Walsall Healthcare
NHS Trust

Quality Account
2025/26

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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, and considers the views of patients, their families and carers, our staff and the public. The Trust also 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 quality improvement priorities, or Trust's future quality improvement priorities, please contact:

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Part 1: Statement of Quality from the Chief Executive Officer

Welcome to our annual Quality Account for 2025/26, which sets out our progress – working in collaboration with our partners - to deliver high-quality care to patients who access our services, both in our hospital and in the community.

The past 12 months have once again presented challenges for the NHS as we all focus our efforts on the national priorities which include reducing the time people wait for elective care and improving A&E waiting times and ambulance response times.

Demand for acute services has continued to rise against a backdrop of unprecedented periods of industrial action while we try to meet the growing needs of our ageing population and address health inequalities. And managing our finite resources is an ongoing challenge.

All our patients deserve the highest standard of care, and this Quality Account shares areas of best practice, as well as areas where we need to make further improvements to ensure they receive this.

We monitor our safety, clinical effectiveness, and patient experience through a range of methods including audits, patient surveys and sub-committees that report to Board as well as regular reviews with the Black Country Integrated Care Board. Regulators and peer reviews externally assess our healthcare services.

Whilst appreciating there is always more to do, we're encouraged by the progress the Trust has made in access and flow:

- RTT performance ranked 1st in the Midlands throughout 2025/26, with 52 week waits delivered and waiting lists at their lowest in over four years
- Cancer pathways improved, including recovery of 62 day performance
- Achieved 86.69% against the 4 hour standard, ranking 6th nationally and 2nd in the Midlands — our best performance in over four years
- Ambulance offload times averaged 18 minutes, demonstrating strong patient flow and timely access

Our community services include five virtual wards providing care for patients who would otherwise be in hospital and patient and family feedback has been largely positive. We are working to maximise the opportunities these create in linking community and acute hospital services together to ensure patients move quickly through the system.

We continue to collaborate with patients, their families and carers and our stakeholders to co-design our services and ensure the patient voice is at the heart of all we do.

Around his time last year, we were all anticipating the content of the government's 10 Year Health Plan. It was released last summer and, as we expected, it focuses on three key shifts in healthcare:

- Hospital to community
- Analogue to digital
- Sickness to prevention

This direction aligns with our own vision for Walsall Healthcare and were drivers for us as we developed a refreshed joint strategy with The Royal Wolverhampton NHS Trust earlier this year.

We know the challenges that healthcare services face when meeting the varied – and often complex - needs of the people they serve are not going to suddenly reduce. Add into this the necessity of managing our finances efficiently and using our resources in the most effective way possible and it's clear the NHS cannot continue to operate in the way it traditionally has done for so many years.

We're proud that Transforming Care Together, our refreshed strategy, encourages a strengthening of community services, development of neighbourhood teams, expansion of elective capacity, modernised outpatient care, and improved access to diagnostics, ensuring patients receive timely, co-ordinated and convenient care.

Our pledge is that by 2031, patients will experience faster access to care in their communities, staff will work in a digitally enabled and supportive environment, our organisations are fit for the future, and patients will benefit from improved ways of communicating with our clinical teams.

The strategy is bold and brave, and it takes account of the fast-moving advancements being made through digital technology that will undoubtedly help us to innovate to become fit for the future.

In 2025, I had only recently joined the organisation. Now, after more than 12 months spent with committed, passionate teams who are striving to make a difference to all communities, I want to say how proud I am of what we have achieved so far. Thank you. I know we will go on to make an even greater impact while continuing to create supportive environments that prioritise our patients' needs whilst nurturing those who care for them.

Signed:

Joe Chadwick-Bell

Chief Executive Officer Walsall Healthcare NHS Trust

Vision and Values

As our previous joint Walsall Healthcare and The Royal Wolverhampton NHS Trusts' strategy was coming to an end, we have taken the opportunity to co-design a new five-year strategy.

This aligns with the NHS 10 Year Health Plan priorities:

- Analogue to digital
- Illness to prevention
- Acute to community

It also takes advantage of the opportunities of our integrated Group model and recognises the national challenges around productivity.

Our new strategy for 2026/31 is Transforming Care Together.

Our vision remains: To deliver exceptional care together to improve the health and wellbeing of our communities. And the four Cs from our previous strategy – Care, Colleagues, Collaboration and Communities – are still the strategic aims that guide us.

Walsall Healthcare's Values of Professionalism, Teamwork, Compassion and Respect, as chosen by staff, also remain.

At the heart of Transforming Care Together is our "wheel" which details our ten objectives.

We want every colleague to understand how their role contributes to our collective success, making us proud to be part of this organisation. To help, we have set three key priorities for this year:

- We want our colleagues to feel cared about
- We want to improve safety by reducing the time patients wait
- We want to deliver our services efficiently

By 2031, we will have transformed into digitally-enabled, community-focused organisations that deliver exceptional quality of care closer to home, where clinically appropriate. We will operate within our means and empower our staff to innovate and excel.

We will have transformed our services, so care is delivered in communities, hospitals focus on emergency and complex care, and digital innovation empowers both patients and staff to achieve better outcomes.

We will work effectively with primary care and our partners across integrated neighbourhood health teams to provide co-ordinated, person-centred care that keeps people healthy and independent in their communities.

Part 2: Looking back 2025/26 - Priorities for Improvement

Priority 1 – Patient Safety

What we said:

Prevention of avoidable hospital deconditioning.

Key actions we will take:

- 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 (Eat, Drink, Dress, Move to Improve) status into Clinical Accreditation reports to influence local Quality Improvement

The aim for 2026/27

- 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

What we did:

- Delivery was monitored through the Safer Mobility Group, Tissue Viability Group, Mouth Care Group, Nutrition Steering Group and Infection Prevention and Control Group
- Ward-based training on falls prevention and management was restarted to support safer mobility and reduce deconditioning
- Quality in Care workshops were launched, bringing together Falls Prevention, Patient Assessment, EDDMI and the Quality Framework
- A multidisciplinary inpatient EDDMI workstream was developed and launched in Elderly Care/MLTC, focusing on safe bedside mobility, getting up and moving, Bathroom First, safer footwear and enhanced supervision
- Practical ward-based changes were introduced to promote mobility, dignity and independence, including Bathroom First, safer footwear initiatives and the cessation of routine slipper sock use
- EDDMI conferences and follow-up workshops were used to support teams to develop local quality improvement ideas and share good practice
- The nutrition and hydration element was strengthened through MUST improvement work, revised fluid balance documentation and related training
- The mouth care element was progressed through oral health workstreams, SOP development and associated safety actions
- EDDMI themes were linked into Clinical Accreditation and wider quality improvement processes to support local improvement activity

What we said:

Mental Health

Key actions we will take:

- 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
- Develop a policy that supports all age mental health patient journey, to support all clinical areas in accessing mental health support when required
- Ensure both Trusts have a mental health risk assessment to support the requirements for patient safety and enhanced observations when required

The aim for 2026/27

- 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 receive excellent quality of care and treatment

What we did:

- MEED unable to progress due to limited dietetic support
- raining packages available on MyAcademy, including use of ligature cutters. IKON training rolled out
- Policies available for all age groups which support best practice and current evidence
- RCEM risk assessment ratified and in place in emergency department

What we said:

Safeguarding

Key actions we will take:

- Robust oversight of patient feedback, safeguarding referrals, quality concerns raised via external routes, incidents and excellence to drive continuous improvements

The aim for 2026/27

- To ensure 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 detailed within the revised Black Country Integrated Care Board Safeguarding Assurance Framework for Commissioned Services

What we did:

- The Trust has continued to discharge its statutory duties and responsibilities in line with the above
- The Safeguarding Team has developed improved pathways to support oversight, collection and analysis of data and responses to safeguarding concerns and referrals, including those raised externally or internally via incidents.
- These are governed via established structures and overseen by the Executive Lead for Safeguarding in addition to ICB colleagues who provide external scrutiny of safeguarding processes and responses in place to safeguard children and vulnerable adults who access Walsall's services
- The governance processes also ensure progression and escalation to the Senior Executive Team when barriers are met
- There is ongoing review of processes and adaptation to focus and drive improvement both targeted within specific divisions and Trust wide
- Implementation of standardised monthly communications across internal forums and divisions with a focus on key topics such as Section 42 enquiries, Domestic Abuse, How to make a good quality safeguarding referrals, How to contact the Safeguarding Team for advice and support, Learning from Safeguarding Adult Reviews, Child Safeguarding Practice Reviews and Domestic Abuse-Related Death Reviews to improve staff knowledge and response to safeguarding concerns
- There has been a focus on strengthening relationships with our partners in Walsall Council as well as internally to support more collaborative working to achieve improved outcomes for our patients and families
- More robust processes have been implemented to support the inclusion of an expert safeguarding lens where concerns are raised regarding staff working in a position of trust to inform proportionate responses to maintain the safety of patients, staff and visitors
- There has been an increase in engagement and attendance at a variety of internal forums to drive the safeguarding agenda, incorporating the focus for the key actions outlined for this priority area
- The Think Family Approach has been a thematic communication to improve a holistic safeguarding response to support practitioners to think beyond the presenting adult or child
- There has been an increase in the offer of safeguarding supervision across the Trust to support improved safeguarding responses
- Level 3 Safeguarding Adult Training has been reviewed and refreshed to reflect revisions to pathways, processes and legislation
- The Safeguarding Team has developed a new Trust Intranet page to enable staff to easily access the resources they require 24/7 to support them in effectively discharging their safeguarding responsibilities
- Making safeguarding personal has continued to be promoted via advice and support, supervision and training to ensure that patients' wishes and feelings are at the centre of decision making
- There are mechanisms in place to capture the voice of the child across the Trust, and this is a key area promoted by the Safeguarding Team through supervision, communications and training

- There is a robust audit cycle in place to drive safeguarding improvements. These encompass both internal and multi-agency audits across varying aspects of the wider safeguarding agenda
- There is a process in place to ensure timely review of safeguarding-related policies
- Identified actions in the Section 11 and Care Act Compliance self-assessment audit covering the period 2023/25 have been completed and implemented
- A refreshed compliance audit was completed in September 2025 and an associated action plan is in place to support progression of the identified requirements

What we said:

Safe Discharge

Key actions we will take:

- 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

The aim for 2026/27

- Ensure 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)

What we did:

- Established a discharge steering group
- Established key working groups for EDS, and discharge processes
- Introduced a new discharge checklist to support staff to ensure all elements of the discharge process are complete

What we said:

Infection prevention

Key actions we will take:

- Actions from IPC Delivery Plan
- Note to incorporate IP should have QI as a strong component regards CDIFF and Gram negs, particularly device related

The aim for 2026/27

- Recognising the challenges posed by the COVID-19 pandemic and the learning realised, our aim will be to fully deliver on all key priorities as outlined within the joint Infection Prevention and Control (IPC) Delivery Plan (2023)

What we did:

- Embedded a reduction in glove use as part of business as usual practice alongside a targeted awareness campaign. A reduction has been noted in the 2025/26 financial year, with final data pending confirmation
- Worked collaboratively with the Quality Team to support the implementation of EDDMI initiatives, providing specialist IPC input and preventative strategies
- IPC staff completed essential or full Quality Improvement training, with learning embedded into practice and aligned to the annual work plan
- Maintained and regularly updated local policies in line with the latest evidence base and the National Infection Prevention and Control Manual
- Continued delivery of both mandatory and ad hoc surveillance to identify emerging trends and themes, supporting organisational learning and improvement

- Actively engaged internal and external stakeholders to support initiatives aimed at reducing Gram negative bloodstream infections, CAUTI, HAP, and improvements for long stay patients
- Achieved improvement in Clostridioides difficile rates through an ongoing multifactorial improvement programme, which was presented and shortlisted for the Nursing Times Awards
- Led the full implementation of PSIRF across Trust governance processes, with assurance reports presented to Divisional Incident Review Meetings and the IPC Committee, reporting to the DIPC
- Supported the Trust's green and sustainability agenda through specialist IPC expertise and advice
- All statutory IPC duties have been maintained. This summary is not exhaustive; full details of activity and deliverables are outlined within the IPC Annual Work Plan

What we said:

Full implementation of Saving Babies Lives to prevent avoidable harm

Key actions we will take:

- 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

The aim for 2026/27

- 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

What we did:

- Saving babies Lives Care Bundle Ver 3 (SBLCB ver 3) received LMNS ICB signoff on 18 February 2026 and is 99% compliant
- Safety Action 6 SBLCB ver 3 within the Maternity Incentive Scheme Year 7 was fully compliant with all applicable criteria stated
- The service has embedded the care bundle principles into clinical practice, education and training. This can be evidenced via the Quarterly Saving Babies Lives Ver 3 Care Bundle reports where progress with each element is detailed. Obstetric and Midwifery staff also complete the electronic learning around the care bundle this currently sits at 95.16%. SBLCB ver 3 is also on the agenda for all PROMPT training days
- Now that SBLCB ver 3 implementation has been successful, the Consultant Midwife is working with the Trust deteriorating patient group to support continued compliance. The service is utilising RCOG "Teach or Treat", "Team of the Shift" and "Advise, Inform & Do" to support identification and action for deterioration in maternity patients. The service has also signed up to the "Avoiding Brain Injury in Childbirth (ABC)" programme with Midwives on a training programme to deliver this

What we said:

Improvements in deteriorating patient workstreams using the PIER (Prevention, Identification, Escalation and Response) approach

Key actions we will take:

- Implementation of workstreams to Prevent, Identify, Escalate and Respond to patient deterioration across a variety of settings, including in the wider community

The aim for 2026/27

- 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

What we did:

- Established Deteriorating Patient Group oversight to co-ordinate deteriorating patient workstreams and assurance
- Developed and implemented a deteriorating patient dashboard to improve visibility of deterioration metrics
- Strengthened identification of deterioration through routine monitoring of observations on time, including divisional and community reporting
- Progressed the NEWS2 Scale 2 workstream to improve consistency of use, documentation, governance and digital support
- Updated deteriorating patient SOPs and policy arrangements to reflect revised working practices
- Advanced a more standardised approach to oxygen, suction and bedspace safety checks
- Implemented the Wellness Round/Patient Wellness Document as part of Martha's Rule to support early recognition and escalation of deterioration
- Supported rollout through training, communication, ward champions and defined assurance processes
- Worked with community and system partners on PIER-linked frailty and falls prevention activity to reduce deterioration across settings

What we said:

VTE compliance

Key actions we will take:

- 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

The aim for 2026/27

- Continuous improvement towards achieving the national operational standard of 95% set by the NHS Standard Contract

What we did:

- New VTE Chair was in place since June 2024
- Trial of mandated VTE risk assessments through use of EPMA – further build of the VTE Assessment module within EPMA is needed to meet the requirements
- Continual monitoring and sharing of monthly compliance is being done at the Thrombosis Group monthly meeting
- Continuous improvement towards achieving the national operational standard of 95% set by the NHS Standard Contract – improvement was achieved at Arrivals Lounge (Elective Surgery cases where VTE assessment compliance improved from an average of 78% (Q4 2024 to 95% Q1 2025/26 onwards)

Priority 2 – Clinical Effectiveness

What we said:

Reduce the time people wait for elective care

Key actions we will take:

- Improve 18 weeks RTT to 65% nationally by March 2026
- Improve 18 weeks RTT for a first appointment to 72% nationally by March 2026
- 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

The aim for 2026/27

- 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

What we did:

- Improved RTT performance to 73.2% by March 2026
- Improved wait to first appointment to within 18 weeks to 81%
- Achieved < 1% of total PTL waiting over 52 weeks
- Achieved 87.2% for 28 day FDS by end of March 2026
- Achieved 80.6% 62 day standard by end of March 2026

What we said:

Improve A&E waiting times and ambulance response times

Key actions we will take:

- 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

The aim for 2026/27

- Improve A&E waiting times, minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours by March 2026
- A higher proportion within 12 hours DTA across 2025/26 compared to 2024/25

What we did:

- Increased utilisation of SDEC by reviewing criteria and estates needs
- Virtual Ward promotion and education remains ongoing including design of our Virtual Ward pathways to increase utilisation to allow more people to be managed safely in the comfort of their own homes
- Length of stay once people are clinically optimised and ready to leave our hospital is improving with our partners engagement in particular out of borough partners
- ED and UEC performance improved significantly towards the end of financial year with Walsall being placed 2nd in the region for improved performance for both 4 hour decision making and reduction of patients waiting more than 12 hours for inpatient care

What we said:

Outpatient Transformation

Key actions we will take:

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

The aim for 2026/27

- Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients

What we did:

- Walsall led the roll-out of tele dermatology across the ICB, following a successful pilot. GPs use digital images that are transferred to clinicians to triage, diagnose, monitor and assess skin conditions. This has enabled patients to receive expert dermatological advice and treatment without the need for a hospital visit. Almost 49% of referrals are now dealt with remotely. This has freed up vital capacity for patients who do need to be seen in the hospital
- We have piloted the use of Ambient Voice Technology (AVT) in Outpatients with great success. We improved the turnaround time of patient and GP correspondence by 99.8% from an average of 9.3 days to just 18 minutes, with the GP receiving the correspondence in real time. This is now being rolled out across all Outpatient specialties
- The majority of our Outpatient services are now on the patient portal, this is a patient's personal online health account and a digital tool that links into the NHS app. Patients can see their appointments in one place and, in the future, will be able to see their letters, test results and be able to rearrange appointments, without the need to phone the hospital. This should reduce the number of patients who currently miss their appointments
- We continue to work with primary care colleagues in developing pathways that streamline care for patients, with a focus on what services we can deliver closer to a patient's home

Priority 3 – Patient Experience

What we said:

Priority Area – Strengthening Organisational Response to National Mandated Surveys

Key actions we will take:

- 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

The aim for 2026/27

- To 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 these and trends

What we did:

- Established a systematic survey insight process, ensuring that all national patient experience survey results (Inpatient, Maternity, CYP, UEC, and NCPES) were shared and reviewed at appropriate divisional and Trust-wide meetings within four weeks of publication
- Introduced a new "Corporate Survey Tracker", enabling leaders to upload actions against specific trends over time, benchmark against national averages, and identify areas of improvement more rapidly
- Delivered staff engagement sessions and learning workshops to ensure teams understood survey results, patient comments, and how insight links to day-to-day practice
- Demonstrated some measurable impact, including early improvements in communication scores, enhanced discharge information processes, and updated patient-friendly materials co-designed with service users

What we said:

Priority Area – Embedding the PHSO Complaint Standards and Learning from Excellence

Key actions we will take:

- Percentage of complaints resolved within the PHSO (Parliamentary Health Service Ombudsman) 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

The aim for 2026/27

- To 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
- Introduce improved performance indicators for complaint handling including the number of reopened complaints, and the number of complaints referred to the Parliamentary Health Service Ombudsman (PHSO)
- 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

What we did:

- PHSO standards fully embedded in policy which was amended to reflect and ratified in 2025. Policy contains, for the first time, a comprehensive toolkit as a standalone document which further supports the standards by guidance and templates contained within
- Performance indicators exist but in light of new 'Group' policy are being reviewed for consistency against Group Trust and new PHSO standards. New performance indicators effective from April 2026
- Recommendations considered and featured alongside the new policy and implementation of PHSO standards. Complaint process accessible in variety of ways, email, telephone, face to face and via advocacy service
- Monthly monitoring performance undertaken based on metrics and published Trust wide in the implementation of dashboards which were implemented in 2025

Other highlighted points

- Implemented the 'Ask, Listen, Do' approach to hearing and responding to concerns - designed to support organisations to listen, learn from and improve the experiences of children and adults who are autistic or have a learning disability, their families and carers and make it easier for people, families and paid carers to give feedback, raise concerns and complain
- Launched real-time Patient Voice Dashboards combining all modes of feedback in one place allowing for easier staff access to the data and themes arising
- Both Walsall Healthcare and The Royal Wolverhampton NHS Trusts (RWT) – redesigned dashboards for monthly real time overview of complaints compliancy. This included an introduction of an Executive-led dashboard with weekly data of activity at operational level
- Introduced new risk matrix for determining complex complaints.. Reviewed final complaint sign off process for more operational approval (specifically at RWT at present) based on risk matrix and methodology. This enables more efficiency in complaint handling timescales providing a greater degree of patient satisfaction
- At RWT – reviewed complaints management for Non-section 42 complaints and implemented a more proactive approach in collaboration with Local Authority and Quality Matters teams

What we said:

Priority Area – Embedding the PHSO Complaint Standards and Learning from Excellence.

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- Launched real-time Patient Voice Dashboards combining all modes of feedback in one place allowing for easier staff access to the data and themes arising
- Both Walsall Healthcare and The Royal Wolverhampton NHS Trusts (RWT) – redesigned dashboards for monthly real time overview of complaints compliancy. This included an introduction of an Executive-led dashboard with weekly data of activity at operational level
- Introduced new risk matrix for determining complex complaints.. Reviewed final complaint sign off process for more operational approval (specifically at RWT at present) based on risk matrix and methodology. This enables more efficiency in complaint handling timescales providing a greater degree of patient satisfaction
- At RWT – reviewed complaints management for Non-section 42 complaints and implemented a more proactive approach in collaboration with Local Authority and Quality Matters teams

What we said:

Priority Area – Integrating volunteering to enhance patient experience

Key actions we will take

- Increase 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

The aim for 2026/27

- 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

What we did:

- Held recruitment events to increase the volunteer workforce, recruiting new volunteers across both acute and community settings, with a focus on supporting patient navigation, wayfinding, and companionship roles
- Launched a refreshed training and induction programme, including dementia awareness, communication skills, safeguarding, and cultural competency to ensure volunteers were confident and well-prepared
- Integrated volunteers into patient flow initiatives, such as supporting discharge lounges, reception areas, outpatient check-in points, and community children's clinics
- Improved volunteer visibility through branded clothing, clearer role descriptions, and the introduction of volunteer hubs in high-footfall areas
- Captured patient feedback on volunteer impact, with consistently positive comments about kindness, reassurance, and reduced anxiety for patients and families
- Strengthened partnerships with VCSE organisations, particularly around joint roles, pathway support, and the emerging 50/50 Volunteer Programme across the Walsall–Wolverhampton footprint
- Introduced volunteer recognition and development pathways, increasing retention and promoting volunteers into more skilled patient-facing roles
- Demonstrated improvements in staff experience, with clinical teams reporting reduced pressure in non-clinical tasks due to enhanced volunteer support
- Commissioned HACT to conduct an independent social value evaluation, providing an external assessment of the impact created by the volunteering programme across Walsall and Wolverhampton. HACT's report identified £2.4 million in measurable social value, demonstrating the significant contribution volunteers make to patient experience, staff wellbeing, community connection, and organisational resilience

Formal complaints, Informal complaints (PALS concerns), queries and compliments

During 2025/26 a total of 3749 contacts were received by the Patient Relations Team which included 719 written complaints. Of these written complaints, 199 were downgraded to an informal concern. Ten informal to formal complaints and five MP letters were received (an increase of 217 contacts overall for the year compared to 2024/25) and an average of 14.7 contacts per working day (including compliments). Although there has been a decrease in activity, this has been impacted by a significant decrease in compliments.

The Patient Relations Team continues to adopt a proactive early intervention approach working with complainants to achieve local resolution on concerns. These cases are resolved negating the need to escalate to operational teams, whether this be for formal or informal complaints.

The average response rate with an agreed timeframe during 2025/26 was 67%. This is a 15% decrease in comparison to 2024/25 (82%). The increase in volume and amended Quality Assurance process are noted as contributory factors to this decline.

There is little variation between the key themes of complaints year on year. Clinical care and assessment is the dominant theme, followed by appointments and attitude.

During 2025/26, there were 535 complaints which required a written response, which is an increase of 51.5% in comparison to the previous financial year (353).

Complaint outcomes

During 2025/26, from 380 cases which were closed, the Trust determined 20% of cases were not upheld, (an increase of 2%), 74% were partially upheld (a decrease of 2%), and 6% were upheld (an increase of 1%). One complaint was withdrawn within this period.

As with the previous year, the Trust's performance measured for complaint outcomes for cases upheld was significantly lower than the national average of 25% (as recorded by NHS Digital [1] for 2024/25).

Parliamentary and Health Service Ombudsman

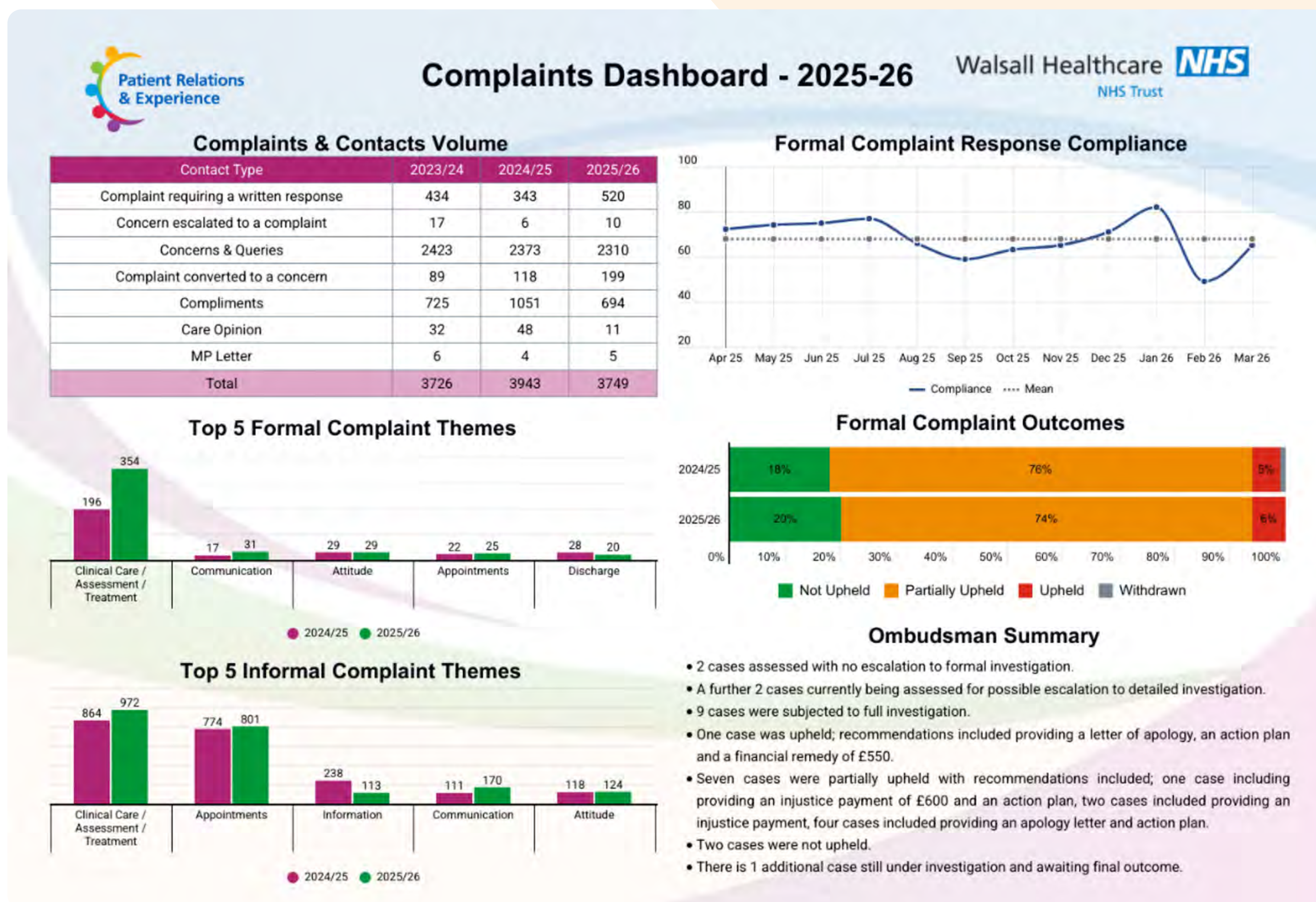
For this financial year a summary of PHSO activity is as follows:

- Two cases assessed with no escalation to formal investigation
- A further two cases currently being assessed for possible escalation to detailed investigation
- Nine cases were subjected to full investigation
    - One case was upheld; recommendations included providing a letter of apology, an action plan and a financial remedy of £550
    - Seven cases were partially upheld with recommendations included
    - One case included providing an injustice payment of £600 and an action plan
    - Two cases included providing an injustice payment
    - Four cases included providing an apology letter and action plan
    - Two cases were not upheld
    - There is one additional case still under investigation and awaiting final outcome

The cases closed during the period may not necessarily correlate with the cases received due to the receipt date or completion dates falling outside of the respective reporting periods.

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



Complaints & Contacts Volume

Contact Type	2023/24	2024/25	2025/26
Complaint requiring a written response	434	343	520
Concern escalated to a complaint	17	6	10
Concerns & Queries	2423	2373	2310
Complaint converted to a concern	89	118	199
Compliments	725	1051	694
Care Opinion	32	48	11
MP Letter	6	4	5
Total	3726	3943	3749

Key achievements for complaint management

We have produced an updated joint Group Complaint Handling Policy to ensure standardisation and consistency across both Walsall Healthcare and The Royal Wolverhampton NHS Trusts.

We have updated our literature to ensure our complaints and PALS process is accessible.

In addition, we have:

- Launched several E-learning packages across both organisations, including formal complaint investigation and language services modules
- Developed an updated formal complaint investigation toolkit for complaint handlers
- Promoted early contact as a standard approach within the formal complaints process thus providing the opportunity for early resolution and resulting in the downgrading of formal complaints
- Implemented a real time weekly dashboard in addition to the monthly dashboards for directorates to support a more proactive approach to patient feedback
- Increased the use of virtual interpreting services Trust wide, including launching video interpreting throughout the Outpatients Department. This allows equal access to services and ensures patients have better understanding of care delivery and clinical interaction
- Promoted early contact within the formal complaints process, which has resulted in a 68.6% increase in the number of downgraded complaints
- Increased the use of virtual interpreting services Trust wide, including launching video interpreting throughout the Outpatients Department

Looking Forward 2026/27 - 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, the Executive Teams within the divisions and Directorate Management teams. The final priorities for 2026/27 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 our mistakes if things 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 2026/27
Reducing avoidable harm through quality improvement	• Strengthen initiatives associated with the Eat, Drink, Dress, Move to improve implementation across all care pathways • Deliver an updated Clinical Accreditation programme to span across different care pathways • Monitor implementation of patient safety initiatives through a suite of deteriorating patient metrics • Triangulate audit and Clinical Accreditation data in combination with Nursing Sensitive Indicators and operational metrics to identify areas for improvement in process • Revise clinical documentation to optimise holistic assessments • Implement targeted interventions to prevent healthcare-associated infections in accordance with our Infection Prevention Annual Programme • Improve Maternity safety and outcomes through implementation of national Saving Babies' Lives initiatives and local improvement actions	• To reduce avoidable harm across care settings and services through the systematic implementation of evidence-based quality improvement initiatives, measurable reductions in harm indicators, and strengthened clinical governance processes • Enhance quality assurance and continuous improvement through our quality improvement actions • To reduce unwarranted variation in clinical outcomes by improving performance against key outcome measures, including Summary Hospital-Level Mortality Indicator (SHMI), 14-day and 30-day readmission rates and timely follow-up after discharge • To improve patient flow and continuity of care by ensuring safe, timely discharge processes and effective follow-up, including reducing avoidable readmissions and improving responsiveness to urgent community and crisis care needs • To sustain reductions in healthcare-associated infections including Clostridioides difficile, MRSA and Gram-negative bacteraemias • Reducing delays in planned inductions, improving monitoring and response to fetal wellbeing, reducing perinatal harm and variation in outcomes

Patient Experience

Section	Key Actions we will take	Aim for 2026/27
We will deliver care that is consistently person-centred, responsive, and compassionate by embedding the patient and community voice across all services.	• Strengthen mechanisms to routinely capture, analyse, and act on patient, carer, and community feedback across all services • Ensure that learning from feedback, complaints, compliments, and surveys is systematically translated into service improvement • Implement actions in response to survey findings, with clear ownership and measurable improvement trajectories • Embed Patient Advice and Liaison Service (PALS) and complaints learning into divisional governance and quality improvement cycles, in line with PHSO standards • Further develop and expand the Trust volunteering programme to support patient experience priorities	• Improved performance in the CQC Inpatient Survey satisfaction measures • Reduction in the average number of days from discharge ready to actual discharge • Increased evidence of learning from patient feedback, complaints, and compliments translating into measurable service improvements • Enhanced patient involvement in care decisions and improved communication across all care settings

Clinical Effectiveness

Section	Key Actions we will take	Aim for 2026/27
We want to improve safety through reducing the time patients wait	• Deliver sustained improvements in referral-to-treatment (RTT) pathways to reduce waiting times and minimise delays to diagnosis and treatment • Improve access to diagnostics and cancer pathways to support earlier diagnosis and intervention • Use benchmarking data, national guidance, and best practice to identify variation and target improvement efforts in priority pathways • We will maintain regular reviews of staffing levels and skill mix aligned to service demand and patient acuity • Strengthen Same Day Emergency Care, admission avoidance, and system co-ordination to improve outcomes and experience • Expand the use of digital solutions to support pathway optimisation, real-time decision making, and improved access to care • Strengthen community-based models of care to reduce unnecessary hospital attendance and admission • Optimise inpatient pathways to reduce length of stay, particularly for older adults and those with complex needs	• Increased proportion of patients treated within 18 weeks (RTT) across acute and community pathways • Reduction in 52-week waits in both acute and community services • Improved performance against diagnostic waiting time standards (≤6 weeks) • Improved cancer pathway performance • Improved urgent and emergency care performance including reductions in long waits in the Emergency Department and Urgent Community Response performance • Reduction in average length of stay for older adult patients • Improved alignment between planned and actual performance across key access standards

Workforce

Section	Key Actions we will take	Aim for 2026/27
We want our colleagues to feel cared about	• Promote a culture where colleagues feel cared for, valued, and able to speak up safely. This will include continued access to Freedom to Speak Up services and embedding learning from concerns raised • Supporting staff health, wellbeing, and experience through a comprehensive health and wellbeing offer to support physical and psychological wellbeing. Maintained oversight of Professional Advocates and peer support networks across the organisation. We will identify and address variation in staff experience through targeted, data-driven interventions • Embed coaching leadership approaches to support compassionate, inclusive leadership at all levels. Support teams to develop local improvement plans reflecting their specific needs and challenges Strengthen appraisal processes to ensure meaningful conversations, clear objectives, and personalised development plans • Strengthen education, training, and competency frameworks to support safe and effective care. Enhance career development pathways, including leadership development, healthcare support worker (HCSW) progression, and preparation for advanced and new roles • Supporting Recruitment, Retention, and Workforce Sustainability • Reduce reliance on temporary staffing through improved workforce planning and retention strategies • Embed Quality Improvement skills and methodologies across the workforce to empower staff to lead and sustain improvements. Ensure staff are equipped to support new models of care, including virtual care, neighbourhood working, and integrated services	• Improvement in NHS Staff Survey engagement and experience scores • Improvement in raising concerns (speaking up) sub-score • Improvements in workforce metrics including sickness absence rates • Sustained improvements in National Education and Training Survey satisfaction • Increased staff seasonal vaccination uptake • Reduction in temporary staffing costs as a proportion of total pay bill • Reduced variation in staff experience across teams and staff groups

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 both Trusts.

Mandatory Statements of Assurance from the Board

Statements on the Performance of National Audits:

Review of Services

Participation in Clinical Audit

During 2025/26, there was a programme of national clinical audits and national confidential enquiries covering NHS services.

During that period Walsall Healthcare participated in 92% of the National Clinical Audits ans Confidential Enquiries Programme which it was eligible to participate in. The National Clinical Audits and National Confidential Enquiries that Walsall Healthcare was eligible to participate in during 2025/26 are below:

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
BAUS Data & Audit Programme	BAUS British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	N/A	N/A	Services managed at RWT
	BAUS Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	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 Spinal Registery	British Spinal Registry	Yes	Data submission in Progress	In progress
Intensive Care National Audit & Research Centre (ICNARC)	Case Mix Programme (CMP)	Yes	100%	In progress
Emergency Medicine QIPs:	Adolescent Mental Health	Yes	Data submission in progress	In progress
	Care of Older People	Yes	91%	Not yet reported
	Time Critical Medications	Yes	64%	Not yet reported
	Mental Health Self Harm	Yes	77%	Not yet reported
Epilepsy 12	National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%	Not yet reported

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
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 - Maternal Programme	Yes	Data submission in progress	In progress
	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Programme	Yes	Data submission in progress	In progress
Medical and Surgical Clinical Outcome Review Programme	Learning Disabilities	Yes	100%	Report not yet received
	Plural Procedures	Yes	Data submission in progress	Completed / Report received and discussed at Care Group
	Rib Fractures	Yes	Data submission in progress	Report not yet received
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	N / A	N / A	Not undertaken at WHT

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
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 Footcare Audit (NDFA)	Yes	Data submission in progress	In progress
	National Diabetes Inpatient Safety Audit (NDISA)	No	N/A	Care Group decision to not undertake anticipated to submit 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

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
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

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
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 (NCAP)	N / A	N / A	Not undertaken at WHT
National Comparative Audit of Blood Transfusion	National Comparative Audit of NICE Quality Standard QS138	Yes	N/A	Unable to submit due to vacancy
	National Comparative Audit of Bedside Transfusion Practice	Yes	N/A	Unable to submit due to vacancy
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

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
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	Data submission in progress	In progress
NNAP	National Neonatal Audit Programme	Yes	Data submission in progress	In progress
NOD	Age-related Macular Degeneration Audit	N / A	Not applicable	Informed by Service Provider - Department were awaiting EPR to be installed in order to submit data, however, unable to obtain funding to implement, Department Risk 5633
	Cataract Audit	N / A	Not applicable	Informed by Service Provider - Department were awaiting EPR to be installed in order to submit data, however, unable to obtain funding to implement, Department Risk 5633
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

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
National Pulmonary Hypertension Audit	National Pulmonary Hypertension Audit	N / A	N / A	Undertaken at designated pulmonary hypertension centres
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
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
Child Health Clinical Outcome Review Programme	Emergency non-Elective Procedures in Children and Young People	Yes	93%	Not yet reported
Child Health Clinical Outcome Review Programme	Stabilisation of the Critically Ill Child	Yes	Data submission in Progress	In progress

Programme Name	National Audit Title	Trust Participation (56 / 58)	% of the No of cases Submitted	Actions / Comments
UK Cystic Fibrosis Registry Adults / Children	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
Cleft Registry and Audit NEtwork (CRANE) Database	Cleft Registry and Audit NEtwork (CRANE) Database	N / A	N / A	Not undertaken at WHT
National Obesity Audit (NOA)	National Obesity Audit (NOA)	Yes	100%	Submitted for tier 4 services
UK Interstitial Lung Disease (ILD) Registry	UK Interstitial Lung Disease (ILD) Registry	N / A	N / A	Not undertaken at WHT
UK Parkinson's Audit	UK Parkinson's Audit	Yes	100%	Not yet reported

Title	Action
2-year reviews audit Community Services	WHT worked with the Department of Health (DoH), to improve the 2-2.5-year uptake and has met the increase uptake figures provided by DOH since August 2025. WHT has changed record keeping processes to further support the patient records. The Trust feeds into the DOH regularly and has received a letter of commendation on improved processes. WHT has a planned programme of reviews supported on In-phase review processes and to assess compliance to standards.
Documentation Audit across Community Services	To support the audit process reviews are now conducted on In-phase and reported through the care groups / divisions.
Audit of PGDs at Goscote Hospice	Ward manager to work with the QI Nurse to develop improved processes to support compliance with PGD prescriptions and documentation. Reaudit will take place in 12 months to ensure that all the relevant standards have improved.
Validation Review of Business Continuity Management at WHT	Some elements were unable to be reviewed as they were in their infancy and will require a further review. Variable assurance was available for the BCPs assurance of Divisional sign off and oversight and would benefit from standardization, utilising the governance structures across WHT to support engagement, oversight and accountability. Overall, there was positive assurance in place for the templates and management of BCPs against the core standards.

Title	Action
Ordering Blood Tests on Medical Wards	The actions included the introduction of ward-level guidelines / protocols for blood test management and to educate junior doctors on diagnostic stewardship. To re-audit following interventions to assess impact and improvement
Audit of Acute Upper Gastrointestinal Bleeding (AUGIB) and the use of Blood	The actions included the introduction of ward-level guidelines / protocols for blood test management and to educate junior doctors on diagnostic stewardship. To re-audit following interventions to assess impact and improvement. The audit noted local guidelines needed to be updated for acute upper GI bleeds and awareness of the guidelines and care bundles to ED and Acute Medicine. To liaise with acute medical team to further develop and promote the use of bundle. To re-audit after the above interventions.
Audit and QIP on COPD admission bundle	To promote and educate the ED/AMU staff on use of bundle. To explore the option of bundle printouts to be available in ED/ AMU to help increase the awareness and use of the admissions bundle. To complete the 2nd cycle of audit to ascertain changes and improvements.
Antibiotic stewardship performance review on Ward 15 (diabetes / endocrine / renal)	Conduct regular refresher training on the Antibiotic Stewardship Programme as part of Resident Doctors' Induction. Re-audit antimicrobial prescribing after 3–4 months to reassess compliance with local guidelines and appropriate duration of therapy. Introduce and display Antibiotic Stewardship posters in all clinical areas for educational purposes. Provide regular reinforcement during board/ ward rounds, prompting nurses and resident doctors to challenge inappropriate or unnecessarily prolonged antibiotic prescriptions.
Revalidation of Multidisciplinary Team Meetings in Walsall Manor Hospital	Variable points were noted and fed into a QI initiative focusing on the following: 1. Workforce and Planning: • Implement the "HEE Star model" for systematic workforce redesign • Create SMART team and individual development plans 2. Organisational Culture: • Formal recognition of MDT outputs at board/Trust level • Created documented strategies supporting MDT practice 3. Safe Spaces and Shared Goals: • Quarterly reflective "safe-space" MDT workshops • Embed shared goal recording in minutes and QI dashboards 4. Infrastructure and Boundaries: • Explore hybrid co-location and virtual workspace platforms 5. Narrative an Impact: • Use structured 'patient stories' in board meetings, newsletters, and cross-system learning forums • Develop a strong MDT "narrative" to build cultural identity across the Trust

Title	Action
Optimizing Application of the D-Dimers and Wells score in the diagnosis of pulmonary embolism	Overall good compliance noted with areas for improvement around education and awareness including 1. Improving teaching session in SDEC / AMU 2. Posters in SDEC and AMU 3. Share relevant information in Doctors' group chat 4. Educate SDEC Nurses to remind Doctors to follow the pathway before requesting CTPA 5. Re-audit following a period of embedment
Audit on Lying and standing Blood pressure in patients admitted to AMU	The re-audit demonstrated improvements in compliance to the set standards from 20.8% in the first round to 90% in the final round. It was agreed to share the outcomes and findings with the Care Group.
An audit reviewing pre-operative fasting guidelines for patients undergoing anaesthesia.	Overall good compliance was noted, agreed to develop a SOP
A review of Genetic tests ordered over 3 years and how this has impacted treatments.	No action required
Venous thromboembolism prophylaxis in post bariatric surgery patients in Walsall Manor Hospital	• Excellent compliance to VTE prophylaxis in bariatric surgery at Walsall Manor Hospital • Post operative DVT/PE was 0%
Consenting Neck of Femur (NOF) Fractures for Surgery - A Clinical Audit at Walsall Manor Hospital	Results to be shared with all the team at the staff meeting with proposals for further improvement including: • Stickers that can be attached to the consent forms which include all the risks as mentioned in the BOA guidelines • Posters outlining the consent process and the standards that are required in all appropriate areas (Ward 10, Ward 12, ED)
Improving Gentamicin Prescribing on Surgical Wards	Improved compliance noted clear and measurable service improvement following interventions implemented after Cycle 1. Marked improvement in documentation quality and escalation practices for urgent epidural requests. The following procedural standards are now embedded in routine practice: • Clear escalation protocol agreed at the start of each shift, with documented timing of escalation • Avoidance of non-indicated routine blood testing in healthy parturient, and at aesthetic discretion if unsure • Early anaesthetic involvement for difficult cannulation. Mandatory documentation of request time, attendance time, commencement time, and reason for delay • Early escalation to get additional ODP from CEPOD to help with epidural

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Electronic Discharge Summaries in Trauma and Orthopaedics: An Audit Reviewing Completion Rates	Variable compliance was noted and the following action was put into place - deliver session to all Doctors to reinforce the importance of accurate and clear discharge letters (induction and departmental teaching). Re-audit in due course.
Audit on delays in labour receiving appropriate reviews	Overall good compliance was indicated, findings shared with teams for information, and forms part of ongoing training.
Clinical Audit of Continuous Positive Airway Pressure (CPAP) Therapy Compliance	No action required good compliance noted.
Review of Emergency Caesarean section audit	Overall good compliance was indicated, findings shared with teams for information. A Consultant Midwife email set up to refer women that are deemed high risk. The Tropophobia score has been tested by our digital lead this is now being explored by the Perinatal Mental Health Midwife / Consultant with regards to going live.
Follow ups mentioned on EDSs	Variable compliance noted. Actions were taken to improve our follow up documentation on CareFlow Connect and use of prompts under the Recommendations column for all admissions to Ward 21.
Re-Audit on Paediatric Sepsis management & Antibiotic administration within the 1st hour' at Manor Hospital	Overall good compliance noted but improvements were taken to disseminate e-Sepsis training to all clinical staff and complete a blood pressure recording audit. Undertake regular documentation audits.
A Review of the Management of Non-gonococcal Urethritis in the Walsall Integrated Sexual Health Service	Variable compliance was noted; actions were taken to improve and re-educate members of the team on: • Recommended vs alternative antibiotic regimens and the reasons why alternative regimen was prescribed • Creation of a mandatory partner notification field for all patients to ensure appropriate documentation is completed for each patient
Audit of adequacy of the large joints magnetic resonance imaging	This audit highlighted areas for improvement in large joint MRIs which is to be addressed though radiographer education sessions.

Statements on the Performance of National Audits:

Type 2 diabetes – spotlight audit 2023/24 (NPDA)

The Care Group reviewed the report and noted that from the five recommendations in the report Walsall Healthcare was fully compliant with said actions.

The report has been shared for wider learning with the Paediatric and community groups.

Hip Fracture care in 2024 (NHFD)

The report was reviewed and shared with the care group and division and Spotlight on Improvement session.

A comprehensive action plan was developed with several key actions undertaken to support improvement and improve compliance to the five national recommendations noted in the report.

- To establish an electronic data capture for femur fracture patients within ED and develop continuous monitoring for improvement
- Review the current fragility fracture patient flow, to develop support and improve flow
- Create audit tool as part of National NHFD work for Physios to use locally and conduct an audit to ascertain improvement
- Orthogeriatric business case developed to support compliance and follow up on the bone strengthening medication
- Agreement for protocol to enable provision of Zoledronate on surgical wards
- Ongoing review of femur fracture pathway and creation of non-ambulatory femur fracture pathway for completion

Maternity and perinatal care – State of the Nation 2023 (NMPA)

The report was reviewed and shared with the Care Group / Division.

The actions were aligned and merged with the standards for Maternity care – confidential enquiries 2021/23 (MBRRACE-UK) action plan, work has been in progress towards these, and it's anticipated this will be completed in the next financial year.

Inpatient falls – Stepping towards improvement (NAIF/FFFAP)

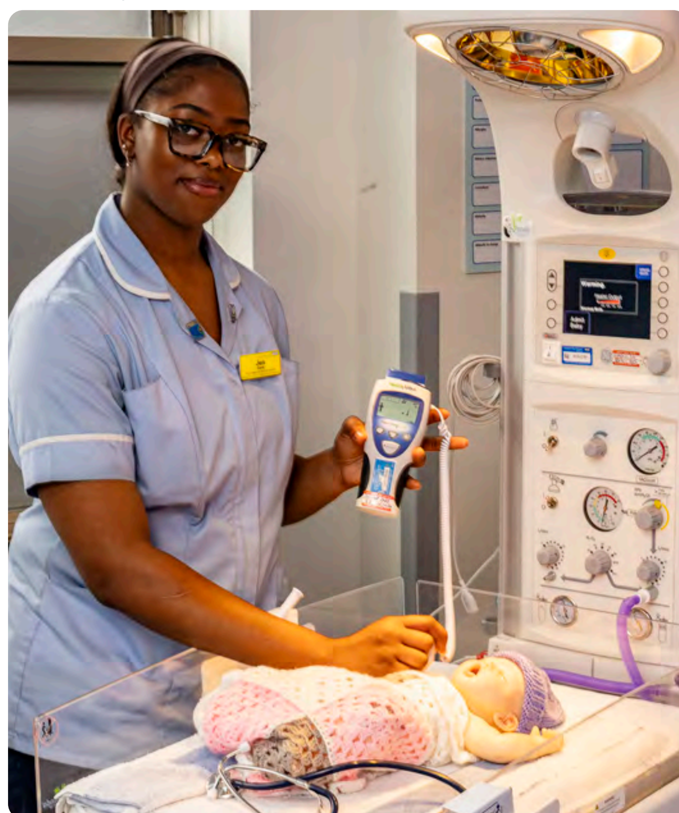
This report was shared corporately across Walsall Healthcare for oversight, awareness and improvement.

From the report, a comprehensive action plan has been developed by the Corporate Nursing Team to support compliance to the national recommendations of which there were five in total. The below actions are in progress:

- Review education and training resources available for staff for recording lying and standing BP within in electronic systems
- Ward Development Programme to support oversight of staff training compliance
- Develop mandated fields within System C that improve electronic data capture
- Recirculate Falls Prevention and Management Key Messages teaching aids to all wards and departments
- Initiate and undertake a QI Cycle to improve compliance
- Continue to promote registrant uptake of eLearning Falls Prevention and Management modules in My Academy

Lung cancer – 2023 patient cohort (NLCA/NATCAN)

Outcomes remain comparable to the previous reporting,. The Trust has been requested, by the West Midlands Cancer Alliance to review local data regarding data for stage 11B/1VB PS0-1 NSCLC 70> should receive SACT. Action in progress and an update is expected in due course when the Trust presents to cancer alliance group in the new financial year.



RCEM Time Critical Medications

Improved case ascertainment was established and work around a quality improvement initiative was initiated between the ED team and Pharmacy. As a result of this improvement work, multiple improvements were implemented and ongoing work continues to improve and drive changes. An example of the implemented changes saw an improvement of Time Critical Medications administered according to the patient's usual regime from 35% to 85%. Further work is in place to improve the standard for self-administration including the development of the self-administration policy to support Nursing staff.

Life-limiting conditions, and palliative and end-of-life care (NCMD)

A national recommendation highlighted the need for bereaved families to be allocated a key workier to support the bereavement process. At present Walsall does not have a key worker post, this has been highlighted to the Board and added to the risk register with a business case being developed to support this role in the future. The Trust was compliant with one of the national recommendations in ensuring awareness of children with life-limiting conditions with an electronic flagging system. A further recommendation sits outside of the Trust's control with the ICB to oversee and manage funding for this service development.

ICNARC Q2 & Q3

Managed through Critical Care Outreach group - Q3 indicators demonstrated full compliance to standards following actions taken in Q2 and this has been shared with the care group and division.

Ovarian Cancer Report 2025 (NOCA/NATCAN)

The report highlighted several positive improvements nationally for survival outcomes however, concerns were noted for emergency admissions and treatment being recorded within nine months of diagnosis.

WHT had further notifications of improvement needed to services for capacity for Pathology and turnaround times, low access to interventional radiology. The actions relating to this report are being undertaken at system level with the West Midlands Cancer Alliance gathering information, analysing issues, and formulating an action plan.

Local Clinical Audit

Walsall Healthcare registered 204 audit projects of which 74 remain in progress and 114 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
2-year reviews audit Community Services	WHT worked with the Department of Health (DoH), to improve the 2-2.5-year uptake and has met the increase uptake figures provided by DOH since August 2025. WHT has changed record keeping processes to further support the patient records. The Trust feeds into the DOH regularly and has received a letter of commendation on improved processes. WHT has a planned programme of reviews supported on In-phase review processes and to assess compliance to standards.
Documentation Audit across Community Services	To support the audit process reviews are now conducted on In-phase and reported through the care groups / divisions.
Audit of PGDs at Goscote Hospice	Ward manager to work with the QI Nurse to develop improved processes to support compliance with PGD prescriptions and documentation. Reaudit will take place in 12 months to ensure that all the relevant standards have improved.
Validation Review of Business Continuity Management at WHT	Some elements were unable to be reviewed as they were in their infancy and will require a further review. Variable assurance was available for the BCPs assurance of Divisional sign off and oversight and would benefit from standardization, utilising the governance structures across WHT to support engagement, oversight and accountability. Overall, there was positive assurance in place for the templates and management of BCPs against the core standards.
Ordering Blood Tests on Medical Wards	The actions included the introduction of ward-level guidelines / protocols for blood test management and to educate junior doctors on diagnostic stewardship. To re-audit following interventions to assess impact and improvement.
Audit of Acute Upper Gastrointestinal Bleeding (AUGIB) and the use of Blood	The actions included the introduction of ward-level guidelines / protocols for blood test management and to educate junior doctors on diagnostic stewardship. To re-audit following interventions to assess impact and improvement. The audit noted local guidelines needed to be updated for acute upper GI bleeds and awareness of the guidelines and care bundles to ED and Acute Medicine. To liaise with acute medical team to further develop and promote the use of bundle. To re-audit after the above interventions
Audit and QIP on COPD admission bundle	To promote and educate the ED/AMU staff on use of bundle. To explore the option of bundle printouts to be available in ED/ AMU to help increase the awareness and use of the admissions bundle. To complete the 2nd cycle of audit to ascertain changes and improvements.

Title	Action
Antibiotic stewardship performance review on Ward 15 (diabetes / endocrine / renal)	Conduct regular refresher training on the Antibiotic Stewardship Programme as part of Resident Doctors' Induction. Re-audit antimicrobial prescribing after 3–4 months to reassess compliance with local guidelines and appropriate duration of therapy. Introduce and display Antibiotic Stewardship posters in all clinical areas for educational purposes. Provide regular reinforcement during board/ward rounds, prompting nurses and resident doctors to challenge inappropriate or unnecessarily prolonged antibiotic prescriptions.
Revalidation of Multidisciplinary Team Meetings in Walsall Manor Hospital	Variable points were noted and fed into a QI initiative focusing on the following: 1. Workforce and Planning: • Implement the "HEE Star model" for systematic workforce redesign • Create SMART team and individual development plans 2. Organisational Culture: • Formal recognition of MDT outputs at board/Trust level • Created documented strategies supporting MDT practice 3. Safe Spaces and Shared Goals: • Quarterly reflective "safe-space" MDT workshops • Embed shared goal recording in minutes and QI dashboards 4. Infrastructure and Boundaries: • Explore hybrid co-location and virtual workspace platforms 5. Narrative an Impact: • Use structured 'patient stories' in board meetings, newsletters, and cross-system learning forums • Develop a strong MDT "narrative" to build cultural identity across the Trust
Optimizing Application of the D-Dimers and Wells score in the diagnosis of pulmonary embolism	Overall good compliance noted with areas for improvement around education and awareness including 1. Improving teaching session in SDEC / AMU 2. Posters in SDEC and AMU 3. Share relevant information in Doctors' group chat 4. Educate SDEC Nurses to remind Doctors to follow the pathway before requesting CTPA 5. Re-audit following a period of embedment.
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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 2025 to 31 March 2026 the Trust was issued with 12 Patient Safety Alerts (NPSA) from the Central Alerting System. Eight of these alerts have been completed in line with the stipulated completion periods, three were issued as information alerts, two were deemed not applicable to the organisation and two remain in progress at the time of reporting.

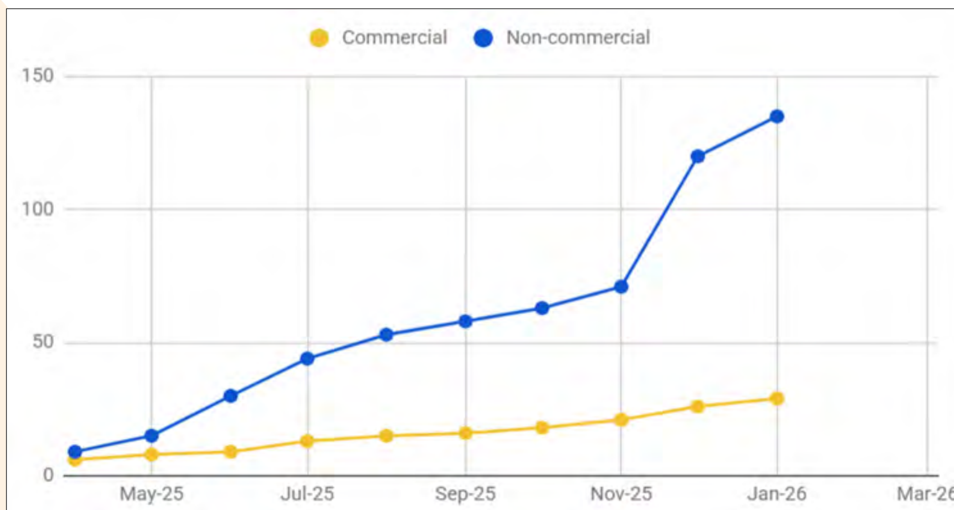
Participation in Clinical Research

Research activity at Walsall Healthcare continued to grow steadily throughout 2025/26, expanding opportunities for patients across Walsall and the wider Black Country to take part in high quality clinical research. This year marked a steady performance to date across commercial and non-commercial research opportunities, with research becoming increasingly visible, inclusive, and embedded within routine clinical care.

New guidelines implemented by the DoH to reduce time taken to set up and deliver clinical trials in the UK have been implemented. The timeline allocated for recruitment into trials set at 30 days currently shows Walsall achieving 100%. Set up studies for December was at 67% against the 60-day benchmark.

The Trust has continued to perform well in research activity when benchmarked against similar sized Trusts across the West Midlands (i.e. George Eliot).

Overall recruitment from April 2025 to January 2026 shows Walsall as recruiting 164 participants into research studies, of which 29 were into clinical trials and 135 Non-Commercial trials. This recruitment covers 12 specialties. This figure is a decrease from 2024/25 (343).



All studies undertaken during 2025/26 were approved by the Health Research Authority. Public engagement strengthened further through participation at Walsall Pride, a Research Participant Thank You event, and demographic analysis to ensure research reflects local communities. There is now an established dedicated research space to see research participants. Research Governance is now undertaken by the research project team at The Royal Wolverhampton NHS Trust.

Specialities involved in research

Research activity at WHT has continued to diversify across a broad range of clinical specialties. Areas of active research during 2025/26 included Dermatology, Cardiology, Oncology, Critical Care, Orthopaedics, Neonatal and Maternity Care, Emergency Care, ED, Paediatrics, Microbiology and Palliative Care. Dermatology is the standout specialty for increasing clinical trial activity.

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

Specialities opened
Dermatology
Cancer
Children
Trauma and Emergency Care
Cardiovascular
Critical Care
Infection
Anaesthesia, Perioperative Medicine and Pain Management
Diabetes, Metabolic and Endocrine
Musculoskeletal and Orthopaedics
Gastroenterology and Hepatology
Reproductive Health & Childbirth
Palliative Care

New and expanding areas included the introduction of palliative care research at Walsall with the first palliative care study opening early February 2026.

Workforce capacity has been challenging in 2025/26. The team has been creative in introducing non-traditional roles to support the delivery of research. As commercial research increases, however, traditional roles (Nursing) will be required to support the capacity of the team due to insufficient cover across the week.

Focus for 2025/26

The focus for 2025/26 is on sustaining growth and diversification of WHT's research portfolio. Priorities include continuing to expand commercial research, forging new relationships with pharmaceutical colleagues, enhancing capacity within emerging specialties, streamlining governance processes and cross-working with The Royal Wolverhampton NHS Trust Governance Team in the setup of studies.

They also include ensuring national timelines are met, safeguarding compliance with national governance timelines and strengthening representation of underserved communities. Supporting clinicians interested in leading their own research will remain a priority, alongside maintaining strong collaboration with RWT through the Group research model. We also need to ensure staff capacity matches the growth and development of research opportunities in Walsall, working in collaboration with the West Midlands RRDN (Regional Research Delivery Network) and CRDC (Commercial Research Delivery Centre).

CQUIN (Commissioning for Quality and Innovation Payment Framework)

The Commissioning for Quality and Innovation (CQUIN) financial incentive scheme was not included within the 2025/26 NHS Standard Contracts with our ICB and NHSE commissioners.

The full breath of Walsall Healthcare NHS Trust's income in 2025/26 is not conditional to achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

NHS No. Completeness

Walsall Healthcare NHS Trust submitted records during 2025/26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was: (update as at 23/02/26)

- 99.87% for admitted patient care
- 99.95% for outpatient care
- 99.69% for accident and emergency care

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

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

*as at 24/02/2026

Information on Registration with the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Walsall Healthcare NHS Trust during 2025/26.

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

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

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Clinical Coding Error Rate

Walsall Healthcare NHS Trust was not subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

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

It commissioned Solventum (formerly 3M) in November 2025 to undertake a Data Protection and Security Toolkit audit for coded data 2025/26. The audit sample of 200 episodes was drawn from coded activity in NHS Quarter 2 2025/26. Specialties audited include Pain, Obstetrics, Neonates and a random selection from the admissions to Ward 29. 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 2.6 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. This achievement reflects the consistently high quality of clinical coding within the organisation and is highly commendable.
- In this audit, Walsall Healthcare NHS Trust has once again achieved the attainment level of Advisory for 2025/26. This is the second consecutive year that the Trust's clinical coding team has achieved the higher level of accuracy and reflects the whole team commitment to data quality.
- The department has successfully implemented the action plan from previous audits, completing all measures within its scope of influence.
- All mandatory training is up to date. Coders have opportunities to attend relevant specialty workshops to enhance their skills. Senior coders provide mentoring and monitor the work of novice coders.
- The Clinical Coding Team Management deserves recognition for the significant progress achieved since the last audit. Many specialty areas have successfully transitioned to electronic source documents, substantially reducing the volume of paper records held within the department.
- Clinical documentation quality remains a significant challenge, with frequent gaps and incomplete details impacting coding accuracy. In some cases, coders must rely on outdated clinical letters, particularly within Pain Management, which increases the risk of inaccuracies. Additionally, occasional non-coder errors have been identified, primarily due to missing or unclear clinical information rather than coding practice

	Level of attainment Mandatory	Level of attainment Advisory	Trust percentage correct
Primary diagnosis	>= 90.0%	>= 95.0%	95.5%
Secondary diagnosis	>= 80.0%	>= 90.0%	98.5%
Primary procedure	>= 90.0%	>= 95.0%	97.5%
Secondary procedure	>= 80.0%	>= 90.0%	93.0%

Information Governance Toolkit attainment levels

Data Security Incidents

In 2025/26, the Trust managed all data security incidents in accordance with the National Data Guardian's Data Security Standards and NHS England's Data Security and Protection Toolkit (DSPT), ensuring appropriate investigation, learning and assurance.

Data Protection Legislation specifies that a personal data breach, that 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 one incident that met the criteria during this period:

Incident Date:	Nature of Incident:	No. Data Subjects Involved:	Description of Incident:	ICO Decision / Further Action:
May 2025	Temporary system configuration change resulted in staff absence reason information being visible to wider users	12	A system setting was inadvertently amended, briefly exposing absence reason data; the Trust acted swiftly to contain the issue, liaised with the supplier and restored correct permissions.	Reported within 72 hours. The ICO closed the case with advice, and no further action required recognising prompt Trust mitigation and improved controls.

Incidents classified at lower severity level

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

Summary of Other Data Security Related Incidents in 2025/26		
Category	**Breach Type**	**Total**
A	Confidential patient breach	37
B	Confidential information leak	39
C	Consent not gained	0
D	Post incorrectly sent/addressed	31
E	Record keeping – incomplete	17
F	Missing records	3
G	Records lost in transit	3
H	Records not provided	0
I	Reports (results) – missing/unfiled	0
J	Loss of data via electronic transmission	25
K	Incorrect delivery of electronic data	4
	Total	**159**

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

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

In June 2025, the Trust completed its annual Data Security and Protection Toolkit (DSPT) assessment and was rated 'Approaching Standards'. This was supported by our mandatory internal audit, and an agreed Improvement Plan established. The Trust remains on course to meet the required Standards by June 2026.

Data Security and Protection Toolkit Assessment 2025/26 (V8)

In 2025/26, the Trust has continued to strengthen its data security arrangements through the updated DSPT framework. This enhanced version of the DSPT now incorporates the National Cyber Security Centre's Cyber Assessment Framework (CAF), which provides a clearer and more modern way of assessing how well organisations protect their systems and data.

The DSPT remains the national tool all NHS organisations must use to show they handle patient information safely, responsibly, and in line with the National Data Guardian's Data Security Standards.

The Trust's 2025/26 assessment is currently being finalised and is expected to be published in June 2026.

Our commitment

Walsall Healthcare NHS Trust is committed to protecting patient information and ensuring strong standards of data security. Strategic oversight of data security is provided through the Trust's Information Governance Steering Group, comprising senior leaders including the Caldicott Guardian, Senior Information Risk Owner, Cyber Security Lead and Data Protection Officer. This group plays a pivotal role in ensuring that robust data security and information governance remain embedded within the Trust's strategic priorities and underpin the safe, high-quality care we deliver.

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. The Trust monitored these standards annually up to February 2024, when the last audit took place.

in April 2025, however, it was decided the Trust would no longer continue with these audits, for the following reasons:

As per the risk update, it was documented that:

- The risk score has been reduced to 9, from 12 initially
- The 7-day service is no longer on the Quality Committee’s meeting agenda
- The risk can be closed as the standards have been replaced with a new standard for care of acutely unwell patients in their first 72 hours in hospital. CMO/CNO/COO to discuss an implementation plan for the new standards with a completion of self-assessment and confirming the needs of a new organisational risk

No date has been provided for the reintroduction of national reporting.

National Core Set of Quality Indicators

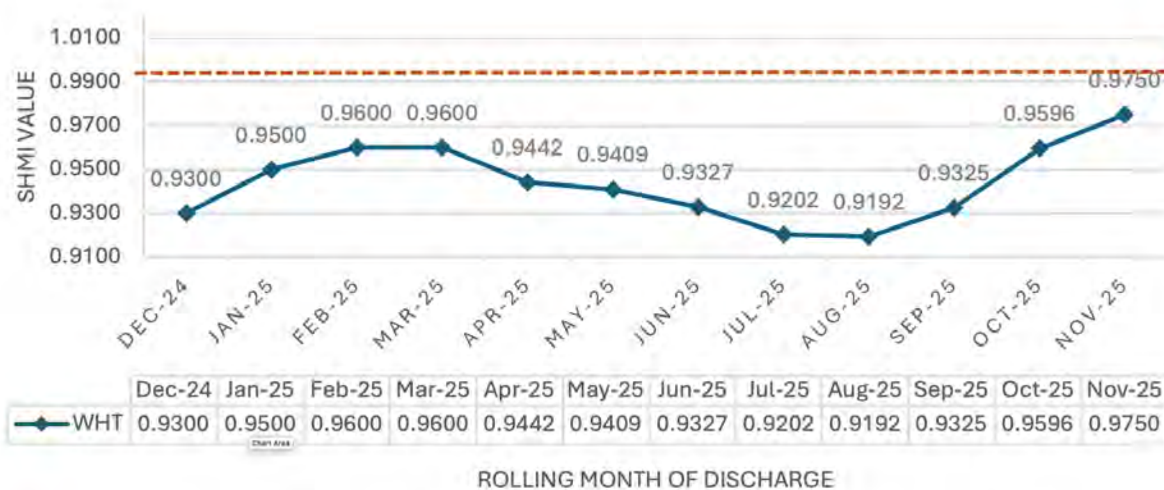
Core Quality Indicators - Summary Hospital Level Mortality Indicator (SHMI)

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

The published SHMI value for the 12-month rolling period (published by NHS Digital – please note data is 6 months behind when published) December 2024 to November 2025 is 0.9750 (0.98). 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 Learning from Deaths Group outlining issues identified and action plans as necessary. This is monitored monthly.

SHMI (excluding palliative)



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
WHT	0.9300	0.9500	0.9600	0.9600	0.9442	0.9409	0.9327	0.9202	0.9192	0.9325	0.9596	0.9750

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 Same Day Emergency Care 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 be in a position to implement this change in July 2024, however, as the ECDS (which is externally managed) was not be 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 January 2025 to March 2026:

Month	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Palliative Medicine Deaths	23	14	12	17	19	18	17	17	19	18	17	19	17	19	17
Total Hospital Deaths	141	105	110	115	111	101	117	101	118	128	114	118	108	95	118

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 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
SJRs	7	18	11	7	9	13	23	5	13	7	16	13	17	10	10
Total Hospital Deaths	141	105	110	115	111	101	117	101	118	128	114	118	108	95	118

SJR outcomes (total deaths reviewed categorised by outcomes)

	Q4 (2024/25)	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)	Total
Number of deaths	356	327	336	360	321	**1700**
Number of completed SRJs	29	24	28	19	12	**112**
Number of deaths thought to be more likely than not due to problems in the care provided	6	4	6	2	2	**20**

This data refers to the number of SJRs completed.

The total number of deaths in the Trust for the reporting period is 1,700.

Number of completed SJRs with scores of 1-3a is 20.

Percentage of avoidable deaths is 1.18%.

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 Trust is looking to introduce a Community SJR process that will feed into the Learning from Deaths meetings.

The table below sets out the number of GP referrals following implementation:

Month	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
GP Referrals	122	103	102	83	100	98	109	82	89	117	87	118	124	86	99

Core Quality Indicators – Learning from Deaths

Deaths at the Trust were recorded using the Clinical Outcomes Review System (CORS). This company went into liquidation, however, from 25 February 2025. The Trust now has its own Datix Mortality Module, which became live on 1 November 2025. This enables the Trust to look at trends such as specialty, causation and seasonal variations reasons for death

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 Learning from Deaths 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. In addition, we also have independent LeDeR death reviews, which are fed into Learning from Deaths meetings.

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 Learning from Deaths Group.

The Trust-based mortality data is also presented bi-monthly at the Black Country ICS Mortality Review Group, where performance is comparable with neighbouring Trusts and learning is shared at a system level.

At Trust level, a six monthly report is presented at Quality and Safety Oversight Group (QSOG), Trust Management Committee (TMC), Group Quality Committee and Clinical Quality Review Meeting (CQRM).

Specialties report to the Learning from Deaths Group to set out themes, lessons learned and action plans. These are reviewed regularly, and has resulted in the following learning/ improvements:

Critical Care

- Introduce daily review of VTE prophylaxis
- Early ITU review for recent ITU discharged patients requiring level 3 care and Documentation.
- Adequately managed blood pressure
- Appropriate escalation and management for blood investigations.
- Introduce documentation audit.

End-of-Life care – Palliative Medicine

- Recognition of dying patients
- Discussions with families being documented in notes
- Anticipatory prescribing of EoL drugs
- Implementation of End of Life Care Steering Group (March 2026)
- Continued focus on NACEL report

General Surgery

- Decreased numbers of deaths (especially emergency deaths) triggering SJRs (6 completed Oct 2024 to Mar 2025; compared to 11 Oct 2023 – Mar 2024)
- Improve flow through surgical department
- Ongoing Colorectal Improvement Programme
- Colorectal ward round
- MDT working
- Continuing low number of deaths triggering SJRs
- Good team building through interaction and trust
- Better documentation of risk and appreciation of futile/high risk surgery
- Colorectal ward round
- MDT working

Community Deaths

- Good practice - discharge was supported
- To implement LFD process
- Primarily Nurses completed SJR training
- Creating process to recognise patients for SJRs
- Request for LFD members to be patient as the team continues to learn and fine tune process
- Governance lead being identified

Perinatal Mortality

- MDT review of pathway for mortuary transfers, Neonatal death thematic review and increased uptake of clinicians using interpreting service
- Use of MBRRACE PMRT parent engagement forms
- Introduction of saturation monitoring for the neonates prior to discharge
- Increased uptake of clinicians using, accessing and booking interpreting services
- Increase in staff providing the PeriPerm passport for women requiring intrauterine transfer
- PMRT previews graded C or D taken to monthly clinical audit meeting for dissemination of learning.

Gastroenterology

- Communication with relatives / duty of candour and escalation of care / RESPECT form
- Regular communication between different Trusts / teams.
- Continued to seek advice from HPB team.

LeDeR Reviews

- Positive feedback identified in two out of three LeDeR reviews relating to good practice of an acute learning disability Nurse
- The application of the Mental Capacity Act 2005 remains a recurrent theme identified in LeDeR reviews
- Ongoing issues with obtaining medical notes when requesting to undertake reviews.

Cardiology

- Need for escalation to Consultants
- Improved documentation required
- Inappropriate troponin testing
- Late referral submission
- Handover issues

Nephrology

- 7-day working from AKI CNS team
- Twice a day lap generated AKI list
- Referrals seen within 2 hours during working hours
- Wide MDT working and Community teaching for Nurses/ANP
- Next steps include data on post op AKI mortality and morbidity / Length of stay and Quarterly mortality data on patients transferred to RWT for acute dialysis

Emergency Department

- Family members updated regularly
- Early involvement of GI Team for UGIB
- Daily reviewed daily by ward team and regular blood tests done

Ward 15 – Diabetes/Endocrinology

- Documentation:
- Ask Earl
- Discussions with Family and Next of Kin
- Delayed Ambulance Handovers
- Delayed ECGs
- GP medical Referrals
- Smart Doctor
- Class Doctor

Respiratory

- EDS audit undertaken within Respiratory
- NICE guidelines do not provide specific information for the content of an EDS for deceased patients, however it is important t they are completed
- When SJRs are required, medics often look at EDS for case note review and learning
- Discussion held regarding audit undertaken in 2018 which was published in BMJ, where EDS completion compliance was only 34% out of 114 patients
- Bereavement boxes located on wards, for notes of each deceased patient to be kept together, which is achieving 100% compliance for EDS
- Internal audit information presented for deceased respiratory patients in 2024/25 – only 46% of patients had EDS completed. Lots of work to be undertaken

Frailty

- Presented at special request following an increase in deaths within the department
- RESPECT discussion to be included in the comprehensive geriatric assessment
- Redesign of the holistic frailty assessment clerking to the mini comprehensive geriatric assessment documentation
- Meeting with palliative care and ED on improvements possible in an ED setting
- To audit RESPECT discussion / completion in frailty assessed patients
- ED teaching 15/10/25
- Palliative care SPEARS teaching 29/10/2025
- Learning shared with the frailty working group

Infection Control

- Improvements needed around VIP scoring
- Better documentation
- Re-screening patients sooner
- Awareness of inappropriate antimicrobial prescribing

Fractured Neck of Femur

- Current 30-day Mortality Data is slightly above national average, but the Trust is not an outlier (6.1%)
- Local inpatient mortality improving with one spike in Sept/Oct 2025
- Ortho-geriatric assessment within 72 hours has improved to national average
- Nutrition assessment is improving but still below average
- Prompt surgery within 36 hours is a persistent challenge due to theatre capacity
- Ortho-geriatric business case submitted for daily input and ward rounds
- Learning included improving family engagement, documenting previous complications, involving respiratory/ITU early for high-risk patients, ensuring risk-benefit discussions and capacity documentation

Deteriorating Patient

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

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

Looking at the PROMS data report issued April 2026, it is indicating that the Trust has not submitted enough records to be included in the data analysis.

Upon review of the records, however, the Trust has submitted the following number of PROMS:
Hip - 49
Hip Revision - 2
Knee - 57
Knee Revision – 8

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 2024/25.

The Trust believes the performance reflects that:

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

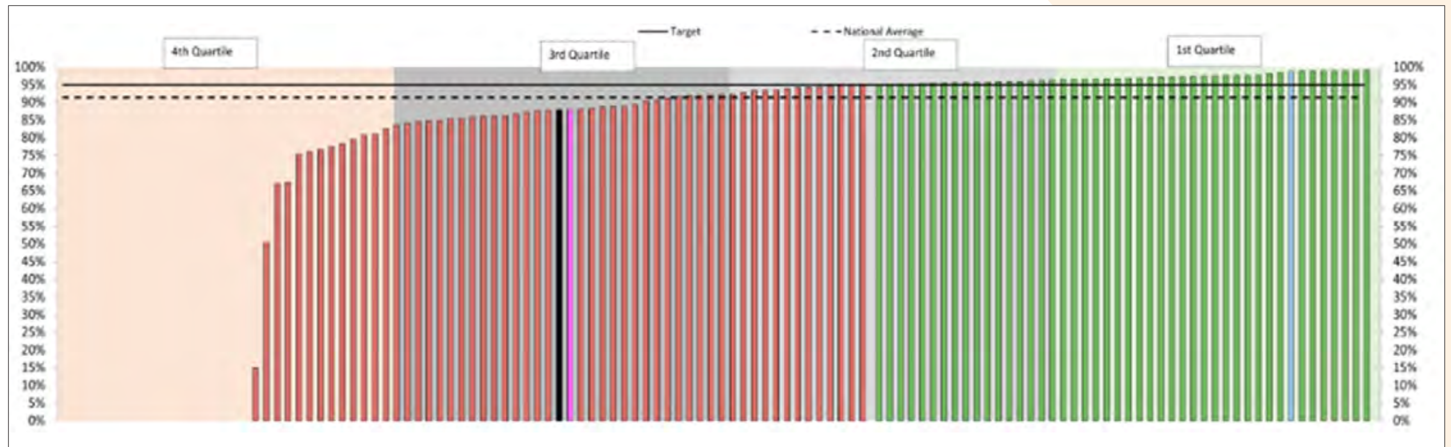
Indicator	2022/23			2023/24			2024/25			2025/26		
		0 to 15	>=16		0 to 15	>=16		0 to 15	>=16		0 to 15	>=16
The percentage of patients aged (i) 0 to 15; and (ii) 16 or over, Re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	Apr 22	15.02%	11.41%	Apr 23	16.15%	12.38%	Apr 24	16.54%	10.42%	Apr 25	17.10%	10.74%
	May 22	16.95%	10.99%	May 23	17.35%	10.81%	May 24	16.30%	9.53%	May 25	14.88%	10.96%
	Jun 22	18.25%	11.88%	Jun 23	16.81%	10.13%	Jun 24	15.35%	10.21%	Jun 25	14.90%	10.94%
	Jul 22	19.27%	12.35%	Jul 23	18.11%	11.45%	Jul 24	16.40%	10.41%	Jul 25	15.61%	10.34%
	Aug 22	14.32%	11.37%	Aug 23	17.19%	10.97%	Aug 24	16.69%	10.28%	Aug 25	17.49%	10.61%
	Sep 22	15.48%	9.78%	Sep 23	18.24%	11.03%	Sep 24	16.26%	10.79%	Sep 25	16.61%	10.87%
	Oct 22	18.49%	9.97%	Oct 23	20.65%	11.34%	Oct 24	17.54%	10.28%	Oct 25	16.59%	10.34%
	Nov 22	18.73%	10.52%	Nov 23	18.25%	10.72%	Nov 24	19.44%	10.59%	Nov 25		
	Dec 22	15.09%	11.13%	Dec 23	16.04%	12.25%	Dec 24	15.85%	10.68%	Dec 25		
	Jan 23	18.85%	11.41%	Jan 24	17.52%	11.54%	Jan 25	14.12%	10.24%	Jan 26		
	Feb 23	19.98%	11.44%	Feb 24	18.74%	11.38%	Feb 25	15.50%	10.13%	Feb 26		
	Mar 23	15.99%	11.63%	Mar 24	16.17%	11.19%	Mar 25	14.60%	10.71%	Mar 26		

Core Quality Indicators – Venous Thromboembolism (VTE)

National reporting on Venous Thromboembolism (VTE) assessment performance has been made available since early 2025.

Figure 1 shows the latest published results. Based on Q3 2025/26 (Oct-Dec 2025) report, out of 107 general and acute Trusts, Walsall's position is at 78 (87.95% compliance), while RWT is at 77 (87.97% compliance) . The national reporting is a standing item on the Thrombosis Group meeting agenda.

Figure 1: National VTE Performance Benchmarking Chart, Q3 2025/26 (Oct-Dec 2025)



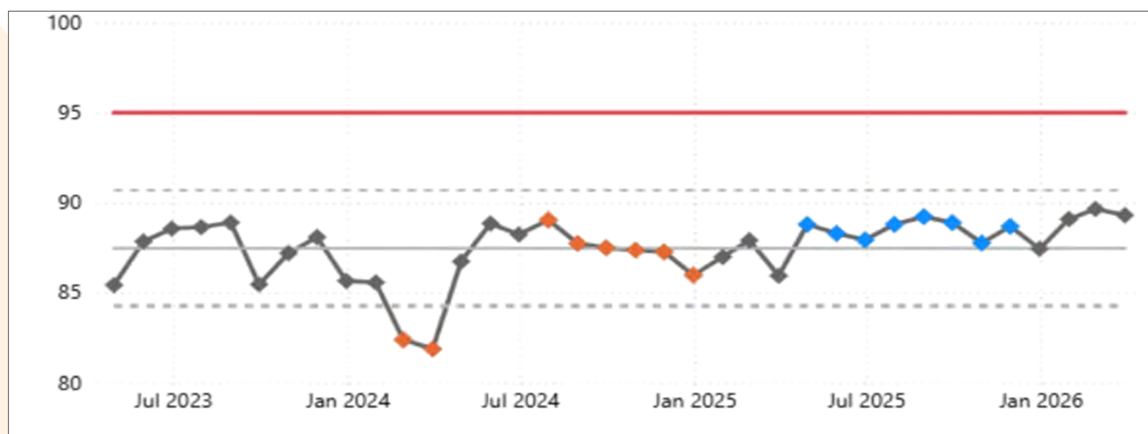
The Trust continues to monitor and report internally on a monthly basis. Figure 2 shows the updated report.

VTE assessment remains below the required compliance target of 95%.

The Thrombosis Group meets monthly and is chaired by the Trust VTE Lead. The group looks at trends, learning on improving VTE assessment performance and reviews the VTE Policy. Practices from areas with good VTE assessment performance (WCCSS Division, Elective Surgery) were shared, while engagement with stakeholders from AMU and SACU is in progress to review improvement measures.

During the Thrombosis Group meeting, incidents of Hospital Acquired Thrombosis (HAT) were reviewed and the learnings were shared.

Figure 2: VTE Risk Assessment- % within 14 hours of admission (Apr 2023 to Mar 2026)

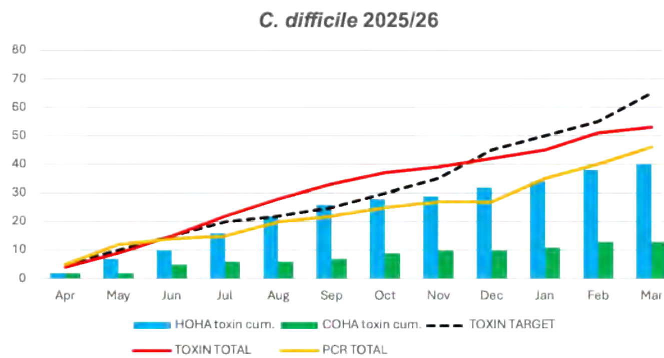


Core Quality Indicators - Clostridium *Difficile*

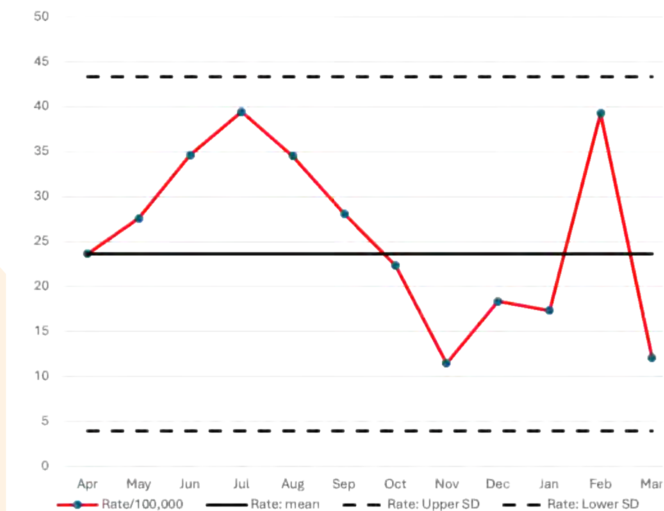
The graphs below present cases of toxin-producing Clostridioides difficile (C. *difficile*) identified at Walsall Healthcare NHS Trust between April 2025 and March 2026.

These cases meet the definitions for either Hospital-onset, Healthcare-associated (HOHA) or Community-onset, Healthcare-associated (COHA) infection.

C. difficile 2025/26



SPC Chart:*C. difficile* toxin rate / 100,000 bed days



The IPC Team undertakes reviews of all HOHA and COHA C. *difficile* cases, conducted in with multidisciplinary review. Outcomes and key learning points are reported through divisional governance meetings and to the IPCC, providing assurance to the DIPC.

Between April 2025 and March 2026, there were 53 confirmed cases of toxigenic C. *difficile*, comprising 40 HOHA and 13 COHA cases, against an annual trajectory of 65. This represents a reduction from the 69 cases reported in the previous financial year and demonstrates a 23.2% improvement compared with 2024/25.

The LIPCN, working in collaboration with the MDT, undertook quarterly reviews of all C. *difficile* cases classified as HOHA or COHA.

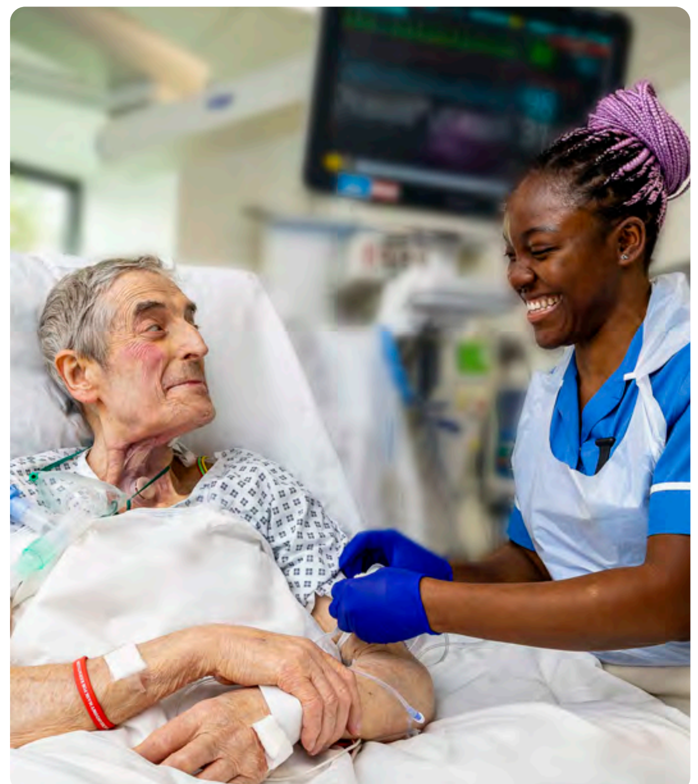
The primary objective of these reviews was to evaluate the effectiveness of the multimodal interventions implemented over recent years and to assess their impact on reducing C. *difficile* cases.

In addition, the reviews sought to identify areas requiring further action to support the continued reduction of C. *difficile* rates at Walsall Healthcare NHS Trust.

Key themes and learning identified through the quarterly reviews were shared with divisional stakeholders to inform practice improvement and support sustained improvement.

The common risk factors identified were consistent with national guidelines and expectations and included:

1. Exposure to multiple antibiotic therapies within the preceding six weeks
2. Age over 65 years
3. Multiple comorbidities and recent and/or frequent healthcare interventions
4. Proton Pump Inhibitor (PPI) use
5. Previous history of C. *difficile* infection
6. Use of laxatives



Key themes identified from case reviews for 2025/26:

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 at the point specimens were obtained, largely due to limited availability of isolation facilities
- Inconsistent documentation of the onset of loose stools on the Bristol Stool Chart
- Variability in hand hygiene performance and practice
- Issues relating to the cleanliness of shared patient equipment; however, no transmission was directly attributed to this factor

3. **Infection prevention and control in the environment:**

- Insufficient isolation facilities to meet clinical demand
- Variations in environmental cleanliness standards

4. **Increased Complexity of Care and an Ageing Population**

- Increasingly ageing patient population
- Multiple co morbidities requiring complex, multidisciplinary care approaches
- Prolonged lengths of stay
- Challenges in accessing primary care services and the need for patients to attend multiple acute healthcare settings across the region
- Improved diagnostic investigations to support treatment initiation (e.g. urine samples, chest X-ray)

5. **Educational Needs**

- Gaps in staff knowledge regarding the practical application of AMS principles, particularly in empowering the Nursing workforce
- The need for improved adherence to IPC policies and practices, including hand hygiene, use of personal protective equipment (PPE) and compliance with isolation protocols

Summary of target interventions for 2025/26:

1. **Case Identification and Surveillance**

- Ongoing investigation of potential patient to patient transmission through the identification of Periods of Increased Incidents (PIIs), with isolates submitted for ribotyping where appropriate and in line with national guidance
- The IPC Nursing Associate provides targeted support to frontline teams, particularly within admission areas, to enable early sampling of patients presenting with diarrheal symptoms, supporting prompt intervention and isolation
- Daily review of all CDI cases is undertaken by the IPCT, with weekly multidisciplinary reviews involving Microbiology, IPC and AMS teams
- Daily review of all stool samples received to identify and act on any potential missed cases within the diagnostic pathway

2. **Reduction in Disease Severity and Treatment Requirements**

- Patient harm continued to reduce, with approximately 60–70% of patients not requiring treatment due to mild disease severity

3. **Isolation and Environmental Controls**

- IPC practitioners complete daily assessments of isolation requirements across the Trust, working in collaboration with clinical site teams to ensure timely and appropriate patient placement. Isolation decisions are recorded, monitored and reviewed through IPC incident reporting systems and the risk register, with oversight via IPCC
- Enteric audits are undertaken following the identification of new cases to assess compliance with best practice. These are now embedded within the Trust audit platform and reported routinely to IPCC, with a structured process for escalation or improvement actions
- Enhanced environmental cleaning measures, including Hydrogen Peroxide Vapour (HPV) and ultraviolet (UV) disinfection, continue to be utilised where indicated
- The proactive deep cleaning programme remains embedded and operates as part of business as usual across the Trust

4. **Built Environment and Equipment Assurance**

- The IPC Team supports refurbishment and capital development programmes across the Trust to mitigate infection risks
- Where retained estates do not fully meet current standards, risks are actively reviewed and escalated to prioritise areas with higher potential impact
- Quarterly training, delivered in partnership, is provided on decontamination of shared equipment and promotion of patient hand hygiene

5. **Antimicrobial Stewardship (AMS) and Clinical Practice**

- AMS 'time out' interventions continue to be embedded within clinical practice, supporting improvements in appropriate antimicrobial use
- Targeted AMS interventions have been implemented in areas where prescribing concerns were identified
- Treatment pathways remain under review, including consideration of Faecal Microbiota Transplantation (FMT) for recurrent CDI

6. **System-Wide and Strategic Collaboration**

- The IPC Team remains actively engaged with the Integrated Care Board (ICB) HAI Group to support a system wide approach to reducing HAIs, including C. difficile and associated harm
- Syndromic surveillance and targeted quality improvement (QI) programmes continue as part of routine practice, focusing on hospital acquired pneumonia (HAP), urinary tract infections (UTIs), CAUTIs and surgical site infections (SSIs). These priorities are captured within the Trust's IPC Annual Work Plan for 2025/26

Core Quality Indicators - Incident Reporting

2024/25 (Full Year Data)			2025/26 (Full Year Data)		
Incidents	% Resulting in Death	% Resulting in Severe harm	Incidents	% Resulting in Death	% Resulting in Severe harm
16757	0.08% (13)	0.17% (28)	15314	0.10% (16)	0.24% (36)

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 2024, the Maternity Survey 2025, the National Cancer Survey 2024, 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 'mystery patient scheme incorporates relevant questions to continuously evaluate and monitor our progress.

The Adult Inpatient Survey 2024

(Updated: Adult Inpatient Survey 2024 – Walsall Healthcare NHS Trust)

The Adult Inpatient Survey 2024 invited 1,250 patients from Walsall Healthcare NHS Trust, with 323 responses, giving a 30% response rate, consistent with 2023.

Overall Performance

Compared with all other NHS Trusts in England, Walsall Healthcare NHS Trust performed:

- About the same on the vast majority of benchmarked questions (38 questions)
- Somewhat worse than expected on 4 questions
- Worse than expected on 4 questions
- No areas performing better or much better than expected nationally
- Year on year analysis showed:
    - 2 questions significantly improved
    - 36 questions showed no significant change
    - 0 questions significantly worsened

Key areas where patient experience could improve

The survey identifies the five questions where patient experience was lowest relative to the national average for Walsall:

- Night-time sleep disruption from hospital lighting, staff noise, and other patients (multiple sleep-related indicators appear in bottom 5)
- Length of time waited before admission to a ward
- Information provided while waiting to be admitted
- Ability to get help when needing staff attention
- Information about care while on a Virtual Ward

(These appear as bottom-five scores or highlighted low-performing benchmarks in 2024.)

- Additional recurring themes across section scores and trend analysis:
- Noise at night continues to be a long standing issue (also a 2023 concern).
- Waiting list communication remains weak, consistent with 2023 –37% national comparison.
- Discharge information shows mixed performance, including:
    - Not enough notice
    - Limited discussion of home support or equipment
    - Lack of clarity about who to contact after discharge (one of the lowest-performing areas nationally)
- Information about medication at discharge remains historically low (2023) and continues as a 2024 weakness.

Areas where patient experience is strongest

The Trust's five strongest performing areas relative to the national average in 2024 were:

- Help to eat meals (featured as a top-five positive variance)
- Enough to drink
- Cleanliness of hospital environment
- Help washing / maintaining personal care
- Food available outside set mealtimes

In addition, Walsall continues to perform strongly in:

- Kindness and compassion
- Respect and dignity
- Privacy during examinations

These strengths reflect consistent positive performance also highlighted in the 2023 results.

Actions to address areas for improvement

In response to the themes raised in the 2024 Adult Inpatient Survey, Walsall Healthcare NHS Trust is progressing the following improvement actions:

1. **Strengthening Communication and Information Provision**

- Redesign of waiting list communication, including simplified written information and digital updates
- Improved discharge communication pathways, building from low performance in both 2023 and 2024
- Updated medicines information, using clearer take home leaflets and structured conversations at discharge

2. **Enhancing Noise-at-Night Interventions**

- Continued implementation of enhanced Quiet Hours and Quiet Protocol
- Increased ward-level monitoring of noise sources, with focus on:
    - Staff conversations
    - Trolleys/equipment at night
    - Patient-to-patient disruption

3. **Strengthening Patient and Family Involvement**

- Embedding techniques to:
  - Improve participation in care planning
  - Encourage questions using empowerment prompts
- Earlier, more structured involvement of carers/ families in discharge planning, reflecting low 2023 and 2024 outcomes

4. **Supporting staff in communication and interaction skills**

- Targeted development for ward teams on:
  - Explaining reasons for ward moves
  - Providing consistent information
  - Involving patients in decision making
- Reflects communication and relational care areas that showed limited or no statistical change

5. **Enhancing real-time feedback loops**

- Expansion of QR code enabled feedback tools on wards
- Greater visibility and responsiveness to FFT and Mystery Patient themes

Future Plans

To ensure sustained and long-term improvements, the Trust will:

- Continue strengthening digital and face-to-face insight systems, enabling more diverse patient voice input across inpatient pathways
- Work with Divisions on targeted improvement programmes for:
  - Admission waiting list communication
  - Discharge planning conversations
  - Night-time noise
- Use trend analysis from 2020/24 to prioritise persistent issues and prevent recurring declines

Urgent and Emergency Care Survey 2024

Summary and related Divisional actions

1. Overview of the 2024 UEC Survey (WHT)

Published November 2024.

The Trust performed about the same as other Type 1 Emergency Departments nationally across most indicators.

Top Five Scoring Areas

Area	Score	Insight
Feeling safe in A&E	**8.1**	Strong positive sense of safety.
Support after leaving A&E	**7.6**	Good discussion of follow up care needs.
Privacy at reception	**7.1**	Patients felt sufficiently private when speaking to staff.
Explanation of test results	**7.3**	Reasonable clarity but still not optimal.
Access to food and drinks	**6.6**	Moderate performance; service inconsistent.

Themes:

WHT performs strongly in privacy, feeling safe, and aftercare conversations.

Bottom Five Scoring Areas

Area	Score	Insight
Explanation for waiting with ambulance crew	**4.6**	Significant communication gaps.
Information to support recovery at home	**6.4**	Lacked clear discharge/recovery guidance.
Communication about patient anxieties/fears	**5.8**	Missed opportunities for reassurance.
Information on new medications	**4.2**	Very low; inconsistent medication counselling.
Updates on wait times	**4.0**	Major dissatisfaction with waiting communication.

Themes:

The Trust must prioritise improving communication, especially around:

- Wait times
- Ambulance handover delays
- Medicine information
- Recovery instructions
- Emotional reassurance

2. Key survey themes for WHT

Strengths

- Patients generally feel safe, treated with privacy, and supported after A&E attendance
- Good clinical reassurance and operational safety practices

Areas needing improvement

- Communication (main theme) – waiting times, ambulance holds, anxiety management
- Discharge clarity – medications, home care, who to contact
- Ambulance handover explanation – consistently low scoring
- Food/drink access – practical comfort support during long waits

3. Related actions already underway (from MLTC PEG January 2026)

These actions are directly aligned with the 2024 UEC survey findings and come from WHT's MLTC Divisional Patient Voice Report, Emergency Department updates, safety frameworks, and operational programmes.

3.1 Communication improvements (Survey: waits, ambulance handover, anxieties)

Actions in progress

- Continuous updating of the UEC action plan based on mystery patient insight, FFT, PALS, formal complaints
- Focus on improving:
  - Ambulance wait time explanations
  - Waiting time updates
  - Conversations about fears/anxieties
  - Post-discharge information
- ED information screens upgrade request:
  - Dedicated server allowing ED to control content
  - Screens to display patient journey steps, seasonal illness information, self-help, and operational updates
  - This supports improved waiting-time communication and managing expectations
- Triage senior decision maker within 60 minutes to reduce uncertainty and long waits
- Improved communication pathways through digital enhancements and ICS aligned updates

3.2 Improvements to post discharge care communication (Survey: medication information, home recovery)

Actions in progress

- Divisional work on post-discharge care pathways, including:
  - Criteria Led Discharge (CLD) trial on Ward 15 to be rolled out Trust wide
  - Enhanced Discharge Matron oversight for quality of information
  - Review of "**Leaving Hospital**" patient information section
- Revised patient information leaflets about discharge expectations and recovery
- Increased collaboration with the Trust Discharge Working Group
- Strengthened explanation processes regarding:
  - Medicines to take at home
  - Equipment for home
  - Recovery steps

3.3 Medication information and safety (Survey: low score on "information on new medication")

Actions in progress

- Time Critical Medicines (TCM) Quality Improvement Project:
  - Identification of TCM within 30 minutes of arrival
  - "TCM" narrative on Careflow, orange alert cards, stickers at triage
  - Improved prescribing timeliness (84% of identified TCM were prescribed)
  - Aim: consistent and clear medication counselling before discharge
- Trust wide plan proposed:
  - Multi disciplinary champions in every ward/department
  - Replace insulin-only stickers with TCM stickers
  - Strengthened self-administration policy guidance
  - Aligns directly with UEC low scoring on medication information

3.4 Patient safety, privacy and dignity (Survey strengths but corridor care risk)

Actions in progress

- Implementation of the new ED Corridor Policy:
  - "Corridor care is unacceptable except in extremis"
  - Principles include:
    - Risk assessment
    - Escalation
    - Reporting incidents via Datix
    - Corridor audit added to InPhase system
    - Focus on maintaining privacy and dignity under pressure
- Estates projects reviewing lighting, corridor usage, and noise levels, including in ED.

Although the survey scored strongly on privacy (7.1), these actions maintain safety during overcrowding.

3.5 Food and drink provision (Survey score: 6.6 – "moderate")

Actions in Progress

- Divisional complaints showed multiple ED concerns about lack of beverage provision.
- This directly aligns with the survey finding
- Actions now include:
  - Volunteer provision of drinks/snacks
  - Regular comfort rounds
  - Reviewing vending/refreshment access and temperature control in waiting areas

3.6 Listening to patients (Survey: anxieties/fears discussions scored low)

Actions in progress

- Increased staff engagement through the Divisional "Open Door" listening time for staff—improves culture, affecting bedside compassion
- Mystery Patient and FFT themes feed directly into UEC staff feedback loops

4. Additional UEC Relevant Findings from complaints and feedback

All insights from MLTC report are aligned with the UEC survey themes.

Trends reinforcing UEC survey themes

- 18 ED-related complaints in one month

Themes:

  - Poor communication
  - No updates
  - Delays
  - Lack of beverages
  - Cold environment

These mirror the survey's areas needing improvement (waiting updates, anxiety reassurance, drink/food access, discharge clarity).

5. Summary: combined survey findings plus current actions

WHT Strengths

- Safe environment
- Privacy
- Good discussions about post care
- Improving discharge pathways

WHT Priorities

- Communication (wait times, ambulance delays, fears/anxieties)
- Discharge clarity (medication + home recovery)
- Access to food/drinks
- Improved culture and staff communication

Actions already underway (Evidence linked)

- Enhanced ED information screens
- Waiting time communication improvements
- Ambulance handover explanation redesign
- Criteria-led Discharge trials
- Enhanced medication information (TCM project)
- Corridor Care SOP + InPhase audits
- Lighting/noise/sleep environment improvements
- Beverage/comfort rounds
- Expanded patient information resources
- MDT alignment on discharge quality

These directly align with all five lowest-scoring areas of the UEC survey.

6. Final Statement for Governance / PEG

Walsall Healthcare NHS Trust performed comparably with other Type 1 Emergency Departments in the 2024 UEC Survey, with particular strengths in privacy, patient safety and support after leaving A&E. Key opportunities exist in improving communication regarding waiting times, ambulance delays, explanation of new medications, reassurance of patient anxieties, and clarity of home recovery information.

The MLTC Division has already implemented or commenced multiple aligned actions, including improved ED information systems, enhanced triage communication, strengthened discharge pathways, medication safety initiatives, corridor care governance, and targeted comfort/support measures. These address all five of the lowest scoring survey indicators and are monitored through FFT, PALS, mystery patient insights and InPhase audit systems.

Key weaker areas:

Postnatal care at home: Score 7.1 (band: somewhat worse).

Specific issues:

Question Code	Question Summary	Score	Performance Band
G4	Would you have liked to have seen/ spoken to a Midwife?	4.1	Worse
G11	Information about mental health changes after birth	5.9	Worse
G15	Out-of-hours feeding support	4.7	Somewhat worse
F4	Triage waiting times	4.6	Worse

Recommended focus actions:

- Improve postnatal continuity and accessibility:
  - Review home visits or proactive contact provided in the first 4 weeks
  - Ensure clear communication on who to contact for mental health and physical recovery support
  - Strengthen follow-up systems to ensure consistent Midwife engagement post-discharge

Enhance out-of-hours support:

- Strengthen evening/weekend helplines for feeding and urgent advice

Ensure staff are trained to provide consistent, empathetic, and practical guidance during out-of-hours calls

- Promote awareness of available support channels among new parents.

Reduce triage waiting times:

- Review staffing and triage processes for timely assessment
- Implement real-time monitoring of waiting times to identify and address bottlenecks
- Explore digital triage tools or pre-assessment systems to streamline patient flow

Summary Insight:

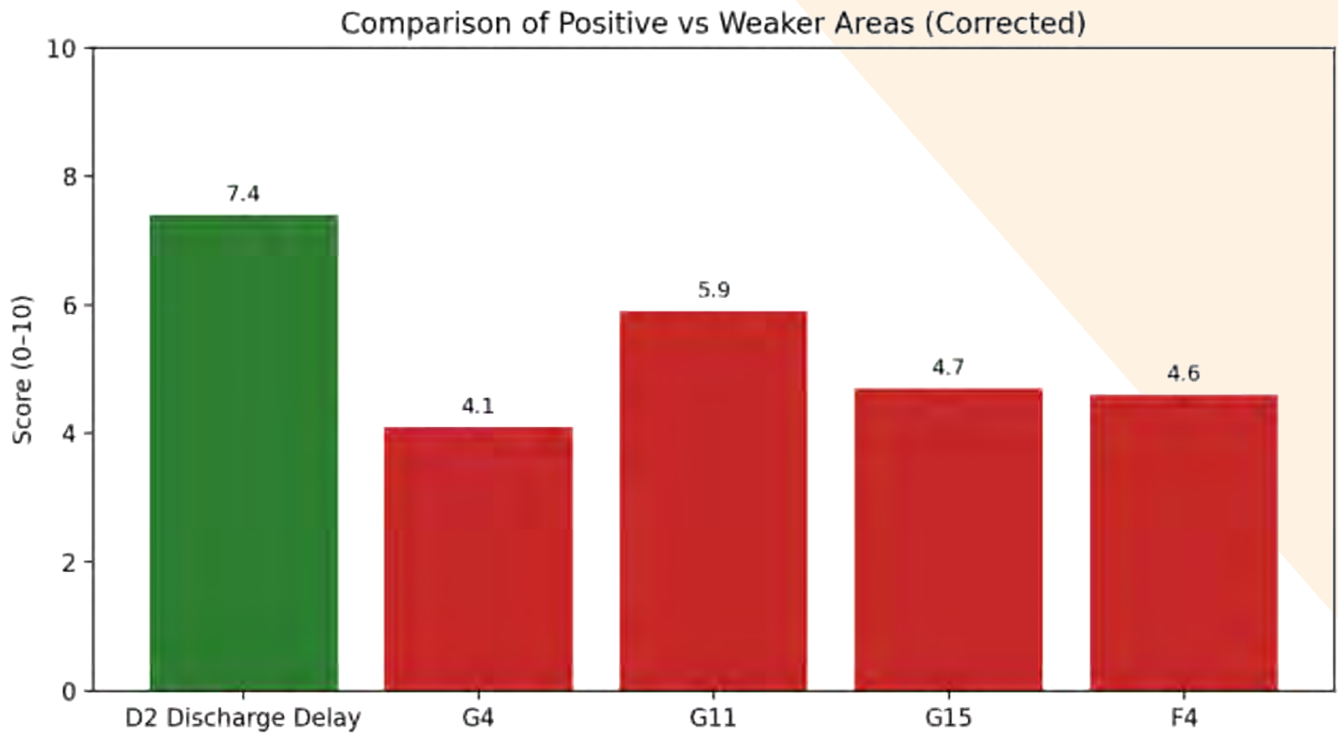
While overall performance aligns with national averages, targeted improvements in postnatal care accessibility, mental health communication, and triage responsiveness will significantly enhance patient experience and outcomes.

Positive highlight: Discharge delays (Question D2) scored 86, somewhat better than most Trusts, with no change from last year.

Positive Highlights

Question Code	Question Summary	Score	Performance Band
D2	On the day you left hospital, was your discharge delayed for any reason?	7.4	Somewhat better

Visual Summary



Maternity Survey 2025

Overall performance:

- Mostly "About the same" as other Trusts across 52 questions
- Worse than most Trusts: 3 questions
- Somewhat worse: 2 questions
- Response rate: 29.9% (88 respondents)

National Cancer Survey 2024

This dataset summarises WHT's 2024 performance across the national Cancer Patient Experience Survey. It includes case mix adjusted scores, expected ranges, year on year change, and tumour group variations.

Overall position

WHT performs within the expected national range on most questions, with notable strengths in care co-ordination, diagnostic communication, and dignity, while weaker areas relate to aftercare, GP support, and emotional support.

Overall care rating remains high at 8.86/10, though slightly reduced over three years.

Key strengths

1. Diagnostic pathway

- Patients received clear information before diagnostic tests (Q05: 0.887)
- Staff were well prepared and informed (Q06: 0.817)
- High levels of privacy when receiving test results (Q09: 0.920)

2. Communication at diagnosis

- Very strong performance in allowing a supporter at diagnosis (Q12: 0.911), significantly above expected range
- Diagnosis explained clearly (Q14: 0.832)

3. Care co-ordination and support

- Excellent scores for:
  - Having a main point of contact (Q17: 0.946)
  - Helpful advice from contact person (Q19: 0.960)
  - Care planning support (Q25–Q26)
  - Information on available support (Q27: 0.917)

4. Treatment experience

- Good dignity and respect (Q37: 0.812)
- Strong improvement in pain control (Q36: +0.12 over two years)

Key areas for improvement

1. Emotional and psychological support

- Ability to discuss fears or worries with staff is low during inpatient care (Q35: 0.568)
- Emotional support at home post treatment is among the lowest scoring areas (Q53: 0.483)

2. GP and community aftercare

Significantly weak in:

- GP support during treatment (Q51: 0.460)
- GP cancer care review (Q52: 0.240)
- Community support at home (Q50: 0.569)

3. Understanding results and side effects

- Declines in understanding diagnostic results (Q08: –0.081 over two years)
- Limited understanding of long term side effects across tumour groups
- Information on recurrence signs is mid range but falling (Q55: 0.666)

4. Responsiveness on wards

- Getting help when needed (Q34: 0.680) shows mixed performance
- Involvement in inpatient decisions is improving but still modest (Q33: 0.679)

Tumour-group variation

Performance varies significantly:

- Haematology, prostate and upper GI patients report the most positive experiences
- Colorectal, urology and some breast cohorts frequently score lower, especially on aftercare, long term side effect information, and GP support

Overall summary

WHT demonstrates strong communication, high levels of dignity, excellent care co-ordination, and a consistently strong patient centred diagnostic experience.

Aftercare and GP integration remain the Trust's most persistent challenges, however, with additional gaps in emotional support, fear/worry discussion, and clarity around long term effects.

Despite these issues, WHT maintains a high overall care rating, with many areas showing meaningful improvement compared with previous years.

Core Quality Indicators - Friends and Family Test

The Friends and Family Test (FFT) is a nationally mandated patient feedback tool used across NHS services in England. Introduced in 2013 and updated in April 2020, it enables providers to capture patient experience in real time and use this insight to drive service improvement.

FFT is required across all NHS-funded services, including:

Acute inpatient and day-case services

- Accident and Emergency (A&E)
- Maternity Services (antenatal, birth and postnatal)
- Community services
- GP practices
- Outpatients
- Mental health services

Patient recommendation to friends and family

- During 2025/26, FFT results remained strong across most touchpoints, with several areas showing modest improvement compared to 2024/25, as illustrated in the below charts.
- Inpatient and Outpatient services demonstrated gradual improvement over the year, while Community continued to achieve consistently high recommendation scores, despite a small reduction towards the end of the reporting period
- Emergency Department FFT scores remained variable, though Quarter 4 performance showed improvement when compared to earlier in the year
- FFT results across Maternity Services showed greater variation, with some performing well and others experiencing a decline compared to the previous year
- When benchmarked against national averages, the Trust performed strongly in Community and ED services

Performance across all touchpoints compared favourably with the Black Country ICB, where the Trust exceeded local averages in all reported areas with three touchpoints exceeding national benchmarks.

Friends and Family Test	Inpatients				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2025/26	89%	89%	90%	92%	93%	92%	93%	94%	81%	79%	78%	83%	99%	99%	98%	97%
Difference	1%	0%	2%	3%	1%	0%	1%	1%	0%	-6%	0%	2%	0%	0%	-1%	-2%
2024/25	88%	89%	88%	89%	92%	92%	92%	93%	81%	85%	78%	81%	99%	99%	99%	99%
Response rate	22.2%	19.2%	17.4%	17.2%	15.7%	12.9%	11.6%	10.8%	13.1%	12.4%	12.9%	14.9%	8.3%	4.8%	4.6%	3.8%

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
2025/26	83%	87%	89%	94%	94%	94%	90%	90%	95%	91%	87%	91%	97%	93%	97%	86%
Difference	-2%	-2%	-4%	-1%	-4%	5%	0%	1%	6%	3%	-3%	-3%	5%	-1%	6%	-4%
2024/25	85%	89%	93%	95%	98%	89%	90%	89%	89%	88%	90%	94%	92%	94%	91%	90%
Response rate	8.6%	12%	11.5%	7.2%	23.7%	22.1%	26.8%	20.8%	30.9%	30.5%	33.5%	18.7%	13.1%	15%	12.5%	5.0%

Regional and National Comparison	In patients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
National	-5%	-1%	1%	4%	-4%	0%	-1%	0%
Black Country ICB	1%	3%	9%	5%	2%	3%	6%	6%

Core Quality Indicators - Supporting our staff

The 2025 NHS Staff Survey benchmark report for Walsall Healthcare NHS Trust contains the results of the 2025 staff survey. The results 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.

The 2025 staff survey results reflected at service and divisional level there were some positive results, however the Trust's overall results reflected a decline across all nine indicators suggesting that a greater level of focus is required at individual, team and service level to ensure colleagues feel cared for at work.

Over 2025/26 the Trust has successfully retained accreditation against the Race Equality Code following a period of formal assessment and embedded an accredited framework to support colleagues affected by menopause in the workplace. Our focus on behaviours of colleagues treating each other with civility and respect has continued with more than 2,100 colleagues attending the civility and respect programme.

Ways in which staff can speak up

Freedom to Speak Up (FtSU)

Creating a culture where every member of staff feels safe, supported and empowered to speak up remains a core priority for the Trust. Freedom to Speak Up (FtSU) is central to delivering high quality, compassionate care, ensuring that concerns are raised early, listened to carefully and acted upon in a timely and transparent manner. Our FtSU service plays a vital role in this work, offering independent advice, guidance, challenge, and supporting colleagues who feel unable to raise concerns through other routes.

There is a total of 1.4 WTE FtSU guardians at Walsall Healthcare NHS Trust, consisting of a full-time lead guardian/clinician and a part time guardian. They are supported by 11 champions. Members of staff can contact a guardian in several ways to arrange a face-to-face or virtual meeting. They can use 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 Trust Board has shown its full commitment and support to embed FtSU within the organisation.

The Trust set out the below objectives to achieve a well-led speaking up organisation.

1. The Executive Team and all managers model the behaviours required to promote an open and positive organisational culture
2. The Executive Team will remove barriers to facilitate a diverse and inclusive approach to speaking up, particularly amongst vulnerable groups such as BAME and LGBT+ staff members who can sometimes feel more reluctant to raise concerns
3. The means to provide advice and listen to staff in relation to concerns they have raised are created
4. Organisational leaders, with support from FtSU guardians, including managers, create and implement a process to ensure staff receive timely feedback and details of what action has been taken when concerns have been raised
5. Staff know how to access the Trust's speaking up channels and where to go for support and advice on how to raise concerns

The Trust continues to meet these objectives and during the past 12 months developed and implemented three mandated FtSU training modules, civility and respect training as well as the implementation of the behavioural framework

As of March 2026, 83.05% of all staff had completed the Speak Up training, 77.92% of managers had completed the Listen Up training and 57.01% of senior leaders had completed the Follow Up training.

Speak Up Activity in 2025/26

Between 1 April 2025 and 31 March 2026, the FtSU team has received 359 concerns. This highlights employees' increasing confidence to use the FtSU service to discuss issues that may be affecting them at work. Of the concerns raised, 26% related to patient safety and quality and 41% to inappropriate attitudes and behaviours.

2025/26	Total number of cases brought to Freedom to Speak Up Guardians	Number of cases raised anonymously	Number of cases with an element of patient safety / quality	Number of cases related to behaviours, including bullying / harassment
01/04/2025	20	3	11	16
01/05/2025	16	1	8	14
01/06/2025	42	0	26	41
01/07/2025	26	18	19	17
01/08/2025	19	15	17	17
01/09/2025	28	5	24	13
01/10/2025	34	9	19	23
01/11/2025	30	9	30	15
01/12/2025	65	28	43	32
01/01/2026	49	27	49	29
01/02/2026	24	4	22	10
01/03/2026	6	0	0	5
Total	**359**	**119**	**268**	**232**

During the year, concerns raised through the FtSU route continued to reflect national themes, with inappropriate attitudes and behaviours remaining a prominent issue. FtSU outreach includes induction training, drop-ins, student and clinical forums, and ward walks.

- Establishment of Matrons FtSU forum, divisional FTSU forums including medical committees
- Regular engagement at student forums
- Speak Up Month attracted more than 250 staff. We delivered snacks to colleagues on the wards and had meaningful discussions about the importance of speaking up. We also hosted 1:1 drop in sessions where staff could share concerns confidentially
- Confidential Speak Up clinics were arranged to address potential barriers that staff had in speaking up with the opportunity to engage with them to look for solutions and incorporate projects like QI
- Collaborative work in arranging Speak Up sessions with wider regional FtSU teams
- Active and ongoing work with Governance, OD, patient groups for triangulation including Health and Safety forum
- Increased awareness Trust wide, bulletin launched in Trust magazine

Guardian of Safer Working

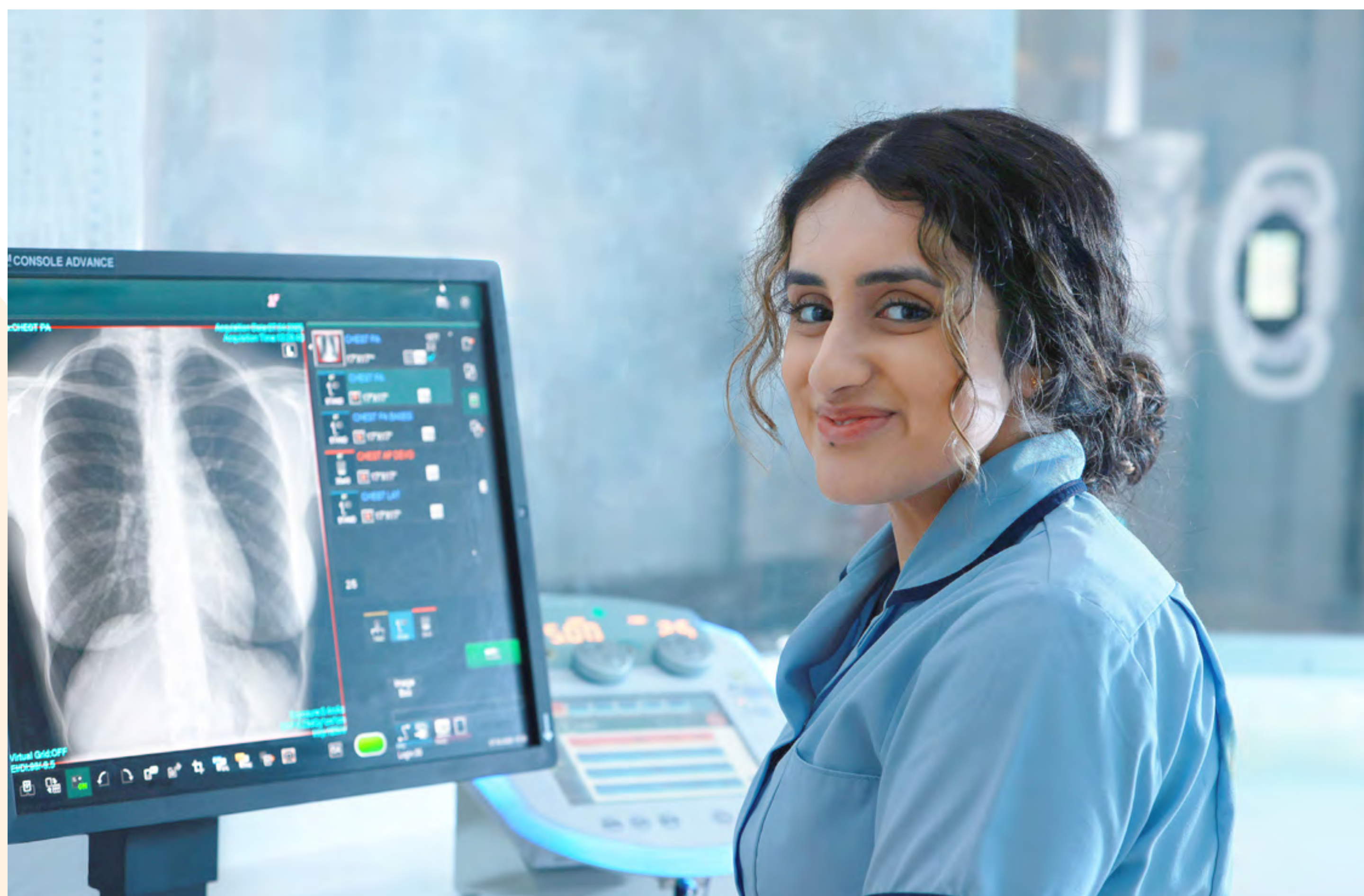
Safety is a high priority for the Trust. The 2016 Terms and Conditions for Doctors and Dentists in training posts safeguards their working hours in terms of total hours worked, breaks whilst at work, and rest periods between shifts. The Guardian of Safe Working monitors compliance with these hours through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

Exception reporting software allows oversight of any breaches, enabling us to monitor trends such that underlying causes for these can be identified and addressed. A total of 139 exception reports were submitted in the calendar year 2025. All of these exception reports were resolved with acceptable outcomes.

In 2025/26, a few reforms are coming into practice as agreed by the government and implementation is ongoing as per the guidance of NHSE.

1. The new ER (Exception Reporting) Reforms have been implemented and were coming into effect from 4 February 2026. This is aimed at a better ER process for the trainees, eliminating the clinical or educational supervisors from the outcoming process. The Medical Staffing Team will now do the ER outcomes in discussion with the GoSWH.
2. The implementation of the "10-point plan to improve the Resident Doctors' working lives" as per the government recommendation is in full swing. The GoSWH plays an important role alongside other stakeholders in the delivery of this plan. It is now being implemented at our Trust as well.

Rostering for Doctors is on the Allocate RLDatix software, allowing greater oversight of rota gaps in order to further improve working hours for the Resident Doctors.



Review of Quality

Our performance in 2025/26

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	2023/24	2024/25	2025/26	National Target 2025/26	Agreed trajectory
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral	61.16% (Mar 24)	69.54 (Mar 25)	73.19% (Mar 26)	92%	73.04%
Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	n/a	0.01% (Mar)	<1%	
% of service users waiting less than 6 weeks from referral for a diagnostic test		91.44% (Mar 25)	70% (March) 75.45% (Year)	95%	n/a
Percentage of A+E attendances where the service user was admitted, transferred or discharged within 4 hours of their arrival at an A+E department	74.87%	76.03%	86.69% (March) 76.18% (Year)	78% by March 2026	
Waits in A+E from arrival to discharge, admission or transfer (waiting more than 12 hours)	5.81%	5.59%	3.43% (March) 7.08% (Year)	<2%	4.80%
Percentage of service users waiting no more than 28 days to communication of definitive cancer / not cancer diagnosis	80.10%	83.62%	85.10%	80%	
Percentage of service users waiting no more than one month (31 days) from decision to treat / earliest clinically appropriate date to any cancer treatment	97.10%	97.87%	97.40%	96%	

Percentage of service users waiting no more than two months (62 days) from urgent GP referral (including for breast symptoms), NHS cancer screening or consultant upgrade (as appropriate) to first cancer treatment	76.30%	78.77%	76.70%	75%	
Ambulance Handover - % of clinical handovers completed within 15 minutes of recorded time of arrival at ED	45.70%	32.98%	32.34%	65%	n/a
Ambulance Handover - % of clinical handovers completed within 30 minutes of recorded time of arrival at ED	90.22%	80.95%	82.48%	95%	n/a
Ambulance Handover - % of clinical handovers completed within 60 minutes of recorded time of arrival at ED	97.76%	91.63%	92.90%	100%	n/a
Mixed Sex Accommodation Breaches	10	0	0	0	n/a
Zero tolerance methicillin resistant Staphylococcus aureus	2	3	2	0	n/a
Minimise rates of Clostridium difficile	92	69	53	65	n/a
VTE risk assessment: all inpatient service users undergoing risk assessment for VTE	88.93%	87.47%	88.69%	95%	n/a
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	85.07%	84.28%	84.30%	90%	n/a

Proportion of inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	72.73%	79.16%	81.42%	90%	n/a
Community health services two-hour urgent response standard	86.78% (March 24)	70.87%	72.27%	70%	

To note the following national contract changes:

From April 2024:

Amendment to the diagnostic standard to the % of service users waiting less than 6 weeks from referral for a diagnostic test

From April 2025:

Introduction of a new metric; Percentage of RTT waits over 52 weeks for incomplete pathways

Agreed trajectories refer to the trajectories submitted during the annual planning cycle

A Consolidated Annual Report on Rota Gaps

Resident 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 92.55% across all training grades, an increase of 2.51% on 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.

NHS Birmingham, Black Country and Solihull Integrated Care Board statement on Walsall Healthcare NHS Trust (WHT) Quality Account 2025/26

1.1 Birmingham, Black Country and Solihull Integrated Care Board (ICB) as co-ordinating commissioner for Walsall Healthcare NHS Trust, welcomes the opportunity to provide this statement for inclusion in the Trust's 2025/26 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 12 June 2026, and the review has been undertaken in accordance with the Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

1.3 The information provided within this account presents a balanced report of the healthcare services that Walsall Healthcare NHS Trust provides. The report demonstrates the progress made by the Trust against the 2025/26 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and priorities set for 2026/27.

1.4 During 2025/26, the ICB worked collaboratively with Walsall Healthcare NHS Trust to review progress against key quality improvement programmes, including safeguarding assurance, infection prevention, deteriorating patient initiatives, maternity safety through the Saving Babies' Lives Care Bundle, and discharge transformation. Through regular quality surveillance, governance meetings and system-wide oversight arrangements, the ICB provided assurance, challenge and support to help drive continuous improvement in patient safety, clinical effectiveness and patient experience. We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2026/27.

1.5 The ICB welcomes the opportunities presented in the report to strengthen partnerships through Walsall place arrangements, assuring alternative pathway arrangements through the neighbourhood models of care and reducing demand upon emergency services.

1.6 We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2026/27.

Yours sincerely,

Sally Roberts

Chief Nurse/Clinical & Quality Officer

Birmingham, Black Country and Solihull (Cluster) Integrated Care Board

Healthwatch Walsall Response To: Walsall Healthcare NHS Trust Quality Account 2025/26

Healthwatch Walsall welcomes the opportunity to respond to the Trust's Quality Account for 2025/2026.

Undoubtedly, the Trust has made progress this past year as highlighted in some of the key metrics.

We note improvements in referral to treatment times, a reduction in waiting lists and cancer pathways improved, all of which should help raise patient experience of services.

This is encouraging, given that the last CQC inspection rated the Trust as requires improvement overall, (report published 12/1/2026).

It is hoped therefore, that the progress the Trust is making across a range of disciplines will manifest in a more positive CQC rating at the next inspection.

The NHS faces significant challenges in achieving the Government's 10-year health plan, whilst at the same time managing both resources and finances effectively. In this respect, the shift from hospital to community for services, will be fundamental to the Trust in continuing to meet patient expectations.

The roll out of virtual care and wards is a progressive step and Healthwatch Walsall would be interested in undertaking a piece of work for the Trust to evaluate patient feedback in this area.

We note the Trust's ongoing progress against its priorities of patient safety, clinical effectiveness and patient experience. Regarding the latter, we hope the Trust will endeavour to factor in the importance and relevance of ongoing independent public engagement.

Healthwatch Walsall has consistently maintained an open working relationship with the Trust over the years, enabling our organisation to observe many aspects of service provision, representing the views of patients and the public first hand, often facilitating improvements in outcomes.

The Trust has identified its continued commitment to work closely with partners across the VCSE sector.

The Quality Account shows that the Trust has a robust approach to complaints and their investigation process.

In particular, we like the increased use of virtual interpreting services especially in Out-Patients, enabling patients to have a better understanding of the care process.

Communication, either whilst in care at the Trust, (for example UTC), or indeed regarding appointments, always ranks high in respect of any dissatisfaction expressed via feedback to Healthwatch Walsall.

There is a comprehensive system of internal clinical audits. It would be interesting to understand who undertakes these audits and if they are independent to the system.

The information derived from the maternity survey 2025 is important and topical. It is good to see that the Trust has highlighted post-natal care as an important area to tackle, together with improved communication and emotional support.

In addition, a commitment to reduce triage waiting times should be recognised.

Healthwatch Walsall has considered undertaking some focus group work around this subject during 2026/2027 and would welcome the opportunity to discuss such with the Trust directly.

We note the ongoing utilisation of the Friends and Family Test in which there has been improvement over 2024/2025. Nevertheless, we would continue to emphasise the importance of listening to patient stories and journeys in conjunction with collectable data and the gradual uptake of the NHS app by patients.

The metrics as published towards the end of the Quality Account should really be summarised at the beginning, enabling the reader to assess the Trust's overall performance against National targets.

Whilst the Trust is achieving in a great number of areas, there are still some gaps in service provision, for example:

- percentage of service users waiting less than 6 weeks from referral for a diagnostic test, 75.45 % (annual) vs 95 % target.
- percentage of A&E attendances where service user was either forwarded in care journey or discharged within 4 hours of arrival, 7.08% (annual) vs less than 2%.

We would also encourage the Trust to publish and share an easy read version of its Quality Account, incorporating brief key data.

Finally, we would like to recognise the ongoing hard work undertaken by all the Trust's employees and volunteers. The constant pressures that are exerted on the organisation are immense. Nevertheless, the Trust should be congratulated for continuing to work hard in seeking to extend the quality of care for all citizens of Walsall'

Healthwatch Walsall

June 2026

Statement of Director Responsibilities in respect of the Quality Account 2025/26

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 2025 to March 2026
    - Papers relating to quality reported to the Board over the period April 2025 to March 2026
    - Feedback from local Black Country Integrated Care Board dated June 2026
    - the 2025 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, KCV CBE, Chair

Date: 30 June 2026

Joe Chadwick-Bell, Group Chief Executive Officer

Date: 30 June 2026

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement has confirmed in the Quality Accounts requirements for 2025/26 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

Call 0300 456 2370 or email: wht.patientexperienceteam@nhs.net

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。