Quality Account 2017/18

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Becoming your partners for first class integrated care

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Glossary

Walsall Healthcare NHS Trust is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete.
This data quality agenda presents an on-going challenge from ward to Board.
Identified risks and relevant mitigation measures are included in the WAHT risk register.
This report is the most complete and accurate position available.
Work continues to ensure the completeness and validity of data entry, analysis and reporting.

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

I am pleased to present the annual Quality Account for Walsall Healthcare NHS Trust which provides a full picture of the quality of the services we provide both in our hospital and the community. It details the progress made in meeting our quality improvement priorities over the last year, our performance against key measures and also where we will be concentrating our improvement efforts in 2018/19. Some of the year's highlights are also included.

I may have only joined the Trust recently – in February 2018 – but I have seen first-hand the excellent progress that has been made here so far. The focus is now on keeping up this momentum and not losing sight of what still needs to be done.

After being rated as "inadequate" by the Care Quality Commission following its 2015 inspection, the re-inspection the Trust had in June 2017 was an important indicator for the organisation of how well it had responded to the issues identified.

The new rating of "requires improvement" given in December 2017 is an important step on the way to "good and beyond" and reflects the considerable work of the Trust's staff and their desire to provide better care. The "outstanding" rating received for community services was also a real achievement

Maternity was the one service that remained "inadequate" but the continuing drive to improve is monitored by the Trust, its commissioners, the CQC and NHS Improvement and significant change is being implemented and felt positively. The Chief Inspector of Hospitals Inspection Report is described in more detail on page 10

Performance snapshot:

The Trust experienced significant emergency pressures combined with a difficult winter which resulted in utilisation of additional capacity to service increased emergency activity and additional sessional work needed to support referral to treatment (RTT).

Full details of our performance against key measures are contained in this report but improvements included:

- Cancer 2 Week Waits – 25th (Q4 17/18) compared to 41st (Q3 17/18)
- Total Time Spent in ED Overall – 79th (Apr 18) compared to 92nd (Mar 18)

The Trust has declined in:

- SHMI* – 110th (Oct16-Sept17) compared to 101st (Jul16-Jun17)
- Cancer 62 Day RTT – 38th (Q4 17/18) compared to 28th (Q3 17/18)
  * Standardised Hospital Mortality Indicator

Quality Priorities:

For 2017/18 The Trust set itself three quality priorities:

1 Medicines safety
2 Care of deteriorating patients in hospital
3 Assessment and development of equality and diversity

While the first two priorities have seen improvements through strong internal and external focuses, we acknowledge that we still have a lot of work to do around equality and diversity.

All three improvement priorities will be continued into 2018/19 with an additional priority: The quality of the health record.

Learning from feedback:

Another important indicator of how well the Trust is doing is feedback from patients and their families as well as our own staff.

The 2017 national staff survey results for Walsall Healthcare showed that colleagues are not as satisfied with their experience at work and feeling engaged in the organisation's objectives, as many other Trusts.

Whilst the results have not deteriorated from 2016 they have only marginally improved. There are clear signs that staff feel they are listened to compared with last year and have more of a say than previously. But there are also clear signs of the pressure staff are feeling, with more people feeling work-related stress and also feeling less well paid than previously.

These results must motivate the Trust to continue trying to improve the culture of the organisation while accepting that change will take time.

Over the last year we have continued to implement our patient experience strategy that puts the patient 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.
We saw patients reporting a better experience in our hospital through the Friends and Family Test (FFT), national and local surveys. More than 52,000 patients responded to our feedback surveys and 91% said they would recommend our services.

Key improvements included the introduction of the Quiet Protocol to help patients sleep well at night, establishing a patients' reading panel, piloting the Always Event® improvement programme and the 'Observe and Act' tool for a better feel of the total experience journey. Key areas highlighted for improvements in our national surveys included communication, patient involvement in decisions about care and treatment, arrangements around discharge and waiting times.

Investment:

Work is well underway to house two new state-of-the-art MRI scanners at Walsall Manor Hospital as part of the Trust's overall £50 million investment in healthcare services. This investment will also see the creation of our new Integrated Critical Care Unit, a new Obstetric Theatre and expansion of the Neonatal Unit and the redevelopment of the Emergency Department.

This major investment will not only enhance our patients' experience but will also improve the working environment for staff; helping the Trust to retain its workforce and build on training and advancement opportunities.

Quality Commitment:

In conclusion, to achieve a rating of “good” or “outstanding” for the whole Trust we know we need to use a more sophisticated approach to quality improvement. This approach is described on page 8 and explains our aim to develop an Integrated Improvement Programme which will help revise and focus our Quality Commitment.

We have built on the success of our internal Listening into Action approach and created a Quality Improvement Academy to help colleagues at all levels of the organisation improve the quality of their work through guidance and training. Learning from what goes well is as important as learning from errors, so Learning from Excellence has been introduced to balance incident reporting and use the same review methods to undertake a “right cause analysis”.

It is my personal aim to work with the Trust Board and colleagues across all levels of the organisation to empower staff to make the changes they want to make to improve the quality of care received by all patients who use our services.

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

Richard Beeken
Chief Executive

1.1 Introduction

NHS Trusts are required to publish a Quality Accounts every year under section eight of the Health Act (2009). They are reports to the public from NHS providers about the quality of the services they deliver and must include prescribed information set out in the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (quality Account) Amendment Regulations 2012. Additionally, every year, NSE England (the organisation that runs NHS services in England) requires that further specific pieces of information are included within the document.

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

Copies of this document are available from our website (www.walsallhealthcare.nhs.uk), by email to communications@walsallhealthcare.nhs.uk or in writing from:

Trust HQ
Walsall Healthcare NHS Trust,
Walsall Manor Hospital,
Moat Road,
Walsall,
WS2 9PS

Please contact us if you would like a copy of the Quality Account in large print or in another community language for people in Walsall.

A glossary is provided at the end of this document to explain the main terms and abbreviations that you will see used in the document.

We welcome your feedback on our Quality Account. We welcome your feedback on any aspect of this document. You can let us know by using the contact details above.

Our Services

Walsall Healthcare NHS Trust was formed on 1 April 2011, bringing together the teams at Walsall Hospitals NHS Trust and NHS Walsall Community Health. We are an integrated healthcare organisation with an annual turnover of circa. £240m and our 4,000 staff serve the 269,000 residents of the borough of Walsall providing a comprehensive range of hospital and community healthcare services in their own homes. As an integrated provider of healthcare, many services have moved beyond traditional boundaries for the benefit of patients.

Walsall Manor Hospital houses the full range of district general hospital services under one roof. The £170 million development of our Pleck Road site was completed in 2010 and the continued up-grading of existing areas ensures the Trust has state of the art operating theatres, treatment areas and equipment.

The Trust has 606 inpatient beds including 536 Acute and general beds, 57 Maternity Beds and 13 Critical Care Adult beds and a specialist Palliative Care Centre. We also provide high quality, friendly and effective community health services from some 60 community settings, such as health centres, GP surgeries and, importantly, in people's own homes. Covering Walsall and beyond, our multidisciplinary services include rapid response in the community and home based care, so that those with long term conditions and the frail elderly, can remain in their own homes to be cared for.

The Trust's Palliative Care Centre in Goscote is our base for a wide range of palliative care and end of life services. Our teams, in the centre and the community, provide high quality medical, nursing and therapy care for local people living with cancer and other serious illnesses, as well as offering support for their families and carers.

Our extensive Lifestyle Management service provides smoking cessation, drug and alcohol support, a Physical Activity team and a Health Training service. Working with all areas of the Trust, the team ensure lifestyle management features across our range of healthcare services.

Services are organised for management purposes into four divisions:

- Surgical Division,
- Medical and Long Term Conditions (includes adult community services),
- Women's, Children's and Support Services (includes children's community Services and Mid-wife led unit) and also Diagnostic and therapy services including Pathology, Pharmacy, Physiotherapy.
- Corporate Services (includes estates management, Specialist services including Tissue Viability, infection control and the Palliative Care (including Goscote Palliative Care Centre).

Our strategic plan

In 2016 we committed ourselves to a five-year journey to deliver our vision of **becoming your partners for first class, integrated care**. This vision was supported by five strategic objectives form the basis for our two year operational plans for 2017/18 – 2018/19– years 2 and 3 of the plan. By 2021 we will be an organisation that is community focussed, with a workforce that is engaged and empowered and working with partners to ensure financial sustainability. Embedding service improvement tools and methodologies will be integral part of our approach to ensure that the organisation builds and maintains a culture of continuous improvement and efficiency.

Our commitment to partnership work continues as we work with organisations across the Black Country STP on plans for pathology and maternity services; as well as centralising acute stroke services at Royal Wolverhampton NHS Trust. In the borough of Walsall we have agreed to a programme of work to transform the way we delivery placed based care as a integrated system.

At its simplest we will embed the improvements in quality and safety, culture and performance that we have begun this year whilst also tackling our significant financial challenge to ensure we are sustainable. We are aiming to deliver:

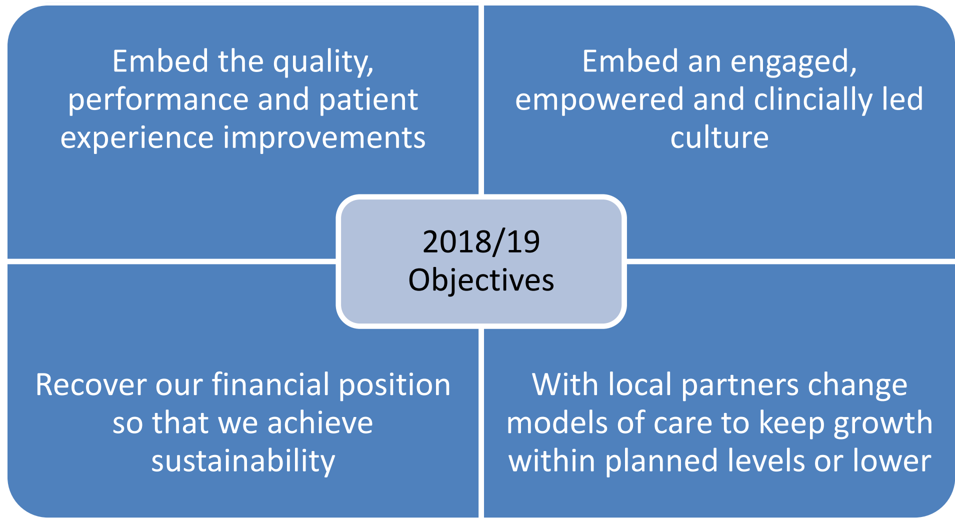
- **Safe, High Quality Care** – by continuing to improve the quality of the care we provide, delivering a renewed focus on patient experience and continuing to reduce long waits for care;
- **Care at Home** – with our partners in the Walsall health and social care economy, progressing the delivery of the Walsall integrated model for health and social care. This will be through integrated locality teams and an integrated intermediate care with a discharge to assess service. We have agreed to work with Walsall CCG to seek to keep hospital activity at 2016/7 forecast outturn levels during the period of this plan;
- **Work with Partners** – continuing to grow the Walsall Together and Black Country Providers Partnership as well as developing stronger relationships with our local GP Federations;
- **Value our Colleagues** – embed Listening into Action as “the way we do things” along with a clinically-led model for our services and a longer-term workforce plan developing new roles and reducing reliance on agency staff;
- **Use Resources Well** – take definitive steps to tackle our financial challenges by delivering deficits of no more than £20.5m in 2017/18 and £15m in 2018/19, delivering a £11m and £13m savings programme respectively. This includes a capital programme of £52m to complete our redevelopment plans for ITU, maternity and neonatal and ED and our acute assessment unit plus MRI and gamma camera diagnostic capacity.

There is no doubt that the financial challenge we face is significant and is shared by Walsall CCG as our main commissioner. After a number of years of increasing deficits we are seeking to halt this trend and begin to reduce the deficit over the life of this plan.

The work that commenced in 2017/18 to review our service sustainability will continue at pace in 2018/19. It will see a shift from a short-term focus on ensuring our services are safer and performance improves, to a longer-term focus on the delivery of a safe and sustainable model of care. Phase one of this work was completed in February 2018 and the next phase will commence in March 2018. Further information is available in the Trust’s Annual Report.

Trust Objectives 2018/19

As part of our annual planning process we reviewed our annual objectives with our clinical leadership teams and have revised them as shown below. As part of our commitment to embedding clinical leadership, the descriptions of our objectives are at a higher level than previous, so that each of our management teams can devolve more operationally focused objectives to their teams. These high-level objectives are set out below.



Trust Objectives 2018-2019

Our approach to quality improvement

The Board is committed to ensuring patients receive the highest level of safe, high quality, compassionate care, through a shift to a culture of continuous quality improvement based upon the sustainable implementation of a Trust wide Integrated Improvement Programme

A Service Improvement Strategy was developed in 2017 outlining the approach in improvements to clinical services and how they would be developed to be sustainable in the future.

Executive leadership, accountability and responsibility for quality governance are held by the Director of Nursing and the Medical Director. Improved quality governance oversight and integration with corporate governance will be overseen by the Trust's new Director of Governance.

The Trust's Quality Strategy, our ''Quality Commitment'' was approved at Trust Board in November 2016 and continued through 2017/18. This framework sets out what our strategic commitment to safe, high quality care means in practice. It incorporates national and local drivers, commissioning priorities and is consistent with STP quality priorities. It is based on three main sections:

Provide effective care	– Improve Patient Outcomes
Improve safety	– Reduce Harm
Care and compassion	– Improve Patient Experience

The actions to implement the Quality Commitment and those included in the Patient Care Improvement Plan developed after the 2015 CQC inspection helped to improve our ratings and the Trust is now rated overall as 'Requires Improvement'. The results are provided in this report.

To get all our services to a "good" or "outstanding" rating, we know we have to change and improve our approach to quality improvement. This approach will include agreeing a set of measurable improvements which will be underpinned by a clear line of sight that shows how services and colleagues at every level contribute to achieving them, giving colleagues the skills to improve, and a system which will monitor, support and hold leaders to account for the improved performance or achievements of the aims.

An Integrated Improvement Programme (IIP) will be developed to incorporate on-going "must do" actions following the CQC inspection report. It will also include the aspirational quality and safety ambitions driven by our clinical teams' vision for outstanding services.

The Quality Commitment will be revised to capture the high level aims and replicated at Divisional and Care Group level to show the contributions from the individual services and measures of performance. The plan will set out achievable, sustainable, incremental plans that include thematic corporate, divisional and care group actions.

A new Quality Improvement Faculty has been established to support colleagues on the improvement journey. This encompasses the existing Listening into Action (LiA) Programme and the Service Improvement Team. This will provide additional innovative, research, and evidence based support to the services and clinicians. The first phase focuses on Human Factors in Maternity and Gynaecology.

The revised governance and assurance structure implemented in 2015 continues and is aligned with the clinically led management model in the Divisions providing ward to board reporting and assurance. However the intention is to review these arrangements during the first quarter of 2018/19.

The Quality Governance Advisors embedded in the three Divisions have delivered expertise in embedding governance structures and processes at a clinical and managerial level and whilst they will continue to do so it is also planned to strengthen this at divisional and care group level so as to ensure we move to high performing clinical leaders from ward to board.

Section 2 – Review of Quality Performance

2.1 Progress since the CQC inspection report

The 2015 Chief Inspector of Hospital's report rated the Trust as inadequate. The considerable amount of work and initiatives undertaken to engage with patients and staff, an improvement plan captured in the Trust's Quality Commitment, the Patient Care Improvement Plan (PCIP) and supported by initiatives such as the Listening into Action (LiA) to enable bottom up change, has helped the Trust to improve the quality of services it delivers.

The December 2017 Chief Inspector of Hospital's Inspection Report demonstrated this improvement:

- **Trust** was rated overall **Requires Improvement**.
  - **Caring** **Good**
  - **Maternity Services** **Inadequate**
  - **Community services** **Outstanding**

The feedback from the inspectors was that they saw "a very different Trust" to the one they visited back in 2015 confirming that our improvement journey is starting to show significant results. Our staff has been the driving force behind many of these improvements and we thank them again in this report for their commitment and pride in their services. Particular credit should go to our community services teams for their rating of "Outstanding" and to our Emergency Department team who are no longer rated "Inadequate"

Overall Trust Rating: Requires Improvement

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Walsall Manor Hospital

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

Community Services Rating: Outstanding ☆

The Maternity service saw marginal improvement but remained with an "Inadequate" rating. In the nine months since the inspection, further improvements have been made in the Maternity Service under the new leadership team. The Task Force approach will however continue to drive improvement and support the new management team to achieve a rating of at least good in the next CQC inspection. The Task Force meets monthly and, with Chief Executive leadership, provides oversight of the range of actions required within these service areas. Examples of progress include: improved compliance with CTG monitoring, implementation of the Birth-rate Plus Acuity Tool to ensure continuous evaluation and provision of safe staffing and HDU trained midwives on every shift.

The Urgent and Emergency Services were previously rated 'inadequate' but have improved significantly. Work continues to improve the service and we have therefore asked the Emergency Care Improvement Programme (ECIP) for support to improve patient flow along emergency pathways based on the principles outlined in the Good practice guide: Focus on improving patient flow.

The aim is to improve and maintain Emergency Department (ED) performance against the 4hr wait standard to above 90% in 2018/19.

The priority areas for the programme are:

1. Establish an improvement approach to support the UEC improvement programme
2. Test and implement effective emergency department and acute pathway improvements
3. Test and implement improved ward processes including; the SAFER patient flow bundle, Red2Green days approach and a robust model for escalation, response and constraint resolution
4. Co-design, test and implement new ways of working to improve the management of frail older adults across Walsall
5. Improve admission, transfer and discharge processes including; discharge to assess, home first and trusted assessment.

We have improved the pathways between the ED and community and rapid response services, and this is achieving positive outcomes in terms of reducing pressures on the front door. The Trust has moved forwards with partnerships within intermediate care and is now midway through an integrated service with the Local Authority which includes a shared management team.

The size and condition of the ED also needs to be addressed. A business case to build an ED that can adequately cater for the needs of Walsall's population is progressing and there is confidence that it will be agreed during 2018/19.

We have always been very clear that this latest inspection was an important milestone on our improvement journey but that it was not the end of the journey. We know that we need to continue to build on the foundations we've laid and to work with partners across the health and social care system to collectively deliver services that meet the needs of the communities we serve.

The Integrated Improvement Plan will support our ongoing strategy and we will be working with our clinical teams to take the action needed to ensure that all of our teams are able to achieve “good” or “outstanding” ratings in the future.

Other quality highlights from 2017/18:

While there was an understandable focus on the CQC re-inspection in 2017, a considerable amount of improvement work was under way at all levels of the Trust and a selection of the improvements made, achievements attained and awards received by our services and staff are described below.

Listening Into Action (LiA)

LiA is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of your organisation, in a way that makes them feel proud.

To date over **60 teams** have used LiA as a way of engaging with stakeholders around improvements in their areas and the wider health economy.

Outcomes during the past 12 months include: -

- Infection prevention and control have increased the knowledge of ANTT (Aseptic Non-touch technique) in key target areas from 40% to 96% in just 20 weeks.
- The communications team have reduced the number of global emails sent out by 70% since the introduction of Daily Dose.
- Learning from Excellence launch has seen over 160 nominations for outstanding clinical practice.
- Tissue Viability have secured replacement mattresses and have predicted savings of £120k in 2018-19. Early review has seen a 50% reduction in pressure ulcers.
- Paediatrics OPD has reduced DNA rates by 4% and increased 4% increase in clinic utilisation.

Maternity Dashboards Sept 17 to end Feb 18:

- Emergency C-Section rates **reduced by 7.8%**
- Overall C-Section rates **reduced by 1.3%**
- Skin to skin rates for term (>37 weeks) babies within the first hour of birth have increased from 46.45% (16/17 FY) to 53.38% **A Rise of 6.93%**
- Referrals to Quit Smoking Team have increased by 68% Sept 2017-end Feb 2018

Neonatal Unit (NNU) data trend:

- % of term admissions to NNU/TC with low temp (<36.5) has been reduced from: 25% (2016) to 16% (Jan-March 2017) to **10.9%** (Oct - Dec 2017)

Urology OPD

- 62% reduction in Outpatient Department (OPD) follow-up backlog list.
- Achieving 31 and 62 day cancer targets

Consent

- Consent training figures increased from 2 in 2016 to 150 in 2017

Infrastructure developments:

- Building work on the new **Integrated Critical Care Unit** has started with completion due in the Winter of 2018.
    - The new development is bringing together Walsall Manor Hospital's Intensive Therapy Unit (ITU) and the High Dependency Unit (HDU) creating an 18-bedded unit, which is an increase of five beds.
    - The new ICCU will allow the Trust to treat many patients in individual rooms, preventing cross infection and ensuring their dignity and privacy.
    - The standardisation of equipment at every bed space will mean any bed can be used for either an HDU or ITU patient, preventing them having to be moved.
    - Each bed will have a ceiling-mounted pendant that supplies a comprehensive range of essential services including essential gases, power for equipment and IT links.

- Community nursing teams have gone live with **mobile technology** as part of an £800,000 Walsall Healthcare investment.
    - The new Totalmobile system is a switch from a paper-based patient assessment system and means that community staff can give patients the results of their blood tests for example, reducing any delay in starting treatment.
    - They can also access details of new patients more quickly and the devices offer greater security for lone workers.
    - The new system incorporates the capture of referral and contact information, dynamically schedules appointments and allows visit information to be inputted on to the system via Samsung Galaxy Tablets.

- A new **Gamma Camera** has been installed in the Manor Hospital.
    - The equipment, which is used to detect cancerous tumours and a host of other medical problems, is costing in excess of £650,000.
    - The existing camera was installed a decade ago and is outdated. The new has a SPECT/CT attachment. This will improve image quality and diagnosis and offer an improved service to patients. It will be possible to perform modern examinations, and patients who currently have to travel to other hospitals for their examination will now be able to receive this in Walsall.

Initiatives:

The **High Flyers** project commenced in 2014 following three serious incidents occurring within a short period of time to complex patients who did not meet the normal criteria for requiring hospital admission and care, but had multiple long standing social and lifestyle issues, including alcohol abuse, which impacted on their health and required additional support. The aim was to reduce the impact of not intervening, the revolving door of attendances to A&E, the missed opportunities to intervene and catastrophic outcomes for the patients.

We looked for:

- Patterns in attendances and admission - Who attends particularly ED, how often and themes
- Were there already plans in place to support complex patients and why were they proving ineffective?

We found:

- The top 15 attenders accounted for 499 attendances to ED in a seven month period.
- The top 5 attenders accounted for 53% of this total.

We took action:

- A multidisciplinary team was created to review the first ten 'High Flyers'. A lead agency was identified for each with an individual management plan in place, copied to their GP.
- A No Fixed Abode (NFA) Algorithm was been developed, regarding how to better manage these patients when they present to ED or are admitted to ensure safe discharge
- GPs were provided with information on how to refer patients to the team

The results were impressive with a 47% reduction in attendances in the first nine months. Fewer admissions were also seen releasing beds and reducing costs.

This work continued through 2017/18 and has been recognised nationally. The team have recently been invited to present to the All Parliamentary Alcohol Select Committee in June 2018 to present on the work. There will be a presentation with questions and a report will be produced to share with other local authorities/ healthcare trusts, in order to further replicate similar projects across the country. The Isle of Wight Local Authority have also contacted the team asking them to support a project development relating again to High Flyers, and sharing Walsall's approach

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. Between August 2017 and March 2018 164 nominations were made. Each of these 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.

> *Following the successful MRI brain scan of a very frightened child, we dreamt, "What if it was this good, every time." We then interviewed all those involved in the patient pathway- consultant, play specialist, radiographer, parent and child, asking the question, "What made it so excellent?" We then re-designed the process around this great experience and develop a Standard Operating Protocol (SOP).*

Although the initiative is in its early days, it's clear that learning from what goes right balances some of the perceived negativity of incident reporting, which, by definition, something hasn't gone right. It extends beyond just patient safety and learning from improved processes and patient experiences is just as valuable.

The team presented a poster at the international Learning from Excellence Conference in November 2017. Further information is available at: https://learningfromexcellence.com/

Awards:

Children's Services APP won the Patient Experience Network (PEN) National Awards

Category: **Innovative Use of Technology/Social Media**

- Walsall Healthcare NHS Trust won this national award thanks to an innovative app designed to help young patients and carers have a great experience while in hospital.
- Independent body The Patient Experience Network (PEN) recognised the app, developed by Paediatric Consultant Dr Hesham Abdalla; noting it to be significant in improving communication between staff and patients.
- The Walsall Children's Healthcare app was prompted by Dr Abdalla's experience of shadowing a patient on the hospital's Paediatric Assessment Unit and seeing the alarm on a mother's face when her daughter's oxygen levels started to dip.
- The app, which is free to download from Google Play and Apple App store, includes helpful guidance such as frequently asked questions, video clips on what to expect with procedures such as MRI scans and even fun games to keep the patients entertained while on the ward.

Walsall Healthcare's 0-5 Health Visiting (Healthy Child Programme) service has achieved the prestigious Baby Friendly Award.

- The Baby Friendly Initiative, part of Unicef (United Nations Children's Fund), recognises the excellent support in infant feeding and parent-infant relationships Walsall Health visiting Service offers to Walsall families.
- "We decided to implement the initiative to increase breastfeeding rates and to improve care for all mothers in Walsall," said Caroline Mansell, Baby Friendly Implementation Manager.

The Patient Safety Teams have been shortlisted for the 2018 Patient Safety Awards – being held in June 2018

Category: Clinical Governance & Risk Management
Title: An integrated approach of changing cultures in Clinical Governance/ Patient Safety

Patient Safety teams for Medicine and Surgery with Walsall Healthcare have been shortlisted for a national award which recognises services that have gone above and beyond in delivering safe care for patients.

The role of Patient Safety is to help monitor risk, to support with incident reporting and to facilitate investigations where necessary; all with an end goal of supporting colleagues to learn from incidents that will prevent them from happening again.

2.2 Progress with quality improvement priorities for 2017/18

We have made some good progress with two of the three improvement priorities included in the 2017/18 Quality account but each of them requires further work to sustain the improvements made and to achieve the intended result.

Priority 1 : Improve Medicine Safety Standards specifically: • Controlled drugs standards • Safe Storage • Reduction in missed doses • Use of Medicines Safety Thermometer • Preventing Harm from Insulin	Partly achieved

Overview of performance / achievement of the priority:

Controlled Drugs (CD) Standards = Not achieved
Controlled Drugs Standards in the Trust were identified as a corporate risk over a year ago. Subsequent audits have identified that the risk remains despite action plans drawn up for completion by ward managers after each quarterly audit cycle. Quarterly Controlled Drug audit results have been routinely reported at monthly senior nurse, Divisional quality meetings and the Medicines Management Committee (MMC), highlighting areas of non-compliance and recommendations regarding improvement.

Safe storage of medicines = Achieved
Weekly ward storage audits continue to be carried out in 32 wards and departments. The results are shared at the time of the audit with the ward manager. Furthermore, the monthly RAG rating report for each division is shared with ward managers and matrons. Percentage compliance remains relatively stable above 90% overall.

A monthly drug trolley audit commenced in February 2018 with compliance in March 2018 at 77%

Medicines Safety Thermometer = Partially achieved
A Medicines Safety Thermometer audit will be conducted on an annual basis each year. There are four key measures worthy of note. The overall results since data collection began showed that:

We performed better than the national average (between June 2014 and June 2017) in three categories:

- Proportion of patients with reconciliation started within 24 hours of admission
- Proportion of patients with a medicine allergy status documented
- Proportion of patients with an omission of a critical medicine in the last 24 hours

We performed worse than average in one category:

- Proportion of patients who have had an omitted dose in the past 24 hours

Prescribing Safety Thermometer = Partially achieved
The Prescribing safety Thermometer audit was undertaken for a local CQUIN directed at improving prescribing standards. The audit will now be completed on an annual basis. In April 2017, the insulin prescribing standards targets had been achieved. Although the saline flush prescribing standard and the warfarin prescribing standard targets had not been achieved the compliance with standards had improved since the start of the audit. Oxygen prescribing standard target remained consistent throughout the audit period at just over 93%

How the improvement will be sustained:

Safe storage of medicines
It is anticipated that the percentage compliance with the weekly ward storage audit standards will continue to remain above 90%. The key to sustaining improvement is good communication between pharmacy staff and ward managers in addressing medicine storage issues arising from weekly ward storage audit results. It is anticipated that percentage compliance with drug trolley audits will follow suit once routinely embedded.

Next steps:

Controlled Drugs (CD) Standards
It has been agreed by the Director of Pharmacy, the Medication Safety Officer and senior nursing colleagues that nursing staff will carry out a monthly CD self-audit with the pharmacy continuing to carry out the quarterly CD audit; this will ensure that nursing staff are identifying any issues in a timely way before the pharmacy quarterly audit is completed and will ensure that compliance rating is not solely based in the quarterly audit result. Furthermore, key messages regarding CD standards i.e. what staff are expected to achieve, will be attached to the front of each ward/department CD register.

Medicines Safety Thermometer
The Medicines Safety Thermometer audit is due to be revisited in June 2018 and the results will be reported to MMC and Medical Advisory Committee (MAC). In the meantime an omitted doses audit, using a template agreed at the West Midlands Medicines Safety Group, has been completed with the full report to follow shortly.

Reducing the rate of medication omissions is one of the actions on the Medicines Safety Group work plan for the next year.

Prescribing Safety Thermometer
The Prescribing Safety Thermometer audit is due to be revisited in May 2018 and the results will be reported to MMC and MAC.

Improving Prescribing of high risk medicines such as Warfarin, Insulin, Opiates is one of the actions on the Medicines Safety Group work plan for the next year.

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

Overview of performance / achievement of the priority:

While progress has been made in achieving this priority, we continue to work to implement best practice. With regards to deterioration and sepsis, training has continued for all clinical staff in the form of bespoke sessions and on the mandatory clinical update sessions. Audit for both Deterioration and Sepsis has continued throughout the year.

Sepsis – there continues to be difficulty in evidencing that antibiotics have been administered to the patient within 1 hour on the inpatient wards. Screening has improved however use of the sepsis bundle could be improved to evidence care given

Deterioration – work continues around timeliness of observation to improve and sustain

performance, documentation of escalation and treatment plan to be improved.
How the improvement will be sustained: Both deterioration and sepsis are audited monthly. • Sepsis is a national CQUIN and audited in line with national guidance which involves the auditing the records of 50 patients within A&E and 50 in patients with regards to Sepsis screening, antibiotic usage and review of antibiotics. • Deterioration is audited by reviewing all patients, in 1 week, who on their observations (pulse, blood pressure, temperature, respirations etc.) scored 5 or above on the early warning score which highlighted the need for a clinical review. Key elements such as timing of observations, escalations to medical staff and documentation of clinical review are audited.
Next steps: As the improvement priority has not yet been completed, these are the steps we will be taking to continue to implement best practice with monitoring by the Resuscitation Committee: • The West Midlands Quality Review Service (WMQRS) will undertake an audit of deterioration and Sepsis in September 2018 • Mandatory training to be reviewed regarding content and competence. • Continue to feedback results of audits and learning points through Resuscitation Committee and the Trust Management Board (TMB) • Learning points to be included in reports from incidents raised and investigated. • To learn from incidents that have 'gone well' using Quality improvement initiatives. • To review skills of nursing staff on base wards to include bladder catheterisation, ABGs, Competence to certify deaths which will relieve some of the low level tasks that out of hours services such as ACPs/outreach team are requested to do and hence releasing time to treat and manage the sickest patients. • To review Patient Group Directives (PGDs) across all wards, but specifically on the assessment areas allowing the nursing staff to administer the first antibiotics within the specified 60 minutes. • Trust wide re-education and training about the difference between the dying patients (who invariably deteriorates) versus the deteriorating patient. Support will be sought from the palliative team to improve education for clinicians so that they feel confident to make the distinction.

Priority 3: Complete the assessment of the Trust's compliance with Equality and Diversity System 2	Not achieved
Overview of performance / achievement of the priority: In October 2016 an Equality and Diversity Practitioner (RMB) was commissioned to undertake a review of Equality and Diversity provision across the Trust. The review included a progress map against key requirements, targets and indicators used to measure success or compliance with the Public Sector Equality Duty. The Trust has made some progress in embedding some of the actions arising from the review including a revised governance structure and the setting up of an Equality, Diversity and Inclusion Committee (EDIC) led by a Non-Executive Director. The RMB report also identified several clear opportunities for further development including the creation of an expert corporate role for equality and diversity across the Trust to help drive the agenda forward for patients. In July 2017 the Trust approved a jointly funded post with Dudley Group NHS Foundation Trust NHS as part of the Employers Diversity Partner Programme and following a recruitment process the post-	

holder commenced employment in November 2017 on a 12 month fixed term basis.

Completion of EDS2 and grading assessment remains a key and urgent priority. The Trust has already agreed to engage with patients and colleagues, utilising our internal data sources to identify a schedule of departments to 'deep dive'. There will be a key balance between identifying areas that require support and areas where we can learn from excellence. This work has somewhat stalled due to the workforce lead leaving the Trust. However in December, the Patient Equalities lead supported by the Head of Learning Development, attended by invite the West Midlands Ambulance Service (WMAS) EDS2 Grading event. WMAS is ranked as one of the leading NHS providers – outstanding in all fields for implementing and learning from EDS2. In attending the grading event WMAS has agreed to support the process here at Walsall in order for us to progress and complete this well overdue action.

How the improvement will be sustained:

The agreement to a fixed term post has enabled both Trusts to start to make progress on a number of shared priorities and benefit from work undertaken across both sites. In re-confirming the commitment made, the main focus of this work is to support the development of patient/service elements of equality work. This should enable us to evidence better engagement with those groups and establish key areas to improve service delivery; supporting a robust equality impact process and agree actions; and improve data collection on patients using our services.

Next steps:

EDS 2 deep dive is underway. Information collated will allow an initial and then final grading event to take place.

The Quality Commitment

The actions to achieve the 66 individual elements included in the Quality Commitment have been reviewed using confirm & challenge meetings with the Divisions which also tested progress with their own Divisional Level Quality Commitments.

The year-end position is provided overleaf.

As can be seen elsewhere in this and the CQC Inspection Report, progress has been made and the Quality Commitment has served a useful role in focussing activity. However, the ratings show that the timeliness or level of achievement has fallen behind where we ideally wanted to be.

The development of the Quality Commitment alongside the Integrated Improvement Plan is described in an earlier section of this report and will take place early in 2018/19. This will help to further evolve and effectively direct our improvement efforts in the coming years.

OUR QUALITY COMMITMENT

Provide safe, high quality care across all our services

PROMISES

- **Part of one team** working together with well-informed colleagues who understand each other's roles to deliver and improve services
- **Supported to meet our high standards** in a team that sets clear expectations, supports and challenges you to live up to them, is open and honest about what's going well and what's not and takes time to reflect and improve
- **Appreciated** by colleagues who value and respect them as individuals and recognise their efforts and achievements

- **In safe hands** of highly skilled, efficient, reassuringly professional teams providing first class joined-up care

- **Cared for** as an individual by kind and considerate people who involve you and your family in your care
- **Welcomed** by friendly, helpful and attentive staff who value your time

AIM

Provide Effective Care – Improve Patient Outcomes	Improve Safety – Reduce Harm	Care and Compassion – Improve Patient Experience
To deliver sustainable evidence based care/best practice and effective pathways and to improve clinician and patient reported outcomes	To reduce avoidable death and injury, to improve patient safety culture and leadership and to reduce the risk of error and adverse incidents	To listen, respond to and learn from patient feedback and as a result improve patient experience of care

17/18 PRIORITIES

	Clinical Effectiveness Committee / Trust Quality Executive	RAG
	Review and improve pathways of care:	
E1	- Improve pathway from ED -> AMU	Amber
E2	- At end of life - acute and community	Green
E3	- Paediatric pathways especially from ED -> Wards	Green
E4	- Step down critical care beds	Yellow
E5	- Normal Birth – reduce C-section/intervention rates	Red
E6	- Fractured Neck of Femur Pathway	Amber
E7	- Improve response times/delays – C-section and induction	Amber
E8	Implement actions to meet the National 7 day service clinical standard	Amber
	Embed monitoring and learning from:	
E9	- Mortality reviews and mortality alerts	Amber
E10	- Clinical incidents	Amber
E11	Improve process for responding to NICE technology appraisals and CAS alerts	Amber
E12	Introduce SAFER bundle	Amber
	Improve our elective care pathway:	
E13	- 18 weeks	Amber
E14	- Cancer	Green
E15	- OPD / Follow Up Back Log	Amber
E16	Establish a sustainable future for stroke services	Hatched
E17	Deploy mobile technology for community services	Green
E18	Development of integrated locality teams with partner agencies	Green
E19	Develop and introduce new roles within clinical workforce	Amber
E20	Improve medicines delivery system and therefore access to medications	Green
E21	Improving services for people with mental health needs who present to A&E	Green
E22	To set up and operate advice and guidance services for non-urgent GP referrals	Amber
E23	All first outpatient services to be available on NHS e-referral service	Amber
E24	Supporting proactive and safe discharge – Acute Providers	Amber

	Risk Management Committee / Trust Quality Executive	RAG
S1	Implement best practice standards around timely identification of patients with sepsis and utilisation of the sepsis bundle. *	Red
S2	- Including assessments of clinical antibiotic review between 24 – 72 hrs of patients with sepsis who are still inpatients at 72 hrs.	Green
S3	Implement best practice standards around acting on deterioration of patients – late observations, escalation & clinical review *	Amber
S4	Improve antibiotic stewardship and deliver planned reduction in antibiotic use.	Green
S5	Improve medicines safety standards	Amber
S6	- Hospital / community acquired pressure ulcers	Yellow
S7	- Hospital / community acquired falls	Yellow
S8	- Hospital / community acquired infection	Green
S9	- Hospital / community acquired VTE	Amber
S10	Embed compliance with DNACPR standards	Amber
S11	Ensure safe staffing levels measured using recognised acuity tools, capacity / demand modelling and national guidance.	Amber
S12	Conduct a bi-annual safety culture survey via MAPSAF	
S13	Ensure 'no harm' to patient waiting times in excess of accepted standards.	Amber
S14	Ensure staff are trained and have the right equipment to do their job.	Red
S15	Ensure maternity staffing meets acuity	Amber
S16	Deliver actions agreed from specialty risk summits – urology	Yellow
S17	Deliver actions agreed from specialty risk summits - respiratory	Green
S18	Embed new approach to incident investigation.	Green
S19	Use quality impact assessment to inform safety impact of transformation or savings programmes	Yellow
S20	Improve care/treatment on AMU	Amber
S21	Alcohol and Tobacco Screening and Brief Advice	Green
S22	Improving assessment of wounds which have failed to heal after 4 weeks	Green
S23	Improve neonatal critical care community outreach	Green

	Patient Experience Committee / Trust Quality Executive	RAG
	Deliver patient experience work plan including key thematic work streams:	
C1	- Response to inpatient survey – communication	
C2	- Improve customer care at front desks.	Amber
C3	- Reduce internal transfers	
C4	Improve FFT response rates to understand patient views	Amber
C5	- Inpatients	Green
C6	- Maternity	Amber
C7	- Emergency Department	Yellow
C8	Embed interpreter service and improve access to services	Green
C9	Ensure safeguarding vulnerable people's standards met	Yellow
C10	Ensure Duty of Candour standards are met	Amber
C11	Use equality impact assessment to ensure fairness of services	
C12	Embed public / patient engagement approaches	Amber
C13	Improve information for patients and relatives on admission and at discharge.	Amber
C14	Ensure patient access to food and fluids meets their individual needs	Yellow
C15	Complete assessment of Trust compliance with Equality & Diversity System 2 and plan action as a result. *	Green
C16	Develop division and care group patient experience improvement plans	Amber
C17	Dementia– increase use of screening tool	Red
C18	Personalised care and support planning for people with Long Term Conditions	Yellow
C19	Ensuring the needs for patients with learning disabilities are met by making appropriate and timely reasonable adjustments.	Amber

RAG	Key
Red	Significantly behind plan/not delivering expected standards
Amber	Behind plan and / or standards not quite met
Green	On plan / standards met
(blank)	Not commenced

Staff and Public Engagement / Communication

Supporting Work Programmes / Infrastructure

Quality System | Organisational learning, culture and leadership | Staff numbers, skills & competence | Audit & measurement | Systems & Processes | Service Improvement and transformation

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

2.3 – Patient Safety

Incident reporting

The aim of reporting incidents is to learn and improve the safety and effectiveness of the service we provide to our patients. Investigations into specific incidents help to identify the cause and patterns or trends in report to target reviews help to show where we need to look more deeply to understand what is happening. The reporting of incidents is encouraged to promote an open and transparent culture and maximise the opportunities for learning.

The Trust has an electronic incident management system to record incidents or near miss event. A high number of incidents reported reflect a good reporting culture. Incidents are reviewed: those which caused the least harm are looked at by the team where the event happened. The more serious incidents have a deeper level of investigation.

A total of **14,336** incidents *(including clinical, health and safety and non-clinical) were reported by Trust staff during 2017/18, representing a 5% increase on 2016/17.*

Actual Impact	Incidents Reported	
Near Miss	381	2.6%
No harm/minor harm	13608	95.0%
Moderate harm	304	2.1%
Major harm	37	0.2%
Catastrophic harm	6	0.1%
TOTAL	**14336**	

The low number of near misses reported is likely to be caused by the design of the system we use to record incidents. Near misses have a separate form but this is not well used and near misses are frequently reported as no harm incidents.

The Trust is in the top 25% of reporters of patient safety incidents when compared with similar Trusts reporting to the National Reporting and Learning System (NRLS) and was the second highest reporting trust in the report published for the six month period ending in September 2017

The most frequently reported patient safety incidents were associated with

- Non-pressure ulcer wounds sustained during WHT care, including skin tears and impact injuries
- Patient falls
- Medication Errors
- Staffing
- Pressure Ulcers acquired whilst receiving WHT care
- Health Records

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

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

Serious Incidents

A Serious Incident is an event that has caused serious harm. This is when the harm is life changing or may even be the unexpected or unexplained death of a person. We consider each case very carefully.

The three clinical Divisions hold a Safety Huddle each week to review incidents. Any incidents that have, or may have caused significant harm are taken to the weekly Serious Incident Meeting to decide whether it is a serious incident, the level of investigation required, the lines of enquiry to follow, the investigation lead and checks whether the Duty of Candour has commenced.

This not only helps to identify serious incidents but also where to target our investigation resources to maximise learning opportunities.

The team selected to review the incident includes an investigator from a specialty not involved in delivering the care. The areas to investigate are determined from an initial case review to target efforts. Information is drawn from medical records, staff accounts and comparison between what happened and what should have happened. The aim of the review is to learn and reduce the risk of a similar incident occurring again so the recommendations are developed with this in mind.

The management team responsible for the area where the incident occurred develop actions based on the recommendations and are responsible for their implementation and testing whether they have been effective.

A total of **167** Serious Incidents occurred in 2017/18, compared with 135 in 2016/17.

This increase is attributable to the local agreement made with the CCG to report unstageable pressure damage (with effect from April 2017), as a Serious Incident.

Serious Incident Category	Total
Pressure ulcer meeting SI criteria	98
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	14
HCAI/Infection control incident meeting SI criteria	11
Slips/trips/falls meeting SI criteria	11
Treatment delay meeting SI criteria	11
Sub-optimal care of the deteriorating patient meeting SI criteria	6
Surgical/invasive procedure incident meeting SI criteria	5
Confidential information leak/information governance breach meeting SI criteria	3
Abuse/alleged abuse of child patient by third party	1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1
Adverse media coverage or public concern about the organisation or the wider NHS	1
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	1
Maternity/Obstetric incident meeting SI criteria: mother only	1
Medication incident meeting SI criteria	1
Screening issues meeting SI criteria	1
TOTAL SI'S REPORTED	**167**

Pressure Ulcers acquired in hospitals continues to be the highest reported category of Serious Incident during 2017/18 and 98 incidents were reported compared to 64 incidents during 2016/17. Benchmarking will be undertaken to determine comparison of pressure ulcer reporting against other organisations in 2018/19 but a comparison with other Trusts shows very wide variations in the categories and numbers of SIs reported in the West Midlands.

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

- Revision and implementation of the Consent policy and the provision of an information leaflet (EIDO) handed to the patient pre-operatively for both single and dual procedures.
- Senior Sisters notify the staffing hub when expected staffing levels are impacted at low levels.
- Revision of the Electronic Foetal monitoring policy to include full implementation of NICE guidance.
- Extensive audit programme effected to ensure paediatric patients were appropriately vaccinated
- MDT preparation and management has been incorporated into radiologists workload.
- Standard Operating Procedures for the receipt of internal referrals has been implemented and is utilised by the medical secretaries for outpatient scheduling.
- Reinforcement and adherence to the surgical handbook has been undertaken within the General Surgery specialty.
- Revision of the VTE policy has been updated to reflect current guidelines and VTE has been incorporated into the Vitalpak system
- Task and finish group for Sepsis/Deteriorating patient is scheduled and takes place on a monthly basis.
- Establishment of an error and discrepancy monitoring panel to review Consultant Radiologists activity.
- Consultants' and their respective secretaries now receive red flag imaging notifications
- A live dashboard has been activated to identify patients who should have received follow-up appointments on a daily basis and any outstanding status.
- Development of an acute neurology pathway for AMU
- Standard operating procedures have been implemented in relation to the processes for posting external and confidential mail.
- The processes for transporting patient information within the community have been strengthened

Never Events

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

We have reported 3 Never Events in 2017/18 in the categories listed below. Two investigations have concluded with one in progress during the production of this account.

Never Event Category	Root cause / contributory factors	Principal actions taken
Retained foreign object post procedure (Maternity)	There was a lack of clarity of roles and responsibilities pre and post procedure for perineal trauma; re: the counting and documentation of swabs, needles and instruments.	• Removal of all small swabs from Delivery suite with immediate effect. • Liaison with BadgerNet lead and IT software providers to review documentation for swabs on electronic system as a priority • Review of all equipment packs utilised for delivery suite to ensure appropriate equipment is in place. • Immediate safety checklist has been implemented in the interim.
Wrong route administration of medication (Maternity)	a) Lack of physical barrier(s) to prevent the connection of an epidural into the wrong port and identification thereafter. b) Failure to follow Trust guidelines and policies for the establishment and management of epidural analgesia in labour	• All clinical staff working within maternity has been provided with information on the incident with a reminder to be vigilant following the siting of epidurals. • Currently investigating the equipment used for the use of epidural analgesia and revision of the trust guideline for siting of epidurals.
Wrong site surgery (Gynaecology)	Investigation in progress	• Immediate actions to protect patients from harm have been taken while the investigation is in progress.

Prevention of Future Deaths Reports - Section 28 of the Coroner's Act

Coroners have a duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. This includes Hospital Death (Clinical Procedures and medical management) related deaths.

The Black Country Coroner issued the Trust with two Prevention of Future Deaths reports in 2017/18. These are described below along with the actions we have taken. Further details can be found on the Coroner's website:

Coroner's Concerns	Recommendations	Principal actions taken
A missed opportunity and failure by the Radiologist to assess a scan which would have resulted in further investigation of the "mass" that was identified. Failure to note a fracture from the x-ray during the admission.	In relation to the failure to note the scan results, you may consider re-visiting your procedures and systems to ensure that this is not replicated as part of your internal serious incident investigation of the "mass" that was identified	The red flag system to alert staff to abnormal scan results and the order in which records are presented in the system to Radiologists has been reviewed and staff trained. The system for imaging discrepancy and error rate monitoring has been reviewed to ensure they are in accordance with Royal College guidelines and identify individual training issues which require further support
Failures to properly implement sufficient training for staff during the introduction of a new IT system (Lorenzo). This resulted in the premature closing of her access plan and effectively no further review.	You may wish to consider further reviewing the systems in place to ensure that all relevant patients identified during the relevant period have been identified and further treatment offered as needed. In addition you may wish to review that this IT system change did not result in any other patients across the Trust having their cases closed prematurely.	The initial review of patients identified a small number who were contacted and recalled for review. No significant harm has occurred to them. The wider system issue continues to be explored and will be reported to the Coroner before the May 2018 deadline.

Duty of Candour

The Duty of Candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong.

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

We also monitor the initiation of the Duty through the weekly Safety Huddles and Serious Incident meeting and measure compliance with the process by logging when patients are informed and letters and reports are provided to them. We are currently trialling an integrated information form and notification to simplify the process.

The report from the CQC inspection in June 2015 recorded that staff demonstrated a good understanding of the principles of being open and transparent with patients, when it should be applied and the process for doing so, with the exception of Maternity staff. Remedial action has been taken in this service to ensure that staff do understand and apply the process and this is supported by the Division's weekly Safety Huddle which monitors incidents and the application of the Duty.

Clinical Claims

The Trust in the financial year 2017-2018 reported 59 clinical negligence claims to NHS Resolution (NHSR), an increase of 6 claims on the last financial year. In 2017-18, NHSR, on behalf of the Trust, settled 67 claims.

Further detail on the Trust's claims history can be obtained via the NHLA (NHS Resolution) website www.resolution.nhs.uk

The Trust adopts a 'lessons learned' approach to the handling of clinical negligence claims. During 2017/18, Litigation Forums in Trauma & Orthopaedics, Accident & Emergency, General Surgery and Obstetrics met to analyse trends in claims received, identify areas of potential risk in individual cases and drive improvement work. These forums work on a peer review basis. We have noted that improvement programmes have resulted in a reduction in claims in the following areas:

- Complications associated with bariatric surgery
- Retained products of conception following birth
- Claims associated with consent
- Claims involving delayed diagnosis of fractures

We have also identified areas for improvement during 2018/19:

- Inpatient Falls
- Hand injuries
- Upper limb surgery
- Delay/failure to follow up'

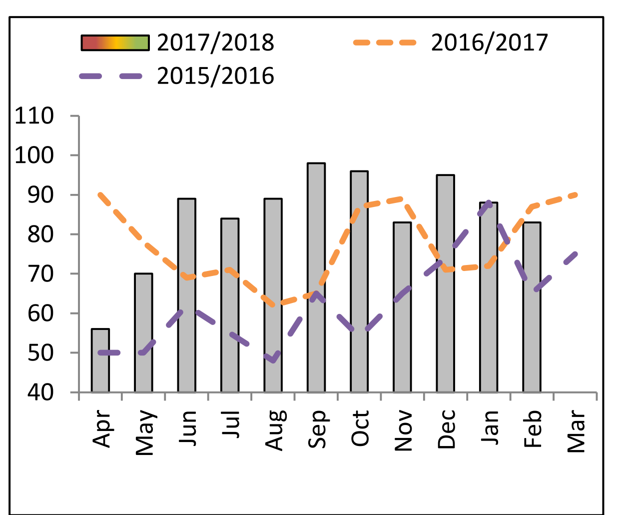
Patient Falls in hospital

Patient falls are the cause of a significant numbers of injuries and death in hospitals. With the exception of a spike in falls recorded in September 2017 Walsall Healthcare has a falls rate which remains consistently lower that the national rate of 6.63 falls for 1000 occupied bed days and so has a lower rate of falls than similar Trusts.

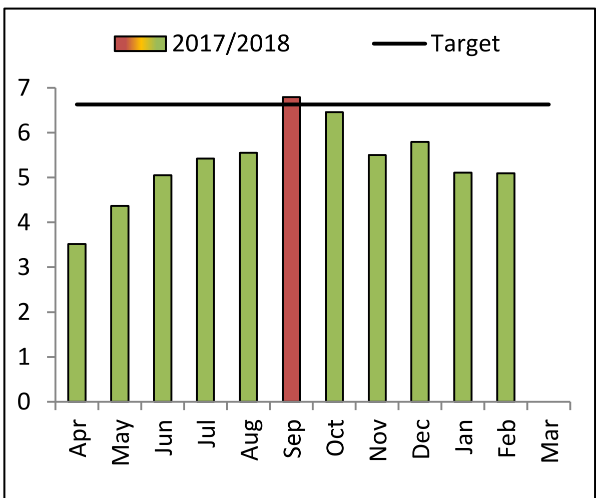
All falls causing injury are investigated and reviewed in the Falls Surveillance Group which includes a member of the Quality Team from Walsall CCG. The Trust has reinvigorated the Falls Steering Group which has representation from both the Acute Hospital and Community Services and has defined workstreams. NICE guidance has been implemented across the Trust which has resulted in a change to how patients are assessed for Falls risk and falls prevention.

	Total Falls Reported			Falls – Rate per 1000 bed days		
Month	2015/2016	2016/2017	2017/2018	2015/2016	2016/2017	2017/2018
April	50	90	56	2.77	5.13	3.52
May	50	78	70	2.88	5.03	4.36
June	62	69	89	3.75	3.87	5.05
July	55	71	84	3.11	4.24	5.42
August	48	62	89	3.15	3.63	5.55
September	65	65	98	3.87	4.12	6.80
October	54	87	96	3.06	5.11	6.46
November	65	89	83	3.77	5.42	5.50
December	74	71	95	4.08	3.94	5.79
January	88	72	88	5.02	4.19	5.11
February	65	87	83	3.72	5.41	5.10
March	75	90		4.33	5.28	

Patient falls in hospital 2017/18



Falls – Rate per 1000 bed days 2017/18



Pressure ulcers

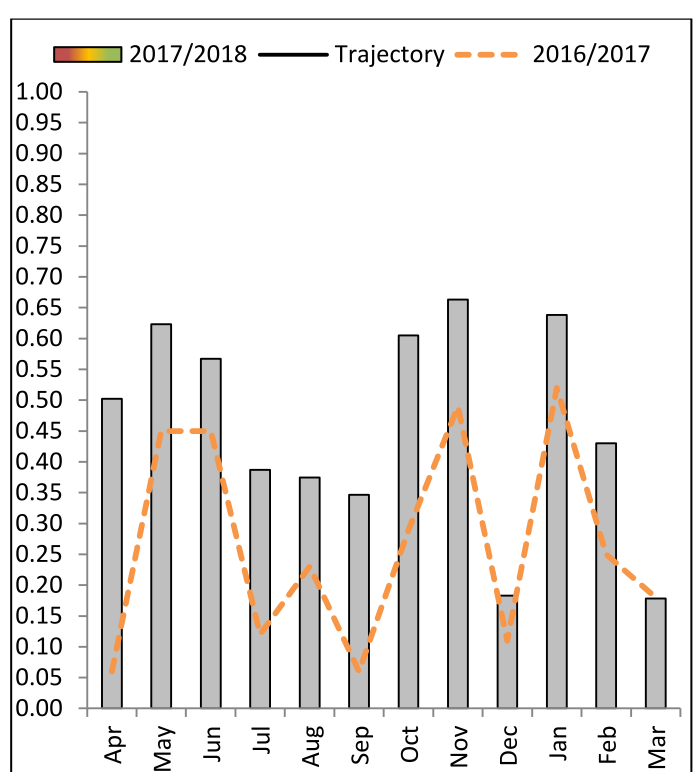
Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time. They're most common on bony parts of the body, such as the heels, elbows, hips and base of the spine. They often develop gradually, but can sometimes form in a few hours

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

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

- Following the review of hospital mattresses in 2016/17 the Trust has invested in new higher specification base mattresses which has resulted in the development of a new process for the ordering of air mattresses.
- Competencies have now been agreed and Tissue Viability are progressing with assessment of community wound care link nurses
- The Nursing Admission document & comfort rounds are undergoing alteration and plan to include the new proposed SKIN bundle form. The Pressure Ulcer Prevention pack will incorporate Waterlow/ SKIN bundle and patient information in one document, which will form part of the admission document.

	Pressure Ulcers - Avoidable Rate per 1000 bed days (cat 2, 3, 4 & Unstageable)	
Month	**2016/2017**	**2017/2018**
April	0.06	0.5
May	0.45	0.62
June	0.45	0.57
July	0.12	0.39
August	0.23	0.37
September	0.06	0.35
October	0.29	0.61
November	0.49	0.66
December	0.11	0.18
January	0.52	0.64
February	0.25	0.43
March	0.18	0.18



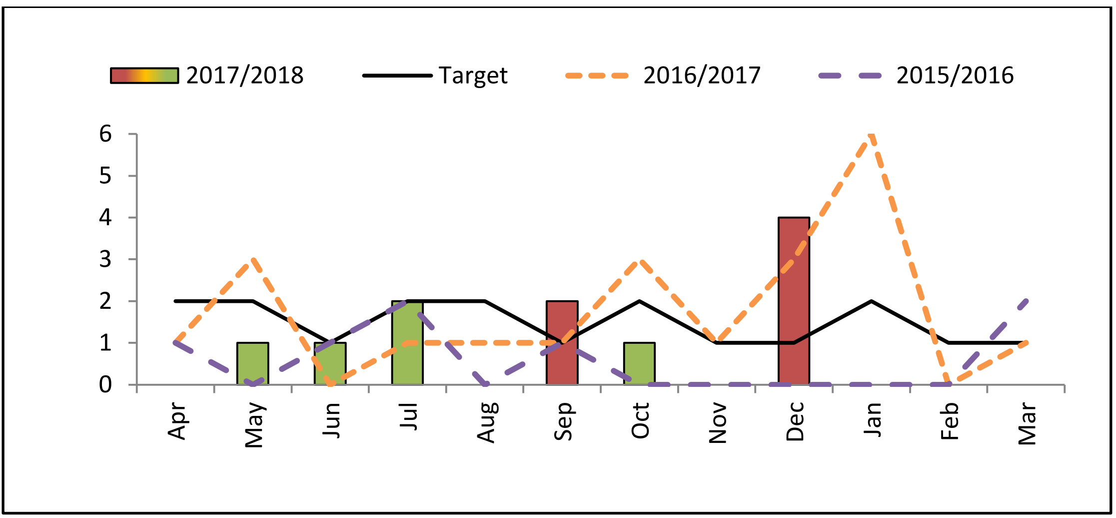
Infection Control

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

c. Difficile

C. Diff rates per 100,000 bed-days				
	2014-15	2015-16	2016-17	2017-18
Trust attributed	16	7	21	11
Total bed days	169384	169544	167564	159179
Rate per 100,000 bed days for specimens taken from patients aged two years and over	9.4	4.1	12.5	6.9
National Average	15	15	13 * (National published figures published before Q4 16/17 available hence used Q4 15/16 as a proxy)	Not available

In 2017/18 the number of cases of patients with C.Diff reduced to 11, against a target of 18 for the year. Every case has been reviewed. We found that 5 cases that were deemed unavoidable. This means that the care that the person received during their stay could not have prevented this infection, nor would different care have changed that.



The Infection Control Team initiated a daily review of our admissions areas in 2016/17 to identify patients who present with an increased risk of infection and take earlier action to treat patients at risk. This has led to early intervention and helped to reduce the number of cases this year. An important factor is staff following the basics of infection control so continuing education and audit of practice remains a priority.

MRSA Bacteramias

We have not had any cases of MRSA bacteraemia (blood stream infections) assigned to the Trust in 2017/18, making it over two years since our last case.

There was one case in the wider community in Walsall and this was deemed unavoidable due to the patients underlying condition.

The maintenance and improvement of infection control practice to prevent cases continues and includes screening all our admitted patients for MRSA carriage on admission and the safe use of devices such as cannulas and urinary catheters.

Safeguarding – Adults and Children

The Trust has a statutory duty under both Section 11 of the Children Act 2004 and the legal framework created within the Care Act 2014 to ensure that arrangements are in place to ensure that the Trust, and all staff working within it, have regard to the need to safeguard and promote the welfare of children, young people and adults at risk. The Trust reports to both the Walsall Safeguarding Children's Board and Walsall Safeguarding Adults Board. The Trust continues to have representation on all sub-groups of both Adult and Children Safeguarding Boards.

The Trust also has responsibility for monitoring the health of Looked After Children within Walsall and provides support and Health Assessments to our population of children who are in care. The Trust continues to provide the Health representation within the Multi-Agency Safeguarding Hub (MASH) where we work together with our partners to make decisions to ensure the safety of children in Walsall. The success of the MASH has seen a significant rise in the number of appropriate referrals it receives.

Safeguarding Adult and Children training has been challenging for the organisation, the Trust has ensured that there are enough training spaces to ensure staff are compliant and have developed a system of automatically booking staff onto sessions to ensure they remain green for compliance. PREVENT training continues and whilst there has been a marked improvement the Trust is still not 85% compliant as per NHS England's trajectory.

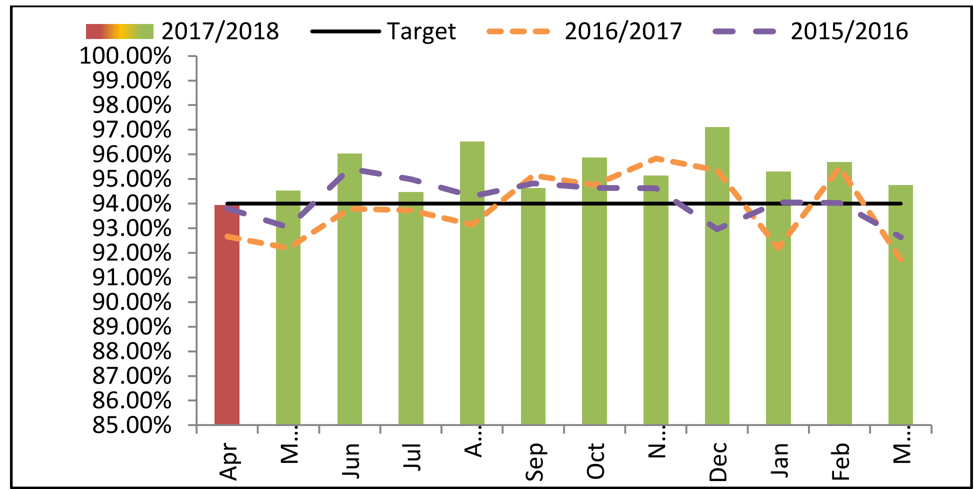
Safety Thermometer

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

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

An internal target of 94% Harm Free Care was set which has continually been achieved since May 2017

Graph showing Safety Thermometer performance for the last three years



Venous Thromboembolism (VTE)

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

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

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

The VTE indicator was qualified in the 2017/18 Quality Account as our external auditors found that the indicator reporting the percentage of patient's risk assessed for VTE did not meet the accuracy, validity and reliability dimensions of data quality set out in the Audit Guidance. An action plan was subsequently developed to address these issues raised.

The Trust aims to achieve as a minimum, the national quality requirement of assessing 95% of patients who were admitted to hospital for the risk of VTE. The trust has previously struggled to meet the requirement but did so in March 2017/18 and we intend to maintain this performance.

To improve measurement and support an improved performance, the Trust has developed two IT systems for assessing and recording VTE assessment: the Vitalpac system in all adult wards and Badgernet within maternity services. A single process has now been implemented for the collection and reporting of data through the IT systems negating the need for scrutiny of the patient record.

To support this transition the VTE policy was also reviewed, robust training was implemented, revised patient information leaflets were developed and revised reporting governance was implemented.

During the period April 2017 to March 2018 the overall Trust performance has improved from 80.34% to 93.53%.

We have acknowledged the concerns raised in the CQC inspection report and the CCG Performance Contract Notice relating to Standard SC22 regarding the continued failure to achieve the quality performance indicator.

The action plan has been developed further to mitigate any risk to patients and assure future performance. This includes the following:

- Performance monitoring - The provision of VTE assessment performance reports to senior clinical managers on a daily basis and weekly to Clinical Directors, Consultants and Ward Sisters for them to manage performance.
- Accountability - Improved accountability by including VTE performance in the divisional quarterly reviews as part of the Divisional Accountability Framework
- Training - The provision of training on the VTE assessment and IT systems for new medical staff and others to ensure the process is understood and recorded accurately
- Provision of a dedicated resource of a senior nurse to embed the SOP, identify and resolve barriers in system and process
- Responding to thrombosis - Implement a more robust process for monitoring, recording and reviewing reported hospital acquired thrombosis.
- Audit - Undertake biannual audits to assure appropriate prophylaxis is prescribed and administered

The Trust has stated that the national standard will be achieved and sustained by the end of June 2018.

Freedom to Speak Up Guardians

The Francis reviews into care at Mid Staffordshire Hospitals made a number of recommendations to deliver a more consistent approach to whistleblowing and freedom for staff to speak up across the NHS and the report identified the Freedom to Speak Up Guardian as an important role. All NHS trusts and NHS foundation Trusts are required by the NHS contract (2016/17) to nominate a Freedom to Speak Up Guardian.

We appointed three members of staff to undertake this local guardian role. A Transparency and Openness Steering group was created to assist the Guardians and a set of actions developed. An early review of the 95 concerns raised with the Guardians between November 2016 and May 2017 showed that the 45% of the concerns were related to patient safety with 28% related to attitudes and behaviours of colleagues, which can have a detrimental effect on morale and the safety culture.

One year on from their appointment, the role of the Freedom to Speak Up Guardians is being reviewed to learn from experience and improve the service provided.

Sign up to Safety

In 2014, Sign up to Safety was launched to bring organisations together behind a common purpose; to create the conditions for making care safer. Led by the Divisional Quality Governance Teams, the Trust has been an active participant in the campaign helping to improve our patient safety culture.

In addition to the work to improve care described in this report, including, preventing patient falls and pressure ulcers, the avoidance of venous thrombosis (VTE) detecting and quickly treating patients whose condition is deteriorating, including from sepsis. Further improvements involved improving the way in which we consent patients for treatment to better describe the risks, benefits and options available so a better informed choice can be made. We continue to reach out to colleagues to improve the understanding of how to learn to improve safety and encourage local action to do so. During 2017/18 the following have been in place:

- Risk Roadshows – The Divisional Quality Governance Teams visit wards and departments to have a conversation about incidents, actions, the Duty of Candour and learning from other incidents
- Patient Safety Kitchen Table events – where else would you feel safe and have truly open and honest conversation without judgement? The teams hold several events a year to have an open discussion about patient safety with clinical colleagues
- Divisional Safety Huddles - Led by the Divisional Directors, new incidents are reviewed every week so that immediate actions can be taken to prevent further harm, previous actions are followed up and learning from investigations is shared.
- Sharing the results of incident investigations at ward level to improve local engagement and learning
- Risk Register Reviews - building on the foundations set out when we the risk register was transferred from paper documents to electronic database. The Divisional Governance Teams continue to actively work at department, Care Group and Divisional levels with check & challenges to test risk management and advise on when to escalate risks for higher level management.

2.4 - Clinical Effectiveness

Mortality Review

To learn from a review of the care of patients who have died, the Trust uses the standardised method for reviewing patient records, introduced by the National Mortality Case Record Review Programme in conjunction with the Royal College of Physicians (RCP). A senior clinician has been identified as the lead for mortality and specialty leads have been nominated. The RCP training programme for clinicians reviewing patient records using this tool has commenced.

Learning from deaths

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards “from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals”. This was further reinforced In December 2016 when the Care Quality Commission published its review Learning Candour and Accountability. A review of the way NHS trusts review and investigate deaths of patients in England. In response, the Secretary of State accepted the reports’ recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die.

In March 2017 the National Quality Board, NQB, released National Guidance on Learning from Deaths as a national endeavour to initiate a standard response.

This Trust is committed to responding to the guidelines and In response to the national guidelines the trust developed the Learning from Deaths Policy as per the guidelines in October 2017. The policy sets out the approach and standards the Trust will implement to align to the national recommendations to ensure deaths are reviewed in a structured manner. This policy also describes how relatives and carers are involved in reviews appropriately, problems in care or process that may have contributed to a death are identified, lessons are learnt actions are taken, shared learning takes place and systems, practices and processes are changed to reduce the risk of premature death. Findings from the reviews of deaths, lessons learnt and actions taken will be shared at public forums to demonstrate appropriate governance, transparency, acknowledgement and action for issues that may have contributed to a patient death.

During the period 2017 - 2018 the Trust commenced a programme of work to implement the NQB guidelines to include a governance process, reviewing deaths, identifying lessons learnt, developing action plans and reporting performance and finding internally and externally to the organisation. The processes have incorporated the national safeguard framework to ensure duty of candour and appropriate serious incident and root cause analysis process have been utilised.

The processes and systems currently in place strive to review all deaths using the Royal College of Physicians, RCP, Structured Judgement Review (SJR), process for a cohort of patients each month determined by using a set of triggers identified from the NQB guidelines. This process was launched in June 2017 and further developed during the year following a group of clinicians undertaking the RCP training in the use of the SJR approach and the launch of the Trust learning from death policy. The deaths are reviewed by the clinical teams to determine any issues in care or process that may have contributed to the

patient death. Any issues that are identified as contributing to poor care are reported via the Trust's incident reporting system and managed to determine cause, lessons learnt and actions.

Similarly, in addition to the learning from death process any deaths reported to the Coroner are managed via the serious incident reporting system and acknowledge coronial recommendations and the development of action plans to address preventing future death notifications.

We will continue to develop and embed governance and learning processes in respect of being owned and driven by the clinical teams. We will also continue to develop processes to strengthen the bereavement services available for relatives and carers and implement the role of the Medical Examiner as per the Department of Health proposals to support in a wider system approach to learning from death and supporting bereaved relatives and carers.

- *The mandatory statement required by NHS England on learning from deaths is provided in the appendix.*

Mortality rates - HSMR and SHMI

The Hospital Standardised Mortality Ratio (HSMR) is a ratio of the number of in-hospital deaths to the expected number of in-hospital deaths. The performance of the trust is referenced against a national ratio of 100.

The Summary Hospital-level Mortality Indicator (SHMI) is similar but includes patients who die up to 30 days after being discharged from the Trust
For both measures, a number less than 100 indicated that there have been fewer deaths than expected.
The Trust performance against the two key national indicators for mortality Hospital Standardised Mortality Rate and Standardised Hospital Mortality Index has been variable during the year 2017/18.

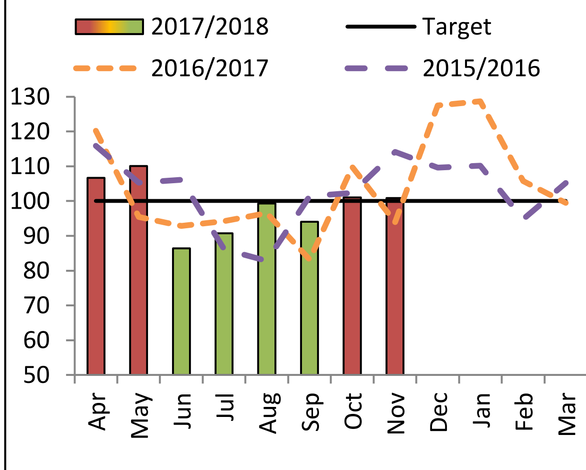
The latest available figures show that for the year to date

- HSMR October 2017 92.68
- SHMI September 2017 97.22

HSMR Performance 2016-2017

2017/2018
Target
2016/2017
2015/2016
130
120
110
100
90
80
70
60
50
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

SHMI Performance 2016-2017



NICE Guidance

Every piece of guidance published by the National Institute for Health and Care Excellence (NICE) is assessed for its potential relevance to this Trust and senior clinicians asked to determine whether the Trust is compliant, the guidance does not apply or we are not compliant and so need to take action to do so.

Our overall response rate of from clinicians for their reviews of compliance is 100% for 2017/18.

Technology appraisals (TA) must be implemented within three months of publication. The majority of TAs relate to the use of drugs. Our commissioners assist in the funding of these drugs in advance of the TA being published and the drug is made available within the three month period so the legal requirement is met.

The results simply show the clinician's response, which we aim to improve in 2018/19 by creating Clinical Effective Leads in each of our Care Groups, overseen by the Clinical Effectiveness Committee and responsible for the management of the review and response for NICE guidance and the Clinical Audit Programme which is used to test the ongoing compliance with a selection of NICE guidance each year.

7 day services – progress

The NHS England paper "Everyone Counts" was published in December 2012. The Seven Day Service Forum was established in response and focussed in the first stage of its work on the variations in outcomes for patient admitted as emergencies over weekends and particularly, mortality, length of stay in hospital, readmissions to hospital and patient experience. Ten clinical standards were developed to describe the standards of emergency care that patients should expect to receive 7 days per week.
Four of these clinical standards are considered to have the greatest impact on the quality of care patients receive.

2. Time to first consultant review
5. Availability of diagnostics
6. Consultant led interventions
8. On-going consultant review

The Trust is working towards delivery of these standards by April 2020. With a tolerance of 95% achievement for all patients admitted as an emergency.
The Trust participated in the NHSE 7 Day survey in 2017 relating specifically to Standard 2.

The table below shows progress for standards 2 and 8.

	Survey		
	September 2016	**March 2017**	**September 2017**
2. Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	62%	79%	79%
8. Proportion of patients seen every 24 hours		88%	

A further self-assessment of all 4 standards will be undertaken during March and April 2018.

We have assessed the results to understand what we need to do to achieve these standards. The delivery of 7 day services does not stand on its own, it is integral to service strategies such as stroke care and will require some reconfiguration and redesign of the way in which we, and the wider health community, deliver care. This will include supporting ongoing consultant review in medical wards outside the Acute Medical Unit, direct admissions to Cardiology and the “Walsall Together” initiative which integrates community based services.

2.5 Patient Experience

During 2017-2018 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:

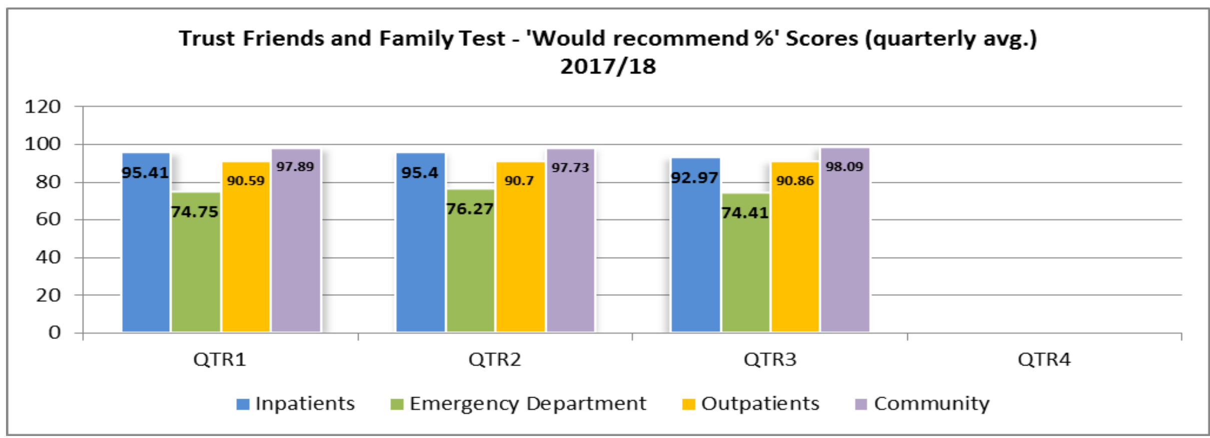
> *"How likely are you to recommend our wards/emergency department/services to friends and family if they needed similar care and treatment".*

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. We continually 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 2017-2018

During 2017-2018 the Trust received **??** FFT responses from patients about their experience of access care and treatment across acute and community services.

The charts below show FFT results for positive recommendation percentages for the FFT for inpatients, A&E, outpatients and community services in 2017-2018:



The **Community Service** recommendation score of 98% (quarter avg.) was ranked high nationally. Currently, most of the Trust's Community services conduct FFT only once a month using paper surveys. Use of 'Badgernet' devices for online FFT surveys has been

agreed in principle with phased roll out proposed from April 2018. This will facilitate wider coverage and real time feedback collection/reporting.

Benchmark comparisons

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

The emergency department recommendation scores continue to trail the national average by about 10%.

FFT Recommendations Score Comparison with National Data		
Clinical Area	National Average	Walsall Healthcare Trust
Inpatients	96%	94%
Emergency Department	86%	76%
Outpatients	94%	91%

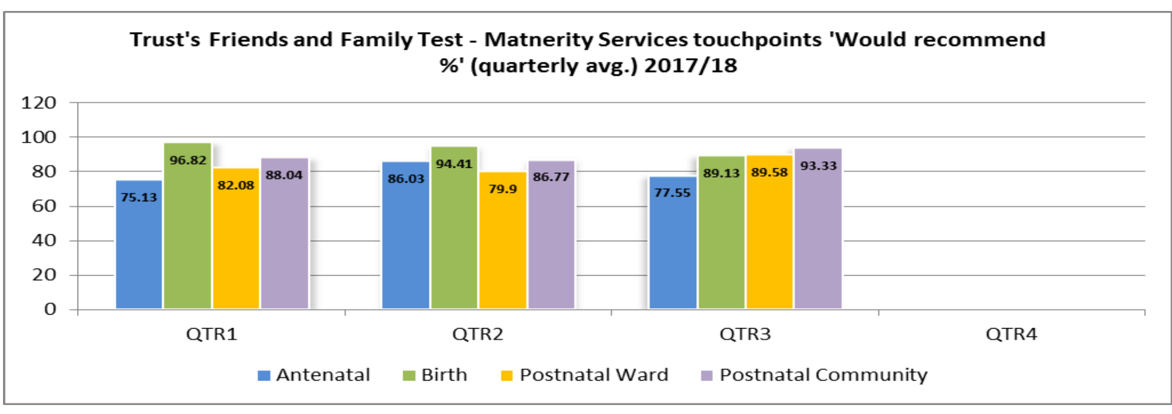
Improvement Actions:

- All wards and departments display their FFT results on a weekly basis.
- The inpatients response rates (receiving feedback) have been consistently high compared to national average.
- IPAD pilot on four wards was successful in significantly increasing the response rate on the inpatient wards. Other wards are actively exploring funding options to roll this out on their areas.
- All Divisions have action plans aimed at improving both FFT response rates and positive recommendation scores through responding to patient feedback from the FFT.
- Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night. A wider campaign was agreed and implementation is planned for May/June 2018.
- Volunteer support has increased across the wards to assist with mealtimes, patient visiting and dementia tea parties.
- Joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time.
- Piloted the Observe & Act Tool which paves the way for using lay members to identify and co-produce service improvements.

FFT Maternity Services

The chart below show FFT results for positive recommendation percentages for the FFT for maternity services in 2017-2018.

All maternity touchpoints which includes antenatal, birth, postnatal ward and postnatal community improved their recommendation score over the year. Response rates still remain low.



Maternity FFT Recommendations Score Comparison with National Data		
Clinical Area	National Average	Walsall Healthcare Trust
Antenatal	97%	83%
Birth	97%	95%
Postnatal ward	95%	91%
Postnatal community	98%	97%

In relation to national comparisons the antenatal FFT trails behind the national average by more than 15% while the FFT for birth trails behind by about 6%.

Improvement Actions:

- Whose Shoes event held where a number of pledges have been made by a range of staff to continue to improve the patient experience.
- Proactive Maternity Voices Partnership Group

Patient Surveys

The results of the national surveys are included in the Patient Care Improvement Plans for individual service areas and reported divisionally and at Trust Quality Executive and Trust Patient Experience Group. The performance of Walsall Healthcare NHS Trust in relation to the National Patient Surveys published in 2017 are outlined below.

National Emergency Department Survey 2016
(CQC reports published in October 2017)

The CQC 2016 National Emergency Department Survey covered patients seen in September 2016. The results were published in October 2017.

A total of 1250 questionnaires were sent and 293 completed surveys were returned, giving the Trust a response rate of 24%. The overall national response rate was 27%.

33 questions showed no significant change in score since the 2014 survey.

The questions where the Trust was in the ‘worse’ than most other NHS Trusts category related to patients:

- Feeling they had enough time to discuss their health or medical problem with a doctor or nurse
- Feeling that the doctor or nurse explained their condition and treatment in a way they could understand
- Feeling that the doctor or nurse listened to what they had to say
- Feeling that the doctor or nurse discussed any anxieties or fears they had about their condition or treatment
- Feeling that staff explained the reasons for tests in a way they could understand
- Describing the emergency department as clean
- Being able to access suitable food and drink if they wanted to
- Being treated with respect and dignity

National Emergency Department Survey 2016	**Compared with other trusts**
N/A	Better
• Time to talk for feeling hey had enough time to discuss their health or medical problem with a doctor or nurse • Clear explanations for feeling the doctor or nurse explained their condition and treatment in a way they could understand • Being listened to for feeling the doctor or nurse listened to what they had to say • Discussing anxieties or fears for feeling the doctor or nurse discussed any anxieties or fears they had about their condition or treatment • Information for being given the right amount of information about their condition or treatment • Privacy for being given enough privacy during examinations and treatment • Explanations about tests for feeling that staff explained the reasons for tests in a way they could understand • Cleanliness for describing the emergency department as clean • Access to food and drink for being able to access suitable food and drink, if they wanted to • Information about resuming usual activities for staff explaining when they could resume their usual activities • Contact information for being told who to contact if they were worries about their condition or treatment after leaving • Respect and dignity • For being treated with respect and dignity	Worse
All other questions	About the same

2017 National Maternity Survey Results

(CQC reports published in January 2018)

Mothers who gave birth at Walsall Healthcare NHS Trust during January and February 2017 took part in the 2017 CQC Maternity Survey to give feedback about their experiences of care and treatment they received. A total of 300 surveys were posted and there was a 31% response rate (92 responses). The results were published in January 2018.

Generally, the results showed that the Trust performed 'about the same' on most of the questions when benchmarked against other Trusts nationally. The only question that put us as 'worse' in the comparisons were related to skin to skin contact with the baby shortly after the birth..

On comparison with our 2015 Maternity Survey results, the 2017 Survey showed that we improved in 73% of the questions and there was a slight decline in performance in 27% of the questions. Provision of information to mothers on their own physical recovery after the birth was significantly improved when compared to our 2015 survey results. Our score for the question about any concerns raised during labour and birth being taken seriously remained unchanged from the last survey.

2017 National Maternity Survey Results	Compared with other trusts
N/A	Better
• Skin to skin contact Having skin to skin contact with the baby shortly after birth	Worse
All other questions	About the same

National Children & Young People Survey Results 2016

(CQC reports published in November 2017)

This CQC National Children and Young Peoples Inpatient/Daycase Survey 2016 covered patients who were discharged during November and December 2016. The results were published in November 2017.

There were three version of the questionnaire:

- For children aged 0-7yr olds (answered by parents/carers of children only)
- The other two being questionnaires 8-12yrs and 12-15 yrs (both answered by parents/carers and children).

With 147 completed surveys returned, the Trust had a response rate of 21%.

Compared with the Trust's 2014 survey, the 2016 survey showed no change in overall scores for 40 questions. There were no questions with significantly better or worse scores. The Trust did score better than most Trusts for parents and carers being able to access hot drinks when in hospital.

- The Paediatric healthcare app, co-produced with patients, parents/guardians and staff members, was launched to improve experience of patients and their families when using hospital services. This app won a national award for innovative use of technology at the Patient Experience National Awards.

National Children and Young Peoples Inpatient/Daycase Survey 2016	Compared with other trusts
• Access to hot drinks for parents and carers being able to access hot drinks when in hospital	Better
N/A	Worse
All other questions	About the same

National Cancer Survey Results 2016
(CQC reports published in July 2017)

The responses received for the survey was 250 completed responses from an adjusted sample of 378. This is a 66% response rate (comparing favourable against a national response rate of 67%. The results were published in July 2017.

There were no statistically significant changes (either improvement or deterioration) for any questions between 2015 and 2016.

Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.5

- 1 Question continues to score above expected range
- 8 Questions score below expected range
- 43 Questions score within expected range:
  5 questions score above national average
- 5 questions equal to national average
- 33 questions below national average

Areas for further consideration and potential improvement include:

- Staff Attitude and Communication Skills
- Information giving, especially related to test results and efficacy of treatment
- Keeping patients updated and management of patient expectations
- Time keeping and organisation of clinics and day case treatment
- Support for patients during and after treatment; including Living with and beyond Cancer programmes (Survivorship)+

National Cancer Survey Results 2016	Compared with other trusts
• Hospital staff gave information on getting financial help	Better
• Given complete explanation of test results in understandable way • Patient had confidence and trust in all ward nurses • Hospital staff definitely did everything to help control pain • Doctor had the right notes and other documentation with them • Beforehand patient had all information needed about radiotherapy treatment • Beforehand patient had all information needed about chemotherapy treatment • Patient definitely given enough support from health or social services after treatment • Patient's average rating of care scored from very poor to very good	Worse
All other questions	About the same

National Inpatient Survey Results 2017

Please note: The CQC will publish the report on 13th June 2018, after this report is completed. It will be available on the CQC website http://www.cqc.org.uk/publications/surveys/surveys

With 476 completed surveys returned, the Trust had a response rate of 39.4%.
The Trust scored an average score of 70% which is the same as in 2016. The Trust was banded in the 'worse' category on national comparison for 13 questions in the 2016 Inpatients survey.

Compared with the 2016 survey, on our current results the Trust showed a 5% or greater improvement on 5 question scores and a 5% or greater reduction in score on no questions. The 'significantly better' scoring questions were:

- If you brought your own medication with you to hospital, were you able to take it when you needed to?
- Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Our Strengths

- Reduced noise at night from staff
- There have been some improvements in staff information giving since 2016.

Areas for Improvement

The Trust scored low on 45 out of 55 questions which cover core areas of:

- Waiting times
- Staff information giving and communication including – consistency, providing explanations about condition, operations or treatment and medicines information.
- Care including – practical and emotional support, pain management , respect and dignity
- Discharge planning and aftercare
- Hospital environment and facilities including – single sex accommodation and privacy.

National Inpatients Survey Results 2017	Compared with other trusts
Information available after 13th June 2018	Better
• Information provision about condition or treatment in A&E • Being given enough privacy when being examined or treated in A&E • Waiting a long time to get a bed on a ward after arrival at the hospital • Staff explaining reasons for moving patients during hospital stay in a way they could understand • Doctors answering patient's questions in a way they could understand. • Patients having confidence and trust in doctors • Doctors talking in front of patients as if they were not there • Hospital having enough nurses on duty to care for patients • Patients having confidence and trust in other clinical staff treating them	Worse

• One member of staff saying one thing and another saying something quite different to patients • Patients being involved in decisions about their care and treatment as much as they wanted to • Patients having confidence in the decisions made about their condition or treatment • Feeling involved in decisions about discharge from the hospital • Knowing what would happen next about their care • Staff telling about medication side effects to watch for when patients went home • Patients being told how to take medications in a way they could understand when leaving the hospital • Staff taking patient's family or home situation into account when planning their discharge	
Information available after 13th June 2018	About the same

Patient Experience Initiatives undertaken in 2017-2018.

Some of the initiative undertaken in 2017-2018 to improve patient experience are outlined below.

- The patient experience dashboard has been developed as part of the Trust's Accountability and Performance Framework which informs services about the feedback performance trends.
- A new feature was created by the Patient Experience Team for all the FFT touch point to celebrate the positive comments from the FFT (Friends and Family Test). Every month, one 'Star Comment' which shone the spotlight on the excellent experience and care being provided by ward/department teams is picked and sent to the area leaders who then use it as positive recognition to add value to our their interactions with their teams.
- 'Soundbites' audio recordings are now used at all Patient Experience Group meetings and its use is being encouraged at divisional and care group meetings.
- The User Information Reading Panel is composed of volunteers who review and comment on the non-clinical information produced by staff members. They give suggestions on the what information should be included, how to make it user-friendly and easy to understand, and general format of leaflets and posters. Uptake of the panel's services is increasing as staff are getting more aware of co-producing information for patients and service users.
- Following an audit of 'noise at night' undertaken by volunteers and staff members a 'Quiet Protocol' was developed and implemented
- Maternity Services organised an 'Whose Shoes' event with support from the national team and was attended by a wide range of staff and service users and are developing an action plan following this event.
- Introduction of the 'Observe and Act Programme' as an approach to look at a person's total experience of a service from their perspective. Through observations good practice and areas for improvement are highlighted and action plans agreed with local teams
- Development of 'You and I' patient experience sessions on the wards which have increased the awareness and the importance of gaining patient feedback. Improvement actions are agreed with teams and support is provided by the Patient Experience Team to make this happen

Patient Experience Initiatives 2018-2019

The following Patient Experience initiatives are planned for 2018-2019:

- Work with NHSI in relation to the introduction of the patient experience 'Always Events' The Patient Experience Team has identified an area to pilot the 'Always Events' which focuses on those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care system. On completion of the pilot the programme will be rolled out to other areas/teams.
- Co-production approach used in the development of the Paediatric Healthcare mobile phone app.

Patient Opinion/NHS Choices/CQC

Since April 2017 there have been 68 comments made about the Trust via the NHS Choices/Patient Care Opinion website, this includes 22 Compliments. The key category types reported on the website include Clinical Care, Assessment and Treatment, appointment queries, communication and attitude. This mirrors the feedback received via all categories of complaint and concern.

Feedback posted on the NHS Choice/Patient Opinion website is acknowledged with a request to contact the Trust to discuss the situation further offered. In 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.

Compliments, Concerns and 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+ the best care possible to our patients.

Complaints, Concerns and Complements
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 **2017/2018** a total of **3661** contacts were received by the Patient Relations Team which included a total of 284 written complaints, 25 informal to formal complaints and 8 MP letters (in total a reduction of 9 complaints overall for the year compared to 2016-2017).

Complaint Type	2015-2016	2016-2017	2017-2018
Formal Complaint	370	284	280
Informal to formal complaint	29	32	25
Informal concern	2418	2091	2164
Formal to informal	29	20	8
Compliment	441	635	734
Comments/suggestion/referred on	123	297	455
MP letter	6	6	8
Total	3416	3109	3674

The Division of Medicine and Long Term Conditions continues to receive the largest number of complaints accounting for 52% of all the complaints received. The main theme emerging from formal complaints was ‘clinical care, assessment and treatment’, accounting for 58% of all complaint categories. Other themes included communication, appointments, diagnosis and issues associated with discharge from hospital.

In 2017-2018 the number of complaints versus patient activity was 8.6%. This is worked out as the number of complaints divided by-elective, non-elective and emergency patients (36315) and multiplied by 1000.

A number of interventions throughout 2017-2018 such as negotiating timeframes with the complainant, Divisional huddles and focused feedback to complaints investigating officers have seen an significant improvement in response times, with 89% of all complaints responded to within the timeframe agreed, compared to 79% in 2016-2017.

In addition to complaints, the complaints team received 2164 informal contacts. The main theme of concerns raised are regarding appointments which have increased this year, clinical care, assessment and treatment, communication and information request and issues related to staff attitudes.

Patients unhappy with the outcome of our complaints processes can ask for their complaint to be reviewed by the Parliamentary and Health Service Ombudsman (PHSO). In 2017-2018 a total of 8 cases were referred to the PHSO. In the last year 3 were not upheld and 4 partially upheld with the outcome being an apology and an action plan to rectify any failures that were identified, in the remaining case the outcome is yet to be determined.

Some of the lessons learned from investigated complaints include:

- Following a patient complaint about their surgical stocking being too tight after an operation which caused wounds which required redressing regularly the surgical wards developed a checklist for all patients regarding the use and monitoring of surgical stockings, ensuring that a patient’s stockings are checked regularly, and that any changes and actions taken are documented. This checklist is now in every patient folder.
- Following a complaint about a nurse failing to escalate an abnormal blood sugar to the medical team the ward have developed a NEWS escalation stamp that can be used to document escalation in the patient case notes
- Following complaints about confusing signage regarding the escalators in the Hospital main atrium this was changed to make this clearer for visitors

Complaints Monitoring Panel

The Complaints Monitoring Panel, set up in October 2015 with the purpose of the panel to assist the Trust in improving complaints handling procedures and help to improve standards in decision making has continued to meet throughout 2017-2018. The panel has undertaken the following work during this year:

- Completed Complaints Investigation Masterclass training
- Reviewed PHSO cases to gain a better understanding how complaints are investigated at that level
- Led a workshop that reviewed a sample of complaint responses, response satisfaction survey findings and equality monitoring data
- Contributed to the development of a revised complaints information leaflet, and supported and reviewed a draft unreasonable behaviour guideline

Complaint Satisfaction Questionnaire

Our Trust feedback survey is provided to all complainants to enable them to provide feedback on their experience of the complaints process at the Trust. Feedback received is outlined as follows based on 15% return rate (49 responses):

- Making a complaint was straight forward : 86%
- I knew I had the right to complain: 89%
- I knew that my care would not be compromised by making a complaint: 92%
- The staff who spoke to me regarding my complaint were polite and helpful: 86%
- My complaint was acknowledged within 3 working days: 79%
- I was informed about the complaints process: 91%
- I was informed of any delays and updated on the progress: 83%
- I received a resolution in a time period that was relevant to my particular case and complaint: 91%
- I am happy with my overall response time to my complaint: 85%
- I feel the Trust has taken my comments on board and have made changes to improve the things that I was unhappy with: 74%
- I would complain again if I felt the need to: 100%

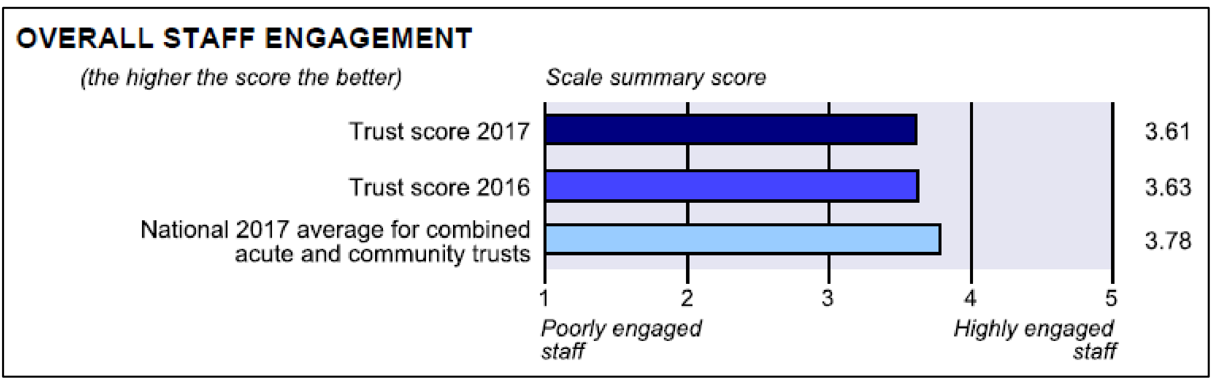
2.6 - What our staff say

Every year the NHS ask an independent company to survey the opinions of staff about working in the organisation where they are employed. The survey results are published on the internet through NHS England. The survey looks at 32 factors and compares information from the previous year as well as how the organisation measures against other NHS organisations. Some of the factors the survey asks questions about are for instance: staffing levels, support for learning, and their experience of violence or bullying and incidents.

The 2017 questionnaire was sent to all colleagues in the Trust and 1536 responded, a response rate of 36% compared with the response rate for all combined acute and community trusts in England of 40.4%.

Following the 2016 Staff Survey results we employed a Staff Engagement lead to better understand what lay behind the disappointing results and to lead the engagement with staff and improve both the staff experience at work and the level of satisfaction felt.

Summary of 2017 results:



- The 2017 results have remained relatively static measured against the Key Findings* compared nationally to the 2016 survey with :
    - No change in 28 Key Findings
    - Improvement in 3 Key Findings
        - Reporting errors, near misses or incidents in the last 12 months,
        - agreeing that staff role makes a difference to patients and
        - effective use of patient/service user feedback;
    - Worsening in 1 Key Finding
        - Staff recommendation of the organisation of a place to work or receive treatment
- The Trust has improved by 2% or more from 2016 results for 42% of the survey (35 questions)
- The Trust has worsened by 2% or more from 2016 survey for 13% of the survey (11 questions)
- The Trust has stayed about the same (within 1%) from 2016 survey for 45% of the survey (37 questions)
- According to Listening into Action we have improved from 37th out of 37 for Acute & Community Trusts to 35th out of 37.

** The Key findings are marked as no change if the information is statistically insignificant. The statistics are based on a series of questions asked within each key finding and are calculated (weighted) to give the overall figure.*

Some clear movement has been observed for specific questions:

Improved:

- 5% more people say they are involved in deciding on changes introduced
- 7% more people feel that the organisation would treat them fairly if involved in an issue
- 5% more people say they are given feedback about changes in response to reported errors, near misses and incidents
- 4% less people state they have received training, learning or development in the past 12 months
- 4% more people state that where they did receive development it helped them be more effective
- 8% more people agree they receive regular updates on patient experience in their areas
- 9% more people agreed feedback received from patients is used to make informed decisions
- 4% more staff stated that the last time they experienced physical violence they did not report it

Worsened:

- 3% more people say they have suffered work-related stress compared with 2016
- 4% more people say they are dissatisfied with their level of pay compared with 2016
- 4% more people stated communications between senior management and staff is effective

Our response:
The Staff Engagement Lead is building on the work done in 2017 and coordinating additional work to continue to improve staff satisfaction. This work includes:

- The Staff Engagement Lead has reviewed all the topics with the Trust Executive members as well as senior leaders and agreed 5 key topics to focus on first, which are more likely to have the strongest positive impact.
- agreeing a template for divisional areas to identify 5 areas that require their focus. HR will have oversight of these plans and Divisional areas will have ownership and accountability for delivery of them.
- Two groups have been established to support the engagement work - the 55 'Engagents' and the Passionate for Engagement Group (PEG)
- Values have been revised and established and will be launched early in 2018/19
- Feedback has been provided to some colleagues, as a result of the focus groups, to assist their future performance.
- Manager feedback sessions have been run to share best practice in delivering feedback
- 360 feedback is currently being piloted by Board, Exec through to Teams of Three Managers and their equivalents
- A pledge from the Board is being developed relating to a zero-tolerance towards bullying and harassment

2.8 - Overall Activity Levels and Performance against Core Operating Standards

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

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

Activity				
	2014-15	**2015-16**	**2016-17**	**2017-18**
Emergency Activity	35,056	38,420	35,154	31,847
Day Case	22,281	21,864	21,515	22,253
Elective	3,968	3,749	3,422	3,725
Outpatient	262,038	263,380	248,452	230,583
A & E	66,777	64,806	64,686	74,003
Community	340,158	329,939	344,377	361,113
Total	730,278	722,158	717,606	723,524

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

In Walsall there are some of these that we have managed to achieve every year for some time. We are pleased to be able to report that we are improving the performance of all our cancer and cancer related targets.

Others targets we have not achieved. We have taken steps to change the way we work in order to reach the standards. In particular we have been working at the way we manage our waiting lists this year by monitoring all of our systems and patients waiting, to show a steady improvement in 2018. (Alison should be able to show waiting list reduction on last 12 months)

Emergency patients arriving to A&E is one of our biggest challenges as more patients arrive every year who are older, yet more sick in their presentations. We have had less long waits in the department than last winter. All of our teams are now changing the way they work to improve the patient wait times in A&E. This includes; daily huddles of Senior Doctors to review the hospital patient's waiting against beds available, streamlining ward rounds, working closely to support GPs with the heaviest workloads to reduce patients arriving at A&E, putting social care teams into A&E to help get people home with support as quickly as possible and finally to get better use of our discharge lounge so hospital beds are ready for A&E patients more quickly.

Performance against standards

Measure	Actual 14 - 15	Target 15-16	Actual 15-16	Target 16-17	Actual 16-17	Actual 17-18
Total Time in A & E 4 Hour wait	89.1%	95%	87.90%	95%	84.10%	82.67%
C. Diff Cases	16	18	7	18	21	11
MRSA Cases	0	0	1	0	0	0
% of patients whose operations were cancelled for non-clinical reasons		0.75%	0.47%	n/a	0.65%	0.45%
Cancer 2 week wait	91.7%	93%	90.80%	93%	96.4%	**95.2%
Cancer 2 week wait Breast Symptoms	91.7%	93%	90.80%	93%	96.2%	**96.0%
Cancer 31 day diagnosis to treatment	98.9%	96%	99%	96%	99.2%	**99.3%
Cancer 31 day wait surgery	99.2%	94%	97.30%	94%	99.0%	**98.8%
Cancer 31 day wait drug	99.6%	98%	99.50%	98%	100.0%	**100.0%
Cancer 62 day wait all cancer	76.7%	85%	79.80%	85%	87.0%	**88.1%
Cancer 62 day wait screening	96.4%	90%	100%	90%	95.9%	**97.7%
Cancer 62 day wait consultant upgrade	90.5%	92.10%	91%	91%	92.2%	**86.1%

2.9 CQUIN

A set of Commissioning for Quality and Innovation (CQUIN) goals were agreed with our commissioners for 2016/17. The table below shows the progress made in achieving these goals with information available at the time this report was approved.

CQUIN SCHEME	Type	Potential Monies Available	% Achieved
Support engagement with STP's	National STP	£914,168	100%
STP's risk reserve	National STP	£914,168	100%
NHS Staff & Wellbeing	National CCG's	£460,151	66%
Proactive & Safe Discharge	National CCG's	£460,151	97%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	National CCG's	£257,685	60% confirmed 15% not achieved 25% TBC
Improving services for people with mental health needs who present to A&E	National CCG's	£257,685	100%
e-Referrals	National CCG's	£257,685	50% confirmed 50% TBC
Wound Care - Community	National CCG's	£257,685	100%
Preventing ill health by risky behaviours – alcohol and tobacco	National CCG's	£276,091	100%
Personalised Care / support planning - Community	National CCG's	£257,685	100%
Offering Advice & Guidance	National CCG's	£257,685	50% confirmed 50% TBC
Non - PICU	NHS England Specialised	£37,878	100%
Medicine Optimisation	NHS England Specialised	£76,427	65% confirmed 35% TBC
Neonatal Outreach	NHS England Specialised	£37,878	100%
Dental	NHS England Public Health	£34,962	100%
Totals		£4,757,984	TBC

Section 3 - Priorities for improvement 2018/19

Safe		**1 Implement best Practice around resuscitation, acting on deterioration and utilisation of the sepsis bundle**
Effective		**2 Ensuring the Patient receives the right care, in the right place, at the right** **3 To maintain a secure, accurate, complete and contemporaneous record for each patient**
Caring		**4 Complete the assessment of the Trust's compliance with Equality and Diversity System 2.**

The Quality Commitment on page 24 shows the extent of the work being undertaken to improve the quality and safety of care we provide.

This will be revised for 2018/19 to reflect on the progress made, learning from the CQC inspection and from our wider quality improvement work that supports us getting to good and beyond. We expect it to be the pinnacle of our Integrated Improvement Programme currently being developed.

3.1 Priorities for improvement 2018/19

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

Lead

Medical Director – Divisional Medical Director MLTC

Plan

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

How will we measure this?

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

Where and when will we report the progress

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

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

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

Priority 2: Ensuring the Patient receives the right care, in the right place, at the right

Lead

Medical Director/Chief Operating Officer and Director of Nursing

Plan

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 and 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

How will we measure this?

Multi-disciplinary team audits undertaken monthly on a cohort of patients to review key metrics of care across the patient's care episode including for example: ED performance (e.g. time to triage, Length of time in ED), referral time and transfer times to specialities, wait times for investigations, assessments (including VTE, Falls, MUST, Pressure Ulcers, Medicines reconciliation, timely recording of observations and other safety checks), discharge planning and EDD versus actual DD.

Where and when will we report the progress

The Trust Management Board

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

By embedding ownership and accountability within clinical areas and at ward level for these key metrics of effectiveness and quality

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Priority 3: To maintain a secure, accurate, complete and contemporaneous record for each patient

Lead

Director of Strategy, Director of Nursing, Medical Director

Plan

The objective is to maintain 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 strategic direction is to move to a fully digitalised patient record, this includes scanning the paper based record and preventing further paper records being produced by introducing electronic forms (eForms) and the implementation of an electronic document management system (EDM)

Secure, Accurate and Complete.
A number of activities are being undertaken within the Health Records Department to improve storing, tracking , availability, quality and completeness of the current medical record. The activities include improved tracking systems, storage rationalisation, monitoring availability of patient records, standard processes for record quality checks, review of none Health Record staff training requirements for maintaining health records. These activities will be aligned to the roll out of the EDM and Electronic Form projects.

Contemporaneous
Patient record audits will be undertaken, reviewing medical and nursing records. The audit will incorporate 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

How will we measure this?

- The number of records available for an patient-out patient appointment or planned surgery.
- The number of records not tracked out of the health record library, not traceable
- Volume of records held on site
- Monitoring of the risks relating to Health Records recorded on the trusts risk management system.
- EDM project plan
- eForms project plan
- Outputs from the patient record audits
- Outputs form the Patient consent audit
- Improvements following development and implementation of specialty action plans in response to patient record audits

Where and when will we report the progress

The Health Records Committee will provide oversight
The Trust Management Board will monitor progress
Divisional Boards and quality teams

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

Quality audit check of the patient record after an inpatient episode or an Outpatient appointment, this includes both paper based record and the digital based record in our EPR

Priority 4: Complete the assessment of the Trust's compliance with Equality and Diversity System 2.

Lead

Director of Nursing, Director of Organisational Development and Human Resources

Plan

Completion of EDS2 and grading assessment remains a key and urgent priority.

The Trust has already agreed to engage with patients and colleagues, utilising our internal data sources to identify a schedule of departments to 'deep dive'. There will be a key balance between identifying areas that require support and areas where we can learn from excellence. Progressing this work on was delayed due to the workforce lead leaving the Trust. However in December, we attended by invite the West Midlands Ambulance Service (WMAS) EDS2 Grading event. WMAS is ranked as one of the leading NHS providers – outstanding in all fields for implementing and learning from EDS2. In attending the grading event WMAS has agreed to support the process here at Walsall in order for us to progress and complete this well overdue action.

Plan:

1. The Trust will take place in the Equality, Diversity and Human Rights Week. 14-18 May utilising this opportunity to promote activity and gather evidence to support the 'deep dive' exercise
2. Lead Directors to request information for grading assessment from the areas identified for the 'deep dive' exercise.
   - School Nursing – Rated Outstanding in the Pulse Check
   - Speech and Language - Rated Outstanding in the Pulse Check
   - T&O – Worst Performing Area in the Pulse Check
   - Pharmacy - Worst Performing Area in the Pulse Check
   - Learning Disabilities – as a standalone service due to it being a protected characteristic.
3. Information collated will allow initial grading assessment to take place and then a final, lay assessment grading event will be arranged.

How will we measure this?

The agreement to a fixed term part time equalities post has enabled the Trust to start to make progress on a number of priorities and benefit from work undertaken across the Organisation. The main focus of this work has been to support the development of patient/service elements of equality work. This should enable us to evidence better engagement with those groups and establish key areas to improve service delivery; supporting a robust equality impact process and agree actions; and improve data collection on patients using our services. We have further agreed to bring the patient and staff approaches together and plan to appoint to a 6 month secondment post commencing in July 2018 to assist the work already begun.

Where and when will we report the progress

- Equality Diversity and Inclusion Committee - Quarterly
- People and Organisational Development Committee – Bi-Monthly
- Patient Experience Group – Bi-Monthly

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

- Ongoing monitoring of actions undertaken
- Review the EDS2 assessment annually and extending this to other areas
- Engage with the NHS Employers Equality and Diversity Partners Programme

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3.2 CQUIN for 2018/19

A set of Commissioning for Quality and Innovation (CQUIN) goals has been agreed with our commissioners for 2018/19

CQUIN Ref.	CQUIN Scheme Name	17/18 CQUIN Value	Exc Lead
	STP Support engagement	**£914,168**	DoF
	STP risk reserve	**£914,168**	DoF
WCCG			
1	Improving staff health and wellbeing	**£460,151**	OPD & HR
2	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	**£257,685**	MD
3	Improving services for people with mental health needs who present to A&E	**£257,685**	COO
4	Offering advice and Guidance (A&G)	**£257,685**	D of S&T
5	NHS e-Referrals (Year 1 only)	**£257,685**	D of S&T
6	Supporting Proactive and Safe Discharge – Acute Providers (inc ECDS)	**£460,151**	COO (D of S&T)
7	Preventing ill health by risky behaviours – alcohol and tobacco	**£276,091**	DoN
8	Improving the Assessment of Wounds	**£257,685**	DoN
9	Personalised Care and Support Planning	**£257,685**	DoN
WCCG		**£2,742,503**	
NHS E Specialised Commissioners			
1	Medicines Optimisation	£76,427	MD
2	Paediatrics - non PICU	£37,878	COO
3	Neonatal Outreach	£37,878	DoN
NHS E Totals		**£152,183**	
NHE E Public Health (Shropshire LAT and Bham and BC LAT)			
1	Dental – audit of Daycase activity	**£34,962**	**COO**

Further details of the agreed goals for 2017/18 and for the following 12 month period are available on request from the Director of Finance

3.3 Who has been involved in setting our improvement priorities

Our 2017/18 improvement priorities have been continued. Improvement in the quality of the health record has been added to this list. The need to improve health records was identified throughout the Chief Inspector of Hospitals Inspection report and is clearly something we need to focus our attention on.

Our key stakeholders have had the opportunity to contribute to and comment on the improvement priorities selected during the 2017/18 year and the drafting of this Quality Account.

Appendices:

1. **Assurance Statements by the Trust**
   Review of Services
   National Confidential Enquiry and Clinical Audit participation
   Research and Development
   Registration with the Care Quality Commission
   Quality of Data
   Learning from Deaths
   Mandatory Indicators and National Targets

2. **Statements**
   Healthwatch
   Overview & Scrutiny Committee
   Clinical Commissioning Groups

3. **Statement of Director's responsibilities in respect of the Quality Account**

4. **Independent Assurance Report**

Appendix 1

Assurance Statements by the Trust

Review of services

During 2017/18 the Walsall Healthcare NHS Trust provided and/ or sub-contracted 88 NHS services. Walsall Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 88 of these NHS services. The income generated by the NHS services reviewed in 2017 - 18 represents 100 per cent of the total income generated from the provision of NHS services by the Walsall Healthcare NHS Trust for 2017 - 18

Care Quality Commission (CQC)

Walsall Healthcare NHS Trust is required to register with the Care Quality commission and its current registration status is Registered (without any compliance conditions and licensed to provide services.

Walsall Healthcare NHS Trust has the following conditions on registration:

- No additional conditions to those imposed by registration

The current inspection ratings for the Trust following the Chief Inspector of Hospital's inspection in June 2017 are provided below:

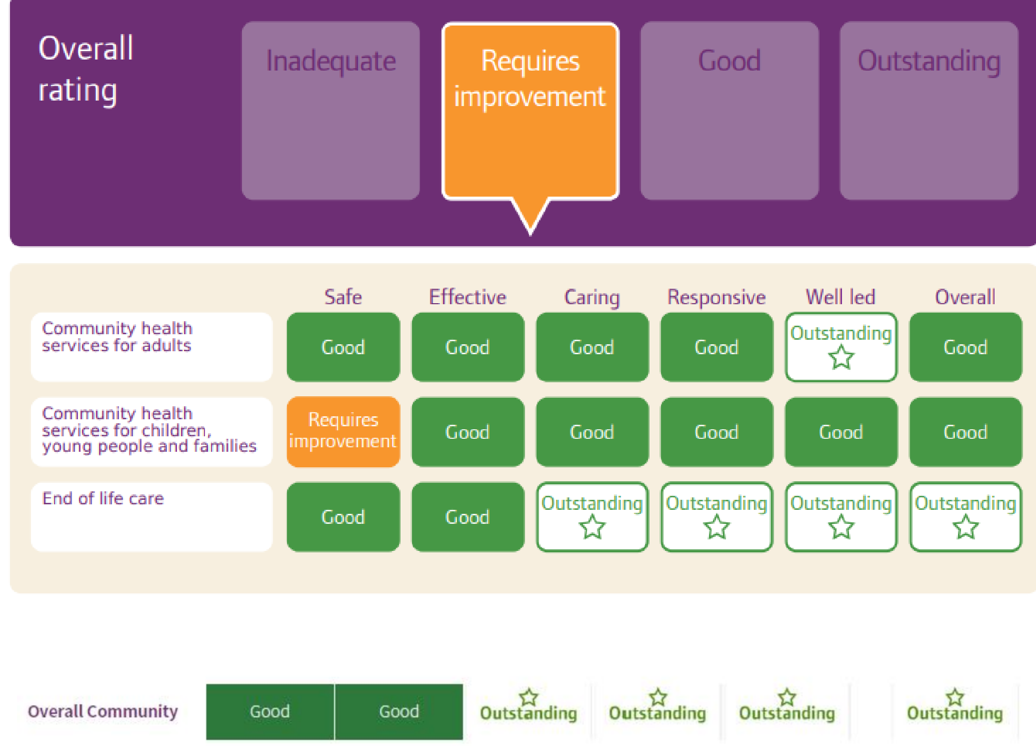
Overall Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Walsall Manor Hospital

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

Community Health Services



The Care Quality Commission has taken enforcement action against Walsall Healthcare NHS Trust during 2017-18.

- The Trust received a Section 29a warning notice following the inspection in June 2017
  - Monitoring, recording and escalation of concerns for Cardiotocography (CTG) requires significant improvement
  - There are insufficient midwives with HDU training to ensure that women in HDU are cared for by staff with the appropriate skills.
  - Safeguarding training is insufficient to protect women and babies on the unit who may be at risk.
  - There are insufficient numbers of suitably qualified staff in the delivery suite and on the maternity wards
- The final inspection report also listed ‘enforcement’ notices. These were:
  - Regulation 18 (1) The registered provider did not ensure there were adequately qualified staff across maternity services to meet the needs of woman and their babies to protect them from abuse and avoidable harm.
  - Regulation 12 (2)(b) The registered provider did not Monitor, record and escalate concerns for Cardiotocography (CTG) to protect women and their babies from abuse and avoidable harm
  - Regulation 13(2): Safeguarding - Safeguarding training across maternity services was insufficient to protect women and babies on the unit who may be at risk.

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

- In response to the report the Trust has developed a Patient Care Improvement Plan to manage the must and should do actions listed in the report. The work and progress will be regularly reported to the Board, Further work is being undertaken to plan to achieve higher ratings and develop the actions to achieve this. A broader Integrated Improvement Programme will be developed to encompass both these aspirational elements and the response to the must and should do actions identified in the report.
- The Maternity service continues to hold the Maternity Oversight Committee which oversees and monitors progress with the detailed Maternity improvement plan that encompasses the findings of the 2017 inspection report and the section 29a notice

Walsall Healthcare has made the following progress by 31st March 2018 in taking such action:

- The PCIP has been developed and reviewed at its first cycle
- Maternity have continued with the details Maternity Improvement Plan and in relation to the Section 29a notice have undertaken the following:
    - Staffing - the maternity service has closely monitored the staffing levels on Delivery Suite and the maternity wards and provided a weekly report to CQC detailing, both the numbers of midwives available each shift and also the corresponding acuity within delivery suite. The acuity is measured using the BirthRate plus intrapartum tool, endorsed by NICE. Improvements continue to be made. In March 2018 the incidence of midwifery staffing numbers below optimum for Delivery Suite was 14% and for the wards was 2%
    - Safeguarding training – Consultant training has met the required target. Only level 3 training targets for midwives have not yet been met (84% against a target of 90%)
    - Midwives with HDU training - Each shift now has a HDU competent midwife allocated when the roster is created. The requirement for a HDU competent midwife has been added into the R-roster template to ensure at least 1 x trained HDU midwife is rostered on every shift. In addition the printed roster also highlights who this midwife is and all off duty swaps must be appropriate and agreed by the DS manager or matron to maintain HDU cover each shift. The safety huddle conducted 3 times per day monitors whether a woman requiring HDU care is being cared for by a non HDU competent midwife. There were 4 shifts in March 2018 which did not have HDU cover available. There were no reported incidents or adverse outcomes during these shifts and support is available from the Critical Care Outreach Team and also the Anaesthetic team if required.

Walsall Healthcare NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017/18:

- Review of health services for Children Looked After and Safeguarding in Walsall

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

- An action plan is to be submitted to the CQC in response to recommendations made around a range of issues and services. These include
    - Robust risk assessments for vulnerability in Maternity
    - Communication on Safeguarding risks and Concerns in ED
    - Quality of Health Records and the provision of Electronic Health records
    - Health representation in the Multi-agency Safeguarding Hub (MASH)
    - Capacity within the Health Looked after Children service

Walsall Healthcare NHS Trust has made the following progress by 31 March 2018 in taking such action:].

- Although the report was published post 31st March 2018 many of the recommendations were already being implemented.
    - Establishment of specialist midwife for Vulnerable Families
    - Redesign of both the Adult and Child Causality Card documentation to ensure Safeguarding considered
    - An alternative solution for Electronic records following the decommission of the previous electronic child health system
    - Review and Refresh of the Children Safeguarding Team within Walsall Healthcare Trust had commenced. Which included health representation in MASH and capacity within the Looked after Children service

Participation in Clinical Audits

During 2017/18, 34 national clinical audits programmes and national confidential enquiries covered NHS services that Walsall Healthcare provides.

During that period Walsall Healthcare participated in 91%% of the national clinical audits programmes and national confidential enquiries which it was eligible to participate in.
The reports of 19 national clinical audits were reviewed during 2017/18 and the Trust intends to take the following actions to improve the quality of the healthcare we provide.

The national clinical audits and national confidential enquiries that Walsall Healthcare was eligible to participate in during 2017/18 are below.

National Audit Title	Trust Participation	% of the No of cases Submitted	Actions / Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	Data Submission in progress	Results have been shared with the Care group and included in the Divisional report On-going - Assurance of care standards all within expected ranges full report and action plan will be developed as soon as received in the Trust.
Adult Cardiac Surgery	x	-	Not applicable at Walsall Healthcare NHS Trust
Bowel Cancer (NBOCAP)	✓	90%	Data upload successful awaiting report.
Cardiac Rhythm Management	✓	100%	On-going
ICNARC - Case Mix Programme	✓	100%	On-going
Child Health Clinical Outcome Review Programme	✓	100%	On-going
Chronic Kidney Disease in primary care	x	-	Not applicable at Walsall Healthcare NHS Trust
Congenital Heart Disease (CHD)	x	-	Not applicable at Walsall Healthcare NHS Trust
Coronary Angioplasty /	x		Submitted as part of the Paired hospital – New Cross Hospitals NHS Trust.

National Audit of Percutaneous Coronary Interventions (PCI)			
Diabetes (Paediatric) NPDA	✓	100%	On-going
Elective Surgery (National PROMs Programme)	✓	100%	On-going
Endocrine and Thyroid National Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
Falls and Fragility Fractures Audit Programme	Partial	100%	Results have been shared with the Care group and included in the Divisional report Partial compliance in the programme, Walsall Healthcare Actively participated in National Hip Fracture but did not participate in Fracture Liaison Service – the National reports recommends that the Trust actions this section going forward
Head and Neck Cancer Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
Inflammatory Bowel Disease Programme Register	x	0%	Capacity pressures – unable to support Risk on risk register to support
Learning Disability Mortality Review Programme	✓	100%	
Major Trauma Audit	✓	91%	Results have been shared with the Care group and included in the Divisional report • A slight reduction in case attainment was noted from 96.8% last year to 68.6% this fiscal year. • 1 Of the core standards has improved relating to length of stay for ISS patients. • Rehabilitation standards remained consistent with previous yeas data. • Of the 5 core standards measured 3 have decreased compliance and are below the expected Trauma unit average.
Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	100%	Results have been shared with the Care group and included in the Divisional report Key outcomes of the MRACE noted of the 4,865 babies born within the Trust in 2015: • The stabilised & adjusted mortality rates for the Trust were lower than those seen across similar Trusts and Health Boards. This had been noted /reported on in the CQC report. • The proportion of mothers under 25 years of age was considerably higher than that of the UK as a whole: 28.1% versus 19.0%. Work streams are continuing in this area.

Medical and Surgical Clinical Outcome Review Programme NCEPOD	✓	60%	On-going
Mental Health Clinical Review Programme	✓		Not applicable at Walsall Healthcare NHS Trust
National Cardiac Arrest Audit	✓	48%	Results have been shared with the Care group and included in the Divisional report A new carbonised cardiac arrest form has been introduced to improve documentation and increase data completeness and included in the patient record.
National Chronic Obstructive Pulmonary Disease Programme	✓	100%	Results have been shared with the Care group and included in the Divisional report Majority of standards fell within the national average, variance with staffing number with Walsall falling lower than the national average; early post discharge for this cohort of patients with a diagnosis of acute exasperation of COPD a business case is in development to enable an improvement to discharges and meeting the BPT quality outcomes.
National Comparative Audit of Blood Transfusion	✓	100%	Awaiting the report
National Diabetes Audit – Adults	✓	100%	Results have been shared with the Care group and included in the Divisional report • Fully participated in the years programme • Care group dashboards continue to incorporate divisional audit results. • Training continues to evolve on the intranet to provide educational support. • Successful bid for increased specialist nursing support submitted to improve the practice for patients with diabetes.
National Emergency Laparotomy Audit	✓	85%	Results have been shared with the Care group and included in the Divisional report • Data upload successful awaiting report. • Actions taken to improve the booking form pre operatively to include the P Possum risk scoring algorithm. • Surgery improvement project is proposed to review options to improve Elderly care input.
National Heart Failure Audit	✓	90%	Results have been shared with the Care group and included in the Divisional report • The introduction/participation in the BPT was successful following the results of heart failure audit. • Additional data support was provided within the division to improve data capture. • Pathway awareness raising sessions

			from the audit and sharing of the outcome/pathway with the emergency team.
National Joint Registry	✓	100%	On-going
National Lung Cancer Audit	✓	100%	On-going
National Neurosurgery Audit Programme	x	-	Not applicable at Walsall Healthcare NHS Trust
National Ophthalmology Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
National Prostate Cancer Audit	✓	90%	On-going
National Vascular Registry	x	-	Not applicable at Walsall Healthcare NHS Trust
National Neonatal Audit Programme	✓	100%	On-going
Nephrectomy Audit BAUS	✓	TBC	On-going
Oesophago-gastric Cancer Audit	✓	TBC	On-going
Paediatric Intensive Care	x	-	Not applicable at Walsall Healthcare NHS Trust
Percutaneous Nephrolithotomy BAUS	x	-	Not applicable at Walsall Healthcare NHS Trust Not carried out at Walsall however hope to participate nest year.
Prescribing Observatory for Mental Health	x	-	Not applicable at Walsall Healthcare NHS Trust
Radical Prostatectomy audit	x	-	Not applicable at Walsall Healthcare NHS Trust
Sentinel Stroke National Audit Programme	✓	100%	The reports were discussed at the care group / and the speciality management group. A business case was proposed the merge services to improve patient care and provide a specialised service to patients in the borough. As a result the outcome of the audits have been feed into producing a sustainable specialised service managed from New Cross with community support for Stoke rehab being offered as post discharge support, which will look into hand over and improvement in support stoke patients in the region.
Specialist rehabilitation for patients with complex needs	x	-	Not applicable at Walsall Healthcare NHS Trust
Stress Urinary Incontinence Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
BAUS Urology Audits: Cystectomy	x		Not applicable at Walsall Healthcare NHS Trust
BAUS Urology Audits:	✓	TBC	On going

Nephrectomy			
BAUS Urology Audits: Urethroplasty	x	-	Care group decision not to participate this year risk assessment completed.
Fractured Neck of Femur CEM	✓	100%	Complete
National Audit of Breast Cancer in Older Patients	✓	100%	Data upload successful awaiting report
National Audit of Intermediate Care	✓	TBC	Completed restoration open for 2018 - Report Requested
National Audit of Psychosis	x	-	Not Applicable to Walsall NHS Trust Mental Health led audit
National Audit of Seizures and Epilepsies in Children and Young People	✓	TBC	Didn't run in 2017/2018 time frame
National Bariatric Surgery Registry	✓	100%	Data upload successful awaiting report
National Maternity and Perinatal Audit	✓	TBC	On going
Pain in Children CEM	✓	100%	Awaiting report for national comparators
Procedural Sedation in Adults (care in emergency departments)	x	-	Not Applicable to Walsall NHS Trust
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	100%	Awaiting report for national comparators
UK Parkinson's Audit	✓	100%	Results have been shared with the Care group and included in the Divisional report • All patients were reviewed by a specialist with the last year – on Parr with the national averages, and all medical reviews were completed with 12 months with the majority completed in the 6/12 months criteria. • 4 people received the appropriate oral and written communication in line with the national standards 16 was noted to be not applicable. • Standard C 100% of people with Parkinson's who have sudden onset of sleep should be advised not to drive and to consider any occupational hazards - Achieved • 100% of patients on dopamine agonists are monitored for impulse control disorders including dopamine dysregulation syndrome (Parkinson's NICE R 54) Achieved • Standard E: If an ergot-derived

			dopamine agonist is used, 100% of patients should have a minimum of renal function tests, erythrocyte sedimentation rate (ESR) and chest radiograph (CXR) performed before starting treatment, and annually thereafter (Parkinson's NICE R30 and 40) Achieved • For 100% of people with Parkinson's end-of-life care requirements should be considered throughout all phases of the disease. Limited documented evidence however this standard was poor nationally. • 100% of people with Parkinson's and their carers should be given the opportunity to discuss end-of-life issues with appropriate healthcare professionals. Evidence in - 50% of the cases.

The reports of 31 local clinical audits were reviewed by the provider in 2017/18 and Walsall Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided (see below)

Title	Outcome	Action
Sepsis CQUIN	Sepsis Audit – The screening patients using the appropriate Screening and Action Tool across the Trust was not always optimised.	The Trust Implemented a universal Sepsis Screening and training workshops and safety events were held across the organisation. • A revised screening tool was launched in the emergency department. • Deteriorating patient and sepsis training was trialled on the 20 February to raise awareness. • Trust wide support of national sepsis day to raise awareness.
Deteriorating Patents	Reviewed a number of cases and identified a number of issues linked to documentation.	A number of quality work streams commenced to improve the issues noted that includes the new Transfer of Care Policy and the amended SBAR tool that improves communication by ensuring concise focused information of the care needed.
Paediatric Sleep Study	Identified a number of blockages and communication barriers for the patient journey.	New process to improve the patient journey were devised that will reduce time spent waiting for clinics to occur and expedited results.
Handover Audit - Re-Audit on Current Practice	Handover issues were identified	A joined approach was introduced to reduce time and improve communication between teams.
NNU outpatient	The audit identified that follow up	A text reminding system was

appointments	appointments were only attended by 25% of patients and DNA of patients were high in high risk preterm babies.	introduced that sought to remind patients of appointments a review is to be undertaken in 2018 programme to demonstrate improvement.
VTE Performance Paediatric – Learning from Audit – Sepsis Re-Audit outcome	The use of the paediatric sepsis 6 bundle had improved from the previous study. Nursing staff feel more empowered using the bundle and the escalation was expedited. There were indications of a timely review by senior doctors. All patients had their antibiotics reviewed within 72 hrs, and there was a better patient outcome and no retrievals	Continue and improved display of posters/ pathways in all relevant clinical areas, and work between A&E and Paediatric team needs to remain collaborative.
Spot audit of non-technical skills and clinical quality carried out on wards 10 and 11	100% completion of introduction to patient, giving clear instructions, maintaining privacy and dignity and legible documentation in the notes reflect good communication skills within the teams. The results demonstrate good practice with >80% compliance with team working elements of non-technical skills. Of concern is the 78% compliance with hand hygiene between patients, the 39% discussion re IV fluids and NBM status and 17% amber care /DNAR assessment. Improvements could also be made in reviewing analgesia/VTE etc Some of these are more relevant to the day 1 post take ward round, rather than those who have been an in-patient for a while	Incident report equipment failures • Continuous education to all by Seniors with regards to standards required for ward round • Regular peer audits to be undertaken and fed back to Care Group
An Audit of Pre-Operative Administration of Prophylactic Antibiotics	46% of patients who did not receive antibiotics may have benefitted from doing so 91% of patients who received prophylactic antibiotics may not have required them or required an alternative agent	The Trust brought together a MDT to bring together formal guidance and clinical preference A project reviewing all medical guidance and formalising the governance process around these is underway..
Laparoscopic management of ectopic pregnancy	Good compliance was noted overall	Improve the process of communication for negative laparoscopy results to enhance the patient experience.

Participation in Research

The number of patients receiving relevant health services provided or sub-contracted by Walsall Healthcare NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 374.

The number of patients recruited in 2016/17 was 494 and in 2015/16 was 502. Although there is a decrease in number of patients recruited this year in clinical research, we are opening more complex research studies and this demonstrates Walsall healthcare's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. This year, we recruited the most number of patients in a commercial Dermatology study and Sexual Health clinical research studies in UK. We were also the first in West Midlands to recruit plus completed the full allocated number of patients for a National Sexual Health study this year.

Walsall Healthcare was involved in conducting 41 clinical research studies, 39 non-commercial and 2 commercial studies. Walsall Healthcare completed 80% of these studies as designed within the agreed time and to the agreed recruitment target. 20% of these studies are still on going. Walsall Healthcare used national systems to manage the studies in proportion to risk. Of the 12 studies given permission to start, 80% were given permission by an authorised person less than 30 days from receipt of a valid complete application. 100% of the studies were established and managed under national model agreements and 25% of the 12 eligible research involved used a Research Passport or letter of access to run the studies. In 2017-18 the National Institute for Health Research (NIHR) supported 3 of these studies through its research networks, using NIHR CRN research staff support.

In the last three years, 2 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

Goals agreed with commissioners

CQUIN Performance - A proportion of Walsall Healthcare NHS Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Walsall Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The table showing the achievement of these 2017/18 goals is on page 57

Data Quality

Walsall Healthcare NHS Trust submitted records during 2017 - 18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

– which included the patient's valid NHS number was:

99.84% for admitted patient care
99.84% for outpatient care
99.30% for accident and emergency care

“– which included the patient’s valid General Medical Practice
Code was:

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

Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made. Walsall Healthcare NHS Trust submitted records during 2017-18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The Trust can confirm that it submitted data during the reporting period to both SUS and HES systems for national reporting purposes.

Walsall Healthcare NHS Trust will be taking the following actions to improve data quality:

- Identified indicators for Patient Demographic details – process in place for cleaning the data for duplicate patient records, merges, nhs number consolidation with the Spine etc
- Identified indicators that are associated to Access Plans, Referrals, ADT’s (Ward based admissions, discharges and transfers), Outpatient appointments etc
- Clean up data on the CDS extraction for CCG submitted data on a scheduled basis
- Process in place to identify users that are creating errors and liaise with IT Training for further support where required

Information Governance Toolkit

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

Walsall Healthcare NHS Trust score for 2017/18 for Information Quality and Records Management, assessed using the Information Governance Toolkit was
72% (green)

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

Clinical Coding

Walsall Healthcare was not subject to the Payment by Results clinical coding audit during 2017/18 by NHS Improvement.

A similar requirement is now covered by the Information Governance Toolkit.

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
93.50%	96.73%	99.23%	91.81%

Learning from Deaths

Mandatory Statement

During the reporting period 2017-2018 the Trust has implemented the SJR approach to deaths occurring in the trust falling into 16 key cohorts

1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision
2. All patients with a learning disability
3. All patients with a mental health illness
4. All maternal deaths
5. All children and young people up to 19 years of age
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work
7. All 0-1 day LOS who are not receiving specialist palliative care
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care
9. All elective surgical patients
10. All none elective surgical patients
11. All unexpected deaths/ coroner reported
12. All Deaths in critical care
13. A random selection of 20% of those other than listed above
14. 20 patients per month to be reviewed by the palliative care team to review EOL care
15. All patients readmitted within 30 days
16. Those patient with 4 or more inpatient admissions within a 12 month period

Utilising this methodology the number of deaths to be reviewed each month is as follows

June 2017		**July 2017**	
Total Number of Deaths	80	Total Number of Deaths	81
Total Number to be Reviewed	62	Total Number to be Reviewed	62
August 2017		**September 2017**	
Total Number of Deaths	88	Total Number of Deaths	62
Total Number to be Reviewed	52	Total Number to be Reviewed	35
October 2017		**November 2017**	
Total Number of Deaths	86	Total Number of Deaths	80
Total Number to be Reviewed	68	Total Number to be Reviewed	51
December 2017		**January 2018**	
Total Number of Deaths	133	Total Number of Deaths	139
Total Number to be Reviewed	103	Total Number to be Reviewed	88
February 2018		**March 2018**	
Total Number of Deaths	109	Total Number of Deaths	113
Total Number to be Reviewed	71	Total Number to be Reviewed	71

The number of cases reviewed to date per quarter of deaths that occurred in the reporting period are:

Quarter	Number of Case Reviews Completed
Q1	212
Q2	101
Q3	146
Q4	121

During the reporting period the trust has reported 1166 deaths.

For this period the Trust has recorded 4 deaths which were judged as being as a result of a problem in care or system, 0.3%. 2 occurred in Q1 and 2 in Q3.

Key themes identified from these deaths were

- Timely recognition and response to the deteriorating patient
- Maintaining professional standards in relation to record keeping internally and in communication with other care providers
- Timely and effective Consultant to Consultant referral
- Human errors in imaging interpretation
- Failure to use red flag notification to a clinician on identification of an imaging anomaly
- Patient lost to follow up following an original review and plan for review

In response to these findings the trust via the root cause analysis process clearly identified care and system issues, lessons learnt and developed concise action plans

Key actions taken to address these issues have been

- External review by WMQRS of the sepsis and deteriorating patient systems and processes
- Launch of FEVERED initiative as a trigger for staff
- Additional training led by Sepsis UK
- A trust wide multi professional documentation audit of the patient record. To be owned by each specialty and accountability to be managed by the specialty teams
- Review of the provision , quality and timeliness of patient electronic discharge summaries to GPs
- Development and implementation of an inpatient referral standard operating procedure
- Ensure the system for imaging discrepancy and error rate monitoring is robust to assure that individual errors in reporting are monitored to ensure they are in accordance with Royal College guidelines and identify individual training issues which require further support.
- Review PACS and CRIS interoperability issue to ensure all colleagues are supported in completing imaging reporting accurately.
- Ensure that all colleagues are fully aware of the requirement to utilise the urgent red flag where it is required regardless of referrer or modality.
- Share learning amongst all radiologists to ensure learning.
- Discuss with individual image reporters relating to identified errors and practice issue for consideration within their on-going professional reflection and development.
- Ensure clinicians across the Trust are reminded of their professional responsibility to review and act on all requested investigations regardless of if they are identified as being urgent.
- Review the process for managing complaints and incidents identified via them to assure incidents and serious incidents are identified at the earliest opportunity to support learning and maintaining patient safety
- Review of all patients who have open access plans and have exceeded their guaranteed access date. This work is being led by the trust access team in conjunction with clinical leads across the trust for all specialties.

It is envisaged that the impact of these actions will reduce the risk of future deaths occurring due to those issues in care or process that have been identified.

During the previous reporting period 2016- 2017 the trust identified 3 deaths identifying issues in care or process that were more likely than not to have been due to a problem in care.

Mandatory Indicators

NHS Outcomes Framework Mandatory Indicators

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

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

NHS Outcomes Framework Domain 1

Title	Indicator	2016/17	2017/18	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 16 – 120.23 May 16 – 95.42 June 16 – 92.83 July 16 – 94.24 August 16 – 96.57 September 16 – 83.21 October 16 – 109.84 November 16 – 93.95 December 16 – 127.45 January 17 – 128.67 February 17 – 105.75 March 17 – 99.49	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	1.00	Latest position – Mar18 Issue (Oct 16 – Sept 17) Highest Performing Trust – The Whittington Hospital NHS Trust (0.73) Lowest Performing Trust – Wye Valley NHS Trust (1.25%)
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	2016 Apr - 36.3% 2016 May - 41.4% 2016 Jun - 38.2% 2016 Jul - 40.2% 2016 Aug - 39.8% 2016 Sep - 37.3% 2016 Oct - 31.9% 2016 Nov - 31.6% 2016 Dec - 30.5% 2017 Jan - 27.9% 2017 Feb - 32.9% 2017 Mar - 38.9%	2017 Apr - 31.5% 2017 May - 31.2% 2017 Jun - 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%	Not yet available from NHS Digital	Not yet available from NHS Digital
	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 2016/17 Adjusted average health gain	2017/18	National Average 2016/17 (provisional data -) Adjusted average health gain	Upper and Lower 95% control limit for the Trust (provisional data –) 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	Published Feb 18 **EQ5D 0.373 (95% CL)** **EQVAS 11.459** **OHS 17.360 (99.8%CL)**	Provisional data for April 2017-Dec 2017 will be available in June 2018 The Full 2017/18 data will not be available until August 2018	Published Feb 18 EQ5D 0.437 EQVAS 13.1 OHS 21.4	EQ5D 0.382-0.492 EQ VAS 8.849-17.376 OHS 19.483 - 23.276
	(iv) knee replacement surgery	Published Feb 18 **EQ5D 0.308** **EQVAS 8.253** **OKS 16.7**	Provisional data for April 2017-Dec 2017 will be available in June 2018 The Full 2017/18 data will not be available until August 2018	Published Feb 18 EQ5D 0.323 EQVAS 6.9 OKS 16.4	EQ5D 0.274-0.371 EQ VAS 3.120- 10.580 OKS 14.694 -18.093
	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 quality of its services, by:		• 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 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.

<table>
<tr><th>Title</th><th>Indicator</th><th>2016/17</th><th>2017/18</th><th>National Average</th><th>Highest and lowest NHS Trust and Foundation Trust scores for the reporting period</th></tr>
<tr><td rowspan="3">Readmission rates</td><td>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.</td><td>0 – 15 = 8.75%

16 or over = 9.72%</td><td>0 – 15 = 8.71%

16 or over = 10.67%</td><td>Not Available</td><td>Not Available</td></tr>
<tr><td colspan="2">Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="3">The figures provided above are based on 28 days but the Trust locally reports this metric as patients who are readmitted within 30 days of a previous discharge.</td></tr>
<tr><td colspan="2">Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="3">- 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.</td></tr>
</table>

NHS Outcomes Framework Domain 4

Title	Indicator	2016/17	2017/18	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 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**	Trust score worse than national score Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score	N/A
	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 quality of its services, by:		• An Ipad pilot on four wards was successful in increasing accessibility and involvement of patients with feedback activity on the inpatient 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. • 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	2016/17	2017/18	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%	48%	69% (2017/2018 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 2016 and 2017 respectively. The results of this were surprising as did not reflect the much better results of the Staff FFT for the same question and Key Finding 1 (which this forms part of) was the only Key Finding where the Trust saw a drop with 28 staying the same and 3 improving against a national average where 22 worsened (according to NHS Employers Edition published 22/3/18) so the results for this were not in keeping with what we expected nor our improved CQC rating.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		The questionnaire was sent to all colleagues and 1536 responded, equating to a 36% response rate. This was 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 factor we have been focusing attention on in culture, recognising this needs to improve. Focused actions have been implemented and staff continue to have the opportunity to contribute towards change and an improved culture through a number of new and existing channels. Targeted divisional action plans are being introduced as we all as a Trust-wide approach to improve this result for the 2018 Staff Survey. 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)

<table>
<tr><th>Title</th><th>Indicator</th><th>2016/17</th><th>2017/18</th><th>National Average</th><th>Highest and lowest NHS Trust and Foundation Trust scores for the reporting period</th></tr>
<tr><td rowspan="3">Patients who would recommend the Trust to their family or friends</td><td></td><td>March 2017 (% Recommended)
Inpatients – 90%
ED – 78%
Outpatients – 89%
Community – Not Reported
Antenatal – 80%
Birth – 95%
Postnatal Ward – 77%
Postnatal Comm – 100%</td><td>March 2018 (% Recommended)
Inpatients – 94%
ED – 76%
Outpatients – 92%
Community – 97%
Antenatal – 81%
Birth – 100%
Postnatal Ward – 96%
Postnatal Comm – 98%</td><td>Inpatients: 96%
Outpatients: 94%
A&E: 86%
Community Services: 95%
Antenatal (Maternity): 96%
Birth (Maternity): 97%
Postnatal Ward(Maternity): 95%
Postnatal Community(Maternity): 98%
Note: No national data for November 2017.</td><td>N/A</td></tr>
<tr><td colspan="2">Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="3">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</td></tr>
<tr><td colspan="2">Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="3">• 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 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.</td></tr>
</table>

NHS Outcomes Framework Domain 5

Title	Indicator	2016/17	2017/18	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	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	Apr 16 = 96.88% May 16 = 95.05% Jun 16 = 96.06% Jul 16 = 97.17% Aug 16 = 96.74% Sep 16 = 94.49% Oct 16 = 87.85% Nov 16 = 88.61% Dec 16 = 86.33% Jan 17 = 86.23% Feb 17 = 82.23% Mar 17 = 82.49%	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 = 93.45% Jan 18 = 91.30% Feb 18 = 93.18% Mar 18 = 95.49%	Latest position - Quarter 3 17/18 = 91.17% (based on 132 Acute Trusts)
	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	2016/17	2017/18	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	12.5	6.9	13 * (National published figures published before Q4 16/17 available hence used Q4 15/16 as a proxy)	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		

<table>
<tr><th>Title</th><th>Indicator</th><th>2016/17</th><th>2017/18
Latest available data to September 2017</th><th>National Average
(April – Sep 2017)
The latest data available</th><th>Highest and lowest NHS Trust and Foundation Trust scores for the reporting period</th></tr>
<tr><td rowspan="4">Incidents</td><td>The number and, where available, rate of patient safety incidents reported within the trust during the reporting period,</td><td>10,667 incidents reported and equating to 63.66 incidents per 1,000 bed days</td><td>5,868 incidents reported and equating to 76.2 incidents per 1,000 bed days</td><td>5,226 incidents reported and equating to 42.84 incidents per 1,000 bed days</td><td>10,016 incidents reported by Croydon Health Services NHS Trust and equating to 111.69 incidents per 1,000 bed days.

1,133 incidents reported by South Tyneside NHS Foundation Trust and equating to 23.47 incidents per 1,000 bed days</td></tr>
<tr><td>the number and percentage of such patient safety incidents that resulted in severe harm or death</td><td>60

0.6%</td><td>20

0.3%</td><td>18

0.3%</td><td>13 incidents (0.1%) – Croydon Health Services NHS Trust

0 incidents (0%) – South Tyneside NHS Foundation Trust</td></tr>
<tr><td colspan="2">Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="3">• The data is provided by the National Reporting and Learning System (NRLS)</td></tr>
<tr><td colspan="2">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</td><td colspan="3">• 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</td></tr>
</table>

Appendix 2 - Statements

Healthwatch Walsall Quality Account Response 2017/18

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

Whilst the Trust has made progress around a number of the priorities highlighted by the CQC inspection, it is evident that further work is needed to bring some of its services for the people of Walsall up to a consistently good standard.

In relation to patient experience we feel there is considerable dependency by the Trust on Friends & Family Test (FFT) feedback and the complaints processes in determining patient experience indicators. It is important to incorporate other qualitative data from mechanisms such as patient stories, co-design, the National Always Events and the use of the Observe and Act tool as promoted in the report.

Patient and staff surveys highlight room for improvement. We recommend further communication with patients and the public about how service changes are being made and timescales for this. We also believe there needs to be a 'sign up' or commitment by all staff around the Integrated Improvement Programme for Quality Improvement.

It is clear that financial pressures are being faced across NHS nationally, however tackling the financial challenges locally must still ensure patient quality and choice in all aspects of care.

It is pleasing that work has progressed to improve pathways between the Emergency Department (ED) and rapid response services as evidenced by the CQC no longer rating the service inadequate. However, FFT feedback for most of the year tell us that only 75% of patients are likely to recommend the service.. We have consistently raised issues around the physical limitations of the ED and Urgent Care service and lack of effective signposting and routes. We urge the Trust and NHS partners to prioritise the capital build programme to improve safety, quality and experience for patients.

In 2017 Healthwatch Walsall undertook a consultation with patients and relatives using A&E at Walsall Manor hospital. As a result of this work a number of recommendations were made in relation to patient experiences, triage and communication. We welcome the hospitals approach to incorporating these recommendations into the ED patient experience action plan.

We congratulate the work and national recognition around the reduction in High Flyers and it is positive to see such 'High Flyers' accessing the most appropriate care but also the positive impact in the reduction in hospital resources.

Maternity and gynaecology departments remain a concern for the people of Walsall and we are concerned to note the service is still rated inadequate by CQC for over 2 years. Urgent and sustained improvement is paramount to securing patient confidence. This is reflected by FFT feedback which remains poor when compared to national averages
FFT feedback is still poor when viewed against national averages:

Antenatal: 80% (national: 97%)
Birth: 94% (national: 97%)
Postnatal: 84% (national: 95%)
Postnatal (Community): 89% (national: 98%)

Initiatives such as the 'Whose Shoes 'events are a welcome opportunity to help inform service improvements based on patients' experiences. Healthwatch wish to see services developed jointly by mothers, families, midwives, staff and doctors working together to improve the experience. Recognising diversity, disability and ethnicity should be an important part of this process. This example of public involvement forms part of the Trust's key objectives and we look forward to monitoring and supporting this in 2018/19.

It is encouraging to see that the promotion of Listening into Action has enabled staff to gain a more direct input into maternity practice. The dashboard has shown some positive improvements from Sep 17 - Feb 18 such as a reduction in both emergency and overall C-section rates by 7.8% and 1.3% respectively and work around ensuring CTG monitoring. However, the Trust should not lose sight of the necessity to increase the provision of adequately trained midwives whilst acknowledging the national challenges in this area. Healthwatch recognises the Trust's commitment to improving maternity services and we will continue to monitor this.

The Trust is a leading partner in the emerging place-based model to integrate primary, community & social health and care services, known local as Walsall Together. Now that the outline business case has been approved by all partners, we look forward to seeing extensive activity to engage the public and patients in the design, delivery improvement and governance of integrated local services.

Healthwatch Walsall acknowledges that the Trust has made significant progress following its 2015 CQC rating of 'inadequate' to the rating of 'requiring improvement' last year. All local health and social care partners should redouble efforts and ambition to shift the rating towards good.

Healthwatch understands the challenging climate in which the Trust's health and community services operate. In the year that celebrates the 70th anniversary of the NHS we look forward to working alongside the Trust to maximise the patient voice.

Overview and Scrutiny Committee

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

Walsall Clinical Commissioning Group

Walsall Clinical Commissioning Group (CCG) welcomes the opportunity to comment on Walsall Healthcare NHS Trust Quality Account 2017/18. The CCG notes that the year has been challenging for the Trust and that there has been a lack of senior clinical engagement and leadership which has impacted on the quality and development of services.

The CCG is pleased to note the work undertaken by the Trust to achieve the improved CQC rating of *Requires Improvement* and congratulates the Trust on achieving an overall rating of *Outstanding* for the Community Services. It is encouraging that the Trust recognises that to improve their CQC rating further a changed and improved approach to quality improvement is required and that the Trust has plans to achieve this through the development of an Integrated Improvement Programme. The establishment of the Quality Improvement Faculty and the use of Learning from Excellence to improve quality is to be commended.

The CCG is disappointed that Maternity Services have been rated as *inadequate* since 2015 and that a Section 29a Notice was issued by the CQC following their inspection in 2017. We acknowledge some progress and improvements made by the Maternity Department in response to the findings of the inspection; however these are yet to be sustained. The CCG requires assurance that the service adequately serves the needs of the population of Walsall and we continue to attend the Maternity Oversight Board chaired by the Trust Chief Executive to gain assurance of progress and improvement within the services.

The Trust has found it a challenge to achieve Accident and Emergency four hour waits targets, however the CCG recognise that this as a challenge for the majority of acute trusts nationally. The Trust's aim to improve and maintain Accident and Emergency performance during 2018/19 is positive and we are encouraged by the partnership working being undertaken by the Trust with stakeholders. The CCG will continue to work collaboratively with all stakeholders to support the achievement of the target. We are pleased to note the positive impact on admissions made by the High Flyers Project and that this is being acknowledged nationally.

The CCG is also pleased to note that the Trust is committed to partnership working across the Black Country STP with plans for pathology and maternity services and the successful centralisation of stroke services at the Royal Wolverhampton NHS Trust.

Walsall Together is an ambitious and exciting programme to transform the health and social care in Walsall. The CCG notes the Trust engagement with the initiative to achieve service development and redesign, including the achievement of 7 day services.

The CCG acknowledges the awards received by the Trust with the Patient Experience Network National Award and the Baby Friendly Initiative within health visiting and also on being shortlisted

for a Patient Safety Award. The Trust needs to work towards achieving Baby Friendly Initiative within the hospital to promote breastfeeding and the associated health benefits for the population of Walsall.

The CCG acknowledges that there has been progress made with two of the Quality Improvement Priorities identified in 2017/18, Medicines Safety and Care of the Deteriorating Patient. It is disappointing that the Trust has not progressed with the third priority; Compliance with Equality and Diversity. However it is encouraging that all three priorities will be continued in 2018/19 with an addition of Record Keeping.

The CCG commends the Trust for their achievement of zero MRSA bacteraemia cases for two years. There is further work required by the Trust to improve compliance with VIP scores within ward areas.

The CCG notes the improvement in VTE assessment and the work undertaken to achieve. This now needs to be sustained and embedded into practice.

The CCG acknowledges that the Trust has undertaken work to implement new national guidance for mortality reviews to ensure that lessons are learned and that work will continue to further develop this process in 2018/19.

The CCG is disappointed that the Staff Survey results did not demonstrate the expected significant improvements despite the initiatives introduced by the Trust in 2016/17. We recognise that the Trust has plans to build further on the work undertaken in 2017 to improve staff satisfaction and anticipate improved results in 2018/19.

Results of patient surveys are also disappointing but the CCG recognises that the Trust is taking action to improve FFT response rates and scores and look forward to an improvement in 2018/19.

The CCG notes that Safeguarding Adult and Children training and PREVENT training has been a challenge for the Trust and that further work is required to ensure compliance with NHSE trajectories. The CCG will continue to monitor and support the Trust to achieve compliance; however this will require senior clinical commitment and leadership from the Trust to be successful.

In conclusion, we recognise that the Trust has a new leadership and executive team and anticipate that this will impact on progress in improving the quality of care provided by a responsive, visionary and resilient approach to making changes in the delivery of care. We support the priorities identified by the Trust for 2017/18 to further improve the quality, safety and experience for the population of Walsall. We will continue to support the Trust in achieving these priorities.

Signed:

Title: Chief Officer

Date: 25.05.18

Signed:

Title: Chief Nursing Officer/Director of Quality

Date: 26.05.18

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

Date 26/6/18

Richard Beeken

Chief Executive

Date 26/6/18

Appendix 4

Independent Assurance Report

[Ernst & Young]

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 20th April 2018 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 2018 ("the Quality Account").

This report is made solely to the Trust's Directors, as a body, in accordance with our engagement letter dated 20th April 2018. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018 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 2018 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 guidance.

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

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

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

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

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with the other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014-15'. These are:

- Board minutes for the period April 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from the Commissioners dated 25/05/2018;
- feedback from Local Healthwatch dated 25/05/2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated April 2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey 2017;
- the latest national staff survey 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 24/04/2018;
- the annual governance statement dated 16/05/2018;
- the latest 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. 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 2018:

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

Ernst and Young LLP

Stephen Clark
For and on behalf of Ernst and Young LLP
Birmingham
28th June 2018

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.

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

Walsall Healthcare NHS
NHS Trust

Quality Account 2017/18

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