NHS
Walsall Healthcare
NHS Trust

Quality Account
2021/21

Caring for Walsall together

Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

Contents

Part 1: A Statement On Quality From The Chief

Welcome to the Quality Account for Walsall Healthcare Trust 2020/21.

Healthcare provision throughout the pandemic has been incredibly challenging for everyone across our organisation and has required an unprecedented response by the Trust and wider system partners to ensure we provided safe, high quality care to those using our services.

The Acute hospital peaked at 188 COVID-19 positive inpatients in April 2020 and 28 patients in Critical Care in Wave 1; 157 COVID-19 positive inpatients in November 2020 and 22 patients in Critical Care in Wave 2; and 268 COVID-19 positive inpatients in January 2021 and 30 patients in Critical Care (including Ward 17 Non-Invasive Ventilation Unit) in Wave 3. The pandemic placed unprecedented strain on emergency care services in both the hospital and in the community, and on critical care services through which patients with COVID-19 presented, but also had a significant impact on elective services.

The pressure in our community services was of a similar intensity. Teams were tasked with prioritising caseloads to look after patients with acute conditions at home for longer than normal due to shielding and limited access to planned care. The community teams worked with Walsall Together partners in an integrated way to manage patients safely and in a timely manner and clinical risk assessment processes were aligned to national guidance.

Despite the pressures of the pandemic, 2020/21 has been a year of progress for the Trust.

Despite the impact of the pandemic, our staff have worked tirelessly to preserve access to elective services and have undertaken over 200,000 outpatient consultations – many virtually to reduce the risk of cross-infection. We have also undertaken 16,598 elective inpatient and daycase admissions, using our segregated Outpatient and Daycase Centre to provide safe elective care with minimised risk of cross-infection. The Trust Board took an explicit decision following Wave 1 to prioritise access to diagnostic services due to the recognition that even routinely requested diagnostic tests can frequently detect serious disease which needs urgent treatment, and due to the recognition that a clear confirmed diagnosis ensures patients can be most accurately prioritised for subsequent treatment. We are proud to have ended the financial year with the 3rd best Diagnostic (DM01) waiting times of any general acute Trust in the country and three consecutive months of waiting times in the top five best performing general acute Trusts in the country.

Community teams coordinated by Walsall Together worked in an integrated way to manage patients at home safely. This included a complete support package of some additional 80 staff to manage the risk and illness in the boroughs care homes, a team specifically set up to manage patients recovering from COVID-19 and most importantly working with the third and voluntary sectors to ensure that patients that were locally isolated were risk assessed, safeguarded and provided with food and other shopping items as required.

In response to the pandemic, the Trust has maintained Infection Prevention and Control standards (in line with national guidance), revised COVID-19 clinical pathways and contributed to multicentre research studies. Our Learning from Deaths process allowed the trust to reduce avoidable harm. In addition, we have continued to focus on other key areas by facilitating faster treatment for patients with lung cancer and improving outcomes for patients with hip fractures. Communication with patients has been enhanced by ensuring that all out-patient letters are now written to patients, with a copy sent to the GP.

Despite the pressures of the pandemic, 2020/21 has been a year of progress for the Trust. We have had relentless focus on the improvements needed following the publication of our Care Quality Commission (CQC) report, and our Improvement Programme has developed to provide a clear roadmap to ensure we deliver continual sustained improvements for our staff and the public who use our services.

Thank you to all those who supported the development of this Quality Account and I hope you enjoy reading the achievements of the last year.

To the best of my knowledge, the information in this document is accurate.

Prof. David Loughton, CBE
Interim Chief Executive Officer

Date: 30th June 2021

Statement of Director's responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

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

(a) the content of the quality report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2020 to March 2021
- papers relating to quality reported to the Board over the period April 2019 to March 2021
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 6th May 2021
- the latest national patient survey 27th October 2019
- the 2020 national staff survey 11th March 2020
- the Head of Internal Audit's annual opinion of the trust's control environment dated June 2021
- CQC inspection reports dated 18th November 2020 and 19th May 2021

(b) the quality account presents a balanced picture of the Trust's performance over the period covered

(c) the performance information reported in the quality account is reliable and accurate

(d) there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

(e) the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

(f) the quality account has been prepared in accordance with Department of Health and Social Care guidance

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

By order of the board

Professor Steve Field CBE, Chair
Dated: 30th June 2021

Prof David Loughton CBE,
Interim Chief Executive Officer
Dated: 30th June 2021

Part 2: Priorities For Improvement And Statements Of Assurance From Board

2.1 Review of 2020/21 Quality Priorities

Please note that Statistical Process Charts (SPC) symbols are explained in Appendix 3.

Our teams have faced unprecedented challenges over the last year as we have all worked together to ensure our patients receive the highest possible standards of care throughout the pandemic.

Whilst the pandemic has undoubtedly affected the pace of change achievable, we are proud that we have continued to progress against a broad range of workstreams within our Safe, High Quality Care Improvement Programme.

The Trust made a commitment to the following quality improvement priorities for 2020/21:

- **Harm free care**
- **Patient priorities**
- **Learning from deaths**
- **Learning from COVID-19**
- **Improving cancer pathways**
- **Reducing health inequalities**

The following section sets out our progress against these priorities.

Our teams have faced unprecedented challenges over the last year as we have all worked together to ensure our patients receive the highest possible standards of care throughout the pandemic.

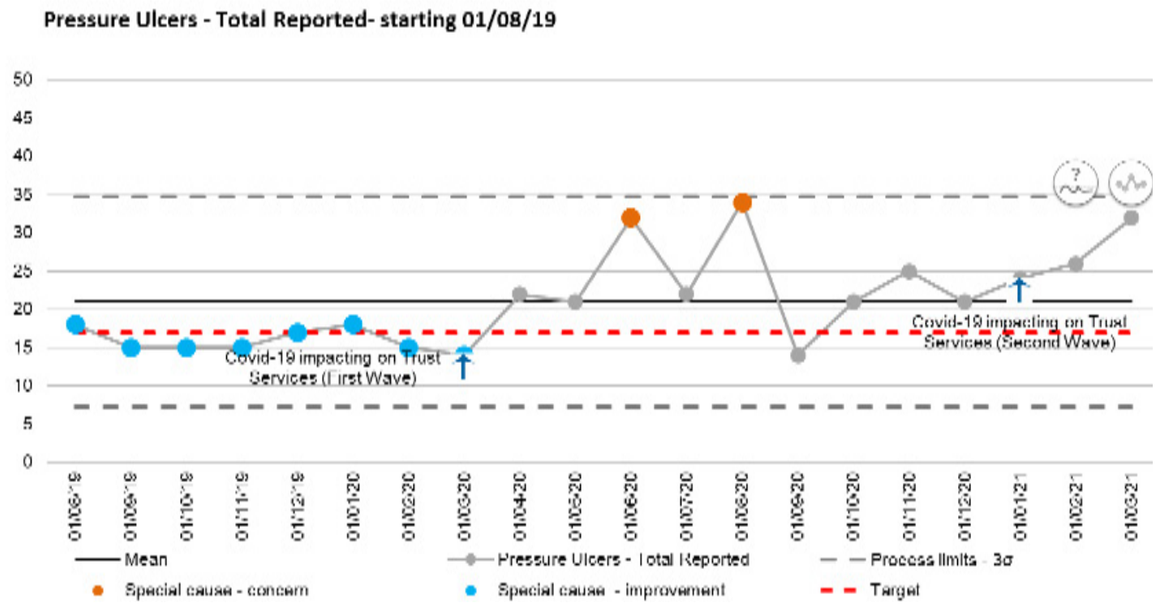
2.1.1 Harm free Care

We will focus improvement and delivery of care excellence in the aspects of harm free care set out below. We will review our metrics to ensure we focus on delivery of outcome measures that directly impact on care outcomes; for example measuring Venous thromboembolism (VTE) risk assessments to number of those at risk, who were subsequently prescribed appropriate dose of treatment and that treatment was administered will have the optimal impact on harm reduction.

The areas indicated in harm free care will be measured against peer group benchmarks (whilst keeping a view on the best) and we will strive to be the above the mean of our peer group in majority of quarters. Where there are no external benchmarks we will use internal benchmarks to determine the mean state. We have also invested in the Perfect Ward app to support data collection and understanding of 'where we are' and demonstrate real time quality improvement in clinical care indicators.

(a) Tissue Viability

Numbers of hospital acquired pressure ulcers during 2020/21 were comparable to numbers in 2019/20. This is despite an increase in both patient numbers and increased acuity of patients in hospital during the COVID-19 pandemic, and the association between COVID-19 and tissue damage in acutely unwell patients.



The Tissue Viability Team has led a number of initiatives over the last year including:

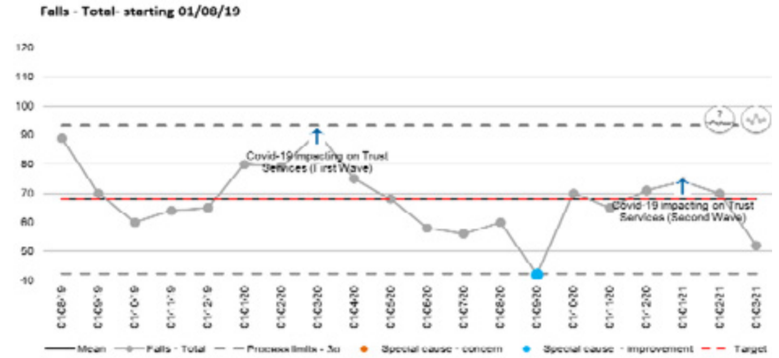
- Development of a leaflet which was distributed to care home staff within the borough providing guidance in the correct use of barrier creams to prevent moisture damage or deterioration of moisture lesions.
- Development of a wound care leaflet for community health care professionals and their patients / carers. This guided staff and patients in the care of their wounds and encouraged self-care management.
- A discharge letter has been designed and is now in use for community staff to confidently discharge patients if no tissue viability need is identified.
- An infection management/dressing pathway has been developed to ensure appropriate use of anti-microbial dressings across both hospital and community services.
- The Tissue Viability Team is undertaking a research project in conjunction with Stafford University and the Faculty of Research and Clinical Education (FORCE) team to review COVID-19 related skin changes.
- The team has collaborated with a wound care company to provide bite size training on wound care management via Microsoft Teams.
- Pressure ulcer training folders have been devised for clinical areas to support staff recognition of pressure damage. A pocket guide has also been developed that highlights pressure ulcer categories, deep tissue injury and the difference between moisture and pressure; alongside a dressing selection chart and a mattress chart.
- The Perfect Ward audit for tissue viability has been validated against best practice guidelines. The audit is being undertaken by ward teams monthly and the corporate nursing team quarterly on a rolling programme.

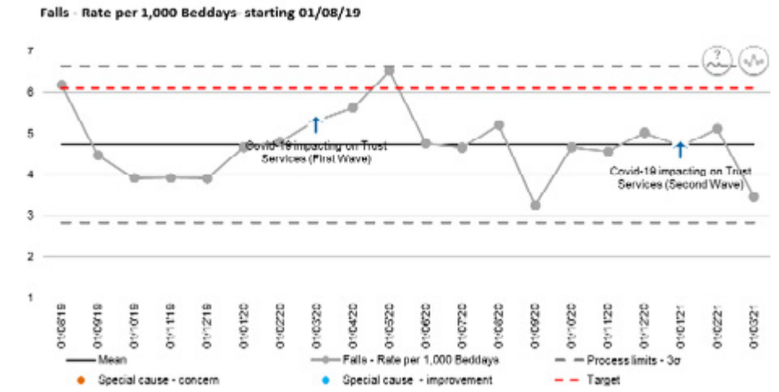
(b) Falls and Deconditioning

The Trust proposed a reduction of 10% for the period 2020/21, an average of 70 falls per month and a maximum total of 840 for the year. This reduction has been achieved with an outturn of 762 for the year, 63.5 per month, despite COVID-19 pressures relating to increased acuity and occupancy.

The Royal College of Physicians guidelines for falls per 1000 occupied bed days suggest a performance of 6.6 to be the national average. The Trust target was set at 6.1 in line with regional peers. The Trust delivered less than 6.1 falls per 1000 bed days for 11 out of 12 months with an average of 4.8 falls per 1000 bed days.

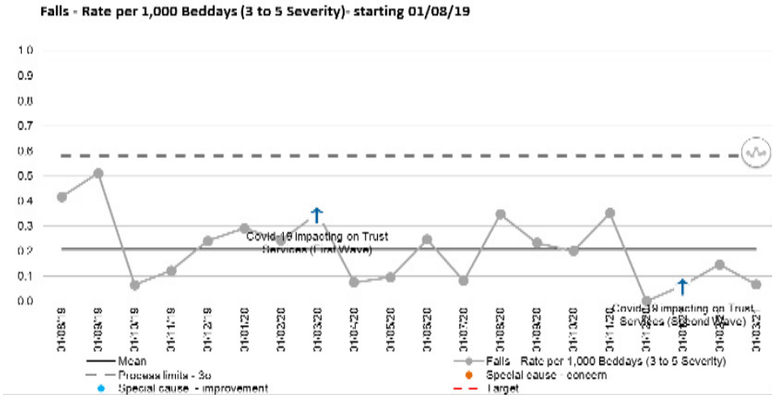
The Trust aspired to deliver less than 0.19 falls with a severity of 3-5. The Trust achieved this target for seven out of 12 months with an average performance of 0.16.

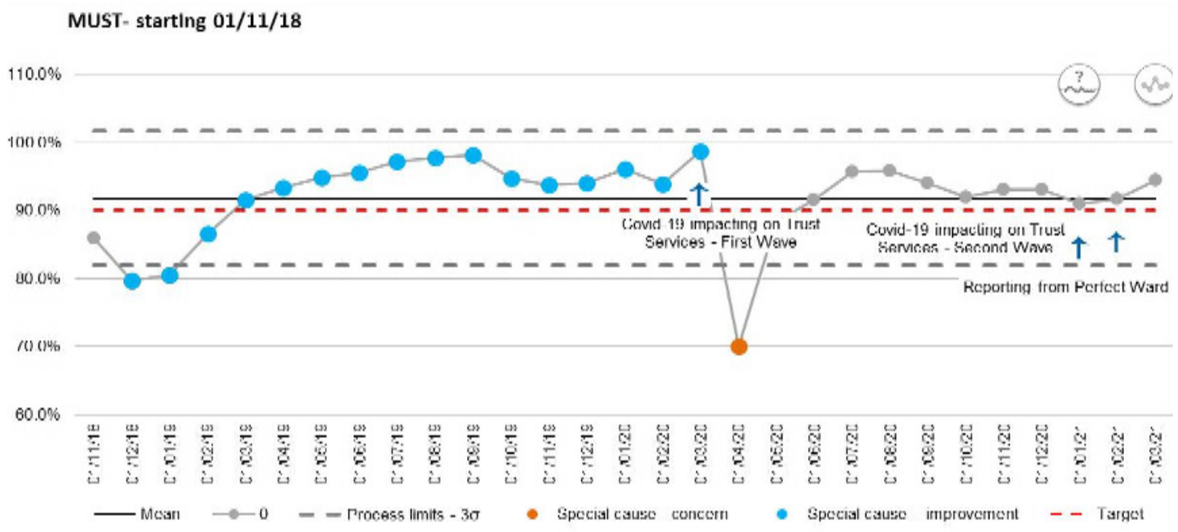




Progress against the Safe High Quality Care Falls and Deconditioning Prevention Strategy:

- Revision of the Trust governance process for recording, reporting and managing falls has started, implementing initial case reviews with shared learning and escalation through divisional safety huddles attended by the corporate nursing team,
- Review of the current serious incident review tool is underway to ensure accurate, concise meaningful reviews supported by the Clinical Commissioning Group (CCG).
- Work has started in developing a falls and deconditioning prevention education and development programme to be delivered through e-learning as part of the fundamentals of care education programme





(c) Nutrition and Hydration

The Nutrition Ambition 2021-2024 was launched Trust wide in March 2021 and set out a clear ambition to deliver a number of key objectives over the next three years:

- Deliver outstanding nutrition and hydration care
- Optimise nutritional assessment and care planning
- Provide high quality food to meet the needs of our patients
- Promote a safety culture around nutrition and hydration

Achievements through the Safe High Quality Care Improvement Programme for 2020/21 include:

- Nutritional intake has been monitored through patient records and audited through Matrons' audits and more recently via the Perfect Ward app. Patient experience is recorded through communication with the patients during mealtimes. There is also an element within the Perfect Ward app to capture patient experience for nutrition and hydration.

- The Walsall Food Faves initiative was launched and, in conjunction with service users, new menus were designed and developed. Further work is on-going looking at a specific menu for patients with allergies.

- The Perfect Ward audit for nutrition/hydration has been validated against best practice guidelines and is being undertaken by ward teams monthly and the corporate nursing team quarterly on a rolling programme.

- Compliance against MUST (Malnutrition Universal Screening Tool) was recorded using a paper-based Matron audit system. More recently this data is being collected via the Perfect Ward app. The trust target of 90% has been maintained throughout the year apart from a dip in compliance during Wave 1 of the COVID-19 pandemic. No reduction in compliance was seen in Wave 2.

(d) Early detection and escalation of deterioration through the use of NEWS2 and appropriate escalation and standardised clinical management

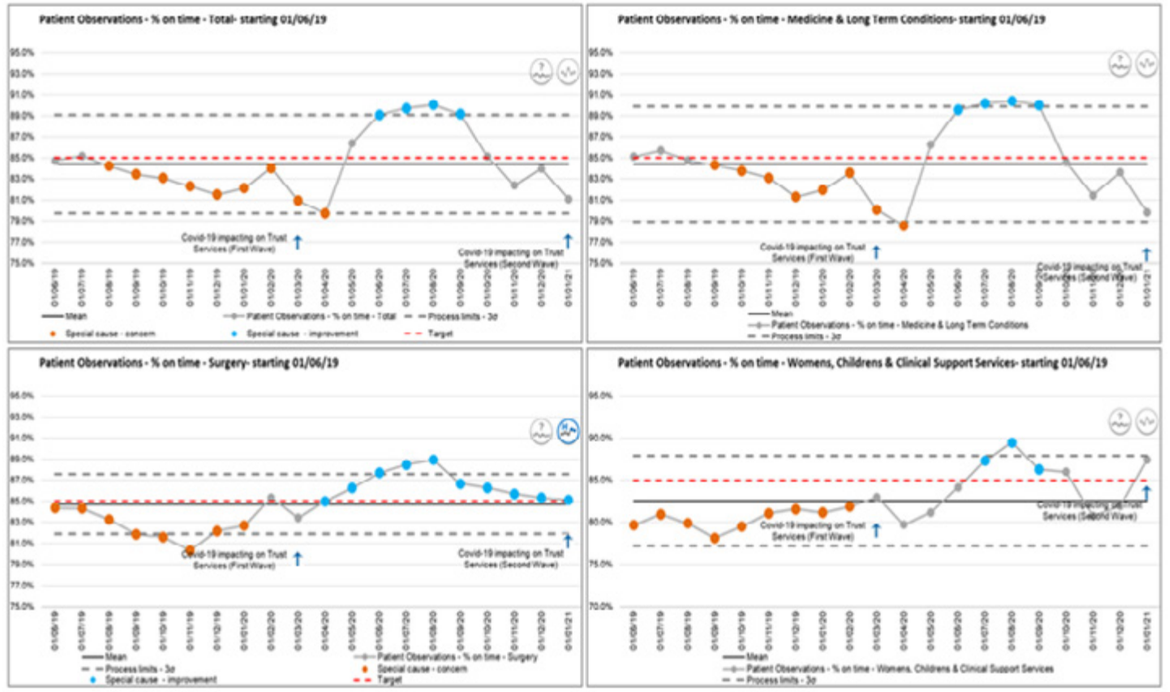
There has been increased focus in ward areas via Matrons and Ward Managers ensuring oversight of performance. Both Wave 1 and Wave 2 of the pandemic negatively impacted on this metric but June to September 2020 saw the Trust's best performance to date. The reduction in performance in October 2020 correlates with the introduction of an electronic patient record system (Medway) in October 2020 which impacted on performance especially within the Emergency Department.

Learning from Deaths reviews have shown the need to improve the recognition and management of patients who deteriorate, including those with sepsis. Key areas of work include:

- Improvements in monitoring and escalation of patient observations when there is deterioration through the Medway E-sepsis alert module, and a deteriorating patient bundle tool to reduce clinical variability.
- A workforce, training and pathway review of the critical outreach team in order to respond in a timely manner. Mean time to respond from the critical outreach team has been maintained at four minutes or less.
- A robust package of training via the Acute Illness Management (AIM) course in partnership with the Faculty of Research and Clinical Education Team and Resuscitation Team.

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Patient Observations - % of obs completed on time (Target = 85%)	Trust	82.12%	84.03%	80.94%	79.70%	86.40%	89.09%	89.70%	90.03%	89.15%	85.13%	82.38%	83.96%	81.10%
	MLTC	81.95%	83.58%	80.06%	78.55%	86.25%	89.55%	90.16%	90.39%	90.01%	84.61%	81.44%	83.61%	79.82%
	SURG	82.69%	85.33%	83.43%	85.00%	86.25%	87.71%	88.48%	88.93%	86.67%	86.27%	85.70%	85.32%	85.13%
	WCCSS	81.15%	81.88%	83.00%	79.72%	81.18%	84.15%	87.32%	89.47%	86.29%	85.98%	80.76%	81.92%	87.45%

The E-sepsis module was implemented in December 2020. A dashboard of performance has been developed to track and drive improvement.



(e) Healthcare acquired infections

Reduction of healthcare acquired infections (HCAIs) remains a key priority for the Trust.
COVID-19

All healthcare acquired COVID-19 cases since September 2020 have had a case review to identify where systems and practices could be improved to reduce the risks of HCAI in line with NHSEI recommendations.

Improvement action highlights:

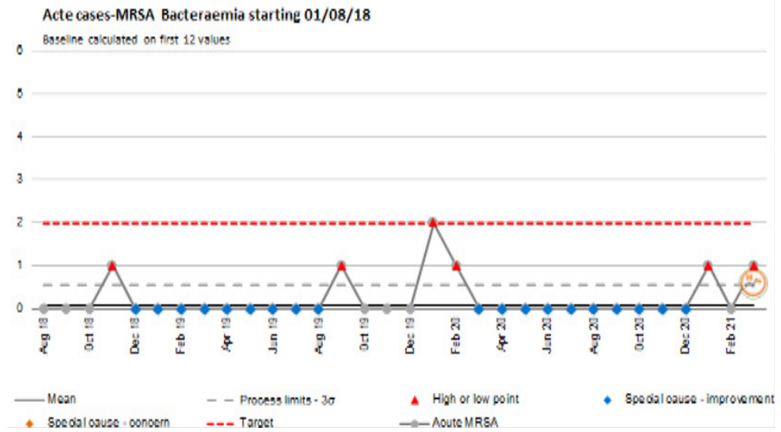
- An updated communications and education campaign based on the "Every Action Counts" national infection prevention and control (IPC) resources. This includes methods of communication reaching out to patients, such as clear visual information provided on meal trays.
- Use of DnaNudge testing in the Emergency Department to aid patient streaming and updated flow processes incorporating NUDGE testing.
- IPC has been monitoring and educating areas on all aspects of Trust and national guidance on prevention of COVID-19.
- Senior nursing and medical staff continue to challenge and correct poor practice in their areas so that there is ward and divisional ownership around improvement of practice.

2020/21	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Max Cases per Month	3	2	2	2	2	2	3	2	2	2	2	2
Actual acute cases	4	3	3	3	3	2	5	2	0	2	2	3
Cumulative YTD projected	3	5	7	9	11	13	16	19	21	24	26	29
Acute Cumulative actual	4	7	10	12	16	18	23	25	25	27	29	32

Clostridium difficile Toxin (C.diff)
The Trust target for 2020/21 has been internally agreed at 29 cases in the absence of a national target. The total number of cases reported for the year is 32.

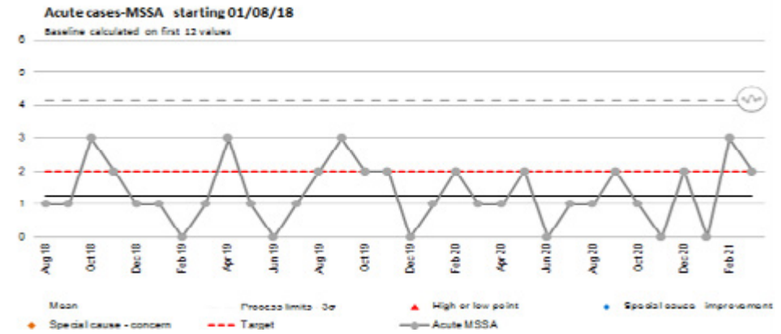
Each acute acquired C.diff infection is robustly reviewed with an identified root cause of the infection.

The focus for 2021/22 actions to prevent C.diff include a collaborative approach between the IPC Team and Antimicrobial Pharmacist to educate clinical colleagues on antimicrobial stewardship; increased support from the IPC Team to emergency care pathway areas to emphasise prompt stool sampling in the clinical management of patients; and projects to prevent Gram-negative infections and revision of the C.diff pathway/ward round to support prevention of relapse.



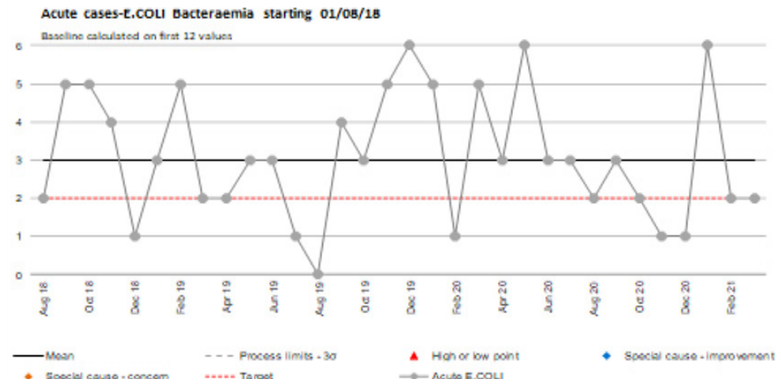
MRSA Bacteraemia
The Trust target for 2020/21 has been internally agreed at 0 cases in the absence of a national target. The Trust has reported a total 2 cases in 2020/21.

Focused work continues to improve the MRSA screening performance which
remains below the Trust target of 95%. The IPC Team is working collaboratively with the quality team to support rapid improvement through audit and education.



MSSA Bacteraemia
There is no national or locally agreed target for MSSA Bacteraemia, however the objective of the Trust is to reduce the numbers of cases on a year by year basis. The previous years figures have been used as a means of monitoring performance.

A syndromic approach to infection prevention, focusing on device management in the prevention of vascular associated infections aims to prevent incidence of MSSA and MRSA bacteraemias.



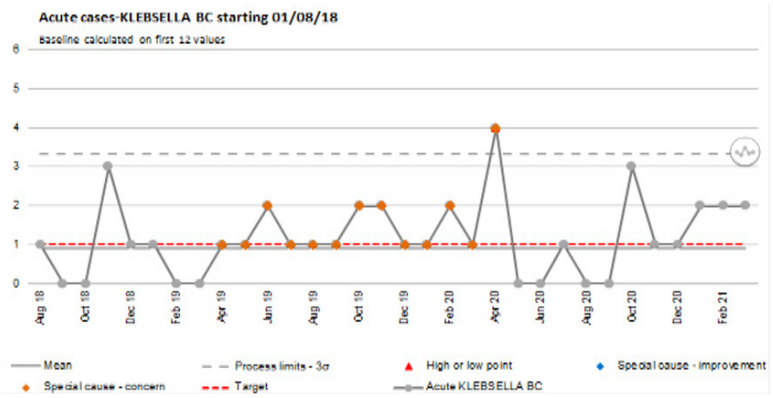
E.coli Bacteraemia
Reporting of E.coli Bacteraemia has been mandatory since June 2011. All cases are reviewed and a table top review completed if a patient dies and E.coli is indicated as a cause of death, or areas of concern are identified during the review.

There is no national or locally agreed acute target for E.coli Bacteraemia however the objective of the Trust is to reduce the numbers of cases on a year by year basis.

Klebsiella Species Blood cultures

Reporting of Klebsiella Species Bacteraemia has become mandatory since April 2017. All cases are reviewed and a table top review completed if the patient dies and this organism is indicated as a cause of death or areas of concern are identified during the review.

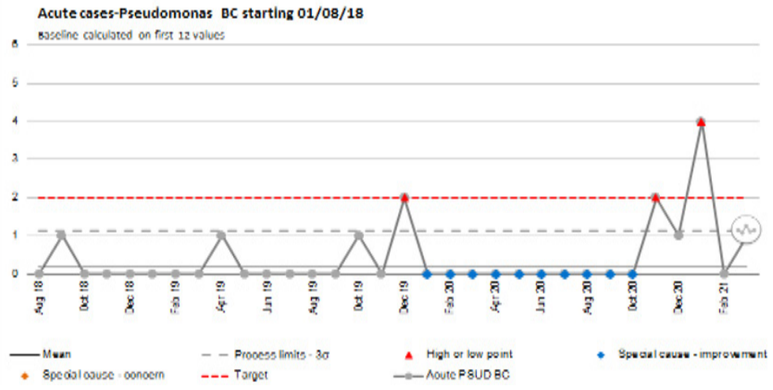
Due to the low levels within the Trust a monitoring target has not been applied to the organism.



Pseudomonas Aeruginosa blood culture

Reporting of Pseudomonas Aeruginosa Bacteraemia has become mandatory since April 2017. All cases are reviewed and a table top review completed if the patient dies and this organism is indicated as a cause of death or areas of concern are identified during the review.

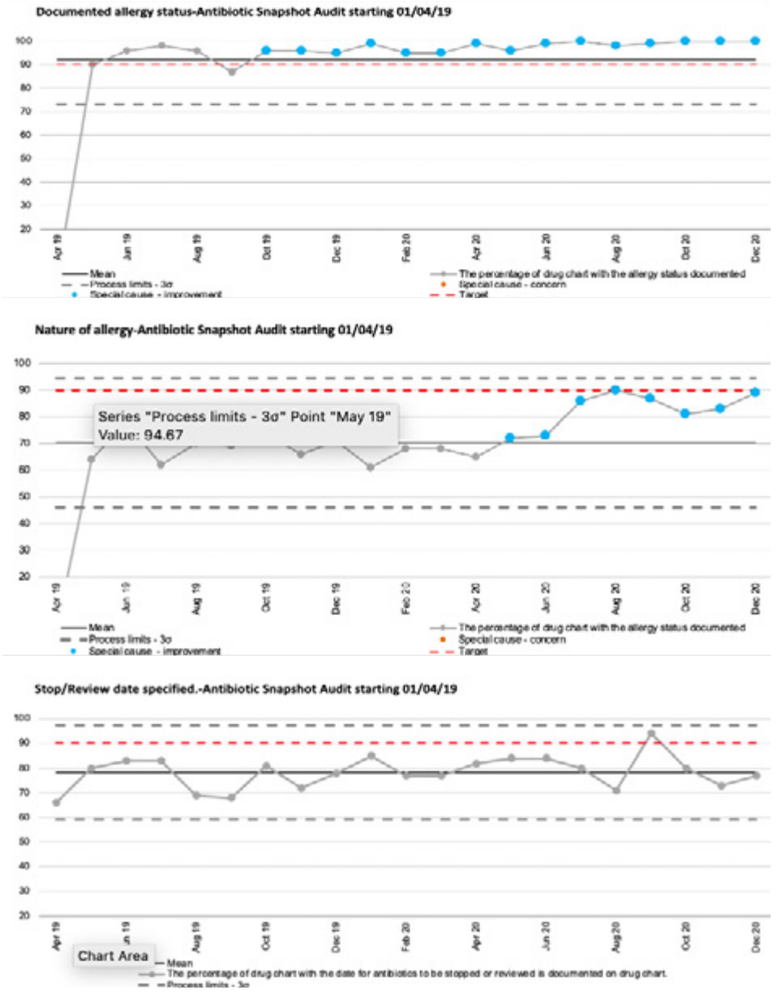
Due to the low levels within the Trust a monitoring target has not been applied to the organism.



(f) Improve Learning from Medication Errors

Antibiotic stewardship promotes the safe, justified use of antibiotics to treat infectious diseases. Our actions over the last year have ensured that all patients have their allergy status recorded, and almost 90% had the nature of the allergy described. Work will continue to make sure that the indication and duration of treatment is also specified reliably as this protects against inappropriate or excessive antibiotic administration.
There has been an increase in performance in three out of the four KPI's:

KPI	Attained	% Change	Target	RAG rating
Documented allergy status	100%	increase 0.5%	90%	
Nature of allergy documented	89%	increase 6%	90%	
Stop/review date specified on drug chart	77%	increase 4%	90%	
Indication specified on drug chart	73%	decrease 5%	90%	



The Medicines Improvement Programme has been developed which is part of the Safe High Quality Care Improvement Programme:

- The initial workstreams will start to look at controlled drugs management and prescribing.
- A quality improvement project has started which looks at the dispensing of medicines in the discharge lounge to improve the patient flow at discharge from hospital.
- Pharmacy are working with community division colleagues to support safer prescribing with insulin.
- Pharmacy also supported an initiative called 'Oxygen October' which increased publicity around oxygen being a 'medicine' and therefore, the requirement for it to be prescribed and managed as a medicine in line with the Medicines Policy.

(g) Continence

The Continence Team has developed a programme of work which includes:

- Managing patients at home safely and through the integrated locality teams.
- Community teams coordinating the integration of pathways so that transfer between hospital and home care is seamless
- Continue to standardise risk assessments and care plans across the trust to be in line with the Perfect Ward audit tool.
- Catheter care, principles of catheterisation and continence assessment with management will be included in the Trust fundamentals of care e-learning package which is under development by the Faculty of Research and Education.
- Work continues to update the catheter passport and establish its use digitally.
- Continued links with the quality team in regard to practical training for the acute staff that have completed theory training.
- Work started on the completion of a continence ambition 2021-2024 and completion date was May 2021.
- Work ongoing with the discharge liaison team, integrated front door service, wards and CCG to assist in safe discharges from wards and the Emergency Department for patients with continence and/or urology needs.

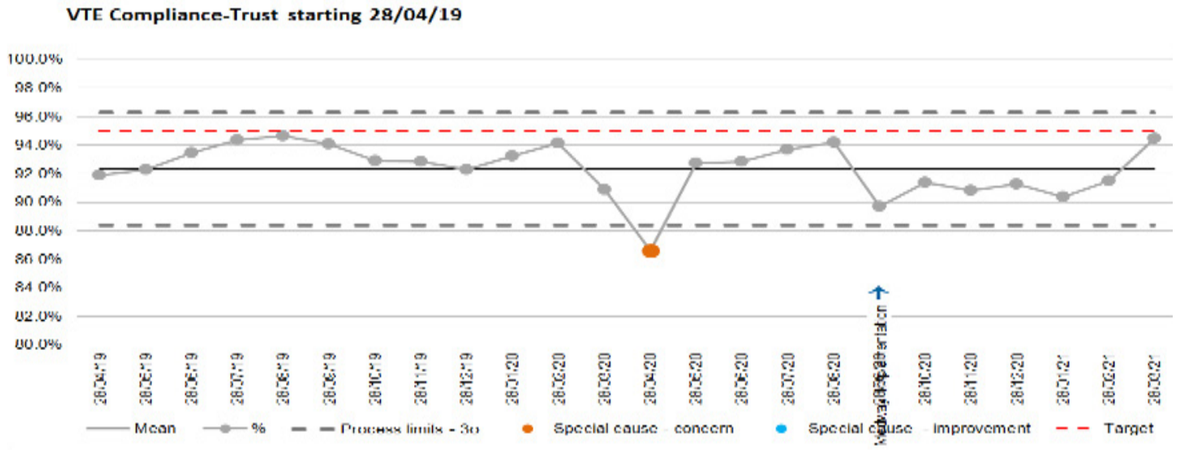
(h) Venous Thromboembolism (VTE)

Daily compliance data is produced and circulated to Consultants to ensure all services are kept up to date with performance. Overall compliance for the period April 2019 to March 2021 is illustrated below.

A number of measures have been taken with a view to improving compliance:

- The Thrombosis Group has been launched and is an additional platform for discussions relating to VTE compliance and overview of hospital acquired thrombosis, and will be focussing on areas where compliance is low and support is needed. A Trust Clinical Lead and Chair of the Thrombosis Group has been appointed who is a Royal Wolverhampton NHS Trust Haematologist.
- A two-step improvement programme has been agreed by the Trust to improve compliance for VTE assessments.

Stage 1 – in the immediate term to ensure accountability for VTE assessment compliance, a process for auditing and improving accountability has been established.
Stage 2 – consider implementation of a "mandatory step" in Medway which is a long term solution and will provide sustainability and accountability.



(i) Writing to Patients

Patient communication is essential, especially at a time when our out-patient clinic appointments are being delivered through different media i.e. phone, video, etc.
National best practice standards advised that communication is improved by writing directly to patients, rather than through the GP. In June 2020, the Medical Directorate set the standard to a default position in writing consultation letters to patients, with a copy to their GP.

2.1.2 Patient Priorities

Patient experience is an essential part of understanding whether we are delivering safe, effective and personalised care. We are committed to learning from the experience of those using our services and have developed a set of 12 patient priorities based on patient and public feedback that will support development of detailed plans to support the organisation to improve in the identified areas during 2020/21

The last 12 months have been challenging, with our dedicated team of volunteers having to step down due to the restrictions that were put in place due to the pandemic. Notwithstanding this, we have recruited over 50 response volunteers to help us with a variety of different tasks from delivering personal protective equipment (PPE) to ward areas, facilitating video calls, assisting general office with lost property, meeting and greeting patients/visitors, supporting pharmacy with collection and delivery of medication, supporting the Parcels 2 Patients service and general ad-hoc duties. As restrictions have eased some of our response volunteers have started to go back to work, however we are continuing to recruit volunteers to support the organisation and enhance the patients experience.

Whilst some of the priorities set for 2020/21 have had to be paused due to the pandemic, those progressed are as follows:

(a) Piloting a complaint investigation 'support hub' with the division of Medicine. If successful we will roll this out across Divisions.

The investigation support hub was piloted and assisted the division of medicine with volume management and an overall reduction in the number of days to complete a response. The Patient Experience Team extended divisional access to the hub during the height of the pandemic and although this has since been scaled back, the Patient Experience Team provides support with locating and obtaining records, statements, and use of the investigation guide.

(b) Develop an e-learning module with certification to replace the Trust complaints update which is out of date.

Due to the pandemic the Patient Experience Team ceased face to face training and began development of an e-learning package which will consist of three e-learning modules. Module 3 has been completed and the investigation guide has been produced, is in place and being used by complaints coordinators.

(c) Introduce virtual meetings for patients/ families rather than meeting face to face following COVID-19 adjustments.

Virtual meetings are offered and the Patient Experience Team has conducted 22 formal meetings via Microsoft Teams/Zoom this year

(d) Improve patient, carer and service user involvement in co-designing service improvements including Emergency Department and Urgent Care Centre new build, Outpatients and Catering.

The aim was to adopt new virtual ways of interacting with wider audiences in an inclusive way, and develop patient panels with specific services to improve services for patients and families.

In 2019/20, as part of the new Emergency Department and Acute Medical Unit new build programme, Matrons within the Emergency Department, Acute Care and Paediatrics and the Senior Project Managers developed a framework that would see co-design and co-production of services and departments using patient engagement and involvement. This continued throughout 2020/21.

In July 2020, a Patient Engagement Framework was developed and Patient Engagement Groups, which are Matron-led started in November 2020.

The Children's Ward Senior Sister and Play Specialist led a piece of work with catering colleagues to redesign the menu for children and young people and a new supplier was identified. This formed part of the wider Walsall Food Choices (#walsallfoodfaves) project incorporating learning from the previous mealtime experience pilot project on Ward 1. Following an online consultation with patients and residents various dishes have been added to the rotating menu.

Staff on Ward 11 worked with dietitians to focus on nutrition, looking at ways they can work with families and carers to better support patients and improve their recovery. The improvement project was developed to better meet the needs of its patients, some of whom are among the sickest in the hospital and require a lengthy stay. The project was developed after a complaint was received regarding nutrition and is a fantastic example of how teams can learn from complaints to improve the care and support they give to patients. Staff on the ward now take round a snacks trolley each day and have also installed a fridge on the ward so that food can be brought in from relatives.

(e) Develop a structured programme to learn from our 'Hear2Care' Patient Experience Stories.

Patient, carer and staff experience stories are shared at the Trust Board and Quality, Patient Experience and Safety Committee of the Board, as well as other staff and team meetings. Progress in 2020/21 includes:

- Introduction of a video calling service to the Trust to help keep patients connected with their loved ones, while the hospital is restricted to visiting.
- Partnered with Project Wingman to introduce an airport style first class lounge run by furloughed or redundant aviation crew. The lounge is available for staff to take a well-deserved break away from their busy work environment.
- Introduction of a 'Parcels 2 Patients' service, which is run by the volunteers with support from the Patient Experience Team. This initiative supports relatives who want to bring in belongings to their loved ones.
- Patient involvement to influence the feel, look and design of the new Emergency and Urgent Care Centre.
- 'Hear2Care' patient, carer and staff experience stories programme improved and expanded.
- Feedback Friday and promoted positive feedback for services/ wards on our website and social media.
- Lay reading panel participation increased for reviewing non-clinical patient leaflets/ information.

As the pressures of the pandemic ease on the Trust, the priorities we set for 2019/20 to undertake the NHSI Patient Experience Improvement Framework self-assessment; review and refresh the Patient Experience & Involvement Strategy; and develop a Patient Partnership Council; customer care guides and values based customer care programme; will be reviewed in setting the 2020/21 priorities. 3719 contacts were received by the Patient Relations Team in 2020/21, a total of which were 294 written complaints which includes seven informal to formal complaints and seven MP letters, a decrease of 31 written complaints overall for the year compared to 2019/20.

2.1.3 Learning from deaths

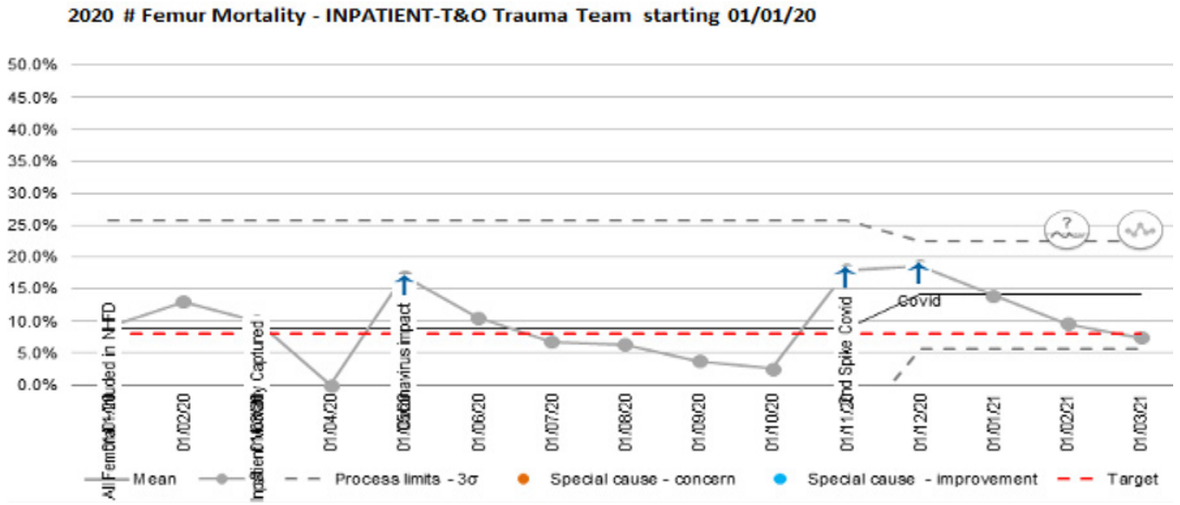
The Trust aims to be in the top quartile for the peer group in preventing avoidable deaths. Priorities have been set through a thematic review of lessons learnt from the Learning from Deaths Programme in 2019/20 to meet this aim.

A review of lessons from structured judgement reviews from March 2019 to March 2020 shows themes of responding to deterioration, end of life care and cancer delays. Along with the red SHMI (Summary Hospital-level Mortality Indicator) alert for fractured neck of femur and COVID-19, these themes form our focus for learning this year. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

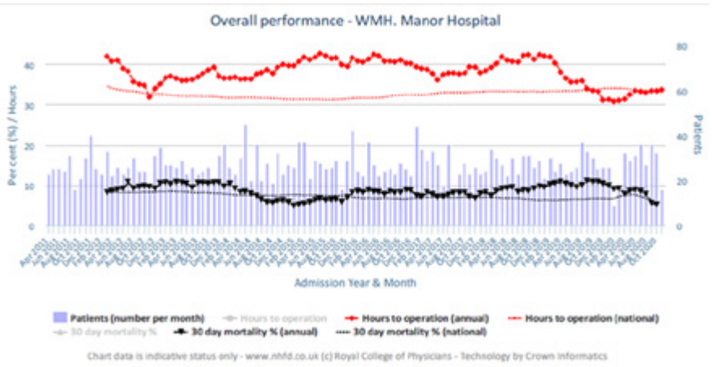
These themes are included in the Safe, High Quality Care Improvement Programme and monitored quarterly at the Mortality Surveillance Group.

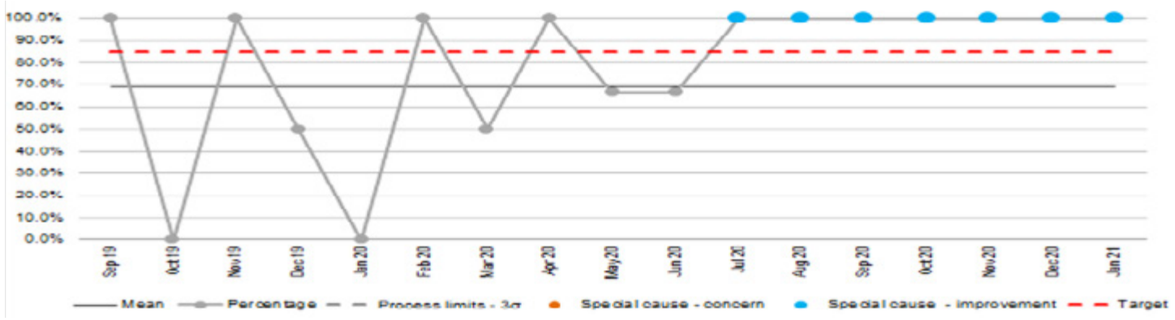
(a) Improvements in pathway for patients with fractured neck of femur.

Monthly mortality from fractured neck of femur is tracked through the Mortality Surveillance Group. Mortality rates from fractured neck of femur were reducing until the pandemic; the additional difficulties caused by the pandemic were addressed promptly.



Since the start of the Safe High Quality Care Improvement Programme to October 2020, our time to operation has reduced to be in line or below national performance with a reduction in 30 day mortality rate. Trust performance in the National Hip Fracture Database Royal College of Physicians can be seen here. More rapid access to surgery has been associated with reducing 30 day mortality, which is now in line with national performance.





(b) Improvement in cancer pathways to reduce delay and clinical variation in order to support best outcomes

Review of a cluster of serious incidents associated with deaths from delays in the lung cancer pathway resulted in an improvement programme from March 2020.

The 62 day performance for lung cancer has improved to above the target of 90% consistently with reduced delays since the lung improvement programme was introduced. There have been no serious incidents raised from delays associated with deaths or concerns with treatment since implementation of the improvement programme. The two week wait referral pathway has been streamlined with electronic triage and direct GP access to imaging.

Upgrades for lung cancer are small numbers; however there are still some delays within this pathway. The Trust continues to work with partner tertiary centres to reduce these delays, some of which have been impacted by COVID-19.

(c) Improved end of life care to support end of life discussions and planning including DNAR (Do Not Attempt Resuscitation) and MCA (Mental Capacity Act Assessment).

The need to improve the end of life care pathway has been a consistent theme of Learning from Deaths. The recommended actions are driven and monitored via the Safe High Quality Care and Care at Home Improvement Programmes. Updates are presented to the Mortality Surveillance Group quarterly and include:.

- The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) tool went live on 1st January 2021, supported by ward champions. By using the ReSPECT process, we will be able to improve personalised care by talking about much more than just resuscitation. We will be able to engage with patients and their families and make decisions together to effectively plan their care in the event of a situation where they are unable to express their own wishes.
- Simplified individualised end of life care plans and Blossom boxes are now available across all areas. The boxes are provided to patients identified as approaching the last hours or days of their life and will support all medical and nursing staff to ensure a consistent approach.
- Nurses who specialise in frailty have been recruited into the community with a more focused role. The Edmonton frailty assessment tool has been agreed to implement across all teams. Relaunch for frailty assessment education pathway took place in February 2021.
- Links with the learning from Community Care Home Review of COVID-19 deaths including a support team for care homes being established with training and resources provided.
- Recruitment of a new Consultant who supports the Goscote Hospice and community palliative care team.

Specific actions were recommended to the Emergency Department after a review of deaths resulting in an end of life pathway which has been implemented.

2.1.4 Learning from COVID-19

We recognise the need to learn from our experience:

- Updating pathways based on our audits and new research
- Participation in research nationally
- Sharing best practice through Fast Learning groups and Grand Rounds
- Maintaining national best practice with regards to Personal Protective Equipment
- Ensuring Personal Protective Equipment available at all relevant areas
- Carrying out risk assessments in clinical and non-clinical areas

The Medical Directorate established a COVID-19 Learning Group which reviewed and responded to changes in national clinical guidance and evidence for the optimal treatment of COVID-19 from regular literature reviews from the Trust library service. A suite of COVID-19 clinical resources was formed and published on the Trust Intranet. The guidance was supplemented by a training programme through the Critical Care Team, Resuscitation and Simulation Team, and Trust Grand Rounds.

The Mortality Surveillance Group commissioned a review of COVID-19 deaths in Wave 1, where 195 sets of medical notes had a Structured Judgement Review (SJR) out of 202 deaths from mid-March to the end of June 2020. Learning which was implemented included an electronic handover system to enable faster referral and review by the Critical Care Team, updates to the COVID-19 clinical protocol in line with new guidance, formation of a Microsoft Teams COVID-19 app and intranet site for easy access to clinical resources and training via clinical forums such as Trust Grand Rounds. The report included an analysis of sociodemographic trends of death from COVID-19 and was received at the Quality, Patient Experience and Safety Committee in September 2020. COVID-19 deaths continue to be scrutinised by Medical Examiner Officers in accordance with the Trust's Learning from Deaths Policy.

The Trust commissioned a serious incident investigation into healthcare acquired infections for COVID-19 during 2020/21. This review found that 21/221 (9.5%) of COVID-19 deaths followed a nosocomial infection. A thematic review of learning from all cases was included and recommendations have been implemented with a plan for audit of assurance. The review and report was received at the Quality, Patient Experience and Safety Committee in January 2021.

2.1.5 Improving cancer pathways

Through a focus on lung cancer and colorectal pathways through 2020/21 we will introduce new ways of working to support the implementation of 28-day fast diagnosis target. We will streamline cancer referral pathways both internally and with external partners, ensure every patient has the best possible standard of care based on national best evidence by setting and implementation of multi-disciplinary team standards. For patients who have a delay in the cancer pathway, we will implement a robust mechanism to review all 104 day breeches.

We have been able to continue with oncological procedures despite unprecedented pressures across our Critical Care Unit. Even during periods with >300% of our normal capacity on our Critical Care Unit – requiring the deployment of staff from across other departments – we continued with breast, colorectal, gynaecological, urological and head and neck oncological procedures. Patients requiring additional support following their cancer operation have benefited from the introduction of our new Enhanced Recovery Unit on the ring-fenced elective wing of the Manor Hospital. Other aspects of our services have developed amidst the COVID-19 pandemic. We have introduced a swabbing service for all surgical patients, introduced Faecal Immunochemical Testing and expanded CT colonoscopy testing for our colorectal patients. In March 2021 we are treating 72.4% of our GP-referred cancer patients within 62 days, materially better than the 57.4% in the Black Country & West Birmingham (BCWB) ICS, and 60% in the West Midlands, and consistent with 73.9% in England.

2020/21 has also seen us progress a host of collaborative work with other Trusts in the Black Country and West Birmingham Integrated Care System (ICS). The Trust has offered support to other trusts in the Black Country and West Birmingham by creating additional capacity for patients requiring surgery for colorectal cancer.

We will be working more closely with the Royal Wolverhampton NHS Trust for our urology service. The Trust is pursuing an expansion in the breast service, offering further support for oncological procedures across the ICS and involvement with technology solutions, such as a virtual assessment service within dermatology. We believe this approach will offer our patients faster access to expert opinion, diagnostics and treatment.

2020/21 has also seen us progress a host of collaborative work with other Trusts in the Black Country and West Birmingham Integrated Care System (ICS).

2.1.6 Board Priorities

Through the Walsall Together partnership develop collective responsibility to reduce health inequalities and provide better outcomes for the people of Walsall, through the development of a Population Health and Inequalities Strategy for Walsall

As a formal committee of the Trust Board, the Walsall Together Partnership Board brings together 11 organisations from physical and mental health, commissioning, social care, public health and third sector and voluntary organisations including housing to work collaboratively to directly address health inequalities.
A tiered Model of Care has been co-developed with an increased level of focus on services outside of the acute setting, to move the system towards a population management orientated model with a clear focus on prevention and early intervention. The Resilient Communities element of the Operating Model is a fundamental change in the way a population's health and wellbeing is supported and managed, with the largest volume of care and support provided in the community by Place Based Teams co-located to ensure integrated and joined-up delivery of care.

The model below is now monitored in a monthly governance cycle through the Partnership Board with a full suite of operational and performance measures for assurance. The teams in public health and Walsall Together are now working with commissioners and system partners to develop a longer-term suite of outcome measures that will show progress on health inequalities.

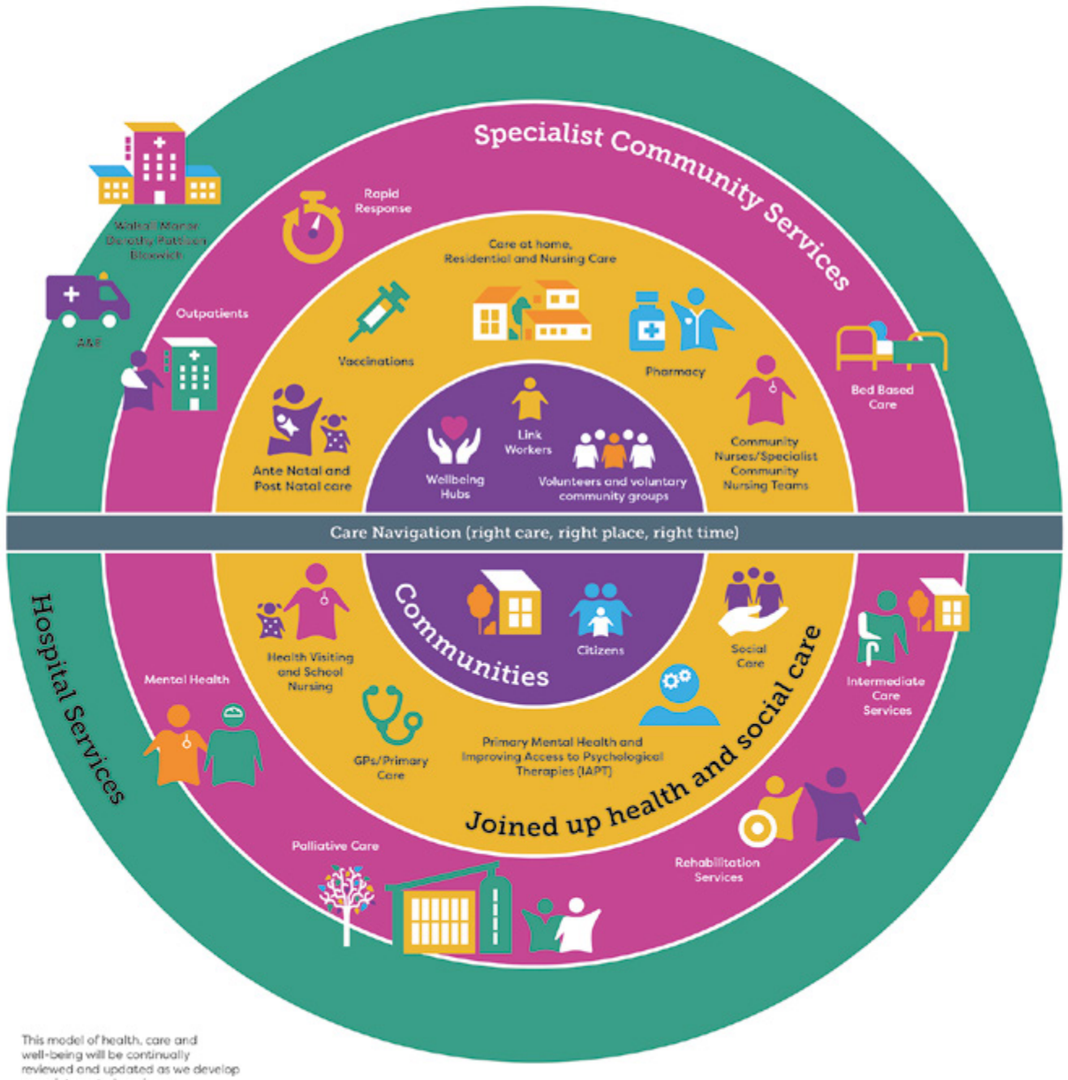
Model of Care Tiers	Description
Tier 0 - Resilient Communities	Prevention, identification, early intervention and pro-active self-care, health and wellbeing services.
Tier 1 - Integrated Primary, Long term condition management, Social and Community Services	Integrated Primary, Long term condition management, Social and Community Services Integrated health and care, delivering primary, social and community care at scale, with teams working through a hub and spoke model across each locality
Tier 2 - Specialist Community Services	Accessible, high quality care with local hospital teams working in a locality to deliver specialist care, outpatient, and diagnostic services, delivered from "Health and Wellbeing Centres" – repurposed estate used as a hub for MDTs
Tier 3 - Intermediate, Unplanned and Crisis Services	Network of specialist care delivered from a selection of Health and Wellbeing Centres, preventing unnecessary hospital admissions
Tier 4 - Acute and Emergency Services	Access to high quality acute hospital services for patients when they need specialist intervention, provided both in-borough and through a wider network

Walsall Together

Collaborating for happier communities

Model of Health, Care and Well-Being

Our vision of how health, care and well-being will look for the people and communities of Walsall



This model of health, care and well-being will be continually reviewed and updated as we develop more integrated services.

2.2 Priorities for Improvement for 2021/22

The quality priorities were informed by reviewing the progress against the 2020/21 Quality Priorities and the themes highlighted from ward and department audits and the following

- Quality and safety information
- External assessments
- Local and national audit
- National priorities for sepsis,
- Safe staffing,
- Falls, pressure ulcers and infection control
- Analysis of incidents
- Analysis of complaints
- Feedback from national and local in-patient surveys
- Priorities set out in the Safe High Quality Care Improvement Programme

Improving Patient Safety	Measurement for success	Strategic Objective
Timely escalation and response to deteriorating patients	• Reduction in avoidable harm and death associated with missed opportunities when compared to 2020/2021 • Improvement in timely identification and treatment of sepsis compared to 2020/2021	Safe high Quality care
Patients who have mental health care needs will receive safe care in line with Mental Health Act expectations	• Development of mental health strategy • Delivery of year 1 objectives	Safe High Quality Care
Reduction in avoidable harm to patients	• Development of Skin Integrity Ambition 2021-2024 and delivery of year 1 objectives • Development of Safe Mobility Ambition 2021-2024 and delivery of year 1 objectives • Development of Continence Ambition 2021-2024 and delivery of year 1 objectives • Delivery of Nutrition Ambition year 1 objectives • Reduction in HCAI rates	Safe High Quality Care
Timely assessment and prophylactic treatment of VTE	• VTE assessment in line with Trust target • Audit data to demonstrate VTE prophylactic treatment prescribed and administered appropriately	Safe High Quality Care
Timely escalation and response to Safeguarding concerns	• Safeguarding training performance in line with trust targets and audit performance confirms training knowledge retained and evident in practice • Increase in WHT reported safeguarding incidents compared to 2020/2021	Safe High Quality Care

Improving Patient Safety	Measurement for success	Strategic Objective
Consent	• The measures for this priority are in development and will be reviewed by the Quality, Patient Experience and Safety Committee	Safe High Quality Care
Mental Capacity Act	• Ensuring training and implementation supports clinical practice that is in line with legal requirements and allows us to provide patient-orientated care, with full recognition of safeguarding principles	Safe High Quality Care
Learn from complaints and patient feedback to provide an excellent patient experience	• Reduction in the number of complaints when compared to the 2020/2021 baseline • Development of, and delivery against 2021/2022 patient priorities	Safe High Quality Care
Develop and implement Excellence in Discharge Programme	• Upward trend in patients reporting involvement in their discharge arrangements when compared to 2020/2021 • Reduction in complaints regarding discharge process	Safe High Quality Care
Review quality of complex discharges through the integrated care pathway	• The measures for this priority are in development and will be reviewed by the Quality, Patient Experience and Safety Committee	Work with partners
Development of Dementia Strategy 2021-2024	• Delivery of year 1 objectives	Safe High Quality Care
Development of End of Life Care Strategy 2021-2024	• Delivery of year 1 objectives	Safe High Quality Care
Improve person centred decision making in regards to emergency situations and at the end of life	• ReSpect training compliance in line with trajectory • ReSpect audit data performance	Safe High Quality Care
FORCE	• TBC (ensuring that we provide our patient the chance to contribute to local and national research projects and that we take this earning to improve patient care)	Safe High Quality Care
Scope opportunities to develop an integrated community therapy service across health and social care	• The measures for this priority are in development and will be reviewed by the Quality, Patient Experience and Safety Committee	Work with Partners
Elimination of agency usage wherever possible	• Increase in substantive whole time equivalent (WTE) staff • Reduction in agency usage compared to 2020/2021 • Reduction in redeployed hours compared to 2020/2021	Valuing colleagues Use of resources

In addition to the above priorities our Infection, Prevention and Control team is currently preparing to deliver the annual programme of work for 2021/22:

- **Community:** There will be a focus on reduction of Gram-negative associated infections by utilising a syndromic approach to infection prevention. This will initially look at innovations to reduce the risk of catheter associated urinary tract infections (CAUTI) in the community. The team will work closely with continence specialist nurses and clinical colleagues within the division to look at standards of aseptic technique, ongoing assessment for urinary catheterisation and a plan to trial a new method of meatal cleaning for urinary catheter insertion, replacing saline for a chlorhexidine solution.

- **Surgery and Maternity:** The IPC programme plans to revitalise surgical site infection (SSI) surveillance processes by undertaking a multimodal review of environment and practice in the surgical pathway using the One Together framework and reviewing themes from incident reports. A launch event is planned in May 2021, presenting the key findings of the review and sharing best practice from SSI experts in other NHS Trusts to start a new Trust wide SSI group.

- **Medicine:** A rapid improvement programme has been planned in departments in the division to focus on standards of aseptic technique and the management of peripheral vascular devices. This will be a collaborative approach to improvement with the IPCT Team and Quality Team. Findings from the programme will be reviewed for further standardisation in education provided Trust wide.

In 2021/22 our Faculty Of Research and Clinical Education (FORCE) team will continue to focus on COVID-19 studies, but will endeavour to open a wider portfolio of studies. The team will focus on reviewing and restarting non-COVID studies and increase the number of studies undertaken across the Trust along with increasing 'home grown 'research working in collaboration with our academic partners (Staffordshire/Wolverhampton University). The department will ensure to scope potential areas where there is growth for research in relation to population need; this will support stability within the department. Its Research & Professional Strategy three year plan:

- Re-energising and stabilising governance framework through effective R&D committee.

- Introduction of a sub committee to review appropriateness of re-opening non-COVID studies.

- Training-Programme for developing research skills developed with Professional Development colleagues and the Clinical Research Network (CRN) to ensure availability of professional development for staff. Primary Investigator masterclasses run for senior staff to take on more research studies.

- Redesign of Team FORCE webpage and introduction of CHATBOT (Innovation funding gained for this project)

- Edge embedded into core process and data recording

- Performance Monitoring – Undertaken weekly to identify any missing data or discrepancies in information.

- Collaboration with Stafford University to support 'home grown' researchers prepare and submit bids for grant funding

- CRN Innovation Bid success to support 'Hexitime' Project

- Recognition of outstanding contribution to recruitment into research through the introduction of certificates

Detailed below are some of the improvements Team FORCE has identified as key for 2021/22: in line with its Research & Professional Strategy three year plan:

- Embedding research into core work for clinical staff
- Approval and embedding of Research and Clinical Education strategy to give clear direction and accountability.
- Capitalise on University relationships and wider participation to more services
- Encourage more clinicians to be involved in research-increase the number of PI's across the Trust i.e. Doctor, Nurse , health professional
- Sustainability of staff
- Patient involvement-Patient representative to be invited onto R&D committee
- Increase a wider portfolio of research activity across Walsall Healthcare NHS Trust
- Forge extended partnerships with industry partners and increase commercial research across the Trust
- Promote Research and Education through a 'Research Event'

2.3 Statements of Assurance from the Board

2.3.1 Review of Services

During 2020/21 the Trust provided and / or sub-contracted 129 relevant health services.

The income generated by the relevant health services in 2020/21 represents 100% of the total income generated from the provision of NHS services by the Trust for 2020/21.

2.3.2 Participation in Clinical Audit

During 2020/21, 50/52 (96%) national clinical audits and one (100%) national confidential enquiry covered relevant health services that the Trust provides.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit Title (n=65)	Trust Participation (50/52)	% of the No of cases Submitted	Actions / Comments
Serious Hazards of Transfusion (SHOT)	✓	Data submission in progress	Data submission in progress not due to complete till July 2021
National Asthma and COPD Audit Programme (NACAP) – COPD	✓	Data submission in progress	Ongoing data submission
National Asthma and COPD Audit Programme (NACAP) - Asthma	✓	Data submission in progress	Ongoing data submission
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation	✓	Opens March 2020	Data submissions ongoing till March 2021
National Diabetes Adult - Inpatient Audit	✗	Data submitted	Postponed due to COVID till 2021
National Diabetes Adult - Foot Care Audit	✓	Data submission in progress	Ongoing data submission
National Diabetes Adult – Pregnancy	✓	Data submission in progress	Ongoing data submission
National Diabetes Adult – Harms in England	✓	Data submission in progress	Ongoing data submission.
National Diabetes Adult – Core	✓	Data submission in progress	Ongoing data submission
National Paediatric Diabetes Audit	✓	Data submission in progress	Ongoing data submission
National Lung Cancer Audit (NLCA)	✓	100%	Data submitted await report
Antennal and New Born National Audit protocol 2019 - 2022	✓	Data submission in progress	Ongoing data submission
Pain in Children – CEM	✓	100%	Data submitted await report.
Infection Control – CEM	✓	100%	Data submitted await report.
Fracture Neck of Femur - CEM	✓	100%	Data submitted await report
Major Trauma Audit - TARN	✓	100%	Data for the period submitted - On-going data submission await the report
British Spine Registry	✓	100%	Ongoing submission
National Audit of Heart Failure	✓	Data Submission in progress	Ongoing data submission

National Audit Title (n=65)	Trust Participation (50/52)	% of the No of cases Submitted	Actions / Comments
National Audit of Cardiac Rehabilitation	✓	Data Submission in progress	Ongoing data submission
Cleft Registry and Audit Network	✗	N/A	Not undertaken at the Trust
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	Data Submission in progress	Ongoing data submission
Cardiac Rhythm Management	✓	100%	Ongoing data submission
National Oesophago-Gastric Cancer	✓	100%	Data Submitted await report
UK IBD Registry	✗	N/A	Suspended due to COVID
Mental Health Clinical Outcome Review Programme	✗	N/A	Not undertaken at the Trust
Sentinel Stroke National Audit – Community	✓	100%	Data submissions ongoing
Adult Cardiac Surgery	✗	N/A	Not undertaken at the Trust
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	✗	N/A	Submitted as part of New Cross data
BAUS Urology Audits - Nephrectomy audit	✓	Data submission in progress	Ongoing data submission
National Prostate Cancer Audit	✓	Data submission in progress	Ongoing data submission
Case Mix Programme (CMP) - ICNARC	✓	100%	Ongoing data submission
National Audit Of Breast Cancer in Older People	✓	On-going data submission	Awaiting the report
National Bariatric Surgery Registry	✓	100%	Ongoing data submission
National Bowel Cancer Audit	✓	100%	Data submission ongoing final data submission April 2021

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Part 2: Priorities For Improvement And Statements Of Assurance From Board

National Audit Title (n=65)	Trust Participation (50/52)	% of the No of cases Submitted	Actions / Comments
National Emergency Laparotomy Audit	✓	34%	The number of cases submitted during this period was reduced due to the COVID pandemic (28/82 cases were submitted which is a reduction on last year's submission of 99 cases). Restoration plans are underway for the current data period.
Perioperative Quality Improvement Programme	✗	N/A	Not undertaken in 2020/21 due to clinical burden re-evaluated and due to submit in 2021/22
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	✓	Data submission in progress	Falls data – Ongoing data submission
Elective Surgery (National PROMs Programme)	✓	Data submission in progress	On-going data submission
National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	✓	Data submission in progress	Data submission on-going
National Ophthalmology Audit	✗	N/A	Not applicable patients treated at New Cross
National Vascular Registry	✗	N/A	Not undertaken at the Trust
BAUS Cystectomy	✗	N/A	Not undertaken at the Trust
BAUS Radical Prostatectomy Audit	✗	N/A	Not undertaken at the Trust
MBRACE-UK	✓	100%	Ongoing data submission
National Maternity and Perinatal Audit (NMPA)	✓	100%	Ongoing data submission
National Comparative Audit of Blood Transfusion – 2020 Audit of The Management of Paediatric Anaemia	✓	100%	Awaiting the report
National audit of Seizures and Epilepsies in Children and Young People	✓	Data submission in progress	Ongoing data submission
National Audit of Care at the End Of Life	✗	N/A	Data postponed by national body due to COVID-19

National Audit Title (n=65)	Trust Participation (50/52)	% of the No of cases Submitted	Actions / Comments
National Neonatal Audit Programme	✓	Data submission in progress	Ongoing data submission
Paediatric Intensive Care	✗	N/A	Not undertaken at the Trust
Learning Disability Mortality Review Programme	✓	100%	Ongoing data submission
Surgical Site Infection Surveillance Service	✓	100%	Ongoing data submission
Mandatory Surveillance of HCAI	✓	100%	Ongoing data submission
Reducing the impact of Serious Infections	✓	100%	Ongoing data submission
National Audit of Dementia	✓	N/A	Data Differed due to COVID-19
National Cardiac Arrest Audit (NCAA)	✓	Data submission in progress	Ongoing data submission
National Audit of Anxiety and Depression	✗	N/A	Not undertaken at the Trust
Prescribing Observatory for Mental Health	✗	N/A	Not undertaken at the Trust
UK Cystic Fibrosis Registry	✗	N/A	Not undertaken at the Trust
BAUS Urology Audit – Female Stress Urinary incontinence (SUI)	✗	N/A	Not undertaken at the Trust
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	✗	N/A	Not undertaken at the Trust
Child Health Clinical Outcome Review	✓	Data submission in progress	Ongoing data submissions
National Clinical Audit of Psychosis	✗	N/A	Not undertaken at the Trust
National Congenital Heart Disease (CHD)	✗	N/A	Not undertaken at the Trust
National Joint Registry (NJR)	✓	Data submission in progress	Ongoing data submission
Neurosurgical National Audit Programme	✗	N/A	Not undertaken at the Trust

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Part 2: Priorities For Improvement And Statements Of Assurance From Board

National Audit Title (n=65)	Trust Participation (50/52)	% of the No of cases Submitted	Actions / Comments
National Audit of Pulmonary Hypertension	✗	N/A	Not undertaken at the Trust
NHS Provider Interventions With Suspected / Confirmed Carbapenemase Producing Gram Negative Colonisation / Infections	✓	100%	Ongoing data submissions
Out of Hospital Cardiac Arrest Registry	✗	N/A	Not undertaken at the Trust
Society Acute Medicine Bench Marking Audit SAMBA	✓	N/A	Data eiffered due to COVID-19
Uk Registry of Endocrine and Thyroid Surgery	✓	100%	Submitted as part of New Cross submission
Uk Renal Registry National Acute Kidney Injury Programme	✓	100%	Submitted as part of New cross submission
PHE – Data Submission	✓	100%	Improvements have been made to admissions and discharge profiles to ensure an accurate treatment pathway for all COVID-19 positive patients
NCEPOD - Dysphagia in Parkinson's Disease	✓	Data submission in progress	Ongoing data submission

The number of local clinical audits reviewed by the Trust was reduced due to the COVID-19 pandemic and as a result there were 70 registered Clinical Audit projects. Six are in progress and 30 were completed during the period of 2020/21 to allow clinical time to be prioritised. Reports from these audits are presented at multi-speciality meetings where recommendations and actions are derived to improve the care delivered. Some examples are detailed below:

Title	Outcome	Action
Infection Control COVID Admission Assessment	Good compliance was identified against the BAF standards for COVID positive patients on admission	The findings were presented to all care groups and reinforced the importance of documenting the positive COVID status to ensure patients adhere to self-isolation on discharge and follow up for long COVID is adhered to.
Audit of Compliance against COVID NG188	Good overall compliance was noted in adherence to the long term follow up of patients who had been discharged post COVID.	To share the findings with the care groups and to reinforce the importance of long term COVID follow up and raise awareness of the NICE guidance.
Oxygen Prescription – Trust wide Audit	Initial low compliance 53.7% compliance to oxygen prescribing standards.	An oxygen campaign was launched in the Trust by way of the following actions: • Initiate a campaign of Trust wide education, tweeting a countdown to the month long Oxygen October with weekly audits of all ward areas during that month. • Information stand, information boards and put up posters, give out badges to act as a prompt and reminder on oxygen prescribing Give out oxygen wall hangers, formulated a trust wide screen saver and gave out ward information packs. We ran an ongoing Twitter campaign. Reviewed the Oxygen Policy and update onto the Intranet incorporating NICE guidance standards.
Assessment and follow up of VTE	Good compliance was noted overall however referral process in line with guidelines was low.	To improve referral to anticoagulation clinic by raising awareness of the referral criteria by presenting the results across the care groups and sharing a copy of the referral pathway.
Snapshot Audit on VTE Assessment and Prescribing VTE Prophylaxis against NICE NG 89	Good over all compliance with VTE assessment however improvements required with timeliness of VTE completion	The following actions were taken to improve the timelines of assessment. • Educating all the trainees and non-trainees. • Displaying the posters in the ward near computers to remind doctors to do VTEs. • IT system modification to complete VTE before online prescribing medications / ordering investigations. • Before moving the patient to another ward VTE should be completed otherwise patient should not move. EDS doctor check VTEs between 10:30am-11Am then 5pm-5:30pm

Title	Outcome	Action
NatSSIPs LocSSIPs	The audit identified compliance across the Trust was improving but still failed to meet national recommendations	Actions taken included: • Integration of LocSSips into the care flow package for ED enabling live status in 2021/2022. • Action tracker and a move towards electronic data capture across the Trust is in progress. • Local Audits are being returned and disseminated to care groups that show compliance data monthly and to provide assurance
Patient Experience in Imaging during pandemic	Good Compliance Overall	Actions Included: • Infection control to be improved in particular hand washing through education and by reinforcing best practice across the care groups. • Share the results at monthly Quality Improvement meeting to ensure all members of the imaging team are aware of results of this survey • Reinforcement from reception staff regarding availability of face masks and sanitiser on arrival • All members of imaging team to be challenged if not using appropriate PPE and infection control processes. • Ensure all staff have completed mandatory IPC training Consider a written/non- verbal method to provide patients information regarding results of scan. For example, slips of paper with printed information allow patients to refer to it at a later date and can also serve as a reminder
Delays in Lymphoma Pathway	Identified delays in lymphoma diagnosis	To investigate the feasibility of introducing a dedicated lymphoma diagnostic pathway and clinic
Identifying pre-operative predictions for same day discharge following elective hip and knees arthroplasty	Walsall has an increased length of stay for this cohort of patients	Develop a pathway to streamline day surgery arthroplasty to include formal physiotherapy schedule and validated pre-operative medical assessment scoring system
Heavy Menstrual Bleeding	Good compliance overall	To work with GPs on referral processes around women undergoing a pelvic ultrasound and provide patients with information and pharmaceutical treatment prior to outpatient appointment

2.3.3 Participation in Clinical Research

Research and Development (R&D) refers to innovative activities undertaken by the NHS, corporations (e.g. pharmaceutical) or governments in developing new services or products, or improving existing services or products. From an NHS perspective, research can be either commercial (clinical trials) or non-commercial (academic). Having a balanced portfolio is important for the Trust as it offers patients the opportunity to be involved in a variety of research studies.

The R&D Department was amalgamated with the Professional Development Unit in 2020 and launched the new Faculty of Research and Clinical Education (FORCE). FORCE supports the Trust to ensure that evidence based care is central to all clinical work and that there is growth of research across the Trust.

The number of patients receiving relevant health services provided or subcontracted by the Trust in 2020/21 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1279. The Trust uses one of the five Research Ethics Committees the West Midlands and they review research proposals and give an opinion about whether the research is ethical. Anyone undertaking research which relates to the Trust applies to one of these committees to gain research ethical approval. The Trust then undertakes capacity and capability of all studies as per the Health Research Authority and in line with the Ethic Committee's approval. Heath Research Authority approval applies to all project-based research taking place in the NHS in England and Wales. The R&D Department will then issue Trust approval.
COVID-19 saw the National Institute Health Research (NIHR) focus on Urgent Public Health (UPH) studies. Taking part in these UPH studies was priority. In 2020 the Trust participated in seven UPH COVID-19 studies. The key studies included: the RECOVERY Study, SIREN Study and ISARIC Study.

Walsall Healthcare NHS Trust Recruitment Data

Number of Open Studies (COVID-Non COVID)	11
Number of Studies in set-up	6
Number of Studies in Suspension/on hold/ due to COVID 19	8
Number of Closed Studies*	2
Number of Studies recruiting on CPMS and missing on EDGE	0
Total	**27**
Total Number of Studies with Complete and Accurate Data	27
% of Studies with Complete and Accurate Data	100%
Number of Studies with Missing Data	0
Number of Studies with Data Discrepancies	0

Overview of Studies at Walsall Healthcare NHS Trust

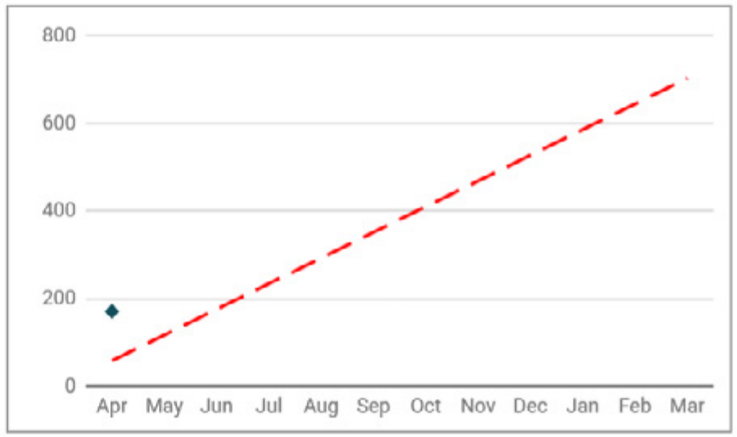
The Trust has a good record in recruiting to time and target on commercial/non-commercial studies. In 2019 the Trust closed 16 non-commercial studies all of which hit their target and closed green (RAG rated). No commercial studies closed in 2019. In 2020 the direction of research changed due to COVID-19. Emphasis was focused on opening Urgent Public Health Studies as stipulated by the Department of Health and Social Care.

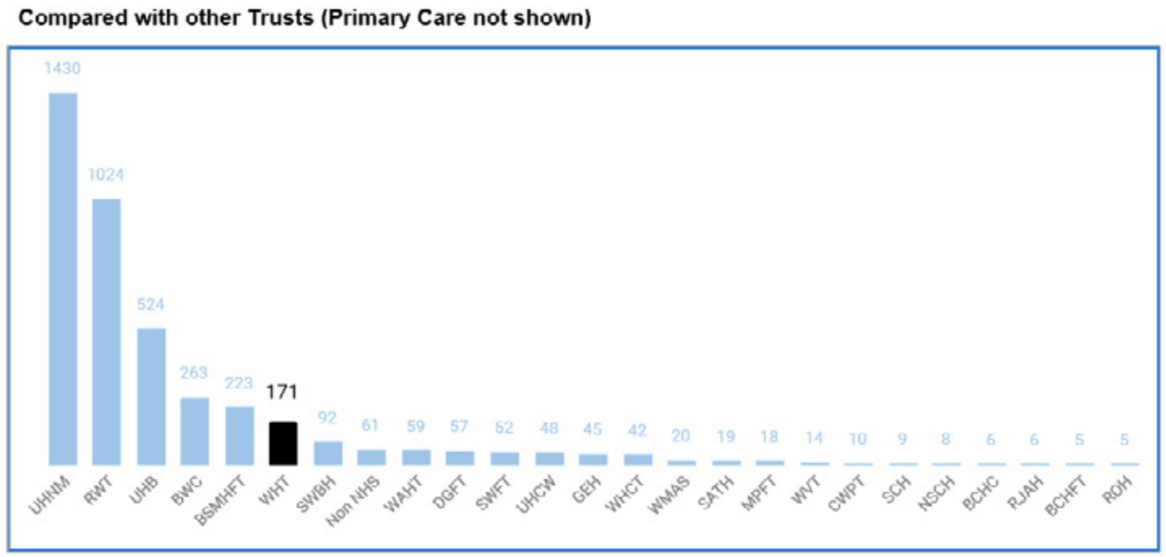
The graph above shows a steady increase in recruitment and performance overall to early 2021. Last year was a challenging year for the team and many changes took place in staffing and processes which impacted on the its ability to open new studies. Emphasis was placed on opening UPH (Urgent Public Health Studies) which shifted our focus; we were able to open key UPH studies as stipulated by the DoH i.e. RECOVARY, ISARIC, SIREN GenOMMICC . Non-COVID studies were suspended and recruitment halted prematurely. The team had to think creatively and be innovative as to how to open and recruit into the UPH studies which proved successful.

The 2021/22 year sees new challenges and opportunities for the FORCE team. We will see new members join therefore rebuilding and stabilising the team will be important. The team will be in a good position to increase and grow its portfolio and this will enable us to see the number of recruits increase again for the year 2021/22. With the establishment of a core Research & Professional Development Committee the Trust is well placed to increase research capacity during 2021/22. The FORCE team are committed to improving the quality of care offered to patients though research.

The graph below shows recruitment as per new financial year – April 2021
Based on recruitment in CPMS, successfully transferred from Edge or manually uploaded as provided by the CRN:

	Target	Recruits
Apr	59	171
May	117	
Jun	176	
Jul	234	
Aug	293	
Sep	352	
Oct	410	
Nov	469	
Dec	527	
Jan	586	
Feb	644	
Mar	703	





2.3.4 CQUIN (Commissioning for Quality and innovation Payment Framework)

The Trust's income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. This was due to NHS England/Improvement issuing a publication on 26th March 2020 advising of the revised arrangements for NHS contracting and payment during the COVID-19 pandemic, including CQUIN being suspended for all providers.

2.3.5 Information on registration with the Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is "registered without conditions"

The Care Quality Commission has issued three enforcement notices to Walsall Healthcare NHS Trust as follows:-

- Regulation 12 HSCA (RA) Regulations 2014 Safe care
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

No enforcement action was taken against the Trust during 1st April 2020 and 31st March 2021.
CQC Inspection Area Ratings (Latest report published 17th November 2020)

Overall Trust Rating: Requires Improvement

Safe	Requires Improvement	
Effective	Requires Improvement	
Caring	Good	
Responsive	Requires Improvement	
Well Led	Requires Improvement	

In response to the report the Trust has continued to manage the must and should actions via the CQC action plan, along with the requirement notices issued. The work and progress has been reported to the Quality, Patient Experience and Safety Committee and the Trust Board

The Trust participated in a short notice announced focused inspection by the CQC of the Emergency Department and Maternity Services at the Manor Hospital on 8th and 9th September 2020. The CQC also carried out an unannounced inspection on 9th March 2021 which focussed on parts of the 'safe and responsive' CQC domains within the Medical Division. The Trust has developed an action plan in response to the CQC findings. That action plan is monitored by the Quality, Patient Experience and Safety Committee and the Trust Board.

The list of must do and should do actions from the CQC inspections appears at Appendix 1.

2.3.6 Secondary User Services

The Trust submitted records during 2020/21 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics (HES) for national reporting purposes.

The percentage of records in the submitted data which included a valid NHS number was:

- admitted patient care = 99.83%
- outpatient care = 99.81%
- accident and emergency care = 99.39%

The percentage of records in the submitted data which included a valid General Medical Practice Code was:

- admitted patient care = 100.00%
- outpatient care = 100.00%
- accident and emergency care = 100.00%

2.3.7 Information Governance Toolkit attainment levels

The Trust is a recognised and registered Data Controller with the Information Commissioners Data Protection Register and has current Data Protection registration.

All organisations that have access to NHS patient data and systems must use the Data Security and Protection Toolkit (DSPT) to provide assurance on their practice. The DSPT is divided into ten sections against the National Data Guardian's 10 Data Security Standards. Organisations are expected to achieve a rating of 'Standards Met' where evidence has been provided and confirmed for all mandatory assertions.

The DSPT submission is normally made on 31st March each year, however NHS Digital has confirmed that, due to COVID-19, the submission will be made on 30th June 2021. The Trust submitted a baseline assessment on 26th February 2021 providing evidence of the organisation's current position in relation to achievement of the 10 National Data Standards. The assessment was reviewed by the Trust's auditors and a rating of 'Significant Assurance with Some Improvement Required' was assigned. No areas of concern were noted and the Trust is on track to achieve 'Standards Met' for 2020/21.

The Trust's toolkit is shared with the CQC, NHS England and Improvement, and provides important evidence for the key line of enquiry on Information in the CQC well-led inspection.

2.3.8 Clinical Coding

The Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.

2.3.9 Information on the quality of data

The Trust will be taking the following actions to improve data quality:

- Monitoring Reports – additional reports created by Information Services will be used by the Data Quality Team to review, manage, and identify data quality issues.
- Development of a Data Quality Strategy / Delivery Plan – we will co-create a data quality strategy and delivery plan with organisational leads, co-ordinated through a Data Quality Group.
- Increased Visibility/Communication Plans – the Data Quality Team will align with all levels of the organisation to advise and support staff. Data quality information will be sent weekly using internal communications, reporting on identified data quality issues and progress.
- Further Training for Data Quality Staff – Data Quality Team to be provided withfurther training on reporting tools including Power BI/SQL enabling a more self-sufficient and pro-active approach to identifying and monitoring data quality issues.
- Data Quality Training – Empowering users and exposing them to data quality issues that have been identified, and how they can be stopped moving forward. Providing webinars, training videos and data quality meetings to support and guide staff.
- Trust Induction – Securing a place on the agenda at Trust induction to demonstrate why data quality is important for staff, patients and the trust and re-enforcing that it's everyone's responsibility.
- Consistency Between Systems - Standard policies and procedures will apply to all systems within the Trust and we will promote data quality within all data collection systems.

2.3.10 A consolidated annual report on rota gaps

The Trust has implemented a software management system to improve identification and management of rota gaps which will aid the development of a sustainable workforce. As part of this implementation, a new bank staff tool will be introduced, allowing medical workforce direct access to available shifts and to self-book. The COVID-19 pandemic has had an impact on staffing levels with increased reliability on bank and agency staff. Redeployment of clinical staff throughout the pandemic has helped ease the strain on areas under pressure.

Partnership working with Medical Training Initiative (MTI) schemes continues. The Clinical Fellowship Programme, in partnership with the Royal Wolverhampton NHS Trust is now established, with the first four Clinical Fellows coming into post from end March 2021.

Recruitment continues to be a focus for attention, particularly in hard to recruit to areas. In 2021/2022 the Trust will continue to build on the relationship with the Royal Wolverhampton NHS Trust and work closely with the MTI and Clinical Fellowship Programme. Work with the software management system will continue with the aim of providing a streamlined approach to rota management.

2.3.11 Learning from Deaths

There have been a total of 682 COVID-19 deaths in the hospital to 31 March 2021. COVID-19 deaths are scrutinised by the medical examiners and escalated at Structured Judgement Reviews (SJRs) in line with the Learning from Deaths Policy. Any COVID-19 deaths associated with a hospital acquired infection are reported with an incident via the Trust's incident reporting system.

In line with National Quality Board (NQB) guidance the Trust has adopted and embedded its Learning from Deaths Policy to include the Learning Disabilities Mortality Review (LeDeR) process. The trust has four Medical Examining Officers (MEO) led by a lead examiner. Deaths are scrutinised by the MEOs as part of the certification process. The MEOs raise cases of patients where SJRs are recommended. SJRs are also triggered in accordance with the NQB policy. There were 14 LeDer deaths and all have been examined using SJR methodology.

The pandemic has placed challenges on the learning from death process reviews. The Trust has been able to maintain a high rate of MEO reviews, however some specialities, which have been significantly affected by increased COVID-19 clinical workload, have not been able to maintain high rates of SJR reviews. This includes critical care, respiratory and care of the elderly. The Trust has supplemented these reviews by employing medical support workers who are retired, experienced consultants to undertake some reviews, as well as implement a process to enable off site reviews from clinicians who are shielding or isolating.

(a) During 2020/21, 1650 of the Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 399 in the first quarter;
- 238 in the second quarter;
- 465 in the third quarter;
- 548 in the fourth quarter.

(b) By 19th March 2021, 512 case record reviews and 34 investigations had been carried out in relation to 667of the deaths included in the reporting period

In 34 cases a death was subjected to both a structured judgment case record review and a more detailed investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 235 in the first quarter;
- 59 in the second quarter;
- 127 in the third quarter;
- 91 in the fourth quarter.

(c) 41, representing 2.5%, of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 22 representing 1.38% for the first quarter;
- 4 representing 0.25% for the second quarter;
- 7 representing 0.42% for the third quarter;
- 8 representing 0.48% for the fourth quarter.

These numbers have been estimated using the Learning From Deaths case reviews by medical examiner scrutiny and Structured Judgment Reviews.

(d) The trust uses a variety of mechanisms and forums to learn from patient deaths, celebrate good practice and to communicate findings to clinical and nursing teams. These include:

- Mortality Surveillance Group
- Mortality Surveillance Group intranet site and Teams page
- Learning Matters Newsletter
- Divisional Safety huddles
- Care Group Meetings and Divisional Quality Boards
- The 'Daily Dose' e-mailed to all staff on a daily basis

Learning from deaths is part of the Safe High Quality Care Improvement Programme, with learning monitored via the Mortality Surveillance Group and reported quarterly to the Quality, Patient Experience and Safety Committee.

Through the learning from deaths process, we have seen:

- Reduced mortality rates from fractured neck of femur until October 2020, with a potential impact of COVID 19 noted subsequently
- No further serious incidents associated with deaths from delays in the lung cancer pathway
- Implementation of the Medway eSepsis module to recognise, escalate and respond faster to sepsis

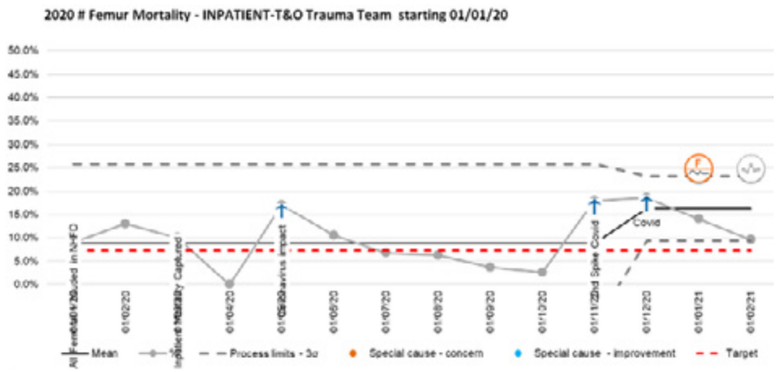
(e) Examples of learning from mortality reviews are included in this Quality Account and also include:

- Review of the heart failure pathway to include recruitment of a Consultant to work across the Acute and Community Divisions and the implementation of a virtual heart failure ward for a multi-disciplinary ward round.
- Communication and commitment to include mouth care as a fundamental of care in partnership with the Nursing Directorate
- Review and improvements to the head injury pathway with a new clinical guideline and streamlining of referrals with University Hospital Birmingham
- Improvements to reduce deaths in children such as vitamin D prescribing and post-natal advice to families
- Learning from complaints has been incorporated into the schedule of the Mortality Surveillance Group.

Actions include:

- o Additional focused training for teams involved based around the family story of their bereavement.
- o Increased availability of the bereavement booklet, including an online version.
- o Input to the improving end of life work stream.

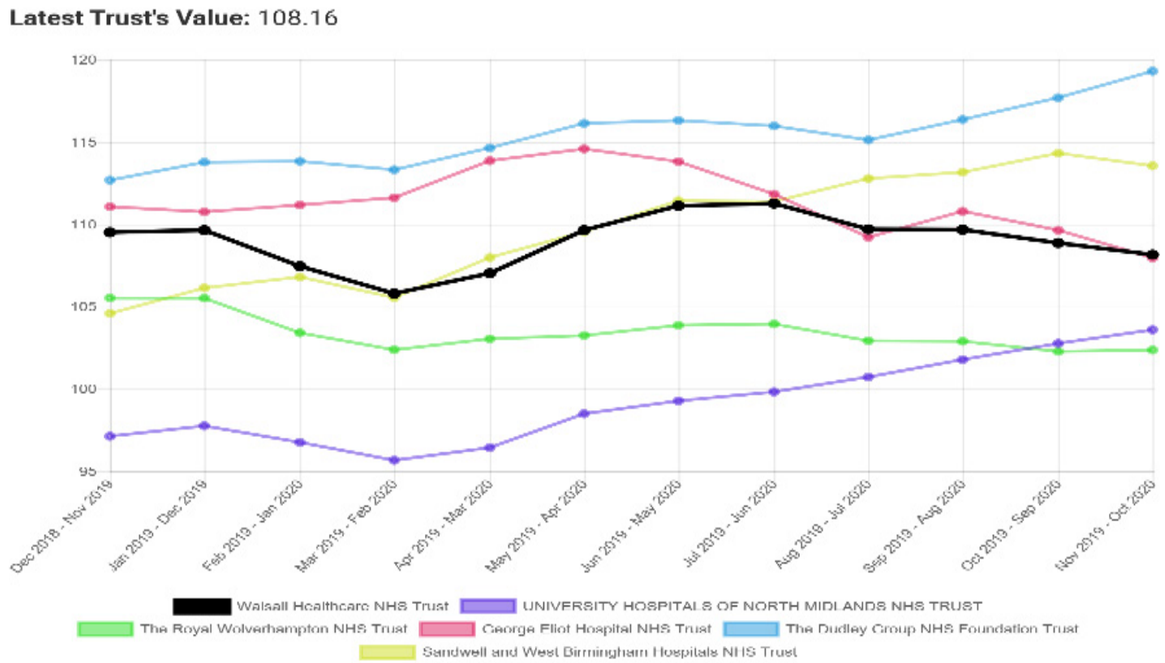
(f) The Trust SHMI for fractured neck of femur deaths has now reduced. The Trust no longer has a risk from the CCG around learning from deaths. Our Quality Improvement project for reducing deaths from fractured neck of femur has seen a reduction in the SHMI despite the impact of COVID-19.



The Trust uses two key national benchmarks as the primary indicator for mortality, for comparison against regional peers: Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index, (SHMI). Data is provided by NHS Digital and hosted by Healthcare Evaluation Data (HED), and shows the trust is in a comparable or improved overall position relative to regional peers.

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-10	Sep-20	Oct-20
HSMR	114.41	103.98	106.15	101.94	96.89	103.33	114.70	107.94	129.47	118.16	110.72	144.51	143.16	128.06	108.49	104.46	105.65	118.77	121.63
SHMI	97.48	99.57	108.71	107.23	109.82	117.41	112.96	103.76	106.84	98.70	95.65	132.23	144.36	120.04	111.45	90.53	112.16	99.71	
Crude Mortality Rate	4.60	4.00	3.50	3.20	3.08	3.23	3.71	3.91	4.89	4.22	3.95	5.80	8.08	5.67	3.90	3.85	3.80	3.61	3.57

Monthly Rolling SHMI local comparators regional



2.3.12 Reporting against Core Indicators

See Annexure 2 for the core indicators.

Part 3: Review Of Other Quality Indicators

This section of the report provides further information on the quality of care we offer, based on our performance against the NHS Improvement Single Oversight Framework indicators, national targets, regulatory requirements, and other metrics we've selected.

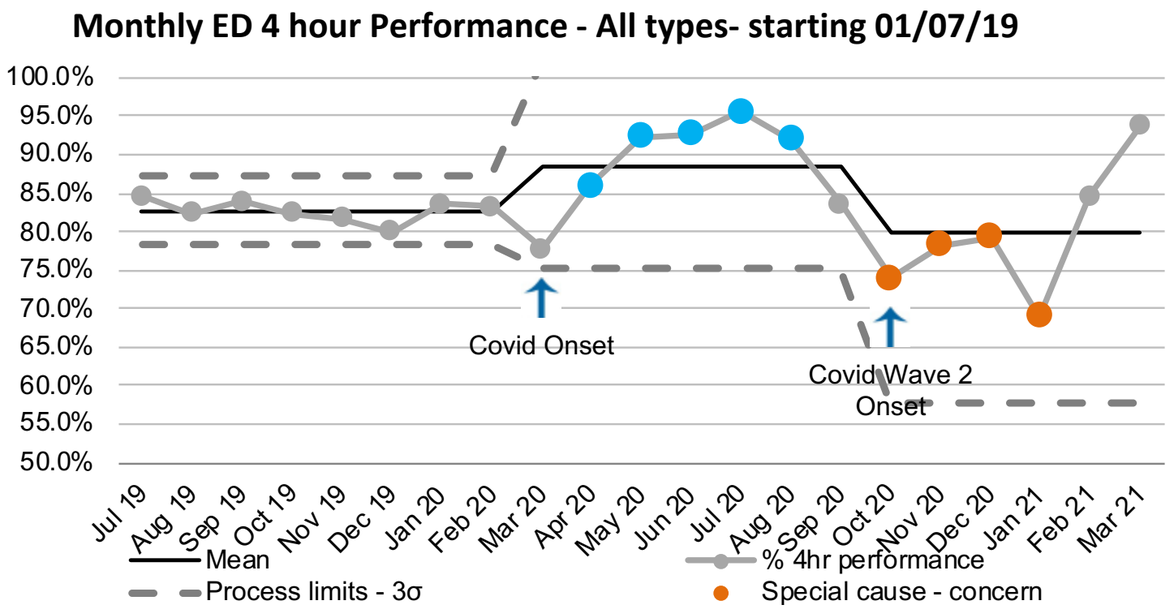
NHS Improvement uses a number of national measures to assess services and outcomes. Performance with these indicators acts as a trigger to detect potential governance issues.

As anticipated, performance against the NHS constitutional standards has been impacted as a result of COVID-19. Despite the impact of COVID-19 however, we end the financial year with the second best Diagnostic waiting times in the country (as measured through the DM01 6 week wait standard) of all 122 reporting general acute Trusts; the 14th best 4-hour Emergency Access Standard performance in the country (out of 113 reporting general acute Trusts); and both 18 week Referral to Treatment and 62-day Cancer GP Referral to Treatment waiting times performance that is better than the national average.

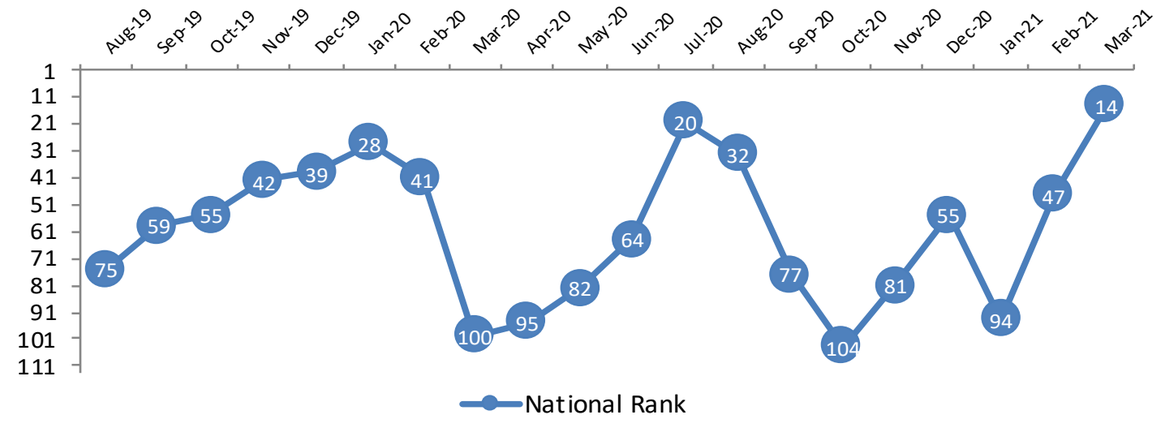
3.1 NHS Oversight Framework Performance

The NHS Oversight Framework outlines the joint approach NHS England and NHS Improvement take to oversee organisational performance and identify where commissioners and providers may need support. The Trust's performance under the quality of care and outcomes section of the framework is set out below for the following metrics:

(a) 4 Hour Emergency Access Standard: This measures compliance against the national standard of: 95% of patients attending the Emergency Department (ED) should leave the department within 4 hours.
The Trust's performance can be seen below from July 2019 to March 2021



National Ranking of 4-hour Emergency Access Standard (Type 1 & 3) performance -National rank out of 113 reporting Acute Trusts



As can be seen on the chart, the COVID-19 pandemic led to significant variations in performance during the 2020/21 financial year, and can be best understood in four distinct periods:

April - August 2020: COVID-19 First Wave and Recovery: The rapid growth of COVID-19 positive inpatients from zero on 12th March 2020 to 188 on 10th April 2020 necessitated a reconfiguration of wards and new streaming processes. This adversely affected performance, however low hospital ED attendances and occupancy following the first national lockdown contributed to four successive months of performance above 91%. Of particular note, July was the first month on record that the Trust met the 95% constitutional standard.

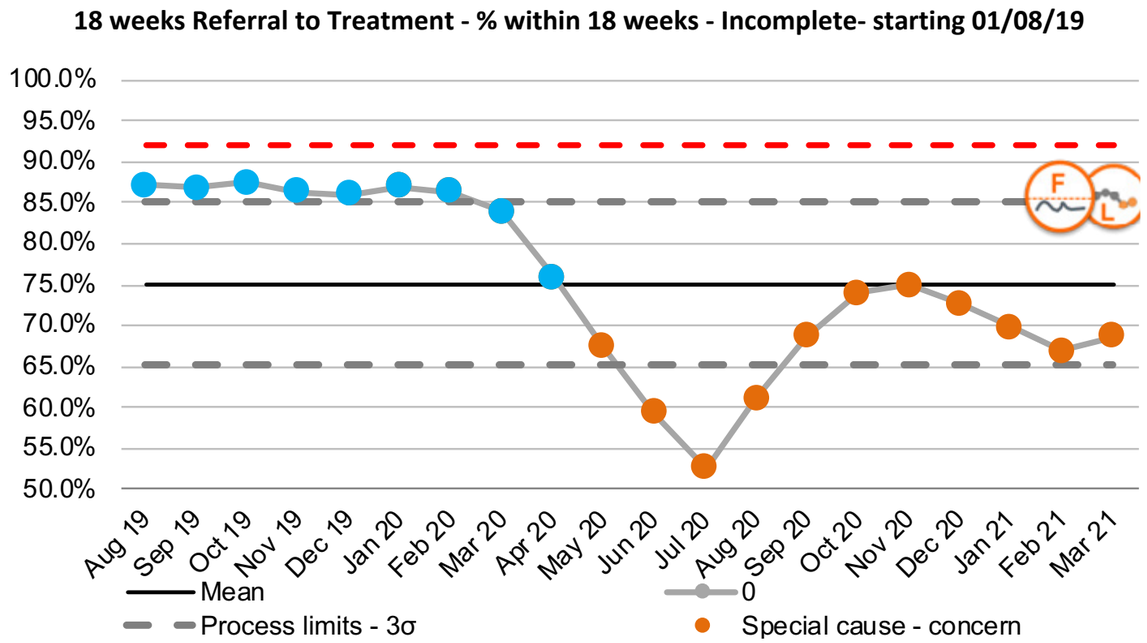
September - October 2020: Medway Implementation: The Trust implemented the first phase of its new Electronic Patient Record (EPR) in September 2020 and ED moved to an electronic clinical record for the first time. This temporarily adversely affected performance whilst the service adjusted to EPR.

November 2020 - January 2021: Recovery, Second Wave and Third Wave: After significant work on internal processes and staffing, performance improved in November and December to 78% and 79% respectively. These improvements were impacted by the COVID-19 second wave which led to COVID-19 positive inpatients increasing throughout autumn to a peak of 157 on 10th November 2020. January 2021 saw the COVID-19 third wave result in COVID-19 positive inpatients rising from 114 on 1st January to 268 on 18th January 2021. This extreme increase saw Walsall become the trust with the highest prevalence of COVID-19 positive inpatients in the Midlands, causing extreme pressure on the emergency care pathway.

February and March 2021 - Recovery: As wave 3 subsided, the ED leadership team has driven improvements to processes, staffing, leadership and morale. This has resulted in the highest proportion of patients being triaged within 15 minutes in the organisation's history; the highest proportion of patients seen by a doctor/practitioner within 60 minutes of arrival and the best ambulance handover (less than 30minutes) in the West Midlands. These improvements have also led to performance in March 2021 achieving 93.72% and the Trust being ranked 14th best in the country – the highest national ranking on record.

As the Trust was one of the most affected trusts in the country by the pandemic, we experienced significant variance in performance and national ranking corresponding with the three waves of the virus.

(b) Referral to Treatment:
This measures compliance against the national standard of: 92% of patients should wait no longer than 18 weeks from GP referral to treatment (reported as a month end snapshot)

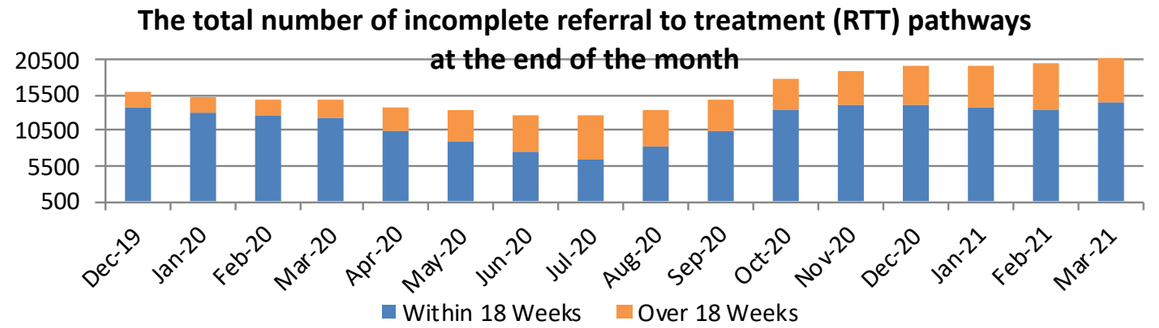


The NHS Chief Executive, issued instructions on 17 March 2020 setting out actions for Trusts in response to the COVID-19 pandemic. Trusts were advised to free up maximum inpatient and critical care capacity, and to assume the postponement of all routine elective activity from 15th April 2020 for a period of at least three months. Waiting lists were reviewed and patients prioritised based on those most urgently requiring surgery. National contracts were quickly mobilised with the independent sector to support elective procedures particularly for cancer and urgent patients. Appointments were converted to video or telephone in place of face to face where possible reducing the numbers of patients attending the hospital.

Clinical staff were redeployed to support COVID-19 Critical Care expansion plans and strengthened emergency care. The reduced level of elective theatre capacity and routine outpatient activity resulted in a decline in 18 weeks referral to treatment performance from February 2020 to August 2020, not only in Walsall but across the country.

Recovery planning started during April 2020 and the Trust established an Executive-led governance structure to safely restore and recover outpatient, diagnostic and elective surgical services. The key tenet of the strategy was the outpatient and daycase centre wing of the hospital segregated as a designated elective care (outpatient, diagnostic and surgery/ procedures) centre, and to maximise the use of virtual or community delivered outpatients wherever possible.

The chart below shows the number of patients waiting at each month end snapshot.



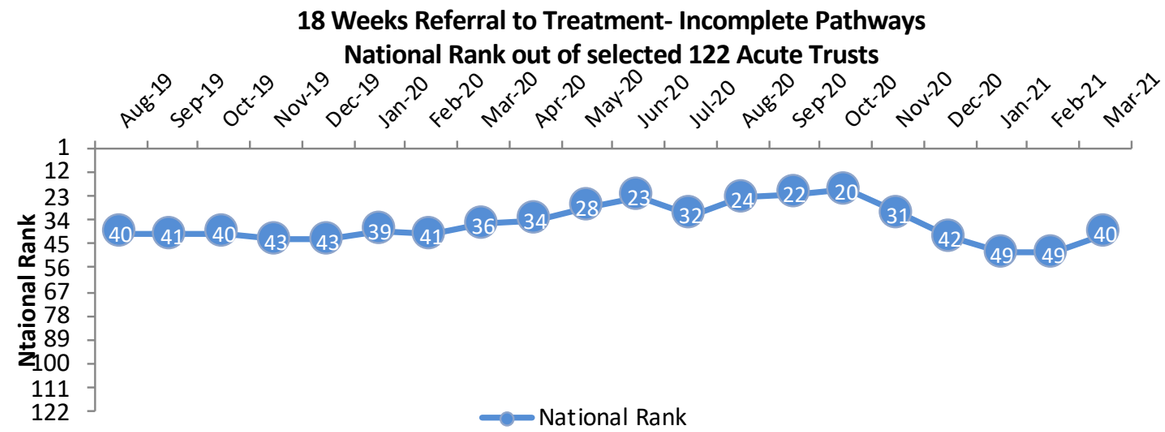
As the first lockdown relaxed, a phased return to elective surgery started. However, the second surge of COVID-19 over autumn 2020 exceeded planning parameters of only being at half the level of April's surge. Consequently, the Trust once again reduced routine elective surgery during November and reduced targeted outpatient clinics as well, to release staff to safely cover non-elective inpatient wards and critical care.

During February 2021 the Division of Surgery developed an elective surgical restoration plan that, over an eight week period, built in recuperation time through annual leave and psychological wellbeing support for staff that had worked on Critical Care during the pandemic, before material increases in routine elective surgical operating begin.

These plans started on 8th March 2021, and resulted in a return to seven elective operating theatres from May 2021. Patients were prioritised using the national clinical validation of surgical waiting lists framework.

Despite cessation of routine elective services during March and April 2020, and reduced elective operating capacity again since November 2020 over the second and third waves, the Trust's 18 week referral to treatment national ranking position remains in the Top 50.

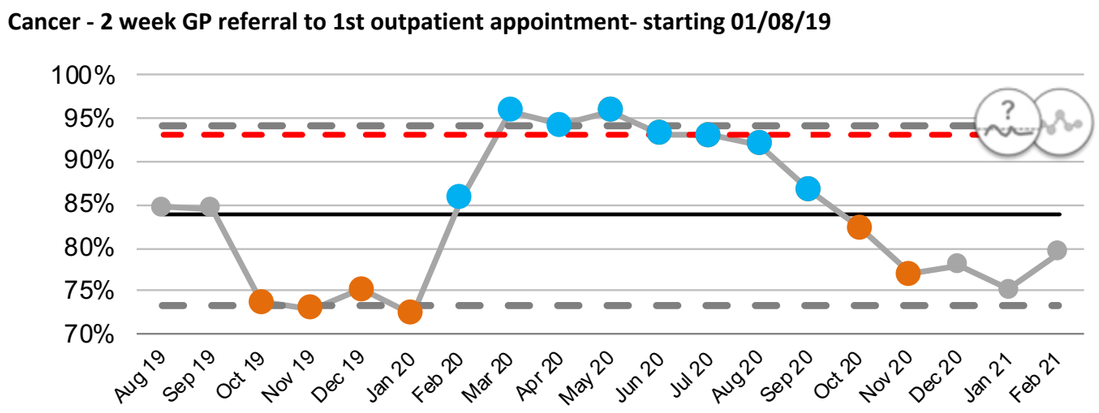
As a result of reduced elective activity, the number of patients waiting 52 weeks or more for treatment has increased. However, when compared to Trusts within the Midlands region, the Trust continues to have the third lowest proportion of its incomplete waitlist over 52 weeks in the Midlands.



(c) Cancer

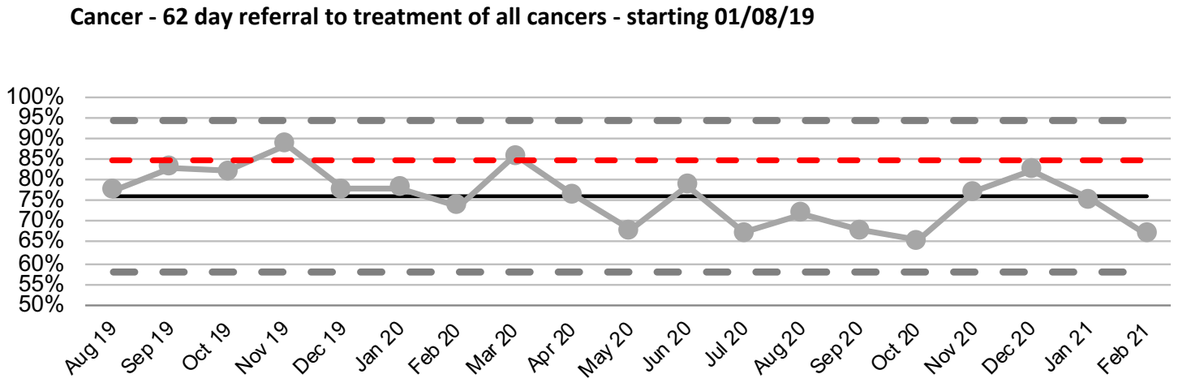
Collaborative working across the region via the West Midlands Cancer Alliance to improve the 2 week wait performance resulted in Walsall receiving increased referrals from out of borough, that have adversely affected 2 week waiting times, particularly for patients with suspected Breast Cancer.

Suspected cancer performance:



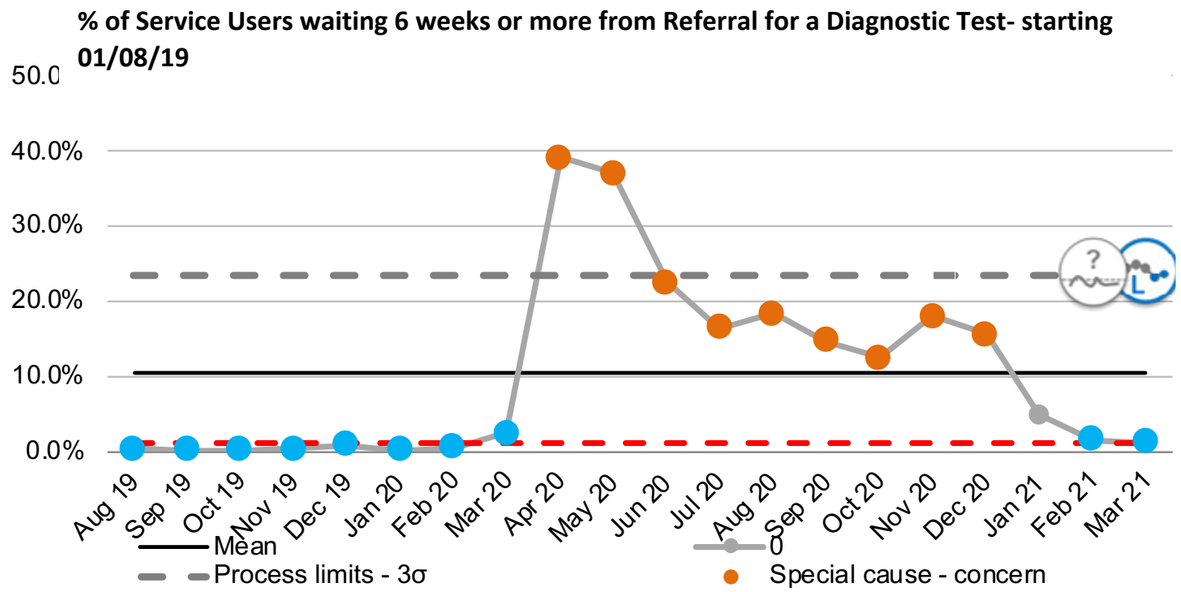
Although the national directive was to postpone all routine elective activity from 15th April 2020 for a period of at least three months, cancer patients were prioritised for surgery. Contracts with the Independent sector mobilised quickly which enabled patients to be treated at Little Aston Hospital. Performance was affected due to insufficient capacity, however, not only within Walsall but across the region. Despite being below the constitutional standard of 85%, 62 day cancer performance is significantly better than the West Midlands Cancer Alliance average performance and is in line with the national average.

The Trust currently forecasts to have recovered to meet Cancer constitutional standards by late Summer 2021.



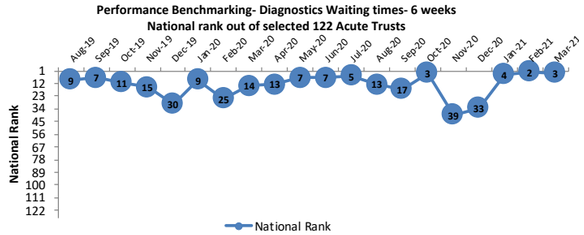
(d) Diagnostic (DM01):

This measures compliance against the national standard of: no more than 1% of patients should be waiting 6 weeks or more at the month end for a diagnostic test.



Pre-April 2020 the Trust was able to consistently meet this constitutional standard. However, the COVID-19 pandemic presented a significant challenge to the delivery of diagnostics and was detrimental to performance, particularly during wave 1. Restoration and recovery work across diagnostics services started following the first wave of disease and has proved very successful driving an improvement in overall Trust DM01 from 67.70% in May 2020 to 1.12% in March 2021.

Despite cessation of most routine 6 week wait diagnostics during March and April 2020 and the reduction in capacity for routine diagnostics resulting from measures implemented to maintain COVID-19 pathway segregation, the Trust's national DM01 ranking position has performed very well improving to second best in England in March 2021 out of 122 reporting general Acute Trusts.



The Trust aims to provide high quality care for patients requiring assessment of mental health disorders, in line with the Core 24 standards, and responds promptly to any concerns that are raised through incidents or complaints. We are continuing to work with commissioners and providers to ensure that these standards are maintained for patients in the Emergency Department or wards. These aspirations will form part of our strategy for mental health services through 2021/22.

3.2 Never Events

A Never Event is defined as a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented.

During 2020/21 there have been no Never Events reported by Walsall Healthcare NHS Trust.

Should a Never Event Occur it would be investigated via the Trust local serious incident investigation process, based upon national best practice, with lessons shared widely with action to prevent recurrence monitored.

3.3 Serious Incidents

In broad terms, Serious Incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

During 2020/21, the Strategic Executive Information System (StEIS) system shows the Trust reported 112 Serious Incidents compared to 94 in 2019/20. The main categories were 46 incidents associated with Healthcare Acquired Infections (HCAI); 14 incidents of Treatment Delays meeting SI criteria; 12 slips trips and falls meeting the serious incidents criteria and 12 Sub-optimal care of the deteriorating patient meeting Serious Incidents criteria. HCAI related serious incidents were the most notable theme and directly attributed to the pandemic, specifically ward closures due to COVID-19 outbreaks and in addition, serious incidents reported as COVID-19 related deaths. These cases were identified following comprehensive individual mortality reviews and then once themed, were subsequently incorporated into serious incident cluster investigations. A full list of Serious Incidents reported during this period, is detailed in the table here:

Incident Type	Total Reported
HCAI/Infection control incident meeting SI criteria	46
Treatment delay meeting SI criteria	14
Slips/trips/falls meeting SI criteria	12
Sub-optimal care of the deteriorating patient meeting SI criteria	12
Maternity/Obstetric incident meeting SI criteria: baby only (this include fetus, neonate and infant)	8
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	6
Surgical/invasive procedure incident meeting SI criteria	4
Pending review (a category must be selected before incident is closed)	3
Medication incident meeting SI criteria	2
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include fetus, neonate and infant)	2
Major incident/ emergency preparedness, resilience and response/ suspension of services	1
Confidential information leak/ information governance breach meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria: mother only	1
Total	**112**

To share learning from incidents, complaints, claims and other sources, the Trust has implemented a new initiative to amalgamate learning from all divisions, through a Lessons Learned magazine coordinated by the Patient Relations Team.

3.4 National Patient Safety Alerts

The Department of Health and Social Care and its agencies have systems in place to receive reports of adverse incidents and to issue Alert Notices and other guidance where appropriate. These alerts provide the opportunity for Trusts to identify deficiencies in their systems and to correct them by learning lessons from identified risks. All NHS bodies have a duty to promptly report adverse incidents and take prompt action on receipt of Alert Notices.

For the period 1st April 2020 to 31st March 2021 the Trust has been issued with a total of seven Patient Safety Alerts from the Central Alerting System. Four of these alerts have been completed in line with the stipulated completion periods. Three remain ongoing with work in progress - no delays are anticipated for completion within the timescales. There are three outstanding alerts that have breached the implementation date and work is progressing to close these in line with the recommendations.

3.5 Duty of Candour

The Trust has a clear policy which sets out how we meet the legal requirements as well as promoting a culture within the organisation that encourages candour, openness and honesty. The process is set out so that staff are supported to inform patients and their families and carers about where we are investigating the care we have provided to identify areas where this could be improved, provide reasonable support to them and to understand the necessity for providing truthful information and above all provide an apology to those affected. Family Liaison Officers assist patients and their families in this process.

There is a Duty of Candour guidance pack which gives staff useful information on all of the above aspects of the process. The governance team also supports staff with the process and continue to provide bespoke individual training to colleagues where any gaps in the undertaking of the duty of candour are identified. The Trust uses a series of information leaflets, targeted towards specific patient groups (adult inpatients, paediatrics, maternity). These are given to patients and families at the time verbal conversations are held to provide useful information about the process which will be followed and key contact details to enable engagement throughout the following weeks. It also provides patients with the opportunity to raise any questions which can be addressed within the investigation and/or supported by the patient relations team. The leaflet also enables the Trust to comply with the regulation to provide in writing a summary of what was verbally discussed. For maternity, the Healthcare Safety Investigation Branch (HSIB), an external organisation, has set criteria for referrals. Patients are provided with a copy of their leaflet with contact information, which also provides consent to the family to allow access to their records for them to continue the investigation.

The Trust monitors the compliance with the application of the statutory duty of candour requirements through the Ulysses Safeguard system, with regular assurance and monitoring of this through divisional quality governance structures and escalation to the Patient Safety Group. This is escalated to the Quality, Patient Experience and Safety Committee, and the Clinical Quality Review meetings conducted with the Clinical Commissioning Group. Duty of Candour compliance is reported quarterly through all divisional quality boards.

3.6 Implementation of priority clinical standards for 7 day services

National reporting on 7 day service has been suspended for 2020/2021 and a decision is pending in relation to reporting in 2021/2022.

The Trust continues to work towards achieving the ten care standards with particular reference to the four core standards identified:

- Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
- Standard 5: the availability of six Consultant-directed diagnostic tests for patients to clinically appropriate timescales: is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.
- Standard 6: timely 24-hour access 7 days a week to nine Consultant-directed interventions.
- Standard 8: All patients with high dependency needs should be seen and reviewed by a Consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a Consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Provision of a 7 day service is a component of the Trust wide Improvement Programme and continues to be a focus for Divisions. Care Groups are identifying areas where action is needed to achieve the provision of a 7 day service. Rotas within Obstetrics and Gynaecology have recently been changed, in light of the Ockenden Report, to improve consultant cover over weekends. A business case has been developed in relation to the provision of a full rehabilitation service across 7 days.

The COVID-19 pandemic has had an impact on how the Trust operates, with many Care Groups moving to a 7 day service with Consultant rounds during the weekend. This has been particularly prevalent in the Medicine and Long Term Conditions Division. The Trust continues to collate evidence around enhanced services in order to identify good practice and how this can be continued post covid.

In addition, medical workforce job planning has been reviewed and changes made to support 7 day service. The implementation of rota management software has supported this work and provides a clearer understanding of workforce requirements for a sustainable service highlighting capacity and demand for future planning.

3.7 Patient Experience and Learning from Complaints

3.7.1 Patient Relations and Experience

The Patient Relations and Experience Team manages complaints, concerns and compliments received on behalf of the Trust and also administers the Friends and Family Test. The team strives to be as responsive and proactive to queries and concerns as possible aiming to provide on-the-spot advice, information and support for patients and relatives if they wish to raise concerns. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services. The Patient Relations Team aims to respond to issues raised in a timely and effective manner, irrespective of whether they have been raised as concern or a formal written complaint. The majority of concerns can usually be resolved swiftly by the staff that are caring for patients. Sometimes, however, patients or a family may want to talk to someone who is not involved in their care and the Patient Relations Team is then able to help.

The COVID-19 pandemic has affected the way in which the team operates in the main for the past year. Following receipt of national guidance there was a pause in the complaints process which was in place from March – June 2020. We did not implement the guidance in full and service provision continued with some operational changes to our usual functions to accommodate family liaison and support for those affected by COVID-19. Given the unprecedented situation relaxation of some of the standards relating to timeframes was expected hence in line with guidance we wrote to all existing complainants advising of likely delays and all new complaintants (post-COVID-19) the same. Despite this we have a recovery plan for delays in place and relaxation of the regulations have been extended to take into account the second and third wave effects of the pandemic.

3.7.2 Complaints and Concerns

A complaint is an expression of dissatisfaction received from a patient, their representative or visitor about any aspect of Walsall Healthcare NHS Trust service. Complaints require a formal response from the Trust. The complainant will be asked their preferred method of feedback; this is often a written response from the Chief Executive or nominated deputy.

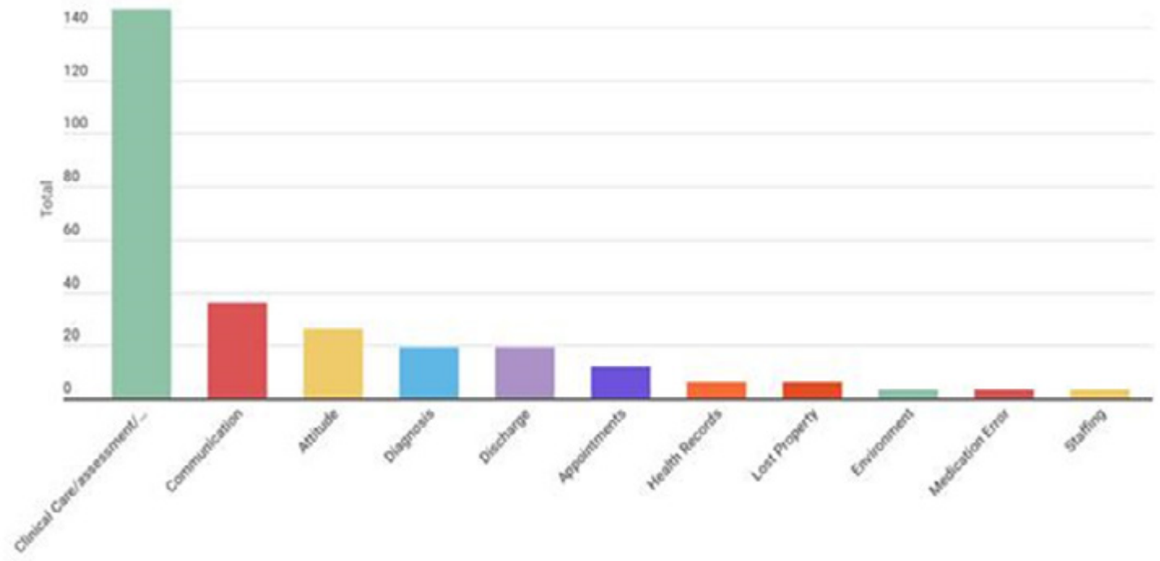
Concerns are defined as issues which may require further enquiry, advice or information in order to resolve them. These are best dealt with by the Patient Advice and Liaison Service (PALS) and/or the service in which the concern originated. When a concern is raised which cannot be satisfactorily resolved without an investigation, then it is to be processed as a complaint.

During 2020/2021 a total of 3719 contacts were received by the Patient Relations Team which included a total of 294 written complaints. These included seven informal to formal complaints and 7 MP letters (a decrease of 31 complaints overall for the year compared to 2019-2020) and an average of 14 contacts per working day.

Incident Type	2018-2019	2019-2020	2020-2021
Complaint requiring a written response	318	309	280
Concern converted to a complaint	22	10	7
Concern	2402	2306	2026
Complaint converted to a concern	13	23	16
Compliment	527	536	416
Comments/suggestion/ referred on/NHS choices/ family liaison	486	479	967
MP letter	9	6	7
Total	**3777**	**3660**	**3719**

(a) Complaints by theme

During 2020/2021, there were 409 complaint types by category with the main theme emerging from formal complaints being treatment care and supervision. This accounted for 50% of all complaint categories, 147 complaints fell within this domain.



(b) Responding to complaints

We recognise that responding to patient complaints in a timely way is important, however we are also keen not to compromise the quality of our investigation or the completeness of our response.

Due to the ongoing COVID-19 pandemic NHS England and NHS Improvement supported a system wide "pause" of the NHS complaints process which allowed all health care providers in all sectors to concentrate their efforts on the front-line duties and responsiveness to COVID-19. The initial "pause" period was recommended for three months from March – June 2020. All health care providers could opt to operate as usual regarding the management of complaints if they wished to do so and this "pause" was not being enforced. We opted to continue management of complaints albeit the reduced level of clinical staff available did have some impact on our timeframes. Due to subsequent second and third wave rise in infections further guidance was issued in relation to complaint timeframes and non-enforcement of delays providing complainants were made aware.

Based on the table below – the overall average score (number of days to complete) is 42.5% which given the current pressures this last year is not overly excessive. The overall longest wait for a response is 62.5 days which again has reduced considerably from 259.7 days in April 2020.

Division	Average Days to respond 1 April 2020 to 31 March 2021
Adult Community	29.6
Corporate Function	22
Estates And Facilities	43.2
Medicine And Long Term Conditions	52.6
Surgery	58.7
Women's Children's and Clinical Support	38.6

(c) Parliamentary Health Service Ombudsman (PHSO)

The PHSO paused existing health casework and stopped accepting new health complaints on 26 March 2020 to help the NHS focus resource on tackling the COVID-19 pandemic. Reviews of new caseload and ongoing investigations re-commenced on the 1st July 2020.

In 2020/21 a total of three cases were accepted via the PHSO for investigation. This equates to 1% of all complaints received. There are two cases open from the previous year 2019/20. Themes emerging include: Concerns highlighted with regard to clinical care assessment and treatment, poor communication, inadequate pain management and poor nursing care. Of those closed in the previous year one complex and historic case was upheld. One case was partially upheld and one was not upheld.

(d) Concerns

There were a total of 3009 concerns received during 2020/2021, a decrease of 386 concerns from the previous year (3395). This figure includes concerns (2042), comments, suggestions and queries and referred on (894), Family Liaison 58, Losses and Compensation two, Healthwatch referrals nine, other PALS nine. MLTC equated to 38% (1147) of the total activity, with Surgery 33% (997) and WCCSS 13% (403).

(e) Friends and Family Test

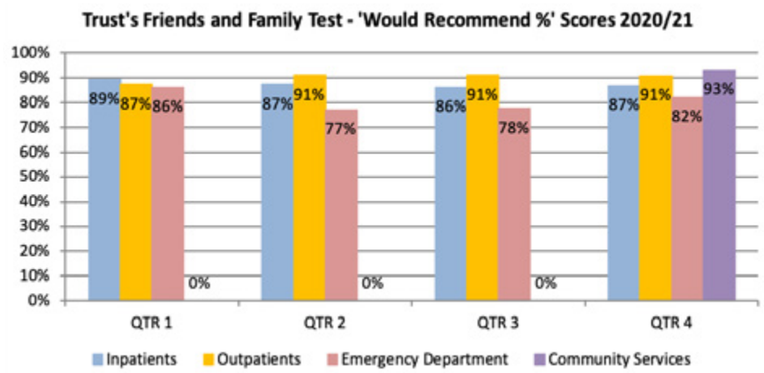
Over the last year, we have progressed further with our work for putting patients and carers' voices at the heart of our services to ensure that the trust has a co-ordinated approach of 'listening to' and 'learning from' feedback. We have particularly increased patient involvement in production and design of services and clinical units.

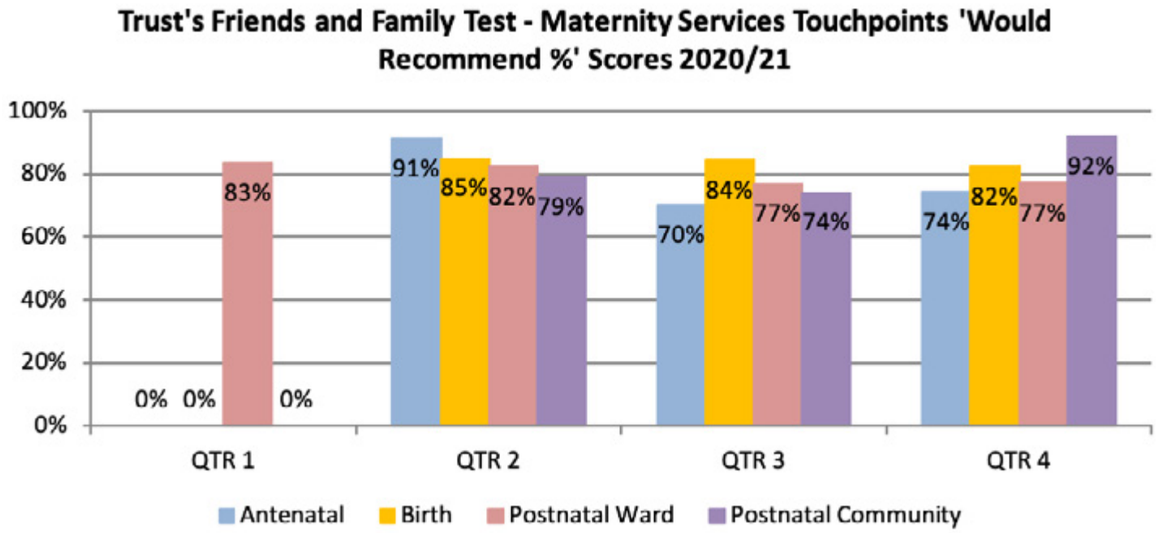
Around 88% of patients who used our hospital and community services said they would recommend us to their friends and family if they needed similar care or treatment. This recommendation score is based on over 29,000 Friends and Family Test (FFT) surveys completed by our patients and service users. Our national survey results continued to show improvements and also highlight areas where more work is needed such as communication, patient involvement in decisions about care and treatment, arrangements around discharge and waiting times.

Due to the COVID-19 pandemic the submission of FFT data to NHS England and Improvement from all settings was also been temporarily suspended. With this in mind we decided to stop all collection methods and date submission with immediate effect for all services. We took a brief pause while we worked with Healthcare Communications to move away from using iPads and paper to collect the FFT data in inpatient areas and move towards SMS texting and Interactive Voice Messages.

The Trust's overall recommendation figure has seen a slight decrease when compared to the previous year and the number of people who have responded to the Friends and Family Test is also lower than the previous year. The change in methodology, the lower response rate and the temporary suspension in the Friends and Family Test would explain why our overall recommendation rate is lower.

The chart below shows average FFT results for positive recommendation scores (%) for Inpatients, Emergency Department, Maternity Services, Outpatients and Community Services during 2020/21

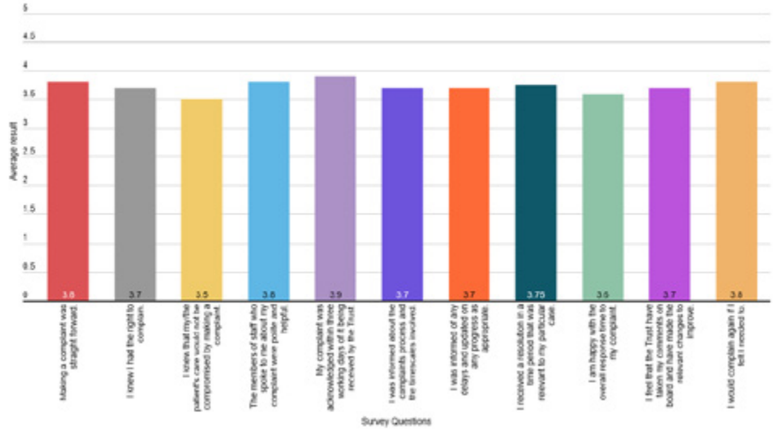




Feedback comments and themes
Patients positively commented the most about staff attitude, implementation of care, the environment and the clinical treatment. The themes below have been generated from over 20,000 FFT comments given by patients.

(f) Complaint Satisfaction Questionnaire

The Parliamentary Health Service Ombudsman (PHSO) user-led vision for raising concerns and complaints in health and social care forms part of our Complaints Policy. The vision was developed by the PHSO working inclusively with patients and service users. It starts with the complaint journey: a map of the route a patient or service user will go through when they make a complaint about a service they have received, and a series of simple statements that reflect what a good outcome would look like for the patient and service user at each stage of that journey. Beneath these overarching statements there are further statements that illustrate the expectations that patients and service users expressed when asked about what a good complaint journey would look like to them.



Our Trust feedback survey is based on the 'I' statements outlined in the user-led vision. Answers are requested using a scale of 0-5 with 0 as completely disagree and 5 completely agree. Feedback received is outlined as follows based on a 12% return rate (32 responses): Average score is 3.7 out of 5.

(g) Equality Monitoring Survey

An equality monitoring form is in place and is issued at the point of acknowledgement of a written complaint with 14% (40) returned in 2020/2021.

- Ethnicity: 39% of respondents identified themselves as White British, 13% Polish, 10% Black British, 3% Pakistani, 3% Bangladeshi and 7 British Asian.
- Age: 23% were aged 31-40, 23% 51-60, 22% 21-30, 10% 41-50, 10% 61-70, 6% 51-60 3% 81plus.
- Religion or belief: 42% Christianity, 29% no-religion, 10% Islam, 7% Buddhism, 6% did not specify
- Sexual Orientation: 90% Heterosexual, 7% Bi-sexual, 3% preferred not to say
- Gender: 52% Female, Male 42%, 6% did not answer
- Gender re-assignment: 58% No, 42% did not say
- Relationship status: 3% Married, 15% living with partner, 11% single, 2% did not respond
- Pregnancy: 93% were not pregnant at time of making a complaint, 4% were. 3% preferred not to say
- Disability: 74% stated no, 26% yes.

Inclusive learning from feedback

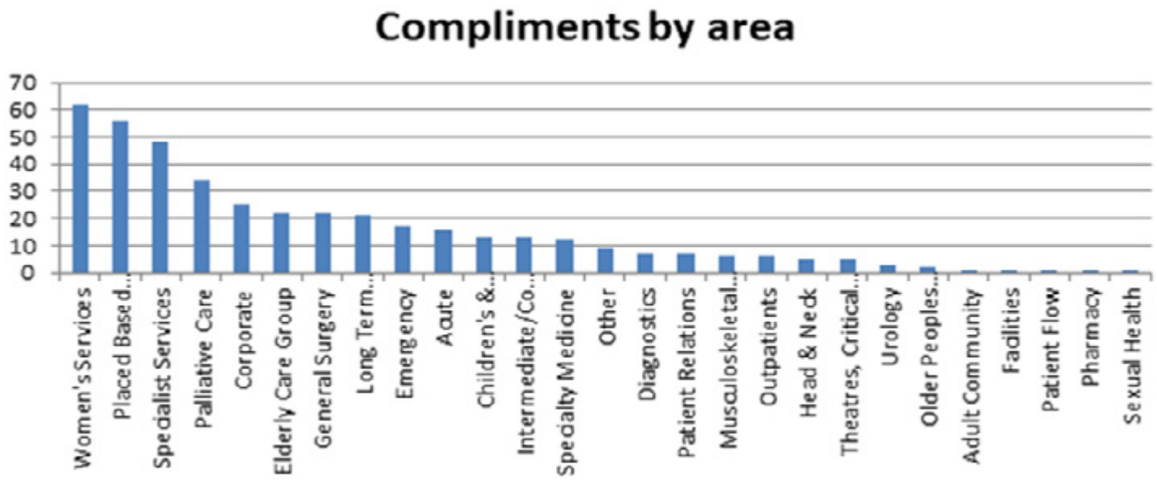
Following a complaint about lack of support for an inpatient with hearing loss, the trust has purchased six mobile digital interpreting units, called Wordskii on Wheels, or WOW. These units will enable bedside access to a British Sign Language (BSL) interpreter via video conferencing where quick access to an interpreter is needed. We have also incorporated learnings around this area into our Equality, Diversity and Inclusion e-learning package, so that staff across the trust have up-to-date guidance.

We are also developing a communications toolkit and we will make this available digitally in an accessible format to all trust staff. The toolkit will provide details on how to book and provide an interpreter, in addition to providing staff with some basic information about the communication needs people may have, including a picture, symbol and photo resource which can be used to help staff and patients communicate together.

The emergency department (ED) has now allocated two learning disability champions. These champions have met with the trust's learning disability nurses and discussed how care can be improved when patients with learning disabilities attend ED and what reasonable adjustments can be implemented. The learning disability nurses are developing a resource package which will be given to the champions and reviewed monthly. The champions will be able to contact the nurses at any time for advice and support. They will also explore areas and pathways within accident and emergency which can be improved and how, with the learning disability nurses giving their continual support

3.7.3 Compliments

Compliments account for 10% of all contacts received. A total of 416 Compliments were received by the Trust. Women's Services (62), Placed Based Teams (56), Palliative Care (34) and Corporate (25) accounted for the majority of compliments recorded 54%.



"She was very professional and understood how my issue was affecting me. She went above and beyond to help me with my issues which have been outstanding since last year if not before."

"I have worked as a GP partner at St Peter's Surgery for 13 years Sister H is most certainly the best nursing professional that has ever worked with my patients in the 13 years I have worked here (including all the community matrons/district nurse/COPD nurses that I have interacted with)."

"To whom it may concern, I just wanted to email you to let you know what an amazing job the antenatal team have been doing. I've had 5 pregnancies in total and I can honestly say this has been my best experience so far. Considering the current situation the staff in the antenatal unit have been so efficient and thorough with me, nothing has been too much trouble, everything is double checked, and I have felt safe and at ease every visit."

"I attended the orthopaedic clinic today to receive results from X-Ray's on my knee and shoulder the doctor and nurse gave me outstanding care and attention. I must admit I cried, knowing that something could at last be done. A big thank you. Also I have a big fear of lifts and the staff that also went in the lift with me."

"I would like to thank you for the excellent service we have received from you. Within days of our referral we were visited and several aids were fitted to our home which has made our lives so much easier. The gentleman who fitted them was quick, clean and efficient please pass on our thanks to all concerned."

3.8 NHS Staff Survey

Our 2020 NHS Staff Survey results showed an overall improvement across six of the ten themes compared to the results of the 2019 survey. In response to the outcomes of the 2019 survey and to support staff responding to the COVID-19 pandemic, throughout 2020 the trust applied a particular focus to the health and wellbeing of colleagues and made a strategic commitment to addressing workforce inequality by ensuring inclusion and our colleagues were consulted and involved in critical decision making.

This year's survey provided encouragement that colleagues had recognised the improvement in health and wellbeing support available to them in that:

- Our health and wellbeing index score increased from 5.5 in 2019 to 5.7 in 2020.
- More staff told us that their line manager took a positive interest in their health and wellbeing. An increase from 68.2% in 2019 to 69.2% in 2020.

From an equality, diversity and inclusion perspective, the survey results clarified that there is still much work to do as the index outcome fell from 8.8 in 2019 to 8.7 in 2020. Throughout 2020 the trust undertook a comprehensive consultation and engagement exercise with colleagues and service users to understand what was most important to them in terms of equality, diversity and inclusion. This feedback was core to the development of the Equality, Diversity and Inclusion Strategy which is underpinned by a detailed delivery plan which will be overseen by the People and Organisational Development Committee in 2021-2022. The committee will also focus on the Trust's operational and strategic interventions which aim to improve staff experience and eliminate differential colleague experience based on ethnicity, age, disability, sexuality, gender, religion and other protected characteristics which are highlighted as areas requiring improvement from the 2020 National Staff Survey.

Our Employee Engagement Index score increased from 6.6 in 2019 to 6.7 in 2020, with staff telling us this year that they felt more able to make suggestions and improvements in the work of their team/department compared to previous years. The number of colleagues advocating for the trust as a place to work and a place to be treated increased to the highest rate in five years. This complements an increased index score of 7.3 for quality of care compared to 7.2 in 2019 and is encouraging considering a significant proportion of our workforce live within the community that the trust serves. There remains significant improvement required to bring staff experience metrics in line with the national average benchmark scores across the trust. The chart below shows how the trust compares with the ten overall theme scores within the National Staff Survey 2020 and illustrates the level of improvement required. The Improvement Programme work-stream Value our Colleagues provides the detailed plan for improving staff experience metrics and outcomes.

Our 2020 NHS Staff Survey results showed an overall improvement across six of the ten themes compared to the results of the 2019 survey.

3.9 Freedom to Speak Up

Our Freedom To Speak Up (FTSU) Objectives 2020/21 are set out in the FTSU Strategy 2020/21 and are as follows:

- The Executive Team and all managers model the behaviours required to promote an open and positive organisational culture.
- The Executive Team will remove barriers to facilitate a diverse and inclusive approach to speaking up, particularly amongst BAME and LGBTQ+ staff members who can sometimes feel more vulnerable.
- The creation of the means to provide advice and listen to staff in relation to concerns they have raised.
- Managers and FTSU Guardians create and implement process to ensure staff receive timely feedback and details of what action has been taken when concerns have been raised.
- Staff know how to access the Trust's speaking up channels and where to go for support and advice on how to raise concerns through them.

Goals of the Trust's FTSU Improvement Plan are:

- Staff feel confident and safe to speak up
- We have a speaking up culture that is responsive to workers who raise concerns.
- We have an effective process to share information from across the organisation to identify emerging patient safety issues and cultural hotspots.
- We share good practice and learning from concerns raised with the Trust Management Board
- We understand workers' anxieties around speaking up and have support processes in place to address any victimisation of workers that speak up.

The FTSU Guardians will:

- Support staff to raise concerns, through giving advice, escalating concerns, and signposting employees, whilst maintaining confidentiality
- Develop and deliver communication and engagement programmes to increase visibility and awareness of the FTSU service
- Promote local speaking up processes and sources of support and guidance, demonstrating the impact of FTSU in the organisation and celebrating speaking up.
- Work with HR and staff side to ensure that speaking up guidance and processes are clear and accessible, reflect best practice, and address and any local issues that may hinder the speaking up process.
- Develop and ensure staff are issued with a written guide on speaking up as part of the recruitment process
- Ensure that information and guidance on speaking up is incorporated into the induction programs for all staff.
- Ensure groups of staff and individuals who may find it difficult to speak up are given additional support.
- Taking part in National Guardian Office training which may include supporting fellow FTSU Guardians, developing personal networks, peer-to-peer relationships, contributing to wider networking events, and sharing and learning from best practice.

The Trust has set up an initiative to allow colleagues' access to Trust Board members to have confidential one to one meetings. This was initially with the Chair of the Trust Board and more recently by the Non-Executive Director for Speaking Up.

Staff are able to contact one of the trust's FTSU confidential contact links to raise a concern. It is part of this years' action plan to align a confidential contact list with each Directorate and act as ongoing support to those who raise a concern. Their role is to assist and support any colleagues should they be subject to adverse behaviours as a result of speaking up.

There is a network of equality, diversity and inclusion cultural ambassadors and colleagues may choose to use these staff advocates to highlight difficulties they are experiencing and referral made to FTSU Guardians if appropriate. Staff are able to raise concerns anonymously though the incident reporting system. Initial contact with FTSU Guardian can be made via a submission form on the trust's intranet site.

Themes	% for Trust
Attitudes and behaviours	36%
Equipment and maintenance	5%
Staffing levels	11%
Policies, procedures	27%
Quality and Safety	13%
Performance capability	2%
Service Changes	2%
Other	4%
Total	**100%**

We are in the process of formulating a process that will capture the experience of the person who discloses a concern. Gathering information at three and six months after the individual has raised a concern. Individuals who disclose that they are experiencing any negativity as a result of raising concerns can be identified and supported.
These are the themes from FTSU cases with percentages for the period 1st April 2020 to 31st March 2021.

The FTSU Guardians will support staff to raise concerns, through giving advice, escalating concerns, and signposting employees, whilst maintaining confidentiality

3.10 Mental Health Service

Currently the Trust provides an enhanced Older People Mental Health Liaison Service, which is now fully established with five Band 7 Clinical Nurse Specialists. We work with our partners within Black Country Partnership NHS Foundation Trust who provide services for:- crisis, Home Treatment Team, eating disorders, Child and Adolescent Mental Health Service, Mental Health Liaison Service and any other mental health service stated within the improvement plan. It is those partners who provide the necessary mental health metrics for the NHS single oversight framework rather than the Trust.

We are proactively working with our partner organisations to improve overall mental health services and come in line with the NHS Mental Health Long Term plan. We are in the process of mapping out our services and pathways for mental health patients in our care; this is inclusive of secondary services and the voluntary sector.

Our aim is to improve mental health awareness for all of our staff to enable us to identify mental health needs and support patients in accessing the appropriate pathways. As an organisation the NHS Mental Health implementation plan supports us in aiming for excellence and having clear aspirations of service improvements for all our patients.
By July 2021 we hope to have developed a clear Mental Health dtrategy that will evidence our key aims for improving patient care. This will focus on working in partnership, training, education, pathways and an understanding of excellence in care for mental health patients. We equally have an aspiration for the Older People's Mental Health Liaison Team to have achieved accreditation by 2023. The strategy will support us with maintaining focus on the NHS Mental Health Long Term plan with a timely proactive approach.

3.11 Quality Improvement Academy and Quality Service Improvement and Redesign Programmes

At the start of February 2020, the Quality Improvement (QI) Academy was looking forward to a year where five cohorts of the Quality Service Improvement and Redesign (QSIR) Practitioner programme would run, with six additional trainers bringing the total to 12 accredited trainers. It was anticipating being able to provide QI coaching support to front line staff as they undertook their QI improvements through 2020/21. We started the first days training for two cohorts of staff in late February 2020 who would have completed the majority of their training during 2020/21.

With effect from 17th March 2020 in response to the COVID-19 pandemic, all non-essential training ceased, 101 delegates paused their training and the six colleagues about to complete their accreditation as trainers had their assessments postponed.

There was uncertainty at the beginning of the financial year 2020/21 regarding what support the QI Academy and the QI team would be able to deliver. The QSIR Fundamentals and Practitioner programmes were only accredited to be delivered face-to-face and could not be transferred to virtual programmes. The roll out of the QI Huddle Boards was suspended because it required a component of face-to-face training to be undertaken. The Trust induction session became virtual and no longer included a QI component.

By April 2020 half of the QI team had been redeployed into patient facing roles and half were focusing on helping staff to get their concerns heard. The team introduced a manual collection of staff concerns from clinical areas which were the COVID19 receiving areas. The opportunity to use a mobile app to collect those concerns to instantly inform the command teams was introduced and the QI team undertook the monitoring, progressing and feedback to staff. The rapidly increasing library of COVID-19 clinical resources was curated by the QI Team and at that point the majority of activity through the QI Academy ceased.

Plans for regional training for anaesthetic trainees, the QI Awards, QSIR Fundamentals and Practitioner training all stopped as other things which needed a more urgent response were prioritised. The QI Academy meetings moved to virtual and continued throughout the year. This was in part to offer support to colleagues and as a forum for any improvement ideas.

QI changes are tenacious and across the organisation pockets of improvement, using QI tools and techniques, were being seen - even through the peak of the pandemic. This provides evidence that the training completed within 2019/20 had been adopted by colleagues and was making a difference. Through the first peak of COVID-19, over 42 days, there were 294 app submissions which were collated, prioritised escalated and a response provided, and over 100 clinical guidelines for care of patients through COVID-19 were curated. Improvements were made in the 'little things making a big difference' in the Critical Care Unit and the COVID-19 receiving wards.

The introduction of the QI Huddle boards was trialled in the Catheterisation Laboratory by a redeployed member of the QI Team and also in the Critical Care Unit and Palliative Care Team helping to identify the additional training needed. Boards were placed in the Neonatal Unit and Paediatric Assessment Unit to meet staff requests. Quality improvement, by association, could be seen and other departments also sought boards. These new areas did not have staff who had undertaken QI training available to support them however, so their request is on hold until training needs can be fulfilled.

Requests to the National QSIR Team from across the country brought the QSIR Virtual programme, which members of our QI Team were heavily involved in developing, supporting the beta testing and piloting a cohort in August 2020. During August the QI Team also delivered socially distanced QSIR Fundamentals to a local Trust, starting the development of its QSIR journey, and supported the Electronic Staff Records team in mapping their processes to improve the on-boarding of all the volunteers new to the organisation.

In September 2020 QSIR Practitioner Restart groups were identified from areas where their projects would have the most contribution to improving services and supporting staff. To comply with social distancing the numbers were significantly reduced, but three small cohorts recommenced their training only for it to be stopped by the second pandemic wave in December – one day from completing the course.

By November 2020 cohorts of the QSIR Virtual programme had been established and by the end of March 2021 six cohorts of the Virtual Programme had been completed with a total of 78 Walsall staff having completed the training, along with 35 delegates from other local NHS organisations who joined our programme. Virtual training elements had also been undertaken by a further 47 Walsall colleagues and 44 colleagues from other areas, including colleagues from as far away as Bristol, Lewisham and Barnsley.

The QSIR accredited trainers within the organisation reduced to cour following two colleagues moving to other organisations in February and March 2020, and the national team had not confirmed the process for restarting the accreditation by the end of March 2021. There are a further five colleagues who have expressed interest in becoming trainers who will be supported when the accreditation process starts up again.

An assessment of colleagues who had undertaken QI training was undertaken in February 2020 and identified that 51% of colleagues who had undertaken the QSIR Practitioner, 40% of those who had completed the QSIR Fundamentals and 75% of those who have recently completed the QSIR Virtual programmes were actively involved in improvement work across the organisation.

Looking forward to 2021/22 Plans are in place to continue with QSIR Virtual delivery with three cohorts already planned for April – June. The QSIR Restart groups priority is to complete the QSIR Practitioner programme and training dates for new cohorts are identified to take colleagues from September 2021, subject to face-to-face training restarting. Delegates on the QSIR Practitioner are likely to be prioritised if they are working on elements of the Trust's Improvement Programme or key areas where improvements are required.

The QISR Fundamentals training for Regional Anaesthetic Trainees and an additional session for Consultants have been rescheduled and a QSIR Fundamentals session each month is proposed. Closer working with local organisations to support them in increasing their ability to deliver QSIR training going forward is also planned through 2021/22.

The QI Huddle boards will start to be rolled out with Day Case Surgery and Pharmacy, as well as medical wards requesting this tool.

It may take a while to build up the accredited trainers within the organisation once the national accreditation restarts, but on the whole the desire for applying QI methodology and undertaking training to support colleagues is even stronger than ever.

Part 4: Statements From Our Stakeholders

The Trust distributed the Quality Account to stakeholders, however did not receive any statements for inclusion.

Appendices

Appendix 1: Summary of findings - CQC report

Between 8 and 9 September 2020, the CQC inspected the core services of Urgent and Emergency Care and Maternity Services. The report was published on 18 November 2020.

On 9 March 2021, the CQC inspected the core services of Medicine. The Trust was issued a Section 29a warning notice on 31st March 2021 and the final CQC report was published on 19th May 2021.

During both inspections the CQC noted areas of good practice across the services inspected, however inspectors also highlighted areas for improvement:

2020 inspection - Areas of improvement that the Trust must improve:

- The provider must ensure they support staff to participate in mandatory training (regulation 18(2)(a))
- The provider must ensure that staff are continued to be supported to complete their safeguarding training (regulation 18(2)(a))
- The provider must ensure that risk assessments are completed for patients within the department, particularly in relation to sepsis management (regulation 12(2)(b))
- The provider must ensure they have processes in place to enable staff to safely care for patients detained under the mental health act (regulation 17(2)(b))
- The provider must ensure they deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs (regulation 18(1))
- The provider must ensure they maintain accurate, complete and contemporaneous records in respect of each service user (17(2)(c))
- The provider must ensure they evaluate and improve their practice in respect of processing information required by external bodies (regulation 17(2)(a))

2020 inspection - Areas of improvement that the Trust should improve:

- The provider should ensure there are procedures and processes around restraint and rapid tranquilisation to make sure people are protected (regulation 17(2)(b))

2021 inspection – Section 29a issued due to the following concerns:

- The medical division did not always provide safe care and treatment. There was insufficient or suitably qualified staff to provide patients with the timely or appropriate care they required to meet their needs
- There was not an effective risk and governance system that supported safe and quality care. Governance processes did not continually improve the quality of the service, identify and mitigate risks and safeguard the standards of care for patients. There was an inability to recognise and address areas of concern and missed opportunities for making improvements. This meant required improvements may not be identified or implemented within staff teams to ensure patients receive appropriate care
- Robust arrangements were not in place to provide assurance of safe and effective patient discharges. This meant patients were put at risk of significant harm as they were not always discharged safely with appropriate care and treatment

2021 inspection - Areas of improvement that the Trust must improve

- The Trust must ensure that all staff are competent in the use of the recommended summary plan for emergency care and treatment (ReSpect) forms (Regulation 12 Safe care and treatment)
- The trust must ensure staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted on the ReSpect forms (Regulation 9 Person centred care)
- The Trusts must ensure systems are put into place to ensure staffing is actively assessed, reviewed and escalated appropriately to prevent exposing patients to the risk of harm (Regulation 18 Staffing)
- The Trust must ensure systems are put in place to ensure that staff are suitably qualified, skilled and competent to care for and meet the needs of patients within all areas of the medical services (Regulation 18 Staffing)
- The Trust must ensure effective risk and governance systems are embedded that supports safe, quality care (Regulation 17 Good Governance)
- The Trust must ensure systems and processes are established and operated to effectively investigate, immediately upon becoming aware of, any allegation or evidence of such abuse (Regulation 13 Safeguarding service users from abuse and improper treatment)
- The Trust must ensure all staff adhere to policies and procedures to ensure patients are kept safe from avoidable harm of infection (Regulation 12 Safe care and treatment)
- The Trust must ensure staff are documenting that discharge planning is taking place and discharge checklists are used to ensure a safe discharge (Regulation 12 Safe care and treatment)

2021 inspection - Areas of improvement that the Trust should improve:

- The Trust should consider adapting the international rounding timings so that they are individualised to the patient and meet the needs of the patient
- The Trust should consider how they assure themselves patients observations are completed within the specified timeframe
- The Trust should consider improving awareness and knowledge amongst all staff in the use of alternative communication aides when meeting the individual needs of patients

Appendix 2: Mandatory indicators

NHS Outcomes Framework Domain 1

Title	Indicator	2019/20		2020/21		National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI)	a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period;	Apr-19	97.48	Apr-20	143.86	1.00 (100)	Latest Position (October 2019 to November 2020) Highest Performing Trust – University College London Hospitals NHS Foundation Trust (0.70) Lowest Performing Trust – The Dudley Group NHS Foundation Trust (1.19)
		May-19	99.57	May-20	119.39		
		Jun-19	108.71	Jun-20	111.31		
		Jul-19	107.23	Jul-20	90.46		
		Aug-19	109.82	Aug-20	112.20		
		Sep-19	117.41	Sep-20	106.92		
		Oct-19	112.96	Oct-20	104.23		
		Nov-19	103.40	Nov-20	120.28		
		Dec-19	106.40	Dec-20	96.34		
		Jan-20	98.29	Jan-21	117.32		
		Feb-20	94.45	Feb-21	N/A		
		Mar-20	130.51	Mar-21	N/A		
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	April 2019 to March 2020 = 28%		Latest Position (November 2019 to October 2020) = 27%		Latest Position (November 2019 to October 2020) = 36%	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	The data reported represents the trusts performance against the national benchmarks. The data represents deaths occurring across primary and secondary care. Variances in performance represent the health demographics of the population, seasonal trends in keeping with the national picture and the effects of COVID 19. The Trust recognises areas where there is learning and has instated improvement programmes to reduce avoidable deaths in line with the National Learning From Deaths Process.					
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	See sections 2.1.3, 2.1.4 and 2.3.11					

NHS Outcomes Framework Domain 1

Title	Indicator PROMs case mix-adjusted scores	TRUST 2019/20 Adjusted average health gain		TRUST 2020/21 Adjusted average health gain		National Average 2019/20 Adjusted average health gain		Upper and Lower 95% control limit for the Trust Health Gain
Patient Recorded Outcome Measures (PROMS)	(i) groin hernia surgery	No longer measured		No longer measured		N/A		N/A
	(ii) varicose vein surgery	No longer measured		No longer measured		N/A		N/A
	(iii) hip replacement surgery	EQ5D	0.45	EQ5D	0.47	EQ5D	0.46	N/A
		EQVAS	16.57	EQVAS	7.54	EQVAS	14.23	
		OHS	21.83	OHS	18.53	OHS	22.69	
	(iv) knee replacement surgery	EQ5D	0.35	EQ5D	0.23	EQ5D	0.34	N/A
		EQVAS	7.46	EQVAS	4.33	EQVAS	7.89	
		OKS	17.96	OKS	12.89	OKS	17.49	
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	The health gains associated with hip and knee replacement surgery have reduced in 2020/21. We know that patients waiting for hip and knee replacement surgery have been waiting longer as a result of the COVID-19 pandemic. The impact of the delay has resulted in deteriorated function and health related quality of life (HRQoL) for these patients. These findings should not be of particular concern for Walsall and such findings are corroborated in recently published literature on the topic. Furthermore, the outcome described through composite measures such as EQ5D, EQVAS and Oxford Scores are multifactorial and often represent outcomes beyond just the impact of hip and knee disease. The proportionally higher prevalence of COVID-19 amongst the Walsall population – when compared nationally – would have compounded the adjusted health gains when compared both to previous years and nationally.						
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• We communicate with the National Proms team to discuss ways of improving PROMs participation rates, including attending their regional events. Information Leaflets in different languages are available via the PROMS Website and link given to the Pre-operative Services. • Future audits looking at PROMS and variations of outcomes are planned for 2021/22 and the Orthopaedic Department has had a strong year with research. Several studies have been published, including notable publications in the Annals of The Royal College of Surgeons of England. • Procedures are being prioritised in accordance with prioritisation guidance issues by the Federation for Surgical Specialty Associations (FSSA), which accounts for both the procedure and patients' clinical presentation						

Title	Indicator PROMs case mix-adjusted scores	TRUST 2019/20 Adjusted average health gain	TRUST 2020/21 Adjusted average health gain	National Average 2019/20 Adjusted average health gain	Upper and Lower 95% control limit for the Trust Health Gain
			• Walsall continues to capture a range of patient recorded outcome measures (PROMs) and has been awarded a Data Quality Provider award by the National Joint Registry for this work. • All operating sessions were reinstated promptly following the 2nd surge of COVID-19 hospitalisations. The department returned to a full complement of operating sessions from May 2021, ahead of other Trusts regionally. • We attend the Yearly National PROMS summit to learn from other Trust experience.		

Title	Indicator	2019/20			2020/21			National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Re-admission rates	The percentage of patients aged (i) 0 to 15; and (ii) 16 or over, Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.		0 to 15	>=16		0 to 15	>=16	N/A	N/A
		Apr-19	9.84%	11.57%	Apr-19	6.15%	12.43%		
		May-19	8.64%	12.71%	May-19	6.31%	14.25%		
		Jun-19	9.62%	12.36%	Jun-19	4.88%	14.06%		
		Jul-19	8.35%	11.97%	Jul-19	7.25%	13.89%		
		Aug-19	9.79%	13.15%	Aug-19	10.23%	14.51%		
		Sep-19	9.29%	11.61%	Sep-19	12.56%	13.38%		
		Oct-19	10.10%	11.20%	Oct-19	15.97%	13.22%		
		Nov-19	10.41%	11.92%	Nov-19	17.74%	12.44%		
		Dec-19	9.04%	11.67%	Dec-19	13.60%	12.17%		
		Jan-20	12.87%	11.76%	Jan-20	13.99%	12.65%		
		Feb-20	10.98%	10.77%	Feb-20	16.56%	12.73%		
		Mar-20	6.49%	10.29%	Mar-20	N/A	N/A		
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	The figures provided above are taken from HED and based on the number of spells per month and the number of emergency readmissions within 28 days, no exclusions							
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• Increases in adult readmission rates from May 2020 is as a consequence of the decrease in the overall number of non-elective inpatients (the denominator) with the most acute still being admitted to hospital (the numerator). • In November 2020, the Trust launched the Covid Safe at Home Pathway in which inpatients with stable Covid-19 but with moderately low oxygen saturation levels could be discharged and monitored in the community with pulse oximeters. This enabled 215 patients to either be discharged earlier or avoid admission altogether. • The MLTC Division has launched a hot clinic in Neurology, a Day Case Ascitic Drain service and a Day Case Pleural Effusion service in order to reduce both admissions and readmissions from patients with chronic conditions.							

Title	Indicator	2019/20	2020/21	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
			• The month 6 Review of Non-elective pathways took place last summer (predominantly around supporting hospital capacity in response to COVID-19). This identified opportunities for intervention around some categories of re-attenders and also people who were being admitted despite there being an agreed personalised care plan that had been made by community practitioners with the individual. • This learning was applied to the implementation of the Integrated Assessment Hub, a community-led initiative based in Walsall Manor Hospital which was implemented in Q3 2020/21. The IAH focuses on preventing readmission / re-attendance to hospital by providing access to community pathways, while it ensures that advanced care plans are followed and patients are treated for any acute exacerbation and then discharged to continue their agreed programme of care in a domiciliary setting. • Work has started on a population health management approach by Community Services which has identified a cohort of frail elderly in one part of Walsall who have a higher use of non-elective and a lower use of elective services compared with other parts of the borough. A series of targeted interventions is being worked up in conjunction with public health support.			

NHS Outcomes Framework Domain 4

Title	Indicator	2018 (these results relate to 2017 results which were received in 2018)	2019 (these results relate to 2018 results which were received in 2019 – these results are embargoed until 20.6.2019 & do not include national bench marking)	2020 (these results relate to 2019 results which were received in 2020)	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patients' needs	The trust's responsiveness to the personal needs of its patients during the reporting period	Q34: Were you involved as much as you wanted to be in decisions about your care & treatment? **6.8/10** Q37: Did you find someone on the hospital staff to talk to about your worries and fears? **4.9/10** Q39: Were you given enough privacy when discussing your condition or treatment? **8.2/10** Q58: Did a member of staff tell you about medication side effects to watch for when you went home? **4.0/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **7.3/10**	Q34: Were you involved as much as you wanted to be in decisions about your care & treatment? **6.9/10** Q37: Did you find someone on the hospital staff to talk to about your worries and fears? **5.2/10** Q39: Were you given enough privacy when discussing your condition or treatment? **8.3/10** Q58: Did a member of staff tell you about medication side effects to watch for when you went home? **4.3/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **7.3/10**	Q34: Were you involved as much as you wanted to be in decisions about your care & treatment? **6.8/10** Q37: Did you find someone on the hospital staff to talk to about your worries and fears? **4.4/10** Q39: Were you given enough privacy when discussing your condition or treatment? **8.3/10** Q58: Did a member of staff tell you about medication side effects to watch for when you went home? **3.9/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **6.7/10**	Trust score about the same as national score Trust score is below the national score Trust score about the same as national score Trust score about the same as national score Trust score is below the national score	N/A
Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:				The Trust follows the National Survey programme for implementing the CQC surveys. The data collated is processed by National Survey Co-ordination Centre and published by CQC via its public website.		
Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:				• The Friends & Family Test (FFT) provides additional insight into the views and experiences of the patients that use our services. Teams use this information in huddles, team meetings, and discussions with the Patient Experience Team. Positive feedback is promoted through a weekly social media post. This boosts morale of staff. Positive feedback is also posted on the Trust website. • Local Surveys are also used with teams to build on FFT and national survey feedback to gain a wider understanding of the patient experience and identify where improvements can be made or best practice celebrated. • Patient, carer and staff experience stories are shared at every Trust Board and Quality, Patient Experience and Safety Committee meetings as well as other staff and team meetings. The stories shared are either patients, carers and staff attending in person or a video/audio is played.		

Title	Indicator	2019/20	2020/21	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The data provided is from question 18d in the National NHS Staff Surveys 2019 and 2020 respectively. Significantly higher than the previous year, however significantly below the national average.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		The questionnaire was sent to all colleagues and 1396 responded, equating to a 33% response rate, an increase of 2% on the previous year. This was lower than the national average response rate of 45% for all combined acute and community trusts in England. Since the survey has taken place analysis of the results at Organisational and Divisional Level work has taken place. Agreement of priority areas for action and focus lover 2021/22 - Equality, Diversity and Inclusion, Line Managers and reducing Bullying and Harassment. Divisional Boards will review local results and learn from external best practice to define actions they will undertake. A staff experience and engagement oversight group will meet each month to take assurance on the improvement plan for response rate and results – divisional learning will be presented at private Trust Board each month. The assurance will be provided each month to the People and Organisational Committee outlining progress.		

Title	Indicator	2019/20	2020/21	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patients who would recommend the Trust to their family or friends		March 2020 - % Rec	January 2021 - % Rec	February 2020 - % Rec	N/A
		Inpatients 95%	Inpatients 87%	Inpatients 96%	
		ED 83%	ED 82%	ED 85%	
		Outpatients 92%	Outpatients 91%	Outpatients 94%	
		Community 98%	Community 100%	Community 96%	
		Antenatal 100%	Antenatal 73%	Antenatal 95%	
		Birth 98%	Birth 76%	Birth 97%	
		Postnatal Ward 100%	Postnatal Ward 80%	Postnatal Ward 95%	
		Postnatal Comm 97%	Postnatal Comm 92%	Postnatal Comm 98%	
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The Trust follows the nationally mandated process for implementing the FFT programme. - Data collated is submitted monthly to NHS England via UNIFY2 submissions - FFT results are published NHS England on their public websites		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		The trust has launched the Enhancing the Ward Experience (EWE) volunteer role which puts young volunteers on our wards to support both patients and staff. The trust has introduced a responder volunteer to support patients during COVID-19. To help them access services, way find and to distribute PPE freeing up staff to delivery high quality care. Volunteers are also supporting the 'Parcels for Patient's initiative which enables the delivery of parcels to the wards at a time when patients cannot have visitors. The trust will be relaunching the Friends and Family Test. Due to the clinical effects of COVID-19 a disruption to normal feedback collection methods led to a trust need to consider, in its fullest context, how the use of the Friends and Family Test and other forms of feedback translate real time feedback into near time action.		

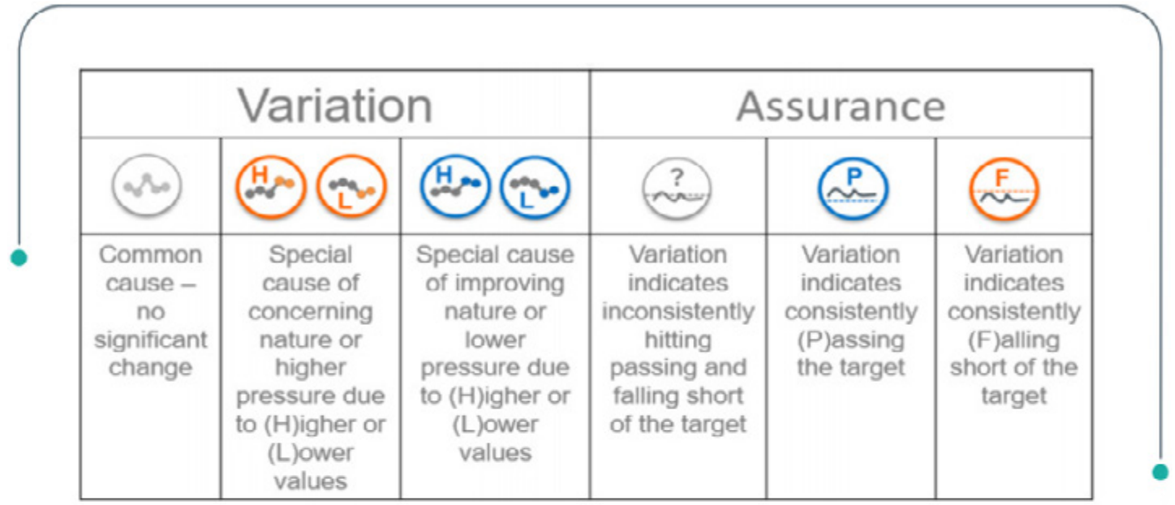
NHS Outcomes Framework Domain 5

Title	Indicator	2019/20		2020/21		National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Venous thromboembolism risk assessments	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	Apr-19	91.01%	Apr-20	84.24%	Quarterly submission of VTE data was postponed in April 2020 due to COVID-19 Latest national position – Quarter 3 2019/2020 = 95.33% (excluding Independent Providers)	Latest position – Quarter 3 2019/2020 Highest Performing Trust – Salisbury NHS Foundation Trust (99.67%) Lowest Performing Trust – Blackpool Teaching Hospital NHS Foundation Trust (74.07%)
		May-19	92.02%	May-20	91.13%		
		Jun-19	92.29%	Jun-20	92.83%		
		Jul-19	93.20%	Jul-20	93.67%		
		Aug-19	93.83%	Aug-20	94.15%		
		Sep-19	93.42%	Sep-20	89.51%		
		Oct-19	92.06%	Oct-20	91.24%		
		Nov-19	92.26%	Nov-20	90.74%		
		Dec-19	88.87%	Dec-20	90.98%		
		Jan-20	92.61%	Jan-21	90.39%		
		Feb-20	94.04%	Feb-21	91.50%		
		Mar-20	90.75%	Mar-21	94.45%		
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	April 2019 to March 2020 = 28%		Latest Position (November 2019 to October 2020) = 27%		Latest Position (November 2019 to October 2020) = 36%	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	The Thrombosis Group has been launched and is an additional platform for discussions relating to VTE compliance, over view of hospital acquired thrombosis, and will be focusing on areas where compliance is low and support is needed. A Trust Clinical Lead and Chair of the Thrombosis Group has been appointed who is a Royal Wolverhampton Trust Haematologist. In the immediate term to ensure accountability for VTE assessment compliance, a process for auditing and improving accountability has been established.					
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	Implementation of a "mandatory step" in Medway. This is the long term solution and will provide sustainability and accountability. Assessment compliance will increase as the electronic step provides a gatekeeper to completion of VTE assessments. There will also be accountability as an electronic patient record system will provide footprints of clinicians accessing records and therefore easily identifiable. See section 2.1.1 for a description of the actions taken					

Title	Indicator	2019/20	2020/21 (April to December)	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	21.23	25.44	N/A	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	The Trust has a process in place for collating data on C Difficile cases - data collated internally and submitted monthly to Public Health England			
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• Delivering a collaborative approach between the Infection Prevention specialist nurses, Consultant Microbiologist and Antimicrobial Pharmacist who undertake weekly ward rounds of current inpatients which consists of a thorough review of treatment and infection prevention measures within the clinical area. • Increased support from IPCT to emergency care pathway areas to emphasise prompt stool sampling in the clinical management of patients • Workstreams to prevent syndromic infections including urinary tract infections and pneumonia across the health economy to prevent use of antibiotics • Antimicrobial audit and educational support to clinical areas to promote stewardship • Working with colleagues across the health economy to develop a Proton Pump Inhibitor de-prescribing pathway Implementing an updated Trust cleaning matrix demonstrating roles and responsibilities in the effective decontamination of a bed space following discharge/transfer of patients			
	Data source	Combined monthly snapshot in line with KH03 definition			

Title	Indicator	2019/20 (Apr 2019 – Mar 2020) The latest data available	National Average (Apr 2019 – Mar 2020) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for April 2019 – March 2020	2020/21
Incidents	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period,	11,982 incidents reported and equating to 75.05 incidents per 1,000 bed days	12,777 incidents reported and equating to 50.5 incidents per 1,000 bed days	44,025 incidents reported by University Hospitals Birmingham NHS Foundation Trust and equating to 48.5 incidents per 1,000 bed days.	The Official Statistics publishing schedule is changing We are now publishing the Organisation and National level patient safety incident reports (OPSIR and NAPSIR) once a year rather than every six months, with the next publication due in September 2021. This will contain one year's worth of data from April 2020 – March 2021 Please visit the following page for more information: https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/
	The number and percentage of such patient safety incidents that resulted in severe harm or death	56 1.1%	19.5 0.3%	95 incidents (0.5%) – University Hospitals Birmingham NHS Foundation Trust 45 incidents (1.4%) – Medway NHS Foundation Trust	Not Available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	• The data is provided by the National Reporting and Learning System (NRLS)			
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• Continuing to promote incident reporting through patient safety workshops and by providing feedback to staff on incidents reported and action taken as a result. This is reflective in the increased number of incidents reported per 1,000 bed days compared to the previous Quality Account			

Appendix 3: STP Charts Explained



Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

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