Herefordshire Council

AGENDA

Health & Social Care Overview and Scrutiny Committee

Date: **Friday 7 June 2013**

Time: **10.00 am**

Place: **The Council Chamber, Brockington, 35 Hafod Road, Hereford**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

David Penrose, Governance Services
Tel: 01432 383690
Email: dpenrose@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format or language, please call David Penrose, Governance Services on 01432 383690 or e-mail dpenrose@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Health & Social Care Overview and Scrutiny Committee

Membership

Chairman	**Councillor JG Jarvis**
Vice-Chairman	**Councillor SJ Robertson**
	Councillor PA Andrews
	Councillor PL Bettington
	Councillor WLS Bowen
	Councillor MJK Cooper
	Councillor KS Guthrie
	Councillor JLV Kenyon
	Councillor JG Lester
	Councillor MD Lloyd-Hayes
	Councillor J Stone
	Councillor GA Vaughan-Powell
	Councillor PJ Watts

AGENDA

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive details of any Members nominated to attend the meeting in place of a Member of the Committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interest by Members in respect of items on the Agenda.

4. MINUTES 9 - 14

To approve and sign the Minutes of the meeting held on 2 May 2013.

5. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

To consider suggestions from members of the public on issues the Committee could scrutinise in the future.

(There will be no discussion of the issue at the time when the matter is raised. Consideration will be given to whether it should form part of the Committee's work programme when compared with other competing priorities.)

6. QUESTIONS FROM THE PUBLIC

To note questions received from the public and the items to which they relate.

*(Questions are welcomed for consideration at a Scrutiny Committee meeting so long as the question is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it **no later than two working days before the meeting** to the Committee Officer. This will help to ensure that an answer can be provided at the meeting).*

7. WYE VALLEY NHS TRUST QUALITY ACCOUNTS FOR 2013/14 15 - 84

To note the Wye Valley NHS Trust Quality Accounts for 2013/14.

8. WYE VALLEY TRUST RESPONSE TO THE CLINICAL COMMISSIONING REPORT 'WYE VALLEY NHS TRUST QUALITY CONCERNS'

To consider and comment on the Wye Valley NHS Trust response to the Clinical Commissioning report 'Wye Valley NHS Trust Quality Concerns'.

9. WORK PROGRAMME 85 - 94

To consider the Committee's Work Programme.

PUBLIC INFORMATION

Public Involvement at Scrutiny Committee Meetings

You can contact Councillors and Officers at any time about Scrutiny Committee matters and issues which you would like the Scrutiny Committee to investigate.

There are also two other ways in which you can directly contribute at Herefordshire Council's Scrutiny Committee meetings.

1. Identifying Areas for Scrutiny

At the meeting the Chairman will ask the members of the public present if they have any issues which they would like the Scrutiny Committee to investigate, however, there will be no discussion of the issue at the time when the matter is raised. Councillors will research the issue and consider whether it should form part of the Committee's work programme when compared with other competing priorities.

2. Questions from Members of the Public for Consideration at Scrutiny Committee Meetings and Participation at Meetings

You can submit a question for consideration at a Scrutiny Committee meeting so long as the question you are asking is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it **no later than two working days before the meeting** to the Committee Officer. This will help to ensure that an answer can be provided at the meeting. Contact details for the Committee Officer can be found on the front page of this agenda.

Generally, members of the public will also be able to contribute to the discussion at the meeting. This will be at the Chairman's discretion.

(Please note that the Scrutiny Committee is not able to discuss questions relating to personal or confidential issues.)

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YOU HAVE A RIGHT TO: -

- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.

- Inspect agenda and public reports at least five clear days before the date of the meeting.

- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.

- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.

- Access to a public Register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.

- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the Council, Cabinet, Committees and Sub-Committees.

- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.

- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).

- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

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HEREFORDSHIRE COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health & Social Care Overview and Scrutiny Committee held at Council Chamber - Brockington on Thursday 2 May 2013 at 7.00 pm

Present: **Councillor JW Millar (Chairman)**
Councillor SJ Robertson (Vice Chairman)

Councillors: PA Andrews, WLS Bowen, MJK Cooper, AJW Powers and GA Vaughan-Powell

In attendance: **Councillor PM Morgan (Cabinet Member, Health and Wellbeing)**

Officers: **J Davidson (Director For People's Services), G Dean (Scrutiny Officer), P Meredith (Head of Safeguarding & Review) and DJ Penrose (Governance Services)**

32. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors PL Bettington, KS Guthrie, JLV Kenyon, MD Lloyd-Hayes, J Stone and PJ Watts.

33. NAMED SUBSTITUTES (IF ANY)

Councillors AJW Powers for Councillor MD Lloyd-Hayes.

34. DECLARATIONS OF INTEREST

There were no declarations of interest.

35. MINUTES

The Minutes of the Meeting held on 12 April 2013 were approved.

36. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

There were no suggestions.

37. QUESTIONS FROM THE PUBLIC

There were no questions from the public.

38. CARE QUALITY COMMISSION (CQC)

The Committee received a presentation from Deb Holland, Compliance Manager, Care Quality Commission (Central West). During her presentation, she highlighted the following areas:

- That they had the power to undertake criminal and civil prosecutions for lack of compliance, but that these were powers that were used as a last resort.

- Changes would be made as a result of the Mid Staffordshire NHS Foundation Trust Public Inquiry which would see greater specialisation by CQC in the future. It was not

clear at this stage how the changes would be implemented. The national compliance rate for Adult Social Care was 80%, whilst Herefordshire Adult Social Care Services had a 90% rate. There had been only four incidents of major non-compliance within Adult Social Care as a whole, and only seven warning notices had been issued. This was better than the national average.

- There had been no 'never' events in either the Leominster or Herefordshire hospitals.

- A greater focus would be provided for the inspection plan in the coming year, as the Chief Inspector would look at five key questions, whilst more use would be made of intelligence from partners when planning and undertaking inspections.

In reply to a question, she said that organisations did submit a self-assessment form at registration, but that after that point they were subject to inspection from CQC. Non-compliant GP surgeries would be inspected in the coming year, but it was not expected that there would be any problems.

- That any information that inspectors received from the public was anonymised when acted upon, and there was a team to work with whistle-blowers. Safeguarding issues would be referred to the Local Authority, but the CQC would inspect establishments where such issues had been raised.

- In reply to a question, the Compliance Manager said that awareness of the work of CQC would be helped by the involvement with LINk and Healthwatch.

The Chairman said that there was a need for the Committee and CQC to maintain a good working relationship, and thanked Ms Holland for her presentation.

39. HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

The Committee received a report from the Herefordshire Clinical Commissioning Group (HCCG) from Mr Jon Wicks, Interim Chief Officer and Mr David Farnsworth, Executive Nurse Quality Safety. During his report, Mr Wicks highlighted the following areas:

- The CCG had been authorised, and the process had identified that it would benefit from support in developing its Integrated plan, oversight and management of Quality, Innovation, Productivity and Prevention *(*QIPP) and strategic planning and development. A programme of support has been agreed with NHS England, and it was expected that this would continue over a period of approximately 6 months.

- That the Herefordshire Clinical Commissioning had held its first public Board meeting. There were four GP's elected onto the Board to form the Governing Body, with two lay members.

- That a review of the costs of urgent care systems was underway.

- That the introduction of a Map of Medicine for GPs would set out the steps for treatment for the most common clinical conditions. This would be available to all GPs and would improve their ability to make appropriate referrals.

- That savings required in the QIPP programme would be required by the commissioners, and half of these had already been identified. The CCG was confident that the target could be delivered. In reply to a question from a Member, he went on to say that these savings would be achieved through transitional changes in the system. National changes in pricing methodology for

patients had also worked in the HCCG's favour. There had been changes in how the costs of maternity care were calculated, and it had been possible to make savings with the Wye Valley Trust as a result.

In reply to a question, Mr Wicks said that the CCG was financially stable with a balanced financial plan that included built in contingencies.

In reply to a question, Mr Farnsworth said that there had been a soft launch of the 111 service in the County on 19th March, for which there had been a great deal of preparation. There had been significant performance issues at this stage, and the service had been returned to Primecare after 10 days. The service had been stabilised and issues had been addressed by the provider. It was agreed that regular performance data from the 111 service should be provided to the Scrutiny Officer.

Mr Farnsworth went on to report that information sharing between all health agencies had led to heightened concerns over quality performance at the Wye Valley NHS Trust (WVT), and in response some high level assurances were being sought. The report before the Committee was intended to provide detail of concerns to Members, whilst keeping them informed of assurances being sought and how this work was being monitored.

In February 2013, the Francis report (part 2) had been published, and triggered a detailed scrutiny of mortality at all NHS Trusts. Initially 5 Trusts had been identified as significant outliers, with a further 9 trusts then being added to a national programme of scrutiny by Sir Bruce Keogh. During the previous year, WVT had previously seen a worsening mortality index, but as with other areas of care, this had been improving. The Trust was not included in the national programme. Concerns had been raised as the Hospital Standardised Mortality rate for the Trust had increased in February to over 134, which would have placed them under the aegis of programme of scrutiny chaired by Sir Bruce Keogh

The Trust had worked with the national mortality leads to review these figure, which had been reduced to 117 in March. It was anticipated that on-going work by both the Trust and the CCG would be sufficient to address this area of concern. Continued updates on the work in place to improve quality have been received by the CCG, and these were monitored internally through the designated CCG board committee (Quality & Patient Safety). The overall programme of assurance would be led by NHS England and would report to a Risk Summit, where the actions would be monitored through the governance structures of each agency, and collectively through the Quality Surveillance Group. The CCG would provide continued updates to the Health Overview & Scrutiny Committee as required. The CCG had been satisfied that wider assurances were available to counter concerns that there was immediate risk to patient safety.

In reply to a question from a Member, he said that these figures were standardised to take into consideration factors such as elderly patient groups and periods of bad weather. Where specific spikes appeared in the data, issues could be quickly identified and addressed.

The Chairman welcomed the report from the CCG, and said that it demonstrated the speed with which an issue was recognised and then actioned upon. The issues in the report had been discussed with the Chief Executive of the Wye Valley NHS Trust and consideration was being given as to how such issues could be dealt with in the future. The Trust had undertaken to provide a report on the matter to the next meeting of the Committee.

RESOLVED: That the report be noted.

40. QUALITY ACCOUNTS: WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST

The Committee received a report on the West Midlands Ambulance NHS Foundation Trust Quality Accounts 2013-14 from Michelle Brotherton, General Manager (West Mercia). During her report, she highlighted the following areas:

- That the Trust had been through both the Monitor and Care Quality Commission (CQC) inspection processes and were fully compliant with both organisations.

- The patient safety priorities for 2013-14. The first of these was a focus on the Falls Pathway in order to aid falls prevention and to ensure that patients were referred to the right place at the right time for an improved outcome. Patient falls had been reduced by 70% in 2012, and there had only been 36 falls whilst patients were in the care of the Trust.

- There were a number of priority areas for the Service in the coming year, which would include infection prevention and control of premises, vehicles and hand hygiene, the introduction of a key performance indicator to improve the quality of care given to patients with lower limb fractures, and monitoring of cannulation procedures.

In the ensuing discussion, the following points were raised:

- That there had been concerns about the Make Ready system, but that a Review undertaken by the Committee had addressed issues that had been raised by Members. The Service did send a regular postcode breakdown of ambulance response time targets to the Chairman. The Unions had initially opposed the system, but now saw it as a great step forward.

In reply to a question, she went on to say that the targets in the Accounts had been agreed by the Trust's Governors, whilst the lower limb targets were national ones.

The Chairman thanked her for her presentation.

41. CHILDREN'S SOCIAL CARE EXTERNAL AUDIT REPORT

The Committee received a report on the audit programme undertaken in response to the OFSTED Inspection Report into Children's Safeguarding in Herefordshire from the Head of Safeguarding and Review.

He reported that the findings of the audit reflected the conclusions of the Ofsted inspection in respect of interagency thresholds for service, case work, recording, management decisions and oversight, as well as the outcomes for children. The findings also reflect Ofsted's areas for improvement. There were a number of recommendations for improvement for inclusion in an action plan arising from the audit programme, and these were outlined in the report before the Committee.

RESOLVED:

That

a) **The report be noted; and;**

b) **That Recommendation would be made through the Task and Finish Review of the Scrutiny of Children's Safeguarding in Herefordshire.**

42. FEEDBACK FROM MEMBERS SEMINARS ON CHILDREN'S SAFEGUARDING

The Committee noted a report on the feedback from the Member's Seminar on Children's Safeguarding.

RESOLVED: That the report be noted.

43. WORK PROGRAMME

The Committee noted its Work Programme.

The Chairman reported that the number of presentations that the Committee currently received took up a great deal of time and could be delivered through a programme of seminars open to all Members.

RESOLVED: That the Work Programme be noted.

The meeting ended at 21:40 **CHAIRMAN**

Herefordshire Council

MEETING:	**HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**
DATE:	**7 JUNE 2013**
TITLE OF REPORT:	**WYE VALLEY NHS TRUST QUALITY ACCOUNTS FOR 2013/14**
REPORT BY:	**DIRECTOR OF NURSING AND QUALITY AND MEDICAL DIRECTOR, WYE VALLEY NHS TRUST**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

To consider the Wye Valley NHS Trust Quality Accounts for 2013/14.

5. Recommendation(s)

THAT: The Quality Accounts be noted.

6. Key Points Summary

6.1 The Committee is asked to note the Wye Valley NHS Trust Quality Accounts for 2013/14.

7. Appendices

7.1 The Wye Valley NHS Trust Quality Accounts for 2013/14.

8. Background Papers

8.1 None identified.

Quality Accounts 2013/14

Statement on Quality – A Letter from Our Chief Executive

Dear Patients, Relatives, Carers and Colleagues of Wye Valley NHS Trust

Insert picture of Chief Exec

I am delighted to introduce the Wye Valley NHS Trust Quality Accounts 2012/13. This report not only showcases where we believe we have performed well over the past 12 months but it also highlights where we will be focussing our efforts to improve patient care. We recognise that, in areas, there is room for improvement and the Trust fully acknowledges the challenges ahead of us and we are dedicated to making these improvements.

This document is set out into 3 areas;

1. **Priorities for Improvement**
   Sets out our 3 key areas for improvement over the next financial year

2. **Review of Quality Performance 2012/13**
   This section looks back at our quality performance over the past financial year.

3. **Mandatory Statements Relating to Quality of Services**
   The Department of Health mandates statements we must produce in relation to the quality of our services.

This year has seen the publication of the report following the Francis Inquiry. This report, its findings and the 290 recommendations that came from the Francis Inquiry will form a key part in driving improvements and ensuring honesty and openness with our patients and their carers. We have already identified the key recommendations applicable to our Trust and presented the findings of the Francis Inquiry to the Trust Board. Next year our Quality Accounts will detail what action we have taken to implement these recommendations and the data on the quality of services we provide should reflect these improvements throughout the year.

The future of Wye Valley NHS Trust has been widely publicised in local and regional media. The government requires all Trusts to attain Foundation Trust status, or an equivalent, by 2014. Many of you will be aware that Wye Valley NHS Trust cannot achieve Foundation Trust status alone as it cannot meet national financial requirements. We are therefore exploring different options and are consulting with local partners, patients, staff and the wider public. Throughout these consultations the quality of care provided by the Trust will remain at the forefront of any decisions made and until consultation has taken place it is business as usual and that includes driving forward improvements in the quality of care we provide.

We welcome feedback on our Quality Accounts as well as any feedback on our services (positive or negative). If you do have any feedback please do not hesitate to contact the Quality & Safety Department on 01432 355444 x5823 or via email at safety@wvt.nhs.uk.

To the best of my knowledge the information in this report is a true and accurate reflection of the current position of Wye Valley NHS Trust.

Yours sincerely
Derek Smith

Interim Chief Executive

Section 1: Priorities for Improvement

What are our priorities for improvement?

The key to improving our services is recognising and acknowledging where we have not performed well and where focussed efforts will truly benefit our patients. Below we set out what our priorities for 2012/13 are and we are disappointed that despite focussed efforts and hard work from staff we were unable to meet some of our goals from our previous Quality Accounts (please see page X). These goals will form part of our priorities again for the forthcoming financial year. Our priorities for this year are;

Priority	Responsible Officer
To eliminate all avoidable category 2, 3 and 4 pressure ulcers	Director of Nursing & Quality
To achieve a reduction in the hospital standardised mortality rate (HSMR) and summary hospital-level mortality indicator (SHMI) in line with the national average	Medical Director
To reduce diagnostic waiting times for patients waiting over 5 weeks	Medical Director

How have we chosen these priorities?

We believe that these priorities play a key role in ensuring quality services for our patients.

The first two priorities; pressure ulcers and mortality rates, have been carried over from our previous years Quality Accounts. Unfortunately we were not able to meet the targets we set our selves but we have made progress and are dedicated to ensuring these targets are met in this next financial year.

The Midlands and East Strategic Health Authority have an ambition to eliminate avoidable pressure ulcers and we have aligned ourselves with that ambition.

Safety

Priority 1

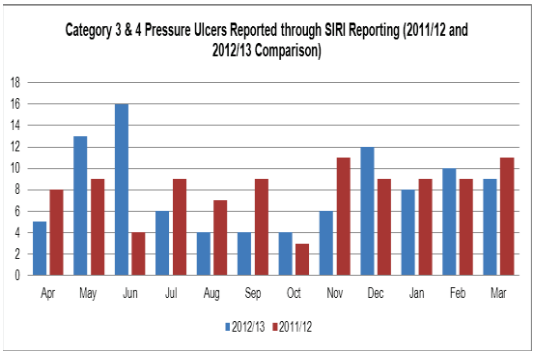
To eliminate all avoidable category 2, 3 and 4 pressure ulcers

Rationale

This is a key priority for the Trust and the Midlands and East Strategic Health Authority (SHA) and was identified in our previous years Quality Accounts. Despite efforts to eliminate pressure ulcers in 2012/13 we were unable to achieve our goal and therefore to drive further improvements the elimination of pressure ulcers has been highlighted as a priority again for this year. For more information on the work undertaken in 2012/13 to reduce avoidable pressure ulcers please go to page X.

Baseline

This chart shows the number of category 3 and 4 pressure ulcers reported in 2011/12 (the red bars) and 2012/13 (the blue bars). After an initial spike in June 2012 the numbers of pressure ulcers decreased through to October 2012. November 2012 saw a spike in activity which is where we also saw an increase the number of category 3 and 4 pressure ulcers reported. We have closely monitored pressure ulcers and for further analysis on the Trust performance against reducing pressure ulcers in 2012/13 please see page X.



Our Goal

The Trusts goal is to eliminate all avoidable category 2, 3 and 4 pressure ulcers.

Monitoring & Reporting

Category 3 and 4 pressure ulcers are reported through our Serious Incident Requiring Investigation (SIRI) process which means they are escalated from the frontline through the Quality & Safety Department and then escalated up to Director level and the Herefordshire Clinical Commissioning Group (CCG). This process happens almost straight away in most cases which means real time reporting and a speedy commencement of root cause analyses (RCA) to help determine what happened and why.

The numbers of category 3 and 4 pressure ulcers including number reported, where they are reported from, whether they were determined avoidable or unavoidable and where they were acquired from is reported on a monthly basis to the ward/department, Quality Committee, Trust Board and Herefordshire CCG.

These reporting mechanisms have worked well for us and we will continue to report category 3 and 4 pressure ulcers through these routes again this year. However, we do intend to take

a fresh eyes approach to our reporting to ensure we are not duplicating work.

How the Goal will be achieved

We identified and implemented a number of actions and measures throughout the past financial year and further information on these can be found on page X.

We intend to continue with these prevention methods throughout the next financial year and ensure they are embedded into every day practice. Further actions we will be taking are;

- Target specific high risk areas where pressure ulcers are more evident with further input from tissue viability team working clinically.
- Continue mini RCAs on all category 2 pressure ulcers to prevent further deterioration
- Ensure all patients at risk have SSKIN bundle booklet.
- Ensure further training is available for Health Care Assistants on a regular basis.

Responsible Officer

The Tissue Viability Team will lead and support staff in identifying and preventing pressure ulcers under the direction of the Director of Nursing and Quality.

Clinical Effectiveness

Priority 2

To achieve a reduction in the hospital standardised mortality rate (HSMR) and summary hospital-level mortality indicator (SHMI) in line with the national average by 31st March 2014

Rationale

Again, this was a key priority identified in our previous Quality Accounts , we will be ensuring that reducing mortality rates remains a priority for the forthcoming financial year. A lot of work has been dedicated to reducing mortality rates in the past financial year and we have made progress in understanding the complex data that lies behind HSMR and SHMI. Further information of this progress can be found on page X.

Mortality indicators are often highlighted in the media and you will have probably heard of them before. The term 'mortality indicators' can often be misconstrued and it's therefore important to understand that these are complex measures which are not used to determine quality of care but provide an indication of the quality of care amongst other performance indicators. In depth reviews are triggered by high mortality rates. Further information on mortality rates can be found on page X.

Baseline

Both HSMR and SHMI are compared against other Trusts nationally and the national average is 100.

Mortality Indicator	Annualised Rate
HSMR	105 (Feb 2012 to Jan 2013
SHMI	111.92 (Oct 2011 to Sept 2012)

Comment [s1]: This will be updated prior to publication

Our Goal

As previously mentioned the national average for both HSMR and SHMI is 100. It is our aim to have a HSMR and SHMI of 100 or below by 31st March 2014.

Monitoring & Reporting

Mortality is reported and discussed at Mortality Review Group meetings, Quality Committee, Trust Board, Clinical Quality Review Forum and Joint Mortality Review Meetings.

We will be further widening the reporting and monitoring of mortality rates to consultants through their speciality meetings in 2013/14. It's important that consultants are aware of the mortality rates and how the Dr. Foster tools can be used to further understand the data that lies behind them.

How the Goal will be Achieved

2012/13 has seen the development of a new electronic mortality system which allows consultants to review all in hospital deaths that occurred under their care electronically which then feedbacks through the Mortality Review

Group and allows sharing of lessons learnt. This system was introduced in March 2013 and 2013/14 will see this process being embedded into everyday working and enhancement of sharing lessons across specialities.

The Mortality Review Group will also continue to undertake exception reviews where issues and trends are identified. A number of exception reviews were undertaken in 2012/13 and the results of these can be found on page X.

We have also undertaken a robust joint review process with Herefordshire CCG. These reviews included;

- Died within 30 days of admission
- Deaths in day of admission
- Deaths attributed to fracture neck of femur

2013/14 will focus on implementing the findings of these reviews (which can be found on page X) and also identifying further areas in need of joint review. A more proactive and well proven approach to reducing mortality is the use of care bundles. These are targeted key interventions during the early part of an acute admission to hospital. We are already using the care bundle approach in acute stroke and we will soon be using this approach for patients with fractured neck of femur. The action plan is to audit their usage and to implement further bundles in 2013/14.

We will also be looking at standardising early warning systems this forthcoming year. As you can see from the baseline data the mortality indicators are not real time and we are often responding to data which is several months old. Early warning systems again constitute a more proactive approach to patient safety.

Responsible Officer

The Medical Director is the responsible officer for driving improvements in mortality rates.

Patient Experience

Priority 3

To reduce diagnostic waiting times for patients waiting over 5 weeks by 31st March 2014

Rationale

This is a new priority for 2013/14. We believe that the number of patients waiting over 5 weeks for diagnostic assessments should be kept to a minimum.

Baseline

To be added

Our Goal

Our goal is to reduce diagnostic waiting time for patients waiting over 5 weeks by 31st March 2014.

Monitoring & Reporting

Diagnostic waiting times are reported on a monthly basis to Trust Board and the Clinical Quality Review Forum through Trust Board.

How the Goal will be Achieved

A review of all diagnostic waits and targets where patients are regularly waiting over 5 weeks is to be undertaken with the aim to identify efficiencies in resources. This review and its findings is to be reported to Trust Board in July 2013.

Responsible Officer

The Medical Director is the responsible officer for reducing diagnostic waiting times.

Section 2: Review of Quality Performance 2012/13

This section details the quality performance of Wye Valley NHS Trust from 1st April 2012 to 31st March 2013. For ease, we have displayed the data under 3 key headings;

- Part 1: Safety
- Part 2: Experience
- Part 3: Effectiveness

In each of these sections we will summarise where we have done well and where we think we need to improve and how we will make these improvements.

Also included in this section is the progress we made against our priorities from our previous Quality Accounts. These were;

Priority	Goal	Deadline	Status	Page
Reduction of Avoidable Category 3 and 4 Pressure Ulcers	No avoidable category 3 and 4 pressure ulcers	December 2012	✗	See page X
Reduction in Readmission Rates	Reduce emergency readmission rates by 2%	March 2013	✗	See page X
Reduce Mortality Rates	HSMR and SHMI rate of 100 or lower	March 2013	✗	See page X
Monitor Patient Feedback against the Key Patient Experience Question 'How likely is it that you will recommend this service to family and friends ' on a scale of 1 to 10	Improved response against baseline	March 2013	✓	See page X

Quality is high on the agenda throughout the Trust and the safety of our patients is paramount. Winter 2012/13 saw exceptionally increased emergency admissions to Hereford County Hospital and Community Hospitals which has had a significant impact on the pressure placed on services. Safety and quality has remained at the forefront of day to day working but this has had an impact on incident reporting and patient experience contacts we have received. The significance of this impact can be seen within the relevant sections of this report.

The Trust structure for monitoring quality and safety takes into account the need for ward to board communication. Each of the four service units is required to review key quality performance information such as; incidents, complaints, clinical audits and CQUINs, among

others. This is then reported to Quality, Performance and Finance Meetings on an exception basis and then incorporated into the report to the Quality Committee, Trust Board and Clinical Quality Review Forum.

Where we have done well

- Increased frequency of reporting
- Improved reported structures
- Improved data analysis

Where we need to improve

- Improved reports to Service Units (data overload)
- Prevent duplication of work

Part 1: Safety

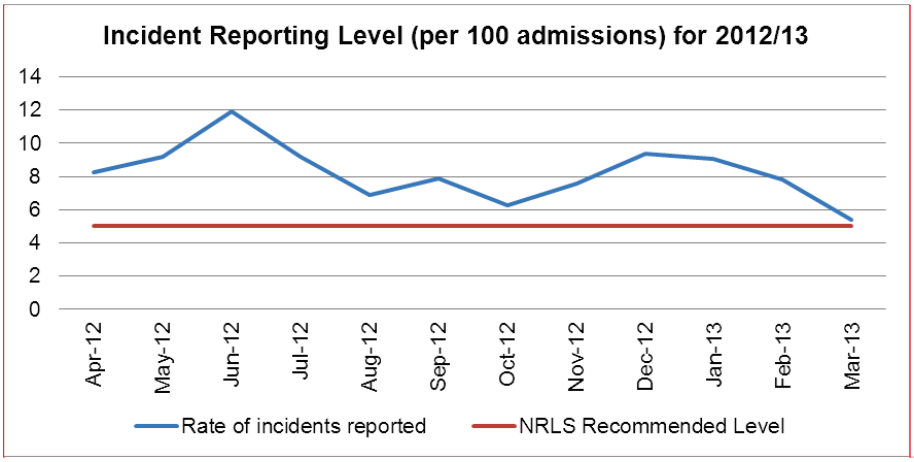
Incident Reporting

Timely reporting of incidents with appropriate management, investigation, learning and change is a fundamental tool for risk management and improving quality and safety in both Clinical and Non-Clinical areas. Inadequate incident management may lead to deterioration in quality and safety, loss of reputation, public concern and potentially loss of services.

What is the reporting culture?

The reporting culture of Wye Valley NHS Trust is to actively encourage reporting of both actual and near miss events. The numbers of incidents reported are measured per 100 admissions every month. Genrally the higher the rate of incidents, the stronger the reporing culture is in the organisation with a recommended rate from the National Reporting and Learning System (NRLS) of 5 per one hundred admissions.

Historically, staff have been able to report incidents via paper incident forms which are then reviewed and signed off by their line manager and the Quality & Safety Department. We have continued to roll out web based reporting this year and have provided training and support materials to drive and enhance the safety culture within our organisation. It is hoped this will lead to quicker and more cost effective reporting of incidents.

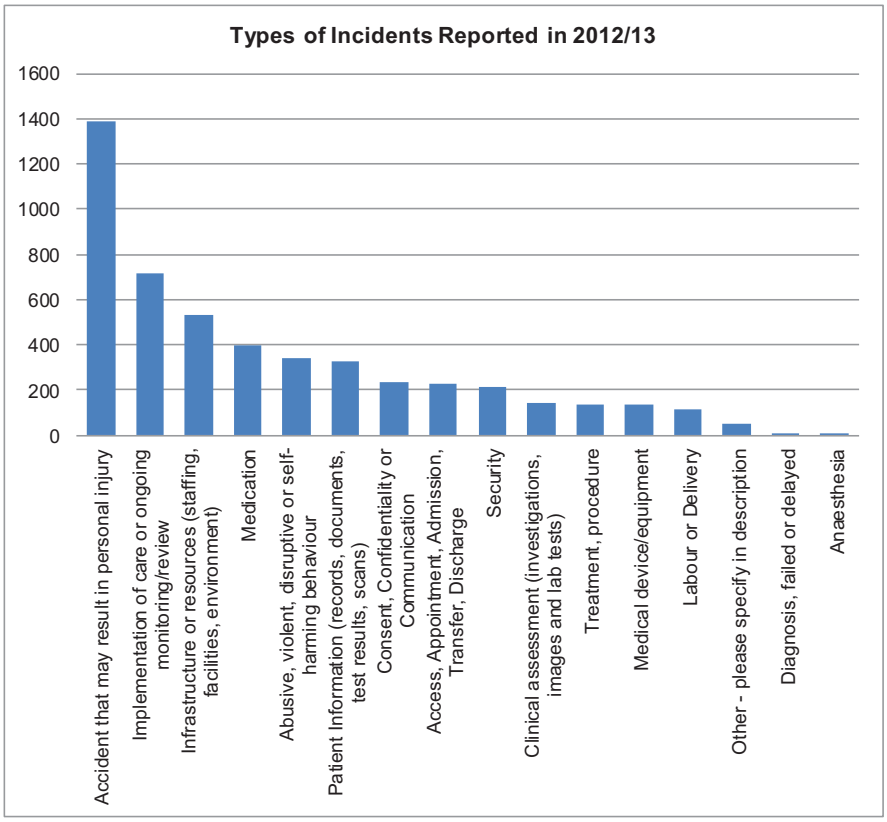


Comment [s2]: This graph will be updated prior to publication

This charts shows the incident reporting rate for Wye Valley NHS Trust form April 2012 to March 2013. The red line shows the recommended level and the blue line is our reporting level. We are consistently above the recommended level which shows a good reporting culture.

What types of incidents are reported in our organisation?

There are a number of different types of incidents that are reported within the Trust which are split into categories for easier analysis. In additon, trends can be simply identified, monitored and appropriate action taken when necessary.



The chart above shows the types of incidents by category that occurred within the Trust April 2012 to March 2013. The top 3 reported incidents this year are;

1. **Accidents that may result in personal injury**
   The majority of incidents included in this category are patient falls. This was one of the top 3 incidents reported last year and we are pleased to see that in this financial year we have seen an approximate decrease of 10% in the number of falls reported.
2. **Implementation of care or ongoing monitoring/review**
   These incidents are particularly made up of reports of pressure ulcers. Again, these were in the top 3 incidents reported in the previous year and this is why reduction of pressure ulcers forms part of the Trusts priorities for the forthcoming financial year.

Category 3 and 4 pressure ulcers are also reported as Serious Incidents Requiring Investigation (SIRIs) and we have provided more information on these on page X.

3. **Infrastructure or resources**
   In this category of incidents staff are able to report and record concerns about staffing levels amongst facilities or environmental concerns. This is new to the top 3 incidents reported this year. A targeted programme of risk assessments has been undertaken.

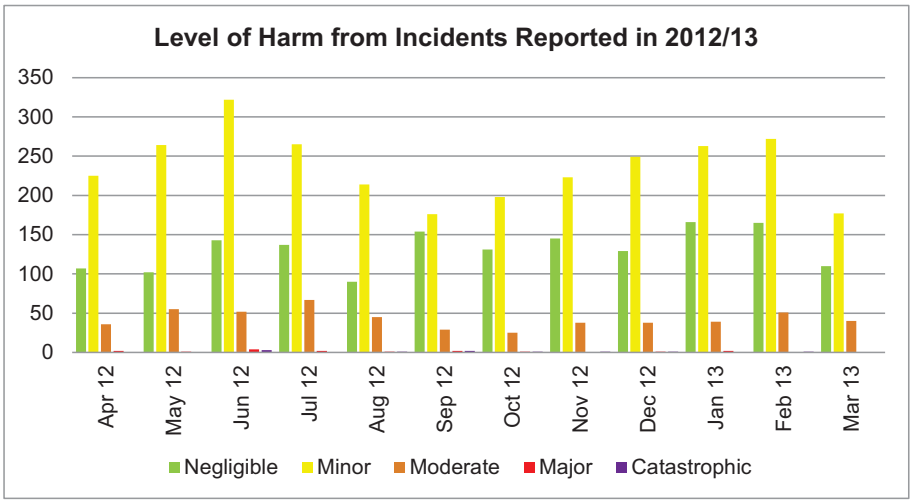
What is the degree of harm of the incidents reported?

All incidents are rated by the degree of harm and are categorised as follows:-

- Negligible
- Minor
- Moderate
- Major
- Catastrophic

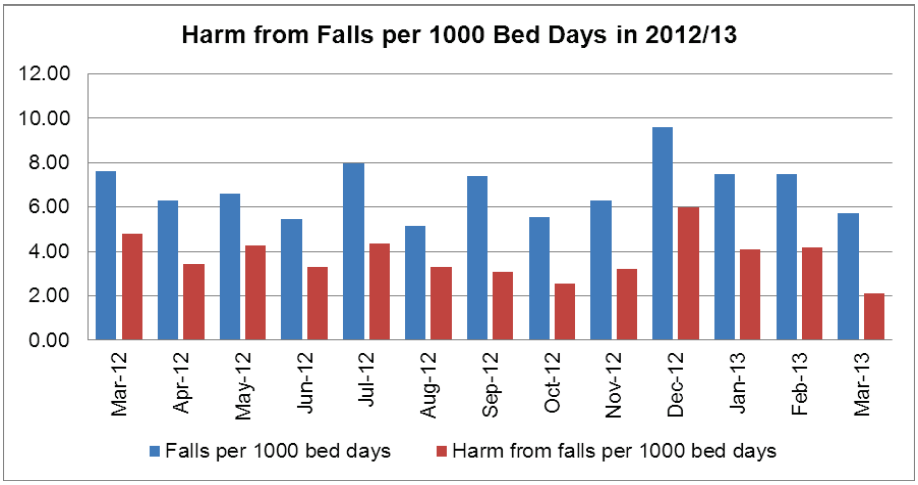
The degree of harm from incidents is measured by the Trust to improve the knowledge about how these incidents occur and affect patients. This will help to concentrate efforts on those incidents that cause a higher degree of harm but also understand multiple incidents of the same nature which occur and result in minor harm.

The chart below shows the degree of harm for incidents reported from April 2012 to March 2013.



What action was taken as a result of incidents reported?

Patients falls and pressure ulcers are the two highest reported types of incidents within the Trust. Further information on pressure ulcers is provided later in this document (see page x) therefore in this section we will focus on the work we have undertaken to reduce harm from patient falls.



The above graph shows the number of falls per 1000 beds days compared with the number of these incidents resulting in harm. We report falls per 1000 bed days to ensure comparable and consistent reporting month on month and also with other Trusts. Not all falls result in harm and others reported are those that a near misses. The blue bars in the chart above show the number of falls reported per 1000 bed days and the red bars are the number of falls where harm has occurred per 1000 bed days.

A number of actions have been implemented this year that have contributed to the approximate 10% reduction in patient falls;

- Intentional rounding - staff checking individual patients for their required needs on a frequent basis
- Introduction of new nursing assessment documentation, this has shown improved and focussed attention on the key assessments that need to be undertaken (including falls risk assessment)

We recognise that some falls cannot be prevented without restrictions to patient's privacy and dignity and when this occurs staff make sure that patients receive a prompt response that gives them the best possible chance of recovery if injury occurs.

Also included below are some specific actions taken from individual incidents;

Concerns raised by one ward about the condition of a patient on transfer from another area.

The concerns were forwarded to the area concerned and a root cause analysis investigation was instigated, this identified care delivery of minimal handover given to receiving ward and patient transfer was not planned. Actions were identified to prevent the incident from happening again with the use of the handover checklist to ensure all information was received about the patient.

Further information was required around the circumstances of a potential confidentiality breech with patient's information, where an individual received someone else's letter.

The department was asked to investigate the situation and provide a response. It was found that no medical details were revealed to the other person however actions were put into place to ensure that information is handled on an individual basis.

Serious Incidents Requiring Investigation (SIRI)

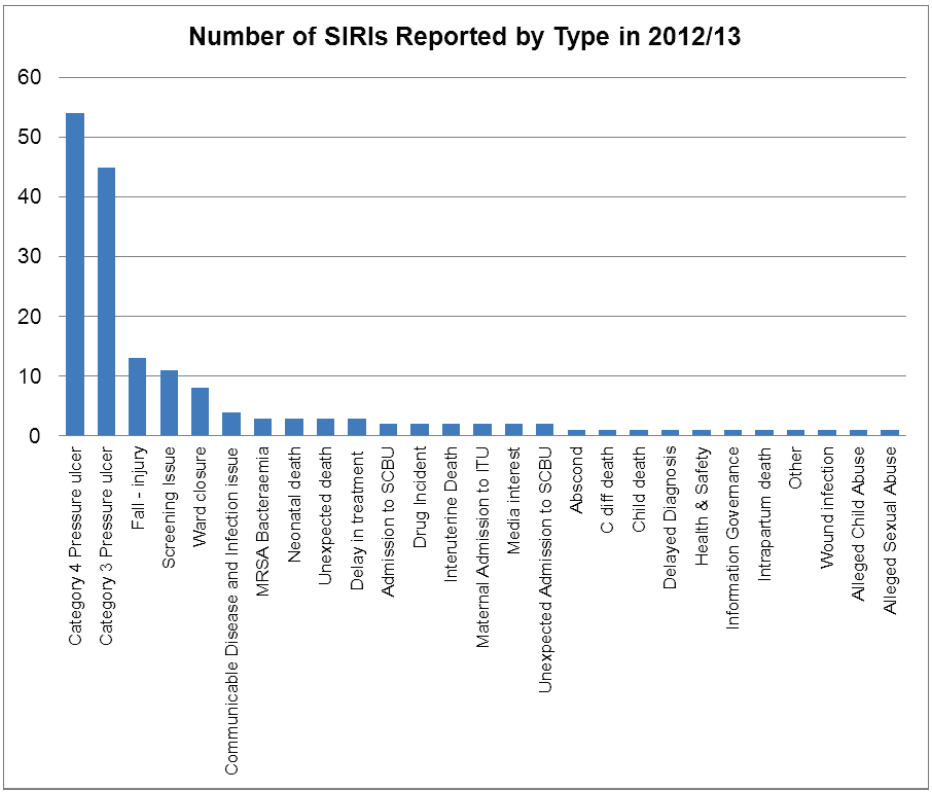
SIRIs are incidents that occur that have, or potentially may have, caused serious harm to patients or the Trust. Although measures are in place to prevent these incidents, when things do go wrong we ensure staff are open and honest about what has happened and encourage speedy reporting of such incidents. This allows for a culture of learning which in turn will benefit patients by strengthening what we already do to ensure harm doesn't come to patients whilst in our care.

The current process is for SIRIs to be reported immediately through the Quality & Safety Team, who then notify the relevant external organisations, we then commence an RCA investigations. These investigations are led by a lead clinician or nurse and follow the incident trail to determine why the incident occurred and how it can be prevented in the future. In some instances a Non Executive Director is involved in the investigation to give a 'fresh eyes' perspective on the investigations and to ask the questions that a health professional may not think to ask. Staff members are giving training on how to complete these investigations and we are looking at strengthening this training in the forthcoming year.

Before investigations are signed off as complete they are subject to rigorous review by Executive Directors and the Hereford Clinical Commissioning Group to ensure necessary steps have been taken to identify the root cause and put in place mitigating actions to prevent incidents from reoccurring.

What types of incidents are reported as SIRIs?

Any types of incident could potentially be reported as a SIRI depending on the consequence, however there is national guidance available to ensure that the Trust reports accurately. The graph below shows all the types of incidents reported as SIRIs in 2012/13.



What are the top three types of incidents reported as SIRIs in our organisation?

The top 3 incidents reported as SIRIs are

- Category 4 pressure ulcers
- Category 3 pressure ulcers
- Falls resulting in a moderate or above injury (e.g. fracture).

What action are we taking as a result of SIRIs?

Pressure ulcers are the most reported SIRIs and as such are a priority for the Trust. This was a priority last year and will continue to be a priority this year. A significant amount of work has been undertaken by the Tissue Viability Team and nursing staff to reduce pressure ulcers;

- All category 3 and 4 pressure ulcers are subject to a RCA.
- Tissue Viability Team support provided to nursing staff undertaking the RCA.
- Introduced the use of SSKIN bundle to assess and monitor the patient's skin integrity in both the hospitals and the community. This tool provides prompts to both staff and patient's;
  Skin care prompts the risk assessment of the skin integrity,
  Support Surfaces reviews the mattresses and cushions in use,
  Keep moving encourages giving advice about repositioning,
  Incontinence ensuring the patient's continence is assessed and finally
  Nutrition encourages the patient's diet to be assessed**.**

The chart on page X shows our progress last year (blue bar) compared with 2011/12 (red bar) and as you can see we were making good progress in reducing pressure ulcers from June 2012 to October 2012. November 2012 saw an increase which then escalated significantly in December 2012.

A process is in place that all child deaths in Herefordshire are reported through our systems and then are reviewed by Herefordshire Safeguarding Childrens Board.

As you will have seen from 'Section 1: Priorities for Improvement' pressure ulcers is a priority for 2013/14. Our aim is to have no avoidable category 2, 3 and 4 pressure ulcers by X.

Healthcare Associated Infections

Healthcare Associated Infections are often reported in the media and you may have heard about MRSA and Clostridium *difficile* (usually called c diff) before. We have a team of people dedicated to fighting these healthcare associated infections and this year they have continued to ensure knowledge, practice and the clinical and non-clinical environments are developed and maintained and in turn supporting the effective prevention of healthcare associated infections.

Every member of staff receives infection prevention education on induction to the trust and annually thereafter. We are pleased that at year end we've had 100% attendance at these sessions.

Organism & Location	Externally set Maximum 2012/13	Actual 2012/13
MRSA Bacteraemia	1 Case	3 Cases
Clostridium	21 Cases	10 Cases

***difficile* – Acute site**		
Clostridium *difficile* – Community site	5 Cases	6 Cases

MRSA Bacteraemia

Of the three cases shown in the table above two were from the same patient case although reportable separately as from two separate blood cultures.

This year the government has said that hospitals will be penalised for any MRSA bacteraemias which might be considered preventable.

Clostridium Difficile (Acute and Community)

We have invested in a number of measures to reduce *Clostridium difficile;*

- All patients on antibiotics are also now routinely offered probiotic yoghurt
- Hydrogen peroxide technology is used to decontaminate the hospital environment.

Mortality

Mortality rates are a complex indicator of the quality of care provided within our organisation. There are two mortality rates we monitor (and are monitored against). These are;

- HSMR – a measure of in-hospital deaths
- SHMI – a measure of all deaths within 30 days of discharge from the Trust

Mortality rates across the NHS have recently been highlighted in the media and we appreciate that it can be daunting to patients, relatives and staff to read that your local Trust has higher than average mortality rates. We have taken steps to reassure the public, through press releases, that we are taking this matter seriously and are taking steps to reduce our mortality rates.

What are our mortality rates?

Mortality Indicator	Most Recent Rate	Annualised Rate
HSMR	129 (January 2013)	105 (February 2012 to January 2013
SHMI	97.02 (July 2012 – September 2012)	111.92 (October 2011 to September 2012)

This is the second time we have been under the national average in the past 3 years

Comment [s3]: This will be updated prior to publication.

This table shows that our annualised HSMR remains above average (100) but this does need to be understood within the context of an integrated care organisation (where both acute hospital and community hospital care takes place); also the volatility of this indicator is high.

Our SHMI has reduced considerably since last year and our action plan is to reduce this further still.

What action have we taken to reduce mortality rates?

We did not meet our goal in reducing mortality rates last year but we did however make progress in understanding the data behind these complex indicators and establishing systems that will help us to reduce mortality rates in the forthcoming year.

Actions we have taken this year include;

- Introduction of care bundles and review of early warning systems.
- Introduced electronic system to ensure all in hospital deaths are reviewed by the consultant in charge of the patients care at the time of death.
- Set up monthly mortality review group meetings with representation from medical, quality, information and commissioning staff.
- Taken part in joint reviews with our commissioners, looking at patients who died on day of admission and patients who died within 30 days of discharge.
- Carried our exception reviews into areas identified as having a higher than expected mortality rate.

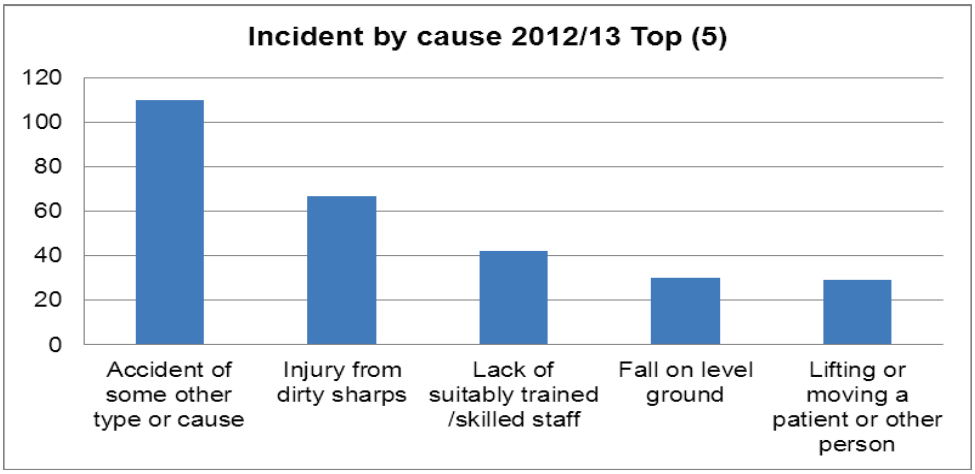
Reducing mortality rates is a priority for the Trust again this year (see page X).

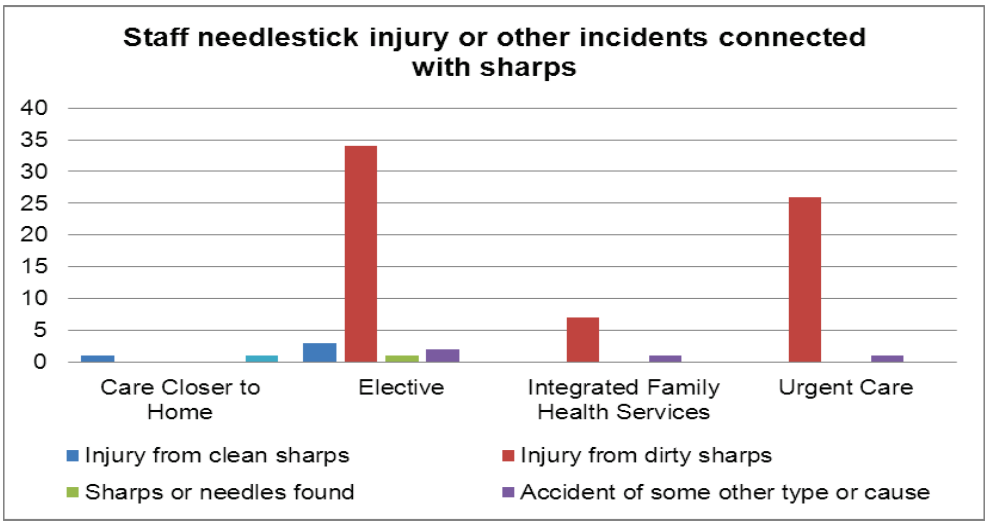
Health & Safety

We have effective management arrangements in place to ensure the wellbeing of staff, patients, visitors, contractors & others who may be affected by our activities and to minimise the adverse impacts to individuals and the business from ill health & injury.

We appointed a new Health & Safety Officer in May 2012 part of the Health & Safety Officer role is to evaluate the Health & Safety Services at WVT. The Health & Safety Officer has looked at what the Trust needs to achieve to comply with all Health & Safety acts/legislation such as the HASAWA1974, Management regulations, Control of Substances Hazardous to Health (COSHH), Display Screen Equipment (DSE), Personal Protective Equipment (PPE), first Aid at work, Manual Handling operations regulations (MHOR), Provision and use of work equipment (PUWER regs) Lifting Operations Equipment Regs (LOLER) and amongst others. To achieve all of this the Trust needs to invest in Health & Safety training for Ward/Dept Managers & Health & Safety Reps to enable them to achieve and implement all of the Health & Safety policies, risk assessments, audits within the Trust. This will also include new policies the Trust need to develop.

Health & Safety Incidents Reported





Safety Alerts - Central Alerting System (CAS)

What are safety alerts and how are they relevant to patients?

CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS.

The Quality and Safety Department escalate and monitor, Medical Device Alerts (MDA), Estates and Facilities (EFA) and National Patient Safety Alerts (NPSA).

Safety alerts are issued by the Department of Health on a regular basis and can relate to medical equipment or clinical processes. The aim is to share best practice and highlight any areas of concern.

How many has the Trust received that is relevant to them?

Of the 92 safety alerts received during this reporting period:

- 28 have been relevant to the Trust. 100% of the safety alerts relevant to the Trust have been completed within time frame.
- 8 assessing relevancy to the Trust, still within time frame.

How have we taken action to implement and adhere to these safety alerts?

Action has been taken against all of the relevant safety alerts. When the Trust receives safety alerts, the alerts are escalated to managers and service delivery managers to assess relevancy to their departments/areas and to take action as prescribed in the safety alert.

Example 1

Alert Ref & Title	Originated by	Issue Date	Compliance Achieved Within Deadline?
MDA-2012-060 Powered wheelchairs. All chairs in the Harrier range. Manufactured by Invacare	MHRA Medical Device Alerts	22/08/2012	✓

The above safety alert resulted in;

- Ensuring staff were aware of the revised guidance regarding removal and refitting of the drive wheel
- Invacare being informed that the Field Safety Notice has been received and that the revised procedure has been reviewed and understood responsible for maintenance of Harrier wheelchairs have a copy of the amended procedure
- Maintenance staff having a copy of the amended procedure

Example 2

Alert Ref & Title	Originated by	Issue Date	Compliance Achieved Within Deadline?
MDA-2012-0075 All medical devices and medicinal products containing chlorhexidine	MHRA Medical Device Alerts	25/10/2012	✓

This safety alert resulted in the Trust ensuring staff:-

- Were aware of the potential for an anaphylactic reaction to chlorhexidine record know allergies in patient notes
- Checked the labels and instructions for use to establish if products contained chlorhexidine prior to use on patients with a known allergy
- Checked whether chlorhexidine was used or was impregnated in a medical device that was used if a patient experiences an unexplained reaction
- Reported allergic reactions to products containing chlorhexidine to the MHRA to note further guidance on anaphylaxis is available from NICE, the Resuscitation Council and the AAGBI.

RIDDOR Reports

It's a legal requirement set out by the Health & Safety Executive to report RIDDOR's. All RIDDOR reportable incidents are investigated by the Trust and recommendations made to ensure there is no re occurrence.

Number of RIDDOR reported to the HSE for 2012/13

Over Seven Day Injury Preventing Person From Working	Major Injury: Break/Fracture/Head Injury	Fatality	Dangerous Occurrences
8	2	0	1

RIDDOR Reported by Service Units

Care Closer to Home	Integrated Care	Urgent care	Elective Care	Corporate
2	2	6	0	1

Lessons Learned and Good Practices Identified from Health & Safety

During 2012/13 lessons/changes have been made following incidents, Health & Safety reports, Staff concerns that have been reported/raised with the Health & Safety Department as below;

Example 1: Hutted Corridor (Entrance)
Following incident reports/injuries reported by staff in regard to slippery entrance in inclement weather, a Health & Safety Risk Assessment was completed with recommendations to change flooring and mechanise doors to close automatically.

The entrance has now been changed thus eliminating the risks/hazards.

Example 2: En-Suite Shower Units at Community Hospital
Following Health & Safety Inspection at Ross Community Hospital it was noted that the two en-suite shower rooms used for infected cases were of the old type shower units, which was a slip, trip, fall hazard for patients and staff.

The shower units have now been changed for flat sloping floors in line with current Health technical memorandums, which will eliminate risks/hazards.

Patient Safety Walkrounds

What are Patient Safety Walkrounds?

We have been carrying out Patient Safety Walkrounds for a number of years now and we've found them to be a beneficial for the Trust Board, senior managers, frontline staff and patients. Patient Safety Walkrounds gives Executive Director, Non Executive Directors and senior managers a scheduled opportunity to visit wards/departments and discuss with staff and patients their views on how services can be improved.

How many have been carried out this year and what action has been taken as a result?

The Walkround Team (usually made up of one Executive Director, one Non-Executive Director, a member of the Quality & Safety Department and a senior manager) undertake walkrounds on a monthly basis and 18 walkrounds have been carried out this year.

At the end of a walkround a summary report is compiled and actions identified. Here are some examples of actions that have been taken as a result of these walkrounds.

- Resus trolleys were updated and system of checking clarified to ensure sufficient supplies at all times in Radiology.
- Ward cleanliness audit carried out on Arrow Ward to ensure compliance is maintained.
- Organised Infection Control Team to shadow District Nurses to ensure cross learning for both teams.

Next year we are planning on introducing a programme of unannounced visits influenced by the '15 Steps' initiative designed by the NHS Institute for Innovation and Improvement.

Summary of Safety

Where we have done well

- Maintained a good reporting culture for incidents
- Approximate 10% reduction in patient falls reported
- Under maximum level of Clostridium difficile for County Hospital
- 100% of CAS alerts completed and closed within timeframe
- 100% of SIRIs closed within timeframe since January 2013.

Where we need to improve

- Reduction in avoidable category 2, 3 and 4 pressure ulcers.
- Over the maximum level for MRSA bacteramias and Clostridium difficile in community sites
- Reduction in mortality rates in line with national average
- IOSH Training to be commenced in April/May 2013

Part 2: Effectiveness

External & Peer Reviews

The Trust is subject to external and peer reviews from various sources including the Care Quality Commission (CQC), Patient Experience Action Team (PEAT) and West Midlands Quality Review Service (WMQRS), amongst others.

We welcome these reviews as it provides a 'fresh eyes' approach to reviewing the services we provide and identifies areas for improvement and celebrates areas of good practice.

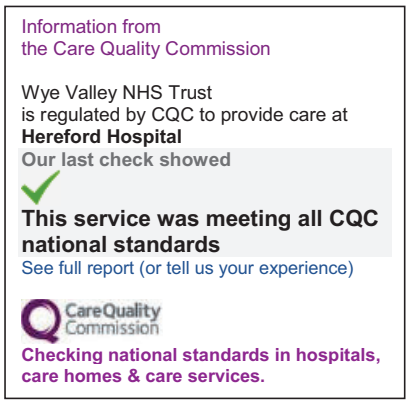
What reviews have taken place in 2012/13 and what happened as a result?

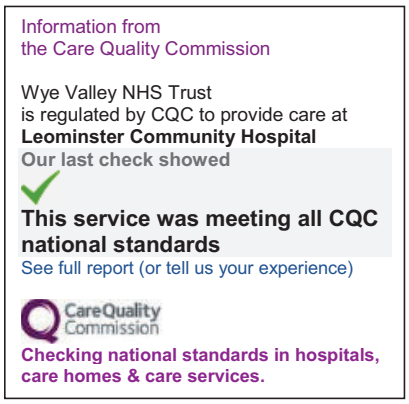
CQC Reviews

The CQC monitor quality of care for all NHS Trusts. A programme of announced and unannounced inspections (as well as other sources of intelligence) demonstrates the quality of care

The CQC visited the Trust on;

- 16th July 2012 to undertake an unannounced visit at Leominster Community Hospital
- 26th November 2012 to undertake an unannounced visit at Hereford County Hospital





You can use the 'widgets' above to access the full reports from these reviews but to summarise;

What the CQC Said – Hereford County Hospital

'A team of four inspectors carried out an unannounced visit to Hereford hospital. We spent time on four wards at the hospital, where we observed the care and support that people received from staff. We spoke with seventeen people using the service and with two relatives who were visiting. We also spoke with staff and we reviewed records.

People were very positive about the staff at the hospital, describing them as, "very cheerful and friendly" and, "very good at asking if I need anything". We saw that staff were attentive to people's needs and spent time making sure that people had what they needed and were comfortable. People told us that they felt safe and well cared for at the hospital. One person said, "I feel privileged to have received the treatment I've had".

We saw staff providing care and support to people in accordance with their care plans. Staff had a good understanding and knowledge of people's individual needs. They showed empathy and sensitivity when talking with people.

Staff received the training they needed to carry out their roles. At our previous inspection in March 2012, we had concerns about some aspects of record keeping at the hospital. The trust had sent us a detailed action plan to tell us how they would make the necessary improvements. At this inspection, we found that there were effective systems in place to ensure that records were accurate and fit for purpose.'

What the CQC Said – Leominster Community Hospital

'We carried out an unannounced inspection of Leominster Community Hospital on 16 July 2012. At this inspection we checked some aspects of the care and treatment provided at the hospital. We spoke with five people who used the service, two relatives who were visiting and with staff, local GPs and the ward sister. We also spent time watching how staff supported people, and we looked at a sample of care records.

People told us that they were pleased with the care they received at the hospital. They spoke highly of the staff, describing them as "very helpful", "nice and friendly" and "good at their jobs".

We saw that people were being encouraged to be as independent as possible. Staff offered people choices, such as what they would like to drink and where they would like to sit. Staff had a good knowledge and understanding of each person's needs.

People told us that staff were approachable and that they did not usually have to wait if they needed assistance.

Some records did not give an accurate picture of the care that had been provided.

People knew how to raise any concerns and were confident that they would be listened to and that action would be taken.'

WMQRS

In September and November 2012 the WMQRS reviewed the Trust against standards for Long Term Conditions. The visit involved the Trust preparing a self assessment and evidence folders showing how we thought we complied against the standards. A team (made up of peers from other Trusts) then visited the Trust and provided their assessment of how they thought we performed against the standards.

Overall the review was positive, however, concerns were identified with the management of medicines within community hospitals, which are being regular reviewed and monitored. It was commented that the Trust continues to provide excellent leadership and support for improving staff training. It was also noted that the Trust had an innovative approach to encouraging staff participation in the training and education programme by providing out of hours training.

NHSLA

The NHSLA is responsible for managing negligence and other claims against the NHS in England. They help to resolve disputes fairly, share learning about risks and contribute to improvements in the safety of NHS patients and staff. They are also responsible for advising the NHS on human rights case law and handling equal pay claims.

An important aspect of their work is to produce risk management standards based on the causes of claims against which trusts are assessed and provide financial incentives to trusts that demonstrate compliance with them. The Trust had previously achieved Level 1 of these standards in March 2012 by demonstrating that 47 out of 50 policies and procedures which are required to manage risk were in place.

A working group has met throughout 2012/13 to ensure that progress continued to be made in all the Level 1 policies and also to prepare for the next stage of assessment, Level 2. The organisation intends to submit for level 2 assessment in 2014/15.

PEAT

What is PEAT?

PEAT is an annual assessment of inpatient healthcare site in England. PEAT inspects standards across a range of services such as food, cleanliness and patient environment. The results from PEAT allow us to benchmark our services with other NHs Trusts and aids us in driving improvements.

What were the results for Wye Valley NHS Trust?

Scoring:

	2008	2009	2010	2011	2012
Bromyard Community Hospital					
Environment	4	4	4	4	4
Food	4	4	5	5	5
Privacy & Dignity	5	4	4	4	4
Hereford County Hospital					
Environment	4	4	4	4	4
Food	4	5	4	4	5
Privacy & Dignity	No score	4	4	4	5
Hillside					
Environment	4	5	4	4	4
Food	4	4	5	5	5
Privacy & Dignity	5	5	4	4	4
Leominster Community Hospital					
Environment	4	4	4	4	4
Food	4	4	4	4	5
Privacy & Dignity	5	5	4	4	5
Ross Community Hospital					
Environment	4	4	4	4	4
Food	4	4	4	5	5
Privacy & Dignity	5	5	4	4	4

Introduction of Patient-Led Inspection Programme in 2013/14

The existing PEAT inspections will be replaced in this year with a new Patient Led Assessments of the Care Environment (PLACE). This assessment differs from PEAT through the increased involvement of Patient Assessors. Patient Assessors represent users of healthcare services and, with the exception of staff employed by the hospital or organisation being assessed, anyone is eligible to act as a Patient Assessor. All PLACE teams include at least two patient assessors and the assessment process focusses on the environment in which care is provided with particular emphasis on cleanliness, general condition, appearance, maintenance, privacy, dignity and the provision of food and drinks. Staff attitudes and behaviours are not included as part of this assessment.

CQUINs

Every NHS Trust is set CQUIN targets. There are national CQUINs and then locally set CQUINs and the key aim to these CQUINs is to drive improvement in services. It's also important to note that CQUINS have a financial incentive attached them.

This year the Trust achieved 100% in meeting its CQUIN targets.

CQUIN	Description	Target	Status at Year End
VTE Risk Assessment	Percentage of all adult inpatients who have had a VTE Risk Assessment on admission to hospital using the clinical criteria of the national tool.	>90%	✓
VTE Prophylaxis	Percentage of all adult inpatients who have been assessed to be at increased risk of VTE who have received appropriate prophylaxis based on national guidance (NICE 2010)	95%	✓
Dementia Case Finding	Patients aged 75 years and above who are admitted as an Emergency who have a length of stay of more than 72 hours, are asked the case finding question "have you/has the patient been more forgetful in the	90%	✓

CQUIN	Description	Target	Status at Year End
	past 12 months to the extent that it has significantly affected your/their daily life).		
Diagnostic Assessment for Dementia	**Patients aged 75 years and above who have scored positively on the case finding question Assess and Investigate:** carry out a diagnostic assessment including investigations to determine whether the presence of a dementia is possible. People with a known diagnosis of dementia will be considered to have had a diagnostic assessment	90%	✓
Referral for Specialist Diagnosis	**Referral:** for specialist diagnostic assessment by a clinician with appropriate skill or training. Patients who are 75 years and above who have been identified with a positive or inconclusive assessment is referred for further diagnostic advice or follow up	90%	✓
NHS Safety Thermometer	Completion of the National Safety Thermometer Tool each month	100%	✓
Acute Inpatient Survey	Adult Inpatient survey which is Nationally coordinated between Oct – Jan for Patients who have been admitted between July – August	Score of >67	✓
Patient Experience Establishing	To establish the Net Promoter question for 10% of inpatient	Establish question and implement for	✓

CQUIN	Description	Target	Status at Year End
Question and baseline score	discharges at or within 48hours of discharge	10% of discharges for month 1	
Patient Experience Board and Commissioner Reporting	Monthly Trust Board Minutes that clearly demonstrate reporting of Net promoter score broken down to service unit and wards, Board Challenge and actions relating to improvement	Monthly	✓
Patient Experience Weekly Reporting	Collate and review the Net Promoter Score on a weekly basis commencing in Quarter 2 (1st July 2012)	100%	✓
Patient Experience Performance Improvement	Achieve a 10 point improvement in Net Promoter Score or achievement/maintenance of top quartile performance throughout 2012/2013	10 Point Improvement/Top Quartile	✓
Net Promoter	The Net Promoter Question to be asked of people who accessed services	2.5% People who have accessed services	✓
Real Time Feedback	Three Questions will be asked of Patients alongside the Net Promoter 1. On arrival did Staff introduce themselves to you 2. Were you given an opportunity to discuss your condition with a healthcare professional 3. Were you given information about your	Qtr 1 Minimum 2.5% Qtr 2-4 Improve in baseline score	✓

CQUIN	Description	Target	Status at Year End
	medications		
Using Patient Intelligence to improve services	Data related to Patient Experience is triangulated and considered to ensure that the experience of the wider population using and accessing health care services are considered.	Evidence of Feedback, analysis and improvement	✓
Making Every Contact Count Organisational Board Commitment	Making Every Contact Count requires evidence of Board Commitment and sign off to make sure people are referred to appropriate services, increase Staff competence and confidence to raise a lifestyle issue with a service user	Qtr 1 Sign off by Board, Qtr 4 Measurable Progress Report	✓
Making Every Contact Count Brief Intervention Training	Number of eligible frontline staff who have training in healthy lifestyles brief intervention	Qtr 1 Eligible Numbers of Staff, Qtr 2-Qtr 4 Numbers of Staff trained	✓
Making Every Contact Count Brief Intervention Referrals/Signpost	Signposting/referral for Service Users to Stop smoking services, and other lifestyle services	Qtr 2 2000 Qtr 3 3000 Qtr 4 3000	✓
Dementia awareness training	Percentage of eligible patient facing clinical staff attend training in dementia awareness	>80%	✓
Standardisation of Outpatient Clinic Letters	Standardisation, improved quality and timeliness of outpatient clinic letters	90%	✓

Promoting Normal Birth

What is promoting normal birth?

The World Health Organisation (WHO) defines normal birth as spontaneous in onset, low risk at the start of labour and remaining so throughout labour and delivery, with the infant being born spontaneously in the vertex position between 3- and 42 weeks gestation and after birth the mother and infant are in good condition.

What this means is we want to encourage normal birth as evidence suggests that it results in better quality, safer care for mothers and their babies.

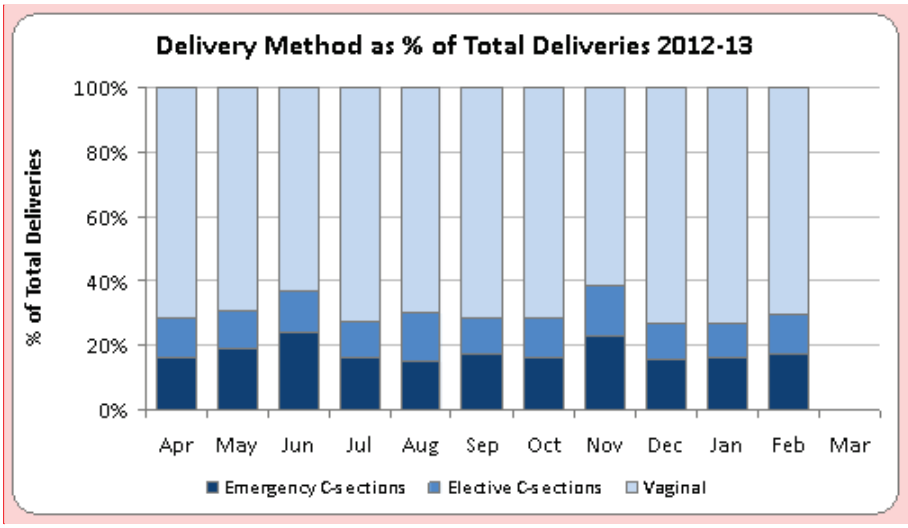
> *All the staff I have met have been very friendly, caring and helpful we have had a lovely experience having our second son compared to our experience here four years ago with our first son.*
>
> *Maternity Friends & Family Test, March 2013*

How did the Trust perform in promoting normal birth and what actions were taken to improve this?

A self improvement tool was piloted for maternity services across the NHS in 2008. This pilot was successful and the NHS Institute for Innovation and Improvement ran change initiatives with staff in maternity services. These changes were;

- Initiation of Consultant of the week to provide senior cover on delivery suite. This has been welcomed by staff and provides women with immediate access to a Consultant Obstetrician.
- Recruitment drive for midwives to increase the midwife to birth ratio. A monthly rolling programme has been successful in increasing the midwife to birth ratio and continues.
- A project plan has been developed to support a local midwife led unit and is key within the strategic business plan.
- Midwives have undertaken normality training and monthly birth normality focus meetings are held in the maternity service.
- A new Midwifery led 'vaginal birth after Caesarean Section' (VBAC) clinic was commenced in September 2012 for those women who have previously been delivered by Caesarean section. The emphasis and focus of this clinic is to inform and educate women that a normal birth pathway can often be achieved following a Caesarean section. The VBAC clinic and pathway of care has agreement and support from the Consultant Obstetric team.
  The VBAC clinic has been well received by women and attendance rates are excellent. An audit will commence in April 2013 to evaluate the VBAC success rate.

The chart below shows the delivery methods used in 2012/2013 and it highlights the need for continued focus on promoting normal birth at Hereford County Hospital.



Comment [s4]: This chart will be updated prior to publication

NICE Quality Standards

Quality standards are developed by the National Institute for Health and Clinical Excellence (NICE), and address the three dimensions of healthcare quality – clinical effectiveness; patient safety and patient experience. The quality standards set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. They include a set of specific, concise statements with associated measures.

Each NICE quality standard contains up to 15 specific quality statements which describe key markers of high-quality, cost-effective care for a particular clinical condition or pathway. Quality measures for each of the quality statements are also provided, with the aim of improving the structure, process and outcomes of health and social care.

Patients and carers can use NICE quality standards to understand what service they should expect from their health and social care provider.

The following Quality Standards, relevant to the services provided by Wye Valley NHS Trust, were published in 2012/13.

- Ovarian cancer – published May 2012
- Bacterial meningitis and meningococcal septicaemia in children and young people – published June 2012
- Colorectal cancer – published August 2012
- Stable angina – published August 2012
- Antenatal care – published Sept 2012
- Nutrition support in adults – published November 2012
- Asthma – published February 2013
- The epilepsies in adults – published February 2013

- The epilepsies in children and young people – published February 2013
- Hypertension – published March 2013
- Diagnosis and management of venous thromboembolic diseases – published March 2013

What action do we take on NICE Quality Standards?

Within the Trust, quality standards are accessed from the NICE website at the time of publication. A local baseline assessment spreadsheet is then developed, which is used to record a baseline assessment of the Trust's position against each quality statement.

For each quality standard a Trust lead is appointed, with responsibility for working with others to complete the spreadsheet by gathering evidence against each quality statement and using the quality measures to assess local practice where these are applicable. If results show that actions are required to implement a quality statement or improve performance, a formal action plan is developed and implemented. Results and action plans are routinely reported through the Trust's clinical service units and Trust governance committees.

This process has been applied to all quality standards published in 2012/13.

Effectiveness Summary

Where we have done well

- 100% achievement on CQUINS
- 2 CQC visits which showed the Trust was meeting essential standards of quality and safety

Where we need to improve

- WMQRS raised issues regarding management of medicines in community hospitals

Part 3: Experience

Local Patient Experience

What do we do locally to improve Patient Experience?

Various mechanisms to measure and act on the patient experience are utilized by the Trust. The major development this year has been the introduction of the 'Net Promoter' or 'Friends and Family Test'. All Trusts in the Midlands and East Region have participated in the Friends and Family Test in the acute setting since 1st April 2012 and over 2.500 patients have taken part. The question asked was:-

How likely are you to recommend this service to Friends and Family? Please rate on a scale of 0 to 10

Results are fed back to the Director of Nursing & Quality on a weekly basis so any 'hotspots' can be identified in real time and looked into further, if appropriate. All Ward Sisters receive monthly reports.

April 2012	**47.6%**
May 2012	49.72%
June 2012	64.94%
July 2012	63.35%
August 2012	64.32%
September 2012	68.85%
October 2012	63.76%
November 2012	60.28%
December 2012	50.25%
January 2013	70.66%
February 2013	67.61%
March 2013	69.89%

The test has identified many areas of good practice with 'kindness of staff' featuring highly, however, areas for improvement have also been identified and actions have been implemented to address these.

The Friends and Family Test has also been extended into the A&E Department and Community sites over the past 12 months.

Although the introduction of the Friends and Family test has been the main focus for this year, the patient experience team continue to use a variety of methods to capture views, including the use of volunteers to carry out more in-depth interviews with patients, feedback from PALS and Complaints, comments cards and suggestion boxes. All this feedback is shared with wards and department at the time and forms part of monthly reports to the Service Units which also identify trends.

The success of the pilot 'Friends and Family Test' has resulted in national roll out from 1st April 2013, initially for acute inpatients and A&E, with the intention to extend to other patient areas in the future.

National Surveys

Inpatient Survey

The national inpatient survey was carried out for patients aged 16 years or older, with at least one overnight stay in the County Hospital between June to August 2012. This survey is undertaken year on year;

This year we should significant improvement on 10 questions;

- Were you ever bothered by noise at night from other patients?
- Did you get enough help from staff to eat your meals?
- Did doctors talk in front of you as if you weren't there?
- Did you have confidence and trust in the nurses treating you?
- Did nurses talk in front of you as if you weren't there?
- Were you given enough privacy when being examined or treated?
- Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Were you told how to take your medication in a way you could understand?
- Were you given clear written or printed information about your medicines?

We didn't score significantly worse on any questions when compared to the previous year but we did score in the bottom 20% of Trusts for;

- Were handwash gels available for patients and visitors to use?
- Were you offered a choice of food?

Benchmarking against other Trusts is valuable information to measure our performance but also so patients can get a feel of what they can expect when they visit the Trust. We're pleased that we were in the top 20% of Trusts for these questions;

- How do you feel about the length of time you were on the waiting list?
- Did you share a room with opposite sex patients?
- Did you ever use the same bathroom or shower area as patients of the opposite sex?
- Did you ever feel threatened during your stay in hospital by other patients or visitors?
- Did you get enough help from staff to eat your meals?
- Were you given enough privacy when discussing your condition or treatment?
- Were you given enough privacy when being examined or treated?
- Were you given clear written or printed information about your medicines?

A&E Department Survey

The national A&E Department Survey carried out in March 2012 was published in January 2013. The survey results overall were comparable with the last survey carried out in 2008.

Four questions showed a 5% or move improvement in the following areas:

- Given enough privacy when discussing condition at reception
- Being informed of medication side effects to look for
- Doctors and nurses talking in front of the patient as if they were not there
- Explanations of test results.

Areas where the Trust showed room for improvement included:

- Being kept informed of how long they needed to wait
- Who to contact when discharged from the department
- Staff doing all they can to help control pain

The Trust was in the top 20% nationally with respect to not feeling threatened by other patients and staff explaining why tests were needed.

The two key areas highlighted for improvement were keeping patients informed of length of wait and pain management

Claims

All claims for compensation arising from allegation of clinical negligence will pass through the NHS Litigation Authority (NHSLA) via a nominated representative at Trust level.

How many claims have been reported?

The table below shows the number of claims opened in the financial year with a breakdown by Service Unit.

Service Unit	Total
Care Closer to Home	1
Elective Care	9
Integrated Family Health Services	5
Urgent Care	1
Total for Wye Valley NHS Trust	16

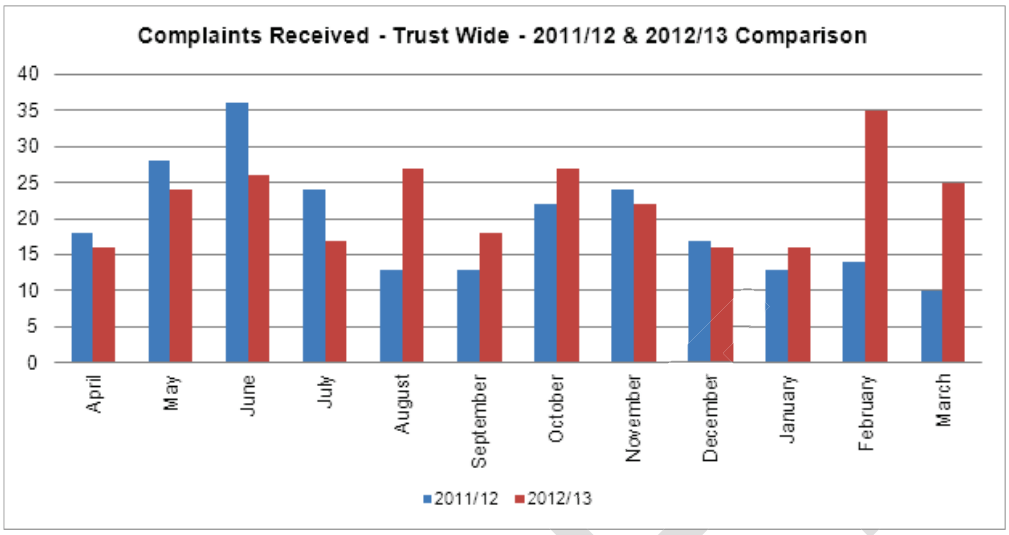
You can see from this table that Elective Care received the highest number of claims this year. It's also important to note that nationally maternity services (which sit in Integrated Family Health Service Unit) account for a significant number and proportion of the cost of claims. This is addressed through a specialist set of standards Clinical Negligence Scheme for Trusts specifically for maternity services which are assessed by the NHSLA.

Complaints

How many complaints have we received this year?

We welcome feedback and this also means recognising where we've gone wrong and making every effort to make sure it doesn't happen again.

This year we received 286 complaints compared to 230 in 2011/12. This is an increase and the chart below shows how many complaints we received compared to the previous year month on month. February 2013 has seen a significant increase which is believed to be as a result of the winter pressures experienced across the Trust.



Complaints can also be referred to the Health Service Ombudsman if complainants feel their concerns haven't been fully addressed. 10 complaints were raised through this stage this year and of these complaints;

- 1 is awaiting outcome of investigation
- 4 are awaiting initial decision to investigate
- 3 have been referred back to the Trust for additional work
- 2 have not been upheld

What were the key themes in the complaints received?

The top 3 most complained about aspects of care were;

- Clinical treatment
- Attitude of staff
- Admission, discharge and transfer arrangements

Action is taking on an individual complaint basis to address the specific concerns raised by patients and their families or carers but we are also monitoring these trends and looking at ways to address the reoccurring issues across the organisation.

We've also identified, through monitoring of trends, that the majority of our complaints are regarding Accident & Emergency and Lugg. These are being addressed through a targeted action plan.

What actions have we taken as a result of complaints?

We measure how long it takes to respond to complaints and whether they were responded to in timeframe or not. This year our response rate was 64%. We want to improve on this and

are therefore implementing a new process for complaints which puts more onus on the Service Units to respond fully and in a timely way.

Compliments

Compliments by far outweigh the number of complaints we receive and we receive and we have received in excess of 4000 compliments this year.

Section 3: Mandatory Statements Relating to Quality of NHS Services Provided

Introduction

This section includes all the mandatory sections that are required as part of the Department of Health Quality Accounts Toolkit. It provides details of key quality aspects relevant to the Trust.

Review of Services

During 2012/13 the Wye Valley NHS Trust provided and/ or sub-contracted 54 NHS services.

Wye Valley NHS Trust has reviewed all the data available to them on the quality of care in 54 of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of NHS services by Wye Valley NHS Trust for 2012/13.

Participation in Clinical Audit

During 1st April 2012 – 31st March 2013, 34 national clinical audits and 4 national confidential enquiries covered NHS services that Wye Valley NHS Trust provides.

During that period Wye Valley NHS Trust participated in 82% of national clinical audits and 100% of national confidential enquires which it was eligible to participate in.

The table below lists the national clinical audits and national confidential enquiries that Wye Valley NHS Trust was eligible to participate in during 2012/13 and indicates whether or not participation took place.

Eligible National Audits	Participating
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) - *National Institute for Cardiovascular Outcomes Research*	Yes
Adult Asthma - *British Thoracic Society*	Have not participated in 12/13 but have participated in previous rounds. Data for this round could not be submitted within deadlines
Adult Community Acquired Pneumonia - *British Thoracic Society*	Yes
Adult Critical Care – *Intensive Care National Audit &*	Yes

Research Centre	
Bowel Cancer (NBOCAP) - *NHS Information Centre*	Yes
Bronchietasis (Adult) - *British Thoracic Society*	Not participated in 12/13 but have participated in previous rounds. Decision taken to concentrate resources on other respiratory audits.
National Cardiac Arrest Audit - *Intensive Care National Audit & Research Centre*	Not participating in national audit but undertake a continuous local audit of cardiac arrests.
Cardiac Arrhythmia – *National Institute for Cardiovascular Outcomes Research*	Yes
Comparative audit of blood transfusion programme - *NHS Blood & Transplant* ▪ Blood sampling and labelling	Yes
Chronic Obstructive Pulmonary Disease (COPD) - *Royal College of Physicians*	New audit due to start 13/14 – Registered to participate
Diabetes (Adult) – *NHS Information Centre* ▪ National Diabetes audit (adults) ▪ National diabetes inpatient audit	Yes – participate in both audits
Diabetes (Paediatric) - *NHS Information Centre*	Yes
National Emergency Laparotomy Audit - *Royal College of Anaesthetists*	New audit due to start 13/14 – Registered to participate
Emergency Use of Oxygen - *British Thoracic Society*	Yes
Epilepsy 12 (Childhood Epilepsy) – *Royal College of Paediatrics and Child Health*	Yes
Paediatric Fever - *College of Emergency Medicine*	Yes
Fractured Neck of Femur - *College of Emergency Medicine*	Not participated in 12/13, resources not available to meet deadlines for submitting data
Head and Neck Oncology (DAHNO) - *NHS Information Centre*	Yes
Heart Failure – *National Institute for Cardiovascular Outcomes Research*	Yes
Hip Fracture Database (NHFD) - *NHS Information Centre*	Yes
Inflammatory Bowel Disease (IBD) – *Royal College of Physicians*	Yes
Lung Cancer (NLCA) - *NHS Information Centre*	Yes
National Joint Registry (NJR) – *National Joint Registry Centre*	Yes
Neonatal Intensive and Special Care (NNAP) - *Royal College of Paediatrics and Child Health*	Yes
Non-invasive Ventilation (Adults) - *British Thoracic Society*	Not participated in 12/13, resources not available to collect the required

	data.
Oesophago-gastric Cancer (NAOGC) - *NHS Information Centre*	Yes
Paediatric Asthma - *British Thoracic Society*	Yes
Paediatric Pneumonia - *British Thoracic Society*	Yes
Parkinson's disease - *Parkinson's UK*	Yes
Potential Donor Audit (Organ Donation) - *NHS Blood and Transplant*	Yes
Renal Colic - *College of Emergency Medicine*	Not participated in 12/13, resources not available to meet deadlines for submitting data
Sentinel Stroke National Audit Programme (SSNAP) - *Royal College of Physicians*	Yes
Severe Trauma - *Trauma Audit & Research Network, TARN*	Yes
National Audit of Dementia (NAD) – *Royal College of Psychiatrists*	Yes
National Patient Reported Outcome Measures survey programme	Participating
Elective surgery - *National PROMs Programme*	Yes
National Confidential Enquiries	Participating
National Review of Asthma Deaths	Yes
Child Health Review Programme	Yes
Maternal, infant and newborn programme	Yes
National Enquiry into Patient Outcome and Death	Yes

The national clinical audits and national confidential enquiries that Wye Valley NHS Trust participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Percentage of eligible cases submitted	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction	100%	
Adult community acquired pneumonia	Data submission ongoing	.
Adult Critical Care	100%	
Bowel cancer	Data submission ongoing	.

National Audits	Percentage of eligible cases submitted	Comments
Cardiac Arrhythmia	92.5%	For procedures up to end of February 2013, March data submission ongoing
Comparative audit of blood transfusion – Blood sampling and labelling	100%	
Diabetes (Adult) programme: ▪ National diabetes audit (adults) ▪ National diabetes inpatient audit	 100% 100%	The inpatient audit was of all eligible inpatients on one specified day
Diabetes (Paediatric)	100%	
Emergency use of oxygen	100%	
Epilepsy 12 (Childhood Epilepsy)	Data submission ongoing	
Fever in children	100%	
Head and neck oncology	100%	
Heart failure	32%	Only 63/203 cases have so far been uploaded due to Heart Failure Service staff sickness
Hip fracture database	100%	
Inflammatory bowel disease	Data submission ongoing	
Lung cancer	100%	
National joint registry	96%	Submission rate based on interim figures. Data

National Audits	Percentage of eligible cases submitted	Comments
		submission ongoing.
Neonatal intensive and special care	100%	
Oesophago-gastric cancer	Data submission ongoing.	
Paediatric asthma	100%	
Paediatric pneumonia	100%	
Parkinson's disease	100%	
Potential donor	100%	
Sentinel Stroke National Audit Programme	SINAP 63% SSNAP –ongoing data submission	Submission of data for SSNAP started January 2013. Replaced previous SINAP project which ceased December 2012.
Severe Trauma	24.6%	Data submission ongoing.
National Audit of Dementia	100%	

National Patient Reported Outcome Measures survey programme	Percentage of eligible cases submitted	Comments
Elective surgery (National PROMs Programme)	91.7%	Figure based on national provisional data on completion of pre-operative questionnaires published by NHS Information Centre for April – September 2012, pre-operative questionnaires

National Confidential Enquiries	Eligible cases submitted
▪ Asthma Deaths	All requested clinical questionnaires have been

	submitted
• Child Health Reviews – UK Themed Review - Epilepsy	No eligible cases
• Maternal infant and perinatal	All eligible cases notified to the enquiry
• Patient Outcome and Death Studies:	
	Ongoing study.
- Subarachnoid Haemorrhage	Organisational questionnaire submitted 2/2 clinical questionnaires submitted
- Alcohol Related Liver Disease	Organisational questionnaire submitted 3/3 clinical questionnaires submitted
- Bariatric Surgery	Organisational questionnaire only required - submitted
- Cardiac arrest procedures	Organisational questionnaire completed 1/1 clinical questionnaires completed

Review of Clinical Audit Reports

Within Wye Valley NHS Trusts the reports of national and local clinical audits are reviewed by the clinical teams involved in the audit. If review indicates that improvements are required, action plans are devised and implemented. Reports and action plans of all audits are reviewed by the Service Units Governance Groups. Reports and action plans from national audits are reported to the Trust's Quality Committee (sub-committee of the Trust Board). This Quality Account gives details below of reports and action plans that reached the stages of reporting to Quality Committee and/or Service Unit Governance Groups in 2012/13.

The reports of 29 national clinical audits were reviewed by Wye Valley NHS Trust in 2012/13 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Acute Coronary Syndrome or Acute Myocardial Infarction - This continuous audit looks at the care given to patients who have suffered a heart attack, or other acute coronary syndromes, including their management before arrival in hospital.
2011/12 data reported in September 2012 did not identify any areas where actions were needed. Care will continue to be monitored through continuous national data collection, with local monthly reporting and review.
Adult Critical Care - This national audit has been running since 1994 and now collects data from 90% of adult critical care units in England, Wales and Northern Ireland. Data on patient activity and outcomes of all patients admitted to critical care are submitted to ICNARC for analysis and reporting. Data are compared for all units and amongst similar units and trends over time are produced.
April 2011-March 2012 data reported November 2012 indicate that the Trust's critical care unit is providing good quality care in terms of mortality, unit-acquired infection and discharge. Currently, the national centre is investigating a possible problem with reporting on re-admission rates and the outcome is awaited.

Bowel cancer - This on-going national audit collects information on all aspects of the clinical care given to patients who have been newly diagnosed with bowel cancer.

The 2011 report was reviewed using the nationally produced local action planning toolkit. All national recommendations were examined to assess whether they were met within the Trust. In line with national recommendations, actions are being taken to:

- Review processes for collecting data, to be focussed on the multidisciplinary team.
- Review treatment protocols for obstruction and for pre-operative radiotherapy.
- Review the provision of training for laparoscopic surgery.

National Comparative Audit of Blood Transfusion Programme

A. Audit of Blood Sample Collection and Labelling (2012).

The aim of this audit was to determine the causes of blood sample labelling errors. Results from the organisational audit and the clinical audit showed that no specific actions were required.

B. National Comparative Audit of the Medical Use of Red Cells (2011).

The aim of this audit was to establish if medical patients are being appropriately transfused with red cells.

Actions from results for 2011, reported in 2012.

- Present results and recommendation on post-transfusion haemoglobin to medical staff
- Laboratory staff to check that haematinics are done on patients with low or high MCV

National Diabetes Audit Programme (Adult) - The programme has two components.
A. The National Diabetes Audit (NDA) collects retrospective data on an annual basis.
B. National Diabetes Inpatient Audit is a one-day snapshot audit of inpatient care for patients with diabetes.

A. National Diabetes Audit (NDA), 2010/11

Included in the audit were all patients attending diabetes clinics at the County Hospital between 1st January 2010 and 31st March, 2011. Data were collected on 657 patients. Review of the results showed no specific actions were required by the Trust's Diabetes Team .

B. National Diabetes Inpatient Audit 2011

Review of the results led to the following actions:

- Diabetes Specialist Nursing time allocation to be reviewed as part of service reorganisation.
- Retrospective audit and root cause analysis of events leading up to admission with diabetic foot problems planned
- Profile of diabetes foot multidisciplinary team to be raised, with a review of team structure and responsibilities to be undertaken.
- Mandatory free e-learning modules on Safe Use of Insulin and Safe Use of Intravenous Insulin produced by NHS Diabetes to be completed by all hospital clinical staff and pharmacists.

Diabetes (Paediatric) - This on-going audit looks at the care of infants, children and young people (under 25 years) with diabetes mellitus being cared for in paediatric diabetes units in England and Wales.

Results published in autumn 2012 were reviewed by the paediatric diabetes team and led to the following action:

- An annual review proforma, to serve as a checklist for care processes and as a record of their completion, has been devised.

Emergency use of oxygen 2011 - This national audit co-ordinated by the British Thoracic Society started in 2008 and consists of an annual round of data collection from current inpatients. The Trust has participated in each round. It assesses the practice of prescribing, monitoring and reviewing oxygen against standards set by the British Thoracic Society.

- Feedback has been given to both nursing and medical teams in all areas, to highlight any issues revealed from results.
- All ward sisters have been asked to nominate a staff nurse to take on the role of oxygen link nurse.
- Weekly ward-based audits to be undertaken, with results fed back to staff in productive ward meetings.
- Respiratory team to meet with medical and nursing staff to establish root cause of any problems with oxygen and plan actions to resolve any problems identified.

Epilepsy 12 (Childhood Epilepsy) - This national audit by the British Paediatric Neurology Association was a UK-wide collaborative clinical audit of health care for children and young people with suspected epileptic seizures.

Results published in September 2012 were reviewed by the lead Consultant Paediatrician with the following actions:

- Results presented to and discussed at Paediatric multidisciplinary meeting
- Business case being developed for the appointment of an Epilepsy Specialist Nurse
- Continuing education on seizure and syndrome classification to be provided within the Paediatric department
- Key staff to attend West Midlands Neurology Forum meetings held at Birmingham Children's Hospital and to attend relevant courses

Hip fracture database - This database continuously captures data on the management of hip fractures and secondary prevention and compares results with six best practice standards of care.

Results for October 2011 – September 2012 were reviewed and the following actions are being taken:

- Patients being discharged direct to home to be promoted through weekly multidisciplinary team meetings to discuss discharge planning, optimising patients and trouble shooting problems in real time
- The Osteoporosis and Fracture Liaison Clinical Nurse Specialist to work with Lead Anaesthetist for Hip Fractures to increase the recording of ASA grades on anaesthetic charts for hip fracture patients

Lung cancer - This on-going audit captures data on all aspects of care for patients diagnosed with lung cancer, or mesothilioma, in each calendar year.

The 2011 report, covering patients seen in 2010, included assessment against 19 national recommendations. The Lung Cancer Multidisciplinary Team reviewed these recommendations and planned actions as follows:

- Cancer Data Team to check that all relevant data fields are completed for each patient
- Multidisciplinary Team co-ordinator to monitor data completion and request any missing

data from the team
- Radiologists to implement agreed protocol on booking of CT scans on relevant patients prior to bronchoscopy

National joint registry - The National Joint Register has been running since 2003. Its purpose is to collect high quality and relevant data about joint replacement surgery in order to provide an early warning of issues relating to patient safety.

The 9th Annual Report, 2011/12, published in 2012, was reviewed and the following action planned:

- To enable a better understanding of the components used, the NJR regional co-ordinator will generate a report of components used by the Trust so that an assessment can be made of whether high rated components are used or whether there is a great variety of components. Concentrating use on fewer components may give scope for better purchasing power.

Neonatal intensive and special care – The National Neonatal Audit Programme (NNAP), which has been running since 2006, is delivered by the Royal College of Paediatrics & Child Health Research and Policy Department and funded by the Department of Health.

Results for January – December 2011, published 2012, were reviewed and the following actions agreed:

- The Badger system (the electronic system used to record the data) and the data required are to be highlighted to relevant clinical staff. For each new group of junior doctors at induction; in specific training and updating for Special Care Baby Unit nursing staff.
- A pathway has been established from April 2012 for all eligible babies to be referred for review and assessment by the Community Paediatric Team for developmental assessment and 2 year follow-up. Follow-up to be arranged for babies discharged before the pathway was implemented.

Oesophago-gastric cancer – This national audit was the second round of an audit which first collected data in 2007-2009. The 2012 report focused on the results of an organisational audit undertaken with cancer networks and Trusts and also on longer-term follow-up and in-depth analysis of data collected in the first round.

The 2012 report led to eight national recommendations. Locally these have been reviewed by the Upper Gastrointestinal Multidisciplinary Team, to establish the Trust position against each recommendation and plan actions for any recommendations not already met. The following actions are being taken:

- The number of emergency admissions of patients with upper gastrointestinal cancer is to be identified by lead consultant and multidisciplinary team. This information is needed for Cancer Networks in developing strategies for reducing emergency admissions.
- The number of emergency (re)admissions of palliative care patients with upper gastrointestinal cancer is to be identified and then assessed for further appropriate action by lead consultant and multidisciplinary team.

National Paediatric Asthma Audit - This audit by the British Thoracic Society collected data over a one month period on children over the age of one year admitted to hospital with wheezing or asthma, to look at the delivery of their care and compare it with national guidance.

Results were published in 2012. The following actions are being taken:

- Results presented and discussed at multidisciplinary paediatric meeting
- A local proforma to be designed to collect additional data in conjunction with the next round of the national audit, to enable comparison with guidelines.

Paediatric pneumonia - This national audit was carried out by the British Thoracic Society and collected data on children admitted to hospital with a diagnosis of pneumonia during November 2011 to January 2012. Data on patient demographics, clinical presentation, investigations, treatment and outcomes were collected.

Results published in 2012, with the following actions taken:

- Results presented at paediatric audit meeting and judicious use of azithromycin emphasised. An email explaining this has been sent to any consultant staff not present at the meeting.
- BTS pneumonia guideline added to respiratory file on Children's Ward and put on to the Trust intranet.

Parkinson's disease - This national audit started in 2010 and data collection is on an annual cycle. The Trust has participated in each round of the audit. The 2011 round was expanded to cover Parkinson's patient management in elderly care, Occupational Therapy, Physiotherapy and Speech and Language Therapy.

Areas where improvements are needed have been identified and actions planned, as follows:

Patient management in Elderly Care

- To ensure regularity and documentation of monitoring and assessment an annual checklist has been developed. A proforma for patients assessed in outpatients has been developed.
- Use the modified UPDRS part II scale annually, to improve assessments of motor and activities of daily living.

Speech and Language Therapy (SLT)

- Earlier referral to SLT discussed with Consultant and Parkinson's Disease Nurse Specialist, to promote patients being referred at an earlier stage in the disease.
- Register patients who are seen within Education Groups with access to SLT.
- To increase the access to Lee Silverman Voice Therapy, the evidence-based therapy recommended for people with Parkinson's Disease, a second therapist is to be trained in this technique.
- Lee Silverman Voice Therapy style assessment and therapy to be rolled out in a more limited way for those patients who cannot benefit from intensive therapy.

Physiotherapy

- Review referral pathway to establish if time from referral to initial assessment can be reduced.
- To increase the use of Quick Reference Cards for people with Parkinson's Disease, these cards will be made accessible to all physiotherapists in the team.

Occupational Therapy (OT)

To improve activities of daily living intervention and documentation, the following actions are being taken:

- Review O.T. documentation to clearly identify all aspects of assessment for PD clients
- Continuing professional development updates for OT to include functional tasks for clients with PD

To increase the provision of information on mobility and activities of daily living to clients:

- Parkinsons Disease and Rescue information leaflets to be accessible to Occupational Therapists on network drive.
- Compile departmental Occupational Therapy.advice/cueing booklet

Potential donor – The National Potential Donor Audit (PDA) commenced in 2003 as part of a series of measures to improve organ donation. The principle aim of this audit is to determine

the potential number of solid organ donors in the UK.

Review of results from 2011/12 data has shown no improvement actions were required.

Sentinel Stroke National Audit Programme (SSNAP)

This new national audit which started in 2012 replaces and builds on the work of two previous projects – Sentinel Stroke Audit and the Stroke Improvement National Audit. SSNAP started with an organisational audit in 2012. The clinical audit will cover acute, rehabilitation and follow-up care of patients with stroke. Collection of patient data started in January 2013.

The Stroke Improvement National Audit ceased in December 2012, this national project looked at the process of care for patients with stroke during the first three days of their hospital stay.

- **Stroke Improvement National Audit Programme (SINAP)**

This audit was launched by the Royal College of Physicians in 2010 and collects prospective data continuously via a web-based system. The Trust has participated throughout the life of SINAP and performance has improved during that time. Results are reported nationally on a quarterly basis.

- Quarterly reports for 2012/13 have been reviewed.
- Results have been used to inform regular meetings at which delivery of stroke care is reviewed.

Data submission to SINAP ceased at the end of 2012, to be replaced by the new Sentinel Stroke National Audit Programme (SSNAP).

- **Sentinel Stroke National Audit Programme (SSNAP)**

This new national audit comprises two elements; organisational and clinical (patient). The results of the organisational audit were published in December 2012.

- Results of the organisation study reviewed
- Applications to be made for additional resources to enable service changes in accordance with study national recommendations

Severe Trauma (Trauma Audit & Research Network)

This on-going national audit looks at aspects of the care given to patients with severe trauma, including before arrival in hospital, and measures survival rates according to severity of trauma.

The Trust's Trauma Sub-group reviews each quarterly report to assess whether any improvement actions are required. No actions have been found to be necessary from reports in 2012/13.

The reports are also used to inform the content of multi-disciplinary trauma meetings.

Fever in Children – College of Emergency Medicine National Audit 2011- This audit looks at the treatment of feverish children (under 5 years of age) presenting to Emergency Departments with a medical condition against the clinical standards set by the College of Emergency Medicine (CEM)

- The need for a full set of observations to be performed within 20 minutes, with documentation of appropriate action taken, to be raised with staff in Accident & Emergency through training sessions and a letter sent to all members of staff.

Renal Colic – College of Emergency Medicine National Audit 2011– This audit looks at the treatment of adult patients presenting to Emergency Departments in severe or moderate pain with renal colic against the clinical standards set by the College of Emergency Medicine (CEM)

- Increase awareness of guidelines management of urinary tract infection using renal colic

protocol
Vital Signs Audit – College of Emergency Medicine National Audit 2011 This audit looks at the treatment of adult patients triaged to the majors area of Emergency Departments against the clinical standards set by the College of Emergency Medicine (CEM)
• The need for a full set of observations to be performed within 20 minutes, with documentation of appropriate action taken, to be raised with staff in Accident & Emergency through training sessions and a letter sent to all members of staff.
Severe Sepsis and Septic Shock - This is an audit of the treatment of severe sepsis and septic shock against the clinical standards published by the College of Emergency Medicine (CEM) based on the guidelines and care bundles published by the Surviving Sepsis Campaign.
▪ Present results of audit at grand round ▪ A sepsis pathway is being built into the new Accident & Emergency IT system, to improve use of the Sepsis Bundle

The reports of three national audits, which are not included on the national list for Quality Accounts, were also reviewed by Wye Valley NHS Trust in 2012/13.

National Difficult Airways Audit – This national project was a year-long data collection exercise to determine the incidence of major complications of airway management during anaesthesia. Data on the number and types of anaesthetics performed were collected in participating Trusts over a two week period.
The study report findings and recommendations were reviewed by the Clinical Lead for Difficult Airways. No improvement actions required.
National Audit of Laparoscopic Theatre Equipment – 2012 This national audit run by the Association of Laparoscopic Surgeons of Great Britain and Ireland aims to assess the quality of theatre equipment available to surgeons using laparoscopic techniques. The first round of the audit was in 2010, with a further round in 2012, in the form of a survey. The Trust first participated in 2012, when a total of 241 hospitals took part.
Review of results showed no improvement actions were required.
National Colonoscopy Audit 2011 This national audit is requirement for 'light-touch' accreditation by the Joint Advisory Group on gastrointestinal endoscopy. It collected data on all colonoscopies on adults undertaken in the UK over a two week period. Information was collected on caecal intubation and polyp detection rates as well as complications.
Results were reviewed and no improvement actions are required. The Trust continues to audit outcome measures on a 6-monthly basis.

The reports of two national confidential enquiry studies were reviewed by Wye Valley NHS Trust in 2012/13 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Cardiac Arrest Study - National Confidential Enquiry into Patient Outcome and Death The aim of the study was to describe variability and identify remediable factors in the process of care of adult patients who receive resuscitation in hospital, including factors which may affect the decision to initiate the resuscitation attempt, the outcome and the quality of care following the resuscitation attempt, and antecedents in the preceding 48 hours that may have offered opportunities for intervention to prevent cardiac arrest.
Following the publication of the study findings and recommendations the following actions have been taken: ▪ An educational event on the National Confidential Enquiry into Patient Outcome and Deaths, open to all Trust staff, was held. The principal author of the cardiac arrest study was one of the guest speakers and presented the study findings. ▪ A local audit on the documentation of "Do Not Attempt Resuscitation" orders has been established ▪ The study's findings and recommendations have been reviewed and an action plan devised to implement any recommendations not already met in full ▪ Information leaflets for patients and carers made available in clinical areas
Bariatric Surgery Study - National Confidential Enquiry into Patient Outcome and Death Aim of the study was to describe variability and identify remediable factors in the process of care (from referral to follow-up) for patients undergoing bariatric surgery.
Wye Valley Trust does not perform bariatric surgery and therefore did not participate in the full study. However, all Trusts admitting emergency patients were requested for data on their facilities and equipment for patients who are morbidly obese. The Trust reviewed the findings of the study and compared the Trust's facilities and equipment against the study recommendations. No improvement actions required.

The reports of 27 local clinical audits were reviewed by Wye Valley NHS Trust in 2012/13 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Review of Local Clinical Audits

Review and Outcomes Of Hepatitis C Treatment Services - This re-audit was chosen to evaluate the treatment service offered to patients locally, and to establish whether updated NICE Guidance had been adhered to following Technology Appraisal Guidance TA200 launch at the end of 2010.
Results showed that NICE guidance was followed – No actions required
Compliance with HHT unstable coronary syndrome (NSTEMI) guideline on prescribing enoxaparin for medical patients admitted with chest pain – This audit looks at compliance with the Trusts (NSTEMI) guideline on prescribing.
• Patients weight (kg) should be recorded on the inpatient medication chart at the point of prescribing SC enoxaparin for ACS – action: report back to doctors at a regular lunchtime / audit meeting and include in the Urgent Care governance newsletter • Reduce enoxaparin to once daily when EGFR<30ml/min – action: Provide an "Aide memoir" for nurses and doctors and make available on intranet
Audit of Repeat OGD Gastric Ulcers - The aim of this audit is to follow up all newly diagnosed gastric ulcers over a 6 month period between 1st October 2011 and 31st March 2012. The results are compared to the previous similar audit in 2010 to assess whether

improvements have occurred and the recommendations made previously have been followed.
• This audit has shown an improvement in practice for repeat Endoscopy for patients with gastric ulcer and the current practice of booking the repeat Endoscopy at the time of initial diagnosis of gastric ulceration should continue. • The Unisoft programme requires Endoscopists to enter gastric ulcer follow up under the Indications screen and Endoscopists should be aware of this issue. • The Unisoft GI audit toolkit could be improved to identify patients with previous gastric ulceration and either pop up a reminder to the Endoscopist to tick the appropriate indications box or automatically assume the repeat Endoscopy is being undertaken for gastric ulcer healing. • Until improvements in the Unisoft audit toolkit are made a manual verification of gastric ulcer follow up will be required in future audits to ensure the audit data accurately reflects clinical practice.
Accident & Emergency Department Record Keeping Audit - To assess the quality of record keeping in 'A&E Record Cards' that are used in the Accident & Emergency Department
• Development of the new A&E electronic patient record system to resolve any data quality issues • Annual audit to monitor compliance
Audit of use of Rituximab for use in various haematological Conditions – This audit is to see if current practice complies with NICE guidance and PCT agreement (ITP) and to look at response to treatment and adverse effects experienced as a result of this treatment
Results showed that no actions or change to current practice required.
Re-audit of Appropriate use of FFP The aim of this audit is to assess compliance in issuing Fresh Frozen Plasma (FFP) against the Trust Guidelines for the use of FFP. These guidelines are based on the national BCSH guidelines for the use of FFP, Cryoprecipitate and Cryosupernatant.
• Laboratory staff must request and check that a coagulation test has been performed pre FFP • Laboratory staff must ensure that the patients weight is obtained prior to thawing of FFP • Re-audit in 3 years as this is part of a rolling programme on auditing the appropriate use of blood and blood components
Annual Review of Paediatric Type 1 Diabetes – This audit looks at local clinical practice of annual review of patients with type 1 diabetes.
• All patients to be reviewed by a consultant • Increase awareness and implementation of all aspects of NICE guidelines for annual reviews
Audit Assessing the Safe Monitoring of Gentamicin and Vancomycin in Adult Patients at Wye Valley Trust – This audit was carried out as It has been highlighted by several members of the pharmacy department that serum levels were not being taken appropriately, which could potentially lead to patient toxicity.
• Development of a dedicated pro-forma for Vancomycin regimes • Development of a dedicated pro-forma for bd/tds Gentamicin regimes

- Inclusion in annual clinical audit cycle, for antimicrobials

Glaucoma – This audit looks at compliance with NICE guidance

Results show that no actions or change to current practice required.

Compliance with NICE guidelines on duration of treatment with trastuzumab in early-stage and advanced breast cancer – This audit is based on compliance of NICE guidelines

A high level of compliance with guidelines in the use of trastuzumab in early-stage and advanced breast cancer within our trust has been demonstrated in this audit. No actions or change to current practice required.

Audit of documentation of allergy in patients prescribed quinolone antibiotics - The aim of this audit was to ascertain the quality of allergy documentation as poor documentation can lead to inappropriately prescribed quinolone antibiotics

- Amend the inpatient medication chart to prompt for more detailed information
- Develop a patient information leaflet about antibiotics, including advise about allergy versus intolerance
- Update pharmacy procedures for antibiotic monitoring and clinical standards to include advice to patients
- Trust Antibiotic policy to be updated, including specific information supporting the use of penicillin in antibiotic intolerance
- Utilisation of the SCRIPT training for medical staff
- Inclusion of antibiotic training on the mandatory Trust refresher courses

Audit of IV paracetamol prescribing at Hereford County Hospital – This audit is to assess whether IV paracetamol is being prescribed according to its licensed indications at Hereford County Hospital

- Educate doctors about how to correctly prescribe IV paracetamol according to its licensed indications during Tuesday surgical teaching sessions and at departmental induction
- Redesign the drug charts to include a box at the top of the page to document weight.
- Include a check box to highlight if the patient is in a high risk weight category.
- Change the route box on the drug chart to clearly show 'one route only'.
- Nursing staff not to administer any medication prescribed in multiple rates.

3 Counties Cancer Network, Small cell lung cancer audit 2010-2011 - Annual audit of all small cell lung cancer patients in Three Counties Cancer Network. Aim of the audit is to see how local practice compares with the other counties and national guidelines in terms of time intervals taken for diagnosis, including time line to various investigations and treatment.

No actions or change to current practice required

Management of Fractured Neck of Femur in the Emergency Department – This audit looked at the management of fractured neck of femur in the emergency department

Results indicate a need for an improved proforma and guidelines for the management of fractured neck of femur:

- Nurse led X-ray requests to be implemented
- Proforma to be standardised and include a prompt for analgesia and include details of appropriate initial management

Diabetes in Pregnancy – This audit was carried out to look at compliance with the NICE Clinical Guidelines for Diabetes in Pregnancy

- Ultrasonographers to complete examination of the four-chamber view of the fetal heart

and outflow tracts between 18-20 weeks of pregnancy

- Discharging Community Midwife to document in the woman's hand held postnatal notes, under management plan, that a fasting plasma glucose measurement be carried out the week before the 6 week postnatal check and annual measurement thereafter.
- Supply Postnatal care for Gestational diabetes leaflet in discharge pack
- To supply written information according to standards and document in Diabetic handheld notes.
- To supply education and information to patients regarding pre-conceptional care

Management of diabetic ketoacidosis on the children's ward – This audit looked at the care of patients treated on children's ward with diabetic ketoacidosis since adoption of BSPED DKA 2009 guidelines in 2010.

- To revise the current care pathway in line with BSPED guidelines
- To make medical and nursing staff aware of the revised pathway, and of the necessity of completion for every admission with DKA
- Junior doctors to be informed at induction, and to reinforce this at teaching/ diabetes update forums

Day Case Cataract Pathway 2011 – This audit looks at the predicted and actual outcome after cataract surgery from a clinical and patient view.

Key findings are those of stability. The report was discussed with the multidisciplinary team and a key action was identified.

- Explore the very small number of poor outcomes (patient satisfaction with outcome score of very unhappy and unhappy) this will help to understand some of the reasons for a poor outcome and may identify actions to improve on this cohort of patients.

Handover of responsibility for patients in post anaesthetic care unit (PACU) – This audit was carried out as recovery staff highlighted substandard handovers had been received.

- Include this topic in trainee teaching.
- Poster in theatre and recovery to increase awareness.
- Email throughout anaesthetics dept about the findings of this audit and the expected standards

Referrals to Dental Therapists – This audit was carried out to assess the quality of referrals made to Dental Therapists

- All dental therapists will promote good practice in the writing of referrals and will identify the individuals who do not meet the standards and guide them accordingly.
- All dental therapists will ensure the template stickers are available at all sites and encourage use where needed

Audit of compliance with self administration of medication procedure – This audit looks at compliance for the self administration and supervised administration of medication for adult patients

- Update current Trust Patient's Own Policy
- Inform managers/sisters of audit results and subsequent actions (at Sister's meeting)
- Access to procedure document and related paperwork – files to be created for each ward to include a quick guide to procedure for ward staff
- To brief Pharmacy staff about their responsibilities to ensure procedure is followed
- Pharmacy staff to highlight patients who are self-administering and ensure documentation is completed
- Include guidance on self administration procedure in the new inpatient medication chart

'Audit of compliance with British Society of Gastroenterologists (BSG) guidelines for the timing of surveillance colonoscopy for patients with increased risk of colon cancer' - This audit assessed the compliance of the vetting process with the national BSG guidelines
• Agree departmental policy of following BSG guidelines • Ensure all surveillance requests are sent for validation
Placement of nasogastric tubes - This audit was carried out to check compliance with National Patient Safety Agency guidance on checking and confirming the correct positioning of a nasogastric tube in the stomach
• Redesign documentation to improve compliance • Educate Users through communication book and notice board
Management of ectopic pregnancy – this audit looks at the appropriateness of care given to patients in early pregnancy presenting with lower abdominal pain with or without per vaginal bleeding, and the effectiveness of diagnosis and management offered.
• More medical and conservative management should be offered to suitable patients, which will help preserve their fallopian tubes and avoid unnecessary exposure to anaesthetic and surgery. • Ensure patients are offered counselling information leaflets.
Ophthalmology General Clinical Case Note Review – this audit was carried out to look at the quality of clinical case notes
• Results showed that no actions or change to current practice required just to re-audit to monitor compliance.
Audit of Antibiotic Prophylaxis in Abdominal, Colorectal, Urology and Hernia Repair Surgery – Audit of compliance with antibiotic policy guidelines
• Update antibiotic policy guidelines • Drug chart to be redesigned to include prompts for the details of allergy / intolerance to be recorded • Pharmacist to monitor through monthly antibiotic audits and quarterly benchmarking audits • Report quarterly to Elective Care Service Unit, and monthly via Infection, Prevention and Control Committee
Preoperative Assessment Investigations – This audit was carried out to monitor compliance with NICE Clinical Guideline 003
• Results showed full compliance, no actions required
Resuscitation Trolley Audit - The resuscitation trolleys have historically been audited on a regular basis to ensure that the equipment is intact and also to expose any failure in the regular checks that are required.
• Feedback given to each clinical area on a monthly basis to raise immediate awareness of and rectify any issues

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Wye Valley NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was [insert number]..

Use of the CQUIN payment framework

A proportion of Wye Valley NHS Trust income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Wye Valley 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.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available electronically at [provide a web-link]

Comment [s5]: This will be added prior to publication.

Statements from the CQC

Wye Valley NHS Trust is required to register with the Care Quality Commission and its current registration status is without conditions. Wye Valley NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Wye Valley NHS Trust during 2012/13.

Wye Valley NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13;

- Unannounced visit at Hereford County Hospital on 26th November 2012
- Unannounced visit at Leominster Community Hospital on 16th July 2012

These visits showed the Trust were meeting CQC standards.

Statement on relevance of Data Quality and your actions to improve your Data Quality

Wye Valley NHS Trust will be taking the following actions to improve data quality;

- Ensure continuous development and monitoring of Data Quality through the Trusts Information Quality Data Management Group.
- Regularly action and update the overall DQ Action plan and complete the Maternity DQ plan.

NHS Number and General Medical Practice Code Validity

Wye Valley NHS Trust submitted records during 2012/13 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:
99.71% for admitted patient care;
99.81% for out patient care; and
98.90% for accident and emergency care.

– which included the patient's valid General Medical Practice

Code was:
100% for admitted patient care;
100% for out patient care; and
98.91% for accident and emergency care.

Information Governance Toolkit attainment levels

Wye Valley NHS Trust Information Governance Assessment Report score overall score for 2012/13 was 75% and was graded green.

Clinical coding error rate

Wye Valley NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were;

- Primary Diagnoses Incorrect 5.4%
- Secondary Diagnoses Incorrect 8.3%
- Primary Procedures Incorrect 6.7%
- Secondary Procedures Incorrect 7.9%

Related NHS Outcomes Framework Domain & who will report on them	*2012/13 percentage/proportion/score/rate/number, comparison against national average and benchmark (where possible)*	*2011/12 percentage/proportion/score/rate/number, comparison against national average and benchmark (where possible)*	*Supporting Statement*
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to— (a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. *The palliative care indicator is a contextual indicator.			
1: Preventing People from dying prematurely **2: Enhancing quality of life for people with long-term conditions** **Acute trusts**	Trust scores (a) 111.92 (October 2011 to September 2012) (b) 16% (October 2011 to September 2012) **National Average** (a) 100 (b) 18.9%	Trust scores (a) 116.56 (April 2011 to March 2012) (b) 17.7% (April 2011 to March 2012)	The Wye Valley NHS Trust considers that this data is as described for the following reasons please see page X The Wye Valley NHS Trust intends to take the following actions to improve this rate, and so the quality of its services, by (please see page X)
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.			
3: Helping people to recover from episodes of ill health or following injury All acute trusts	Trust score (i) * (ii) 56.1% (iii) * (iv) 85.7%	Trust score (v) 48% (vi) 48.6% (vii) 94% (viii) 80%	The Wye Valley NHS Trust considers that this data is as described for the following reasons;

	National score (i) 51.4% (ii) 51.7% (iii) 89.8% (iv) 79.4%	National score (i) 49.8% (ii) 53.2% (iii) 87.4% (iv) 78.4%	• The Trust has high completion rates due to a well defined and robust process for identifying relevant patients before their operation • Reasons for non completion are recorded so that appropriate action can be taken to rectify any failures. The Wye Valley NHS Trust to take the following actions to maintain this percentage, and so the quality of its services, by reviewing participation rates and the outcome scores on a regular basis.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged— (i) 0 to 14; and (ii) 15 or over, readmitted 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.			
3: Helping people to recover from episodes of ill health or following injury All trusts	Source: CHKS Trust position 6.0% compared to peer group of 7.1%	Source: CHKS Trust position 5.9% compared to peer group of 6.3%	The Wye Valley NHS Trust considers that this data is as described for the following reasons – this is our current readmission rate. The Wye Valley NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing our focus on low readmission rates.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care			

Comment [s6]: This only 2010/11 on NHS Information

Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.			
4: Ensuring that people have a positive experience of care All acute trusts	Not available at present.	Trust score: 63.3 National score: 67.4	The Wye Valley NHS Trust considers that this data is as described for the following reasons; • This measure is a composite of 5 questions asked in the inpatient survey. The Wye Valley NHS Trust intends to take the following actions to improve this score and so the quality of its services, by reviewing the results of the inpatient survey and identifying key actions to improve patient experience.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to 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.			
4: Ensuring that people have a positive experience of care All trusts	Trust score: 3.30 National average: 3.57	Trust score: 3.35 National average: 3.50	The Wye Valley NHS Trust considers that this data is as described for the following reasons The Wye Valley NHS Trust intends to take the following actions to improve this score and so the quality of its services, by
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.			
5: Treating and caring for people in a safe environment	Please note this information is for quarter 3	Please note this information is for quarter	The Wye Valley NHS Trust considers that this data is as

Comment [s7]: This is no the NHS Information Centre indication of date they will be

and protecting them from avoidable harm All acute trusts	in 2012/13. Trust percentage: 93.2% National percentage: 94.1% National percentage is for NHS acute providers. This is the category Wye Valley NHS Trust is placed in.	4 in 2011/12. Trust percentage: 91.5% National percentage: 92.5% National percentage is for NHS acute providers. This is the category Wye Valley NHS Trust is placed in.	described for the following reasons it reflects our current position. The Wye Valley NHS Trust intends to take the following actions to improve this percentage and so the quality of its services, by aiming for 95% attainment in 2013/14.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to 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.			
5: Treating and caring for people in a safe environment and protecting them from avoidable harm All acute trusts	Not available	Trust score: 42.7 National score: 21.8	The Wye Valley NHS Trust considers that this data is as described for the following reasons, it relates to the time period 2011/12 during which (April-June 2011) there was an outbreak of the C. difficile 027 strain which led to additional cases. The Wye Valley NHS Trust undertook a full review of the outbreak and has completed all the actions from the resulting action plan. There have been no further outbreaks due to C. difficile since this time
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the			

Comment [s8]: This is no the NHS Information Centre indication of date they will be

trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.			
5: Treating and caring for people in a safe environment and protecting them from avoidable harm All trusts	Not available.	Trust score: 8.07 (1st April 2011 to 30th September 2012) Recommended level: 5	The Wye Valley NHS Trust considers that this data is as described for the following reasons; • The Trust encourages open and honest reporting of any incidents or near misses. The Wye Valley NHS Trust intends to take the following actions to improve this rate and so the quality of its services, by rolling out the use of Datix Web across the Trust to electronically report incidents.

Comment [s9]: This is no the NHS Information Centre indication of date they will be

Herefordshire Council

MEETING:	**HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**
DATE:	**7 JUNE 2013**
TITLE OF REPORT:	**COMMITTEE WORK PROGRAMME**
REPORT BY:	**ASSISTANT DIRECTOR – LAW, GOVERNANCE AND RESILIENCE**

1. Classification

Open.

2. Key Decision

This is not a key decision.

3. Wards Affected

County-wide.

4. Purpose

To consider the Committee's work programme.

5. Recommendation(s)

THAT: the work programme as appended be noted, subject to any comments the Committee wished to make.

6. Key Points Summary

6.1 The Committee is asked to note its work programme and to note progress on current work.

7. Alternative Options

7.1 It is for the Committee to determine its work programme as it sees fit to reflect the priorities facing Herefordshire. Any number of subjects could be included in the work programme. However, the Committee does need to be selective and ensure that the work programme is focused on the key issues, realistic and deliverable within the existing resources available.

8. Reasons for Recommendations

8.1 The Committee needs to develop a manageable work programme to ensure that scrutiny is focused, effective and produces clear outcomes.

9. Introduction and Background

9.1 An outline work programme only is appended for this meeting. This is because the programme is under continuous review.

10. Key Considerations

10.1 The work programme needs to focus on the key issues of concern and be manageable allowing for urgent items or matters that have been called-in.

11. Community Impact

11.1 The topics selected for scrutiny should have regard to what matters to the County's residents.

12. Equality and Human Rights

12.1 The topics selected need to have regard for equality and Human rights issues.

13. Financial Implications

13.1 The cost of the work of the Scrutiny Committee will have to be met within existing resources. It should be noted the costs of running scrutiny will be subject to an assessment to support appropriate processes.

14. Legal Implications

14.1 The Council is required to deliver an Overview and Scrutiny function.

15. Risk Management

15.1 There is a reputational risk to the Council if the Overview & Scrutiny function does not operate effectively. The arrangements for the development of the work programme should help mitigate this risk.

16. Consultees

16.1 Following initial consultations on topics for scrutiny with Directors and Members of the Cabinet, all members of the Council were invited to suggest items for scrutiny.

17. Appendices

17.1 An outline work programme for the Committee.

Executive Rolling Programme (as at the time of going to print).

18. Background Papers

18.1 None identified.

HEALTH AND SOCIAL CARE OVERVIEW & SCRUTINY COMMITTEE
ITEMS IDENTIFIED FOR INCLUSION IN THE WORK PROGRAME

DRAFT WORK PROGRAMME

11 JULY 2013 at 7pm	
Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.
Strategic Plan for Delivering Adult Services	To consider a quarterly report containing a schedule of performance reports outlining the savings that are being achieved through the Strategic Plan. (July12)
Health Watch	To receive a progress report on Health Watch
Work Programme	To consider the Committees Work Programme
12 SEPTEMBER 2013 at 7pm	
Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.
Work Programme	To consider the Committees Work Programme
11 OCTOBER 2013	
Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.
Strategic Plan for Delivering Adult Services	To consider a quarterly report containing a schedule of performance reports outlining the savings that are being achieved through the Strategic Plan. (July12)
Work Programme	To consider the Committees Work Programme
7 NOVEMBER 2013 at 7pm	
Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.
Work Programme	To consider the Committees Work Programme
6 DECEMBER 2013	
Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.
Work Programme	To consider the Committees Work Programme

Children's health and wellbeing (a focus on Childhood obesity)
National Health Policies

The following issues are suggestions from the public for inclusion

the impact of housing developments in Herefordshire on Hereford hospital and other social services

Executive Rolling Programme: **June 2013**

Final Decision Maker	Meeting / Decision Date	Issue Type: • KEY • Budget & Policy Framework Item (B&PF) • Non Key	Report Title	Purpose	Directorate and Lead Officer
CABINET	13/06/13 Additional Meeting	**KEY & EXEMPT**	Future Contractual Arrangements	Future contractual arrangements to replace the Amey contract.	Places and Communities / Richard Ball / Rob Ewing
CABINET Portfolio – CM EH&P	20/6/13	**KEY**	Housing Allocations Adoption Policy	The Housing Allocation Policy describes the criteria that Herefordshire Council uses to prioritise affordable housing for those with a housing need. The Local Authority is using powers under the Localism Act 2011 which gives increased flexibility to review its policy to enable them to manage their housing registers which better reflects local demand, whilst still protecting the most vulnerable.	Places and Communities / Richard Gabb
CABINET Portfolio – CM FM	20/6/13	Non Key	Budget Monitoring Report	To report the financial position for both Revenue and Capital.	Corporate Services / David Powell
CABINET Portfolio – CM CS	20/06/13	Non Key	Understanding Herefordshire Annual Report		Corporate Services / Jenny Lewis
CABINET Portfolio – CM CS	20/06/13	Non Key	2012/13 Year end report (*Performance*)		Corporate Services / Jenny Lewis
CABINET Portfolio -	20/06/13	Non Key	Review of Complaints Policy	To agree any changes to the policy in the light of the review	Corporate Services: Jenny Lewis
CABINET Portfolio -	20/6/13	**KEY**	Open Book Review of Residential and Nursing Home Fees for Older People	To approve the future pricing model for fee increases in the future.	

GENERAL OVERVIEW AND SCRUTINY COMMITTEE ITEMS – JUNE 2013				
MEETING/ BRIEFNG DATE	**ITEM**	**PURPOSE**	**O&SC PRE-DECISION PRIOR TO:**	
			A&G Committee Cabinet Council	**Meeting Date**
18 June 2013	Local Development Framework	To consider the results of the LDF consultation prior to consideration by Cabinet		

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE ITEMS – JUNE 2013				
MEETING/ BRIEFNG DATE	**ITEM**	**PURPOSE**	**O&SC PRE-DECISION PRIOR TO:**	
			A&G Committee Cabinet Council	**Meeting Date**
7 June 2013	Wye Valley Trust (tbc)	To consider the Quality Accounts		
7 June 2013	Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.		
7 June 2013	Work Programme	To consider the Committees Work Programme		

Executive Rolling Programme: **July 2013**

Final Decision Maker	**Meeting / Decision Date**	**Issue Type:** • **KEY** • **Budget & Policy Framework Item (B&PF)** • Non Key	**Report Title**	**Purpose**	**Directorate and Lead Officer**
CABINET Portfolio	4/7/13	**B&PF** *decision of Council - July requires 28 day notice	Local Development Framework	To consider the revised LDF for adoption by Council	Places and Communities / Yvonne Coleman
Audit & Governance Committee	5/7/13	N/A	Annual Audit Fee Letter and Plan		Corporate Services / David Powell
Audit & Governance Committee	5/7/13	N/A	Annual Governance Statement		Corporate Services / David Powell
Audit & Governance	5/7/13	N/A	Annual Internal Audit		Corporate Services /

Final Decision Maker	Meeting / Decision Date	Issue Type: • KEY • Budget & Policy Framework Item (B&PF) • Non Key	Report Title	Purpose	Directorate and Lead Officer
Committee			Plan		David Powell
Audit & Governance Committee	5/7/13	N/A	Audit and Governance Committee Work Programme		Corporate Services / David Powell
Audit & Governance Committee	5/7/13	N/A	Amendments to the Planning Code		
COUNCIL	19/7/13	N/A	Hereford and Worcester Fire and Rescue Authority Report		
COUNCIL	19/7/13	N/A	Leader's Report	To receive the Leader's report, which provides an overview of the Executive's activity since the last COUNCIL meeting.	
COUNCIL	19/7/13	N/A	Audit and Governance Committee Report including Standards Panel Report	To receive a report on standards case (Cllr Glenda Powell)	Corporate Services
COUNCIL	19/7/13	**B&PF same as KD requires 28 day notice**	Local Development Framework core strategy	To consider the revised LDF for adoption by Council	Places & Communities Andrew Ashcroft
COUNCIL	19/7/13	N/A	Electoral Review of Herefordshire	To receive a report on the Boundary Commission's final recommendations of the Electoral Review of Herefordshire	Corporate Services
COUNCIL	19/07/13	N/A	Appointment of Returning Officer & Electoral Registration Officer		Corporate Services John Jones
CABINET Portfolio – CM CS	25/7/13		Integrated Corporate Performance Report Q1		Corporate Services
CABINET Portfolio – CM FM	25/7/13	Non Key	Budget Monitoring Report	To report the financial position for both Revenue and Capital.	Corporate Services / David Powell
CABINET Portfolio -	25/7/13	Non Key	Local Account	To approve the Local Account relating to Adult Social Care Performance.	People's Services / Peter Sowerby
CABINET	25/7/13	**KEY**	Post 16 Learners with Learning Difficulties & Disabilities (LLDD)		People's Services

Final Decision Maker	Meeting / Decision Date	Issue Type: • KEY • Budget & Policy Framework Item (B&PF) • Non Key	Report Title	Purpose	Directorate and Lead Officer
			Review		
CABINET	25/7/13	KEY	Next Stage Integration – Wye Valley		People's Services
CABINET	25/7/13	KEY	Short breaks and Respite Procurement		People's Services / Philippa Granthier
CABINET	25/07/13	KEY	Community Support Services / Domiciliary Care Element	To set out procurement approach and timeframes for a decision on whether to extend domiciliary care contracts or to procure within the current timeframes of contacts due to expire Oct 2013 To provide cabinet with options for models of domiciliary care provision for a decision which model to procure.	People's Services David Powell Wayne Welsby
Cabinet Member	25/7/13	Non Key	School Transport Review		People's Services
CABINET MEMBERS CS & E&C	July 2013 (TBC)	KEY	Buttermarket Refurbishment	To establish if and how the Council wishes to fund the refurbishment of the Buttermarket and to clearly set out the options available in managing the delivery of the project should it progress	Places and Communities / Chris Jenner

GENERAL OVERVIEW AND SCRUTINY COMMITTEE ITEMS – JULY 2013				
MEETING/ BRIEFNG DATE	ITEM	PURPOSE	O&SC PRE-DECISION PRIOR TO: A&G Committee Cabinet Council	Meeting Date
8 July 2013	Music Service	Agreed in July 2011 to review after 2 years. To receive an update on how the service is performing since the reconfiguration of the Service in 2011 including accessibility to the service; peripatetic links to the schools and school results.		
8 July 2013	Budget Monitoring	To consider the Executives response to the Council's budget position.		
8 July 2013	Implications for Scrutiny following the Francis Inquiry Report	To consider the implications for scrutiny following the Francis Inquiry Report – Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.		

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE ITEMS – JULY 2013				
MEETING/ BRIEFNG DATE	**ITEM**	**PURPOSE**	**O&SC PRE-DECISION PRIOR TO:**	
			A&G Committee Cabinet Council	**Meeting Date**
11 July 2013	Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.		
11 July 2013	Strategic Plan for Delivering Adult Services	To consider a quarterly report containing a schedule of performance reports outlining the savings that are being achieved through the Strategic Plan. (July12)		
11 July 2013	Health Watch	To receive a progress report on Health Watch		
11 July 2013	Work Programme	To consider the Committees Work Programme		

Executive Rolling Programme: **August 2013**

Final Decision Maker	**Meeting / Decision Date**	**Issue Type:** • **KEY** • **Budget & Policy Framework Item (B&PF)** • Non Key	**Report Title**	**Purpose**	**Directorate and Lead Officer**
Audit & Governance Committee	6/8/13	N/A			

Executive Rolling Programme: **September 2013**

Final Decision Maker	Meeting / Decision Date	Issue Type: • KEY • Budget & Policy Framework Item (B&PF) • Non Key	Report Title	Purpose	Directorate and Lead Officer
CABINET Portfolio CM MC	September 2013	KEY	Waste Contract		Places & Communities / Andy Tector
Audit & Governance Committee	6/9/13	N/A	Counter-fraud and Corruption Policies – Biennial Review		Corporate Services / David Powell
Audit & Governance Committee	6/9/13	N/A	Whistle Blowing Policy – Biennial Review		Corporate Services / David Powell
CABINET Portfolio – CM FM	19/09/13	Non Key	Budget Monitoring Report	To report the financial position for both Revenue and Capital.	Corporate Services / David Powell
Council	27/9/13				

GENERAL OVERVIEW AND SCRUTINY COMMITTEE ITEMS – SEPTEMBER 2013				
MEETING/ BRIEFNG DATE	ITEM	PURPOSE	O&SC PRE-DECISION PRIOR TO: A&G Committee Cabinet Council	Meeting Date
3 September 2013	Waste Contract update	To receive an update on the Waste Contract prior to consideration by Cabinet		

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE ITEMS – SEPTEMBER 2013				
MEETING/ BRIEFNG DATE	ITEM	PURPOSE	O&SC PRE-DECISION PRIOR TO: A&G Committee Cabinet Council	Meeting Date
12 September 2013	Recovery Plan for Children Safeguarding	To receive a progress report on the Action Plan.		
12 September 2013	Work Programme	To consider the Committees Work Programme		