GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

Meeting and date: Trust Board - December 2012

Title: Patient Safety and Quality Report

Summary of paper: This report comprises:
- A summary of the Trust’s performance against key Patient Safety and Quality Indicators Section A and Appendix A. A briefing from the Patient Safety and Quality Committee (PSQC) comprising:
  1. Patient Safety and Clinical Risk Section B
  2. Clinical Effectiveness – Section C
  3. External Review and Regulation – Section D and Appendices B and C
  4. NHSLA – current summary risk assessment Appendix D

Recommendations/decisions required:
- To note the patient safety report and provide assurances to Trust Board that actions are being progressed as appropriate

Link to strategic objectives:
To deliver consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% (upper quartile) of comparable Trusts in delivering HSMR, Patient Satisfaction and Staff Satisfaction.

To improve the patient and carer experience of every aspect of the service and care that we deliver.

To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work, and to receive treatment.

Resource Implications:
Financial Implications will be associated with CQUIN

Regulations and legal considerations:
Regulatory Implications for some indicators – Monitor and CQC (This is shown in Appendices A and B)

Quality consideration and impact on patient and carers:
Improved communications, and faster access to services, promotes patient choice. Assurances of the quality of care provided.

Consultation/Communication:
Directorate Performance Meetings
Patient Safety and Quality Committee

Risk issues:
Contractual
Financial – CQUIN
Confidentiality: Regulatory – CQC/Monitor
This report does not contain any confidential information.

Equality Impact Assessment: Great Western Hospitals NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of its service, population and workforce, ensuring that none are placed at a disadvantage over others.

This report has been assessed against the Trust’s Equality Impact Assessment Tool which is attached.

Name of Lead Executive Director: Dr A Troughton, Medical Director

Name of Author: Ruth Lockwood, Associate Director for Patient Safety and Quality
Hilary Shand, Director of Operations
A - Patient Safety and Quality Dashboard November 2012 (Appendix A)

November - Patient Safety and Quality Dashboard

The November 2011/12 dashboard provides the month 8, October (some months 7 where reporting is in arrears) data for key performance targets required for Monitor, PCT Contract and Quality Account – Appendix A.

Key Achievements

Indicator 1J – Incidence of MRSA bacteraemia (COMBINED)  
Target 4 or less  
November 0  
YTD 2

Indicator 45J - All adult admissions to be assessed for VTE risk on admission (COMBINED)  
Target >=90%  
November 92.8%  
YTD 93.7%

Indicator 58J - Reduction of harm for falls S=Severe, D=Death (COMBINED)  
Target <26 a yr  
November - 0  
YTD 14

Key Areas for Focus

Indicator 2J – Incidence of *Clostridium difficile* COMBINED  
Target <=30  
November/December to date 3  
YTD actual 21

There were two cases (inpatient) of *Clostridium difficile* reported during November for the GWH Hospital (Acute). The locally agreed limit is to report no more than 21 cases for the Great Western Hospital (Acute), and no more than 9 within GWH, community. Achieving this limit remains a concern. Weekly multidisciplinary ward rounds continue to review each case. An external peer review has been arranged for 12th and 13th December 2012 to determine if there are additional improvements that could be made.

The Trust has now reported 21 (combined cases, including one reported in December at time of writing report) against a combined trajectory of 30. As an Acute trust we have reported 17 cases against 21 with 4 cases reported in the community beds. and no further community cases since July.
Quarterly *Clostridium difficile* Infections reported against MONITOR’s Trajectory

<table>
<thead>
<tr>
<th>Monitor</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Accum.</th>
<th>Quarter 3</th>
<th>Accum.</th>
<th>Quarter 4</th>
<th>Accum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GWH Acute (5.25 per Q)</td>
<td>8</td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>23</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>GWH Community (2.25 per Q)</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>5</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GWH Combined</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GWH Combined</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

The table above demonstrates that we were above MONITOR trajectory during Quarter 2. We are currently within the Quarter 3 trajectory and there is potential to return within the overall trajectory if no more than 2 *Cdiff* infections are reported prior to the end of December 2012.

**Indicator 35G – Percentage of operations cancelled on the day for non-clinical reasons - GWH**
- Target <=0.8%
- November = 0.9%
- YTD actual 0.7%

During November, there was unfortunately an increase in cancelled ops. This is the main reason due to increased cancellations for no beds due to the operational pressures, increased sickness and increased emergencies particularly in urology and breast. There are weekly cancelled ops meetings to assess areas of concern and each potential cancellation is reviewed on a case by case basis. Wherever possible, the patient is postponed to the following day to reduce the impact on patient and reduce performance risk.

There has also been an increase in additions to the waiting list and this means that some lists have been overbooked. Each list is being reviewed by an anaesthetist and discussed with the surgeon to assess if the booked patients can be operated on without the risk of cancellation. This
needs to be balanced with the need to increase productivity through theatre to manage our waiting list pressures within our resources to reduce performance and financial risk.

**Indicator 78G – Stroke patients spending 90% of time on stroke unit - GWH**
Target >=80%
November = 75%
YTD actual 69.2%

A Stroke services improvement action plan is in place. The plan continues to be reviewed and is supported by the local Cardiac and Stroke Network. The action plan is monitored for service improvement through weekly operational meetings.

Please refer to stroke indicators report at appendix C.

**Indicator 79G – % high risk of stroke who experience a TIA are assessed and treated within 24 hours - GWH**
Target >=60%
October = 50%
YTD actual 50.9%

As per commentary for Indicator 78G above.

**Indicator 81G – Inpatient discharge summaries to be with GPs within 1 working day of discharge EDS - GWH**
Target = 95%
November = 63.6%
YTD actual 63.8%

A project manager who will lead across this indicator and Indicator 82G (below) will be appointed in the new year. Following appointment a revised action plan and trajectory for achievement of this target will be agreed.

**Indicator 82G – Clinic letters to be typed and with GPs within 2 working days - GWH**
Target >=90%
November = 59.3%
YTD actual 60.8%

As per commentary for Indictor 81G (above).

**Indicator 92W – Data quality on ethnic group – all patients episodes should have a valid ethnicity code (except births) - Wiltshire**
Target = >=85%
November = 81.3%
YTD actual 80.3%

Data on ethnicity for the Community sites is adversely affected by the data collection for maternity patients. While the data is collected accurately for almost every patient on booking, this is recorded on the existing Maternity System (MDS) and is not as accurately collected on the Medway PAS for outpatient and admitted episodes for the same patients. This issue will be resolved with the implementation of the new Maternity system which was due to be implemented in December. However the implementation has been delayed and the Trust Informatics Team are planning to update the data on Medway in the interim.
Indicator 100W – Average length of stay of post acute/rehabilitation patients on Neighbourhood Team caseload - Wiltshire
Target = <45 days
November = 56 days
YTD actual 41.3 days

Delays are now being tracked on a daily basis and NT coordinators are meeting regularly with their social care counter parts to ensure patients are discussed and required actions agreed.

Indicator 101W – Referral to Management Pathways – % non-admitted pathways within 18 weeks - Wiltshire
Target = >=95%
November = 93%
YTD actual 98.6%

There are 4 Wiltshire Community Services impacting ion the achievement of this target as follows:

- Outpatient Physiotherapy
- Podiatry
- Wheelchair Service
- Stroke Coordinator

There are issues around data quality and reporting across these services, these are both IT and information.

Action plans are in place to improve data and a meeting is planned in early January to review plans and actions to improve reporting. There have also been some issues with administration resources to support the outpatients booking in community services and these are now resolved.

Indicator 102W – Referral to Management Pathways - % of incomplete pathways within 18 weeks - Wiltshire
Target = >=92%
November = 90.0%
YTD actual 99.4%

As per action for Indicator 101W above.

Indicator 107W – CHC annual review completed within 12 months - Wiltshire
Target = >=90%
November = 84.0%
YTD actual 86%

There were 25 reviews due in November and 21 were completed and a further one was completed late. Three were not carried out these are being investigated.
B – Clinical Risk and Patient Safety December 2012

Never Events

Following discussion with the Commissioners and SHA a previous serious incident reported in August 2012 has been re categorised as a Never Event.

- **Directorate:** Planned care - Ophthalmology
- **Incident Type:** SURGICAL ERROR – BCC LESION REMOVAL UPGRADED TO NEVER EVENT WRONG SITE SURGERY
- **Incident summary:** Removal of the wrong skin lesion from near the right eye of a patient on 24th July 2012.
- **Being Open:** The patient has been informed that an investigation is being undertaken into the incident. The findings from the investigation will be shared with the patient.
- **Due date:** Investigation completed - presentation due at PSQC January 2013.

Three Never Events have been reported 2012/13 to date

The South of England Thematic Review of Never Events 2011/12 recognised that the number of reported serious incidents requiring investigation, in general, is increasing. This is a reflection of the way that the NHS has embraced an open reporting culture. However, organisations should now be working on effective strategies to reduce the number of incidents occurring. A number of the strategies are available especially relate to preventing Never Events

<table>
<thead>
<tr>
<th>Incident number</th>
<th>Directorate</th>
<th>Source/ Commissioning PCT</th>
<th>Incident type</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>51313</td>
<td>Unscheduled &amp; Community Care</td>
<td>Warminster NT/WCHS</td>
<td>Community Acquired Grade 4 Pressure Ulcer</td>
<td>Grade 1</td>
</tr>
<tr>
<td>51289</td>
<td>Unscheduled &amp; Community Care</td>
<td>Chippenham NT/WCHS</td>
<td>Community Acquired Grade 4 Pressure Ulcer</td>
<td>Grade 1</td>
</tr>
<tr>
<td>50749</td>
<td>Women's and Children’s</td>
<td>Delivery (GWH)/SWINDON</td>
<td>Stillbirth</td>
<td>Grade 1</td>
</tr>
<tr>
<td>51722</td>
<td>Planned Care</td>
<td>Ophthalmology/SWINDON</td>
<td>Failure of follow-up arrangements - untreated proliferative retinopathy</td>
<td>Grade 1</td>
</tr>
<tr>
<td>51740</td>
<td>Planned Care</td>
<td>Theatres /SWINDON</td>
<td>Patient misidentification – CVC line</td>
<td>Grade 1</td>
</tr>
<tr>
<td>51819</td>
<td>Women’s and Children’s</td>
<td>PAW/WCHS</td>
<td>Strep A infection</td>
<td>Grade 1</td>
</tr>
<tr>
<td>52076</td>
<td>Unscheduled &amp; Community Care</td>
<td>Saturn Ward/SWINDON</td>
<td>Hospital Acquired Infection - Ward closure</td>
<td>Grade 1</td>
</tr>
<tr>
<td>52090</td>
<td>Unscheduled &amp; Community Nurses/WCHS</td>
<td>District Nurses/WCHS</td>
<td>Community Acquired Grade 3 Pressure Ulcer</td>
<td>Grade 1</td>
</tr>
</tbody>
</table>
Relevant immediate actions have been taken where appropriate. Investigation leads have been identified. Root cause analysis and serious investigation reports are being completed for the above stated incidents. The progress against investigations and action plans will be monitored by the PSQC.

**Key learning and improvements from serious incident action plans completed November 2012**

<table>
<thead>
<tr>
<th>Incident number</th>
<th>Incident Type</th>
<th>Confirmed change or action completed</th>
</tr>
</thead>
</table>
| 44461 and 46824       | Ward Closures - Norovirus      | • Infection Control Guideline for patients requiring transfer from a closed ward to another ward for clinical reasons has been revised within the Outbreak Policy.  
• Ward staff were briefed on the use of fans and door closing in an isolation room.  
• An out of hours flow chart that has been added to the Outbreak and Ward Closure Policy that is now available on the intranet.  
• Ward staff responsible for communicating the ward closure status will ensure that the email has been sent correctly.                                                   |
| 48433                 | Treatment delay                | • A new stroke proforma with instructions for administration of aspirin is now in use.  
• There has been clarification with the medical teams involved regarding medical responsibility.                                                                                                                         |
| 38348 and 47115       | Patient falls                  | • 1:1 guidance is available under templates on T-drive for all ward managers to access.  
• Implementation and further education of SAFE tool and the importance of documentation and reassessments was cascaded throughout the staff.  
• The stock level of slipper socks was increased.  
• There is a new process in place for obtaining low beds when all in use.  
• Information to all wards on how to hire low beds from outside sources out of hours was disseminated at the Falls Prevention Group.                                                                                     |
| 46454, 4938, 4, 49059, 48, 408, 47425, 47417, 48413 | Community Acquired Pressure Ulcers | • Case notes were reviewed by Band 6 nurse and all assessments completed.  
• Spot checks were carried out on patient notes at 2 weekly intervals.  
• Training sessions on documentation were held for the staff nurses involved to ensure improved documentation in future cases.  
• This incident was a result of the patient’s lifestyle choices. Clinicians visiting daily continued to encourage patient, offering support and further information in a format that was suitable and best for the patient.  
• NT Co-ordinator discussed the incident at team meeting and circulated the Wiltshire Pressure Ulcer policy for all to sign.  
• The team have a new Band 6 nurse  
• NT Coordinator has discussed with GP surgery the fact that this incident, caused in part by non concordance with care regime, should be discussed at a clinical meeting at the practice. |
• There was a discussion of friction/shearing within the Neighbourhood Team at a team meeting.
• All relevant clinical staff have completed a tissue viability update.

Serious Incidents 2012/13 Q1 and Q2 reported by directorate

Unscheduled and Community Care are the highest reporting directorate. The majority of pressure ulcers and slips trips and falls occur in the Unscheduled and Community Care directorate.

Incident investigations and action plans overdue (all incidents)

• 942 overdue incident investigations
• 23 overdue Serious Incident Action Plans: (USC 11, Planned 2, D&O 0, W&C 1)
• 10 overdue internal RCA investigations
• 0 overdue Serious Incident investigations

With the exception of serious incidents and never events, incident forms cannot be submitted to the NRLS by the Clinical Risk and Health and Safety teams until the investigation is complete.

Directorates are now being provided with monthly data of incidents with overdue investigations.

The Clinical Risk team are working with Directorates to set realistic goals to reduce the backlog. Unscheduled and Community Care in particular are currently working on a long term plan to address the back log and improve processes for timely investigations.


In October 2012 the Department of Health published the updated never events policy framework in order to address areas of uncertainty and provide greater clarity about never events and the recommended response to them following feedback from stakeholders. The document also contains data on the number and types of never events reported, revealing 326 never events were reported to strategic health authorities in 2011/12.
This review demonstrated that 37 never events were reported during this period in the South West SHA region. The Trust reported 3 never events during 2011/12 and 3 never events to date during the 2012/13 financial year.

The updated Never Events framework now includes a Prevented Never Event criteria. Prevented never events are defined as incidents that may have been never events had action not been taken to avoid an incident meeting the never events criteria and where such action is not part of the specified preventative action detailed in the relevant associated guidance or safety recommendations. For example, it is a prevented never event where an opioid naïve patient receives an opioid overdose, but the error is rescued and severe harm or death is prevented through rapid naloxone administration. This is also an actual patient safety incident and should be reported as such, but is not an actual never event and so is not subject to cost recovery, for example. Prevented never events are not the same as near miss or no harm incidents.

The Clinical Risk team has sent a summary of the Never Event list, including the prevented Never Event criteria to site communications for Trust wide circulation and to be included in the next Alf and Safety Bulletin circulated to junior doctors. The Clinical Risk team is coordinating a review of all 25 never events, to identify any gaps in nationally recommended never event preventative measures, and those recommendations outlined in the South of England thematic review. This report is due for completion February 2013.

National Reporting and Learning System Organisational feedback report (NRLS) October 2011 to March 2012

In September 2012 the NRLS published all NHS Trust’s Organisational Feedback Reports for the period Oct 2011 to Mar 2012. Our Trust is clustered with other medium acute organisations.

Reporting culture
The Trust’s reporting rate decreased from 8.18 incidents per 100 admissions during Apr-Sept 2011, to 5.79 per 100 admissions during Oct 2011 to Mar 2012. Organisations that report more incidents usually have a better and more effective safety culture. You can’t learn and improve if you don’t know what the problems are. The Trust’s reporting rate is below average, the median reporting rate within our cluster group is 6.7 incidents per 100 admissions.

### Degree of harm to patients Oct 2011 to Mar 2012

<table>
<thead>
<tr>
<th>Degree of harm</th>
<th>Incidents across cluster</th>
<th>% of incidents across cluster</th>
<th>Incidents from your organisation</th>
<th>% of incidents from your organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>84946</td>
<td>70.7%</td>
<td>1773</td>
<td>69%</td>
</tr>
<tr>
<td>Low</td>
<td>27304</td>
<td>22.7%</td>
<td>666</td>
<td>25.9%</td>
</tr>
<tr>
<td>Moderate</td>
<td>7031</td>
<td>5.8%</td>
<td>107</td>
<td>4.2%</td>
</tr>
<tr>
<td>Severe</td>
<td>743</td>
<td>0.6%</td>
<td>16</td>
<td>0.6%</td>
</tr>
<tr>
<td>Death</td>
<td>201</td>
<td>0.2%</td>
<td>7</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120,225</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>2,569</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

GWH NHS Foundation Trust report a similar cross section of incidents by degree of harm as a percentage of all incidents reported.
<table>
<thead>
<tr>
<th>Incident type</th>
<th>Incidents across cluster</th>
<th>% of incidents across cluster</th>
<th>Incidents from your organisation</th>
<th>% of incidents from your organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access, admission, transfer, discharge (including missing patient)</td>
<td>9182</td>
<td>7.6%</td>
<td>176</td>
<td>6.9%</td>
</tr>
<tr>
<td>Clinical assessment (including diagnosis, scans, tests, assessments)</td>
<td>6330</td>
<td>5.3%</td>
<td>92</td>
<td>3.6%</td>
</tr>
<tr>
<td>Consent, communication, confidentiality</td>
<td>4187</td>
<td>3.5%</td>
<td>67</td>
<td>2.6%</td>
</tr>
<tr>
<td>Disruptive, aggressive behaviour</td>
<td>419</td>
<td>0.3%</td>
<td>7</td>
<td>0.3%</td>
</tr>
<tr>
<td>Documentation (including records, identification)</td>
<td>7492</td>
<td>6.2%</td>
<td>125</td>
<td>4.9%</td>
</tr>
<tr>
<td>Implementation of care and ongoing monitoring / review</td>
<td>13189</td>
<td>11%</td>
<td>177</td>
<td>6.9%</td>
</tr>
<tr>
<td>Infection Control Incident</td>
<td>2180</td>
<td>1.8%</td>
<td>126</td>
<td>4.9%</td>
</tr>
<tr>
<td>Infrastructure (including staffing, facilities, environment)</td>
<td>7843</td>
<td>6.5%</td>
<td>93</td>
<td>3.6%</td>
</tr>
<tr>
<td>Medical device / equipment</td>
<td>4254</td>
<td>3.5%</td>
<td>177</td>
<td>6.9%</td>
</tr>
<tr>
<td>Medication</td>
<td>13505</td>
<td>11.2%</td>
<td>278</td>
<td>10.8%</td>
</tr>
<tr>
<td>Patient abuse (by staff / third party)</td>
<td>302</td>
<td>0.3%</td>
<td>4</td>
<td>0.2%</td>
</tr>
<tr>
<td>Patient accident</td>
<td>31011</td>
<td>25.8%</td>
<td>837</td>
<td>32.6%</td>
</tr>
<tr>
<td>Self-harming behaviour</td>
<td>279</td>
<td>0.2%</td>
<td>7</td>
<td>0.3%</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>14862</td>
<td>12.4%</td>
<td>308</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>5190</td>
<td>4.3%</td>
<td>95</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120,225</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>2,569</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The Trust has a similar reporting profile as other organisations within the cluster. A slightly higher percentage of patient accident incidents was reported by the Trust, this group of incidents includes patient falls.

It is vital that organisations report and submit incidents promptly both locally and nationally. Trust should upload incidents to the NRLS at least monthly. The time lag between an incident occurring and being submitted to the NRLS by the Trust has increased from 50% of incidents being uploaded within 20 days during Apr – Sept 2011, to 50% of incidents being submitted more than 31 days after the incident. Incident investigations must be completed prior to the clinical risk team and health and safety team submitting to the NRLS. A timely investigation must be completed to reduce time lag between incident occurring and submission to the NRLS.

**Patient Safety Thermometer**

The PSQC received a brief presentation of the background to this national initiative and how data is being collected and submitted. Patient harm and trend reports will be shared once sufficient
data has been collected. Currently, individual wards are receiving their own reports on this. The next steps include refining processes, establishing a review group and reporting framework and a mechanism for managing results.

**Mortality**

The Trust HSMR for the first six months of the year (April – September) is 91.2 with only September having an HSMR above 100. Although higher than the August position of 89.0 this continues the positive trend in the current year and appears consistent with the overall trend for most Trusts in the former SHA. The HSMR for the month of September was 101.8.

The Trust Mortality Group has agreed an updated action plan. The process of investigating Dr Foster red bell alerts and CQC queries is being standardised to ensure a consistent approach for investigations and reports. A review of departmental mortality meetings will start in January 2013. This will ensure sharing of best practice and that lessons are learned from review of cases. This will also ensure that information included in the trust mortality database can be used to demonstrate areas for improvement and lessons learned from case reviews.

The Mortality Group continues to monitor mortality trends at its monthly meetings and drills down to diagnosis or operative procedure group to target areas for further investigation and audit. To date the group has monitored both HSMR and SHMI data. HSMR data is only available three months in arrears and SHMI is published quarterly. Crude mortality rates are available a month in arrears and trends in overall HSMR generally follow changes in crude mortality. The mortality group has therefore recently arranged to monitor all of these measures.

The graph below shows the SHA and GWH HSMR performance for the most recent thirteen month period ending September 2012. The Trust continues to generally follow the trend for improvement in HSMR across the former SHA although the month of September moves the Trust above the SHA average. The mortality group continues to analyse mortality data in detail to determine the reasons for variations in performance in order to make improvements. This analysis leads to review of both clinical coding and clinical care in areas of concern.

**Hospital Mortality HSMR GWH and South West SHA**

![Graph showing HSMR Mortality GWH and SHA - Most Recent 13 Months](image-url)
SHA Acute Trust HSMR April 2012 – August 2012

The graph below shows the HSMR performance for Acute Trusts in the former South West SHA for the first six months of 2012/13. The Trust is placed seventh best performing of seventeen Trusts and there are only two Trusts that have exceeded the 100 HSMR level in this period.

Infection Prevention and Control (IP&C)

<table>
<thead>
<tr>
<th></th>
<th>Limit</th>
<th>Reported</th>
<th>GWH (Acute)</th>
<th>GWH (Community / Maternity)</th>
<th>Non-Acute Trust (non-GWH)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>November</td>
<td>Total</td>
<td>November</td>
</tr>
<tr>
<td>MRSA Bacteraemia</td>
<td>2 – GWH Acute</td>
<td>On target</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2 – GWH Comm</td>
<td></td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>MSSA Bacteraemia</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Ecoli Bacteraemia</td>
<td>NA</td>
<td>NA</td>
<td>2</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>21 – GWH Acute</td>
<td>1.75 above 1.25 below</td>
<td>2</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>9 - GWH Comm</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GRE Bacteraemia</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mortalities</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
MRSA Bacteraemia (MRSAB)

GWH – Acute
There were no MRSA bacteraemias reported during November apportioned to GWH (Acute) Trust.

GWH – Community/Maternity
There were no MRSA bacteraemias reported during November apportioned to GWH (Community/Maternity) Trust.

Non-Acute Swindon and Wiltshire
There were three non-Acute Trust apportioned cases reported during this period from the GWH laboratory, one of which is being considered as a contaminant. This is currently being investigated.

Clostridium difficile Infection

There were two cases of Clostridium difficile reported during November for the GWH Trust. These patients were inpatients within the Great Western Hospital (Acute). There was a delay in obtaining one sample from LAMU, which resulted in the case being attributed to the acute Trust. There were no cases identified within GWH Community Hospitals.

The locally agreed limit is to report no more than 21 cases for the Great Western Hospital (Acute) and no more than 9 cases for GWH, Community Hospitals/Wiltshire Maternity Services.

We have seen a sharp increase in non acute apportioned cases this month, however there appear to be no geographical commonalities with GP surgery or hospital spells. There were seven cases apportioned to the Non-Acute Trust during this period. Two were inpatients on SwICC, two were admitted for less than four days attributed to Swindon GPs. One was admitted less than four days attributed to a Wiltshire GP, one was a Wiltshire GP sample and one was ‘other GP’ admitted less than four days.

Outbreak Reports

Group A Streptococcus

A wound swab has detected Group A streptococci from a lady who delivered her baby at Frome Maternity hospital. At present there are no clear links to the previous cases reported at the PAW. Typing, staff screening and environmental swabs have been obtained. The HPA have been informed. This is being investigated as a serious incident and will be reported upon through this process.

Ward Closures

Saturn Ward was closed from the 27th to the 29th November due to diarrhoea and vomiting of unknown aetiology. Woodpecker had a bay(s) closed between the 28th November and 3rd December due to confirmed 3 confirmed cases of Norovirus.

Legionella Monitoring

Remedial works have been commenced to remove dead legs at community sites. The incident investigation report is awaited. On going monitoring continues with much improved results. The ongoing reporting has been handed to the water management meeting,
C - Clinical Effectiveness (CA&E)

Section 1- NICE Summary Reporting 2012-13

All NICE guidance that is confirmed as compliant by the clinician is automatically added to the directorate audit plan to provide compliance assurance.

To date:
- 4 guidance’s with action plans are within the time frame allowed to become implemented and embedded within clinical practice.
- 6 guidance’s have been confirmed as not fully compliant, risk assessments and action plans have been requested to be formulated for implementation.
- 4 Technology Appraisal’s where the prescribing protocol is under discussion.
- Trust wide compliance of 98 % has been attained this month which meets the Trust’s contractual obligation.

Table below outlines the above:

<table>
<thead>
<tr>
<th>Status</th>
<th>NICE Guidance</th>
<th>Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently being implemented</td>
<td>CG141 Acute Upper GI Bleed</td>
<td>Unscheduled Care</td>
</tr>
<tr>
<td></td>
<td>CG132 Caesarean section (update)</td>
<td>Women’s &amp; Children’s</td>
</tr>
<tr>
<td></td>
<td>CG134 Anaphylaxis</td>
<td>Trust-wide</td>
</tr>
<tr>
<td></td>
<td>MTG11 Mega soft patient return electrode for use during monopolar electro surgery</td>
<td>Planned Care</td>
</tr>
<tr>
<td>To be implemented – action plans requested/awaited</td>
<td>CG85 Glaucoma</td>
<td>Planned Care</td>
</tr>
<tr>
<td></td>
<td>CG145 Spasticity in children and young people</td>
<td>Women’s &amp; Children</td>
</tr>
<tr>
<td></td>
<td>CG149 Antibiotics for early onset neonatal infection</td>
<td>Women’s &amp; Children’s</td>
</tr>
<tr>
<td></td>
<td>CG50 Acutely III patients in Hospital</td>
<td>Unscheduled Care</td>
</tr>
<tr>
<td></td>
<td>PH39 Smokeless tobacco – South Asians</td>
<td>Planned Care</td>
</tr>
<tr>
<td></td>
<td>TA260 Migraine</td>
<td>Diagnostics &amp; Outpatients</td>
</tr>
<tr>
<td>Under discussion</td>
<td>TA254 Multiple sclerosis (relapsing-remitting) - fingolimod</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TA248 Diabetes (type II) - exenatide (long acting)</td>
<td></td>
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<tr>
<td></td>
<td>TA256 Atrial Fibrillation (stroke prevention) - rivaroxaban</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TA249 Atrial Fibrillation – dabigatran etelilate</td>
<td></td>
</tr>
</tbody>
</table>

**NICE Quality Standards**: The recently published NICE Quality Standards Statements are currently being reviewed by the Clinical Leads with necessary action plans in place, where appropriate.
Section 2- Dr Foster Red Bells

New Alerts – awaiting Dr Foster report to be published for December 2012.

Completed Dr Foster Investigations

Readmission alert – Maternity and Neonatal

Current performance indicates no clinical concerns for Re-Admissions after Delivery and currently within expected levels. The actions being taken forward following this review are:

- Review of clinical coding processes focussed on patient deaths to improve accuracy. By: March 2013. Lead/s: Peter O’Driscoll (Head of information)
- Ensuring that patients admitted to ITU are reviewed by the relevant specialty on the post take ward round. By: Immediate. Lead/s: Associate Medical Directors
- Continue to development of end of life care pathways and advance care planning. By: March 2013. Lead: Kate Tredgett (Chair EoL Group)
- Continue monitoring numbers of patients discussed at mortality group. Further develop database to include monitoring of quality of patient records. By: February 2013. Lead/s: Mark Juniper (Chair Mortality Group).
- Current performance indicates we are within expected levels since the alert.

Ongoing Dr Foster Investigations

<table>
<thead>
<tr>
<th>Alert Summary</th>
<th>Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay- (Spondylosis- Back Problem)</td>
<td>Planned Care</td>
</tr>
<tr>
<td>Mortality - Therapeutic Operations on Jejunum and Ileum</td>
<td>Unscheduled Care</td>
</tr>
<tr>
<td>Length of Stay -Therapeutic Endoscopic procedures on Upper GI Tract</td>
<td>Unscheduled Care</td>
</tr>
<tr>
<td>Mortality – Acute Myocardial Infarction</td>
<td>Unscheduled Care</td>
</tr>
<tr>
<td>Mortality – Cancer of Prostate</td>
<td>Planned Care</td>
</tr>
<tr>
<td>Mortality - Cancer of breast</td>
<td>Planned Care</td>
</tr>
<tr>
<td>Mortality - Cancer of bronchus</td>
<td>Unscheduled Care</td>
</tr>
<tr>
<td>Mortality - Therapeutic endoscopic procedures on ureter</td>
<td>Planned Care</td>
</tr>
</tbody>
</table>

Section 3-Clinical Audit Plan Update

Progress with the audit plan and other clinical audit & effectiveness activity is reported to the Directorate Governance Meetings monthly. This enables all these key areas to be reported and
discussed at Directorate level with any exceptions reported to PSQC. Compliance with the Trust Clinical Audit Plan remains at 100%.

60% completed audits to date this year have resulted in learning and a change in clinical practice.

Progress with the audit plan and other clinical audit & effectiveness activity is reported to the Directorate Governance Meetings monthly. This enables all these key areas to be reported and discussed at Directorate level with any exceptions reported to PSQC. Compliance with the Trust Clinical Audit Plan remains at 100%.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Key Drivers</th>
<th>Directorate</th>
<th>Compliance</th>
<th>Actions/Learning from the Project</th>
</tr>
</thead>
</table>
| **Assessment of patent canulas in situ for CT/MRI in-patients** | 1. Aims to improve efficiency 2. Link to CQC | Diagnostics and Outpatients | Areas for improvement | • It was discovered there are wide variations in practice in ensuring patients are properly prepared for their scans.  
• These results are planned to be presented at the Radiology clinical governance steering group meeting where actions will be agreed by the consultants to improve the service. |
| **Acute Oncology Service (AOS) Audit** (To examine the length of stay for oncological and haematological patients after emergency admission with complications of their cancer or of their active treatment) | 1. Link to CQC 2. Patient/Carer/Staff Survey 3. Aims to improve efficiency | Diagnostics and Outpatients | Areas for improvement | • Actions include: continue monitoring and audits. Review policies and protocols to ensure they are in line with NICE, Thames Valley Cancer Network and Acute Oncology Services, by March 2013.  
• Provide ongoing re-educating/informing non-resident Oncologists about new pathways via email and link to Intranet  
• Provide education programme/training tracker for Trust/Thames Valley Cancer Network (TVCN) Acute Oncology Services Guidelines. |
| **Medicines Waste** (To identify the savings made since green bags have been generated). | 1. Aims to improve efficiency 2. High volume/cost area 3. Evaluation of new process 4. Link to CQC | Diagnostics and Outpatients | Areas for Improvement | • Overall, avoidable waste has significantly been reduced compared to January 2012.  
• To Take Aways (TTA's) prescriptions are to be written in advance to avoid patients going home without their medicines.  
• Continue the promotion of the green bag scheme which was introduced in May 2012. |
<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Key Drivers</th>
<th>Directorate</th>
<th>Compliance</th>
<th>Actions/Learning from the Project</th>
</tr>
</thead>
</table>
| Management of Stillbirth at GWH 2008-2010 | 1. Essence of care  
2. Identified area of local concern  
3. Aims to improve efficiency  
4. High risk area  
5. Link to CQC  
6. PCT request to identify risk factors for Stillbirth | Women’s and Children’s | Areas for Improvement | • Improvements are to be made to the checklists to include:  
  - Documentation of the informing consultant  
  - Urine dip as part of the infection screen  
  - Postnatal care  
• Improved documentation is required when taking consent for a post mortem.  
• Exploration of separate facilities from antenatal and postnatal wards for women undergoing stillbirth / late termination.  
• Revision of local guidelines is underway, based upon latest Royal College of Obstetrics and Gynaecology (RCOG) guideline. |

**Section 4- NCEPOD (National Confidential Enquiries into Patient Outcomes and Deaths).**

- Two new studies planned:  
  - Tracheostomy related complications – Pilot Stage commenced.  
  - Death following lower limb amputation – Spring 2013  
- Trust participation for NCEPOD studies remains at 100%.

**Studies in progress**

- Alcoholic Liver Disease  
- Subarachnoid Haemorrhage

**Awaiting Local action Plan**

Action Plan is in the process of being reviewed and formulated for the following studies:  
- Peri-operative Care  
- Cardiac Arrest  
- Bariatric Surgery
D – Regulation

External reviews – Appendix B

1 New Reviews / Report updates

1.1 External regulatory reviews

The CQC began inspecting Maternity Services throughout the Trust as an unannounced inspection from 11th December for three to four days potentially. The focus areas are GWH, PAW and Trowbridge Hospital Maternity Departments.

They are focusing on the following Outcomes:

- 1-Respecting & involving
- 4-Care and welfare
- 13-Staffing levels (they require stats)
- 16-Quality of service /Governance
- 8-Cleanliness and Infection Control.

In addition they have requested a presentation (for the week commencing 17th December 2012 to show how Maternity Services are compliant with Outcome 16 - Governance. This is being arranged.

1.2 External visits- NHS Wiltshire Quality Assurance Visit 6th December 2012

To validate and triangulate contractual evidence that providers share with the Commissioners, NHS Wiltshire have created an inspection framework with a focus on actual observation of the care environment and patient experience feedback.

An inspection visit using this framework was completed at Princess Ann Wing on 6th December; visiting both Delivery Suite and Mary ward. The visiting Commissioning team consisted of the Head of Quality and Patient Safety, Clinical Governance Lead B&NES (who is also a GP in Bath) and a Non Executive Director for NHS Wilt’s Trust Board.

The visit began by a tour of both areas, followed up by interviews with two patients, two Consultants and two nurses. Verbal feedback was given at the end of the visit as follows.

Improvement feedback includes-

- Requirement to improve signage to the unit
- Redecoration required in both areas
- Medical staff communication improvements as identified by Consultants
- Requirement to replace the vacant Foetal Medicine post within RUH
- New IT System C integration plan with GP’s/community teams
- Clearer breast feeding establishment pre discharge policy (as intelligence had alerted Commissioners that this potentially was not always the case, although this was disputed by the team on the day)

Positive feedback was good however and includes-

- The visiting team thanked everyone for a productive and supportive visit
- The team were assured by staffing levels on Mary ward despite initial misunderstanding
• Excellent patient feedback with one patient stating that staff were ‘one step ahead’ of her needs at all times
• Good structures and knowledge around patient safety incidents
• Despite initial concerns around 3rd and 4th degree tears, were delighted to hear of additional training for staff to support episiotomy and suturing procedures and found this a ‘good innovation’.

The report is to be expected within two weeks for factual accuracy agreement. NHS Wiltshire will share the report with B&NES and Wiltshire CCG’s and the Trust Board.

1.3 Informal and Peer Reviews

Infection Control peer review took place on 12th and 13th December 2012. A summary report is awaited.

1.4 CQC Notifications

There has been one notification sent to the CQC as required since the last report:

The CQC have been notified of a Never Event, confirmed post Serious Incident Investigation and following consultation with our commissioners due to complexity of the case. The case involves removal of the wrong skin legion.

1.5 CQC Consultation-Strategy 2013-2016

1.6

Following approval by Trust Board, we have formally responded to the CQC in light of their recent ‘next phase’ consultation. Our response included:

• The need for assurance of robustness and timeliness of data.
• Improved communication and information (QRP specific).
• The CQC to work in symmetry with other regulators to ensure a consistent approach and reduce ‘red tape’.
• To provide clear expectations for all and improved feedback channels to the CQC to supports trust in developing an open culture thus promoting improvements and public/provider confidence.

2 Clinical Standards Group (CSG) – 29th of November 2012

2.1 Internal CQC Compliance Assessments

The CQC outcomes on the Table below were reviewed by the CSG to inform the latest internal compliance judgement. As a result: Outcomes 1 and 10 remain amber until additional evidence is sought and actions are completed.
2.2 Internal inspections

The proposals for internal inspections are now being finalised. Meanwhile two specific areas have been visited by the Quality Standards Manager and observed as follows:

**WHO checklist**

In response to the recent Never Event, and in conjunction with internal spot checks of WHO checklist documentary compliance, an observational unannounced internal inspection was completed by the Quality Standards Manager on 5th November 2012. A summary of recommendations is as follows:

**Patient records**

- The completed WHO forms are not currently added to patients medical records. This would prove invaluable for clinical risk investigations and potential litigation requests, ensuring comprehensive notes collation (each checklist clearly identifies the patient’s details).

**Incident reporting**

- IR1s (incident reporting forms) are not currently completed when a non-compliance is found with the WHO checklist. This is managed locally within Theatres. If an IR1 completion is introduced this would ensure clearly documented non-compliance reporting and investigation; enabling clear trend analysis and internal monitoring against risk of non-compliance.

**Comments during inspection**

- It was clear that the staff wanted the inspector to observe compliance, but the comments made could be misconstrued to indicate that the WHO checklist is not always fully completed and that additional effort was made based on the observational inspection. Staff briefing would be recommended to ensure this is not misinterpreted at future inspections.

**Princess Ann Wing Observational Inspection**

- In preparation for the Commissioners Quality Walkabout visit and to support the staff in each area, an informal observation tour was undertaken by the Quality and
3 Quality Risk Profile (QRP) Changes

Every (QRP) risk dial is an estimate based on statistical analysis of the available data and therefore may differ from an Inspector’s judgement or from a Trust’s internal assessment of compliance” (CQC Guidance on using your QRP).

The CQC QRP data refresh for the Trust at the end of October shows one ‘one shift’ change as below. The CQC QRP data refresh for the Trust at the end of October shows one ‘one shift’ change as below.

<table>
<thead>
<tr>
<th>Outcome Number and Description</th>
<th>Previous QRP Dial</th>
<th>Current QRP Dial</th>
<th>Change</th>
<th>Explanation of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Assessing &amp; monitoring the quality of service provision</td>
<td>High Green</td>
<td>Low Yellow</td>
<td></td>
<td>Total number of data items: 40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number of qualitative data items: 8</td>
</tr>
</tbody>
</table>

The CQC have been asked to provide clear information and rational for the changes to the QRP. Unfortunately this has not been forthcoming. A meeting is being arranged with our local CQC inspector to pursue this. Our concern is not unique having discussed this with other trusts within the South West. This concern was also raised at a CQC workshop.

4 CQC Registration and Statement of Purpose

The Trust’s registered locations currently stand as follows:

- Great Western Hospital
- Chippenham Community Hospital
- Frome Victoria Hospital
- Hillcote, Salisbury
- Paulton Memorial Hospital
- Princess Anne Wing, Royal United Hospital
- Savernake Hospital
- Shepton Mallet Community Hospital
- Trowbridge Community Hospital
- Warminster Community Hospital

The CQC issued the Trust with a new Certificate of Registration on the 02/11/2012 to reflect these changes.

Outstanding applications, which we are currently seeking further clarity from the CQC upon, are:

- To add the PAW as a location in respect of the regulated activity of surgical procedures.
- To add GWH as location in respect of the regulated activity of Nursing Care.

We aim to complete the work on these last two items within the next month.

5 NHSLA
Acute Standards

Following the two day assessment on 22nd and 23rd November 2012 the trust achieved compliance at Level 2 of the Acute Risk Management Standards scoring 49 out of 50.

The two day assessment went well with members of staff attending to support evidence of implementation throughout the assessment. The assessor reported that the staff were knowledgeable in the processes and had ownership of their areas of responsibility.

The assessors commended the trust on the management of the health records reviewed.

Following the formal report received of the level 2 assessment an action plan is being developed and implemented.

The NHSLA working group will continue to meet weekly. A n assessment of where we are with regard to Level 3 compliance will be undertaken during January 2013 and will inform Executive Committee in February 2013. This will enable local decisions to be made as to future assessments and at what level.

Maternity Standards - CNST

An informal CNST assessment was undertaken by our NHSLA inspector on 7th December 2012. There is much work to be done prior to the formal assessment in May 2013 which includes the completion of many Maternity Guidelines/Policies. Roles and responsibilities are currently being clarified and a second informal assessment is planned for early January 2013. Once completed, an internal assessment and gap analysis will be completed and an action plan developed to progress toward achieving level 2 in May 2013.

The NHSLA leads are working together with the maternity team and the structure and work programme will mimic that put in place for progressing the NHSLA acute standards. A detailed report and action plan will inform the Executive Committee in February 2013.

6 Quality Account

All improvement measures are included within the Patient Safety and Quality Dashboard (Appendix A). Exceptions noted:

- *Clostridium difficile* – over trajectory, see Section A, key areas to focus

7 Whistle-blowing

One case was reported in November where the issue of discrimination against those with mental health issues was raised. This is being investigated.
## EC Patient Safety and Quality Dashboard 2012/13

### EC Patient Safety and Quality Dashboard 2012/13

| No | Indicator | Column 1 | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 | Column 7 | Column 8 | Column 9 | Column 10 | Column 11 | Column 12 | Column 13 | Column 14 | Column 15 | Column 16 | Column 17 | Column 18 | Column 19 | Column 20 | Column 21 | Column 22 | Column 23 | Column 24 | Column 25 | Column 26 | Column 27 | Column 28 | Column 29 | Column 30 | Column 31 | Column 32 | Column 33 | Column 34 | Column 35 | Column 36 | Column 37 | Column 38 | Column 39 | Column 40 | Column 41 | Column 42 | Column 43 | Column 44 | Column 45 | Column 46 | Column 47 | Column 48 | Column 49 | Column 50 | Column 51 | Column 52 | Column 53 | Column 54 | Column 55 | Column 56 | Column 57 | Column 58 | Column 59 | Column 60 | Column 61 | Column 62 | Column 63 | Column 64 | Column 65 | Column 66 | Column 67 | Column 68 | Column 69 | Column 70 | Column 71 | Column 72 | Column 73 | Column 74 | Column 75 | Column 76 | Column 77 | Column 78 | Column 79 | Column 80 | Column 81 | Column 82 | Column 83 | Column 84 | Column 85 |
# EC Patient Safety and Quality Dashboard 2012/13

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<th>Indicator</th>
<th>Current Yr</th>
<th>Previous Yr</th>
<th>CCG 6</th>
<th>CCG 8</th>
<th>Year 12</th>
<th>Year 13</th>
<th>Goal</th>
<th>Report 2012-13</th>
<th>Report 2013-14</th>
<th>Notes</th>
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<tbody>
<tr>
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<td>Reduce Grade 2 and above acquired pressure ulcers by patients GHN</td>
<td>New Indicator 2012-13</td>
<td>GA, PCT</td>
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<td>GA, PCT</td>
<td>&lt;=1%</td>
<td>35.0%</td>
<td>32.8%</td>
<td>60.7%</td>
<td>61.1%</td>
<td>67.7%</td>
<td>68.3%</td>
<td>61.3%</td>
</tr>
<tr>
<td>483</td>
<td>Stroke patients spending 60% of time on stroke unit</td>
<td></td>
<td>GA, PCT</td>
<td>&lt;=2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>484</td>
<td>Stroke patients spending 60% of time on stroke units</td>
<td></td>
<td>GA, PCT</td>
<td>&lt;=2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>485</td>
<td>% high risk of Stroke who experience a TIA are assessed and treated within 24 hours</td>
<td></td>
<td>GA, PCT</td>
<td>&gt;=60%</td>
<td>33.3%</td>
<td>33.3%</td>
<td>27.2%</td>
<td>33.3%</td>
<td>25.9%</td>
<td>25.9%</td>
<td>25.9%</td>
</tr>
<tr>
<td>486</td>
<td>2 week RAPID CVAH</td>
<td></td>
<td>GA, PCT</td>
<td>&gt;=60%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>487</td>
<td>Implant discharge summaries to be sent to GP within 1 working days of discharge</td>
<td></td>
<td>GA, PCT</td>
<td>Report</td>
<td>84.6%</td>
<td>71.6%</td>
<td>65.5%</td>
<td>64.1%</td>
<td>69.3%</td>
<td>95%</td>
<td>TBD</td>
</tr>
<tr>
<td>488</td>
<td>Care letters to be typed and with GP - within 7 working days</td>
<td></td>
<td>GA, PCT</td>
<td>Report</td>
<td>58.6%</td>
<td>61.2%</td>
<td>51.1%</td>
<td>57.0%</td>
<td>63.8%</td>
<td>95%</td>
<td>TBD</td>
</tr>
<tr>
<td>489</td>
<td>% women seen a midwife by 12 weeks and 8 days of pregnancy</td>
<td></td>
<td>GA, PCT</td>
<td>Report</td>
<td>91.1%</td>
<td>95.8%</td>
<td>90.3%</td>
<td>90.3%</td>
<td>90.3%</td>
<td>90.3%</td>
<td>90.3%</td>
</tr>
<tr>
<td>490</td>
<td>% women seen a midwife by 12 weeks and 8 days of pregnancy</td>
<td></td>
<td>GA, PCT</td>
<td>Report</td>
<td>95.6%</td>
<td>95.6%</td>
<td>95.6%</td>
<td>95.6%</td>
<td>95.6%</td>
<td>90.3%</td>
<td>90.3%</td>
</tr>
<tr>
<td>491</td>
<td>Data quality on all group: All patient episodes should have a valid discharge code</td>
<td></td>
<td>GA, PCT</td>
<td>Report</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
</tr>
<tr>
<td>492</td>
<td>Data quality on all group: All patient episodes should have a valid discharge code</td>
<td></td>
<td>GA, PCT</td>
<td>Report</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
<td>96.8%</td>
</tr>
</tbody>
</table>

*Note: All indicators are reviewed quarterly and progress is reported to the appropriate committees.*

**Target to split on 1 Maternity, 4 Inpatients and 2 Community (Live at Home) - ACCC Category A and C - Community Care (Live at Home), and 3 Health and Social Care (Live at Home and Community Care).**

Appendix A: Report for quarter ended 30th June 2013.

**Quality Information:**
- **MRCI:** Measurement, Reporting, Compliance, Improvement
- **MPSIS:** Management of Patient Safety, Improvement, and Stewardship
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix B:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix C:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix D:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix E:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix F:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix G:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix H:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix I:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix J:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix K:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix L:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix M:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix N:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix O:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix P:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix Q:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix R:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix S:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix T:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix U:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix V:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix W:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix X:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix Y:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services

**Appendix Z:**
- **EC:** Emergency Care
- **WCHS:** Warwickshire Community Health Services
## EC Patient Safety and Quality Dashboard 2012/13

<table>
<thead>
<tr>
<th>No</th>
<th>Indicator</th>
<th>Description</th>
<th>New Indicator 2012-13</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>K7W</td>
<td>Data quality on ethnic group - all Patient episodes should have a valid ethnicity code (except EPSI)</td>
<td></td>
<td>PCT &lt;=65%</td>
<td></td>
</tr>
<tr>
<td>K7W</td>
<td>Increase the total number of people who are discharged from a community hospital to their original residence</td>
<td></td>
<td>PCT &gt;=75%</td>
<td></td>
</tr>
<tr>
<td>D7T</td>
<td>% of patients who require Prehospital care given is WCHS</td>
<td></td>
<td>Mean: &lt;=89%</td>
<td></td>
</tr>
<tr>
<td>D8W</td>
<td>Number of full-time staff who achieve their choice of place of birth, through community care rather than WCHS</td>
<td></td>
<td>Mean: 77%</td>
<td></td>
</tr>
<tr>
<td>G9W</td>
<td>Core plan must have involvement in the development of EPS, are plan WCHS</td>
<td></td>
<td>PCT &gt;=100%</td>
<td></td>
</tr>
<tr>
<td>100G</td>
<td>Average LOS of post-evacuation patients as the Neighbourhood Teams increased WCHS</td>
<td></td>
<td>13, 28, 50, 50</td>
<td></td>
</tr>
<tr>
<td>100H</td>
<td>Referral to Management Pathway - % of non-excluded pathways within 18 weeks for non-excluded patients whose clock stopped during the period</td>
<td></td>
<td>PCT &gt;=10%</td>
<td></td>
</tr>
<tr>
<td>101H</td>
<td>Referral to Management Pathway - % of complete pathways within 18 weeks for patients on incomplete pathways at the end of the period</td>
<td></td>
<td>PCT &gt;=65%</td>
<td></td>
</tr>
<tr>
<td>102H</td>
<td>Urgent Dental Access % as in under 45th WCHS</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>103H</td>
<td>Community Dental Services, 8 weeks for non-Urgent 1st Apointments, WCHS</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>106W</td>
<td>GCHD - 1st Review seen within 12 weeks, WCHS</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>107W</td>
<td>GCHD - Fast Track 3 week review, WCHS</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>108W</td>
<td>GCHD - Annual Review completed within 12 months, WCHS</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>109W</td>
<td>All adult patients have a 1 YRS assessment in hospitals using the national tool (within 4 years), WCHS</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>110W</td>
<td>EPS of patients who require prehospital care given is WCHS</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>111W</td>
<td>Patients requiring urgent care are assessed within 15 mins - Neighbourhood Teams</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>112W</td>
<td>Prison - Percentage of new prisoners aged 40 and above offered health checks in accordance with the NICE Health Check Programme</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>113W</td>
<td>Prison - Referral to urgent GP appointment</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>114W</td>
<td>Prison - Time between referral to Mental Healthcare Services for acute appointments</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>115W</td>
<td>Prison - Percentage of Upward visits reviewed within 31 days</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>116W</td>
<td>Prison - The between referrals to GTS service and 6 weeks mammography assessment complete</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>117W</td>
<td>All prisoners to be offered Health &amp; Wellbeing at initial health screening</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>118W</td>
<td>Prisoners given copy of medical records at time of discharge</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>119W</td>
<td>CPR - Percentage of patients in Year 8 who have height and weight reviewed who are obese</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>119W</td>
<td>CPR - Percentage of smokers having screening completed by 9th week (Continued)</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

*Notes: Underlined indicators indicate new indicators for 2012-13.*
<table>
<thead>
<tr>
<th>Site</th>
<th>Date of Inspection in 2011/12</th>
<th>Inspection focus</th>
<th>Outcomes Assessed</th>
<th>Inspection Outcome</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warminster Community Hospital</td>
<td>20th May 2011 (Pre Merger)</td>
<td>Full Review of compliance</td>
<td>1,2,4,5,6,7,8,9,10,11,12,13,14,15,16,17,21</td>
<td>Compliant with recommended improvements</td>
<td>Action plan completed, Internal inspection completed 09/07/12 compliance achieved</td>
</tr>
<tr>
<td>Great Western Hospital</td>
<td>12th April 2011</td>
<td>Dignity &amp; Nutrition for older people</td>
<td>1,2,4,5,6,7,8,9,10,11,12,13,14,15,16,17,21</td>
<td>Improvement measures required</td>
<td></td>
</tr>
<tr>
<td>Trowbridge Community Hospital</td>
<td>29th June 2011</td>
<td>Review of compliance</td>
<td>1,2,4,5,6,7,8,9,10,11,12,13,14,15,16,17,21</td>
<td>Compliant with recommended improvements</td>
<td>Action plan completed, Internal inspection completed 16/09/12 compliance assurance</td>
</tr>
<tr>
<td>Great Western Hospital</td>
<td>12 &amp; 13th July 2011</td>
<td>Full Review of compliance</td>
<td>1,2,4,5,6,7,8,9,10,11,12,13,14,15,16,17,21</td>
<td>Compliant with recommended improvements</td>
<td>Work continues to progress long-term actions and monitoring continues</td>
</tr>
<tr>
<td>Savernake Community Hospital</td>
<td>19th October 2011</td>
<td>Review of compliance</td>
<td>1,2,4,5,6,7,8,9,10,11,12,13,14,15,16,17,21</td>
<td>Compliant with recommended improvements</td>
<td>Action plan completed, Internal inspection completed 16/09/12 compliance assurance</td>
</tr>
<tr>
<td>Chippenham Community Hospital</td>
<td>8th November 2011</td>
<td>Review of compliance</td>
<td>1,2,4,5,6,7,8,9,10,11,12,13,14,15,16,17,21</td>
<td>Compliant with recommended improvements</td>
<td></td>
</tr>
<tr>
<td>Great Western Hospital</td>
<td>8th December 2011</td>
<td>Review of compliance</td>
<td>1,2,4,5,6,7,8,9,10,11,12,13,14,15,16,17,21</td>
<td>Compliant with recommended improvements</td>
<td></td>
</tr>
</tbody>
</table>

Outcome 1: Improvement action progressing, All ESG removed by end of September 2012

Outcome 2: (Theater 2) Plan completed, Internal inspection for assurance completed 26/09/12 compliance assurance
Compliance declared to the CQC from 26/09/12.
Re-inspection took place 05/07/12.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Date</th>
<th>Inspection Type</th>
<th>Specialist Review/Compliant</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Western Hospital</td>
<td>8th Feb 2012</td>
<td>IR(ME)R Inspection (Radiology)</td>
<td>Specialist review</td>
<td>Non compliance</td>
</tr>
<tr>
<td>Great Western Hospital</td>
<td>21st March 2012</td>
<td>CQC Termination of pregnancy review</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td>Great Western Hospital</td>
<td>5th of July 2012</td>
<td>Review of Compliance - Follow up to December 2011 Inspection</td>
<td>Compliant</td>
<td></td>
</tr>
<tr>
<td>Great Western Hospital</td>
<td>22nd &amp; 23rd of November 2012</td>
<td>NHSLA Acute &amp; Community Level 2</td>
<td>All Standards</td>
<td>Outcome of Inspection Awaited</td>
</tr>
<tr>
<td>Great Western Hospital</td>
<td>11th December 2012</td>
<td>CQC Maternity service inspection</td>
<td>1, 4, 8, 13, 16</td>
<td>Inspection Outcome awaited</td>
</tr>
</tbody>
</table>
Stroke Key Indicators

November 2012 Performance

Jessica Close
Stroke Information Manager

13th December 2012
1  Stroke Key Indicators

The performance of GWH on the nine key indicators of the National Sentinel Stroke Audit has been reported below. The NSSA expanded the indicators as a result of the 2010 Clinical Audit to include direct admission to an acute stroke unit, speech and language therapy assessment within 72 hours of admission and documentation that the diagnosis was discussed with the patient.

1.1  90% Length of Stay on an Acute Stroke Unit

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Stay in Acute Stroke Unit</td>
<td>56.52%</td>
<td>71.43%</td>
<td>50.00%</td>
<td>66.00%</td>
<td>82.00%</td>
<td>62.75%</td>
<td>68.29%</td>
<td>75.00%</td>
<td>66.13%</td>
</tr>
</tbody>
</table>

The quarter target for IPMR was first achieved for Quarter 4 of 2010-2011 and was maintained until Quarter 4 of 2011-2012; a total of five consecutive Quarters. However, GWH has failed to meet the target for Quarter 1 and Quarter 2 of 2012-2013.

The Stroke Vital Sign has not been met for November, 8 patients did not meet the minimum 90% length of stay on an Acute Stroke Unit. Of the patients whose admission was delayed to the Acute Stroke Unit, 4 were delayed due to delayed referral to the Stroke Team, 2 patients were delayed due to diagnosis and 1 was delayed due to bed availability.

1.2  Direct Admission to an Acute Stroke Unit

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Admission</td>
<td>50.00%</td>
<td>64.29%</td>
<td>63.33%</td>
<td>68.00%</td>
<td>74.00%</td>
<td>76.47%</td>
<td>73.17%</td>
<td>75.00%</td>
<td>67.42%</td>
</tr>
</tbody>
</table>

The above indicator was introduced as a result of the 2010 NSSA Clinical Audit. Despite the increase in bed pressures (reduction of bed base at GWH and increasing emergency admissions), since Jul-12 at least 68% of patients have been admitted directly to the Acute Stroke Unit from A&E, in November the indicator reached 75%. The improved performance of this measure coincides with the initiation of the Stroke Action Plan in August.

1.3  Brain Imaging within 24 Hours of Admission

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain Imaging</td>
<td>95.65%</td>
<td>100.00%</td>
<td>96.67%</td>
<td>96.00%</td>
<td>96.00%</td>
<td>98.04%</td>
<td>97.56%</td>
<td>93.75%</td>
<td>97.10%</td>
</tr>
</tbody>
</table>

Performance on this indicator has always been consistently high, with an average over the year of 97% of patients receiving brain imaging within 24 hours since Apr-12.
1.4 Swallow Screen within 24 Hours of Admission

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swallow Screen</td>
<td>65.22%</td>
<td>76.19%</td>
<td>73.33%</td>
<td>82.00%</td>
<td>86.00%</td>
<td>82.35%</td>
<td>78.05%</td>
<td>78.13%</td>
<td>78.06%</td>
</tr>
</tbody>
</table>

The trend for swallow screens follows a similar trend to the performance of the IPMR length of stay indicator. Most commonly, patients fail to receive their swallow screen within 24 hours as the patients were not admitted directly to the Acute Stroke Unit, highlighting the need for patients to be admitted to the Acute Stroke Unit for appropriate stroke care. In November, the patients who missed their swallow screen were patients who took more than 24 hours to reach ASU or were never admitted at all, with the exception of one patient who took 9 hours to reach ASU.

1.5 Aspirin within 48 Hours of Admission

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>95.65%</td>
<td>95.24%</td>
<td>96.67%</td>
<td>96.00%</td>
<td>94.00%</td>
<td>94.12%</td>
<td>97.56%</td>
<td>87.50%</td>
<td>95.48%</td>
</tr>
</tbody>
</table>

Performance on this indicator has always been consistently high, with an average over the year of 95% of patients receiving aspirin within 48 hours since Apr-12.

1.6 Speech and Language Therapy Assessment within 72 Hours of Admission (if required)

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SALT Swallow Assessment</td>
<td>97.83%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>98.00%</td>
<td>96.00%</td>
<td>98.04%</td>
<td>92.68%</td>
<td>100.00%</td>
<td>97.42%</td>
</tr>
</tbody>
</table>

The above indicator was introduced as a result of the 2012 NSSA Clinical Audit. Performance on this indicator has been consistently high; averaging at 97% for the year and 100% has been achieved for three months of the year so far.

1.7 Physiotherapy Assessment within 72 Hours of Admission

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT Assessment</td>
<td>91.30%</td>
<td>92.86%</td>
<td>100.00%</td>
<td>98.00%</td>
<td>98.00%</td>
<td>96.08%</td>
<td>95.12%</td>
<td>93.75%</td>
<td>95.81%</td>
</tr>
</tbody>
</table>

The percentage of patients who receive their physiotherapy assessment within 72 hours of arrival to hospital is high, averaging at 96% over the year. Patients whose physiotherapy assessments are delayed are usually due to stroke patients not being referred to the Acute Stroke Unit (as the physiotherapists will assess patients who have not yet been admitted to the Acute Stroke Unit), or the patient's admission to the Acute Stroke Unit was delayed.

1.8 Occupational Therapy Assessment within 4 Working Days of Admission

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
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<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT Assessment</td>
<td>93.48%</td>
<td>95.24%</td>
<td>94.67%</td>
<td>94.00%</td>
<td>98.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>96.88%</td>
<td>95.81%</td>
</tr>
</tbody>
</table>

The percentage of patients who receive their occupational therapy assessment within four working days of arrival to hospital has achieved 96% over the year. Occupational therapy assessments that are delayed are usually due to a delay in the patient's admission to the Acute Stroke Unit.
1.9  Rehab Goals Agreed within Five Days

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
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<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Goals Agreed Within 5 Days</td>
<td>71.74%</td>
<td>54.76%</td>
<td>46.67%</td>
<td>70.00%</td>
<td>64.00%</td>
<td>68.63%</td>
<td>95.12%</td>
<td>100.00%</td>
<td>68.06%</td>
</tr>
</tbody>
</table>

There have been changes with the wording of this indicator, as the wording of the indicator has now changed the data collection has been adapted (since the beginning of October). Therefore the performance on this indicator has improved, as seen in the above figures, achieving 100% for the first time in November this year.

1.10  Weight Screen during Admission

<table>
<thead>
<tr>
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<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Screen</td>
<td>97.83%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>95.68%</td>
</tr>
</tbody>
</table>

Performance on this indicator has always been consistently high, with an average over the year of 100% of patients receiving a weight screen during admission since Apr-12; 100% has been achieved for seven of the eight months of the year so far.

1.11  Mood Screen during Admission

<table>
<thead>
<tr>
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<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Screen</td>
<td>93.48%</td>
<td>97.62%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>96.08%</td>
<td>97.56%</td>
<td>96.88%</td>
<td>97.74%</td>
</tr>
</tbody>
</table>

Performance on this indicator has always been high, with an average over the year of 98% of patients receiving a mood screen during admission since Apr-12; In November the only patient who did not receive a mood screen was a patient who was never admitted to the Acute Stroke Unit.

2  Achievement of All Nine Key Indicators

<table>
<thead>
<tr>
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<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nine Key Indicators</td>
<td>36.96%</td>
<td>40.48%</td>
<td>33.33%</td>
<td>42.00%</td>
<td>50.00%</td>
<td>45.10%</td>
<td>63.41%</td>
<td>62.50%</td>
<td>44.84%</td>
</tr>
</tbody>
</table>

The achievement of all nine indicators for patients has increased to 66% in October, and remained high at 63% in November.