Walsall Healthcare NHS
NHS Trust

Quality Account
2018/19

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Caring for Walsall together

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

Quality Account

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2 A statement on quality from the Chief Executive

I am pleased to present Walsall Healthcare NHS Trust Quality Account 2018/19. This document is an honest reflection of our performance, challenges and achievements during 2018/19 and describes the quality improvement priorities for 2019/20.

We started this year planning to move from being an organisation previously rated as "Inadequate" to one rated "Requires Improvement", focussing our improvement programme on the quality priorities we agreed and developing a culture of continuous quality improvement which addresses the three pillars of quality in healthcare, Safety, Effectiveness and Experience.

Our new Values

In July our staff were instrumental in developing four new Values for the organisation to signal its commitment to doing the right thing by patients and its workforce.

During this refresh the Trust revisited the existing vision statement, following a variety of views and discussions with, staff and other internal and external stakeholders, the new vision statement was agreed as "***Caring for Walsall Together".***

We launched a new accountability framework, performance review meetings with Divisions and our weekly quality assurance meetings. Our new Medical and Nursing Directors reinforced the expected standards with those accountable leaders, through their professional forums.

Another key element of our Improvement Programme has been our work on patient flow. We revised and re-launched work to deliver best practice in admission avoidance, inpatient care coordination and discharge. Poor patient flow and resultant bed occupancy remains one of our greatest risks as an organisation, given it is a driver to many other issues, such as mortality, outcomes and experience.

We also revised and re-launched our escalation management procedures in tandem with our robust, week by week winter plan. These changes, operationally deployed, led to far greater operational resilience. We delivered some of the best Emergency Department (ED) 4 hour performance in the region during this year and saw very high attendance and admission levels, often exceeding not only our evidence based predictions for the month but also exceeding our predictions for the busiest month of January.

Our Patient Safety teams for Medicine and Surgery were named winners in the 'Integrated approach of changing cultures in clinical governance/patient safety' category at this year's Health Service Journal (HSJ) Patient Safety Awards. Staff were recognised for their efforts around embedding the 'Learning from Excellence' approach to working, hosting Risk Roadshows for frontline staff, creating patient liaison roles that enable clear communication between

the Trust and the people we care for and for encouraging active conversations around risk reporting – amongst many other things.

Our maternity services received a 2 day unannounced inspection on 5th and 6th June, which colleagues in that service responded to well. As a result the service was rated requires improvement.

During January and February 2019, the Care Quality Commission (CQC) undertook a number of unannounced inspections and have inspected ED, Medical inpatient areas, Maternity (including community midwifery), Surgery (including theatres) and Sexual Health. Overall, it is my interpretation of that informal feedback thus far, that our organisation has performed much better than in recent times, against the key lines of enquiry in the core service domains (Safe, effective, responsive, well-led, caring). Particular note has been made of how professional, positive, welcoming and improvement orientated our front line staff are. In addition, our maturing patient safety culture has been highlighted as has the improvements we have made in the visibility and supportiveness of our clinical and managerial leaders in the Trust.

NHS Improvement (NHSI) conducted the Use of Resources inspection on the 8 February 2019 and a well-led inspection was conducted by the CQC on 18-20 March 2019.

Our Patient Care Improvement Plan (PCIP) was further refined and became the extant vehicle for assuring ourselves regarding quality improvement against those quality fundamentals, at both corporate and divisional level. Using the PCIP, we developed a new performance report/dashboard.

An important part of the Quality Account is looking forward to the year ahead. We are pleased to include our new Quality Improvement Priorities for 2019/20, which will support our endeavours to provide excellent and high quality healthcare for our patients.

Progress made against the new Quality Improvement Priorities will be monitored and reported via the established governance structure. This includes monitoring each of the priorities via the Quality Patient Experience and Safety Committee where indicators and metrics are reported through the Quality Dashboard.

Best Wishes

Richard Beeken
Chief Executive

2 Priorities for improvement and statements of assurance from the Board

2a. Review of 2018/19 Quality Priorities

The Trust made a commitment to the following quality improvement priorities for 2018/19.

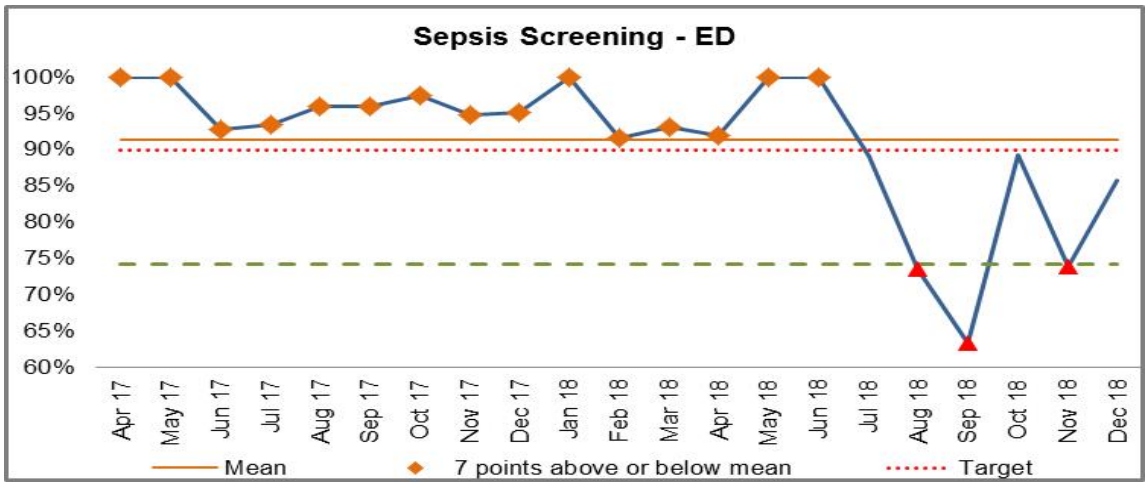
Domain	Outcome measure / indicator	How we will measure achievement	2018/19 performance	Improvement achieved
Safe	Implement best practice around resuscitation, acting on the deterioration and utilisation of the sepsis bundle	We will undertake monthly audits	Year to date (Quarter 3) 86.05% 1771 staff across 9 separate staff groups have been trained to date.	Part Achieved
Effective	Ensuing the patient receives the right care, in the right place at the right time	We will undertake monthly audits	reduction in bed days used of 5190 versus the prior year	Part achieved
Effective	To maintain a secure, accurate, complete and contemporaneous record for each patient	We will undertake monthly audits	Compliance levels increased from 30% to 89.1%	Part Achieved
Caring	Complete the assessment of the Trust's compliance with Equality and Diversity System 2	Appointment of equalities post	Equality, Diversity and Inclusion Manager appointed	Achieved

2b. **What the Trust has done to address the Quality Improvement Priorities**

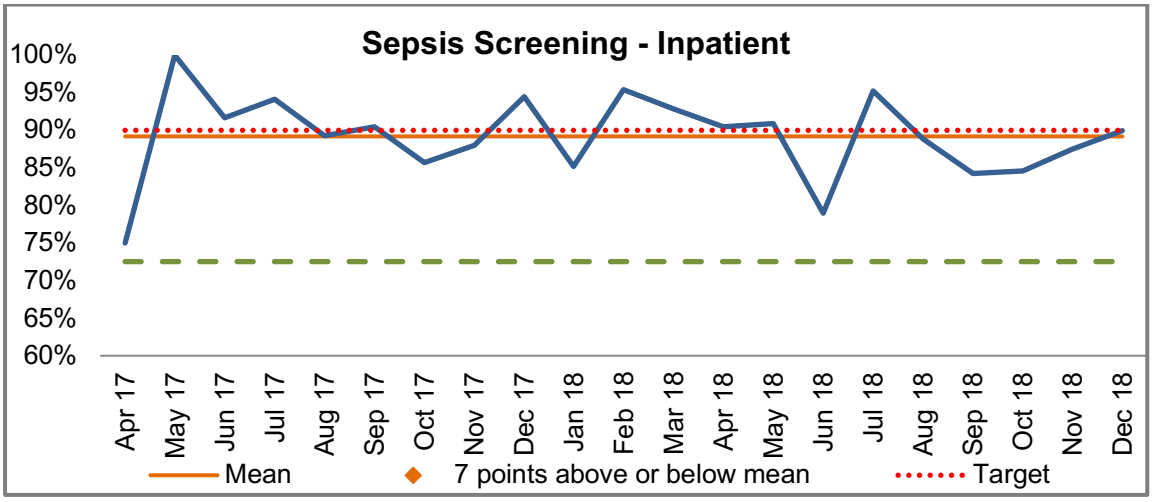
Priority One: Implement best practice around resuscitation, acting on the deterioration and utilisation of the sepsis bundle

This priority aims to ensure the Trust implements best practice with regards to deterioration and sepsis.

The Trust has performed consistently above the 90% target from April 2017 through until July 2018 when performance significantly deteriorated and remained below the target throughput Quarter 3. Data for Quarter 4 (January to March 2019 is still pending).



It has been identified that this may be due to the screening tool being moved from the front page of the ED CAS card to within the ED CAS card and it has been decided to move this back to the front page. The re-emphasis on completing the sepsis tool is also being promoted as part of the National Early Warning Score (NEWS) 2 implementation work which went live in May 2019 with the corporate nursing team providing support and education. With regard to inpatient areas the sepsis screening shown below:



The Quality Facilitator (Sepsis) continues to walk the wards reviewing patients with sepsis / suspected sepsis. A daily report is generated from the data stored in Vital Pac

for those patients trigging 5 on their Early Warning Score, when these patients are reviewed many have preset parameters in place which explains why they are triggering. However those triggering the sepsis pathway are reviewed alongside a review of the prescribing and timeliness of administration of antibiotics. This process will allow the organisation to identify reasons for the delay in antibiotics being administered and hence allow for solutions to be explored.

The Trust has a Sepsis and Deteriorating patient group which met in April 2019 and agreed that this Group will merge with the Resuscitation Committee going forward to enable all aspects of deterioration and care planning including AMBER Care Bundle and the RESPECT document to be considered for implementation.

The Trust has continued to focus on delivering training for staff on the deteriorating patient and the use of the sepsis bundle. 1771 staff across 9 separate staff groups have been trained to date.

Staff Group	Count of Staff Group
Add Prof Scientific and Technic	83
Additional Clinical Services	468
Administrative and Clerical	27
Allied Health Professionals	99
Estates and Ancillary	5
Healthcare Scientists	20
Medical and Dental	163
Nursing and Midwifery Registered	904
Students	2
Grand Total	**1771**

Adult Community Services, have reviewed the Organisational 'Adult Deteriorating Patient Escalation Policy' and have adapted an element of the policy to ensure there is timely recognition of both expected and unexpected deterioration in patients condition and that there is a clear process for escalation and treatment for patients.

Bespoke training for early recognition of sepsis has been developed and rolled out across Community teams. Training includes basic fundamentals of care, recognition of sepsis, specific common causative themes across adult community i.e. urosepsis, pneumonia and recognition of frailty. 230 staff, so far, have attended a training session and feedback has been extremely positive. Similar work streams have been delivered across Nursing and Residential care homes.

In September 2018, a review of the care of the deteriorating patient pathway was undertaken by the West Midlands Quality Review Service (WMQRS). The WMQRS review outlined that the Trust had demonstrated some clear achievements in their response to improving care for patients, specifically a reduction in the number of

Serious Incidents relating to Deteriorating Patients. Areas of good practice were outlined.

Priority Two: Ensuring the patient receives the right care, in the right place at the right time

This priority aims to improve the effectiveness, quality and safety of patient care by ensuring that the patient receives the right care and expertise, at the right time, and in the right place. We know from our own performance targets and from patient feedback that we do not always provide care in a timely way, and consistently complete all assessments and evaluations of care. The aim is to improve the overall patient experience of care by ensuring that key activities take place consistently for each and every patient regardless of the care setting.

This work draws together activities undertaken across the patient journey to improve the effectiveness of care and will incorporate some of the initiatives already underway including the implementation and embedding of Safer / Red to Green, development of ward based multidisciplinary leadership (with the ward manager and a designated named consultant jointly taking accountability for ward processes and performance) and a visible leadership programme with non-clinical manager engagement at ward level.

A number of approaches to achieving this priority aim were identified including admission avoidance, reduced length of stay (LOS) and improved discharge to social care. These areas where supported to deliver projects which would improve patient outcomes by reducing the number of patients admitted to acute inpatient pathways, reducing the LOS of patients who were admitted through improved pathway management and better integration of community and social care in the discharge pathways Due to the complexity of measuring improvement at the patient level the agreed metric for the measurement of improvement was the total number of bed days consumed by general and acute (G&A) activity vs the prior yr.

Overall the work done to improve patient outcomes in 2018/19 led to a reduction in bed days used of 5190# versus the prior year. This was achieved despite the fact that attendances to the ED department rose by 3026 in the same period generating a calculated additional demand of 9986 bed days of demand. The effective improvement was, therefore, in the region of 15’000 bed days

#data source - bespoke patient level report by information services April 2019 inclusive of medicine, surgery and women & children’s services – beds occupied at midnight

Overall the trust managed an increased demand of 4% on the equivalent of 41 less beds occupied. The most significant impact of this on patient safety and outcomes were:

- Year on Year reduction of wards nursing additional
- period

patients on wards who were not in a recognised bed space. This reduced to the point that only 1 incident was reported during the October 18 – March 19

- ED waiting times, both 4hr wait to be seen and patients waiting for more than 4 hours from decision to admit to being admitted to the hospital improved versus the previous year.
- Friends and Family (FAF) feedback for the ED department improved over the winter period indicating a better patient experience and outcome.
- Additional capacity areas in Clinical Investigation Unit (CIU) and Endoscopy were used for a significantly lower number of days than in the previous year (endoscopy was not used at all)
- The identified capacity ward (ward 10) was not used until Jan 5th versus a predicted need of 1st week in December

During the 2018/19 period the Trust operated with an increased level of operational rigour which was, in part underpinned by improved use of Safer and Red to Green. Whilst use of this methodology was, and still is evident it remains sporadic and inconsistent in significant areas of the Trust. Sustainable adoption of these principals will continue to need support to embed it effectively and consistently.

These areas of under-delivery need to be taken in context as other elements of the improvement plan including the production and management of a full G&A Winter Plan, reduction of elective inpatient activity to support non-elective demand (and subsequent reduction of medical outliers to allow elective activity to re-commence) and sustained delivery of Ambulatory pathways throughout the winter period were delivered as planned and have had a demonstrable impact on patient safety.

Increased operational leadership, improved rigour, appropriate challenge and improved use of escalation processes mitigated some of the remaining variability in ward processes and supported a reduction in LOS, and an increase in episodes for patients staying less than 2 days is further indication that work on improving flow in the acute pathways improved outcomes.

In summary the identified and agreed improvements were delivered but the consistency and sustainability of the change was not achieved. The elements of improvement around Safer and Red 2 Green remain a key focus for the Trusts improvement work in the coming months, along with further work at the system level to maximise the capacity and capability within the Walsall Together partnership. A set of improvement priorities has been agreed for the coming year with a focus on implementation in time for the winter months. This will be supported by the Trusts Quality & Safety Improvement Academy (QSIA) cohort, Programme Management Office (PMO) function, senior management, external support and will have full executive sponsorship.

In addition to the work described above, a focus has been on ensuring that patients receive accurate and timely assessments including Venous thromboembolism (VTE), Falls, Skin Integrity, Malnutrition Universal Screening Tool (MUST), Timely recording of observations. This has included establishing and embedding ward /board rounds and linked to the work on Red2Green.

Daily safety huddles have been established on the ward, led by any member of the Multi Disciplinary Team (MDT) with a focus on aspects of quality and safety of care including assessments, sepsis, vitalpac, IPC. These are currently beginning to embed but needs further focused work to make these truly multidisciplinary

Matrons Quality Assurance Audits have continued and link into Priority 3 below which review the quality of care looking at timely assessments of skin integrity, falls, MUST, Observations, Infection Prevention & Control (IPC). This information is collated monthly and inputted into an individual ward dashboard.

Nursing Quality Assurance Metrics meetings take place monthly, attended by matrons and Divisional Directors of Nursing and are chaired by the Director of Nursing. These meetings identify areas of care that require focus and the agreement of any additional support required for these wards. These meetings also triangulate all quality and safety data with workforce data for each ward.

Ward review process have been undertaken across all adult inpatient medical and surgical wards to evaluate care on the wards across all key quality and safety Key Performance Indicators (KPIs) and benchmark against CQC Key lines of Enquiry (KLOE)s.

Adult Community services continue to focus on delivering services around 8 integrated 'place based' health and social care teams with the aim of providing an MDT approach for the right patient at the right time. The place based teams bring 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 enhancing outside of hospital care.

Community services aim to deliver services through integrated locality based teams which are grouped around GP practices offering 24/7 services as standard with engaged, highly flexible responsive community staff.

To equip services to face the unprecedented demand for 'care closer to home' existing services and resources have been re-modelled and this has included realigning and investing in existing community services to enable delivery of an enhanced model of care, assessment of risk of the frail elderly population and stratification of risk with a clear pathway of patient care delivered based on need. The model of care includes an integrated "Wrap Around" approach to patient care through collaborative work between Primary and Secondary care and includes Frail Elderly Services within acute hospital environment, a "Rapid Response" Service for patients who are sub acutely unwell, medical outreach support and robust community nursing teams with specialist intervention aligned to place base.

Rapid Response – Rapid Response Team (RTT) manages sub-acutely ill patients who require rapid, intensive interventions to either avoid a hospital admission. Referrals to Rapid Response are increasing month on month and have recently increased from an average of 150 each month to over 230. This team has recently been expanded, have been able to evidence high quality patient care and admission avoidance and have been consistently

preventing hospital admission for up to 90% of patients being seen having both short and long term acute admission avoidance.

Significant redesign has been undertaken across both Community Continence and Respiratory services and initial review included activity, skills, local population needs in relation to bladder and bowel care and urology conditions and respiratory co-morbidities. Investment into the teams has resulted in additional staff recruitment and the specialist clinicians having a wider remit across their specialities, and being located and part of the place based teams rather than part of a borough wide service. Early outcomes include improved productivity, greater integration and MDT, pilot of Consultant led MDT

Enhanced MDT is being supported and rolled out across Primary Care and there are now 14 practices participating covering 32% of the population list size. A locality based MDT is due to be piloted in one locality as soon as approval is agreed by the Clinical Commissioning Group (CCG) with the General Practitioner (GP) Leadership, this would see multiple practices participating in four locality MDT's on a regular basis rather than multiple MDT's across the borough that are proving difficult to accommodate by all participating organisations.

Priority Three: To maintain a secure, accurate, complete and contemporaneous record for each patient

The focus of this priority was to ensure the Trust maintains securely an accurate, complete and contemporaneous record in respect of each patient, including a record of care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided. The Trust aimed to ensure 95% compliance against professional standards by December 2018. Delivering this priority will also address the regulatory breach Regulation 17 Healthcare Supply Chain Association (HSCA) (RA) Regulations 2014 Good Governance, issued by the CQC in December 2017.

The priority also planned to look at a number of additional issues including addressing the physical condition of the paper records by 31st March 2018, confirming the Trust strategy for Electronic Patient Records by 30th June 2018 and implementation of "Total Mobile" notes implemented across community services.

Focussing on maintaining a secure, accurate, complete and contemporaneous record for each patient a patient record audit was implemented across the Trust, which included reviewing medical and nursing records. The audits incorporated reviews of assessment documentation, contemporaneous standards utilising national and peer group tools and professional standards guidelines as a reference guide for the local tool used Biannual Patient Consent Audit.

A new multi-professional audit process and tool was developed and piloted alongside the other fundamental standards peer review audits. At the start of the audit results indicated approximately 30% compliance. Each Division individually agreed a plan to improve compliance by December 2018 and the following results were delivered.

Month	Percentage compliance
November 2018	83.4%
December 2018	86.8%
January 2019	86.3%
February 2019	86.4%
March 2019	85.6%
April 2019	89.1%

Walsall Healthcare NHS Trust identified a clear gap between information systems and services required to meet current and future requirements and those that are presently available to our staff working in the community. Gaps included community teams using a labour intensive cumbersome paper based patient assessment process and the inability to access diagnostics and partner Information Technology (IT) systems whilst undertaking patient care in patients own homes. As described above a business case was developed for investment in mobile technology to support an integrated workforce management and mobile

working solution to bridge the identified gaps. A Project Board was set up which has met monthly since project has commenced, Board having Executive Sponsorship and a Project Initiation Group has also been set up which has met frequently during the project. Following a significant amount of resource investment into training and ensuring mobile apps were fit for purpose, including review of assessment, care planning and evaluation documentation for uploading onto the devices, actual roll out in use of mobile technology commenced in February 2018 and to date now has 317 active mobile users across 13 community teams.

In March 2019 the Trust Board agreed to implement a new electronic patient record for the Trust. This was following consideration of a business case which set out details of staff engagement events held in June 2018 regarding the functionality of its core Information systems. An electronic patient record (EPR) is a structured collection of patient medical information, both clinical and administrative data, stored accurately electronically in order to provide patient information to clinicians across the Healthcare Economy. The initial phase of this development will involve the replacement of the Trust's Patient Administration System (PAS) (and other modules), due for completion in March 2020. This will be the enabler for the development of a full EPR.

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

The Trust appointed an Equality, Diversity and Inclusion Manager for a 6 month period starting in September 2018. A key outcome was the completion of the Equality Diversity System (EDS)2 self-assessment and this was completed in draft in March 2019.

Quarterly progress reports on the progress towards completing the EDS2 self assessment was reported to Equality, Diversity and Inclusion Committee during 2018 -2019 and through to the People and Organisational Development Committee bi-monthly.

The Trust continue to monitor compliance with the Equality and Diversity System 2 and extending this to other areas the EDS2 assessment and engage with the NHS Employers Equality and Diversity Partners Programme, there has been initial engagement with NHSE and further steps will be taken within 2019

2c Priorities for improvement 2019/20

During February 2019 the Trust reached out to its membership groups, hard to reach groups, staff and stakeholders and invited them to participate in engagement events to help the Trust select the quality improvement priorities for 2019/20. Three events were held involving staff and members of the public (39 people attended) along with an online survey (53 people completed). Each group reviewed a long list of quality priorities which were developed using quality indicators from national, regional and local level intelligence, ensuring that the measures were relevant to the Walsall population.

Those participating in the involvement and engagement events were asked to select their top 5 or 6 priorities from the long list. This information was refined into a short list and shared with the Quality Patient Experience and Safety Committee at its meeting on 28 February 2019.

The following list of Quality Improvement Priorities for 2019/20 is therefore a product of this process.

We will monitor the progress of these priorities through the Quality Patient Experience and Safety Committee and sub group governance structures.

Domain	Outcome measure	Metric
Safety	Delivery of best practice / fundamentals of care Reduce the number of inpatient falls and falls with harm,	Reduce falls by 20% 85 inpatient falls per month = no more than 68 inpatient falls per month (review after 6 months with stretch target if this is achieved in first 6 months) The Trust had 86 falls in December 2018 Falls per 1,000 bed days also increased to 5.68.
	Reduce the number of category 2 pressure ulcers across the Trust and aim to eliminate category 3 and 4,	20% reduction with review at 6 months and re-set target December 2018 there were 21 hospital or community acquired pressure ulcers across the Trust There was a total of 11 category two pressure ulcers, 1 category

		three pressure ulcer 9 unstageable pressure ulcers The category 3 pressure ulcer and 8 of the unstageable pressure ulcers were all attributed to the hospital
	At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission using the nationally recognised MUST	At least 95% across all Ward completion of MUST score
	Continue to implement extended working in a number of areas through new service delivery models	Priority Standards 2. Time to first consultant review, within 14 hours in the acute admission setting 5. Availability of diagnostics 6. Consultant led interventions 8. On-going consultant review, all patients to be reviewed every 24 hours. By April 2018, 7 day services will be available to 50% of the population and April 2020 available to 100% of the population.
	Learning from deaths – recruitment of medical examiner	Implementation of the Medical Examiner role, responsibilities and processes. Recruiting to the Medical Examiner role
	Reduce harm from sepsis: increase the number of patients screened, and give antibiotics within an hour of a patient being diagnosed with sepsis	Reduction in harm from sepsis by increasing the number of patients screened for sepsis and to give antibiotics within one hour of patients being diagnosed with sepsis antibiotic administration within one hour from Ed and Inpatients. Target

		90%
Effective	Safe and effective discharge and improving our patients' experience of getting home	Improved feedback from the people who use our services about the discharge process, firstly about communication and secondly about information regarding the discharge process. We also aim to see more positive feedback from our staff. A system will be designed and in place for reviewing (a snapshot of) potentially avoidable readmissions within 30 days. This will be similar to the work on learning from deaths and will be a snapshot audit. With regard to discharge following inpatient or daycase care or A&E attendance, we aim to issue a Discharge Summary to the patient's GP within 24 hours; and following outpatient attendance, to issue a Clinic Letter to the patient's GP within 7 calendar days. Trust locally agreed target is 48 hours for inpatients EDS's. Current performance is at 85.23% for April 2019. Target is 100%.
Experience	Improve communication with patients through the provision of a 'Values Based Customer Care Programme (initial pilot and then full role out)	Pilot in 4 wards and review at 6 months for roll out across organisation
	Undertake the NHSI Patient Experience Improvement Framework self-assessment and develop actions following self-assessment to ensure compliance against the framework is achieved.	Undertake a self assessment by Q2 Action plan implementation in Q3/4

2d Statements of assurance from the Board

2di Review of Services

During 2018/19 Walsall Healthcare NHS Trust provided and/ or sub-contracted 136 NHS services.

Walsall Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 136 of these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of NHS services by the Walsall Healthcare NHS Trust for 2018/19.

2dii Participation in Clinical Research

Research & Development (R&D) refers to innovative activities undertaken by the NHS, corporations (Pharmaceutical) or governments in developing new services or products, or improving existing services or products. From an NHS perspective research can be either Commercial (clinical trials) or Non-commercial (academic). Having a balanced portfolio is important for Walsall Healthcare NHS Trust as it offers patients the opportunity to be involved in a variation of research studies.

The R&D department continues to support the development and growth of research across the Trust. For the growth, delivery and performance of research to continue there is a need to nurture and increase the infrastructure of the R&D team.

The number of recruits to National Institute for Health Research (NIHR) Portfolio Studies in the current year, as a percentage of agreed targets for Walsall Healthcare NHS Trust was 528; the number recruited to date is 521 (99%).

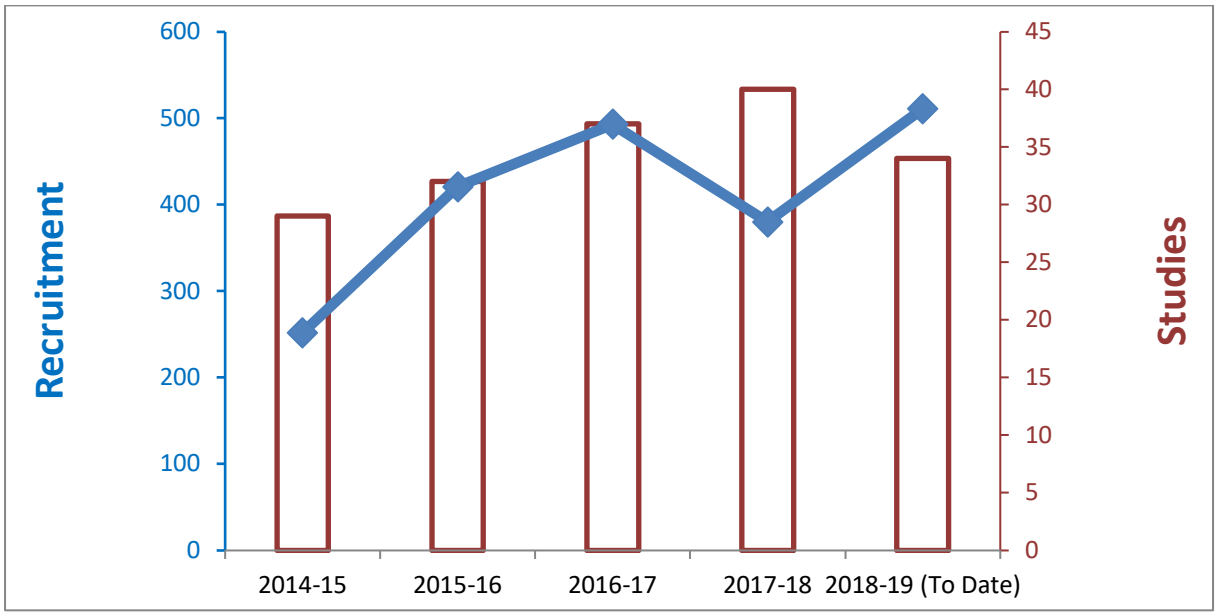
This table outlines the number of studies open, in set-up, suspended, missing information closed and total numbers of studies (2018/19).

Walsall Healthcare NHS Trust	
Number of Open Studies	24
Number of Studies in set-up	3
Number of Studies in Suspension	0
Number of Closed Studies*	29
Number of Studies recruiting on CPMS and missing on EDGE	1
Total	57
Total Number of Studies with Complete and Accurate Data	51
% of Studies with Complete and Accurate Data	89%
Number of Studies with Missing Data	5
Number of Studies with Data Discrepancies	2
*** studies with actual closed date in 2018/19 or actual closed date is blank**	

Walsall Healthcare NHS Trust Recruitment Data

Table1: Overview of Studies at Walsall Healthcare NHS Trust

Walsall Healthcare NHS was involved in conducting 57 clinical research studies, 53 non-commercial and 4 commercial studies. The Trust has a good record in recruiting to time and target on commercial trials, previous performance from 2014-2016 shows of the 5 studies which participated in research all trials either hit their target or exceeded their target. In 2018 the Trust closed 2 commercial studies which excelled in recruitment the areas were Dermatology and Infection (HIV). Non-commercial (24 studies) are proceeding and recruiting well. Of the opened studies 6 are due to close in 2019 there for highlighting the need to take on more research studies.



Graph showing research growth from 2014-2019 (February)

Recruitment

Table 2 gives an overall of performance since 2014 to present time, the graph shows a steady increase in recruitment and performance. The R&D department are commitment to improving the quality of care offered to patients thought research.

Moving forward

In 2019 the R&D department will need to increase the number of studies undertaken across the Trust. The department will need to scope potential areas where there is growth for research this will support stability within the department. The Trust needs to grow its commercial research portfolio this will generate income which could be used to further develop the department.

Detailed below are some of the improvements the R&D department has identified as key for 2019

- Clearer Communication -Regular team meetings will include study performance and delivery of studies
- Review of potential studies- Research nurses and relevant support services to be involved in the initial stage of agreeing to opening studies at Trust

- Training-The provision of training on using EDGE for research purposes has been delivered to Pharmacy colleagues and clinical staff (research nurses and governance team). This training will improve on the accuracy of data being recorded and will streamline current processes
- Performance Monitoring – Undertaken weekly to identify any missing data or discrepancies in information.

2diii Participation in Clinical Audit

During 2018/19, 52 national clinical audits programmes and national confidential enquiries covered NHS services that Walsall Healthcare provides.
During that period Walsall Healthcare participated in 95% of the national clinical audits programmes and national confidential enquiries which it was eligible to participate in. The 52 national clinical audits and national confidential enquiries that Walsall Healthcare was eligible to participate in during 2018/19 are below.

National Audit Title (n=71)	Trust Participation (52)	% of the No of cases Submitted	Actions / Comments
Adult Community Acquired Pneumonia	□	Data Submission in progress	On-going data submission
Non-Invasive Ventilation	□	Data Submission in progress	Data Submission in progress not due to complete till June 2019
Serious Hazards of Transfusion (SHOT	□	Data Submission in progress	Data Submission in progress not due to complete till July 2019
National Asthma and COPD Audit Programme (NACAP) – COPD	□	Data Submission in progress	On-going data submission not due to complete till May 2019
National Asthma and COPD Audit Programme (NACAP) - Asthma	□	Data Submission in progress	On-going data submission not due to complete till May 2019
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation	□	Opens March 2019	Data submissions not open yet not due start till March 2019
National Diabetes Adult - Inpatient Audit	□	Data Submission in progress	On-going data submission
National Diabetes	□	Data	On-going data submission

Adult - Foot care Audit		Submission in progress	
National Diabetes Adult – Pregnancy	□	Data Submission in progress	On-going data submission
National Diabetes Adult – Harms in England	□	Data Submission in progress	On-going data submission
National Diabetes Adult – Core	□	Data Submission in progress	On-going data submission
National Paediatric Diabetes Audit	□	Data Submission in progress	On-going data submission
National Lung Cancer Audit (NLCA)	□	100%	Data Submitted await report
National Audit of Intermediate Care	□	100%	Report received Action on going to implement National recommendations.
Vital Signs in Adults- CEM	□	100%	Data submitted await report.
Feverish Children – CEM	□	100%	Data submitted await report.
VTE Risk in Lower Limb Mobilisation - CEM	X	N/A	Not undertaken at Walsall Healthcare NHS Trust
Major Trauma Audit - TARN	□	100%	On-going data submission
NCEPOD - Acute Heart Failure	□	Data not submitted	Action ongoing to implement NCEPOD recommendations
National Audit of Heart Failure	□	Data Submission in progress	On-going data submission
National Audit of Cardiac Rehabilitation	□	Data Submission in progress	On-going data submission
National Audit of Pulmonary Hypertension	□	Data Submission in progress	On-going data submission
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	□	Data Submission in progress	On-going data submission
Cardiac Rhythm Management	□	100%	On-going data submission

National Oesophago-Gastric Cancer	□	100%	Data Submitted await report
UK IBD Registry	X	None	Under negotiation
National Audit of Dementia	□	100%	Data Submitted await report
Sentinel Stroke National Audit	□	Data Submission in progress	Data Submitted await report
Adult Cardiac Surgery	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	x	N/A	Submitted as part of New Cross data
BAUS Urology Audits - Nephrectomy audit	□	Data Submission in progress	On-going data submission
National Prostate Cancer Audit	□	Data Submission in progress	On-going data submission
Case Mix Programme (CMP) - ICNARC	□	100%	On-going data submission
National Audit Of Breast Cancer in Older People	□	100%	The Trust was an outlier for review by the Clinical Nurse specialist however a review into the data could not evidence any support of this – the report forms part of the model hospital work stream to improve the breast service.
National Bariatric Surgery Registry	□	100%	On-going data submission
National Bowel Cancer Audit	□	100%	On-going data submission final data submission April 2019
National Emergency Laparotomy Audit	□	99%	Total number of cases 220 Total Meeting NELA criteria 132 131 cases submitted
Falls and Fragility Fractures Audit	□	Data Submission in progress	Hip Fracture Database Need numbers Falls data – Ongoing data submission

programme (FFFAP) - National Hip Fracture Database			
Elective Surgery (National PROMs Programme)	□	Data Submission in progress	On-going data submission
National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	X	N/A	Not undertaken at Walsall Healthcare NHS Trust
National Ophthalmology Audit	X	N/A	Not applicable patients treated at New Cross
National Vascular Registry	X		Not undertaken at Walsall Healthcare NHS Trust
BAUS Cystectomy	X	N/A	Not undertaken at Walsall Healthcare NHS Trust
BAUS Radical Prostatectomy Audit	X	N/A	Not undertaken at Walsall Healthcare NHS Trust
MBRACE-UK	□	100%	On-going data submission
National Maternity and Perinatal Audit (NMPA)	□	100%	On-going data submission
National Comparative Audit of Blood Transfusion - Fresh Frozen Plasma	□	100%	Awaiting the report
National audit of Seizures and Epilepsies in Children and Young People	□	Data Submission in progress	On-going data submission
NCEPOD - Cancer in Children, Teens and Young Adults	X	N/A	Not undertaken at Walsall Healthcare NHS Trust
National Neonatal Audit Programme	□	Data Submission	On-going data submission

		in progress	
Paediatric Intensive Care	X	N/A	Not undertaken at Walsall Healthcare NHS Trust
Learning Disability Mortality Review Programme	□	100%	On-going data submission
Seven Day Hospital Services	□	100%	On-going data submission
Surgical Site Infection Surveillance Service	□	100%	On-going data submission
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	□	100%	On-going data submission
Reducing the impact of Serious Infections	□	100%	On-going data submission
NCEPOD - Pulmonary Embolism	□	100%	Awaiting the report
National Cardiac Arrest Audit (NCAA)	□	Data Submission in progress	On-going data submission
National End of Life Care Audit	□	100%	Data Submitted await the report
National Clinical Audit of Specialist Rehabilitation for Pts with Complex Needs following Major Injury	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
National Audit of Anxiety and Depression	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
Prescribing Observatory for Mental Health	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
UK Cystic Fibrosis Registry	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
BAUS Urology Audit – Female Stress Urinary Incontinence	x	N/A	Not undertaken at Walsall Healthcare NHS Trust

(SUI)			
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
Child Health Clinical Outcome Review	□	Data Submission in progress	Ongoing data submissions
National Clinical Audit of Psychosis	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
National Congenital Heart Disease (CHD	x	N/A	Not undertaken at Walsall Healthcare NHS Trust
National Joint Registry (NJR)	□	Data Submission in progress	Ongoing data Submission
National Mortality Case Record Review Programme	x	N/A	Not undertaken at Walsall Healthcare NHS Trust – Local review in progress
Neurosurgical National Audit Programme	x	N/A	Not undertaken at Walsall Healthcare NHS Trust

The number of local clinical audits reviewed by Walsall NHS Trust was 100 during the period of 2018/2019. Reports from these audits are presented at multi-speciality meetings where recommendations and actions are derived to improve the care delivered. A few examples are provided below:

Title	Outcome	Action
Fall Audit	Poor documentation noted – limited assurance of falls compliance	Introduced the safety huddles / pit stops with an aim to improve patient safety and reduce the risk of falls
Surgical Re-Admissions	The audit identified 84% were re-admitted under the surgical team, with 16% admitted under the medical teams. From the case identified only 341 were true re-admissions with factors such as abdominal pain, infection, wound concerns, bleeding or infection.	Ensure patient leaflets identify the expectations following surgery. Ensure follow up process is clearly discussed with the patients Identify linkage with the pain management team to support the needs of patients
MEKOS	People who had been seen by the team felt that they had been asked what their goals were and felt involved in the goal setting process.	To investigate carbonising the goal setting documentation The team to document when the patients are receiving the goal setting

	The team were aware their goals had been reviewed and could comment if the they had achieved their goals or not. It was noted that the team were also comprehensive at setting goals quickly, setting measurable goals and reviewing goals by six weeks. The results were much improved from the previous audit in 2014.	leaflet on the goal setting pro forma and when they are given a copy of their goals The team to document the reasons for the goals not being achieved as per the reasons on the goal setting documentation. To incorporate the new starter audit into the induction checklist so it is a continuous audit process.
30 day PEG insertion audit	Overall good compliance was noted with National Guidance	Nutrition Nurse to continue education of staff in Accident & Emergency (A&E) and ward 16 on the use of the placing BGT's where possible when patients are admitted with displaced Percutaneous Endoscopic Gastrostomy (PEGs, to avoid endoscopy where) we can. Liase with other Trusts to compare mortality rates and waiting times.
Pre-operative Medicines reconciliation audit	Good compliance for post-operative VTE and post antibiotic prescribing	Nursing protocol introduced not to release patients till the Drug chart is completed to further increase compliance.
Inpatient Post Pacing Management Audit	85 Cases reviewed • There was a clear improvement in documentation. • Good and clear and accurate indication for pacing. • There was a letter for each procedure with all details. • There was clear documentation of presentation and diagnosis in discharge summary. • Documentation of minor complications to be improved • Consider departmental Antibiotic protocol.	1. To follow the implemented Antibiotic Protocol to ensure a uniform standard of care 2. To continue best medical practice to ensure the implant rates are keeping up with the European average and ahead of the curve in the UK to better benefit the patients served 3. Consider electronic record of procedures to improve documentation of complications

Audit of compliance with Attention deficit hyperactivity disorder (ADHD) NICE guidance 2008 / New NICE Guidance 2018	Good compliance to National Institute for Clinical Excellence (NICE) guidance	To improve BP chart not used consistently in accordance to NICE guidance. To develop a strategy to improve the Transition from children's services to adult care.
Self-reporting of physical and emotional health in looked after children	Good overall outcomes noted However Over 2/3rds have support/people to talk Foster carers for a quarter of these children raised concerns about the emotional and mental health problems	Early identification and referral to specialist services to support emotional and mental health Liaison with Looked After Children (LAC) Child and Adolescent Mental Health Services (CAMHS) in improving the support Developing screening questionnaires for younger LAC children to identify emotional and mental health state
Audit of Psychology Provision for Children & Young People with Diabetes	Current psychology provision to Children and Young People (CYP) with diabetes is not compliant with BPT standards Cases are referred to CAMHS only after all other options have been exhausted All referrals to CAMHS have been accepted and seen multiple times before discharge. Median time to be seen by CAMHS is over 3m – Timeliness questionable! CAMHS service structure is confusing for lay person (e.g., choice clinics, partnership clinics etc.) Only 28% of patients referred to CAMHS class the service received as 'Good	Bring psychology provision to CYP with diabetes in line with BPT and NICE guidance Dedicated psychologist within the diabetes team is included in business case for transition service
Referrals of patients with suspected spinal pathology from a DGH to a tertiary	Varying standards of documentation of neurological findings on NORSE referrals Lumbar pathology generally documented better	To firm up documentation to improve referral process. To utilise the results into the business care for the development of the spinal

centre	PRs – recorded as done in just over half of cases	services at Walsall Hospitals.

2div CQUIN

A proportion of the Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services.

This income related to quality improvement is part of the Commissioning for Quality and Innovation payment framework, and formed part of agreements with local Clinical Commissioning Groups, NHS England and the Local Authority. The financial value attached through the framework to delivery of the agreed improvement goals in 2018/19 was 2.5% of the value of all healthcare services commissioned through the respective contracts. This equated to just above £4.9million for the Trust in 2018/19.

There were 11 CQUIN schemes for 2018/19. This includes 7 National (CCG) schemes, 3 NHS England Specialised Commissioning scheme and 1 NHS England Dental scheme.

2dv Information on registration with the Care Quality Commission (CQC)

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

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

The CQC also carried out a comprehensive inspection of the Trust's medicine and critical care services at Walsall Healthcare NHS Trust on 4 – 6 February 2019, of urgent and emergency care, surgery and maternity services at Walsall Healthcare NHS Trust on 11 – 13 February 2019 and Community Sexual Health Services at Walsall Healthcare NHS Trust on 25 and 26 February 2019. Finally an inspection of the Trusts Well Led requirements was undertaken on 19-21 March 2019.

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

The final Quality Reports detailing the inspection findings and ratings are unlikely to be published until the summer. Therefore the current ratings for the Trust are detailed below:

Ratings	
Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

The Trust has not been subject to any enforcement notices during 2018/19, however it continues to implement the recommendations of the three enforcement notices against Regulation 18 HSCA (RA) Regulations 2014 Staffing, Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment and Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

In response to the report the Trust has developed a Patient Care Improvement Plan to manage the must and should do actions listed in the report along with the requirement notices issued. The work and progress has been regularly reported to the Quality, Patient Experience and Safety Committee and Board.

Walsall Healthcare NHS Trust has participated in one special review by the CQC relating to Special Education Needs and Disability (SEND) Ofsted/CQC Local Area Inspection during 2018/19. The draft report is expected to be published soon.

2dvi Information Governance Toolkit attainment levels

The Board made a number of key appointments in relation to Information governance arrangements in 2018/19. The role of Director of Governance was appointed to and the existing Director of Strategy & Improvement was assigned as the Senior Information Risk Owner. A new Medical Director was also appointed and assigned as the Trusts Caldicott Guardian.

During 2018/19 all NHS Trusts were required to carry out an information governance self-assessment using the new Data Security & Protection Toolkit. The Data Security & Protection Toolkit was introduced in 2018 and encourages a compliance assessment against the 10 National Data Standards. These standards are:

- Personal confidential data
- Staff responsibilities
- Training
- Managing data access
- Process reviews
- Responding to incidents
- Continuity planning
- Unsupported systems
- IT protection
- Accountable suppliers

In order to achieve ‘standards met’ Walsall Healthcare NHS Trust must confirm achievement of 100 mandatory assertions, and provide evidence items to support each declaration.

Unfortunately the Trust was unable to demonstrate the required target of 95% of all staff being appropriately trained. Walsall Healthcare NHS Trust’s Information Governance Assessment for 2018/19 is therefore ‘standards not fully met – (plan agreed)’.

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

The Trust continues to monitor its Information Governance mandatory training compliance, and through audit monitors records quality, storage and retention. Our Information Governance improvement plan for 2018/19 is overseen by our Information Governance Steering Group, chaired by our Interim Trust Secretary.

2dvii Clinical Coding

Walsall Healthcare was not subject to the Payment by Results clinical coding audit during 2018/19 by NHS Improvement.

2dviii Information the quality of data

Walsall Healthcare NHS Trust can confirm that it submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) for national reporting purposes.

The percentage of records in the submitted data which included a valid NHS number was:
99.8 % for admitted patient care
100.0 % for outpatient care
99.4 % for accident and emergency care

The percentage of records in the submitted data which included a valid General Medical Practice Code was:
100.0 % for admitted patient care
100.0 % for outpatient care
100.0 % for accident and emergency care

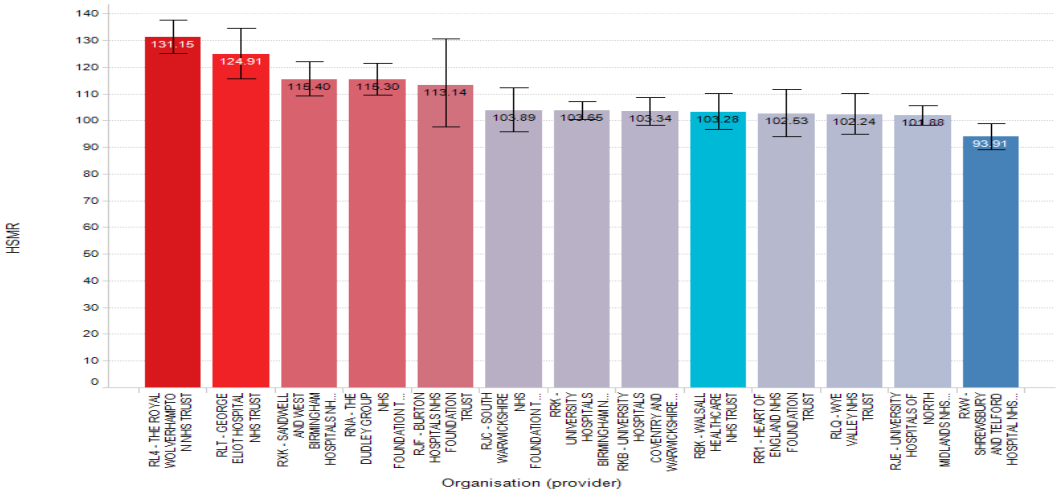
Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.

2dviiii A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps

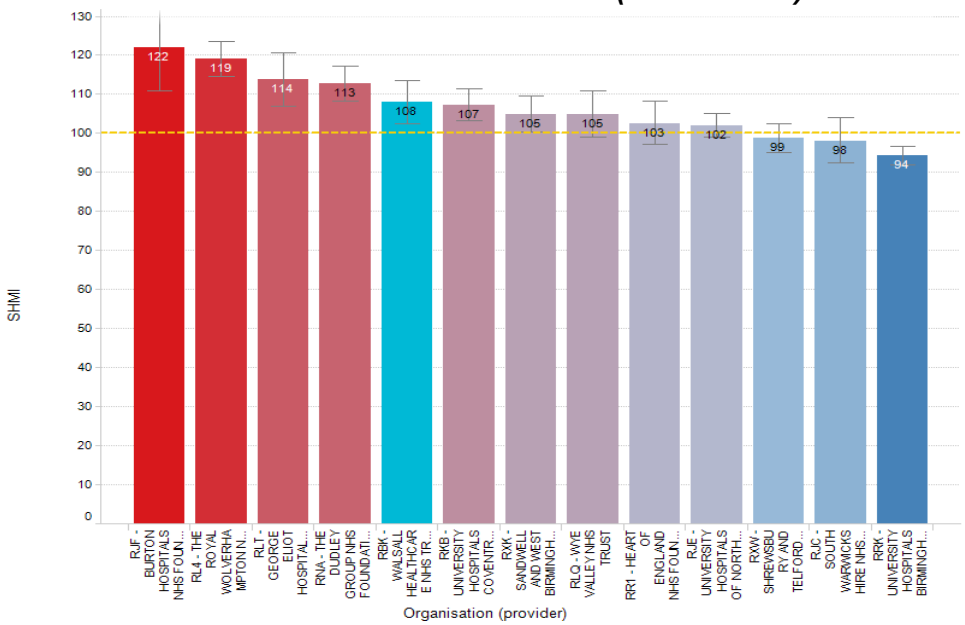
The Guardian of Safe Working, Dr Riaz Bavakunji has attended the Trust Board routinely to present his quarterly report. In addition the Guardian has prepared an annual report on rota gaps and vacancies and this will be considered by the Board at its June 2019 meeting. This report highlights that in general organisational changes occurred that included recruitment into some unfilled posts. Anaesthetics and Medicine is the main area of concern with regards to recruitment gaps at middle grade. The rota is managed internally so that trainees are content and not overworked in Anaesthetics. The Trust has procured a multi-functional IT system to support with the effective management of the medical workforce. All medical rotas are currently in transitional phase and being managed through Allocate with support and guidance from a lead clinician in all specialities. Anaesthetics have devised a rota that is appropriate for delivery of service that still ensures adherence to national regulatory requirements. The Trust has developed a medical workforce programme of work recognising the challenges in recruitment, retention and medical education. Gaps in rotas and escalation and exception reporting processes are in place and managed effectively through the Guardian of Safe Working supported by the Medical Director.

2dvx Learning from Deaths

During the reporting period April 2018-March 2019, 979 patients died as in-patients of Walsall Healthcare NHS Trust or within 30 days of discharge.
The Trust uses two key national benchmarks as the primary indicator for mortality, for comparison against regional peers: Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index, (SHMI). Data is provided by NHS Digital and hosted by Healthcare Evaluation Data (HED), and shows the trust is in a comparable or improved overall position relative to regional peers.



HSMR V LOCAL COMPARATORS (REGIONAL)

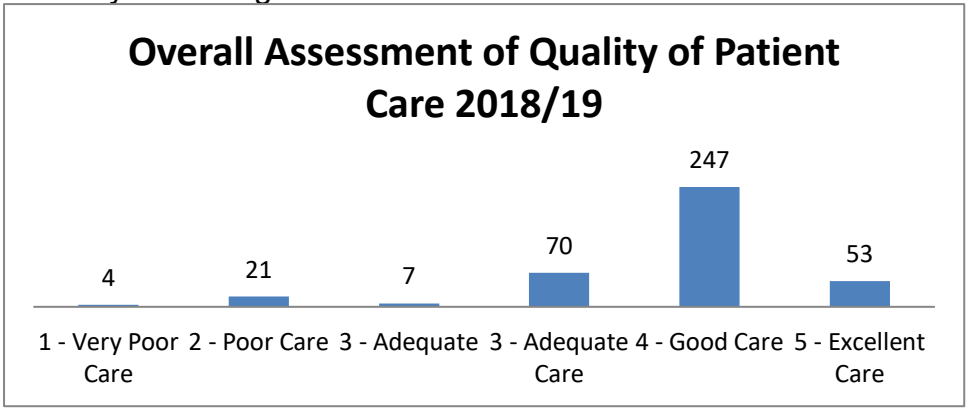


SHMI V LOCAL COMPARATORS (REGIONAL)

In line with National Quality Board (NQB) guidance the trust updated its Learning from Deaths (LfD) Policy in 2017 to include the Learning Disabilities Mortality Review (LeDeR) process. In addition, the Structured Judgment Review (SJR) process was embedded in practice in 2017/18 to identify patients for review using a defined set of triggers derived from NQB guidelines. In total, 655 deaths were flagged for review in this way

2018/19	Deaths	Flagged for review
Q1	251	166
Q2	189	141
Q3	259	179
Q4	280	169

In 2018/19 403 (61% of flagged records) patient records were reviewed. In each case an assessment was made by the reviewing clinician of the overall quality of patient care. Assessment of quality of patient care is done using a standardised mortality screening tool. The results for 2018/19 are as follows:



Trust-wide, mortality review and return rates have been recognised as an area for improvement. An audit in March 2019 indicated that notes were made available promptly but reviews were not being carried out in a timely fashion. Remedial actions were agreed further through the Mortality Surveillance Group and Medical Advisory Committee, and Divisional leads expected to provide oversight.

In 2019/20 the trust will implement the statutory Medical Examiner to support the system-wide approach to learning from deaths and supporting bereaved relatives and carers. As part of the implementation process, the trust will move to align data collection with the dataset mandated by the National Quality Board (NQB).

While the mandatory implementation date has been delayed by the Department of Health and Social Care to 2020, an options appraisal is underway to determine in what manner to implement and embed this process.

The trust uses a variety of mechanisms and forums to learn from patient deaths, celebrate good practice and to communicate findings to clinical and nursing teams. These include:

- Mortality Surveillance Group
- Resuscitation Group
- Divisional Safety huddles
- Care Group Meetings and Divisional Quality Boards
- The ‘Daily Dose’ e-mailed to all staff on a daily basis

Some of the learning, service developments and changes in practice identified from reviews in 2018/19 included:

- The Consultant Lead for palliative care will attend the obstetrics and gynaecology quality group to give support and guidance in managing patients and their End of Life (EOL) needs.
- A trust wide seminar was held March 2018 to include a presentation by the palliative care lead relating to effective communication with patients and carers
- Revision of the hyperkalaemia clinical guideline following an increase in mortality rates, integrating the guideline with the August 2018 Patient Safety Alert.
- Review of the commissioner/acute collaborative learning from death framework in conjunction with Public Health and Social Care.
- Working with Walsall CCG to develop and embed a Designated Doctor of Death role and Child Death Overview Panel, to improve the child death review process.
- Fractured neck of femur deaths: Review of anaesthetic trauma pathways to reduce delays in accessing theatre for non-elective patients. Appointment of a Trauma and Orthopaedic Surgeon to lead the #NOF pathway
- Speech and Language Therapy (SALT): To improve pneumonia-related ill health and mortality, SALT have put an action plan in place to embed improved oral care trust-wide.

3 Review of other quality performance

3a Quality Improvement Academy

Quality Improvement (QI) Academy & QSIR Programmes - In February 2018 the Quality Improvement (QI) Academy was established and the first cohort of staff enrolled. They completed their training within the 2018/19 financial year, with 31 members of staff completing the initial two cohorts offered through the QI Academy. The original projects undertaken through and supported by the QI Academy included:

- To increase appraisal compliance and quality
- To improve our IT Service Desk provision and reputation
- To improve oral care, reduce hospital acquired respiratory tract infections and improve patients wellbeing
- To improve the number of mental capacity assessments by 50% with the North Locality Team
- To support emotional wellbeing of women and families in Walsall in pregnancy and beyond.

Also commenced during 2017/18 was the training of 5 members of Trust staff to become Quality, Service Improvement and Redesign (QSIR) practitioners who completed their accreditation to be able to teach the QSIR curriculum within the Trust. QSIR is a nationally recognised QI training programme developed and supported by NHS Improvement.

Three cohorts of staff groups have enrolled and commenced on a five day QSIR Practitioner programme within the organisation and have identified 19 projects which they want to apply QI Methodology in to make improvements and currently 42 members of staff working through the five day programme. (A table of projects currently being supported by the QI Academy is given at Appendix 1). These project groups are supported through a coaching approach by members of the QI Faculty to ensure that the project groups understand the tools and methodologies and are supported to deliver changes in service.

There is a one day QSIR Fundamentals programme which gives an introduction to QI methodologies and how to get started on small tests of change. This has predominantly been delivered to nursing colleagues and 49 people have completed this so far, with more session planned throughout 2019/20 that are open to all staff groups.

QI Sessions within Induction Programmes
At the induction day for Senior Trainee Doctors the QI faculty had a discussion with the incoming Doctors about their understanding of what Quality Improvement is and how they have been involved so far and could be further engaged with QI projects within the Trust. There was also a session for Junior doctors as part of their Induction training.

In September 2018 the trust revised the programme for Corporate induction and this now includes session “Your role in Quality Improvement” outlining some basic principles and encouraging colleagues new to the organisation to look at how we do things with their fresh eyes and see if we can make improvements. So far 399 new

members of the Trust have been through this training.

Ad hoc QI training
A general introduction to Quality Improvement, covering Process mapping, PDSA cycles and the Model for Improvement has also been delivered as part of the Band 2 – 6 development programme and also within the "Stepping Up" programme. The sessions were delivered by members of the QI Faculty, however these programmes are co-ordinated through Learning and Development.

QI Conferences
There have been two QI Conferences held within the last year, one in June 2018 and one in March 2019. Speakers across the two conferences included an update on the projects supported by the early cohorts of QI Academy, presentations on QI Academy and what the offer to staff was and a presentation on the Learning from Excellence movement by Dr Adrian Plunket at the June Conference. At the March conference we had poster presentations from QI projects which have been completed across the trust, wider than those supported by the QI Academy, presentations on the progress one of the original project has made and how it has been sustained, an update on the Human Factors training being delivered by Dr Hesham Abdalla and a key note speech from Professor Michael West of the Kings fund on compassionate leadership.

Human Factors
Early work had been undertaken through 2017 by Dr Abdalla on raising the awareness of Human Factors and the impact within our services. Having secured external funding, a programme of training was delivered, focussing on maternity, obstetrics, gynaecology and paediatric services.

The training that has been established includes facilitated skills drills scenarios, Practical Obstetric Multi-Professional (PROMPT) training with multi-disciplinary training days. The training has been running through the whole of 2018/19 using the Patient Safety Collaborative funding and a total of 565 episodes of training taken up by colleagues within the Trust through the different elements of training including the Human Factors Conference.

QI Academy Sponsored Interventions
The QI Academy has sponsored the adoption of a number of tools across the organisation. These include the Situation. Background, Assessment and Recommendation (SBAR) campaign and the use of CUS (I am Concerned, I am Uncomfortable, This is a Safety issue) tool to communicate concerns to colleagues. These have been supported and promoted through the Human Factors work.

QI Strategy
The Trust has developed a QI Strategy which sets out the QI tools , methodology and approach which it will continue to promote over the next four years and how this will be supported.

3b Duty of Candour

Walsall Healthcare NHS Trust has a clear policy which sets out how we meet the legal requirements as well as promoting a culture within the organisation that encourages candour, openness and honesty. The process is set out so that staff are supported to inform people about things that have gone wrong, provide reasonable

support and to understand the necessity for providing truthful information and above all provide an apology to those affected.

There is a Duty of Candour guidance pack as an appendix to the policy which gives staff useful information on all of the above aspects of the process. The Patient Safety teams also support staff with the process and continue to provide training via clinical update, safety huddles and one to one training. The Trust has an information leaflet in use which is given to patients/families at the time of the verbal conversation and provides useful information on the process for them to take away. It also gives names and contact numbers should they be needed. The leaflet also enables the Trust to comply with the regulation by formally reiterating the verbal conversation. The Trust measures the compliance of the duty requirements through the Clinical Governance Safeguard Database and monitors the stages during regular meetings with the Divisions. All of the above with the improvements made since the 2015 CQC inspection were recognised and noted by the CQC during the 2017 Inspection.

3c Patient Care Improvement Plan (PCIP)

The Trust has developed a Patient Care Improvement Plan to manage the must and should do actions and regulatory requirements identified in the CQC report. The work and progress has been regularly reported to the Quality, Patient Experience and Safety Committee and the Board. The PCIP has been further refined during the year and a governance framework has been developed which includes: quality assurance of the content (by the governance team) and monitoring of the completion of actions and evidence of their effectiveness (via the Care Group / Divisional Quality meetings) in achieving the objective.

Workshops have been held with staff on the development of outcome measures and staff were given the time to get together as Care Groups to develop their PCIPs. The PCIP has been expanded to include all action plans (from incident, complaint, mortality & external reviews etc.) into one overarching action plan, so that delivery could be monitored more easily via the quality meetings.

3d Number of Never Events

A never event is defined as a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented. In 2018 the Never Event list was updated to include a new category, ‘unintentional connection of a patient requiring oxygen to an air flow meter’

During 2018/19 there has been 17 never events in the Trust, 1 Unintentional connection of a patient requiring oxygen to an air flow meter and 16 - never event – wrong prosthesis/implant.

3e Number of serious incidents

During 2018/19 the Trust had 143 Serious Incidents, compared with 167 in 2017/18. The main categories being pressure ulcers (56), medical equipment (17) and slip trips and falls (15).

Pressure Ulcers acquired in hospitals continues to be the highest reported category of Serious Incident during 2018/19 and 56 incidents were reported which is a significant

decreased compared to 98 incidents during 2017/18.

The Trust are undertaking a number of initiatives to reduction pressure ulcers which include collaborative work with Ward 2 and the District Nurses in the North locality. On Ward 2 the new Skin Bundle was implemented with ongoing support from the Tissue Viability Team. The results showed that although the overall number of pressure ulcers did not reduce with 7 reported April to September 2018 and 7 reported during the pilot from October to March 2019, the higher categories of pressure ulcers did decrease from 6 category 3 or above pressure ulcers reported from April to September 2018 and 4 category 3 or above reported from October to March 2019, a 33% reduction during this improvement work. An education programme was implemented for the District Nursing Team in the North Locality From August to October 2018 6 pressure ulcers were reported compared to 2 from November to January 2019.

The new Skin bundle and comfort round was rolled out across the adult inpatient areas in March 2019 supported by the Tissue Viability Team.

The key learning messages from SIs are cascaded via a number of sources including weekly Divisional Safety Huddles, Patient Safety Boards in each area, Quarterly Patient Safety/Risk Roadshows; 'Incidents at a glance' one page summaries describing the incident, lessons learnt, Monthly Lessons learned bulletin, Social media feedback has started – Twitter / Yammer with development of a blog / vlog planned. Feedback following an incident is also covered in Clinical Update training.

3f Learning from complaints

Walsall Healthcare NHS Trust remains committed to improving the experience of all patients, their families and carers who access services both within the hospital and community, and learning from their feedback to improve the care we provide to ensure we deliver and the best care possible to our patients. The Patient Relations Team manages complaints, concerns and compliments received on behalf of the Trust. The Team strives to be as responsive and proactive to queries and concerns as possible managing a caseload that averages 10 contacts per working day each year. Working closely with Divisional teams, Care Group's and staff of all levels, the team seeks to maintain an appropriate level of contact with the complainants and where required external agencies; responding in a way that is both 'person centered' and effective in addressing the complainants concerns.

Complaints, Concerns and Compliments

A formal complaint is one in which the patient or relative asks for an investigation and a written response. Where possible, the Divisions work with the complaints team to resolve issues without a full investigation. For example, concerns about appointments can often be resolved quickly by the local teams.

During 2018/2019 a total of 3777 contacts were received by the Patient Relations Team which included a total of 349 written complaints, 22 informal to formal

complaints and 9 MP letters (an increase of 27 complaints overall for the year compared to 2017-2018).

Complaint Type	2016-2017	2017-2018	2018-2019
Formal Complaint	284	280	318
Informal to formal complaint	32	25	22
Informal concern	2091	2164	2402
Formal to informal	20	8	13
Compliment	635	734	527
Comments/suggestion/referred on	297	455	486
MP letter	6	8	9
Total	3109	3674	3777

The Divisions of Medicine and Long Term Conditions generated the greatest number of complaints, accounting for 48% of all complaints received, with Surgery accounting for 30% and Women's Children's and Clinical Support Services WCCS 19%. Corporate functions, Urgent Care, Estates and Facilities and Adult Community account for the remainder (3%)

In 2018-2019 the number of complaints versus patient activity was 10%. This is calculated as the number of complaints divided by-elective, non-elective and emergency patients (36,227) and multiplied by 1000.

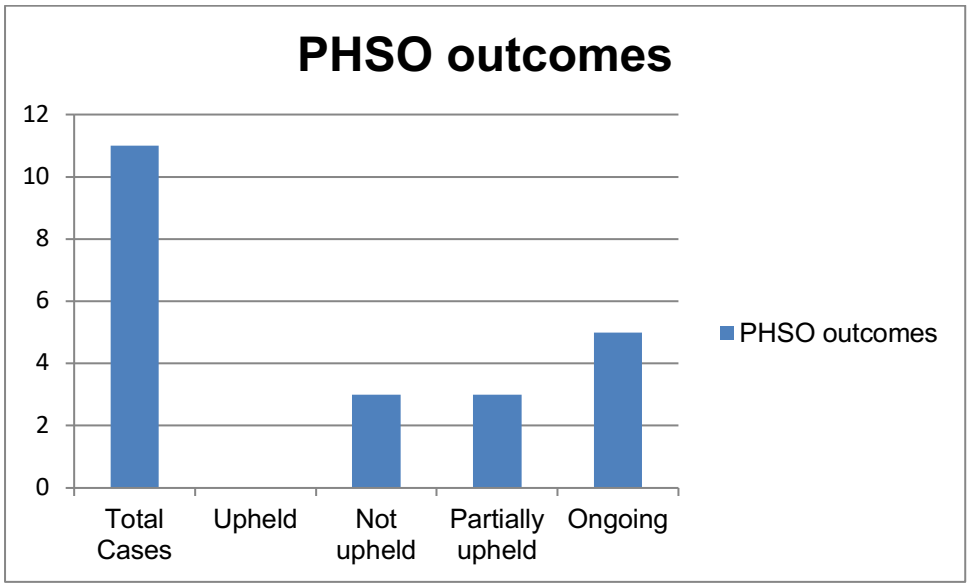
87% of written complaints were completed within agreed timescales for 2018/2019. Disappointingly this is a slight reduction of 2% from the previous year attributable largely to the Division of Medicine and volume increase.

We recognise that responding to patient complaints in a timely way is important however we are keen not compromise the quality of our investigation or the completeness of our response. However we acknowledge that this is an area where the Trust could improve on and we aim to review the timescales for responding to patient complaints during 2019/20.

285 complaints were resolved out of 352, 63 are currently ongoing. Of the 87% completed within timeframe 10, 30, 45 working days, the figure includes 43% resolved within 30 working days. (36 Complaints were completed from the year end 2016/2017 and are included in this figure).

There were a total of 2888 concerns received during 2018/2019 an increase of 211 concerns from the previous year (2627). This figure includes concerns (2402), comments, suggestions and queries and referred on (486). Surgery equated for 26% (907) of the total activity, with MLTC 27% (920) and WCCSS 19% (671). The main themes identified via the number of concerns raised are regarding appointments 858 a decrease of 69 on the previous year (927), clinical care, assessment and treatment 578 a decrease of 112 (690), information requests and communication. 125 contacts referred to staff attitude.

In 2018/19, a total of 11 cases were accepted via the PHSO for investigation out of 54 contacts made. This equates to 3% of all complaints received. There are 3 cases open from the previous year 2017/2018. 6 cases completed during this year with 5 ongoing. Themes emerging include: Concerns highlighted with regard to clinical care assessment and treatment, poor communication, inadequate pain management and poor nursing care.



Some of the lessons learned from investigated complaints include:

Complaint: Complaint regarding the access team regarding not receiving letters and not documenting a cancellation and the GP receiving a 'did not attend letter'. Difficulties in accessing call centre.

Outcome: The Trust replaced the call handling equipment. The new functionality enables us to provide a much improved service to patients by reducing queues and providing assurance to the callers that they are going to be answered.
This also enables the Trust to measure accurately calls that are abandoned and use this as a quality measure. This development has given us improved information to develop the service around patient needs. In addition to this we are using a text reminder system and options to communicate by text and email to the Call Centre

Complaint: Complainant unhappy with treatment provided by the community nursing team. Appointments being changed without notification. Delays with appointments and communication issues regarding dressings.

Outcome: Mobile technology has been introduced into the community nursing team, this will support scheduling and allocation of patient visits electronically and will eliminate the risk of human error when allocating work. Patients that are not allocated a visit on their scheduled day will then be contacted and informed of their new appointment date. All community nursing teams have a daily clinical sister triage nurse, who ensures prompt triage of any in-coming calls and concerns to the team, this should prevent delays in patients or relatives receiving telephone calls back and

visits scheduled. All community nursing teams have a clinical sister with wound care responsibility, who will monitor patients with complex wounds to ensure the correct treatment regime is initiated. Anchor Meadow team have introduced a referral book for visit requests by the wound care link nurse within the team, this will ensure prompt triage of these patients and prevent delays in receiving wound re-assessments. The NHS dressing supply chain is currently being trialled within one of our community nursing teams, whereby commonly used dressing supplies are kept as stock within the team base; this will hopefully be rolled out across all community teams and will prevent delays in dressing supplies being delivered to patients and aid continuity in patient care.

Complaint: Complainant unhappy with delay in surgery. Advised individual funding request was sent in September. Has now been advised surgery cannot be completed at our Trust. Unhappy as she was not advised of this before.

Outcome: Staff received training regarding the process for Individual Funding Requests - the time frames involved and the process referring consultants should follow.

Complaint: Complaint regarding a discharge home and left alone as NOK was out and had not been notified until they came to visit on the ward of the discharge

Outcome: The ward carried out a review of the discharge checklist and procedures for checking and removing cannulas. The ward clerk concerned underwent additional training in customer service and now keeps a log of telephone calls made to relatives when patients are being discharged.

Complaint Satisfaction Questionnaire

The Parliamentary Health Service Ombudsman (PHSO) user-led vision for raising concerns and complaints in health and social care forms part of our Complaints policy. The vision was developed by the PHSO working inclusively with patients and service users. It starts with the complaint journey: a map of the route a patient or service user will go through when they make a complaint about a service they have received, and a series of simple statements that reflect what a good outcome would look like for the patient and service user at each stage of that journey. Beneath these overarching statements there are further statements that illustrate the expectations that patients and service users expressed when asked about what a good complaint journey would look like to them.

Our Trust feedback survey is based on the 'I' statements outlined in the user-led vision. Answers are requested using a scale of 0-5 with 0 as completely disagree and 5 completely agree. Feedback received is outlined as follows based on 30% return rate (88 responses):

- Making a complaint was straight forward : 78%
- I knew I had the right to complain: 89%

- I knew that my care would not be compromised by making a complaint: 83%
- The staff who spoke to me regarding my complaint were polite and helpful: 79%
- My complaint was acknowledged within 3 working days: 73%
- I was informed about the complaints process: 77%
- I was informed of any delays and updated on the progress: 76%
- I received a resolution in a time period that was relevant to my particular case and complaint: 78%
- I am happy with my overall response time to my complaint: 72%
- I feel the Trust has taken my comments on board and have made changes to improve the things that I was unhappy with: 77%
- I would complain again if I felt the need to: 91%

Patient Opinion/NHS Choices/CQC

Since April 2018 there have been 19 comments made about the Trust via the NHS Choices/Patient Care Opinion website. The key category type is clinical care, assessment and treatment, 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.

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 terms of CQC we have 9 patient concerns logged. Some of these were also received as formal complaints and were investigated accordingly; where no contact was made with the Trust directly, feedback was provided directly to the CQC following investigation for contact to be made with the person raising the complaint.

3g National Patient Safety Alerts

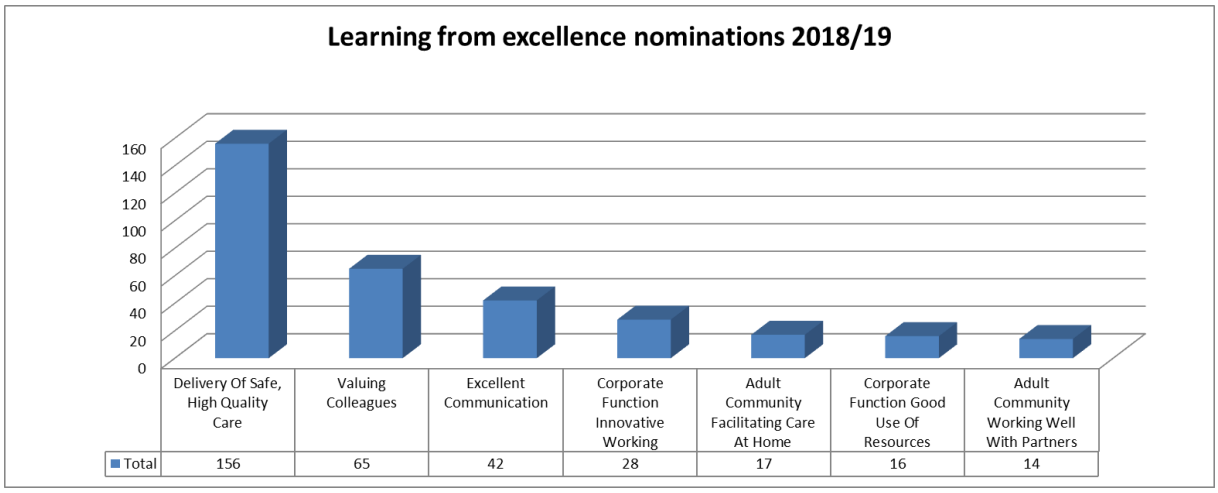
The Department of Health and its agencies have systems in place to receive reports of adverse incidents and to issue Alert Notices and other guidance where appropriate. These alerts provide the opportunity for Trusts to identify deficiencies in their systems and to correct them by learning lessons from identified risks. All NHS bodies have a duty to promptly report adverse incidents and take prompt action on receipt of Alert Notices.

For the period 1 April 2018 to 31 March 2019 the Trust has been issued with a total of 9 Patient Safety Alerts (PSA) from the Central Alerting System. Two of these alerts have been completed in line with the stipulated completion periods. 5 remain ongoing with work in progress no delays are anticipated for completion within the timescale. There are 2 outstanding alerts that have breached the implementation date and work is progressing to close these in line with the recommendations.

3h Learning from Excellence

If we can learn when things go wrong, shouldn't we be able to learn when things go right?
This is the premise behind Learning from Excellence (LfE). Inspired by initiatives in local Trusts (notably Birmingham Children's Hospital) and now gaining national recognition, we have adapted our incident reporting system as a means to capture "Excellence Nominations". Staff can quickly enter the details of an individual or team who have excelled.

During 2018/19, there were 328 Excellence nominations made. Each nomination was reviewed by the team guiding the initiative and selected excellence events have been subjected to a 'Right Cause Analysis' to understand what went right and to see if the same approach could be used elsewhere.



3i Patient Safety Walkabout visits

Walsall CCG visits the Trust routinely to assess standards of care in clinical services and assist the achievement of continuous improvement. As in all patient safety walkabout visits, initial feedback is provided to the visited areas and the division so that appropriate immediate action can happen. Once the formal report is received from the CCG it is disseminated to the appropriate areas and divisions.

The expectation is that the reports are reviewed and that practice is improved based on any issues identified. Patient safety walkabout visit reports are discussed at divisional meetings and at a Trust Committee level via the Quality Patient Experience and Safety Committee.

In addition, the Trust is working closely with Healthwatch Walsall to develop a joint working protocol to support the

work of both organisation in engaging with the public on the services delivered in Walsall by the Trust and to observe the nature and quality of services and to collect the views of users at the point of service delivery.

3j Mortality Review Process

The Trust Mortality Policy has been reviewed and revised to introduce a new Learning from Deaths Policy which includes identification of the Structured Judgement Review (SJR) as the Trust tool of choice. Reviews are consultant-led and follow the SJR process which was implemented in 2017/18. Lessons learnt and areas of good practice are discussed first within Care Groups then at the Mortality Surveillance Group.

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

3k Implementation of priority clinical standards for 7 day services

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

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

The Trust is working towards delivery of these standards by April 2020 with a tolerance of 90% achievement for all patients admitted on an emergency care pathway. The Trust participates in national 7 Day Service Audits and performs above the required level of overall performance for standards 2 and 8. However, a self-assessment of Standard 8 identified that we are compliant for twice daily reviews and we are compliant for those patients requiring once daily review during the week but not at weekends. This is consistent with the current medical workforce job plans in that senior decision makers do not undertake routine acute medical ward rounds on Sundays.

3I Focus on Patient Experience

During 2018-2019 the Trust has received feedback directly from patients, families and carers through our Friends and Family Test (FFT), National and Local Surveys. Overall most of our services were rated as providing a positive experience however the feedback also highlighted areas which require improvement.

Friends and Family Test

We aim to offer all patients the opportunity to respond to the FFT question and to have the opportunity to tell us about anything else we could have done to improve their experience.

The Friends and Family Test (FFT) asks patients:

> *"How likely are you to recommend our wards/emergency department/services to friends and family if they needed similar care and treatment".*

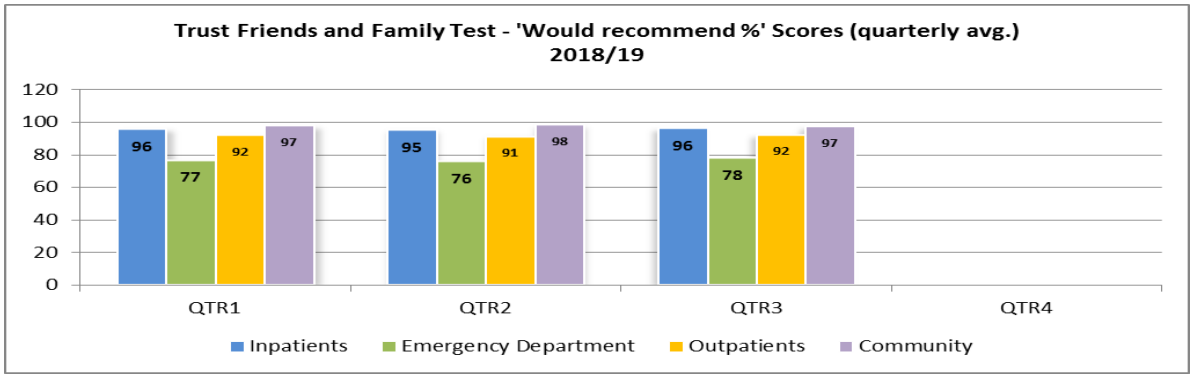
Responses to the FFT for inpatients/day cases, accident and emergency, outpatient and maternity are reported monthly to NHS England for publication on their website and NHS Choices website. This feedback and scores are shared with frontline staff and leaders through weekly reports and real time information through an online portal. We monitor the proportion of patients who would/would not recommend our services and identify key themes from the comments made to continually improve our services.

Inpatients, Emergency Department, Outpatients and Community Services FFT 2018-2019

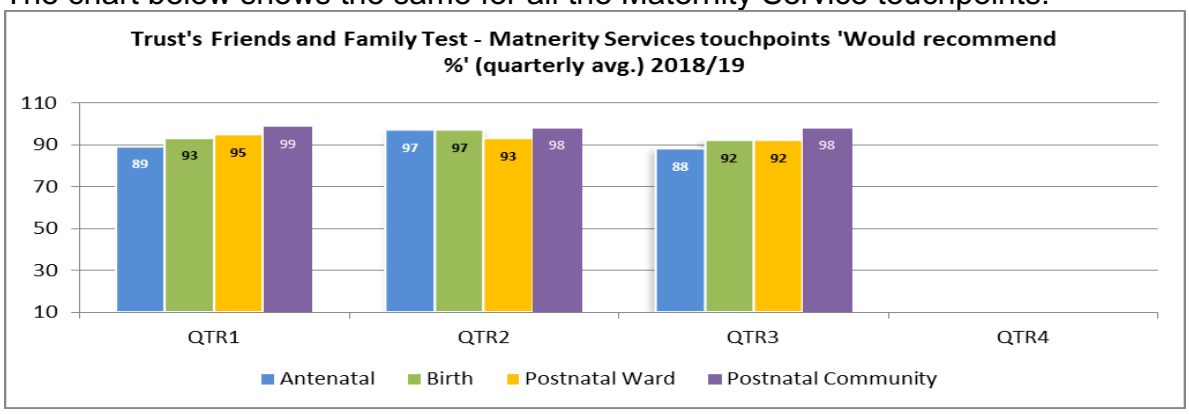
Over the last three quarters we have continued to implementing our patient experience strategy that puts the patient and carer voice at the heart of our services and ensures that the Trust has a co-ordinated approach of 'listening to' and 'learning from' patient feedback.

About 92% of patients who used our hospital and community services said they would recommend us to their friends and family if they needed similar care or treatment. This score is based on over 39,000 Friends and Family Test (FFT) surveys completed by our service users. Our national and local surveys results continued to show improvements and also highlight areas where more work is needed.

The chart below shows average FFT results for positive recommendation scores (%) for inpatients, A&E, outpatients and community services in first three quarters of 2018-2019.



The chart below shows the same for all the Maternity Service touchpoints:



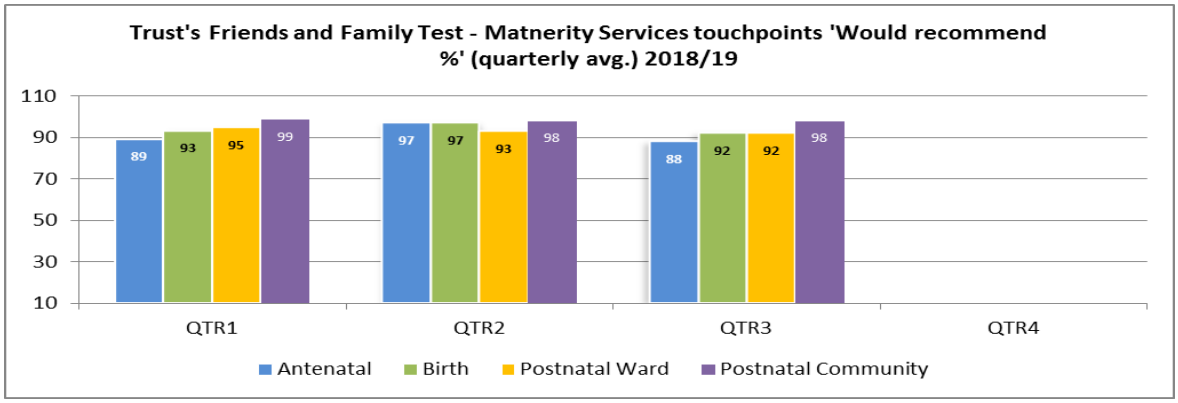
Benchmark comparisons

The table below shows benchmark comparison for the positive recommendation percentage for the FFT for inpatients, emergency department, and outpatients for Walsall Healthcare NHS Trust and national averages.

FFT Recommendations Score Comparison with National Data		
Clinical Area	National Average	Walsall Healthcare Trust
Inpatients	96%	95%
Emergency Department	87%	77%
Outpatients	94%	92%

FFT Maternity Services

The chart below show FFT results for positive recommendation percentages for the FFT for maternity services in 2018-2019.



Maternity FFT Recommendations Score Comparison with National Data		
Clinical Area	National Average	Walsall Healthcare Trust
Antenatal	97%	91%
Birth	97%	94%
Postnatal ward	95%	93%
Postnatal community	98%	99%

Key improvements include:

- 'Back to Basics' A&E patient experience improvement project which has been shortlisted for a national award
- Enhancing the Quiet Protocol with sleep packs to help patients sleep well at night
- Continuing our work with the Patient Information Reading Panel to review information for patients
- Spreading the use of 'What matters to me' patient boards on wards
- Implementing the Always Event® improvement programme
- Collaborative working with Healthwatch Walsall and volunteers to conduct ward reviews
- Pharmacist at discharge lounge project for improving discharge experience and patients having better understanding of their medications
- Improving patient experience at the Imaging department through observational visits on different patient pathways and successful implementation of radiographer-led discharge for A&E patients.
- We have now entered the second phase of our 'You & I' programme for staff engagement in patient experience by covering the Maternity Services.
- Continuing the staff pledges from the Maternity 'Whose Shoes' event.
- Enhanced Maternity Voices Partnership Group
- Rollout of 'Staff Recharge Stations' which provide quick access to drinks and snacks for staff on busy clinical areas.
- Working on co-creating an improved triage system for the maternity delivery area.
- The Patient Experience team's work is part of projects for QSIR training through the Quality Improvement Academy.
- Increasing use of co-production and co-creation of improvements by involving patients and carers.

Key areas highlighted for improvements in our national surveys and FFT included communication, patient involvement in decisions about care and treatment, arrangements around discharge and waiting times.

Patient Surveys

National Inpatient Survey Results 2017 (results published in 2018)

With 476 surveys returned completed, the Trust had a response rate of 39.4%.

Our Results - summary

The Inpatient Survey comprises of 80 questions of which 62 are measured, the questions are broken down into 11 sections. The Overall scores for each section compared nationally can be seen below together with individual questions where the score was Worse. No questions scored Better compared nationally.

	Patient Response	Comparison with other Trusts 2017
The Emergency Department / A&E Department	**7.8 / 10**	**Worse – overall**
Information - for being given enough **information** on their condition or treatment in A&E	**7.5 / 10**	**Worse**
Privacy - for being given enough **privacy** when being examined or treated in A&E	**8.0 / 10**	**Worse**
Waiting lists & planned admissions	**8.6 / 10**	**About the same - overall**
Waiting to get a bed on the ward	**6.2 / 10**	**Worse – overall**
The hospital and ward	**7.7 / 10**	**About the same - overall**
Changing wards at night - for **staff explaining** the reason for needing to change wards at night	**5.4 / 10**	**Worse**
Doctors	**8.1 / 10**	**Worse – overall**
Answers to questions - for doctors **answering their questions** in a way they could understand	**7.7 / 10**	**Worse**
Confidence and trust - for having **confidence and trust in the doctors** treating them	**8.5 / 10**	**Worse**
Acknowledging patients - for **doctors not talking in front of them**, as if they weren't there	**8.2 / 10**	**Worse**
Nurses	**7.6 / 10**	**About the same – overall**
Enough nurses - for feeling that there were **enough nurses on duty** to care for them	**6.6 / 10**	**Worse**

	Patient Response	Comparison with other Trusts 2017
Care and treatment	7.6 / 10	Worse – overall
Confidence and trust - for having **confidence and trust in any other clinical staff** (e.g. physiotherapists, speech therapists, psychologists) treating them	7.8 / 10	Worse
Communication - for **not** being told one thing by a member of staff and something quite different by another	7.5 / 10	Worse
Involvement in decisions - for being **involved** as much as they wanted to be in decisions about their care and treatment	6.8 / 10	Worse
Confidence in decisions - for having **confidence** in decisions made about their condition or treatment	7.7 / 10	Worse
Operations & procedures	7.9 / 10	About the same – overall
Leaving hospital	6.6 / 10	Worse – overall
Involvement in decisions - for being **involved in decisions** about their discharge from hospital, if they wanted to be	6.3 / 10	Worse
Care after discharge - for knowing what would **happen next with their care** when **leaving** hospital		
Medication side effects - for being **told about medication side effects** to watch out for (those given medicines to take home)	6.3 / 10	Worse
Taking medication - for being told **how to take** medication in a way they could understand (those given medicines to take home)	4.0 / 10	Worse
Home and family situation -for hospital staff considering their family and home situation when planning their discharge, if this was necessary	7.6 / 10	Worse
	6.2 / 10	Worse
Overall views of care and services	4.2 / 10	About the same – overall
Overall experience	7.9 / 10	About the same – overall

National Cancer Survey Results 2017 (Published September 2018)

Improvements are small but represent an improvement direction rather than deterioration.

243 surveys returned from an adjusted sample of 417 giving a 58% response rate (down from 66% last year)

- 3 questions have a statistically significant increased score from 2016 results; remaining 49 questions show no statistically significant change on any of the questions for Walsall results from previous year. However with comparison against national averages there are slight changes to the scoring outside range from last year.
    - Scores within range have increased from 42 to 46
    - Scores above expected range have increased from 1 to 2
    - Scores above or equal to average have increased from 9 to 15
    - Scores within range but below average have decreased from 41 to 31
    - Scores below expected range have decreased from 8 to 4
- Patients average rating of overall care is 8.7 (increased from 8.5). This is within range but slightly below average. No longer lowest of 12 Trusts in West Midlands area (1 lower, 3 equal, 7 higher).

Identified themes from scores and patient free text comments tell us we are doing well with many aspects of care delivery for cancer patients including: staff attitude, implementation of care and treatment, communication and information, waiting

times, patient feeling well cared for. Things we could do better are also highlighted within same themes.

2018 National Maternity Survey Results

- 98 maternity service users responded to the survey
- The response rate for the Trust was 33%.

Our trust's results were better **than most trusts for 1 question.**

Q: On the day you left hospital, was your discharge delayed for any reason?

Compared to our 2017 survey results, the trust scores were not significantly better in any questions.

Our trust's results were worse than most trusts for 6 questions.

Q: When you were at home after the birth of your baby, did you have a telephone number for a midwife or midwifery team that you could contact?

Q: Would you have liked to have seen a midwife. (Care at home after the birth)
Compared to our 2017 survey results, the trust score was significantly lower for this question.

Q: Did a midwife or health visitor ask you how you were feeling emotionally?

Q: Were you told who you could contact if you needed advice about any emotional changes you might experience after the birth?

Q: Were you given information or offered advice from a health professional about contraception?

Q: Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP?

Our trust's results were about the **same** as other trusts for 43 questions.

3n NHS Staff Survey

This benchmark report for Walsall Healthcare NHS Trust contains results of the 2018 NHS Staff Survey. This year the results of the survey have been collated into ten themes (see below). The results are presented in the context of the best, average and worst results for similar organisations, for Walsall Healthcare NHS Trust the benchmark group is Acute and Community Trusts.

1. The response rate for the Trust was 40% against 41% for the national average for the benchmark group. Completed questionnaires 1,694, 2018 response rate 40%

2. The benchmark report shows a statistically significant improvement in the staff engagement score between 2017 and 2018.

3. The benchmark report shows improvement on five of the ten themes between 2017 and 2018, although not at a statistically significant level.

4. The benchmark report shows stability on four of the ten themes detailed below between 2017 and 2018. The last theme (morale) was introduced in 2018 and therefore is not benchmarked at this point.

The themes are as follows:
Equality, diversity & inclusion – improvement
Health & wellbeing – stable
Immediate managers – stable
Morale – new
Quality of appraisals - improvement
Quality of care - stable
Safe environment - Bullying & harassment - stable
Safe environment - Violence - improvement
Safety culture – improvement
Staff engagement – statistically significant improvement

3o Freedom to Speak Up

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

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

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

2019. The speaking up agenda goes someway towards enabling the trust to meet key priorities of improving patient safety and developing the culture of the organisation.

During the period April 2018 to January 2019 a total of 81 concerns were raised to Trust Guardians, indicating that staff are confident to use internal routes to speak up for help and support to ensure action is taken. Of the concerns raised, 43% related to quality and safety, 24% to patient experience and 12% on policy, process and procedure. During the financial year, the Trust launched (1st February 2019) a new area in its Safeguard incident reporting system for FTSU concerns and receiving feedback on actions taken, also this new provision includes the ability to report anonymously.

The Freedom to Speak Up Guardians and Trust Board reviewed the approach to speaking up within the Trust in order to learn from experience and develop an action plan to improve the service provided, this was reported to Trust Board in February 2019.

4. Statement from our stakeholders

Healthwatch Walsall Response

To : Walsall Healthcare NHS Trust Quality Account 2018/19

Healthwatch Walsall welcomes the opportunity to comment on the trusts' quality accounts 2018/19. Healthwatch Walsall have over the last year built on a positive working relationship with the trust at delivery and strategic level and we endeavour to continue building on this working relationship.

It is positive that the trust is honest about some the challenges that it has faced both due to internal and external factors and to proactively ensure its performance is transparent to wider stakeholders and around its accountability. We also welcome the opportunity to undertake Healthwatch outreach across the trust and to be continuously involved in the ward reviews where we have incorporated further elements to patient engagement.

We congratulate the trusts success in changing cultures in clinical governance and patient safety and its commitment to delivering performance around the quality priorities.

Safe care is a must and we welcome improvements to reduce pressure ulcers and to also ensure safe patient discharge across the hospital. However, it is evident that the trust is looking at developing new concerted efforts to reduce pressure ulcers and increases in tissue viability measures.

We also welcome the trusts' closer working relationships with other providers and particularly Dudley and Walsall Mental Health Trust, Walsall Borough Council and the emerging Primary Care Networks to ensure the 'patient' receives the right care in the right place at the right time.

It is stated that formal complaints against the Trust have risen 2018/19 at 318 vs 2017/18 at 280. Main reasons are recurring themes, i.e. clinical care assessment & treatment, poor communication, pain management and poor nursing care. We hope that efforts are made in

order to ensure perception and delivery of care improvements where patients / family members have highlighted concern.

The FFT surveys indicating who would 'recommend' highlights that ED is still a problem for the Trust, average 77% against 87% National average
Patient surveys for 2017, published 2018, indicate that the Trust is 'still perceived' to be doing worse/about the same than other Trusts in most disciplines. We welcome however that the trust is not as heavily reliant on FFT but using several other systems to gather patient experience.

It highlights that there were 9 patient safety reports and 5 ongoing through the Patient Safety Alerts. We would like to see a comparative to other trusts as it is unclear if this figure is high or low.
The quality account is honest about the need for improvements as noted around the national surveys in a number of areas and we feel it is important that a robust action plan is developed to address these issues particularly around communication and patient involvement.

Since Healthwatch's recent meeting with the hospital we welcome developing a closer joint working protocol to supporting both organisational and patient engagement.

Healthwatch have been working closely with the Trust Patient Engagement Team and we endeavour to strengthen this relationship. This team has been doing some effective work in supporting the Self Care Management Team and the volunteers and we welcome any statement about the importance of self-care management particularly for those with long term conditions and as this is evident as an important theme with the NHS Long Term Plan - published earlier this year.

We look forward to working closer with the Trust going forward.

On behalf of the Healthwatch Walsall Team

Paul Higgitt, Healthwatch Walsall Manager

NHS
Walsall Clinical Commissioning Group

20 May 2019

Dear

Re: Quality Account 1 April 2018-31 March 2019

NHS Walsall Clinical Commissioning Group is pleased to have had the opportunity to review the draft Quality Account 2018/2019 for Walsall Healthcare NHS Trust (WHT).

In a joint vision to maintain and continually improve the quality of services WHT has worked collaboratively with commissioners to sustain and progress a comprehensive quality framework that includes nationally mandated quality indicators alongside locally agreed quality improvement targets. There are robust arrangements in place with WHT to agree, monitor and review the quality of services, covering the key domains of safety, effectiveness and experience of care.

In preparing this statement, key intelligence regarding quality, safety and patient experience has been reviewed to test the accuracy of the information reported in the account. It is the CCG's view that the account accurately reflects the quality improvements made by WHT in 2018/2019.

2018/2019 has been a challenging year for WHT, moving from an organisation previously rated by the Care Quality Commission (CQC) as "Inadequate" to one rated "Required Improvement". The Trust has taken positive steps to ensure that patient safety and experience of care is the focus of their Improvement Programme and has remodelled their senior, operational and governance leadership teams to reflect this. Key achievements include; to ensure the right care, in the right place and at the right time for patients with the improved Safer and Red to Green initiatives. These have resulted in reduced lengths of hospital stay, avoided admissions and improved Integrated health and social care services following discharge.

Focus on preventing infections has been maintained and the Trust has recognised that further improvements are required and will be implementing the use of the National Early Warning Score 2 (NEWS2) to quickly recognise and appropriately manage clinical deterioration in patients from May 2019. This will support the improvement initiatives following the West Midlands Quality Review Service (WMQRS) of the care of the deteriorating patient pathway which was undertaken in September 2018.

The National NHS Contract and Commissioning for Quality and Innovation (CQUIN) Scheme provides us with additional processes and evidence that quality improvements are made. Although, September and November data saw a fall in sepsis performance, we note the progress made by the Trust during 2018/19 to deliver the important national CQUIN on screening all patients at risk of severe sepsis and improving the delivery of antibiotics for people with sepsis.

We can also confirm that work has been undertaken within WHT to improve the quality of investigation reports into Serious Incidents and Never Events. The draft Quality Account has listed 4 Never Events for 2018/19, we would ask if this figure could be checked before the final Quality Account is published.

WHT has shared with the CCG its proposed priorities for 2019/2020 which includes; reducing the number of inpatient falls and falls with harm, eliminating Grade 3 and 4 pressure ulcers, reducing the number of reported Grade 2 pressure ulcers, 95 percent of patients to have a nutritional assessment within 24 hours of admission, learning from death reviews and improving the patient experience scores as reported through the Friends and Family Test. We recognise there are still improvements to be made and therefore support the priorities chosen.

We look forward to receiving the CQC's published report following their inspections to the Trust in February 2019 and the Well Led inspection in March 2019.

In conclusion, WHT has made good progress over the last year with evidence of improvements in key quality and safety measures. The CCG recognises the Trusts commitment to working closely with commissioners and the public to ensure the ongoing safe delivery of safe, high quality services and we look forward to continuing this positive collaborative relationship in the forthcoming year.

Yours sincerely

Mrs Sarah Shingler
Chief Nursing Officer/Director of Quality

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF WALSALL HEALTHCARE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

This report is produced in accordance with the terms of our engagement letter dated 13th March 2019 for the purpose of reporting to the Directors of Walsall Healthcare NHS Trust (the 'Trust') in connection with the Quality Account for the year ended 31 March 2019 ("the Quality Account").

This report is made solely to the Trust's Directors, as a body, in accordance with our engagement letter dated 13th March 2019. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 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 permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors as a body, for our examination, for this report, or for the opinions we have formed.

Our work has been undertaken so that we might report to the Directors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

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,the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

- Friends and Family Test
- Rate of clostridium difficile infections

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

Respective responsibilities of Directors and Ernst & Young LLP

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 and Social Care 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 accordance with section 8 of the Health Act 2009 and the criteria set out in the National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("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 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 the other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014-15'. These are:

- Board minutes for the period April 2018 to June 2019;
- papers relating to quality reported to the Board over the period April 2018 to June 2019;
- feedback from the Commissioners dated 19/05/2019;
- feedback from Local Healthwatch dated 21/05/2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated April 2019;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey 2018;
- the latest national staff survey 2018;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23/05/2019;
- the annual governance statement dated 23/05/2019;
- the Care Quality Commission inspection report dated 20/12/2017;

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included, but were not limited to:

- 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.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Account**.** The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent 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 and Social Care. 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.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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.

Stephen Clark
For and on behalf of Ernst and Young LLP
Birmingham
19th June 2019

1.The maintenance and integrity of the Walsall Healthcare NHS Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.

2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Appendix 1 – summary of findings CQC report

Action the hospital MUST take to improve:

Maternity and Gynaecology
Risks are explained when consenting women for procedures.
The service uses an acuity tool to evidence safe staffing.
Action plans are monitored and managed for serious incidents.
Lessons are shared effectively to enable staffing learning from serious incidents, incidents and complaints.
Staff follow best practice national guidance.

Urgent and Emergency Services
Take action to improve ED staff's compliance with mandatory training.
ED completes the action plan compiled following the CQC inspection carried out in September 2015.

Critical care
Plans are in place for staff within the critical care unit to complete mandatory training. This includes appropriate levels of safeguarding training.
All staff working within the outreach team are competent to do so. Children and young people
All local guidelines are updated and regularly reviewed for staff to follow.

Outpatients and Diagnostic Imaging
Staff undertake required mandatory and safeguarding training as required for their role.
All staff within outpatients have the required competencies to effectively care for patients, and evidence of competence is documented.
All staff receive an appraisal in line with local policy.
Patients medical records are kept secure at all times.
All outpatient clinics are suitable for the purpose for which they are being used. End of life care
Attendance for mandatory training is improved.
Undertake required safeguarding training as required for their individual role.
All staff are trained and competent when administering medications via syringe driver.

Medical care
Mandatory training is up-to-date including safeguarding training at the required level. There are sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep patients safe.

Surgery
All professional staff working with children have safeguarding level 3 training.
All staff are up-to-date with safeguarding adults.
The safeguarding adults and safeguarding children policies are up-to-date and include relevant references to external guidance.
Patient records are completed, that entries are legible and each entry is signed, dated with staff names and job role printed.
All shifts have the correct skill mix for wards to run safely.
All staff are up-to-date with mandatory training.

Community Services for Children and Young People
Ensure blind cords are secured in all areas where children and young people may attend.
Ensure patient records remain confidential and stored securely.

Continue to follow standard operating procedures with medicines in special	schools.

Appendix 2 – Mandatory indicators

NHS Outcomes Framework Domain 1

Title	Indicator	2017/18	2018/19	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;	April 17 – 106.68 May 17 - 110.10 June 17 – 86.40 July 17 – 90.69 August 17 – 99.28 September 17 – 94.05 October 17 – 101.03 November 17 – 100.88 December 17 – n/a January 18- n/a February 18 – n/a March 18 – n/a	April 18 – 117.63 May 18 – 110.95 June 18 – 106.79 July 18 – 82.86 August 18 – 98.45 September 18 – 103.75 October 18 – 99.2 November 18 – 95.07 December 18 – 104 January 19 – n/a February 19 – n/a March 19 – n/a	1.00	Latest position – Feb19 Issue (Oct 17 – Sept 18) <u>Highest Performing Trust</u> – Homerton University Hospital NHS Foundation Trust (0.69) <u>Lowest Performing Trust</u> – South Tyneside NHS Foundation Trust (1.27)
	b) the percentage of patient deaths with palliative care coded at either diagnosis	2017 Apr - 31.5% 2017 May - 31.2% 2017 Jun -	2018 Apr - 34% 2018 May - 37% 2018 Jun - 35% 2018 Jul - 25% 2018 Aug - 32%	Not yet available from NHS Digital	Not yet available from NHS Digital

	or specialty level for the trust for the reporting period.	40.7% 2017 Jul - 33.8% 2017 Aug - 25.8% 2017 Sep - 35.5% 2017 Oct - 35.3% 2017 Nov - 30.8% 2017 Dec - 20.9% 2018 Jan - 28.7% 2018 Feb - 31.5% 2018 Mar - 28.3%	2018 Sep - 25% 2018 Oct - 24% 2018 Nov - 25% 2018 Dec - 19% 2019 Jan - X 2019 Feb - X 2019 Mar - X		
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The data reported represents the trusts performance against the national benchmarks. The data represents deaths occurring across primary and secondary care. Variances in performance represent the health demographics of the population, seasonal trends in keeping with the national picture. The trust has not reported any CUSUM alerts for this period.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See section 2.4		

NHS Outcomes Framework Domain 3

Title	Indicator PROMs case mix-adjusted scores	TRUST 2017/2018 Adjusted average health gain	TRUST 2018/2019	National Average 2017/18 Adjusted average health gain	Upper and Lower 95% control limit for the Trust Health Gain
Patient Recorded Outcome Measures **(PROMS)**	(i) groin hernia surgery	No longer measured	No longer measured	N/A	N/A
	(ii) varicose vein surgery	No longer measured	No longer measured	N/A	N/A
	(iii) hip replacement surgery	EQ5D – 0.514 EQVAS – 23.164 OHS – 20.625		EQ5D – 0.458 EQVAS – 13.877 OHS – 22.210	N/A
	(iv) knee replacement surgery	EQ5D – 0.353 EQVAS – 5.632 OKS – 16.264		EQ5D – 0.337 EQVAS – 8.153 OKS – 17.102	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		Oxford Hip Score (OHS) is a validated tool for the measurement of pain and function related to hips before and after replacement surgery. The lower the score the worst outcome perceived by the patient. (Worst pain and function 0 – 48 Best pain and function. It also affected by the overall health state of the patient and as the general population in Walsall has high levels of deprivation this is reflected in the EQ5D measurement.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the		• New Patient Information Booklets that include up-to-date information regarding why PROMs is collected and Why it is important to the patient and the Trust. • Joint School recommenced November 2017. Joint School presentation mirrors the Patient Information Booklet regarding		

	quality of its services, by:	PROMs participation • Pre-operative Assessment Clinics are collecting, monitoring and submitting both the HIP & Knee Booklets to the performance Department for entry onto the database • We are planning a Poster campaign in Pre-operative Assessment Clinic to back up our drive for patients to participate • We communicate with the National Proms team to discuss ways of improving PROMs participation rates. Interpreter facilities are now available via the National PROMs team hotline. Information Leaflets in different languages are available via the PROMS Website and link given to the Pre-operative Services. • We attend the Yearly National PROMS summit to learn from other Trust Experience • Orthopaedic Consultants are to do NJR / PROMS Peer Audit where they present their own NJR data to each other to provide professional challenge • Professor Briggs GIRFT review due 31st July 2018 regarding Hip & Knee replacement Walsall overall outcomes for NJR / PROMS / SSSI. • The MSK Care Group is working in partnership with GP Colleagues to ensure we operate on the patients in most need for the surgery. Patients who are medically fit, meet the BMI of 35 or below, and fully understand why they are having a major operation. We therefore hope to ensure that we meet/exceed the patients expectation for having the surgery thereby improving patient satisfaction and thus improving the PROMS. Research has shown that patient who have a higher BMI than 35 do not have such good outcome in the long term as patient who are below the BMI threshold.

Title	Indicator	2017/18	2018/19 (April 2018 to February 2019 YTD	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 15; and (ii)16 or over, Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	0 to 15 = 9.11% 16 & Over = 10.93%	0 to 15 = 9.09% 16 & Over = 11.07%	N/A	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The figures provided above are based on the Trust locally reported metric which looks discharges within a month who then subsequently readmitted within 30 days of this discharge.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		- In depth analysis is to be undertaken during the coming months to review emergency readmissions to establish trends and identify patients with high number of admissions. - The community services review all frequent admissions known to their caseloads and have demonstrated a reduction in admissions over the past year. Following a revised methodology to determine the performance for readmissions a robust piece of work will be undertaken in Month 6 to analyse trends and determine strands of work to be undertaken to review causation for key cohorts of patients. - In line with this, work will be developed to link the work currently		

		being done in the community around frequent admissions to those who are readmitting within 30 days to aid a better understanding of why these patients are frequently being admitted.

NHS Outcomes Framework Domain 4

Title	Indicator	2017 (these results relate to 2016 results which were received in 2017)	2018 (these results relate to 2017 results which were received in 2018)	2019 (these results relate to 2018 results which were received in 2019 – these results are embargoed until 20.6.2019 and do not include national benchmarking)	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The trust's responsiveness to the personal needs of its patients during the reporting period	Q32: Were you involved as much as you wanted to be in decisions about your care and treatment? **6.6/10** Q35: Did you find someone on the hospital staff to talk to about your worries and fears? **5.1/10** Q37: Were you given enough privacy when discussing your	Q34: Were you involved as much as you wanted to be in decisions about your care and treatment? **6.8/10** Q37: Did you find someone on the hospital staff to talk to about your worries and fears? **4.9/10** Q39: Were you given enough privacy when	Q34: Were you involved as much as you wanted to be in decisions about your care and treatment? **6.9/10** Q37: Did you find someone on the hospital staff to talk to about your worries and fears? **5.2/10** Q39: Were you given enough	Trust score about the same as national score Trust score about the same as national score	N/A

		condition or treatment? **8.3/10** Q57: Did a member of staff tell you about medication side effects to watch for when you went home? **3.9/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **6.9/10**	discussing your condition or treatment? **8.2/10** Q58: Did a member of staff tell you about medication side effects to watch for when you went home? **4.0/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **7.3/10**	privacy when discussing your condition or treatment? **8.3/10** Q58: Did a member of staff tell you about medication side effects to watch for when you went home? **4.3/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **7.3/10**	Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score	
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:			The Trust follows the National Survey programme for implementing the CQC surveys. The data collated is processed by National Survey Co-ordination Centre and published by CQC via their public website.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the			• Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night, full protocol		

	quality of its services, by:		implementation is scheduled for quarter 1 of this year. • The Trust has joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time.

Title	Indicator	2017/18	2018/19	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.	48%	49%	69% (2018/2019 for Combined Acute & Community Trusts)	N/A
	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 2017and 2018 respectively. Although improved from the previous year the results of this were surprising as did not reflect the much better results of the Staff FFT for the same question during Q2 prior to the National Staff Survey, published by NHS England 22/11/2018.		
	Walsall Healthcare NHS Trust has		The questionnaire was sent to all colleagues and 1694 responded,		

	taken the following actions to improve this number, and so the quality of its services, by:	equating to a 40% response rate, an increase of 4% on the previous year, but lower than the national average response rate of 43% for all combined acute and community trusts in England. Since the survey was launched there has been a significant amount of work in understanding staff opinion and the main factors we have been focusing attention on is Health & Wellbeing, Safety Culture, Equality, Diversity and Inclusion, Bullying & Harassment and Staff Engagement. An organisational action plan is being introduced as a Trust-wide approach to improve this result for the 2019 Staff Survey. A local Pulse survey will be undertaken in July 2019 to assess for any improvements at the midway point of the National Staff Survey taking place. We would expect to see more staff recommending the Trust as a place for treatment to their friends and family in line with the Staff Friends and Family Test improvement scores we have seen.

(There is not a statutory requirement to report this indicator)

Title	Indicator	2017/18	2018/19	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patients who would recommend the Trust to their family or friends		March 2018 (% Recommended) Inpatients – 94% ED – 76% Outpatients – 92% Community – 97% Antenatal – 81% Birth – 100% Postnatal Ward – 96% Postnatal Comm – 98%	March 2019 (% Recommended) Inpatients – 95% ED – 78% Outpatients – 92% Community – 97% Antenatal – 100% Birth – 94% Postnatal Ward – 92% Postnatal Comm – 100%	February 2019 (% Recommended) Inpatients: 96% Outpatients: 94% A&E: 85% Community Services: 96% Antenatal (Maternity): 95% Birth (Maternity): 97% Postnatal Ward(Maternity): 95% Postnatal Community(Maternity): 98%	N/A
	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	• All wards and departments display their FFT results on a weekly basis for patients, visitors and staff members. • An Ipads pilot on four wards was successful in increasing accessibility and involvement of patients with feedback activity on the inpatient			

	the quality of its services, by:	wards. • Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night, full protocol implementation is scheduled for quarter 1 of this year. • Volunteer support has been increased across the wards and A&E to assist with activities like mealtimes, patient visiting, dementia tea parties and waiting area support. • The Trust has joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time. • Observe & Act Tool was piloted which paves the way for using lay members to identify and co-produce service improvements.

NHS Outcomes Framework Domain 5

Title	Indicator	2017/18	2018/19	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 17 = 80.34% May 17 = 87.73% Jun 17 = 81.91% Jul 17 = 79.28% Aug 17 = 88.30% Sep 17 = 90.75% Oct 17 = 90.45% Nov 17 = 89.95% Dec 17 =	Apr 18 = 96.35% May 18 = 96.28% Jun 18 = 96.50% Jul 18 = 95.57% Aug 18 = 95.08% Sep 18 = 94.38% Oct 18 = 94.64% Nov 18 = 95.11% Dec 18 =	Latest national position – Quarter 4 2018/2019 = 95.67% (excluding Independent Providers)	Latest position – Quarter 4 2018/2019 Highest Trust = KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST (99.59%) Lowest Trust = BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (74.03%)

		93.45% Jan 18 = 91.23% Feb 18 = 93.18% Mar 18 = 95.49%	94.67% Jan 19 = 95.00% Feb 19 = 93.61% Mar 19 = 91.94%		
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		This data is reflective of the trust performance for VTE assessment of all appropriate admissions as determined by the use of a robust methodology for determining the performance developed and embedded since March 2017. The improved performance represents the use of a single electronic data sources for adult and maternity services and strategies supported by senior clinical and nursing team members to embed a revised system and process.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See section 2.3 for a description of the actions taken		

Title	Indicator	2017/18	2018/19	National Average (2017/2018)	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	6.9	12.2	13.7	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		- The Trust has a process in place for collating data on C Difficile cases - data collated internally and submitted monthly to Public Health England		
	Walsall Healthcare NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:		Please refer to section 2.6		
	Data source		Combined monthly snapshot in line with KH03 definition- bed days figure used for 2018/2019 is 155,990 (in line with quarterly KH03 submissions)		

Title	Indicator	2017/18	2018/19 (April – Sep 2018) The latest data available	National Average (April – Sep 2018) 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,	11,645 incidents reported and equating to 72.86 incidents per 1,000 bed days	5,628 incidents reported and equating to 74.5 incidents per 1,000 bed days	5,607 incidents reported and equating to 44.46 incidents per 1,000 bed days	23,692 incidents reported by University Hospitals Birmingham NHS Foundation Trust and equating to 51.9 incidents per 1,000 bed days. 566 incidents reported by Weston Area Health NHS Trust and equating to 13.1 incidents per 1,000 bed days
	the number and percentage of such patient safety incidents that resulted in severe harm or death	44 0.4%	18 0.3%	19 0.3%	87 incidents (0.4%) – University Hospitals Birmingham NHS Foundation Trust 3 incidents (0.5%) – Weston Area Health 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 action taken as a result. This is reflective in the increased number of incidents reported per 1,000 bed days compared to the previous Quality Account			

Appendix 3: Statement of director's responsibilities in respect of the Quality Account

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

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

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

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

By order of the Board,

Danielle Oum
Chair

Richard Beeken
Chief Executive

Appendix 4 - Glossary

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

A&E	Accident and Emergency (see ED)
CD	Controlled Drugs
C. Difficile	Clostridium difficile
CCG	Care Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
ECIP	Emergency Care Improvement Programme
ED	Emergency Department (see A&E)
EDIC	Equality, Diversity and Inclusion Committee
EDS2	Equality and Diversity System 2
FFT	Friends and Family Text
GP	General Practitioner
HDU	High Dependency Unit
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
LiA	Listening into Action
MAC	Medical Advisory Committee
MMC	Medicines Management Committee
MRSA	Meticillin resistant Staphylococcus aureus
IIP	Integrated Improvement Programme
ITU	Intensive Therapy Unit
LfE	Learning from Excellence
MRI	Magnetic Resonance Imaging - a technique to take a cross sectional image of a patient

MRSA BSI	Meticillin resistant Staphylococcus aureus blood stream infections
NQB	National Quality Board
NFA	No Fixed Abode
NIHR	National Institute for Health Research
NNU	Neonatal Unit
NRLS	National Reporting and Learning System
OPD	Outpatient Department
PEG	Passionate for Engagement Group
PDG	Patient Group Directives - Who can supply and or administer specific medicines to patients without a doctor under a PGD and which medicines can be administered
PE	Pulmonary embolism – a blood clot in the lung
R&D	Research and development
RCP	Royal College of Physicians
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.
SOP	Standard Operating Procedure
SPECT	Single-photon emission computed tomography – a technique to take a cross sectional image of a patient
SI	Serious Incidents
TC	Transitional Care (between the Neonatal Unit and the post natal ward)
TMB	Trust Management Board
WHO	World Health Organisation
VTE	Venous Thromboembolism
WMAHSN	West Midlands Academic Health Science Network
WMAS	West Midlands Ambulance Service

WMQRS	West Midlands Quality Review Service