- Trust Research and Development Projects
- Trust Policy Group meetings
- Infection Control Committee
- Patient Information Boards
- Digital Innovation Group
- Reviewing patient leaflets
- Contributing to RWT research projects.

### 2. Membership Base

Throughout the year, the Council have continued to attract interest from new members. During 2020-21 we have recruited an additional 4 members, and have had 1 member resign due to a new employment opportunity.

## Complaints Management

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

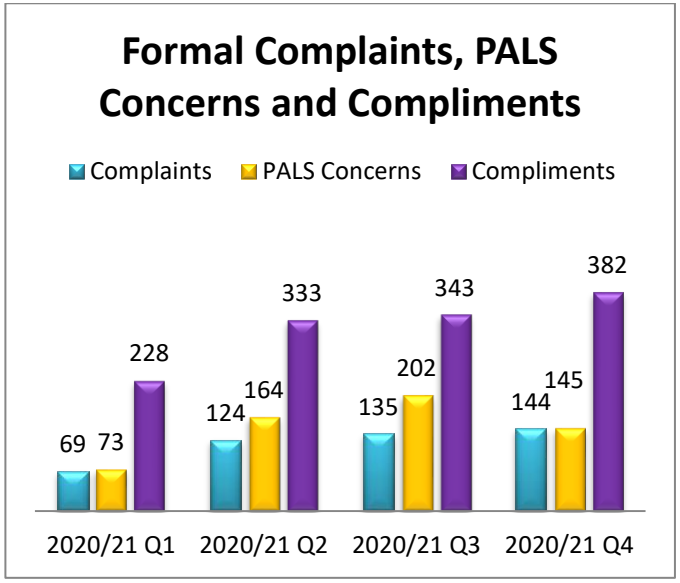
The Trust continues to annually review its approach to complaints management to ensure that complaints are handled with sensitivity, timeliness and subject to a robust and thorough investigation and response. Formal complaints are managed in accordance with the relevant statutory regulations.[2] The Trust has continued to see improvement in the timeliness of complaint handling, informing the complainants of the progress of their complaint and positive outcomes following external review from the Parliamentary Health Service Ombudsman (PHSO).

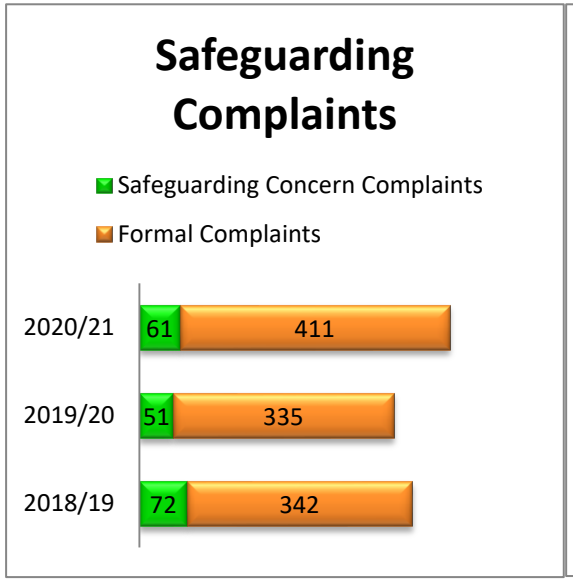
Key points for 2020/21 include:

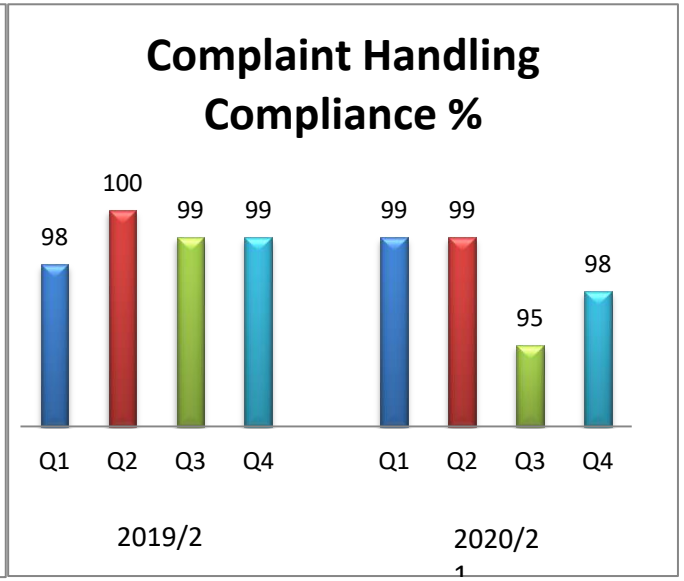
- Aimed to resolve all complaints speedily and efficiently whilst, during investigation, keeping the complainant informed, as far as reasonably practicable, as to the progress of the investigation and any delays.

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

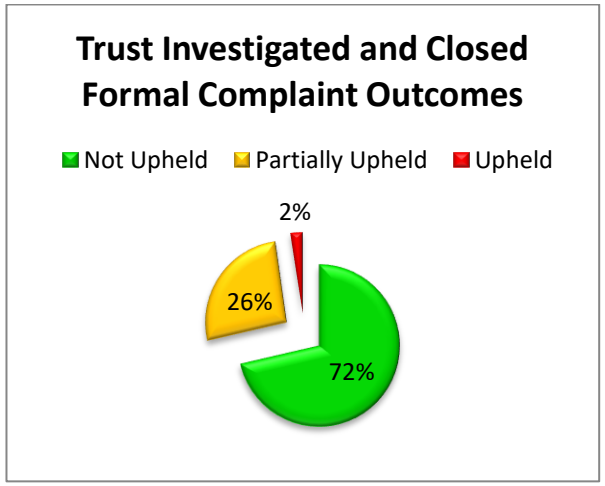
- Compliancy against policy with response times reaching an average of 97% for the year, and ensured that complaints resolution was timely and proportionate, where possible, offering the complainant the option for early resolution through meetings and mediation. This is a slight reduction of 2% of compliance with response times when compared to the previous year.
- The volume of PALS concerns has reduced by 25% to 584. However, the Trust has experienced a 22% increase in the volume of formal complaints (472). This in part may be due to the closure of the onsite Patient Experience hub for a large part of the year and also restrictions on in-patient visiting, both due to the pandemic.
- There were 61 complaints which did not meet the safeguarding criteria (section 42) and were subject to a complaint investigation, compared to 51 for year 2019/20.
- Similarly, there were 61 safeguarding complaints investigated and closed within this period. 53 were not upheld, 8 were partially upheld. There were no complaints for which the outcome was fully upheld.
- During the year 2020/21, from the 449 cases which were closed, the Trust determined that 72% of cases were not upheld, 26% were partially upheld and 2% were upheld. As with the previous year, all divisional complaint outcomes were significantly lower than the national average of 31.8% (as recorded by NHS Digital) for cases upheld.
- In terms of the outcomes of PHSO investigations which were ongoing from the previous year and were closed during 2020/21, (4 cases), it is noted that one case was fully upheld with a financial redress of £2,000, and 3 cases were partially upheld with a total financial redress of £1450. No other financial redress was awarded during the year.
- It is noted that for the previous year (2019/20) 10 cases were subject to a full PHSO investigation in comparison to the 3 for this year. This represents 0.6% of the total of complaints received. The PHSO suspended receipt of new cases for investigation during the peak of the COVID-19 pandemic and are now considering new cases. This potentially could have an impact on cases considered for the year 2021/22.
- Upon initial assessment the PHSO's decision was not to take any further action for 4 cases received in 2020/21. This provides assurance to the PHSO around the thoroughness of the Trust's investigation and response letters and of the remedial work undertaken to bring complaints to a satisfactory resolution.
- Quarter on quarter, there has been an increase in compliments received throughout the year although this is a reduction compared to the volume recorded in 2019/20.

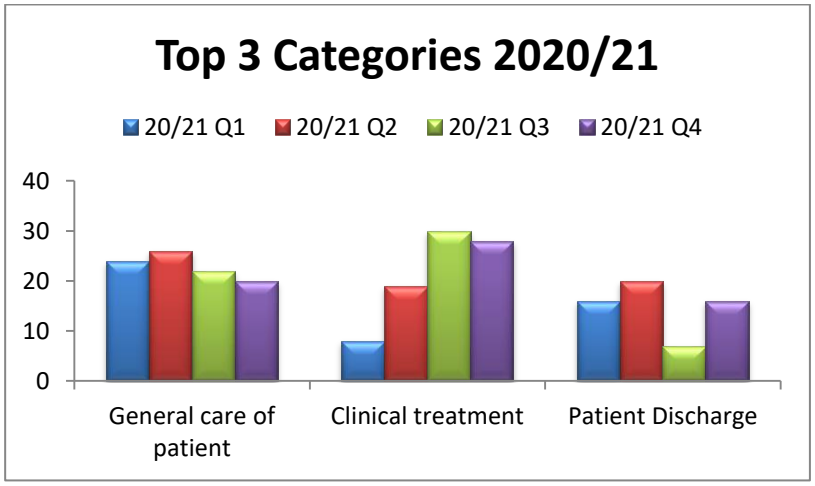



There is little variation between the key themes of complaints year on year, with the highest subjects being, general care of patient, clinical treatment and patient discharge. Upon analysis, it is noted that the complainants were seeking reassurance about their loved one's care whilst unable to visit and communication may not have been as timely or effective as desired. The table below illustrates the top 3 categories.



### Volunteering

The Trust is fortunate to have the support of volunteers, who are unpaid members of our local community who offer their time willingly to help.

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. Volunteers add an important 'extra' factor to helping us provide a positive patient and visitor experience in The Royal Wolverhampton NHS Trust (RWT).

2020/21 certainly was a year of huge change within voluntary services at RWT. Our existing voluntary workforce prior to the COVID-19 pandemic, were stood down due to a combination of factors. As a result, the Trust decided to hold recruitment for a COVID-19 specific 'Community Clinical Volunteer' role to provide much needed support to our clinical areas.

We successfully managed to recruit 120 volunteers by May 2020 and allocated people to ward areas. Volunteers were provided with training in bed making, nutrition and serving refreshments, dementia, and infection prevention.

The role of the volunteers was extremely successful. While volunteers were deployed initially into areas of greatest need to perform essential tasks such as bed making, volunteers also got involved with examples of truly enhancing the patient experience, including helping set up a new patient lounge, helping to create and facilitate a VE Day socially distanced tea party celebration, and helping patients undertake video calls with loved ones. Later we expanded the roles to include supporting the COVID-19 swab hub, internal vaccination hubs, virtual COVID-19 ward, a discharge follow up call scheme, and an activity programme at our rehabilitation hospital.

During recruitment, we particularly increased the number of younger volunteers supporting the Trust by linking in with local schools and colleges.

A further recruitment for clinical volunteers took place in late 2020 and we received a further 100 applications. Our successful volunteers program has gained national attention.

## Equality, Diversity and Inclusion

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

Key initiatives during 2020/21 included:

- **Publication of the Trust Annual Equality, Diversity and Inclusion Report.** The report underwent a significant change in presentation and a reduction in size to make it sharper and more focused. It provides an in-depth analysis of the equality related information collected across the Trust. Follow up actions have been created in order to address imbalances in diversity in the workforce and to improve accessibility for the communities that the Trust serves.
- **Review of the Equality Analysis Process**. The process for carrying out Equality Analysis' has been streamlined through changing the pro-formas and updating the Equality Analysis policy document. This should lead to a simpler process and an improvement in the standard of future Equality Analysis'.
- **Interpreting and Translations Services.** Following the switch to a new provider in December 2019 there has been significant improvements in this service. This is evident through factors such as staff feedback; coverage of bookings approaching 100%; minimal cancellations; translation turnaround times and access to a wider range of languages.
- **Review of Accessible Information Standard (AIS).** The Trust AIS working group completed a fundamental review of the action plan, which has been in place since 2016. The action plan has been streamlined and now effort is concentrated on a small number of fundamental items to drive improvement.
- **Equality Delivery System – Goal 1: Better Health Outcomes.** The Trust has been addressing the remaining goal within the national EDS2 framework. A portfolio of evidence has been completed for the four health outcomes, with a view to obtaining a final rating through stakeholder engagement.

## 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

In a difficult year due to the pandemic PLACE was carried out slightly differently and nationally PLACE was paused. However, the Trust decided to complete PLACE Lite whereby we tried to visit as many areas as possible to carry out the audit. Again, the results from the

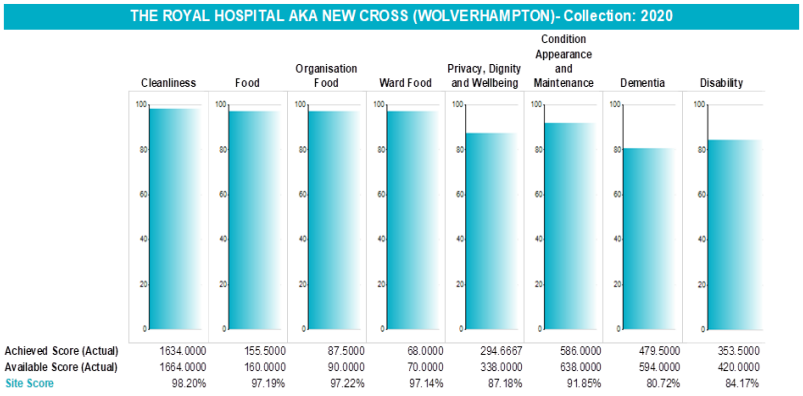
audits were very good with all areas of the Trust achieving high scores. Unfortunately, we are unable to compare nationally as not all Trusts decided to partake in PLACE Lite.

| | Date | No of Patient Assessors | No of Staff | No of Wards inspected | No of Outpatients inspected | No of food tastings |
|---|---|---|---|---|---|---|
| **New Cross** | October 2020 | 0 | 8 | 6 | 6 | 1 |
| **West Park** | October 2020 | 0 | 4 | 3 | 2 | 1 |
| **Cannock Chase** | October 2020 | 0 | 4 | 2 | 3 | 1 |

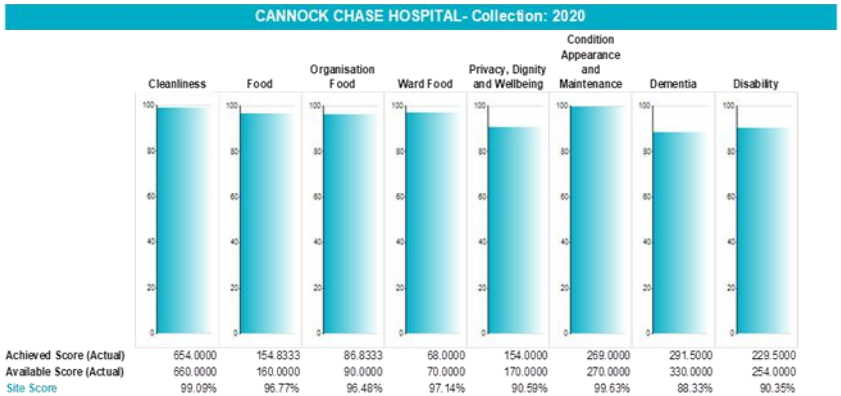
In addition, all sites had an external and internal assessment of general areas. The assessment process was undertaken by staff only due to COVID-19. The assessment process was not a technical audit.

The scoring is clear and in most cases was either a pass (2 points), a qualified pass (1 point) or a fail (no points). The assessment questions were the questions used in the 2019 PLACE Assessment as no new assessment information was available in 2020.

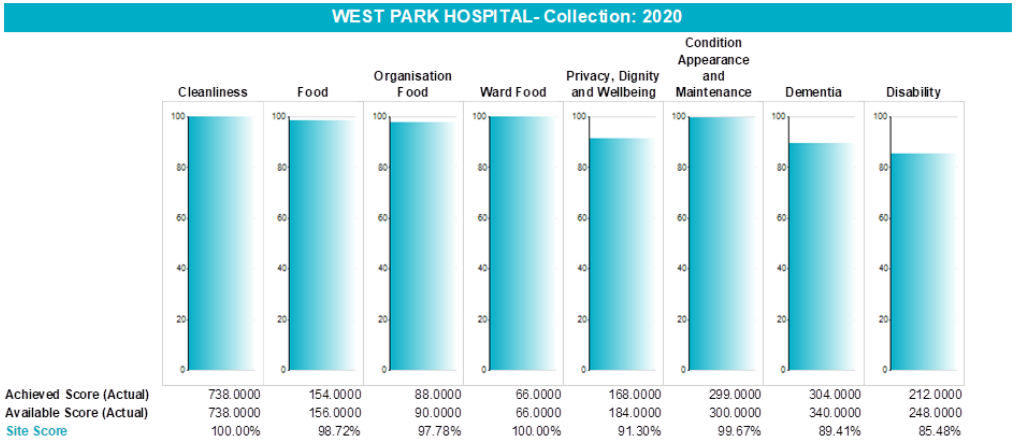
## RESULTS - NEW CROSS




## RESULTS – CANNOCK CHASE HOSPITAL



## RESULTS – WEST PARK




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

- All areas, across all sites, have scored highly. Unfortunately there is no national average for comparison.
- The Trust organisational score for cleanliness across the sites was 99%.
- The organisational score across all elements of the food service is 98% against last year's score of 97%.
- Condition, Appearance and Maintenance remains high scoring at 96%.
- The Environment Group is continuing support improvement relating to Dementia and Disability scores.

Moving forward into the next year we will be continuing to improve disability access to Trust buildings and ensuring the Trust is dementia friendly. The Trust will also plan to continue to address environmental issues that affect patients, staff and visitors by ensuring the environment is as welcoming as possible.

# Chaplaincy Services

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

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

During the financial year 2020/21 and throughout the COVID-19 Pandemic, the chaplaincy team were PPE fit tested very early on and this enabled the team to have an active ministry presence throughout the twelve-month period, responding to requests from all wards and departments in each of the three Trust sites, continuing to offer support to patients, their families, staff and volunteers in these most challenging times.

In addition, the team have also offered an increased amount of telephone support to patients, their families and staff members throughout this time. Bereaved families were offered chaplaincy team support within the Swan suite and an innovative new service was developed, in which faith specific prayer by request, accompanied the viewings of deceased loved ones.

Other initiatives included:

- A new area of ministry has been developed within the Swan Suite.
- Families of the deceased have been contacted by the Bereavement support team and offered the opportunity to attend an accompanied viewing of their loved one in the Swan Suite.
- Families were also offered the choice of multi faith chaplaincy support (male or female) or bereavement team support.
- A faith specific personalised order of service/prayer card is now given to each family who wish chaplaincy support and additional copies are offered and dispatched at each individual family's request.
- Families are also offered a knitted or crochet heart, with one heart remaining with their loved one and the other to be taken home
- For those who may not wish to attend a viewing or who may be prevented from doing so, due to their own need to shield for example, the opportunity for a chaplain to visit the Swan Suite to offer prayer for their loved one is offered.
- Prayer visits are made at 8.30am each morning and are offered individually.
- Prayer cards can then be dispatched at family request.

During this extremely busy period, the team had seen an increase in the number of staff wishing chaplaincy support which was given. However, they have rigorously maintained their twenty four hour on call service for patients and the call out response time remains consistently within a thirty minute period.

Whilst the weekly Sunday services at both Cannock and New Cross, in line with national guidance have been and remain temporarily stood down, however the chapel and prayer spaces have remained open throughout this period (ensuring social distance is adhered to) and additional prayer and reflective spaces were temporarily made available, so that staff did not need to leave their clinical areas.

# Primary Care Network (PCN)

The Royal Wolverhampton Primary Care Network (RWTPCN) serves 60,215 patients. This model of delivery of care offers a unique opportunity to re-design services from initial patient contact through to on-going management and end of life care. As a single organisation, the challenges associated with the scope of responsibility, funding, differing objectives and drivers are reviewed, which enables clinicians to design more effective, high quality clinical pathways to improve access and positively impact on patient outcomes.

RWTPCN formed a group within Division 3 alongside Adult Community Services in December 2019. This has encouraged further group working to deliver a unified community and primary care service.

### Appointment access data

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

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

| Average per week per 1000 patients | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| | 87.98 | 84.65 | 111.4 |

### GP Patient Survey results

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

| | 2018 | 2019 | 2020 | Local Average | National Average |
|---|---|---|---|---|---|
| Through to surgery phone | 75% | 77% | 65% | 66% | 68% |
| Receptionists are helpful | 91% | 92% | 88% | 87% | 89% |
| Patients satisfied with GP appointment times available | 67% | 69% | 65% | 66% | 65% |
| Speak/See preferred GP | 50% | 45% | 43% | 49% | 48% |
| Patients offered choice of appointment | 60% | 61% | 59% | 59% | 62% |
| Patient satisfied with type of appointment offered | 76% | 75% | 70% | 71% | 74% |
| Patient took the appointment they were offered | N/A | N/A | 91% | 71% | 74% |
| Experience of making an appointment was good | 69% | 70% | 64% | 65% | 67% |
| Wait 15 mins or less for an appointment | 70% | 71% | 73% | 69% | 69% |
| Last Healthcare Professional they saw or spoke to gave them enough time | 88% | 85% | 83% | 84% | 87% |
| Last Healthcare Professional they saw was good at listening to them | 89% | 87% | 87% | 86% | 89% |
| Last Healthcare Professional they saw was good at treating them with care and concern | 87% | 86% | 86% | 84% | 87% |
| Last Healthcare Professional they saw involved them in decisions about care | 93% | 94% | 89% | 91% | 93% |
| Confidence and trust in the last Healthcare Professional seen | 96% | 95% | 95% | 95% | 96% |
| Healthcare professional recognised or understood any mental health needs | 86% | 85% | 84% | 84% | 86% |
| Felt their needs were met during their last general practice appointment | 95% | 94% | 94% | 93% | 95% |
| Enough support from local services or organisations in the last 12 months for LTC | 85% | 80% | 76% | 77% | 78% |
| Overall experience as good | 86% | 85% | 81% | 81% | 83% |

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

As part of the Trust's commitment to transparency, key information is shared with our teams, Directorate and Division through the Performance and Governance meeting structures to provide quality assurance.

Notable achievements during 2020/2021 include:

- Advance Nurse Practitioner led home visiting service; this service allows GPs to dedicate more time providing patient care.
- Extended phlebotomy hours for patients.
- Recruitment of social prescribers for RWTPCN; a joint partnership with the Wolverhampton City Council.
- Successful delivery of RWTPCN COVID-19 vaccination centre and vaccines provided to over 15,000 patients/staff across Wolverhampton and beyond.
- Development of the COVID-19 virtual care assistant in partnership with Babylon.
- Improved performance in annual learning disability health checks.
- Recruitment of a dedicated Advanced Nurse Practitioner (ANP) to deliver the Care Home Enhanced service for RWTPCN.
- Recruitment of a Physician Associate with a specialist interest in Learning Difficulties.
- Expansion of the RWTPCN Pharmacy team to support future developments of a shared PCN sexual health service with specialist staff.
- Rapid response to COVID-19 and ensuring patient care was able to continue.

## Continuous Quality Improvement

Continuous Quality Improvement (CQI) is the application of a systematic approach to tackle complex challenges that are common in healthcare. It is focused on improving patient/staff outcomes and experience and is a way of giving everyone a voice, bringing staff and service users together to improve and redesign the way that care is provided. Continuous quality improvement can be a powerful vehicle for improving organisational effectiveness and behaviours.

The Trust established a Continuous Quality Improvement Team in April 2019 to support the realisation of the Trust's vision and support a culture of Continuous Quality Improvement. The team consists of a mixture of programme partners as well as clinical leads who organise their work around the following three priorities:

1. Building CQI capability and capacity – focus on training colleagues within the organisation in CQI methodology. Following successful completion of the QSIR accreditation process, the team began training colleagues in both fundamentals (for new starters at induction) and practitioner courses (for existing colleagues). The team had trained 307 colleagues in fundamentals prior

to the COVID-19 outbreak and a further two cohorts at practitioner level. The team were on course to achieve the November 2020 target of having 1,000 fundamentals and 100 practitioner colleagues trained prior to the COVID-19 restrictions which impacted on training. In the absence of face to face training, the CQI team have rolled out virtual CQI training (QSIRV) which has been well received across the organisation.

2. Patient safety. In the Patient Safety theme, work continues with clinical teams and has focused on sepsis, stroke, heart failure, pneumonia, renal failure and now liver disease. A recent addition of a senior nurse to the permanent team has helped progress the excellent work being undertaken with falls and helped significantly in exploring issues related to late observations and patient monitoring**.** The team has heartened by the positive response received from the mortality group and stakeholders within.

3. Patient flow - The highlights from the Patient Journey theme include the completion of the role out of the huddle tool across Division 2 – this is providing accurate and unique data in a timely fashion about the constraints in the system providing clear targets for improvement work internally and with our partners. A big piece of work has also commenced in looking at the improvements that have been implemented during COVID-19 in Outpatients and how these are sustained going forward. A group titled 'Outpatient Futures' is now established and is taking stock of these improvements and what outpatient pathways might look like going forward.

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

## Use of the CQUIN payment framework

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) Payment Framework. CQUINs enable the organisation to focus on the quality of the services delivered, ensuring that the Trust continuously improves and drives transformational change with the creation of new, improved patterns of care. These will impact on reducing inequalities in access to services, improve patient experiences and the outcomes achieved. CQUIN initiatives are owned by identified service leads, who develop action plans with support from the contracts team to ensure the required changes are delivered. CQUINs are agreed during the contract negotiation rounds with input from clinical leads and Executive Directors including the Chief Operating Officer and the Deputy Chief Nurse. Any areas of clarification or concern are highlighted to commissioners during this negotiation period to ensure the CQUIN requirements are relevant and achievable to the organisation.

**Review of 2020/21:**

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

of the COVID-19 pandemic, the CQUIN scheme was suspended. At the time of writing, the Trust is not expecting the CQUIN scheme to be introduced before October 2021.

# Looking forward 2021/22

# Priorities for Improvement

Workforce Safe Care Patient Experience

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

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

# Priority 1 – Workforce

## Nursing, Midwifery, Health Visiting and Allied Health Professionals Workforce

**Key areas of focus for 2021/22 will include:**

- Strengthen our focus on retaining our Nursing, Midwifery and Health Visiting workforce.
- Finalise and implement Internal Transfer Framework to support retention of staff.
- Design and deliver online packages using the Virtual Learning platform.
- Build the number of Professional Advocates.
- Continue to expand and provide innovative pre-registration placements in Nursing and Midwifery.
- To work closely with the quality team to demonstrate impact of training and development on patient outcomes.
- Measure retention of international nurses.
- Expand the access Nurses, Midwives and Health Care Assistants have to continuing professional development using the virtual learning platform.
- Daily utilisation of the Safe Care system in all ward staffing meetings including live redeployments captured. Safe Care system to be used by on call managers to ensure safest staffing achieved Trust wide.
- Review pipeline for unregistered workforce by widening employment opportunities.
- Ensure role clarity and consistency of competency for unregistered and registered workforce.
- Continue to enhance the governance framework for Advanced Clinical Practice roles.

## Allied Health Professionals (AHPs)

**Key areas of focus for 2021/22 will include:**

- To continue to increase the availability of apprenticeships for AHPs, with Physiotherapy and Occupational Therapy apprenticeships already embedded within the organisation.
- After the success with the Clinical Placement Expansion Programme for Physiotherapy, we will share the learning across all the professions with a view to increasing student placements.
- E-roster for AHPs and Pharmacy. E-Community where applicable and job planning for AHPs. Review of JDs.
- Further AHP recruitment events are planned and we will be supporting a virtual AHP work experience event in May 2021.

# Clinical System Framework (CSF)

Our new Clinical System Framework (CSF) was launched in March 2020. It has been the culmination of several months' hard work, discussion and collaboration between the Trust's Nurse, Midwife and Health Visitor colleagues and the Trust is delighted that its allied health professional workforce has also collaborated to produce the CSF. The operational multi-functional framework produced provides a road map for priorities and improvement journey for the next 2 years. The milestones set will help the Trust to monitor, learn and drive improvement within the organisation. It will be fundamental in helping to deliver the very best possible care and most importantly help to achieve the best possible patient outcomes and experience.

The contribution of Allied Health Professionals to this CSF framework, which has replaced the Nursing System Framework, is a positive step forward for the Royal Wolverhampton NHS Trust and will create stronger links in practice which will enhance the care delivered.

Over the next two years we plan that the CSF will be integrated into all of our work programmes and our day to day operational business. The CSF unites us all and it is the Trust's shared vision for continuous improvement providing safe, effective and high-quality care for all our service users.

# Medical Workforce

**Key areas of focus for 2021/22 will include:**

**Consultants**

- Continue to develop internally trained senior medical staff from fellowship programme.
- Aim to strengthen links with neighbouring organisations where the national consultant resource is limited.
- Introduce the new SAS (Specialist and Associate Specialist) national contract.

**Junior medical staff / fellowship**

- Ongoing development and expansion of fellowship programme.
- Embrace and adopt required changes to training structure and supervision requirements.

**Medical students**

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

## Health and Wellbeing

The Royal Wolverhampton NHS Trust's People Strategic aim is:

- **Attract, retain and develop our staff and improve employee engagement.**

To support this aim, the following key objectives have been agreed for 2021/22:

(1) Maintain the lowest vacancy levels in the Black Country - The target outcome is to ensure the Trust's vacancy rate remains the lowest of acute providers in the Black Country.

(2) Increase the percentage of staff who deem the organisation has taken positive action on their health and wellbeing - The target outcome is to maintain the Trust's upper quartile position in the staff survey. During 2021/22, the Trust will continue to embed and progress its health and wellbeing approaches to support our workforce.

(3) Improve overall employee engagement - This will be measured by benchmarking ourselves against our peers with the aim to show continual improvements in response to the 9 staff engagement theme questions.

(4) Reduce the gap in engagement scores for Black Asian and Minority Ethic (BAME) staff and improve Workforce Race Equality Standard (WRES) Metrics - A detailed analysis will be undertaken to identify gaps against staff engagement theme metrics with 2020 staff survey data and 2021 WRES metrics. This objective is also supported by specific actions set out in the Trust's Equality, Diversity and Inclusion delivery plan and through engagement with the BAME Employee Voice group.

# Priority 2 – Safe Care

The Trust will continue to focus on driving improvements in safe care and maximise learning opportunities to continuously improve patient care and experience. During 2021/22, the focus will be on the following specific areas:

**(1) Achieve best practice for the management of COVID-19 inpatients, preventing the spread of Infection and minimising the impact of COVID-19.**

The emergence of COVID-19 has had a huge impact on the Trust, and will continue to have influence on Trust plans moving forward. The organisation has, and will, continue to base actions related to COVID-19 on the best available evidence and aligned with the local and national guidance. Activity will include:

- Bed management plans will need discussion and development to enable safe patient placement and management particularly if a rise in cases occurs.
- Ensuring that the learning from COVID-19 incidents is implemented and embedded.
- Explore the expansion of COVID-19 point of care testing capacity in the organisation where appropriate.
- Increase the number of RWT staff receiving 1st vaccinations.
- Complete 2nd vaccinations.
- Establish a process for vaccination of new starters.
- Be flexible to the currently unknown requirements for a future vaccination programme.

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

The Trust will continually refine its processes for learning and continue to:

- Undertake Root Cause Anlaysis (RCA) investigation and Structured Judgement Review (SJR) on all Health Care Acquired Infection (HCAI) COVID-19 Death incidents (meeting the definition of probable and definite hospital acquired).
- Panel review of SJR and RCA to determine harm causation, extract learning for sharing and redress action.
- Collective action plan accumulated of learning themes and specific redress actions.
- Learning communicated to teams via email, risky business, sharing of RCA for learning.

**(3) Reduce harm by assessing, recognising and responding to prevent patient deterioration.**

The Trust has continued to focus on recognising and responding to deteriorating patients and strengthening the identification and management of sepsis. To further support this initiative, the Trust has amalgamated our Sepsis Team and Critical Care Outreach Team to work under the same umbrella with a goal to strive to continuously improve both sepsis compliance and management of deteriorating patients. This dedicated collaborative team will provide structure to support early detection and treatment of both deterioration and sepsis throughout a twenty-four-hour period.

To facilitate the delivery of early identification and management of the septic patient within one hour, the Trust Sepsis Team and Critical Care Outreach Team will work towards a collaborative approach.

Going forward for 2021/2022, as part of our overarching Clinical Service Framework, the strategy for the deteriorating patient and sepsis is to demonstrate an improvement of ten percent in line with compliance with protocol by December 2021, with a further ten percent improvement by December 2022. In terms of mortality related to sepsis to demonstrate a five percent improvement annually by December 2022.

**Key areas of focus for 2021/22 will include:**

- Publication of a monthly “Vitals sepsis module screening compliance” report.
- Continue with sepsis ward rounds and campaign about the sepsis six highlighting the importance of senior clinician review.
- Whilst we continue to work collaboratively with the third-party provider for updates and version releases, we aim to build our own reports, ensure clinical validation and develop a deeper understanding of data flow.
- Ensure real time visibility of data for clinical staff.
- An additional educational focus to support a relaunch of both training incorporating the use of the electronic Vital Pac system and the sepsis bundle for our Health Care Assistants and registered practitioners, to ensure continuous quality improvement trust wide.

**(4) Promote equality out of outcomes by routinely reporting user outcomes (reducing health inequalities) LD, Maternity, BAME, Continuity of carer.**

**Key areas of focus for 2021/22 will include:**

- Production of a Maternity Dashboard focusing on data relating to inequalities to enable areas for improvement to be identified and provide an ability to measure outcome from improvement initiatives commenced.
- Continue to drive improvements in continuity of carer and achieve determined objectives in relation to the number of BAME women receiving continuity of carer during their pregnancy.
- Continued participation in Learning Disability Mortality Review programme (LeDeR) and ensure learning is embedded.
- Further improve the number of Learning Disability annual health checks conducted within our Primary care GP practices.

**(5) Mental Health**

The Trust is registered by the Care Quality Commissioner for the regulatory activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 (MHA). This regulated activity relates to the treatment of people who are detained in, or recalled to, hospital for assessment and/or medical treatment under the Mental Health Act 1983.

Mental Health will remain an area of priority and is embedded in the Trust Quality and Safety Strategy. Key actions for 2021/22 are to:

- Expand Level 2 Mandatory Training.
- Launch Level 3 Mandatory Training, application of the MHA.
- Audit of reports of MHA applications against the MHA administration policy.
- Review of emergency and urgent care environments and pathways for patients with Mental Health.
- Review provision of mental health care in the Trust.

### (6) Safeguarding

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

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

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

Key priorities for the forthcoming year include:

- Additional recruitment for Maternity Safeguarding posts.
- Review and update the Safeguarding training programme to include Learning Disability and Autism element.
- Refresh Safeguarding Children and Adult Policies on a regular basis (including Prevent and Safeguarding Supervision policy).
- Progress with work around Mental Capacity Act assessments across the Trust.
- Continue to support staff with safeguarding cases by offering reflective supervision.
- Monitor Deprivation of Liberty Standards (DoLS) applications.

# Priority 3 – Patient Experience

## Co-Design and Co-Production

The key priorities for the Patient Experience Team during the financial year of 2021/22 will be to look at putting patient engagement and involvement at the heart of decision making and driving forward improvements in delivery of care. Some of these initiatives will include:

- Work with our stakeholders in the design and implementation of a co-design and co-production toolkit.
- Involve patients and their loved ones in the co-design and co-production of several key work streams including:
  Mental Health, Learning Disabilities, Maternity Services, Pediatrics and Stroke Services.

- To review milestones and outcomes for year 2 of the Patient Experience, Engagement and Public Involvement Strategy and refresh the strategy where applicable to focus on the emphasis of ensuring patient involvement in all we do.
- Gathering feedback from seldom heard communities by a range of mechanisms.
- To design and implement a robust system using a variety of patient experience metrics to identify areas for targeted improvement.
- To understand patient experience metrics for patient groups where inequalities exist and implement changes to improve experiences for these cohorts.

## Complaint Management

Actions to improve outcomes for the new financial year:

- A review of the formal complaints policy to ensure the process is clear and accessible to all.
- Joint PHSO and Patient Experience Team complaints training to be facilitated and delivered.
- Quarterly review of the complaints performance to be undertaken by the Council of Members.
- Complaints to be used as a metric to identify performance issues and highlight and share learning and good practice.

## Patient Access Waiting Times

- A focus on waiting times to improve 62-day cancer performance, a reduction in the 52 week waits and RTT waiting times.

## Cancer diagnostics and treatments including:

- Improvement of the general Patient Experience – We recognise that our 62-day cancer performance is in the lowest quartile – to address this we are renewing our focus on improving all cancer pathways with the Trust cancer team and CQI team. We are establishing a Cancer Improvement Board which will be chaired by the Chief Medical Officer with CEO oversight.
- Improvement in nationally reported outcomes.

## Volunteering

- To design and implement a comprehensive career pathway to assist our young volunteering workforce.

# Statements of Assurance from the Board

# Mandatory Quality Statements

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

## Review of services

During 2020/21, The Royal Wolverhampton NHS Trust provided and/or subcontracted nine categories of service; those being:

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

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

The income generated by the NHS services reviewed in 2020/21 represents 79% of the total income generated from the provision of NHS services by The Royal Wolverhampton NHS Trust for 2020/21.

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

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

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

There are approximately 370 doctors in-training who rotate throughout the Trust at any one time. In accordance with the terms and conditions of service for doctors and dentists in training (England) 2018, each trainee doctor is issued with a work schedule containing the number and distribution of contracted hours as well as the intended learning outcomes that are mapped to the educational curriculum. There is time for activities such as quality improvement, patient safety, periods of formal study (other than study leave) and research. In addition, 2 hours per week (or one day per month) self-development time (SDT) was allocated to all Foundation Year doctors intended to be used for activities such as formal meetings with educational/clinical supervisors, reflective practice and completion of e-portfolios. All trainee work rotas at the Trust are compliant with the requirements of the new junior doctor contract.

However, trainee doctors may be obliged to work more than their contracted hours from time to time. The report from the Guardian of Safe Working (GoSW) in 2020/21 highlighted a limited number of exception reports submitted by doctors in training. Foundation year doctors represented the highest proportion of the total number of exception reports submitted. In this situation, there is a formal exception reporting procedure for reporting extra hours or educational issues. The process involves submission of an exception report that leads to a meeting with the educational or clinical supervisor to agree an outcome such as time off or compensation. As a result of national changes and trainee feedback, the procedure for exception reporting has been updated.

The previous 2019/20 report highlighted the challenge in moving away from Emergency Medicine (ED) 1:2 weekend frequency. The Trust has now been able to move away from the previous 1:2 weekend frequency rota for ED which came into effect in August 2020.

In addition, a quarterly Trust wide junior doctor forum remains in place. It is attended by the Chief Executive and Chief Medical Officer, which provides a regular opportunity for feedback in respect of the trainee experience at the Trust.

The Pandemic period saw a further review of all rotas. In particular additional posts were implemented to support the Medicine Rotas. These posts were filled as part of the successful Clinical Fellowship Programme which continues to contribute to the reduction of agency usage and expenditure.

## Participation in Clinical Audits

The aim of clinical audit is for the Trust to use it as a process to embed clinical quality, to bring improvements in patient care, create a culture that is committed to learning and continual development, and a mechanism for providing evidence of assurance about the quality of services. During 2020/21 Clinical Audit Activity was suspended at certain points as a result of the COVID-19 pandemic, this meant that the Trust has seen lower levels of audits completed than we would normally expect. A focus on urgent COVID-19 audits, both National and Local, and prioritisation of the high-risk areas for Directorates was the principal objective of plans this year.

During 2020/21 there were 57 National Audit Projects/National Confidential Enquiries covering relevant health services that The Royal Wolverhampton NHS Trust provides and were included on HQIPs (Healthcare Quality Improvement Partnership) National Audit Registry. Many of these projects however suspended data collection at some point/completely during 2020/21 due to the COVID-19 pandemic. The Royal Wolverhampton NHS Trust participated in 49 (86%). There were a further 26 National Audit Projects registered on RWTs Clinical Audit Database where Directorates submitted data to that weren't included on HQIPs Directory.

The reports of 25 previously completed National Clinical Audit projects that were reviewed by the provider in 220/21 are shown below with the actions the Trust intends to take to improve the quality of healthcare provided.

The 3 National Confidential Enquiries that The Royal Wolverhampton NHS Trust was eligible to participate in and aimed to collect data for are below. The National reports are currently awaited.

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

There were 8 National Clinical Audits that The Royal Wolverhampton NHS Trust did not participate in during 2020/21 due to the COVID-19 Pandemic; data collection was suspended.

| National Clinical Audit & Enquiry Project Name | Work Stream | Directorate |
|---|---|---|
| National Audit of Dementia | Care in general hospitals | Care of the Elderly |
| Medical and Surgical Clinical Outcome Review Programme | Dysphagia in Parkinson's Disease | Neurology |
| Emergency Medicine QIPs | Fractured Neck of Femur (care in emergency departments) | Emergency Department |
| Emergency Medicine QIPs | Infection Control (care in emergency departments) | Emergency Department |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) | Paediatric Asthma Secondary Care | Children's' services |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme | Asthma (Adult and paediatric) | Children's services |

| | | |
|---|---|---|
| (NACAP) | | |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) | N/A | Children's services |
| National Paediatric Diabetes Audit (NPDA) | N/A | Children's services |

The National Clinical Audits that the Trust participated in during 2020/21 and remain in progress are shown in **Appendix 1**.

The reports of 25 previously completed National Clinical Audit projects that were reviewed by the provider in 2020/21 are shown in **Appendix 2**, with the actions the Trust intends to take to improve the quality of healthcare provided.

**Clinical Audit Activity**

In total 433 clinical audits were registered on the Clinical Audit Database across the Trust, 183 (42%) of which were completed by the 31st March 2021. The adjusted completion rate (excluding National Audits) was 61%. The completion rate is lower than previous years due to the COVID-19 pandemic.

**Clinical Audit Outcomes**

The results of 183 clinical audits were reviewed by the provider, and a compliance rating against the standards audited specified.

38 local 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 be considered for re-audit against these standards once actions have been appropriately embedded. Details of these actions are outlined in **Appendix 3**.

Clinical audit drives continuous improvement through assessment of patient care and the delivery of a better experience for our patients. We expect to see some of the challenges experienced in 2020/21 due to the COVID-19 Pandemic to continue in 2021/22. However, one of the main focuses for Clinical Audit will be to continue to participate in important COVID-19 National and Local projects. Patient Safety remains at the very forefront of Clinical Audit and projects undertaken this year will be centred on key priorities for the Trust and those projects that will deliver on service improvement and better care for our patients. National audits which halted data collection in 2020/21 that re-start this year will be contributed to along with key quality improvement projects the Trust needs to make improvements for our patients in service delivery and treatment.

# Participation in Clinical Research

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

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

**Review of 2020/21:**

As part of the national response to the Coronavirus outbreak, the Trust participated in 24 research projects during the past year which investigated the management and treatment of COVID-19. Over 6000 patients and staff at RWT have participated in these studies.

15 of these studies were designated by the National Institute of Health Research as Urgent Public Health Research (NIHR UPHR). They are Consultant led, with delivery supported by a dedicated team from the R&D Directorate working alongside clinical teams.

In total, over 4200 participants have been involved in this priority research. 333 patients with COVID-19 being cared for at RWT, either in hospital or in one of its general practices, have participated in vital and ground-breaking interventional studies to test the effectiveness of various treatments on the disease.

RWT has consistently been in the Top 15 acute Trusts nationally for the number of NIHR UPHR studies open and in the Top 20 for the number of participants recruited and 3rd in the West Midlands region.

In addition to COVID-19 research, a number of studies within other high priority clinical specialities have continued with 394 participants recruited into 40 research projects including Oncology, Haematology, Rheumatology, Cardiology/Cardiothoracic, Obstetrics, Surgery, Paediatrics, Gastroenterology and Respiratory.

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

Research participants surveyed showed:

- 95% felt their involvement was valued.
- 95% felt they had been treated with courtesy and respects at all times.
- 91% would take part in research again.

**Key Objectives for 2021/22**

- Continue to ensure that patients are given the opportunity to participate in clinically appropriate research trials.
- Continue with programme to resume and grow non- COVID-19 research.
- Meet the National Institute of Health Research High Level Objectives for research delivery and performance.
- Focus on research that reflects the health needs of the local population, through collaborations with academic and industry partners.

## Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration statement is registered with no conditions. During the pandemic the CQC adopted a Transitional Monitoring Approach (TMA), this involved telephone calls with organisations and reviewing a number of Key Lines of Enquiry (KLOE) questions. The Trust was engaged with three CQC TMA calls relating to Emergency Department (ED), Infection Prevention (IP) and Well-Led. The feedback from CQC for ED and IP were of a good standard and the Trust had a verbal report from the CQC as being low risk in all areas for the Well-Led review.

Over the year various notifications were submitted to CQC relating to temporary closures in Primary Care, Urgent Treatment Centres due to COVID-19 and one change related to temporary appointment of nominated individual due to internal cover arrangements.

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

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

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

- Expansion of the Trusts' Data Quality Team to provide training and support, ensuring data is entered correctly at source.

## NHS Number and General Medical Practice Code Validity

### Clinical Coding Error Rate

Clinical coding audits were conducted and conformed to the Data Security & Protection Standards Advisory Level. The area audited as part of this was Admitted Patient Care for General Medicine and General Surgery. The audit exceeded the accuracy level required and attained Data Security and Protection Toolkit purposes for Standards Exceeded.

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

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

| General Medicine Specialty | General Surgery Specialty |
|---|---|
| Primary Diagnoses correct 99% | Primary Diagnoses correct 98% |
| Primary Procedures correct 95.92% | Primary Procedures correct 98.84% |

The overall Healthcare Resource Group error rate for the audit was 2.5% of the total number of episodes, which is a change of 0.4% absolute and -0.2% net. All recommendations following the audit have been completed.

Admitted Patient Care & Outpatient - NHS Number and General Medical Practice Code Validity Updated as per Month 10 - 2020/21. (Data extracted on 17/02/2021).

The Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data demonstrates an improvement in every area against the 2020/21 submission, which included the patient's valid NHS number:

- 99.9% for admitted patient care.
- 100% for outpatient care.

- 97.8% for accident and emergency care.

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

- 100% for admitted patient care.
- 100% for outpatient care.
- 97.8% for accident and emergency care.

A&E - NHS Number and General Medical Practice Code Validity Updated as per Month 11 - 2020/21. (Data extracted on 24/03/2021).

# Information Governance Toolkit

**SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2010-2021.**

The table below details the incidents reported on the NHS Digital incident reporting tool and to the Information Commissioners Office (ICO), within the financial year 2020-2021. Any incidents that are still being investigated for the period 2020-21 are not included. The incidents listed below are for The Royal Wolverhampton NHS Trust and GP partnerships that have joined the Trust as listed below.

| Date incident occurred (Month) | Nature of incident | No. of data subjects | Description/ Nature of data involved | Further action on information risk |
|---|---|---|---|---|
| November 2020 | Disclosed in error - email | 10 | A member of staff sent out a New Starter form via the recruitment system to at least 10 new starters. Unfortunately, the member of staff did not check the new starter form prior to attaching it to the system and the form was not blank, it contained sensitive personal information about an individual. They are aware that at least 3 of the recipients have read the email as they received phone calls from these individuals yesterday advising they had received it | Contacted system provider to break the link in the email so individuals who had not opened the email prior to this could no longer see the email attachment.<br><br>They also contacted all known recipients and asked to delete the email and situation was contained. |

| | | | | |
|---|---|---|---|---|
| November 2020 | Disclosed in error – email | 1 | Clinical letter for child ‘A’ was sent with details for child ‘B’. Both children were being treated at the same clinic however information disclosed included the wrong diagnosis for child A. | Correct letters were sent to the relevant children’s GPs / Children Hospital Consultants and advised to ignore the previous letter and confidentially destroy. Change in process with medical secretaries was implemented to ensure adequate checks are done on letters before being sent to patients and an audit was requested to ensure all letters sent around the same time were correct. |
| December 2020 | Lost or Stolen Paperwork | 40+ | A member of staff who was planning on working from home, took blood request/referral forms home so they could book clinic appointments for the referrals. On their way home their car was stolen with belongings, the blood request forms were among their belonging in the car. Blood forms contained name, address, sex, DOB, NHS Number and were all for glucose tolerance tests. | Car and its contents were not recovered. All patients were identified and were rebooked in for appointments so no delay on clinical care. |

**Incidents classified at lower severity level**

Incidents classified at severity level 1 are aggregated and provided in table below:

| **SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2012-21** | | |
|---|---|---|
| **Category** | **Breach Type** | **Total** |
| A | Corruption or inability to recover electronic data | 2 |
| B | Disclosed in Error | 85 |
| C | Lost in Transit | 3 |
| D | Lost or stolen hardware | 0 |

| | | |
|---|---|---|
| E | Lost or stolen paperwork | 7 |
| F | Non-secure Disposal – hardware | 0 |
| G | Non-secure Disposal – paperwork | 3 |
| H | Uploaded to website in error | 0 |
| I | Technical security failing (including hacking) | 5 |
| J | Unauthorised access/disclosure | 8 |
| | | 113 |

**Data Protection and Security Toolkit (DSPT) Return 2019/ 2020 – final submission**

Due to the current situation relating to COVID-19, NHS Digital recognises that it will be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. NHS Digital has therefore taken the decision to push back the 2019/20 deadline for DSPT submission to 30 September 2020. The results for the final submission for 2019-20 indicate that standards were met for all shown below.

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

**Looking forward to 2020/21 Data security and Protection**

Due to the current COVID-19 response the DSPT for 2020-21 will not be submitted until June 2021, in line with the newly set date by NHS Digital. The Trust however continues to work towards achieving compliance with the DSPT which will be published later this year. An internal audit of the DSPT tin November 2020 provided significant assurance of the processes and evidence that is in place to support the DSPT submission.

The Trust continues to monitor patterns and trends of data security incidents and continues to implement measures to reduce these to the lowest level practicable. Current risks include continued and increasing risk of external threats in relation to Cyber Security, particularly via email phishing. Other risks to data security include disclosure in error via various means, and this is attributed to the ways of working in health, with increased remote working being required during the COVID-19 period. Work continues in this area to improve controls and practices to manage this risk. The Trust are continuing to embed the requirements of the General Data Protection Regulation 2016 (GDPR) into Trust practices, monitored via various groups, ensuring data privacy is at the forefront of the care that we provide and the information that is captured.

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

## Seven Day Services

The 7 Day Working Audit for financial year 2020/21 was suspended due to the COVID-19 pandemic. We were due to undertake an audit in March and September 2020, however, NHSE/I confirmed that this is suspended due to COVID-19 so there is nothing to report for this year.

## The Learning Disability Improvement Standards

The Trusts Learning Disability (LD) Team provides support for children, young people and adults with a LD. The team are able to identify patients using an electronic flagging system and ensure that all identified patients are reviewed by a learning disability nurse during their admission and are offered support for outpatient appointments, making reasonable adjustments when required. Our flagging system holds above the national average number of flags. Reasonable adjustments can include:

- Communication
- Physical changes to the environment
- Admission and discharge planning
- Extended appointments.

To support the staff to make reasonable adjustments we are able to provide RWT staff a programme of blended training, including ‘hand’s on’ training to enable them to adjust the care to meet the additional support needs a person may have as a result of their LD. The team work closely with Wolverhampton’s Specialist Community LD Team to ensure continuity of care for people using our services.

The Trust undertakes an internal review of all patients known to have a learning disability that die whilst in our care. The Trust is fully engaged in the National Learning Disability Mortality Review Process (LeDeR) undertaking reviews into the deaths of people with

learning disabilities and sharing good practice and implementing change when areas are identified as requiring improvement.

The Trust has participated in the NHS England Improvements Learning Disability Programme for the second year, areas of good practice were highlighted for carers support and that patients with LD felt that they were treated with dignity and respect.

Dementia training at level 1, in line with Health Education England requirements, is mandatory for all disciplines of Trust staff via e-learning and as at 31st March 2021, the Trust compliance rate for this level is 98%.

Although level 2 dementia training has been suspended during the coronavirus pandemic, some bespoke sessions have been facilitated for key departments.

# 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 2020/21:

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

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

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

| Indicator | September 2019 - August 2020 | October 2019 - September 2020 | November 2019 - October 2020 |
|---|---|---|---|
| SHMI RWT | 1.023 | 1.018 | 1.016 |
| SHMI England | 1 | 1 | 1 |

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

The SHMI has reduced compared to 2019/20 as the Trust has been categorised within the "as expected" range over the past year. The improvement in SHMI is a result of both an increase in expected deaths and a decrease in the observed deaths.

**The Royal Wolverhampton NHS Trust has taken the following actions to improve SHMI and the quality of its services in 2021/22 as outlined below:**

- The Trust continues to have reporting and investigation mechanisms for the SHMI, overseen by the Mortality Review Group (MRG). All diagnosis groups with a higher than expected SHMI are investigated via a case note review with results reported at the MRG and action plans developed.
- Despite the SHMI improving, the Trust continues with a key programme of work designed to scrutinise clinical care, provide assurance that gaps in care are identified and acted upon, gaps in quality of documentation are identified and corrected and systems of care provision are developed to the benefit of individual patients and the wider population.

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

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

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

## Core Quality Indicators – Summary of Patient Death with Palliative Care

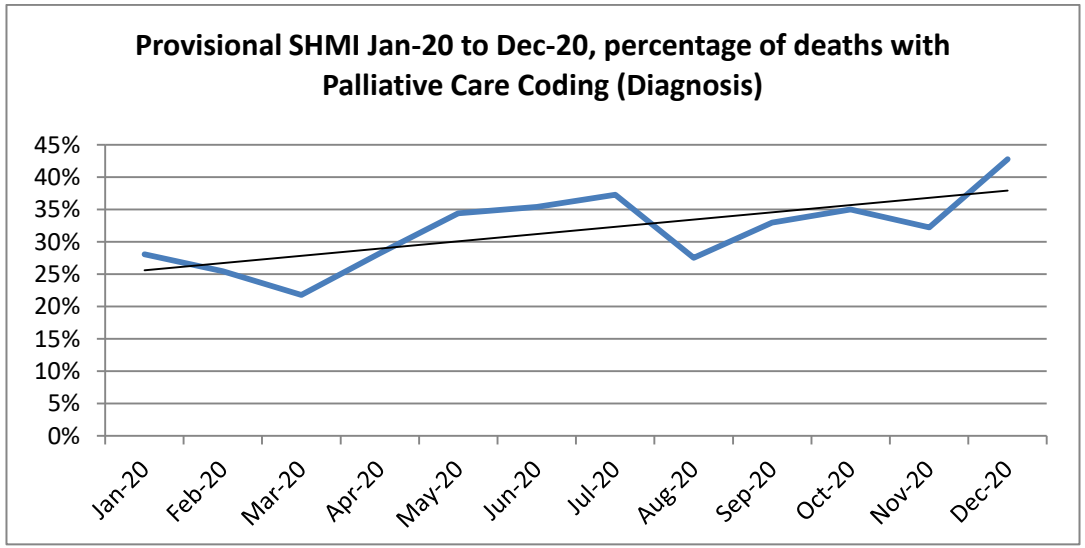
The data made available to the Trust by the information centre with regard to the percentage of patient deaths with palliative care coding at either diagnosis or specialty level for the Trust for the reporting period.

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

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

| | Current Period: | Previous Period: Oct 2018 to Sept 2019 | National Performance | | |
|---|---|---|---|---|---|
| | | | Average | Lowest | Highest |
| **Percentage of Deaths with palliative care diagnosis coding** | **29** | **22** | **36** | **12** | **58** |

**Data Source –** https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2021-03/palliative-care-coding




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

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

- Continued expansion of the palliative care team.
- Continuing to improve awareness of palliative and end of life pathways, using quality improvement initiatives to roll out gold framework standards.
- Development of end of life services for specific diagnostic groups e.g. chronic kidney disease, focusing on community support and promotion of achieving care in the patients' preferred place.
- Continued expansion of educational events for Trust staff (nursing, medical, acute and community), including development of joint education provision with local hospice providers.
- Take forward an NHS England/Improvement project focusing on increasing identification of patients from South Asia with the intention of improving advance care planning.
- The Trust will be working collaboratively with the BAME support worker appointed at Compton Hospice to support with referrals between the Trust and Compton, translation, signposting and ensuring patients have access to culturally appropriate literature to help patients access services.

# Core Quality Indicators – Learning from Deaths

**Actions taken by The Royal Wolverhampton NHS Trust in relation to mortality 2020/21:**

The Trust continued to work on implementing the Learning from Deaths guidance to ensure that we promote learning from mortality reviews and improve how we support and engage with the families and carers of those who die in our care.

The Trust has an established Mortality Review Group (MRG), chaired by one of the Divisional Medical Directors. The group meets every month to oversee progress with the implementation of the Trust's Learning from Deaths Policy, Quality Improvement Plan for Mortality and the associated work streams. Reports are provided from this group to the Trust's Quality Governance Assurance Committee and Trust Board.

In 2020/21, there have been several streams of work to enable the Trust to learn from deaths which are detailed below.

**1. Scrutiny and review of deaths in hospital**

The introduction of the Medical Examiner role in 2018/19 has meant that over 90% of in hospital deaths are scrutinised by an independent medical colleague within days of the death. The aim is to improve this further to achieve scrutiny in 100% of cases.

The Trust's policy, in line with national guidance, is that where potential areas of concern with care are identified at the scrutiny stage, the

Medical Examiner refers these cases for a more detailed review by one of the members of the mortality reviewer team. This process is called a Structured Judgement Review (SJR) and is a standard national process. SJR reviews will include cases where relatives have raised concerns as well as a group of conditions were mandatory referral is required. In addition, a random selection of 10% of cases are chosen for review. A Learning from Deaths IT system has been developed and implemented across the organisation in 2020/21 which records all Medical Examiner reviews, SJR's and learning from deaths.

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

In response to alerts of high SHMI for specific diagnostic groups, the Trust reviewed a cohort of cases and clinical pathways related to the following: Pneumonia, Chronic Renal Disease, Sepsis, Heart Failure and Liver Failure.

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

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

**3. Quality of coding and documentation**

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

**4. Learning from Deaths including engagement with families**

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

## 5. Provision of end of life care in community settings

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

## 6. External Reviews

The Trust receive an annual audit of the learning from death processes via the Trust auditors Grant Thornton UK to provide assurance to the Board of the progress against the mortality improvement agenda. Following a review from an external medical consultant an action plan has been developed with the recommendations which the Trust are working towards to further enhance and improve mortality.

## Plans for 2021/22

The MRG will continue to progress the Trust's Mortality Improvement Programme and associated plan, underpinned by the Mortality Strategy.

Key areas of focus will include:

- Monitoring of SHMI - despite the Trust's SHMI improving and now being within expected range, the Trust will continue to monitor the mortality rates in specific diagnostic groups and where a rising trend is seen will instigate case note and clinical pathway review.
- End of Life Care - Provision of end of life care in community settings rather than in hospital has been a constant theme in case note reviews. Through the Integrated Care Alliance, the partners will continue the ongoing work in an effort to identify and provide services for those people at the end of life and in their preferred place of care.
- Review of Out-of-Hospital Deaths - Most primary care providers currently review the care of patients who subsequently die in their population. However, there is no systematic methodology which allows for recording of outcome or learning across organisations. As part of the COVID-19 pandemic a review of out of hospital deaths was undertaken with Wolverhampton CCG and was extended to the other areas of the Black Country and West Birmingham Sustainability and Transformation Partnership (STP). Following this review, the Trust has commenced discussions with the Primary Care Networks and will pilot a Medical Examiner and Mortality Review system in the Trust's primary care practices during 2021/22. A standard operating procedure is currently being developed for this service.

| | Prescribed information | Form of statement |
|---|---|---|
| **A** | The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure. | During April 2020 and March 2021, 2195 adult patient hospital deaths were recorded at the Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period:<br><br>[543] in the first quarter<br>[384] in the second quarter<br>[578] in the third quarter<br>[690] in the fourth quarter |
| **B** | The number of deaths included in item A which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure. | By the 31st March 2021, [2141] case record reviews and [26] investigations have been carried out in relation to [2195] of the deaths included in item A.<br><br>In [10] cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:<br><br>[471] in the first quarter (ME Assessments 378, SJRs 93)<br>[377] in the second quarter (ME Assessments 309, SJRs 68)<br>[606] in the third quarter (ME Assessments 468, SJRs 138)<br>[687] in the fourth quarter (ME Assessments 601, SJRs 86) |
| | | Case record review includes 2 separate and linked mortality review process and they include Medical Examiners scrutiny and Structured Judgement Reviews (SJR). The Trust endeavours to subject all hospital deaths to Medical Examiner (ME) review and a proportion of deaths are identified for Structured Judgement Reviews.<br><br>The ME role is to examine deaths to:<br><br>• Agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing |

| | | |
|---|---|---|
| | | it.<br>• Discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death.<br>• Act as a medical advice resource for the local coroner.<br>• Inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures.<br><br>The Structured Judgement Review (SJR) methodology blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.<br><br>The Trust has agreed a set of criteria where a SJR is required, these are:<br>• Elective admission<br>• Mental Health ICD code<br>• Unexpected deaths<br>• Learning Disability deaths in hospital<br>• DATIX incident<br>• 10% Random selection<br>• Directorate request<br><br>Please note: 100 Structured Judgement Reviews stage 1 (SJR1) remain outstanding across Q4 2020/21 which are actively being progressed. It is also important to note that cases that have been through Medical Examiner (ME) process are included in the above figures. |
| **C** | An estimate of the number of deaths during the reporting period included in item B for which a case record review or investigation has been carried out which the provider | A total of 4 cases [0.18%] representing [number as percentage of number in item A] percentage of the adult patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. |

| | | |
|---|---|---|
| | judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this. | In relation to each quarter, this consisted of:<br><br>[0.05%] for the first quarter<br>[0.14%] for the second quarter<br>[0%] for the third quarter<br>[0%] for the fourth quarter<br><br>These numbers have been determined using evidence from the Root Cause Analysis (RCA) investigations involving deaths that were subject to review under the serious incident framework.<br><br>(The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated). |
| **D** | A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C. | Learning from the reviews/investigations of those adult patients identified in item C are as follows:<br><br>**Case 1 - Summary only: Death of a patient with history of kidney/pancreas transplant in 2014 attended Emergency Department (ED) on 4 occasions over 3 days.**<br><br>**Learning identified:**<br>Importance of escalation for senior review following re-attendance within 72 hours and ensuring all medical history is considered and diagnostic tests are re-considered.<br><br>**Case 2 - Summary only: Death of patient undergoing emergency endoscopy under general anaesthesia for major variceal haemorrhage sustained a tension pneumothorax.** |

| | | |
|---|---|---|
| | | **Learning identified:**<br>Importance of awareness of relevant staff that hypoxia and ventilation difficulty may be due tension pneumothorax.<br><br>Ensure staff are aware of rare complications, and to look for and recognise the signs of a tension pneumothorax.<br><br>Ensure theatre personnel give extra consideration when turning patients who have endotracheal tubes, endoscopes or other equipment in situ. |
| | | **Case 3 - Summary only: Death patient brought in to ED with laceration to head following unwitnessed mechanical fall at home. Patient had multiple co-morbidities. Patient noted to be on anticoagulant therapy (Apixaban).**<br><br>**Learning identified:**<br>Ensuring that medication and venous thromobemolism (VTE) assessments are discussed and captured during daily MDT ward huddle or ward round.<br><br>The importance of a clear nursing protocol of escalation/sourcing of any medication not available on the ward.<br><br>Enhance and strengthen the monitoring of VTE assessment, monitoring and escalation.<br><br>**Case 4 - Summary only: Death of patient with background Huntingdon's Disease, traumatic head injury (bilateral subdural haemorrhage as in patient elsewhere) in July 2020. Patient had been improving; sustained a head trauma (banged his head on table). The patient deteriorated clinically over several days. This deterioration was misdiagnosed as due to a urinary tract infection.**<br><br>**Learning identified:**<br>Ensuring that any head trauma in particular at-risk patients is considered as |

| | | |
|---|---|---|
| | | significant even if there is no external evidence of trauma and patient does not have immediate neurological deterioration.<br><br>The importance of ensuring clinicians are aware of cognitive bias and the impact it may have on differential diagnosis. |
| **E** | A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item D). | **Case 1**<br>• Review ED 72hr re-attender protocol around the requirement of investigations and senior review based on clinical presentation and frequency of re-attendance<br>• Develop ED guidelines for the management of transplant patients<br>• Case to be used at junior doctor induction/training to provide education around management of complex patients.<br><br>**Case 2**<br>• RCA Synopsis to be discussed at the next Governance Meeting to share findings with staff that hypoxia and ventilation difficulty may be due tension pneumothorax<br>• Train relevant staff to remember rare complications, and to look for and recognise the signs of a tension pneumothorax<br>• Communicate to theatre personnel the importance of consideration when turning patients who have endotracheal tubes, endoscopes or other equipment in situ<br>• Clinical Director to consider changes to anaesthetic practice to include the position of the endotracheal tube (and to regularly check its position).<br><br>**Case 3**<br>• Review multi-disciplinary team ward huddle and content of huddle tool to ensure medication and VTE assessments are discussed and captured<br>• Development of local nursing escalation procedure for non-availability of medication<br>• Review VTE monitoring/escalation process to strengthen accountability |

| | | |
|---|---|---|
| | | • Themed analysis of VTE related medication incidents over last 12 months to be linked with current Continuous Quality Improvement (CQI) projects<br><br>**Case 4**<br>• Arrange bespoke education of delayed presentation of neurological conditions for MDT. Record for use by others<br><br>• Reflection by medical team involved in care with emphasis on diagnostic reasoning<br><br>• Trust wide communication via shared learning<br><br>• Individual reflection, learning and identification of training needs for staff involved (all professions). |
| **F** | An assessment of the impact of the actions described in item E which were taken by the provider during the reporting period. | The MRG will continue to progress the Trust's mortality improvement programme and associated plan, underpinned by the Mortality Strategy. |
| **G** | The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item B in the relevant document for that previous reporting period. | [0] case record reviews and [0] investigations completed after 31st March 2020 which related to deaths which took place before the start of the reporting period are included with this information. |

| | | |
|---|---|---|
| **H** | An estimate of the number of deaths included in item G which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this. | 0.0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.<br><br>The methodology used in all cases was through the Root Cause Analysis (RCA) investigations involving deaths that were subject to review under the Serious Incident Framework. The determination whether they were more likely than not to have been due to problems in care is undertaken as part of the RCA process and reviewed/agreed through the Trust Executive Significant Event Review Group (ESERG). |
| **I** | A revised estimate of the number of deaths during the previous reporting period stated in item C of the relevant document for that previous reporting period, taking account of the deaths referred to in item H. | 0.11% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient as previously reported. |

# 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 assess the quality of care delivered to NHS patients from their perspective, regarding the health gains for the following two surgical interventions using pre and post-operative survey questionnaires:

- Hip replacement surgery
- Knee replacement surgery

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

The table outlines the Adjusted post-op score by procedure based on the EQ-5D Index.

| | April 18 – March 19 | April 19 – March 20 | National Average 19 - 20 |
|---|---|---|---|
| Hip Replacement Surgery | 0.78 | 0.79 | 0.80 |
| Knee Replacement Surgery | 0.75 | 0.75 | 0.75 |

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

- For hip replacement, 137 patients completed the questionnaire. 86.9% of these patients reported improvement, 5.1% unchanged and 8% worsened.
- This has resulted in a score for the reporting period of 0.01 under the national average.
- For knee replacement, 146 patients completed the questionnaire. 82.2% of these patients reported improvement, 9.6% unchanged and 8.2% worsened.
- This has resulted in a score for the reporting period equalling the national average.
- For both hip and knee surgery, the data demonstrated the Trust score to be broadly in line with the national average with a slight increase on the previous year's performance. However, the number of patients completing the questionnaire did decline significantly.

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

- A PROMs audit to be undertaken as part of the Trusts Audit Programme in 2021-22.
- Education for patients continues to be provided pre-operatively, and the PROMS questionnaire explained and provided to patients at their preoperative appointment. Due to COVID-19 the number of patients completing their questionnaires for the next year is expected to be lower than previous years due to decreased activity.
- Alongside commissioners, the Trust will continue to regularly review its orthopaedic pathways to ensure optimum care is provided to patients post operatively through follow-up.

# Core Quality Indicators – Re-admission Rates

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

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

| Readmissions | | | | | | | Grand Total |
|---|---|---|---|---|---|---|---|
| Age | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | |
| Aged 4-15 | 440 | 505 | 423 | 359 | 428 | 269 | 2,424 |
| 16yrs and over | 5,966 | 5,443 | 5,165 | 5,677 | 6,018 | 4,051 | 32,320 |
| Grand Total | 6,406 | 5,948 | 5,588 | 6,036 | 6,446 | 4,320 | 34,744 |

| Total Admissions | | | | | | | Grand Total |
|---|---|---|---|---|---|---|---|
| Age | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | |
| Aged 4-15 | 5288 | 5429 | 5117 | 4,668 | 4,813 | 2,899 | 28214 |
| 16yrs and over | 115288 | 118585 | 117355 | 117,669 | 120,049 | 90,876 | 679822 |
| Grand Total | 120576 | 124014 | 122472 | 122,337 | 124,862 | 93,775 | 708036 |

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

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

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

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

- Use of the huddle tool and huddle education and support to improve predictability and communication about discharge date.
- Further improvement work with partners on the discharge to access (D2A) process to capture and embed the learning from the COVID-19 pandemic.
- Continuing to work with local residential and nursing homes with regards transfer of patients back to their care.
- Partnership with other Trusts as part of the Alliance16 initiative to improve patient flow.

# Core Quality Indicators – Safety Thermometer (Harm Free Care)

Due to contractual changes there is no longer a requirement to report and publish safety thermometer metrics and performance.

# Core Quality Indicators – VTE Prevention

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

| | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | Q4 2019/20 | Q1 2020/21 | Q2 2020/21 | Q3 2020/21 | Q4 2020/21 | 20/21 Year End |
|---|---|---|---|---|---|---|---|---|---|
| RWT | 94.92% | 95.17% | 94.70% | 93.20% | 93.24% | 94.00% | 93.48% | 93.41% | 93.56% |

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

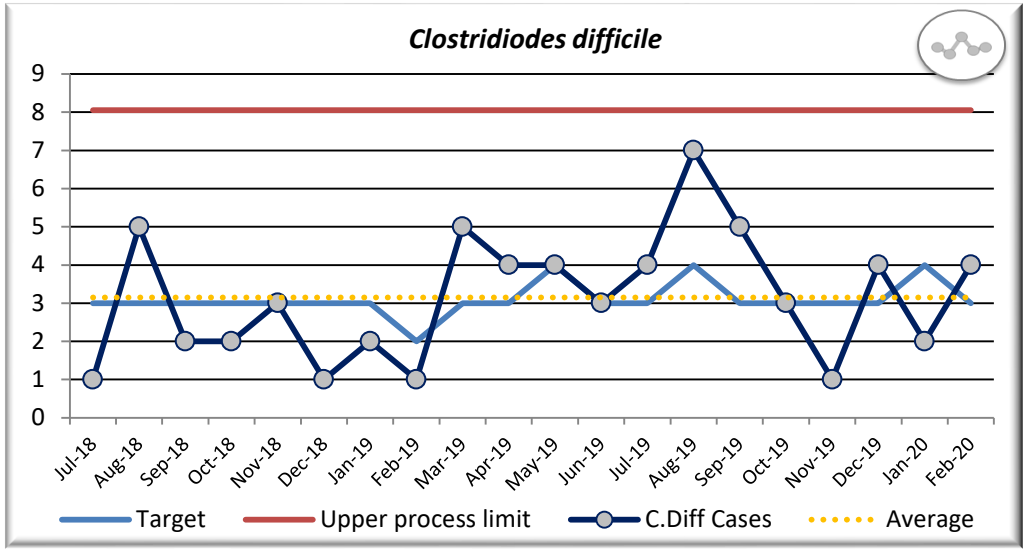
- The numerator is the number of adult in-patients that have received a VTE assessment upon admission to the Trust using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with published guidance).
- The denominator is the number of adult inpatients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

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

- Continue with improvement plans in order to achieve 95% and above compliance.
- Continue targeted development and implementation of clinical area specific continuous quality improvement plans.
- Regularly review and implement updates of national COVID-19 guidance and respond to emerging evidence and new information.
- Continue work to implement the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) knowing the score for Pulmonary Embolism (PE) diagnosis and management.
- Implementation during April 21 of VTE prevention measures for patients in lower limb casts as per the most recent NICE guidance NG89.
- Resume the work of the Anti-Coagulation In-reach Team.
- Continuation of the work with the electronic prescribing team to link VTE risk assessment and prescription.
- Continuation of the work on a reporting system using electronic data for prescriptions and administration and work with individual clinical areas on a roll out plan.

# Core Quality Indicators – *Clostridioides* ***difficile*** **(previously known as *Clostridium difficile*)**

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




| | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cases | 3 | 2 | 5 | 2 | 6 | 2 | 2 | 7 | 2 | 5 | 5 | 5 |
| Target | 3 | 3 | 4 | 3 | 3 | 4 | 3 | 3 | 4 | 3 | 3 | 4 |

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

Samples received in the laboratory are processed according to national guidance, ensuring that every sample that requires a *Clostridioides difficile* test is tested appropriately. In 2020-21 a new laboratory information system was installed, with the capability to automatically identify those samples that require *Clostridioides difficile* testing according to age and location.

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

- Nursing quality metrics
- Laboratory data
- Domestic monitoring
- Mortality information
- National HCAI data capture system monitoring.

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

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

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

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

During 2020/21 there was no agreed trajectory for cases due to the COVID-19 pandemic. The target used for the data above was based on the previous year's trajectory, which was itself based on only 9 months data, and so was lower than it would have been had it been based on numbers for a full year. The impact of the COVID-19 pandemic in 2020/21 was such that there was little capacity to focus on *Clostridioides difficile* reduction. Efforts were made to continue where possible:

- Environmental controls are a top priority in the Trust's approach in tackling *Clostridioides difficile*. The deep clean schedule was completed where possible but not all areas were cleaned according to schedule. Regular environment audits were undertaken, results of which continued to be monitored through the Environment Group which reports to the Trust Infection Prevention Group. During the pandemic additional chlorine-based cleaning was taking place and wherever possible Hydrogen Peroxide

Vapour (HPV) was used in individual bays and side rooms.

- Surveillance of cases to identify potential cross-transmission continued, with meetings and action plans enacted where indicated. Due to the COVID-19 pandemic the typing of strains by the reference laboratory was unavailable for some months.
- The availability of Human Probiotic Infusion (HPI) was halted during the early stages of the pandemic but is again available for appropriate cases. This is incorporated into the treatment algorithm which ensures they are used more often with recurrent disease for improved outcomes.
- Follow up of cases in the Community has continued to ensure treatment is completed and to facilitate appropriate intervention and advice if symptoms return.

During 2021/22 there has not yet been an agreed trajectory; this will be released in Quarter 2 by NHSE/I, however the Trust will focus on the following aspects:

- Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data.
- Sustain *Clostridioides difficile* reduction with a lower tolerance of individual cases.
- Antibiotic stewardship activities to be refreshed following limited activity in 2020-21 due to pressures of COVID-19 pandemic.
- A deep clean programme for inpatient and outpatient areas is undertaken efficiently and completed by the end of the year - including bespoke deep clean plan for hard to clean areas (e.g. Acute Medical Unit, Emergency Department, Integrated Critical Care Unit).
- A bed cleaning service is currently available for medical wards whereas beds, lockers and tables are removed from the ward once the patient has been discharged and replaced with furniture that has been through a thorough clean including HPV. A business case is currently in progress through Hotel Services to provide a full service to New Cross site in a bespoke setting.

# Core Quality Indicators – Incident Reporting

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

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

| 2019/20 (Full Year Data) | | | 2020/21 (April - September) | | |
|---|---|---|---|---|---|
| Incidents | % resulting in Death | % resulting in severe harm | Incidents | % resulting in Death | % resulting in severe harm |
| 11514 | 0.2% (19) | 0.1% (12) | 4342 | 0.2% (9) | 0.1% (6) |

Data source – Trust Data NRLS 2021

The Trust defines severe or permanent harm as detailed below:

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

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

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

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

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

- The promotion and encouragement of a healthy reporting and learning culture to continuously improve patient safety.
- The engagement of staff in implementing a learning framework that ensures the proactive and reactive learning is shared.
- The introduction of the new requirements from the National Patient Safety Strategy including the Patient Safety Specialist role, Patient Safety Syllabus training, Incident Response framework, Investigation, Improvement and Human Factors methodology.

# Core Quality Indicators – National Inpatient Survey

The 2020 Inpatient Survey was part of a National Survey Programme run by Care Quality Commission (CQC) to collect feedback on the

experiences of inpatients using the NHS services across the country. The results contribute to the CQC's assessment of NHS performance as well as ongoing monitoring and inspections. The programme also provides valuable feedback for NHS trusts, which they can then use to improve patient experience.

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

Once the results are known the Trust will compile a comprehensive action plan to make service changes to improve the patient experience where possible.

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

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

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

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

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

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

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

| Survey Response Rate | | | | |
|---|---|---|---|---|
| | Q1 2020/21 | Q2 2020/21 | Q3 2020/21 | Q4 2020/21 |
| Emergency Department | 16% | 17% | 18% | 18% |
| Inpatients | 29% | 35% | 31% | 27% |
| Maternity | 12% | 12% | 13% | 12% |
| Outpatients | 14% | 19% | 18% | 18% |
| | | | | |
| **Percentage of Patients who would recommend the Trust** | | | | |
| | Q1 2020/21 | Q2 2020/21 | Q3 2020/21 | Q4 2020/21 |
| Emergency Department | 89% | 82% | 84% | 84% |
| Inpatients | 93% | 92% | 91% | 90% |
| Maternity | 92% | 86% | 86% | 92% |
| Outpatients | 94% | 93% | 94% | 94% |
| | | | | |
| **Percentage of Patients who would not recommend the Trust** | | | | |
| | Q1 2020/21 | Q2 2020/21 | Q3 2020/21 | Q4 2020/21 |
| Emergency Department | 7% | 11% | 10% | 10% |
| Inpatients | 4% | 4% | 4% | 4% |
| Maternity | 5% | 10% | 7% | 5% |
| Outpatients | 2% | 2% | 2% | 2% |

**The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2021/22 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.
- Use FFT amongst other metrics to identify areas for improvement.

**Please note that national reporting of FFT has been suspended during the peak of the pandemic however the Trust has continued to survey where possible. As a consequence, there are no national comparisons.**

# Core Quality Indicators – Supporting Our Staff

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

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

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

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

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

| | Recommendation Rates - Work | | | Recommendation Rates - Care | | |
|---|---|---|---|---|---|---|
| | **Q2 2019/20** | **Q4 2019/20** | **Q3 2020/21** | **Q2 2019/20** | **Q4 2019/20** | **Q3 2020/21** |
| RWT | 81% | 73% | **75.5%** | 90% | 82% | **80%** |
| Average | 66% | No data | **67%** | 81% | No data | **74%** |
| Highest | 97% | No data | **84%** | 100% | No data | **92%** |
| Lowest | 33% | No data | **47%** | 50% | No data | **50%** |

There has been a further and notable increase in both the Trust recommender rates, based on the two Staff Friends and Family Test questions:

- 75.5% of staff recommend the Trust as a Place to Work.
- 80.4% of staff recommend the Trust as a Place for Care/Treatment.

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

- Benchmarking ourselves against our peers with aim to show continual improvements against national scores.

**Note: The Staff Friends and Family Test (FFT) reporting was suspended nationally during the COVID-19 pandemic and therefore there is no additional comparative data available for 2020/21.**

**National NHS Staff Survey**

The Trust has again undertaken a full census of the national NHS Staff Survey, whereby all of our staff have been invited to provide feedback on their workplace experience. The findings were grouped into 10 themes in 2020:

- Equality, Diversity & Inclusion
- Health and wellbeing
- Immediate Managers
- Morale
- Quality of Care
- Safe Environment – Bullying and Harassment
- Safe Environment – Violence
- Safety Culture
- Staff Engagement
- Team Working

There were improvements in two of the themed areas, which have been reported as statistically significant; these are **Health and Wellbeing and Morale.** These improvements are particularly notable in terms of staff experience, given the unprecedented and extremely difficult circumstances that staff have continued to work in during this last year of the COVID-19 pandemic. It is also a highly positive response to the targeted and increased overall health and wellbeing support packages provided to staff across the organisation during this period.

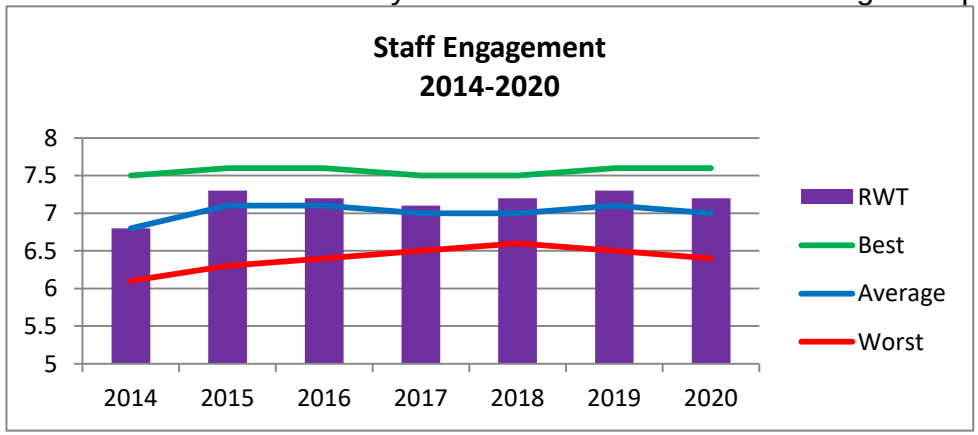
The table below shows a comparison between 2019 and 2020 results for each of the 10 survey themes; the 'Appraisals' theme was removed in order to focus on experiences in the COVID-19 pandemic. Themes are on a 0-10 point scale, where 10 is the best score attainable.

| Theme | 2019 score | 2019 respondents | 2020 score | 2020 respondents | Statistically significant change? |
|---|---|---|---|---|---|
| Equality, Diversity & Inclusion | 9.2 | 3303 | 9.1 | 3252 | Not significant |
| Health & Wellbeing | 6.2 | 3340 | 6.4 | 3277 | ▲ |
| Immediate Managers | 7.0 | 3339 | 7.0 | 3278 | Not significant |
| Morale | 6.4 | 3286 | 6.5 | 3266 | ▲ |
| Quality of Care | 7.8 | 2837 | 7.8 | 2701 | Not significant |
| Safe Environment – Bullying & Harassment | 8.2 | 3306 | 8.2 | 3238 | Not significant |
| Safe Environment – Violence | 9.6 | 3315 | 9.6 | 3242 | Not significant |
| Safety Culture | 6.9 | 3308 | 6.9 | 3264 | Not significant |
| Staff Engagement | 7.3 | 3357 | 7.2 | 3275 | Not significant |
| Team Working | 6.7 | 3306 | 6.6 | 3234 | ▼ |

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

## Staff Engagement

The graph below provides a comparison for each year from 2014 to 2020 and Staff engagement levels within RWT have remained fairly consistent over the last six years as well as above the average comparator group.




The 2020 NHS staff survey included reporting experiences for the 10 themes by COVID-19 classification breakdown:

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

There were slightly higher levels of engagement recorded by staff 'required to work remotely' and staff 'shielding for self'; compared to all staff.

The Trust's staff engagement approaches in this last year have been with a focus on listening and learning sessions, surveys and focus groups, and engaging with our Employee Voice groups. In addition, there has been regular communication and updates provided across the organisation through daily/weekly communications bulletins, video messages and senior leadership briefings. Feedback from staff was included in designing and implementing a number of successful changes to many of the Trust's working practices, policies and processes.

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

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

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

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

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

- Embedding of the new national staff FFT and Pulse survey guidance.
- Re-introduce a local quarterly ‘pulse survey’, with questions linked to chosen NHS staff survey themes (linked to point above).

## Supporting Staff through Speaking Up

The Trust has been working with the Freedom to Speak Up (FTSU) Guardian to progress the below five identified FTSU objectives and has devised a Speak Up Vision. The objectives below have been successfully achieved and are evidenced in the FTSU Guardian Board reports.

1. Raise the profile and develop a culture where speaking up becomes normal practice to address concerns.
2. Develop mechanisms to empower and encourage staff to speak up safely.
3. Ensure that the Trust provides a safe environment for employees and others to raise concerns and speak up.
4. Ensure that concerns are effectively investigated and the Trust acts on its findings.
5. Ensure shared learning amongst local/regional/national Networks.

Despite the challenges of COVID-19 the Guardian has worked with the organisation to provide the safest way to deliver FTSU support and has also offered support to the Contact Links (volunteer employees supporting FTSU). This year there has been a significant increase in the number of cases being reported to the Guardian, a good indicator of speaking up culture as evidenced in the most recent FTSU Trust Board report.

The National Guardian’s Office (NGO), NHS England and Improvement have published a FTSU Index report. The report brings together

four questions from the NHS Staff Survey that relate to whether staff feel knowledgeable, secure, and encouraged to speak up and whether they would be treated fairly after an incident. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made (National Guardian Office: 2020).

The RWT FTSU Index Score has seen a positive increase year on year:

- 2018 77%
- 2019 78%
- **2020 78.4%**

The 2019 RWT FTSU Index score recorded a midrange position of 78% which was slightly lower than the national benchmark median score of 79%. In 2020, this position has improved slightly to 78.4% however national benchmarking data is currently not available. The Trust is showing improvements to its FTSU culture; however further actions to embed FTSU within the organisation are required to ensure RWT achieve an above average FTSU Index score. The Guardian will work closely this next year with key stakeholders of the Trust to support actions in improving the FTSU Index score.

During the last unprecedented year, FTSU has focused on, online awareness training sessions and responded to departmental concerns. Training packages have been devised and delivered combining Equality, Diversity & Inclusion (EDI), Psychological Safety, and safe speaking up environments. This has been well received and has been successful due to the collaborative approach taken with the Trust EDI Lead, HR Advisory, Governance, Divisional, Departmental leads, and the Education & Training department.

Freedom to Speak Up at RWT is a valuable resource that ensures safe speaking up cultures, enabling to keep our patients and workforce safe. We have aligned our FTSU approach to our Trust values of being, Safe and Effective, Kind and Caring and Exceeding Expectation.

The next year of FTSU will focus on embedding the National Guardian e-learning for health programme into our e-learning platforms, expanding the volunteer support, reviewing the current FTSU resource the Trust has in place and working in collaboration with key partners in the Trust to contribute to further embedding a culture of FTSU.

# Review of Quality

# Our performance in 2020/21

**OVERVIEW OF THE QUALITY OF CARE BASED ON TRUST PERFORMANCE**

As part of the standard NHS contract, the Trust is required to monitor and report performance against a set of key metrics. These indicators are all reported to the Trust Board on a monthly basis.

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

## Performance against the National Operational Standards:

| Indicator | Target 2020/21 | Performance 2020/21 | Performance 2019/20 | Performance 2018/19 |
|---|---|---|---|---|
| Cancer two week wait from referral to first seen date | 93% | **86.71%** | 82.11% | 83.18% |
| Cancer two week wait for breast symptomatic patients | 93% | **51.14%** | 35.19% | 51.12% |
| Cancer 31 day wait for first treatment | 96% | **85.66%** | 87.14% | 90.15% |
| Cancer 31 day for second or subsequent treatment - Surgery | 94% | **75.15%** | 84.84% | 76.02% |
| Cancer 31 day for second or subsequent treatment - Anti cancer drug | 98% | **97.58%** | 99.66% | 100.00% |
| Cancer 31 day for second or subsequent treatment - Radiotherapy | 94% | **92.51%** | 90.87% | 87.95% |
| Cancer 62 day wait for first treatment | 85% | **55.30%** | 58.07% | 62.78% |
| Cancer 62 day wait for treatment from Consultant screening service | 90% | **58.57%** | 60.18% | 78.48% |
| Cancer 62 day wait - Consultant upgrade (local target) | 88% | **68.68%** | 74.49% | 81.90% |
| Emergency Department - total time in ED | 95% | **85.56%** | 85.91% | 91.12% |
| Referral to treatment - incomplete pathways | 92% | **65.26%** | 84.31% | 90.44% |
| Cancelled operations on the day of surgery as a % of electives | <0.8% | **0.34%** | 0.65% | 0.47% |
| Mixed sex accommodation breaches | 0 | **0** | 0 | 0 |
| Diagnostic tests longer than 6 weeks | <1% | **45.27%** | 3.2% | 1.5% |

## Performance against other national and local requirements

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

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

| Indicator | Target 2020/21 | Performance 2020/21 | Performance 2019/20 | Performance 2018/19 |
|---|---|---|---|---|
| Clostridium Difficile | 40 | **46** | 43 | 31 |
| MRSA | 0 | **2** | 0 | 2 |
| Referral to treatment - no one waiting longer than 52 weeks | 0 | **2,409** | 0 | 0 |
| Trolley waits in A&E longer than 12 hours | 0 | **169** | 38 | 7 |
| VTE Risk Assessment | 95% | **93.57%** | 94.48% | 93.26% |
| Duty of Candour - failure to notify the relevant person of a suspected or actual harm | 0 | **1** | 0 | 1 |
| Stroke - 90% of time spent on stroke ward | 80% | **91.88%** | 94.08% | 93.55% |
| Maternity - bookings by 12 weeks 6 days | >90% | **92.00%** | 90.60% | 90.80% |
| Maternity - breast feeding initiated | >64% | **71.50%** | 69.90% | 64.90% |

# ENGAGEMENT IN THE DEVELOPING OF THE QUALITY ACCOUNT

Prior to the publication of the 2020/21 Quality Account, we have shared this document with the following:

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

In 2021/22 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.

# Statement from Wolverhampton Clinical Commissioning Group

Signature: PRINT NAME: SALLY ROBERTS

Title: this has changed

Date:

CITY OF WOLVERHAMPTON COUNCIL

# Statement from City of Wolverhampton Council Health Scrutiny Panel

Cllr XXX

Chair of Health Scrutiny Panel

City of Wolverhampton Council

# Statement from Healthwatch

# Statement of Director Responsibilities in respect of the Quality Account 2020/21

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.

Add David's signature

Add Steve's signature

By order of the Board

David Loughton, CBE

Chief Executive

*Add date*

Professor Steve Field, CBE

Chairman

*Add date*

# Statement of Limited Assurance from the Independent Auditors

Due to the coronavirus (COVID-19) pandemic, a decision was made nationally in January 2021 to suspend the assurance audit element of the Quality Account 2020/21.

**Appendix 1 – National Clinical Audits that the Trust participated in during 2020/21 and remain in progress**

The 79 national Clinical Audits the Trust collected data for in for 2020/21 are as follows.

The reports for the 2020/21 data will be reviewed and presented locally as and when they are made available to the Trust by the relevant Coordinating Centre.

| National Clinical Audit, Enquiry or Programme | Work Stream/ Component | Lead Directorate |
|---|---|---|
| BAUS Urology Audits | BAUS Cytoreductive Radical Nephrectomy Audit | Urology |
| BAUS Urology Audits | BAUS Renal Colic Audit | Urology |
| Breast and Cosmetic Implant Registry (BCIR)<br>BCIR operate a continuous data collection model. | Breast Implant – cosmetic augmentation and breast reconstruction with implant including revision and removal | General Surgery |
| British Spine Registry | N/A | T&O |
| Case Mix Programme (CMP) | N/A | Critical Care |
| Elective Surgery (National PROMs Programme) | N/A | T&O |
| Emergency Medicine QIPs | Pain in Children (care in emergency departments) | ED |
| Falls and Fragility Fractures Audit programme (FFFAP) | Fracture Liaison Service Database | Rheumatology |
| Falls and Fragility Fractures Audit programme (FFFAP) | Fracture Liaison Service Database / Vertebral Fracture Sprint Audit | Rheumatology |
| Falls and Fragility Fractures Audit programme (FFFAP) | National Audit of Inpatient Falls | T&O |
| Falls and Fragility Fractures Audit programme (FFFAP) | National Hip Fracture Database | T&O |

| | | |
|---|---|---|
| Inflammatory Bowel Disease (IBD) Audit | Inflammatory Bowel Disease (IBD) Biological Therapies Audit<br>work streams | Gastroenterology |
| Learning Disabilities Mortality Review Programme (LeDeR) | N/A | Trust wide |
| Mandatory Surveillance of HCAI | N/A | Microbiology |
| Maternal, Newborn and Infant Clinical Outcome Review Programme | Perinatal Mortality Surveillance | Obstetrics |
| National Acute Kidney Injury Programme | N/A | Renal |
| National Audit of Breast Cancer in Older People (NABCOP) | N/A | General Surgery |
| National Audit of Cardiac Rehabilitation<br>Continuous data collection | N/A | Cardiology |
| National Cardiac Audit Programme (NCAP) | National Audit of Cardiac Rhythm Management (CRM) | Cardiology |
| National Cardiac Audit Programme (NCAP) | Myocardial Ischaemia National Audit Project (MINAP) | Cardiology |
| National Cardiac Audit Programme (NCAP) | National Adult Cardiac Surgery Audit | Cardiothoracic |
| National Cardiac Audit Programme (NCAP) | National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) | Cardiology |
| National Cardiac Audit Programme (NCAP) | National Heart Failure Audit | Cardiology |
| National Diabetes Audit - Adults | National Diabetes Foot Care Audit | Diabetes |
| National Diabetes Audit - Adults | NaDIA-Harms - reporting on diabetic inpatient harms in England | Diabetes |
| National Diabetes Audit - Adults | National Core Diabetes Audit | Diabetes |
| National Diabetes Audit - Adults | National Pregnancy in Diabetes Audit | Obstetrics |
| National Emergency Laparotomy Audit (NELA) | N/A | Critical Care |
| National Gastro-intestinal Cancer Audit Programme (GICAP) | National Oesophago-gastric Cancer (NOGCA) | Oncology |
| National Gastro-intestinal Cancer Audit Programme | National Bowel Cancer Audit (NBOCA) | Oncology |
| National Joint Registry (NJR)<br>Continuous data collection | 8 workstreams; Hip Replacement, Knee Replacement, Ankle Replacement, Elbow | T&O |

| | | |
|---|---|---|
| | Replacement, Shoulder Replacement, Implant Performance, Hospital Performance & Surgeon Performance | |
| National Lung Cancer Audit (NLCA) | N/A | Respiratory |
| National Maternity and Perinatal Audit (NMPA) | N/A | Obstetrics |
| National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) | N/A | Neonatal |
| National Prostate Cancer Audit (NPCA) | N/A | Urology |
| Perinatal Mortality Review Tool | N/A | Obstetrics |
| Perioperative Quality Improvement Programme (PQIP) | N/A | Critical Care |
| RESECT - transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment | N/A | Urology |
| Sentinel Stroke National Audit programme (SSNAP) | N/A | Stroke |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | N/A | Pathology |
| Society for Acute Medicine's Benchmarking Audit (SAMBA) | Acute Internal Medicine / General Internal Medicine | AMU |
| Surgical Site Infection Surveillance Service | N/A | Infection Prevention |
| Trauma Audit & Research Network (TARN) | N/A | ED |
| UK Cystic Fibrosis Registry | N/A | Respiratory |
| UK Renal Registry | N/A | Renal |
| Audit of the management of Primary Biliary Cholangitis (PBC) in the United Kingdom, supported by the British Society of Gastroenterology (BSG) and British Association for the Study of the Liver (BASL): the UK-PBC Audit. | N/A | Gastroenterology |
| Fragility Fracture Post- Operative Mobilisation ( FFPOM) | N/A | Care of the elderly |

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| National Audit (QIP) - Project Assessing the Management of Endometrial Hyperplasia (pre and post 2016 green top guideline). | N/A | Gynaecology |
| Evaluation of Practice Patello-Femoral Instability Collaborative | N/A | Trauma & Orthopaedics |
| GlobalSurg-CovidSurg Week international audit. Coordinated by NIHR Global Surgery Unit, University of Birmingham. | N/A | Head & Neck |
| NICE NG 118: COVID Stones: An observational multi-centre cohort study investigating the clinical management and outcomes of ureteric stones during the COVID-19 pandemic in the United Kingdom | N/A | Urology |
| UK CoTS (COVID Trauma Surge) project | N/A | Trauma & Orthopaedics |
| UK COVID and Gynaecological Cancer Study | N/A | Gynaecology |
| KPI's - 12 month for each procedure | N/A | Gastroenterology |
| Gastric Ulcer Audit | N/A | Gastroenterology |
| Post Colon Colorectal Cancer (PCCRC) | N/A | Gastroenterology |
| Small Bowel Capsule Endoscopy | N/A | Gastroenterology |
| GI Bleeding Audit 2020 | N/A | Gastroenterology |
| Flexi Audit: April 20 - Sept 20 - 6 month review | N/A | Gastroenterology |
| OGD Audit: April 20 - Sept 20 - 6 month review | N/A | Gastroenterology |
| Colon Audit | N/A | Gastroenterology |
| IQILS Audit | N/A | Gastroenterology |
| National GRS ERCP | N/A | Gastroenterology |

| | | |
|---|---|---|
| Motor Neurone Disease Care Audit | N/A | Neuro Rehab |
| NATIONAL COVID surg cancer | N/A | Cardiothoracic Surgery |
| National re-Audit Management of syphilis as per BASHH Guidelines | N/A | Sexual Health/GUM |
| CovidSurg-Cancer: an international cohort study assessing the safety of surgery for all types of cancer during the COVID-19 pandemic and the impact of the pandemic in cancer delay and treatment pathways. | N/A | General surgery |
| CovidSurg: an international cohort study, aiming to assess the outcomes of surgery in patients diagnosed in COVID-19 | N/A | General surgery |
| CovidCollab - A panspecialty international project to determine point of care predictors from routinely collected data. (National Audit) 19/20 | N/A | Care of the elderly |
| Regional Audit: Data collection for Neck of Femur patients during the COVID-19 Outbreak - Contribution to a regional Orthopaedics collaborative project in the Midlands | N/A | Trauma & Orthopaedics |
| National (BASHH) SAS AUDIT on NSU/ non chlamydia non gonococcal | N/A | Sexual Health/GUM |
| National Child Mortality Database | N/A | Children's services |

## Appendix 2 – National Clinical Audits reviewed by the Trust in 2020/21 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 2021/22 audit plan for subsequent re-audit.

The reports of 25 completed National Clinical audit projects have been reviewed in 2020/21 by the provider to date and the actions being taken to continue improvement are below.

| 2020/21 Audit ID | National Clinical Audit, Enquiry, Project name & Work-stream | Lead Directorate | Compliance rating | Actions identified to improve the quality of healthcare provided |
|---|---|---|---|---|
| 5515 | GlobalSurg-CovidSurg Week | Trauma & Orthopaedics | Not Applicable | Not applicable |
| 5450 | Functional outcome measures from patients from neuro rehabilitation unit from the West Park Hospital | Neuro Rehab | Minor Non-Compliance | Cross checking for completion score by a senior team member |
| 5378 | A snapshot of presentation and management of acute appendicitis during the COVID-19 pandemic ( Local and national findings - HAREM Study) | General surgery | Not Applicable | N/A - no audit standards |
| 5321 | National Joint Registry (NJR) Annual Report (2019/20) Data) | Trauma & Orthopaedics | Fully Compliant | Consideration to be given to; addition in NoF booklet/ On call team/ Hip fracture nurse check |
| 5318 | PROMS (Patient Reported Outcome Measures) Audit 2019-20 data | Trauma & Orthopaedics | Not Applicable | No actions required there was nothing in the data to inform any change of practice. |
| 5313 | 2020/21 BAUS National Complex Surgery Audits/ National Prostate Cancer | Urology | Not Applicable | Not Applicable |
| 5307 | Retrieval of caval filters | Radiology | Fully Compliant | Discussion in Interventional Radiology meeting.<br>Always clearly document initial decision to retrieve or not.<br>Ensure clear responsibility for following-up all patients. |
| 5279 | National BHIVA Audit 2019 data | Sexual Health/GUM | Fully Compliant | Ensure pathways into HIV care are readily accessible with clear guidance for all health care professionals and peer/community support organisations. |

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| | | | | This should be kept updated and communicated to colleagues, especially general practice.<br>Routinely discuss all relevant topics including U=U (undetectable equals untransmittable) and availability of peer/community support with newly diagnosed individuals.<br>Review individuals who have not started ART (antiretroviral treatment) within 6-8 weeks of diagnosis to identify possible support need. |
| 5210 | NELA - National Emergency Laparotomy Audit (relates to 2018/19 submission of data). 2020/21 | Critical Care | Minor Non-Compliance | A regular forum has been set up to discuss and try to improve aspects of care.<br>Clinical Directors and Medical Directors should ensure local workforce planning facilitates the consultant presence throughout the perioperative journey 24/7. This should include the wider multidisciplinary team.<br>Local NELA leads should include the wider multidisciplinary team such as geriatricians, radiologists, physicians and emergency department doctors in the design and delivery of the emergency laparotomy care pathway.<br><br>Medical Directors, Clinical Directors and Leads should design and implement NELA pathways of care and improvement work that includes ED teams to ensure the most rapid, seamless management of these high risk patients.<br>Medical Directors should direct Clinical Directors to broaden the local NELA team by appointing ED physicians as NELA clinical leads. |
| 5172 | Safety Of The Use Of Direct Oral Anticoagulants (DOACs) In Morbidly Obese Patients With Non-Valvular Atrial Fibrillation (NVAF) Undergoing Elective Direct Current Cardioversion (DCCV) (2020/21) | Cardiology | Minor Non-Compliance | This will be re-audited as part of the national program to see if world-wide levels are still rising |

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|---|---|---|---|---|
| 4750 | National Hip Fracture Data Annual Report - 2019 Data 2019/2020 | Trauma & Orthopaedics | Minor Non Compliance | On-going improvement of this service, with dedicated lead and fracture nurse. Care of Elderly fully involved as well. |
| 5012 | NCEPOD - In hospital management of out of hospital cardiac arrests 2019/2020 | Critical Care | Fully Compliant | Not applicable as fully compliant |
| 4900 | National Smoking Cessation Audit 2019 | Respiratory medicine | Fully Compliant | Not applicable as fully compliant |
| 4887 | SAMBA 2019/20 - Society for Acute Medicine Benchmarking | Acute medicine | Moderate Non-Compliance | A review of time from DTA (daytime arrival) to consultant review will be included in the next SAMBA audit |
| 4761 | National ICNARC Case Mix Audit & Research Programme for Critical Care (relates to 2018/19 data cycle). 2019/2020 | Critical Care | Fully Compliant | Not applicable as fully compliant |
| 4723 | National Audit Management of syphilis as per BASHH Guidelines 2019/20 | Sexual Health/GUM | Minor Non-Compliance | Actions needed; repeat STS bloods at 3, 6 and 12 months then ongoing 6 monthly if needed until results stable. Arrange 3 month blood repeats for our patients and STS contacts should be treated on presentation. |
| 4628 | Learning Disability Mortality Review Programme (LeDeR) 19-20 | Trust wide | Not Applicable | All National recommendations are reviewed and appropriate actions are agreed upon and monitored via the Trust Mortality Review Group. |
| 4119 | Cancer Services<br>National End of Life Audit 2019 data | Oncology | Minor Non-Compliance | Continue to promote use of SWAN, care in the last days of life document.<br>Increase End of Life training available. |
| 4057 | PROMS (Patient Reported Outcome Measures) Audit 2018-19 data | Trauma & Orthopaedics | Fully Compliant | Not applicable as fully compliant. |
| 4055 | Cancer Services<br><br>National Gastro-intestinal Cancer Audit Programme (National Oesophago-gastric Cancer (NOGCA) National Bowel Cancer Audit (NBOCA)) | Oncology | Fully Compliant | Not applicable as fully compliant. |

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| 4054 | Cancer Services<br>National Bowel Cancer (NBOCA) 2018/19 data | Oncology | Moderate Non-Compliance | Discussion of the audit results will occur at the Directorate Governance meeting and a local action plan will be discussed and implemented. |
| 4051 | National Falls and Fragility Fractures Audit programme (FFFAP, 2018/19) | Rheumatology | Significant Non-Compliance | A business case will be written to get the FLS team fully commissioned. This will allow the FLS team to increase the capacity and improve the efficiency within the service e.g. use of technology etc. |
| 4048 | National Diabetes Audit - Adults (National Care Diabetes Audit) 2019 data | Diabetes | Minor Non-Compliance | Discuss finding at Governance Meetings. Review national recommendations and implement local action plan if required. |
| 4047 | National Diabetes Audit - Adults (National Diabetes Inpatient Audit (NaDia) -reporting data on services in England and Wales) 2018 data | Diabetes | Fully Compliant | Not applicable as fully compliant. |
| 3436 | National Diabetes Audit - Adults, Foot Care Audit 2015-18 | Diabetes | Fully Compliant | Not applicable as fully compliant. |

## Appendix 3 – Local Clinical Audits reviewed by the Trust in 2020/21 with actions intended to improve the quality of healthcare provided

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

| Directorate | Audit Title | Compliance Rating | Actions identified to improve the quality of healthcare provided |
|---|---|---|---|
| Radiology | CTPA indications and outcomes in COVID-19 positive cohort compared to COVID-19 negative cohort | Significant Non-Compliance | Radiology CD to email out to clinicians.<br>ICE CTPA request update. |
| Therapies & Dietetic Services | Diabetic Foot Screening | Moderate Non-Compliance | Re-audit non-compliant staff.<br><br>Discuss with IT team as a priority for New EPR plan; modify data collection system to make mandatory in new Electronic |

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|---|---|---|---|
| | | | Record. |
| Therapies & Dietetic Services | Foot Health Skin Integrity Trigger Tool -re-audit | Moderate Non-Compliance | Review documentation<br>Staff that did not comply with process to be re-audited. |
| Safeguarding | Compliance Against CP 11 and the Mental Capacity Act 2005 when completing DNACPR | Significant Non-Compliance | A Trust wide action plan has been developed to address the non-compliance. A MCA task and finish group has been convened. The Trust risk level for Risk No. 5388 Mental Capacity Assessments has been escalated to red for closer monitoring and improvement. |
| Urology | Audit of Stent Stickers | Moderate Non-Compliance | To remind all clinicians to add sticker post op to any stent or ureteroscopic procedure. |
| Trauma & Orthopaedics | Evaluation of appropriateness of knee MRIs in patients above 60 years: A QIP | Moderate Non-Compliance | To present findings to Primary Care and Triage. |
| Cardiothoracic Surgery | Audit of Pacing box checklist form | Moderate Non-Compliance | Discussion amongst senior colleagues<br>Re-audit to check compliance.<br>Aim for pacing sheet completion by shift Registrar.<br>Intraop documentation- aim to be completed by ICU handover teams.<br>Switched off/ PWTCO needs documenting<br>Enforced by colleagues as patient safety issue.<br>Reinforce check |
| Trust wide | Adult and Paediatric Cardiac Arrest Trolley Audit 2019 data | Significant Non-Compliance | Results have been appropriately disseminated across all participating Directorates. A working group will be set up to review options regarding equipment availability, and checking procedures. A risk assessment has been completed. Any identified incidents / risks trends reported to be reviewed for potential escalation. |
| Stroke | Review of current practice of urinary catheterisation in the stroke unit at New Cross Hospital, Wolverhampton | Moderate Non-Compliance | Daily review of electronic reminders or handover sheets prompting 'Think Catheter/Continence' would be important to reduce catheter days and potential infection rates.<br>Stamp/Sticker in Medical Notes highlighting date of catheter |

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| | | | insertion may also serve as a reminder to clinicians to prioritise continence in association with other post stroke parameters |
| Stroke | A QIP on VTE assessment in stroke unit. | Moderate Non-Compliance | Protocol & written guidance on VTE assessment for Junior Doctors, Nurses and Ward Clerks.<br>VTE alert on handovers.<br>VTE stamps on each patient after ward-rounds.<br>Consultants ensuring VTE assessment is completed by Junior Doctors during ward round. |
| Trauma & Orthopaedics | QIP: The design and implementation of 'A Femur Fracture Admission Blood Profile Panel' to improve patient care delivery | Moderate Non-Compliance | Better awareness in all staff involved in the process, so as to improve the number of venepunctures undertaken in the first 24 hours of admission/pre-operatively. |
| Accident & Emergency | Fractured Neck of Femur | Significant Non-Compliance | Design of potential Rapid Assessment Triage proforma.<br>A requirement for pain scores to be completed on arrival to hospital. |
| Stroke | Audit of End of Life care delivery in terminally ill stroke patients admitted to Stroke Unit, New Cross Hospital - | Moderate Non-Compliance | Plan to develop a proforma /check list with all parameters discussed in relation to EOL care and put in the patient's notes while decision is made. Learning from audit shared with all members of the stroke multidisciplinary team. Planned involvement of palliative care team in morning huddles and aims for early referral following identification of suitable patients. |
| Rheumatology | Mycophenolate counselling-contraceptive advice/pregnancy test and documentation (QIP). | Significant Non-Compliance | To ensure patients starting on MMF have documented education on pregnancy/contraception. To ensure clear documentation in the patient notes that conception advice and risks of mycophenolate have been given to all female patients.<br>This will be discussed in the departmental meeting to come up with the most appropriate way to document drug education and documentation. |

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|---|---|---|---|
| Rheumatology | Hydroxychloroquine monitoring - compliance to new clinical guideline from The Royal College of Ophthalmologist. | Significant Non-Compliance | Recommendations include displaying posters in clinic rooms and noticeboards in the Rheumatology department as a reminder to clinicians to refer patients for HCQ retinopathy monitoring. Alongside this, a reminder email will be sent to rheumatology consultants covering key points of the guideline. Data will be collected in 6 months to complete the cycle to assess any improvement in the number of referrals for retinopathy monitoring. A complete action plan will be determined after discussion at the Governance meeting. |
| Rheumatology | Monitoring of JAK inhibitor in Rheumatology department (20/21) | Moderate Non-Compliance | We will stress the importance of timely disease activity assessment visits in next governance meeting but due to COVID-19, more assessments are being done virtually and physical assessment are not always possible during the current COVID-19 era. |
| Primary Care Services (VI) | Medicines Storage | Significant Non-Compliance | Each practice has an action plan to progress. A PCN level action plan has also been developed to prioritise and progress the eight areas with 0-10% compliance. A re-audit will occur every 6 months until we have achieved 100% compliance across all practices. |
| Children's Services – Acute | Newly Diagnosed Juvenile idiopathic Arthritis (JIA) | Significant Non-Compliance | Currently an Amber Risk on the Directorate Risk Register to allow for closer monitoring.<br>Ophthalmology to review capacity for clinics. |
| Trauma & Orthopaedics | Re-audit: Informed Surgical Consent in Neck of Femur cases | Moderate Non-Compliance | To write to consultants involved about the deficiencies identified in this audit and reinforce the importance of adding these to the consent process. |
| Trauma & Orthopaedics | Audit of informed surgical consent gained in Neck of Femur cases - Standards used as per the British Orthopaedics Association | Moderate Non-Compliance | To write to all the clinicians that are involved in the consent process and highlight the deficiencies identified in this audit and to reinforce the importance of the risks. |
| Rheumatology | Audit of CP50- Results filing in rheumatology (based on the local SOP in this area; SOP 2. | Moderate Non-Compliance | Will query departmental feedback regarding our improving, but unsatisfactory performance. Will send an all user email communication regarding ICE filing in the department- |

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| | Rheumatology CP50 Compliance and ICE Results Review Policy) | | encouraging trainees and staff to file results as outlined in our local policy for CP50: SOP 2. Rheumatology CP50 Compliance and ICE Results Review Policy. |
| Children's Services – Community | Paediatric Palliative Care Service Evaluation | Moderate Non-Compliance | Will review current method for reviewing ACPs.<br>Provide training for community paediatric team in completing advance care plans.<br>Will arrange flag on portal for children with Advance Care Plans.<br>Ensure the development of palliative care service within community paediatrics. |
| General surgery | Imaging of Acute Pancreatitis | Moderate Non-Compliance | We will look to put in place Cycle 3 of the audit and amend the acute pancreatitis proforma with information on how to request CT ABP; timings on when to request CTs in acute pancreatitis and USS. |
| Head & Neck | ENT referrals Project | Moderate Non-Compliance | Provide communication to ED and to Primary Care GPs that guidance is available from ENT on diagnosis of Quinsy and guidance available on the management of Otitis Externa to GPs. |
| General surgery | Terminal ileum biopsies for patients undergoing colonoscopies for symptoms of diarrhoea | Significant Non-Compliance | Further detailed analysis of results required. Will raise awareness about the importance of TI intubation and conduct a re-audit. |
| Therapies & Dietetic Services | (SALT) Head and Neck and Voice Services Benchmarking Exercise | Moderate Non-Compliance | Arrange discussions with ENT colleagues to establish a system which would allow a regular session to allow for joint assessment and management of patients referred with voice disorders.<br><br>Agree a business plan to increase capacity within the Voice Service to allow for continuity of joint voice services after pilot and thus freeing up clinical time for a Macmillan clinician to expand services to Head and Neck |
| Children's Services – Community | Blood Born virus screening in unaccompanied asylum seekers (2019/2020) | Moderate Non-Compliance | A local pathway needs to be devised for unaccompanied asylum seeking children for screening. |

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| Pharmacy | An audit of the co-amoxiclav prescriptions dispensed by Boots/main pharmacy during April 2019. | Moderate Non-Compliance | Further investigations required on why large amount of prescriptions were inappropriate. The results will be discussed with the ED governance team, and fed back to ASG (Antimicrobial Stewardship Group), as well as IPCG (Infection Prevention and Control Group). An audit of the Mediwell prescriptions for co-amoxiclav is required to identify if there is a difference in the prescribing trend out of hours. |
| Haematology | Haematology NG51, QS161 Management of Sepsis in CHU | Moderate Non-Compliance | Ensure appropriate antibiotic & IV fluids are given.<br>Ensure use of Sepsis Toolkit on Vitalpac.<br>Request "Sepsis Pack" on ICE including FBC, U&E, LFT, CRP, Coagulation Profile, Lactate, Blood C/S, Line C/S, Urine C/S, Throat Swab, Wound Swab.<br>Monitor & document hourly Urine Output on Vitalpac.<br>Appropriate Escalation & Documentation in patient note.<br>Regular training, teaching, posters & awareness sessions for Doctors & Nurses.<br>Re-audit at regular intervals |
| Children's Services – Acute | SIckle Cell Disease (2019/2020) | Significant Non-Compliance | Continued education; refresh knowledge of guidelines and management of sickle cell in staff.<br>Business case to be submitted for Haematology specialist nurse to lead nurse training.<br>Update Sickle cell guideline to include Proforma for sickle crisis for prompting reassessment.<br>Vital Pac for observation to include pain monitoring and electronic prompts. |
| Trust wide | Health Records OP07 - Documentation 19/20 | Moderate Non-Compliance | Results will be disseminated to all Directorates who participated.<br>Due to the consistent results, Health Records will be exploring alternative ways of capturing data to provide assurance of compliance with OP07 going forward. |
| Renal medicine | Documentation of fluid status assessment for patients in the Acute Medical Unit | Significant Non-Compliance | Suggested future interventions include having a prompt on EPMA when prescribing fluids, targeting core medical trainees and registrars and offering education to the nursing |

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| | | | staff to involve them in this aspect of patient care. |
| Trauma & Orthopaedics | Consent form 4 in Neck of Femur fractures - a retrospective audit on accuracy, appropriateness and compliance | Moderate Non-Compliance | Develop poster for education purposes, present findings in Governance meeting and re-audit once further education has been provided. |
| Gynaecology | 'See and Treat' - A Patient Satisfaction Survey | Moderate Non-Compliance | Present findings in department and ensure staff understand that they are to offer women, from the outset, the choice of having the procedure performed as a day case procedure under general or regional anaesthetic as per national guidance. |
| Adult Community Services | Deteriorating Patient Escalation audit | Moderate Non-Compliance | Sharing of the audit and reminder to all staff to complete NEWS2 score on initial assessment.<br>Sharing of audit and recirculation of NEWS2 chart as a reminder. |
| Diabetes | Hypothyroidism in pregnancy | Moderate Non-Compliance | Patients with underactive thyroid are actively encouraged to increase levethyroxine doses as soon as they become aware that they are pregnant. There is now a dedicated telephone clinic within obstetrics that ensures early and routine follow up of pregnant mothers with hypothyroidism. |
| Gynaecology | NICE NG 126: Management of Ruptured Ectopic Pregnancy Audit | Moderate Non-Compliance | To disseminate the findings and highlight the recommendations to colleagues in ultrasound department. |
| Gynaecology | An Audit on the Management of Ovarian Cancer (NICE CG122/QS018/IPG470) British Cancer Society Guidelines 2018/2019 | Moderate Non-Compliance | To advise at Gynae care meeting that:<br>- For patients <40 years, tumour markers must include CA125, bHCG and AFP<br>- An ultrasound abdomen pelvis should be the first imaging modality in secondary care with suspected ovarian cancer<br>- Risk of malignancy index should be documented for all suspected cases. |

# How to give comments

We welcome your feedback on this Quality Account and any suggestions you may have for future reports.
Please contact us as indicated below:

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