Walsall Healthcare NHS
NHS Trust

Quality Account
2019/20

Caring for Walsall together

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

Contents

We have tried to make this document as straightforward and reader-friendly as possible.
A glossary of terms used throughout the document can be found on pages 68-69.

Part 1:
A statement on quality from the Chief Executive

I am pleased to present Walsall Healthcare NHS Trust's Quality Account 2019/20. This document is an honest reflection of our performance, challenges and achievements during 2019/20 and describes the quality improvement priorities for 20/21.

We started this year enjoying the moment of coming out of special measures, after three years of work which concentrated on the fundamentals of care, staffing safety, patient safety culture, staff engagement and leadership improvements. With enthusiasm the Trust commenced work to look "beyond special measures" as and engage the organisation in the development of our improvement programme – the vehicle for delivering our strategic objectives and our aim of achieving outstanding rated services by 2022. We launched our improvement programme with an engagement event on this with our top 100 leaders, system partners and patient representatives in June.

The Trust's vision is to "Care for Walsall together" to reflect our aims of reducing health inequalities in our diverse and deprived borough. We will deliver this in partnership with social care, mental health, public health and associated charitable and community organisations, through our role as host provider of the Walsall Together partnership. In 2019 the Trust and statutory organisations in the borough, approved the Walsall Together Business case. That case signals a radical shift in where we will invest in the future – out of hospital care, population health management and a move away from acute hospital locus.

The Trusts maternity services have continued to improve and received an improved rating of 'good' during the latest inspection. The trust's new £5.6m Neonatal Unit at Walsall Manor Hospital opened in November 2019. The unit houses a purpose-built Intensive Therapy Unit and High Dependency Unit and a new obstetric theatre has also been created. Walsall's Midwifery-Led Unit (MLU) re-opened for intrapartum care on 6 January 2020. The MLU also continues to offer supportive antenatal, postnatal and perinatal mental health clinics.

I have been delighted that Walsall Healthcare has continued to climb both the national and regional performance league tables for delivery of the 4-hour emergency access standard. This standard remains the best proxy indicator of safety and experience for urgent, non-elective care. Our national ranking for the 4-hour emergency access standard rose from 108th (out of 132 trusts) in April 2019 to 53rd in February 2020, (out of 118 trusts, the number has reduced due to a number of trusts scoping the new national ED measures and not submitting the 4-hour data). Our Midlands regional ranking rose from 15th (out of 21 Midland trusts) to 9th (out of 29 Trusts) in February 2020. March 2020 saw deterioration in ED 4-hour performance in the early phases of the Covid-19 pandemic.

The Trust has responded well, in large part, to the COVID challenge from a quality and safety perspective. By virtue of being the borough with the highest COVID incidence rate per 100,000 population and because the Black Country system had the highest incidence rate nationally, we were tested fairly early on with regard to the correct admission pathways and effective cohorting and segregation.

Our response to the Covid-19 pandemic and the restoration and recovery of services remains a key focus for this Trust through 2020/21, along with tackling health inequalities and making Walsall an exceptional place to work. I fully recognise the immense pressure colleagues have been under for a prolonged period of time. The wellbeing and welfare of patients, carers and colleagues is a priority for me and the Trust.

An important part of the Quality Account is looking forward to the year ahead. We are pleased to include our new Quality Improvement Priorities for 2020/21, informed by the priorities within our improvement programme, which will support our endeavours to provide excellent and high-quality healthcare for our patients.

Best Wishes

Richard Beeken
Chief Executive

Part 2:
Priorities for improvement and statements of assurance from the board

1 Review of 2019/20 Quality Priorities

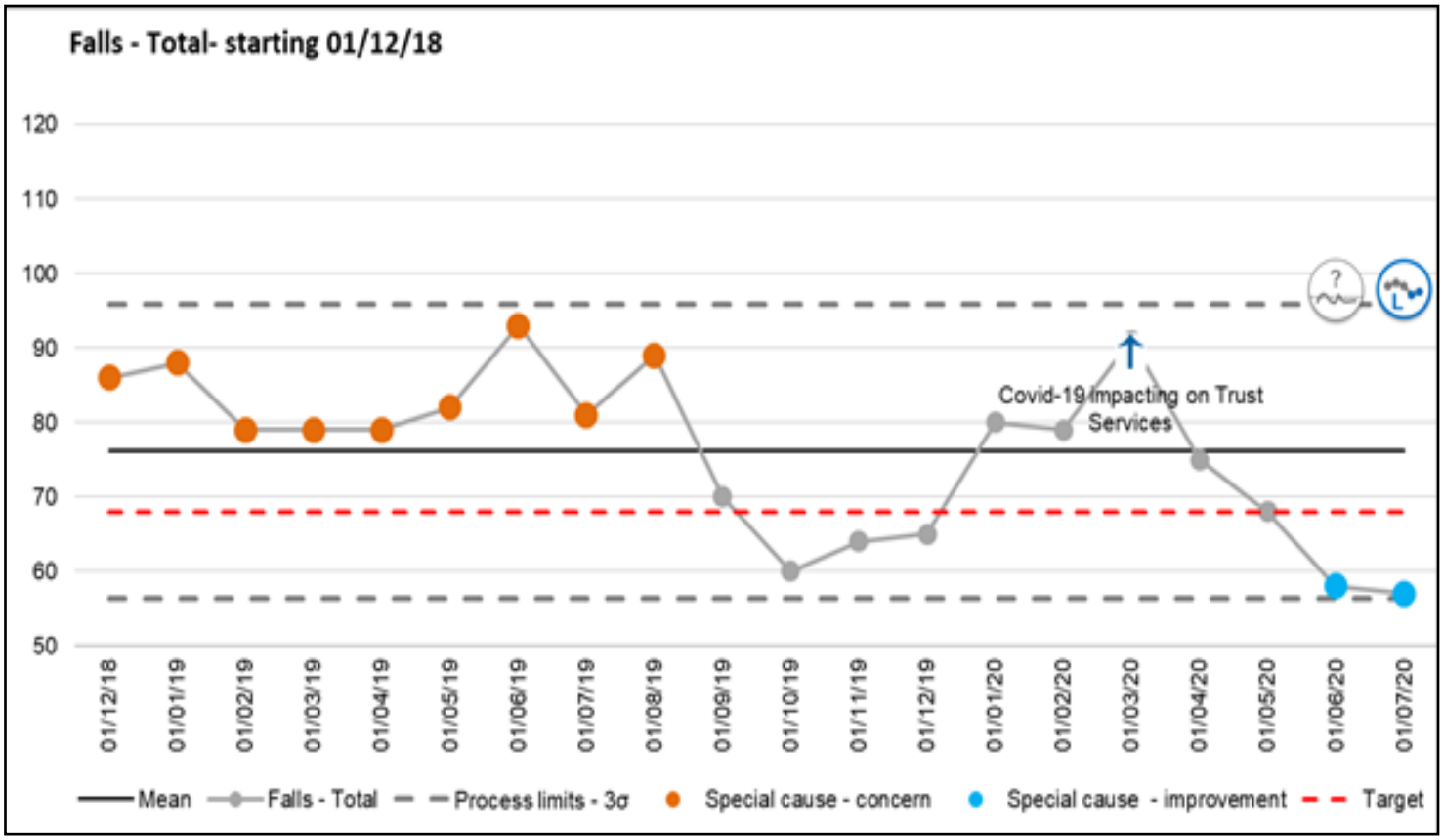
The Trust made a commitment to the following quality improvement priorities for 2019/20.

1.1 Reduce the number of inpatient falls and falls with harm

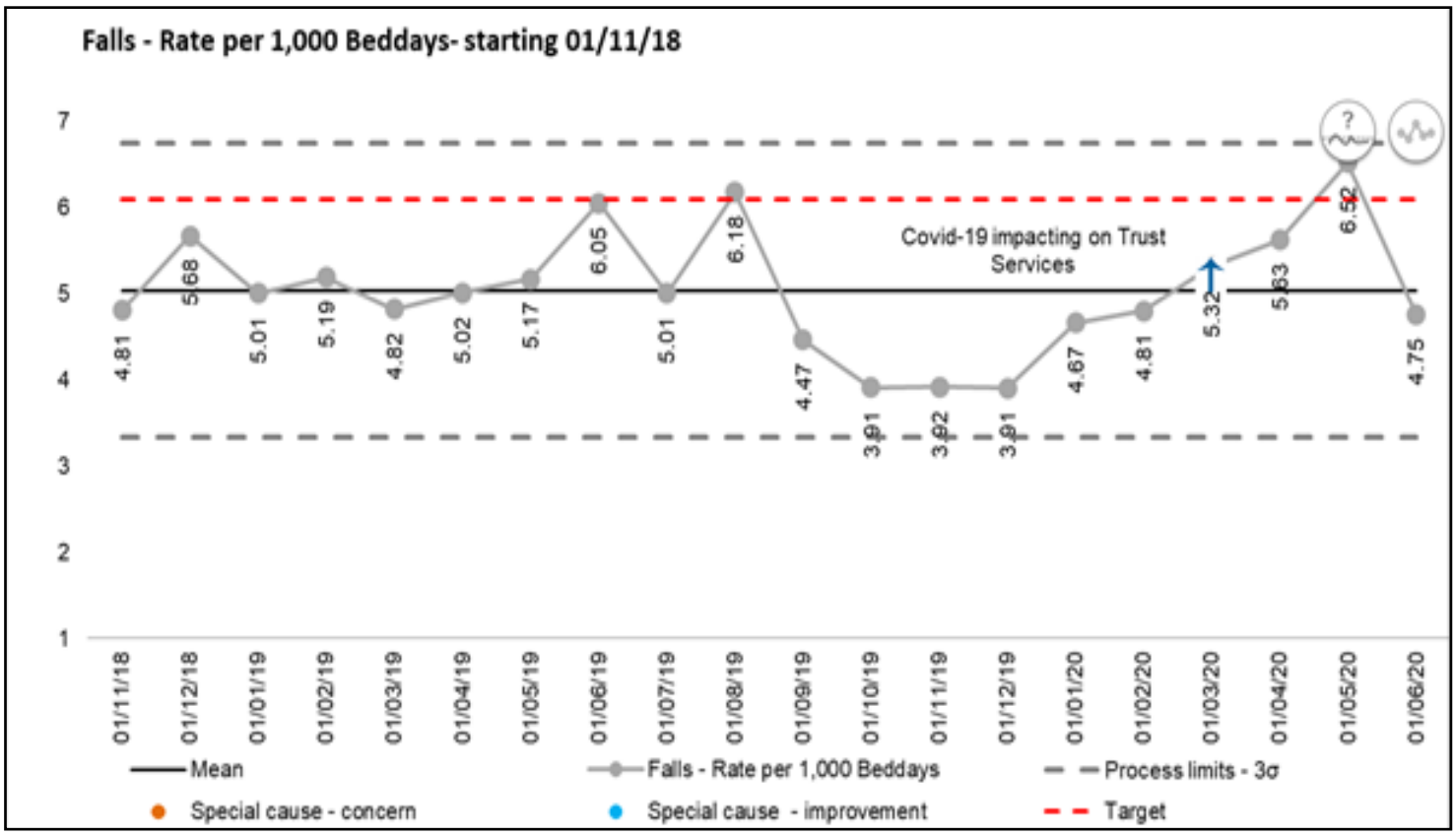
We have seen an overall reduction in falls since 2017.

The number of falls overall for 2017 /18 was reported as 1026; by 2019-2020 the overall number of falls was 933 which represent a reduction of approximately 9% over the two year period. This is slightly short of the NHSi proposed reduction of 10% as identified by the NHSi Falls collaborative.

The trust has seen a gradual reduction in the average number of falls per month over the period from 85.5 for 2017 /18 to 77.75 for 2019 to 2020.



The RCP guidelines for falls per 1000 OBD suggest a performance of 6.6 to be the national average. The trust target has been determined as 6.1 in line with regional peers. Since November 2018 the trust has seen 2 rises above this point, August 2019 to 6.18 and May 2020 to 6.52, the latter being a peak during COVID 19 escalation.



1.2 Reduce the number of category 2 pressure ulcers across the Trust and aim to eliminate category 3 and 4.

The Tissue Viability Team launched the skin bundle in April 2019; a pressure ulcer prevention document and since the commencement of this we have seen a reduction in pressure ulcers.

The skin bundle document was added to the Matrons audit for monitoring.

The tissue viability team provide training sessions on pressure ulcer prevention, wound management and back to basics throughout the year with bitesize training to support AMU and Ward 1 to support those teams improve practice.

For these wards we are also produced a pocket guide which has the category of pressure ulcers, difference between pressure and moisture, equipment selection guide and dressing selection chart.

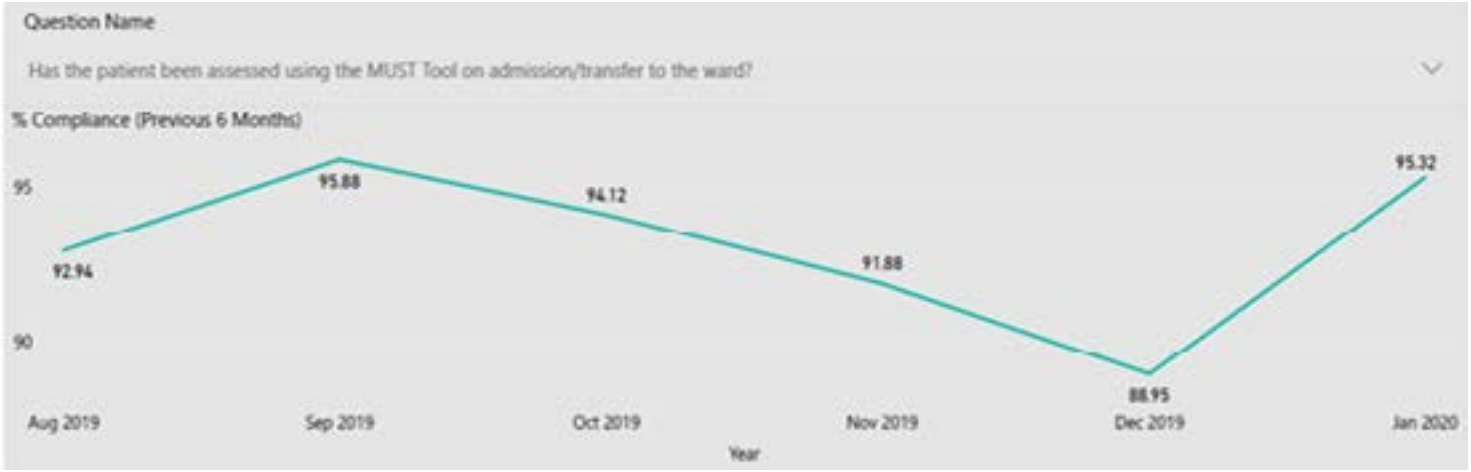
Each November the team actively take part in Stop the Pressure which is national campaign to raise awareness of prevention of pressure ulcers. Last November the tissue viability team walked the hospital as pressure hero's highlighting the importance of pressure ulcer prevention, the importance use of skin bundle document and categorisation of pressure ulcers.

We continue to monitor pressure ulcer trends via RCAs as this helps us identify area of learning.

A wound assessment chart was launched in December 2019 and work continues to instil the wards the need for assessment and reassessment of wounds.

1.3 At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission using the nationally recognised MUST

Maintaining adequate hydration and nutrition for those in our care remains a high priority and completion of a nutritional assessment ensures we are able to plan safe, evidence based and effective plan of care. Ongoing focus and training on this aspect of care has continued over the last year and will remain a priority for 20/21



1.4 Continue to implement extended working in a number of areas through new service delivery models

Current Provision - Critical Care

The Trust now has a 24/7 Critical Care Response Team (CCRT) service, comprising of three band 7's (1 is covering half Follow-up clinic) plus 4 band 6 nurses. ICU rotates all band 6's into CCRT for their development. Prior to rotation all band 6 nurses would have to pass Advanced Life Support and the Trust are looking at sending staff on Health assessment courses. At present there are 3 staff on the Advances Clinical Practitioner programme, at the end of their study (end of year) they would all be Non-Medical Prescriber. All staff that complete health Assessment course are able to apply to complete NMP course. Additionally, there is also 1 whole time Practice Development Nurse.

As a result of Covid 19, the Trust has been able to temporary increase follow-up clinic nurse to full time and 1 extra Practice Development Nurse is in place to support nursing staff across the Trust.

Planned Provision (included in STP capacity spreadsheet) – Critical Care

Planned introduction of 24/7 Advanced Critical Care Practitioner (ACCP) within critical care. The ACCP role is a way of working which crosses professional boundaries. ACCPs are currently developed from experienced nurses, physiotherapists, paramedics or other related health care professionals. In the future it is envisaged that ACCPs may also be drawn from other emerging healthcare roles.

Current Provision - Non Elective Services (Wards 9, 11, 12)

1 Advanced Care Practitioner Trauma and Orthopaedics.

Planned Provision (included in STP capacity spreadsheet) - Non Elective Services (Wards 9, 11, 12)

Addition of three Advanced Care Practitioner's (ACP) to support ACP led SACU to provide 7 day cover (10pm - 8am; 7 days per week) and ACP led Elective and Emergency wards. 24/7 Mon- Sun.

Theatres

3 staff are trained in surgical first assistance and 1 SCP in place.

1.5 Learning from deaths – recruitment of medical examiner

A lead medical examiner has been appointed and we have completed the recruitment of 3 medical examiners (ME) to support the system-wide approach to learning from deaths and supporting bereaved relatives and carers. As part of the implementation process, the trust will move to align data collection with the dataset mandated by the National Quality Board (NQB). The ME undertakes proportionate scrutiny of all non-coronial deaths. Any issues or concerns identified in care, system or process or any learning points are identified and managed through the learning from death governance processes.

1.6 Reduce harm from sepsis: increase the number of patients screened, and give antibiotics within an hour of a patient being diagnosed with sepsis.

A professional lead for Quality has been appointed to the corporate nursing team whose role will be to support and contribute to the national deteriorating patient strategy. Responsibilities will include the implementation of the NHSi guidelines, collaborative working with the regional networks, implementation of national CQUINS relating to the deteriorating patient monitoring and analysing performance and facilitating the development of action plans to address areas of underperformance. This relates specifically to the national indicator for administration of antibiotics and the CQUIN relating to unexpected transfers to critical care monitoring identification, escalation and response. The professional lead will facilitate

education and training for the nursing teams working collaboratively with medical teams and ensure effective policies and procedures and developed and embedded to support in the reduction of harm and death relating to undetected or untreated deterioration in patients.

1.7 Safe and effective discharge and improving our patients' experience of getting home.

Audits from discharge lounge

With the implementation of the outpatient parenteral antibiotic therapy (OPAT) policy, there is greater involvement of antimicrobial team to increase the quality of OPAT discharges, but encourage oral switch where possible. Weekly antimicrobial team and OPAT team MDT help to keep patients safe at home. The OPAT team have developed a 'cellulitis referral service' and 'ward review service' where they regularly attend wards to prompt discharge via the OPAT route.

The Trust has introduced a service for 24-hour infusion pumps at home, which allows patients with complex antimicrobial needs to be cared for in their own home, receiving either flucloxacillin or piperacillin-tazobactam.

Furthermore, the antimicrobial team has conducted a weekly induction programme for 4-hours of training for new entry FY1s to enhance their understanding of antimicrobial use and stewardship and increased pharmacy education so they can confidently conduct antimicrobial review.

1.8 Improve communication with patients through the provision of a 'Values Based Customer Care Programme'

Background

During 2017, a number of staff were involved in the co-design of a customer care approach which had been identified as a priority within the Patient Experience Strategy. The Trust also pledged to initiate welcome improvements at reception desks and identified Customer Care as one of its Quality Commitment pledges. A 'Putting Patients First' workshop was held and consultation and support was gained from an exemplar in the field of Customer Care via the John Lewis Partnership. This resulted in the development of the 'Hand in Hand' customer care approach and a train the trainer session being developed with a number of staff and teams engaged in trialling the approach within their areas:

- **Patient Relations and Experience,**
- **Atrium Reception,**

- **Clinical Measurement Unit,**
- **Access Call Centre, and**
- **East Locality District Nurses.**

Feedback following the training session was extremely positive and a number of workplace improvements followed including clerical officer uniforms, de-cluttering and welcome signs at reception desks. Taking the customer care programme forward was delayed due to the on-set of the new Trust values as it was felt that these should be integral to any new offer. Now the values have been launched the programme has been amended to reflect these, upholding respect, compassion, teamwork and professionalism as a values based approach in delivering Customer Care to colleagues, patients and partners.

Developing The Approach

John Lewis Partnership

The approach focuses on understanding people and being capable of empathy. When people are busy at work, we can often lose sight of the simplicity of a positive human interaction - something that is at the core of the John Lewis approach. Brilliant basics - are simple factors that can make or break a service interaction (10 top things such as being smartly dressed, smiley, heads up and ready to help). These are the total basics and are introduced to all John Lewis staff on their induction as they are critical to setting the foundational standards of the service environment they to operate in.

There are common similarities with the John Lewis approach and that expected of us in the Healthcare setting. The John Lewis approach encourages co-ownership encouraging the involvement of colleagues in understanding their service environment and setting the standards against which they are going to operate.

Applying the approach to Walsall

The 'Putting Patients First' workshop discussed what 'Outstanding' would look like and what were the barriers to delivering this. It was agreed that simple positive human interactions often made the most difference and they were not resource intensive either.

As a result five Customer Care Commitments were developed which were to be applied to individuals and their teams. It would be up to each area to demonstrate how they would apply these and what positive actions they would take to ensure improvements were made. This was called 'Hand in Hand' as it was essential that the commitments applied to everyone from staff to our patients. However, since the launch of the Trust values the offer was amended to reflect these as the initial commitments are reflected in the behaviour framework. In doing so, the behaviour framework is the success criteria in which to assess how Trust staff are 'upholding the values' to enhance both the colleague and patient experience.

Values Based Customer Care

The programme: 'Delivering exceptional customer care – that upholds the values we are signed up to'

- The team nominate a staff member to complete the Train the trainer session, (3 Hours duration). They become the named 'Values Envoy' responsible for taking the training back, delivering a team talk and completing the Customer Care Toolkit including an initial assessment of where they are on their customer care journey.
- The 'Values Envoy' are allocated a 'Values Sponsor'
- The sponsor support the envoy in developing their identified actions into reality and in the grading of whether a team are delivering Bronze, Silver or Gold customer care – these will be termed the 'Values Mark' and determined on the level of consistency of practice using the behaviour framework as success criteria. The sponsor will work with teams to upskill and move them onto Gold – and beyond.
- The aim is to have a sustainable programme of improvement which can be linked to the Friends and Family Test, Staff and Pulse survey measures as a guide as to whether the programme is having an impact. However, we should not initially over complicate matters and produce unrealistic targets – small steps – 1% improvements across the board!
- The 'Values Mark' – beyond brilliance! We should recognise exemplar activity and share this – if a team is graded as Gold then they should commit to one of two things:
  1) On board another team and act as 'sponsor' to their 'envoy'
  2) Support a team not yet there in moving them on through the levels of values mark in a 'coaching' capacity.

This programme is designed to empower staff and teams to deliver and own standards of customer care applicable to them, as described above the initial 'Hand in Hand' pilot has been amended to reflect the Trust values so we have a consistent approach from Induction and beyond – the golden thread being the values of Respect, Compassion, Teamwork and Professionalism. The Trust Induction Customer Care session has also been revised to reflect the Trust values as the preferred approach as to what is expected.

Progress

- ✓ 12 teams piloted the Values Based Programme since April 2019 – Podiatry, Informatics, General Office, Antenatal, Trust HQ PA's, West 1 Community Nursing, ED Reception, Community Midwives, RTT and Re-design, Imaging, Dietetics, Adult Community Nursing,
- ✓ 3 Values Sponsor's assigned
- ✓ Team location visits undertaken, Bentley, Blakenall, General Office, ED reception, Trust HQ
- ✓ Action plan's completed – these are under review.

Examples of changes made:

In addition the values based customer care sessions are delivered to all new staff at Trust induction, the session includes two case studies of a patient and staff experience and a discussion thereof applying the values to the impact.

General Office	• Privacy sign in place in waiting area • Instruction leaflet for car parking passes • Ownership for issues raised • Use of voicemail in busier periods to allow face to face customers priority • New deceased database has been implemented to electronically store deceased information in one place making the process of obtaining Medical Certificate of Cause of Death more efficient • Supporting others - demonstrating compassion, empathy, and alternatives • Values team assessment undertaken
Podiatry	• Values team assessment undertaken and team discussion held • Listen to FFT feedback at team meetings • Changed way people can book appointments to prevent call delays • Information leaflets provided in different languages • Telephone etiquette in place • Information signs and roll up banners in place at community venues • De-clutter environment at Brace Street, privacy area at Anchor Meadow • Stakeholder survey in place
Adult Community	• Embracing change through Walsall Together collaborative • Locality Based working and administrative support re-structure • Total mobile roll out made it easier to record care and provide feedback to patients • Looking at self-service kiosk integration of information with GP surgeries • 'My name is' principles reinforced
Trust HQ PA staff	• Team discussion held including values focussed assessment • Monthly team huddles initiated • Feel delivering a 'silver' level of customer care • Share and support concerns more openly to support each other to maintain professionalism • Recognition/thank you cards issued

Next steps

The programme requires dedicated resource to enable pace and reach of wider staff groups. Initial gradings are to be shared with teams once sponsors have completed their 1-2-1 assessments with teams.

2 Priorities for improvement 2020/21

Harm free Care

We will focus improvement and delivery of care excellence on the following aspects of harm free care:

- **Tissue Viability**
- **Falls and Deconditioning**
- **Nutrition and Hydration**
- **Mouth Care**
- **Deteriorating patient and sepsis**
- **Healthcare associated infections**
- **Improve learning from Medication Errors**
- **Continence**
- **VTE**

We will review our metrics to ensure we focus on delivery of outcome measures that directly impact on care outcomes; for example measuring 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.

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.

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 the last year to meet this aim and include:

1. **Improvements in pathway for patients with fractured neck of femur.**
2. **Early detection and escalation of deterioration through the use of NEWS2 and appropriate escalation and standardised clinical management.**
3. **Improvement in cancer pathways to reduce delay and clinical variation in order to support best outcomes.**
4. **Improved end of life care to support end of life discussions and planning including DNAR MCA.**
5. **Improved prevention, diagnosis and treatment of hospital acquired pneumonia and adoption and spread of effective, evidence-based practice - chronic obstructive pulmonary disease discharge care bundle.**
6. **Implementation of Emergency Department safety checklist to reduce mortality from long waits in ED.**

Learning from Covid

We recognise the need to learn from our experience:

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

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 MDT standards. For patients who have a delay in the cancer pathway, we will implement a robust mechanism to review all 104 day breeches.

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

3 Statements of assurance from the board

3.1 Review of Services

During 2019/20 Walsall Healthcare NHS Trust provided and/ or sub-contracted 136 NHS services.

The income generated by the NHS services in 2019/20 represents 100 per cent of the total income generated from the provision of NHS services by the Walsall Healthcare NHS Trust for 2019/20.

3.2 Participation in Clinical Research

Research & Development (R&D) refers to innovative activities undertaken by the NHS, corporations (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 Walsall Healthcare NHS Trust as it offers patients the opportunity to be involved in a variation of research studies.

The R&D department has been 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. For the growth, delivery and performance of research to continue there is a need to nurture and increase the infrastructure of the FORCE team and to change the culture of research activity to ensure that research is everyone's business and a core part of all clinical roles within the trust.

The number of recruits to NIHR Portfolio Studies in the year (2019/20), as a percentage of agreed targets for Walsall Healthcare NHS Trust was 66% [Target was 703; the number recruited 465.]

Table 1 opposite outlines the number of studies open, in set-up, suspended, missing information closed and total numbers of studies (2019/20).

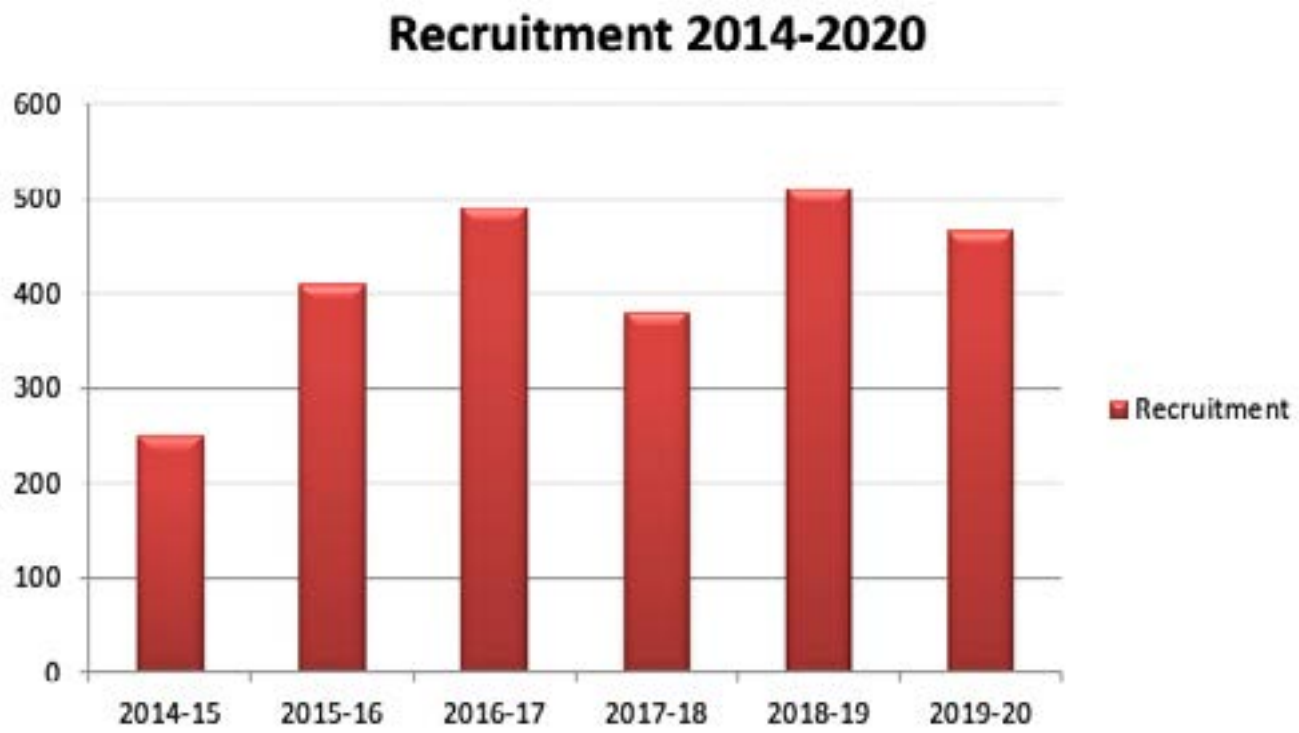
Overview of Studies at Walsall Healthcare NHS Trust

The Trust has a good record in recruiting to time and target on commercial trials, previous performance from 2014-2019 of the 9 studies which participated in research 7 trials hit their target. 2 studies excelled in recruitment the areas being Dermatology and Infection (HIV). In 2019 Walsall Healthcare NHS Trust closed 16 non-commercial studies all studies hit their target and closed green (RAG rated). No commercial studies closed in 2019. There is a need for the Trust to open more studies and have a balance portfolio (commercial and non-commercial).

Walsall Healthcare NHS Trust Recruitment Data ***Table 1***

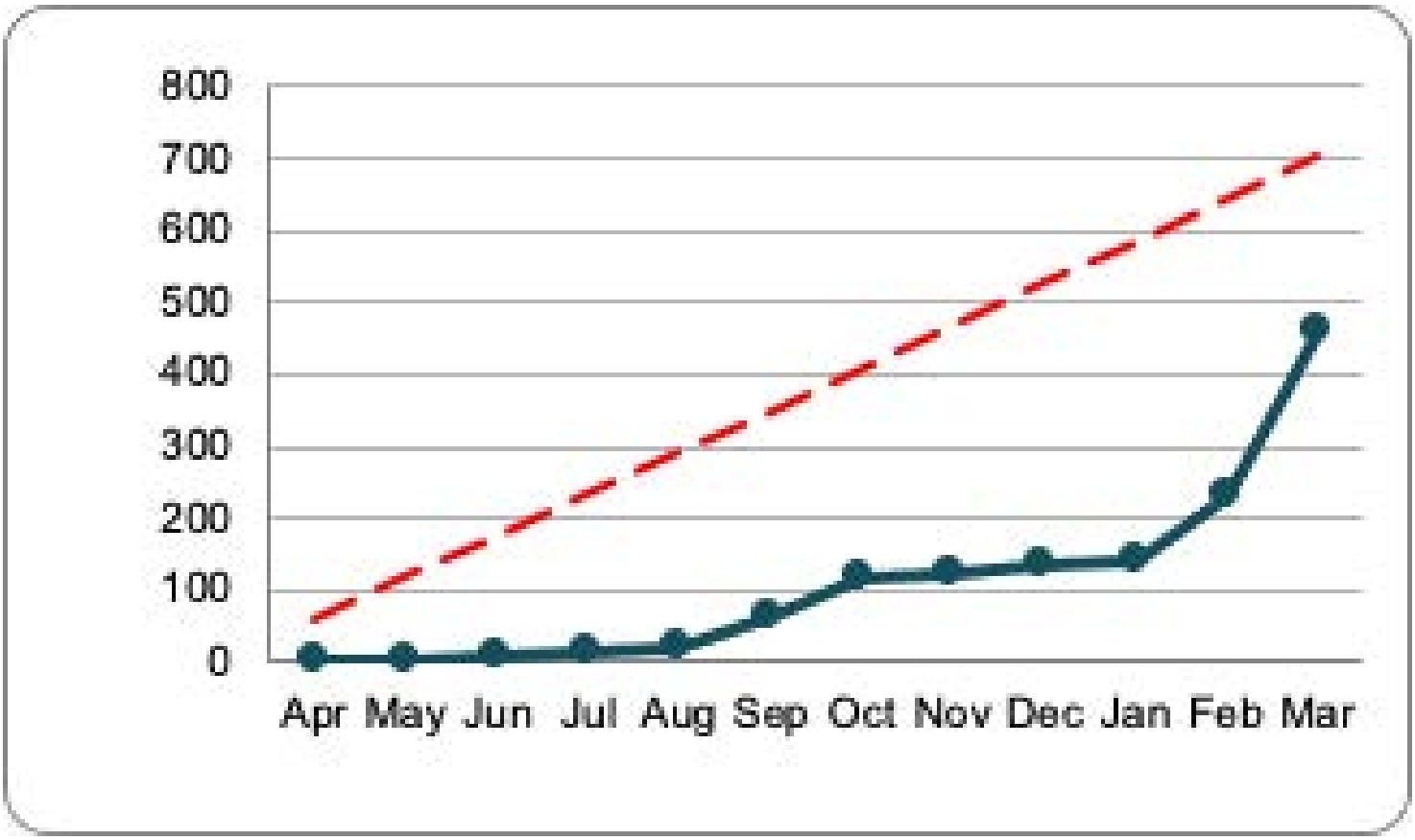
Walsall Healthcare NHS Trust	
Number of Open Studies	9
Number of Studies in set-up	5
Number of Studies in Suspension	1
Number of Closed Studies*	16
Number of Studies recruiting on CPMS and missing on EDGE	0
Total	31
Total Number of Studies with Complete and Accurate Data	31
% of Studies with Complete and Accurate Data	100%
Number of Studies with Missing Data	0
Number of Studies with Data Discrepancies	0

Research recruitment from 2014-2020 (February) **Graph 1**



Graph 1 gives an overall of performance since 2014 to present time; the graph shows a steady increase in recruitment and performance overall to end of year 2019. 2019/20 was a challenging year for the team and many changes took place in staffing and process which impacted on the team's ability to recruit into studies. Covid 19 hit in the last month resulting in all non-Covid Studies being suspended and recruitment halted prematurely. It has taken some time to rebuild but the team is now in a good position to see the number of recruits increase again for the year 2020/21. The FORCE team are committed to improving the quality of care offered to patients though research.

Recruitment as at 24/03/2020 **Graph 2**



Moving forward

In 2020/21 the FORCE team will be focussing primarily on Covid 19 Studies and in particular vaccine studies will be introduced in the autumn. We also need to review and restart our non-Covid studies and increase the number of studies undertaken across the Trust. The department will need to scope potential areas where there is growth for research in relation to population need; this will support stability within the department. The Trust needs to grow its commercial research portfolio however we are anticipated some challenges to this in 2020/21 due to slow recovery in industry from Covid. This will impact on our ability to generate income which could be used to further develop the department.

Detailed below are some of the improvements Team FORCE has identified as key for 2020/21:

- Embedding research into core work for clinical staff.
- Approval and embedding of Research and Clinical Education strategy to give clear direction and accountability.
- 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 CRN to ensure availability of professional development for staff. PI masterclasses run for senior staff to take on more research studies.
- Digital transformation of Research processes, Innovation funding gained for virtual assistant project, Edge to be embedded into core process and data recording and Redcap installed for researchers to use.
- Performance Monitoring – Undertaken weekly to identify any missing data or discrepancies in information.

3.3 Participation in Clinical Audit

During 2019/20, there were a number of national clinical audits programmes and national confidential enquiries covering NHS services that Walsall Healthcare provides.

During that period Walsall Healthcare participated in 100% of the national clinical audits programmes and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that Walsall Healthcare was eligible to participate in during 2019/20 are below.

National Audit Title (n=65)	Trust Participation (48)	% 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 2020
National Asthma and COPD Audit Programme (NACAP) – COPD	✓	Data submission in progress	On-going data submission not due to complete till May 2020. Action plan in progress for 2018/19 outcomes.

National Asthma and COPD Audit Programme (NACAP) - Asthma	✓	Data submission in progress	On-going data submission not due to complete till May 2020
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation	✓	Opens March 2019	Data submissions ongoing till March 2020
National Diabetes Adult - Inpatient Audit	✓	Data submitted	Data collected and submitted 27/09/2019 - Await copy of report
National Diabetes Adult - Foot Care Audit	✓	Data submission in progress	On-going data submission
National Diabetes Adult – Pregnancy	✓	Data submission in progress	On-going data submission
National Diabetes Adult – Harms in England	✓	Data submission in progress	On-going data submission. Report expected May 2020
National Diabetes Adult – Core	✓	Data submission in progress	On-going data submission
National Paediatric Diabetes Audit	✓	Data submission in progress	On-going data submission
National Lung Cancer Audit (NLCA)	✓	100%	Data submitted await report
NCEPOD – In Hospital Management of Out of Hospital Cardiac Arrests	✓	Data submission in progress	Data submitted await report
Mental Health – CEM	✓	100%	Data submitted await report
Assessing Cognitive Impairment in Older People – CEM	✓	100%	Data submitted await report.
Care of Children in ED - CEM	✓	100%	Data submitted await report
Major Trauma Audit - TARN	✓	100%	Data for the period submitted - On-going data submission await the report
NCEPOD –Acute Bowel Obstruction	✓	66%	Action ongoing to implement NCEPOD recommendations

National Audit of Heart Failure	✓	Data Submission in progress	On-going data submission
National Audit of Cardiac Rehabilitation	✓	Data Submission in progress	On-going data submission
NCEPOD – Dysphagia in Parkinson's Disease	✓	Data Submission in progress	On-going data submission
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	Data Submission in progress	On-going data submission
Cardiac Rhythm Management	✓	100%	On-going data submission
National Oesophago-Gastric Cancer	✓	100%	Data Submitted await report
UK IBD Registry	✓	100%	Data collection ongoing – deadline April 2020
NCEPOD – Long Term Ventilation in Children	X	N/A	Not undertaken at the Trust
Sentinel Stroke National Audit – Community	✓	100%	Data submissions ongoing
Adult Cardiac Surgery	X	N/A	Not undertaken at the Trust
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	X	N/A	Submitted as part of New Cross data
BAUS Urology Audits - Nephrectomy audit	✓	Data submission in progress	On-going data submission
National Prostate Cancer Audit	✓	Data submission in progress	On-going data submission
Case Mix Programme (CMP) - ICNARC	✓	100%	On-going data submission
National Audit Of Breast Cancer in Older People	✓	On-going data submission	Awaiting the report
National Bariatric Surgery Registry	✓	100%	On-going data submission
National Bowel Cancer Audit	✓	100%	Data submission ongoing final data submission April 2020
National Emergency Laparotomy Audit	✓	99%	Total number of cases 213. Total Meeting NELA criteria 130. 129 cases submitted

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	X	N/A	Not applicable patients treated at New Cross
National Vascular Registry	X	N/A	Not undertaken at the Trust
BAUS Cystectomy	X	N/A	Not undertaken at the Trust
BAUS Radical Prostatectomy Audit	X	N/A	Not undertaken at the Trust
MBRACE-UK	✓	100%	On-going data submission
National Maternity and Perinatal Audit (NMPA)	✓	100%	On-going data submission
National Comparative Audit of Blood Transfusion - Fresh Frozen Plasma	✓	100%	Awaiting the report
National audit of Seizures and Epilepsies in Children and Young People	✓	Data Submission in progress	On-going data submission
NCEPOD - Cancer in Children, Teens and Young Adults	X	N/A	Not undertaken at the Trust
National Neonatal Audit Programme	✓	Data submission in progress	On-going data submission
Paediatric Intensive Care	X	N/A	Not undertaken at the Trust
Learning Disability Mortality Review Programme	✓	100%	On-going data submission
Surgical Site Infection Surveillance Service	✓	100%	On-going data submission
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	✓	100%	On-going data submission
Reducing the impact of Serious Infections	✓	100%	On-going data submission
NCEPOD - Pulmonary Embolism	✓	100%	Awaiting the report
National Cardiac Arrest Audit (NCAA)	✓	Data submission in progress	On-going data submission

National Audit of Anxiety and Depression	X	N/A	Not undertaken at the Trust
Prescribing Observatory for Mental Health	X	N/A	Not undertaken at the Trust
UK Cystic Fibrosis Registry	X	N/A	Not undertaken at the Trust
BAUS Urology Audit – Female Stress Urinary incontinence (SUI)	X	N/A	Not undertaken at the Trust
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	X	N/A	Not undertaken at the Trust
Child Health Clinical Outcome Review	✓	Data Submission in progress	Ongoing data submissions
National Clinical Audit of Psychosis	X	N/A	Not undertaken at the Trust
National Congenital Heart Disease (CHD)	X	N/A	Not undertaken at the Trust
National Joint Registry (NJR)	✓	Data Submission in progress	Ongoing data submission
Neurosurgical National Audit Programme	X	N/A	Not undertaken at the Trust

The number of local clinical audits reviewed by Walsall Healthcare NHS Trust was 106 during the period of 2019/20. 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
Prolonged Jaundice Audit	The audit identified there was potential to over screen babies when jaundice was not fully visible.	To develop a SOP to support to enable first line testing to occur and help to streamline screening thus reducing potentially unnecessary testing.
Post Take Ward Round Standards – Re Audit	Poor documentation was identified during the original review. The re-audit demonstrated that overall improvements had been achieved however further work was necessary to the proforma once fully embedded.	To continue with the proforma that acts as a prompt for investigations, to support patient safety and patient flow. To continue the audit as a Quality improvement project in the next financial year.
30 day mortality post endoscopy	All endoscopies were done for an appropriate indication. Rockall score not done in	Information sessions to be scheduled to ensure all staff understand the importance of

	15% of the patients	documenting the Rockall Score
Effective Theatre Utilisation during Summer Holidays	The review identified theatre utilisation was reduced during the summer weeks and was suboptimal (<90%)	A trial period of theatre utilisation is to be undertaken during the Easter holidays 2020 with the aim of improving theatre productivity.
Oxygen prescription audit Trust Wide	The audit identified low compliance to the standards	An action plan was derived that constitutes a trail pharmacist on a ward as a pilot to review the prescriptions daily. Investigation underway to identify feasibility of changing the Drug charts to place oxygen in the prescribed medicines section to act as a prompt reminder.
Overdose of insulin due to incorrect abbreviations	The audit identified good practice however the clinical guidance on the intranet were outdated	Action was taken to ensure the out of date guidance was removed and replace with the UpToDate guidance. Regular audits by pharmacy to continue
Mis selection of high strength midazolam	The audit identified an out of date policy was on the intranet. High strength doses were found in areas with no evidence of a risk assessment in the ward areas.	Pharmacy acted on the outcome and removed all high strength dosages from areas. The policy is in the process of review. All areas reminded about the risk assessments that need to be completed in line with National guidance. All antidotes to be checked in areas that carry high strength doses. Spot audit to be conducted.
NatSSIPs LocSSIPs	The audit identified compliance across the Trust was improving but still failed to meet National recommendations	An action plan is in place to drive compliance and improvements through standardisation and target forms for the areas of use. Regular walk about to raise awareness and act as prompts. An Observation audit is to be targeted in the new financial year to supplement the notes review. Established monthly submission checks to give ownership to the areas of use.
Resources to support safer bowel care for patient at risk of autonomic dysreflexia	Good compliance was noted against the national standards apart from attendance at the training programme.	An action plan to improve compliance is in development.
Valproate	Poor documentation around the use and reviews were identified.	An action plan is to be developed to review current practices and adopt /accept National guidance.

3.4 CQUIN

A proportion of the Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services.

This income related to quality improvement is part of the Commissioning for Quality and Innovation payment framework, and formed part of agreements with local Clinical Commissioning Groups, NHS England and the Local Authority. The financial value attached through the framework to delivery of the agreed improvement goals in 2019/20 was 1.25% of the value of all healthcare services commissioned through the respective contracts. This equated to just above £2.2 million for the Trust in 2019/20.

There were 5 CQUIN schemes for 2019/20. This includes 3 National (CCG) schemes, 1 NHS England Specialised Commissioning scheme and 1 NHS England Dental scheme.

3.5 Information on registration with the Care Quality Commission (CQC)

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

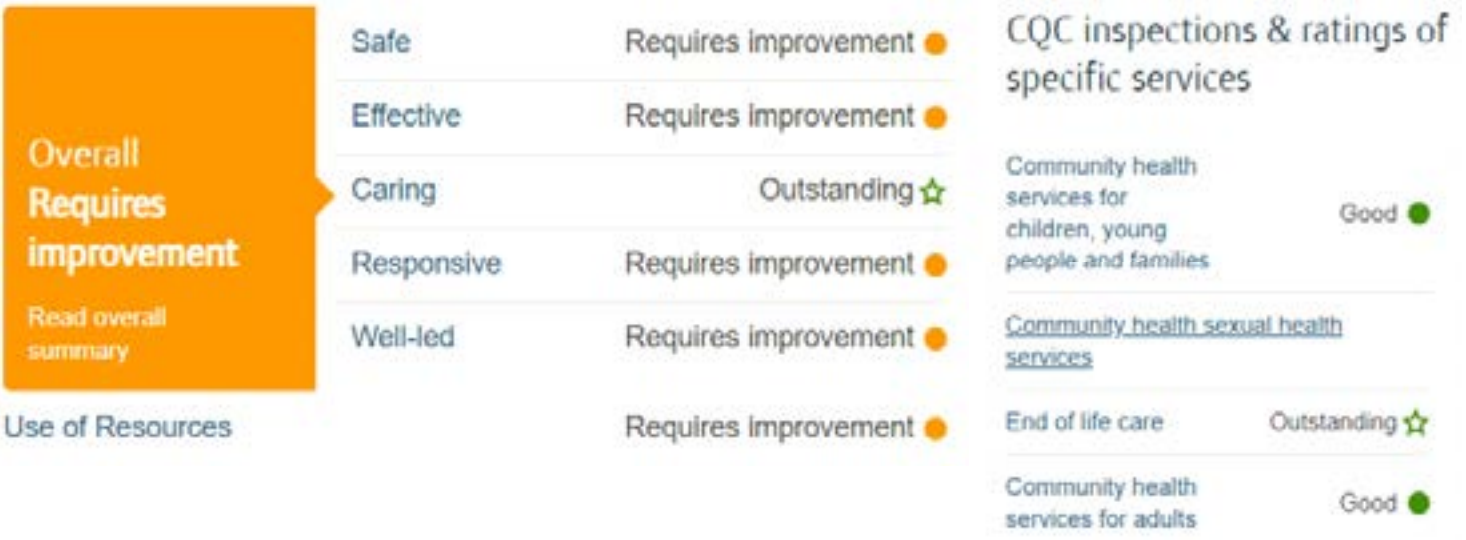
The Trust received an unannounced focus inspection of its maternity services on the 5, 6 and 12 June. The purpose of the inspection was to determine if the maternity services at Walsall Healthcare NHS Trust had made the improvements highlighted following the 2017 inspection and if the requirements of the warning notice had been met.

The CQC also carried out a comprehensive inspection of the Trust's:

- **medicine and critical care services on 4 – 6 February 2019,**
- **urgent and emergency care, surgery and maternity services on 11 – 13 February 2019,**
- **Community Sexual Health Services on 25 and 26 February 2019 and**
- **Well Led requirements was undertaken on 19-21 March 2019.**

In addition, NHS Improvement (NHSI) conducted the Use of Resources inspection on the 8 February 2019.

The final Quality Report detailing the inspection findings was published on 25 July 2019 with the results shown below:-



Ratings for the Combined Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Community	Requires improvement Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019
Overall trust	Requires improvement Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019

Ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Good Dec 2017
Community health services for children and young people	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Community end of life care	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017
Community health sexual health services	Requires improvement Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Overall*	Requires improvement Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019

Ratings for Manor Hospital

The Trust was subject to 5 enforcement notices as follows:-

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good ↑ Jul 2019	Good → ← Jul 2019	Good ↑ Jul 2019
Medical care (including older people's care)	Requires improvement → ← Jul 2019	Requires improvement ↓ Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Good → ← Jul 2019	Requires improvement ↓ Jul 2019
Surgery	Requires improvement → ← Jul 2019	Requires improvement → ← Jul 2019	Requires improvement ↓ Jul 2019	Good → ← Jul 2019	Requires improvement ↓ Jul 2019	Requires improvement → ← Jul 2019
Critical care	Good → ← Jul 2019	Requires improvement → ← Jul 2019	Good → ← Jul 2019	Requires improvement → ← Jul 2019	Requires improvement → ← Jul 2019	Requires improvement → ← Jul 2019
Maternity	Requires improvement → ← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good → ← Jul 2019
Services for children and young people	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
End of life care	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Outpatients and Diagnostic Imaging	Good Dec 2017	N/A	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017
Overall*	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019

- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 12 HSCA (RA) Regulations 2014 Safe care
- Regulation 11 HSCA (RA) Regulation 2014 Need for consent
- Regulation 5 (Registration) Regulation 2009 Registered manager condition

In response to the report, the Trust has continued to manage the must and should actions via the Patient Care Improvement Plan (PCIP) along with the requirement notices issued. The work and progress has been reported to the Quality, Patient Experience and Safety Committee and Trust Board.

3.6 Information Governance Toolkit attainment levels

Walsall Healthcare NHS 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 assessment enables organisations to measure their performance against the National Data Guardian's (NDG) 10 data security standards, compliance with legislation and central guidance to assess whether personal information is handled appropriately, and protected from unauthorised access, loss, damage and destruction.

The Trust has completed the DSPT for 2019/20 evidencing the requirements and providing assurance in relation to 115 of 116 mandatory assertions. The Trust was unable to demonstrate the required target of 95% of all staff being appropriately trained in data security awareness. Walsall Healthcare NHS Trust's Information Governance Assessment for 2019/20 is therefore 'standards not fully met – (plan agreed)'.

The Trust continues to monitor its Information Governance mandatory training compliance, and through audit scrutinises records quality, storage and retention. Our Information Governance improvement plan for 2019/20 was overseen by our Information Governance Steering Group, chaired by our Director of Governance and attended by the Trust's Caldicott Guardian and Senior Information Risk Owner.

The Trusts' toolkit is shared with the Care Quality Commission (CQC), NHS England and Improvement, and provides important evidence for the key line of enquiry on Information in the CQC well-led inspection.

3.7 Clinical Coding

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The audit used the Clinical Coding Audit Methodology v13.0 from the Clinical Classifications Service (CCS) at NHS Digital. The auditors are approved by the CCS and follow the Clinical Coding Auditor Code of Conduct Version 10.0.

The audit of 202 Finished Consultant Episodes (FCEs) was commissioned by the Head of Clinical Coding at the Trust. The audit sample of 202 episodes for this report was drawn from activity between April and June 2019 in two areas; General Medicine and Dermatology. The audit took place 11-12th February 2020.

Results

The overall coding inaccuracy rate of 2.6 per cent is much lower than the national 6.5 per cent average error rate as identified in the latest available national Payment by Results Report for 2014/15.

The accuracy of the coded clinical data has increased in every area since the 2018/19 audit was undertaken. The accuracy of the diagnosis coding has improved so that now only 2.6 per cent of diagnosis codes are inaccurate in any way. Excluding the non-coder errors, related mainly to documentation availability, the overall error rate is just 1.6 per cent.

Area	Level of attainment - Mandatory	Trust Percentage - Correct
Primary Diagnosis	>=90.0%	* 92.1%
Secondary Diagnosis	>=80.0%	98.4%
Primary Procedure	>=90.0%	97.2%
Secondary Procedure	>=80.0%	96.9%

* Excluding the Non-Coder Errors, the accuracy of the primary diagnosis is 98.0%

3.8 Information on the quality of data

Walsall Healthcare NHS Trust can confirm that it submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) for national reporting purposes.

April 2019 to March 2020

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

- admitted patient care = 99.54%
- outpatient care = 99.94%
- accident and emergency care = 99.48%

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%

Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.

3.9 A consolidated annual report on rota gaps

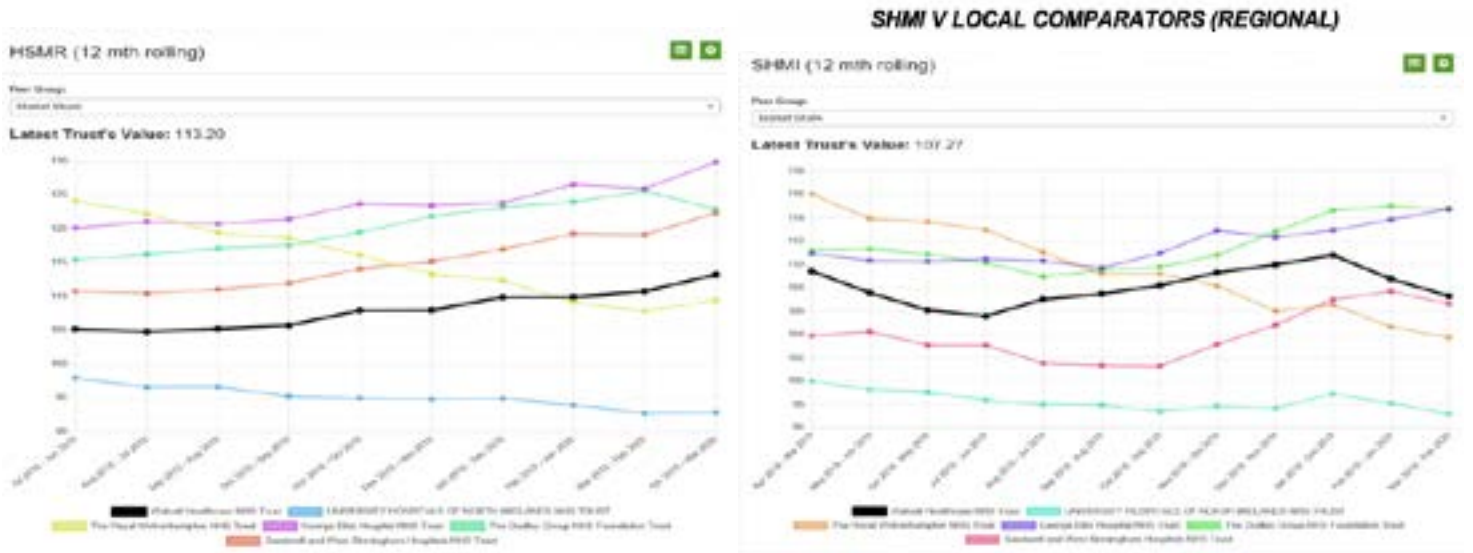
A Programme Lead for medical workforce was appointed in July 2019. Since then, the Trust has successfully implemented a new job planning and WLI policy, undertaken Trust wide job planning and is in the process of implementing the remaining units within a software management system to help utilise medical staff to reduce rota gaps and developed a more sustainable workforce programme. The Trust has also gained approval to work in partnership with RWT's Clinical fellowship programme that will work alongside our MTI recruitment programme in the appointment and development new doctors. The Trust has also approved the recruitment of workforce into ambulatory emergency care pathways in line with its strategy for Walsall Together.

In 2020/21, the Trust will continue to develop new roles, implement the SAS charter and continue partnership working with MTI schemes, particularly for difficult to recruit into specialities.

3.10 Learning from Deaths

During the reporting period April 2019-March 2020, 1066 patients died as in-patients of Walsall Healthcare NHS Trust or within 30 days of discharge.

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.



In line with National Quality Board (NQB) guidance the trust updated its Learning from Deaths (LfD) Policy in 2017 to include the Learning Disabilities Mortality Review (LeDeR) process and in 2019 to include a clear internal governance structure to link for Trust wide learning in line with Safeguard. In addition, the Structured Judgment Review (SJR) process was embedded in practice in 2017/18 to identify patients for review using a defined set of triggers derived from NQB guidelines. In total, 658 deaths were flagged for review in this way.

Trust Overview	April – March 2020
Number of Deaths	**1066**
Number Scrutinised by ME	**51**
Number Appropriate for Review (Adult Inpts)	**658**

In 2019/20, 475 (81% of flagged records) patient records were reviewed. In each case an assessment was made by the reviewing clinician of the overall quality of patient care. Assessment of quality of patient care is completed using a standardised mortality screening tool. The results for 2019/20 are as follows:

Score (2019/2020)							
1	**2**	**3a**	**3b**	**3**	**4**	**5**	**LD**
1	8	10	84	8	294	83	10

Trust-wide, mortality review and return rates have been recognised as an area for improvement. Audits show that of the notes available, 75% of reviews had been completed. Remedial actions were agreed further through the Mortality Surveillance Group and Medical Advisory Committee, and Divisional leads expected to provide oversight.

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**
- **Resuscitation Group**
- **Divisional Safety huddles**
- **Care Group Meetings and Divisional Quality Boards**
- **The 'Daily Dose' e-mailed to all staff on a daily basis**

Some of the learning, service developments and changes in practice identified from reviews in 2019/20 included:

- Working with Walsall CCG to develop and embed a Designated Doctor of Death role and Child Death Overview Panel, to improve the child death review process.
- Fractured neck of femur deaths: A quality service improvement project which has streamlined the pathway leading to faster access to theatre for operating, more consultant involvement and joint orthogeriatrics pathways of care including post-operative delirium assessment, physiotherapy assessment on the first day after surgery and reduction of acute kidney injury. Further improvements are on-going including benchmarking and learning from other Trusts.
- Speech and Language Therapy (SALT): To improve pneumonia-related ill health and mortality, SALT have put an action plan in place to embed improved oral care trust-wide and to support safer nutrition.

Part 3:
Review of other quality performance

1 Quality Improvement Academy

QI Academy & QSIR Programmes

At the start of February 2020, the QI Academy completed its second year of delivering training, building on the sound foundations developed through its first year in 2018 and now using the QSIR Programmes. During 2019/20 the accredited QSIR trainers delivered 12 open sessions of the one day QSIR Fundamentals programme and three sessions for specific staff groups including; the Palliative Care Team leaders, regional library managers and delegates on the Band 2 – 6 Development Programme. Delegates on the Senior Nursing Development Programme were encouraged to participate in the QSIR Fundamentals programme to support their delivery of a QI project, which was an essential part of their overall programme. A total of 179 members of staff undertook this QSIR Fundamentals programme during 2019/20.

The QSIR trainers also delivered 5 cohorts of the 5 day QSIR Practitioner course, through which 87 members of staff completed their training and 20 members of staff need to finish one or two days to complete and are scheduled to do that during 2020/21.

The Trust currently retained has 5 Accredited QSIR trainers having lost 2 but recruited and accredited 2 others. Retaining trainers and developing more is an ongoing priority for the QI Academy. To address this there are an additional 6 colleagues undertaking the training that, once accredited, should be able to deliver training through 2020/21.

The plans for delivering 5 fully subscribed cohorts during 2020 have been finalised and submitted to the Advancing Change and Transformation Academy who accredit the QSIR Programmes. There is also a plan to deliver a further 5 cohorts through 2021. Achieving these plans would give approximately 10% of the Trusts staff as having completed the 5 day programme by December 2021.

One of the key elements of delivering QI changes is Leading Quality Improvement and the QI Academy is developing a programme for those managers who will lead and support colleagues to deliver QI Changes locally.

QI Sessions within Induction Programmes

The QI Session continues to be an essential part of the trust's Induction programme and the slide set has been refreshed to cover the three key QI tools and approaches which the Trust has undertaken;

- Model for Improvement,
- Measurement for Improvement and
- NHS Sustainability model.

All new starters joining the trust undertake this session.

The QI faculty have strengthened the approach for induction for incoming Doctors about their understanding of what Quality Improvement is, how it differs from clinical audits and how their colleagues have been involved and they could become involved in on-going QI projects or identify new ones in their specific areas. There was also a session for junior doctors as part of their Induction training.

Ad hoc QI training

Ad hoc QI Training has been delivered to teams from the Pharmacy department, Chemotherapy Daycase, Adult and Children Safeguarding team, Anaesthetics team and A&E staff. These have used the QSIR Fundamentals as the basis for their training. More is planned for 2020/21 including a session for regional anaesthetics and intensive care staff, which has been supported by the West Midlands deanery for study leave.

In the summer of 2019, the QI Academy delivered 4 awareness raising sessions for Healthcare Systems Engineering. Over these 4 workshops, 47 members of trust staff had their understanding of what causes delays and capacity challenges through clinics challenged and then supported to design a system that delivered a scenario that had improved safety, effective flow, improved quality and productivity. Two colleagues have started the Health Care Systems Engineering programme to develop in-house practitioners and are working on projects in Antenatal and Trauma and Orthopaedics.

QI Awards and QI Conference

The first QI Awards evening was held in July 2019 where medical colleagues were able to submit abstracts on QI Projects that they had undertaken with a view to being invited to either deliver an aural presentation or submit a poster. There were 32 posters and 5 presentations on the evening. Plans for the 2020 QI Awards session are currently being developed and it will be open to all colleagues from across the Trust and its partner organisations.

There was one QI Conference during 2019/20 held in November 2019 where colleagues who had undertaken the 5 day QSIR Practitioner programme were able to present on their QI changes. Also within that day was a break out session where the National Analytics team from NHS England and Improvement delivered a session on measurement for improvement and their "Plot the Dots" session.

Human Factors

The trust was commissioned to deliver a limited number of sessions on Human Factors through 2019/20 which were delivered and planning for a larger programme for 2020/21 are being developed and have been supported with external funding.

QI Strategy

The Trust has revised its original QI Strategy setting out its continued approach to build capacity, capability and confidence in the application of the QI tools, methodology and approach, which it will continue to promote over the next few years.

New for 2020/21

As well as the aspects mentioned above for continued embedding of QI within the organisation, the introduction of Improvement Huddle Boards is just being initiated and will be progressed through 2020/21. These are a combination of the Improvement Boards that both Western Sussex NHS Foundation Trust and Birmingham Women's and Children's NHS Foundation Trust are using for local improvements within services, departments and wards, and a story board that explains what the aims and drivers for the service are.

The QI Academy is developing a programme for supporting those colleagues who undertook the QSIR Practitioner Programme to become QI Coaches and for them to support their colleagues across the trust.

2 Duty of Candour

Walsall Healthcare NHS 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.

There is a Duty of Candour guidance pack as an appendix to the policy which gives staff useful information on all of the above aspects of the process. The Patient Safety teams also support staff with the process

and continue to provide bespoke individual training to colleagues where identified. The Trust uses a series of information leaflets in use, targeted towards specific patient groups (adult inpatients, paediatrics, maternity) which is 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. The leaflet also enables the Trust to comply with the regulation to provide in writing a summary of what was verbally discussed.

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. During the Trusts CQC inspection in 2019, they noted that consistent application of the duty of candour process, particularly ensuring patients and / or their families and carers have the opportunity to meet with representatives of the Trust, was an area for the Trust to seek to improve; this has been a component of the Trusts PCIP action plan to ensure this recommendation is acted upon and implemented fully in all areas.

3 Patient Care Improvement Plan (PCIP)

The Trust has continued to use the PCIP however it is the intension of the Trust, as it builds its overall Trust Improvement Programme, to incorporate the Patient Care Improvement Plan enabling a more systematic, trust wide approach. To enable this, the PCIP has since been "Themed" to allow for easier alignment to the overarching Improvement Programme also enabling improved aggregation to the Trust Improvement KPI's. This will also further improve the Divisions ability to work collectively across Division and with our Partners enabling a Project Delivery approach to be adapted which can be support by the QI Academy. This will also improve the Governance of the PCIP by incorporating it into a Trust Wide Programme Governance Framework.

4 Number of 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 2019/20 there has been 1 Never Event reported by Walsall Healthcare NHS Trust, which related to a retained foreign object post procedure which was identified to have occurred in 2017; this incident was investigated via the Trust local serious incident investigation process, based upon National best practice, with lessons shared widely with action to prevent recurrence monitored.

5 Number of serious incidents

During 19/20, the STEiS system shows the Trust reported 94 serious incidents compared to 143 in 2018/19, the main categories were 21 incidents of Treatment delays meeting SI criteria, 21 slips trips and falls meeting SI criteria and 19 HCAI infection control serious incidents.

The key learning messages from SIs are cascaded via a number of sources including weekly Divisional Safety Huddles, local ward, departmental and other local based initiatives where available, 'Incidents at a glance' one page summaries describing the incident, lessons learnt, and Monthly Lessons learned bulletin.

6 Learning from complaints

The Patient Relations team provides access to the department via a designated email address, telephone, the Trust website, and via the receipt of written correspondence - the team also offers face to face contact via the department from 09:00 hours to 16:00 hours Monday – Friday. There is also an answer machine for out of hours.

Patient Relations is at times perceived to be just about 'complaints' when in fact our work and the support we provide is much broader. Everyone is welcome to contact the department whether they are a patient, relative, carer or member of staff, and a friendly, professional welcome is given to all. We have access to a wide range of information to help where we can and during the day we respond to many requests for information and advice and signpost all who access our service in the right direction. Our remit is 'if we don't know, we will find out who does'. The team also continues to attend the ward and clinic areas as and when we are required.

We provide support to Trust staff enabling them to respond to concerns and complaints in a positive manner. For example; helping to resolve concerns as and when they happen; providing information to the patient with respect to internal processes, i.e. being involved in Multi-Disciplinary Team Meetings (MDT) and arranging attendance and guidance.

The Patient Relations team also provides pastoral support and family liaison support to the complainant through the complaints process. The team continues to work closely with the Divisions to respond in a proactive manner to concerns received within the Trust. This entails immediate involvement of the Divisions as well as contacting nursing staff, clinicians and administration staff in any particular area, to liaise and respond to concerns in real time. By providing the link between staff, patient, relative or carer and offering the support to everyone involved leads to a greater degree of satisfaction for all concerned and embeds a culture where learning and feedback is valued.

The team continues to encourage the empowering of staff to work with us proactively to resolve concerns at source. The team provides support to staff, patients, carers and their relatives through difficult times without always having to engage in the formal complaints process. In the past year we produced a guide to assist staff in informal resolution of concerns in addition to a separate guide to aid effective resolution of complaint meetings. We are always appreciative of the support we receive from staff from all areas and levels as this provides us with the confidence that we work as one team, successful in the building of firm relationships with our colleagues.

We work closely with the Patient Safety, and Adult and Children's Safeguarding Leads, and attend the weekly divisional safety huddles providing information on complaints and concerns received each week, as well as providing the more positive aspects of information received. These meetings assist in the triangulation of incidents, claims and complaints discussed on an individual basis to enable a more in depth discussion to assist with the decision making of how they are to be taken forward. These can include complaints that are also reflected in a Serious Untoward Incident, complaints received from MPs, and where specialist advice is required. This ensures prompt decision making regarding the progression of these complaints and, where appropriate, instigation of investigations through the Root Cause Analysis process or independent reports from clinical and nursing experts externally.

The Department also works with the legal and claims team to liaise with relatives who have any outstanding concerns following an inquest and acting on communication/instruction from the Coroner. Working with the office of the Parliamentary Health Service Ombudsman (PHSO), we have built positive links with case workers; providing the necessary information and advice for a speedy and thorough resolution to their investigations. This enabled us to take an active role in the forthcoming national standardisation of Complaints and the development of an accredited training programme.

Advocacy links are maintained via ICAS (Independent Complaints Advocacy Service) and Healthwatch to ensure that the complainant is signposted to independent advice and direction to an advocate that is right for them when this is required. As such our relationship with Healthwatch Walsall has grown and we have worked alongside Healthwatch to provide information and resolution to concerns or questions when raised.

We have seen a reduction of the number of contacts responding to both the complaint satisfaction survey and equality monitoring survey. This will need to improve and a variety of options will be utilised in order to further capture this valuable information.

Our priorities for 2020/2021 include:

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

1) **Develop an e-learning module with certification to replace the Trust complaints update which is out of date.**
2) **Introduce virtual meetings for patients/families rather than meeting face to face following COVID -19 adjustments.**
3) **Improving the collection of Equality data, the team will also be scoping using the envoy messaging service to obtain feedback on the service.**

2019-2020 Activity

During 2019/2020 a total of 4,176 contacts were received by the Patient Relations Team which is an increase of 399 contacts from the previous year. This figure includes a total of 359 written complaints (KO14a) about care addressed in letters to the Chief Executive. Of these 344 were written complaints, 6 were letters received via Members of Parliament (MP letter) and there were 9 informal to formal converted complaints. The total figure represents an overall increase of 13 complaints compared to the previous year 2018/2019. Throughout this report 'K041a' written complaints are referred to as 'complaints' and these are managed through the Trust's complaints process and reported quarterly to the HSCIC (Health and Social Care Information Centre).

Complaints

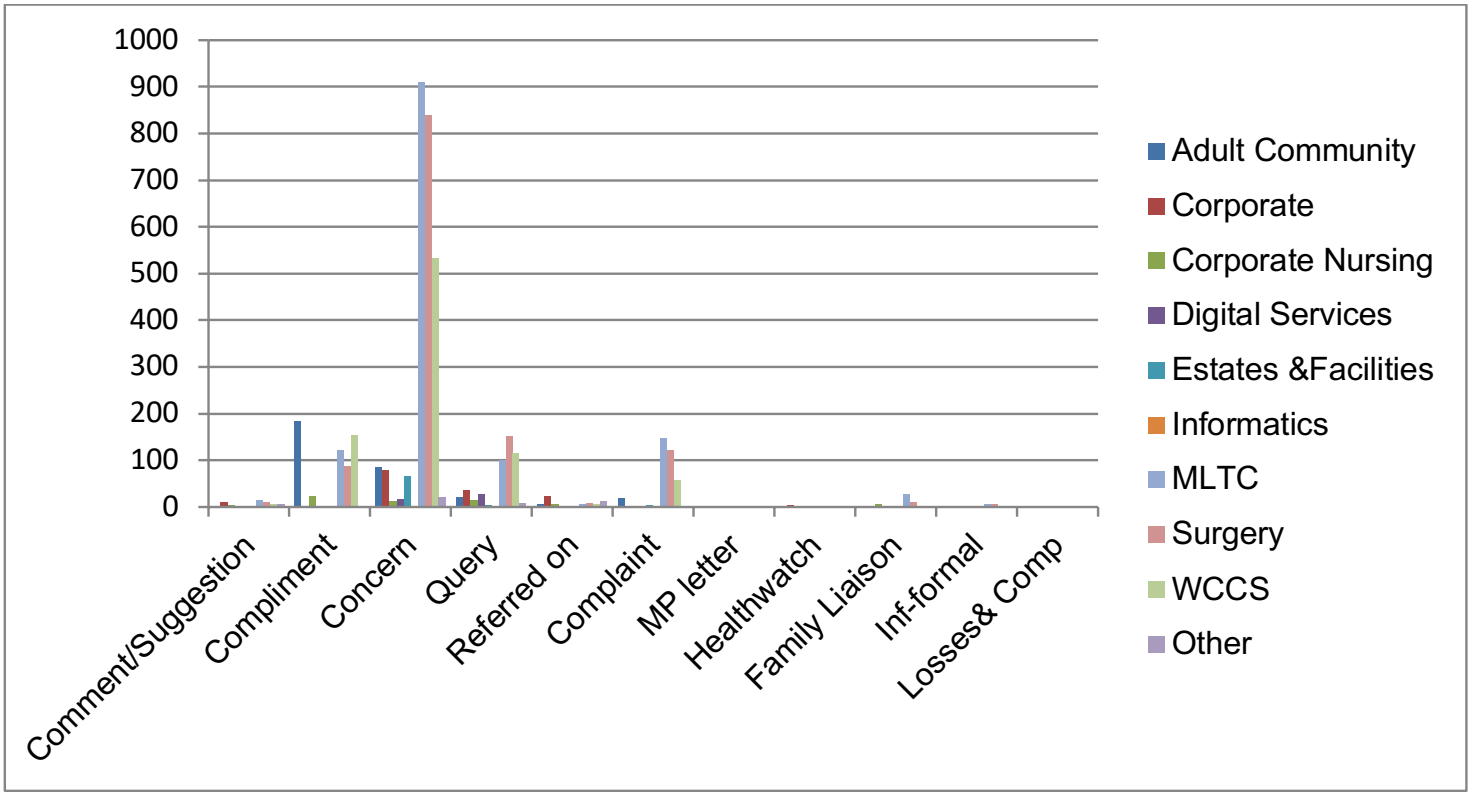
This section details written complaints received during 2019/20.

Complaints by Division

- There has been an overall increase of 13 complaints compared to the previous year 2019/2020. The Divisions of Medicine and Long Term Conditions (MLTC) and Surgery generated the greatest number of complaints, accounting for 77% of all complaints received.

MLTC (152 complaints), Surgery (127), Women's Children's and Clinical Support Services (WCCS-60). Corporate functions, Urgent Care, Estates and Facilities and Adult Community account for the remainder.

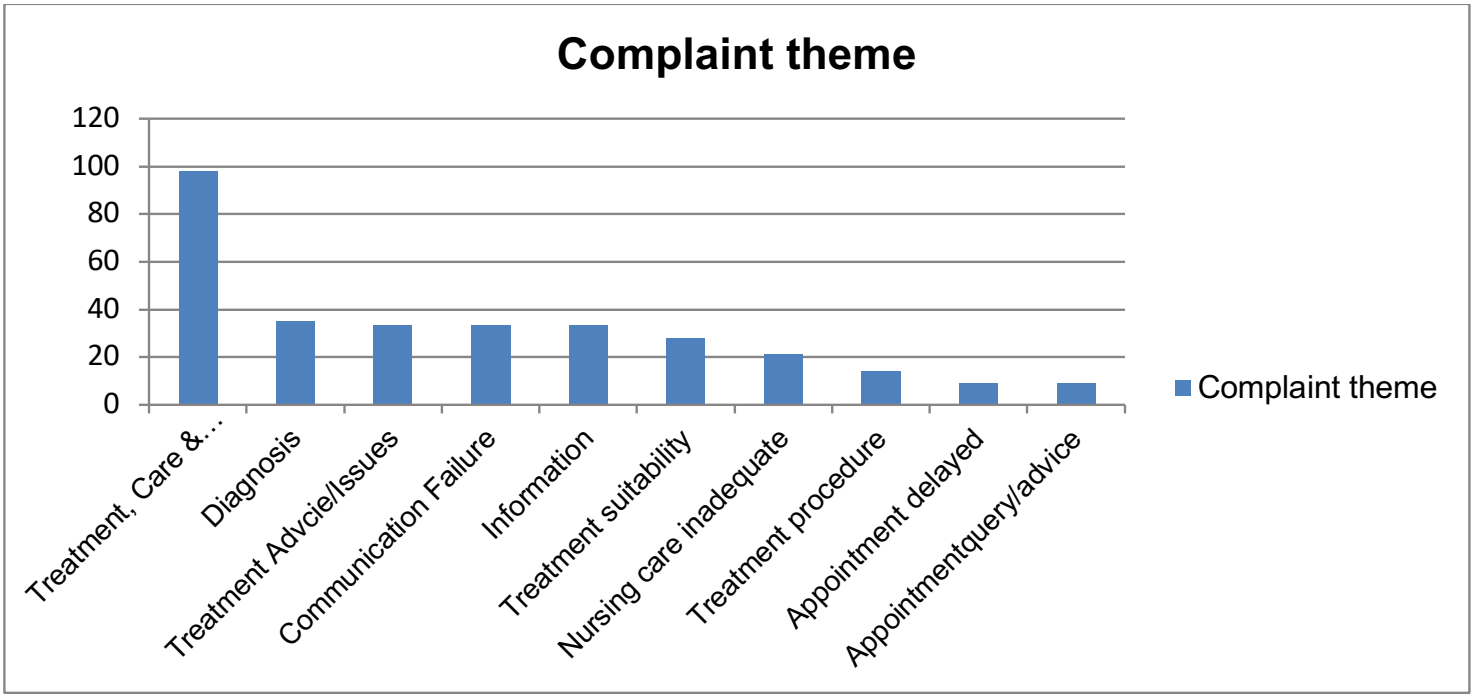
Complaints by activity type Table 2.



Complaints by category type

During 2019/2020, there were 409 complaint types by category with the main theme emerging from formal complaints being treatment care and supervision. This accounted for 24% of all complaint categories, 98 complaints fell within this domain. The top 10 category types from all complaints are highlighted in the table below.

Complaints by category Table 3



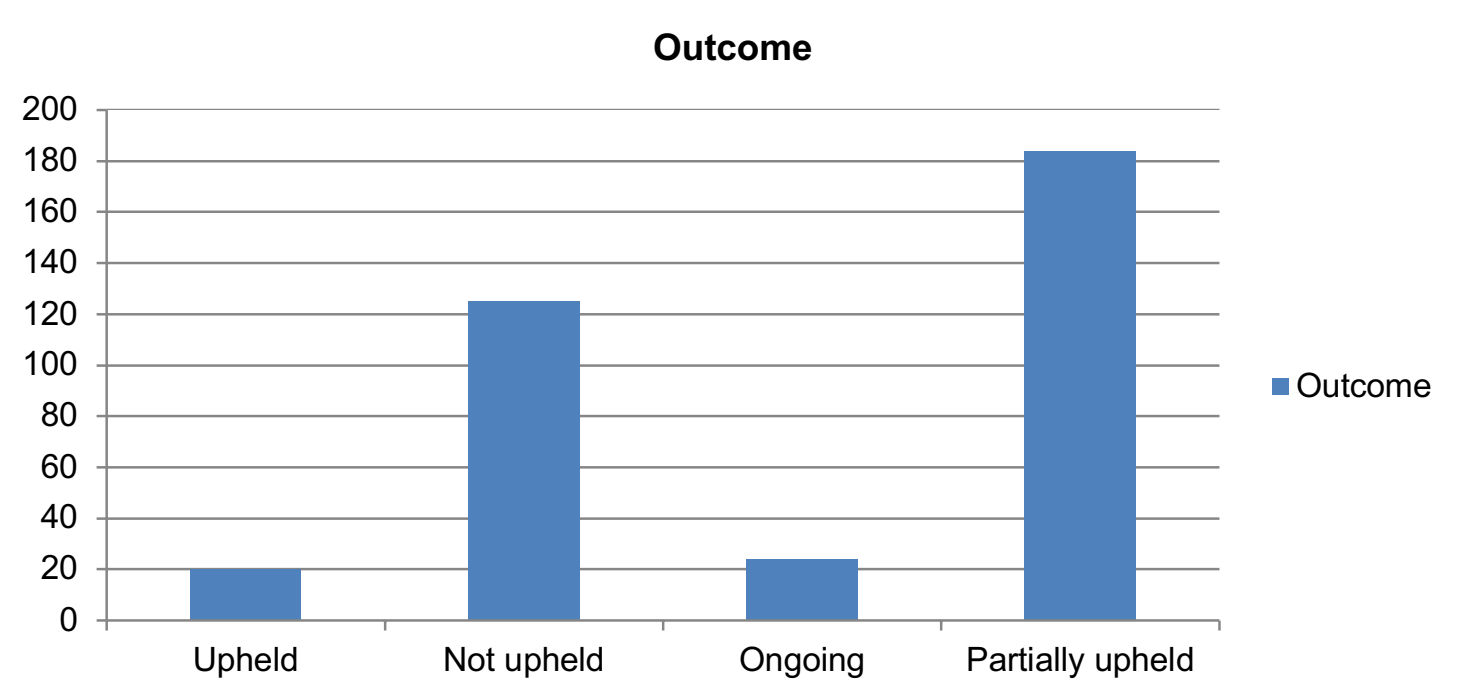
Complaints via patient activity (10,000 spells) 2019/2020

The number of complaints versus patient activity was 9%. This is calculated as the number of complaints divided by-elective, non-elective and emergency patients (40,942) and multiplied by 1000.

Complaints by outcome

At the time of completing this report, the total number of complaints resolved was 334.
20 complaints were upheld with 126 not upheld and 186 partially upheld. 21 complaints are ongoing with 4 withdrawn.

Complaints by outcome Table 4

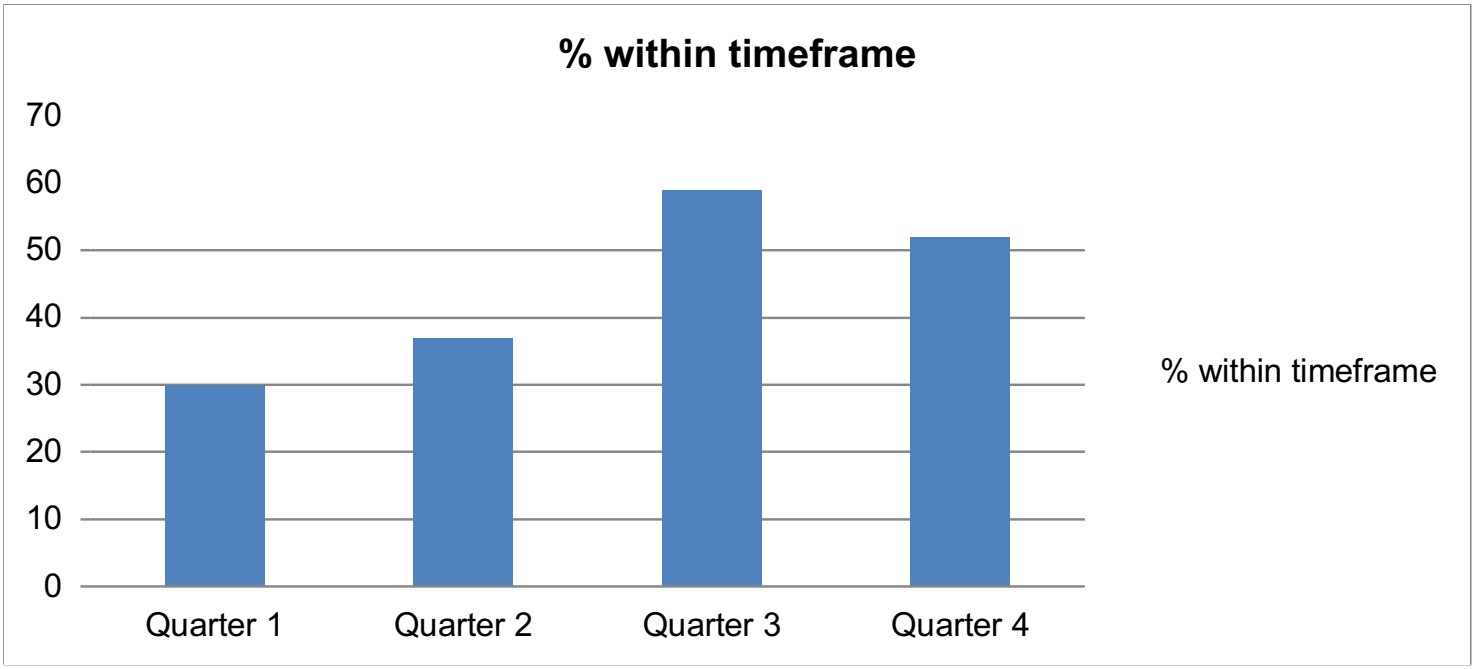


Response times

The 2009 Complaint Regulations removed the 25 working day target to provide greater flexibility with the intention for minor complaints to be resolved much quicker whilst accepting that longer timescales will be needed for the most complex/severe. The Trust target is 80% of all complaints to be completed within 30 working days. 45% of written complaints were completed within 30 working days for 2019/2020.

During the year there was a change in the approach used to record complaints completed within timeframe, from timescales agreed with the complainant (which the regulations allow) to one which focused directly on number of days to complete. The difference in recording highlighted that in the main the organisation was not meeting the local target of completion within 30 working days for 80% of all complaints. Actions have been undertaken to address this in year with a reduction in the backlog of complaints and a clear escalation process where support is required.

Complaints timeframe Table 5

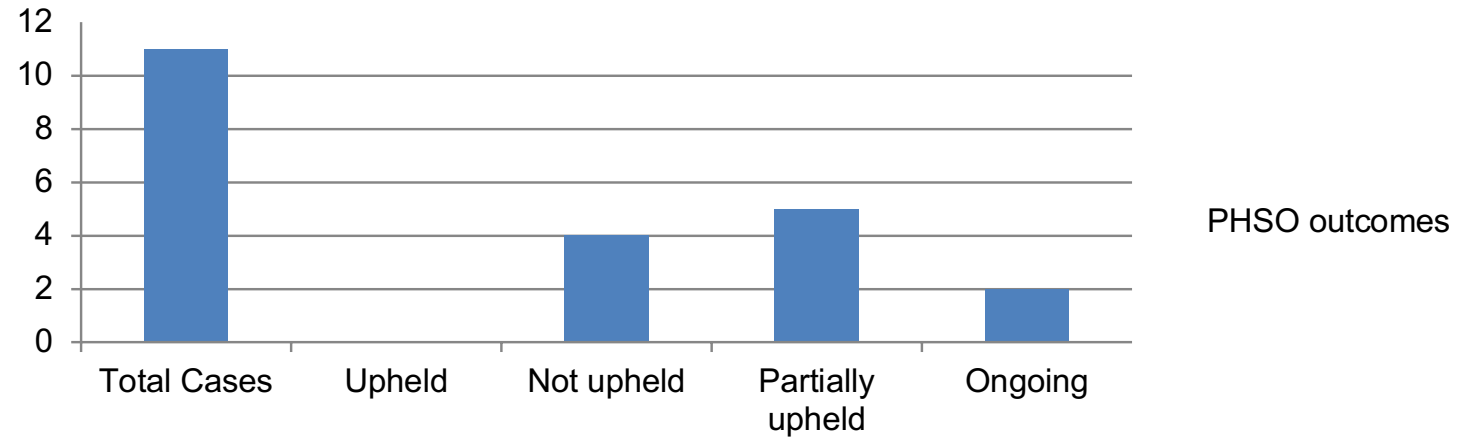


Supportive action is in place to manage caseloads and provide ongoing support for the divisions. This has included a deep dive of all cases identifying complaints that can be responded to via available records, and some support via re-deployed nursing staff – one each from Surgery and Medicine who have coordinated, led and investigated a number of additional complaints. Patient Relations team staff have also acted as coordinators in order to 'template' complaints where investigation statements have been received. In addition complaints requiring escalation i.e. potential serious incidents, safeguarding, mortality/subject judgement reviews are also facilitated.

Parliamentary and Health Service Ombudsman (PHSO) Cases

In 2019/20, a total of 11 cases were accepted via the PHSO for investigation. This equates to 3% of all complaints received. There are nil cases open from the previous year 2018/2019. 9 were cases completed during this year with 2 ongoing.

PHSO Cases and outcome Table 6



Themes emerging include:

- **Concerns highlighted with regard to clinical care assessment and treatment,**
- **poor communication,**
- **inadequate pain management and**
- **poor nursing care.**

Outcome from PHSO cases closed & lessons learned from complaints closed

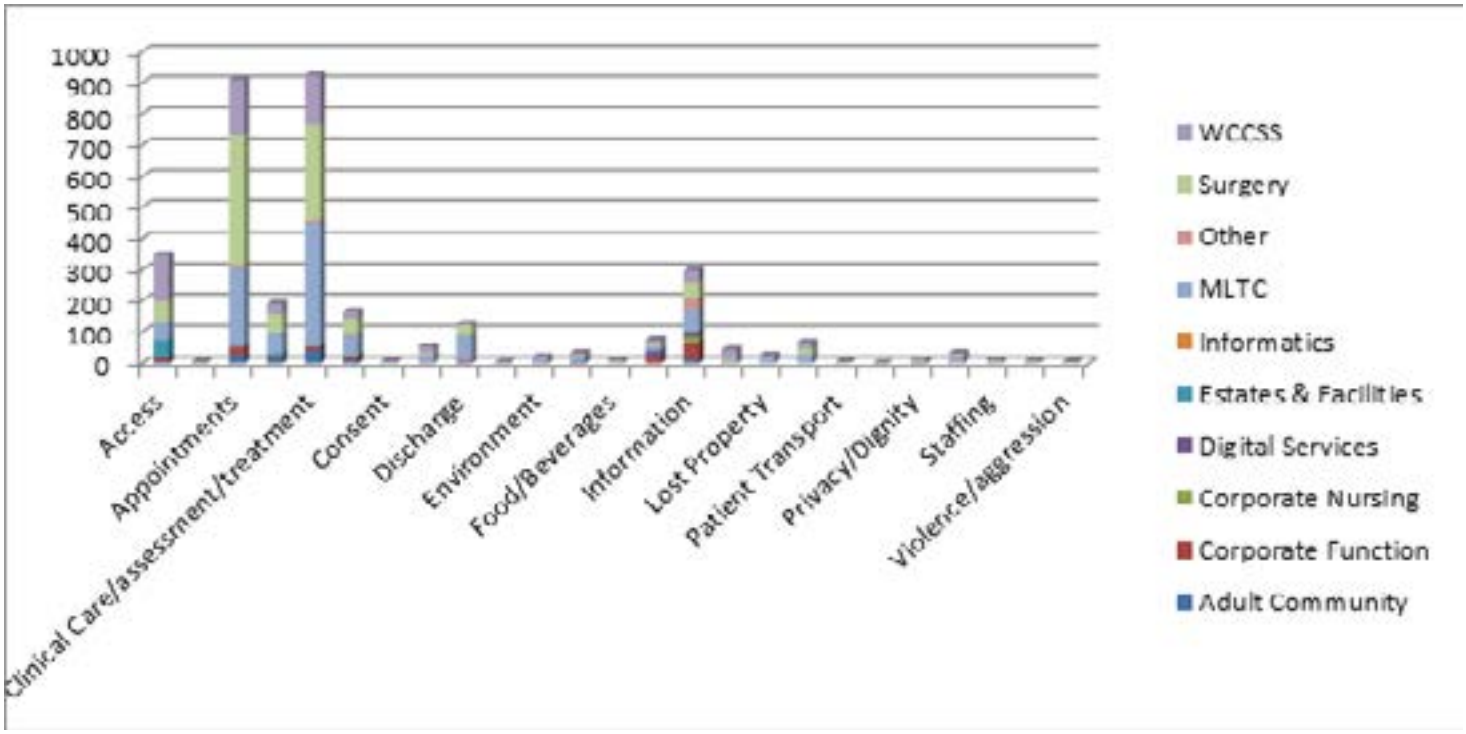
Action plans are submitted within a timeframe set by the PHSO and evidence is included of compliance. Lessons learned from complaints closed are recorded and disseminated.

Concerns

There were a total of 3,395 concerns received during 2019/2020 an increase of 507 concerns from the previous year (2,888).

This figure includes concerns (2,834), comments, suggestions and queries and referred on (553), Losses and Compensation 3, Health watch referrals 2, other PALS 3. MLTC equated for 33% (1,133) of the total activity, with Surgery 32% (1,074) and WCCSS 20% (685).

Concerns by category and type Table 7

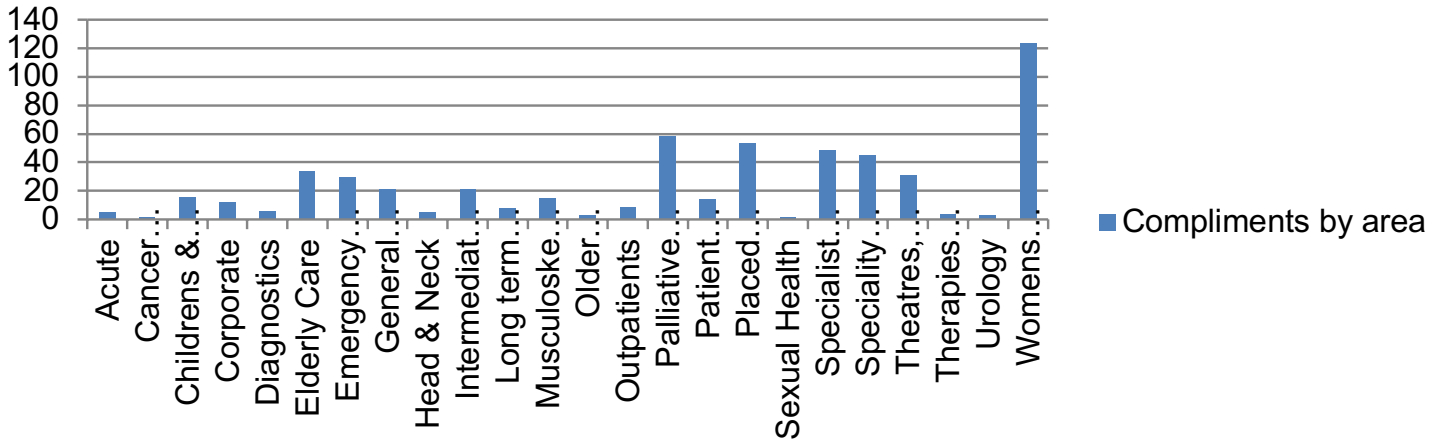


The main themes identified via the number of concerns raised are clinical care, assessment and treatment (925) 27%, Appointments (910) 26% and patient access issues (appointment linked) (348), 10%.

Compliments

439 compliments were received by the Trust. Women's Services (124), Placed based teams (54), Palliative Care (50) and Specialist Services (49) accounted for the majority of compliments recorded – 64%.

Compliments Table 8



☺ Please thank the staff for community nursing South team - the staff were professional, treated my dad with kindness and respect in what is and remains a very difficult time for you all

☺ Karen is a true asset to the health in pregnancy team and I only wish I was eligible to access her services longer

☺ Ward 7 – 'From me to you, and all you do, I send this card to say thank you – to all doctors and nurses at Walsall Manor Hospital especially Ward 7 for all you have done for me'

☺ Ward 15 – 'Every person on this ward gives 100% of their profession and care, my hospital stay could not have been made any easier and a massive thank you from me and my family'

☺ West 2 Community Nurses – 'Thank you so much for all you have done for me and continue to do for me – it is very much appreciated'

☺ Accident & Emergency – 'The nurse who looked after me was very professional and caring she gave us information that was factual but in a way that did not make it too distressing, she also ensure I was comfortable and is a credit to the profession'

Complaint Satisfaction Questionnaire

Our feedback survey is based on the 'I' statements outlined in the Parliamentary Health Service 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 10% return rate (38 responses):

- **Making a complaint was straight forward : 87%**
- **I knew I had the right to complain: 97%**
- **I knew that my care would not be compromised by making a complaint: 82%**
- **The staff who spoke to me regarding my complaint were polite and helpful: 87%**

- **My complaint was acknowledged within 3 working days: 85%**
- **I was informed about the complaints process: 90%**
- **I was informed of any delays and updated on the progress: 90%**
- **I received a resolution in a time period that was relevant to my particular case and complaint: 73%**
- **I am happy with my overall response time to my complaint: 74%**
- **I feel the Trust has taken my comments on board and have made changes to improve the things that I was unhappy with: 79%**
- **I would complain again if I felt the need to: 87%**

Equality Monitoring

An equality monitoring form is in place and is issued at the point of acknowledgement with 5% (18) returned in 2019/2020. Key highlights:

- **33% of service users who responded to our survey where White British, the remaining 11% where British Asian, 5% Bangladeshi, Black British and White Irish, Romany Gypsy/Traveller and Afghan.**
- **88% of all service users who responded to our survey where age 51 plus (51-60, 61-70, 71 80 and 81 and over. Only 12% where under 30.**
- **50% of service users stated their religion was Christianity, 11% Islam, and 17% did not wish to say, or had no belief.**
- **39% of responses were received from females, 33% men and 11% did not wish to state.**
- **62% of patients who responded were heterosexual, 11% Homosexual Male, 5% did not wish to state.**
- **Relationship status was varied, with the highest response being married (40%) 16% Living with a partner, single 17%.**
- **Of those who responded NIL were pregnant at the time of making a complaint with no respondent stating they had recently given birth.**
- **73% of respondents would consider themselves not to have a disability. 16% stated they had a disability namely physical impairment, long term illness and a mental health need.**

7 National Patient Safety Alerts

The Department of Health 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 1 April 2019 to 31 March 2020 the Trust has been issued with a total of 9 Patient Safety Alerts (PSA) from the Central Alerting System. Two of these alerts have been completed in line with the stipulated completion periods. 5 remain ongoing with work in progress no delays are anticipated for completion within the timescales. There are 3 outstanding alerts that have breached the implementation date and work is progressing to close these in line with the recommendations.

8 Learning from Excellence

If we can learn when things go wrong, shouldn't we be able to learn when things go right?

This is the premise behind Learning from Excellence (LfE). Inspired by initiatives in local Trusts (notably Birmingham Children's Hospital) and now gaining national recognition, we have adapted our incident reporting system as a means to capture "Excellence Nominations". Staff can quickly enter the details of an individual or team who have excelled.

During 2019/20, there were 244 Excellence nominations made:

- **30 in Adult Community,**
- **56 in Medicine and Long Term Conditions,**
- **53 in surgery and**
- **97 in Women's Children's and Clinical Support services.**
- **The remaining nominations were spread across the corporate services including Estates and Facilities.**

9 Patient Safety Walkabout visits

Walsall CCG visits the Trust routinely to assess standards of care in clinical services and support the Trust to achieve continuous improvement across all services. As in all patient safety walkabout visits, where initial feedback is provided to the visited areas. Once the formal report is received from the CCG it is disseminated to the appropriate areas and divisions.

The reports are reviewed and where any issues have been identified then actions are agreed within the Divisions to address the issues. Patient safety walkabout visit reports are discussed at divisional meetings and at a Trust Committee level via the Quality Patient Experience and Safety Committee.

Healthwatch Walsall is included as a key member of the Ward Review team who undertake unannounced visits to each ward at least annually to assess the ward against the five key domains of the CQC framework. Repeat visits are undertaken where standards fall short or where a ward requires a level of support to achieve improvement. The Ward Review report is seen by the Quality Patient Experience and Safety Committee every six months.

All members of the Trust Board are invited to take part in walkabout visits each month across the Hospital divisions and Community services using this as an opportunity to seek and provide feedback to the range of areas visited.

10 Mortality Review Process

The Trust Mortality Policy has been reviewed and revised to link the Learning from Deaths Policy with the Trust Safeguard Governance Process. Reviews are consultant-led and follow the Structured Judgment Review (SJR) process. Lessons learnt and areas of good practice are discussed first within Care Groups then at the Mortality Surveillance Group. A serious incident investigation is conducted for cases where the SJR identified sub-standard care with dissemination of lessons learnt via the monthly mortality report.

The Trust Mortality Surveillance Group is chaired by the Medical Director and reports to the Quality, Patient Experience and Safety Committee. There is representation from Walsall CCG and the group reviews the mortality dashboard, peer benchmarks, HSMR, crude mortality rate and other indicators monthly. The group decides monthly where trends require investigation, and allocates ownership as necessary.

11 Implementation of priority clinical standards for 7 day services

We will continue to implement extended working in a number of areas through new service delivery models. It has been determined that there are four priority clinical standards of the suite of ten that are considered to have the greatest impact on the quality of care patients receive, these are:

- **Time to first consultant review**
- **Availability of diagnostics**
- **Consultant led interventions**
- **On-going consultant review.**

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.

This standard was not met by the Trust at the last submission (Autumn 2019), however as part of a trust-wide medical workforce programme (MWP) of work the clinical teams are engaged in 4 key focus groups overseen by a formal programme board. The objectives of the MWP is to undertake a full workforce review to ensure effective utilisation of resources, understand the workforce requirements of each specialty to sustain services. A particular focus will be to provide 7 day medical workforce resources.

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. The Trust met this standard with the exception of MRI. Patients requiring MRI within this time frame would not be managed at the trust and would be redirected to a MTC as per network agreements.

Standard 6: timely 24-hour access 7 days a week to nine consultant- directed interventions. The Trust achieved this standard via a combination of inhouse and off site arrangements.

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.

Cardiology and acute medicine are meeting this standard by delivering a consultant-led ward round. A business case to support further medical speciality ward rounds on Sunday has been developed. Women's and Children's services have met this standard.

T&O have introduced Consultant ward rounds over the weekend and weekend cover with Consultants onsite from 9.00 am to 9.00 pm and 9.00 pm to 8.30 am non-resident.

Non Elective Services - Trauma and Orthopaedics are planning the addition of x3 ACP's to support ACP led SACU to provide 7 day cover (10pm - 8am; 7 days per week) and ACP led Elective and Emergency wards. 24/7 Mon- Sun.

12 Focus on Patient Experience

Undertake the NHSI Patient Experience Improvement Framework self-assessment and develop actions following self-assessment to ensure compliance against the framework is achieved

- Undertake the self-assessment with clinical groups using the NHSI Patient Experience Improvement Framework.
- To identify 3 key elements from the self-assessment and develop action plans for implementation.

Improve patient, carer and service user involvement in co-designing service improvements including ED & UCC New Build, OP, Cancer Services and Catering.

- Adopt new virtual ways of interacting with wider audiences in an inclusive way.
- Develop Patient Panels with specific services to improve services for patients and families.

Review and refresh the Patient Experience & Involvement Strategy.

- Working in collaboration with staff, patients, carers and wider community with wide consultation.

Develop a Patient Partnership Counsel to ensure the Trust works collaboratively with patients, service users and carers to deliver the Patient Experience & Involvement Strategy.

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

- Facilitating improvement initiatives with Divisions, Care Groups and front line staff.

Customer Care

Making Customer Care 'Everyone's Business'

We will produce a customer care guide for staff that underpins the values of the organisation. The aim of the guide is to develop a set of core and supporting standards to ensure that every patient or visitor of our Trust receives an outstanding service which reflects excellence in care.

The Trust has previously piloted a 'Values Based Customer Care Programme' and it is intended that this is re-launched and rolled out as quickly as possible subject to resources.

Values Based Customer Care

The pilot programme will be reviewed prior to roll-out with the intention of empowering staff and teams to deliver and own standards of customer care applicable to them, using the staff guide as a reflection of the Trust values and expectations. The Trust Induction Customer Care session has already been revised to reflect the Trust values and is the preferred approach to engaging staff at the on-set of appointment.

Measures:

- Reduction in number of complaints and concerns
- Increase in satisfaction via the in-patient survey
- FFT local measures to reflect WHNHST as place of choice

13 NHS Staff Survey

The 2019 NHS Staff Survey benchmark report for Walsall Healthcare NHS Trust contains the results of the 2019 NHS Staff Survey. This year the results of the survey have been collated into eleven themes (see below) with team working as a new category. The results are presented in the context of the best, average and worst results for similar organisations, for Walsall Healthcare NHS Trust the benchmark group is Acute and Community Trusts.

1. **The response rate for the Trust was 31% against 46% for the national average for the benchmark group. Completed questionnaires 1,299, 2019 response rate 31%.**

2. **The benchmark report shows a statistically significant lower score for equality, diversity & inclusion between 2018 and 2019.**

3. **The benchmark report shows a statistically significant lower score for immediate managers between 2018 and 2019.**

4. **The benchmark report shows no significant change on the remaining nine of eleven themes between 2018 and 2019.**

5. **The benchmark report shows stability on nine of the eleven themes detailed below between 2018 and 2019.**

The themes are as follows:

- **Equality, diversity & inclusion – decline**
- **Health & wellbeing – stable**
- **Immediate managers – decline**
- **Morale – stable**
- **Quality of appraisals - stable**
- **Quality of care - stable**
- **Safe environment - Bullying & harassment - stable**
- **Safe environment - Violence - stable**
- **Safety culture – stable**
- **Staff engagement – stable**
- **Team working - new**

14 Freedom to Speak Up

Sir Robert Francis' review of whistleblowing in the NHS, 'Freedom to Speak Up' (FTSU), was published in February 2015.

'Freedom to Speak Up 'concluded that the NHS does not consistently listen or act on concerns raised by whistle-blowers and that some individuals have suffered detriment as a result of raising concerns. The review set out a number of principles for NHS organisations to adopt in order to ensure that NHS staff are encouraged and supported to share concerns. The report established the Freedom to Speak Up Guardian role as a way of encouraging and supporting speaking up. All NHS Trusts and NHS Foundation Trusts were required by the NHS contract (2016/17) to nominate a Freedom to Speak Up Guardian.

The Trust has three established Freedom to Speak Up Guardians, all of whom are clinicians and between them work with the Trust Board to develop a culture within the Trust where openness, transparency and speaking up is encouraged and recognised as a way of supporting patient safety and care. The Trust Guardians report to the Chief Executive Officer, have an established Non-executive Board Director lead and an Executive Board Director sponsor to help them develop the approach within the Trust. Effective speaking up arrangements are important to help to protect patients and improve the experience of NHS workers. The Care Quality Commission (CQC) assessed the Trust's speaking up culture during its well-led inspection during March 2019. The speaking up agenda goes some way towards enabling the trust to meet key priorities of improving patient safety and developing the culture of the organisation.

During the period April 2019 to January 2020 a total of 80 concerns were raised to Trust Guardians, indicating that staff are confident to use internal routes to speak up for help and support to ensure action is taken. Of the concerns raised, 55% related to quality and safety, 10% to patient experience and 9% on policy, process and procedure. The Trust has an area in its Safeguard incident reporting system for FTSU concerns and receiving feedback on actions taken, which includes the ability to report anonymously.

The Freedom to Speak Up Guardians and Trust Board reviewed the approach to speaking up within the Trust in order to learn from experience and develop an action plan to improve the service provided, and during 2019 and 2020 has been working on developing practice and learning from best practice with the support of NHS Improvement.

Part 4:
Statements from our stakeholders

Walsall CCG

NHS Walsall Clinical Commissioning Group is pleased to have had the opportunity to review the draft Quality Account 2019/2020 for the Walsall Healthcare NHS Trust and considers that this Quality Account is a true reflection of the work undertaken.

The CCG wishes to acknowledge the hard work and commitment to improvement in quality and CQC rating. We would like to congratulate the Trust on their CQC 'Care' rating of 'Outstanding' in July 2019, progress with the Care for Walsall Together Strategy and the improvements seen in Maternity Services.

The CCG acknowledges the Trust's achievements against Quality Standards during 2019/20 and welcomes the Trust's achievements related to National Core Quality Indicators including reducing the prevalence of falls and grade 3 and 4 category pressure ulcers, Friends and Family Test feedback, complaints feedback and ensuring that all standards applicable to mortality reviews and learning from deaths have been met.

The CCG notes the progress made against the Trust's Priorities for Improvement for 2019/20 including; the appointment of a Professional Lead for Quality, Care Excellence Strategy, Quality Improvement Academy and the Values Based Programme with reference to the John Lewis approach.

The CCG supports and welcomes the Priorities for Improvement for 2020/21 including; a 10 percent reduction in the prevalence of falls, the introduction of the Complaints Investigation Support Hub and the focus of the FORCE team on further COVID-19 studies and vaccine studies.

The CCG recognises however that there areas needing further work including; Serious Incident management, compliance with Mandatory Training requirements, specifically Safeguarding Level 3, Cancer Harm Reviews, and the sustainability of full health economy checks and reviews via MASH management.

We recognise the Trust's commitment to working closely with commissioners and the public to ensure the ongoing delivery of safe, high quality services and we look forward to continuing this positive collaborative relationship in the forthcoming year.

Appendix 1: Summary of findings - CQC report

The Trust was inspected in February 2019, and the following core services were visited:

Between 4 and 6 February 2019, CQC inspected the core services of critical care and medicine.

Between 11 and 13 February 2019 CQC inspected urgent and emergency care, surgery and maternity.

Between 25 and 26 February 2019 CQC inspected community sexual health services.

The CQC carried out the well led review from 19 March to 21 March 2019.

The CQC report was published in July 2019 during their inspection saw a number of areas of improvement and outstanding practice, and gave the Trust a rating of requires improvement, and recommended the Trust be removed from special measures.

The CQC found areas of outstanding practice across the Trust, however also highlighted areas for improvement including seven breaches of legal requirement, and also found 59 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of its services

Areas of improvement that the Trust must improve:
Ensure compliance with the requirements of the fit and proper person's regulation. (Regulation5).

Ensure the effectiveness of governance arrangements and the board is consistently informed of and sited on risks. (Regulation17).

Must improve mandatory and safeguarding training compliance for all urgent and emergency care staff. (Regulation 18).

The trust must ensure all staff have regard for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010 when assessing patients and delivering care, including ensuring mental capacity assessments are detailed, compliant with legislation and best practice, and is undertaken in away and at a time that recognises patient's abilities.(Regulation11).

The medical service must have systems in place to maintain safe staffing ratios and skill mix on medical wards. (Regulation18).

Ensure staffing levels on surgical wards are safe and reduce the risk of patient harm. This includes reviewing, monitoring and recording patient acuity (Regulation18: Staffing).

The trust must ensure the care and treatment provided to patients is safe.
This includes keeping up to date patient care records, adherence to infection prevention and control practices and systems and processes which prevent never events (Regulation12: Safe care and treatment).

Critical Care Must ensure the staffing cover provided by the critical care outreach team complies with required standards.

The trust should take care to improve:
Urgent and Emergency Care should improve waiting target compliance levels for triage and treatment in the urgent and emergency for all patients.

Should consider replacing old or missing equipment in the urgent and emergency department.

The medicine service should ensure that all intravenous fluids are always securely stored in locked cupboards.

The medicine service should monitor mandatory training and safeguarding rates to ensure that the trust targets are met.

The medicine service should use audits to monitor and improve the quality of the service.

The trust should ensure all staff are given an appropriate handover when starting or covering shifts.

The trust should ensure any store room where medication is stored is locked and doors are closed.

The trust should ensure all surgical staff comply with the World Health Organisation checklist and the five steps to safer surgery.

The trust should ensure medical and nursing staff are compliant with all mandatory training.

The trust should ensure all patients receive care which protects their privacy and dignity.

The trust should consider that all incidents are reported promptly.
The trust should consider monitoring the performance in relation to sepsis management.

The Trust should consider recording all risks on the relevant risk registers and are understood and mitigated appropriately.

The trust should consider improving the process of collecting, analysing, managing and using data in relation to the surgical assessment unit and surgical sterilisation unit to support and improve performance.

Consider improving mandatory training compliance levels for medical staff to comply with trust targets.

Consider improving ways to monitor and drive improvement for non-compliance with infection prevention and control practices.

Consider updating all critical care policies to ensure they are up to date.

Consider providing information to patients and those close to the in different languages.

Consider giving patients the option to use patient diaries.

Consider Reporting Data for All quality indicators to the Intensive Care National Audit and Research Centre (ICNARC).

Consider auditing the performance of the critical care service against the Guidelines for the Provision of the Intensive Care Services (GPICS) standards to assess areas of compliance and non-compliance.

Consider exploring the range of pathway options for patients requiring discharge from the critical care unit to expedite discharge.

Consider supporting a patient forum group for the service to enable patients and their relatives to provide feedback and views on any aspect of their experience during their care and treatment.

The maternity service should ensure all staff are fully compliant with infection prevention control procedures.

The maternity service should ensure all inpatient staff have enough basic equipment such as fetal monitoring machines and thermometers to carry out their roles effectively.
Ensure all surgeons attend all crucial stages of the surgical safety checklist.

The maternity service should ensure complaints are investigated and closed in line with their complaints policy.

Ensure the maternity risk register is kept up to date.

The maternity service should ensure they always follow best practice when prescribing, giving, recording and storing medicines.

The maternity service should ensure it closes all complaints in the timeframe set out in the service wide complaints policy.

The maternity service should encourage managers to utilise the mechanisms in place to manage risk.

Should ensure car parking at the sexual health satellite clinic is controlled in a way that does not present a safety risk to occupants of the clinician emergency evacuation.

Should review health and safety monitoring and practices to reduce the risk of injury, abuse and violence to staff for community sexual health staff.

Should improve monitoring of appointment cancellations for community sexual health to address trends.

Should review arrangements for trust-level and senior management communication with community sexual health.

Staff to ensure they feel supported and have access to managers during periods of change and high levels of pressure.

Should address the negative views held by staff of the working culture and vision and strategy of the trust.

For the overall trust:

The trust should ensure there are appropriate processes in place to investigate and learn from patient deaths.

The trust should ensure that duty of candour processes are followed and that families have the opportunity to meet with representatives of the trust where there has been harm.

The trust should ensure that there are suitable processes in place for patients detained under the Mental Health Act 1983 that ensure detentions are legal and their rights are protected.

The trust should ensure that there are networks in place to support and promote staff equality and diversity.

Appendix 2: Mandatory indicators

NHS Outcomes Framework Domain 1

<table>
<tr><th>Title</th><th>Indicator</th><th colspan="2">2018/19</th><th colspan="2">2019/20</th><th>National Average</th><th>Highest and lowest NHS Trust and Foundation Trust scores for the reporting period</th></tr>
<tr><td rowspan="12">Summary Hospital Mortality Indicator (SHMI)</td><td rowspan="12">a) the value and banding of the summary hospital-level mortality indicator (“SHMI”) for the trust for the reporting period;</td><td>Apr-18</td><td>121.88</td><td>Apr-19</td><td>97.89</td><td rowspan="12">1.00 (100)</td><td rowspan="12">Latest position – Jul 20 Issue (Mar 19 – Feb 20)

<u>Highest Performing Trust</u> – University College London Hospitals NHS Foundation Trust (0.68)

<u>Lowest Performing Trust</u> – The Rotherham NHS Foundation Trust (1.19)</td></tr>
<tr><td>May-18</td><td>119.98</td><td>May-19</td><td>100.07</td></tr>
<tr><td>Jun-18</td><td>117.74</td><td>Jun-19</td><td>109.21</td></tr>
<tr><td>Jul-18</td><td>91.9</td><td>Jul-19</td><td>110.40</td></tr>
<tr><td>Aug-18</td><td>108.33</td><td>Aug-19</td><td>113.09</td></tr>
<tr><td>Sep-18</td><td>113.39</td><td>Sep-19</td><td>120.68</td></tr>
<tr><td>Oct-18</td><td>105.13</td><td>Oct-19</td><td>117.14</td></tr>
<tr><td>Nov-18</td><td>100.53</td><td>Nov-19</td><td>107.11</td></tr>
<tr><td>Dec-18</td><td>103.26</td><td>Dec-19</td><td>109.39</td></tr>
<tr><td>Jan-19</td><td>118.39</td><td>Jan-20</td><td>96.35</td></tr>
<tr><td>Feb-19</td><td>113.36</td><td>Feb-20</td><td>94.71</td></tr>
<tr><td>Mar-19</td><td>121.62</td><td>Mar-20</td><td>NA</td></tr>
<tr><td rowspan="3"></td><td>b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.</td><td colspan="2">April 2018 to March 2019
= 31%</td><td colspan="2">Latest Position (March 2019 to February 2020)
= 29%</td><td>Latest Position (March 2019 to February 2020)
= 37%</td><td>N/A</td></tr>
<tr><td colspan="2">Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="4">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. The trust has not reported any CUSUM alerts for this period.</td></tr>
<tr><td colspan="2">Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="4">See section 2.4</td></tr>
</table>

NHS Outcomes Framework Domain 3

Title	Indicator PROMs case mix-adjusted scores	TRUST 2018/19 Adjusted average health gain		TRUST 2019/20 (Apr to Sept) Adjusted average health gain		National Average 2018/19 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	0.411	EQ5D	0.50	EQ5D	0.50	N/A
		EQVAS	13.338	EQVAS	13.929	EQVAS	13.8	
		OHS	19.434	OHS	24	OHS	22	
	(iv) knee replacement surgery	EQ5D	0.281	EQ5D	0.54	EQ5D	0.3	N/A
		EQVAS	2.557	EQVAS	11.810	EQVAS	7.5	
		OKS	15.778	OKS	20.35	OKS	17	
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	Oxford Hip Score (OHS) is a validated tool for the measurement of pain and function related to hips before and after replacement surgery. The lower the score the worst outcome perceived by the patient. (Worst pain and function 0 – 48 Best pain and function. It also affected by the overall health state of the patient and as the general population in Walsall has high levels of deprivation this is reflected in the EQ5D measurement.						
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• New Patient Information Booklets that include up-to-date information regarding why PROMs is collected and why it is important to the patient and the Trust. • Joint School recommenced November 2017 and subsequently capacity was increased from March 2019 to ensure availability for patients to attend. Joint School presentation mirrors the Patient Information Booklet regarding PROMs participation; in addition the MSK data clerk attends and supports to assist improved submission rates. • Pre-operative Assessment Clinics are collecting, monitoring and both the HIP & Knee Booklets to the performance Department for entry onto the database. A second opportunity is made available to capture any missed data at Joint school. • 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. • We attend the Yearly National PROMS summit to learn from other Trust Experience. • Future audits looking at PROMS and variations of outcomes are planned for 20/21.						

<table>
<tr><th>Title</th><th>Indicator</th><th colspan="3">2018/19</th><th colspan="3">2019/20 (April 2019 to August 2019)</th><th>National Average</th><th>Highest and lowest NHS Trust and FT scores for the reporting period</th></tr>
<tr><td rowspan="4">Readmission rates</td><td rowspan="2">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</td><td></td><td>0 to 15</td><td>>=16</td><td></td><td>0 to 15</td><td>>=16</td><td rowspan="2">N/A</td><td rowspan="2">N/A</td></tr>
<tr><td>Apr-18</td><td>8.26%</td><td>11.61%</td><td>Apr-19</td><td>9.84%</td><td>11.57%</td></tr>
<tr><td colspan="2" rowspan="2">Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td>May-18</td><td>8.52%</td><td>11.34%</td><td>May-19</td><td>8.64%</td><td>12.71%</td><td rowspan="2">The figures provided above are taken from HED and based off the number of spells per month and the number of emergency readmissions within 28 days</td></tr>
<tr><td>Jun-18</td><td>9.56%</td><td>10.29%</td><td>Jun-19</td><td>9.62%</td><td>12.36%</td></tr>
<tr><td colspan="2" rowspan="2">Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td>Jul-18</td><td>6.20%</td><td>10.56%</td><td>Jul-19</td><td>8.35%</td><td>11.97%</td><td rowspan="2">- In depth analysis is to be undertaken during the coming months to review emergency readmissions to establish trends and identify patients with high number of admissions.
- The community services review all frequent admissions known to their caseloads and have demonstrated a reduction in admissions over the past year. Following a revised methodology to determine the performance for readmissions a robust piece of work will be undertaken in Month 6 to analyse trends and determine strands of work to be undertaken to review causation for key cohorts of patients.
- In line with this, work will be developed to link the work currently being done in the community around frequent admissions to those who are readmitting within 30 days to aid a better understanding of why these patients are frequently being admitted.</td></tr>
<tr><td>Aug-18</td><td>6.52%</td><td>11.23%</td><td>Aug-19</td><td>9.79%</td><td>13.15%</td></tr>
<tr><td></td><td></td><td></td><td>Sep-18</td><td>8.05%</td><td>11.17%</td><td>Sep-19</td><td>9.29%</td><td>11.61%</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Oct-18</td><td>7.40%</td><td>11.75%</td><td>Oct-19</td><td>10.10%</td><td>11.20%</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Nov-18</td><td>8.81%</td><td>10.84%</td><td>Nov-19</td><td>10.41%</td><td>11.92%</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Dec-18</td><td>6.95%</td><td>11.55%</td><td>Dec-19</td><td>9.04%</td><td>11.67%</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Jan-19</td><td>9.36%</td><td>10.85%</td><td>Jan-20</td><td>12.87%</td><td>11.76%</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Feb-19</td><td>12.41%</td><td>10.60%</td><td>Feb-20</td><td>10.94%</td><td>10.33%</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Mar-19</td><td>11.33%</td><td>11.74%</td><td>Mar-20</td><td>N/A</td><td>N/A</td><td></td><td></td></tr>
</table>

NHS Outcomes Framework Domain 4

Title	Indicator	2017 (these results relate to 2016 results which were received in 2017)	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 benchmarking)	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The trust's responsiveness to the personal needs of its patients during the reporting period	Q32: Were you involved as much as you wanted to be in decisions about your care & treatment? **6.6/10** Q35: Did you find someone on the hospital staff to talk to about your worries and fears? **5.1/10** Q37: Were you given enough privacy when discussing your condition or treatment? **8.3/10** Q57: 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? **6.9/10**	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? **4.9/10** 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**	Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score Trust score about the same as 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 their 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, 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.		

<table>
<tr><th>Title</th><th>Indicator</th><th>2018/19</th><th>2019/20</th><th>National Average</th><th>Highest and lowest NHS Trust and Foundation Trust scores for the reporting period</th></tr>
<tr><td rowspan="3">Staff recommending the trust as a provider of care</td><td>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.</td><td>49.3%</td><td>48.8%</td><td>71% (2019/2020 for Combined Acute & Community Trusts)</td><td>N/A</td></tr>
<tr><td>Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="4">The data provided is from question 21d in the National NHS Staff Surveys 2018 and 2019 respectively. Slightly lower than the previous year. Surprising again this year as this did not reflect the much better results of the Staff FFT for the same question during Q2 prior to the National Staff Survey, published by NHS England 22/11/2019.</td></tr>
<tr><td>Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="4">The questionnaire was sent to all colleagues and 1299 responded, equating to a 31% response rate, a decrease of 9% on the previous year. This was lower than the national average response rate of 46% 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 over 2020/21 - Equality, Diversity and Inclusion, Line Managers and reducing Bullying & Harassment. Divisional Boards will review local results and discuss actions they will undertake within the division across the three areas of focus. A Divisional staff experience improvement plan will be presented at Divisional Performance Boards. Updates will be provided to the People and Organisational Committee outlining progress.</td></tr>
<tr><td rowspan="3">Patients who would recommend the Trust to their family or friends</td><td></td><td colspan="3"><table>
<tr><th colspan="2">March 2019 - % Rec</th><th colspan="2">January 2020 - % Rec</th><th colspan="2">December 2019 - % Rec</th></tr>
<tr><td>Inpatients</td><td>95%</td><td>Inpatients</td><td>96%</td><td>Inpatients</td><td>96%</td></tr>
<tr><td>ED</td><td>78%</td><td>ED</td><td>77%</td><td>ED</td><td>85%</td></tr>
<tr><td>Outpatients</td><td>92%</td><td>Outpatients</td><td>91%</td><td>Outpatients</td><td>94%</td></tr>
<tr><td>Community</td><td>97%</td><td>Community</td><td>97%</td><td>Community</td><td>95%</td></tr>
<tr><td>Antenatal</td><td>100%</td><td>Antenatal</td><td>94%</td><td>Antenatal</td><td>95%</td></tr>
<tr><td>Birth</td><td>94%</td><td>Birth</td><td>100%</td><td>Birth</td><td>97%</td></tr>
<tr><td>Postnatal Ward</td><td>92%</td><td>Postnatal Ward</td><td>100%</td><td>Postnatal Ward</td><td>95%</td></tr>
<tr><td>Postnatal Comm</td><td>100%</td><td>Postnatal Comm</td><td>99%</td><td>Postnatal Comm</td><td>98%</td></tr>
</table></td><td>N/A</td></tr>
<tr><td>Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="3">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</td></tr>
<tr><td>Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="3">
All wards and departments display their FFT results on a weekly basis for patients, visitors and staff members.
An IPad pilot on four wards was successful in increasing accessibility and involvement of patients with feedback activity on the inpatient wards.
Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night, full protocol implementation is scheduled for quarter 1 of this year.
Volunteer support has been increased across the wards and A&E to assist with activities like mealtimes, patient visiting, dementia tea parties and waiting area support.
The Trust has joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time.
Observe & Act Tool was piloted which paves the way for using lay members to identify and co-produce service improvements.
</td></tr>
</table>

NHS Outcomes Framework Domain 5

Title	Indicator	2018/19		2019/20		England 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-18	96.34%	Apr-19	91.01%	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-18	96.28%	May-19	92.02%		
		Jun-18	96.50%	Jun-19	92.29%		
		Jul-18	95.57%	Jul-19	93.20%		
		Aug-18	95.08%	Aug-19	93.83%		
		Sep-18	94.38%	Sep-19	93.42%		
		Oct-18	94.63%	Oct-19	92.06%		
		Nov-18	95.11%	Nov-19	92.26%		
		Dec-18	94.67%	Dec-19	88.87%		
		Jan-19	95.00%	Jan-20	92.61%		
		Feb-19	93.61%	Feb-20	94.04%		
		Mar-19	91.94%	Mar-20	90.75%		
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	This data is reflective of the trust performance for VTE assessment of all appropriate admissions as determined by the use of a robust methodology for determining the performance developed and embedded since March 2017. • The improved performance represents the use of a single electronic data sources for adult and maternity services and strategies supported by senior clinical and nursing team members to embed a revised system and process.					
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• See section 2.3 for a description of the actions taken					

Title	Indicator	2018/19	2019/20	National Average (2017/2018)	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.	12.18	21.23	13.7	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 rate, and so the quality of its services, by:		For 2019/20 WHT trajectory was no more than 26 cases. This is an increase on the trajectory from 2018/19 but this is due to changes in the criteria used for assignment of cases. For 2019/20 a case will be classified as an acute case if the stool sample is taken the day of admission, plus 1 day; whereas in 2018/19 it was day of admission plus 2 days. In addition a new criteria has been added this year which means any patient who has been in WHT in the last 4 weeks will also count as a WHT case. Please refer to section 2.6		
	Data source		Combined monthly snapshot in line with KH03 definition		

Title	Indicator	2018/19 (April – Sep 2018)	2019/20 (April – Sep 2019) The latest data available	National Average (April – Sep 2019) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Incidents	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period,	5,628 incidents reported and equating to 74.5 incidents per 1,000 bed days	5,993 incidents reported and equating to 78.5 incidents per 1,000 bed days	6,276 incidents reported and equating to 50 incidents per 1,000 bed days	21,685 incidents reported by University Hospitals Birmingham NHS Foundation Trust and equating to 48.0 incidents per 1,000 bed days. Whittington Health NHS Trust reported 1,392 incidents which equates to 27.8 incidents per 1,000 bed days.
	the number and percentage of such patient safety incidents that resulted in severe harm or death	18 0.3%	32 0.6%	19.4 0.3%	95 incidents (0.5%) – University Hospitals Birmingham NHS Foundation Trust 0 incidents (0.0%) – Airedale NHS Foundation Trust
	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 rate (for incident reporting) and number (of incidents that result in severe harm or death) 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:
Statement of director's responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

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

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

By order of the Board,

Danielle Oum
Chair

Richard Beeken
Chief Executive

Appendix 4: Glossary

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

Abbreviation	Description
A&E	Accident and Emergency (see ED)
C. difficile	Clostridium difficile
CCG	Care Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
DNAR	Do not attempt resuscitation
DSPT	Data Security and Protection Toolkit
ED	Emergency Department (see A&E)
FFT	Friends and Family Text
GP	General Practitioner
HED	Healthcare Evaluation Data
HRG	Health Resource Group - a grouping consisting of patient events that have been judged to consume a similar level of resource.
HSMR	The Dr Foster Hospital Standardised Mortality Ratio
ICNARC	Intensive Care National Audit and Research Centre
IDDSI	International Dysphagia Diet Standardisation Initiative
ITU	Intensive Therapy Unit
LeDeR	Learning Disabilities Mortality Review
LfD	Learning from Deaths
LfE	Learning from Excellence
LiA	Listening into Action
MAC	Medical Advisory Committee
MCA	Mental Capacity Act 2005
MMC	Medicines Management Committee
MCCD	Medical Certificate Of Cause Of Death
MRI	Magnetic Resonance Imaging - a technique to take a cross sectional image of a patient
MRSA	Meticillin Resistant Staphylococcus Aureus
MRSA BSI	Meticillin Resistant Staphylococcus Aureus Blood Stream Infections
MTI	Medical Training Initiative
MUST	Malnutrition Universal Screening Tool
NDG	National Data Guardian
NEWS2	National Early Warning Score. This is the latest version which advocates a system to standardise the assessment and response to acute illness.

Abbreviation	Description
NFA	No Fixed Abode
NIHR	National Institute for Health Research
NNU	Neonatal Unit
NQB	National Quality Board
NRLS	National Reporting and Learning System
OPAT	Outpatient parenteral antibiotic therapy
OPD	Outpatient Department
PALS	Patient Advice & Liaison Service
PE	Pulmonary embolism – a blood clot in the lung
PEG	Passionate for Engagement Group
PGD	Patient Group Directives - Who can supply and or administer specific medicines to patients without a doctor under a PGD and which medicines can be administered
PHSO	Parliamentary and Health Service Ombudsman
QSIR	Quality, service improvement and redesign
R&D	Research and development
RCP	Royal College of Physicians
SAS doctor	Includes staff grade, associate specialist and specialty doctors* with at least four years of postgraduate training, two of which are in a relevant specialty. SAS doctors are a diverse group with a wide range of skills, experience and specialties
SALT	Speech and Language Therapy
SHMI	Standardised Hospital Mortality Indicator – this looks at the relative risk of death of all patients managed by the Trust and includes the period up to 30 after discharge.
SI	Serious Incidents
SJR	Structured Judgment Review
SOP	Standard Operating Procedure
SPECT	Single-photon emission computed tomography – a technique to take a cross sectional image of a patient
TC	Transitional Care (between the Neonatal Unit and the post-natal ward)
TMB	Trust Management Board
VTE	Venous Thromboembolism
WHO	World Health Organisation
WMAHSN	West Midlands Academic Health Science Network
WMAS	West Midlands Ambulance Service
WMQRS	West Midlands Quality Review Service