







NHS
Walsall Healthcare
NHS Trust

Quality Account 2023/24

Respect
Compassion
Professionalism
Teamwork

Contents

Why are we producing a Quality Account?

All NHS Trusts are required to produce an annual Quality Account, to provide information on the quality of the services they provide to patients and their families.

Walsall Healthcare NHS Trust (WHT) welcomes the opportunity to be transparent and able to demonstrate how well we are performing, considering the views of service users, carers, staff, and the public. We can use this information to make decisions about our services and to identify areas for improvement.

Getting involved

We would like to hear your views on our Quality Account. If you are interested in commenting, or seeing how you can get involved in providing input into the quality improvement priorities, Trust's future quality improvement priorities, please contact:

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Part 1: Statement on Quality from the Chief Executive

I am pleased to present the Annual Quality Account for 2023/24, detailing our commitment to delivering the highest standard of care for patients at Walsall Healthcare NHS Trust. This document sets out how our teams have performed against last year's objectives and describes our collective efforts to promote a culture of continuous improvement, as underpinned by the five-year strategy and Quality Framework that we share with our group partner Trust, The Royal Wolverhampton NHS Trust.

I joined the Trust at the beginning of the current financial year, and it has been an absolute pleasure to familiarise myself with the many and varied initiatives that have contributed to a successful 2023/24 for the organisation. I want to express my gratitude to all the staff whose hard work has been instrumental to the Trust making sustained progress on patient care, amid the challenges of increased demand on services, periods of industrial action, and financial constraints in the NHS.

The Trust's highlights from the past year include:

1. **Patient Safety:** This remains our top priority. Over the past year, we have seen various successes including a timely and effective transition to the new Patient Safety Incident Response Framework, alongside mortality rates that remain among the lowest in the region, and lower than average rates of hospital acquired infection.

2. **Clinical Effectiveness:** Our focus on this area of delivery is reflected in our patient outcomes: With the exception of April 2023, which achieved 74% compliance, the Trust has achieved the 28-day Faster Diagnosis Standard every month of the year 2023/24 with more than 75% of patients being given a confirmed diagnosis within 28 days.

3. **Patient Experience:** We believe that patient experience is a critical component of healthcare quality. Feedback from the Friends and Family Test showed the Trust's average recommendation score for 2023/24 was 89%, a 3% increase on 2022/23 and 7% on 2021/22. Most improved areas are Inpatients, Outpatients, and Community, improving or sustaining for all quarters, and Postnatal Community, improving each quarter when compared to the previous ones.

4. In response to the National CQC Adult Inpatient Survey results, a mealtime experience survey was completed in October 2023. Areas to celebrate included 'getting enough to drink', meals being presented well and food served hot. Recommended areas for improvement included 'getting meals' in an understandable language, food that met any dietary needs or requirements, getting enough help to eat meals, and snacks between meals.
5. **Staff Engagement and Training:** Our staff are at the heart of everything we do, and we recognise the impact that good staff engagement can have on a patient's experience and outcomes – if they are cared for by motivated staff who feel valued. The Trust continued to achieve a high level of engagement in the 2023 Staff Survey, with 2,381 participants equating to 46% - compared to the median national average response rate for the sector which was 45%.
   Walsall achieved the highest response rate of the four Black Country acute Trusts and is the only Trust to have improved across all indicators for the second consecutive year.
6. **Innovation and Improvement:** Innovation is key to our continued success, and we continue to invest in and promote improvement, gaining significant staff engagement in our Quality Improvement programme, which has delivered benefits ranging from frontline digital innovations to increased capacity for our Virtual Ward and Discharge to Assess pathways – supporting faster discharge and reducing re-admission.
7. **Community Engagement and Integration:** We continue to work closely with our community partners to deliver integrated care services. As well as recruiting Patient Involvement Partners to help shape our services, we have embraced new ways of working to improve patient flow. This includes the recent extension of our Urgent Community Response a 24/7 service.

Looking Ahead

While we are proud of our achievements, there are areas for improvement which are set out clearly in this report. Our ambition for a culture of continuous quality improvement depends on us learning from our successes and tackling our challenges too. In 2023/24 we saw an increase in the number of reported patient incidents, which is in fact positive – because it is only by encouraging open, transparent reporting with a focus on capturing learning, that we can get the best standards of data to help us identify where we can make things better. Informative and high-quality reporting will be a significant theme across this year's quality improvement activity.

Other areas of focus for the coming year include:

- Improving patient flow in urgent and emergency care, by expanding same day emergency care services and virtual wards, while working with partners to speed up discharge from hospital.
- Reducing waiting times: in cancer services this means increasing the percentage of early diagnoses and reducing the number of patients waiting more than 62 days, while eliminating the longest waits in elective services and working towards a return to pre-pandemic activity levels.
- Further improving patient safety by focusing on staff training and competency, to further embed a culture of continuous learning with the ambition of eliminating avoidable harm.

As I lead this Trust into 2024/25, I would like to reaffirm our commitments to quality, and to continually striving for excellence in all areas of patient care. I look forward to working with our patients, staff and partners to build on our successes and address the challenges ahead.

Thank you for your continued support.

Signed:

Caroline Walker

Interim Chief Executive Officer

Walsall Healthcare NHS Trust

Vision and Values

Vision

Our vision is to "To deliver exceptional care together to improve the health and wellbeing of our communities". It has been updated to reflect the closer working of our organisation with local partners and to focus on our core purpose of improving the health and wellbeing of our communities.

Our strategy includes a new vision, as voted on by colleagues. It is:

To deliver exceptional care together to improve the health and wellbeing of our communities

A vision is more than a few words – it reflects our aspirations, helps to guide our planning, support our decision making, prioritise our resources and attract new colleagues.

Values

Our values reflect the culture we want to create and inform the behaviours we wish to demonstrate. The Trust has its own set of values (shown below), developed and co-produced with our colleagues. Over time we expect to move to a common set of values that covers both Walsall Healthcare and The Royal Wolverhampton NHS Trust.

Part 2: Looking back 2023/24 Priorities for Improvement

Priorities for improvement
Priority 1 - Patient Safety

What we said
Patient Safety **Embed a culture of learning and continuous improvement at all levels of the organisation.** **Key actions we will take:** • Transition to the Patient Safety Incident Response Framework (PSIRF) • Transition to Learn from Patient Safety Events (LfPSE) • Increase uptake of Level 2 syllabus training **The aim for 2023/24** • Transition to PSIRF achieved by the national deadline • Ensure 100% of incidents uploaded to LfPSE by the national deadline
What we did:
Transition to the Patient Safety Incident Response Framework (PSIRF) • In preparation for the transition to Patient Safety Incident Response Framework (PSIRF), workstreams were set up which aimed to enable staff to help shape what PSIRF could look like in practice. The workstreams focused on building the patient safety profile and planning how to respond to incidents, exploring the structures and ways of working under PSIRF, reviewing the training that would be required for staff and developing the processes for engaging patients and staff following an incident. The Patient Safety Incident Response Policy and Plan was created during this time and the transition to PSIRF started in November 2023. The transition is expected to continue as we become more familiar with the new ways of working, and this is supported by a dedicated group aimed at overseeing and providing structure for implementation. • The transition to Learn from Patient Safety Events (LfPSE) was successfully completed in February 2024 and 100% of all patient safety events have been reported to LfPSE from the implementation date.

Looking back 2023/24

What we said

Urgent and emergency care and patient flow.

Deliver safe and responsive urgent and emergency care in the community and in hospital.

Key actions we will take:

- Expand with partners from across the system, we will support the flow of patients through UEC:
- Expand and maintaining the use of same day emergency care (SDEC) services to avoid unnecessary hospital stays
- Expand virtual wards, allowing people to be safely monitored from the comfort of their own homes
- Work with partners to speed up discharge from hospital and reduce the number of patients without criteria to reside

The aim for 2023/24

- Year on year improvement in the percentage of patients seen within four hours in A&E
- Reduce adult general and acute bed occupancy to 92%
- Consistently meet the 70% two-hour urgent community response time

What we did:

Expanding and maintaining the use of Same Day Emergency Care (SDEC) services to avoid unnecessary hospital stays:

- Same Day Emergency Care services have made significant improvements in 2023/24. The Medical SDEC Unit has been relocated to a newly refurbished and expanded location, which has supported a 62% increase in activity since April 2023. The Trust remains a consistent high performer with regards to SDEC and ranks 7th and 30th nationally for medical and surgical SDEC rates respectively.

Expanding virtual wards, allowing people to be safely monitored from the comfort of their own homes:

- Steady improvement has been made in the utilisation of Virtual Wards and they have contributed to the Trust's emergency length of stay being within the lowest decile nationally. By the start of 2024/25, the Trust will have rolled out an automated approach to Virtual Ward referrals based on vital information collected electronically on a daily basis. It is anticipated that the Virtual Wards having a readily accessible list of referrals to triage will result in further improvements in Virtual Ward utilisation.

Working with partners to speed up discharge from hospital and reduce the number of patients without criteria to reside:

- The expanded Intermediate Care Service has enabled the Trust to make continual improvements in discharges from Walsall Manor Hospital. In 2023/24, the Trust has continually held fewer than 40 medically optimised patients in an acute inpatient bed whilst awaiting further support out of hospital. This excellent progress is reflected in a range of performance metrics, including but not limited to:
  - Ambulance Handovers (< 30 minutes) – ranked 1st within the West Midlands as of January 2024
  - Consistently within the lowest decile for the proportion of patients within the Manor Hospital with a length of stay beyond 14 and 21 days respectively
  - Consistently within the lowest decile for the Trust's average length of stay for emergency admissions, excluding admissions staying same day discharges
- Year on year improvement in the percentage of patients seen within four hours in A&E
- The Trust demonstrated improvement against the 4-hour Emergency Access Standard early in 2023/24. Whilst performance against the standard has since dropped, the Trust has maintained performance within the best quartile of Trusts nationally. A comprehensive Improvement Programme is in place, which includes the introduction of a Hot Imaging Suite, new clinical pathways for managing GP Referrals and plans to reduce waiting times for non-admitted patients.
- 2023/24 also was the first full year the Trust has spent in the new Urgent and Emergency Care Centre, housing both the Emergency Department and the Acute Medical Unit. The new centre has supported the Trust to improve against a range of Society of Acute Medicine standards, including a length of stay on the Acute Medical Unit of only 16 hours, whilst caring for sicker patients across two bays of patients who require enhanced monitoring.

NHS England has also introduced a new 'GIRFT Emergency Medicine Index', offering a composite metric of the overall performance of Emergency Care. Across all Acute Hospital sites in England, the Trust ranks within the upper quintile and has attracted external attention. Visits have been hosted for other Trusts and the Trust has been part of NHS England's Emergency Care Improvement Support Team's inaugural Peer Review programme to improve emergency care standards nationally.

Reduce adult general and acute bed occupancy to 92%.

- Acute bed occupancy has fluctuated in 2023/24, largely staying within 94 to 98%. Occupancy has not reduced to the desired 92% despite those improvements in rates of same day emergency care and the length of stay for emergency admissions.

Looking back 2023/24

What we said

Priority Area – Quality Improvement

Embed a culture of learning and continuous improvement at all levels of the organisation.

Key actions we will take:

- Produce a gap analysis on how both Trusts (WHT and RWT) rank against the four components of a quality management system (quality planning, quality control, quality improvement and quality assurance), and review how we triangulate data to understand priorities.
- All members of divisional and care group/Directorate leadership teams to attend a one-day quality service improvement and redesign fundamentals (sessions scheduled from January 2023)
- Year-on-year roll-out for QI huddle boards across both Trusts to targeted areas e.g. low evidence of improvement work, non-clinical areas.

The aim for 2023/24

- Completed gap analysis by end of 2023/24
- Increase in the number of staff trained following triumvirate training
- Introduction of 10 QI huddle boards per site/annum

What we did:

With our colleagues at RWT we will publish a patient experience strategy for 2022-2025

All members of divisional and care group/Directorate leadership teams to attend a one-day quality service improvement and redesign fundamentals (sessions scheduled from January 2023):

We have delivered training to 97 managers, Heads of Departments and Leads over the past year, from all Divisions, including Corporate Services and Estates and Facilities. In addition, we have delivered several bespoke QI training sessions incorporating the leadership and wider divisional teams.

Year-on-year rollout for QI huddle boards across both Trusts to targeted areas e.g. low evidence of improvement work, non-clinical areas and Introduction of 10 QI huddle boards per site/annum:

We have had great success with the rollout of our huddle boards, particularly within Estates and Facilities and the Community Division. We currently have 13 boards actively being used in both clinical and non-clinical areas. There are a further three requests for boards and we have areas identified to begin our virtual huddle board pilot which includes the 0-19 Service and Performance & Information Team.

Summary	Totals
Boards active & in use	13
In progress (the next areas to be active)	3
Expressions Of Interest	1

The Trust submitted a gap analysis showing our self-assessment against the five domains of a Quality Management System as identified by NHS Impact (Improving Patient Care Together – NHSE).

We have seen a sustained increase in staff attending QI training from the majority of the clinical and non-clinical areas with all of our courses fully booked, and additional sessions provided during November and December to address the training waiting list.

Priority 2 - Clinical Effectiveness

What we said

Priority Area – Our People

The right workforce with the right skills, in the right place at the right time.

Key actions we will take:

- Recruit and retain staff using targeted interventions for different career stages
- Improve retention using bundles of recommended high impact actions
- Develop and deliver the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and Discharge to Assess models

The aim for 2023/24

- To improve staff turnover by the end of 2023/24

What we did:

- As of 31 March 2024, Walsall Healthcare NHS Trust employed 5,288 substantive staff. Of these, 4,454 colleagues were permanently employed and a further 834 colleagues were employed on fixed-term contracts of employment.
- During 2023/24, the average full-time equivalent (FTE) workforce totalled 5,036.75. The following table provides a snapshot of the average workforce composition during this period:

Looking back 2023/24

2023/24 Average FTE (Full-Time Equivalent Workforce)	Permanently Employed	Other	Total Workforce
Registered Nursing & Midwifery	1,548	161	1,709
Registered Allied Health Professionals	310	9	319
Registered Healthcare Scientists	94	1	95
Registered Scientific, Therapeutic and Technical	41	1	42
Clinical Support	929	155	1,084
Infrastructure Support (Administrative, Clerical and Estates)	1,114	96	1,210
Medical and Dental	531	47	578

Our workforce is predominately female (80.39%), and this is the predominant gender in all of the staff groups except for medical and dental staff where the position is the reverse.

During the year we have welcomed more than 46 nurses and 45 Medical & Dental internationally educated colleagues through our Clinical Fellowship Programme. Overall, there were 142 more substantive staff employed at the Trust in March 2024 compared to April 2023. Specifically, there was a 7% increase in substantive registered and a 9% increase in medical staff across the Trust.

As an anchor employer working with housing group whg, the Trust has continued to support people from the local community to gain employment into a range of roles in health and social care. Over the course of the year 22 members of staff have been recruited.

What we said

Priority Area – Cancer Treatment

Prioritise the treatment of cancer patients, focusing on improving outcomes for those diagnosed with the disease.

Key Actions we will take:

- Maintain focus on operational performance, prioritising capacity for cancer patients to support the reduction in patients waiting over 62 days
- Increase and prioritise diagnostic and treatment capacity for suspected cancer, including prioritising new community diagnostic centre capacity
- Implement priority pathway changes for low gastrointestinal (GI), skin and prostate cancer

The aim for 2023/24

- Reduction in the number of patients waiting more than 62 days for treatment, and meeting the cancer faster diagnosis standard by March 2024
- Ensure 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed, or have cancer ruled out, within 28 days.

What we did:

Focus on operational performance in order to achieve reduction in patients waiting more than 62 days has been achieved through bi-weekly monitoring in restoration and recovery meetings lead by the Chief Operating Officer and monthly Divisional Performance Meetings lead by the Executive Team. Increased service capacity has been realised through the operational delivery of increased Theatre sessions, increased Endoscopy sessions and increased booked clinic utilisation.

Increase and prioritise diagnostic and treatment capacity for suspected cancer, including prioritising new community diagnostic centre capacity:

Radiology – The service has developed a 10-day KPI for all suspected cancer referrals which saw the department maintain a 70% success rate. There is ongoing work to improve this further in the 2024/25 financial year with the introduction of an imaging cancer tracker role which will be dedicated to improving this pathway.

Implement priority pathway changes for low gastrointestinal (GI), skin and prostate cancer:

The number of patients waiting more than 62 days for treatment has been reduced and has been below trajectory throughout 2023/24. There was a slight increase in the number of patients waiting more than 62 days during September and October due to increased demand on Endoscopy services. The position was recovered from December 2023.

With the exception of April 2023, which achieved 74% compliance, the Trust has achieved the 28 day Faster Diagnosis Standard every month of the year 2023/24 with more than 75% of patients being given a confirmed diagnosis within 28 days.

75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed, or have cancer ruled out, within 28 days:

What we said

Priority Area – National Elective Care Strategy

Deliver the priorities of the National Elective Care Strategy

Key actions we will take:

- Deliver an increase in capacity through the Community Diagnostic Centre and Theatre expansion programme.
- Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients.
- Increase productivity using the GIRFT (Getting it Right First Time) programme and improving Theatre productivity

The aim for 2023/24

- Eliminate waits of over 65 weeks by the end of 2023/24
- Meet the 85% Theatre utilisation expectation

Looking back 2023/24

What we did:
Deliver an increase in capacity through the Community Diagnostic Centre and Theatre expansion programme: • Community Diagnostic Centre – WHT has limited access to the Cannock Diagnostic Centre run by RWT and in the past year it has been under construction which has meant no extra capacity has been gained by the Walsall population. • The Theatre expansion case funded an additional 6.5 theatre sessions per week from October 2023, increasing elective surgical capacity. • The Minor Surgery Procedure Room opened on 2 April 2024, which will deliver an additional 10 elective sessions per week.
Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients: • The Trust has undertaken an Outpatient Transformation project with Four Eyes insight, focusing on increased booking utilisation, reduction of DNA rate and addressing inequalities in outpatients. Following the project, booked clinic utilisation has increased from 88% in 2022 to 92% in 2023 and DNA rates have reduced from 11.3% in 2022 to 11% in 2023. The DNA rate has increased above the 2022 baseline in three of 12 months due to failure of the SMS messaging reminder system. DNA rates continue to improve through 2024 with the overall performance at 9.1%.
Increase productivity using the GIRFT (Getting it Right First Time) programme and improving Theatre productivity: • The Trust has recently gained GIRFT Elective Hub Accreditation status. As part of this accreditation the Trust has an ongoing "Hub Optimisation Plan (HOP)" which is reviewed by GIRFT at three months, one year and three years post-accreditation. The HOP includes an action to increase high volume low complexity lists, thus increasing productivity in line with the GIRFT guidance. The Trust is working towards this action, although the ability to run low complexity lists is sometimes limited by the need to prioritise long waiting and clinically urgent patients. The newly established Minor Surgery Procedure Room will enable to Trust to focus efforts on increasing high volume low complexity lists outside of the main Theatre environment, making best use of Theatre estate for patients requiring General Anaesthetic.
Eliminate waits of over 65 weeks by the end of 2023/24: • The Trust eliminated elective waiting times over 65 weeks by the end of March 2024, with the exception of patient choice (two patients).
Meet the 85% Theatre utilisation expectation: • Theatre utilisation from January 2023 until February 2024 has ranged between 100% and 96% - the average utilisation during this period has been 98%. This data excludes Theatre sessions lost due to industrial action impact. Theatre utilisation for the same period, including sessions lost to industrial action remains above the target at 89%. • In session, utilisation has remained in the upper quartile nationally since 2020. Capped 2023/24 is 83%, an increase from 82.6% in 2022/23 and uncapped is 86% during 2023/24 and 2022/23. Theatre utilisation is impacted by cancellations on the day. There is a quality improvement project in place to reduce on the day cancellations.

Priorities for improvement
Priority 3 - Patient Experience

What we said

Patient Safety

Embed a culture of learning and continuous improvement at all levels of the organisation.

Key actions we will take:

- The key priorities are outlined within the joint Patient Experience Enabling Strategy (2022-2025). These include:

Pillar One - Involvement

- We will involve patients and families in decisions about their treatment, care and discharge plans.

Pillar Two - Engagement

- We will develop our Patient Partner programme and use patient input to inform service change and improvements across the organisation

Pillar Three - Experience

- We will support our staff to develop a culture of learning to improve care and experience for every patient.

What we did:

We will develop our Patient Partner programme and use patient input to inform service change and improvements across the organisation:

- We have an active Patient Involvement Partner programme which meets regularly and contributes to service design and improvement. In the last year our Patient Partners have been involved in the Electronic Discharge Working Group designed to simplify communication with patients on discharge and the summary provided.
- Patient Partners were part of the focus groups concerned with elective care recovery - particularly the Four Eyes Insight improvement programme which reviewed DNA rates for outpatient appointments. (Finalist in the HSJ partnership awards)
- Our Patient Partners have conducted 15 steps reviews of Neonatal and Maternity Services.
- Our Little Voice partners have been actively involved in reviewing Children and Young People's services including inpatient ward areas, Outpatients, Audiology, and Imaging. This initiative won the Communicating Effectively category in the National Patient Experience Network Awards and was overall winner for 2023.
- Patient Partners reviewed various leaflets with one partner designing and initiating a new patient information sheet for post operative shoulder guidelines.
- We have recruited to and trained four Patient Quality Improvement (QI) partners. The QI partners have been trained in Quality Improvement tools and techniques by our QI Team and will be asked to support a consistent approach to making changes on all projects they become involved in.

Looking back 2023/24

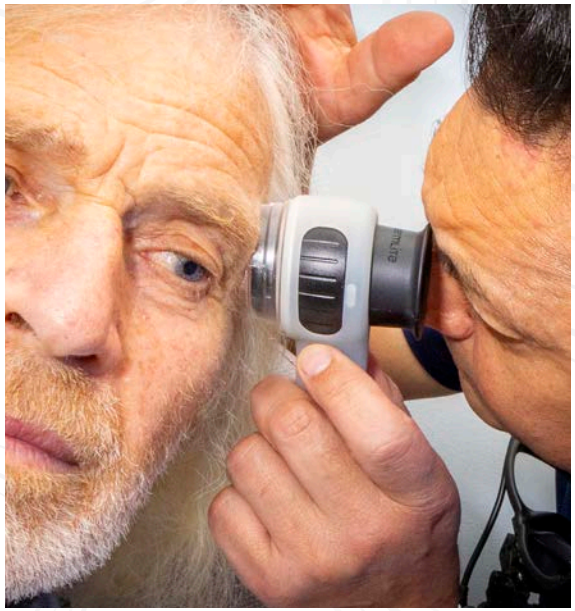
We will support our staff to develop a culture of learning to improve care and experience for every patient:

- We have adopted the new PHSO complaints standards. The PHSO complaint standards were introduced in April 2023 and set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS- funded care. The complaint standards aim to ensure the complaint process is fair, transparent, and accessible for everyone. As an organisation, we were identified as an early adopter of the draft PHSO complaint standards which allowed us timely access to the guidance and enabled us to tailor our complaint process towards them. This included us engaging with our divisional leads and care group teams to ensure staff were clear on the expectations of the standards, prior to implementation This included revising our templates, redeveloping our surveys, arranging training sessions with staff and developing our formal complaint investigation toolkit.

Our formal complaint investigation toolkit was developed with these standards in mind and outlines the formal complaint process to be followed by the complaint handler. Throughout the PHSO complaint standards and our own process, there is a clear focus on involvement and communication with the service user, with the aim of improving their experience throughout the complaint process.

- We introduced Reflective Shoes. Reflective Shoes was introduced following the implementation of the PHSO complaint standards. In line with the core messages within the standards, involvement and communication, the Reflective Shoes action plan was developed.
- The purpose of Reflective Shoes is to enable the complaint handler to host an open, reflective conversation with a staff member or team in relation to a concern which has been received. The template prompts staff to discuss how the service user may have been thinking and feeling at that time and if there were any contributory factors. The second part of the template asks staff to discuss how it felt reading/hearing the complaint and what learning could be implemented because of the concerns. Reflective Shoes also asks how staff will reflect on their practice after hearing the concern, and if they require any support. When this process is followed it enables us to provide a more personal response to the family, particularly where our actions are concerned, and allows us to move from "we will" to "we have" therefore embedding a culture of learning from experience.
- Fundamentals of Care. Introduced by the Quality Team in early 2023, we led an hour workshop focused on patient experience. The workshops were held with different wards across the Trust, enabled discussion around patient experience and identified barriers to delivering a good patient experience. They enabled front line colleagues a safe space to discuss the challenges they face in their roles that impact patient experience, and the opportunity to discuss solution- focused actions they can take back to their ward areas. The workshops were an opportunity to raise awareness of patient experience resources, patient relations activity, and local resolution. Discussions were also held around families and carers, with information sharing of the Family and Carer Support Service, our Commitment to Carers, and how this service can support frontline staff in identification of unpaid carers.
- Patient Voices Resources Page .We launched the Patient Experience Resources Page in Q2 of 2023/24. It enables all staff to easily access patient experience data for their department, division, or at Trust level. The resource page consists of the Friends and Family Test, Themed Analysis, Mystery Patient and Patient Relations Dashboards, they are in their work and a demographic dashboard was due to launch. Feedback has been positive for these resources, with many colleagues expressing how valuable they are in their work, enabling the Trust to bring intelligence together and allowing triangulation of quality indicators.
- National Survey Workshops. In 2023/24 the team reviewed its process for managing the CQC national surveys. Historically, this has been led by service leads and has at times disassociated frontline staff from the importance of the surveys and the actions from them. The national survey workshops were led with a cross section of staff for the Adult Inpatient, UECC, Cancer and Maternity surveys.
- Across these workshops the team engaged with 100 plus staff and Patient Partners to present the findings, discuss the barriers, and identify practical actions teams can take forward. Feedback from staff engaged in the workshops revealed they celebrated being a part of the process and felt included in something that previously they knew little or nothing about.
- Band 5 Development Days, Learning from Patient Experience. We led an interactive two-hour session on the weekly Band 5 Nurse Development Days on the importance of Patient Experience helping to foster a learning culture that is borne from the lived experiences of the case studies we share.


URGENT & EMERGENCY CARE CENTRE



Priorities for Improvement and Statements of Assurances

Our Quality Priorities for 2024/25

Each year the Trust is required to identify its quality priorities. We consulted on both the quality strategy and annual quality priorities. The draft priorities were shared with commissioners, Healthwatch, our governors, the Trust Management Committee, the Executive Teams within the Divisions and Directorate Management Teams. The final priorities for 2024/25 were agreed by the Trust Board.

The chosen priorities support several quality goals detailed in our quality strategy as well as three key indicators of quality:

The strategies define in detail how we will strive to excel in delivery of care, which is one of the four strategic aims of the joint Trust Strategy. These can be located …… [insert links?]

Looking forward 2024/25

The priorities detailed below have been identified and agreed in the Quality and Safety Enabling Strategy and the Patient Experience Enabling Strategy. These are the first joint strategies for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). The strategies define in detail how we will strive to excel in delivery of care, which is one of the four strategic aims of the joint Trust Strategy.

Our key priority areas have been agreed based on information from various local, regional, and national sources, including recent engagement with our staff, patients, partners and the communities we serve.

Patient Safety	Having the right systems and staff in place to minimise the risk of harm to our patients and being open and honest and learning from mistakes if things do go wrong.
Clinical Effectiveness	Providing the highest quality care with world-class outcomes whilst also being efficient and cost effective.
Patient Experience	Meeting our patients' emotional needs as well as their physical needs.

The priorities identified below are specifically drawn from both above strategies.

The priorities are captured in the overarching themes of the Quality & Safety Enabling Strategy.

Our People

- Priority Area – The right workforce with the right skills, in the right place at the right time

Embed a culture of learning and continuous improvement at all levels of the organisation

- Priority area – Quality improvement
- Priority area – Patient safety
- Priority area – Patient involvement

Prioritise the treatment of cancer patients focused on improving the outcomes of those diagnosed with the disease

- Priority Area – Cancer treatment

Deliver safe and responsive urgent and emergency care in the community and in hospital

- Priority Area – Urgent and emergency care and patient flow

Deliver the priorities of the National Elective Care Strategy

- Priority Area – National Elective Care Strategy

Priority 1: Patient safety

Priority area – Patient safety Embed a culture of learning and continuous improvement at all levels of the organisation.	**Key actions we will take:** • Transition to the Patient Safety Incident Response Framework (PSIRF) **The aim for 2024/25** • Training Needs Analysis (TNA) by March 24 • Level 1 & 2 – 50% of priority staff identified in TNA to be completed in 2024/25 • Three PSIRF roles – minimum of 30% of need of TNA met by 31 Dec 2024
Priority area – **Urgent and emergency care and patient flow** Deliver safe and responsive urgent and emergency care in the community and in hospital.	**Key actions we will take:** • Working with partners from across the system, we will support the flow of patients through UEC • Expand and maintain the use of same day emergency care (SDEC) services to avoid unnecessary hospital stays • Expand Virtual Wards, allowing people to be safely monitored from the comfort of their own homes • Work with partners to speed up discharge from hospital and reduce the number of patients in hospital without criteria to reside **The aim for 2024/25** • Year on year improvement in the percentage of patients admitted, discharged or transferred within four hours in A&E, and in the proportion of patients conveyed by ambulance receiving handover within 30 minutes of arrival • Consistently meet the 70% two-hour urgent community response time • Reduce the proportion of patients waiting in ED >12hrs from arrival • Revise the process of Discharge Ready date (without criteria to reside)
Priority area – Quality improvement Embed a culture of learning and continuous improvement at all levels of the organisation.	**Key actions we will take:** • Produce a gap analysis on how both Trusts (RWT/WHT) rank against the four components of a quality management system (quality planning, quality control, quality improvement and quality assurance), and review how we triangulate data to understand priorities • All members of divisional and care group/Directorate leadership teams to attend one day quality service improvement and redesign fundamentals (sessions scheduled from January 2024) • Year-on-year roll-out plan for QI huddle boards across both trusts to targeted areas e.g., low evidence of improvement work, non-clinical areas **The aim for 2024/25** • Build actions/recommendations against gap analysis completed during 2023/24 • Increase in the number of staff trained following triumvirate training • Increase use of QI huddle boards per site • Build evidence of huddle board use and improvements identified • Aim to improve NHS Impact self-assessment score

Priority 2 – Clinical effectiveness

Priority area – Our people The right workforce with the right skills, in the right place at the right time	**Key actions we will take:** • Recruit and retain staff using targeted interventions for different career stages • Improve retention using bundles of recommended high impact actions • Develop and deliver the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models **The aim for 2024/25** • To work with system partners to ensure we have appropriate staffing in key areas to facilitate safe, effective patient care
Priority area – Cancer treatment Prioritise the treatment of cancer patients, focusing on improving outcomes for those diagnosed with the disease	**Key actions we will take:** • Maintain focus on operational performance, prioritising capacity for cancer patients to support the reduction in patients waiting over 62 days • Increase and prioritise diagnostic and treatment capacity for suspected cancer, including prioritising new community diagnostic centre capacity • Implement priority pathway changes for lower gastrointestinal (GI), skin, and prostate cancer **The aim for 2024/25** • Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 • Maintain focus on performance to reduce, the number of patients waiting over 62 days • Maintain performance against 28-day Faster Diagnosis Standard (75%) • Maintain focus on performance against combined 62-day Referral to Treatment standard (85%)
Priority area – National Elective Care Strategy Deliver the priorities of the National Elective Care Strategy	**Key actions we will take.** • Deliver an increase in capacity through the community diagnostic centre and Theatre expansion programme. • Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients. • Increase productivity using the GIRFT (Getting it Right First Time) programme and improving Theatre productivity. **The aim for 2024/25** • To continue to monitor (and eliminate) over 65 week waits and continue to increase elective activity through increased elective and diagnostic operating. • To comply with national standards to reduce long waiting times; ensuring no patient waits in excess of 65 weeks (excluding patient choice). • Meet the 85% Theatre utilisation expectation. • Reduce the total number of patients awaiting elective treatment by 10% over the course of the financial year 24/25.

Looking forward 2024/25

Priority area – Review of GIRFT(i) and Model health system data(ii) (i) Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change (ii) The Model Health System is a data-driven improvement tool that enables NHS health systems and Trusts to benchmark quality and productivity.	**Key actions we will take** • Review model health system and Getting It Right First Time (GIRFT) data to guide relevant aspects of activity, quality, and safety. **Aim for 2024/25** Through the Further Faster programme - deliver rapid clinical transformation with the aim of reducing 52-week waits in Cohort 1; • Map current pathways against the GIRFT Specialty Outpatient Guidance to identify the gaps and opportunities and implement plans. • Engage with the Specialty Clinical Groups to a) overcome barriers to adopting the best practice pathways; b) work together with our national clinical leadership to build on that guidance further. • Embed GIRFT/Model Health metrics into Directorate and Divisions review processes. • Regular benchmarking of GIRFT data and alignment with Quality Improvement plans.

Priority 3 – Patient experience

Priority area – Patient involvement Embed a culture of learning and continuous improvement at all levels of the organisation.	**Key actions we will take:** • The key priorities are outlined within the joint Patient Experience Enabling Strategy (2022-2025). These include: **Pillar one – Involvement** • We will involve patients and families in decisions about their treatment, care, and discharge plans. **Pillar two – Engagement** • We will develop our Patient Partner programme and use patient input to inform service change and improvements across the organisation **Pillar three – Experience** • We will support our staff to develop a culture of learning to improve care and experience for every patient. **The aim for 2024/25** • We will involve patients and families in decisions about their treatment, care, and discharge plans. • Ensuring that people from minorities (ethnic minorities, disabilities, religious groups, LGBT+ groups) have services that do not discriminate and equally meet their needs alongside others. • We will support our staff to develop a culture of learning to improve care and experience for every patient. • Reducing complaints, learning from them, and encouraging better attitudes and practice from employees • Using our Patient and Partner Experience Group meeting to gain assurance, monitor and manage patient experience workstreams and initiatives. • Implement a real time dashboard for Directorates to encourage a more proactive approach to patient feedback.

Within the Quality and Safety Enabling Strategy there are also several priority areas identified under the overarching theme of "fundamentals", which are based on internal and external priorities. The Trust will also be expected to deliver on the specific objectives linked to the strategy under this section. [INSERT LINK TO STRATEGY]

Fundamentals – based on internal and external priorities:

- Priority Area – Prevention and management of patient deterioration
- Priority Area – Timely sepsis recognition and treatment
- Priority Area – Medicines management
- Priority Area – Adult and children safeguarding
- Priority Area – Infection prevention and control
- Priority Area – Eat, Drink, Dress, Move to Improve
- Priority Area – Patient discharge
- Priority Area – Maternity and neonates
- Priority Area – Mental health
- Priority Area – Digitalisation

The Quality and Safety Enabling Strategy also includes the following priority area, which is part of the "Care" strategic aim of the Trust Strategy:

Deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations.

- Priority Area – Financial sustainability

This will focus on ensuring that we best use the finite resources available to us, which include, (but are not limited to), people, physical capacity and finances, as well as maximising opportunities offered through collaborative working between WHT and RWT.

Mandatory statements of assurance from the Board

Review of services

Participation in clinical audit

During 2023/24, there were several national clinical audit programmes and national confidential enquiries covering NHS services.

During that period, Walsall Healthcare participated in 92% of the national clinical audit programmes and 100% of the national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Walsall Healthcare NHS Trust was eligible to participate in during 2023/24 are as below.

National Audit Title	Trust Participation (50/56)	% of the No of cases Submitted	Actions / Comments
Serious Hazards of Transfusion -(SHOT)	Yes	Data submission in progress	In progress
National Comparative Audit of Blood Transfusion – Audit of NICE QS 138	No	N/A	Trust decision not to participate
National Comparative Audit of Blood Transfusion – Bedside Transfusion Audit	Yes	Data submission in progress	Not yet reported
National Asthma and COPD Audit Programme (NACAP) – COPD	Yes	Data submission in progress	In progress
National Asthma and COPD Audit Programme (NACAP) - Asthma	Yes	Data submission in progress	In progress
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation	Yes	Data submission in progress	In progress
National Asthma and COPD Audit Programme (NACAP) – Paediatric Asthma – Secondary Care	Yes	Data submission in progress	In progress
National Diabetes Audit- Inpatient Safety Audit	No	N/A	To commence in April 2024
National Diabetes Adult - Foot Care Audit	Yes	Data submission in progress	In progress
National Diabetes Adult – Pregnancy	Yes	Data Submitted	Not yet reported
National Diabetes Adult – Core	No	N/A	To commence in April 2024
National Paediatric Diabetes Audit	Yes	Data submission in progress	In progress
National Lung Cancer Audit (NLCA)	Yes	On-going data submission	Not yet reported
	Yes	100%	Not yet reported

Statements of Assurance

National Audit Title	Trust Participation (50/56)	% of the No of cases Submitted	Actions / Comments
Care of Older People – CEM	Yes	Data submission in progress	In progress
Mental Health (Self Harm) – CEM	Yes	Data submission in progress	In progress
Major Trauma Audit – TARN	Yes	100%	Subject to a cyber-attack – in progress
Cleft Registry and Audit Network	No	N/A	Not undertaken at the Trust
National Audit of Heart Failure	Yes	Data Submission in progress	In progress
National Audit of Adult Cardiac Surgery	No	N/A	Not undertaken at the Trust
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Data Submission in progress	In progress
National Congenital Heart Disease	No	N/A	Not undertaken at the Trust
Cardiac Rhythm Management	Yes	Data submission in progress	In progress
National Audit of PCI	No	N/A	Submitted as part of The Royal Wolverhampton NHS Trust submission
National Gastro Intestinal Programme	Yes	Data submission in progress	In progress
National Oesopago – Gastric Cancer	Yes	Data submission in progress	In progress
National Gastro Intestinal Programme	Yes	100%	Report received Nov 2022, good compliance
National Bowel Cancer Audit	Yes	100%	In progress
UK IBD Audit Programme	No	N/A	Trust decision not to take part

National Audit Title	Trust Participation (50/56)	% of the No of cases Submitted	Actions / Comments
Mental Health Clinical Outcome Review Programme	No	N/A	Not undertaken at the Trust
Sentinel Stroke National Audit – Community	Yes	Data submission in progress	In progress
BAUS Urology Audits – BAUS Nephrostomy Audit	No	N/A	Submitted as part of The Royal Wolverhampton NHS Trust submission
National Prostate Cancer Audit	No	N/A	Submitted as part of The Royal Wolverhampton NHS Trust submission
Case Mix Programme (CMP) – ICNARC		On-going data submission	In progress
Yes	100%	In progress	In progress
National Audit of Metastatic Breast Cancer	Yes	Data submission in progress	In progress
National Audit of Primary Breast Cancer	Yes	Data Submission in progress	Not yet reported
National Emergency Laparotomy Audit	Yes	Data Submission in progress	Not yet reported
National Vascular Registry	No	N/A	Not undertaken at the Trust
Elective Surgery (National PROMs Programme)	Yes	Data Submission in progress	In progress
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Yes	100%	Not yet reported
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Yes	Data Submission in progress	In progress
Fracture Liaison Service Data Base	Yes	Data Submission in progress	In progress
National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	Yes	Data Submission in progress	In progress

Statements of Assurance

National Audit Title	Trust Participation (50/56)	% of the No of cases Submitted	Actions / Comments
MBRACE-UK - Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Yes	100%	Not yet reported
MBRACE - Maternal mortality confidential enquiries	Yes	100%	Not yet reported
MBRACE – Perinatal Mortality Surveillance	Yes	100%	Not yet reported
MBRACE - Maternal mortality surveillance	Yes	100%	Not yet reported
MBRACE - Perinatal mortality and serious morbidity confidential enquiry	Yes	100%	Not yet reported
National Maternity and Perinatal Audit (NMPA)	Yes	100%	Not yet reported
National audit of Seizures and Epilepsies in Children and Young People	Yes	100%	Not yet reported
National Audit of Care at the End Of Life	Yes	Data Submission in progress	In progress
National Neonatal Audit Programme	Yes	100%	Not undertaken at the Trust
	Not yet reported	On-going data submissions	Report received Sept 2022, good compliance noted
Paediatric Intensive Care	No	N/A	Not undertaken at the Trust
Learning From Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)	Yes	100%	In progress
National Audit of Dementia	Yes	65%	Not yet reported
National Cardiac Arrest Audit (NCAA)	Yes	Data submission in progress	In progress
Prescribing Observatory for Mental Health	No	N/A	Not undertaken at the Trust

National Audit Title	Trust Participation (50/56)	% of the No of cases Submitted	Actions / Comments
UK Cystic Fibrosis Registry	No	N/A	Not undertaken at the Trust
NCEPoD / Testicular Torsion	No	N/A	WHT No Data Submitted
NCEPoD / Juvenile Idiopathic Arthritis	Yes	Organisational Data Submitted	Clinical Treatment Not Undertaken at WHT
National Clinical Audit of Psychosis	No	N/A	Not undertaken at the Trust
National Joint Registry (NJR)	Yes	Data Submission in Progress	In progress
National Audit of Pulmonary Hypertension	No	N/A	Not undertaken at the Trust
Out of Hospital Cardiac Arrest Registry	No	N/A	Not undertaken at the Trust
Peri Operative Quality Improvement Programme	No	N/A	Trust decision not to take part
Society Acute Medicine Bench Marking Audit	Yes	100%	In progress
SAMBA	Yes	100%	Report under review by the Care Group
Chronic Kidney Disease Registry	No	100%	Submitted as part of The Royal Wolverhampton NHS Trust submission
NCEPoD - Community Acquired Pneumonia	No	N/A	WHT – No Data Submitted
NCEPoD – End of Life Care	Yes	Data Submission in Progress	In progress
NCEPoD – Endometriosis	No	N/A	WHT - No Data Submitted
NCEPoD – Rehabilitation following Critical Illness	Yes	Data Submission in Progress	In progress

Statements of Assurance

National Audit Title	Trust Participation (50/56)	% of the No of cases Submitted	Actions / Comments
National Audit of Cardiac Rehabilitation programme	Yes	Data Submission in progress	In progress
National Audit of National Cardiovascular Disease Prevention in Primary Care	No	N/A	Not Undertaken at WHT
National Child Mortality	Yes	Data Submission in progress	In progress
National Perinatal Mortality Review Tool	Yes	Data Submission in progress	In progress
Respiratory Audit – Adult Respiratory Support Audit			
No	N/A	Submitted as part of the ICNAR Data	
Breast and Cosmetic Implant Registry	Yes	Data Submission in progress	In progress
British Hernia Society Registry	TBC		
National Bariatric Surgery Registry	Yes	Data Submission in progress	In progress
National Obesity Audit	TBC		
National Cataract Audit	TBC		

Statements on the performance of National Audits:

The Inbetweeners – NCEPoD Study

A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services. The report identified several national recommendations, following a review by the Trust. Good compliance with the recommendations was noted in the form of SOPs and Policies that meet all the outlined recommendations.

CEM Infection Prevention and Control

The report identified a good level of compliance with the national standards measured around screening and isolation. A review of the mandatory training was conducted to improve and further underpin policies around COVID-19 screening that fell short of the national average.

National Audit of Care at End of Life (NACEL) Fourth Round of the audit 2022/23 report

The report identified that good compliance to above average with face-to-face specialist palliative care services, recognition of end-of-life and service that prioritises care compassion and dignity. Walsall Healthcare responded to four of the standards that fell below national average, by relaunching the End-Of-Life Plans and ReSPECT training - a Quality Standards audit tool that prompts and acts as guide to all staff along with further education and development around the end stages of life incorporated into the Gold Standard Framework.

ICNARC Quarterly Quality Report 2023/24 - Q1 – Q3

Overall compliance was noted as good for all the quality indicators. Quarter 3 identified new quality indicators; Walsall fell slightly below the standard level and a number of new processes have been implemented to support data capture to ensure an accurate reflection of the current level of compliance. These will be re-evaluated in Q4 to establish if any further improvement work is required.

Regional report – Asthma Audit

Walsall Healthcare performed in line with the national average for the majority of the identified KPIs. Two KPIs were noted as requiring improvement in relation to Peak Flow Measurement at arrival and BTS discharge bundles. The team agreed to continue to build on supporting the ASK Earl referrals for ED patients to support improvement in care delivery to those asthmatic patients within ED. A further agreement was to establish a Tier 3 Asthma Service that will provide oversight and strategic direction to achieve the KPIs for adult patens with asthma presenting to WHT.

National Audit of Inpatient Falls NAIF, 2023, 2022 Clinical Data

The national report identifies improvements since 2021 in six key areas of assessment - vision, lying and standing BP, medication review, delirium, mobility and continence. Local data is pending.

Of the five overarching recommendations the Trust has made progress with three.

1. Walsall Healthcare uses its own data as the focus for quality improvements. The Trust has implemented Falls Review and Accountability meetings to identify learning, actions and trends. The Trust uses Tendable Audit Tools to identify gaps in assessment and management of falls.
   The Trust undertakes intense scrutiny and validation of all falls to identify, themes, trends and learning. The themes trends and learning are used to develop key QI projects through a Shared Decision-Making Group.
   The Trust utilises outcomes from SIs and concise investigations to inform learning and developments. The Trust undertakes a monthly Falls Steering Group for shared learning from each division.
2. The Trust has developed and implemented an evidence based MFRA. The MFRA incorporates lying and standing BP assessment as per the RCP guidelines and the use of supporting learning material. Compliance is measured through Tendable Audit Tools and is included in eLearning and face to face training resources.
3. A post falls protocol has been developed and is currently in the ratification stages. Post falls care is included in the eLearning and face to face training.

There are two recommendations for focus in the coming year.

- A proposal has been made to review the medical assessment tool currently used within the Trust to incorporate robust and evidence-based delirium assessments and incorporate frailty assessments for patients admitted directly to inpatient facilities.
- Proposal to review training and education for medical staff in relation to post fall management of patients and administration of analgesia

Fracture Liaison Service Database Annual Report

From the 11 KPIs in place, Walsall Healthcare was higher than the national average in

eight of these. FLS are encouraged to use the FLS- DB live data to identify areas of achievement and improvement as an integrated component of regular governance meetings.

All senior executive decision-makers should hold a key stakeholder meeting to explore how local needs for fragility fracture patients can be met. This is being addressed with the Black Country ICB, meetings with ICB in relation to FLS service delivery, staffing and FLS-DB KPIs.

The reports of 26 national clinical audits were reviewed by the provider between April 2023 andMarch 2024 and Walsall Healthcare intends to take the following actions to improve the quality of healthcare provided. A summary of the reports reviewed is noted in the table below:

National Audit Title	Actions taken
Pulmonary Rehab	Of the six recommendations in the report that are applicable to the service, there were five that were already being achieved giving WHT good compliance. There was one standard that required improvement relating to distance assessments. Action was taken to address walking distance assessments – this is now standard practice for all patients in our care.
National Audit of Care at the End of Life: Third round of the audit	Report and recommendations reviewed, local action plan developed, including development and delivery of education programme to support communications training and introduction of end-of-life specialist nurse practitioner post.
SSNAP Annual report 2022	Report and recommendations reviewed, local actions developed; a good standard of care was noted overall with actions being taken to improve the speech and language service currently provided.
National Oesophago-Gastric Cancer Audit Short Report 2022	All national recommendations are reviewed, and a local action plan is in place to strengthen working between dieticians at Walsall Healthcare NHS Trust and dieticians at QE.
The 'So What' of Maternity Data	All recommendations have been reviewed; local actions to form part of the Ockenden report.
National Neonatal Audit Programme summary report on 2021 data	Report received and reviewed; actions taken include posters to raise awareness, educational sessions to all staff groups and the purchase of new equipment and training for safe use.
Case Mix Programme - ICNARC	Presentation and review of national data, no formal action plan required.
National Diabetes Foot Care Audit: Interval review	Presentation and review of national data, no formal action plan required.
Cardiac Arrest	The overall data completeness remains high for Walsall Healthcare NHS Trust. Action taken to further embed the electronic form to support submissions to capture data on patients in real time.
National Paediatric Diabetes Audit Annual Report 2022/23	All national recommendations are reviewed, and a local action plan is in place to address any areas of potential improvement
National Audit of Breast Cancer in Older Patients: 2022 annual report	Report reviewed and no areas of concern, no formal action plan required.
National Cardiac Audit Programme 2022 Report: The heart in lockdown	Report reviewed and no areas of concern, no formal action plan required.
Fractured Neck of Femur - CEM	Presentation and review of national data has taken place. Actions were agreed by the care group to include education and training
Eighth Patient Report - National Emergency Laparotomy Audit	Report received and reviewed, actions and recommendations noted – a formal action plan is in development

Local Clinical Audit

Walsall Healthcare initially registered 123 audit projects, of which 39 are in progress and 76 have been completed. 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
NatSSIPs LocSSIPs	Trust-wide compliance has showed consistent improvement over the last 12 months both with audit returns and compliance to standards.	The current process has been reviewed in line with NatSSIPS2 which was recently published and changes have been made to the current process to support patient safety.
Review of Implementation of Physiotherapy Outpatient Clinic, Walsall Palliative Care Centre	Good use of the service provision and compliance to the standards was noted. There was a noted improved use of physiotherapeutic exercise equipment and increased scope of assessment and intervention techniques were evident. There was positive feedback from the Friends and Family Test triangulating the outcome of the local audit findings.	Recommendations noted to: 1. Monitor fortnightly 2-3 hours, review for another six months to consider monthly clinics to support patient choice. 2. Offer appointments from 9.30am onwards, aiming for back-to-back appointments where possible again to further support patient choice.
Oxygen management in Modular block Walsall Manor Hospital	Variable compliance was noted regarding oxygen guidelines management within elderly care.	Recommendations noted to: 1. Share and disseminate outcomes through delivery of training sessions, posters, and safety huddles. 2. Additional teaching (Nurses and Junior Doctors) in the process around oxygen prescribing. 3. Questionnaires for ward staff in relation to understanding and accessing the guidelines for oxygen.
CTPA use in Acute Medicine Department	An improvement was noted in the CTPA yield in comparison to the first audit but still below standard.	Following loc improvement from the audit, a quality improvement has been established to drive the compliance improvements – in progress.
AKI management and compliance to the trust AKI guidelines	Majority of the cases of AKI were stage 1. It was noted that dehydration secondary to reduced oral intake and sepsis were leading causes of AKI. Variable compliance to the AKI bundle	Share and disseminate outcomes through delivery of training sessions, posters, and safety huddles. Focused delivery in hand overs for AKI patients is currently being tested. Discussions at safety huddles to improve usage of the AKI care bundle.

Statements of Assurance

An assessment and improvement of the timely removal of peripheral iv catheter on the ward – Re - Audit	Demonstrable improvements noted from the previous audit in relation to Idle cannulas, and reduction in over 72 hours usage.	Share and disseminate outcomes through delivery of training sessions, posters, and safety huddles.
PEG Insertion Audit	Whilst the number of PEGs planned/ placed has increased, numbers remain low compared to earlier years. Again, this is likely explained by the relocation of stroke services to a neighbouring Trust, as well as head and neck cancer patients receiving treatment elsewhere. Compliance with national guidance regarding antibiotic prophylaxis was good. There have been no deaths post PEG during this audit period within 30 days of insertion, giving us a 0%, 30-day mortality rate. The national standard is below 5%. Patients were seen within one week of referral apart from one patient who was initially a non-urgent referral in the community. Procedures were done, on average within one month of assessment, apart from one patient who became unwell whilst awaiting a date and was admitted.	Actions to be taken: 1. Continue with documentation of prophylactic antibiotics on all Endoscopy reports for patients that have a PEG placed. Nutrition Nurse continues to keep spreadsheet of patients to help with future audits. 2. Nutrition Nurse to continue to assess all patients referred for a PEG and discuss at Nutrition MDT each week. 3. Nutrition Nurse to continue to review inpatients 24 hours prior to the planned procedure, and outpatients one week prior, to assess if the patient is still fit enough to proceed, or if it needs to be postponed. 4. Continue to promote Nutrition MDT and importance of involvement of Nutrition Nurse. 5. Continue to promote the use of Trust guidance (available on the intranet) around Nutrition and Hydration in Advanced Dementia and Feed at Risk to avoid inappropriate referrals. Re-audit every six months.
Prevalence/Identification of patients suitable for high Triglycerides treatment with fatty acids	Of a total of 952 patient blood screens, 28 patients were identified as eligible for omega 3 fatty acid treatment on secondary prevention grounds as the NICE guidance.	Patients to be invited to a Nurse-led cardiology clinic to discuss treatment pathways.
JAG Clinical Outcomes	Fully compliant with the standards	No actions required.
Documentation of blood gas results in ED notes	Variable compliance was noted	All trainee anaesthetists should receive specific training in providing peri-operative care for people with hip fractures. To continue to participate in the national programme. To actively participate in the femur fracture steering group.

Clinical QI Audit and data collection of hip fracture patients having surgery	Variable compliance to the guidance.	All trainee anaesthetists should receive specific training in providing peri-operative care for people with hip fractures. To continue to participate in the national programme. To actively participate in the femur fracture steering group.
Neuromuscular Monitoring according to AAGBI Guidelines	Variable compliance to the guidance.	Develop departmental professional practice initiative to support improvement in NMB monitoring.
Acute Achilles Tendon Rupture Pathway	Overall good compliance was noted for the audit, the introduction of the pathway has seen improvement	1. Share outcomes with ED and Physiotherapy. 2. Conduct a further review on pre and post operative interventions assessing the effectiveness of VACOPED boot.
Surgical Site Infection Audit: Operation Note and Inpatient Documentation	Specific documentation of early intra-operative SSI prevention steps remains below standard.	1. Share outcomes with the team. 2. Consideration of mandatory electronic operation notes. 3. Continue encouragement for nursing documentation with consultant input where needed.
Operation documentation standards within general surgery	Overall the audit noted good compliance to the RCS standards. Areas for improvement are required on general documentation. The audit demonstrated better documentation compliance in the typed operation notes as opposed to written operation notes in terms of legibility	To investigate the feasibility of moving to typed operation notes within General Surgery and providing links into Fusion
A retrospective audit of the supervision of Orthodontic Therapists at Walsall Manor Hospital	Variable compliance in relation to comprehensive prescription and a review by consultant dentist every other visit.	To develop a SOP that sets out key documented standards to ensure the metrics are achieved.
Patient self-administration of subcutaneous biologic treatment	In conclusion - most patients in this audit had a good level of awareness on how to administer subcutaneous TNF alpha blockers injections.	In conclusion - most patients in this audit had a good level of awareness on how to administer subcutaneous TNF alpha blockers injections.

Consent and anaesthetic documentation	The audit demonstrated variable compliance with the agreed standards.	Recommendations: Further work required by the Divisional Governance Group to develop the requirements for electronic records to support and improve documentation. Teaching sessions on anaesthetic documentation, medico legal importance and familiarity with our anaesthetic chart.
Patient Flow from ED	Majority of patients were referred to PAU by ED. The reasons for attendance varied and included blood results and jaundice, non-respiratory conditions. Majority of cases were discharged within an average of 5.9 hours.	1. Prolonged jaundice clinic separate from PAU role for Virtual Ward Nurses 2. Re-audit post PAU move. 3. Reviews can be booked into RAC Clinics /clear instructions to GP on EDS. 4. Consultants to triage referrals after moving to new PAU. 5. Optimise MRI success rate to reduce re-attendance.
Prescription Re-Audit	An improvement was noted in many standards when comparing the two audits.	Education and advice to staff on prescription requirements.
Let thy breast milk be thy medicine	The audit demonstrated a 100% compliance to the checklist. The Midwifery Team was aware of the new preterm breast milk leaflet.	Ongoing teaching about better quality use of the checklist.
Testing times for RFTs	The audit highlighted that most tests can be performed within the allocated time	No actions needed compliant to standards.
Audit on croup management	Most children treated for croup (89%) received dexamethasone, while a small fraction (11%) was discharged home without treatment. Steroid treatment was more likely to be variable in children with moderate to severe croup with some children receiving dexamethasone and budesonide as first line and others receiving either dexamethasone or budesonide. Most children treated for croup (93%) were either given a croup leaflet or discharge advice, while a small fraction (7%) was discharged without leaflet or advice	Recommendations: Standardise the treatment of croup across all paediatric areas. Trust-wide croup guidelines/patient leaflet developed (available on the Trust intranet page under paediatric local guideline and ED ASK EARL)

EDS - evaluate clinical interventions made by Pharmacists at Walsall Manor in 2022 on EDS prescriptions in comparison to previous data sets.	There has been a slight improvement in the number of EDS with a full allergy status documented from 68% in 2022 to 72% in this re-audit. Pharmacist EDS intervention rates were lower on this re-audit (44%) in comparison to the previous audit (64%)- overall improved quality in EDS writing	Recommendations 1. The implementation of mandatory education and training sessions for current staff and new staff at induction of prescribing requirements on discharge. This can take place in FY1 induction and NMP conference as well as departmentally to target FY2s and ACPs. Clinical Fellow – twice a year Improvements required to Fusion's EDS System: 2. Mandating acknowledgement of each pre-admission medication as either continue, stopped, or suspended before a prescriber can authorise an EDS. 3. Mandating of allergy status - doctors unable to authorise EDSs without full completion. 4. Segregated section on Fusion for CDs with pre-populated templates to reduce error rate with prescribing CDs. The Fusion Team has already been contacted about the above request and we are waiting to hear whether it will be approved or not. 5. To disseminate audit findings across the different care groups through lead pharmacists for improvement plans in their respective areas. 6. Re-audit at six-monthly intervals
Post Meningitis Follow Up Care	Overall good compliance noted	Continue with current practice
Child Protection Medical Examination Audit	Maintaining standards with respect to time of CP medical examination and ensuring CP medical examinations done by junior colleagues are appropriately supervised	Continue with current practice
Consultant Review Times For Admitted Patients – Re Audit	Achieving standards 2 and 3 showing an improvement from the previous audit	Recommendations: Standard 1 - Establish a clear referral pathway for ED referrals
Assessing adequacy of knowledge of Ottawa rules for knee, ankle and foot X-Rays amongst ED Healthcare Professionals at the Manor Hospital - Re-audit of implemented interventions (2nd Cycle, closed loop)	Following the implementation of the educational intervention, this closed-loop second audit cycle demonstrates an improvement in the knowledge of ED Healthcare Professionals at WHT regarding the Ottawa rules for knee, ankle and foot X-rays.	Continue with current practice.

Statements of Assurance

Assessing adherence to Neuroimaging Protocols for children with suspected Physical Abuse	All children under the age of one that were audited received CT head imaging on the same admission (large majority received on the same day) in line with local protocol and RCR guidelines.	Recommendations: 1. Present the audit results to radiographers and paediatricians. 2. Update Local Forensic SOP to incorporate the RCR recommendation in Forensic SOP 3. A copy of the guidelines readily available in the department to meet the ideal window of follow-up skeletal surveys
Neonatal Alert Referrals	Full compliance noted	Recommendation : Switch to continuous data collection

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 2023 to 31 March 2024 the Trust has been issued with a total of 18 Patient Safety Alerts (NPSA) from the Central Alerting System. Nine of these alerts have been completed in line with the stipulated completion periods, three were issued as information alerts, one was deemed not applicable to the organisation and five remain in progress at the time of reporting.

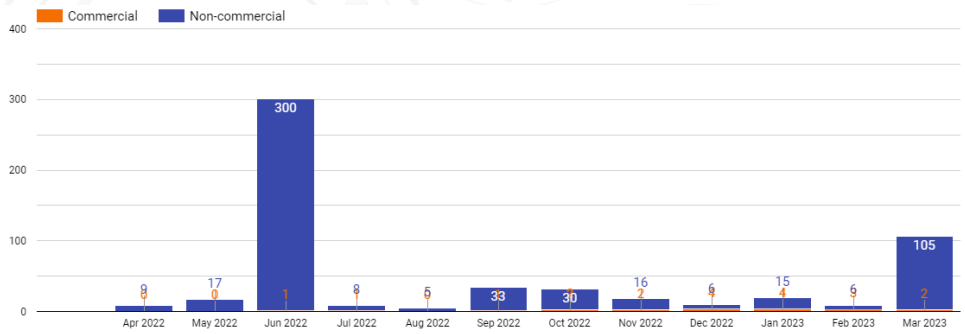
Participation in Clinical Research

Opportunities for the population of Walsall to be involved in research continues to grow.

The total number of patients receiving relevant healthcare services provided or subcontracted by Walsall Healthcare NHS Trust in 2023/24 who were recruited into studies approved by the HRA (Heath Research Authority) ethics committee was 239. This covers 15 specialities which include: Reproductive Health & Children, Renal Disorders, Musculoskeletal Disorders, Health Service research, Diabetes, Dermatology, Cardiovascular disease, and Anaesthesia & Perioperative medicine. Of the 239 participants recruited into studies, 23 were recruited into clinical trials. Of the studies opened, five were clinical trials.

The Trust has seen a decrease in the number of participants recruited into research studies from the previous year 2022/23 - this may be because in June 2022 WHT had a study opened which recruited 300 participants. Recruitment into clinical trials, however, has increased overall. The predicted growth for clinical trials will exceed previous years. There are currently five studies in set-up and three in the pipeline.

The Trust has maintained and formed strong working relationships with pharma colleagues. This has helped grow and develop an intense portfolio within areas such as Dermatology and Cardiology. New Specialities now engaging in research include Rheumatology, Gastroenterology, and Sexual Health.



The below table illustrates the varied speciality areas Walsall Healthcare NHS Trust is research-active in, with studies in set up or in the pipeline:

Specialities Opened	Specialities In Set up	Specialities in the pipeline
Cancer	Paediatrics/Children	Cardiovascular
Critical Care	Cardiovascular	Dermatology
Respiratory	Musculoskeletal	Rheumatology
Surgery	Surgery	Sexual Health
Dermatology	Dermatology	
Cardiovascular	Reproductive Health & Birth	
Reproductive Health & Birth	Cancer	
Emergency Medicine		
Paediatrics/Children		
Tissue/Viability/Diabetes		
Maternity		
Education Related		

Cardiovascular, dermatology and surgery dominate research activity across the Trust, having a number of studies opened, in set up or in the pipeline.

New growth areas include rheumatology, respiratory, sexual health, maternity, dietetics and emergency medicine.

CQUIN (Commissioning for Quality and Innovation Payment Framework)

The Commissioning for Quality and Innovation (CQUIN) financial incentive scheme was included within the 2023/24 NHS Standard Contracts with our ICB and NHSE Commissioners.

The full breath of Walsall Healthcare NHS Trust's income in 2023/24 is conditional to achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. Where all the conditions outlined within Paragraph 1 and 2 of Schedule 3F of the aforementioned ICB contract are met, however, the Commissioner provides assurance that where any under-achievement against CQUIN goals trigger a reduction in the planned CQUIN value, the value of that under-achievement will be ringfenced, and fully re-invested within the Trust.

CQUIN aligned to NHSE contracts adopts a similar approach, but also proposes, that in exceptional circumstances, the ring-fenced value due to any under-achievement could be re-invested within the ICS footprint. It is noted that the NHSE commissioner would have to demonstrate exceptionality.

Information on registration with the Care Quality Commission

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

The CQC has taken enforcement action against Walsall Healthcare NHS Trust during 2023/24. The Trust was issued an Improvement Notice Issued under the Health and Safety at Work etc. Act 1974 and the Ionising Radiation (Medical Exposure) Regulations 2017 ('IR(ME)R') on 20 February 2024.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Information on the quality of data - Secondary User Services

Walsall Healthcare NHS Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.88% for admitted patient care
- 99.95% for outpatient care and
- 99.54% for accident and emergency care

The percentage that included the patient's valid General Medical Practice Code was:

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

Clinical coding error rate

Walsall Healthcare NHS Trust was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

The Trust has taken the following actions to improve data quality:

The Trust commissioned 3M to undertake a Data Protection and Security Toolkit audit for coded data 2023/24 and the results are in the table below.

The aim of the audit is to check that clinical coding processes are in place and to ensure the inputted data complies with national clinical coding standards. Coded clinical data will always be audited against the national clinical coding standards.

In addition to the accuracy scores below, the auditor also noted the following:

- The Trust should be proud of the quality of the coded clinical data. The overall coding inaccuracy rate of just 2.3 per cent is well below the national 6.5 per cent average error rate as identified in the latest available national Payment by Results Report.
- The depth of coding (number of recorded diagnosis codes) in this sample is 10.4 which is well above the current national average of 5.7. The team is understaffed and there is a rolling, six-week backlog so it is testimony to the ethos of the team that it does not simply add the minimum information in favour of quickly reducing this backlog.

	Level of attainment Mandatory	Level of attainment Advisory	Trust percentage correct
Primary diagnosis	>= 90.0%	>= 95.0%	97.0%
Secondary diagnosis	>= 80.0%	>= 90.0%	98.1%
Primary procedure	>= 90.0%	>= 95.0%	91.4%
Secondary procedure	>= 80.0%	>= 90.0%	98.0%

Information governance toolkit attainment levels

Data Security and Protection Toolkit (DSPT)

Walsall Healthcare NHS Trust measures performance against the National Data Guardian's 10 data security standards to ensure appropriate data security and handling of personal information is maintained.

Data Protection Legislation specifies that an information breach, that affects personal data and is likely to result in an adverse effect to the rights and freedoms of individuals, must be reported to the Information Commissioner's Officer (ICO) using the on-line tool. During the financial year 2023-2024, there have been no incidents that met these criteria.

Incidents classified at lower severity level - Incidents classified at severity level 0/1 are aggregated and provided in the table below. Please note this is not all incidents, only those classified as 0/1 against the categories below

Category	Breach type	Total
A	Confidential patient breach	123
B	Confidential information leak	22
C	Consent not gained	2
D	Post incorrectly sent/addressed	20
E	Record keeping – incomplete	11
F	Missing records	34
G	Records lost in transit	2
H	Records not provided	2
I	Reports (results) – missing/unfiled	10
J	Loss of data via electronic transmission	6
K	Incorrect delivery of electronic data	26
	Total	**258**

Walsall Healthcare NHS Trust Data Protection and Security Toolkit return 2023/24

An 'Approaching Standards' submission was published in June 2023; the mandatory internal audit of the DSP toolkit supported this self- assessment.

An Improvement Plan was established and accepted by NHS Digital with the Trust expected to achieve the required standards by April 2024. The organisation's status will then be adjusted to 'Standards Met'.

Data Protection and Security Toolkit return 2023/24 is currently being ratified and will not be published until June 2024.

Walsall Healthcare NHS Trust recognises the importance of robust information governance and data security in practice. Assurance continues to be provided to the Trust Board via the Information Governance Steering Group. Membership includes the Caldicott Guardian, Senior Information Risk Owner and Data Protection Officer, who oversee all associated workstreams.

Statement regarding progress in implementing the priority clinical standards for seven-day hospital services

National reporting on seven-day service has been suspended since March 2020. Walsall Healthcare NHS Trust continues to monitor against the standards annually, however. The results of the audits are reported to the Quality Committee which is a sub committee of the Trust Board.

The last audit took place in February 2023 (the next audit is currently underway and results are not available at time of reporting). See below for detail on to the four core standards. The results evidenced significant improvement on the previous audit, with the Trust now meeting the following two standards where it had not the previous year:

Standard 2 (time to first Consultant review, within 14 hours in the acute admission setting)

- Standard 8 (ongoing Consultant review, all patients to be reviewed every 24 hours)

Standard 2 - Time to first Consultant review, within 14 hours in the acute admission setting:

Walsall Healthcare NHS Trust achieved an overall compliance of 93% (against a standard of 90%) of patients reviewed by a Consultant within 14 hours of admission. This is an improvement on the previous audit result of 60%. Compliance was as follows: weekday 94% and weekend 100% (compared to previous results: weekday 59% and weekend 73%).

Standard 5 - Assesses the availability of six diagnostic tests for weekdays and weekends. Overall compliance (i.e. achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments, with 50% weighting given to each. Walsall Healthcare NHS Trust met this standard.

Standard 6 - Timely 24-hour access seven days a week to nine Consultant-directed interventions.

Assesses the availability of each of the nine interventions for weekdays and weekends. Overall compliance (i.e., achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments. This overall score is based on a 50% weighting for weekday and weekend availability. Walsall Healthcare NHS Trust met this standard.

Statements of Assurance

Standard 8 - Ongoing Consultant review, all patients to be reviewed every 24 hours.

Daily review compliance is at 91% (compliance at last report was 53%), against the 90% compliance target.

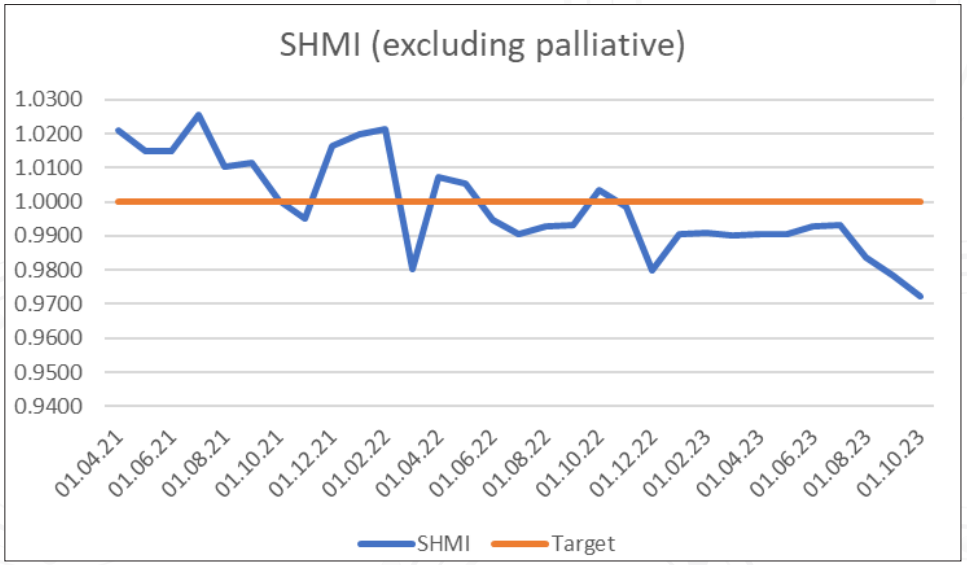
The results of the audits have significantly improved on the previous years. Previously identified areas for improvement and quality measures the Trust introduced should continue have a positive effect on the next audit.

National Core Set of Quality Indicators

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

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of several factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI value is measured against the NHS average which is 1. A value below 1 denotes a lower-than-average mortality rate and therefore indicates good, safe care.

The published SHMI value for the 12-month rolling period (published by NHS Digital March 2024) November 2022 to October 2024 is 0.972. These values are within the expected range and relate to the acute Trust, excluding palliative care.



Core Quality Indicators – Summary of patient deaths with palliative care

The data is provided to the Trust by the medical examiner team for patient deaths with palliative care at either diagnosis or specialty level for the reporting period as below:

Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Palliative Medicine Deaths	14	10	15	13	14	11	12	10	9	10	14	16	18	11	16
Total Hospital Deaths	139	104	120	125	120	106	105	105	113	124	109	164	168	113	149

The Trust has an established medical examiner and mortality reviewer service so that all deaths are scrutinised, and a significant selection undergo a Structured Judgement Review (SJR):

Month	Apr 22	May 22	June 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
SJR requested	7	7	8	3	3	11	16	16	26	13	15	9
Total deaths (hospital)	125	120	106	105	105	113	124	109	164	168	113	149

SJR outcomes (total deaths reviewed categorised by outcomes)

	Q1	Q2	Q3	Q4	Total
Number of deaths	349	322	395	429	1495
Number of SJRs	17	8	31	17	73
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	4	1	4	5	14

This data refers to the number of SJRs completed.

The total number of deaths in the Trust for 2022/2023 is 1,495.

Number of completed SJRs with scores of 1-3a is 14.

Percentage of avoidable deaths is 0.94%.

- This means that learning from deaths is now an established part of the Trust's governance process and has provided important information on the care of patients who were in the last months and weeks of life. This information has contributed to improving the Trust's ability to identify key areas of focus.
- The community ME programme continues to be rolled out to all Walsall GPs with 48% of Walsall GPs now part of the programme and meetings arranged in April to encourage GPs to sign up in advance of the statutory date.
- The ME programme in the community was due to become statutory in April 2023, however this has been moved to summer 2023 and we are awaiting notification of the exact date.
- Walsall Healthcare NHS Trust provides integrated specialist palliative care and end-of-life services, with the hospice unit, community teams and hospital team all part of the Trust. This means that we can provide care across boundaries.
- The Trust will take/has taken the following actions to improve the quality of its services:
- The Gold Standard Framework programme in the hospital started in October 2022, helping to offer a systematic approach to end of life care on the wards
- The End-of-Life Task and Finish group is supporting the first cohort on two wards: a medical and surgical ward. Currently both wards are using their daily board rounds to discuss patients and support their wishes and preferences
- The second cohort of six wards will start training in June 2023 and the final cohort of six wards in October 2023. This will include areas such as ICU and AMU.
- The ReSPECT group started in March 2023 with the aim to provide oversight, governance, training compliance, audit and reviewing incidents.

Core Quality Indicators – Learning from Deaths

Deaths at the Trust are recorded using the Clinical Outcomes Review System (CORS). This enables review and discussion at service and Directorate morbidity and mortality meetings. A proportion of deaths also undergo a more detailed review.

Detailed case record review is undertaken using the Royal College of Physicians' Structured Judgement Review (SJR) methodology for any death meeting one of the defined categories below:

- All deaths where bereaved families and carers or staff have raised a significant concern about the quality-of-care provision
- All patients with a learning disability
- All patients with a mental health illness
- All maternal deaths
- All children and young people up to 19 years of age
- All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work
- All elective surgical patients
- All non-elective surgical patients
- All unexpected deaths
- Deaths where learning will inform improvement work.
- Where there have been external concerns about previous care at the Trust.

Specialties may also undertake additional detailed case record reviews as part of their own mortality review processes and feed any lessons learned from this back to the Mortality Surveillance Group. Paediatric and Maternal or Neonatal deaths are reviewed using the Black Country Child Death Review Strategic Partnership and MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) tools respectively.

Sharing of Learning

Learning from reviews of deaths, including those reviewed by detailed case record reviews, is discussed and shared through local specialty and Directorate mortality meetings. Themes from these meetings are shared at the Trust Mortality Surveillance Group.

Specialties report to the Mortality Surveillance Group to set out themes, lessons learned and action plans. These are reviewed regularly, and has resulted in the following improvements:

Lung cancer

- The Lung Cancer Service quality improvement programmes have led to a rapid access suspect referral process with new pathways to identify potential malignancies on imaging
- Appointment of lung nodule tracker and cancer navigation post
- Agreed business case to strengthen respiratory team
- Streamlining and clarifying function of lung cancer MDT
- Trust-wide cancer Power BI dashboard
- New ACP/CNS oncology clinics to support oncologists started 6 February 2023
- Fewer patients waiting excessive time for surgery: change of SLA September 2022
- Additional session providing bronchoscopy

Colorectal cancer

- The Colorectal Cancer Service has implemented a mandated FIT test prior to GP referral since January 23 to streamline referrals, with guidance for urgent referrals circulated to major stakeholders
- Education session arranged with GPs/primary care in February/March 2023
- Additional CNS triage post advertised
- Additional ICB funding to support Endoscopy capacity – delivering an additional 1,434 endoscopies per year
- Extra list through November 2022 to January 2023 to reduce backlog of colonoscopy requests
- Endoscopy equipment – approved (and now delivered) 38 scopes and four stack systems, costing £1.87million.
- Endoscopy suite business case – submitted to the Trust Investment Group, for a £781,000 expansion
- Endoscopy recovery action plan – available if required
- Cancer services have seen reduction of >62-day patients within the patient treatment list (PTL) for February 2023.

An improvement group was established to review practices within colorectal services and the following improvements have been implemented:

- Colorectal performance outcome dashboard has been developed
- Monthly review of colorectal cases to support continuous improvement
- Review of Mortality cases
- Daily consultant ward rounds have been introduced
- Engagement with GPs with feedback on referrals made
- Engagement with the Bowel Screening Centre to enable referral of patients

Breast cancer

- The Breast Cancer Team has expanded with an additional Breast Cancer Nurse to help reduce delays in the cancer performance pathway

Oncology

- A seven-day Acute Oncology Service has been established with a lead Nurse
- The Emergency Department has shown a sustainable significant improvement in ambulance handover and triage, ranking first in the West Midlands for 18 months
- A newly built Urgent and Emergency Care Centre (UECC) opened in March 2023 to improve patient care, experience, and flow
- A new online referral system to the acute medical team (Careflow Connect) has been implemented to expedite and minimise the time spent to refer patients

Renal

A seven-day Acute Kidney Injury Service strarted on 19 November 2022 in collaboration with the Renal Team from The Royal Wolverhampton NHS Trust

- A dashboard for AKI is also being developed in the Trust

Urology

- The Prostate Cancer Service has introduced a 'one stop shop' clinic where patients receive trans-rectal ultrasonography and trans-perineal biopsy as needed rather than wait between assessment and investigation

Perinatal mortality

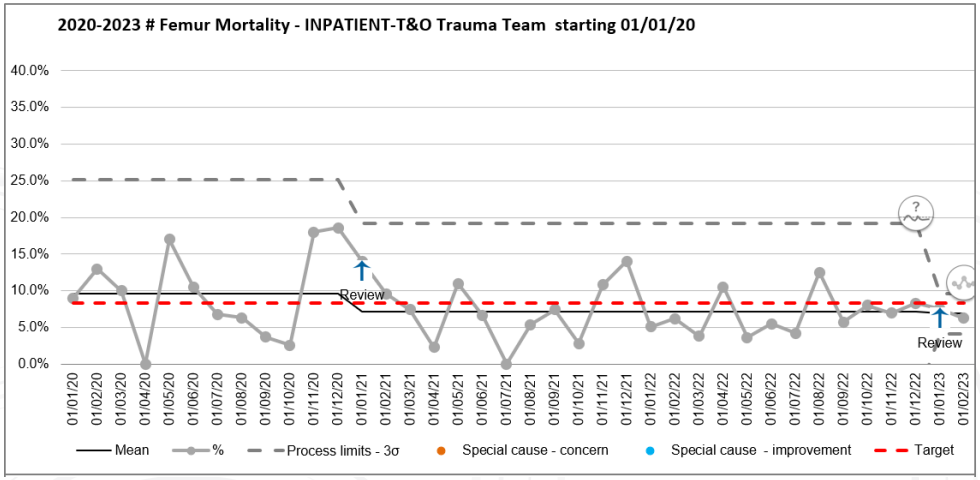
A thematic review was conducted looking at perinatal mortality cases from 1 May 2023 to 31 July 2023 with a further thematic review during August 2023 which identified opportunities to reduce risk for maternal medical conditions before pregnancy and in the early stages of pregnancy. The following actions were agreed:

- Establish pre-pregnancy counselling clinic in line with Ockenden (2022) recommendation.
- Start joint Antenatal Clinic with Obstetric Physician at The Royal Wolverhampton NHS Trust. A maternal medicine lead was appointed in 2020 with two Maternal Medicine antenatal clinics established in April 2023. The clinics are supported by three consultants.
- Review of antenatal virtual appointment pathway to reduce DNA rates and ensure vulnerable/high risk women are seen face to face.
- Improve early booking below 10 weeks to NICE recommendation target of 85% compliance (national average of 65%). Walsall compliance is 55%, up from 42% in April 2023. A self-referral platform was launched in October 2023 which has seen booking improve.
- Improve number of women and families who stop smoking- current compliance meets CNST requirements of >90% at booking and at 36/40, however 33% of women decline the service.
- Twice daily consultant Obstetrician ward round has been implemented
- Themes for improvement were identified with improvement methodology and will be monitored on the PMRT action log monthly
- A working group to review the admission of gestation between obstetric care and gynaecology care to improve the care provided to patients in alignment with Local Maternity and Neonatal System (LMNS)

Deteriorating patient

- Sepsis Outreach Response Team (SORT) was introduced in January 2022 resulting in a significant improvement in the Trust-wide performance against delivery of the "Sepsis Six" and in particular administration of antibiotics within 60 minutes
- The Deteriorating Patient Group has submitted a business case to introduce a 24-hour service from the Sepsis Team

Fracture neck of femur



- Several improvement initiatives were undertaken to improve outcomes and reduce mortality which resulted in the team receiving a HQIP award in April 2022.

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

There were an insufficient number of records submitted for data analysis and the Trust is now reviewing the process to capture this data to improve submissions and data for future years.

Core Quality Indicators - Re-admission Rates

- Using data from the Healthcare Evaluation Data (HED) system, Walsall Healthcare NHS Trust can access full year information for 2022/23. The Trust believes the performance reflects that:

1. Walsall Healthcare NHS Trust has a process in place for collating data on hospital admissions, from which the re-admissions indicator is derived
2. The data is collated internally and then submitted monthly to NHS Digital via the Secondary Uses Service (SUS). This data is then used by the Healthcare Evaluation Data system to calculate readmission rates.

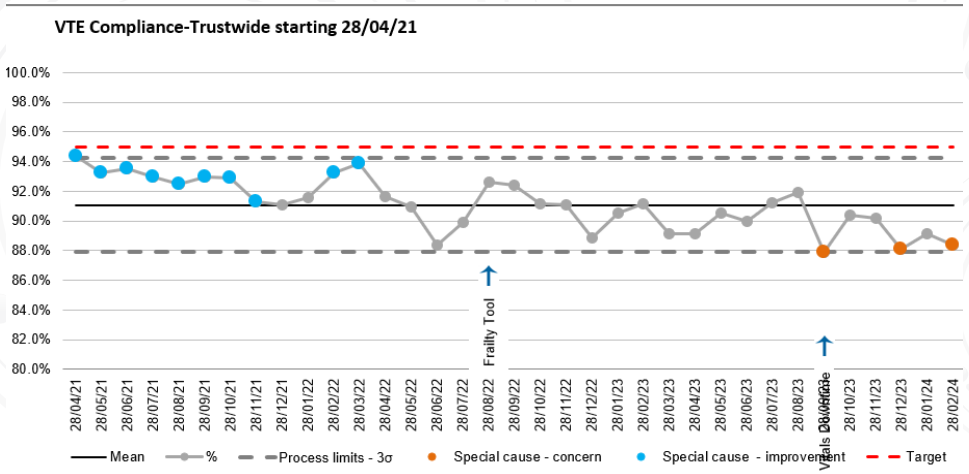
Date	0-15	16 & Over	Date	0-15	16 & Over	Date	0-15	16 & Over
Apr-20	6.15%	12.43%	Apr-21	16.58%	11.34%	Apr-22	15.02%	11.42%
May-20	6.31%	14.25%	May-21	16.99%	11.14%	May-22	16.95%	11.00%
Jun-20	4.88%	14.06%	Jun-21	13.91%	11.15%	Jun-22	18.25%	11.88%
Jul-20	7.25%	13.89%	Jul-21	15.35%	10.74%	Jul-22	19.27%	12.35%
Aug-20	10.23%	14.51%	Aug-21	16.09%	10.51%	Aug-22	14.32%	11.35%
Sep-20	12.56%	13.38%	Sep-21	17.30%	10.70%	Sep-22	15.48%	9.77%
Oct-20	15.97%	13.22%	Oct-21	16.84%	10.68%	Oct-22	18.49%	9.91%
Nov-20	17.74%	12.44%	Nov-21	17.62%	10.98%	Nov-22	18.64%	10.52%
Dec-20	13.60%	12.17%	Dec-21	15.99%	10.45%	Dec-22	15.09%	10.85%
Jan-21	13.99%	12.65%	Jan-22	14.94%	12.34%	Jan-23		
Feb-21	16.56%	12.73%	Feb-22	17.70%	11.51%	Feb-23		
Mar-21	18.15%	11.61%	Mar-22	17.41%	11.67%	Mar-23		

Core Quality Indicators – Venous Thromboembolism (VTE)

National reporting on VTE (venous thromboembolism) assessment was suspended in March 2020 and therefore benchmarking is not available for the period of this report. National reporting started again in April 2024. The Trust continues to monitor and report internally on a monthly basis. See the graph below for performance for 2023/24.

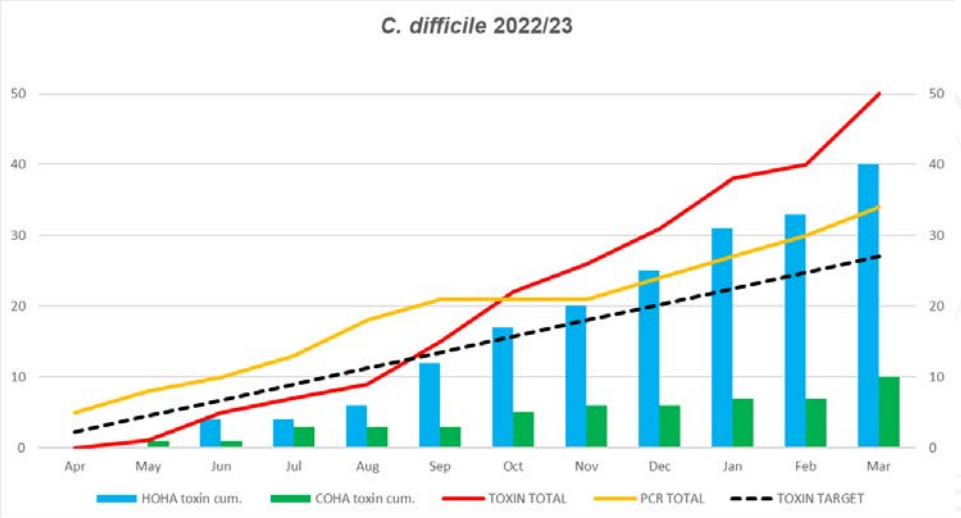
VTE assessment remains below the required compliance target of 95%. Monthly audits are embedded in practice with data shared with consultants and clinical teams to ensure specialties are kept informed of performance to ensure safe patient care. Where compliance is consistently low, Divisions have action plans to improve.

The Thrombosis Group meets monthly and provides the opportunity to discuss compliance and share ideas for improvement. All incidents of pulmonary embolism and deep vein thrombosis are reported together with the outcome of investigations that have been carried



Core Quality Indicators - Clostridium difficile

The graphs below identify C. difficile that are toxin-producing with a specimen that falls under the Hospital-onset Healthcare-associated (HOHA) or Community-onset Healthcare-associated (COHA) definitions between April 2023 and March 2024 at Walsall Healthcare NHS Trust.



The Trust carries out reviews of all HOHA and COHA C. difficile cases and a multidisciplinary review is undertaken to investigate cases where new lessons can be learnt. These are reported to the divisional meetings and at IPCC.

Between April 2023 and March 2024 there have been 92 cases confirmed of HOHA (73) and COHA (19) toxigenic C. difficile against an annual trajectory of 26.

From December 2023, avoidability ceased to be reported, following the introduction of PSIRF process.

Common Trends in Risk Factors:

- Multiple antibiotics within last six weeks
- Over 65 years of age
- Proton Pump Inhibitor (PPI) use
- Previous history of C. difficile

Key themes identified from cases reviews for 2023/24:

1. Antimicrobial Stewardship/Prescribing:

- Absence of CURB-65 scoring to determine the right antibiotic in line with formulary.
- Intermediate and high-risk 'C. difficile-inducing' antibiotics not in line with prescribing guidance for indication.
- Non-compliance to current AMS KPIs: indication, duration, and review.
- Prescribing in primary care of antimicrobials as well as PPI.

2. Fundamentals of Infection Prevention & Control:

- Delays in specimen collection for C. difficile testing.
- Failure to isolate patients when specimens were obtained (due to unavailable isolation facilities).
- Hand hygiene and personal protective equipment technique requiring further improvement.
- Documentation of onset of loose stool on Bristol Stool Chart.

3. Infection prevention & control in the environment:

- Lack of isolation facilities to meet demand.
- Environmental cleanliness: specifically, ability to proactively deep clean the environment. Deep clean decant programme affected by utilisation of Wards 5/6 for operational demand.

Summary of target interventions for 2023/2024:

- Thematic analysis and review of all HOHA and COHA cases were undertaken to highlight common themes and produced a fishbone analysis.
- Targeted intervention to improve knowledge and practical sampling -currently the highest sample across the acute provider for BCPS - this included educational events, ad hoc education, and new resources launched.
- Introduction of a Nursing Associate role in the admission areas to support early sampling for patients presenting with symptoms.
- The severity of illness decreased significantly with more patients not requiring treatment or relapsing due to early identification.
- Isolation demands: supported with installation of Bioquell pods (no en-suites), IPC practitioner daily review of isolation risk across the organisation and liaison with clinical site practitioner to support effective and safe isolation. This is also demonstrated and reviewed at IPCC via IPC incident report and via the risk register.
- Enteric audits performed via the IPC Team and division to gain assurance of practice; now live on Tendable and reported at IPCC.
- Enhanced cleaning regimes available such as HPV and ultraviolet light.
- Active deep cleaning programme, currently on hold due to site pressure, next areas identified as a priority.
- Refurbishment works supported environmental improvements across multiple areas.
- IPC input in all capital projects to ensure latest evidence-based practice is embedded.
- Revision and relaunch of cleaning responsibilities, including practical resources.
- Review of high-risk equipment across the organisation, such as mattresses, commodes etc, to also support Eat Drink Dress & Move to Improve campaign.
- Targeting syndromic infections with the support of the latest data via UKHSA PPS, including pneumonia and HAP, UTI and SSI. Currently, multiple QI and workstreams are captured in the new annual work plan for 2024/25.
- Review of treatment options, including faecal microbiota transplantation.
- Antimicrobial Stewardship improvements, including time-out sessions, and targeted interventions for areas with inappropriate antimicrobial prescribing.
- WHT IPCT represented at the ICB C. difficile task and finish group to achieve a system approach in reducing C. difficile harm between community and acute providers.
- Partner education four times a year as a minimum around principles of IPC.

Core Quality Indicators - Incident Reporting

2022/23 (Full Year Data)			2023/24 (Full Year Data)		
Incidents	% Resulting in Death	% Resulting in Severe harm	Incidents	% Resulting in Death	% Resulting in Severe harm
16681	0.2% (26)	0.2% (32)	20147	0.1% (17)	0.2% (31)

The Trust defines severe or permanent harm as detailed below:

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

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

Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:

- The Trust has a well-embedded reporting culture as evidenced by benchmark comparisons within the National Learning and Reporting System (NRLS) and Learn from Patient Safety Events.

It promotes the reporting of near miss incidents to enable learning and improvement and undertakes data quality checks to ensure that all patient safety incidents are captured and appropriately categorised to submit a complete data set and to enable wider learning from events.

Core Quality Indicators - National Inpatient Survey

All eligible NHS Trusts in England participate in the NHS CQC Patient Survey Programme, asking patients their views on their recent health care experiences. The findings from these surveys provide organisations with detailed patient feedback on standards of service and care and can be used to help set priorities for delivering a better service for patients.

Four National Surveys were published during 2022/23 - the Adult Inpatient Survey 2023, The Maternity Survey 2023, the National Cancer Survey 2022 and the Emergency and Urgent Care Survey 2023. These are analysed and benchmarked against national data, action planning is then undertaken and monitored by the Patient Experience Group and the Trust Quality Committee.

The Adult Inpatient Survey 2023

- The National Adult Inpatient Survey was published in August 2023. A total of 333 Walsall Healthcare NHS Trust patients responded with a response rate for Walsall of 27.59% (National average was 40.2%). The Trust's results were worse than most Trusts for 12 questions, somewhat worse for five questions and about the same as others for 28 questions.
- As the headline survey was shared with us ahead of publication, action planning workshops were held during July with more than 50 staff of all disciplines taking part. Six focus areas have been actioned which responds to the questions where we fared the worst in terms of the survey response. These are:

1. Delayed arrival – time on the waiting list before admission and time waiting for a bed after arriving at the hospital
2. Nutrition and hydration – access to food outside of mealtimes and help from staff to eat meals
3. Treatment and Care – patients able to talk to hospital staff about their worries and fears and staff doing all they can to control pain
4. Leaving hospital – consideration of family and home situation when planning to leave hospital and enough notice about when patients are going to leave
5. Medication – take home medicines, the purpose/side effects/ how to take and written information to take away
6. Continued support – Getting support from health and social are services following leaving hospital and condition management

The action plan has been shared with the Patient Feedback and Oversight Group and regular updates and assurance will be provided through this group in addition to the Patient Experience Group. The actions align with the improvement priorities outlined in our Patient Experience Enabling Strategy and workstreams are underway supporting a response to the focus areas described. The Trust's Mystery Patient scheme questions have also been changed to monitor how we are doing.

Urgent and Emergency Care Survey 2023

Published results were released in July 2023. A total of 224 patients took part in the survey from 1,250 with a response rate of 18% against 23% for all Trusts.

The Trust scored the best nationally for arrival at A&E and patients being given enough privacy when discussing conditions with the receptionist. We also scored amongst the top five nationally for waiting. Given the survey was conducted in the old Emergency Department, overall, this was a positive set of results for the Trust. Urgent and Emergency Care Survey results have been presented to staff and sessions supported by the Patient Experience Team have been held to help clinical staff understand what the data is telling them and what can be done differently or how they can behave differently. The ED Team has resurrected two patient focus groups regarding:

- Frequent patient user group
- ED Mental Health steering group

Both meetings work with internal and external stakeholders to ensure individual patient reviews are completed ensuing the correct care plan and healthcare professionals are involved, supporting a safer and improved patient experience. A medicines reconciliation task and finish group has been brought together for the organisation. There is clinical representation (Medical and Nursing) for MLTC involved as part of the core membership. Actions particularly look at working with the Patient Relations Team to communicate the importance of patients bringing their current medications into hospital with them at initial presentation. This will support the reconciliation process and reduce any medication omissions where drugs may not initially be available.

Maternity Survey 2023

The survey results were published in December. Preliminary results were analysed and shared with the Maternity Division ahead of this in September and an action planning workshop was held. There were 111 Walsall patients who responded to the survey, a response rate of 38% against 43% nationally.

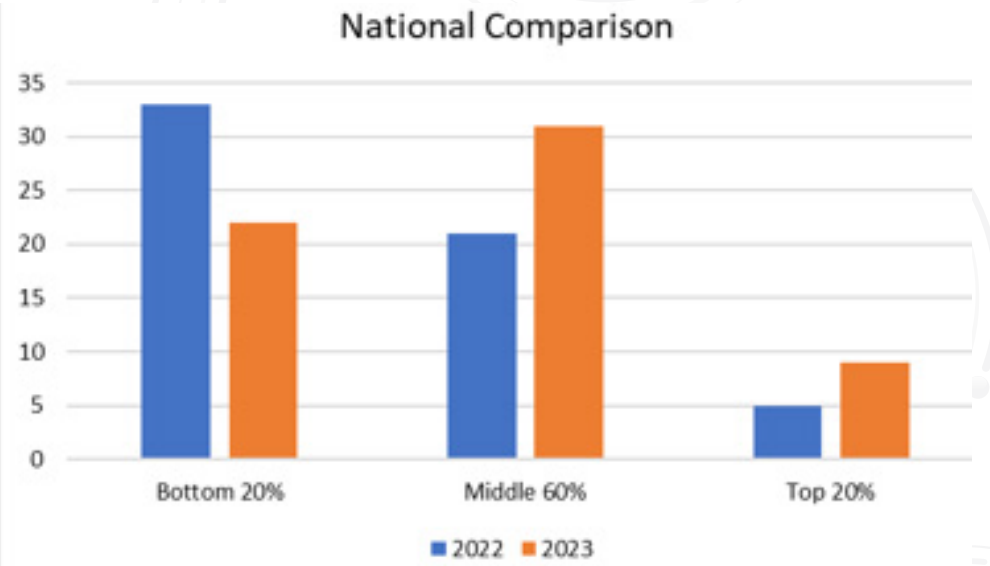
Where experience is best:

- Maternity service users being involved in the decision to be induced (top five Trusts nationally)
- Maternity service users' discharge from hospital not being delayed on the day they leave hospital.
- Maternity service users being given appropriate information and advice on the benefits associated with an induced labour, before being induced.
- Maternity service users being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- Maternity service users feeling that if they raised a concern during labour and birth it was taken seriously.

Where experience could improve:

- Maternity service users being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- Maternity service users being able to see or speak to a Midwife as much as they wanted during their care after birth.
- Maternity service users being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
- Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in hospital.
- Maternity service users feeling that Midwives and other health professionals gave them active support and encouragement about feeding their baby.

Clearly, there is a need to focus on postnatal care and the action plans should reflect this. Reminder of our internal analysis of past results also demonstrates:



- 29 questions have shown consecutive improvement.
- 11 questions improved in 2023 by 105 or more.
- 8 questions dropped in 2022 and improved to the same or better score than 2021.

National Cancer Survey 2022

A total of 217 patients responded out of 471 patients, resulting in a response rate of 46% against a national average of 53% and 13 tumour specific groups. Questions where the Trust scored above the national average included diagnostic tests – being explained in a way that a patient could completely understand - and patients being told they could have a family member, carer or friend with them when they were told their diagnosis. When broken down by tumour group, 37 questions scored above the expected range.

Areas for improvement included decision making, communication, controlling pain treatment and care, waiting and information.

Core Quality Indicators - Friends and Family Test

The Friends and Family Test recommendation scores are illustrated in the tables below; these include percentage changes on 2021/22. The Trust's average recommendation score for 2022/23 was 86 per cent which is a four per cent increase on the previous year. When looking at the different touchpoints, there is a fluctuation of 33 per cent with scores ranging between 99% and 66 %.

Friends and Family Test	Inpatients				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2022/23	85%	86%	85%	88%	91%	91%	91%	92%	74%	76%	74%	84%	98%	99%	98%	98%
Difference	- 2%	+ 2%	=	+ 3%	=	- 1%	+ 1%	=	- 6%	=	- 8%	+ 7%	+ 4%	+ 5%	**+ 3%**	**+ 2%**
2021/22	87%	84%	85%	85%	91%	92%	90%	92%	80%	76%	78%	77%	94%	94%	95%	96%
Response rate (22/23)	**24.6**	**25**	**25**	**28.9**	**19.3**	**20.2**	**20.3**	**20.4**	**16.7**	**18.8**	**20.6**	**22.6**	**7.7**	**4.9**	**3.3**	**84.1**

Friends and Family Test	Antenatal				Birth				Postnatal Ward				Postnatal Community			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2022/23	89%	81%	88%	92%	83%	80%	82%	90%	84%	83%	82%	85%	84%	88%	66%	86%
Difference	+ 2%	- 3%	+ 3%	+ 7%	- 8%	- 12%	- 8%	- 2%	+ 4%	+ 7%	+ 4%	+ 8%	- 10%	- 6%	- 29%	- 10%
2021/22	87%	84%	85%	85%	91%	92%	90%	92%	80%	76%	78%	77%	94%	94%	95%	96%
Response rate (22/23)	**15.6**	**12.3**	**11.7**	**12.1**	**19.4**	**18**	**18.2**	**23.9**	**11.8**	**10.6**	**10.4**	**16.6**	**11.3**	**9.8**	**7.3**	**15.5**

The below table illustrates the percentage difference between the Trust's average recommendation score for each touchpoint and the local ICB (Integrated Care Board) and national results. Whilst some areas require improvement when compared locally and nationally, Outpatients, Antenatal and Postnatal Wards Community all perform better on average locally, with community and ED also outperforming the national average:.

	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
STP*	- 2%	+ 1.4%	+ 6.7%	+ 4.8%	+ 3.4%	- 2.7%	+ 5.4%	- 3.4%
National	- 8.5%	- 1.4%	+ 0.9%	+ 6.9%	- 2.2%	- 9.1%	- 10%	- 11%

Core Quality Indicators - Supporting our staff

The 2022 NHS Staff Survey benchmark report for Walsall Healthcare NHS Trust contains the results of the 2022 staff survey. The results of the survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

The themes of staff engagement and morale remain key performance indicators and, together with the promises above, make nine elements which provide benchmark data at national level.

There has been an improvement across all nine indicators within Walsall's 2022 survey results. Walsall is above the national average on three of the people promises and is equal to the national average on four. Walsall scores marginally (0.1 points) below the national average on two of the indicators (we are compassionate and inclusive, and staff engagement). Nevertheless, 83 per cent of indicators have improved this year and Walsall is the third most improved Trust nationally for staff experience.

The areas remaining for improvement are staff advocating for Walsall as a place to be treated, and having a consistently compassionate culture. There remains work to be done to eliminate discrimination in all forms and particularly race-based discrimination, although there have been improvements in the achievement of workforce race equality standards and the Trust was accredited to the national Race Code which aims to help organisations improve equity through a national governance and assurance framework.

The results for Walsall Healthcare NHS Trust are benchmarked other against 126 'combined acute and community Trusts. The response rate was 47 per cent against 44 per cent for the national average for the benchmark group.

Our 2022 Staff Survey results provided a staff engagement score of 6.7 which has improved on last year, however still 0.1 points below the national average at 6.8. Overall, this demonstrates that the gap between the experience of staff at Walsall Healthcare NHS Trust and the experience of NHS staff in general is narrowing.

Our 2022 Staff Survey results show that more of our staff feel involved in decisions regarding their work and encouraged by line managers and that increased staffing levels have enabled them to feel more supported to provide high levels of care and subsequently to recommend the Trust as a place to work and a place to be treated. The advocacy indicators have improved, however they are still below the national average.

Staff feel they are recognised and rewarded; this indicator is above the national average and the promises 'we each have a voice that counts' and 'we are safe and healthy' both match the national average. The health and wellbeing indicators within the national staff survey results for 2022 exceed the national average and have shown statistically significant improvement over two consecutive years.

Our results for 'we are always learning', 'we work flexibly' and 'we are a team' now exceed the sector benchmark average, and this continues the trend of significant improvement for Walsall as our baseline was in the lowest 20 per cent of trusts nationally in 2019.

The majority of the People Promise scores for the 2022 NHS Staff Survey for Walsall Healthcare NHS Trust are in line with or above the average sector scores. This is a continuing trend of improvement on previous performance for Walsall.

Ways in which staff can speak up

There are three Freedom to Speak Up (FtSU) Guardians within the Trust, who are supported by five FtSU Champions. Members of staff can contact a Guardian to arrange a face-to-face or virtual meeting in several ways: using the contact form on the Trust intranet, emailing the FtSU mailbox, calling a Guardian via their mobile phone/FtSU telephone number/Trust switchboard, or be signposted by a FtSU member.

The Guardians play an active and visible role in raising awareness of the service, supporting staff, and dealing with concerns.

This year, the organisation is reviewing the 'Raising Concerns' policy to include its commitment to supporting individuals who speak up and may be worried about reprisals. The policy touches on ways staff could be treated unfairly or harmed because of speaking up and it sets out how detriment will be addressed by the Trust. Support is offered to such individuals and could include the allocation of a 'buddy'. Anyone found to be involved in causing harm or detriment will subject to the Trust's resolution policy.

Between 1 April 2021 and 31 March 2022 the FtSU team received 110 concerns; this highlights employees' increasing confidence to use the FtSU service to discuss issues that may be affecting them at work. Of the concerns raised, 16 per cent related to patient safety and quality and 35 per cent to bullying and harassment.

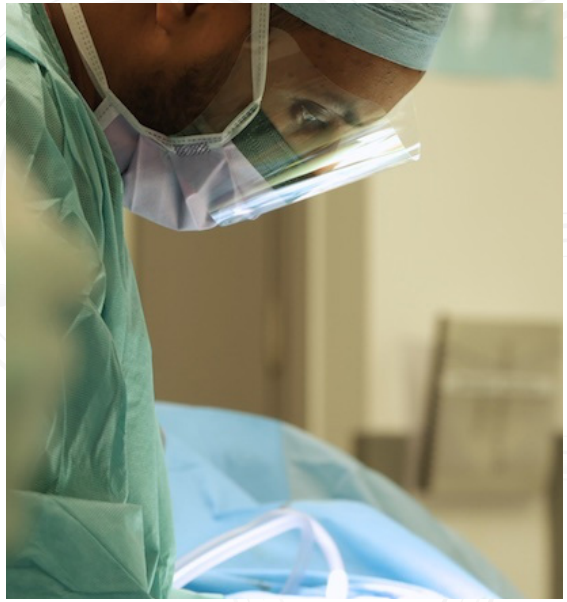
The Guardians work with Trust leaders to regularly review cases that fall within their remit. They also highlight any themes and work proactively with managers to resolve issues.

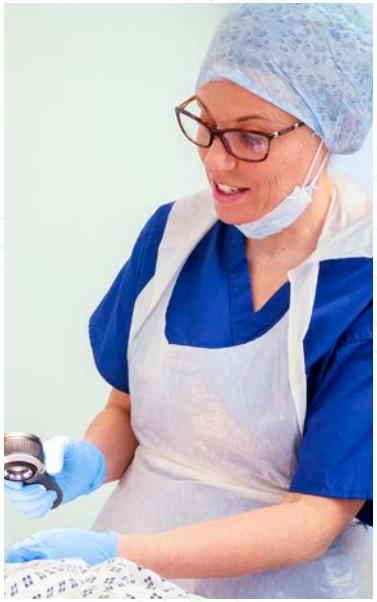
The Guardians will attend events organised in the Trust to highlight the importance of speaking up to improve patient and staff safety. The Director of People and Culture shares FtSU data with the People and Organisational Development Committee (a subcommittee of the Trust Board) quarterly, and an annual report is presented to the Trust Board.

Guardian of Safer Working

Safety is a high priority for the Trust. The 2016 Terms and Conditions for Doctors and Dentists in training posts safeguards their working hours in terms of total hours worked, breaks whilst at work, and rest periods between shifts. The Guardian of Safe Working monitors compliance with these hours through exception reports submitted by individual doctors where those hours are breached. This is to prevent tiredness and fatigue and, in turn, support patient and staff safety.

Exception reporting software allows oversight of hours breaches, enabling the monitoring of trends such that underlying causes for these can be identified and addressed. Forty two exception reports were submitted in 2023/2024. Rostering for doctors is migrating to the same software, allowing greater oversight of rota gaps in order to further improve working hours safeguards.





Review of Quality

Our performance in 2023/24

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

Performance against the National Operational Standards:

Metric	2020 / 2021	2021 / 2022	2022 / 23	2022 / 23	2023 / 24 Target
18 Weeks RTT - Incomplete Pathways	68.72% (Mar 21)	63.10% (Mar 22)	56.36% (Mar 23)	61.16% (Mar 24)	92%
Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	85.07%	82.56%	73.4%	74.87%	76%
Cancer -2 Week Wait from Referral to First Seen Date	83.49%	72.88%	75.3%	78.50%	93%
Cancer -2 Week Wait for Breast Symptomatic patients	60.77%	32.80%	19.8%	59.10%	93%
Cancer 31-Day Wait for First Treatment	97.87%	95.57%	95.2%	96.80%	96%
Cancer 31-Day Wait for Second or Subsequent Treatment - Surgery	97.79%	92.06%	94.3%	96.50%	94%
Cancer 31-Day wait for Second or Subsequent Treatment – Drug	99.07%	98.33%	99%	99.30%	98%
Cancer - 62-Day Referral to Treatment of all Cancers	72.18%	72.26%	65.9%	72.40%	85%
Cancer - 62-Day Referral to Treatment from Screening	92.54%	95.08%	90.1%	94.80%	90%
Cancer - 62-day wait - Consultant Upgrade (Local Target)	79.11%	80.72%	73.7%	77.30%	85
Cancer - 28 Day Combined Standard*	n/a	n/a	n/a	80.10%	75%
Cancer - 31 Day Combined Standard*	n/a	n/a	n/a	97.10%	96%
Cancer - 62 Day Combined Standard*	n/a	n/a	n/a	76.30	85%
% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	14.92%	5.30%	16.99%	23.47%	1%
Mixed Sex Accommodation Breaches	2	0	0	10	0

Performance against the National Operational Standards

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

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

	2020/21	2021/22	2022/23	2022/23	2023/24 Target
Number of C Difficile Cases	32	30	50	92	26
Number of MRSA Cases	2	3	1	2	0
VTE Risk Assessment: all inpatient service users undergoing risk assessment for VTE	91.56%	92.63%	90.64%	88.93%	95%
Ambulance Handover - % of clinical handover completed within 15 minutes of recorded time of arrival	64.34%	55.49%	47.34%	45.70%	65%
Ambulance Handover - % of clinical handover completed within 30 minutes of recorded time of arrival	95.94%	94.84%	89.35%	90.22%	95%
Ambulance Handover - % of clinical handover completed within 60 minutes of recorded time of arrival	94.81%	99.35%	98.05%	97.76%	100%
Time spent in ED - % within 12 hours - Overall (Type 1 and 3)	1.43%	2.18%	6.37%	5.81%	2%
Referral to Treatment - No one waiting longer than 65 weeks	42 (Mar 21)	346 (Mar 22)	314 (Mar 23)	2* (Mar 24)	0
Referral to Treatment - No one waiting longer than 78 weeks	0 (Mar 21)	105 (Mar 22)	1 (Mar 23)	0 (Mar 24)	0

	2020/21	2021/22	2022/23	2022/23	2023/24 Target
Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	61.84% (Mar 21)	59.20% (Mar 22)	79.65% (Mar 23)	84.85% (Mar 24)	90%
Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	32.12% (Mar 21)	57.30% (Mar 22)	77.78 (Mar 23)	72.34 (Feb 24)	90%
Community health services two-hour urgent response standard	67.65% (Mar 21)	91.7 (Mar 22)	78.72 (Mar 23)	86.78 (Mar 24)	70%

2023/24 year to date figures up to March 24 unless specified

To note: From October 2023 the national contract changed for cancer metrics
The new combined metrics:
the 28 day Faster Diagnosis Standard
one headline 62-day referral to treatment standard
one headline 31-day decision to treat to treatment standard
*patient choice

A consolidated annual report on rota gaps

Junior Doctors are allocated to the Trust by the NHSE Workforce Training and Education Directorate. For this year, the Trust's average monthly fill rate has been around 90.19% across all training grades, an increase of more than 10% compared to last year's fill rate. As per agreed process, vacancy gaps in the rotation are discussed with the Divisions, along with the Clinical Fellow Programme Team to find the best way forward to mitigate the gap by making use of the recruited fellows. The Trust currently has a total of 90 who are filling rota gaps across all Divisions.

The recruitment process can take as long as three months to complete, with a further period of assessment and training that must be undertaken before being able to work independently on a rota. This results in some double up costs for a short period of time to ensure the correct training has been signed off. For some rota gaps that are four months or less, the Clinical Fellowship Programme route may be unsuitable, however the medical workforce team is continually working on ways to improve the monitoring of rota gaps to support the divisions with how these can be managed.

Engagement in developing the quality account

Prior to the publication of the 2023/24 Quality Account, we have shared this document with the following:

- Our Trust Board, including combination of Non-Executive and Executive Directors
- Walsall Council
- Black Country Integrated Care Board
- Trust staff

In 2024/25 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered. We would like to thank patients, community representatives for their feedback and members of staff who gave their time to help us select our priorities and ensure that the document is clear and accessible.

Black Country Integrated Care Board (BCICB) statement on Walsall Healthcare NHS Trust (WHT) Quality Account 2023/2024

BCICB welcomes the opportunity to review and provide the following statement for Walsall Healthcare NHS Trust Quality Account - 2023/2024. WHT Quality Account is accurate and in line with the information presented to the ICB via contractual/quality monitoring meetings. The ICB recognises that 2023/2024 has continued to be a challenging year for WHT to deliver services with unprecedented demands outstripping capacity.

We genuinely recognise the Trust's efforts to maintain quality whilst acknowledging the uncertainties and the challenges faced throughout the year. The ICB would like to thank all staff and volunteers working at WHT for their commitment, remaining resilient throughout these challenging times, ensuring patient care is safe and of the highest standard.

We recognise and support the strategic collaboration between Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust, which is a positive step for a system working collaboratively at scale to benefit local populations by improving efficiency, sustainability, and quality of care.

We are proud of our effective working relationship with the Trust, and we recognise the Trust's achievements against the quality priorities and their individual and collective engagement with the commissioners.

The ICB are pleased to note that quality remains a top priority for the Trust, focusing on three main areas: Patient Safety, Clinical Effectiveness and Patient Experience. We will continually monitor trust progress against the delivery of the quality priorities and look forward to seeing the positive impact and outcomes.

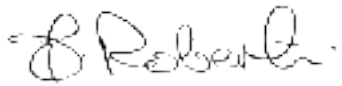
The ICB would particularly like to note the following key achievements for 2023/2024:

- Transition to the Patient Safety Incident Response Framework - The Patient Safety Incident Response Framework (PSIRF) marks a significant departure from the Root Cause Analysis methodology of the Serious Incident Framework (SIF) 2015, with an increased focus on Learning Responses and Outcomes. During 2023/24, the ICB has supported local Trusts and Independent providers with their transition to PSIRF in line with National Guidance. As of April 2024, all NHS Trusts within the Black Country ICS footprint have successfully transitioned to PSIRF. The ICB continues to support PSIRF within Trusts via quarterly PSIRF workshops and will monitor progression of local implementation via the ICB PSIRF Quality Framework.
- Expanding and maintaining the use of Same Day Emergency Care (SDEC) services to avoid unnecessary hospital and expanding virtual wards, allowing people to be safely monitored from the comfort of their own homes. With the expanded Intermediate Care Service, it has also enabled the Trust to make continual improvements in discharges from Walsall Manor Hospital.
- The number of patients waiting more than 62 days for cancer treatment has been reduced and has been below trajectory throughout 2023/2024. With the exception of April 2023, which achieved 74% compliance, the Trust has achieved the 28-day Faster Diagnosis Standard every month of the year 2023/24 with more than 75% of patients being given a confirmed diagnosis within 28 days.
- Feedback from the Friends and Family Test showed the Trust's average recommendation score for 2023/2024 was 89%, a 3% increase on 2022/23 and 7% on 2021/2022.
- The Trust continued to achieve a high level of engagement in the 2023 Staff Survey, with 2,381 participants equating to 46% - compared to the median national average response rate for the sector which was 45%. Walsall achieved the highest response rate of the four Black Country acute Trusts and is the only Trust to have improved across all indicators for the second consecutive year.
- Further developed the partnership approach with The Royal Wolverhampton NHS Trust to improve the standards and consistency of continuing professional development and standards of care.
- Worked with partners within Walsall Together (place-based partnership) and the Integrated Care Board and members, to make improvements to the system of care.
- Whilst we recognise these achievements, we would value delivery of sustainable improvements in the following areas for 2023/2024:
- We recognise that the Trust is represented at the ICB C.Difficile Task and Finish Group to achieve a system approach in reducing C.Difficile harm between community and acute providers with continued efforts to improve clinical and infection, prevention and control practices. However, we expect to see a reduction in hospital-onset C.Difficile infection cases for the year ahead.
- Continue to embed Patient Safety Incident Response Framework (PSIRF) within the organisation for the purpose of learning and improving patient safety.

Engagement

- Members of the system elective and cancer board, we expect the Trust to work with our system partners to achieve three key performance deliverables and metrics set nationally as elective care priorities for 2024/2025.
- We recognise the Trust has a robust cancer harm review process in place, but we expect the Trust to conduct harm reviews for any patient where these delays have impacted clinical outcomes or resulted in patient harm. In addition, we expect that any learning identified from these harm reviews is shared across the organisation and wider system.
- We expect to see further improvements in the trust staff survey and build on current staff survey results, which will allow fresh ideas, team building, co-operation, and positivity and make the Trust a place where the staff want to work and attract others for future employment.
- The ICB also look forward to following the progress of the five-year strategy and Quality Framework that the trust shares with the group partner Trust, The Royal Wolverhampton NHS Trust.

The ICB confirms that the Annual Quality Account information accurately reflects the Trust's performance for 2023/24. It is presented in the format required and contains information that accurately represents the Trust's quality profile and reflects quality activity and aspirations across the organisation for the forthcoming year. We commend the Trust on its commitment to working with the ICB collaboratively and transparently in 2023/24 and look forward to working in collaboration and partnership over the next year.



Sally Roberts

Chief Nursing Officer/Deputy Chief Executive Officer

Black Country Integrated Care Board

Statement of Director Responsibilities in respect of the Quality Account 2023/24

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

- the content of the quality report meets the requirements set out in the annual reporting manual and supporting guidance Detailed requirements for quality reports.
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to March 2024
    - papers relating to quality reported to the board over the period April 2023 to March 2024
    - feedback from local Black Country Integrated Care Board dated June 2024
    - the 2023 national staff survey
- the quality report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

Signature..... Sir David Nicholson, CBE, Chairman Date.....28 June 2024

Signature..... Caroline Walker, Group Chief Executive Officer Date.....28 June 2024

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement have confirmed in the Quality Accounts requirements for 2023/24 that there is no national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account.

How to give comments

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

Please contact us as indicated below:

Patient Experience Team

Walsall Healthcare NHS Trust

Moat Road

Walsall

WS2 9PS

0300 456 2370

email: pals.officer@nhs.net

English

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

Punjabi

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

Polish

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

Russian

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

Lithuanian

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