NHS
Walsall Healthcare
NHS Trust

Quality Accounts
2024-25

Care Colleagues
Collaboration Communities

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Why are we producing a Quality Account?

In line with NHS Trusts across the country, Walsall Healthcare NHS Trust produces an annual Quality Account to provide information on the quality of services provided to patients. This gives the Trust an opportunity to be open and accountable and demonstrate how well the organisation is performing. It also considers the views of patients, their families and carers, our staff and the public. The Trust uses this information and ongoing engagement to shape services and improvements.

Getting involved

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

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Part 1: Statement of Quality from the Chief Executive Officer

Welcome to the Annual Quality Account for 2024/25, detailing the progress we've made in our efforts to deliver high-quality care to patients across all of our communities, working with our partners across the borough.

I am a relative newcomer to Walsall Healthcare, joining the organisation, and The Royal Wolverhampton NHS Trust (RWT), as Group Chief Executive in January 2025, taking the reins from interim Caroline Walker.

This document gives us an opportunity to pause and reflect on our performance against last year's objectives as we continue our collective efforts to promote a culture of continuous improvement, underpinned by the five-year strategy and Quality Framework that we share with RWT.

We are halfway through the joint strategy we launched back in 2022 where we agreed four strategic aims, referred to as the four Cs.

These are:

Excel in the delivery of Care

We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.

Support our Colleagues

We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting diversity of our populations.

Improve the health of our Communities

We will positively contribute to the health and wellbeing of the communities we serve.

Effective Collaboration

We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.

We pledged that everything we do across both organisations should contribute towards achieving goals within at least one of these priority areas. They also align to our overall vision which is to 'To deliver exceptional care together to improve the health and wellbeing of our communities'.

At the time of writing, we were awaiting publication of the government's 10 Year Health Plan which we know will focus on delivering three big shifts in healthcare:

- hospital to community
- analogue to digital
- sickness to prevention

A lot of hard work and innovation has been taking place here in Walsall over the last 12 months – particularly around that switch from hospital to community. We have a Community First programme of work that is focused on ensuring our patients can manage their

conditions at home where they feel happiest, if appropriate, rather than be in hospital. Equally important is the support given to our teams of dedicated community staff to be able to provide the type of services to best support our patients in this way.

We are also concentrating on transformational programmes in Outpatients and Elective Care. The Trust has seen statistically significant increases in Outpatient clinic booking utilisation and decreases in DNA (Did Not Attend) rates that are contributing to improved productivity and reduced non-admitted waiting times.

The second phase of our West Wing Operating Theatre capital development to upgrade Theatres 1-4 will result in a full Theatre suite of modern, high-quality facilities and is anticipated to be complete early in 2026. Elective sessions have been re-provided within the Minor Surgery Procedure Room and at Cannock Theatres for day case elective orthopaedics.

The Trust has seen 8.5% more Type 1 Emergency Department attendances over the last year – driven by growth in Walsall patients and by increasing numbers of patients from other Black Country boroughs as well as further afield.

And in October 2024, a record high Type 1 ED attendances were recorded (12.93% increase on October 2023 showing a statistically significant increase). Three weeks in October ranked in the highest 10 weeks of type 1 attendances recorded at Walsall Manor Hospital.

The Trust has improvement plans in place focusing on improvements in Urgent and Emergency Care, prioritising our strategic priority to shift towards a Community First approach. We are also on track with the Delivery Plan for the first phase of managing the increased Emergency Department attendances forecast as a result of the Midland Metropolitan University Hospital opening.

We remain proud of maintaining ambulance handovers within 30 minutes and have been in the top performing Trusts regionally since November 2020.

Work continues on further improvements to strengthen cancer services, including expanding the Endoscopy timetable to shorten diagnostic waiting times. Engagement with our communities around preventative measures as well as raising awareness of potential signs and symptoms remains an important element of this work.

I have joined the Trust at a time that is extremely challenging for the NHS nationally and locally. But I have seen some fantastic examples of innovation and resilience that will help us make our organisation as sustainable and effective as possible.

Our commitment to quality will not waiver as we go into 2025/26 and I thank our patients, staff and partners for the part they will all play in this focus.

Thank you for your continued support.

Signed:

Joe Chadwick-Bell

Chief Executive Officer Walsall Healthcare NHS Trust

Vision and Values

In the autumn of 2022, the Trust launched its new, five-year strategy. This is a joint strategy with The Royal Wolverhampton NHS Trust which recognises the closer working taking place between the two organisations.

The development of the new strategy encompassed a new set of strategic objectives as well as a new vision.

Our vision, chosen by our colleagues, is to **'To deliver exceptional care together to improve the health and wellbeing of our communities.'**

Walsall Healthcare's values, as chosen by its colleagues, remain unchanged:

- **Respect**
- **Compassion**
- **Professionalism**
- **Teamwork**

Strategic Aims and Objectives 2022-2027

- The Trust has four strategic aims, collectively known as the 'Four Cs' – Care, Colleagues, Colloboration and Communities. Extensive engagement across a wide range of stakeholders identified these areas as those which need prioritising if we are to achieve our vision.
- Underpinning each of these aims, is a set of more specific strategic objectives. These are the practical steps we will take to achieving our strategic aims and will be used to measure our success.

Part 2: Looking back 2024/25 - 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)**

The aim for 2024/25

- Training Needs Analysis (TNA) by March 2024
- Level 1 and 2 – 50% of all staff for Level 1 and 50% of priority staff identified in TNA for Level 2.
- Three PSIRF roles – minimum of 30% of need of TNA met by 31 December

What we did:

- The Trust transitioned to the Patient Safety Incident Response Framework in November 2023 and this continues to evolve as it is being embedded. An updated single group policy and plan is in place, reflecting feedback and learning from the first year of implementation and role-specific training
- The plan for National Patient Safety Syllabus Level 1 and 2 training was postponed in response to the introduction of a revised approach to PSIRF, however, 57% of staff completed Level 1 training and 45.8% of staff completed Level 2 in 2024/25
- The training needs analysis and delivery of PSIRF role-specific training was refreshed to meet the updated need. A minimum of 30% of staff from the TNA were trained by October 2024

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:

- 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)

What we did:

- Started the delivery of the UEC pathway improvement plan in order to positively impact performance.
- Embedded additional capacity to manage the demand from the changes in patient flows as a result of the Midland Metropolitan University Hospital opening in Sandwell
- Operationally extended the hours of the Urgent Community Response Team to ensure sufficient capacity across a 24/7 period to effectively deliver the UCR standard
- Improved the performance of the Intermediate Care Service across all pathways delivering a lower average number of patients with no criteria to reside and a reduced average length of stay

What we said:

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 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 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

What we did:

Progress against our aims for 2024/25:

- The Trust's Strategic Priorities Framework for 2024/25 became a core part of the work of the QI Team, with QI projects that were clearly aligned to the Framework receiving dedicated support. This was evidenced in positive outcomes in specific workstreams, particularly in productivity and efficiencies in length of stay
- QI training for leadership teams (triumvirates) will remain an objective for 2025/26. More than 10% of staff have received QI training
- Huddle boards have increased with 27 in situ, surpassing our target of 15
- A recent report on huddle board use has highlighted inconsistencies in its application although, when used, good improvement ideas are being implemented as a result. This was evidenced recently when the Portering Team presented its successes in improving Radiology turnaround times. The huddle board and its consistent use will be an objective for 2025/26 and has been included within the recently released Nursing Quality Framework
- We will undertake the NHS Impact self-assessment in July 2025.

Priority 2 – Clinical Effectiveness

What we said:

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
- To work collaboratively between the four acute hospital Trusts across the Black Country to achieve the vision of 'One healthcare system, across multiple sites, working in partnership to provide better, faster and safer care to the population of the Black Country and beyond.' This includes collaborating with non-NHS partners such as schools, universities, and local authorities to meet the requirements of the NHS Workforce Plan and the national goals within the People Plan and Promise
- Collaborative working between providers/within the ICS and place-based partnerships means the movement of our staff across organisations should be easier and less organisation-focused
- We recognise the importance of place-based working, and through Walsall Together we can understand the needs and priorities, of the wider needs of the local populations. The Joint Strategy will deliver best where it learns from successes across the places we serve with delivery for the local population, so our organisations support local priorities
- We aim to build on our role as an anchor employer, delivering health equality through employment opportunities that are inclusive and recognise lived experiences as part of our recruitment processes

What we did:

Recruit and retain staff using targeted interventions for different career stages
Specialist Grade - Consultant development roles

- Locum Consultants (not on the specialist register) who were appointed to fill hard to recruit to substantive vacancies posts are transferred to a permanent Specialist Grade post with the following contractual terms
- Specialist Grade post is introduced to the specific division establishment by ringfencing the budget for the substantive consultant post
- The appropriate JD/PS is developed with Royal College approval
- Job plan is agreed with education elements to support Certificate of Eligibility to the specialist register (CESR)
- Following successful CESR registration, a competitive substantive recruitment is initiated to recruit into the substantive Consultant post
- Salary protection is awarded where applicable
- The are currently four locum Consultants that have been transferred into the Specialist Grade post. We have three now progressing the initial conversations of transfer to the Specialist Grade post
- This approach was introduced to provide a structured personal development plan to ensure that locum Consultants transferring to the Specialist Grade post are appropriately supported to achieve specialist registration, secure a permanent substantive post, and continuity of care for patients, to retain long standing locum Consultants in the Trust and reduce turnover and subsequent use of third part ad hoc agencies and associated increasing temporary staff spend

Specialty Doctor – Specialist Grade Development role

- This is development programme created to support a pathway for speciality Doctors wishing to acquire skills and experience to progress to a specialist Grade. It also includes a pathway to achieve CESR
- The programme uses the NHS employers' SAS Doctor's' capability framework. Prospective Doctors undertake self-assessment with support from their SAS tutor and Clinical Director. Where the assessment is successful, they are then recruited substantively into a Specialist Grade post
- The programme has been successful with four specialty Doctors who have been recruited to a Specialist Grade post
- Improve retention using bundles of recommended high impact actions
- We are working to ensure the Trust attracts and retains the right staff with the skills and knowledge to achieve its vision 'to deliver exceptional care together to improve the health and wellbeing of our communities'
- To this end we are working towards a culture that can deliver our strategic aims and objectives and is considered a great place to work, as detailed in section four of our Joint People Strategy – Our Joint People Ambitions. We work to achieve this through the following actions
- In 2024, the Trust adopted the Joint Behaviour Framework, developed in collaboration with our colleagues at RWT - Caring for All. This framework sets out the expected standards of behaviour to foster a listening, kind, inclusive, and professional organisation
- We continue to encourage feedback through the National Staff Survey and quarterly Pulse Survey. The 2024 survey, saw the Trust's highest completion rate of 54% and improvements across six of the nine People Promise elements
- Through our Civility and Respect Programme, we encourage staff to act as allies and to stand up against unwanted and uncivil behaviour, supported by our Behavioural Framework that outlines expected behaviours and our operational approach. We continue to build on our employee voice groups to ensure contributions to collective decision-making and to support all staff, particularly those with protected characteristics
- A Quality Improvement question has been added to the PDR online form to encourage all staff to consider and identify any improvements within their area of work that would improve the patient and staff experience. We have also added an Inclusion question which asks staff to identify what actions they will take to promote equality within their role and wider team. This supports the ongoing commitment to equality and diversity, ensuring that it is an integral part of what and how we do things
- We continue to use data from our Ethnicity and Gender Pay Gap reporting to tackle inequalities through our approaches to attracting and recruiting, using Cultural Ambassadors to ensure the recruitment process is inclusive, equitable and free from bias by actively participating in the process
- Through increasing access to development and career progression opportunities, we aim to grow a workforce that is representative of the communities we serve. We have utilised the apprenticeship Levy to access a range of managerial and leadership programmes to support talent and career progression - these are the Rising Star and Aspire Programmes that offer Senior Leader Level 7 and Chartered Manager Level 6
- The Aspire and Rising Star programme was initially developed to support the development of staff from the BAME community, to support career development of under-represented groups at senior management levels within the Trust
- The programme has now been extended, and additional courses have been introduced to support the development of first-level managers/supervisors. This ensures a more inclusive offer of management development at varying levels to support growth and succession planning within the Trust

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 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%)

What we did:

- The Trust has increased the percentage of patients diagnosed at stage 1 and 2 from 26% during 2023/24 to 32% in 2024/25, in line with the national early diagnosis ambition
- The Trust has continued to reduce the number of patients waiting over 62 days for cancer treatment
- The Trust has continued to maintain performance against the national 28-day Faster Diagnosis Standard of 75%, with the exception of November and December, where the Trust had challenges with capacity for first appointment for suspected breast cancer
- The Trust has met the national performance standard for combined 62-day Referral to Treatment of 70% throughout 2024/25

What we said:

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 2024/25

What we did:

- The Trust maintained having zero patients over 65 week wait on an incomplete RTT pathway from April 2024, with the exception of February 2025 where the Trust experienced a business continuity incident, impacting on elective Theatre capacity

- The Trust has not met the 85% capped Theatre utilisation for the year 2024/25 due to a business continuity incident
- The Trust reduced the total number of patients awaiting elective treatment by 7% during 2024/25

What we said:

Review of GIRFT(i) and Model health system data(ii)

- 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
- 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

The 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.

What we did:

- Delivered improved performance across both RTT and cancer pathways
- Reduced the number of patients waiting 52 weeks by 700 patients

Priority 3 – Patient Experience

What we said:

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 (2022/25). 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
- We will ensure 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
- We will reduce complaints, learning from them, and encouraging better attitudes and practice from employees
- We will use our Patient and Partner Experience Group meeting to gain assurance, monitor and manage patient experience workstreams and initiatives
- We will implement a real time dashboard for Directorates to encourage a more proactive approach to patient feedback

What we did:

Our Patient Relations and Experience Function, through strengthened Family and Carers support and patient involvement mechanisms such as the Patient Involvement Partners (PIPs), will continue to champion personalised care.

- PIPs have already helped shape family and carer support offers
- The Patient Experience Team will further promote co-production, ensuring that patient and family voices are central to care planning discussions
- The stable role of the Family and Carer Officer will continue to offer direct support, ensuring carers are active participants in decision making

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.

- Our commitment to inclusivity is embedded across all functions.
- Patient Involvement Partners sat on the Equality Delivery System (EDS) Task and Finish Group to guide our approach to tackling inequalities
- The Spiritual, Pastoral and Religious Care Team (SPaRC) remains an essential part of delivering inclusive, sensitive support, reflecting the diverse needs of our communities
- Our Reading Panel actively reviews materials to ensure they are accessible and easy read where necessary, and is mindful of different patient needs.
- Attendance and active participation in Walsall Pride

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

- Feedback and insights gathered through surveys, learning walks, and complaints are shared regularly with teams to drive reflective practice
- The Patient Relations Team ensures learning from complaints is fed back to staff in a supportive way to promote service improvement
- Staff engagement through Patient and Partner Experience Group meetings reinforces the importance of patient voice in everyday practice
- Experience-led improvement projects, such as the Mental Health Patient Journey mapping, create learning directly informed by service users

Reducing complaints, learning from them, and encouraging better attitudes and practice from employees.

- Complaints are managed promptly and transparently by our Patient Relations Officers, with learning shared directly with divisions
- Our approach now includes Patient Relations triage (PALS) and a proactive complaints review panel, which involves PIPs for independent input
- Trends and learning themes are identified and discussed at the Patient and Partner Experience Group, reinforcing a cycle of improvement.
- Volunteers and patient-facing staff receive enhanced support and training to embed positive behaviours and excellent communication.

Using our Patient and Partner Experience Group meeting to gain assurance, monitor and manage patient experience workstreams and initiatives.

- The Patient and Partner Experience Group will continue to act as the main forum for oversight, assurance, and escalation
- Patient representatives, including PIPs, sit on this group to ensure authentic voices shape the evaluation of initiatives and feedback loops
- Actions emerging from real-time surveys (e.g., Mealtime Matters, Visiting, and Care in the Place We Live) will be monitored through this group
- PIs are QSIR trained

Implement a real-time dashboard for Directorates to encourage a more proactive approach to patient feedback.

- In 2024/25, a real-time patient experience dashboard was launched, offering Directorates timely access to feedback
- This tool will enable services to spot emerging issues quickly and celebrate positive feedback
- Training and support are provided to help teams interpret data and drive localised improvements without delay

Looking Forward 2025/26 - Priorities for Improvement

How we chose our priorities

Each year the Trust is required to identify its quality priorities. We consulted on the quality framework (2025/28) and the Quality and Patient Experience priorities. The draft priorities were shared with commissioners, Healthwatch, the Trust Management Committee, Local Authority Public Health, Executive teams within the divisions and Directorate Management teams. The final priorities for 2025/26 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:

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.

Progress in achieving our quality priorities will be monitored by reporting to the Quality Boards.

Looking forward:

KO41a Hospital and Community Health Services Complaints collection - NHS England Digital. Strategic Priority: Embedding the PHSO Complaint Standards and Learning from Excellence

Action 1: Ensure the PHSO Complaints Standards are fully embedded across all services, shifting from a reactive approach to one that prioritises learning from complaints, compliments, and excellence in care. Strengthen feedback loops to demonstrate transparency, accountability, and continuous improvement.

Action 2: Introduce improved performance indicators for complaint handling including the number of re-opened complaints, and the number of complaints referred to the Parliamentary Health Service Ombudsman (PHSO).

Action 3: Consider and implement recommendations from the Healthwatch report published January 2025 'A Pain to Complain'. This involves three distinct categories:

- Make the complaints process easier for patients and their families to navigate
- Monitor and improve the performance of organisations that handle complaints
- Develop a culture of listening and learning from complaints

The priorities detailed below have been identified and agreed in reference to the following strategic documents:

- Quality Framework 2025/28
- Quality and Safety Enabling Strategy 2023/26
- Patient Experience Enabling Strategy 2022/25
- Planning guidance: National priorities 2025/26

The above Joint Strategies and Framework for Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) define in detail how we will strive to excel in the 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 the triangulation of information from various local, regional, and national sources, including recent engagement with our staff, patients, partners, and the communities we serve.

The priorities taken from Quality and Patient Experience Actions within the Quality Framework 2025/28 are:

- Embedding Eat, Drink, Dress, Move to Improve (EDDMI)
- Full implementation of Saving Babies Lives to prevent avoidable harm
- Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach

The priorities taken from Patient Experience Enabling Strategy 2022/25 are:

- Strengthening Organisational Response to National Mandated Surveys
- Embedding the PHSO Complaint Standards and Learning from Excellence
- Integrating Volunteering to Enhance Patient Experience

The priorities taken from the Planning guidance: National priorities 2025/26 are:

- Reduce the time people wait for elective care
- Improve A&E waiting times and ambulance response times
- Live within the budget allocated, reducing waste and improving productivity

A more detailed breakdown of the aims and key actions are detailed in the table below:

Patient Safety		
Section	**Key Actions we will take**	**Aim for 2025/26**
Prevention of avoidable hospital deconditioning.	• Monitoring of progress and actions through Safer Mobility Group, Tissue Viability Group, Mouth Care Group, Continence Steering Group, Nutrition Steering Group and Infection Prevention and Control Group. • Incorporating EDDMI status into Clinical Accreditation reports to influence local Quality Improvement	• Implementation of a standard toolkit to embed principles of EDDMI across a variety of settings, including in the community – starting with an inpatient focus for 2025/26, to be expanded in the subsequent financial year. The prevention of patient deconditioning will be incorporated within the EDDMI initiative
Mental Health	• Develop a policy that supports Medical Emergencies for Eating Disorders (MEED) in line with the Royal College of Psychiatrist guidance and ensure that any patients who may be suffering from an eating disorder are supported as per their individual needs • Develop a training package that supports staff to deliver high quality care for mental health patients • To develop a policy that supports an all-age mental health patient journey, to support all clinical areas in accessing mental health support when required. • Ensure that both Trusts have a mental health risk assessment to support the requirements for patient safety and enhanced observations when required	• Continue to meet and adhere to the CQC standards for providers of mental health care and treatment within the acute Trust. Ensure clear processes and policies to support mental health patients of all ages to receive excellent quality of care and treatment
Safeguarding	• Robust oversight of patient feedback, safeguarding referrals, quality concerns raised via external routes, incidents and excellence to drive continuous	• To ensure that the Trust discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004 and the Care Act 2014 set against the objectives

	improvements	detailed within the revised Black Country Integrated Care Board Safeguarding Assurance Framework for Commissioned Services
Safe Discharge	• Through the governance route, strengthen Divisional/Directorate/Care Group oversight and reporting of patient discharge-related concerns, including actions and wider learning. Summary of key themes, learning and actions to be captured in Divisional reports provided to QSAG and QPES	• Ensure that all patients experience a safe and timely discharge and deliver on the discharge related priorities as outlined in the joint Patient Experience Enabling Strategy (2022/25)
Infection prevention	• Utilise NHS England's "Take your gloves off" campaign to support both rationalisation of glove use by our staff and sustainability objectives • Support the "Eat, Drink, Dress, Move to improve" (EDDMI) initiatives across both organisations • IPC staff will undertake Quality Improvement (QI) training • Work with areas utilising Quality Improvement methodology to support them to be able to do the right thing at the right time. The IPC teams will explore the application of behavioural science and human factors in interventions made • Explore interventions, working with industry partners to support improvement in hand hygiene compliance assurance, for example triangulate audit data with alcohol hand gel and soap consumption to establish expected metrics to clinical areas • Facilitate ownership of IPC across all areas • IPC policies will be aligned where possible	• We will enable and empower our staff to be able to practice the fundamental elements of IPC on a consistent basis. This will be achieved through education, educational resources and information, employing innovative methods where appropriate, utilising quality improvement methodologies, aligned policies and IPC visibility. We will facilitate and influence the endeavour to meet and positively exceed nationally set objectives for C diff and Gram negative bacteraemia

	between the two organisations and will incorporate the National IPC Manual • Audit programmes - alignment of templates/frequency/responsibilities for undertaking • Support and participate in initiatives to improve patient mouthcare • Explore and develop innovative methods of education delivery to ensure meaningful and interactive learning that will encourage and engage the workforce • We will actively support the Clinical Nurse Fellow (CNF) support network to ensure our colleagues are inducted with regard to IPC and provided with education and guidance	
Full implementation of Saving Babies Lives to prevent avoidable harm	• Overarching toolkit and monitoring via national database for Saving Babies Lives • Monitoring of progress through Maternity Incentive Scheme Directorate surgeries, Local Maternity and Neonatal System (LMNS) Touch Point meetings, LMNS Quality Surveillance, Quality Committee and Trust Board • Transition of Care Bundle Principles into clinical practice, Education and Training	• Deliver the highest quality maternity services across both Trusts, by delivering the safest care options, offering personalised care and choice, and the optimal patient experience for mothers, babies and their families
Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach	• Implementation of workstreams to Prevent, Identify, Escalate and Respond to patient deterioration across a variety of settings, including in the wider community	• Develop a collaborative strategic approach focusing on the prevention of patient deterioration, including early recognition and treatment. The purpose will be to strengthen the safety culture and prevention of harm to patients in our care that is evidence based and current

VTE compliance	Key actions for 2025/26: • Following the announcement of the chair step-down, appointment of new VTE chair to ensure drive and governance is maintained • trial of mandated VTE risk assessments through use of EPMA • development and distribution of VTE dashboard for live compliance monitoring. • continual monitoring and sharing of monthly compliance	• Continuous improvement towards achieving the national operational standard of 95% set by the NHS Standard Contract

Clinical Effectiveness		
Reduce the time people wait for elective care	• Improve 18 weeks RTT to 65% nationally by March 2026 • Improve 18 weeks RTT for a first appointment to 72% nationally by March 2026 • Reduce over 52 weeks RTT to less than 1% of the total waiting list by March 2026. • Improve 28-day cancer Faster Diagnosis Standard to 80% by March 2026 • Improve cancer 62-day standard to 75% target by March 2026	• Continue recovery of the backlog in elective care resulting from the pandemic, prioritising patients based on their clinical need and reducing the number of patients waiting for the longest time, in line with the priorities of the National Elective Care Strategy
Improve A&E waiting times and ambulance response times	• Expanding and maintaining the use of Same Day Emergency Care (SDEC) services to avoid unnecessary hospital stays • Expanding Virtual Wards, allowing people to be safely monitored from the comfort of their own homes • Working with partners to speed up discharge from hospital and reduce the number of patients without criteria to reside	• Improve A&E waiting times, minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours by March 2026 • Achieve a higher proportion within 12 hours DTA across 2025/26 compared to 2024/25
Outpatient Transformation **Patient Experience**	Ensure Outpatient services are accessible and efficient for all by: • reviewing pathways • identifying digital opportunities to support efficiency • improving the interface between primary and secondary care	• Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients

Patient Experience		
Strengthening Organisational Response to National Mandated Surveys	**Measurable Outcomes:** • Improvement in national patient survey scores over time • Percentage of national survey feedback themes with clear action plans in place • Evidence of tangible service improvements resulting from survey insights • Staff and patient awareness of survey outcomes and resulting actions	**Action:** Ensure that insights from national patient experience surveys (e.g., CQC Inpatient Survey, Maternity, Children and Young People, Urgent and Emergency Care and NCPES) are systematically reviewed, acted upon, and embedded into continuous improvement cycles. Each organisation should demonstrate clear ownership and accountability for addressing themes and trends
Embedding the PHSO Complaint Standards and Learning from Excellence	**Measurable Outcomes:** • Percentage of complaints resolved within the PHSO response timeframe • Evidence of service improvements resulting from complaint themes including triangulation against other patient experience metrics • Increase in the number of shared learning cases from both complaints and compliments • Percentage of staff trained in complaints handling and learning from excellence • Improved patient and staff confidence in the complaints process (measured via surveys after complaint cases are closed and periodic feedback surveys) • Percentage of complaint responses that explicitly outline changes made because of patient feedback • Higher percentage of wider data collection on complaints, such as gender, ethnicity and disability etc in line with protected characteristics groups as defined under equalities legislation	**Action 1:** Ensure the PHSO Complaints Standards are fully embedded across all services, shifting from a reactive approach to one that prioritises learning from complaints, compliments, and excellence in care. Strengthen feedback loops to demonstrate transparency, accountability, and continuous improvement. **Action 2:** Introduce improved performance indicators for complaint handling including the number of re-opened complaints, and the number of complaints referred to the Parliamentary Health Service Ombudsman (PHSO). **Action 3:** Consider and implement recommendations from the Healthwatch report published January 2025 'A Pain to Complain'. This involves three distinct categories: • Make the complaints process easier for patients and their families to navigate • Monitor and improve the performance of organisations that handle complaints • Develop a culture of listening and learning from complaints

Integrating volunteering to enhance patient experience	**Measurable Outcomes:** • Increase in the number of active volunteers contributing to patient experience initiatives. • Positive feedback from patients regarding volunteer interactions, measured through patient satisfaction surveys • Improvement in patient flow and reduced waiting times attributed to volunteer support • Enhanced staff satisfaction due to volunteer contributions alleviating workload pressures	**Action:** Continue to develop, innovate, and implement a comprehensive volunteering programme that aligns with patient experience goals. This includes recruiting, training, and supporting volunteers to assist in various capacities, such as patient navigation, companionship, and administrative support, thereby enriching the overall patient journey.

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.

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 2024/25, there was a programme of national clinical audits and national confidential enquiries covering NHS services.

During that period Walsall Healthcare participated in 97% of the National Clinical Audits and Confidential Enquiries Programme which it was eligible to participate in. The National Clinical Audits and National Confidential Enquiries the Trust was eligible to participate in during 2024/25 are below:

Programme Name	National Audit Title	Trust Participation (56/58)	% of the No of cases Submitted	Actions / Comments
BAUS Data & Audit Programme	BAUS Penile Fracture Audit	N/A	N/A	Services managed at RWT
	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	N/A	N/A	Services managed at RWT
	Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	N/A	N/A	Services managed at RWT
Breast and Cosmetic Implant Registry	Breast and Cosmetic Implant Registry	Yes	Data submission in progress	In progress
British Hernia Society Registry	British Hernia Society Registry	No	N/A	Care Group decision to not undertake this year potentially initiate next year
Intensive Care National Audit & Research Centre (ICNARC)	Case Mix Programme (CMP)	Yes	100%	In progress
Emergency Medicine QIPs:	Adolescent Mental Health	N/A	N/A	Data collection not undertaken this year – National Decision
	Care of Older People	Yes	100%	Completed/Report received and discussed at Care Group
	Time Critical Medications	Yes	35%	Low submissions - action to improve patient identification in the next cycle
Epilepsy 12	National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%	Not yet reported

Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Yes	Data submission in progress	In progress
	National Audit of Inpatient Falls (NAIF)	Yes	Data submission in progress	In progress
	National Hip Fracture Database (NHFD)	Yes	100%	Not yet reported
LeDeR	Learning from lives and deaths – People with a learning disability and autistic people	Yes	Data submission in progress	In progress
MBRACE	Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%	In progress
Medical and Surgical Clinical Outcome Review Programme	Juvenile idiopathic arthritis study	Yes	N/A	Organisational data submitted as a spoke and Hub service
	End-of-Life Care	Yes	100%	Completed/Report received and discussed at Care Group
	Emergency (non-elective) procedures in children and young people	Yes	86%	Report not yet received
	Blood Sodium	Yes	100%	Report not yet received
	ICU Rehabilitation	Yes	100%	Report not yet received
	Acute Limb Ischaemia	Yes	N/A	Organisational data submitted as a spoke and Hub service
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	N/A	N/A	Not undertaken at WHT
National Adult Diabetes Audit (NDA)	National Diabetes Core Audit.	Yes	Data Submission in progress	In progress
	Diabetes Prevention Programme (DPP) Audit	N/A	N/A	Not for secondary care
	National Diabetes Footcare Audit (NDFA)	Yes	Data Submission in progress	In progress

	National Diabetes Inpatient Safety Audit (NDISA)	N/A	N/A	Care Group decision to not undertake this year potentially initiate next year
	National Pregnancy in Diabetes Audit (NPID)	Yes	Data submitted	Not yet reported
	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Data Submission in progress	In progress
	Gestational Diabetes Audit	Yes	Data Submitted	Not yet reported
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	Yes	Data submission in progress	In progress
CVD Prevent	National Audit of Cardiovascular Disease Prevention in Primary Care	N/A	N/A	Not undertaken at WHT
NACEL	National Audit of Care at the End of Life	Yes	Data Submission in progress	In progress
NAD	National Audit of Dementia	N/A	N/A	Nationally not collected this year
National Bariatric Surgery Registry	National Bariatric Surgery Registry	Yes	Data submission in progress	In progress
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	Yes	Data submission in progress	In progress
	National Audit of Primary Breast Cancer (NAoPri)	Yes	Data submission in progress	In progress
	National Bowel Cancer Audit (NBOCA)	Yes	Data submission in progress	In progress
	National Kidney Cancer Audit (NKCA)	N/A	N/A	Services managed at RWT
	National Lung Cancer Audit (NLCA)	Yes	Data submission in progress	In progress
	National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	Data submission in progress	In progress
	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Data submission in progress	In progress

	National Ovarian Cancer Audit (NOCA)	Yes	Data submission in progress	In progress
	National Pancreatic Cancer Audit (NPaCA)	Yes	Data submission in progress	In progress
	National Prostate Cancer Audit (NPCA)	N/A	N/A	Services managed at RWT
National Cardiac Arrest Audit (NCAA)	National Cardiac Arrest Audit (NCAA)	Yes	Data Submission in progress	In progress
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit (NACSA)	N/A	N/A	Not undertaken at WHT
	National Congenital Heart Disease Audit (NCHDA)	N/A	N/A	Not undertaken at WHT
	National Heart Failure Audit (NHFA)	Yes	Data submission in progress	In progress
	National Audit of Cardiac Rhythm Management (CRM)	Yes	Data submission in progress	In progress
	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Data submission in progress	In progress
	National Audit of Percutaneous Coronary Intervention (NAPCI)	N/A	Not applicable	Submitted as part of RWT data
	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N/A	N/A	Not undertaken at WHT
	Left Atrial Appendage Occlusion (LAAO) Registry	N/A	N/A	Not undertaken at WHT
	Patent Foramen Ovale Closure (PFOC) Registry	N/A	N/A	Not undertaken at WHT
	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	N/A	N/A	Not undertaken at WHT
NCMD	National Child Mortality Database (NCMD)	Yes	Data submission in progress	In progress
NCAP	National Clinical Audit of Psychosis	N/A	N/A	Not undertaken at WHT

	(NCAP)			
National Comparative Audit of Blood Transfusion	National Comparative Audit of NICE Quality Standard QS138	Yes	100%	Not yet reported
	National Comparative Audit of Bedside Transfusion Practice	Yes	100%	Completed/Report received and discussed at care group
NEIAA	National Early Inflammatory Arthritis Audit	Yes	Data submission in progress	In progress
National Emergency Laparotomy Audit (NELA)	Laparotomy	Yes	Data submission in progress	In progress
	No Laparotomy	Yes	Data submission in progress	In progress
National Joint Registry	National Joint Registry	Yes	Data Submission in progress	In progress
National Major Trauma Registry	National Major Trauma Registry	Yes	Data Submission in progress	In progress
NMPA	National Maternity and Perinatal Audit	Yes	100%	Not yet reported
NNAP	National Neonatal Audit Programme	Yes	Data Submission in progress	In progress
NOD	Age-related Macular Degeneration Audit	N/A	Not applicable	Submitted as part of RWT data
	Cataract Audit	N/A	Not applicable	Submitted as part of RWT data
NPDA	National Paediatric Diabetes Audit	Yes	Data Submission in progress	In progress
National Perinatal Mortality Review Tool	National Perinatal Mortality Review Tool	Yes	Data Submission in progress	In progress
National Pulmonary Hypertension Audit	National Pulmonary Hypertension Audit	N/A	N/A	Not undertaken at WHT
National Respiratory Audit Programme (NRAP)	COPD Secondary Care	Yes	Data Submission in progress	In progress
	Pulmonary Rehabilitation	Yes	Data Submission in progress	In progress
	Adult Asthma Secondary Care	Yes	Data Submission in progress	In progress

	Children and Young People's Asthma Secondary Care	Yes	Data Submission in progress	In progress
NVR	National Vascular Registry	N/A	N/A	Submitted as part of Vascular Hub
OHCAO	Out-of-Hospital Cardiac Arrest Outcomes	N/A	N/A	Not undertaken at WHT
PICANet	Paediatric Intensive Care Audit Network	N/A	N/A	Not undertaken at WHT
Perioperative Quality Improvement Programme	Perioperative Quality Improvement Programme	Yes	No	Care Group decision not to undertake due to resource implications
POMH	Prescribing Observatory for Mental Health	N/A	N/A	Not undertaken at WHT
QOMS	Quality and Outcomes in Oral and Maxillofacial Surgery	N/A	N/A	Not undertaken at WHT
SSNAP	Sentinel Stroke National Audit Programme	Yes	Data submission in progress	Rehabilitation elements only for WHT
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	Data submission in progress	In progress
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%	Awaiting Report
UK Cystic Fibrosis Registry	UK Cystic Fibrosis Registry	N/A	N/A	Not undertaken at WHT
UK Renal Registry Chronic Kidney Disease Audit	UK Renal Registry Chronic Kidney Disease Audit	N/A	N/A	Not undertaken at WHT
UK Renal Registry National Acute Kidney Injury Audit	UK Renal Registry National Acute Kidney Injury Audit	N/A	N/A	Not undertaken at WHT

Statements on the Performance of National Audits:

Learning from Deaths: Children with learning disability and autistic children aged 4-17 years.

The Care Group reviewed the report and noted that from the nine recommendations, one was deemed applicable to WHT of which the following actions were agreed to improve compliance to the national recommendations:

- Add learning disability and autism to children as an alert on care flow
- All healthcare professionals to make reasonable adjustments when seeing young people
- Consider making use of the “this is me” paperwork for recoding - to be included in grand rounds

All of these have been fully addressed and implemented in Walsall services.

National Audit of metastatic breast cancer

The report has been reviewed by the care group and WHT noted full compliance to the recommendations, as noted below:

- Ensure the care for people newly diagnosed with MBC (either de-novo or recurrent) is discussed within a breast multidisciplinary team (MDT) meeting at WHT. All patients newly diagnosed are discussed at Breast MDT
- Examine biopsy rates for MBC and aim to increase this where feasible if the results may have therapeutic implications
    - All patients who present with MBC have a new biopsy if outside of 12 months of their breast cancer diagnosis. As per NICE guidance, the recommendations are followed: 1.1.6
    - On recurrence, consider reassessing oestrogen receptor (ER) and human epidermal growth factor 2 receptor (HER2) status if a change in receptor status will lead to a change in management. [2017]
- Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions
    - Cancer Services have a nominated data lead
- Ensure the recording of date and type of breast cancer recurrence in cancer datasets
    - All MDT outcomes and updates are collected on the SCR database. Breast cancer recurrence is captured in a specific SCR dataset

National Audit of ovarian cancer

Of the five recommendations. only recommendation five is directly related to secondary care, Recommendations one to four are being addressed at a network level.

Clinical lead confirmed the ovarian cancer audit data is robust at WHT. WHT is performing better than peers and meets the target on most parameters other than performance status (88.9% as opposed to a target of 90%). Staging completeness is 88.9% against a target of 90%).

The report and general discussions were shared with the MDT team with a reminder to complete this data set going forward to ensure WHT has improved data entry around these two parameters.

National pancreatic cancer

The report contains key findings relating to diagnosis, staging and treatment planning, time from referral to start of treatment and survival outcomes. More specifically, it states that many people with pancreatic cancer in England (59%) and Wales (63%) are diagnosed with stage 4 metastatic disease. Only 26% of those with metastatic disease in England and 16% in Wales received active disease-modifying treatment over the Audit period. Unfortunately, two-thirds of these patients die within three months of diagnosis.

The following actions were agreed:

- To ensure a referral process is in place and disseminated to WHT and RWT wards
- To develop a local pancreatic pathway within WHT and RWT ensuring all patients are referred to a dietician after initial contact
- To implement localised protocols and practice to ensure that all people diagnosed with pancreatic cancer are assessed for eligibility for pancreatic enzyme replacement therapy (PERT), and that PERT is offered as recommended in national guidance

National Audit of Inpatient Falls NAIF, 2024 , 2023 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 and builds on previous actions taken by WHT.

- WHT has been preparing for the proposed audit expansion in January 2025 and, as part of this, the Quality Team Falls Prevention Leads will take over responsibility for submission of data and reporting outcomes against recommendation through the Trust Patient Safety Group on a quarterly basis via the Trust Quality Report
- A review of the policies and practice will be undertaken to ensure that older hospital inpatients are enabled to be as active as possible. This will be addressed through the EDDMI project as part of the Trust's revised Quality Framework. Workstreams will be developed to encourage patients to be more active
- Review of the medical assessment tool to provide a robust assessment tool to review delirium, dementia and cognitive orders on admission and during the patient stay , particularly when a change in the patient condition occurs, and develop processes to provide assurances thought the governance systems
- To continue the work initiated from the previous audit in education and training to all staff at WHT

National early inflammatory arthritis

Walsall was identified as an outlier in relation to data submission, not allowing the team to draw any useful performance data to improve services.

The following actions were agreed and implemented:

- Transition of service management to RWT, providing a dedicated clinical team and allowing an enhancement of service to Walsall patients
- An improved triage process where patients are being seen in a timely manner, reducing waiting times

- Improved communication process with a dedicated enquiry line enhancing patient experience
- Patients can be treated at multi centres enabling a greater and expended use of resources
- Regular team meetings including a dedicated data clerk have improved the case ascertainment for 2024

National Neonatal Audit Programme

Overall the outcome was positive for Walsall. There were a couple of areas noted as slightly below national average and work was undertaken to address:

- Good outcomes were noted for antennal MGS04 in <30 weeks which was above the 90%, ROP screening, and parental inclusion was noted to be above the standards for NNAP and national average
- Antenatal steroids, parental consultation with the first 24 hours, and breastfeeding were all in line with the national average
- DCC/OCC was noted as in alert status. A quality improvement project has been initiated and is being monitored closely within the governance process to improve compliance against this standard, thus improving the care provision provided

Local Clinical Audit

Walsall Healthcare registered 250 audit projects of which 56 remain in progress and 133 have been completed. A proportion of outcomes have been identified where improvements could be made. Reports from these audits have been presented at multi-speciality meetings.

Some examples are detailed below:

Title	Action
GI Bleed Audit - Jan - Mar 2024	Actions were taken to update the Endovault system to include endoscopic ordering and ensure Rockall score is printed on reports, to support the management of GI Bleeds. .
Care of the Elderly Prescribing Audit	The audit outcomes were shared with the team for information and a QI project was initiated with the Pharmacy team on error rates. A re-audit has been completed that demonstrates an improved picture and a reduction in incident data.
Audit of QS 211 Epilepsy (Baseline)	Audit outcomes triangulated with the QS211 NICE Guidance Action Plan and a reconfigure clinical letters to capture discussions required from QS 5 & 6
NICE Guidance Compliance - NG 238	Fully compliant -no action required and shared with the clinical team for information and learning.

Adequate completion of Radiology Request Forms	The outcome was discussed and shared with the Radiology and AMU teams. As a result, there was agreement on actions - A&E teaching, posters created with easy to remember guidance, which included liaising with the Imaging department, and included the basic principles. The re-audit noted an improved compliance
PEUGIC audit	The audit actions included a reminder to Endoscopists around photo documentation in upper GI endoscopy - reminder shared. Further education to be provided regarding upper GI endoscopy , lesion recognition and use of NBI on withdrawal of scope. A revived process of Histology results to be reviewed and agreed with Endoscopists.
Vetting Audit - Barrett's Oesophagus	Continue with Barrett's surveillance validation and monitor time slot allocation to ensure appropriate.
Awareness amongst referrers and practitioners about the radiation risks and knowledge about radiological examinations in commonly requested diagnostic investigations	Senior clinicians to discuss indications and rational of scan with junior team for improved awareness.
Improving Clinic Learning on AMU Walsall Manor Hospital using Simulation	Variable compliance to prescriptions was noted. A QI approach is to be undertaken in relation to clinical scenarios simulation and procedures teaching
How appropriate are AXR requests in the ED?	Variable compliance to standards was noted. It was agreed to share the audit outcomes at the clinical teaching sessions to ensure the practice for clinical examination for suspecting intestinal obstruction is to be cross-checked with ED senior clinicians. Posters to be developed and placed in ED highlighting indications.
Completion of CURB-65 Score and Antibiotics Treatment Audit	To ensure accurate scoring of the CURB-65 score and adhere to corresponding treatment guidelines for patients, a shared learning event is to be held. Clinical teams to evaluate the drug chart and consider modifying the treatment plan as required upon the patient's arrival from the Emergency Department.
Acute NIV in management for Acute Hypercapnic Respiratory Failure	Variable compliance to standards was noted. A QI in the process was initiated to improve compliance for patients requiring NIV. A programme of NIV education was initiated to enhance and underpin the knowledge for ED and medical registrars. The audit

	results are to be shared and fed back to the workstream for the Respiratory Support Unit.
Heart failure medical management and IV iron therapy re audit	The audit identified improvements from the last study. Revised local practice was identified for this cohort of patients and shared with the team.
Audit on the Identification, Investigation, and Management of Anaemia in Cardiology Patients Without an Obvious Bleeding Source	The audit revealed significant gaps in adherence to NHS and Trust guidelines, Actions were agreed: To implement guidelines/mandatory checklist within local guidelines to ensure that all patients with anaemia and no obvious bleeding source undergo appropriate investigations unless specifically contraindicated. Ensure timely treatment and appropriate referrals for all patients with abnormal findings. Create and implement standardised protocols for anaemia management and referrals. Conduct training sessions for healthcare providers on the importance of following guidelines and managing anaemia effectively. Consider an audit or QI project to assess the barriers to investigations, treatment, and referrals for anaemia in the Cardiology ward, with a view to increasing compliance with best practice guidelines.
Modern ward rounds	Variable compliance was noted. It was agreed for new complex cases to be discussed at teaching rounds to enhance patient safety and management. Introduce a daily three question family input sheet if family are not present. To initiate a QI to improve each standard.
TOMS outcome measure data	Results to be shared with all of the team at the staff meeting. The future audit of TOMS is to be completed at initial assessment to allow improvements in capturing data to support service evaluation.
Therapy outcome measures of preschool language groups	Results to be shared with all of the team at the staff meeting.
IFDT Quality Audit	No action required
Referral Audit	Overall ,throughout the whole audit, the figures have improved in comparison to March 2024 results. No actions required
Documentation Audit	Overall, good compliance was indicated. Findings shared with teams for information
Discharge Re-design Audit	Overall, good compliance was indicated. Findings shared with teams and GPs for information.
Anaesthesia and perioperative pain management for day case hysterectomy	Variable compliance was noted and actions developed to improve compliance. Shared with the team to remind all staff of the importance of ensuring there is complete documentation of pain scores. Delivery of a training session for Recovery staff on short-acting opioid (IV Fentanyl) use for day case Local SOP developed for the use of short acting opioids rather than morphine for peri-op pain management.

The Clinical Utility of CRP in Elective Orthopaedics - Is it Necessary?	Good compliance noted. Actions were developed to improve education. Education to be provided to all Juniors/ward staff on the practice of CRP.
Assessing the process and outcomes of medical referrals for surgical patients re-audit .	Good outcomes were noted in this re-audit. Several recommendations were made - investigate the feasibility of providing protected time during the day for medical referrals. Introduce a teams form that captures documentation that referrals have been actioned.
Are ENT Histology specimens having timely follow up?	There was a noted delay in follow up on review of the data. A protocol is to be developed to standardise follow ups immediately after a biopsy is performed with automated notifications or alerts for Consultants when results are reported. Utilise the virtual clinic for sharing biopsy results.
Management of patients presenting to T&O with suspected Cauda Equina	Audit actions were developed to enhance the current service provision by introducing a combined-on call MRI service overnight with New Cross, with healthcare staff to note the referral times. Share findings with ED team for awareness.
Assessment of information spread on TikTok regarding post-tonsillectomy care	A total of 38/60 videos were not relevant (e.g. videos demonstrating the procedure, people describing the experience), Recommendations were made to advise patients in clinic to avoid social media advice, referring them to existing ENTUK patient leaflets
Are VRA tick sheets being completed/scanned on to Auditbase?	The results show that compliance with completing the VRA tick sheets is low. Actions were developed with the Paediatric team and a SOP is to be developed to reiterate the importance of completing the VRA sheet to improve communication and documentation.
Audit on trauma and orthopaedic consent forms against RCS England guidelines	Variable compliance was noted and discussion with the senior management team in relation to redesigning the consent forms and stickers to include RCS guidance.
Assessment of pre-operative workup for neck of femur fractures	Variable compliance noted, to explore the development of an ED electronic checklist to support the fracture neck of femur patients in their pre-operative work up.
Optimising PCEA Utilisation: Enhancing Labour Analgesia Prescriptions and Pump Management	Variable compliance. Actions to be taken include staff education, laminated notes on each pump promoting 'Label, lock, prescribe', Inclusion of the information on handling PCEA and Remifentanil PCA in obstetric anaesthesia handbook, Sessions for practical training in handling epidural catheters and pumps during PROMPT.
Prescribing Error Incident Audit	Variable compliance was noted. Actions taken were to continue review of prescription in ward round and remind it is mandatory to check BNFc before prescribing. Mandatory completion of all fields is required on the drug chart. Regular medications prescribing for patients with complex background. To undertake a medication safety and reconciliation audit. Introduce online prescriptions instead of manual. To implement AI enabled virtual assistance for verification of online prescriptions.
"New Salbutamol Weaning Plan" Audit	Good compliance was noted. Continuity of the as required salbutamol weaning with safety netting in place.

Consent forms sticker	Variable compliance was noted. Stickers to be stocked within ANC to ensure constant supply.
Omitted doses audit	The results of this audit revealed that the set standards have not been met and interventions are required to improve future outcomes. The following actions were agreed: 1. MDT involvement – MDT to cascade findings and share with the respective areas by disseminating results at divisional medicines management meetings. 2. Real time feedback – Results of the audit should be provided to the respective ward teams in real time so they have the opportunity to identify any ongoing issues that could have led to the dose omissions and address them in a timely manner. This should be logged as a Pharmacy intervention 3. Regular stocklist reviews – The ward stocklists should be periodically reviewed by the ward Pharmacist in collaboration with the Ward Manager/Nurse In Charge to include frequently ordered medications which may mitigate the potential for omitted doses due to lack of medication availability. 4. Master stocklist review and MS Excel spreadsheet to be updated. Utilise available resources – Ward staff to refer to and share Pharmacy briefing on 'Procedure to access medicines out of hours' including the use of the hospital drug stock locator on the Trust Intranet in and out of hours to prevent missed doses. Re-circulate briefing and distribution list for each ward area. 5. Medicines reconciliation – Discrepancies identified by and noted on the reverse of drug chart by Pharmacy team to be reviewed regularly and actioned by the medical team in a timely manner to promote medicines optimisation. Medicines reconciliation session be integrated into post graduate teaching for FY1 And FY2
Postmenopausal and one-stop clinic audit	Variable compliance noted the following actions: Introduction of triaging to the postmenopausal bleeding clinic including ring-fencing of one stop slots to PMB patients to use slots efficiently. Increasing scanning ability by investing in training consultants on gynaecological scanning. Improve patient communications to discontinue oral anti-coagulants prior to appointment. To share the audit with GPs to improve scan requests and reiterate the appropriate pathway.
Food Allergy in Children and Young People	Documentation has improved overall in clinic and ED but is still insufficient in a few areas to meet the NICE guidelines. The following was agreed to improve compliance to standards: Continue allergy teaching in Paediatrics, consider implementing ED allergy pathway and review and develop the implementation of an ED allergy pathway for children and young people.
Audit of quality of electronic discharge summaries in Paediatrics	Improved compliance was noted. The team agreed to share the outcomes with PAU and Ward 21 and to create a poster to remind areas on the importance of documenting weight on admission.

Coagulation screening and Use of FFP in Neonatal Unit	The audit demonstrated low compliance to the standards, and the following was agreed; to place Iron deficiency leaflets in PAU and Ward 21 and to distribute to team members and explore the development of a QR code for the leaflets to allow greater access.
Audit of Compliance with ADHD NICE Guidance	Medical recommendations followed satisfactorily. The team agreed to update patient information leaflets in line with latest guidance and to discuss with ICB the development of a transition to adult services process and agree funding.
Audit on the management of gonorrhoea in females	Good compliance was noted. Actions were agreed to enhance the service including sending a link to positive patients where written information could be obtained.
Consultant Review Times for Admitted Patients	Good compliance to RCPCH standards was noted, with actions to improve review times within 14 hours and to develop a clear referral process from Paediatric ED to PAU.
Ward staff knowledge of imaging procedures – re-audit	Overall, one year post intervention demonstrated an overall sustained improvement in the level of knowledge of Imaging techniques by Nurses compared to the initial audit. It was agreed to continue to regularly educate clinical teams on processes and to review putting the leaflets on the intranet for increased accessibility.
Drug Chart Audit	The audit noted variable compliance. Actions were agreed around regular team education and training sessions on completion of the drug chart and the legal aspects on the standards associated with them.
Anticoagulation Safety Audit	Variable compliance was noted, and the following actions were noted: regular teaching sessions for clinical teams on updated guidance on anticoagulant prescribing, monitoring and managing ADRs. a refresher session for Pharmacy on the importance on MedRec for patients on anticoagulants prior to admission.
An audit evaluating the management of massive post partum haemorrhage at Manor Hospital	Variable compliance was noted, and the following actions were being considered: introduce a PPH checklist to improve documentation and communication within the clinical teams.
Management of anaphylaxis in children	Good compliance to the standards was noted with a suggested action of improved handover documentation and promotion of patient information leaflets.
To check compliance against a new EEG SOP	The audit noted an update was needed in the SOP and the action is to update the SOP with HV and Photic decisions and to re-audit once this has been completed.

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 2024 to 31 March 2025 the Trust has been issued with a total of 13

Patient Safety Alerts (NPSA) from the Central Alerting System. Twelve of these alerts have been completed in line with the stipulated completion periods. Two were issued as information alerts and none were deemed not applicable to the organisation. One remains in progress at the time of reporting.

Participation in Clinical Research

Research opportunities continue to grow for Walsall patients and the wider population.

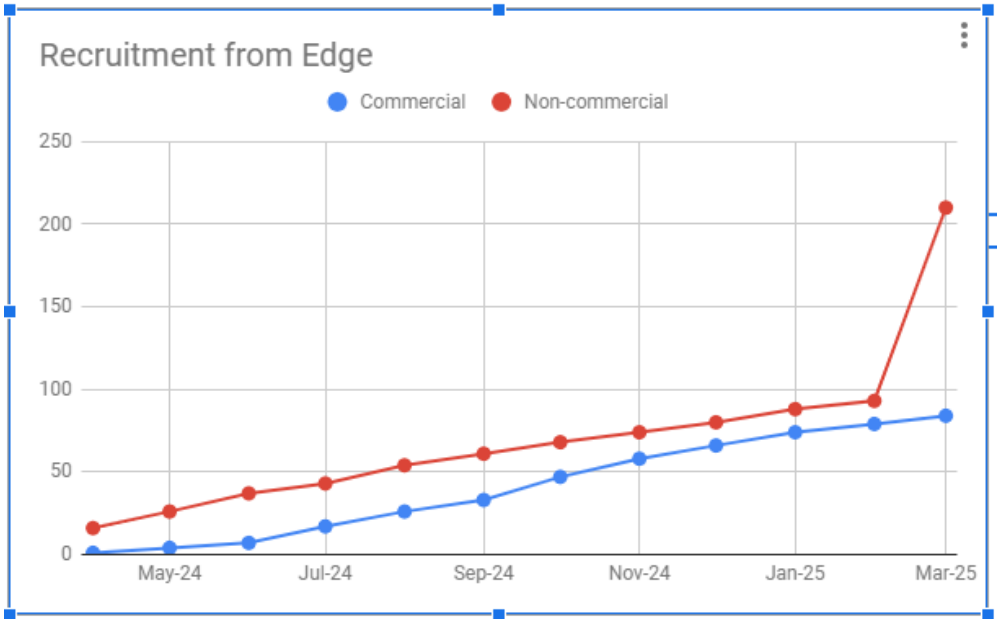
Recruitment into trials has exceeded the previous year (2023/24).

Commercial recruitment (Clinical Trials) to the end of March was 84 - an increase of 61 participants. This is the highest number of recruits into commercial trials for Walsall.

Non Commercial (Academic studies) also increased by 23 participants.

Overall, recruitment as of March 2024 was 343 recruits. All studies have been approved by the HRA Health Research Authority, and are therefore ethically

approved.



The specialities involved in research covered include Dermatology, Cancer, Cardiovascular, Trauma and Emergency care, Gastroenterology, Reproductive and Childbirth, Paediatrics and Microbiology (infection). New areas include Rheumatology, Gastroenterology and Surgery.

The focus for 2025/26 will be to continue to grow the Walsall research portfolio, in particular commercial research, and continue to forge relationships with current Pharma colleagues and develop new partnerships.

The growth will need to be in line with the capacity and skillset of the research team.

Ensuring there is a stable workforce is paramount, having a dedicated space on site will enable that growth as stability of the team. Ensuring Walsall is compliant with national

guidelines on set up of studies will also be important.

There is good communication across WHT and RWT to ensure timelines are met. The clinical team will make it a priority to ensure that Walsall's population is represented in recruitment into trials. however, there is assurance that those clinicians wishing to undertake their own research will be supported

The below table illustrates research active specialities with studies opened, in set up or pipeline:

Specialities opened	Specialities in Set up	Specialities in pipeline
ICU (Critical Care)	Physiotherapy	Dermatology
Dermatology	Cancer	Critical Care
Paediatrics	Rheumatology	Viral (Infection)
Cancer		Gastroenterology
Emergency Care		Rheumatology
Surgery		Reproduce & Childbirth
Cardiovascular		
Gastroenterology		
Reproduce & Childbirth		
Infection (Microbiology)		

CQUIN (Commissioning for Quality and Innovation Payment Framework)

The Commissioning for Quality and Innovation (CQUIN) financial incentive scheme was not included within the 2024/25 NHS Standard Contracts with our ICB and NHSE Commissioners.

The full breadth of Walsall Healthcare's income in 2024/25 is not conditional to achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework

Information on Registration with the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against the Trust during 2024/25.

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 Uses Service

Walsall Healthcare submitted records during 2024/25 to the Secondary Users 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:

1. 99.90% for admitted patient care
2. 99.98% for outpatient care
3. 99.64% for accident and emergency care

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

1. 100% for admitted patient care
2. 100% for outpatient care
3. 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 2024/25 by the Audit Commission.

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

The Trust commissioned Solventum (formerly 3M) to undertake a Data Protection and Security Toolkit audit for coded data 2024/25 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 overall coding inaccuracy rate of just 1.8 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 for 2014/15. The Trust should be proud of the quality of its coded clinical data
- The depth of coding (number of recorded diagnosis codes) in this sample is 6.23, the current (NHSE) average is 6.2 for elective and 6.0 for non-elective care.

There are some very complex comorbidities in this sample, particularly in the random section coded from notes where the depth of coding is 9.5. The coders diligently source and interpret this information. In a team that is understaffed and struggling to cope with a large backlog it would be understandable if they coded as quickly as possible unconcerned about data omission; this is not the case.

Information Governance Toolkit attainment levels

Data Security Incidents

The 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 a personal data breach, which is likely to result in an adverse effect to the rights and freedoms of individuals, must be reported to the Information Commissioners Officer (ICO) using the online tool. The table below shows incidents that met this criteria during this period:

Incident Date:	Nature of Incident:	No. Data Subjects Involved:	Description of Incident:	ICO Decision/ Further Action:
Oct 2024	Unauthorised access	5	Staff member accessed records of individuals known to them without legitimate reason or authorisation.	Member of staff was dismissed following HR investigation. ICO satisfied with actions taken by the Trust.

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

SUMMARY OF OTHER DATA SECURITY RELATED INCIDENTS IN 2024/25		
Category	**Breach Type**	**Total**
A	Confidential patient breach	101
B	Confidential information leak	7
C	Consent not gained	3
D	Post incorrectly sent/addressed	11
E	Record keeping – incomplete	10
F	Missing records	29
G	Records lost in transit	2
H	Records not provided	0
I	Reports (results) – missing/unfiled	9
J	Loss of data via electronic transmission	27
K	Incorrect delivery of electronic data	18
	Total	217

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

Data Security & Protection Toolkit Assessment 2023/24 (V6)

An 'Approaching Standards' submission was published in June 2024; the mandatory internal audit of the DSP toolkit supported this self- assessment. An Improvement Plan was established and accepted by NHS England and the Trust achieved the required Standards in March 2025.

Data Security & Protection Toolkit Assessment 2024/25 (V7)

The Data Security & Protection Toolkit changed in September 2024 to align with the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF). The framework adopts an outcome-based approach with emphasis on the achievement of best practice.

The Trust's assessment is currently being ratified and is expected to be published in June 2025.

Walsall Healthcare 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, Cyber Security Lead 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 continues to monitor against the standards annually, however. The results of the audits are reported to the Quality Committee which is a subcommittee of the Trust Board.

The last audit took place in February 2024 (the next audit was planned for April 2025), see below for detail on to the four core standards. The results evidenced a decrease in results compared to the previous audit, with the Trust not meeting the following two standards where it had 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)

The Trust achieved an overall compliance of 75% (against a standard of 90%) of patients reviewed by a Consultant within 14 hours of admission. This result shows a decrease in compliance compared to the previous audit result of 93%.

Compliance was as follows: weekday 76% and weekend 74% (compared to previous results: weekday 94% and weekend 100%). Following presentation of the report, Divisions were tasked with investigating the reasons behind the decline in compliance to prepare action plans. Staffing levels were reviewed along with admission rates which led to business cases for increased staffing.

The 2025 audit was due to take place in February and be reported in April which will evidence results of Divisional review.

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.

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

Daily review compliance at the last audit showed a result of 62% (compliance at last report was 91%), against the 90% compliance target.

The results of the audits have significantly decreased on the previous year. Previously identified areas for improvement and quality measures the Trust introduced by Divisions should continue to have a positive effect on the next audit.

No date has been provided for the reintroduction of national reporting; however the Trust will continue to audit annually.

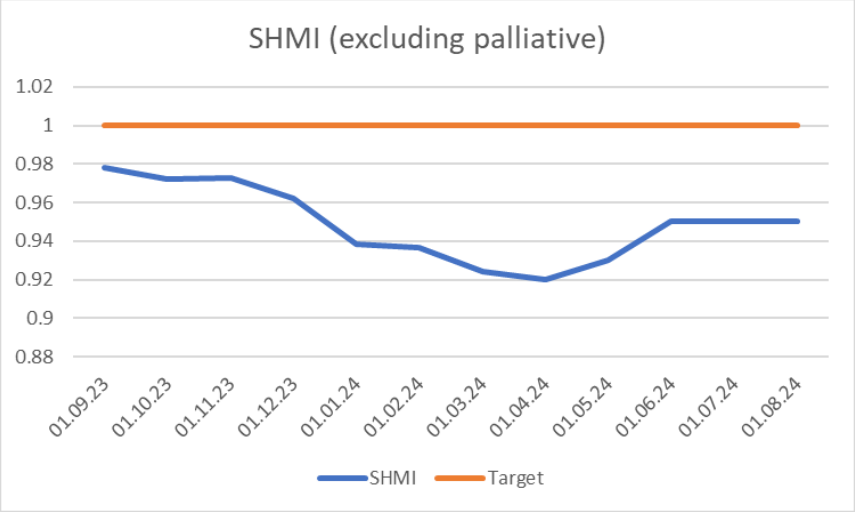
National Core Set of Quality Indicators

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. The SHMI value is measured against the NHS average which is one. A value below one 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 – please note data is six months behind when published) September 2023 to August 2024 is 0.950. These values are within the expected range and relate to the acute Trust, excluding Palliative Care.

We continue to monitor mortality data by ward, speciality, and diagnosis. Reviews of deaths in hospital are carried out to identify any factors that may have been avoidable so these can inform our future patient safety work. Deep dives are carried out if a SHMI alert is received and reports are presented at the Mortality Surveillance Group, outlining issues identified and action plans as necessary. This is monitored monthly.



Changes to reporting of SHMI

The process for reporting Same Day Emergency Care (SDEC) has changed. NHS England announced that from 1 July 2024 the recording and submission of SDEC activity was being migrated from various data sources (such as Admitted Patient Care) to the Emergency Care Data Set (ECDS). This will have an impact on SHMI with an increase in SHMI levels anticipated.

The Trust, (along with several other Trusts throughout England,) was not in a position to implement this change in July 2024, however, as the ECDS (which is externally managed) was not upgraded in time. The delivery of the ECDS upgrade is in

development and upgrades will be completed in cohorts. The Trust's Digital Transformation Board is monitoring the position and will provide an update when available.

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 12 month period Jan 2024 to Dec 2024:

Month	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Palliative Medicine Deaths	16	15	12	0	7	18	14	21	13	15	24	19
Total Hospital Deaths	126	124	125	107	116	129	115	105	93	140	139	181

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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
SJRs	8	11	10	6	9	10	7	7	9	8	11	15
Total Hospital Deaths	126	124	125	107	116	129	115	105	93	140	139	181

SJR outcomes (total deaths reviewed categorised by outcomes)

	Q4 (2023/24)	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Total
Number of deaths	369	352	313	456	1490
Number of completed SJRs	16	8	9	9	42
Number of deaths thought to be more likely than not due to problems in the care provided	2	0	0	4	6

This data refers to the number of SJRs completed.

The total number of deaths in the Trust for the reporting period is 1,490.

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

Percentage of avoidable deaths is 0.40%.

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 became statutory on 9 September 2024. All deaths in the community are referred to the Medical Examiners and cause of death discussed and agreed with GPs. This has resulted in a substantial increase in the work carried out by the Medical Examiner Team. The table below sets out the number of GP referrals following implementation:

Month	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
GP referrals	74	106	87	110	123

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 Child Death Overview Panel (CDOP) 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 have resulted in the following improvements:

Deteriorating Patient

- Work is underway on development of a deteriorating patient dashboard
- Progress has been made with the implementation of Martha's Rule
- ICNAR data shows an improvement in management of deteriorating patient with less sick patients admitted to ICU, thereby improving length of stay and prognosis
- ReSPECT policy has been rewritten with consideration to deteriorating patients
- Monthly meetings with stakeholders held with discussion around policies, NEWS audit

General Surgery

- Increased team working; closer working with care of the elderly Consultant
- Improvements in processes and information through National Emergency Laparotomy

Audit (NELA)
- Sharing learning with teams outside of Surgical Division especially in frail and elderly patients
- Engagement of resident team in reviewing mortalities and morbidities with residents expected to attend and inclusion at general surgical meetings
- Improvements in patient management resulting in shorter length of stay

Perinatal mortality

- Improvements in out of area Community Midwifery care by closer working with neighbouring Trusts
- Increased auditing of fetal movements checklist to ensure compliance
- Increase in number of routine enquiries during contact, including efforts to speak to patient on their own if attending with relatives/friends
- Review of diabetes guideline, led by specialist diabetes Midwives

Emergency Department

- ED newsletter has been introduced
- Additional support provided by Respiratory, Oncology, Cardiology and Pharmacy
- Improvement in completion of ReSPECT forms with improved discussions with next of kin
- Establishment of a mortality team
- Defined MDT approach
- Improvement in early recognition of deteriorating patient

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.

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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 2023/24.

Walsall Healthcare NHS Trust believes the performance reflects that:

1. The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived
2. The data is collated internally and 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.

Indicator	2022/23			2023/24			2024/25		
The percentage of patients aged (i) 0 to 15; and (ii) 16 or over, Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.		0 to 15	>=16		0 to 15	>=16		0 to 15	>=16
	Apr-22	15.02%	11.41%	Apr-23	16.15%	12.38%	Apr-24	16.54%	10.40%
	May-22	16.95%	10.99%	May-23	17.35%	10.81%	May-24	16.30%	9.51%
	Jun-22	18.25%	11.88%	Jun-23	16.81%	10.13%	Jun-24	15.35%	10.17%
	Jul-22	19.27%	12.35%	Jul-23	18.11%	11.45%	Jul-24	16.40%	10.40%
	Aug-22	14.32%	11.37%	Aug-23	17.19%	10.97%	Aug-24	16.69%	10.24%
	Sep-22	15.48%	9.78%	Sep-23	18.24%	11.03%	Sep-24	16.16%	10.75%
	Oct-22	18.49%	9.97%	Oct-23	20.65%	11.34%	Oct-24	17.54%	10.33%
	Nov-22	18.73%	10.52%	Nov-23	18.25%	10.72%	Nov-24	19.44%	10.54%
	Dec-22	15.09%	11.13%	Dec-23	16.04%	12.25%	Dec-24	15.85%	10.49%
	Jan-23	18.85%	11.41%	Jan-24	17.52%	11.54%	Jan-25		
	Feb-23	19.98%	11.44%	Feb-24	18.74%	11.38%	Feb-25		
	Mar-23	15.99%	11.63%	Mar-24	16.17%	11.19%	Mar-25		

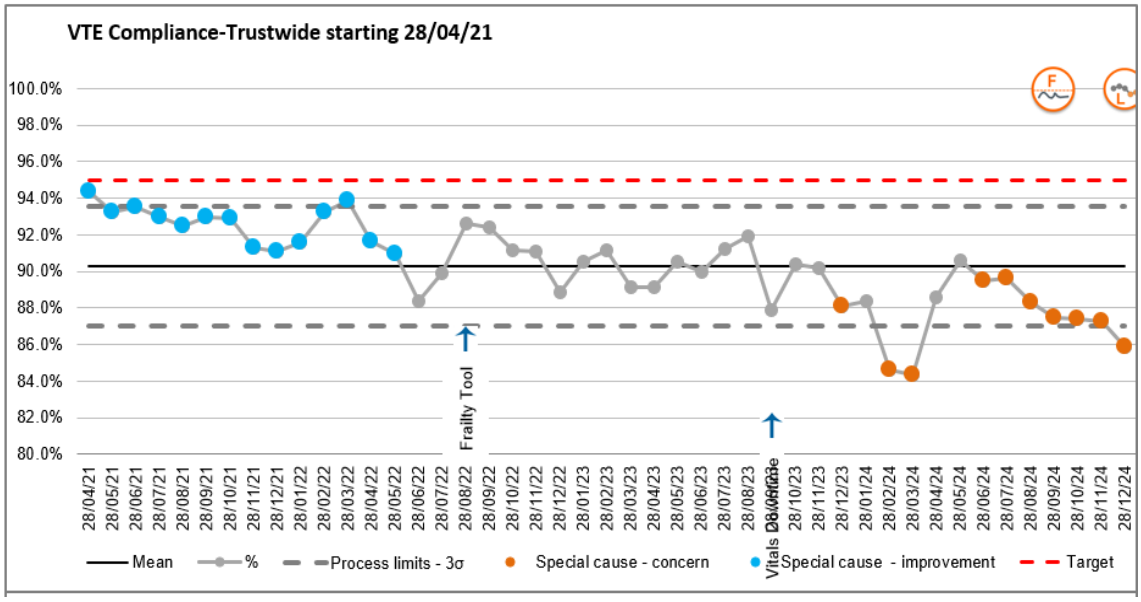
Core Quality Indicators – Venous Thromboembolism (VTE)

National reporting on VTE (venous thromboembolism) started again in April 2024. Results were not published until January 2025, however. The data evidences that no regions achieved the 95% NHS Standard Contract operational standard in either Q1 or Q2 2024/25.

The Trust continues to monitor and report internally on a monthly basis. See the graph below for performance.

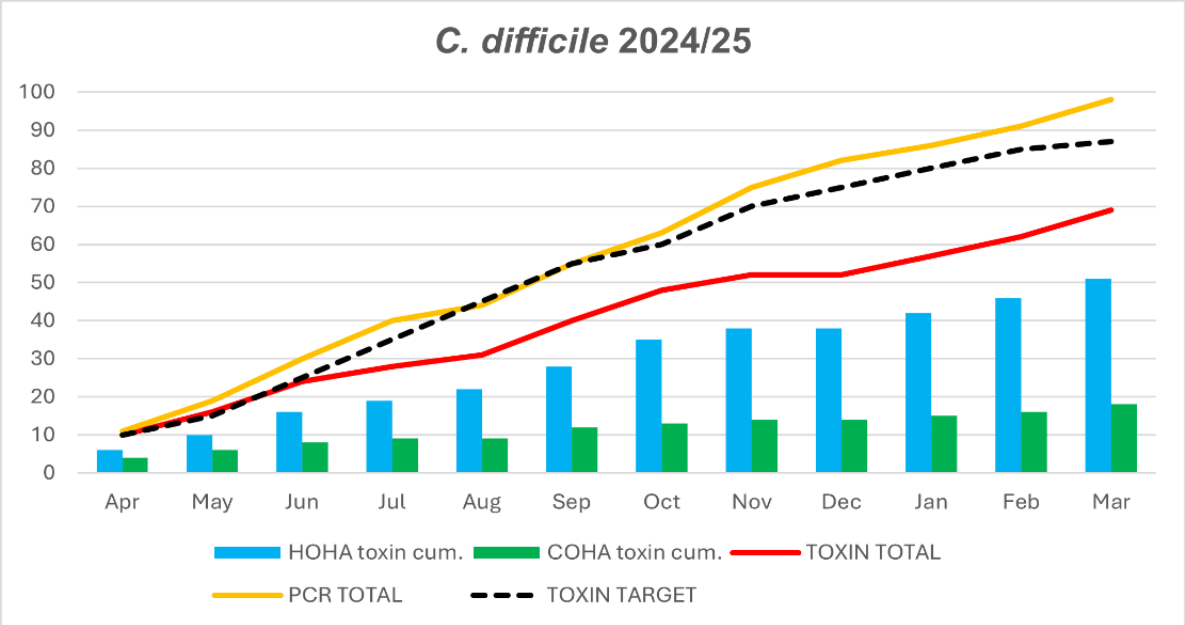
VTE assessment remains below the required compliance target of 95%. Monthly audits are embedded in practice with data shared with Consultants and clinical teams to ensure specialties are kept informed of performance to ensure safe patient care. Where compliance is consistently low, Divisions have action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

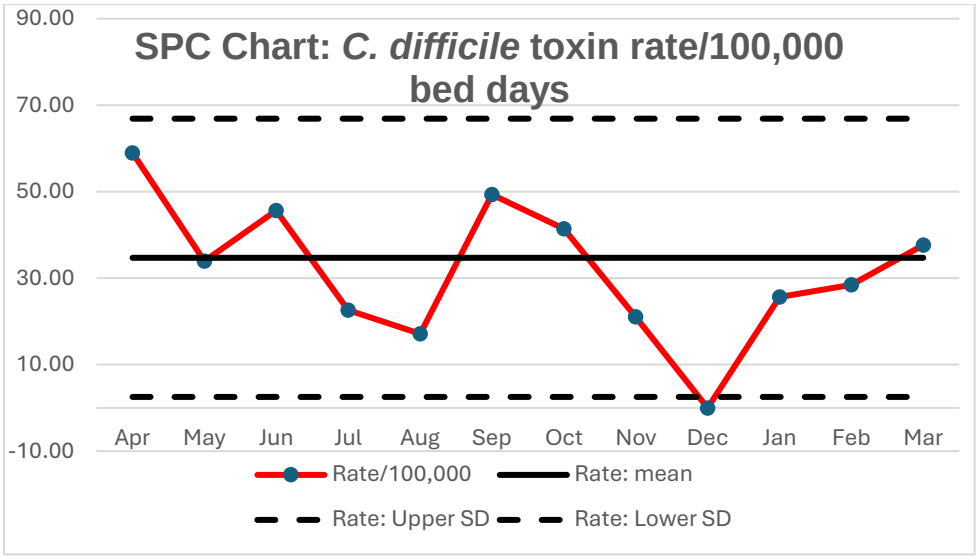
The Thrombosis Group meets monthly and provides the opportunity to discuss compliance and share ideas for improvement. All incidents of pulmonary embolism and deep vein thrombosis are reported together with the outcome of investigations that have been carried out.



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 2024 and March 2025 at Walsall Healthcare NHS Trust.



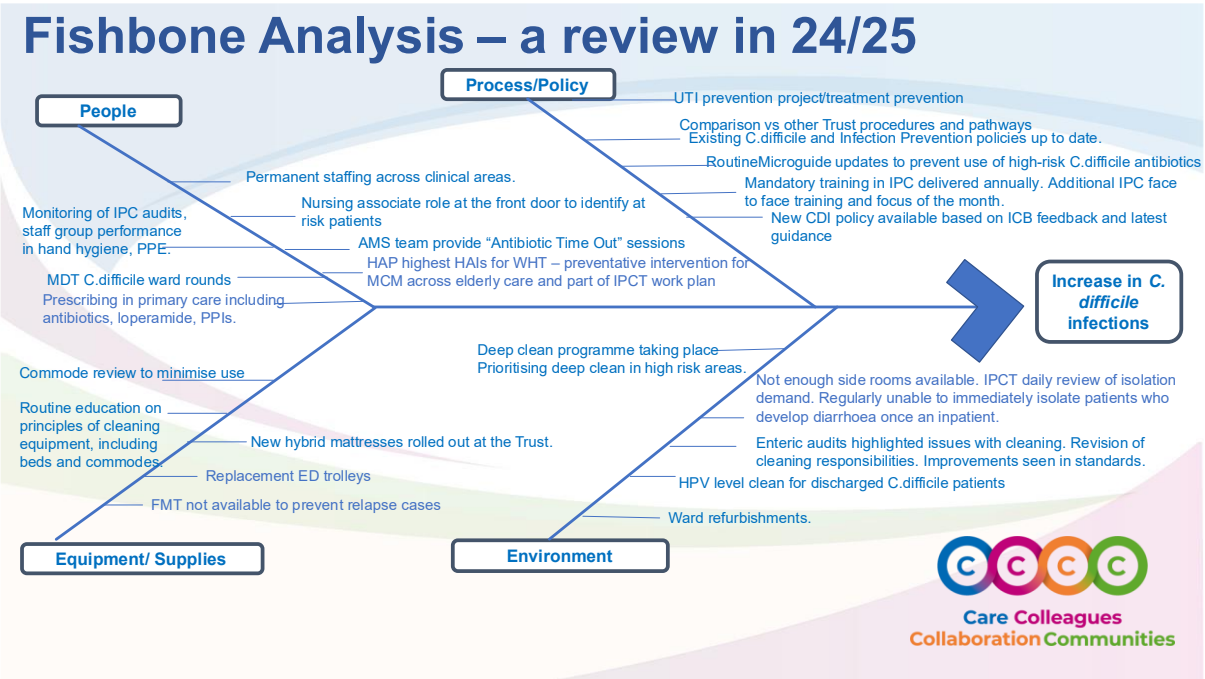


The Trust carries out reviews of all HOHA and COHA C. difficile cases and a multidisciplinary review is undertaken to investigate cases where new lessons can be learnt. These are reported to the divisional meetings and at the IPCC.

Between April 2024 and March 2025, there were 69 cases confirmed of HOHA (51) and COHA (18) toxigenic C. difficile against an annual trajectory of 87.

The DDIPC and LIPCN completed quarterly reviews of all CDIs classified as COHA/HOHA. The primary objective of this review was to evaluate the effectiveness of the multimodal interventions implemented over the past two financial years, determining their impact on reducing CDI cases. Additionally, the review aimed to identify any areas requiring further action to continue reducing CDI rates at Walsall Healthcare.

As part of this process, a fishbone analysis was completed to identify potential underlying causes and to guide the development of interventions for the 2024/25 financial year.



Common trends in risk factors:

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

Key themes identified from case reviews for 2024/25:

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 and 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 and 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

4. Training and Education Needs:

- Gaps identified in staff knowledge regarding the application of AMS principles
- Adherence to IPC policies and practices, including hand hygiene, use of personal protective equipment (PPE), and isolation protocols requiring further improvements

Summary of target interventions for 2024/2025:

A comprehensive thematic analysis and review of all HOHA and COHA CDI cases was conducted. The outcomes and learning were disseminated to key stakeholders, with feedback on actions shared through the Infection Prevention and Control Committee (IPCC).

1. Case Identification and Surveillance

- Ongoing investigation of potential patient-to-patient transmission through the identification of Period of Increased Incidents (PIIs), with submission of isolates for ribotyping
- The IPC Nursing Associate supports frontline clinical teams, particularly in admission areas, to facilitate early sampling of patients presenting with diarrhoeal symptoms. This

early detection supports timely intervention and isolation
- Daily review of all CDI cases is undertaken by the IPC Team, with weekly multidisciplinary reviews involving Microbiology, IPC, and AMS teams

2. Reduction in Disease Severity and Treatment Needs

- There has been a notable decrease in illness severity, with fewer patients requiring treatment or experiencing relapse, attributed to earlier identification and prompt initiation of IPC measures

3. Isolation and Environmental Controls

- Isolation capacity was enhanced through the installation of Bioquell isolation pods in clinical areas
- IPC practitioners complete daily assessments of isolation needs across the organisation, co-ordinating with clinical site practitioners to ensure timely and appropriate placement of patients. Isolation decisions are recorded, monitored, and reviewed via IPC incident reporting systems and the risk register, with oversight by the IPCC
- Enteric audits to assess and assure adherence to best practice following identification of a new case. These audits are now available via the Tendable audit system and are included in regular reporting to IPCC
- Enhanced environmental cleaning protocols, including Hydrogen Peroxide Vapour (HPV) and ultraviolet (UV) disinfection
- The proactive deep cleaning programme continues to be embedded and supported across the Trust

4. Built Environment and Equipment Assurance

- IPC supports with refurbishment and capital improvement projects across the Trust
- A full review of high-risk equipment (e.g., mattresses, commodes) has been conducted to ensure effective decontamination processes. This work aligns with the "Eat, Drink, Dress Move to Improve" campaign to enhance overall patient care
- Quarterly training is provided by partners on the decontamination of shared equipment and the promotion of patient hand hygiene
- A review of cleaning products used for shared equipment has led to the consideration and introduction of peracetic acid, based on current evidence based against Clostridioides difficile spores

5. Antimicrobial Stewardship (AMS) and Clinical Practice

- AMS time-out sessions continue in clinical practice and continue to drive improvements in the appropriate use of antimicrobials
- Targeted AMS interventions have been deployed in clinical areas where inappropriate prescribing patterns were identified
- Treatment pathways are under review, including the use of Faecal Microbiota Transplantation (FMT) for recurrent CDI cases
- Staff education around management of CDI has been a key component of the broader IPC training agenda

6. System-Wide and Strategic Collaboration

- The Trust’s IPC Team is actively engaged with the Integrated Care Board (ICB) C.

difficile Task and Finish Group. This collaboration aims to promote a system-wide approach to reducing CDI cases and harm across both community and acute care settings

- Syndromic surveillance and targeted quality improvement (QI) workstreams are ongoing, focusing on pneumonia, hospital-acquired pneumonia (HAP), urinary tract infections (UTIs), and surgical site infections (SSIs). These are aligned with data from the UK Health Security Agency (UKHSA) Point Prevalence Survey (PPS) and are captured within the Trust's annual IPC Work Plan for 2025/26

Core Quality Indicators - Incident Reporting

2023/24 (Full Year Data)			2024/25 (Full Year Data)		
Incidents	% Resulting in Death	% Resulting in Severe harm	Incidents	% Resulting in Death	% Resulting in Severe harm
20147	0.1% (17)	0.2% (31)	16757	0.08%(13)	0.17%(28)

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 Learn from Patient Safety Events (LfPSE)

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 take part in the NHS CQC Patient Survey Programme, gathering patients' views on their recent healthcare experiences. These surveys provide valuable insight into service and care standards, helping organisations prioritise improvements to enhance patient experience.

The Care Quality Commission (CQC) also uses the survey results to monitor and assess NHS performance at both local and national levels. Findings contribute to regulatory activities, including registration, ongoing compliance monitoring, and service reviews.

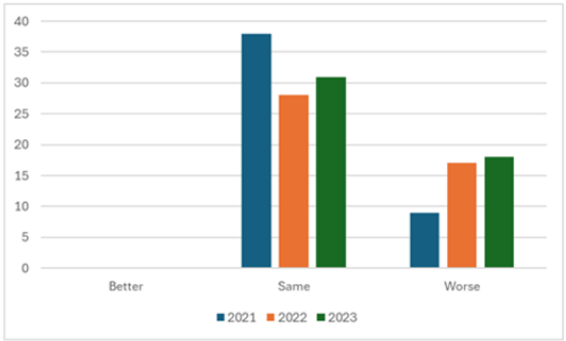
During 2024/25, four national surveys were published: the Adult Inpatient Survey 2023, the Maternity Survey 2024, the National Cancer Survey 2023, and the Emergency and Urgent Care Survey 2024. Survey results are benchmarked against national data, with action planning undertaken and monitored by the Patient Experience Group and the Trust's Quality, Safety, and Experience Committee.

Where applicable, action plans are shared with the Patient Feedback and Oversight Group, ensuring regular updates and assurance. These actions align with the improvement priorities set out in our Patient Experience Enabling Strategy, with active workstreams addressing key focus areas highlighted in each survey. Additionally, our Trust's Mystery Patient scheme incorporates relevant questions to continuously evaluate and monitor our progress.

The Adult Inpatient Survey 2023

Published in August 2024, the survey saw responses from 333 Walsall Healthcare NHS Trust patients, with a response rate of 30%—below the national average of 40.2%. The Trust's results were rated worse than most Trusts for 12 questions, somewhat worse for five questions, and on par with others for 28 questions. This positioned the Trust as a national outlier among those with a higher proportion of 'worse than expected' results.

National Comparison



*2023 – increase in questions

Key findings:

The survey identified key areas requiring improvement, including:

- Waiting times and communication - patients highlighted concerns about the length of time waiting for admission and the availability of timely updates
- Information quality – the need for clearer communication about care, treatment plans, and discharge procedures was emphasised
- Hospital environment and noise levels – noise at night remained a concern for patient rest and recovery
- Staff engagement and support – some patients reported a need for improved interactions with healthcare staff to enhance their overall experience

Improvement actions taken:

Waiting Times and Communication

- A review of Access Team processes to improve communication with patients about

waiting times and delays
- Conducted a Voices in Care: Partnering in Excellence survey to gather more insights on the patient admission experience

Information Quality

- Implementation of an online survey to evaluate the effectiveness of information provided to patients
- Strengthened staff training on patient communication, ensuring that information is delivered clearly and consistently

Noise at Night and Quiet Protocol

- Reinforcement of the ‘Quiet Protocol’ to reduce disturbances during nighttime hours.
- Designed and displayed awareness posters to educate staff and visitors on the importance of minimising noise at night

Staff Engagement and Support

- Enhanced staff training on patient-centred care and effective communication
- Recognition of staff excellence through ‘Learning from Excellence’ initiatives, where positive experiences were shared to promote best practices

The improvement actions will continue to be monitored for effectiveness. Further engagement with patients and staff will help refine these initiatives to ensure a high standard of inpatient care. Future steps include:

- Expanding feedback mechanisms, including digital and in-person patient feedback sessions
- Continuous evaluation of the Quiet Protocol and other environmental factors affecting patient experience
- Strengthening collaboration with hospital divisions to ensure sustained improvements in patient communication and support

Urgent and Emergency Care Survey 2023

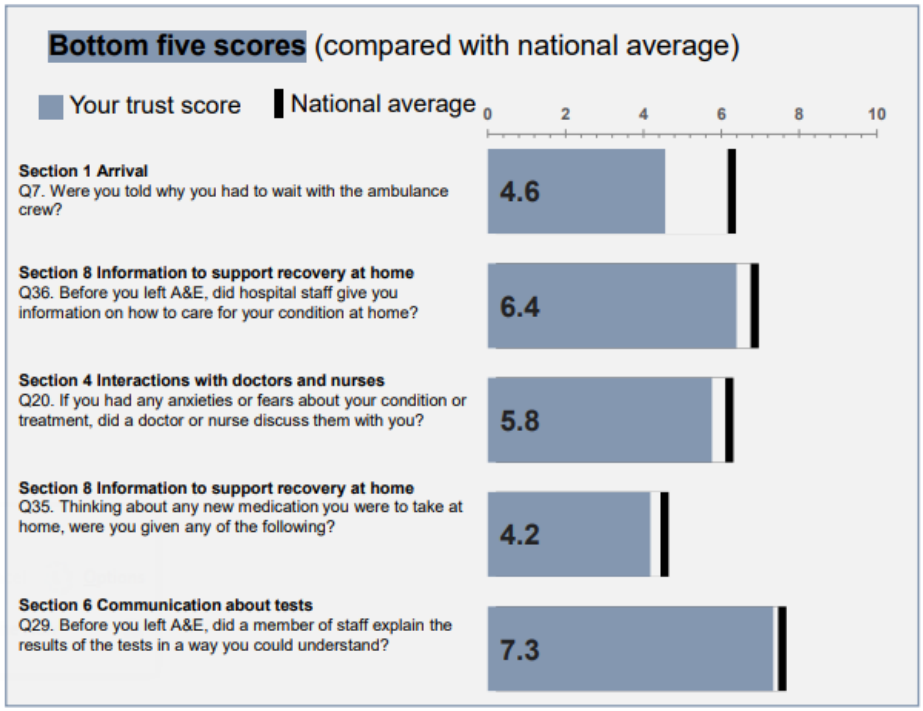
This was published in November 2024. The image below presents the top five scores from an Urgent and Emergency Care (A&E) survey, comparing the Trust's performance with the national average.

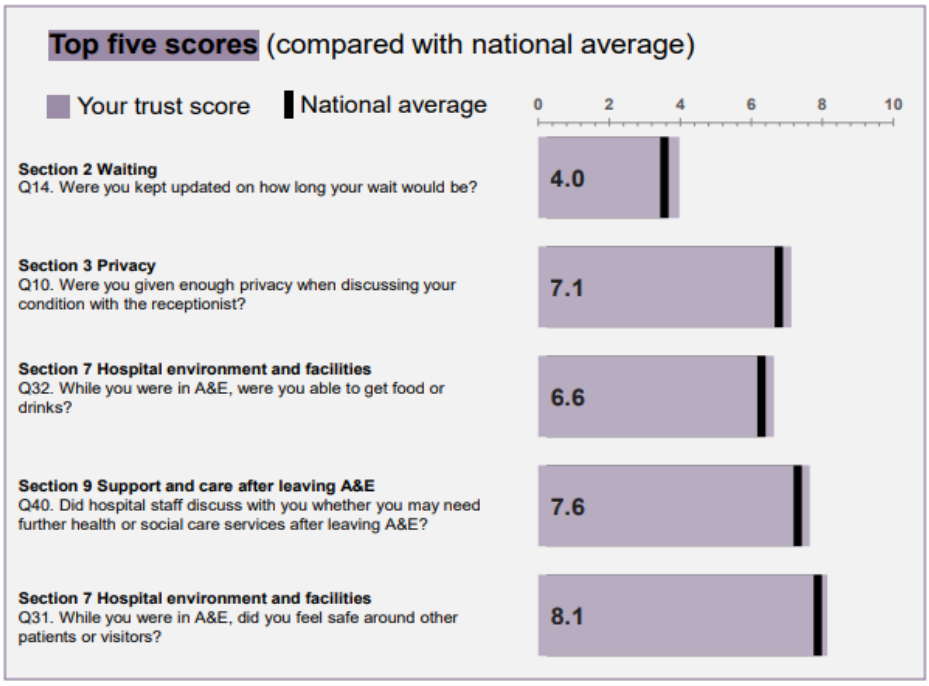
The key findings are:

- Waiting Updates – Score: 4.0
    - Patients reported low satisfaction with being kept informed about waiting times
- Privacy at Reception – Score: 7.1
    - Patients felt they had sufficient privacy when discussing their condition
- Access to Food and Drinks – Score: 6.6
    - Patients had a moderate experience regarding the availability of food and drinks in A&E
- Support After Leaving A&E – Score: 7.6
    - Patients felt staff adequately discussed follow-up care and support needs
- Feeling Safe in A&E – Score: 8.1

- Patients largely felt safe around others in the A&E department

Overall, the Ttust performed well in privacy, safety, and post-care support but showed room for improvement in communication about waiting times and access to food and drinks.





The image above presents the bottom five scores from an Urgent and Emergency Care (A&E) survey, comparing the Trust's performance with the national average. The key areas needing improvement are:

- Explanation of Ambulance Wait Times – Score: 4.6
    - Patients were not adequately informed about why they had to wait with the

ambulance crew
- Information to Support Recovery at Home – Score: 6.4
    - Patients felt they did not receive enough guidance on how to care for their condition after leaving A&E
- Doctor/Nurse Communication About Fears/Anxieties – Score: 5.8
    - Some patients felt their anxieties or fears about treatment were not adequately discussed by staff
- Information on New Medication – Score: 4.2
    - Patients did not receive sufficient information about their new medication before leaving A&E
- Explanation of Test Results – Score: 7.3
    - Patients felt staff could improve in explaining test results in an understandable way

Overall, the trust needs to improve communication, particularly around ambulance wait times, post-discharge care, medication information, and addressing patient concerns. In terms of national benchmarking, the Trust performed about the same overall when compared with all other Trusts.

Maternity Survey 2023

The survey results were published in December 2024 - preliminary results were analysed and shared with the Maternity Division ahead of this in September and an action planning workshop was held. There were 98 Walsall patients who responded to the survey, a response rate of 33% against 41% nationally.

Where experience is best:

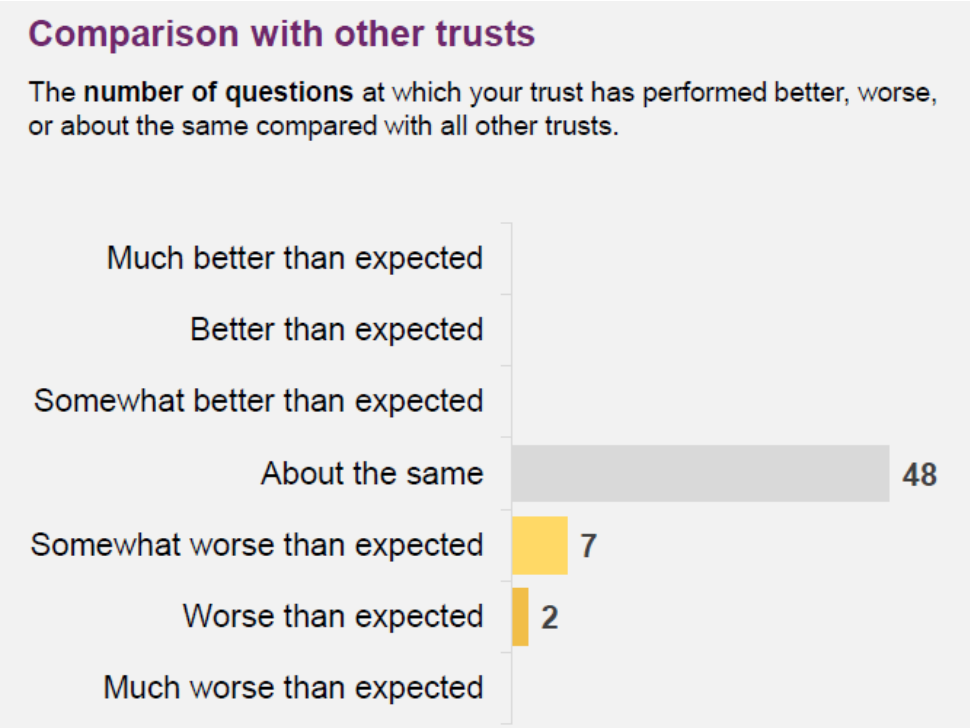
- Postnatal Care: Care in the ward after birth: Delays to discharge on the day of leaving hospital
- Feeding your baby: Decisions about how to feed their baby respected
- Antenatal care: Start of your pregnancy: Information from Midwife or Doctor to help service users decide where to have their baby
- Care after birth: Receiving help and advice from a Midwife about baby's health and progress in the four weeks after birth
- Postnatal Care: Care in the ward after birth: Being able to get help from staff when needed

Where experience could improve:

- Postnatal Care: Care in the ward after birth: Partner or someone else close to service user was able to stay as much as the service user wanted
- Care after birth: Frequency of seeing or speaking to a Midwife
- Labour and Birth: The staff caring for you: Left alone by Midwives or Doctors at a time when it worried them
- Care after birth: Midwife/Midwifery Team being aware of service user and baby's medical history
- Care after birth: Being told who to contact if advice needed about potential changes to mental health after birth

An engagement event was held to disseminate the CQC survey findings. There was

representation of 20 members from the Maternity and Neonatal Voices Partnership (MNVP), ward and intrapartum areas who all participated in the co-production of an action plan, meeting CNST requirements.



National Cancer Survey 2022

The Cancer Patient Experience Survey (CPES) 2023 results were presented in August 2024.

Key Findings:

Areas to celebrate: Some responses were above the expected range.

Above Expected Range

Question Number	Scored Question Text	No. of responses	Case Mix Adjusted Trust Score	Expected Range Lower	Expected Range Upper	2022 Case Mix Adjusted	2021 Case Mix Adjusted	2 Year Change	3 Year Change
Q12	Patient was told they could have a family member, carer or friend with them when told diagnosis	224	91.1%	75.5%	86.3%	84.0%	81.4%	7.1%	9.7%
Q14	Cancer diagnosis explained in a way the patient could completely understand	235	83.2%	71.3%	82.1%	76.5%	78.2%	6.7%	5.0%
Q29	Patient was offered information about how to get financial help or benefits	170	81.0%	61.9%	78.2%	76.3%	85.9%	4.7%	-4.9%
Q53	After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	54	48.3%	19.8%	44.8%	25.8%	34.8%	22.5%	13.5%

Areas for Improvement: Some scores fell below the expected range, while others were within the expected range but showed a decline over two or three years.

Question Number	Scored Question Text	No. of responses	Case Mix Adjusted Trust Score	Expected Range Lower	Expected Range Upper	2022 Case Mix Adjusted	2021 Case Mix Adjusted	2 Year Change	3 Year Change
Q43	Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	230	64.6%	69.9%	87.1%	62.9%	60.0%	1.7%	4.6%
Q38	Patient received easily understandable information about what they should or should not do after leaving hospital	90	81.6%	81.6%	94.9%	81.6%	87.2%	0.0%	-5.6%
Q31	Patient had confidence and trust in all of the team looking after them during their stay in hospital	92	65.1%	68.7%	85.9%	62.4%	77.4%	2.7%	-12.3%

In the expected range
2-year change

Question Number	Scored Question Text	No. of responses	Case Mix Adjusted Trust Score	Expected Range Lower	Expected Range Upper	2022 Case Mix Adjusted	2021 Case Mix Adjusted	2 Year Change	3 Year Change
Q08	Diagnostic test results were explained in a way the patient could completely understand	206	76.6%	72.8%	84.1%	84.7%	74.60%	-8.1%	2.0%
Q41_5	Beforehand patient completely had enough understandable information about immunotherapy	31	81.5%	70.8%	96.7%	90.8%	81.90%	-9.3%	-0.4%

Positive trends: Some questions remained in the expected range but showed significant improvement.

Core Quality Indicators - Friends and Family Test

The Friends and Family Test (FFT) is a mandatory patient feedback tool in the NHS in England. It was introduced in 2013 to help providers understand patients' experiences and drive improvement. Here's a summary of the mandated requirements as of the most recent NHS England guidance (April 2020 onwards)

The FFT must be offered in all NHS-funded services, including:

- Acute inpatient and day-case services
- Accident and Emergency (A&E)
- Maternity (antenatal, birth, postnatal)
- Community services
- GP practices
- Outpatients
- Mental Health services

The FFT recommendation scores are illustrated in the tables below, these include percentage changes on 2023/24. The Trust's average recommendation score for 2024/25 was 91% which is a 2% increase on the previous year, and a 5% increase on 2022/23. When looking at the different touchpoints, there is a fluctuation of 21% with scores, ranging between 78% and 99%.

Friends and Family Test	Inpatients				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2024/25	88%	89%	88%	89%	92%	92%	92%	93%	81%	85%	78%	81%	99%	99%	99%	99%
Difference	-1%	1%	-1%	1%	-1%	0%	1%	1%	-3%	5%	-1%	2%	0%	0%	0%	0%
2023/24	89%	88%	89%	88%	93%	92%	91%	92%	84%	80%	79%	79%	99%	99%	99%	99%
Response Rate	25.6%	23.6%	22.5%	21.6%	17.9%	18.0%	15.1%	15.2%	14.8%	14.6%	13.2%	13.8%	38.0%	43.0%	56.0%	55.5%

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*
2024/25	85%	89%	93%	95%	98%	89%	90%	89%	89%	88%	90%	94%	92%	94%	91%	90%
Difference	-5%	2%	6%	8%	26%	1%	3%	-5%	7%	6%	-2%	-1%	-1%	4%	-7%	-3%
2023/24	90%	87%	87%	87%	72%	88%	87%	94%	82%	82%	92%	95%	93%	90%	98%	93%
Response Rate	88.0%	13.4%	21.3%	23.9%	74.0%	26.4%	18.8%	24.3%	82.5%	45.8%	42.3%	39.5%	27.4%	17.1%	24.0%	37.4%

* Q4 data subject to change in line with March 2025 data submissions for FFT being after reporting date

The below table illustrates the percentage difference between the Trust's average recommendation score for each touchpoint, and the local ICB and national results. All areas, apart from inpatients, outperformed on average locally with Community and ED also outperforming the national average.

Regional and National Comparison	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
National	-6%	-2%	3%	5%	-1%	-1%	-2%	-1%
Black Country ICB	-1%	2%	9%	5%	3%	2%	5%	4%

The ICB and national data at time of reporting was taken over a 10-month period (April 2024 – January 2025).

On review, the FFT results have improved on previous years, highlighting a more consistent score across all touchpoints, and performing better when compared locally

Core Quality Indicators - Supporting our staff

The 2024 NHS Staff Survey benchmark report for Walsall Healthcare NHS Trust contains the results of the 2024 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 nine indicators:

- 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
- Engagement
- Morale

Within the 2024 Staff Survey the Trust achieved its highest response rate of 54% which was above the sector national average score of 49%. The results reflected an improvement across six of the nine indicators, with the Trust achieving a score equal to or higher than the sector national average in five indicators.

The areas highlighted as requiring improvement relate to improving experience at work by focusing on embedding a culture of inclusion and belonging. The Trust's focus on developing a compassionate culture through compassionate leaders and encouraging colleagues to speak up has been reflected by improved results in these areas. This was supported by the intromeduction of the Joint Behaviour Framework in April 2023 and the Civility and Respect Program which, since January 2024, has seen more than 1,300 colleagues attend the training.

Our Joint People Enabling Strategy, introduced in April 2024 sets our four ambitions for Walsall to become a great place to work by:

- Leading by putting our people first
- Ensuring equality, diversity and inclusion in all that we do
- Being a safe and healthy place to work
- Recruiting and retaining the workforce of today and for the future

Our 2024 Staff Survey results show that more of our staff are positively advocating for the Trust as a place to work and a place to be treated than in previous years. Whilst more of our staff believe that the organisation respects individual differences, cultures and working styles, through our Joint People Enabling Strategy we will enhance accountability of leaders and take a transformative approach to developing the sense of belonging and inclusion for all colleagues across the Trust.

In doing so we will amplify the voice of colleagues through our staff networks and ensure active participation in decision making. We will continue to encourage and support colleagues to feel safe to speak up. Our feedback from the 2024 Staff Survey measured through the 'we each have a voice that counts' indicator reflects more colleagues being aware of how to speak up and being confident to do so. We will continue to learn from events and incidents and share feedback with staff to support ongoing improvement.

Ways in which staff can speak up

Walsall Healthcare NHS Trust continues to strengthen and increase awareness to colleagues across the Trust of the Freedom to Speak Up service.

There is a total of three Freedom to Speak Up (FtSU) Guardians consisting of one lead guardian/clinician and two other FtSU Guardians, who are supported by 15 Champions. Members of staff can contact a Guardian to arrange a face to face or virtual meeting, 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 being signposted by a FtSU champion.

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

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.

Between 1 April 2024 and 31 March 2025, the FtSU team has received 362 concerns, this highlights employee's increasing confidence to use the FtSU service to discuss issues that

may be affecting them at work. Of the concerns raised, 12% related to patient safety and quality and 48% to inappropriate attitudes and behaviours.

Over the last year, the FtSU team has delivered a proactive engagement and training programme including:

- drop-in sessions targeting areas with generally high and low reporting
- general drop-ins at a neutral location for all staff
- attendances at Student Nurse and Midwifery forums, which during 2024/25 extended to AHP and Junior Doctor forums
- Continuation of engagement with internally educated colleagues
- Staff inductions targeting all professional groups
- Continued engagement with colleagues to complete the Speak up, Listen Up and Follow Up e-learning based training, which has seen increased levels of compliance throughout 2024/25.
- Hosting a leadership event with headline guests including Dr Jayne Chidgey-Clark, the national guardian for speaking up, and Roger Kline, training leaders on the importance of speaking up and discussing barriers that staff from protected characteristics can often face and how to encourage supporting staff groups to raise concerns

Moreover, Walsall has been recognised for its achievement of having the organisation in the top 10 organisations for improving the FtSU agenda nationally.

The Guardian attends various committees within the organisation to triangulate data and report twice yearly to the Group People Committee (a subcommittee of Trust board) and directly to 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. Ninety seven exception reports were submitted in 2024/25. 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 2024/25

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	2022/2023	2023/2024	2024/2025	24/25 Target
18 Weeks RTT - Incomplete Pathways	68.72% (Mar 21)	63.10% (Mar 22)	56.36% (Mar 23)	61.16% (Mar 24)	69.54% (Mar 25)	92%
Total Time Spent in ED - % within 4 Hours - Overall (Type 1 and 3)	85.07%	82.56%	73.40%	74.87%	76.03%	78%
Cancer - 28 Day Combined Standard	n/a	n/a	n/a	80.10%	83.62%	77%
Cancer - 31 Day Combined Standard	n/a	n/a	n/a	97.10%	97.87%	96%
Cancer - 62 Day Combined Standard	n/a	n/a	n/a	76.30%	78.77%	70%
% of Service Users waiting less than 6 weeks from Referral for a Diagnostic Test					91.44% (Mar 25)	95%
Mixed Sex Accommodation Breaches	2	0	0	10	0	0

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 while 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.

Performance against other National and Local Quality Requirement

Metric	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	24/25 Target
Number of C Difficile Cases	32	30	50	92	69	87
Number of MRSA Cases	2	3	1	2	3	0
VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	91.56%	92.63%	90.64%	88.93%	87.47%	95%

Ambulance Handover - % of clinical handovers completed within 15 minutes of recorded time of arrival at ED	64.34%	55.49%	47.34%	45.70%	32.98%	65%
Ambulance Handover - % of clinical handovers completed within 30 minutes of recorded time of arrival at ED	95.94%	94.84%	89.35%	90.22%	80.95%	95%
Ambulance Handover - % of clinical handovers completed within 60 minutes of recorded time of arrival at ED	94.81%	99.35%	98.05%	97.76%	91.63%	100%
Total Time Spent in ED - % within 12 Hours - Overall (Type 1 and 3)	1.43%	2.18%	6.37%	5.81%	5.59%	<2%
Referral to Treatment - No one waiting longer than 65 weeks	42 (Mar 21)	346 (Mar 22)	314 (Mar 23)	2* (Mar 24)	1* (Mar 25)	0
Referral to Treatment - No one waiting longer than 78 weeks	0 (Mar 21)	105 (Mar 22)	1 (Mar 23)	0 (Mar 24)	0 (Mar 25)	0
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)	85.07%	84.28%	90%
Proportion of Service User 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)	72.73%	79.16%	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)	70.87%	70%

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

From April 2024 the national contract changed for the diagnostics metrics:

Percentage of service users waiting less than six weeks from Referral for a Diagnostic Test

* 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 90.04% across all training grades, matching 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 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 2024/25 Quality Account, we shared this document with the following:

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

In 2025/26 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 qualityof 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 2024/25

BCICB welcomes the opportunity to review and provide the following statement for Walsall Healthcare NHS Trust Quality Account – 2024/25. WHT Quality Account is accurate and in line with the information presented to the ICB via contractual/quality monitoring meetings.

The ICB recognises that 2024/25 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 its individual and collective engagement with the commissioners.

The ICB is 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 2024/2025:

Patient Safety

- PSIRF Transition - Successfully implemented the Patient Safety Incident Response Framework (PSIRF), with over 57% Level 1 and 45.8% Level 2 training completion
- Urgent and Emergency Care - Expanded Same Day Emergency Care and Virtual Wards improved Urgent Community Response performance; reduced ED breaches >12 hours
- Embedding additional capacity to manage the demand from the changes in patient flow as a result of the Midland Metropolitan University Hospital opening
- Ambulance Handover - Consistently maintained handovers within 30 minutes since 2020.
- Quality Improvement - Installed 27 QI huddle boards across clinical areas (surpassing target of 15). Falls prevention initiatives such as multi-disciplinary approaches, including risk assessments and tailored care plans, leading to a measurable drop in patient falls

Clinical Effectiveness

- Staffing Innovations - Developed Specialist Grade posts for long-standing locum consultants and introduced development pathways for specialty Doctors progressing to CESR
- Cancer Care - Increased early-stage cancer diagnoses from 26% to 32%, maintained

62-day cancer treatment performance and 28-day Faster Diagnosis Standard (75%)
- Elective Care - Maintained zero 65-week waits for most of the year and reduced elective backlog by 7%
- GIRFT and Model Health System - Delivered a 700-patient reduction in 52-week waiters and aligned transformation with national clinical guidance

Patient Experience

- Involvement and Feedback - Strengthened Patient Involvement Partners (PIPs) and real-time experience dashboards for proactive feedback. Improved inclusion, particularly through PIPs' engagement in Equality Delivery System work and local events
- Complaint Management - Enhanced responsiveness and learning from complaints via triage and review panels
- Cultural Improvements - Adopted the "Caring for All" behavioural framework with The Royal Wolverhampton NHS Trust, recorded highest-ever National Staff Survey completion rate (54%) with improvements in six of nine People Promise areas and launched inclusive development programmes

Whilst we recognise these achievements, based on the contents of the Trust's Quality Account 2024/25, sustainable improvements can be identified across several domains.

Patient Safety

- Patient Safety Incident Response Framework (PSIRF) fully embedded with training across all staff
- Continue to work with partners from across the system to support the flow of patients through UEC and maintain the use of SDEC services to avoid unnecessary hospital stays
- Expansion of Urgent Community Response (UCR) and Virtual Wards, reducing pressure on inpatient services
- The continued roll out and consistent application to huddle boards across the organisation

Patient Experience

- Staff Survey: Identify improvements in the three domains that the Trust did not improve and identify links between specific actions e.g. behavioural framework and improvements in survey scores to impact change. Work towards increasing response rate further and act on feedback accordingly

Workforce and Development

- Bank and Agency Staffing – Continue to reduce dependency by focusing on recruitment and retention initiatives, improved workforce planning, encouraging internal bank usage over external agency use and implementing robust monitoring systems
- Continue with development pathways like Specialist Grade conversion for Locum Consultants and the Specialist Grade Development programme for Specialty Doctors to support retention and long-term workforce stability
- Continue with initiatives to attract and retain staff with the right skills and knowledge to achieve the Trust's vision

Outpatient and Elective Care

- Continued focus on reducing long waiting lists, particularly for patients waiting over 52 and 65 weeks
- Planned implementation of Patient Initiated Follow-Up (PIFU) to empower patients and reduce unnecessary appointments
- Expansion of virtual consultations to increase flexibility and efficiency

The ICB confirms that the Annual Quality Account information accurately reflects the Trust's performance for 2024/25. 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 2024/25 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

Healthwatch Walsall response to Walsall Healthcare NHS Trust Quality Account 2024/25

Healthwatch Walsall welcomes the opportunity to provide comment on the Trust's Annual Quality Account for the year 2024/25.

The last CQC inspection was in March 2024 and the subsequent report was published in October 2024. The Trust is currently rated as Requiring Improvement overall.

The Trust has consistently held a collaborative approach to working with Healthwatch Walsall, enabling our organisation to gather experiences of the healthcare it provides.

Our recommendations based around patient feedback have always been received positively and implemented wherever possible.

Indeed, it is good to see that the Trust is to consider the recommendations for the current year 2025/26 as highlighted in Healthwatch England's January 2025 report, '**A Pain to Complain.'** It found that very few patients complain, having a low confidence level of anything changing if indeed they did. The findings emphasise the value of listening to independent feedback.

We note the Trust's ongoing commitment to the **four Cs** strategic aims, namely, **excelling in the delivery of care, supporting colleagues, effective collaboration** and **improving the health of the community.**

Concerning the latter, we recognise the work undertaken over the previous year around the Community First programme which enables patients to manage their health conditions within the confines of their own home through initiatives such as Virtual Wards. Healthwatch Walsall would be keen to work with the Trust in gathering feedback designed to ascertain patient experience within this aspect of service provision.

The work being undertaken to manage patient flow is to be commended. This is manifest in the Outpatients and Elective Care work. The increase in Outpatient clinic utilisation, combined with the capital expenditure around Theatre upgrades, should potentially alleviate pressure on overall waiting times for patients. However, the Trust recorded that it missed its target of 85% Theatre utilisation for 2024/25.

Undoubtedly, hospital waiting times consistently feature as a negative response when Healthwatch Walsall are engaging with the public within the borough.

Hopefully, the ongoing work surrounding community may also, at some point, help to ease the pressures faced in Urgent and Emergency Care.

We note the 8.5% increase in type 1 Emergency Department attendances during the past year. This is significant; at the same time the Trust is seeking to reduce the proportion of patients who actually wait more than 12 hours from arrival. This is a demanding situation to manage effectively.

Healthwatch Walsall last carried out a piece of work relating to UTC in 2023/24 and one of the key issues raised by patients was communication, around both waiting times and onward pathways when using this service.

When considering the Trust's performance against both its annual priorities for improvement and the National Operational Standards, there are a number of points to raise.

The achieved 76.06% figure against the **interim** target of 78% for total time spent in ED within 4 hours, only goes to underline the pressures experienced in this area and as referred to earlier. This is despite the improvement initiatives the Trust has put in place within UTC in respect of the priority of patient safety.

The ongoing transition to embedding the Patient Safety Incident Response Framework is noted.

Undoubtedly, staff involvement in this initiative is important and we applaud the Portering Team's contributions towards improving Radiology turnaround times. This demonstrates that direct input taken by colleagues can often have a positive impact on patient experience.

Recruitment and retention of the workforce feature highly within clinical effectiveness and potentially encompass the wider resources of the Black Country ICS.

It would be good to better understand the Trust's plans regarding 'targeted interventions for different career stages', in seeking to develop the requisite multidisciplinary teams and how this may be achieved given the existing financial constraints.

Having the right skills and competencies, in the right place is undoubtedly a challenge, and balancing resources can be difficult.

The project carried out last year by Healthwatch Walsall on Urology Services highlighted some of the issues in achieving such a balance, whilst at the same time providing good patient experience.

Nevertheless, it is good to see several initiatives being undertaken, for example the Speciality Doctor Programme and the transfer of Locum Consultants to permanent Specialist posts is something we should be promoting in and around the borough.

Looking at specialities, the Trust has made progress in Cancer Services. The Trust met and improved over the previous year against the 70% target for 62 days referral to treatment, achieving 78.33%.

At the same time, we note its declared intention to reduce further, the number of patients who do wait more than 62 days by faster diagnosis.

It has also maintained performance against the national 28-day faster diagnosis standard of 75%, (other than for two outlier months), and has increased those patients diagnosed at stage 1 and 2 from 26% to 32%.

We recognise the hard work the Trust is putting into Patient Experience. The Quality Account documents several pathways for involving and engaging with patients designed to improve care provision. This is an aspect of work that Healthwatch Walsall could potentially support the Trust with, by facilitating focused public engagement around differing services.

The Friends and Family Test shows a favourable score at 91% average, with most departments, other than ED, scoring high, (ED averaging circa 80% by comparison).

Within the core quality indicators there is a transparency to learning from deaths and Martha's Rule is observed, requiring a rapid review from a critical care team in the event of deteriorating care.

Finally, we fully extend our thanks and gratitude to all the staff and colleagues at the Trust who work hard to deliver frontline services through sometimes difficult and challenging circumstances.

To this extent, we endorse this Quality Account for 2024/25.

Aileen Farrer

Manager, Healthwatch Walsall

Statement of Director Responsibilities in respect of the Quality Account 2024/25

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

- the content of the Quality Account meets the requirements set out in the annual reporting manual and supporting guidance Detailed requirements for Quality Accounts.
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2024 to March 2025
    - Papers relating to quality reported to the Board over the period April 2024 to March 2025
    - Feedback from local Black Country Integrated Care Board dated June 2025
    - The 2024 National Staff Survey
- the Quality Account presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Account 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 Account.

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

Signature

Sir David Nicholson, CBE, Chair

27 June 2025

Signature

Joe Chadwick-Bell, Group Chief Executive Officer

27 June 2025

Statement of Limited Assurance from the Independent Auditors

NHS England has 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: wht.patientexperienceteam@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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Kurdish

ئەگەر ئەم بەڵگەنامەیە بە شێوازێکی دیکە دەخوازیت بۆ نموونە چاپی گەورەتر، زمانێکی دیکە هتد. تکایە یەکێك لە کارمەندانی سەرپەرشتی تەندروستی ئاگادار بکەرەوە.