Quality Account
2018-19
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PART 1

What is the Quality Account?
What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. The Quality Account for Wye Valley NHS Trust (the Trust) looks back on how well we have done at achieving our goals in the past year. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

How will the quality account be published?

In line with legal requirements, all NHS Healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 30th June 2019. We also make our Quality Account available on our website.

About the Trust

We are an acute and community Trust, providing a wide range of services to people of all ages living in Herefordshire and some of the population of Powys. To do this, we employ over 3000 staff who operate from the County Hospital, many community sites and in people’s homes.

We deliver joined up services, helping people to remain independent at home for as long as possible by providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, we offer a wide range of services to keep you and your family well.

We work as a member of a Foundation Group that also includes South Warwickshire Foundation Hospitals Trust and George Elliot NHS Trust.

Having been rated as ‘Requires Improvement’ by the Care Quality Commission our journey to ‘good’ is well underway and the Quality Account illustrates what we are doing to achieve this.

Wye Valley Trust Mission and Values

Our Mission:

To provide a quality of care we would want for ourselves, our family and friends

Our Values:

- **Compassion** - We will support patients and ensure that they are cared for with compassion.
- **Accountability** - We will act with integrity, assuming responsibility for our actions and decisions
- **Respect** - We will treat every individual in a non-judgemental manner, ensuring privacy, fairness and confidentiality
- **Excellence** - We will challenge ourselves to do better and strive for excellence
Introduction from the Chief Executive

I am pleased to be reflecting on what has been a very positive year of quality and safety improvements for the Trust.

Most notably, during 2018 the Trust had a CQC inspection which acknowledged the progress made over the last few years to improve services. It was pleasing to see our Children’s and Young People’s service rated as outstanding for caring which exemplifies the level of service delivered by this team and others across the organisation.

The Trust continues to focus on improving services and improving the quality and safety of services delivered alongside the progress made in improving our efficiency.

Our biggest achievement this year has been a significant reduction in mortality rates across the organisation. For many years the Trust has been seen as an outlier with the highest rate in England and the latest HSMR of 105.6 is the lowest at the Trust since recording began. Focus on this area has been led by a dedicated team working together with clinicians to review clinical pathways. This work has included collaborative working across the health economy as seen by closer working with local GP’s.

Our positive safety culture continues to be demonstrated through a high level of incident reporting. The Trust is the 5th highest reporter of incidents in England with a large relative proportion of those resulting reassuringly in no harm.

We are proud of the continued reduction in harm to patients in our care. This is demonstrated through a 73% reduction in pressure ulcers acquired in our care. A similarly improving trend continues for patient falls with a 14% reduction seen this year. Progress in these areas has been helped by the introduction of expert panels who review and work with local teams to improve safety. This has been supported by local champions embedding knowledge into practice. Since October 2018 the Trust has performed better than the national average for harm free care as seen through Safety Thermometer data.

We have also made improvements in some harder to measure areas such as dementia and learning disability care. We have also developed a Carers Café which has provided additional support in another hard to measure but beneficial area.

We have improved discharge through better integrated working between health and social care to support patients remaining at home and reduce those waiting for services in hospital.

We identified 8 quality priorities for the year. Even though much progress has been made there is more to do, so many will continue as our priorities for 2019/20.

Our focus will be improving the quality of care and treatment for all patients and especially improving our services for our most vulnerable patient groups.

Glen Burley Chief Executive
Developing our Quality Account – A glance at the year ahead

Trust Objectives:

The Trust objectives for 2019/20 have built on those we had established for 2018/19 yet with more emphasis on developing a sustainable healthcare system, enabling patients to remain independent and working closely with partners from One Herefordshire.

Quality Priorities:

Our quality priorities for the forthcoming year have been developed through consultation and through local intelligence, they ensure that we are tackling those issues that will enable our patients to be safe in our care, treated effectively and receive the very best care. They include:

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing avoidable death rates by:</td>
<td>Reduce the proportion of non-value added time when patients are in hospital:</td>
<td>Support people to improve their health outcomes:</td>
</tr>
<tr>
<td>a. Improved identification, treatment and management of the deteriorating patient</td>
<td>a. Reduce the number of non-clinical ward moves</td>
<td>a. Demonstrate progress against the national Learning Disability Standards</td>
</tr>
<tr>
<td>b. Improved compliance with care bundles</td>
<td>b. Improve discharge planning making HomeFirst the default discharge pathway</td>
<td>b. Contribute to the system childhood obesity reduction target</td>
</tr>
<tr>
<td>c. Improved compliance with venous thromboembolism (VTE) prevention</td>
<td>c. Improve patient involvement when making choices towards the end of life including advanced care planning</td>
<td>c. Improve staff health and well being</td>
</tr>
<tr>
<td>d. Reduce infection rates</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Quality Account – A review and ‘look back’ at 2018/19

The remainder of the Quality Account reflects on the progress achieved throughout 2018/19.

Engagement, reward and recognition

We will always engage with staff on what matters to them and support staff to create sustainable improvements to the quality and safety of their services.

#AmazingWVTstaff is our strap line for employee engagement and has its own twitter account.

The Trust has had a programme of engagement across the organisation which identified key priorities. In 2017 we held a series of staff engagement events where staff were asked to describe their perfect day and what types of things prevented this from happening. The staff engagement events have become an annual event. During the 2018 events staff were asked to describe their experience of recruitment, leadership and appraisal, suggesting areas for improvements. From listening to our staff our approach to appraisal is being reviewed, we have developed our leadership offer and plan to hold further engagement events throughout 2019.

The Going the Extra Mile Scheme acknowledges and celebrates the dedication and achievement of our staff who often go beyond the call of duty to make a difference to the experiences of patients, visitors, colleagues and clients. There were many inspirational nominations and for the first time the overall winners were celebrated at the Trust’s 2018 Annual Public Meeting.

In July 2018 the Trust celebrated the long service many of our staff have given to the NHS. In total the Trust presented 172 awards and a further 41 awards were collected after the event. The awards were issued over 6 categories, 25 years’ service 30 years’ service 35 years’ service, 40 years’ service, 45 years’ service and 50 years’ service. Staff received a personal invitation to the celebration and received a certificate, badge and gift. The celebrations concluded with coffee and cake and were enjoyed by all.
PART 2

Statement of Assurance
Organisational change

Wye Valley Trust is part of a foundation group that also includes South Warwickshire NHS Foundation Trust and George Elliot NHS Trust, which joined in 2018. Each Trust retains its own Trust Board with the common link being a shared Chief Executive Officer and Trust Chairman.

The Foundation Group enables us to strengthen opportunities available to help secure a sustainable future for all three organisations and allows each Trust to maintain its own governance while benefitting from scale and learning across the wider group.

Here at Wye Valley NHS Trust, a fourth division was created in April 2018 in addition to the three existing divisions of Medicine, Surgery and Integrated Care.

The new Clinical Support Division focuses on the provision of support services for patients and includes the departments of Pharmacy, Radiology and Pathology.
Statements of Assurance

Review of services and income:

The Trust provided and/or subcontracted 55 acute and community services for the population of Herefordshire, bordering English counties and Powys. (More detail on these services is provided in Appendix 2). We have reviewed all the data available on the quality of care in all these services.

More detail on the income of the Trust can be found in our Annual Report 2019/20.

The income generated by Wye Valley NHS Trust NHS for services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services.

A breakdown of income received from each body for 2018/19 is illustrated below.
Care Quality Commission (CQC) overview of progress

The Trust welcomed a CQC visit in 2018. The pre-inspection preparation commenced in March 2018, core service inspections took place throughout June 2018 and culminated in the well led inspection in July 2018. Eight core services were inspected:

- Urgent and emergency care
- Surgery
- Outpatients
- Maternity
- Medicine
- Children and Young People
- Community inpatients
- Community end of life care

The results of the inspection were published in October 2018 and the Trust was rated as Requires Improvement overall.

<table>
<thead>
<tr>
<th>Ratings for the whole trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
</tr>
<tr>
<td>Requires improvement 2018</td>
</tr>
</tbody>
</table>

The CQC rated seven of the Trusts 13 services as “good” and six as “requires improvement”. In rating the Trust the CQC took into account the current ratings of the five services not inspected. Acute and community services scored “good” for the caring and well led domains. This is an improvement on the previous inspection and also includes an improved position within the responsive domain. Children and Young People Services received a rating of outstanding.
A rating of inadequate for the responsive domain was given for surgical services. This related to the number of patients waiting too long for procedures. As a consequence the CQC issued a warning notice under section 29a of the Health and Social Care Act, which
specifically related to the length of time patients were waiting for treatment and the significant delays from referral to treatment. The Trust responded to the warning notice with a recovery and action plan which improved our performance and the Trust is now able to report a RTT position of 80.02% English incomplete pathways under the 18 week standard and four patients waiting over 52 weeks for treatment at the end of March 2019.

The CQC has not taken enforcement action against the Trust during 2018/19. The Trust is currently registered with the Care Quality Commission without any compliance conditions and is licensed to provide services.

The CQC identified 13 actions the Trust ‘must’ take and these along with other recommendations are progressing and being monitored through the Trust’s Clinical Quality Committee. Some of these are a particular focus and are included in the Quality Priorities for 2019/20.

**National Audit and National Confidential Enquiries into Patient Outcome and Death (NCEPOD)**

During 2018/19, the Trust participated in 54 (100%) national clinical audits and 100% of the National Confidential Enquiries it was eligible to participate in. The 12 national audits that the Trust did not participate in were due to clinical services not being provided within the organisation. Of the 54 audits 18 national reports were published in 18/19 that were relevant to the Trust, 100% were reviewed by the relevant specialty and where appropriate actions plans have been developed.

**National Audit Compliance**

Compliance with audits, which are part of the National audit programme, are outlined in detail at the end of this section. The following audits have lower than expected participation rates:

<table>
<thead>
<tr>
<th>Audit</th>
<th>Participation rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Surgery (National PROMS Programme)</td>
<td>48%</td>
<td>Data published in February, based on the provisional date release for time period admitted April 2018- September 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Completion of patient questionnaires is not mandatory and reduced rate relates to patient choice</em></td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>70%</td>
<td>National report published November 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>This is an improved position-monitoring continues through Division</em></td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>60%</td>
<td>Report published August 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Participation reduced due to the way data was collected. Action is in place to increase number of patients included in the audit.</em></td>
</tr>
</tbody>
</table>

The national clinical audits and NCEPOD studies that the Trust was eligible to participate in are detailed on the following pages:
<table>
<thead>
<tr>
<th>Eligible National Audits</th>
<th>WVT participation in 2018-2019</th>
<th>% of required cases submitted (position at 31/03/2019)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>✅</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>BAUS Urology Audits: Nephrectomy</td>
<td>✅</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>BAUS Urology Audits: Percutaneous Nephrolithotomy</td>
<td>✅</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>BAUS Urology Audits: Female stress urinary incontinence</td>
<td>✅</td>
<td>N/A</td>
<td>No eligible patients for 2018/19</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>✅</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>✅</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>✅</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>✅</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>✅</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td>✅</td>
<td>48%</td>
<td>Data published in Feb 2019, based on the provisional date release for time period admitted April 2018 to September 2018 N.B Completion of patient questionnaires is not mandatory</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFAP)</td>
<td>✅</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>National Hip Fracture Database</td>
<td>✅</td>
<td>100%</td>
<td>Report published November 2018</td>
</tr>
<tr>
<td>Programme</td>
<td>Complete?</td>
<td>Data Collection</td>
<td>Notes / Status</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fracture Liaison Database</td>
<td>✓</td>
<td>N/A</td>
<td>All eligible cases submitted Report published December 2018</td>
</tr>
<tr>
<td>National Inpatient Falls Audit</td>
<td>✓</td>
<td>N/A</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>✓</td>
<td>Not available</td>
<td>Continuous data collections – all eligible cases submitted</td>
</tr>
<tr>
<td>Major Trauma Audit</td>
<td>✓</td>
<td>100%</td>
<td>Continuous data collections – all eligible cases submitted Report published 2019</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients (NABCOP)</td>
<td>✓</td>
<td>100%</td>
<td>All eligible cases submitted Report published July 2018</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>✓</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>✓</td>
<td>N/A</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>National Audit of Rheumatoid and Early Inflammatory Arthritis</td>
<td>✓</td>
<td>N/A</td>
<td>All eligible cases submitted report not yet due to be published</td>
</tr>
<tr>
<td>National Audit of Seizures and Epilepsies in Children and Young People</td>
<td>✓</td>
<td>100%</td>
<td>All eligible cases submitted Report published January 2019</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>✓</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit programme</td>
<td>✓</td>
<td>N/A</td>
<td>Data collection started November 2018</td>
</tr>
<tr>
<td>National adult asthma audit</td>
<td>✓</td>
<td>N/A</td>
<td>Data collection started November 2018</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit programme</td>
<td>✓</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>In adult secondary care</td>
<td>✓</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Audit Programme</td>
<td>Complete?</td>
<td>Data Collection</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td><strong>National Chronic Obstructive Pulmonary Disease (COPD) Audit programme</strong></td>
<td>✓</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehab Audit</td>
<td></td>
<td>Data collection</td>
<td></td>
</tr>
<tr>
<td>Non-Invasive ventilation in adults</td>
<td>✓</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>✓</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>National Comparative Audit of Blood Transfusion Programme</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit of Fresh Frozen Plasma and Cryoprecipitate in Children and Neonates</td>
<td>✓ 100%</td>
<td>All eligible cases submitted Report published January 2019</td>
<td></td>
</tr>
<tr>
<td><strong>National Comparative Audit of Blood Transfusion Programme</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit of Massive Haemorrhage</td>
<td>✓ 100%</td>
<td>All eligible cases submitted</td>
<td></td>
</tr>
<tr>
<td><strong>National Comparative Audit of Blood Transfusion Programme</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory surveillance of bloodstream infections and Clostridium Difficile Infection</td>
<td>✓ 100%</td>
<td>All eligible cases submitted</td>
<td></td>
</tr>
<tr>
<td><strong>National Comparative Audit of Blood Transfusion Programme</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit of Maternal Anaemia</td>
<td>✓</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme</strong></td>
<td>✓ 100%</td>
<td>Any serious adverse reaction or event involving blood transfusion is reported to SHOT</td>
<td></td>
</tr>
<tr>
<td><strong>National Diabetes Core Audit – Adults</strong></td>
<td>✓ 100%</td>
<td>Data collection</td>
<td></td>
</tr>
<tr>
<td>Audit</td>
<td>Complete?</td>
<td>Percentage</td>
<td>Status</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------</td>
<td>------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit</td>
<td>✔</td>
<td>N/A</td>
<td>Organisational survey required only this year</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Audit</td>
<td></td>
<td></td>
<td>National report not due until 2019</td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit</td>
<td>✔</td>
<td>N/A</td>
<td>Data collection</td>
</tr>
<tr>
<td>National Diabetes HARMS Audit</td>
<td>✔</td>
<td>N/A</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>National Emergency Laparotomy</td>
<td>✔</td>
<td>70%</td>
<td>National Report published November 2018</td>
</tr>
<tr>
<td>Audit (NELA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National End of Life care audit</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases included</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Report published February 2019</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>✔</td>
<td>99%</td>
<td>National Report published December 2018</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Report due before April 2019</td>
</tr>
<tr>
<td>National Maternity and Perinatal</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Audit (NMPA)</td>
<td></td>
<td></td>
<td>Report due before April 2019</td>
</tr>
<tr>
<td>National Neonatal Audit Programme</td>
<td>✔</td>
<td>100%</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>(NNAP) (Neonatal Intensive and</td>
<td></td>
<td></td>
<td>Report published September 2018</td>
</tr>
<tr>
<td>Special Care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>✔</td>
<td>60%</td>
<td>Report published August 2018</td>
</tr>
<tr>
<td>Oesophago-gastric Cancer (NAOGC)</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Report published November 2018</td>
</tr>
<tr>
<td>Program</td>
<td>Eligibility</td>
<td>Reporting Status</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>College of Emergency Medicine (CEM)</td>
<td>✔</td>
<td>N/A</td>
<td>Data submitted. Report date not yet published</td>
</tr>
<tr>
<td>Vital signs in adults (care in the emergency departments)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College of Emergency Medicine (CEM)</td>
<td>✔</td>
<td>N/A</td>
<td>Data submitted. Report date not yet published</td>
</tr>
<tr>
<td>VTE risk in lower limb immobilisation (care in the emergency departments)</td>
<td>✔</td>
<td>N/A</td>
<td>Data submitted. Report date not yet published</td>
</tr>
<tr>
<td>College of Emergency Medicine (CEM)</td>
<td>✔</td>
<td>N/A</td>
<td>Data submitted. Report date not yet published</td>
</tr>
<tr>
<td>Feverish children (care in the emergency departments)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Report published 14th February ?year</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>✔</td>
<td>N/A</td>
<td>Report not yet published</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry (Adults &amp; Children)</td>
<td>✔</td>
<td>100%</td>
<td>Only children not adults relevant to WVT</td>
</tr>
<tr>
<td>Surgical Site Infection Surveillance Service</td>
<td>✔</td>
<td>100%</td>
<td>Reported quarterly</td>
</tr>
<tr>
<td>7 Day Services Self-Assessment</td>
<td>✔</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data reported June 2018</td>
</tr>
<tr>
<td>Reducing the impact of serious Infections (antimicrobial resistance and sepsis)</td>
<td>✔</td>
<td>N/A</td>
<td>Reported quarterly through National CQUIN NC2c</td>
</tr>
</tbody>
</table>

**National Confidential Enquiries and Healthcare Quality Improvement Partnership**

<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility</th>
<th>Reporting Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td></td>
<td>N/A</td>
<td>The Trust contributes all maternal and child deaths to programme</td>
</tr>
<tr>
<td>Healthcare Quality Improvement Partnership (HQIP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Surgical Clinical Outcome Review Programme</td>
<td></td>
<td>N/A</td>
<td>Contributed to the programme via</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Cancer in Children, Teens and Young Adults – Report published November 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Acute Heart Failure – Report published September 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Perioperative Diabetes – report</td>
</tr>
</tbody>
</table>
Learning from Audit

In 2018/19 the clinical audit programme included a total of 219 projects. 45 of these audits had detailed reports and action plans developed. 11 of these were national with 34 being local or other projects. The clinical audit programme is monitored by the Trust’s divisional and directorate governance groups on a monthly basis with oversight through the Clinical Effectiveness and Audit Committee.

Within the Trust, the results from national and local clinical audits are reviewed by the clinical teams involved in the audit. If the review indicates that improvements are required, action plans are devised and implemented.

Seven Day Services Review

Ensuring the provision of safe effective services is essential. As part of this a designated programme of work is under way to review current standards. A focus has been made on the areas which are priority standards and directly influence the care given to patients and patient outcomes. Audits have been undertaken to demonstrate improvement.

There are 10 standards in total and details of progress with a smaller sample of four standards follow. The four represent a sample from the Seven Day Services Clinical Standards.

Please note that most recent data for February 2019 is under review awaiting approval.

Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
Result: The graph which follows shows improved performance in this area. There has been a steady increase from 70% in September 2016 to a current 95% at April 18 exceeding the 90% standard.

Clinical Standard 2 – time to first consultant review

![Graph showing improvement in performance over time.]

Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

Result: MRI scanning and reporting is available daily however the service is currently unavailable out of hours for reporting the within 1 hour for critical patients and within 12 hours for urgent patients. Echocardiography is only available formally weekdays but can be performed by a trained doctor in an emergency on an informal basis.
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

Result: The Trust provides weekday and weekend access to all interventions except interventional radiology which can be provided but on an informal basis only.

Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be
reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

Result: Once daily reviews remain above the 90% standard and twice daily reviews increasing to 100% (note there were no patients who met the criteria as defined in the audit during March 17).

The Case Mix Programme
The Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland. The CMP is listed in the Department of Health’s ‘Quality Accounts’ as a recognised national audit by the National Advisory Group on Clinical Audit & Enquiries (NAGCAE) for ‘Acute’ care.

Currently 100% of adult, general critical care units participate in the CMP. Other specialist units, including neurosciences, cardiac and high dependency units, also participate.

The CMP is open to both NHS (publicly funded) and independent sector critical care units.

Wye Valley NHS has been participating in the CMP since 1996.

The CMP compare the data from all patients admitted to the Intensive Care Unit with the outcomes from other similar patients, other similar units and all the units in the CMP. The unit receives a Data Analysis Report which identifies trends over time showing how the unit compares with others and helps the unit understand more about the care they deliver. It aims to assist them in decision-making, resource allocation and local quality improvement.
The Quality indicator dashboard shows the potential quality indicators (and their agreed thresholds)

**CMP Quality Indicator Dashboard**

The Case Mix Programme (CMP) Quality Indicator Dashboard shows the potential quality indicators (and their agreed thresholds) including those published by the Clinical Reference Group (CRG) for adult critical care as part of specialised commissioning.

The annual quality report has been disseminated to Critical Care Medical and Nursing staff.

**Areas reflecting good practice**

Mortality – the Standardised Morality Ratio (SMR) continues to be below 1 which means that the rate of observed deaths in the study group is less than the expected deaths in the general population.

As a unit we have less blood infections than other units and this is an indication of good local practice.

**Areas requiring improvement:**

Data that reflects the pressures on the hospital as a whole is reflected in the quality indicators. In particular:

- Out of hours’ discharges to the ward (not delayed) – this is unacceptably high and has been audited. Patients are being discharged out of hours to accommodate higher acuity patients whilst our occupancy is frequently over 100%. We are working to reduce this on a number of levels.
• Non-clinical transfers and discharges direct to home whilst still in the green are not as low as we would like and again reflect the pressures on the hospital.

National Audit of Care at the End of Life (NACEL)
The Trust’s Palliative Care Team has participated in The National Audit of Care at the End of Life (NACEL) and the first stage results of the audit (2018/19) have now been published nationally.

The aim of the project is to improve the quality of care of all people at the end of life. The Palliative Care Team reviewed all deaths in the acute hospital in the month of April 2018.

The audit monitors progress against the five priorities for care set out in “One Chance to Get It Right” and NICE Quality Standards.

The first stage of the audit, took place in 2018/19 and included three components:

● Organisational level audit
● Case Note Review
● Quality Survey - The survey was designed to gain feedback from relatives, carers and those close to the person who died on their experiences of the care and support received at the end of life.

Round 2 of the audit started on 1st April 2019 and the Palliative Care Team will be participating on behalf of the Trust, to collect data about the quality of care provided to those at the End of Life in the acute hospital, this time the audit will be concentrating on deaths occurring during the first two weeks of April and May 2019.

A summary of the Trust’s results against the national results of the audit are shown overleaf.

The Trust had identified a number of priorities to address the shortfalls in the audit, particularly in relation to communication and support for families.
## Participation in research

In 2018-2019, 575 patients at the Trust were recruited into 40 studies on the National Institute Health Research (NIHR) Portfolio having been approved by appropriate ethics committees through the Herefordshire and Worcestershire Research Consortium.

This included 72 patients who were recruited into 10 interventional studies. These studies were across a wide range of clinical areas including haematology, rheumatology, paediatrics, oncology, health services research, renal, ageing, respiratory, genetics, stroke, cardiology, dementia, upper GI surgery, anaesthetics, infection control and dermatology.

<table>
<thead>
<tr>
<th>National Results</th>
<th>Wye Valley’s Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognising the possibility of imminent death</td>
<td>9.1</td>
</tr>
<tr>
<td>Communication with families and others</td>
<td>6.6</td>
</tr>
<tr>
<td>Involvement in decision making</td>
<td>8.4</td>
</tr>
<tr>
<td>Needs of families and others</td>
<td>6.1</td>
</tr>
<tr>
<td>Individual plan of care</td>
<td>6.7</td>
</tr>
<tr>
<td>Families and others experience of care</td>
<td>7.1</td>
</tr>
<tr>
<td>Governance</td>
<td>9.5</td>
</tr>
<tr>
<td>Workforce/specialist palliative care</td>
<td>7.4</td>
</tr>
<tr>
<td>Communication with the dying person</td>
<td>6.9</td>
</tr>
</tbody>
</table>
Safety Alerts and Best Practice Guidance

In 2018, compliance with previous Patient Safety Alerts issued by the Central Alerting System (CAS) was reviewed following a number of Never Events. Investigation of these incidents showed that compliance with these alerts was not as thorough as expected. We undertook a review of the processes and commenced a look back event on all alerts issued since 2009.

This review was reported through the Clinical Effectiveness and Audit Committee (CEAC) and demonstrated that:

- the alerts are being managed effectively
- a process is in place to ensure robust on-going management of alerts
- there is an escalation process for non-compliance and outstanding actions

Following the introduction of the new processes, all new alerts have met the expected timescale.

Those alerts which were reviewed as part of the look back exercise and are currently waiting for closure have action plans to address and risk assessments to mitigate the outstanding issues. Progress will be reviewed at CEAC with exception reporting to the Clinical Quality Committee.

Information Governance

Information Governance is how an organisation handles patient and staff information which may be of a sensitive nature. This includes ensuring all information, especially personal, is held legally, securely and confidentially.

The Data Security Protection Toolkit (DSPT) was introduced in 2018/19 and replaces the Information Governance Toolkit (IGT). The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian’s 10 data security standards. The Trust’s end of year submitted position is as below:

<table>
<thead>
<tr>
<th>Progress Dashboard and Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Reporting</td>
</tr>
<tr>
<td>Assertions</td>
</tr>
<tr>
<td><strong>Standard not met</strong>: March 2019</td>
</tr>
<tr>
<td>Staff pass the data security and protection mandatory test</td>
</tr>
</tbody>
</table>

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Clinical coding and error rate

Clinical coding is the translation of medical terminology (written by the clinicians) that describes a patient’s complaint, problem, diagnosis, treatment or other reason for seeking medical attention into standard codes that can then be easily tabulated, aggregated and sorted for statistical and financial analysis, in an efficient and meaningful manner.

Clinical codes can be used to identify specific groups of anonymised patients (for example, those who have had a stroke, or those who have had a hip replacement operation) so that indicators of quality can be produced to help improvement processes.

The Trust has a constant focus on data quality and the need to meet the organisation’s reporting requirements against the National Data Security and Protection Toolkit, Data Quality Standard 1. The Trust uses a variety of systems and processes to ensure poor data quality does not undermine the information being reported. Data quality checks are performed on all main reporting domains (including quality, finance, operational performance, and workforce). The Trust makes use of internal and external benchmarks to highlight areas potentially requiring improvement to data quality.

The following explains the technical nature of recording procedures within a healthcare setting. This is audited for accuracy and to enable comparison across organisations. The results below indicate that we have a good performance in this area:

The following illustrates the percentage coding accuracy at Wye Valley NHS Trust in 2018/19 of which all level 2 standards were met as set by NHS Digital.

<table>
<thead>
<tr>
<th></th>
<th>WVT results</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>Primary procedure</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Secondary procedure</td>
<td>91%</td>
<td>85%</td>
</tr>
</tbody>
</table>

The Trust is committed to ensuring staff are aware of their responsibility for Data Quality (DQ) and the accurate recording of data on Trust electronic systems and paper held records. We have included this responsibility in all job descriptions and regular audits are undertaken. We work closely with our partner IMS Maxims who are supporting with electronic patient record development. The Trust’s commitment to DQ is demonstrated by:

- All staff should be fully trained in the use and recording of data on electronic systems – access should not be given until training has taken place
- All managers are responsible for DQ within their services
- Staff are aware of the reporting mechanisms for DQ issues and complaints
The Trust has a dedicated team, for each electronic system, for managing DQ issues, system management, system configuration in line with national standards and advising staff on managing DQ issues.

Regular reports are sent out for managers to ensure missing data and errors are actioned and regular meetings are held to discuss and report actions of the same.

Audits are carried out monthly to review compliance with recording patient demographic details on the Electronic Patient Record System and the main paper health records for both inpatient and outpatient data and diagnostic and procedure coding for inpatient episodes.

Summary DQ dashboard produced weekly and discussed at weekly Trust wide meeting.

Director led data quality meeting to review issues log following implementation of IMS Maxims.

Additional steps added to commissioning data sets processing to identify incorrectly recorded data and passed to the Electronic Patient Record Support Team to correct for the IMS MAXIMS system.

Implementation of Coding software to improve the quality of the clinical coding.

In 2019/20 we will continue to work with IMS MAXIMS to improve the following aspects of records:

- General Practitioner load data
- Patient Demographic system synchronisation to avoid separation of patient records
- Reported issues and problem records – fixes provided within upgrades to system
- To set up a Data Quality Committee to review issues and processes and decide on ways to improve the same.

The Patient’s NHS number-

A patient’s NHS number is a key identifier for patient records, and the National Patient Safety Agency has found that the largest single source of nationally reported patient safety incidents relates to the misidentification of patients.

The Trust submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics (HES) which are included in the latest published data.

The percentage of records in the published data which included the patient’s valid NHS number for the period April 2018 to March 2019 is detailed below.

<table>
<thead>
<tr>
<th>NHS Number</th>
<th>IP</th>
<th>OP</th>
<th>AE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>75940</td>
<td>413901</td>
<td>60069</td>
</tr>
<tr>
<td>No num</td>
<td>221</td>
<td>567</td>
<td>1006</td>
</tr>
<tr>
<td>Grand Total</td>
<td>76161</td>
<td>414468</td>
<td>61075</td>
</tr>
<tr>
<td>%</td>
<td>99.7%</td>
<td>99.9%</td>
<td>98.4%</td>
</tr>
</tbody>
</table>

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<td>75940</td>
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<td>No num</td>
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<td>61075</td>
</tr>
<tr>
<td>%</td>
<td>99.7%</td>
<td>99.9%</td>
<td>98.4%</td>
</tr>
</tbody>
</table>
The Patient’s Registered GP Practice Code

Accurate recording of the patient’s GP practice is essential to enable the transfer of clinical information from the Trust to their GP.

The Trust submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records which included the patient’s valid General Medical Practice Code was 100 %, apart from A&E.

<table>
<thead>
<tr>
<th>GP Practice Code</th>
<th>Grand Total</th>
<th>Number</th>
<th>No num</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP</td>
<td></td>
<td>76161</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>OP</td>
<td></td>
<td>414465</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>AE</td>
<td></td>
<td>59715</td>
<td>1360</td>
<td>97.8%</td>
</tr>
</tbody>
</table>

Commissioning for Quality and Innovations (CQUIN) 2018/19

The Commissioning for Quality and Innovation (CQUIN) is a framework within the NHS that supports improvements in the quality of services and the creation of new, improved patterns of care including transformational change.

A proportion of Trust income is provided by meeting the CQUIN targets. The Trust received 100% of the CQUIN value that was allocated in the HCCG block contract. Total CQUIN income is circa £3.2m prior to acceptance of final CQUIN reporting.

Each year a number of schemes are identified across a number of areas. This is linked to targets which have a financial reward for achievement. For the first time these CQUINS ran over two years from 2017-19. 2018/19 was the second year of the schemes.

The table on the following pages outlines the schemes, if the targets have been achieved and if not the reasons why.
<table>
<thead>
<tr>
<th>CQUIN Scheme</th>
<th>Improvement Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and Wellbeing: Improving Staff Health and Wellbeing</strong>&lt;br&gt;Aim to improve the support available to NHS Staff to promote their health and wellbeing in order for them to remain healthy and well.</td>
<td>Not achieved&lt;br&gt;Despite the introduction of many initiatives and promotion of existing initiatives, the staff survey results did not reflect the 5% improvement as required to achieve the CQUIN. The Trust will continue to take positive action on health and wellbeing.</td>
</tr>
<tr>
<td><strong>Health and Wellbeing: Healthy food for NHS Staff, Visitors and Patients</strong>&lt;br&gt;Aim to improve the organisation’s behaviour and culture toward food and drink sold on NHS premises by making healthier food and drink more widely available.</td>
<td>Fully achieved&lt;br&gt;The Trust achieved the following in all its food and drink outlets:&lt;br&gt;- No price promotions or advertising on sugary drinks or foods high in fat, sugar and salt.&lt;br&gt;- No sugary drinks or foods high in fat, sugar and salt near the checkouts.&lt;br&gt;- Healthy food and drink options are available at all times&lt;br&gt;- Reduce sugary drink sales and reach 10% or less of total volume of drinks sales.&lt;br&gt;- 80% of confectionary and sweets not exceeding 250Kcals.&lt;br&gt;- 75% of prepacked sandwiches and savoury meals contain no more than 400Kcals and 5g/100g saturated fats.</td>
</tr>
<tr>
<td><strong>Health and Wellbeing: Flu Vaccination</strong>&lt;br&gt;Aim to achieve an uptake of flu vaccinations by frontline clinical staff of 75%</td>
<td>Fully achieved&lt;br&gt;The Trust achieved an uptake of 78.2%</td>
</tr>
<tr>
<td><strong>Timely Identification and treatment for Sepsis in Emergency Departments and Acute Patient Setting</strong>&lt;br&gt;Aim is for screening, identifying and rapidly treating patients who have been diagnosed with sepsis within emergency and acute inpatient settings.</td>
<td>Fully complaint with identification of sepsis in ED at 100%&lt;br&gt;Partially compliant with treatment of sepsis at 64% .</td>
</tr>
<tr>
<td><strong>Empiric Review of Antibiotics</strong>&lt;br&gt;Aim is to review the number of antibiotic prescriptions between 24 to 72 hours of initiation in patients diagnosed with sepsis in order to ensure appropriate antibiotic usage reducing the opportunity for bacteria to develop resistance.</td>
<td>Partially compliant at 21% . Failure to fully document.</td>
</tr>
<tr>
<td><strong>Antimicrobial Resistance and Antimicrobial Stewardship (ensuring we use antibiotics appropriately)</strong>&lt;br&gt;Aim is to reduce total inappropriate antibiotic usage across the Trust.</td>
<td>Partially compliant. Failed to meet target for reduction in one of the components</td>
</tr>
<tr>
<td><strong>Specialised Commissioning CQUINS</strong></td>
<td><strong>Medicines Optimisation</strong></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Improving services for people with mental health needs who present in the Emergency Department</td>
<td>Fully achieved</td>
</tr>
<tr>
<td>Aim to improve the management of patients with mental health conditions who are frequent attenders to the Emergency Department.</td>
<td>The Trust worked in collaboration with colleagues in 2gether (2g) Mental Health Trust. This has resulted in a sustainable approach to implement co-produced care plans for patients with mental health needs.</td>
</tr>
<tr>
<td>Advice and Guidance</td>
<td>Fully achieved</td>
</tr>
<tr>
<td>Aim to improve GP access to consultant advice prior to referring patients into secondary care.</td>
<td>The Trust has successfully implemented A&amp;G across a number of specialities representing 75.64% of all referrals. Achievement target for CQUIN is 75%.</td>
</tr>
<tr>
<td>E-Referral</td>
<td>Fully achieved</td>
</tr>
<tr>
<td>As part of the national NHS Digital paper switch off program, the aim of this CQUIN is to roll out electronic referrals process.</td>
<td>The Trust implemented e-Referral Paper Switch Off as planned on the 30th July 2018, earlier than the target date of 1st October 2018.</td>
</tr>
<tr>
<td>Preventing ill health by risky behaviours – alcohol and tobacco</td>
<td>Partially achieved</td>
</tr>
<tr>
<td>Aim is to support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.</td>
<td>This practice is now embedded as part of the generic assessment on admission to all community hospitals however there is further work required to implement and embed into the acute hospital site.</td>
</tr>
<tr>
<td>Improving the assessment of wounds</td>
<td>Fully achieved</td>
</tr>
<tr>
<td>Aim to increase the number of full wound assessments for patients with wounds that had failed to heal within four weeks in the community setting.</td>
<td>The Trust achieved 81.2% compliance. Achievement target for CQUIN is 80%.</td>
</tr>
<tr>
<td>Personalised Care and Support Planning</td>
<td>Fully achieved</td>
</tr>
<tr>
<td>Aim to identify the number of care planning conversations taking place in the community.</td>
<td>The community teams have been successful in implementing and embedding a process where the cohort of patients are continually being reviewed to ascertain if any improvements have been made to their health and wellbeing.</td>
</tr>
<tr>
<td><strong>Specialised</strong></td>
<td><strong>Medicines Optimisation</strong></td>
</tr>
<tr>
<td>Aim to support the procedural and cultural changes required to fully optimise the use of medicines commissioned by specialised services.</td>
<td>Fully achieved</td>
</tr>
<tr>
<td>The Trust has complied with the following: • Faster adoption of best value medicines as they become available • Improving drug MDS (minimum data set) data quality to include dictionary of medicines and devices code and all other mandatory fields • Increasing the use of cost effective dispensing routes for outpatient medicines • Improving data quality associated with outcomes databases SACT (Systemic Anti-Cancer Therapy) &amp; IvIg (Immunoglobulin treatment).</td>
<td>Wye Valley NHS Trust has signed up to the Armed Forces Covenant, ensuring that the Armed Forces enjoy the same standard of, and access to, healthcare as that received by any other patient referred. The Trust is committed to engaging with local Armed Forces Third</td>
</tr>
</tbody>
</table>
Dental Electronic Referral Management Service (DERMS)
Aim to maximise use of the system’s functionality.

<table>
<thead>
<tr>
<th>Sector, Charity providers within Herefordshire in line with the Armed Forces Covenant pledge.</th>
</tr>
</thead>
</table>
| Dental Electronic Referral Management Service (DERMS) 
Aim to maximise use of the system’s functionality. |
| Fully achieved 
The Trust has implemented and is achieving the following: 
• Keep waiting times to a minimum 
• Reject paper referrals in order to speed up the referral process 
• Reduce referrals that could be safely managed in the community 
• Increase the use of electronic discharge summaries |
PART 3

Quality of Service
Review of priorities for 2018-19

Quality priorities -

The Trust identified 8 quality priorities for 2018/19 which are detailed below:

1. Reducing avoidable death rates
2. Focus on improved identification, treatment and management of the deteriorating patient
3. To ensure timely identification and treatment of sepsis
4. Reducing variation in clinical practice by focussing on complying with care bundles
5. Improve discharge planning, ensuring discharge is timely and respects patient’s wishes
6. Improve urgent care delivery
7. Ensure harm reviews are undertaken for patients who have to wait longer than expected
8. Enhance care for vulnerable patients focussing on dementia and learning disability

Quality priorities – Safe

<table>
<thead>
<tr>
<th>Safe</th>
<th>Achievements:</th>
</tr>
</thead>
</table>
| Reducing avoidable death rates | 1. Developed a Mortality Strategy which focused on understanding the factors which contributed to the increased mortality rates.  
2. Established mortality team to manage the roll out of the Mortality project. The project is based on quality improvement principles, focuses on working alongside clinicians to improve clinical pathways.  
3. There has been a continued improvement in performance and confidence in improving system wide pathways. |
| Focus on improved identification, treatment and management of the deteriorating patient | 1. NEWS2 *launched and implemented across acute and community Hospitals. Included NEWS2 E learning for all clinical staff, additionally scenario based learning and competency developed and monitored for compliance.  
2. Focus on Clinical Practice Week - developed ward based micro teaching sessions with a view to roll out across the Trust |
| To ensure timely identification and treatment of sepsis | 1. NEWS2 implemented in ED to ensure 100% screening compliance. Antibiotics within 1hr remains circa 60%  
2. Improved performance indicators for sepsis with a reduction in HSMR and SHMI  

*News2 is a national scoring system for recording vital signs including heart rate and blood pressure*
Reducing avoidable death rates

Mortality Strategy:

The Trust had a higher than expected mortality rate according to the data generated nationally. This was a significant concern for the Trust and needed focused attention. The reducing mortality strategy was developed and to ensure delivery of the strategy a project team was established to support this work with clinical teams. This work has included improving clinical pathways and understanding data at a speciality level.

The project team have focussed on the following:

- Utilising quality improvement methodology to support clinical teams to lead improvement
- Ensuring there was a robust approach to learning from deaths and have implemented the medical examiner role
- Ensuring that the coding of patient’s comorbidities is accurate
- Agreeing data and measures which are reviewed regularly

Over the year the mortality rate has steadily reduced and now falls well within the normal range. The dashboard below shows the Trust information for mortality over the last year, this is used to review monthly progress.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description/Notes</th>
<th>Data month</th>
<th>Month Actual</th>
<th>Deaths in Month</th>
<th>Trend</th>
<th>Change</th>
<th>Direction of Trend</th>
<th>Trend - April 2016 to latest reported month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude Mortality all</td>
<td>% of Deaths by Admissions</td>
<td>Mar-19</td>
<td>1.3%</td>
<td>96</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude Mortality-Emergency</td>
<td>% of Deaths by Emergency Admissions</td>
<td>Feb-19</td>
<td>0.8%</td>
<td>54</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latest Ratio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude Mortality all</td>
<td>% of Deaths by Admissions</td>
<td>Feb-19</td>
<td>1.9%</td>
<td>66</td>
<td>▼</td>
<td>-0.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude Mortality-Emergency</td>
<td>% of Deaths by Emergency Admissions</td>
<td></td>
<td>6.1%</td>
<td>64</td>
<td>▼</td>
<td>-0.44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description/Notes</th>
<th>Data month</th>
<th>Month Actual</th>
<th>Observed/Expected Deaths</th>
<th>Acute Trust rank</th>
<th>Trend</th>
<th>Change</th>
<th>Direction of Trend</th>
<th>Trend - April 2016 to latest reported month</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHMI</td>
<td>Rolling 12 month Standardised Hospital Mortality Ratio</td>
<td>Dec-18</td>
<td><strong>104.9</strong></td>
<td>Obs. 728 v Exp. 705</td>
<td>73 of 134</td>
<td>▼</td>
<td><strong>-2.19</strong></td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td>SHMI Weekday</td>
<td>Rolling 12 month Standardised Hospital Mortality Ratio</td>
<td>Dec-18</td>
<td><strong>102.62</strong></td>
<td>Obs. 545 v Exp. 531</td>
<td>81 of 134</td>
<td>▼</td>
<td><strong>-3.11</strong></td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td>SHMI Weekend</td>
<td>Rolling 12 month Standardised Hospital Mortality Ratio</td>
<td>Dec-18</td>
<td><strong>104.9</strong></td>
<td>Obs. 183 v Exp. 174</td>
<td>93 of 134</td>
<td>▼</td>
<td><strong>-0.25</strong></td>
<td>▼</td>
<td></td>
</tr>
</tbody>
</table>
As part of the Strategy there was specific focus on clinical areas which were deemed ‘outliers’ for their specialities. These are listed below:

- Sepsis
- CCF (Congestive Cardiac failure)
- Pneumonia
- COPD (Chronic Obstructive Pulmonary Disease)
- Acute Bronchitis
- GI Bleeds (Gastro-Intestinal Bleed)
- #NOF (Fractured Neck of Femur)

The Hospital Standardised Mortality Ratio (HSMR) is used to monitor progress for outlier groups. The table below shows the most current rolling 12 month HSMR (Jan 18 – Dec 18) compared to the previous years reported figures.

There has been significant improvement in a number of areas as shown below:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Septicaemia</td>
<td>137.52</td>
<td>94.83</td>
<td>-42.69</td>
</tr>
<tr>
<td>Gastro-intestinal Bleeds</td>
<td>106.23</td>
<td>111.33</td>
<td>+5.1</td>
</tr>
<tr>
<td>COPD</td>
<td>147.51</td>
<td>115.42</td>
<td>-32.09</td>
</tr>
<tr>
<td>CCF</td>
<td>141.34</td>
<td>92.27</td>
<td>-49.07</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>115.95</td>
<td>91.30</td>
<td>-24.65</td>
</tr>
<tr>
<td>Acute Bronchitis</td>
<td>155.81</td>
<td>126.03</td>
<td>-29.78</td>
</tr>
<tr>
<td>#NOF</td>
<td>118.16</td>
<td>169.40</td>
<td>+51.24</td>
</tr>
</tbody>
</table>

In response to continual surveillance and the rise in mortality, #NOF has been escalated to a mortality outlier status. This area will continue to receive dedicated support to understand the data and develop local improvement plans.

Further development of the mortality strategy has included system-wide meetings to highlight progress and improvements across the Herefordshire health economy with strong engagement from Public Health, Primary Care, CCG, 2G and other local providers.

Following progress with the project a review of the mortality outliers has been undertaken and we will focus on the following areas for 2019 – 2020:

- Respiratory
- #NOF
- Community Hospitals
Learning from Deaths

Learning from deaths is a national initiative, implemented locally, where any patient’s death is reviewed for the quality of care provided in the last days of the patient’s life (first stage review).

During the period between April 2018 and March 2019, there were 784 deaths, of which 666 had a case record review.

The initiative has a set target to review 75% of all patient deaths and the chart below shows progress through the year. Since August 18 we have achieved the standard.

Reviews undertaken:

<table>
<thead>
<tr>
<th>Period</th>
<th>Number Deaths</th>
<th>Number reviewed</th>
<th>% reviewed</th>
<th>Number of 2nd reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qtr 4 2017/18*</td>
<td>278</td>
<td>83</td>
<td>29%</td>
<td>15</td>
</tr>
<tr>
<td>Qtr 1 2018/19</td>
<td>185</td>
<td>110</td>
<td>59%</td>
<td>5</td>
</tr>
<tr>
<td>Qtr 2 2018/19</td>
<td>174</td>
<td>149</td>
<td>85%</td>
<td>23</td>
</tr>
<tr>
<td>Qtr 3 2018/19</td>
<td>212</td>
<td>195</td>
<td>91%</td>
<td>26</td>
</tr>
<tr>
<td>Qtr 4 2018/19</td>
<td>This will be published in the 2019/20 Quality Account</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*requirement to include Q4 2017/18 data as this was not available when the quality account was published (none of the Q4 reviews were judged to be due to problems in care).

Where there is a concern around quality of care provided, a number of reviews proceed to a second judgement review. Using this process clinicians examine the case in much greater detail aiming to derive as much learning as possible and determine the level of avoidability. The numbers of reviews and associated judgements are detailed on the next table and cover the period 1st April 2018 to 31st March 2019 and relate to the month the patient died.

Of those cases reviewed in the year, 2 patient deaths were judged (0.3%) to be more likely than not to have been due to problems in the care provided to the patient.

There were 15 case record reviews and investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period. There were none (0%) that were judged to be more likely than not to have been due to problems in the care provided to the patient.
Learning

The learning, extracted from our mortality reviews, has been used to drive clinical quality improvements and support the development of specific local improvement plans.

Each month the key learning and issues are discussed at the Mortality Committee, with clinical discussions as to the best approach to address these issues.

The key themes from this year’s reviews include:

- Escalation of patients with high NEWS scores.
- Delayed antibiotic administration for patients with a suspicion of sepsis.
- Care Bundle completion by the clinicians.
- End of Life discussions with families and the patient.
- Medical outliers and admission to the specialist ward.
- Increased numbers of ward transfers.

A number of these themes feature in the Quality Priorities that have been set for 2019/20.

Focus on improved identification, treatment and management of the deteriorating patient

During 2018/19 the Trust continued to focus on improving identification of the deteriorating patient. At the start of the year an update of the National Early Warnings Score (NEWS) was issued as NEWS2 by the Royal College of Physicians with the recommendation that all organisations should implement the updated scoring system by March 2019. Therefore, implementation of NEWS2 was a priority during the year.

The Trust launched NEWS2 across the acute site in August 2018 followed by Community Hospitals in November 2018 with a change to all clinical observation documentation. To support implementation, mandatory training was arranged for all staff with compliance reported to the Clinical Quality Committee.
As part of the learning from serious incidents involving failure to identify a deteriorating patient a lack of consistency with escalation to senior nursing and medical staff was identified. To improve this the SBARD (Situation, Background, Assessment, Recommendation and Decision) template was developed, printed and circulated to wards to support critical communication during escalation.

Audits of NEWS compliance during 2018 have identified that the Trust must continue with its focus on supporting staff with the scoring element of the NEWS score and with escalation. The Trust intends to roll out electronic observations in the early part of 2019. This is a system which enables staff to record the patients clinical observations on an electronic platform which will automatically calculate the score. When the system is embedded in practice there is the opportunity to build in automatic escalation.

Given the difficulty in releasing staff for classroom based teaching the Quality Governance Team along with specialist practitioners used Quality Improvement methodology to run a focus on clinical practice week, this involved conducting micro teaching sessions in clinical practice at ward level. The week included scenario and competency based training related to the deteriorating patient including NEWS 2, basic life support and sepsis alongside other important sessions such as falls and pressure ulcers. Following this test week a toolkit to support implementation was developed. This is being used by divisional teams to roll out across all clinical areas during 2019.

To ensure the timely identification and treatment of sepsis

During 2018/19 the Trust made a joint appointment of a Lead Nurse for Sepsis in conjunction with Herefordshire CCG to work across the health community. The main focus of the post is to:

- Focus on training
- Increase awareness through improved communication
- Optimise pre-hospital care

Despite having difficulties in the administration of antibiotics within an hour as seen in the table overleaf there has been a reduction in sepsis related mortality as seen in our HSMR and SHMI with the results at the end of November 2018 being 96.72 and 92.65 respectively. This is the lowest since we started recording this measure. Focussing on pre-hospital care will support the timely delivery of antibiotics. Additionally, the Sepsis 6 (care bundle) is being built into our emergency department electronic record system so that all 6 elements of good practice can be audited and efforts for improvement targeted accordingly.
Quality priorities - Effective
The table below outlines brief achievements with quality priorities for effective care during 2018/19.

<table>
<thead>
<tr>
<th>Effective</th>
<th>Achievements</th>
</tr>
</thead>
</table>
| Reducing variation in clinical practice by focusing on complying with best practice care bundles | 1. Baseline audit completed  
2. Development of group to lead the review of care bundles  
3. Education and communication to raise awareness  
4. Clinical champion identified to lead care bundle work with the medical workforce |
| Improve discharge planning, ensuring discharge is timely and respects patient’s wishes | 1. Wednesday review - all patients who stay over 7 days  
2. Hospital at Home service developed  
3. Project progress reported at Urgent care delivery board and One Herefordshire |
| Improve urgent care delivery                                              | 1. Performance Indicators identified and monitored  
2. Urgent care projects which focus on improvement reviewed as part of “Wye Valley Way”.  
3. Chief Operating Officer is the senior responsible officer for the One Herefordshire Urgent Care Programme Board |

Reducing variation in clinical practice by focusing on complying with best practice care bundles

We have a number of care bundles in use which have been developed to support best practice. When used they help the clinician to check that every aspect of best practice ‘bundle’ have been completed. For this year the focus has been on the following:
The Trust has further work to do in this area and as a consequence these will roll over into the Quality Priorities for 2019/20.

The baseline audit identified that bundles are not embedded in everyday practice and that there is limited knowledge and understanding of their use amongst the junior doctor workforce.

The clinical lead and project group will:

- Review the content of the current care bundles
- Hold a briefing session for Junior Doctors with ongoing training and education
- Establish a way of reporting performance against and compliance with each bundle

Improve discharge planning, ensuring discharge is timely and respects patient’s wishes

In 2018/19, the Trust committed to supporting improved patient safety and flow through effective discharge planning processes. The Trust achieved this improvement by working closely with Integrated Care Alliance partners (for example social care, mental health staff) to support admission avoidance and improve early supported discharge. This was delivered through a number of pieces of work including:

- The development of a system wide discharge policy and patient choice protocol
- The establishment of 12 Discharge to Assess beds which opened in March 2019
- The development of an Integrated Discharge Team between Adult Social Care and the Trust supported by a joint management post
- Increased capacity to ‘Home First’ pathways with joint working between Trust therapy teams and social care domiciliary services
- A ‘front door frailty’ team working to reduce admissions and length of stay for vulnerable, older patients
- Weekly review of all patients who have a length of stay greater than 7 days to identify issues with discharge

The Trust has also participated in an external peer review by the Local Government Association, which identifies best practice and learning to reduce delays in discharge across the health and social care system. This review commended some early good practice across the Herefordshire System, and identified further opportunities to take into the coming year.

Improve urgent care delivery

The Trust has faced a real and significant growth in emergency activity in 2018-2019 and for much of the year was not able to maintain the timeliness of emergency care that it would wish to. The Urgent Care Programme Board has supported many improvement projects over
the year and the Trust was able to deliver a much improved position by the year end, although it was not able to achieve the nationally required standard.

The key projects that have had the biggest impact are:

- The opening of a new 24 bedded Acute Medical Unit in December 2018 has provided a purpose designed environment to deliver senior led, multi-disciplinary care for patients presenting with a broad range of acute medical conditions and support a same-day emergency care approach.

- The reconfiguration of the medical wards at the County Hospital site in December created an increased numbers of ‘Care of the Elderly’ and ‘Respiratory’ beds to better meet the needs of our emergency medical admissions.

- The creation of a ‘Front Door Frailty’ team; a multi-disciplinary team providing rapid assessment and support to patients presenting with ‘frailty’. Frailty is a term used to identify patients who are ageing and require support with mobility or care. This new service has allowed us to prevent unnecessary admissions to hospital and improved care. In addition, it has often shortened the length of stay for those patients who do require an inpatient admission.

The work of the Urgent Care Programme Board was expanded during the year to include all aspects of urgent care across a number of areas including mental health, primary care, community care and secondary care. This work is being actively supported by the national Emergency Care Intensive Support team (ECIST).

**Quality priorities - Caring**

The table below outlines achievements with quality priorities for caring:

<table>
<thead>
<tr>
<th>Caring</th>
<th>Achievements</th>
</tr>
</thead>
</table>
| Ensure that harm reviews are undertaken for patients who have to wait longer than expected | 1. Process in place forClinical review of all patients who have exceeded waiting times.  
2. Joint Harm review process established with Commissioners  
3. Cancer pathway breaches pathway and reporting established |
| Enhance care for vulnerable patients with a particular focus on dementia and learning disability | 1. Dementia training rolled out across organisation  
2. Progress with One Herefordshire dementia plan  
3. Implementation plan to achieve NHSI Learning Disability Standards for acute Trusts |
Ensure that harm reviews are undertaken for patients who have to wait longer than expected

We have three areas where harm reviews are undertaken:

1. For all patients who wait longer than 18 weeks and breach 52 weeks, a harm review is conducted by the responsible consultant following definitive treatment.

2. Where a breach of a cancer pathway occurs an initial review is undertaken which is then submitted for external review, most recently to the harm review panel, in accordance with national guidance.

3. Children who wait longer than 18 weeks for Paediatric Occupational Therapy and Paediatric Speech and Language Therapy are reviewed using agreed processes. This includes undertaking a risk assessment with monthly reporting through the Division. Some delays relate to issues outside the organisations direct control.

Sample cases are reviewed at the Herefordshire Harm Review Panel which is held to provide assurance of the current process.

The panel consists of Trust directors, members of Herefordshire Clinical Commissioning Group and representatives from the Patient Access team.

An example of the 52 week harm review overview is reported below. The information is shared monthly as part of serious incident report to the Clinical Quality Committee and to local commissioners.

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Total Patients Identified for Harm Review</th>
<th>Harm Reviews Completed</th>
<th>Harm Reviews Overdue (TCI in the past)</th>
<th>Harm Reviews Not Yet Due (TCI or OPA on future date)</th>
<th>Harm Reviews not required (patients DNA’d, declined surgery etc.)</th>
<th>Patients assessed as having come to harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>974</td>
<td>542</td>
<td>143</td>
<td>6</td>
<td>283</td>
<td>0</td>
</tr>
<tr>
<td>Welsh</td>
<td>251</td>
<td>148</td>
<td>29</td>
<td>0</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1225</td>
<td>690</td>
<td>172</td>
<td>6</td>
<td>357</td>
<td>0</td>
</tr>
</tbody>
</table>

Ensure care for vulnerable patients with a particular focus on dementia and learning disability

NHS improvement introduced Learning Disability Standards for Acute Hospitals in June 2018 to support people with learning disabilities or autism to receive treatment, care and support that is safe with outcomes equitable to their non-disabled peers.
We completed the NHS improvement Standards Review on the 30th November 2018 which included organisational data, staff survey and a patient survey to look at performance against these standards. We are currently waiting for the results which are due later this year.

We started implementation of the standards with a learning disability project plan presented to Clinical Quality Committee in December 2018.

We have a process in place to recognise patients who have a learning disability, record this in their notes and notify the learning disability liaison team of the admission.

We are working on making reasonable adjustments to care pathways to ensure that people with learning disabilities/autism can access highly personalised care and achieve equality of outcomes.

We have processes to investigate the death of a person with learning disabilities/autism in our care (LeDer programme) and, in 2018/19, two multi-agency reviews have taken place to learn lessons from the findings of these investigations with both reports due to be published imminently.

The Trust has a Supporting Adults with Communication Impairment (SAWCI) group to help identify, support and enable vulnerable adults who have communication problems to communicate effectively. The group introduced communication and activity boxes for every ward earlier this year.

The Trust vigilantly monitors any deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities or dementia and promotes the least restrictive practice in the best interest of individuals.

In 2018/19 the Trust has strived to work and engage with people receiving care, their families and carers, as set out in the NHS Constitution. This has culminated with a draft Carer’s Charter to be launched during Carers Week, June 2019. The charter supports carers having a voice, recognition of the carers’ role, offering some practical support and supporting carers to look after themselves.

In 2018/19 we worked in partnership with key stakeholders to develop and implement the One Herefordshire Living Well with Dementia Strategy which is the implementation of Dementia awareness sessions and Tier 1 training to enhance the knowledge and skills of staff. Alongside the improvements made through the ongoing development of the frailty assessment unit and the opening of a second frailty ward within the acute hospital, the Trust has been supported by Dementia UK to develop an Admiral Nurse Service within Herefordshire.

We participated in the NHSI Enhanced Care Collaborative initiative, resulting in alternative patient focused approaches to caring for the vulnerable patients such as Reminiscence Therapy which has been trialled successfully within one of our community hospitals.
The following areas contribute to quality of services and are reported each year

**Clinical Incident Reporting**

The Trust promotes a culture of safety where staff are encouraged to report all actual or near miss incidents. The chart below is taken from the National Reporting Learning System (NRLS) and demonstrates a high level of reporting. The Trust is ranked 5\textsuperscript{th} out of all English Trusts for incidents reported per 1000 bed days.

During 2018/19 there has been a 0.18\% reduction in total number of patient incidents. The rate of harm remains similar to 2017/18. This is an indication of a good safety culture with high levels of incident reporting and low harm as highlighted in the table below.

<table>
<thead>
<tr>
<th>Level of Harm</th>
<th>No reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>3</td>
</tr>
<tr>
<td>Severe</td>
<td>8</td>
</tr>
<tr>
<td>Moderate</td>
<td>85</td>
</tr>
<tr>
<td>Low</td>
<td>786</td>
</tr>
<tr>
<td>No harm</td>
<td>5100</td>
</tr>
<tr>
<td><strong>Total Incidents reported to NRLS</strong></td>
<td><strong>5982</strong></td>
</tr>
</tbody>
</table>

This demonstrated that those incidents which results in death or severe harm was 0.18\% of the total Incidents reported to NRLS.

The Trust is ranked number 23 in English Trusts for the percentage of no harm incidents as seen in the graph that follows.

Please see Appendix 1 for comparative measures of harm across all NHS Trusts, measured as rate per 1000 bed days.
Top three categories of incidents reported on Datix, the incident reporting system, for 2018/19 were:

- Pressure Ulcers
- Infrastructure including staffing, skill mix and support services
- Patient falls

**Serious Incidents**

A Serious Incident (SI) is defined in the NHS Serious Incident Framework (2015) as an incident that has resulted in:

- The unexpected or avoidable death of one or more people
- The unexpected or avoidable injury to one or more people that has resulted in serious harm
- The unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user; or serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare did not take appropriate action/ intervention to safeguard against abuse occurring; or where abuse occurred during the provision of NHS-funded care

During 2018/19 there have been 77 confirmed SI’s (the same as last year).
The chart below shows a breakdown of serious incidents by type for 2018/19.

There has been a reduction in the number of pressure ulcers, falls and information governance breaches. We have seen an increase in treatment delays and sub-optimal care of the deteriorating patient.
A new approach to the management of serious incidents (SI) was implemented in December 2018. This uses a Case Review template which provides a clear method of communicating the findings from an investigation and linking the learning points to measurable actions. As this process has evolved, staff have become more engaged with the process which has led to them initiating multi-disciplinary round table reviews of incidents in a timely manner.

By changing the process the following outcomes will be achieved:

- Timely reporting to the commissioners
- Pursue Key Lines of Inquiry specific to the incident
- Proportionate investigation process
- Process that identifies areas for learning and good practice
- Develop actions that are SMART and will make a difference
- Improved patient and relative involvement
- Greater support to those staff involved
- Agreed process for communication and feedback
- Full compliance with Duty of Candour regulations
- Staff are trained and feel competent to participate
- Triangulation with complaints, claims, mortality, alerts and quality improvement
- Improve the quality of reviews and provide assurance that changes in practice have been embedded

During 2018/19, two Never Events occurred within the same month (May 2018), they were both the unintentional connection of a patient requiring oxygen to an air flowmeter and both occurred within the Emergency Department.

Following the initial event immediate action was taken to prevent recurrence yet this did not prevent a repeat a week later. This was due to human factors and a breach in the agreed safety measures.

It is important that following such events relevant clinical lessons are identified and disseminated. On completion of the investigation, the outcomes were shared with West Midlands and Welsh Ambulance services and led to a safety alert being cascaded across their services. In addition the learning was shared across the Trust through Clinical Quality Committee and Divisional Quality Governance meetings.

**Duty of Candour**

Following progress made in 2017/18 to ensure verbal duty of candour was being completed at the earliest opportunity, we have continued to review our processes and make improvements. Updates are provided in the monthly divisional and corporate reports and as part of the reporting to Clinical Quality Committee. 89 Duties of Candour were completed in 2018/19.
Reducing Harm to Patients
Pressure area care management

During 2018/19:
There have been 10 serious incidents reported for grade 3 or 4 avoidable pressure damage, this is a 66% reduction from last year.
25 pressure ulcers were acquired in our care. This is a 73% reduction of compared to last year.

Reduce patient falls

During 2018/19 a falls panel was implemented to review and provide an expert review for every patient fall that occurs in the Trust.
The following improvements have occurred:

- 14% reduction in total falls
- 23% increase in harm – this is due to an increase in ‘low harm’ falls
- 66% reduction in falls with harm moderate and above; these are patients who sustain a high level of harm such as a fracture or head injury.
Comparative data are available through the Safety Thermometer and the following charts show falls as a percentage of patients in the Trust each month.

The Trust is shown by the blue line with the England average in pink.

Safety Thermometer
The Trust participates in the NHS Safety Thermometer. This was developed for the NHS by the NHS as a point of care survey instrument, and provides a ‘temperature check’ on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients.

The Safety Thermometer reviews harm associated with venous thromboembolism (blood clot), pressure ulcers, falls, catheters and urinary tract infections. Results from the Safety Thermometer have been used to develop our quality priorities and nationally these results are used to provide a percentage result of harm free care for an individual patient with a national target of 95%. The Trust consistently achieves this target and is above the English average. The Trust performance is denoted below (blue line), with the pink line being the national average.
Venous Thromboembolism (VTE) Risk Assessment

VTE (venous thromboembolism, blood clot) is an important cause of hospital morbidity and mortality. National guidance (NICE CG92, 2010) states that all inpatients should undergo timely “risk assessment” and receive appropriate prophylaxis (preventative treatment) to prevent VTE. A target of 90% compliance for risk assessment within 24 hours was set nationally and revised locally to 95% in 2013, which the Trust has achieved until recently.

In August 2017, the VTE risk assessment was moved to an electronic format as part of the wider roll out of the new electronic patient record. Recorded compliance fell below the 95% standard; with an achievement of 82.57% for VTE assessment during 2017/18 which is well below where we wished to be. Despite some improvement during 2018/19 the standard has remained below 95%.

A review of the electronic data collection in 2018 significantly improved compliance, the average for 2018/19 was 90.5%; however it was recognised that the electronic assessment tool was not completed in all cases. In order to ensure patients were receiving the appropriate prophylaxis audits were completed and the results demonstrated that appropriate preventative treatment had been prescribed despite the assessment not being completed electronically.

For 2018/19 following changes in NICE guidance and a review of excluded cohorts the data collection has changed to include all patients over 16 years old. Therefore it is not possible to compare with 2017/18 data due to changes in data collection.

The chart below shows the level of compliance since April 2018.

VTE Assessment –Trust Position April 18-March 19
An increase in hospital acquired thrombosis has been seen with 73 reported in 2017/18, rising to 100 in 2018/19.

Figures for 2018/19 remain estimated due to a delay in the review each patient record. VTE is a Quality Priority for 2019/20 and will focus on the assessment, review process, overall governance and the learning from hospital acquired thrombosis.

Comparison data is provided by Safety Thermometer data and indicates:
- The Trust is below average for completing risk assessments
- Despite the increasing number of patients acquiring a new VTE, our levels remain similar to other organisations.

Infection Prevention and Control (IPC)

The Health & Social Care Act 2008 requires all Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection (HCAI). The Trust’s nominated Director of Infection Prevention & Control (DIPC) is the Director of Nursing who has Board level responsibility and chairs the Infection Prevention and Control committee.

The DIPC is supported by the Infection Prevention (IP) team who work across all our services. Monitoring and reporting of health care associated infections, both internally and externally, is led by the IP team. The team consists of specially trained nurses and a lead consultant microbiologist. The work of the IP team is detailed in the IP annual programme.

Health care associated infections

There was one MRSA bacteraemia/bloodstream infection (BSI) in the Trust in 2018/19 – this was due to an infection at a cannula site. This was the first MRSA bacteraemia in the Trust for 5 years. The Trust had 23 cases of Clostridium difficile in 2018/19; this exceeded the Trust target of 17. This equates to 1.8 per 1000 beddays.

In 12 cases there were lapses in care which might have contributed to the infection. At the time of reporting 3 cases are still subject to a post-infection case review.

From April 2017, there is an NHS ambition to halve the number of healthcare associated Gram-negative blood stream infections by 2021. The reduction of Gram-negative
bacteraemia is measured using the Trust’s 2016/17 E. coli bacteraemia data as a baseline. Wye Valley NHS Trust had 17 E coli bacteraemia cases in 2016/17.

As of 31st March 2019, 181 patients had been admitted with influenza which added to operational pressures. The impact of flu on Trust staff was minimised as 69% of frontline staff had had their flu vaccine.

The Trust reported one norovirus outbreak in November 2018; six wards were closed to admissions, transfers and discharges to other health care providers due to confirmed Norovirus. In total 59 patients were affected and 26 staff. The outbreak lasted a total of nine days.

Safeguarding patients

Adult Safeguarding is everybody’s business and it means protecting a person’s right to live in safety and free from abuse and neglect. This remains a high priority for the Trust and we continue to work with partner agencies across Herefordshire and beyond to ensure best practice.

We ensure the principles of empowerment, prevention, proportionality, protection, partnership working and accountability have been applied preserving the individual’s wellbeing at its core. The outcomes being that people are:

- Safe and able to protect themselves from abuse and neglect
- Treated fairly and with dignity and respect
- Protected when they need to be
- Able to easily get the support, protection and services that they need.

Making Safeguarding Personal (MSP) has and will continue to remain a high priority and we have ensured the adult, their wishes, choices and desired outcomes have remained at the centre of the safeguarding process as much as possible.

Staff are supported in all aspects of safeguarding and in understanding and applying the Mental Capacity Act and Best Interests Process in everyday practice.

The Trust has an adult safeguarding performance dashboard which is monitored by the Adult Safeguarding Operational Group which reports to the Trust’s overarching Safeguarding Committee. Adult Safeguarding reports are produced quarterly for the Trust Clinical Quality Committee, with a report produced for the Trust Board annually.

87.87% of staff had completed their Adult Safeguarding training at the end of March 2019 which is just under the target of 90%.

The Trust has maintained their commitment to be an active member of the Herefordshire Safeguarding Adult Board and associated sub-groups, contributing to multi-agency audit, Safeguarding Adult Reviews and Domestic Homicide Reviews.

Children’s Safeguarding

Safeguarding children and young people is central to the quality of care of a patient. A child/young person is defined as anyone who has not yet reached their 18th birthday.
The Trust has an established safeguarding children quality framework which includes a safeguarding children performance dashboard and an annual audit plan. This framework is monitored by the Trust’s overarching Safeguarding Committee, with a safeguarding children report produced for the Trust Board annually.

Ensuring staff receive the required safeguarding children training continues to be a priority and compliance rates for Levels 1, 2, 3, 4 and Board level are shown in the following table.

<table>
<thead>
<tr>
<th>Training</th>
<th>March 2019</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% staff trained at level 1</td>
<td>98.64%</td>
<td>90%</td>
</tr>
<tr>
<td>% staff trained at level 2</td>
<td>87.08%</td>
<td>90%</td>
</tr>
<tr>
<td>% staff trained at level 3</td>
<td>89.80%</td>
<td>90%</td>
</tr>
<tr>
<td>% Staff trained to level 4</td>
<td>100.00%</td>
<td>90%</td>
</tr>
<tr>
<td>% Staff trained at Board Level</td>
<td>100.00%</td>
<td>90%</td>
</tr>
</tbody>
</table>

In December 2018 the Trust successfully implemented the Child Protection Information System (CP-IS), a national initiative, which helps health and social care staff to share information about vulnerable children and young people by linking IT systems across health and social care. CP-IS ensures that health and social care staff are notified when a child or unborn baby with a child protection plan (CPP) or looked after child (LAC) status is treated at an unscheduled care setting anywhere in England.

The Trust works collaboratively to support the business of the Herefordshire Safeguarding Children Board (HSCB) in a number of ways: as active participants of the Board and sub groups and aligning safeguarding children priorities to those of the HSCB. During 2018-19 we have continued to support the HSCB providing trainers for GCP2 (Graded Care Programme, a tool which helps professionals measure the quality of care being given to a child) training for Neglect as one of the HSCB priorities and continue to act as Chair and Vice Chair for two of Board’s subgroups. Learning from multi-agency audits, serious case review and practice learning reviews is embedded into practice in a number of ways, including supervision and education.

**National Safety Standards for Invasive Procedures and Local Safety Standards for Invasive Procedures (NatSSiPs and LocSSiPs)**

These are standards that are expected to be complied with in any setting where an invasive procedure is being undertaken. We introduced a NatSSiP steering group in 2016/17, the group has continued to meet and during 2018/19 the following actions have been completed:
- Creation of LocSSiPs Standard Operating Procedure and working document for clinical areas conducting invasive procedures.
- Introduction of LocSSiPs document in practice for Theatres, Radiology, Podiatric surgery, with further roll out across the Trust
- Introduction of centralised management within the Quality and Safety Team
- Inclusion in the Trust’s Audit programme.

**Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)**

RIDDOR is the law that requires employers, and other people in control of work premises, to report and keep records of:

- work-related accidents which cause death
- work-related accidents which cause certain serious injuries (reportable injuries)
- diagnosed cases of certain industrial diseases
- certain ‘dangerous occurrences’ (near miss – incidents with a high potential to cause death or serious injury)

The Trust has a legal duty to report all RIDDOR reportable incidents in a timely manner. Work related accidents which lead to a member of staff unable to work, or are unable to perform their normal duties for a period of more than seven days need to be reported within 15 days of the incident. More serious incidents, deaths, fractures, breaks need to be reported within 48hrs.

During 2018/19 there were a total of 12 RIDDOR reportable incidents. The list below provides an outline of these incidents:

- Sharps injury x (2) involving Blood Borne Viruses (BBV)
- Fractured toe
- Swollen right wrist
- Burn
- Sprain/strain wrist
- Sprain/strain back
- Sprain/strain back and shoulder
- Stress fracture foot
- Blood splash from patient who has a past medical history of Hepatitis C
- Fracture of the right neck of femur (patient)
- Full bottle of urine tipped over hand with cut. Urine from a patient with confirmed Hepatitis C

**Patient Related Outcome Measures (PROMS)**

Participation in the national Patient Reported Outcome (PROMs) programme is mandatory for Trusts in England where the relevant operative procedures are undertaken. The procedures included within the programme are:

- Hip replacements
- Knee replacements

Patients are asked to complete a questionnaire pre-operatively and then at 6 months post-
surgery. The questionnaires include general quality of life measures and some condition specific measures. Comparison is then made of scores pre and post-surgery to gauge the level of health gain following the operation. Results are publicly available through the NHS & Social Care Information Centre website.

**Participation Rates**

Participation rates based on completion of pre-operative questionnaires are measured locally and nationally. The chart below shows the completion rates up to and including March 2019 based on local data.

Chart1 – Participation rates in PROMS April 2018 to March 2019

*It should be noted that completion of questionnaires is voluntary.*

In March 2018 there was a drop in returned questionnaires due to high number of cancelled orthopaedic operations. A number of patients were treated at other organisations with PROMS being managed there.

**Outcomes**

Results of outcomes, in terms of improvement or worsening in post-operative scores compared with pre-operative scores, were also published in February 2019.

The responses from the data outlined below are the patients’ view of the changes to their wellbeing following procedure.
Improving patient engagement

The Trust receives feedback on its services through a number of different sources. This can be through the Friends and Family Test as well as through the compliments, concerns and complaints. The chart below shows the number of responses received across the organisation.
During 2018/19 the Patient Engagement Committee has continued to meet under the leadership of the Deputy Director of Nursing. The members have experienced a wide range of services and are drawn from across the local community. Together they have used their experience to provide feedback and influence direction on Trust initiatives including:

- The Carer’s Charter
- Participation in Patient Led Assessments of the Care Environment (PLACE)
- Reviewed and advised on proposed developments including plans for new wards

Complaints

Previously complaints were reviewed in isolation, more recently these have been added to the Executive Panel which meets weekly to review all incidents, complaints, claims and inquests related to the organisation. This allows for triangulation, learning and efficiency in responding.

During 2018/19 ensuring timely response to complaints has been a priority. This has proved to be challenging for the medical and surgical divisions and relates to the number of complaints received. There has also been an increase in complexity as seen by the number of complaints that involve a number of specialities.

The number of complaints reopened has increased to 55 from 32 in 2017/18.

The number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) was four. This is unchanged from 2017/18.
Compliments:
The number of compliments received in 2018/19 has reduced slightly.

<table>
<thead>
<tr>
<th>Year</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>3742</td>
<td>3266</td>
</tr>
</tbody>
</table>

Friends and Family Test (FFT) – national data collection

Friends and Family Test (FFT) data continues to be collected and reported on monthly. The inpatient recommendation rate remains unchanged at around 95%. When compared with regional results the Trust results are within expected range.

Challenges still continue with results from A&E and Outpatients. Project work is currently underway to improve outpatient information and includes exploring different ways of requesting feedback.
How Staff can raise concerns,

Freedom to Speak Up

Staff can “Speak Up” as stated and supported in our Freedom to Speak Up (FTSU) Policy. The Trust makes a commitment to listen to staff when they speak up about a concern. The policy also gives guidance on making a protected disclosure and signposts staff to the specific criteria required for an individual to be covered by law when they raise a concern (to be able to claim the protection that accompanies it).

The FTSU Policy reflects the template recommended by the National Guardian’s Office (NGO). This national guidance is currently under revision and due for release in April 2019 or soon after. This review, in conjunction with NHS Improvement, takes into consideration the NGO annual case reviews and the recommendations therein. It is also expected to give guidance on Non-Disclosure Agreements. The Trust will continually review its policy in the light of any changes required.
All staff are encouraged to “Speak Up” whenever they see any concerns.

There has been much focus on safety in the NHS and there is a strong commitment across the service to make patient care as safe as possible. The FTSU process forms part of changing the culture within the NHS to encourage staff to speak up freely on patient safety, where staff relationships are not as they should be, health and safety matters or any other matter of concern. Within the Trust we want to ensure our staff want to come to work and have personal satisfaction from doing their job. We want to assure the public that we encourage and support staff to do this safely in a number of ways.

- Staff are encouraged to raise concerns with their line manager in the first instance as speaking up this way can generally resolve issues directly with the staff involved in a timely fashion. It is the foundation to making speaking up business as usual.
- Encouraging staff to receive possible criticisms as an opportunity to learn.
- We hold ‘Open Door’ sessions with our Managing Director and Executive Directors hold “Let’s Talk” sessions in various locations across the county.
- Rumour Mill is an anonymous on line system that is accessed via the Trust’s intranet. This is open to all staff and the Trust’s communication team monitors this and the Guardian is informed of any possible concerns.
- Freedom to Speak Up Champions who are working in a substantive role within the Trust are also available. The Champions refer their cases to the FTSU Guardian.
- The Freedom to Speak Up Guardian provides an independent and impartial source of advice to staff at any stage of raising a concern, and supports access to anyone in the organisation. The Guardian can be contacted in a number of ways: by the FTSU mobile phone, designated email or by speaking to them directly on one of their visits to wards and departments within the Trust.
- If for any reason staff do not feel comfortable raising their concern internally they can also raise concerns with external bodies, which are listed within the Policy.
- There are many on line educational videos that can be accessed and that are promoted within training sessions. These encourage staff to speak up and will signpost how to do this.

In 2018/19, 21 concerns were formally raised, 16 have been concluded with 6 feedback forms completed. Feedback forms are sent to all staff who raise a concern to enable the Guardian to review and make any improvements to the process.

Staff asking for advice but not wanting a concern to be formally raised do not currently form part of FTSU reporting. Based on regional advice, however, from April 2019 this data will be collected and included as part of the reporting process.

Patients can read about our Freedom to Speak Up process on the Trust’s Internet page.

**Staff Friends and Family**

During 2018/19 we have taken a mixed approach to Staff Friends and Family. The survey is completed either electronically or by paper. The survey is completed every quarter except
for the quarter where the staff survey is sent out to prevent survey fatigue. The results in all areas are that staff are ‘likely’ to recommend treatment for family and friends. There are variations within professional groups which require further investigation and may link to specific speciality or professional challenges.

1: Medical and Dental Staff

2: Additional Prof Scientific/Technical Staff group

3: Admin/Clerical and Estates Staff Group

4: Nursing and Midwifery Staff Group

5: Additional Clinical Services Staff Group

NHS staff survey 2018

During the autumn of last year a total of 1250 WVT staff members were invited to complete the annual NHS staff survey, 557 staff members chose to participate giving a response rate of 45% (average for our benchmark group was 41%). The 2018 staff survey asked staff to share their experiences of working for the Trust against 10 themes.

The following chart details the Trust’s performance against the 10 themes, benchmarking this against the best and the worst performers within the benchmark group of Combined Acute and Community Trusts.
4 themes improved:

- Safety Culture (6.3 > 6.6)
- Quality of Appraisals (5.1 > 5.3)
- Staff Engagement (6.9 > 7.0)
- Staff Environment, Bullying & Harassment (7.9 > 8.0)

4 themes remained unchanged:

- Equality, Diversity & Inclusion
- Immediate Managers
- Quality of Care
- Safe Environment – Violence.

Of the remaining two themes, morale is a new theme measured for the first time in the 2018 staff survey, and a reduction in our performance was recorded in the final theme of Health and Wellbeing (6.0 > 5.8). Health and Wellbeing is a Quality Priority for 2019/20.

The Trust values these results, enabling teams to work together to identify the areas we need to improve and rewarding our continuing efforts to identify how best we can move forward as a Trust. The survey results continue to be analysed and communicated to staff members through a number of channels and there will be opportunities for senior managers to work with staff to identify solutions, in particular how we might make this a great place to work, where we are all confident that we are able to give our patients the best possible care and treatment.

The charts below shows the results for recommending the Trust as a place to receive care and treatment (left) and recommending the Trust as a place to work (right)
The positive improvement is a welcomed reflection of our focused work over the previous 12 months, which will continue throughout 2019.

The charts below show the Trust’s performance against appraisal and statutory and mandatory training.

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Actual March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory and Mandatory Training</td>
<td>90%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Appraisals</td>
<td>90%</td>
<td>83.2%</td>
</tr>
</tbody>
</table>

**Staff turnover**

A key priority for the Trust is to recruit new starters and retain existing staff and throughout 2018 we have continued in our efforts to strive to be the best possible place to work. Recruitment and Retention is part of the Trust’s strategic plan and significant plans are in place to address recruitment and retention issues. Recruitment initiatives include open days, international campaigns, development for overseas nurses to gain UK nurse registration and supporting nurse associate programmes and secondments. We are also keen to “grow our own” workforce by offering career opportunities to local residents by engaging with school age children to highlight how the NHS and the Trust are great places to work. The table below provides vacancy and turnover metrics, showing a much improved position from last year where staff turnover was 14.6% and vacancies 9.4%.

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Actual March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness absence %</td>
<td>3.5%</td>
<td>4.63%</td>
</tr>
<tr>
<td>Staff turnover-cumulative % for April 2018-March 2019</td>
<td>10%</td>
<td>11.55%</td>
</tr>
<tr>
<td>Vacancies</td>
<td>5%</td>
<td>6.34%</td>
</tr>
<tr>
<td>Agency spend (%pay costs)</td>
<td>7.4%</td>
<td>9.38%</td>
</tr>
</tbody>
</table>
PART 4

Quality Priorities
Quality Priorities – the year ahead

The Quality and Safety team will provide support to deliver the priorities set out below. These have been developed following a review of the priorities in 2018/19, consultation within the organisation, and intelligence that the Trust receives through a variety of sources. The Trust believes these are key priorities that will ensure we deliver first class care and treatment to our patients.

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reducing avoidable death rates by:</strong></td>
<td><strong>Reduce the proportion of non-value added time when patients are in hospital:</strong></td>
<td><strong>Support people to improve their health outcomes</strong></td>
</tr>
<tr>
<td>a) Improved identification, treatment and management of the deteriorating patient</td>
<td>a) Reduce the number of non-clinical ward moves</td>
<td>a) Demonstrate progress against the national Learning Disability Standards</td>
</tr>
<tr>
<td>b) Improved compliance with care bundles</td>
<td>b) Improve discharge planning making Home First the default discharge pathway</td>
<td>b) Contribute to the system childhood obesity reduction target</td>
</tr>
<tr>
<td>c) Improved compliance with VTE prevention</td>
<td>c) Improve patient involvement when making choices towards the end of life including advanced care planning</td>
<td>c) Improve staff health and well being</td>
</tr>
</tbody>
</table>

Improved identification, treatment and management of the deteriorating patient

During 2019/20 focus will be on:

- Improving mandatory training including e learning
- Improved escalation for NEWS2
- Roll out electronic observations
- Implementation of Rapid Evaluation of Cardiac Arrest And Lesson Learnt (RECALL) - debrief following emergency calls to aid learning
- System wide roll out of NEWS2 including primary care

We will be assessing progress by measuring progress with the following:

<table>
<thead>
<tr>
<th>Number of emergency calls</th>
<th>% Compliance with NEWS2 e learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cardiac arrests</td>
<td>%Compliance with NEWS2 practical assessment</td>
</tr>
<tr>
<td>NCAR audit results-(quarterly) survival to discharge</td>
<td>RECALL assessments and learning</td>
</tr>
<tr>
<td>Number of Serious Incidents relating to the deteriorating patient</td>
<td></td>
</tr>
</tbody>
</table>
For sepsis we aim to improve compliance with the recognition and subsequent treatment of sepsis and we will:

- Develop a sepsis quality improvement group
- Improve compliance with national best practice guidance including the use of the “sepsis six” care bundle
- Monitor compliance through regular audit
- Adopt a system wide approach to education and management, recognising that integrated pathways are safer for our patients.

We will be assessing progress by measuring progress with the following:

<table>
<thead>
<tr>
<th>Screening in A&amp;E</th>
<th>Screening inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics within an hour</td>
<td>Septicaemia mortality</td>
</tr>
<tr>
<td>Emergency Department web based reporting on bundle compliance</td>
<td></td>
</tr>
</tbody>
</table>

**Improved compliance with care bundles**

For 2019/20 this project continues to focus on delivering improved compliance with Care Bundles for the following areas: COPD, Community Acquired Pneumonia, Sepsis and Acute Kidney Injury.

Key objectives include:

- Ensure Care Bundles are evidence based
- Improve training for Junior Doctors
- Develop measures for monitoring
- Prepare for bundles to be built into the electronic patient record
- Scope the end of life care bundle

**Improved compliance with VTE prevention**

Due to concerns identified through a review of the current process during 2018/19 a Trust wide project was launched in March 2019. This aims to go back to basics, understand the issues and addresses them through various work streams.

The key aims for improvement are:

- To achieve and sustain compliance with the 95% standard
- To improve the culture and ownership of VTE to ensure thromboprophylaxis is given as per NICE guidance
- To evaluate the process for reviewing hospital acquired thrombosis to ensure learning opportunities are captured and disseminated.

Specific work-streams include:

- Education and Training
- Policy, procedure and process reviews
- Communication campaign to include patient information
- Governance and Audit

We will be assessing progress by measuring the following:

<table>
<thead>
<tr>
<th>VTE Risk assessment</th>
<th>Number of Hospital acquired thrombus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of VTE</td>
<td>Number of outstanding reviews</td>
</tr>
</tbody>
</table>

**Reduce infection rates**

To reduce infection rates and to achieve the Gram negative bacteraemia target reduction of 50% by 2021 (WVT Target =9)

We will be assessing progress by measuring the following:

<table>
<thead>
<tr>
<th>Number of &gt;AD +1 MRSA Bacteraemia</th>
<th>Number of Klebsiella</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of &gt;AD +1 Clostridium difficile cases</td>
<td>Number of Pseudomonas bacteraemia</td>
</tr>
<tr>
<td>Clostridium difficile cases-lapses in care</td>
<td>Number of E Coli Bacteraemia</td>
</tr>
<tr>
<td>Number of externally reportable &gt;AD+1 Clostridium difficile cases (new reporting)</td>
<td>Hand hygiene</td>
</tr>
<tr>
<td>Number of MSSA cases</td>
<td>Bare below the elbow</td>
</tr>
<tr>
<td>Cleaning Standards</td>
<td></td>
</tr>
</tbody>
</table>

**Reduce the proportion of non-value added time when patients are in hospital**

Reduction of non-clinical ward moves

Ensuring a patient is in the right place for their treatment is the focus of this priority and to reduce patient moves when hospital is at capacity.

Measures for this priority include:

- Number of concerns raised through the complaints process
- Percentage of emergency admissions with more than two bed moves (not including specialist areas)

We will be assessing progress by measuring the following:

<table>
<thead>
<tr>
<th>Patient ward moves emergency admissions (Acute no more than 2 moves)</th>
<th></th>
</tr>
</thead>
</table>

**Improving discharge planning making Home First the default discharge pathway**

For 2019/20 the discharge work will continue building on work completed in 2018/19. This is to:

- Increase number of patients discharged under ‘Criteria led’ discharge
- Continued development of the front door frailty service support
• Review the number of 7 and 21 days stranded patients by utilising improvement in discharge planning.

We will be assessing progress by measuring progress with the following:

| % emergency admissions discharged to place of residence | Emergency admissions within 30 days of discharge (Acute only) |

Improving patient involvement when making choices towards the end of life including advanced care planning

Building on outcomes from the mortality project focus will be on the following:

• Roll out of ReSPECT (end of life care planning tool) across the Trust
• Collaborate with primary care colleagues to introduce learning from deaths into community hospitals

We will be assessing progress by measuring the following:

| Number of people trained in Respect tool | Audit of completed Respect forms |

Supporting people to improve their health outcomes

Demonstrate progress against the national Learning Disability Standards

We will:

• Support continued use of the learning disability passport
• Ensure patients with specialist requirements are identified and offered personalised adjustments
• Monitor complaints and concerns to identify areas for improvement

We will be assessing progress by measuring the following:

| Passports in use | No of disability flags |
| Complaints/Concerns raised | Compliance with LD Standards |

Contribute to the system childhood obesity reduction target

We will support reduction with the current programme of work to reduce childhood obesity.

We will be assessing progress by measuring the following:

| Breast feeding initiation at 6 week target | Year 2 and year 6 national measurement programme follow up health promotion |
| Year 2 and year 6 national measurement programme (numbers participating) | The numbers of families participating in the Fit for Families programme |
| Year 2 and year 6 national measurement programme figures for obesity | Fit for Families programme-outcomes |
Improve staff health and well being

We will support staff to remain fit and well by implementing a number of initiatives. A programme of health and wellbeing initiatives will be publicised and run throughout the year. We will report on the Trust’s sickness position against the target of 3.5% and the percentage of frontline staff who have the flu vaccination.

The Clinical Quality Committee will regularly review the Trust’s progress against the Quality Priorities for 2019/20.
Statement of Assurance: Herefordshire Healthwatch

11 May 2019.

Healthwatch Herefordshire (HWH) welcomes the opportunity to respond to the Wye Valley Trust (WVT) quality report 2018 - 2019 (draft). We recognise the valuable role the quality report plays in ensuring accountability to patients and the community of Herefordshire and to providing high quality services. HWH would like to thank all the staff of WVT for their excellent work often in difficult circumstances.

Healthwatch Herefordshire’s approach to the quality priorities set by WVT:
- Are they patient centred?
- What are the outcomes for patient’s physical and mental health?
- What are patients and their carers experiences in outpatients and emergency medicine departments?
- How safe are WVT services? Reduction of harm and sepsis in particular.
- Is the work of ‘Home first’ and ‘Hospital at home’ services performed by WVT in the community being monitored?
- Can WVT demonstrate to patients and stakeholders how their feedback from survey initiatives is used to shape and improve outcomes and service change to encourage patients to believe that their views matter?

The Care Quality Commission (CQC) inspected parts of the WVT in 2018, specifically:
- Urgent and emergency care,
- Surgery,
- Outpatients
- Maternity,
- Medicine,
- Children and Young people’s services,
- Community inpatients,

Overall the trust was judged to be ‘requires improvement’ the previous inspection result. The high lights of their report were, children’s caring outstanding, on the other hand surgery was considered inadequate and outpatients waiting for too long for referral and to commence treatment. The ‘must improve’ category items were safe seven-day services, the issues of diagnostic services out of normal hours and patient’s escalation management to first consultant review.
How did WVT perform to achieve the priorities they set themselves for 2018 - 2019?

1. Reduction of avoidable deaths. WVT has been successful in reducing these deaths to the national average. More work needs to be done to improve this result further with work with partners in the community. This will continue to be a quality priority in 2019/20.

2. Deteriorating patients. Work and training has commenced through the NHS initiative NEW2. It is noted that treatment for these patients is still sub-optimal and we would like the trust to improve these patients’ outcomes wherever possible. This will continue to be a quality priority in 2019/20.

3. Sepsis. This is still an area of concern and will be carried forward to this year, we hope to see initiatives to improve outcomes and note the appointment of a senior specialist nurse for Sepsis.

4. Variation in clinical practice. This priority will be carried forward to 2019 - 2020 and management will hope to embed care bundles and training into patient management.

5. Delayed discharge of patients to appropriate destinations will continue to be a priority for 2019 - 2020. HWH note the non-clinical discharges and out of normal hours discharges and hope that the new 12 bed unit for patients awaiting assessment for discharge will make a real difference. We would ask that all discharges are planned from the earliest opportunity to be patient and patient’s carers centred with good transparent communication.

6. Integrated urgent care. HWH are pleased with the successful opening of the new 24 bed acute medical unit in December 2018 and its impact on improving winter services. We note the new front door frailty team in the Emergency department and the new ward facilities for the care for the elderly. HWH commend the WVT for the reorganisation of wards to reflect the demand for respiratory patients and to focus on the key indicators to reduce unexpected mortality.

7. Patient harm reviews as a result of delay in referral and treatment. We are most concerned that waiting times for children and young peoples paediatric referral and commencing treatment are still over 18 weeks. Whilst we welcome the new pathways for reviewing harm, we would prefer that the trust put this emphasis on patient health and wellbeing in 2019 - 2020 and speed up the process for patients to be seen and treated. HWH are pleased to see the new E referral system from primary care is working well to patient benefit.

8. Enhanced care for those with learning difficulties and dementia. We note and welcome that this work will continue to be a priority in 2019 - 2020.


**Safe:**
- The deteriorating patient
- Compliance with care bundles
- VTE (venous thromboembolism)
Effective:
- Reduce nonclinical moves in hospital
- Plans to effectively discharge the patients
- Patient involvement in end of life planning
- Advanced care planning
- Infection reduction

Caring:
- Training in and care for those patients with learning difficulties and dementia.
- Childhood obesity reduction
- Staff health and wellbeing.

Increased productivity
- Elective procedure capacity
- Reduce patient waiting times
- Meet cancer diagnosis and treatment times
- Provide extra operating theatre and day case capacity

HWH notes the priorities for 2019 - 2020 and the planned performance standards to achieve these objectives. We look forward to the improvement to services. HWH would like to see a focus on patient real time feedback in all areas of the WVT to be used to develop and improve services. The WVT received many more compliments than complaints in the year. However, there was a 29.4% increase in patients’ complaints. These complaints were principally about surgical failures in treatment and waiting times delays, being referred or commencement of treatment. HWH would like to see focus on reduction of complaints. We would have liked to have seen the trust quantify the quality report. (for example, how many patients seen in the year) this would help the community understand the size and scope of the work of the WVT. HWH commend the WVT for producing a transparent quality report and the real improvements made to patient’s health and wellbeing. We encourage the WVT to seek consistency of data reporting to measure and monitor performance. We look forward to the development of integrated care through One Herefordshire and the new primary care networks. Healthwatch Herefordshire will be monitoring the achievements of 2019/20 priorities and offers the WVT our strong support in harnessing the patient voice in their work.

Healthwatch Herefordshire
Statement of Assurance: Clinical Commissioning Group Herefordshire

Herefordshire CCG response to Wye Valley NHS Trust Quality Account

Herefordshire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Wye Valley NHS Trust for 2018/19.

The CCG acknowledge continuing focus on patient and carer experience and the delivery of improvements to quality of services delivered by the Trust.

The 2018/19 Quality Report demonstrates commitment to addressing challenges and concerns. Herefordshire CCG continues to engage with the Trust and receive feedback and assurance on the quality of the commissioned services by attending the Trust Clinical Quality Committee meetings, at the Contract Quality Review Forum and contracting meetings.

The CCG is pleased to see that the Trust has taken action to:

- Address the longstanding high mortality and work collaboratively with system partners with an effective approach to reducing hospital mortality articulated and implemented.
- Reduce patient harm in relation to hospital acquired pressure ulcers and falls.
- Improve the time to first consultant review.

The CCG notes the work that is being undertaken with regard to improvements in supporting people living with Dementia and Learning Disability Care.

The CCG notes the Trust implemented a new approach to the management of serious incidents in December 2018. The CCG would seek to see continued improvement to ensure learning from incidents is maximised and Duty of Candour evident.

The CCG is pleased to see that the Trust has taken action to ensure there is effective governance in place with regards to Patient Safety Alerts.

The CCG would seek to see an improvement in the National Audit Participation rates for Emergency Laparotomy and Ophthalmology and actions taken to address areas of improvement identified by the End of Life audit.
The CCG notes the Trust has articulated the challenges in achieving timely complaint responses and would seek to see an improvement in this and a focus on communication with families and others in the year ahead.

The CCG note the Trust did not achieve the CQUIN Scheme in relation to staff health and wellbeing and is pleased to note that this will continue to be a focus for the year ahead.

The CCG endorses all Wye Valley NHS Trust priorities for improvement as contained in this report in the expectation that they will lead to improved delivery against effectiveness, service user experience and safety, supporting improved outcomes for service users.

The CCG is pleased to note the priorities for the year ahead include:
- Improved identification and management of the deteriorating patient and focus on management of sepsis and prevention of hospital acquired thrombosis.
- Improving discharge planning.
- Reduction of infection rates.
- Progress against the National Learning Disability Standards.

Following a review of the information presented within this report, coupled with commissioner led reviews of quality across all providers, the CCG is satisfied with the accuracy of the report as currently written recognising there are data elements outstanding at the time of receipt particularly in reference to some of National CQUIN schemes.

Helen Richardson  
Chief Nursing Officer
Statement of Assurance: Adults and Wellbeing Scrutiny Committee

Due to recent local elections the Committee has not met since March 2019 and therefore has not been in a position to comment on the document.
Auditors Report - Limited Assurance Report to the Board of Directors

Independent Practitioner’s Limited Assurance Report to the Board of Directors of Wye Valley NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Wye Valley NHS Trust to perform an independent assurance engagement in respect of Wye Valley NHS Trust’s Quality Account for the year ended 31 March 2019 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 (“the Regulations”).

Scope and subject matter

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

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Percentage of patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of the directors and Practitioner

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

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

- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

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

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

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

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.
We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 28 May 2019 May 2019
- papers relating to quality reported to the Board over the period 1 April 2018 to 28 May 2019 May 2019
- feedback from Herefordshire Clinical Commissioner Group dated May 2019;
- feedback from local Healthwatch organisations dated May 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019;
- the annual governance statement dated May 2019
- the Care Quality Commission's inspection report dated 17 October 2018;
- any other information obtained during our limited assurance engagement.

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

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

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

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary.

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.
The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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

Our audit work on the financial statements of Wye Valley NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Wye Valley NHS Trust’s external auditors. Our audit reports on the financial statements are made solely to Wye Valley NHS Trust’s directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Wye Valley NHS Trust’s directors those matters we are required to state to them in an auditor’s report and for no other purpose. Our audits of Wye Valley NHS Trust’s financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Wye Valley NHS Trust and Wye Valley NHS Trust’s directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The indicator reporting the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period did not meet the six dimensions of data quality in the following respect:

- Validity - for 5 of the 25 cases tested, patient records showed a VTE assessment had taken place but this was not recorded in the electronic system and therefore was incorrectly included in the indicator as a ‘no assessment’.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

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

Grant Thornton UK LLP
Grant Thornton UK LLP
Chartered Accountants
Bristol
Appendix 1: Comparable data summary from data available to the Trust from NHS Digital

The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. Wye Valley NHS Trust considers that this data in the table below is as described for the following reasons: https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

- Performance information is consistently gathered and reported on monthly to the Trust
- Data quality assurance checks are made as described on page 28 of the Quality Account

<table>
<thead>
<tr>
<th>Indicator</th>
<th>WVT latest available</th>
<th>WVT previous</th>
<th>NHS E Ave</th>
<th>NHS E max</th>
<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Outcomes Framework - Indicator 5.2.i - Incidence of healthcare associated infection (HCAI) - MRSA (2017/18)</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>Trust cases. latest 2017/18 Previous 2016/17</td>
</tr>
</tbody>
</table>

Wye Valley NHS Trust is taking the following actions to maintain its zero incidence of MRSA and so the quality of services, by ensuring its strict cleaning, hygiene and hand-washing regimes, having a robust antibiotic prescribing policy and ongoing screening of all people that we admit to hospital.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>WVT latest available</th>
<th>WVT previous</th>
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<th>NHS E min</th>
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</tr>
</thead>
<tbody>
<tr>
<td>NHS Outcomes Framework - Indicator 5.2.ii - Incidence of healthcare associated infection (HCAI) - C. difficile</td>
<td>17</td>
<td>19</td>
<td>31</td>
<td>138</td>
<td>0</td>
<td>Trust cases. latest 2017/18 Previous 2016/17</td>
</tr>
</tbody>
</table>

Wye Valley NHS Trust is taking the following actions to improve the rate of C.Diff infection and so the quality of services, by learning lessons from these investigations, sharing with the clinical area and presenting at the Trust’s Safety Summit meetings.
Wye Valley NHS Trust is taking the following actions to improve the rate of patient safety incidents (including those that result in severe harm or death) and so the quality of services, by organisational learning from incidents including serious incidents, the outcome of investigations are shared at Safety Summit and through Divisional and Directorate governance meetings. Serious incident investigation key findings and actions are presented to the Clinical Quality Committee each month to ensure there is robust scrutiny.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>WVT latest available</th>
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<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported October 2017 - March 2018</td>
<td>65.9</td>
<td>62.5</td>
<td>42.19</td>
<td>158.3</td>
<td>0.01</td>
<td>Reported as per 1,000 bed days. Previous period October 2016 - March 2017</td>
</tr>
<tr>
<td>Summary Hospital-level Mortality Indicator (SHMI) - SHMI data at Trust level (current Oct 2017 to September 2018 Band 2 Previous October 2016 - September 2017)</td>
<td>0.13</td>
<td>0.16</td>
<td>0.25</td>
<td>2.30</td>
<td>0</td>
<td>Reported as per1000 bed days. Previous period October 2016 - March October 2017 Data is banded 1-3 high to low Wye Valley is band 2. Previous period April 17- March 18 (Band 2)</td>
</tr>
<tr>
<td>Summary Hospital-level Mortality Indicator (SHMI) - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. (current Oct 2017 to September 2018 Previous October 2016 - September 2017)</td>
<td>24.3</td>
<td>25.3</td>
<td>33.6</td>
<td>59.5</td>
<td>14.3</td>
<td>Reported as a percentage of all deaths. Previous time period (October 2015 - September 2016)</td>
</tr>
</tbody>
</table>
Wye Valley NHS Trust is taking the following actions to improve its mortality rates and so the quality of services, by increasing the number of mortality reviews, sharing learning, increase the number of patients being cared for in their preferred place of death at end of life and by improving the quality of clinical coding.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>WVT latest available</th>
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<th>NHS E max</th>
<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Reported Outcome Measures (PROMS) Groin Hernia (Latest Apr 2017 to Sept 2017 Previous April 16 - March 17)</td>
<td></td>
<td></td>
<td>0.093</td>
<td>0.051</td>
<td>0.089</td>
<td>0.136 0.029 PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Finalised data for varicose vein and groin hernia procedures for 2016/17 has now been published and finalised data for 2017/18 is due to be published in June 2018. Historical data will be unaffected. Using EQ-5D Index score (a combination of five key criteria concerning general health)</td>
</tr>
<tr>
<td>PROMS Total HIP Replacement (Latest Apr 2017 to 31 Mar 2018 Previous April 16 - March 17)</td>
<td></td>
<td></td>
<td>0.436</td>
<td>0.47</td>
<td>0.458</td>
<td>0.549 0.357</td>
</tr>
<tr>
<td>PROMS Total Knee Replacement (Latest Apr 2017 to 31 Mar 2018 Previous April 16 - March 17)</td>
<td></td>
<td></td>
<td>0.304</td>
<td>0.346</td>
<td>0.337</td>
<td>0.406 0.254</td>
</tr>
</tbody>
</table>
Wye Valley NHS Trust is taking the following actions to improve PROMs outcomes and so the quality of services, by continuing to look at the issues with the PROM outcome scores in greater detail, in particular those patients who have had a negative outcome and analysing patient level information to look at the outliers and their impact on the overall scores. This analysis is undertaken by the surgical teams to understand how we can improve.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>WVT latest available</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Readmits 0-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmits 16+</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Recent data not available from NHS Digital "The update of the Emergency readmissions indicators with more recent data has been put on hold. Work to investigate methodological issues relating to these indicators has been completed. However, a review of the indicator sets in which these indicators are published is currently underway. Pending the completion of this review, the development of these indicators has been paused and so we have no update as to when the indicators will be next released. The latest available data for 2002/03 – 2011/12 for Emergency readmissions to hospital within 28 days of discharge are available via the NHS Digital Indicator Portal: https://indicators.hscic.gov.uk."

Wye Valley NHS Trust is taking the following actions to improve its re-admission rates by monitoring these on a monthly basis as a key performance indicator and so the quality of its services.

National Inpatient Survey: Responsiveness to inpatients' personal needs

<table>
<thead>
<tr>
<th>01 Jun 2003 to 31 Jan 2018</th>
<th>22 Aug 2018</th>
<th>67.3</th>
<th>67.4</th>
<th>68.6</th>
<th>85</th>
<th>60.5</th>
<th>NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs. Trusts were asked to select a sample of patients who were discharged from hospital in July. Current data 2017 and previous 2016</th>
</tr>
</thead>
</table>

link to National Inpatient Survey

Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement.
### Indicator

<table>
<thead>
<tr>
<th>WVT latest available</th>
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<th>NHS E max</th>
<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation</td>
<td>63</td>
<td>58.8</td>
<td>69.9</td>
<td>90.3</td>
<td>49.2</td>
</tr>
</tbody>
</table>

### Staff recommendation: Key Finding 1. Staff recommendation of the organisation as a place to work

<table>
<thead>
<tr>
<th>WVT latest available</th>
<th>WVT previous</th>
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<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.1</td>
<td>55.1</td>
<td>61.1</td>
<td>77.3</td>
<td>47.2</td>
<td>Percentage of staff taking part in the survey. Selection of Community &amp; Acute Trusts Current data 2018 survey latest available</td>
</tr>
</tbody>
</table>

Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement.

**Friend and Family Inpatient services latest 2018/19 March 2019 sample)**

<table>
<thead>
<tr>
<th>WVT latest available</th>
<th>WVT previous</th>
<th>NHS E Ave</th>
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<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>98</td>
<td>98</td>
<td>95</td>
<td>100</td>
<td>77</td>
<td>Figures expressed as percentage who would recommend. February 2019 previous period</td>
</tr>
</tbody>
</table>

**Friend and Family Accident and Emergency services (March 2019 sample)**

<table>
<thead>
<tr>
<th>WVT latest available</th>
<th>WVT previous</th>
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<th>NHS E max</th>
<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>92</td>
<td>91</td>
<td>86</td>
<td>100</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>
### NHS Outcomes Framework - Indicator 4b Patient experience of hospital care

<table>
<thead>
<tr>
<th>WVT latest available</th>
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<th>NHS E max</th>
<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>79.6</td>
<td>73</td>
<td>80.3</td>
<td>91.6</td>
<td>74.8</td>
<td>Latest available 2017 Previous 2016</td>
</tr>
</tbody>
</table>

Wye Valley NHS Trust is taking the following actions to improve the score of its Friends and Family surveys and so the quality of services by reviewing the key learning points from patient comments. Working with divisions to continually improve patients experience as identified in our key priorities for 2017/18.

### VTE risk assessed Quarter 3 (October to December) 2018/19

<table>
<thead>
<tr>
<th>WVT latest available</th>
<th>WVT previous</th>
<th>NHS E Ave</th>
<th>NHS E max</th>
<th>NHS E min</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.61</td>
<td>93.07</td>
<td>95.68</td>
<td>100</td>
<td>56</td>
<td>Expressed as a percentage of patients requiring assessment. Previous Q2 2018/19.</td>
</tr>
</tbody>
</table>

Wye Valley NHS Trust is taking the following actions to improve the number of patients who are risk assessed for VTE and so the quality of services by giving monthly specialty and consultant feedback on percentage performance and ensuring we are identifying patients who should be appropriately risk assessed.
## Appendix 2: Contracted Services 18/19 - Contract Monitoring Services

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Medicine</th>
<th>Integrated Care</th>
<th>Clinical Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>Plastic Surgery</td>
<td>Physiotherapy</td>
<td>Palliative Medicine</td>
</tr>
<tr>
<td>Paediatrics &amp; Neonatology</td>
<td>Accident &amp; Emergency</td>
<td>Occupational Therapy</td>
<td>Anti Coagulant</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>General Medicine</td>
<td>Speech &amp; Language</td>
<td>Haematology</td>
</tr>
<tr>
<td>Obstetrics &amp; Midwifery</td>
<td>Gastroenterology</td>
<td>Dietetics</td>
<td>Chemical Pathology</td>
</tr>
<tr>
<td>ITU</td>
<td>Endocrinology</td>
<td>Podiatry</td>
<td>Radiology</td>
</tr>
<tr>
<td>SCBU</td>
<td>HDU</td>
<td>Orthotics</td>
<td>Audiology</td>
</tr>
<tr>
<td>Podiatric Surgery</td>
<td>Hepatology</td>
<td>Medical Inpatients (Com Beds)</td>
<td>Pathology</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>Diabetic Medicine</td>
<td>Community Adult Nursing Including Sub Specialties</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>MIU</td>
<td></td>
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</tr>
<tr>
<td>Colorectal Surgery</td>
<td>Cardiology</td>
<td></td>
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</tr>
<tr>
<td>Upper GI</td>
<td>Dermatology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>Respiratory Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>Respiratory Physiology</td>
<td></td>
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</tr>
<tr>
<td>ENT</td>
<td>Thoracic Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Nephrology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Neurology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Clinical Neurophysiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Child Health</td>
<td>Rheumatology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Dental</td>
<td>Geriatric Medicine (inc Stroke/TIA)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>