Walsall Healthcare NHS
NHS Trust

Quality Account 2016/17

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Becoming your partners for first class integrated care

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

Contents

Walsall Healthcare NHS Trust is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete.

This data quality agenda presents an on-going challenge from ward to Board.
Identified risks and relevant mitigation measures are included in Walsall Healthcare NHS Trust's risk register.

This report is the most complete and accurate position available.
Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Section 1: Statement on Quality from the Chief Executive 2016/17

I am delighted to present the annual Quality Account for Walsall Healthcare NHS Trust. The aim of the report is to provide an honest account of the quality of the services we provide. The report therefore contains sections describing the progress made in meeting our quality improvement priorities over the last year, our performance against key measures and also where we will be concentrating our improvement activities in 2017/18. Some of the highlights of the year are also included.

The Care Quality Commission (CQC) Chief Inspector of Hospital's inspection in 2015 rated the Trust as inadequate and we were placed in special measures. The Trust's management teams and colleagues have pulled together and delivered really significant changes to our systems, processes and the delivery of care to our patients. The progress each service has made is described in section 2.3 and in our Patient Care Improvement Plan (PCIP) published on the Trust's website. Our full CQC re-inspection in 2017 will be an important milestone for us on our journey and we look forward to showing the progress we are making to ensure our services are Safe, Effective, Caring, Responsive and Well Led.

Just over 12 months ago we began a five-year journey to tackle the quality, cultural, capacity and financial pressures our Trust faces and to deliver our Vision of "Becoming your partners for first class integrated care". This Vision has been developed in partnership with staff who work in our community services and the Manor Hospital and the acknowledgement that its successful delivery will mean changes to the way we provide care, the way we work with each other and the way we work with our partners.

The main principles are:

1. That we will deliver the right care, in the right place, at the right time as we would want it for our families and friends.

2. If we provide a service, we will provide it safely, if we cannot do so on our own, we will work with partners or seek a different provider.

We made a good start and have already come a long way over the last year. We have tackled the immediate safety issues identified during our 2015 CQC announced inspection in our Emergency Department and Maternity Department.

We are also improving our approach to risk and using Listening into Action to make a fundamental change in the way we work and lead. We have established the clinically-led model and significantly reduced our elective care backlogs.

Our Quality Commitment sets out the areas of improvement through which we will increasingly deliver safe, high quality care across all our services. A supporting programme of work is being led by senior colleagues and working groups and closely monitored for its effectiveness by the Trust's committees and ultimately the Board.

We set out ten improvement priorities in last year's Quality Account which were closely tied into our 5 year strategy. Good progress has been made in many of these, particularly in the implementation of systems and processes to support safe and effective care in the A&E and Maternity departments, and the new model of clinical leaders in the Divisions is developing. Some of the improvement priorities, such as the development of stroke services, depend on working with partner organisations.

Safe

We have worked hard to improve the safety of our services by improving the reporting and investigation of incidents, how we say sorry to patients and relatives (the Duty of Candour), acting on the findings of investigations and sharing learning, our management of risk and many other ways described in the Quality Commitment. It is encouraging that we saw fewer serious incidents reported in 2016/17 and no Never Events.

The most reported patient safety incidents are pressure ulcers, falls in hospital and infection control.

- Slightly fewer grade 3 and 4 pressure ulcers developing in hospital have been reported this year and changes to the Tissue Viability Team will help to drive through further improvements.
- The rate of patients falling in hospital remains lower than the national average and we continue to work to prevent patients suffering harm through falling.
- There were no MRSA blood stream infections this year and we narrowly missed the target of 18 cases of clostridium Difficile by 3.

We are working to reduce the harm for patients whose condition deteriorates during their stay in hospital and to identify and manage patients with sepsis better.

Effective

Our mortality rates continue to show fewer deaths than expected in hospital (94.83) and slightly higher than expected for patients discharged from hospital within the last 30 days (105.68). An increase in deaths was seen across the country in December 2011 and January 2017 and we also experienced this, particularly for readmitted patients and those at the end of their lives admitted for palliative care.
Our palliative care and end of life services remain strong as do our community services.

Patient Experience

Our complaints process has improved with better response times and fewer dissatisfied complainants. Training staff and agreeing timeframes for a response with complainants have been key factors. At year-end, 79% of complaints had been responded to within the agreed timeframe. We also saw a reduction of 86 in the number of complaints received from the previous year to 284. The Complaints Monitoring Panel led by lay people continues to add great value to improving processes and learning.
The over-riding theme emerging from formal complaints During 2016/17 was 'clinical care, assessment and treatment' this accounted for 59% of all complaint categories with, communication, appointments, diagnosis and discharge accounting for the majority of the rest.
Some of the actions we have taken to improve care in response to complaints are described in section 2.8.

The Friends & Family Test shows that over 90% of patients would recommend outpatient, inpatient and maternity services and 74.6% A&E,

The results of the National Inpatient Survey undertaken in the summer of 2016 will not reflect the improvements we have since then but the results were poorer than many other Trusts and show that we have to improve in areas such as communicating well with patients, especially about decisions in care, providing information, waiting and work to improve patient confidence in our doctors.

The staff survey, also undertaken in 2016, shows that our colleagues feel safe to report unsafe clinical practice and get support from their immediate managers, but feel less able to contribute to improvements at work, something which Listening into Action programme is designed to help, The development programme for our management teams, our engagement programme and our aim to create a learning organisation are some of the key actions we are taking to improve in this area.

Our performance has seen improvements in meeting all the cancer targets in 2016/17 and no MRSA blood stream infections, but narrowly missing the clostridium Difficile infection target and only achieving 84.1% of patient seen within 4hrs of attending A&E.

The year ahead will be a challenging one as we continue to improve the quality of services and balance the books while working towards delivering a seven day service.

I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information contained in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by Walsall Healthcare NHS Trust.

Richard Kirby
Chief Executive

Walsall Healthcare NHS
NHS Trust

Our vision

Becoming your partners for first class integrated care

so that the people we serve feel...

Welcomed

Cared for

In safe hands

so that our colleagues feel...

Part of one team

Appreciated

Supported to meet our high standards

OUR QUALITY COMMITMENT

Provide safe, high quality care across all our services

PROMISE	• Pa… well-informed colleagues who understand each other's roles to deliver and improve services • **Supported to meet our high standards** in a team that sets clear expectations, supports and challenges you to live up to them, is open and honest about what's going well and what's not and takes time to reflect and improve • **Appreciated** by colleagues who value and respect them as individuals and recognise their efforts and achievements	• **In safe hands** of highly skilled, efficient, reassuringly professional teams providing first class joined-up care	• **Cared for** as an individual by kind and considerate people who involve you and your family in your care • **Welcomed** by friendly, helpful and attentive staff who value your time
AIM	**Provide Effective Care – Improve Patient Outcomes** To deliver sustainable evidence based care/best practice and effective pathways and to improve clinician and patient reported outcomes	**Improve Safety – Reduce Harm** To reduce avoidable death and injury, to improve patient safety culture and leadership and to reduce the risk of error and adverse incidents	**Care and Compassion – Improve Patient Experience** To listen, respond to and learn from patient feedback and as a result improve patient experience of care
16/17-17/18 PRIORITIES	• Review and improve pathways of care: - Emergency admissions - At end of life - acute and community - Paediatric pathways especially from ED -> Wards - Step down critical care beds - Normal Birth - Fractured Neck of Femur Pathway • Implement actions to meet the National 7 day service clinical standard • Embed monitoring and learning from: - Mortality reviews and mortality alerts - Clinical incidents • Embed ward/clinical team performance reviews • Improve process for responding to NICE technology appraisals and CAS alerts • Improve our emergency care pathway - Safer bundle - Improve discharge planning • Improve our elective care pathway - 18 weeks - Cancer - OPD • Embed Clinically Led Modal • Establish a sustainable future for stroke services • Deploy mobile technology for community services • Development of integrated locality teams with partner agencies • Develop and introduce new roles within clinical workforce • Improve medicines delivery system and therefore access to medications	• Implement best practice standards around resuscitation, acting on deterioration and utilisation of sepsis bundle. • Improve antibiotic stewardship and deliver planned reduction in antibiotic use. • Improve medicines safety standards – specifically: - Controlled drug standards - Safe storage medicines - Reduction in missed doses - Use of medicines safety thermometer - Preventing harm from insulin incidents • Reduction of avoidable harm events - specifically: - Hospital / community acquired pressure ulcers - Hospital / community acquired falls - Hospital / community acquired infection - Hospital / community acquired VTE • Improved compliance with DNA CPR consideration • Improved compliance with MCA / DOLs standards • Implement the use of maternity safety thermometer • Ensure safe staffing levels measured using recognised acuity tools, capacity / demand modelling and national guidance. • Conduct a bi-annual safety culture survey. • Ensure 'no harm' to patient waiting times in excess of accepted standards. • Establish a Medical Devices Committee and ensure staff are trained and have the right equipment to do their job. • Deliver PDP especially regarding: - Maternity services - ED and urgent care pathway - Section 29 compliance actions • Review and embed effective risk management system • Embed new approach to incident investigation. • Use quality impact assessment to inform safety impact of transformation or savings programmes • Embed use of safety huddles • Review governance around advanced practice	• Deliver patient experience work plan including key thematic work streams: - Improve customer care at front desks - Reduce internal transfers • Improve FFT response rates to understand patient views • Improve interpreter service and improve access to services • Embed new complaints approach and improve response rates • Ensure safeguarding vulnerable people's standards met • Embed process for triangulating patient views • Introduce "Hello my name is ….." initiative • Ensure Duty of Candour standards are met • Use equality impact assessment to ensure fairness of services • Embed public / patient engagement approaches e.g. - Maternity Liaison Committee - Matron Connect - In Your Shoes • Assess Trust approach and compliance with best practice pain control and develop and implement action as a result. • Improve information for patients and relatives on admission and at discharge. • Ensure patient access to food and fluids meets their individual needs • Complete assessment of Trust compliance with Equality & Diversity System 2 and plan action as a result. • Develop division and care group patient experience improvement plans • Expand volunteer services • Dementia/Safeguarding – increase use of personalised care plans	**STAFF AND PUBLIC ENGAGEMENT / COMMUNICATION**

Supporting Work Programmes / Infrastructure

Quality System | Organisational learning, culture & leadership | Staff numbers, skills & competence | Audit & Measurement | Systems & Processes | Service Improvement & Transformation

Inclusion in CQUIN programme | **Local quality priority** | **Depicts CQC action / national priority**

Section 2: Review of Quality Performance 2016/17

Our Services

Walsall Healthcare NHS Trust is an integrated healthcare organisation based in the West Midlands, serving the 269,300 residents of the borough of Walsall. The Trust provides a comprehensive range of hospital and community healthcare services to their own homes. We are registered with the Care Quality Commission.

The Trust has 606 inpatient beds including 536 acute and general beds, 57 maternity beds and 13 Critical Care adult beds. There is additionally a separate Midwife Led Unit and a specialist Palliative Care Centre.

The Trust is an integrated provider of healthcare, many services have moved beyond traditional boundaries for the benefit of patients. We provide high quality community health services for adults and children, including many specialist clinics, from more than 60 community settings, such as health centres and GP surgeries and, importantly, in people's own homes.

Our multi-disciplinary services include rapid response in the community and home-based care, so that those with long-term conditions and the frail elderly can be cared for in their own homes.

We also provide smoking cessation, drug and alcohol support, a Physical Activity team and a Health Training service via our Lifestyle Management Service.

Services are organised for management purposes into four divisions:

- Surgical Division,
- Medical and Long Term Conditions (includes adult community services),
- Women's, Children's and Support Services (includes children's community Services and Midwifery Led Unit) and also Diagnostic and therapy services for instance Pathology, Pharmacy and Physiotherapy.
- Corporate Services (includes estates management, Specialist services including but not limited to tissue viability, infection control etc and Palliative Care (including Goscote Palliative Care Centre).

2.1 Introduction

Quality Accounts are annual reports to the public from NHS providers about the quality of the services they deliver. The report aims to enhance accountability to the public for the quality of NHS services. The Quality Account for Walsall Healthcare NHS Trust sets out where the Trust is doing well, where improvements in quality can be made and the priorities for the coming year and where we hope to do better still.

Our quality priorities are aligned to the domains of patient safety, clinical effectiveness and patient experience.

We set ourselves ten priorities for 2016/17. Some changed structures or the way we provide care, others sought to provide improvements in the safety of the care delivered. The priorities were identified as part of a programme called the Five Year Forward View. The priorities reflected the overarching work we have undertaken to improve care for patients, even where the aim is to improve for staff or the facilities achieving these aims has the effect of making things better for people being cared for by our staff in those facilities. As the title suggests, some of these improvement priorities will take up to five years to deliver. A summary of our progress at the end of the year is provided below.

The improvement priorities were designed to address the issues reported in the inspection report produced by the CQC following the September 2015 announced inspection. We have made a great deal of progress in that time and a summary of what the CQC told us, what we did and what we still have to do is provided.

2.2 Progress with quality improvement priorities for 2016/17

Priority 1: deliver all of the actions promised within our Patient care Improvement Programme.

Considerable progress has been made during the year and this will be tested when the CQC re-inspect the Trust in 2017. We expect that the large majority of the actions required by the plan will be fully or substantially completed by April 2017. Section 2.3 provides detail for several services. Any remaining actions will continue to be worked on and monitored for completion during 2017/18. Updates on our progress can be found on our website **https://www.walsallhealthcare.nhs.uk/cqc.aspx**

We have been visiting wards and departments on a regular basis to make sure that we are getting it right. Some areas have improved faster than other but all areas are showing improvement.

Priority 2: Improve patient experience as a measured by patient surveys, Friends and Family test, complaints and social media responses. Improve patient experience, so that the Trust will be positioned in the 1st Quartile of all NHS.

More detail of this improvement priority can be found in section 2.8.

It can be seen from the results of the patient survey and from the Friends and Family Test that work for to achieve our objectives continues. This work continues through the improvement programmes.

Priority 3: Embed a culture of safety within the trust measured by the staff feedback, incident reporting, and safety improvement methodology and embedding of Duty of Candour.

Particular emphasis is to be placed upon ED & Maternity.

Good progress has been made in this continuing improvement priority. Training for staff about Patient Safety and investigation has been provided to over 100 members of staff to improve awareness and investigation skills. Training in improvement methods will start in early 2017/18. A Safety Culture Survey has been undertaken twice during the year. The result of the second survey showed an improvement in the opinion of members of staff about the Trust's support for people to report incidents and learn from events.

The Trust has also trained over 100 people in the Duty of Candour, the legal duty to be open and honest when care goes wrong. Section 2.6 includes more detail on how we apply and measure the process.

We have revised and improved our processes for risk management and investigating incidents using root cause analysis with training to support staff in doing these. This has led to a better understanding of the Trust's risks, their management and escalation to higher levels of management for action when required. We consistently complete the investigation of serious incidents within the required timescales, or agreed extensions, and have seen measurable improvements in both the Emergency Department and Maternity including a reduction in the number of serious incidents reported. Learning is shared with the care teams involved in incidents and more widely across the Trust in newsletters and by changing processes and practice.

Priority 4: Refreshed Quality Strategy 2015-17 to incorporate CQC concerns and revise priorities.

During the year the Trust produced the Quality Commitment which brought together all priorities into a one page document. This is available for all staff to see on the intranet. It is shared in this document on page 6.

Behind the single page are a number of projects and plans which together describe how the Trust is working to learn and changing to improve care delivery and patient safety.

Priority 5: Programme to reduce avoidable harm by 20% by the end of 2016/17.

We introduced a programme of work, enhanced after the CQC inspection, to contribute to the reduction in avoidable harm. This links to the Sign up to Safety initiative described later in this report. Measuring avoidable harm is not straightforward but the following initiatives have been introduced:

- The work undertaken as part of the CQUIN to care for patients deteriorating in hospital and those with sepsis.
- Reviewing the care for every patient who dies in hospital – mortality reviews – to see what could be improved in line with the National Quality Board recommendations.
- The work undertaken in the Maternity and Emergency Departments as part of their Patient Care Improvement Plans (PCIP).
- A reviewed consent process that will help to better explain the risks and benefits of diagnostic and treatment procedures so that patients can make an informed decision on the options available and reduce the potential for psychological harm.
- A wealth of other work described in this Quality Account to reduce the incidence of pressure ulcers, infections, patient falls across the Trust and improve medicines safety.
- Engaging with colleagues about patient safety and training them to understand how good practice prevents harm and the value of investigating to understand why things go wrong so they can be improved. This includes hosting Patient Safety 'Kitchen Table' events for colleagues to talk openly about issues in a safe environment.
- No Never Events or MRSA blood stream infections have occurred in the Trust in 2016/17.

Priority 6: Embed a clinical leadership model across all divisions and care groups.

The Trust has been working to address concerns that were raised in 2015 about the strength of the leadership in the organisation. We have focussed our attention on having the right staff and of supporting those staff to be prepared for the challenges of leading in the 21st century. During the year, there have been a number of different ways we have provided support and training to Executives and Managers in the Trust. The Kings Fund provided training. We started a programme of training for all managers called the Effective Leaders Programme. This has added to the knowledge and skills of the Trust leaders.

We have been working to change our management within all divisions such that each clinical area has a Medical, a Nursing and a management lead. As part of this we have recruited a number of new Leaders including a Divisional Director of Midwifery, A Divisional Director of Paediatric Nursing and a Director of Clinical Support Services. Governance Advisors have also been appointed for each of the clinical Divisions to support the clinical leadership model.

Priority 7: Develop existing work and commence the implementation of the Royal College recommendations for the 7 day week.

Walsall Healthcare NHS Trust has identified gaps in relation to delivery of a 7 day service. The Trust continues to work on this as part of a system wide approach.

The key issues include an inability to provide consultant review within 14 hours for wards outside of the core admitting areas that accept direct admissions. Lack of specialist medical cover to provide twice daily reviews for emergency admissions for wards outside of the core admitting areas and lack of provision of a consultant delivered ward round on Sundays.

Priority 8: Further development of the 'Sign up to Safety' campaign to cover specific areas e.g. reduction of harm.

Walsall Healthcare NHS Trust has continued work to follow the national Sign up to Safety campaign. The campaign aims to ensure there is an open, honest approach to recognising that things go wrong and to making changes to improve to reduce avoidable harm to patients.

The original plan included 3 key priorities, Pressure Ulcers, Management of Insulin and Transfer of Patient Care and this is continued in the new Quality Commitment. Section 2.6 contains further information on patient safety.

The Clinical Governance Department has developed in the year to include a clinically qualified Divisional Governance Advisor in each division. The teams have spent time in each ward and Department in their division having conversations with staff to make the connection between issues in the area and lessons that have been learned; between risk management and changing to improve things for patients and staff. Most recently they have held successful patient safety 'kitchen table' events.

Safety Huddles have been introduced in a number of areas which help to share lessons learned and understand the issues that have been reported recently.

At the end of the year we arranged an event that was part of the national 'Patient Safety Kitchen Table'. We gave out information, we offered advice, we discussed the concerns people had and we shared learning. Those who attended gave their views on how they enjoy the support of the experts in the team and how the team can support them further.

Priority 9: Improve the Quality and Safety of our care in specific services:

9a) Safety of Maternity and Neonatal Care.

In addition to the leadership changes for maternity and neonatal care, we are participating in the Sign up to Safety campaign and are committed to supporting the national ambition to halve the number of neonatal and maternal deaths, stillbirths and brain injuries by 2030. We recognise the need for every member of staff to be a patient safety champion. We are also joining Wave 3 of the National Maternity and Neonatal Health Safety Collaborative.

At the centre of the quality improvement plan is maintaining not only the safety of women and babies but also ensuring that they have a positive experience as a result of their interaction with our service. It is essential that we focus on making our services safer and not simply focus on outcomes. In order to do this we are actively involving women not only in their own care decisions but we will also involve women in the development of this plan and other guidance documents in order to fully take account of service user views. This will lead to an enhanced level of care.

It is recognised that outstanding maternity units look beyond guidance and continue to strive for new ways to make their service better. Outstanding units provide a high level of service when things go wrong and have a comprehensive safety system in place to support this. They use incidents and complaints as opportunities for learning across the whole service. The leadership within such units supports an open and honest "no blame" culture in which team work thrives and women are at the centre of their individualised care. The maternity dashboard is used proactively to drive service development and improvement. It is the aim of Walsall maternity to achieve this.

The focus of this improvement plan covers seven areas:

1. *Reducing the Caesarean Section rate*
2. *Reducing the induction of labour rate*
3. *Staffing and capacity including capping of birth numbers*
4. *Improved interpretation of CTGs (monitoring the baby's heart rate during labour)*
5. *Reducing 3rd and 4th degree tears*
6. *Reducing avoidable term admissions to Neonatal Unit (NNU)*
7. *Implementation of the Sepsis Six pathway*

These domains have been specifically chosen as they each have a significant impact upon the health and wellbeing for women and their babies and families. We believe that this safety plan will have a positive impact on these domains and thereby ensure the provision of a high quality, evidence based maternity service which is woman and family centred and focuses not only on the important element of safe care but also on ensuring that the experience of women who we care for is a positive one which takes into account their wishes and needs.

9b) Emergency Department (ED) and Urgent Care Pathway

A wide range of improvements to structure and processes designed to improve the safety for the Emergency Department and its patients have been implemented with continuing work during 2017/18. The improvements made include the following:

- A new Governance structure to support improvements through Emergency Care with the ED Task Group
- Staffing investment of £1.2m to Nurse and Medical workforce to develop a sustainable skilled workforce
- A Paediatric Nurse Team has been introduced into the department to work towards 24/7 cover in the team
- IT systems have been developed to ensure patients with "clinical priority" are managed through Triage using the Fusion Whiteboard
- The governance framework has been further developed to monitor standards of compliance for audits including Triage and Pain Scoring and reporting through Oversight and Care Group Meetings – the end of year report shows 98% average for Triage compliance and 95% for Pain Score completion
- Improved sharing of learning with the team from incidents and other sources using monthly Newsletters, regular Team Meetings and teaching sessions covering Patient Safety and increased visibility in the department of updates and reports on new notice boards
- Professional Standards have been set and established within the ED to maintain safety and quality of care for our patients
- Developed IT to show "real-time" patient activity for the team leaders to use to manage pressures in the department
- Introduced a new Risk Management system and meet regularly with Patient Safety to manage and review risks and mitigations

Safety doesn't sit alone in our work and other actions are in place to improve our clinical effectiveness and caring of patients.

Our work continues into 2017/18 with the following safety priorities:

- Develop the Band 6 Nurse Team Leaders to improve the management of our patients
- Develop regular Nurse In Charge and Team Leader Meetings to support consistent approaches and continuous improvements
- Continue to develop ways of working within our Paediatric Area using the Paediatrics Focus Group
- Implement a sustainable medical model by introducing alternative ways of working and reducing Consultant vacancies

A business case for a redeveloped ED to respond to local changes has been developed with the aim of further improving the ED service. It proposes a newly developed ED and Acute Medical Ward which would increase capacity with the Emergency Department to current standards. The Strategic Outline Case has been approved by the Trust Board and is with NHS England for review before we develop the Outline Business Case over the coming months.

9c) Safety of Cancer Services

The Trust improved its performance during 2016/17 and achieved all of the national cancer waiting time standards.

9d) Establish a sustainable future for the Stroke Service.

The Stroke services continues to perform competitively in relation to performance against Best Practice Tariff and the Sentinel Stroke National Audit Programme (SSNAP) Report. Both these areas provide us with a picture of regional and national performance. The Trust is currently appraising the Stroke Service with consideration of future service demands and the implications that this could have and this is continuing with the inclusion of local health partners and the Clinical Commissioning Groups to ensure that a robust and informed discussion will be made. The aim is that the population of Walsall receive a sustainable and resilient Stroke Service.

9e) Improve the quality of care we provide to patients at the end of their life.

In the last twelve months we have continued and strengthened our approach to understanding and auditing the care we deliver at end of life to our patients. Each month we audit approximately 20% of deaths in our care both in our acute and community setting. The audit focuses around the five priorities for the dying patients and includes bereavement care and support following death. This data is presented in an organisational end of life care dashboard which is circulated to all Divisional Care Group Meetings monthly. In addition to this, we have also begun reporting this year at a Care Group and Community Place based team level, this feedback care of twenty patients who died receiving care from a specific team and mirrors the organisational dashboard. The Teams are then asked to derive an improvement plan which is presented to the organisations End of Life Strategic Delivery Group, this is the overview and monitoring mechanism.

In April 2016 we introduced our new Individualised End of Life Care Plan and Thinking About End of Life Care Booklet across the organisation to support those patients nearing end of life and their families and carers. The booklet was the winner of the BMA Patient Information Awards for the category for user engagement in September 2016. As part of the implementation plan the Specialist Palliative Care Team provided education to staff in all clinical environments in both acute and community care settings. Consequently, approximately 700 staff across the Borough are now trained. Furthermore, for our acute site we are providing monthly data at ward level on the number of patients dying, number of individualised end of life care plans being used, AMBER Care Bundle Use and feedback for bereaved relatives via the organisations amended VOICES Bereavement Questionnaire. The support of families following death on the acute site has also been strengthened in September 2016 with the introduction of a dedicated Bereavement Officer site to improve our immediate information giving and support to newly bereaved families and carers.

Our overarching strategic objective remains unchanged which is to enable more people to die in the place of their choosing. We have continued to develop alternative options for patients rather than hospital wherever possible and have end of life diversionary beds in partnership with a local nursing home and alternative treatment pathways with our local hospice provider. We are also working closely with our accident and emergency departments for those patients admitting to acute care at end of life. Alongside we have also continued to develop our care and support to those patients wanting to receive care at home by engaging with other community service developments such as rapid response teams and will be developing a Hospice at Home project with other partners this year. This allows those patients with needs of greater complexity to receive acute intervention if required and to stay at home safely and supported.

Priority 10: Community Services Development.

10a) Complete the deployment of integrated locality teams with partner agencies in Mental Health, Social Care and Primary Care

Adult Community services are provided by a wide range of services however the vehicle for providing care is driven around seven Integrated 'place based' health and social care teams. The seven teams which are delivered from six bases provide patient care covering four place bases i.e. North, South, East and West.

These team bases and geographical mapping have been re-configured during 2016 and has supported the Walsall Together Collaboration which is a strategic partnership bringing together health and social care, Voluntary services, public health priorities and area partnerships with the aim of further developing our local neighbourhood intelligence, thus developing resilient communities and enhancing Multi-disciplinary Team working and outside of hospital care. These teams work in partnership with acute teams, Specialist teams including Rapid Response, Clinical Intervention and Intermediate Care.

10b) Deploy mobile technology for community Teams

Community nursing services are delighted that they have received approval and funding to be able to change from a paper based patient assessment and service management system to a mobile technology solution. Benefits include diary management, tracking of staff to support lone working and referral management.

Patient care planning, history taking, gaining patient consent are just a few of the functions which will support ensuring Walsall Healthcare Community nursing services are fit for purpose and sustainable. Efficiencies attributable include reductions in community mileage costs and resources to meet increasing demands for care closer to home. Deployment will take place throughout 2017/18.

10c) Build a directory of services and a single point of access to ensure efficient use of resources.

A directory of services has been completed for Adult Community Services which provide details of all the service access points. A single point of access is provided for each of the Integrated Locality teams which are co-ordinated through a clinical triage. These access points are planned to ensure Primary Care referrals are received timely without undue delay and that care is provided with expected response by the right person for the right patient.

10d) Continue the development of integrated pathways that link key services together seamlessly.

During 2016/17 "IV at home" and Rapid Response clinical pathways have been enhanced which have resulted in an increased number of sub-acutely unwell patients receiving safe and effective care in their own homes. Further work is progressing to review respiratory and Urology pathways which will be completed during 2017/18.

2.3 Progress since the CQC inspection report

Division of Medicine and Long Term Conditions

Walsall Healthcare NHS
NHS Trust

What CQC told us	What we did	Where we are heading
• We were not able to provide a protected, suitable physiotherapy environment (stroke ward) • Some of our physio equipment was damaged and did not comply with infection control guidance • Some of our medical wards did not always display up to date patient safety dashboards • Our recording and monitoring of fluid balance needed to be improved • Not all staff understood the meaning of butterfly bays in relation to dementia patients • Many of our staff handling food had not received basic food hygiene training • We did not have a enough nurses attending acute illness training • We needed to improve privacy for in-patients nearing end of life • Within our Emergency department we needed to: • Describe our over-arching vision for the department • Improve arrangements for care of children in the department • Improve our waiting room seating • Keep waiting patients much better informed • Review the purpose of ED log sheets • Increase our staff appraisal rates	• We have a procedure to follow if the physio gym is in use for extra capacity patients • We have replaced damaged physio equipment • We have improved our display of up to date patient safety information on wards and audit this • We have improved nursing assessments and the fluid balance chart has been simplified to facilitate completion • We have improved awareness and use of butterfly symbols to denote patients living with dementia • We have provided basic food hygiene training • A programme of acute illness programme was re introduced during 2016 • We converted non-clinical rooms to patient side rooms on some wards. • A staffing plan with new roles is being recruited to, and we have improved our induction for new staff of all grades and introduced a departmental newsletter • We now have paediatric nurse cover 24/7 and have re-designed and re-defined our waiting area; we have introduced a separate child friendly triage room • We revised our care records and hand over documentation • We improved our staff appraisal rates within the Emergency Department to above the Trust 90% target	• We are introducing revised nursing documentation across all of our wards, to make it easier to manage patient records alongside simplified fluid balance charts • We need to further improve our recognition and management of deteriorating patients and to support this the acute illness programme will be expanded with more training offered across the trust • We now have a clear vision for our Emergency Department and the Trust Board has approved a business case for expansion of these facilities. • We plan to utilise the siderooms and enhance them so they enhance end of life care for those patients who choose to remain in our care

We are most proud of…

• We listened, we learnt and moved forward.

Division of Surgery

Walsall Healthcare NHS
NHS Trust

What CQC told us	What we did	Where we are heading
• We had to improve patient flow to reduce delayed transfers of care and same sex accommodation breaches • Many of our staff handling food had not received basic food hygiene training • We did not ensure that our ward and departmental Resus trolleys were checked every day • We did not have sufficient training for medical devices and IV pumps • Our post –operative facilities for the day surgery area did not always provide a good patient experience • We could not evidence a deep cleaning schedule for our operating and our theatre equipment storage arrangements needed to be reviewed • Recording drug bolus administration in critical care was not clearly documented • We could not show that all of our critical care patients who died had a morbidity and mortality review process of their care and treatment • We needed to ensure that junior doctors working in critical care were available to attend consultant ward rounds • The recovery environment for children post-surgery needed to be improved • We did not always ensure that Children's equipment and resus trolley in theatres were maintained and up to date	• We revised our working procedures for patients stepping down from Critical Care and this helped reduce same sex accommodation breaches • We have provided basic food hygiene training • The checking of trolleys has improved and we are monitoring this • We have improved nurse staff training on certain devices and equipment and will be providing more. • We have worked with Day Surgery and theatres to ensure patient and staff experience is improved in this area • There is a clear schedule of cleaning and monitoring that equipment is stored correctly within theatres and we invited our partners from Public Health to review the changes • In Critical Care, we put in immediate changes to ensure that bolus drugs were appropriately recorded • We improved our mortality reviews for critical care patients • Changes were made to working arrangements to allow junior doctors to attend ward rounds • In children's theatres we have decorated a recovery bay to be child friendly • We have purchased dedicated paediatric resus trollies (the blue ones!)	• We are working with MLTC and the capacity team towards timely discharge of patients to appropriate clinical settings which will both further improve patient flow and reduce same sex accommodation breaches • We are working towards achieving the Royal College of Physicians National Mortality Case Record Review Programme Outcomes of 100% reviews in all services. • We are working with MLTC to devise a clear process to utilise additional capacity in endoscopy for day case surgical procedures. • We are working with the staff in wards and departments on risk identification, and how to access risk registers

We are most proud of…

• We are very proud of all staff in the Division for the positive way in which they have responded to the challenges in our CQC report and the engagement of clinical and non clinical staff at all levels to work together to improve the way we do things for our patients

WC&CSS (Paediatrics)

Walsall Healthcare NHS
NHS Trust

What CQC told us

- To reduce the need for Neonatal Unit admissions for some babies, we were asked to consider implementing a separate transitional care facility for babies that required extra care.
- We were asked to review children's out- of- hours nursing services to ensure any gaps in service provision were covered.
- We were asked to ensure that the way we carried out root cause analyses and the process used to review mortality and morbidity was to ensure all possible contributory factors are considered.
- Our treatment room on the Children's ward was not sufficiently secure and we needed to make changes in our security measures to safeguard children and young people and those who may self-harm.
- We needed to improve staff training and the environment to support safe care of CAMHS patients - Child and Adolescent Mental Health Services.
- We were asked to provide evidence that we had tested the effectiveness of the child abduction policy.
- We were asked to improve the availability and timeliness of patient records for children's outpatient clinics.

What we did

- We successfully opened a new Transitional Care Unit on the post-natal ward on 6 February with very positive service user feedback.
- We reviewed services out of hours and are satisfied that we do not have any gaps in service cover.
- We have trained staff thoroughly on how to conduct these reviews and have had external oversight of our actions.
- We have improved the way we work to ensure that the treatment room is a safe and secure environment for children and young people.
- A concerted effort has been made to provide assurance that we have a safe environment for CAMHS patients within the children ward. We have developed 2 dedicated anti-ligature areas and have recruited support staff to facilitate 1:1 care where this is needed We have also trained 4 members of staff to be able to deliver STORM training.
- A significant level of work to implement and test policy and procedures has been undertaken. We have satisfied ourselves that the security procedures are effective to keep children and young people safe.
- We have changed the way we work to ensure that children's care records are available in OPD when they are needed and there has been a reduction in the number of incidents reported.

Where we are heading

- We have plans to expand our Neonatal Unit to 20 cots in 2018 and work on this is due to commence. We have recruited overseas staff who will commence in post through 2017-18 to support this expansion.
- A training plan to roll-out STORM training to paediatric unit staff is in place. We are also working with our CAMHS colleagues to further develop the self-harm pathway for children and young people to receive their mental health assessment in the emergency department.
- We have invested in the training of advanced practice roles within both neonates and paediatrics and developed 'acute care consultant' posts to ensure sustainability of the medical workforce in the longer term.

We are most proud of…

- The improvements we have made for children and young people who self-harm or have other mental health issues. We were winners in the 'Quality and Safety' trust awards in November 2017 and have made significant improvements to keep this group of patients safe.

WC&CSS (Women's Services)

Walsall Healthcare NHS
NHS Trust

What CQC told us

- When we were benchmarked against other organisations, we found our midwifery staffing levels were lower than recommended for our increasing birth rate.
- Our interventional birth rate is higher than national and we have been asked to implement more active birth and 'Normal Birth' as the usual way forward for most mums to be.
- We were asked to increase our breastfeeding support to new mums, and to change our way of working to implement specialist midwife roles.
- When our policies and guidelines were reviewed, it was clear that some did not meet national standards, many of these were out of date or did not include or reference best practice.
- Some of our staff described that they did not feel included in decisions affecting services.
- Some of our staff felt that they were not supported to develop in their roles.
- To reduce the need for Neonatal Unit admissions for some babies, we were asked to consider implementing a separate transitional care facility for babies that required extra care.
- We did not ensure the birthing pool was always accessible and available for use, our birthing pool room needed to be clear from clutter.
- We were not making the most of technology to support care during labour.
- We were asked to consider using the maternity Safety Thermometer tool to assist with identifying areas for improvement.

What we did

- We have made a significant investment into midwifery workforce of around £2m since the CQC inspection. We have also capped deliveries to 4200 per year, to improve birth to midwife rate whilst awaiting recruitment.
- We have developed a system wide maternity strategy which is monitored through the Maternity Taskforce.
- We are part way through implementing a new midwifery staffing structure and once this is finalised we will be able to make more progress in these areas.
- We are undertaking a review of all of our policies and guidelines and know this will take a while to put right. This remains a risk for us.
- The results of the latest LIA Pulse Check show we have a few further areas to focus on and have informed the on-going Maternity OD program.
- During 2016/17 midwifery was prioritised for investment in training. We were successful in securing £40k of external funding for safety training. There is a programme of Organisational Development underway which many of our staff are taking part in. We now have practice development support for our student midwives.
- We successfully opened a new Transitional Care Unit on the 6 February and feedback shows it is well–liked by families who have used it.
- We have improved the environment in the birthing pool room, developed a SOP for pool evacuation and undertaken skills drills training with staff.
- We have invested in wireless CTG recording and are developing a SOP for their use.
- We implemented the ST tool in 2016 and are developing an action plan to improve findings.

Where we are heading

- Our Birth Rate Plus staffing analysis will report in April and this will inform our staffing plan moving forward. We will soon be implementing our new structure and specialist midwifery roles.
- We will continue to strengthen our approach and focus on active birth and normality.
- We have plans for a capital build to provide a second maternity theatre facility.
- The development of the 'Normality agenda' will be a major focus of our work over the next year

We are most proud of…

- The new Transitional Care Unit, feedback shows it is well–liked by families who have used it.
- Obtaining a wealth of active birth equipment.
- Increased maternity staffing levels.
- The launch of the Normality strategy to increase active birth at Walsall.

WC&CSS (Clinical Support Services)

Walsall Healthcare NHS
NHS Trust

What CQC told us

1 We were asked to review mortuary fridge capacity and maintenance and ensure that sufficient numbers were available and in good working order.

2 The trust was advised to replace unreliable equipment in radiology.

3 We were advised to ensure receptionists are available to meet and greet patients at all times when they are attending for outpatient diagnostic imaging appointments and procedures

4 We were advised to review the provision of physiotherapy services to ensure initiatives such as the 'joint school' can be re-established.

5 The Trust was advised to ensure that there was secure storage of IV fluids in clinical areas

6 The Trust was advised that they must ensure that all medicines that look similar are not stored next to each other.

What we did

1 Investment has been made in an additional 36 fridges, which have been installed so that deceased patients have ready access to well maintained mortuary fridges.

2 Replacement of the gamma camera for the nuclear medicine service has been approved, and installation of a state of the art SPECT / CT gamma camera is due to commence in April 17, reflecting over £600k of investment

3 There has been a workforce review for radiology administration services and new arrangements are in place which provide sufficient cover.

4 The joint school has been reinstated. The provision of therapy services to other services has been reviewed.

5 The Pharmacy team have been supporting weekly basic drug storage audits which demonstrate high compliance across clinical areas

6 Increased monitoring and vigilance by pharmacy technician has improved and maintained improvement in this area.

Where we are heading

1 Working towards a more cohesive Clinical Support Services Team with sharing of good practice supported by an improved clinical leadership model

2 Reviewing options for sustainable capital replacement of expensive radiology equipment to ensure continued delivery of high quality service

3 Collaborative working across Black Country Alliance for Radiology and Pathology

4 Pharmacy development in line with Carter Recommendations

We are most proud of…

1 Investment in equipment Radiology – Modern equipment allowing improved patient diagnosis
2 Sustained standards across clinical support services
3 Development of service level and Divisional Safety huddles
4 Improved clinical leadership model allowing clinical support services to be represented at senior level

WCCSS Community Childrens Services 0-19

Walsall Healthcare NHS
NHS Trust

What CQC told us

- Services for children and young people were delivered in line with best practice guidance and local agreement.
- There was an effective system in place to report and learn from adverse incidents, errors and near misses.
- There was a multi-disciplinary approach to care and treatment and a proactive engagement with other health and social care providers to achieve best outcomes.
- Staff were appropriately trained and competent to do their role.
- We observed interactions across all CYP services were undertaken in a dignified and compassionate way.
- Support for children across CYP services was child centred and we saw children and parents were involved in decision making and treatments and options available to them.
- To review out of hours working for Childrens Community Nursing Teams
- To ensure compliance with Lone Working Policy.
- To achieve full establishment of Community Paediatricians
- Electronic record systems and multiple child records was a risk to patient safety and required improvement.

What we did

- We reviewed the Community Childrens Nursing service to ensure access up to 8pm in line with the highest period of demand .
- All community staff who require a work mobile have now been provided with one.
- All services have reviewed and risk assessed their Lone Working practice to ensure compliance with the policy.
- The Community Paediatric Service is now fully established following the appointment of a 4th Consultant.
- The migration of CHIS to Lorenzo has now been completed.
- A business case has been developed to support an electronic record system – awaiting Board approval.
- All paper records are now compliant with IG and Health and safety requirements

Where we are heading

- There is currently a review of Health Visiting services to consider access to services on Saturdays.
- Audit against Lone Working policy is part of Annual Audit plan.
- Records are being prepared to commence scanning as soon as approval to proceed has been received.

We are most proud of…

- Development of joint working with CAMHs and inclusion in Community Paediatric Panels.
- Securing 0-5 HCP contract to include a Healthy Pregnancy service
- The development of pathways for minor illnesses (including an App for parents); infant feeding; maternal mental health and transition to parenthood.
- Development of the School Nurse Champions programme
- Implementation of Chathealth in SN service
- Ongoing reduction in TP rates
- Shortlisted for HSJ and NT awards for Health transition Service

Adult Community Nursing Services

Walsall Healthcare NHS
NHS Trust

What CQC told us

- Community Health Services for Adults were GOOD overall with 'are services safe' requiring improvement. Areas where 'should do' recommendations were made were;
- We did not always ensure that patients discharged home were issued specialist bespoken equipment.
- We did not always achieve timely patient risk assessments in the home
- We did not have a Performance Dashboard in place to help us know how we are doing in Community
- CQC feedback also included……
- Patients received compassionate care
- Staff discussed planned care and treatment with patients and provided information to reinforce their understanding
- Incidents were reported and investigated thoroughly.
- Culture of openness in reporting with a no-blame policy to encourage learning
- Good initiatives in place to prevent avoidable hospital admissions
- Staff reported they worked within a supportive culture
- Leadership was knowledgeable about quality issues and recognised challenges such as increasing clinical demand
- Specific areas of good practice included…..
- Use of secure and timely medicines system for Rapid Response using pre identified thumb prints of prescribers
- Case management service for Private Nursing homes with evidence of reducing 999 calls

What we did

- Invested time to feed back outcomes of CQC inspection to our adult community workforce, thanking them and praising them for their contribution and informing them of the areas where improvements in quality care can still be made.
- We have improved provision of bespoken equipment to patients – Standard Operating processes have been developed to ensure understanding of the wide range of equipment available to support care at home. There is evidence to demonstrate we have seen an increase in loan of bariatric equipment at home.
- We have recruited to community vacancies and we have robust evidence which demonstrates our improvements in clinical capacity meeting clinical demand.
- We have seen an improvement in timely assessments for patients in their own homes.
- Clinical care audits of 100 patients care per quarter has seen an improvement when comparing quarter 3 outcomes to quarter 1 and 2 2016
- Care Closer to home dashboard which has been in progress since 2014 has continued showing improvements and has been more widely circulated
- Clinical Quality dashboard for all adult community nursing services has been developed and in use since April 2016
- Adult Community Nursing services have been aligned into a Care Group within Division of Medicine and Long Term Conditions with a management structure which mirrors other Care Groups
- Our 5 Integrated health and social care teams have been redesigned into 7 Integrated Health and social care teams across 4 place bases i.e. North, South, East and West. These teams have been aligned to Primary Care, public health priorities and area partnerships and each serve practice populations between 30 and 50,000

Where we are heading

- We want to further embed the arrangements for our health and social care placed based teams to be fully integrated and working in partnership with Primary Care.
- To help us prioritise and manage our work, we are developing robust data sets for each place based team in relation to: population health needs, co-morbidities, themes for emergency admission and length of stay when admitted.
- We are profiling our teams and workforce to best match the local health need, for example, increasing access to respiratory clinicians in areas where prevalence is high
- We are implementing mobile technology across all of adult and children's community nursing services to help us better communicate between teams and ensure patient care is seamless.

We are most proud of…

- Motivated, engaged and compassionate community workforce
- Reduction and maintenance of avoidable patient harms based on percentage of active community caseloads
- Data available on improved productivity, enhanced community nursing capacity and demand
- Partnership working and relationships with health and social care providers
- Outcomes demonstrated in our 'Care Closer to Home' and 'Quality dashboards'.

Medicines Management

Walsall Healthcare NHS
NHS Trust

What CQC told us

CQC and non-CQC Patient Care Improvement Areas

1. Medicines safe and secure storage: medicines are stored appropriately across all services with focus on the following:
   - Ensure that all medicines that look similar are not stored next to each other
   - Ensure that IV fluids are stored in secure environments
   - Ensure that fridges used for the storage of medicines are kept locked and not accessible to unauthorised staff
   - Ensure that fridge temperatures are checked to ensure medicines are stored at the correct temperature
2. Medicines Safety: Medicines are administered and recorded appropriately across all services with focus on sodium chloride flushes
3. Prescribing Safety: Medicines are prescribed in accordance with Trust Medicines Policy with focus on high risk medicine prescribing
4. Controlled Drug (CD) Assurance: Controlled drugs are ordered, received, recorded, dispensed, administered and destroyed in accordance with Trust Medicines Policy and NICE guidelines
5. Medicines Management Governance and Assurance: Trust Board is appraised of risks and issues relating to medicine management and is able to take appropriate assurance

What we did

- Medicines storage actions completed as described. Weekly ward storage template revised to include red flags for audit standards requiring immediate escalation to ward manager. Furthermore, agreement with SNAG that audits will be carried out with nursing staffs where possible. Monthly audits of drug trolleys to be introduced from April 2017 and more comprehensive annual audits to be carried out in all areas where medicines stored.
- Pharmacy technician post established for WCCSS division to address medicines safe and secure storage issues identified by CQC resulting in significant improvements in wards/depts. in medicines storage standards.
- Posters on correct room and fridge storage temperatures designed and disseminated to all wards/depts. New user-friendly fridge and room temperature monitoring charts to be introduced from July 2017.
- Hospital Pharmacy transformation project looking at introduction of dispensing robot, electronic storage systems on wards, improved IV fluid delivery and storage for wards/depts. underway.
- Amendments to drug chart completed. Furthermore, TED stocking pre-printed prescription added and will be introduced from April 2017.
- Medicines Safety Thermometer audits reported as per Action Plan. Pilot project of pharmacy technician medicines administration commenced from Jan 2017 for 3 months; excellent feedback received to-date from the two wards involved in project.
- Medicines Management e-learning modules drawn up and currently being finalised.
- Prescribing Safety Thermometer reported as per Action Plan. Strategy to support with Pharmacist Independent prescribers part of Hospital Pharmacy Transformation project underway.
- Medicines Policy revised and going through ratification process; CD section comprehensively revised. Further to annual CD report, annual CD audit carried out in January and to be repeated in April to provide assurance to Trust Board. CD assurance placed on risk register until such time as CD compliance improves significantly.
- Medicines Management Governance and Assurance actions completed. Revised Pharmacy structure to improve Medicines Management process across the Trust. Improved reporting of Medicines Management issues to DQTs introduced.
- Medicines Management section set up on intranet Info Hub to provide Medicines Management information to Trust staffs at a glance.

Where we are heading

- Weekly ward storage audits carried out by pharmacy collated monthly and reporter to ward managers, matrons, SNAG and Divisional Quality Teams (DQTs).
- Included in weekly ward storage audits are specific areas of focus described.
- Advice provided on medicines safe and secure storage, including how to address non-compliance.
- Room temperature monitors provided to ward/theatres/clinics for all areas where medicines stored.
- In addition to above, insulin storage identified as a risk and added to weekly ward storage audit.
- Drug Chart revised to include pre-printed sodium chloride flushes prescription for dating and signing by prescriber and administration by nursing staffs.
- Monthly Medicines Safety Thermometer audits reported to ward managers, matrons, SNAG & DQTs.
- Develop e-learning modules on Medicines Management for nursing staffs
- Prescribing Safety Thermometer monthly audit introduced, (CQUIN) which includes sodium chloride flush and oxygen prescribing standard (and administration for sodium chloride flush only). Reported to consultants, Medical Director & DQTs
- CD Audit reviewed to ensure fit for purpose; exceptions of quarterly audit and incidents reported to SNAG, DQTs and Quality Executive; review of CD section of Medicines Policy.
- Medicines Management Governance structure and process revised and agreed; Medicines Management Committee Terms of Reference , annual plan and audit plan revised and agreed.

Safety

Incident reporting

The Trust has an electronic incident management system. All staff members can make reports by logging on to the system and incident reporting is encouraged to promote an open, transparent, learning culture. Events leading to no, or minor harm are reviewed by the local care teams. The more significant harm events are reviewed by a lead, with a supporting team, to understand what happened, why it happened and what can be done to reduce the likelihood of it happening again.

A total of 13,533 incidents (including clinical, health and safety and non-clinical) were reported by Trust staff during 2015/16, representing a 1% increase on 2015/16.

Actual Impact	Incidents Reported
Near Miss	232 (1.7%)
No harm / minor harm	13024 (96.2%)
Moderate harm	214 (1.6%)
Major harm	52 (0.4%)
Catastrophic harm	11 (0.1%)
TOTAL	**13533**

The six most frequently reported patient safety incidents were associated with:

- Non-pressure ulcer wounds, including skin tears and impact injuries
- Patient falls in hospital
- Medication errors
- Staffing
- Infection Control
- Pressure ulcers – development associated whilst in the care of WHNHST

The top five most frequently reported health and safety incident/non-clinical incidents were:

- Violence and aggression
- Environment issues
- Data protection – security breaches
- Needles and sharps
- Attitude

There has been a decrease in incidents of violence and aggression although still being reported in high numbers (504 in 2015/16 to 408 in 2016/17).

Serious Incidents

A Serious Incident is an event that has caused serious harm. This is when the harm is life changing or may even be the unexpected or unexplained death of a person. We consider each case very carefully. A team of people including an investigator from a team not delivering the care looks to see if processes were followed as they should have been and if there were any way in which the current practices contributed to the harm caused. Recommendations are made and changes implemented as a result of these investigations.

- We had 135 serious incidents during 2016/17, compared with 160 in 2015/16.

Patients developing category 3 or 4 pressure ulcers whilst in the our care of continues to be the highest reported category of Serious Incident although there has been a decrease in 2016/17 when 64 incidents were reported compared to 74 incidents in 2015/16.

The second highest category of SIs was slips, trips and falls resulting in a patient sustaining a serious injury. The third highest category was Healthcare Acquired Infections (HCAI) incidents.

Detailed below are some of the improvements the Trust has made as a result of Serious Incidents:

- Paediatric 'sepsis six' bundle has been implemented
- Increased awareness and revision to the Safe Haven Policy for confidential information
- Red "urgent" alert added to abnormal radiology findings
- Implementation of new OPD outcome form ensuring appropriate follow-up of cancer patients
- Purchasing falls alarms for use Trust-wide
- Ongoing implementation of falls care bundle to assist in the prevention of patient falls
- Enhanced baby security tagging and revised guidelines
- Escalation Policy/Full Capacity Protocol has been revised and implemented
- Business case approved for paediatric electronic records
- BADGERnet system incorporates a reminder function for additional assessments to be undertaken.
- Communicable diseases management will be undertaken via the Occupational Health department as per revised policy.
- A post-natal risk assessment tool for Venous Thromboembolism (VTE / blood clot starting in a vein) has been enhanced and implemented

Never Events

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

Never Events include incidents such as:

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy

There have been no Never Events reported in Walsall in 2016-17.

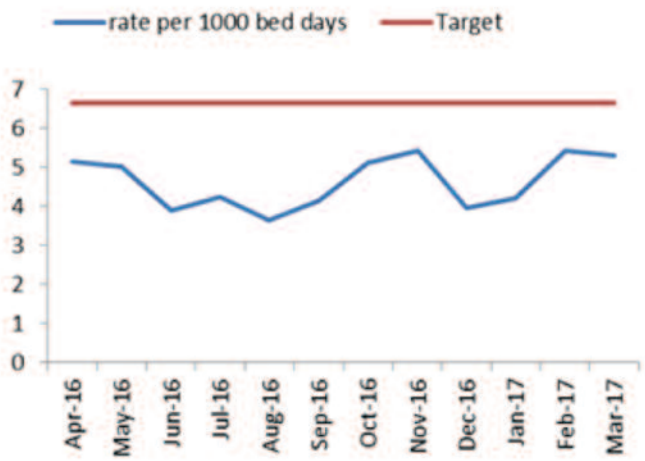
Falls

Falls are the cause of a significant numbers of injuries and death in hospitals. Walsall Healthcare has a record of low levels of reported falls when compared to other similar Trusts. In the last two years, this number has increased and more so in the past year, but the rate of falls remains consistently lower that the national rate of 6.63 falls for 1000 occupied bed days.

All falls causing injury are investigated. The review group considers not only the individual elements of the occurrence but also if there are any similarities to other falls. In this was we look for ways in which we can maintain the low level of falls and therefore reduce the harm occurring to those in our care.

Actions have included the implementation of a falls bundle, a falls steering group and a corporate lead for falls.

Graph showing the rate of falls per 1000 bed days



Pressure ulcers

There have been many changes within the tissue viability service this year with a new team of 3 established in October 2016. Clinical cover improved from October and the team has developed and embedded a new process to support prevention of pressure ulcers (PU) and maintain the service at a safe level.

Pressure ulcer prevention remains high on the agenda with reduction remaining a trust priority. Pressure ulcers that are acquired whilst patients are under the care of the Trust are closely monitored and there is a clear process in place to monitor and investigate incidents of pressure ulcer development.

An investigation is completed for all serious pressure ulcers (category 2, 3 and 4) that have occurred within the trust. The investigations identifies if there are lessons that can be learned to prevent further incidents. Grouped together the investigations also help to identify any trends in good practice as well as those that need improvement.

Some of the work completed and ongoing to address the issues is detailed as follows:

- A review of hospital mattresses has been completed with a recommendation to replace all base mattresses to ensure all patients are nursed on a high-quality mattress in a timely manner. A further review of ordering air mattresses will take place.
- A review of seating to make sure all patients have access to seating when they are very high risk of PU development or wishing to sit out of bed with existing PU outcome?
- PU can be caused when the heel remains in contact with the support surface, even when the support surface is an air mattress. Lack of heel protection has been identified in the trends for investigations in the hospital for category 3 and 4 pressure ulcers. In November 2016 we undertook a campaign to raise awareness in prevention of heel pressure ulcers. Tissue Viability nurses are strengthening this message through education and one to one support on the wards. However, more work will be required to embed the message and improve this are of practice.
- An annual training package has been developed for all aspects of Tissue Viability including pressure ulcer prevention, leg ulcer management and general wound care. The sessions are offered to community teams, hospital staff, nursing homes and practice nurses. Shorter focus sessions have also been offered to capture more staff with dates and subjects sent out monthly and a different focus each month.

Infection Control.

The Trust's Infection Control Team covers both Acute and Community services and works with the Clinical Commissioning Group to extend the service to care homes, GPs and dentists across Walsall.

In 2016 - 17 the number of cases of patients with C. Diff has increased to 21, against a target of 18 for the year. Every case has been reviewed. We found that 11 cases were what are determined to be unavoidable. This means that the care that the person received during their stay could not have prevented this infection, nor would different care have changed that.

The Infection Control Team have initiated a daily review of our admissions areas to identify patients who present with an increased risk of infection and take earlier action to treat patients at risk. An important factor is staff following the basics of infection control so continuing education and audit of practice remains a priority.

MRSA Bacteramias

We have not had any cases of MRSA bacteraemia assigned to the Trust in 2016/17. There have been four cases in the wider community but all these were determined to be unavoidable due to the patient's underlying condition. The maintenance and improvement of infection control practice to prevent cases continues and includes screening all our admitted patients for MRSA carriage on admission and the safe use of devices such as cannulas and urinary catheters.

Hand gel is available in all main entrances and entrances to all patient areas.

Safeguarding

The Trust has a statutory duty under both Section 11 of the Children Act 2004 and the legal framework created within the Care Act 2014 to ensure that arrangements are in place to ensure that the Trust, and all staff working within it, have regard to the need to safeguard and promote the welfare of children, young people and adults at risk. The Trust Safeguarding Committee continues to oversee the work plan and undertakes regular audits to ensure that the safeguarding arrangements in place are effective. The Trust reports to both the Walsall Safeguarding Children's Board and Walsall Safeguarding Adults Board.

Our safeguarding team has been strengthened this year with the appointment of a Senior Corporate Nurse for Quality and Safeguarding. This post will lead, with the Lead Nurse for Adult Safeguarding and the Lead Nurse for Safeguarding Children, on both the adult and children agenda. This Nurse will also manage the Looked After Children Team which provides support and Health Assessments to our population of children who are in care. We have seen a member of the Safeguarding Children Team successfully integrate into the Multi-Agency Safeguarding Hub (MASH) where we work together with our partners to make decisions to ensure the safety of children in Walsall. We have also started a Level 3 Adult Safeguarding training in January 2017 which is going well and on which we hope to build on in the coming year.

An annual report will be published on the Trust's website.

Duty of Candour

When a patient has been affected by an incident, staff have a duty to inform the patient and/or their relatives or carers as appropriate, to apologise for the harm, explain what facts are known at the time, explain how the event will be reviewed, ask for and include the patient or relatives concerns and provide feedback at the end of the process to say what has been found and, if care has fallen short of the standards expected, what will be done to prevent harm occurring to other patients. This is known as Duty of Candour and ensures trusts are open and transparent with patients, relatives and carers. The law requires this to be a formal process when significant harm occurs.

Walsall Healthcare NHS Trust has a policy that describes how we will meet the legal Duty of Candour by setting out the responsibilities of staff, a clear process to report and record incidents, templates, advice and support for staff to apologise, review the event, write a report and provide the results to the patient or relative. The report may identify shortfalls in care or that care was provided appropriately. The point is that we must be open and transparent.

We also measure compliance with the process by logging when a letter recording the initial disclosure conversation is sent and when the results of the review are offered or provided to the patient or relative. This measure is developing as the data capture improves and in the next year, we will add an audit of the quality of the response and communication with patients to our assessment of compliance with the Duty. We monitor our compliance at the Risk Management Committee.

The disclosure of any harm is given initially verbally, in the form of a conversation with the patient or relative, and followed up in writing. Members of staff record the details of the event on the electronic incident reporting system. The Divisional Patient Safety teams check the incidents requiring a formal apology and support colleagues if they need assistance with saying sorry, or by organising meetings, or checking that letters are sent out at the right time. Training and awareness sessions have been provided to colleagues in formal and informal sessions to help them understand when the Duty applies and what they need to do to meet it.

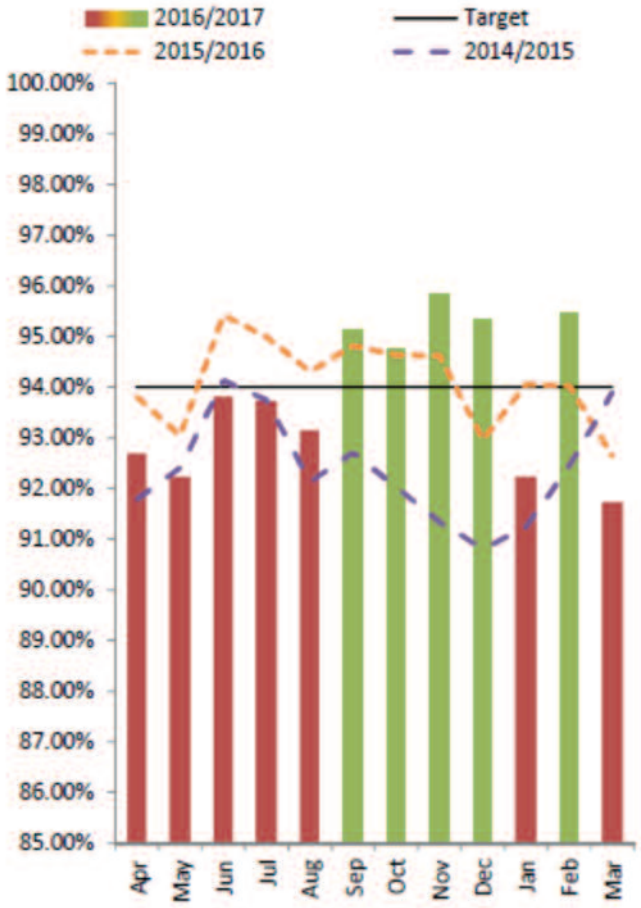
Safety Thermometer

The Safety Thermometer consists of data collection carried out on a predetermined date each month for all inpatients and community service contacts, with certain exclusions, in four particular areas. These are:

- Pressure ulcers,
- Falls
- VTE (Venous Thromboembolism)
- Urinary tract infection in patients with a catheter.

An internal target of 94% Harm Free Care was set and the following graph shows our performance against this target for this past year.

NHS Safety Thermometer



Venous Thromboembolism (VTE)

Venous thromboembolism (VTE) is a blood clot that starts in a vein. There are two types:

- Deep vein thrombosis (DVT) is a clot in a deep vein, usually in the leg, but sometimes in the arm or other veins.

- Pulmonary embolism (PE) occurs when a DVT clot breaks free from a vein wall, travels to the lungs and blocks some or all of the blood supply. Blood clots in the thigh are more likely to break off and travel to the lungs than blood clots in the lower leg or other parts of the body.

VTE is preventable and patients at risk should be assessed when they are admitted and treatment provided to reduce the likelihood of a VTE occurring. The target is to assess 95% of the patients at risk. When a VTE occurs, the patient is treated, the VTE is reported and investigated to determine the cause.

The VTE indicator was qualified in the 2015/16 Quality Account as our external auditors found that the indicator reporting the percentage of patient's risk assessed for VTE did not meet the accuracy, validity and reliability dimensions of data quality set out in the Audit Guidance. An action plan was subsequently developed to address these issues raised.

The action plan made 3 recommendations:

- To undertake a monthly quality audit of VTE
- To undertake a monthly validation audit of those VTE assessments not recorded
- Streamline the paper VTE assessment tool

These recommendations have been undertaken and a revised method for determining performance was implemented from October 2017.

Following this, performance has been determined as:

87.85%	October 2016
88.61%	November 2016
86.33%	December 2016
86.23%	January 2017
81.78%	February 2017

Although this performance is below 95% a definitive performance has proved challenging to determine due to several factors:

- Multiple systems and tools used to assess and record VTE across the organisation
- Availability of patient records
- Interpretation of medical documentation

To address these, the Trust has developed a single process for assessing and recording VTE assessment using an existing electronic patient record system Vitalpac. This method was launched 15th March 2017.

Safety Culture

In the last year we have twice asked staff to tell us about their views on the Trust and its attitude to Patient Safety. The second time the survey was circulated there was a noted change in the responses. 17 of the 22 questions suggested that the Trust had improved in the time between the surveys. Staff feel comfortable to report incidents when they occur, they say they understand who they need to speak to when things go wrong and are clear that the investigations look at the way we do things here and how we can improve. Of the other five questions where an improvement was not reported the matter which concerns staff the most is that they feel unsure of recent changes in the way the Trust is being managed. In 2016 we moved to a clinically led model (where doctors and nurses lead the management teams) and as this embeds further we expect our staff will have a clearer understanding of the management arrangements and where they sit within them.

Effectiveness

Mortality Review

We are committed to identifying, reporting, investigating and learning from the deaths that occur in hospital as a measure of effective care.

To achieve this, it is essential that the Trust analyse quantitative performance data using the key national indicators, Hospital Standard Mortality Ratio, HSMR and Summary Hospital-level Mortality Indicator, SHMI, in conjunction with local reviews of deaths using a qualitative methodology to determine points of learning and operates a transparent governance approach across all specialties to ensure lessons learnt are acted on.

HSMR and SHMI

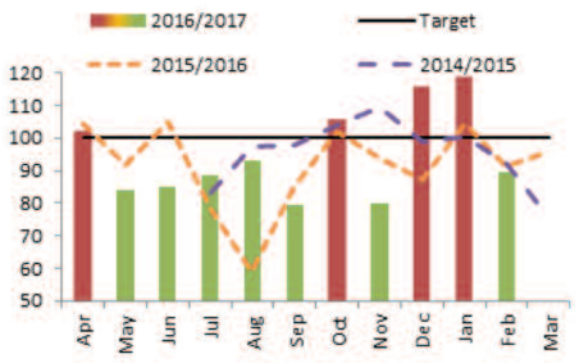
The Hospital Standardised Mortality Ratio (HSMR) is a ratio of the number of in-hospital deaths to the expected number of in-hospital deaths. The performance of the trust is referenced against a national ratio of 100. The latest available figures (February 2017) show that our HSMR was 94.83.

The Summary Hospital-level Mortality Indicator (SHMI) is similar but includes patients who die up to 30 days after being discharged from the Trust. The latest figures (January 2017) show that our SHMI was 105.68.

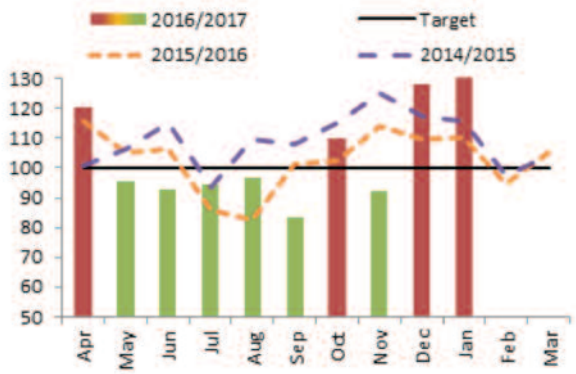
These latest available figures show that for the year to date the HSMR remains below 100 (fewer deaths than expected) but a rise for SHMI has been seen following an increase in deaths during December and January, something that was also seen across the country. Analysis of the patients who died showed that there was a significant increase in patients readmitted within 30 days of being discharged and patients at the end of life receiving palliative care. The reasons for this are being reviewed.

The graphs below show the variation during 2016/17.

HSMR (Hospital Standardised Mortality) Performance 2016 - 2017



SHMI (Summary Hospital-level Mortality Indicator) Performance 2016 – 2017



It is anticipated that SHMI and HSMR will fall to below 100 in month for the remainder of the year.

Mortality and Morbidity

We review all patient deaths that occur in our hospital. Our processes are being strengthened to follow the Royal College of Physicians approach and improving the governance of the mortality reviews undertaken by care groups. All Trusts will be required to report on patient deaths and whether they were avoidable from April 2017.

Getting Theatre Lists started on time:
We looked at what happens when. We worked out the best ways to organise the lists.
We no longer make last minute changes, we share out patients evenly across theatres.
We are starting lists on average 7 minutes earlier.

2.8 Patient Experience

The Trust is committed to seeking and acting upon feedback from patients and their friends and family. This is because we want every patient to have the best experience possible. Feedback helps our staff to know what we are doing well (and we should keep doing) and what we need to change.

These are the ways we gather your feedback:

- From Compliments, Concerns and Complaints.
- From the comments on NHS Choices web site.
- From Patient Experience Surveys.

Improvements in End of Life Care.

- *We introduced the End of Life Care Plan on ward 3 early in the year. This focussed attention on what the patient wants. Patients, relatives and staff helped us to improve on the early idea and to create a document that is now available on all wards.*
- *We now provide better support to relatives.*
- *Staff on the ward have been supported by the specialist team to gain confidence so they can support patients and relatives.*

Compliments, Concerns and Complaints

In July 2016 we reviewed the complaints process with a particular focus on the timeframe for responding to complaints and quality improvements. Approval for a new timeframe was agreed with local resolution targets identifying a 10, 30 and 45 working day timeframe based on agreement with the complainant and the level of seriousness afforded. The previous Trust target for 70% of all complaints to be completed within 30 working days had only been achieved on 3 occasions in 2015/16 with a mean average score overall of 51%.

The changes implemented in 2016 resulted in a steady improvement with the year- end position of 79% of all written complaints responded to within the agreed timeframe. There were 284 written complaint sin 2016/17, a reduction of 86 from the previous year, notably in the Emergency Department and Maternity Theatres and Delivery Suite.

This has been supported by Complaints Investigation Training which has targeted staff that is likely to undertake the role as an investigating officer. In particular this has led to an improvement in the quality of the complaint response judged by the reduced number of cases requesting local resolution meetings and an improvement in the number of cases outstanding - 10% of all live complaints.

During 2016/17, a total of 5 complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO). 1 case had been referred back to the Trust by the PHSO for local resolution as it was considered to be premature. 3 further cases were closed which were received in the previous year 2015/16. There are 4 cases open from the past year (this includes a draft outcome pending comments from staff involved).

Complaint type	2015-2016	2016-2017
Formal Complaint (KO41a)	370	284
Informal to formal complaint	29	32
Informal concern	2418	2091
Formal to informal	29	20
Compliment	441	635
Comment/suggestion/referred on	123	297
MP letter	6	6
TOTAL	3416	3109

The Divisions of Medicine and Long Term Conditions (MLTC) and Surgery generated the greatest number of complaints, accounting for 45% of all complaints received, with Surgery accounting for 32% and Women's Children's and Clinical Support Services WCCS) 18%.

The over-riding theme emerging from formal complaints during 2016/17, was 'clinical care, assessment and treatment' this accounted for 59% of all complaint categories with, communication, appointments, diagnosis and discharge accounting for the majority of the rest.

Lessons Learned arising from closed complaints include:

- The availability of "in date" pregnancy test kits in the Haematology Clinic, so that future patients can have their pregnancy testing undertaken prior to the appointment with the Consultant Haematologist. This will enable the blood test and pregnancy test to be undertaken quickly so that the required medication can be dispensed in a timely manner.

- Following a complaint regarding an MRI scan reporting times, the service has provided some additional capacity to report MRI scans and the current waiting times are no more than four weeks, which meets our internal standards. Additional reporting sessions continue. The percentage of GP referred MRI scans reported within 4 weeks of scan being performed increased from 39% - 95% within the first 6 months of implementation.

- Following complaints regarding delays in arranging rheumatology appointments a proposal has been developed to address these problems at through the Black Country Alliance that includes expertise from Sandwell, City and Dudley. This proposal enabled the joint approach to deliver service resilience and stability enhancing the Rheumatology service by accruing specialised rheumatology consultants and nurses to deliver a high quality service at all three sites. The development has enabled the partnership to share capacity and deliver services in a variety of locations within a timely manner. The new service commenced in October 2016.

- Following a request from a patient with learning disabilities - an easy read complaints leaflet was designed and developed which is now available across the Trust.

Complaints Monitoring Panel

The Complaints Monitoring Panel was set up in October 2015 with the purpose of assisting the Trust in improving complaints handling procedures and to raise standards in decision making. The panel is led by lay members with professional advice provided as and when required. Since its inception the panel has grown in confidence and as a result set up two sub-groups to focus its attention. One sub-group looks at the complaints process, and issues relating to quality. The other sub-group carries out reviews of cases which are proving difficult to resolve where an independent review is offered.

The Group reads the complaint letter and information from the investigation; checks that the response letter is appropriate; considers whether all the complainants' questions have been answered; whether there is evidence that changes have been made in the Trust.

The valuable observations from the Group include:

- Doctors need to listen and take on board what patients, relatives and GP's say about a patient's history.
- Doctors also need to take ward nurses views into account.

Progress:

We have a twice daily board round where nurses, therapists and discharge coordinators discuss all patients with medical staff identifying any problems and discuss each individual case. At the end of the ward round the team gather again in a huddle where they update and share any additional information.

- Staff shortages (i.e. insufficient Clinical Support Workers – CSW's) which are being addressed through recruitment.

Progress:

The Trust has a fully established level of CSW's who help to provide direct care – various recruitment events have taken place including visiting overseas to recruit registered nurses Pilipino nurses who are in the process of being registered with the NMC ready to commence employment as soon as possible. 150 posts have been offered. The Trust do not interview registered student nurse and show them where the vacancies are and they let us know. There is running recruitment for band 5 nurses and specialist night only contracts are offered to bring people back into nursing

NHS Choices

Walsall Healthcare NHS Trust can be found on the NHS Choices web site where the trust is rated as 3.5 stars. Since April 2016 there have been 68 comments made about the Trust via the NHS Choices/Patient Opinion website. The key category type is Clinical Care, Assessment and Treatment, appointment queries, communication and attitude.

This mirrors the feedback received via all categories of complaint and concern. Feedback posted on the NHS Choice/Patient Opinion website is acknowledged with a request to contact the Trust to discuss the situation further offered. In some cases we are able to provide a generic comment if the area involved is known. It is difficult to cross reference some of the contact unless they specifically mention that they are calling following a website posting. However we do get complainants contact following a message posting. In all cases the areas involved are still advised of the comment and where it highlights a serious concern this is escalated for review.

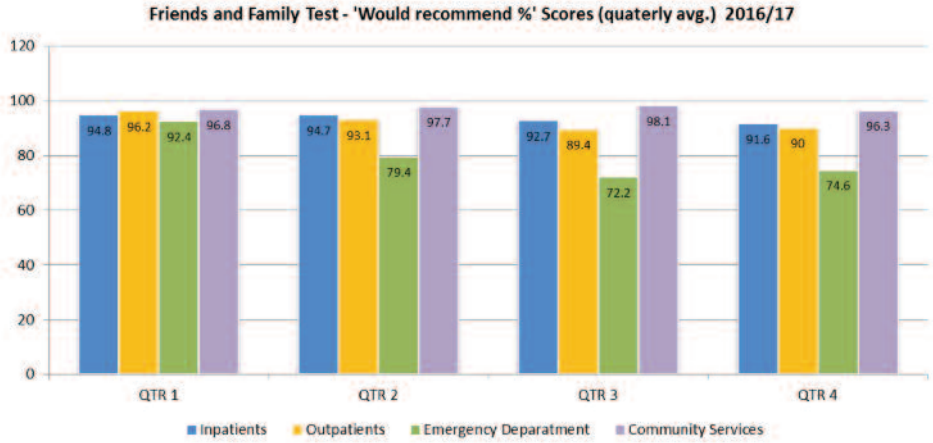
Friends and Family Test

Response rates and positive recommendation percentages have been monitored throughout 2016-17. The results of this are reported to the Patient Experience Group.

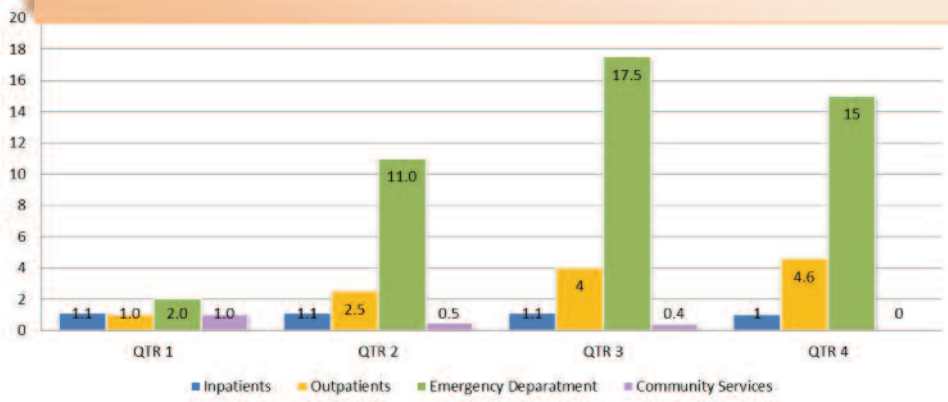
During the year we have been working hard to improve the number of people who have responded to the national questionnaire called the Friends and Family Test. The FFT is made available to patients in a variety of ways including paper cards, mobile SMS texts and Interactive Voice Messages. This has been successful and has also resulted in us gaining more detailed information about concerns people have and about things they wished to thank us for. Recording of call messages are shared with managers and teams in order that our staff know what people think and have an opportunity to use that information to make a difference.

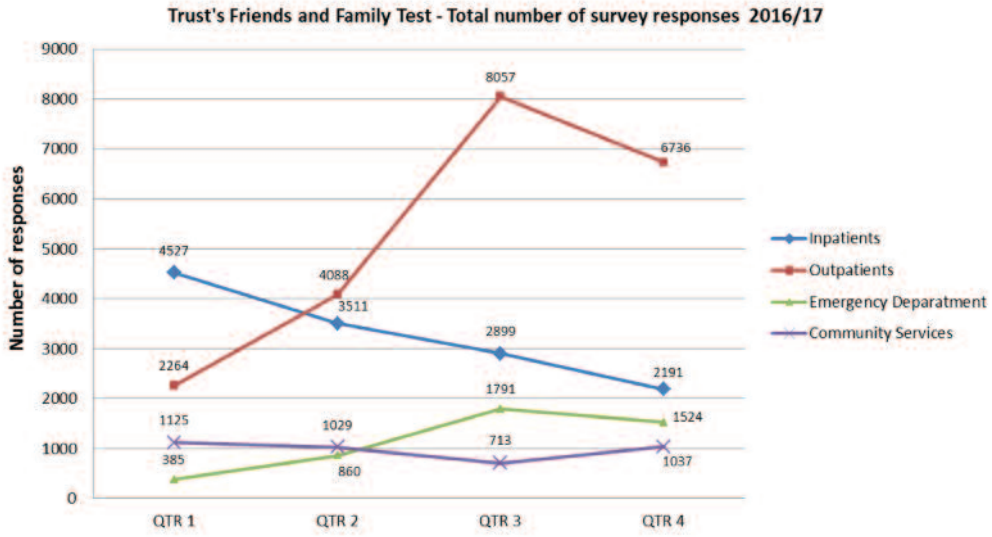
Since 1st April 2016 the Trust has received over 46,000 responses (Apr 16 - Mar 17) from patients on their care and experience of care across the Trust.

TRUST PERFORMANCE – FFT (Apr 16 – Mar 17)
Inpatients, Outpatients, Emergency Department and Community Services



"Dedicated and very caring staff, nothing is too much trouble for them explained everything to me before completing procedure very pleasant staff, particularly the staff looking after me in all a very pleasant time despite my medical conditions."





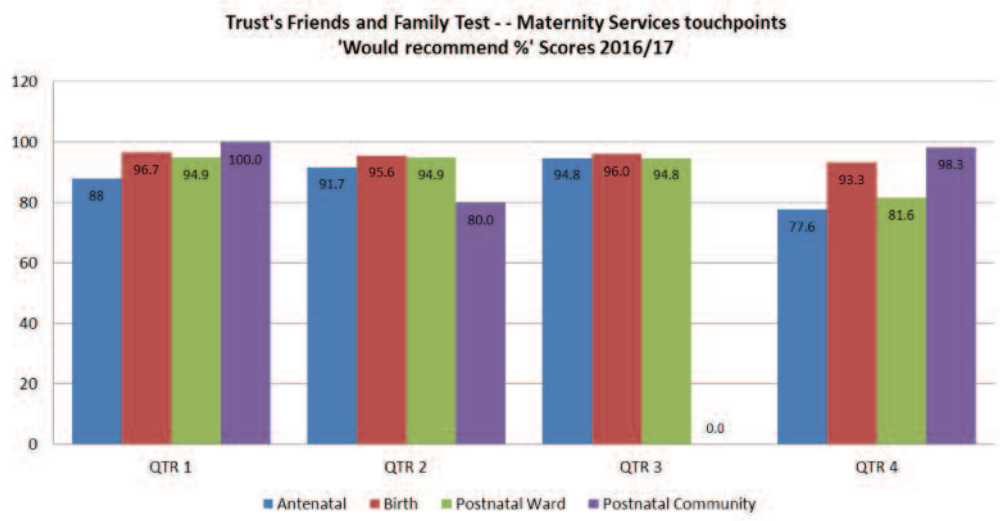
Overall FFT Scores 2016/17				
Inpatients	Q1	Q2	Q3	Q4
Review Count	4527	3511	2899	2191
% likely to recommend	94.8%	94.7%	92.7%	91.6%
% unlikely to recommend	1.1%	1.1%	1.1%	1.0%

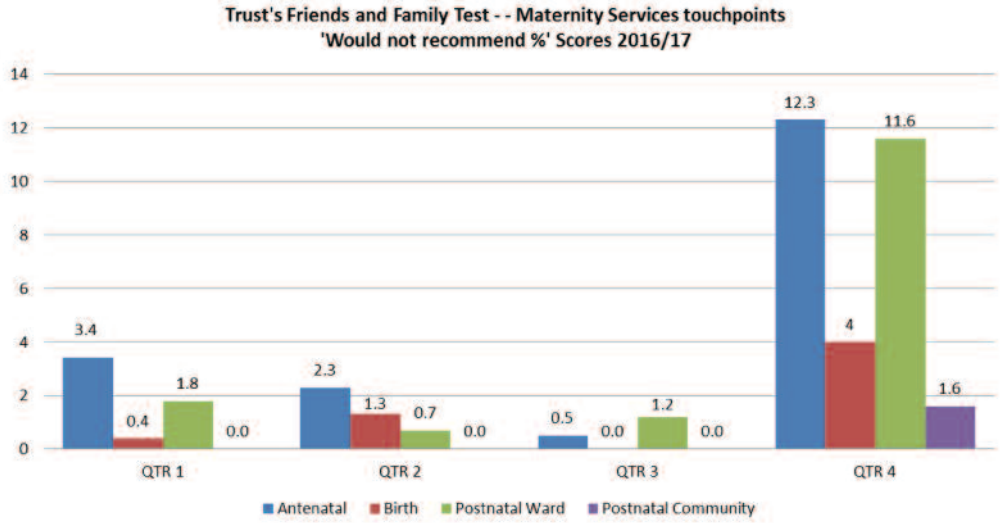
Overall FFT Scores 2016/17				
Outpatients	Q1	Q2	Q3	Q4
Review Count	2264	4088	8057	6736
% likely to recommend	96.2%	93.1%	89.4%	90.0%
% unlikely to recommend	1.0%	2.5%	4.0%	4.6%

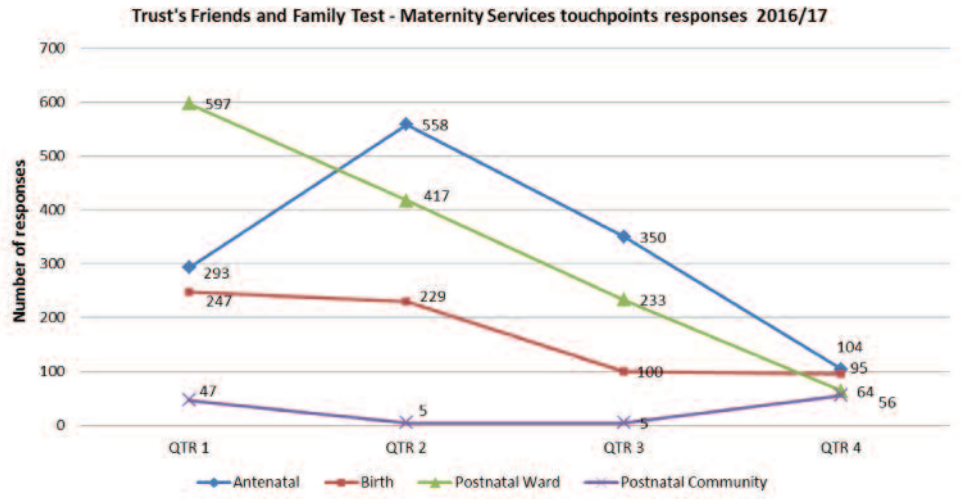
Overall FFT Scores 2016/17				
Emergency Department	Q1	Q2	Q3	Q4
Review Count	385	860	1791	1524
% likely to recommend	92.4%	79.4%	72.2%	74.6%
% unlikely to recommend	2.0%	11.0%	17.5%	15.0%

Overall FFT Scores 2016/17				
Community Services	Q1	Q2	Q3	Q4
Review Count	1125	1029	713	1037
% likely to recommend	96.8%	97.7%	98.1%	96.3%
% unlikely to recommend	1.0%	0.5%	0.4%	0.0%

MATERNITY SERVICES







Overall FFT Scores 2016/17				
Maternity Services - Antenatal touch point	Q1	Q2	Q3	Q4
Review Count	293	558	350	104
% likely to recommend	88.0%	91.7%	94.8%	77.6%
% unlikely to recommend	3.4%	2.3%	0.5%	12.3%

Overall FFT Scores 2016/17				
Maternity Services - Birth touch point	Q1	Q2	Q3	Q4
Review Count	247	229	100	95
% likely to recommend	96.7%	95.6%	96.0%	93.3%
% unlikely to recommend	0.4%	1.3%	0.0%	4.0%

Overall FFT Scores 2016/17				
Maternity Services - Postnatal Ward touch point	Q1	Q2	Q3	Q4
Review Count	597	417	233	64
% likely to recommend	94.9%	94.9%	94.8%	81.6%
% unlikely to recommend	1.8%	0.7%	1.2%	11.6%

Overall FFT Scores 2016/17				
Maternity Services - Postnatal Community touch point	Q1	Q2	Q3	Q4
Review Count	47	5	5	56
% likely to recommend	100.0%	80.0%	0.0%	98.3%
% unlikely to recommend	0.0%	0.0%	0.0%	1.6%

"Incredible service from start to finish after finding out we were expecting two little bundles. Never once felt any problem was too big. Your staff is the best in the business, especially the night shift midwives. Thank you all so much. You helped make our dream of becoming parents a reality! "

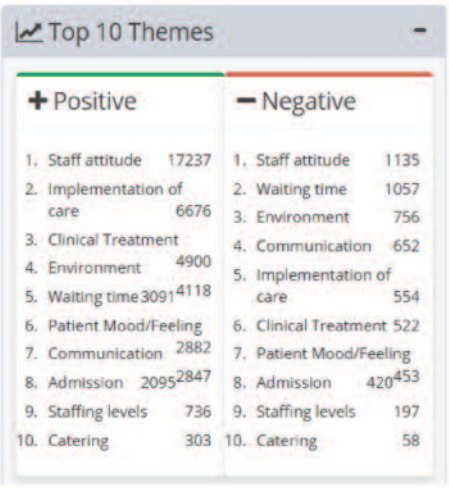
Friends and Family Test Free Text Comments

Overall, the feedback received shows that a positive experience is provided to the majority of patients. By far the most frequent form of feedback received from patients relates to praise for staff, but this praise can also be accompanied by suggestions for improvement: most typically relating to better communication and reducing waiting/delays.

Since 1st April 2016, the Trust has received more than 26,000 free text comments from patients about their care and treatment experience at our Trust. The following tables show the key themes generated from the comments:

Top 10 Words

	+ Positive		− Negative	
1.	Staff	10496	Waiting	722
2.	Attitude	3741	Time	703
3.	Friendly	3691	Staff	376
4.	Treatment	3425	Hours	261
5.	Helpful	2895	Appointment	236
6.	Clinical	2609	Wait	234
7.	Good	2570	Doctor	219
8.	Time	2395	Seen	199
9.	Care	2284	Communication	193
10.	Waiting	1629	Treatment	163



Top 10 Themes

	+ Positive		− Negative	
1.	Staff attitude	17237	Staff attitude	1135
2.	Implementation of care	6676	Waiting time	1057
3.	Clinical Treatment	4900	Environment	756
4.	Environment	4118	Communication	652
5.	Waiting time	3091	Implementation of care	554
6.	Patient Mood/Feeling	2882	Clinical Treatment	522
7.	Communication	2847	Patient Mood/Feeling	453
8.	Admission	2095	Admission	420
9.	Staffing levels	736	Staffing levels	197
10.	Catering	303	Catering	58

National Comparisons

The Table below illustrates the annual comparisons between Walsall Healthcare Trust and National averages.

The valuable observations from the Group include:

FFT Recommendation Score Comparisons		
Areas	National Average	WHT Average
Inpatients	95.75%	93.58%
Emergency Department	86.17%	80.75%
Outpatients	93.08%	92.60%
Maternity Services	96.58%	95.33%

FFT Response Rates Comparisons		
Areas	National Average	WHT Average
Inpatients	25.01%	31.09%
Emergency Department	12.75%	12.01%
Maternity Services	23.08%	16.28%

Improvement Actions - Update

- Continue to explore ways to improve our response rate across all areas Improve information/communication about care, treatment and discharge
- Publicise patient experience data locally, including actions taken as a result of feedback. Improve methods for collection of FFT e.g. SMS/Text/App; Electronic Tablets; Online Surveys etc.
- All wards and departments to continue to display their FFT results and 'You Said We Did' style posters as part of the ward communication boards.
- Use the website as a means of communicating how we are performing with regard to patient experience, publishing friends and family test scores.
- Make FFT inclusive for all
- Increase the visibility of FFT across the Trust.
- Information admission and discharge arrangements (what to expect)
- Environment: signage, food and noise

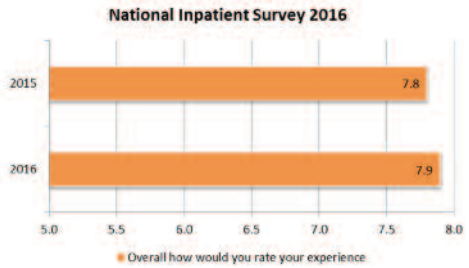
Patient Survey

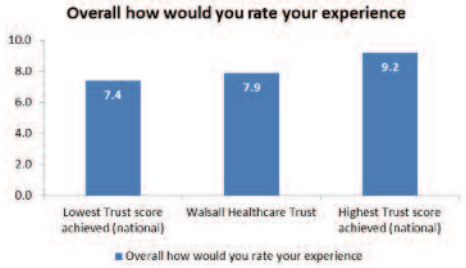
National In-Patient Survey 2016

The 2016 National Inpatient Survey results show that 491 surveys were returned completed, giving the Trust a response rate of 41% which is lower than the 2015 survey (41.40%). While the results have overall improved, we either remained same or slipped behind the progress made by other Trusts in many of the questions. In summary when comparing with 2015 survey results we improved our scores in 17 questions. While others remained the same or worsened. There were an additional two new questions in this survey and therefore there were no comparison scores available for them.

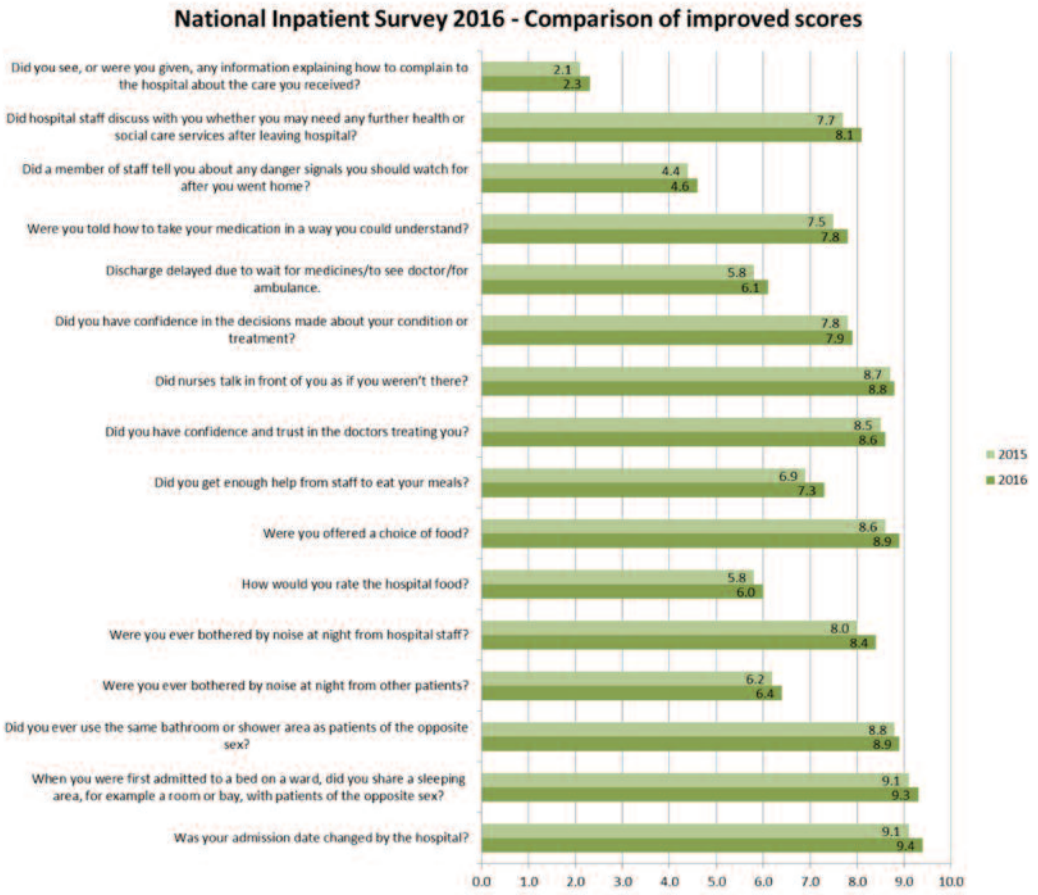
For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

Shown below is the national comparison together with Walsall Healthcare NHS Trust previous years comparisons.





Question scores for Walsall Healthcare NHS Trust that either remained same or improved:



Question scores for Walsall Healthcare NHS Trust that did not improve or were worse:

The questions where the Trust scored worst in can be grouped into the following themes:

- Waiting
- Care and treatment (including privacy and involvement)
- Communications and provision of information/explanations
- Discharge planning and information
- Doctors and Nurses – talking to patients, staffing
- Pain control
- Medicines
- The hospital environment – sleeping arrangements, cleanliness

Our response:

It is clear from the inpatient survey results, that there remains significant room for improving inpatient experience. The actions taken previously within the Trust, whilst showing signs of improvement in some areas, have not been sufficient to shift our overall position when compared to the best performing Trusts. It is the Trust's ambition to be amongst the best performing Trusts in the country for patient experience and therefore both continued effort to maintain good practice and alternative approaches are required to drive a shift in how patients experience care at the Trust. An inpatient experience action plan for 2017/18 has been developed that outlines actions to improve the inpatient experience over the following years.

This survey was conducted in July 2016 and some of the areas identified for improvement are already being actioned including: Pain, Food, Signage, Noise at Night and Discharge. This work will continue with reporting to the Patient Experience Group.

The Action Plan will focus on the top key areas identified such as:

- providing more emotional support for and listening to patients,
- communicating with patients so they feel involved in decisions and plans about their care,
- privacy
- positive patient experience of discharge.

In addition to these themes, the action plan also includes actions to enable staff at ward level to develop measures and evolve responsive action plans, improve FFT data feedback and include patient experience results into operational improvement programmes.

Progress with the inpatient experience action plan will be monitored through the Patient Experience Group, and by the Trust Board through its committee structure.

What our staff say

Every year the NHS ask an independent company to survey the opinions of staff about working in the organisation where they are employed. The survey results are published on the internet through NHS England. The questionnaire was sent to all colleagues in the Trust and 1730 responded, a response rate of 43% compared with the response rate for all combined acute and community trusts in England of 40%. It looks at 32 factors and compares information from the previous year as well as how the organisation measures against other NHS organisations. Some of the factors the survey asks questions about are for instance: staffing levels, support for learning, and their experience of violence or bullying and incidents.

The table below shows the distribution of results from our most recent NHS Staff Survey.

Comparison of Walsall Healthcare with other combined Acute / Community Trusts	2015	2016
Average	7	3
Above (better than) Average	2	2
Above (worse than) Average	8	8
Below (worse than) Average	15	19

The Trust's 2016 survey results have changed little from the 2015 survey results, which was anticipated.

The top improvements from 2015 are:

- How safe staff feel to report unsafe clinical practice.
- Support from immediate managers.

The top three areas to improve are:

- Staff experiencing physical violence from patients, relatives or the public
- Staff able to contribute towards improvements at work
- Staff recommending the organisation as a place to work or receive treatment.

NEXT STEPS

The Trust Workforce Executive will support the Trust to address the identified issues with ongoing work programmes on health and wellbeing, engagement and leadership development. This includes:

- Trust-wide Strategy Engagement Programme – engaging colleagues with the Trust strategy; to ensure every colleague knows their own contribution in creating a sustainable organisation.
- Listening into Action (LiA) – engaging and empowering our colleagues for better outcomes for patients.
- Creating a Learning Organisation – a group has been formed to ensure that the foundations are in place to support colleagues to continuously learn, particularly in relation to incidents.
- Equality and Diversity – a newly developed steering group will provide momentum for progressing the advancement of equality and inclusion.
- Well-Led – continue with the Strategic Leadership programme with the King's Fund and embed the Clinically-led model.

2.11 Equality, Diversity and Inclusion

Getting equality, diversity and inclusion right for our staff, patients, carers, patients, families and communities will support the delivery of strategic objectives to deliver integrated health and social care services that best meet the patient's needs.

In October 2016 an Equality and Diversity Practitioner was commissioned to undertake a review of Equality and Diversity provision across the Trust. The review included a progress map against key legislative requirements, targets and indicators used to measure success or compliance.

The review highlighted a number of recommendations with a focus on three key areas:

1) Workforce – how workforce data is collected, analysed and used. How does this advance equality of opportunity, foster good relations and using Equality analysis to evidence all that can be done is done to eliminate unlawful discrimination.

2) Patient and Service Delivery – how is feedback used to inform service delivery and how inclusive is this in evidencing a human rights based approach to healthcare.

3) Engagement – What group's do we engage with and how meaningful is this. How do we ensure that Trust has a wide enough representation amongst its engagement groups.

The newly reformed Equality and Diversity & Inclusion Steering group will recommend to the Trust Board what our priorities for 2017/18 at present we have discussed three areas from the recommendations from the RMB report & the EDS 2 and WRES standards.

1. Education and Awareness of the Equality and Diversity agenda to ensure it is truly embedded as part everyone's role, to meet our individual needs.

2. Accessibility of our services to ensure we meet the individual needs of our patients, families and staff as we develop our environment.

3. Working with our commissioners and other organisations to support knowledge about our services and patient pathways.

In demonstrating the Trust's commitment to tackling the gap's identified we have already developed a number of exciting plans for Equality, Diversity and Inclusion work undertaken in Q4 2017

- Approved the Equality, Diversity and Inclusion (EDI) agenda as a key theme of the Patient Experience Strategy
- Formalised the Trust EDI reporting structure providing a leadership commitment to drive forward change
- Established delivery groups for workforce and patient EDI actions arising from the gap analysis. Terms of reference for committee/groups and meetings agreed
- Produced a draft and refreshed EDI strategy for consultation
- EDS 2 & Workforce Race Equality Standard (WRES) action plan drafted and amended
- Audit of equality analyses of workforce policies undertaken; policies and EqA's updated
- Make the Difference Calendar issued
- LGBT+ History Month celebrated with displays and communications on the theme of 'LGBT+ Health Pioneers'
- International Women's Day celebrated with colleague stories and communications
- Audit and improvement of inclusive practice in WHT training courses underway
- Plans made for celebration of Equality, Diversity and Human Rights Week (mid-May), Gypsy Traveller and Roma History Month (June) and Disability Awareness Day (12 July)
- Preparation for development good practice guide for care of trans patients underway
- Preparation for EDS2 underway, including working group of key colleagues
- Preparation for WRES and Gender Pay Gap reporting

Staff Survey is telling us there are two key findings for theme of Equality and Diversity and both report no statistical change from 2015. The Trust score in relation to the percentage of staff who experienced discrimination in the last 12 months has remained above (worse than) average at 13%. This saw a decrease from 14% to 12% for BME staff experiencing discrimination, which is below than the national average of 14% with white staff considered average. The proportion of staff that considers that the Trust provides equal opportunities for career progression or promotion remained below (worse than) average at 82%. When this is broken down by ethnicity the proposition that the Trust provides equal opportunities is supported by 85% of white respondents and 71% of BME respondents, an improvement of 3% for BME staff.

As a Trust we acknowledge that there is some work to be done to ensure that the Trust is consistently working at a place where it is both compliant and demonstrating real outcomes for real people. If the key recommendations of the review are followed this will place the Trust in a strong foundational place in demonstrating a strong track record in not just being compliant but embedding equality and diversity into everything that it does.

Overall Activity Levels and Performance against Core Operating Standards

In 2016 we reported that we had become part of a Black Country Alliance. Formed from 3 major trusts within the Black Country (The Dudley Group NHS Foundation Trust, Sandwell and West Birmingham Hospitals NHS Trust and Walsall Healthcare NHS Trust) the aim is to develop the alliance and to review services, provisions and all opportunities to provide an effective service for Walsall and the neighbouring areas. This alliance has been working for almost two years. In that time a number of changes have begun and more are planned. These changes will help us to work more efficiently and more effectively allowing access to up to date tests and diagnostic equipment which we could not afford to buy or staff as a single organisation. It also opens up opportunities in the future to work more closely together in order to be able to provide services every day of the year all day long. To now the changes have been:

Activity

	2013-14	2014-15	2015-16	2016-17
Emergency Activity	34,036	35,420	38,420	35.154
Day Case	23,712	22,281	21,864	21,515
Elective	3,997	3,968	3,749	3,422
Outpatient	324,556	262,038	263,380	248,452
A & E	71,656	66,777	64,806	64,686
Community	411,865	340,158	329,939	344,377
Total	869,822	730,278	722,158	717,606

The Trust records every time a person is provided with advice, assessment, tests and treatment. This is called activity. Nationally there are a number of areas that are set to be able to compare one Trust with another.

Emergency activity is any activity which is not planned through a booked appointment. This may be a person attending the Emergency department or by an urgent admission following a call from a family doctor or from a planned visit to outpatients resulting in the need for a person to be admitted on that day.

Performance against standards

Measure	Target 14-15	Actual 14 - 15	Target 15-16	Actual 15-16	Target 16-17	Actual 16-17
Total Time in A & E 4 Hour wait	95%	89.1%	95%	87.90%	95%	84.10%
C. Diff Cases	28	16	18	7	18	21
MRSA Cases	0	0	0	1	0	0
% of patients whose operations were cancelled for non-clinical reasons	no figures available		0.75%	0.47%	n/a	0.65%
Cancer 2 week wait	93%	91.7%	93%	90.80%	93%	96.09%
Cancer 2 week wait Breast Symptoms	93%	91.7%	93%	90.80%	93%	96.13%
Cancer 31 day diagnosis to treatment	96%	98.9%	96%	99%	96%	99.28%
Cancer 31 day wait surgery	94%	99.2%	94%	97.30%	94%	99.12%
Cancer 31 day wait drug	98%	99.6%	98%	99.50%	98%	100.0%
Cancer 62 day wait all cancer	85%	76.7%	85%	79.80%	85%	86.97%
Cancer 62 day wait screening	90%	96.4%	90%	100%	90%	96.17%
Cancer 62 day wait consultant upgrade	91%	90.5%	92.10%	91%	91%	92.21%

There are some waiting times and that the Department of Health has set targets for Trusts to meet. These are written into the NHS Contract. These are the measures that are often reported by newspapers nationally and locally.

In Walsall there are some of these that we have managed to achieve every year for some time. We are pleased to be able to report that

Others targets we have not achieved. We have taken steps to change the way we work in order to reach the standards. In particular we have been working at the way we manage our waiting lists this year

A & E Improvements

- *£6,000 spent on new equipment in resus.*
- *New paediatric area.*
- *New chairs for the waiting room.*
- *Real time waiting time updates on TV screen.*

2.10 CQUIN

A set of Commissioning for Quality and Innovation (CQUIN) goals were agreed with our commissioners for 2016/17. The table below shows the progress made in achieving these goals.

CQUIN SCHEME	EXEC LEAD	Total £K	Confirmed loss**	Achieved	% Achieved
NHS Staff & Wellbeing	Director of OPD & HR	1,359		1,359	100%
Timely identification & Treatment of Sepsis	Medical Director	453	181	272	60%
Antimicrobial Resistance	Medical Director	453		453	100%
Maternity NHS Safety Thermometer	Director of Nursing	906		906	100%
Local Prescribing	Medical Director	227	76	151	67%
Identification of the Deteriorating Patient	Director of Nursing	1,133	850	283	25%
Neonatal Unit Admissions	Medical Director	83		83	100%
Adult Critical Care Timely Discharge	Chief Operating Officer	83		83	100%
Secondary Care Clinical Attachment in Oral Surgery	Chief Operating Officer	30	15	15	50%
Totals		4,728	1,121	3,607	76%
** £425K in dispute with WCCG for Q3 Deteriorating patients					

Section 3: Priorities for Improvement 2017/18

3.1 Quality Improvement Priorities for 2017/18

Safe

- Improve Medicines Safety Standards

Effective

- Implement best Practice around resusitation, acting on deterioration and utilisation of the sepsis bundle.

Caring

- Complete the assessment of the Trust's compliance with Equality and Diversity System 2

In 2017 The Trust Quality Executive discussed a number of options of matters which were of concern from reports received from other bodies and locally reported incidents. In March it was agreed that for the next year these would be the priorities for quality Improvement. There are detailed measures that have been drawn up, we will measure our current position in a meaningful way depending on the target and we will regularly report to a specific group about the way we are making progress or the issues we encounter as we move through the year before giving a final report on the priorities in next year's Quality Account.

The selected options were presented to a meeting of the Trust Members on 30th March 2017 along with an early draft of the re-styled Quality Account to gain their views. In the last week of March 2017 the Draft Quality Account was also shared with the Clinical Commissioners Quality Team to gain their comments regarding the appropriateness of the chosen quality priorities.

The Quality Commitment on page 6 shows the extent of the work being undertaken to improve the quality and safety of care we provide.

This includes:

Safe: Consent to treatment, safe staffing levels, responding to safety alerts
Effective: Mortality reviews, caesarean section rates, implementing NICE guidance, CQUIN performance
Caring: Taking action following the Patient Survey, discharge planning, communication, information about medicines

Priority 1: Improve Medicine Safety Standards specifically:

- Controlled drugs standards
- Safe Storage
- Reduction in missed doses
- Use of Medicines Safety Thermometer
- Preventing Harm from Insulin

Lead: Medical Director / Director of Pharmacy

Plan

Controlled Drugs (CD) Standards

The Pharmacy Department manages an audit programme which monitors the safe use and management of CDs in all wards and departments to ensure that there is full compliance with legislation and national/regional guidelines. The Pharmacy Department carries out a full standard annual CD audit of 31 CD standards at the beginning of each financial year in April and a quarterly audit of 8 CD standards thereafter.

The audit standards are adapted from the West Midlands Chief Pharmacist Network standards and reflect current legal and professional requirements. The Standards are also reflected in the Trust Medicines Policy, so that audit compliance is also a measure of compliance with the Medicines Policy.

Safe storage of medicines

The Pharmacy department manages an audit programme which monitors the safe storage of medicines in all wards and departments. The Pharmacy department carries out a weekly audit of 13 standards and an annual audit of 21 standards. This audit incorporates standards which address correct insulin storage such as 'Vials of insulin in use must have a date opened written on, no more than 4 weeks previously' and 'Any loose insulin pens must have patient label on (if not discard)'. The latter standard addresses the fact that stock insulin pens must follow the policy of 'One Pen One Patient'. Incorporated into the safe storage of medicines audit is a monthly expiry date check of all medication stored in wards and departments. A monthly audit of medication stored on drug trolleys has recently been introduced.

The audit standards are adapted from the West Midlands Chief Pharmacist Network standards. The Standards are also reflected in the Trust Medicines Policy, so that audit compliance is also a measure of compliance with the Medicines Policy.

Ward storage standards have steadily improved since the introduction of the audit programme. A colour coded room and fridge temperature monitoring chart has been approved for introduction from July 2017 which is expected to support wards in providing guidance on required actions from temperature deviations.

Medicines Safety Thermometer

The Medicines Safety Thermometer is a national measurement tool for improvement which focuses on medicines reconciliation, allergy status, medication omission and identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework.

The Pharmacy department has been carrying out the Medication Safety Thermometer point of care survey on a monthly basis since October 2013. The Medication Safety Thermometer point of care survey and improvement target was agreed as a local CQUIN which was completed in March 2016; however, the survey continues to be completed to monitor that improvements that have been made are sustained.

Prescribing Safety Thermometer

The Prescribing Safety Thermometer was conceived as a local measurement tool for improvement in prescribing standards.

It was agreed in February 2016 with Walsall CCG that one of the CQUINs assigned to pharmacy in 2016/17 would be the implementation of a monthly Prescribing Safety Thermometer audit to be undertaken on all the wards that also have a monthly Medicines Safety thermometer audit undertaken.

How will we measure this?

Pharmacy audit programme.

Where and when will we report the progress?

A report on Medication error incidents, Ward storage audits, Controlled drug audits, Prescribing Safety Thermometer audits and Medicines Safety Thermometer audits is prepared each month by each Principal Pharmacist for their respective divisions. These reports are tabled at the monthly Medicines Management Committee meetings and the Divisional Quality Team meetings. Furthermore, a report which provides an overview of the information provided in these reports is tabled at Medicines Safety Group meetings and Senior Nurse Advisory Group.

How we will make sure that the standard achieve will remain high.

The standards laid out in the audit templates will continue to be monitored as part of the Pharmacy audit programme. Audit templates will be updated when necessary in line with changes in regional and national guidance.

Pharmacy staff are expected to carry out the audits, where possible, together with appropriate ward staff so that feedback may be provided at the time of audit.

Priority 2: Implement best practice around resuscitation, acting on deterioration and utilisation of the sepsis bundle

Lead Medical Director – Divisional Medical Director MLTC

Plan

With regards to deterioration and sepsis, training will continue for all clinical staff in the form of bespoke sessions and on the mandatory clinical update sessions. The Chief Executive officer from the Sepsis Trust will be attending the Trust on May 18th 2017 to give a Sepsis Seminar. The Quality Facilitator takes a key role in working with wards to improve detection of deterioration and sepsis by working alongside them in their day to day activities.

How will we measure this?

Both deterioration and sepsis are audited monthly. Sepsis is a national CQUIN and audited in line with national guidance which involves the auditing of records of 50 patients within A&E and 50 in patients with regards to Sepsis screening, antibiotic usage and review of antibiotics is also reviewed. Deterioration is audited by reviewing all patients, in 1 week, who on their observations (pulse, blood pressure, temperature, respirations etc.) scored 5 or above on the early warning score which highlights the need for a clinical review. Key elements such as timing of observations, escalations to medical staff and documentation of clinical review are audited.

Where and when will we report the progress

The Results of both audits will be reported to the Resuscitation Committee and Trust Quality Executive.

How we will make sure that the standard achieve will remain high

Once achieved improvement will be maintained by continuous audit and training.

Priority 3: Complete the assessment of the Trust's compliance with Equality and Diversity System 2

Lead Director of Nursing

Plan:

- Make necessary changes to recruitment process and achieve "two ticks"
- Commence pay audit to gain a baseline for future annual reviews
- Training evaluation forms with be reviewed to gain information.
- Incidents reported related to work place bullying or harassment will be investigated using the disciplinary processes.
- The Flexible working policy will be audited against the Equality Impact Assessment.

How will we measure this?

Some of the measures will be mandated to us and others will be local measures of progress and success. We will publish our progress against these measures to ensure visibility for patients, the public and our staff. Individual work programmes will have their own milestones and measures but collectively we will focus on:

Working towards internal best practice:

- Information monitored and reported as part of the Public Sector Equality
- Monitoring Report
- Assessment and compliance with the NHS Equality Delivery System
- Progress against the Workforce Race Equality Standard

Working towards external best practice accreditations and standards including:

- Stonewall
- Trans Equality Pledge, Mindful Employer
- Patient Feedback through Surveys, Complaints, Comments & Compliments)
  Response rate and results of Staff Surveys and Feedback activities (including the Friends and Family Test)
- Metrics including Appraisal Rates, access to training opportunities
  Monitoring of cases
- Feedback from Exit interviews
- Observations, workarounds and "back to the floor" by senior leaders
  Benchmarking data from other NHS Trusts

Where and when will we report the progress?

Six monthly reports comparing progress with our ambitions will be published and reported to the Quality Assurance Committee, Equality Diversity & Inclusion Steering Group with an annual report to the Trust Board. We will also report on progress as part of the Trusts Annual Report. In particular, we want all those involved in the management of people for example Clinical Teams of Three, Ward Leaders, Heads of Services, Supervisors, Team Leaders, Trust Board Member to be visible, fair and demonstrate behaviours that embody our vision of Making a Difference.

Where we are doing better than expected or where we have problems achieving the intended aim, we will raise those issues with the Trust Quality Executive.

CQUIN for 2017/18

A set of Commissioning for Quality and Innovation (CQUIN) goals have been agreed nationally for 2017/19.

List of 2017/18 CQUIN

CQUIN Ref.	CQUIN Scheme Name	17/18 CQUIN Value** to be updated when confirmed
WCCG		
STP	support engagement with STP's	£801,934
STP	STP's risk reserve	£801,934
1	Improving staff health and wellbeing	£400,967
2	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	£229,124
3	Improving services for people with mental health needs who present to A&E	£229,124
4	Offering advice and Guidance (A&G)	£229,124
5	NHS e-Referrals	£229,124
6	Supporting Proactive and Safe Discharge – Acute Providers	£400,967
7	Preventing ill health by risky behaviours – alcohol and tobacco	£229,124
8	Improving the Assessment of Wounds	£229,124
9	Personalised Care and Support Planning	£229,124
WCCG		**£4,009,668**
NHS E Specialised Commissioners		
1	Medicines Optimisation £76,427	
2	Paediatrics - non PICU £37,878	
3	Neonatal Outreach £37,878	
NHS E Totals		**£152,183**
NHE E Public Health		
1	Dental - audit of daycase activity £34,962	
Grand Total		**£4,196,813**

Further details of the agreed goals for 2016 - 17 and for the following 12 month period are available on request from the Director of Finance

3.3 Who has been involved in setting our improvement priorities

The improvement priorities for 2017/18 have been taken from the Trust's Quality Commitment. This has been developed partly in response to the CQC inspection report but also to give a clear direction for the Trust's quality improvement activities. A wide range of staff have been involved in the development of these improvement priorities and Walsall Clinical Commissioning Group has also been consulted. Patient engagement in the priorities at this time is less evident as the Trust is focussed on improving to exit special measures.

The improvement priorities have been supported by the Trust's Quality and Safety Executive Committee.

Appendices

Appendix 1

Assurance Statements by the Trust

Review of services

During 2016-17 the Walsall Healthcare NHS Trust provided and/ or sub-contracted 88 NHS services.

"The Walsall Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 88 of these NHS services.

The income generated by the NHS services reviewed in 2016-17 represents 100 per cent of the total income generated from the provision of NHS services by the Walsall Healthcare NHS Trust for 2016-17

Care Quality Commission (CQC)

Walsall Healthcare NHS Trust is required to register with the Care Quality commission and its current registration status is Inadequate.

Walsall Healthcare NHS Trust has the following conditions on registration:

- The system to assess and monitor the quality of services provided is ineffective
- The system to mitigate risks to patients receiving health care is ineffective
- The corporate risk register is not providing an accurate or comprehensive reflection of key risks
- There has been a failure to maintain accurate, complete and contemporaneous records
- There are insufficient numbers of suitably qualified staff
- There is a lack of effective risk management

CQC are due to re-inspect the Trust in 2017.

The overall ratings for the Trust are provided below:

Walsall Manor Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Overall Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

The Care Quality Commission has taken enforcement action against Walsall Healthcare NHS Trust during 2016/17 - the conditions and actions from 2014/15 remain in force.

Following the September 2015 scheduled inspection the Trust was rated as 'inadequate' overall, but 'good' for community health services, and consequently entered special measures. Special measures apply to NHS Trusts and Foundations Trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support.

Walsall Healthcare has not participated in any special reviews or investigations by the Care Quality Commission during 2016/17.

Walsall Healthcare intends to take the following action to address the conclusions or requirements reported by the CQC:

In response to the report the Trust has been following a Patient Care Improvement Plan, the work and progress is regularly reported to the Board, the report can be found on Trust's website:
https://www.walsallhealthcare.nhs.uk/cqc.aspx

Walsall Healthcare has made the following progress by 31st March 2017 in taking such action:

The latest details of the progress made following the CQC inspection report are available on the Trust's website:
https://www.walsallhealthcare.nhs.uk/cqc.aspx

A re-inspection by the CQC is expected during 2017.

Participation in Clinical Audits

During 2016/17, 43 national clinical audits programmes and national confidential enquiries covered NHS services that Walsall Healthcare provides.

During that period Walsall Healthcare participated in 93% of the national clinical audits programmes and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Walsall Healthcare was eligible to participate in during 2016/17 are below.

The reports of 19 national clinical audits were reviewed during 2016/17 and the Trust intends to take the following actions to improve the quality of the healthcare we provide.

NCEPOD		
• Mental Health	Yes	20% (1/5)
• Acute Pancreatitis	Yes	20% (1/5)
• Acute Non Invasive Ventilation	Yes	Closed but not in public domain 13th July becomes live
• Chronic Neurodisability	Yes	Study still open – figures not finalised
• Young People's Mental Health	Yes	Study still open – figures not finalised
• Cancer in Children, Teens and Young Adults	Yes	Study still open – figures not finalised
MBBRACE	Yes	

The national clinical audits and national confidential enquiries that Walsall Healthcare was eligible to participate in during 2016/17 are as follow.

National Audit Title	Trust Participation	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✔	On-going To support the move to Best Practice Tariff data collection will be streamlined
Adult Asthma	✔	Action plan in development
Adult Cardiac Surgery	✘	Not applicable at Walsall Healthcare NHS Trust
Asthma (paediatric and adult) care in emergency departments	✔	Awaiting national report
Bowel Cancer (NBOCAP)	✔	On-going
Cardiac Rhythm Management	✔	On-going
Case Mix Programme	✔	On-going
Child Health Clinical Outcome Review Programme	✔	On-going
Chronic Kidney Disease in primary care	✘	Not applicable at Walsall Healthcare NHS Trust
Congenital Heart Disease (CHD)	✘	Not applicable at Walsall Healthcare NHS Trust
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	✔	On-going
Diabetes (Paediatric) NPDA	✔	Action plan in monitoring stages
Elective Surgery (National PROMs Programme)	✔	On-going
Endocrine and Thyroid National Audit	✘	Not applicable at Walsall Healthcare NHS Trust
Falls and Fragility Fractures Audit Programme	Partial	Partial compliance in the programme, Walsall Healthcare Actively participated in National Hip Fracture but didn't participate in Fracture Liaison Service
Head and Neck Cancer Audit	✘	Not applicable at Walsall Healthcare NHS Trust
Inflammatory Bowel Disease Programme	✔	On-going
Learning Disability Mortality Review Programme	✘	Not applicable at Walsall Healthcare NHS Trust
Major Trauma Audit	✔	On-going
Maternal, Newborn and Infant Clinical Outcome Review Programme	✔	On-going
Medical and Surgical Clinical Outcome Review Programme	✔	On-going
Mental Health Clinical Review Programme	✔	On-going
National Audit of Dementia Audit	✔	Action plan in development
National Audit of Pulmonary Hypertension	✘	Not applicable at Walsall Healthcare NHS Trust
National Cardiac Arrest Audit	✔	On-going
National Chronic Obstructive Pulmonary Disease Programme	✔	On-going
National Comparative Audit of Blood Transfusion	✔	On-going
National Diabetes Audit – Adults	Partial	Partial compliance in the programme, Walsall Healthcare Actively participated in National Inpatient Diabetes Audit but did not participate in National Footcare audit; it is anticipated for data to be submitted in 2017/18. The audit overall identified an improvement year on year for care of Diabetic Patients. Some of the actions taken by Walsall Healthcare to improve patient care are: - Development of e-learning to ensure all is fully aware of the requirements for management of Diabetic patients. - Development of a bid for increased specialist nursing support submitted to improve the practice for patients with diabetes.

National Audit Title	Trust Participation	Comments
National Emergency Laparotomy Audit	✔	On-going. This is the third year this audit has taken part and identified the need to review are consent process as a result we are changing to booking procedure for patients going to theatre to include the PPosum score in line with best practice.
National Heart Failure Audit	✔	On-going
National Joint Registry	✔	On-going
National Lung Cancer Audit	✔	On-going
National Neurosurgery Audit Programme	✘	Not applicable at Walsall Healthcare NHS Trust
National Ophthalmology Audit	✘	Not applicable at Walsall Healthcare NHS Trust
National Prostate Cancer Audit	✔	On-going
National Vascular Registry	✘	Not applicable at Walsall Healthcare NHS Trust
National Intensive and Special Care	✔	On-going
Nephrectomy Audit	✔	On-going
Oesophago-gastric Cancer Audit	✔	On-going
Paediatric Intensive Care	✘	Not applicable at Walsall Healthcare NHS Trust
Paediatric Pneumonia	✔	Action plan in development
Percutaneous Nephrolithotomy	✘	Not applicable at Walsall Healthcare NHS Trust
Prescribing Observatory for Mental Health	✘	Not applicable at Walsall Healthcare NHS Trust
Radical Prostatectomy audit	✘	Not applicable at Walsall Healthcare NHS Trust
Renal Replacement Therapy	✘	Not applicable at Walsall Healthcare NHS Trust
Rheumatoid and Early Inflammatory Arthritis	✔	Services combined with BCA to provide a streamlined service within Rheumatology.
Sentinel Stroke National Audit Programme	✔	On-going
Severe Sepsis and Septic Shock – care in emergency departments	✔	Action plan in monitoring stages. Improvements held within the Emergency Department including launch of the formal Sepsis Screening Tool to ensure appropriate treatment is provided in line with best practice. Development of Sepsis Champions within the area to provide education / training on Sepsis.
Specialist rehabilitation for patients with complex needs	✘	Not applicable at Walsall Healthcare NHS Trust
Stress Urinary Incontinence Audit	✘	Not applicable at Walsall Healthcare NHS Trust
UK Cystic Fibrosis Registry	✘	Not applicable at Walsall Healthcare NHS Trust

National Audit	Action taken
Severe Sepsis and Septic Shock - care in emergency departments	Improvements held within the Emergency Department including launch of the formal Sepsis Screening Tool to ensure appropriate treatment is provided in line with best practice. Development of Sepsis Champions within the area to provide education / training on Sepsis.
National Emergency Laparotomy Audit	Revision of practice to ensure patients has informed Consent prior to procedure.
Diabetes Audit - National Inpatient Audit	Development of e-learning to ensure all are fully aware of the requirements for management of Diabetic patients. Development of a bid for increased specialist nursing support submitted to improve the practice for patients with diabetes.

Local Clinical Audits

The reports of 189 local clinical audits were reviewed by the provider in 2016/17 and Walsall Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided (See the table below which includes a selection of the clinical audits undertaken locally).

Division	Local Clinical Audit Title	Summary of the actions taken
Trust Wide	Antibiotic Audit	Antibiotic stickers to be ordered and implemented across the organisation
		A review of current guidelines on antibiotics to be undertaken and placed on the Trust intranet for access
		Implementation of a rolling audit programme for antibiotic management across the organisation
	Resuscitation Trolley Audit	Instigate self-assessments across ward areas
Surgical Services	Blood Glucose Management in Critical Care	Edit protocol to include instructions for pausing the sliding scale e.g. when BM <8mmol/l in line with the NICE-SUGAR trial
		Increase awareness of the protocol amongst nursing and medical staff e.g. at induction
	Airway Management in ITU	Capnographs to be procured
		Education and Training to be provided to nursing staff re interpretation of capnography trace
		Develop an intubation checklist
		All essential equipment and laminated algorithms to be added to trolley and routinely checked
		Documentation of intubation grading to be routinely audited
	Closed-Loop Audit On Consent For Neck of Femur Fracture Surgery	Raise awareness of the pre-printed labels within the team
		Roll out the pre-printed labels to further common procedures
	Audit of Head Injury Management in patients aged over 65	Consider feasibility of developing a generic Walsall Healthcare email for access to the system
		Establish a better link with the FEP team to assist with management of these patients
		Escalate findings to Dementia Steering Group

Medicine and Long Term Conditions	Management of Gonorrhoea in Male Patients at Walsall	Refer all patients diagnosed with gonorrhea to health advisor - this will improve partner notification
		Remember to document if patient information has been provided - should be included in proformas
		Request patients to give partner details so can be checked if they have been treated
		Ensure patient's contact details are up to date, and that they have given permission to be contacted - this is likely to improve percentage of patients treated and returning for TOC
	Management of Fluid	Consider other options in management of dry mouth for palliative care patients
		Ensure discussion occurs with seniors for patients with increased fluid prescriptions
		Document IV fluid management in the health records
	Management of hypoglycaemia in elderly patients	All elderly patients presenting with hypoglycaemia are to have HbA1c checked
		All patients presenting with hypoglycaemia should be reviewed by a DSN and appropriate glycaemic targets set
		Arrange appropriate follow-up to ensure in line with best practice
	A&E Documentation Audit	Practice to be established for all medics to double-check Triage documentation as standard
	Audit of documentation record of the paediatric patients presenting to ED department	Addition of a new section to the ED card where the name of accepting clinician can be recorded
		Involvement of paediatric nurse in all paediatric cases 24 hours 7 days a week
		Improvement required in documentation of pain score and triage category by all concerned
Women's, Children's and Clinical Support Services	Prolonged Jaundice Screening Audit	Develop a prolonged Jaundice folder to be added into patients notes to allow proper handover and continued monitoring of condition
		File the proforma in folder until all results back, documented and letter sent to parents with cc to GP
		Check sheet patient list which will be in the folder itself
	Postnatal Maternal Re-admissions	Patient information and Education regarding PP headache and regular pain killers and hydration
		Increased involvement of primary care in postpartum women v catheter removal

Participation in Research

The number of patients receiving relevant health services provided or sub-contracted by Walsall Healthcare NHS Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 486.

The number of patients recruited in 2015/16 was 410 and in 2014/15 was 243. This increasing level of participation in clinical research demonstrates Walsall healthcare's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Walsall Healthcare was involved in conducting 52 clinical research studies. Walsall Healthcare completed 90% of these studies as designed within the agreed time and to the agreed recruitment target. Walsall Healthcare used national systems to manage the studies in proportion to risk. Of the 6 studies given permission to start, 5 were given permission by an authorised person less than 30 days from receipt of a valid complete application. 100% of the studies were established and managed under national model agreements. In 2016-17 the National Institute for Health Research (NIHR) supported 36 of these studies through its research networks.

In the last 18 months, the Research & Development department supported the opening of 6 clinical areas recruiting patients in research. We have been chosen by 4 Industry study teams to run studies here in Walsall Healthcare NHS Trust. Our first Dermatology Paediatric Industry study earned us the best recruiting site in UK award and paved the way to now the set up of 2 other industry studies this year.

Goals agreed with commissioners

CQUIN Performance - A proportion of Walsall Healthcare NHS Trust income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between Walsall Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The table showing the achievement of these 2016/17 goals is on page 51.

Data Quality

Walsall Healthcare NHS Trust submitted records during 2016-17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

"– which included the patient's valid NHS number was:
99.83% for admitted patient care;
99.90% for outpatient care; and
99.22% for accident and emergency care"

"– which included the patient's valid General Medical Practice Code was:
96.22% for admitted patient care;
99.48% for outpatient care; and
98.22% for accident and emergency care"

Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made. Walsall Healthcare NHS Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The Trust can confirm that it submitted data during the reporting period to both SUS and HES systems for national reporting purposes. The table below details the percentage accuracy levels for NHS number usage for specific reporting areas:

Area	Inpatients	Outpatients	A & E	Total
NHS number used 2015-16	99.75%	99.82%	98.89%	99.82%
NHS number used 2016-17	99.83%	99.90%	99.22%	99.81%

Information Governance Toolkit

Information governance (IG) in about the proper management of information that an organisation has collected and is storing. The IG Toolkit is a system that allows NHS organisations and partners to assess themselves against national standards. Results are published on 1 April each year.

Walsall Healthcare NHS Trust score for 2016 – 17 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 73% (Green).

The Trust continues to have a satisfactory rating (organisations are rated either satisfactory or unsatisfactory).

Clinical Coding

Walsall Healthcare was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission. A similar requirement is now covered by the Information Governance Toolkit.

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
96.50%	94.22%	92.76%	94.27%

Mandatory Indicators

NHS Outcomes Framework Mandatory Indicators

All trusts are required by the Department of Health to provide a core set of indicators relevant to the services they provide using a standardised statement.

The eight indicators relevant to Walsall Healthcare NHS Trust are provided below using information from the Health & Social Care Information Centre and cover the last two reporting periods where the data is available. They are set out under the NHS Outcomes Framework domains.

NHS Outcomes Framework Domain 1.

Title	Indicator	2015/16	2016/17	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI)	a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period;	(12 month rolling HSCIC) Oct 14 - Sep 15 = 1.06 Banding - 2 (As expected)	(Monthly HED) Jan 17 = 132.22 (12 month rolling NHS Digital) Oct 15 - Sep 16 = 1.04 Banding - 2 (As expected)	1.00	(12 month rolling NHS Digital) Oct 15 - Sep 16 Highest Performing Trust: - The Whittington Hospital NHS Trust (0.69) Lowest Performing Trust :- Wye Valley NHS Trust (1.16)
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	37.5%	34.9%		
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The Trust analyses quantitative performance data using the key national indicators, Hospital Standard Mortality Ratio, HSMR and Summary Hospital-level Mortality Indicator, SHMI, in conjunction with local reviews of deaths using a qualitative methodology to determine points of learning and operates a transparent governance approach across all specialties to ensure lessons learnt are acted on.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Following analysis of national data, reviews of deaths and development of action plans clinical teams develop revised clinical pathways, processes and models of care to improve patient outcomes and reduce the risk of avoidable and premature deaths and assure performance against the national indicators is sustained. An improved governance structure is currently being developed to ensure ownership of reviews by the specialties and care groups and development of subsequent action plans and ensure that shared learning takes place. This will include the development of a Trust wide clinical mortality group with a senior clinician lead and representation of a mortality lead for each specialty to support with mortality reviews and developing work streams within specialties to identify lessons learnt and acting on learning.		

NHS Outcomes Framework Domain 3.

Title	Indicator	2015/16	2016/17	National Average	Upper and Lower 95% control limit for the Trust
	PROMS case mix-adjusted scores	Adjusted average health gain	(provisional data) Adjusted average health gain	(provisional data) Adjusted average health gain	(provisional data) Health Gain
Patient Recorded Outcome Measures (PROMS)	(i) groin hernia surgery	(EQ-5D index measure) 0.067	(EQ-5D index measure) 0.134	Not available	Not available
	(ii) varicose vein surgery		(EQ-5D index measure) 0.129	Not available	Not available
	(iii) hip replacement surgery	(EQ-5D index measure) 0.27	(EQ-5D index measure) 0.365	Not available	Not available
	(iv) knee replacement surgery	(EQ-5D index measure) 0.249	(EQ-5D index measure) 0.195	Not available	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		NHS Digital provide the data		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Not available		

Title	Indicator	2015/16	2016/17	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Readmission rates	The percentage of patients aged (i) 0 to 14; and (ii) 15 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.	March 2106 = 10.01%	March 2017 = 10.08%	Not available	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons: Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		The methodology for calculating readmission rates was changed during 2016/17 to reflect the percentage of emergency admission over all admissions (previous analysis was over emergency admissions). This new methodology has been used to re-calculate 2015/16 in the table, however please note due to configuration changes within Lorenzo the figures are not 100% comparable as the cohorts includes in the calculation are slightly different.		
			The community services review all frequent admissions known to their caseloads and have demonstrated a reduction in admissions over the past year. Following a revised methodology to determine the performance for readmissions a robust piece of work will be undertaken in Month 6 to analyse trends and determine strands of work to be undertaken to review causation for key cohorts of patients.		

NHS Outcomes Framework Domain 4.

Title	Indicator	2015/16	2016/17	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey - Responsiveness to patient's needs	The trust's responsiveness to the personal needs of its patients during the reporting period.	Inpatients: 95.33% Outpatients: 97.25% A&E: 92.50% Community Services: 95.75% Antenatal (Maternity): 88.64% Birth (Maternity): 96.75% Postnatal Ward (Maternity): 93.83% Postnatal Community (Maternity): 99.42%	Inpatients: 93.58% Outpatients: 92.67% A&E: 80.75% Community Services: 97.33% Antenatal (Maternity): 87.58% Birth (Maternity): 95.42% Postnatal Ward (Maternity): 91.42% Postnatal Community (Maternity): 94.50%	Inpatients: 95.75% Outpatients: 93.08% A&E: 86.17% Community Services: 95.25% Antenatal (Maternity): 95.67% Birth (Maternity): 96.58% Postnatal Ward (Maternity): 93.83% Postnatal Community (Maternity): 97.75%	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The Trust follows The nationally mandated process for implementing The FFT programme. - Data collated is submitted monthly to NHS England via UNIFY2 submissions - FFT results are published NHS England on their public websites		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Introduced near real time online survey portal for conducting surveys and viewing results which is now in line with national guidance. The response rates for A&E and Outpatients were poor compared nationally. Staff training and introduction of real-time system has resulted in significant improvements in responses from patients. In excess of 100 staff have been trained to access and action their feedback locally. PE Team works collaboratively with ward/area teams to assist with their PE improvements. A comprehensive PE Strategy has been developed in collaboration with Trust Staff, Partners and Patients/Public to support service improvements across the Trust.		

Title	Indicator	2015/16	2016/17	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	51%	48%	68% (2016)	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The data provided is from question 21d in the National NHS Staff Surveys 2015 and 2016 respectively. Though extremely disappointing, the limited improvement was anticipated, as this has been our first year undertaking the changes required following the CQC inspection.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Whilst the Trust has not seen significant improvement in the overall results we have seen an increase in engagement to complete the survey itself. The questionnaire was sent to all colleagues and 1730 responded, equating to a 43% response rate. This compares favourably to the response rate for all combined acute and community trusts in England of 40%. Walsall Healthcare has seen a growth rate of c20% compared to the 2015 survey. The Trust Workforce Executive and Patient Experience Group will support the Trust to address the identified issues. Progress will be monitored bi-monthly by the People and Organisational Development Committee, with the specific Divisional developments discussed and reviewed at their respective Quarterly Review meetings.		

NHS Outcomes Framework Domain 5.

Title	Indicator	2015/16	2016/17	England Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Venous thromboembolism Risk assessments	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Apr 15 = 95.15% May 15 = 95.71% Jun 15 = 95.80% Jul 15 = 97.13% Aug 15 = 97.59% Sep 15 = 95.99% Oct 15 = 95.25% Nov 15 = 96.22% Dec 15 = 96.37% Jan 16 = 96.62% Feb 16 = 95.09% Mar 16 = 96.59%	Apr 16 = 96.88% May 16 = 95.05% Jun 16 = 96.06% Jul 16 = 97.17% Aug 16 = 96.74% Sep 16 = 94.49% Oct 16 = 87.85% Nov 16 = 88.61% Dec 16 = 86.33% Jan 17 = 86.23% Feb 17 = 82.23% Mar 17 = 82.49%	Latest position - Quarter 3 16/17 = 95.35% (based on 134 Acute Trusts)	Latest position - Quarter 3 16/17 Highest Performing Trust :- Salisbury NHS Foundation Trust (99.69%) Lowest Performing Trust :- Weston Area Health NHS Trust (76.48%)
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The implementation of a revised validation audit methodology		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• To undertake a monthly quality audit of VTE as recorded via Vision • To undertake a monthly validation audit of those VTE assessments not recorded in Vision • Streamline the paper VTE assessment tool • The Trust has developed a single process for assessing and recording VTE assessment, Vitalpac. The use of Vitalpac VTE module, an electronic patient record system, was launched 15th March 2017 • The VTE policy has been revised and will be launched in April 2017 and includes revised and improved patient information leaflets.		

Title	Indicator	2015/16	2016/17	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.		10.39%	Not available	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		• The Trust has a process in place for collating data on C Difficile cases • Data collated internally and submitted monthly to Public Health England • All C Difficile cases are presented at the quarterly meeting Walsall CCG		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Please refer to section 2.6		

Title	Indicator	2016/17	(April - Sept 2016) The latest data available	National Average (April - Sept 2016) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Incidents	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period.	10,505 incidents Awaiting bed days information for second half of 2016/17 as NRLS data not yet available	5,238 63.35 incidents per 1,000 bed days	4,992 41.06 incidents per 1,000 bed days	13,485 incidents reported by Bart Heath NHS Trust @ 43.47 incidents per 1,000 bed days. 1,485 incidents reported by Hinchinbrooke Healthcare NHS Trust @ 43.47 incidents per 1,000 bed days.
	The number and percentage of such patient safety incidents that resulted in severe harm or death.	56 incidents 0.5%	38 incidents 0.8%	19 incidents 0.4%	40 incidents = 0.3% - Barts Heath NHS Trust 3 incidents = 0.2% - Hinchinbrooke Healthcare NHS Trust.
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		• The data is provided by the National Reporting and Learning System (NRLS)		
	Walsall Healthcare NHS Trust has taken the following actions to improve this rate (for incident reporting) and number (of incidents that result in severe harm or death) and so the quality of its services, by:		• Continuing to promote incident reporting through patient safety workshops and by providing feedback to staff on incidents reported and actions taken as a result.		

Appendix 2

Statements

Healthwatch Walsall Quality Account response

Walsall Healthcare NHS Trust

Healthwatch Walsall welcomes the opportunity to comment upon the Draft Quality Account (QA) for the Walsall Healthcare NHS Trust.

The QA shows some progress against the ten priorities for 2016/17, following the Trust being placed into Special Measures in Jan 2016 regarding the majority of inadequate ratings by the CQC with urgent actions placed on a number of areas including the Emergency Department, (ED), and Maternity.

This still has to translate itself to meaningful Patient perception, as the Friends and Family Test (FFT) recommendation for ED shows a deteriorating response for performance with figures of 72.9% for Quarters 4 against 92.4% for Quarter 1 (Apr/16-Feb/17).

Similarly, there is a mixed Quarter 4 FFT response to Maternity with Antenatal, 76.8% and Postnatal Ward, 84.2%, both significantly worsened against Quarter 1 data 88% and 94.9% respectively (Apr/16-Feb/17).

ED results are substantiated against the 95% target of four hours in Accident and Emergency (A&E); the Trust achieved 84.1%; this has worsened year on year (89.1% 2014/15 and 87.9% 2015/16).

Clearly therefore, sustained progress is still required to support the achievement of targets within ED and Maternity and as a consequence raise Patient experiences of receiving better positive care.

Compared to End of Life care delivered by the Community Health Services, it is a great concern that WHNHST does not match this in delivering similar services at the Manor.
We note the leadership changes in Maternity and the commitment to improving the service further by setting out aims and objectives that embrace patient safety and positive patient experiences/outcomes.

A&E is one of the Public's 5 priority areas for Healthwatch Walsall and we will be using the recommendations of our A&E Communication report (Feb 2017) and our Pre-inspection (Apl 2017) to undertake further engagement.

Another priority for Healthwatch Walsall is Cancer Care and the Trust should be congratulated for its strong performance against 2016/17 targets.

We are surprised though to find no mention of cancelling the 100 elective operations in light of the financial and staffing constraints the Trust was under in March 2017.

In addition, its approach to patient safety and the promotion of a Trust wide safety culture should be viewed as wholly positive. The training of 100 members of staff to deal with patient safety & inspection, coupled with 100 trainees in the legal obligation, (duty of candour), to liaise with patients and relatives; then review, investigate and report on initiatives, points to an open culture designed to enhance Patient experience.

The objective for improving and developing Community Healthcare Services through integrating pathways creating a joined up approach facilitated by IT improvements can only be of benefit for Walsall Patients. This is dependent though on the effectiveness of the Walsall Together Partnership. It is essential that all Stakeholders work together to improve the service provision and include Patients and Service Users in the design of these services to achieve better outcomes that improve the Patient/Service User journey.

The draft report contains a great deal of information to satisfy statutory requirements. It is essential the core and salient points with supporting data be abridged to make an easy read document for Patients to gain a clearer understanding of the Trust's progress against its plans hopefully encouraging patient participation both now and for the future.

23rd May 2017

Walsall Social Care Overview and Scrutiny Committee

It has not been possible for the Walsall Social Care Overview and Scrutiny Committee to receive and comment on the Trust's quality account due to a high workload and the timescales involved. Unfortunately, quality accounts are not usually available until after the last Committee meeting, which makes a meaningful commentary that has been agreed by all Members of the Committee difficult to produce. However the Committee has worked and will continue to work with the Trust as a critical friend in their journey of improvement.

25th May 2017

Walsall Clinical Commissioning Group

Commissioner's feedback on Walsall Healthcare NHS Trust Draft Quality Report 2016-17

NHS Walsall Clinical Commissioning Group (CCG) welcomes the opportunity to comment on Walsall Healthcare NHS Trust's 2016/17 Quality Account. The CCG believe that the Quality Account for 2016/17 meets the required content as set out in national guidance and is a good reflection of the quality of services provided by the Trust. Whilst not all data fields were complete in the draft account, the CCG has reviewed the information presented against data sources available to the CCG as part of contracting and performance and can confirm them as accurate.

The Quality Account reflects the challenging year the trust encountered during 2016/17 but also details those areas where improvement has been achieved. We are encouraged with the improvements made in relation to Maternity Services, progress against the majority of actions within the Patient Care Improvement Plan following the CQC inspection in 2015 and the improvement in relation to a number of Cancer measures during 2016/17. We are keen that these improvements are further embedded and sustained during 2016/17.

The challenges experienced by the Trust include the achievement of Accident and Emergency four hour waits target, which is also recognised as a challenge for the majority of acute trusts nationally. This will continue to be one of the biggest challenges faced by the Trust and Walsall system in the forthcoming year. We recognise it will require effective partnership working across the system to support achievement of this target. As a CCG, we will continue to work collaboratively with all stakeholders to support the achievement of the target.

Walsall CCG is aware that 'Improving for Colleagues' was a key Trust objective for 2016/17 and as such was disappointed with the annual staff survey results achieved, despite the Trust employing active staff engagement strategies such as Listening in Action. We recognise that initiatives employed may not have had time to embed at the time when the staff survey was undertaken, so look forward to improvements in this crucial indicator during 2017/18.

Patient feedback is an important part of monitoring and service improvement. We are pleased with how the Trust has made progress handling and responding to complaints. The Trust's strengthening of their complaints process has made a difference. However, the Trust has further work to do in order to ensure learning and feedback from complaints is translated into practice. It is also unsatisfactory that progress has not kept pace with other trusts in relation to results from The National Inpatient Survey. Improving patient experience will be a key priority for the Trust in 2017/18.

Whilst we acknowledge that the local CQUIN in relation to the recognition and response to the deteriorating patient was not achieved by the Trust during 2016/17, the CCG recognises the considerable improvement which has occurred within this key patient safety area and are encouraged that this aspect of clinical care, along with utilisation of the sepsis bundle, has been identified as a key priority for the Trust for 2017/18.

The CCG have worked extensively with the trust to address the significant issues arising from RTT performance. This continues to be a challenge for the trust and local system. The importance of safe and effective elective access pathways are critical in minimising clinical harm, as such processes to identify and minimise have been strengthened.

The CCG has also identified the following areas for further emphasis and improvement for 2017/18:

- Pressure Ulcer reduction in the Community
- Improvements in staff and patient experience
- Falls reduction and embedding learning from falls incidents
- Strengthening processes in Elective Access performance
- Mixed Sex Accommodation breaches
- Achievement of CQUINs

In conclusion, whilst we recognise that the Trust has made progress in a number of areas, we also acknowledge the significant improvement that is still required in order to deliver, safe, effective and efficient patient care for our population. This will require capacity and capability at all levels and key to this is a leadership team who are responsive, visionary and resilient to make change in care delivery at the pace demanded. Looking forward, this includes changes to models of care and collaborative approaches for future care delivery. We support the priorities identified by the Trust for 2017/18 to further improve the quality, safety and experience for the population of Walsall. We will continue to support the Trust in achieving these priorities.

Dr Rajcholan Mohan – Medical Director Walsall CCG
Sally Roberts – Chief Nurse, Director of Quality, Walsall CCG

23rd May 2017

Appendix 3

Walsall Healthcare NHS
NHS Trust

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

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

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

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

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

By order of the Board

Danielle Oum
Chair
Date 29th June 2017

Richard Kirby
Chief Executive
Date 29th June 2017

Appendix 4

Independent Auditor's Limited Assurance Report to the Directors of Walsall Healthcare NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Walsall Healthcare NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE) (page 24); and
- Friends and Family Test (page 29).

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

- 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, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS Choices website in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback from NHS Walsall Clinical Commissioning Group dated 23 May 2017;
- feedback from Healthwatch Walsall dated 23 May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from Walsall Metropolitan Borough Council Health Overview and Scrutiny Committee dated 25 May 2017;
- the latest Care Quality Commission inspection report dated 26 January 2016;
- inpatient survey dated 2016;
- the latest national staff survey dated 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017; and
- the annual governance statement dated June 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Walsall Healthcare NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Walsall Healthcare NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Walsall Healthcare NHS Trust.

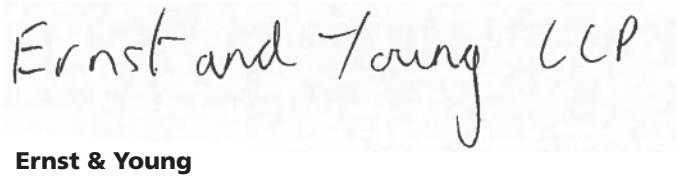
Basis for qualified conclusion

Our testing of the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period found an insufficient audit trail and process for the calculation of the indicator for the period April to October 2016. Our testing also identified 1 out of 28 cases with no VTE assessment documented and 4 out of 28 cases where the date of the assessment was different to that recorded in the Trust's database. The indicator reporting the percentage of patients risk assessed for VTE therefore did not meet the accuracy and reliability dimensions of data quality set out in the Guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.



Ernst & Young

No 1 Colmore Square
Birmingham
30 June 2017

Glossary

This section provides a definition of the terms and acronyms used in this report.

A&E	Accident and Emergency (Emergency Department)
BADGERnet	A paperless patient management system for Maternity
BME	Black and minority ethnic (used to refer to members of non-white communities in the UK)
C. Difficile	Clostridium difficile
CCG	Care Commissioning Group
CDs	Controlled Drugs
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CSW	Clinical Support Workers
CTG	A method of monitoring a baby's heart rate during labour
DVT	Deep vein thrombosis
ED	Emergency Department (Accident and Emergency)
EDI	Equality, Diversity and Inclusion
FFT	Friends and Family Test
GP	General Practitioner
HRG	Health Resource Group - a grouping consisting of patient events that have been judged to consume a similar level of resource.
HSMR	The Dr Foster Hospital Standardised Mortality Ratio
IT	Information Technology
IV	Intra venous
LGBT	Lesbian, Gay, Bisexual, Transsexual
MRSA	Meticillin resistant Staphylococcus aureus
MRSA BSI	Meticillin resistant Staphylococcus aureus blood stream infections
MASH	Multi-Agency Safeguarding Hub
MLTC	Medicine and Long Term Conditions Division
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
NNU	Neonatal Unit
OPD	Outpatient Department
PCIP	Patient Care Improvement Plans
PHSO	Parliamentary and Health Service Ombudsman
PU	Pressure Ulcer
R&D	Research and development
SHMI	Standardised Hospital Mortality Indicator – this looks at the relative risk of death of all patients managed by the Trust and includes the period up to 30 after discharge.
SI	Serious Incidents
SSNAP	Sentinel Stroke National Audit Programme
VTE	Venous thromboembolism
WCCS	Women Children and Clinical Support Services Division
WHO	World Health Organisation
WMAHSN	West Midlands Academic Health Science Network
WRES	Workforce Race Equality Standard

Walsall Healthcare NHS
NHS Trust

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