Great Western Hospitals NHS
NHS Foundation Trust

# Annual Quality Account 2013/2014

**Great Westerns Hospitals NHS Foundation Trust**
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*Our Values*
**Service Teamwork Ambition Respect**

## Contents

## GLOSSARY OF TERMS

| | |
|---|---|
| A&E | Accident & Emergency |
| ANTT | Aseptic non-touch technique |
| C.diff | Clostridium Difficile |
| Carillion | The company that owns and runs the fabric of the site |
| CAUTIs | Catheter Associated Urinary Tract Infections |
| CCG | Clinical Commissioning Groups |
| CLRN | Comprehensive Local Research Network |
| CNST | Clinical Negligence Scheme for Trusts |
| CQC | Care Quality Commission |
| CQUIN | Clinical Quality & Innovation |
| Crescendo | An NHS IT system |
| D&O | Diagnostics & Outpatients |
| DNA – CPR | Do Not Attempt – Cardiopulmonary Resuscitation |
| DNAR | Do Not Attempt Resuscitation |
| DVT | Deep Vein Thrombosis |
| E&D | Equality & Diversity |
| ED | Emergency Department |
| GWH | Great Western Hospitals NHS Foundation Trust |
| HAT | Hospital Acquired Thrombosis |
| HDU | High Dependency Unit |
| HMIP | Her Majesty's Inspector of Prisons |
| HPA | Health Protection Agency – now NHS England |
| HSCIC | Health & Social Care Information Centre |
| HSMR | Hospital Standardised Mortality Rates |
| IP&C | Infection, Prevention & Control |
| LAMU | Linnet Acute Medical Unit |
| LSCB | Local Safeguarding Children's Board |
| MCQOC | Matrons Care Quality Operational Group |
| MHRA | Medicines and Healthcare products Regulatory Agency (MHRA) |
| MIU | Minor Injuries Unit |
| MRSA or MRSAB | Meticillin-Resistant Staphylococcus Aureus Bacteraemia |
| MUST | Malnutrition Universal Screening Tool |
| NBM | Nil by mouth |
| NEWS | National Early Warning System |
| NHS | National Health Service |
| NHSG | Nutrition & Hydration Steering Group |
| NHSLA | National Health Service Litigation Authority |
| NICE | National Institute for Clinical Excellence |
| NPSA | National Patient Safety Agency |
| NRLSA | National Reporting & Learning System Agency |
| PALS | Patient Advice & Liaison Service (Now Customer Services) |
| PAW | Princess Anne Wing (Maternity Department in the Royal United Hospital) |
| PbR | Payment by Results |
| PCR | Polynerase chain reaction (a method of analysing a short sequence of DNA or RNA) |
| PLACE/ | Patient Led Assessment of the Care Environment |
| PEAT | Patient Environment Action Teams |
| PSQC/PSC | Patient Safety & Quality Committee – now the Patient Safety Committee |
| PUs | Pressure Ulcers |
| R&D | Research & Development |
| RCA | Root Cause Analysis (analyses) |
| RCM | Regulatory Control Manager |
| RCOG | Royal College of Gynaecologists |
| REACT | Rapid Effective Assistance for Children |
| RR | Relative Risk |
| SAFE | Stratification and Avoidance of Falls |
| SEQOL | Social Enterprise Quality of Life |
| SMART | Smart, Measureable, Attainable, Realistic, Timely |
| SOPs | Standard Operating Procedures |
| SOS | Swindon Outreach Scoring System |
| SSKIN | Surface Skin Keep Moving Incontinence Nutrition |
| SSNAP | Sentinel Stroke National Audit Programme |
| TVSNs | Tissue Viability Specialist Nurses |
| UTI | Urinary Tract Infection |
| VTE | Venous Thromboembolism |

## PART ONE

## Our Commitment to Quality - Chief Executive's View

At the Great Western Hospital NHS Foundation Trust, patient safety continues to be at the heart of everything we do. We continue to focus our energies on improving safety, patient experiences and staff satisfaction by providing the highest quality care.

The past year has been extremely challenging, however, it has also been an extremely positive and rewarding year and provided opportunity for us to develop and improve the quality of care we provide within the acute and community health care settings for which we are responsible.

We have regularly monitored our quality improvement plans during 2013/2014 through our Patient Safety Committee and newly formed Patient Experience Committee through to Trust Board. We have presented progress to our Council of Governors and we have also ensured our quality improvement plans have been informed by national priorities and our locally agreed quality improvement contracts agreed between our clinical teams and commissioners on behalf of our local population.

This year's Quality Accounts have been driven against a background of significant challenge. The Francis report highlighted the effects on Health Care Providers which fail to deliver safe services for its patients and hence provides a clear focus for all of us to continuously strive to improve and provide the safest care possible. During 2013/2014 we have taken the opportunity to consult widely with staff and patients and develop and finalise our Quality Strategy and ensure it is informed by the findings and recommendations within the Francis Report.

Our specific priorities for quality improvement set out in the Quality Accounts have been chosen to reflect our goals.

- To promote and improve the safety of our patients and prevent avoidable harm.
- To ensure the care we provide is clinically effective and in the best interest of our patients
- To improve the experiences and satisfaction of our patients.

As a consequence of our quality improvement programme, we have improved care in many areas and delivered some significant service improvements and continued to develop our services.

We are proud of our achievements in reducing the numbers of pressure ulcers developing in patients within our care and have significantly reduced the numbers of the more serious pressures ulcers developing within the acute hospital.

Due to the early recognition and prompt management of patients presenting with infectious gastro intestinal illness (Norovirus) we have been able to minimise the number of ward and bay closures needed to contain the virus and hence maximise the use of beds on wards throughout the year particularly during a very busy winter period

The delivery of safe and effective care must be coupled with the experiences of our patients. We have listened to our patients, heard their experiences and continue to share and use this information and the learning from incidents, complaints and audits to continuously improve

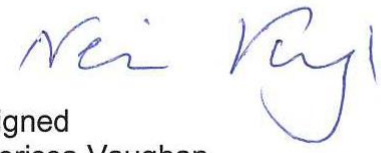
the patient experiences. I am particularly pleased that our annual in-patient survey shows that patients continue to rate their experiences, whilst in our care, highly overall.

The commitment of our staff in delivering high quality care is reflected in our recently published staff survey results. As a Trust we are committed to being an exemplar employer and strive to ensure that all our employees reach their full potential at work and are happy and motivated. Our staff survey shows that our staff reported that their experience of working at the GWH places us in the top 20% of Acute Trusts in the UK for 13 of the 28 measures. These include staff motivation levels, training, appraisals and equal opportunities for promotion.

There are some important and priority elements of patient care where we want to review practice and make improvements over the next 12 months. These are included within our Quality Account improvement plans 2014/15 and Quality Strategy and include:

- Reducing hospital mortalities
- Reducing harm from patient falls
- Zero reporting of Never Events

None of the above would have been possible without the hard work and dedication of our staff and volunteers, along with colleagues working in other allied organisations. Change is needed and is inevitable if we are to continue to improve what we do both inside and outside hospitals and to deliver better care for the population we serve. However, we are confident that our staff will continue to meet the challenges ahead.



Signed
Nerissa Vaughan
Chief Executive

28 May 2014

## PART TWO

**This section provides a review of the progress we have made in our 2013/2014 priorities as published in the last Quality Account and sets out our priorities for 2014/2015**

### Priorities for Improvement

Within its business plan, the Great Western Hospitals NHS Foundation Trust sets out that the provision of safe, high quality, patient care, is its number one priority.

The Trust's aim is to set out a clear quality improvement plan building on current local and national quality improvement initiatives to meet its quality and **safety** objectives and to provide the safest and most **effective** care to enhance the **experiences** of our patients. Where these improvement priorities are informed by our local contractual agreement with our commissioners, this is cited accordingly.

### Priorities 2014/2015

Our commitment to quality will continue through a number of priorities for 2014/2015 which are informed by both national and local priorities and as such, are driven through the Commissioning for Quality Improvement Contracts agreed with our local Clinical Commissioning Groups. These priorities have been shared with agreement sought from the Trust Governors as patient/public representatives, Local Healthwatch Organisations and other key external stakeholders.

Priorities for 2014/2015 are summarised below and they have been set out in the NHS Outcomes Framework which focuses on patient outcomes and experience. We are developing detailed plans with timescales and targets to ensure we deliver these improvement priorities.

| NHS Domain | Darzi Element | Focus | Priority | Rationale |
|---|---|---|---|---|
| 1 | Effective care | Preventing people from dying prematurely | • Hospital Standardised Mortality Ratios (HSMR)/Summary Hospital-level Mortality Indicator (SHMI) | CQC Priority/ Contract/Local priority |
| | | | • Early recognition of the deteriorating patient | CQC Priority Contract/National priority |
| 2 | Effective care | Enhancing quality of life for people with long term conditions | • Dementia | CQUIN/Contract |
| | | | • Safeguarding adults and children | CQC Priority Contract/Regulation/ CQC priority |
| | | | • Review of patients who are being readmitted to hospital within 30 days of discharge | National/Contract/ CCG priority |
| 3 | Effective Care | Helping people to recover from episodes of ill health or following injury | • Nutrition and hydration | CQC Priority Contract/Regulation |
| | | | • Stroke care | National/Contract/ Regulation |
| | | | • Compliance NICE Publications | CQC Priority Contract |
| 4 | Patient Experience | Ensuring people have a positive experience of care | • Friends and family test – patient recommendations | CQUIN/Contract |
| | | | • Complaints<br>Implement a new Complaints System in April 2014 and in doing so, build capability in wards and departments to support local resolution, therefore:<br>• Improving response times<br>• Demonstrating early resolution<br>• More robust investigations and responses leading to less complaints to the Parliamentary & Health Service Ombudsman | CQC Priority / Local<br>Focus on friends and family is the priority |
| | | | • Equality and Diversity | Contract/Regulation/ New project developing |
| 5 | Safe care | Treating and caring for | • Reduce Healthcare Infections | CQC Priority National/Contract/ Regulation/Local |

| NHS Domain | Darzi Element | Focus | Priority | Rationale |
|---|---|---|---|---|
| | | people in a safe environment and protecting them from avoidable harm | • to report zero Never Events<br>• Reduce Incidents and associated harm | CQC Priority Contract/ Local/Regulation |
| | | | • Patient safety thermometer - continue to reduce the following:<br>Falls<br>Pressure ulcers<br>Catheter Associated Urinary Tract Infections (CAUTIs)<br>VTE | CQC Priority CQUIN/Contract/ Local |
| | | | • To reduce Medication Errors | CQC Priority Contract/Local priority |
| | **GOVERNANCE**<br><br>**All of the above are relevant to these indicators** | | • To strengthen and progress full compliance with the CQC regulations | CQC Priority Contract/Regulatory requirement and priority |
| | | | • Implement plans to improve results of the national staff survey | CQC Priority Contract/Regulatory requirement and priority |

## Priorities 2013/2014:

**Safe Care**

- Continue to reduce healthcare associated infections including MRSA and *Clostridium difficile*
- Continue to reduce harm associated with patient falls
- Continue to reduce hospital and community acquired pressure ulcers
- Continue to reduce avoidable mortality, disability and chronic health through improved assessment and management of venous thromboembolism (CQUIN contract)
- Continue to reduce Catheter Associated Urinary Tract Infections (CAUTIs)
- Continue to reduce the incidents of Never Events

**Effective Care**

- Improve the care and management of patients through progressing implementation of the Trust's Nutrition and Hydration action plans
- Continue to sustain our Hospital Standardised Mortality Ratio (HSMR) to below 100
- Improve the management of the deteriorating patient by full completion of the Early Warning Score
- Continue to enhance the quality of life for patients with Dementia
- Continue to adhere to Regulations and Standards for Safeguarding for Adults & Children.
- Carry out a review of patients who are re-admitted to hospital within 30 days of discharge
- Continue to improve on Stroke Care
- Continue to monitor and maintain compliance with national best practice guidelines published by the National Institute for Clinical Excellence.

**Patient Experience**

- Review, assess and improve on feedback arising from the Friends and Family Test – patient recommendations
- Continue to monitor and reduce and learn from complaints
- Ensure that Equality & Diversity is fully established within the organisation

## Review of Quality Performance 2013/14

## SAFE CARE

### Priority 1 – To Continue to Reduce Our Numbers of Healthcare Associated Infections

**MRSA Bacteraemia**

Reducing healthcare associated infection remains an important priority for us and our patients at both local and national level.

During 2013/2014 we reported five cases (all acute) in total.

The Great Western Hospital considers that this data is as described for the following reasons:

In England it is mandatory for health Trusts to report all cases of blood stream infection caused by Meticillin resistant *Staphylococcus aureus* (MRSA) to Public Health England.

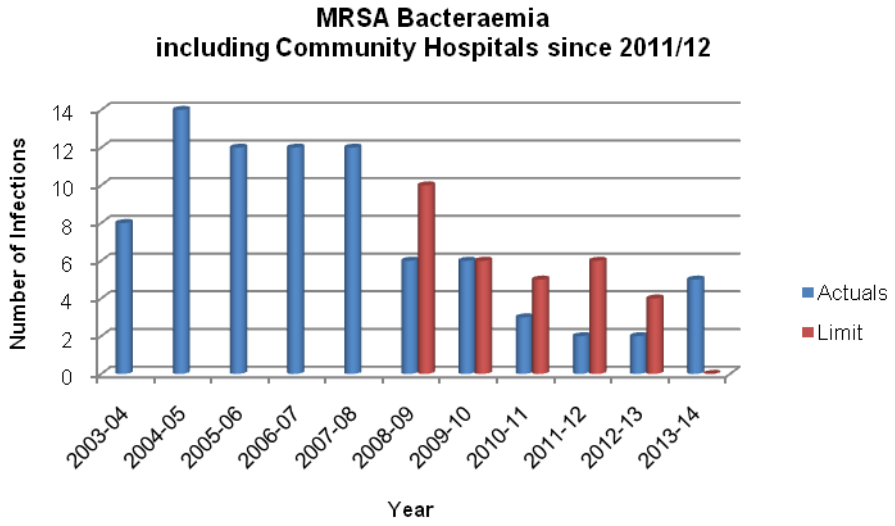
In 2008, all NHS Acute and Foundation Trusts had Trust specific targets set by the Department of Health to reduce the number of health care acquired infections year on year. In 2013 a zero tolerance approach was introduced for Meticillin-Resistant Staphylococcus Aureus Bacteraemia (MRSAB).

All reported cases have been investigated using the Post Infection Review tool in line with national guidelines.

The Great Western Hospital has taken the following actions to improve patient safety, and so the quality of its services, by:

Local initiatives to reduce MRSA bloodstream infections have included:

- Continued use of care bundles, (which is a method of measuring and improving clinical care), for peripheral intravenous lines and urinary catheters, driving practice improvements in areas with low compliance scores
- Refresher training for taking blood culture samples, using aseptic non-touch technique (ANTT) has been, and will continue to be provided for medical, nursing and emergency department practitioner staff. This has been supported by the company which provides our IV cannulation and venepuncture products. This will also be provided by the IP&C nurses when following up contaminated blood culture samples and through drop in sessions held within the Academy on days such as 'World Sepsis Six day' in September.
- Ensuring Infection Control admission risk assessments are completed on all patients and acted upon, including the community inpatient beds
- Daily monitoring of MRSA admission screening of elective and emergency patients, with follow up isolation and decolonisation regimens. This has ensured that over 94% of patients are screened for MRSA skin colonisation on or prior to admission
- Continued improvement of care for patients with diabetes thus helping to reduce complications such as infected ulcers that are often associated with MRSAB's
- Introduction of a 'Sepsis Six checklist' (see Priorities 2014/2015 below for Sepsis Six), providing best care for patients who are admitted showing signs of generalised infection
- Thorough investigation of all MRSAB's. This process promotes input and feedback to clinical staff, including any areas where practice is to be improved




***Including community hospitals since 2011/2012**

Our learning from our reported MRSA Bacteraemias 2013-2014 shows that we need to make improvement in the following areas as priority during **2014/2015**

- Ensuring MRSA screening includes all appropriate sites, including urine samples if a catheter is in situ. Specifying to the laboratory if the urine sample is for MRSA screening
- Improve communication pathways between multi-disciplinary teams and consider proactive management plans for patients with history of MRSA. For example treatment/prophylaxis prior to invasive procedures including urinary catheterisation
- Maintaining consistent IP&C standard precautions and adherence to correct Intravenous care practice and Aseptic Non Touch Technique (ANTT) to prevent cross contamination
- Instigating appropriate re-screening of previously colonised staff working in high risk areas, such as Theatres, ICU and SCBU
- Trust wide role out of a Sepsis Six will provide early diagnosis and management of patients suffering from infections, particularly blood stream infections
- Continuing on-going MRSA screening for elective and emergency admissions, as per IP&C risk assessments

***Clostridium difficile***

The Great Western Hospital considers that this data is as described for the following reasons:

In England it is mandatory for health Trusts to report all cases of *Clostridium difficile* to Public Health England. The nationally mandated goal for 2013/2014 was to report no more than twenty Acute Trust apportioned cases and with no Community Hospital apportioned cases.

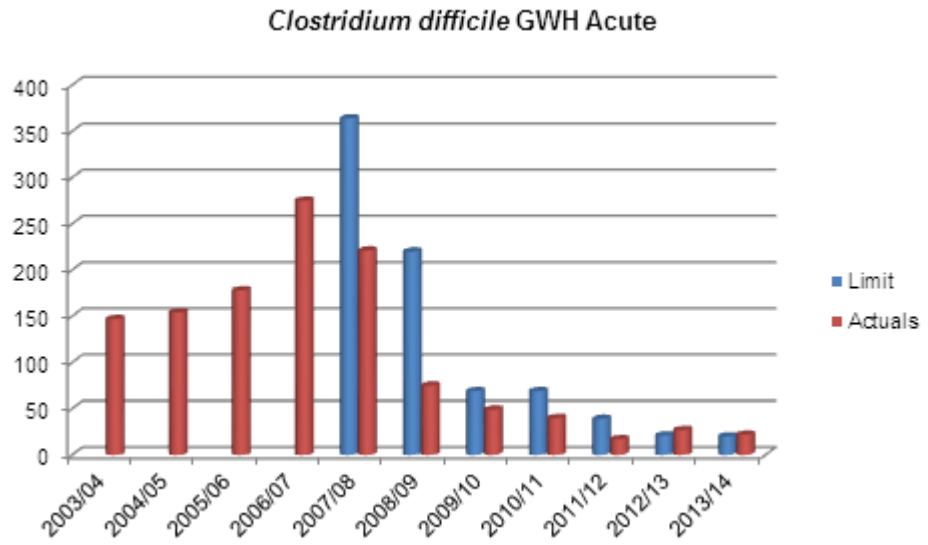
The Trust has reported twenty three *Clostridium difficile* infections within the Acute Hospital and three within the Community Hospitals. *Clostridium difficile* shows a downward trend overall, although during 2011/2012 there was a significant reduction in the number of cases attributed to the Trust and the CCG cases identified through the GWH laboratory. The laboratory revised its *Clostridium difficile* test algorithm during 2012/2013 in response to an external control failure and in consideration to Department of Health updated published guidance on the diagnosis and reporting of *Clostridium difficile.* A more sensitive test was introduced as a result which adheres to the Department of Health two stage test algorithm. This has resulted in an increased number of cases in 2012/2013 but the trust has seen a reduction in total number of cases during 2013/2014.

The Great Western Hospital has taken the following actions to improve patient safety, and so the quality of its services, by*:*

Local initiatives to ensure we continue to reduce these infections have included:

- Promotion of prompt isolation of patients with suspected infective diarrhoea
- Continuation of weekly *Clostridium difficile* specialist review including a Microbiologist, Gastroenterologist visiting patients with *Clostridium difficile* infections, including teleconferences for any positive patients within our community beds

- Inclusion of Polymerase chain reaction (PCR) laboratory test; this is a test for the presence of *Clostridium difficile* capable of causing infection. This test is aimed to support appropriate management, preventing cross-infection and environmental contamination, of those people carrying this infection in their stools (faeces), but not necessarily adversely affected by *Clostridium difficile*
- Review of antibiotic guidelines particularly in 'at risk groups' including pre and post-surgical guidance – in line with NICE Surgical Site Infection guidance
- Promotion of *Clostridium difficile* awareness through Trust newsletters, face to face training on wards, mandatory updates
- Pharmacy antibiotic team are proactively monitoring antibiotic prescribing and promoting the Department of Health's 'Start Smart and Focus' actions, thus engaging staff to reduce antibiotic usage and the incidence of *Clostridium difficile*
- "When to take a stool (faeces) specimen" guidance has been rolled out across the Trust. This provides staff with advice on when to take optimal specimens
- IP&C cleanliness spot checks are carried out across the wards with feedback provided to ward managers and matrons to action and make improvements
- Developed and agreed an assurance framework for cleaning and agreed with Carillion to meet National requirements



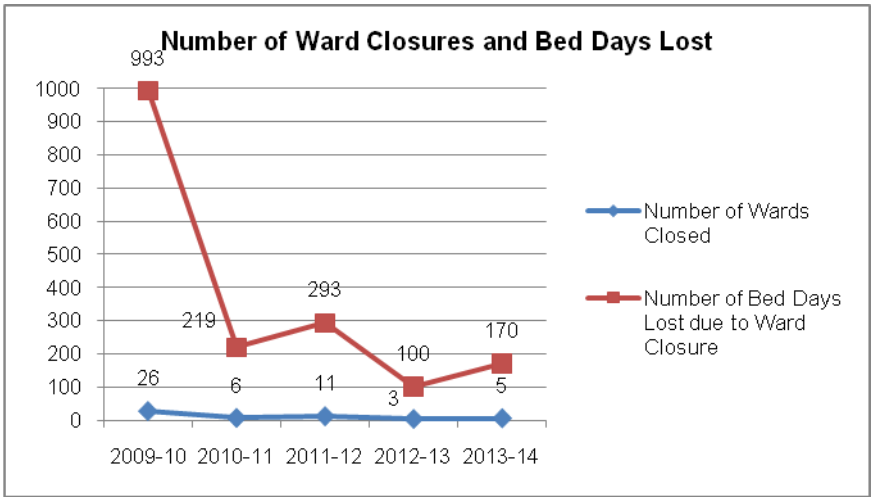

**Priorities for 2014/2015 following our learning during 2013/2014 include:**

- Encouraging front door services (ED and LAMU) to send prompt stool specimens when patients experience unexplained diarrhoea on admission
- Isolating patients within 2 hours of unexplained diarrhoea being reported, to reduce the risk of cross infection
- Striving for environmental cleaning inspections to be 100% to reduce the risk of cross infection
- Promoting the use of hand hygiene/wipes for patients to use prior to meals (EPIC 3) to reduce the risk of cross infection
- Decrease high risk antibiotic prescribing, to reduce the risk of antibiotic related diarrhoea
- Improve antibiotic audit scores, which include adherence to antibiotic guidelines, recording the duration of the course and indication for use
- Consider proactive management of long stay patients (more than 14 days) to reduce the risk of developing *Clostridium difficile*
- The appropriate and effective use of PCR testing for the identification of *Clostridium difficile* carriage amongst patients will be reviewed
- We will fully implement our cleaning strategy and have also set up an environmental cleanliness working group. This group will focus on ensuring consistency of cleanliness throughout our hospitals

**Ward Closures due to Outbreaks of Norovirus**

Each winter most hospitals are affected by an increased prevalence of norovirus. This infection causes acute diarrhoea and vomiting and spreads very easily. This often necessitates either full or partial ward closures. Patients in hospital are more susceptible to these infections, which are usually brought into the hospital by visitors, patients, contractors or staff and then spread very quickly. We have been working hard with our staff and visitors over the past few years to reduce the impact of this seasonal virus. Antiviral hand gel and asking friends and relatives to refrain from visiting if they have been recently unwell, has had a positive impact on reducing the number of wards closed due to this infection.

The chart below shows the number of ward closures each year and the associated impact on the number of empty bed days accumulated during these closures. The winter of 2009/2010 was particularly difficult with many wards being closed for long periods of time. Since 2011-2012 the data also includes the GWH community wards and it can be seen that due to the proactive management and isolation of patients, and early bay closures, the numbers of wards we have needed to close has reduced considerably along with the number of bed days lost due to full ward closure.




Numbers of bed days lost can vary considerably, depending on the type of ward (medical versus orthopaedic) and the period of time the ward is closed (on average, ward closure lasts approximately 7 days often with bay closures for several days beforehand). Bed days lost, are reported once a ward closes to admissions. Bed days lost is the number of beds empty each day within the ward that cannot be used to admit a new patient due to the outbreak.

A ward that discharges patients more quickly than another (due to its speciality) may experience more bed days lost than a ward that has more long stay patients.

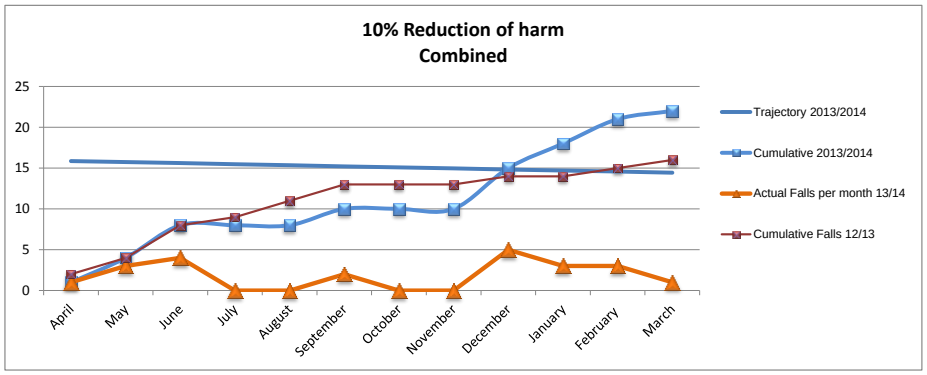
If a ward is managed by bay closures only – bed days lost are not reported within this report. They are reported within the IP&C Annual Report.

## Priority 2 - To Reduce Severe Harm Arising from Patient Falls

A reduction in severe harm suffered by those patients falling while in hospital continues to be a high priority across both the acute and community services. Our overall aim has been a 10% reduction in the number of patients that sustain severe harm from a fall compared with last year, this equated to less than 10 for the Acute hospital and less than 4 across the Community inpatient services. For the year 2013/2014, the key actions from all our serious incidents (SI) have been summarised below.

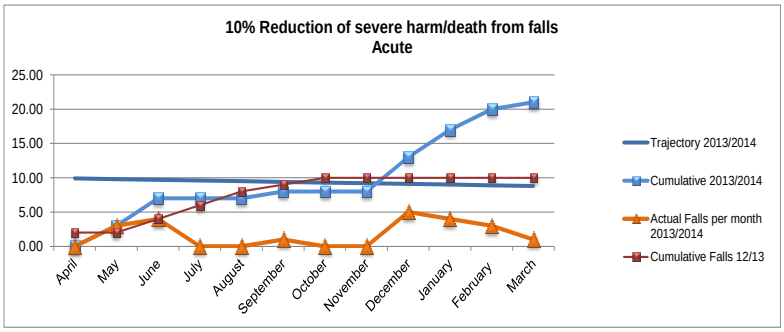
**Definitions:**
**Severe Harm** Where permanent harm, such as disability, was likely to result from the fall.

**Combined Target: A reduction of 10% from the actual for 2012/2013 – trajectory 14**



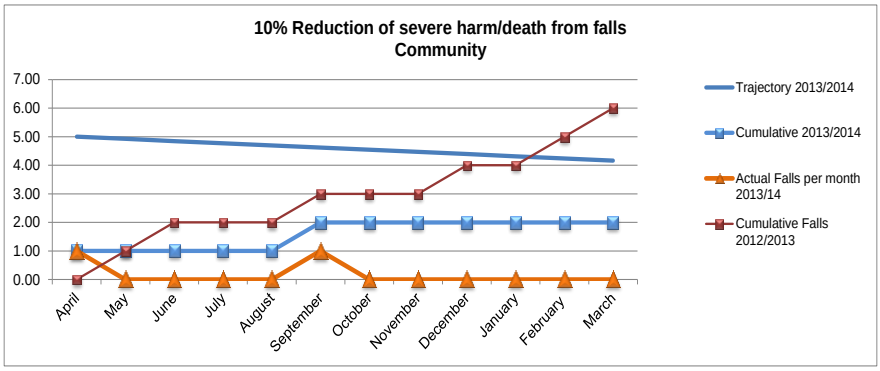

The above graph shows that the Trust reported seven more patient falls during 2013/2014 where severe harm occurred, compared with 2012/13. This is a 30% increase compared with 2012/2013. This year our rate of severe harm from falls is 1.5% compared with last year's 1.1%.

**Acute Target: A reduction of 10% from the actual for 2012/2013 which was 10**




The graph above shows that the falls reduction trajectory within the acute GWH was not achieved i.e., 21 such incidents were reported again a reduction trajectory of 10.

**Community Target: A reduction of 10% from the actual for 2012/2013 which was 5**




The graph above shows that during 2013/2014, we achieved the community falls reduction trajectory i.e., we reported 2 incidents against a trajectory 4.

During July and January the Trust carried out a detailed review of all incidents of falls where patients sustained severe harm or death. The panel concluded that five of the twenty one incidents were unavoidable. The learning

and recommendations of the other sixteen have been shared with all wards, the falls prevention group and presented to the Patient Safety Committee. Details of the learning are provided below.

**Key Actions from serious incidents**
A key focus across community wards has been monitoring the impact of bed sensor alarms, which detect patients moving from beds, to reduce the level of repeat falls reported from the same patients. This has resulted in a 10% reduction in falls occurring by repeat fallers. This data has been used as evidence to support a case of need to purchase some sensor alarms for the community wards. Overall the four community wards have reported 50 less falls this year compared with last year.

The severe harm investigations discovered some gaps in the falls policy being followed and incomplete documentation in some cases. Embedding the Stratification and Avoidance of Falls (SAFE) tool has been a key focus through monitoring compliance across all 21 inpatient wards; the average score to date this year being 88% compliant, aiming for 95% Trust wide compliance. Compliance is monitored and promoted by each individual Ward Manager based on their specific information. This audit provides assurance that every inpatient is being assessed for falls risks within 4 hours of admission, and an appropriate care plan is being put into place fully and reviewed timely.

All acute and community wards this year have received monthly reports on their falls data, which contain shared learning from all falls resulting in harm. For example, one ward has identified more falls were occurring at specific times of the day. This ward has now trialled a different way of working around this time of day which has seen a reduction in incidents at this peak time.

**Priorities for 2014/2015**

- Continue to support the highest risk wards in identifying learning from all reported falls incidents, not just those that result in moderate or severe harm
- Three wards have already started new initiatives such as more frequent care rounding for all patients at night time, monitoring of patients who are at increased risk of falls and ensuring that they are assisted with their toileting/personal hygiene needs
- Our Quality Improvement Plan for 2014/2015 is to be below (better than) the national average number of falls per 1000 occupied bed days, which is 5.6 for Acute and 8.6 for Community inpatients. This year's average being 7.3 for Acute and 10.6 for Community. The quality improvement plan will be driven by the newly formed Fallsafe Operational Group (accountable to the Falls Prevention Group). This is a forum for all ward managers to share learning and give assurance around their care and practices/processes regarding reduction of falls in their areas

## Priority 3 - To Reduce Healthcare Acquired Pressure Ulcers

The reduction in the number of health care acquired pressure ulcers is an organisational patient safety priority and the focus of the Pressure Ulcer Strategy. This ultimately strives to achieve zero avoidable healthcare acquired pressure ulcers by 2015. This strategy focuses on the care we provide to our patients, especially those who are at high risk of developing a pressure ulcer due to immobility.

Every second Wednesday of the month, all wards in the acute and community hospitals and the community nursing teams complete a data collection form. This form includes the number of patients, who develop a pressure ulcer including categories II, III and IV (category II is a superficial wound and a category IV is the deepest category, potentially down to bone). This form is then sent to the Clinical Risk Team who put the information on a national monitoring system called the NHS Safety Thermometer. The safety thermometer was developed for the NHS by the NHS as a point of care survey instrument which measures the proportion of patients with a pressure ulcer on one day per month for all patients receiving NHS funded healthcare. This provides a 'temperature check' on harm that can be used to measure local and system improvement.

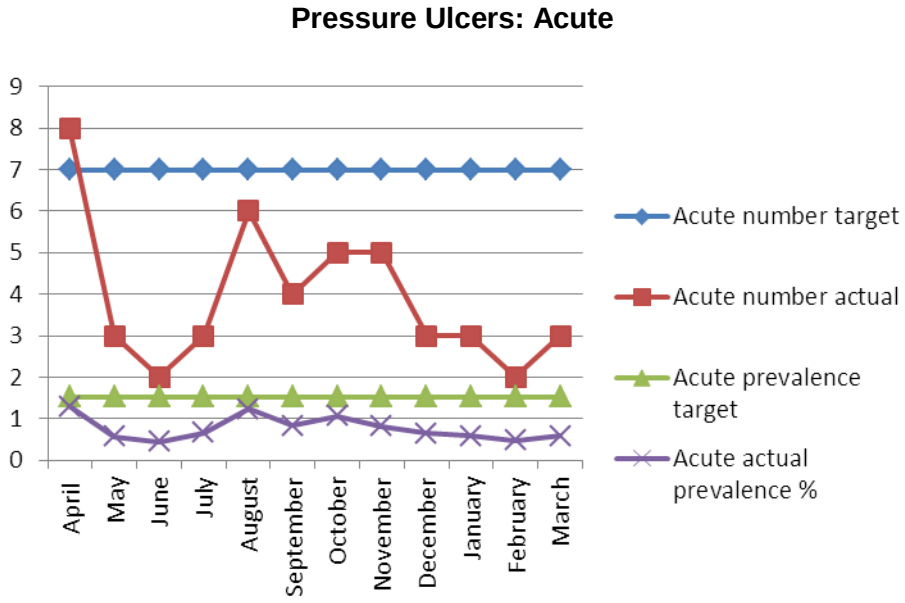
The Tissue Viability Team aim to verify every patient with a pressure ulcer to ensure that it is a pressure ulcer and not caused by moisture or trauma and that it is categorised correctly. This data is analysed by the Tissue Viability Nurse Consultant and triangulated (compared) with the Clinical Risk Team data (as each pressure ulcer is also reported in the Incident Management System) to ensure robust data collection.

The organisation has two Commissioning for Quality and Innovation payment framework (CQUIN) targets for the reduction of healthcare acquired pressure ulcers: A CQUIN enables Commissioners to reward improvement, by linking a proportion of English Healthcare Providers' income to the achievement of local quality improvement goals.

The two CQUIN targets were:

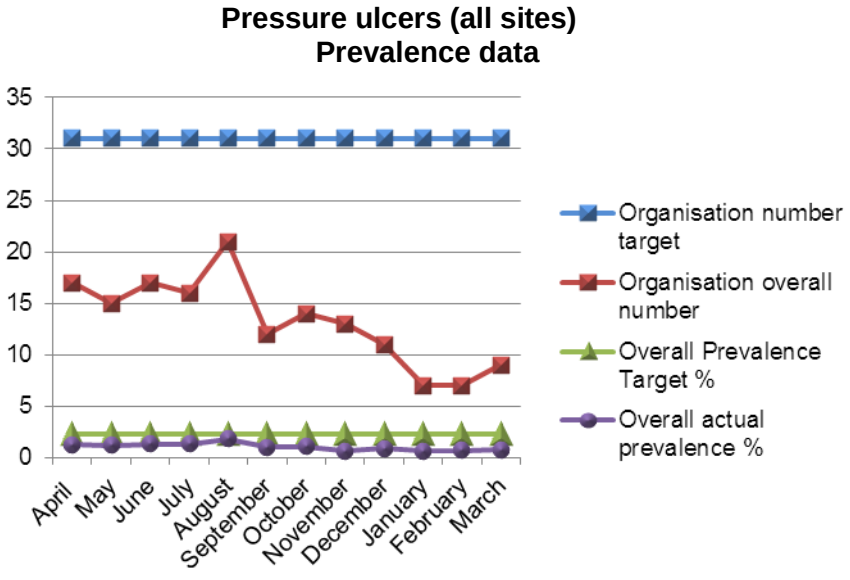
1. Swindon Clinical Commissioning Group (SW CCG). To reduce the prevalence (safety thermometer data) of pressure ulcers, categories II, III and IV by 10% for the acute GWH hospital. The mean number of patients who acquired pressure ulcer per month for 2013/14 was 8.2 therefore the development of less than 7 pressure ulcers (prevalence of 1.5%) was required each month and specifically required in September 2013 and February 2014 to meet the CQUIN/our local improvement plan.

   The graph below shows the number of new pressure ulcers (PU's) that developed each month, from April 2013 to March 2014 using the safety thermometer data, showing that the improvement plans have been achieved each month except April 2013.




2. Wiltshire Clinical Commissioning Group (Wilts CCG). To reduce the prevalence (safety thermometer) of pressure ulcers, categories II, III and IV by 30% by month 11, across the organisation. The mean number of patients who acquired pressure ulcers per month for 2012/2013 was 44, therefore less than 31 pressure ulcers (prevalence of 2.3%) were acquired per month to meet the CQUIN target/our improvement plan

   The graph below shows the numbers of new pressure ulcers that developed each month, from April 2013 to March 2014, using the safety thermometer data.



**Priorities for improvement:**

- The Tissue Viability Specialist Nurses (TVSN's) will continue to verify every pressure ulcer to ensure accurate categorisation and that each patient receives an effective response i.e. care planning and equipment. Verification may be undertaken using medical photography.
- The Pressure Ulcer Prevention and Management policy and Pressure Ulcer Strategy are now embedded in practice. The Tissue Viability team are now embedding a competency based programme with the Trust to ensure that all staff are competent in assessing and managing patients at high risk of developing pressure related skin damage. This will be complete by July 2014
- To support an annual pressure ulcer conference in partnership with NHS England with delegates from SEQOL, Sirona, Royal United Hospitals Trust and GWH NHS Foundation Trust to enhance cross boundary working
- A robust root cause analysis for all pressure ulcers (Category III and IV) is carried out and presented to the Pressure Ulcer Investigation Panel. This is led by the Nurse Consultant with Commissioners, safeguarding leads and clinical risk team to establish an effective action plan
- To roll out of the SSKIN Bundle tool (Surface Skin Keep Moving Incontinence Nutrition) which is an assessment and monitoring tool for patients in their own home. This includes the (SSKIN) Bundle which is a national tool used for pressure ulcer assessment and reduction. This is now being used across the community in all patients' homes who are assessed as being at high or medium risk for pressure ulcer development by the community nursing team and is completed by Social Service carers and Trust Health Care Professionals

## Priority 4 – To Ensure Patients are Assessed for the Risk of Developing Venous Thromboembolism and that these Risks are Managed Appropriately

People who are poorly and have reduced mobility are at increased risk of developing venous thromboembolism (VTE). This is the development of small blood clots in the veins in the leg, which can lead to serious complications such as a pulmonary embolism (blood clot in the lung) if part of the clot breaks off and travels downstream towards the heart. It is therefore very important that we assess patients to identify those at risk of developing a VTE and ensure that we provide the necessary care to prevent this complication occurring. An important VTE preventative measure is to ensure VTE prophylaxis (prevention medication) is given to those considered to be at risk.

**VTE Risk Assessments**

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Data is collated from the electronic nursing care system and compared to the total number of admissions during any given month. For clinical areas that do not use the electronic system, manual collation is used and validated by the lead for VTE and the informatics team. This validation is undertaken weekly and information disseminated to all clinical areas so that any under performance is highlighted and able to be rectified.

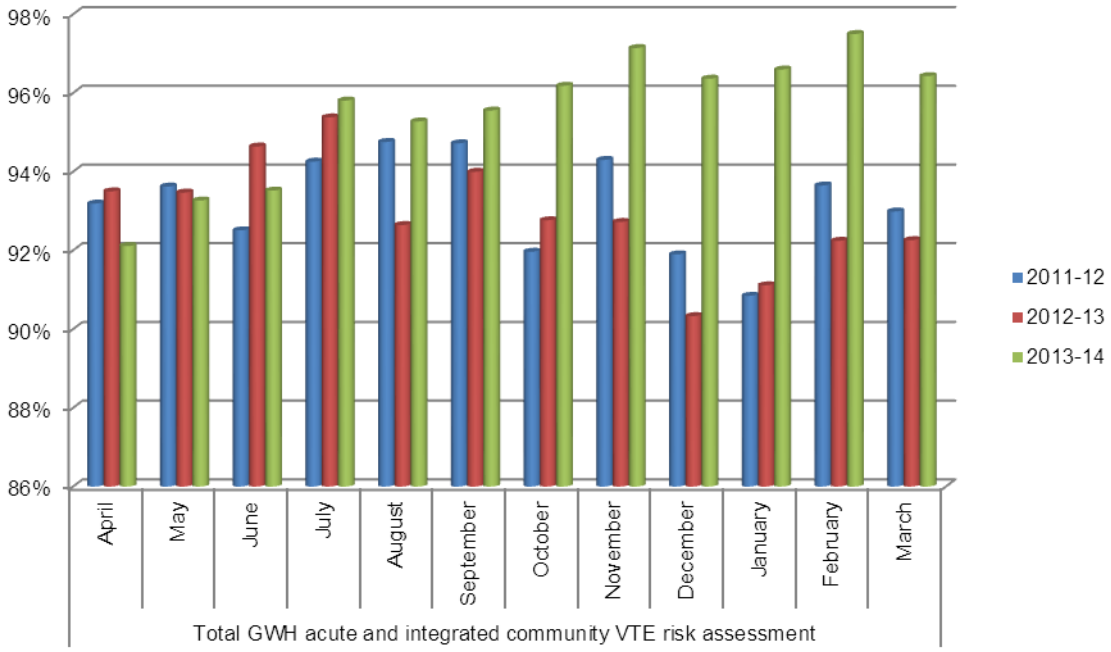
The % target set by the Department of Health increased from April 2013 to 95% and we agreed a trajectory for GWH acute towards this percentage, aiming to achieve 95% by November 2013 which was achieved. For the community hospitals we achieved more than 95% for both general in-patients and maternity patients.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this:

- Continued education sessions at Trust Induction for both the acute and community settings
- Making VTE training available electronically on the Trust's intranet site
- Daily monitoring of the completion of VTE risk assessments through Crescendo, the nursing electronic documentation system, providing daily reports to each ward
- For those areas not using the electronic nursing care system we have utilised the ward clerks in updating the system once the nurse has ensured the risk assessment has been completed, this has led to significant improvements in areas like the Linnet Acute Medical Unit (LAMU)
- Introduction of a weekly report showing the numbers of patients with and without a VTE risk assessment allowing us to monitor progress throughout the month ensuring that any poorer performing areas can be highlighted and action plans put in place
- Raising awareness with patients and relatives by means of information boards and displays

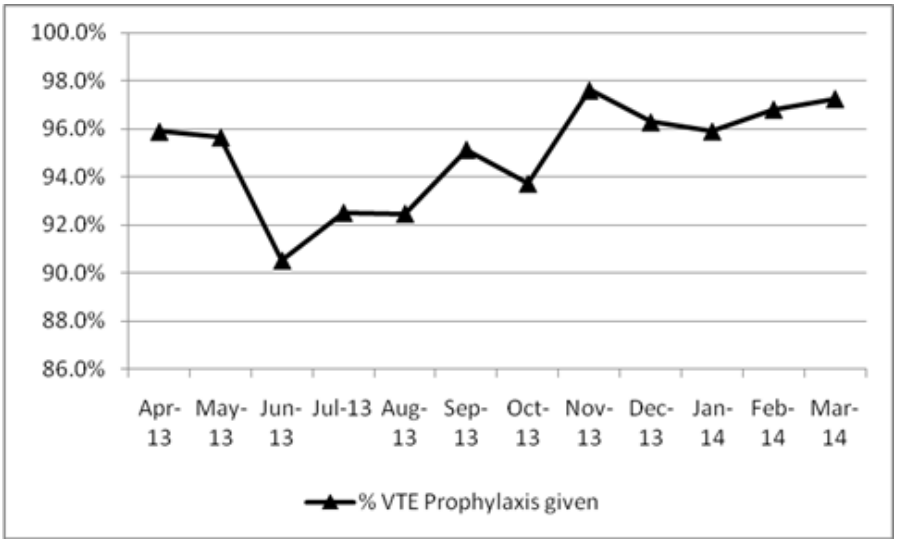
- We have also worked closely with our community partners in healthcare provision to introduce VTE risk assessments into the community for patients who are discharged home with VTE prophylaxis. This will also enable patients who deteriorate at home to be reassessed and for them to receive appropriate VTE prophylaxis, if at risk of a stroke. This is not mandated in the NICE clinical guideline (CG92) but is good clinical practice and has been embraced by the community

The chart below shows the total percentage of patients that have had a VTE risk assessment on admission to hospital and includes data for the community since June 2011.




**Administering appropriate VTE thromboprophylaxis**

Compliance with VTE prophylaxis has been maintained between 90-100% for the last 12 months. Audits evaluating the quality of the risk assessments and appropriate thromboprophylaxis are undertaken each month utilising the Patient Safety Thermometer Tool. This graph shows the number of in-patients on one day in a month along with the number of patients receiving appropriate thromboprophylaxis.




## Hospital Acquired Thrombosis

We also look at the number of Hospital Acquired VTE events (HAT) which relate to a thrombosis (either deep vein thrombosis or pulmonary embolism) that occurs within 90 days of a hospital admission. This is now a CQUIN target which has enabled us to focus on the quality of thromboprophylaxis provided for patients.

Data has been collected since 2010 and the number of VTE events has reduced by 10% in GWH Community and has currently reached a plateau.

### Priorities for 2014/2015 are:

- To sustain the percentage of patients who have a VTE risk assessment > 95%
- To ensure a root cause analysis is carried out for all hospital acquired thrombosis events where a VTE risk assessment and/or received appropriate prophylaxis have not been observed
- To set an achievable, continuous and sustainable improvement outcome

## Priority 5 - To Continue to Reduce Catheter Associated Urinary Tract Infections (CAUTIs)

Urinary tract infection (UTI) is the most common hospital acquired infection with many attributable to an indwelling catheter. This can lead to delays in patient recovery and subsequent discharge.

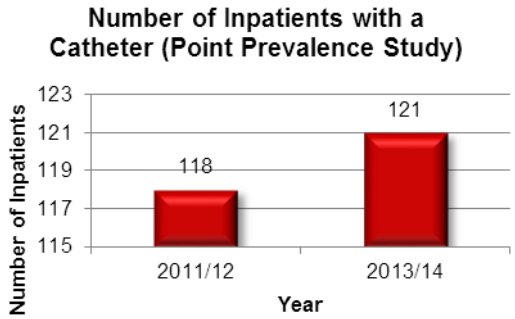
A point prevalence survey was carried out in September 2011 with a follow up survey in 2013-2014 to quantify the number of patients catheterised and the number of patients with a urinary tract infection.

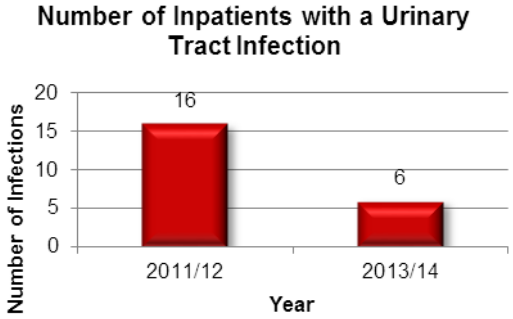
It was felt that the best way to decrease the number of patients with CAUTIs would be to reduce the number of days a urinary catheter was in situ. To achieve this aim a CAUTI Group has been set up meeting 4-6 weekly. The aim of the Group is to assess the risk factors of catheters in general, providing training and education. Use of the care bundle tools will facilitate monitoring of catheter care within the Trust.

A tool for monitoring catheter days, approved by the Policy Governance Group, has been rolled out within the Acute site replacing the care bundles for insertion and on-going care by the end of 2013, with plans to roll out to Community sites in early 2014. This is being progressed using the Patient Safety Thermometer tool. Implementation will involve student nurses visiting clinical areas and physically removing all paper copies of old urinary catheter documentation, then the Trust will uniformly be using the same documentation.

It is planned to repeat the point prevalence study in 2014-2015 to assess catheter usage and urinary infection rates. The priority will be to reduce catheter days and influence staff attitude towards catheter usage.

When comparing the two Point Prevalence Studies, it shows that although the number of patients with catheters has increased slightly, the number of urinary tract infections has decreased. It should be taken into account that these were Point Prevalence Studies (and only carried out in those years within the graphs) and only a snap shot of inpatients on the day of collecting the data.




## Priorities for 2014/2015

The priority for 2014/2015 is the on-going drive to reduce catheter days and thus reduce the risk of urinary tract infections where possible. This could potentially reduce the length of a patient's hospital stay. Patients with urinary tract infections can often require intravenous antibiotics as a line of treatment and other medical conditions can manifest from urinary tract infections increasing the length of stay. We are implementing a tool for staff to document catheter usage and on-going care, thereby ensuring that catheters are inserted and reviewed daily for patients who have a clinical requirement or are admitted into hospital with a long term indwelling catheter.

## Priority 6 - Continue to Reduce the Incidents of Never Events

### Never Events

Never Events are serious, largely preventable Patient Safety Incidents that should not occur if the available preventative measures have been implemented by Health Care Providers. There are 25 Never Events specified in the NHS in England.

A total of four never events were reported recorded by the Trust between April 2013 to March 2014. All four occurred within the Maternity Department:-

1. Retained foreign object post-operation April 2013
2. Retained foreign object post-operation August 2013
3. Retained foreign object post-operation February 2014
4. Retained foreign object post-operation February 2014

The incidents which occurred in April and August 2013 were investigated, reported and managed through the Trust Incident Management and Clinical Governance structures. In addition following the incident in August 2013, the Trust invited a member of the NHS England RCA Academy to advise on the investigation findings. Agreeing to the involvement of NHS England in turn enabled the Trust to contribute to the national deep dive exercise which is currently reviewing effectiveness of investigations within organisations across the NHS. Action plans were developed, with implementation closely monitored by the Clinical Risk Department, reporting through the Patient Safety Committee.

Final reports for the incidents occurring in April and August 2013 have been shared with our Commissioners, the CQC and Monitor. Details of the action plans can be found in the incident investigation reports held in the Clinical Risk Department. The key learning and actions included:

- To improve the format of maternity health records to enable improved record keeping of needle, swab and instrument counts
- To improve training and education for all maternity and obstetric staff across both sites to improve knowledge around swab counting processes
- To improve the governance arrangements for introducing new patient documentation, which should be more robust and subject to scrutiny
- Governance processes in place must be improved to ensure that where discrepancies in assurance exist, for example in the completion of actions from previous serious incidents, that these discrepancies are identified and acted upon. The directorate needs to have systems in place that provide assurance that safety has improved as a result of harm

Following the incidents which occurred in February 2014 the Trust commissioned an external investigator; this investigation is now underway, with final report due in May 2014. An interim improvement plan is in place, monitored by the Directorate and Patient Safety Committee.

**Priorities 2014/2015**

- To monitor and ensure the application of the safety measures put in place in 2013/2014, with regard to the learning from Never Events
- To complete the gap analysis of all safety measures nationally defined to prevent Never Events in order to ensure best practice is in place and promoted

# EFFECTIVE CARE

## Priority 7 - To Meet Patients' Nutritional Needs

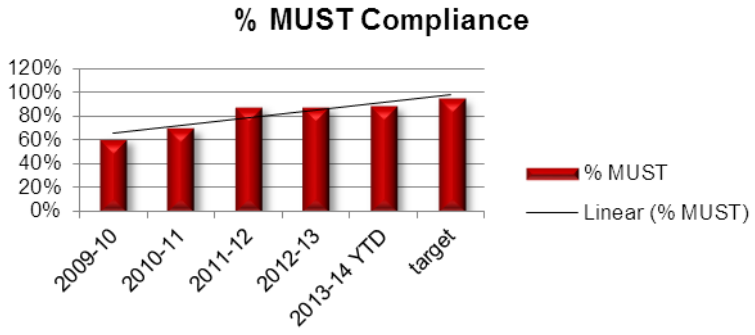
Many of our inpatients are elderly and frail; require assistance with their eating and drinking and consequently are at additional risk of clinical deterioration. 33% of people over 65 years old are malnourished or at risk of malnutrition on admission to hospital. Additional stresses from any acute illness or trauma and the unfamiliarity of their surroundings and foods can further impact adversely on their nutrition and hydration status

Nutritional screening is essential to identify those requiring nutritional support to sustain their nutritional and hydration needs. This includes ensuring appropriate quality and choice of food offered and the meals service itself, such as providing preparation and assistance as required and an appropriate environment.

**Our priorities this year have been to focus on:**

- Improving (or maintaining) compliance with and accuracy of the Malnutrition Universal Screening Tool (MUST), nutrition care plans and documentation of fluid balance (see Graph below)
- Improving in-patients meal-time experience including meals quality, appropriate choice and assistance with meals as required. Any additional capacity required to support this progressing is being pursued.

**Compliance with MUST as measured via crescendo**

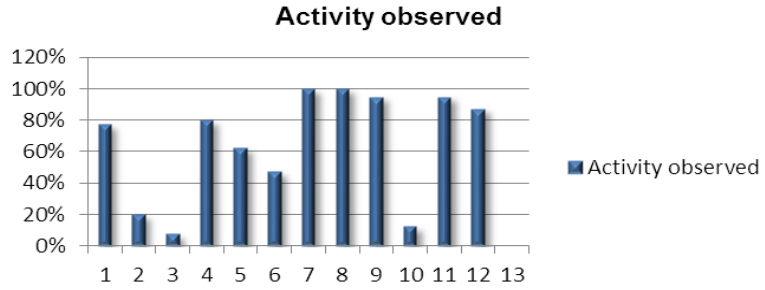



**A summary of some of the progress with the Nutrition and Hydration action plan**

Improving patients' mealtime experience has been a priority this year. The Dietetics team have been working with four wards in particular, as part of a pilot project to improve this and to support the Protected Meal-times Policy, which has now been published.

The meal time observations show 100% compliance (see graph below) with providing assistance to patients with their meals, checking nil by mouth (NBM) status and ensuring no patients are missed.

**Activities observed via meal times observations**




Other areas of good practice but which need to be more consistent include;

- Ordering and serving meals individually (ensures meals are served at the correct temperatures)
- Use of red trays (denotes patients which require assistance with feeding and hydration etc)
- Ensuring patients are given enough time to eat their meals with minimal disturbance

The lowest compliance relates to

- Following the protected mealtime's policy throughout
- The use of the drugs trolley during meal service
- Preparing patients and tables for the meal service
- The number of ward staff supporting the meal service

Feedback from the patient food survey ("diary") undertaken during March 2013 via PALS is being used to review and support menu changes. Particular areas of concern were the lack of choice and quality at supper time (i.e. just soup and sandwich).

- The Dietetics and Catering teams are working together with Carillion to improve meal services and quality of food and extending patient choice for evening meals
- Feedback on meal time observations and soup and sandwich quality improvement have been reported at February Patient Experience Committee
- Good feedback was received regarding the levels of assistance at mealtimes. Also other satisfaction surveys e.g. new Friends and Family Test and Senior Managers walkabouts have provided positive patient feedback and experiences
- The current menu meets existing standards; the dieticians have completed checks to confirm this. A more detailed review and analysis of all the hospital menus is planned for 2014 to meet new guidance which requires provision of meals for those who are nutritionally well (i.e. healthy options) as well those at nutritional risk
- Dieticians have produced a comprehensive check list of all menu items for the GWH ward areas indicating presence of allergens (e.g. gluten) as well as suitability for specific dietary needs such as low potassium or low sodium

In addition a Wiltshire and Swindon wide nutrition screening and care community pathway has been developed and was rolled out from January 2014. The associated care plans have been adapted for each community setting i.e. hospital, care home or patient's own home.

**Hydration**

- All patients at risk of poor hydration have red-lidded jugs
- The Hydrant assessment tool and information for staff and patients has been published
- The mealtimes observations include review of red lids and patients views on drinks as well as meals

**Priorities for 2014/15**

- To secure funding for continuation of GWH based dietetic staffing. If team not funded alternative means of managing at risk patients and progressing actions plan such as auditing meals service and quality will be progressed
- To set up more robust and accurate audit of MUST compliance (quarterly manual audit of compliance and accuracy) as Crescendo audit is purely a count of completion frequently providing an underestimate and incomplete picture as not all areas use this system
- To continue to support wards at meal times including rolling out of meal time observations and triage of dietetic referrals by band 3 dietetic assistant
- To complete a review of GWH menu (dietetics and Carillion alongside appropriate ward areas) to ensure it meets new standards and to improve quality and choice for patients. Its suitability for special diets will also need to be reviewed
- To update integrated Nutrition & Hydration Policy

Progress will be reviewed quarterly by Nutrition & Hydration Steering Group and D&O Directorate Board

## Priority 8 - To Continue to Sustain our Hospital Standardised Mortality Ratio (HSMR) to below 100

The Great Western Hospital considers that this data is as described for the following reasons:

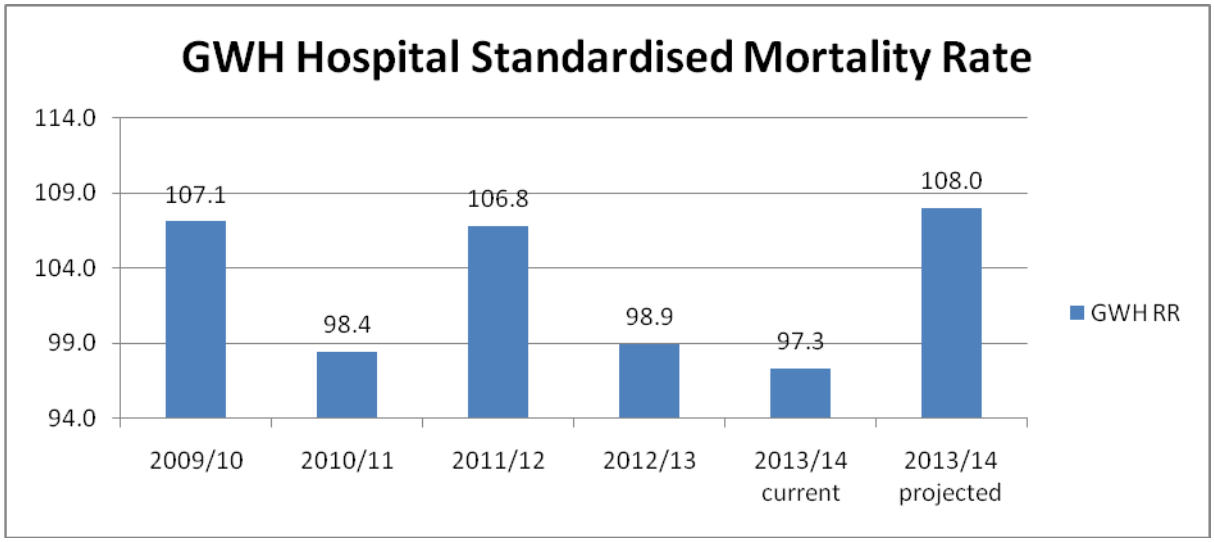
- The data is sourced from Dr Foster and is widely used in the NHS
- The data is refreshed on a monthly basis
- The data is reviewed on a monthly basis by the Trust Mortality Group
- The data is included in the Trust quality and performance dashboards which are reviewed by the Trust Executive Committee and Board as well as relevant CCG Committees
- It is a key indicator of the quality of care we provide

The Hospital Standardised Mortality Rate (HSMR) is an external validated method of calculating and comparing mortality rates. This information is analysed and presented to all Trusts by Dr Foster. Dr Foster is an independent benchmarking organisation specialising in healthcare analysis including mortality rates. HMSR is measured by a Relative Risk (RR) score, which is a ratio derived from the number of deaths in specific groups of patients divided by the risk adjusted expected number of deaths and then multiplied by 100.

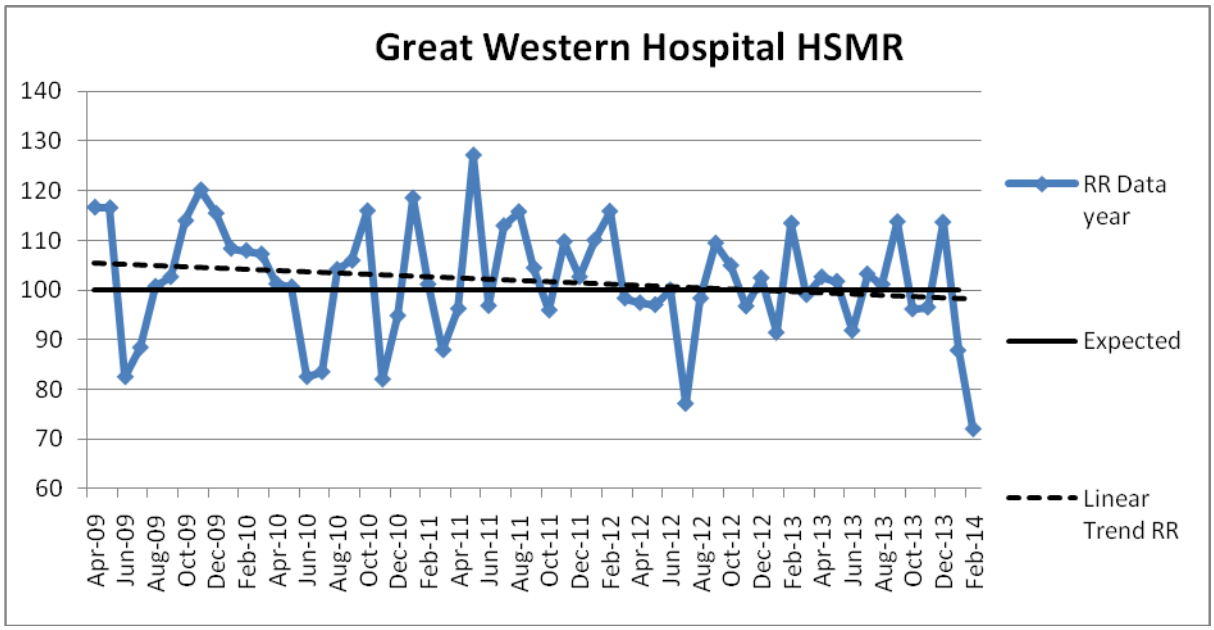
Therefore a local RR figure of 100 indicates that the mortality rate is exactly as expected; whilst a local figure of less than 100 indicates a mortality rate lower (better) than expected. The Care Quality Commission (CQC) uses HSMR values to monitor performance of hospitals and identify areas of practice where improvements in care may be needed.

Each year the risk adjusted element of the RR is rebased (recalculated) by Dr Foster on the expectation that improvements in standards of care and new clinical methods should be reducing the number of hospital deaths on a year on year basis. Therefore for any given financial year the national HSMR Relative Risk will be 100 but when compared to the previous year the RR will appear to be lower. Because of this, Dr Foster normally plots the RR against the risk adjusted element for the year being measured (termed the Data Year).

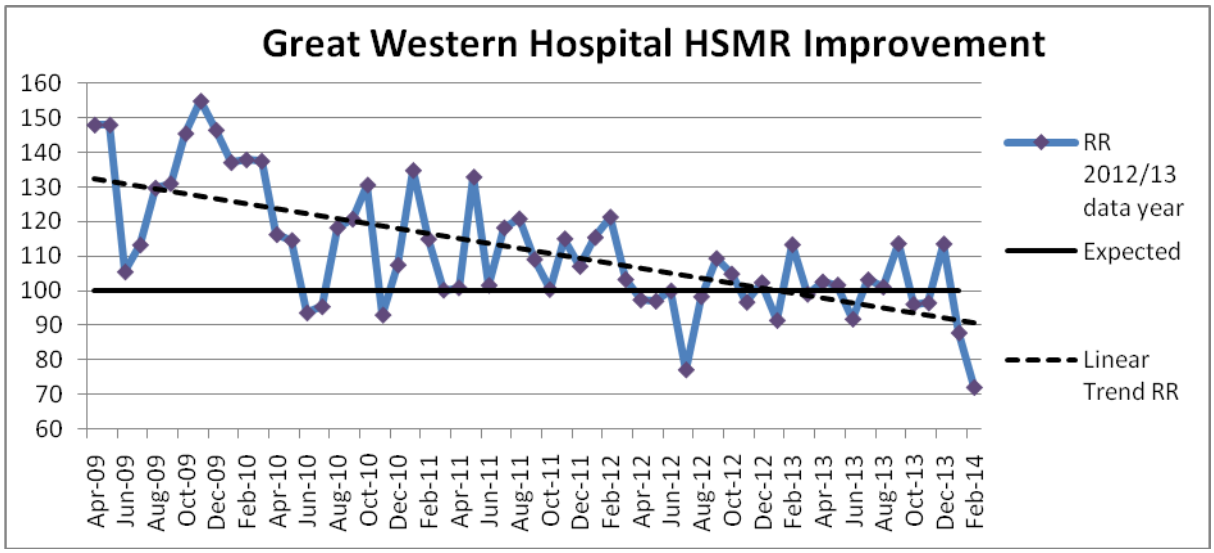
The Graph below shows the year on year HSMR following rebasing which shows a general improvement over time but with a projected outturn in 2013/2014 that is at odds with this improving trend. The current figure of 97.3 for 2013/2014 is prior to rebasing and so is benchmarked against 2012/2013 while the projected figure of 108.0 is Dr Foster's estimate of what the rebased performance will be once the year has ended. (*Note – The Trust is actively reviewing those areas where mortality rates appear high and validating the clinical coding that is used in producing the relative risk figure and this may reduce the projected outturn. In addition the Dr Foster rebase in 2012/2013 was about 6 points and the current 10 point shift is unusually high and is being followed up with Dr Foster)*




The chart below shows the RR monthly trend and is based on the Data Year. It can be seen that the overall trend is downwards yet the actual RR scores for each month are closely set either side of the expected 100 line and variation is reducing.



It is clear from the chart below that by comparing the RR trend for the Trust over the last 5 years using the current base year of 2012/2013 across the whole period that major improvements in the RR score for mortality have been made. That said, because the baseline is being recalculated every year it means that the benchmark is always being lowered (albeit by smaller amounts year on year) so the Trust can never be complacent about the RR performance. This chart tracks HSMR across the Trust's acute and community inpatient activity although the community element is only within the activity from June 2011 onwards.




**CQC Alerts**

The CQC identified two mortality alerts for the Trust in the last year based on figures that suggested there may be an excess of deaths in two different categories. These were deaths due to myocardial infarction (heart attack) and deaths due to pathological fracture (a broken bone where the bone was weak to start with). The Trust therefore investigated both of these alerts by reviewing the care of patients who had died from these conditions. No avoidable deaths were identified in either category.

For patients with heart attacks, it was found that a number of patients had been diagnosed as dying from a heart attack due to an elevated level of a marker of heart disease (troponin) in the blood. When these cases were reviewed by a cardiologist there was generally another explanation for the abnormality in the blood. Changes have been put in place to ensure that raised troponin levels are interpreted correctly.

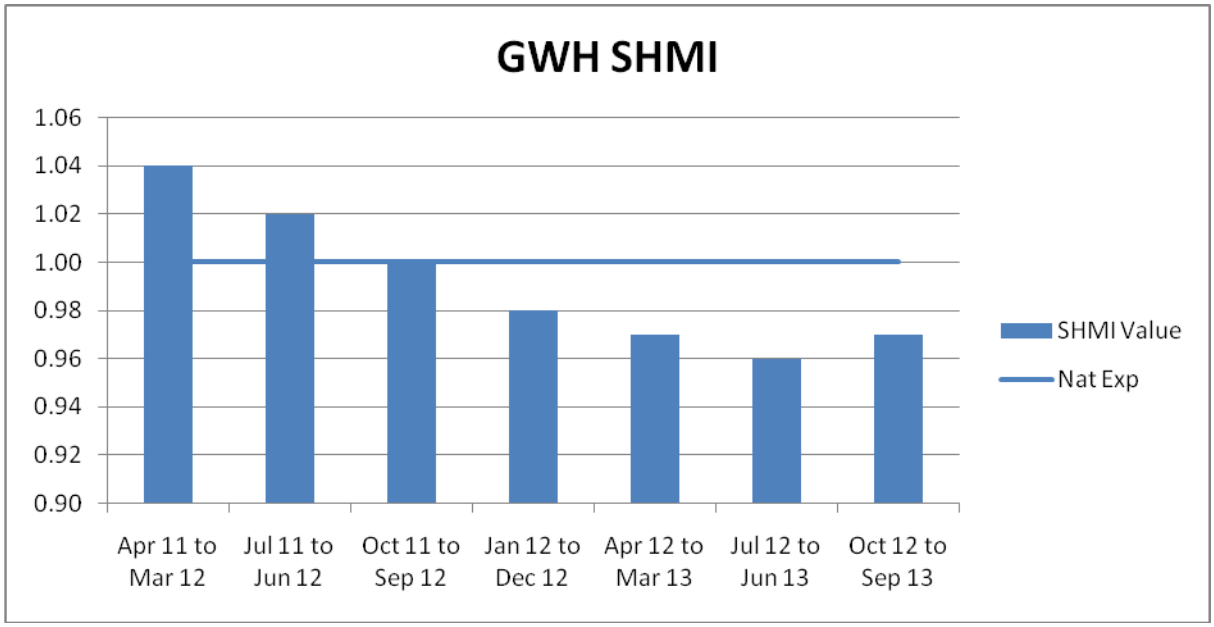
For patients coded as being admitted with a pathological fracture, investigation identified that there had apparently been an increase in the number of cases admitted with this condition. The explanation for this apparent increase was that the coroner had requested that osteoporosis (thinning of the bones) was listed as a factor contributing to hip fractures in elderly patients following falls. These patients should be coded as traumatic fractures for the HSMR calculations but had been allocated to the wrong diagnosis group.

Actions following these investigations have resulted in improvement in the HSMR rates for these diagnoses to lower than expected levels.

**Standardised Hospital Mortality Indicator (SHMI)**

The Trust also monitors its SHMI performance and this is reported to the Trust Mortality Group. The indicator is produced by the Health and Social Care Information Centre. It is similar to HSMR but counts deaths both in hospital and those patients that die within 30 days post discharge from hospital. SHMI is the ratio of observed number of deaths to the expected number of deaths by provider. The trend closely follows the Trust HSMR figures and is published with a longer time lag on a quarterly basis.

The graph below shows the latest published performance for the Trust in rolling year periods. The performance shows an improving trend with the Trust with the rate being below the expected national average rate. Given its similarity to HSMR the SHMI performance is likely to track upwards in the later part of the year




The Great Western Hospital intends to take the following actions to improve this score, and so the quality of its services, by:

- The Trust Mortality Group will continue to review a range of Dr Foster mortality indicators each month and investigates Dr Foster mortality alerts as well as agreeing any other investigations or initiatives prompted by the data and trends
- The Trust has put plans in place to take a more proactive approach to reviewing the care of patients who die. This will give the opportunity to validate coding before it is uploaded to the Dr Foster system
- The Trust also plans to feedback to clinical teams the lessons learned from mortality reviews to ensure that there is continuous improvement in the quality of care delivered to our patients"
- Clinical coders are piloting working more closely with clinicians, including joining ward rounds, to encourage better understanding of the documentation used and codes derived from the information recoded by clinicians

## Priority 9 - To Continue to Improve the Management of the Deteriorating Patient by Full Completion of the Early Warning Score (SOS for Adults and PEWS for Paediatrics)

### Adults Early Warning Score – SOS

Early identification of deteriorating patients, early escalation of care and appropriate intervention is vital to ensure optimal outcomes for both patients and resource deployment within the Trust. Currently the Trust uses the Swindon Outreach Scoring System, a modified early warning scoring system, to help members of the multidisciplinary team to identify deteriorating patients.

In July 2013, The Royal College of Physicians launched a National Early Warning Scoring system (NEWS). While the College is supporting the use of NEWS, there is currently no mandatory requirement for Trusts to change to this system and uptake nationally has been variable, with particular concerns regarding the oversensitivity of the tool. As compliance with the existing Swindon Outreach Score (SOS) system remains consistently over 90%, both within the Great Western Hospital (96%) and within the Wiltshire hospitals (92.5%), the decision has been made to put the Trust wide introduction of NEWS on hold temporarily. The aim will be to evaluate validity and reliability feedback from other Trusts during 2014/2015, particularly in Trusts with a similar catchment of both acute and community areas to ultimately decide if changing from one system to another would be of benefit. NEWS has however been incorporated within the triage tool used by the emergency department and is also being trialled as part of a triage tool by LAMU where a raised level of sensitivity at initial patient assessment and medical prioritisation is deemed appropriate.

A case note review of ten sets of notes has been undertaken during December 2013 and January 2014 by the Critical Care Outreach Nurse Consultant. This audit has shown that the current SOS system is consistently being used across the Trust both before and after an episode of critical illness requiring a patient's admission into Intensive Care/High Dependency.

Until 2013 compliance with the Swindon Outreach Score was monitored through an annual audit of 200 randomly selected observation charts from across the Trust. From April 2013 this audit has been divided into smaller quarterly audits of 50 charts from a cross section of acute ward areas (A), and 50 charts from the community (C). This provides a consistent snapshot of overall compliance with the tools use across the Trust. Quarter 1 (April – June), Quarter 2 (July – September) and Quarter 3 (October – December) data is included in this report. As compliance has remained over 90% current action plans are being maintained in the form of clinical staff training at induction, at annual mandatory training updates and through courses such as the REACT course.

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 (A) | 2014 (C) |
|---|---|---|---|---|---|---|---|---|---|
| **SOS Scoring compliance** | 75% | 80% | 86% | 90% | 93% | 96% | 92% (SOS rolled out to Wilts) | Q1 96%<br>Q2 92%<br>Q3 98% | 92.5%<br>96%<br>95% |

**Priorities for 2014-2015**
GWH will continue to use the SOS scoring system with a view to considering switching to NEWS. Compliance will continue to be monitored using a quarterly audit of observation charts in both acute and community areas.

## Paediatrics Early Warning Scores (PEW)

Children are nursed at The Great Western Hospital in the Children's Unit, Day Surgery Unit (DSU), Shalbourne Suite (Private Patients Unit) and Emergency Department (ED)

The Paediatric Early Warning (PEW) Scoring system has now been in place for several years and the approach to compliance expanded across all areas. The month of January 2014 saw the opening of a Children's area in the Emergency Department – an exciting opportunity to ensure all children will have a PEW from the minute they access the hospital.

During the last 12 months we have adapted our charts and audited the response to include writing age related parameters for each individual child. The tables reflecting this have always been part of the paperwork. They have also been adapted to include space for addressograph labels on all pages since identification of a child required further enhancement. Alongside that the frequency of recording the observations is also written on the chart.

Ensuring actions are also being recorded has also been monitored carefully and an improvement shown reflected in quarterly audit reports.

Year after year we have looked at the way in which we are recognising the stability and also deterioration in children who present to our hospital. Children who are going to become more unwell will, unlike adults, deteriorate rapidly so the PEW scoring must be robust and failsafe and intervention must be immediate if required. During the winter months in particular we see a sharp increase in children requiring high dependency care (HDU) and during the year of 2014 it is the intention to introduce an already adapted Bristol PEW scoring system for babies less than 1 year of age. The intention will be to introduce this for use with older children.

PEW will now start at point of contact in the Emergency Department (ED). This will be completed by a registered nurse with appropriate knowledge and children's experience. The Shalbourne suite (Private Patients Department) has appointed a permanent Paediatric nurse this year to ensure its compliance there. Auditing these areas as well as introducing in DSU is the intention alongside the Children's Unit audits.

**Priorities for 2014/2015**

For the year ahead the focus will be to:

- Elect a PEW working group to raise awareness and ensure priorities are met, including a nurse from Day Surgery Unit (DSU), ED and Shalbourne
- Ensure compliance with quarterly audits and introduce to other areas including ED, DSU, and Shalbourne
- Introduce the Bristol Children's approach to PEW for children up to one year of age
- Continue to complete High Dependency Unit (HDU) national audit on all children that meet the criteria.
- To attend the annual Paediatric Advisory Group to share good practise in all district general hospitals as well as designated children's hospitals

## Priority 10 - To Continue to Enhance the Quality of Life for Patients with Dementia

Progress against the Trust Dementia action plan continues however, the Dementia Strategy Group recognises that the pace of progress seen in the 2012/2013 has been reduced this year. Key achievements have, however, been sustained such as the use of the: 'Forget Me Not' flower on wards and patients notes; the use of 'This is Me' document; basic changes to the environment such as signage and changes of toilet seats and the dementia champions programme. The following actions have been agreed by the Strategy Group and are included in the Trust Strategy Document which was presented to the Patient Experience Committee April 2014.

- Consultant Psychiatrist and Dementia Lead – the new position includes key responsibilities around dementia care. The position has been recruited into by Avon and Wiltshire Mental Health Partnership NHS Trust. The consultant will work closely with the Elderly Care Consultants and Mental Health Liaison nurses, and will join the Trust on 4 May 2014
- A pain assessment tool, that will support staff in assessing pain experience by patients with dementia, has been developed and trialled. The draft policy is being review following comments from the policy and procedure group
- Standard requirements for dementia friendly wards will be developed and included in the Trust Strategy. There is still reserved funding that will meet the needs of basic and essential improvement to the environment
- Dementia training programme is in place. However, Level 1 awareness training is achieved within the Trust induction programme. Level 2 training, that requires more detailed face to face engagement, is not well attended. The main issue is around the release of staff to attend face to face training. The Trust Academy will benchmark training against other Trusts in the South West and implement any new innovations. More emphasis will be placed on training in clinical areas; enhancing the skills of dementia champions and including dementia training on overseas nurses' induction programme and newly qualified nurses' preceptorship courses. Oxford Brookes University has implemented a Dementia module for student nurses. Bespoke training is led by the Mental Health Liaison Nurses and the Dementia Lead
- Dementia champions met in October 2013 to present some innovative ideas that were implemented locally. Some ideas such as a memory corner that have items such as puzzles and old photographs, will be put forward, to be accessible by wards and departments. A case of need is to be submitted to the Charitable Funds. This is included in the new Dementia Strategy

**Priorities for 2014/2015**
The New Dementia Strategy 2014-2016 captures the Trust ambitions for the next 3 years. There is a Strategy implementation timeframe and this will be reported on. The strategy was presented to the Patient Experience Committee in April 2014 and then the Governance Committee

## Priority 11 - Continue to ensure that adherence to Regulations and Standards for Safeguarding for Adults & Children is maintained

### Safeguarding Adults at Risk

- Funding was agreed in early 2013 for a Safeguarding Facilitator's role and a Safeguarding Administrator's role and appointments were made to these positions. There is an interim Safeguarding Adults appointment for GWH community services in Wiltshire. It is envisaged that the substantive position will be advertised in the next 4 to 6 months. These two new safeguarding positions have been recruited into and will help to drive forward all aspects of the Trust ambition to embed a safeguarding culture across the organisation. Interviews for the Community safeguarding facilitator's position were held on 17 April 2014, for which an appointment has been offered
- A Safeguarding Children and Adults Performance Framework has been developed and will be used to provide outcome measures on key areas of focus. The performance framework is in place and agreed by the Governance Committee and a dashboard is in development
- The number of safeguarding referrals made by the Trust has increased significantly compared to the same period 2012/2013. The Trust made a total of 11 referrals between April to September 2012/2013 and 23 referrals during the same period in 2013. The focus this year on raising staff awareness of safeguarding adults, enhanced training for managers and a revised policy would have contributed to the increase in the referrals

**Priorities for 2014/2015**
GWH has teamed up with Gloucestershire NHS Foundation Trust to conduct an on-site peer review of system and processes around learning disabilities and safeguarding. An onsite peer review involving multi-agencies was conducted on 28 March; the reports have not yet been shared.

## Safeguarding Children

The Trust is committed to the well-being of all people using their services and takes the safeguarding of children very seriously. The Trust has a dedicated Safeguarding Children Team provide training, advice and support to all services both in the hospitals and across the community.

The Trust works in partnership with Local Authorities to safeguard children. Each Local Authority has its own Local Safeguarding Children's Board (LSCB) made up of nominated Lead Officers from key organisations and GWH has senior representation on Swindon, Wiltshire and Bath & North East Somerset (B&NES) LSCBs.

The Trust has a statutory duty under Section 11 of the Children's Act 2004 to protect children from harm as part of the wider work of safeguarding and promoting their welfare.

This means working in partnership with other agencies to:

- Protect children
- Identify health and development needs early to ensure the right level of support to safeguard children and young people
- Ensure children grow up in circumstances consistent with provision of safe and effective care
- Processes are in place to learn from events

We aim to fulfil our commitment to safeguarding and promoting the welfare of children by:

- Ensuring there is Senior Management commitment
- Having clear lines of accountability and structures
- Supporting a culture that enables safeguarding issues and promotion of children's welfare to be addressed and ensuring that accurate records are made
- Ensuring staff receive adequate training to safeguard children

**Training**

All staff have a responsibility to safeguard and promote the welfare of children and to fulfil these responsibilities all health staff should have access to appropriate safeguarding training. This training needs to be renewed every 3 years. As at the end of year the training uptake for safeguarding was:

Level 1 – 97.57%
Level 2 – 61.54%

The organisation recognises that the training compliance for Level 2 is not satisfactory, and issues such as data quality and access to training, particularly multiagency training, are currently being reviewed. The Trust has an action plan in place to ensure compliance is improved and the aim is to improve Level 2 up take to 90% in 2014

**Named professionals**
The Trust has named professionals who lead on issues in relation to safeguarding.
The total numbers of professionals are broken down by discipline, as follows:

- 1.0 WTE* named nurse for safeguarding children – community
- 0.4 WTE* named nurse for safeguarding children - acute
- 0.2 WTE* named doctor for safeguarding children
- 1.0 WTE* named midwife for safeguarding children

* Whole Time Equivalent (1 WTE = 1 full time member of staff)

**Assurance framework**

The Trust has a Safeguarding Forum in place which has senior representation from each of the Directorates and reports to Trust Board. This forum oversees safeguarding performance, activity and audit, and sets the safeguarding priorities for the organisation.

Processes are in place to learn from events. This includes the monitoring and investigation of safeguarding incidents and case reviews including multi-agency case reviews as requested by LSCBs. The Trust has contributed to 2 Multiagency Serious Case Reviews in the last year and is implementing the action plan from a third. All actions are currently on target to be achieved.

**Priorities for 2014-2015**

The following priorities have been identified for safeguarding children for 2014-2015:

- Improve staff access to safeguarding children training
- Ensure support and safeguarding supervision is in place for staff that have a particular responsibility to safeguard children
- Ensure a robust audit programme is in place to oversee safeguarding practice and learning

## Priority 12 - To carry out a Review of Patients who are Re-admitted to Hospital within 30 Days of Discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

A readmission to hospital can be a result of less than optimal care provided whilst patients are in hospital and/or less than optimal care provided by supporting services after a patient is discharged home.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services:

Hospital readmissions can be avoided if good local arrangements are in place. In August 2013 a review of emergency readmissions was undertaken in collaboration with our Swindon and Wiltshire commissioners.

The aim of the review was to identify how many patient readmissions were linked to the original in patient care provided and to identify areas for improvement across both acute and community services. This will help to prevent potentially avoidable readmissions in the future.

The review looked in detail at the medical admission notes of a sample of patients originally admitted during May 2013 with a subsequent emergency readmission during June 2013. Patient notes were reviewed using a purposely designed form for the data collection. These notes were reviewed jointly by our lead clinicians and our Swindon and Wiltshire Commissioners. The review was based on thirty sets of patient notes.

Twelve of the patients re-attended via the Emergency Department, seven were referred by an out-of-hours GP, two were ‘planned’ readmissions to a clinical decision unit and two were admitted direct from an out-patient clinic. Twenty-one patients were readmitted from their own home, two from residential care, and one each from a Community Hospital and a Nursing Home.

In the opinion of the reviewing team, 17 (63%) of the patient readmissions were felt to be unavoidable whilst 9 (33%) of re-admissions were felt to be potentially avoidable. Of these, one potentially avoidable re-admission was within the control of GWH; four within the control of Community Services; and four within the control of Primary Care. Actions arising from the review are being progressed within the GWH and one of these specifically relates to the cardiology department appointing an additional locum Consultant to address waiting times.

The report has also been shared with the Commissioners so that key actions can be taken forward to improve the quality of care for patients provided by Primary Care

**30 Day Readmission Comparative Data 2013/2014**

| | Apr 13 | May 13 | June 13 | July 13 | Aug 13 | Sept 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | March 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Re-admission within 30 days of discharge | 8.4% | 8.5% | 8.1% | 7.6% | 8.5% | 8.0% | 7.5% | 7.5% | 7.9% | 7.7% | 7.4% | 7.6% |

## 28 Day Re-admissions

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, see above Priority 12 – 30 day Re-admissions.

The data made available to the NHS Foundation Trust by the Health & Social Care information Centre with regard to:

The percentage of patients aged
(i) 0-15 and
(ii) 16 or over re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reported period.

These figures are based on the crude emergency re-admissions within 28 days of the original date of discharge. These figures are considered to be crude as they take no account of either the original discharge speciality (or condition, diagnosis and procedures) nor the reason (or specialty and diagnoses) for readmission. The age is calculated from the date of the original discharge.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services: See commentary under Priority 12 for 30 Day Re-admissions (immediately above).

### Monthly 28 Day Re-Admissions by Age Band - April 2012 to March 2014

These figures are based on the crude emergency re-admissions within 28 days of the original date of discharge. These figures are considered to be crude as they take no account of either the original discharge specialty (or condition, diagnoses & procedures) nor the reason (or specialty & diagnoses) for re-admission. The age is calculated from the date of the original discharge

| Month of Original Discharge | Total Spells | | | Crude Re-Admission Numbers | | | Crude Re-Admissions Percentage | | |
|---|---|---|---|---|---|---|---|---|---|
| | 0-15yrs | 16yrs+ | Total | 0-15yrs | 16yrs+ | Total | 0-15yrs | 16yrs+ | Total |
| Apr 12 | 783 | 4884 | 5667 | 63 | 390 | 453 | 8.0% | 8.0% | 8.0% |
| May 12 | 888 | 5759 | 6647 | 89 | 478 | 567 | 10.0% | 8.3% | 8.5% |
| Jun 12 | 749 | 5058 | 5807 | 49 | 403 | 452 | 6.5% | 8.0% | 7.8% |
| Jul 12 | 873 | 5474 | 6347 | 60 | 444 | 504 | 6.9% | 8.1% | 7.9% |
| Aug 12 | 721 | 5361 | 6082 | 59 | 404 | 463 | 8.2% | 7.5% | 7.6% |
| Sep 12 | 778 | 5000 | 5778 | 61 | 354 | 415 | 7.8% | 7.1% | 7.2% |
| Oct 12 | 796 | 5659 | 6455 | 66 | 403 | 469 | 8.3% | 7.1% | 7.3% |
| Nov 12 | 718 | 5442 | 6160 | 53 | 457 | 510 | 7.4% | 8.4% | 8.3% |
| Dec 12 | 713 | 4886 | 5599 | 61 | 423 | 484 | 8.6% | 8.7% | 8.6% |
| Jan 13 | 737 | 5192 | 5929 | 78 | 342 | 420 | 10.6% | 6.6% | 7.1% |
| Feb 13 | 607 | 5084 | 5691 | 55 | 378 | 433 | 9.1% | 7.4% | 7.6% |
| Mar 13 | 731 | 5318 | 6049 | 83 | 428 | 511 | 11.4% | 8.0% | 8.4% |
| **Year 2012/13** | **9094** | **63117** | **72211** | **777** | **4904** | **5681** | **8.5%** | **7.8%** | **7.9%** |
| Apr 13 | 749 | 5443 | 6192 | 64 | 434 | 498 | 8.5% | 8.0% | 8.0% |
| May 13 | 664 | 5515 | 6179 | 56 | 449 | 505 | 8.4% | 8.1% | 8.2% |
| Jun 13 | 668 | 5326 | 5994 | 49 | 416 | 465 | 7.3% | 7.8% | 7.8% |
| Jul 13 | 719 | 5802 | 6521 | 45 | 434 | 479 | 6.3% | 7.5% | 7.3% |
| Aug 13 | 691 | 5515 | 6206 | 57 | 455 | 512 | 8.2% | 8.3% | 8.3% |
| Sep 13 | 792 | 5471 | 6263 | 68 | 425 | 493 | 8.6% | 7.8% | 7.9% |
| Oct 13 | 811 | 6085 | 6896 | 62 | 444 | 506 | 7.6% | 7.3% | 7.3% |
| Nov 13 | 699 | 5722 | 6421 | 66 | 423 | 489 | 9.4% | 7.4% | 7.6% |
| Dec 13 | 763 | 5488 | 6251 | 78 | 389 | 467 | 10.2% | 7.1% | 7.5% |
| Jan 14 | 706 | 6042 | 6748 | 81 | 428 | 509 | 11.5% | 7.1% | 7.5% |
| Feb 14 | 653 | 5214 | 5867 | 90 | 333 | 423 | 13.8% | 6.4% | 7.2% |
| Mar 14 | 711 | 5593 | 6304 | 77 | 388 | 465 | 10.8% | 6.9% | 7.4% |
| **Year 2013/14** | **8626** | **67216** | **75842** | **793** | **5018** | **5811** | **9.2%** | **7.5%** | **7.7%** |

## Priority 13 - To Continue to Improve on Stroke Care

The National Stroke Strategy was published in 2007, outlining best practice standards for stroke care in hospitals and the community for rehabilitation.

A specialist stroke unit was established on Falcon Ward at The Great Western Hospital in 2009 with stroke specialist nurses [GWH] and therapists [provided by SEQOL]. Partnership working with commissioners and other service providers was established to develop pathways of care for these patients and their carers'.

Performance has been monitored though national audits and now GWH has a new extensive Sentinal Stroke National Audit Programme [SSNAP] audit tool to capture acute in-patient care and elements of community care. GWH has a dedicated Stroke Information Manager who is responsible for capturing, analysing and reporting very detailed data for every patient admitted with stroke/out-patient Transient Ischemic Attack (TIA [mini strokes where the symptoms come and go]) and this is reported nationally.

We recruited a Stroke Specialist Consultant in August 2013 and a Project Manager to manage the Stroke Improvement Programme at GWH.

These two new posts have created a new focus on stroke care and the detailed audit we are required to perform and submit to SSNAP, which in turn enables us to monitor very closely each patient's pathway from coming into hospital, to discharge or transfer for further rehabilitation and to identify where improvements are needed.

The number of stroke patients presenting here are slowly increasing by an average of 3 patients per month from April 2011; the range of admitted patients is 30-51 patients per month. TIAs are increasing very slightly over the same period; if these are well treated, the number of strokes can be expected to reduce in time.

New working parties to support this improvement work have been set up by The Project Manager and the GWH Stroke Improvement Group meets monthly to drive forward clinical pathway improvements. From September 2013, The Stroke Strategy Improvement Group was established to meet with CCGs and other providers along the stroke pathway and meets every 2-4 months according to need.

**Joint Health and Social Care Plan**

The Stroke Strategy requires us to develop a document that will provide a clear joint care plan – from the patient's perspective including health and social care needs and 85% of patients should have a copy of this on discharge. This plan will involve the patient and their family and respond to the individual's particular circumstances and aspirations and will include working together with other services such as transport and housing as needed. The care plan belongs to the patient and will accompany them to rehabilitation or home on discharge from hospital and can be used by rehabilitation services too. This document is used by all healthcare professionals and can be used in the community too. The care plan was launched here in December 2013 and was reviewed in April 2014 with healthcare professionals and patients and carers. Feedback is very positive from patients, carers and professionals.

**Service evaluation from stroke survivors and carers**

Consultation events took place 2008 – 2010 run by NHS Swindon incorporating the whole pathway of care and these helped to shape local developments in stroke care. Previously there was a dedicated Stroke Carers lead post appointed with NHS Swindon funding through the Swindon Carers Centre with National funding as a pilot and whilst highly successful, funding was not able to continue this beyond 2011. We need to ensure that Carers of Stroke survivors are well supported because they play such a crucial role in supporting people at home after a stroke.

A consultation event for patients and carers took place in February 2014 to evaluate their experiences specifically around their acute hospital admission to GWH and gather these and plan improvements as required. External and Internal stake holders helped to facilitate group discussions and reflections of the patient's experience. The event was opened by the Chief Executive demonstrating the value placed on this consultation.

Generally the feedback was very good especially about the nursing care on Falcon Ward

- "They offered help rather than waiting to be asked"
- The carers and family members felt immediately well cared for on Falcon
- " Everything was well explained to me"

- “The nursing team were just excellent!” “Such a helpful team of nurses!” “The nurses were very good at explaining what was going on but I couldn’t always remember the detail”
- The new joint care plan was very well evaluated and people wished they had had this information on their admission – no suggested changes were identified
- Some good examples of doctors and nurses phoning relatives at home to update them on care and diagnosis which made them feel well-informed and updated on what was happening

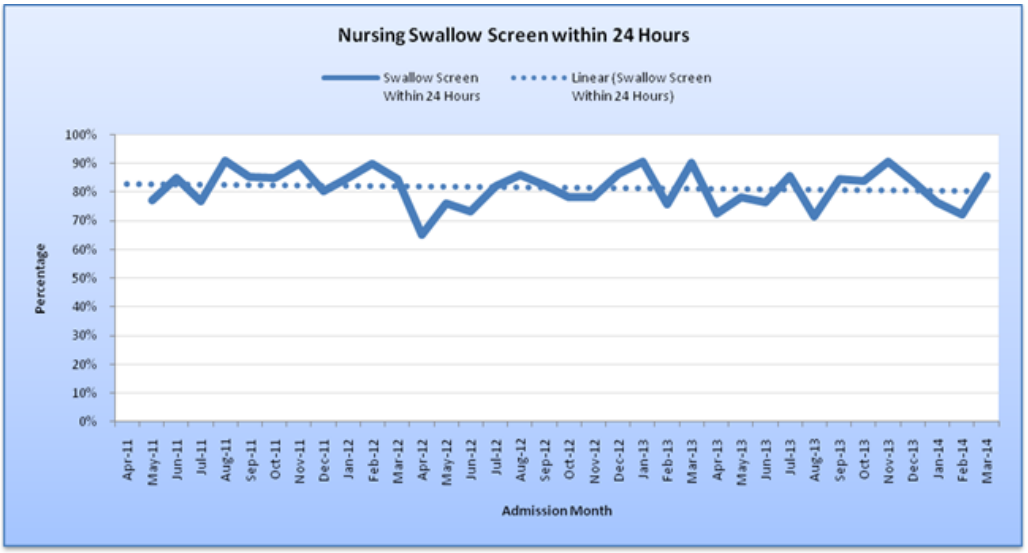
Feedback for action:

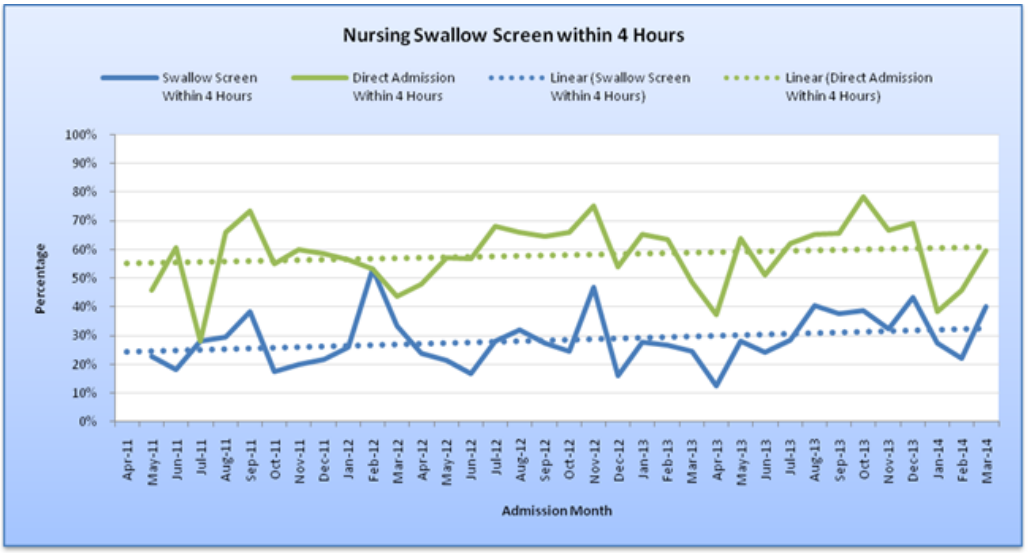
- Weekends felt very quiet and all patients would have liked more therapy at weekends
- Advice needed on managing fatigue for patients and carers
- The carers needed to know as much as the patient, to help support the patient in hospital and at home – very often the person who has had the stroke cannot retain information
- The role of carers – all agreed they did not know what to expect until they got home and more support for them was needed. They said that an event like this to meet other carers was really helpful – just to talk to other carers and get more information from professionals. Discharge from Falcon happens usually in 7-10 days and having someone with a stroke home so soon was scary for most carers and many felt “just left to get on with it”, without enough knowledge and experience in what was expected of them
- The role of the community stroke co-ordinator needs to be introduced to each patient/carer so they know about this role and the community support available and that they can make contact directly
- Noise and environment for recovery - “The ward was noisy after 10pm at night and this added to my exhaustion!” “Patients with dementia should not be on the same ward – too disruptive and took a lot of nursing time which meant I had to wait too long for care” “staff need to tell people to turn off their mobile phones!”
- The Ward Sister and Ward Manager and Matron need to be better identified and these staff need to introduce themselves to patients and their families – this will help with seeking information and knowing who is in charge and helping families better prepare for discharge
- “The 6 week follow-up hospital appointment should be used to better connect with patient and carers needs – just a medical review”

The Ward Manager and Matron will be responsible for making changes to improve care based on this feedback. An action plan for this will be taken to the Stroke Improvement Group in April 2014. The Project Manager will explore options of better care for carers with our partner organisations in the community and commissioners. It was agreed by patients and carers that a consultation event like this should be an annual event.

**Swallow- Screening in 4 and 24 hours**

This is to ensure that if patients cannot swallow as a result of their stroke that they are promptly well hydrated with nasogastric or intravenous fluids. We do well in the 24 hour assessments (graph immediately below), but less well in the assessment required within 4 hours of admission (second graph below). This is an indicator from the National Institute for Clinical Excellence (NICE) Quality Standards which is included as a SSNAP key indicator. The national performance for assessment in 4 hours is 60% and GWH to date is 30%.






The graph above also demonstrates that performance improves when patients are admitted *directly* to Falcon Ward. Improvement is noted from February 2014.

In October 2013, designated A&E nurses attended a specifically commissioned training session to increase the numbers of staff able to assess patients and the stroke registrar is also now trained. They now attend people with suspected stroke in ED and so this will increase the ability to assess patients in ED. Additionally there is a big drive to move people with suspected or diagnosed stroke directly to Falcon Ward and all the registered nurses there can assess for swallowing and there is a bleep system in place so that stroke specialist clinicians go down into ED to assess people for stroke including swallowing assessments. The Project Manager and Clinician will review case by case to ensure that those responsible for providing this assessment are challenged about needing to provide this service and in turn this can be expected to improve the percentage of assessments. There will be some patients where if anxiety is present, or there are other underlying conditions, that a swallow assessment is not immediately appropriate within the 4hours and proceeding with the test could provide a false negative. These cases will now be well documented in the notes and captured in the audit.

However, swallow assessments in 24hrs is consistently high so we know that all patients do have an assessment within 24hrs. This is best delivered when the patient is on Falcon ward by those most experienced in this assessment.

**Provision of 7-day therapy – introducing physiotherapy at weekends**

Specialist stroke therapy is provided by SEQOL for stroke specialist therapists for physiotherapy, occupational therapy and speech and language therapy in normal working hours. Patients must be seen in 72hrs following admission by all therapists and we achieve this for 90 – 100%% of patients.

NICE Quality Statement recommends patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it. The availability of therapy needs to increase to improve this aspect of patients care.

This standard is complex, as many patients simply cannot manage this level of input in the early days following their stroke and others with less severe strokes may not require this level of therapy. Clearly some patients will benefit from this level of input too which is why it has been recommended.

The therapy team works closely with their community colleagues to aid continuity of care and develop care plans to restore as much function as is possible.

A pilot of a Saturday morning therapy service was provided by SEQOL therapists from February to May 2014 on Falcon Ward. This pilot was evaluated looking at outcomes and the service from a patient, carer, therapy and medical and nursing perspective. The Health Psychology Team from Bath University assisted us with this through staff and patient interviews and their report will be included in the evaluation. This work is part of a Masters Level dissertation. This study was funded through ward charitable funds and will be used to inform a business case for a weekend model of therapy.

**Priorities for 2014/2015**

The swallow assessment in 4 hours needs to improve and this will be audited and actions planned accordingly.

We need to secure funding to enable additional weekend therapy and review weekday therapy against the 45 minutes/day standard and the cost of better achieving this. Additionally, a business case has been developed by the project manager to provide stroke specialist stroke consultant weekend ward rounds to ensure better stroke specialist care at weekends for new admissions. This links to the Trust's 7-day working plan.

To further support improvement with the above Stroke Quality Indicators we will also be looking to improve our performance of the 80/90% target [80% of patients spending 90% of their time on the acute stroke unit] through promoting direct admissions to Falcon, the Acute Stroke Unit. This is because we know that this has a positive effect on all aspects of stroke care.

## Priority 14 - Continue to Monitor and Maintain NICE Compliance

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve outcomes for people using the NHS and other public health and social care services. They are accountable to the Department of Health, but operationally they are independent of government.

Their guidance and other recommendations are made by independent committees which provide health and social care professionals with reliable information for clinical and cost effective treatments to raise standards of health and social care. Health care organisations are expected to follow NICE guidance for services and treatments they provide.

Internal monitoring of NICE guidance at The Great Western Hospital NHS Foundation Trust commenced in September 2007 and compliance is based on the initial assessment of all NICE guidance published thereafter. We have a robust internal compliance assessment process which is informed by Senior Clinicians and checked within each directorate prior to advising the Patient Safety & Quality Committee (PSQC) and our Commissioners on compliance. Where exceptions occur, these inform our Commissioners and agreement on funding is sought or exceptions agreed based on risk analysis.

To strengthen our current systems, a new purposely dedicated NICE database was created and implemented at the start of April 2013. This was designed specifically to capture comprehensive information relating to all NICE related activity for each Directorate within the organisation and to enable more robust monitoring. Furthermore, the new system means we are able to produce enhanced reports tailored to specific requirements for the Directorates, the organisation and local commissioners.

Areas of exceptions or non-compliance identified continue to be escalated in the first instance to the relevant directorate, and subsequently to the monthly Patient Safety Committee. For additional assurances, action plans and risk assessments are required to be completed and thereafter registered onto the directorate risk register.

All NICE related activity continues to be regularly monitored in accordance with the Trust policy

**Priorities for 2014/2015**

One of the priorities for next year is to review the process for assessing compliance with NICE and the reliability of data.

## Priority 15 & 16 – Improving Patient Experience & Reducing Complaints

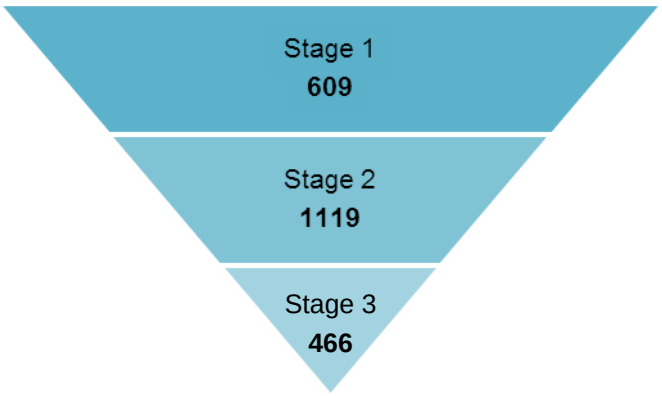
Improving 'Patient Experience' and customer satisfaction is a key priority for the Trust. We want our customers, patients and all stakeholders to become advocates for the Trust and the services we offer.

Over the last year we have developed a more rounded way of understanding what our patients think of our service. We are now operating the Friends and Family test in all major Trust areas. We have been working hard on developing a new complaints system, in consultation with patients, and have used feedback from patients to change and develop services.

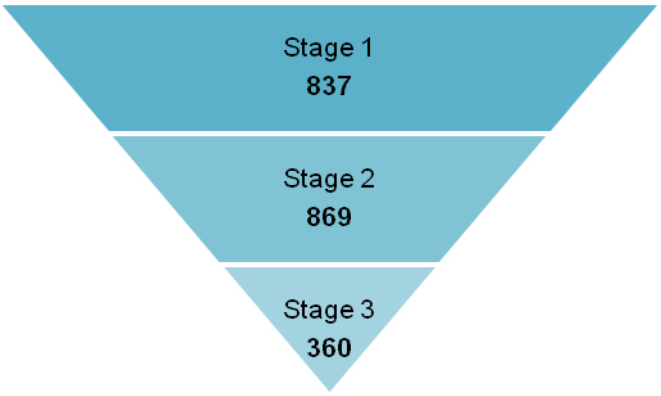
In last year's Quality Account, we set out that we wanted to reduce complaints, and specifically return to a position of fewer complaints progressing through the complaints process with better early resolution.

We have nearly achieved this aim, closing the year in a much stronger position. The graphics below show the change of position from 2012/2013 and 2013/2014 for the makeup of complaints within the complaints process.

**Complaints Received in 2012/2013**




**Complaints Received in 2013/2014**




Further changes include:

- redesigning the complaints process
- removing unnecessary administration
- improving response times
- empowering and supporting staff to resolve issues at ward departmental level.

We have now consulted with major stakeholders and have redesigned the complaints process. The new process, which was implemented on 1 April 2014, simplifies the process for customers and staff. Based on actions rather than paperwork, it strips out unnecessary administration and improves experience.

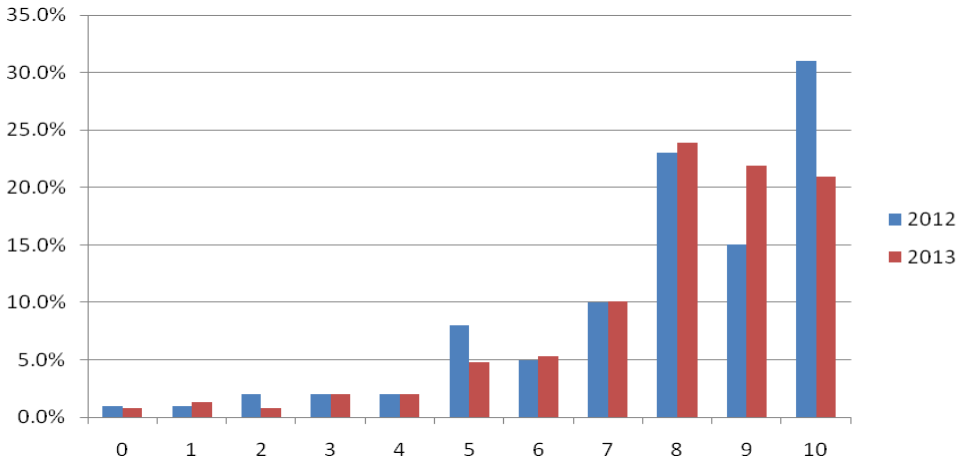
We have also tendered for a new casework and feedback management system to manage customer feedback. For many years a 'risk management' system was used that did not address the 'experiences' of our patients. The new system will enable us to engage much more effectively and dramatically improve patient experience as well as improving administration and staff empowerment.

During the year we have also recruited a new 'Training and Projects Lead' within the Customer Service Team, demonstrating our commitment to learning from what our customers are telling us.

**National Inpatient Survey**

The National Inpatient Survey was carried out in quarter three of 2013 by the Picker Institute. The chart below shows the year on year comparison of how those who took part in the survey rated the quality of the care they received.

**Chart - National Inpatient Survey, question H2**
**Please rate your experience on a scale of 0 - 10**




The chart above shows that, overall, patients have continued to rate their experiences highly.

Other highlights from the survey in the table below, show that in most cases, the Trust has either improved or is continuing to strive to improve performance to meet or exceed its aims.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons because it is a reliable, externally validated measure reflecting the experience of our patients, it is objective and provides and annual snapshot and tells us how we are doing from our patients perspectives and where we have improved and where we need to focus further improvements

| Question | Target | 2012/13 % | 2013/14 % |
|---|---|---|---|
| Were you involved as much as you wanted to be in decisions about your care and treatment? | **GWH** GWH target 52% or more responding 'Yes, definitely' | **51** | **53.2** |
| Did you find someone on the hospital staff to talk to about your worries and fears? | **GWH** GWH target 43% or more responding 'Yes, definitely' | **37** | **37.1** |
| Were you given enough privacy when discussing your condition or treatment? | **GWH** GWH target 73% or more responding 'Yes, definitely' | **73** | **70.8** |
| Did a member of staff tell you about medication side effects to watch for when you went home? | **GWH** GHW target 40% or more responding 'Yes, completely' | **30** | **33.7** |
| Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital? | **GWH** GWH target 63% or more responding 'Yes' | **67** | **67.2** |

**Friends and Family Test**

As in other Trusts, the Friends and Family test has been implemented in most areas including:

- Inpatients
- Community Inpatients
- Outpatients
- MIUs
- A&E
- Day Services
- Maternity

The 'test' should be given to every patient in each group of patients, and asks one mandated question; 'how likely are you to recommend the ward/service/clinic to a friend or family member'. We also provide a free text box to understand why a response was selected, as well as asking other related questions.

Responses are measured are nationally as a 'Net Promoter Score' which must be reported publicly. The Net Promoter Score (NPS) is a metric that is mainly used in the private sector to gauge the loyalty of a business' customers and relationships.

Hospital Trusts can achieve an overall Friends and Family Test score between minus (-)100 and plus (+) 100. A NPS of above +70 is considered a good score and is in-line with other Trusts.

- Our Trust's Friends and Family Test score for April 2014 was +76. This was based on 2009 responses.
- This equates to our Trust scoring 4.78 out of 5 stars (Friends & Family rating system) for April

This information is available on the GWH website and is updated monthly with the previous months NPS and Trust Scoring.

**GWH Trust-wide Net Promoter Score:**

| Month | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NPS | +77 | +78 | +77 | +74 | +72 | +72 | +75 | +73 | +77 | +75 | +76 | +74 |
| Responses | 699 | 1019 | 1739 | 1154 | 1043 | 3764 | 3190 | 2810 | 2534 | 2288 | 2440 | 2172 |

**Priorities for 2014/2015**

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, as follows:

Over the next year, we intend to make our ability to capture and use all kinds of feedback as easy as possible. Using technology, we will reduce jargon, simplify process and help the Trust to deliver a service customer really wants. We will provide better information and make our service as accessible as possible.

During 2014/2015 we will also:

- Implement a new feedback system
- Improve the quality of customer feedback information we hold
- Develop a new Patient Information policy
- Improve the quality of the information we produce
- Improve the Friends and Family NPS
- Develop a robust Trust wide action plan to address the areas within the Picker Survey report, where improvements are required

## Priority 17 - Ensure that Equality & Diversity is fully established within the organisation

Great Western Hospitals' vision for 2014-2017 is: "it wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt"

Our objectives to ensure established Equality and Diversity are; better health outcomes for all; improved patient access and experience; empowered, engaged and included staff; inclusive leadership at all levels:

We aim to provide this by eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act; advance equality of opportunity between people who share a protected characteristic and people who do not share a protected characteristic; foster good relations between people who share a relevant protected characteristic and those who do not share a protected characteristic:

- Age
- Disability
- Gender Re-assignment
- Marriage and Civil partnership
- Pregnancy and Maternity
- Race including nationality and ethnicity
- Religion or Belief
- Sex
- Sexual orientation

The Trust has an active Equality and Diversity (E & D) Working Group with Health Care representatives from across the Trust. The purpose of the group is to develop an awareness of Equality & Diversity considerations, which have the potential to improve outcomes to eliminate discrimination, advance equality of opportunity and foster good relationships. To enhance this we have developed a series of significant actions to deliver specific objectives over the next 12months, which are all incorporated into an action plan and monitored and tracked accordingly. A selection of the high level actions are:

- E&D Directorate Champions – Members of E&D working group to be a “champion” within their directorate for advice on E&D protected characteristics and E&D considerations
- Trust Board knowledge – Board training session to be hosted and Executive leadership knowledge; provide training at an Executive Away Day on protected characteristics and E&D responsibilities
- To review and update the Equality Diversity data set for patients and staff
- To link Equality Diversity Champions within Directorates to Trust Quality Champions
- Directorate training - Training sessions for directorates as part of directorate meeting (annual ½ hour session)
- Matron training – Training tool to be developed to include hard hitting examples related to Trust experience with view to matrons feeding this into wards.
- Include E & D assessment within the Senior Nurse Ward Inspection Tool and the Trust Executive Safety Walkabout
- Patients - Develop appropriate messaging tools to explain E&D / intolerance of inappropriate behaviour towards staff and others with protected characteristics
- Linking E&D into staff appraisals in the same way as the Trust Service, Team, Ambition and Respect (STAR) values
- Review of the current Trust Equality Impact Assessment and check that it is fit for purpose and embed within business planning process
- Incidents & Complaints – Process to ensure any incidents or complaints relating to E&D are identified. This will ensure Trust addresses any feedback / listens to its staff and will increase Trust knowledge
- Networking Groups – Establish groups with specialist focus to provide advice/views of these considerations to assist decision making / awareness and to maintain momentum in addressing these

The Priority for 2014/2015 is to continue to build on the work taking place during 2013/2014

## Clinical Incidents- Serious Incidents and Incident Reporting

The Great Western Hospital considers that this data is as described for the following reasons:

- To drive forward quality improvement through incident investigations and shared learning
- The Trust’s Incident Management Policy complies with the requirements of the National framework for reporting and learning from serious incidents requiring investigation March 2010 and the NHS England Serious Incident Framework March 2013
- Compliance with the Trust Incident Management Policy is audited with a resulting improvement plan biannually
- All incidents reported are reviewed on a daily basis by the Clinical Risk and Health and Safety Departments
- All patient safety incidents reported within the Trust are submitted to the National Reporting and Learning System, reporting performance is evaluated against other medium acute Trusts within the cluster group biannually following the publication of the NRLS Organisational reports

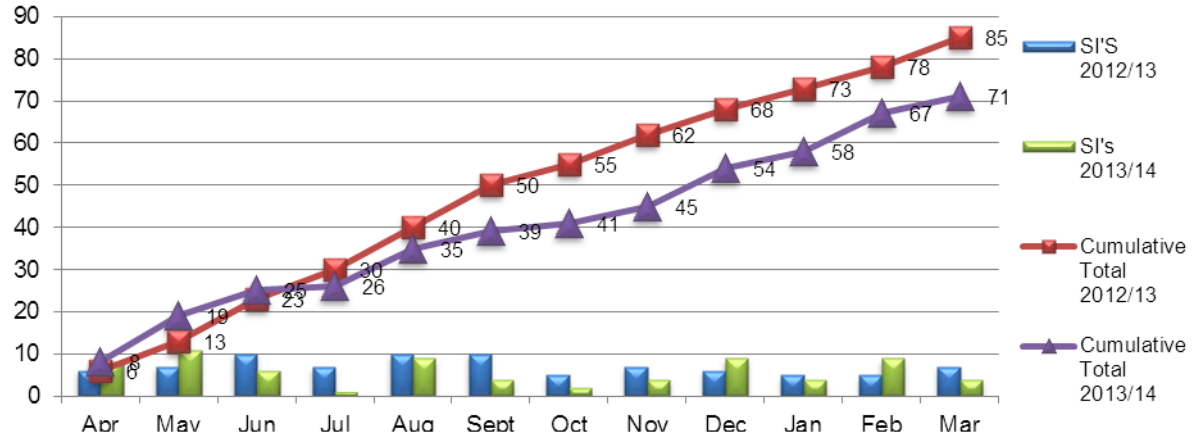
### Serious Incident Reporting

The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation was published by the NPSA in March 2010. The framework provided a consistent approach to reporting and management of Serious Incidents, and a clear definition for serious harm. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

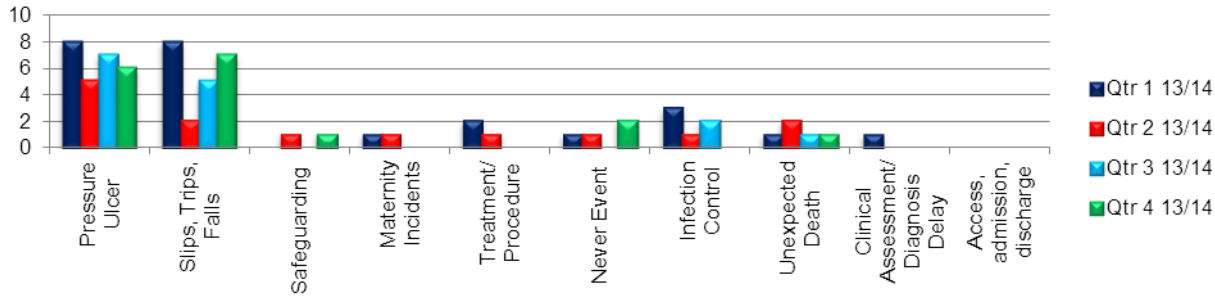
- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);
- A scenario that prevents or threatens to prevent a provider organisation’s ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of ‘Never Events’

A total number of 71 serious incidents were reported and investigated during the period April 2013 to March 2014; a reduction of 14 from 2012/2013.

**Serious Incidents reported 2012/2013 and 2013/2014**




**Serious Incidents by type per Quarter 2013/2014**

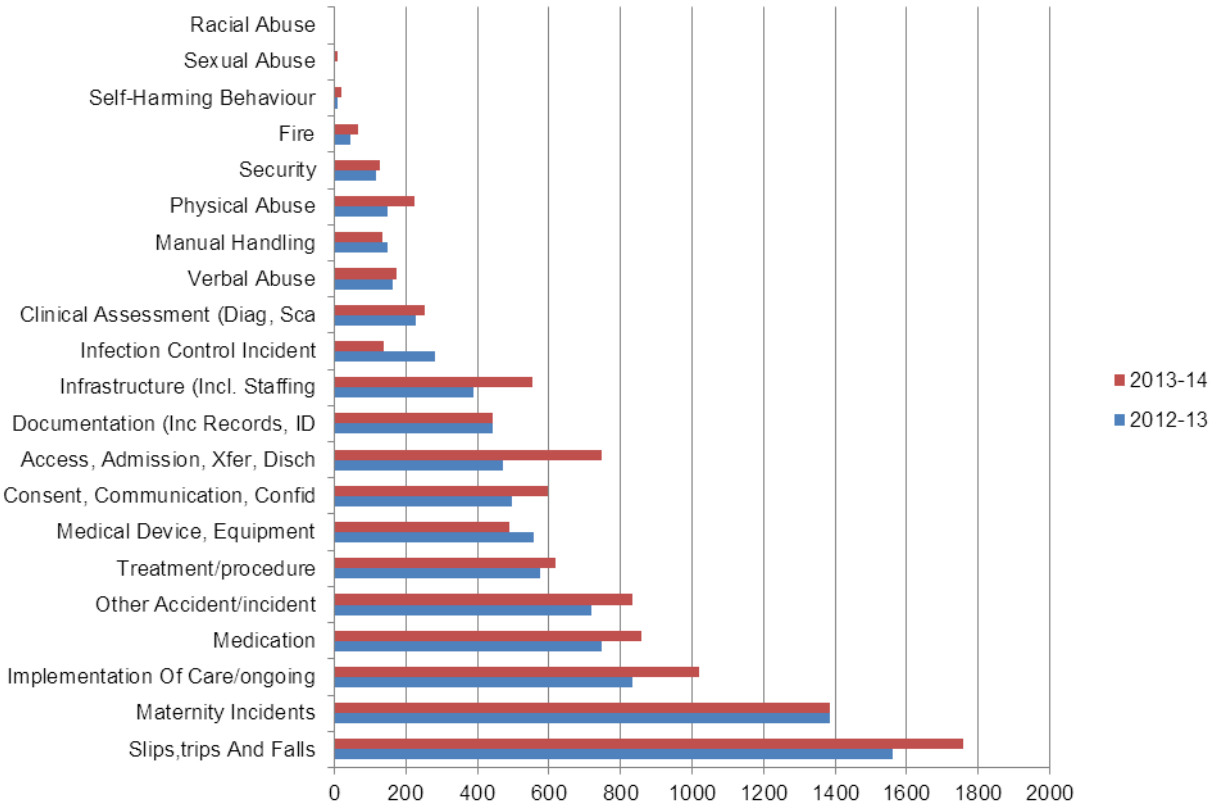



## Incident Reporting

The Trust uploads all reported patient safety incident forms to the National Reporting and Learning System (NRLS) on a weekly basis. The National Reporting and Learning System release an Organisational Patient Safety Incident report twice a year, providing organisational and comparative incident data. The report for the period 1 Apr 2013 to 30 Sept 2013 has been postponed from the March 2014 publication date, due to the NRLS transferring to NHS England. This report is now expected to be published at the end of April 2014.

**What types of incidents are reported in our organisation?**

| | Non clinical incidents/Health and Safety | Patient Safety Incidents reported to NRLS |
|---|---|---|
| 2011/2012 | 8991 | 6507 |
| 2012/2013 | 9320 | 6920 |
| 2013/2014 | 10452 | 6741 |




**Patient safety incidents by degree of harm April 2013 to October 2013 (national comparative data not yet released)**

| Year | 2-None (No Harm Occurred) | 3-Low (Min. Harm) | 4-Moderate (Short Term Harm) | 5-Severe (Permanent Or Long Term Harm) | 6-Death (Caused By The PSI) | Grand Total |
|---|---|---|---|---|---|---|
| Apr 12 - Sept 12 | 2145 (66%) | 800 (25%) | 275 (8%) | 18 (0.5%) | 5 (0.2%) | 3243 |
| Oct 12 - Mar 13 | 2303 (63%) | 1080 (29%) | 275 (7.5%) | 18 (0.5%) | 1 (0.02%) | 3677 |
| Apr 13 - Sept 13 | 2237 (64%) | 1028 (29%) | 216 (6%) | 18 (0.5%) | 4 (0.1%) | 3503 |
| Oct 13 - Mar 14 | 1980 (61%) | 958 (30%) | 283 (9%) | 10 (0.3%) | 7 (0.2%) | 3238 |

The chart above shows the degree of harm following all patient safety incidents. National data is not yet available to benchmark against for the second twelve months of the year (see previous two charts).

## Priorities for 2013/2014

The Great Western Hospital has taken the following actions to improve patient safety, and so the quality of its services, by:

1 **Our Aim:** Improve compliance with the Incident Management Policy and evidence of sustainable changes as a result of serious incident investigations.

**Our Actions:** We have introduced a number of improvements during 2013/2014:-

- Introduced a 6 monthly audit cycle to assess compliance with the Incident Management Policy
- Serious Incident reporting checklists to ensure all reporting requirements are completed by the Clinical Risk Team within timeframe
- Serious Incident Panel process, the function and role of which is continuing to be developed
- Amended the Serious Incident Monitoring Table to document date of knowledge of an incident within the organisation

- The Clinical Risk team monitor that department level investigations are completed within 14 days and report exceptions to PSC and Directorate Management
- We have improved staff information on incident reporting provided at Trust induction
- Documented clear standard operating procedures for incident management within the Clinical Risk and Health and Safety Departments, including clear definitions of actual harm
- Provided guidance for staff on risk assessment (via hyperlink) on the electronic incident form via hyperlink

**Our Achievements:**

| Criterion | Standard | Exceptions | Compliance April 2013 | Re-Audit Compliance Nov 2013 | Compliance |
|---|---|---|---|---|---|
| All incidents are reported to external agencies within timeframe (as defined in Appendix D of Incident Management Policy) | 100% | No exceptions | 59% | 70% |  |
| All department level investigations for low, moderate and high risk incidents investigated within 14 working days. | 100% | No exceptions | 39% | 72% |  |
| All incidents reported on Trust incident form within 24 hours | 100% | No Exceptions | 70% | 81% |  |

In March 2013 the Clinical Risk Department commenced a review of previously closed serious incident investigations, including the never events which occurred in 2012/2013, seeking assurance that action plans had been implemented and evidence of sustained changes in practice. A number of actions were found to have a reduced level of assurance that they had been fully implemented, the report was escalated to the Patient Safety Committee, and actions completed. A rolling audit of previously closed action plans is now in place, aiming to gain assurance of continued change in practice following learning from serious incidents.

2 **Our aim:** Improve compliance with the Being Open Policy for all serious incidents to demonstrate commitment to Duty of Candour

**Our action:** We have made a number of improvements to the process during 2013/2014 to raise awareness of Being Open and Duty of Candour, which is defined in Robert Francis' report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

- Introduced a 6 monthly audit cycle to assess compliance with the Being Open Policy
- Included the concept of Being Open and Duty of Candour at Trust Induction for all new staff
- Created a page on the Great Western Hospitals NHS Foundation internet pages for members of the public to provide members of the public with information on the Trust's commitment to Being Open, and link to Trust policy
- Implemented a mandatory requirement to complete the Information Provided to Patients and Relatives field on the Trust's electronic incident reporting form
- Introduced a help function on the Trust's electronic incident reporting form, providing staff with a quick reference on Trust requirements for Being Open
- Developed a Being Open/Duty of Candour training tracker module, due to go live in April 2014

**Our result:** The Trust has maintained a 100% compliance rate for documentation of Being Open communications following serious incidents. During 2014/15 improvement needs to focus on coordination of communication with patients and their relatives following serious incidents, quality of content of

communication and timely delivery. In addition improvement is required to meet requirements of the Being Open Policy for incidents resulting in low and moderate harm.

1. **Our aim:** Development and delivery of patient safety related training programmes

   **Our action:** -

   - Introduced monthly incident management system trouble shooting sessions available for staff across all settings
   - Revised 1 hour incident investigation training for managers and staff with investigation responsibilities
   - Laminated investigation quick reference guide for all managers
   - Development of Being Open training tracker, due for launch in April 2014
   - Development of Root Cause Analysis training in house, due for launch 2014
   - Improved access to Clinical Risk and Patient Safety Advisors for 1:1 coaching and support during incident investigations and quality improvement activities

   **Our result:** Improved access to training for department level incident management and specialist support during serious incident investigations.

2. **Our aim:** To monitor compliance with all recommended control measures described within the Never Event Framework are in place within the organisation. To ensure that all control measures are in place.

   **Our action:** In January 2013 the Clinical Risk Department commenced a scheduled audit programme, testing compliance with the recommended control measures described within the national Never Event framework, identifying gaps and making recommendations to strengthen controls. The programme of audits continued during 2013/2014, to ensure that adequate control measures are in place to reduce the risk of all 25 of the listed never events.

   **Our result:** Nine audits have now been completed, with actions underway to address and gaps in control measures. Each of the never event topics are being added to the annual audit plan for continued monitoring of compliance.

3. **Our aim:** To describe the process for supporting staff involved in an incident, complaint or claim within a revised policy document. To monitor compliance with this document, to provide assurance of an effective process, which meets both needs of Trust staff and NHSLA requirements.

   **Our action:** The Incident Management Policy has been revised describing the process for staff support arrangements following a serious incident.

   **Our result:** On-going improvements to staff support arrangements in conjunction with the Occupational Health and Human Resources Departments. The Clinical Risk Department now have a process in place to inform the Occupational Health Department when an incident has occurred. The Occupational Health Department proactively contact the Department Manager to offer staff support if required. This process is recorded on the Serious Incident Monitoring documentation within the Clinical Risk Department.
   The Clinical Risk and Human Resources Departments have commenced discussions on developing a process to share learning from individual incidents, and to provide information to enable the Human Resource team to follow up on individual staff support and development requirements.

### Priorities for 2014/2015

- To deliver a mechanism to measure the safety culture within the organisation (safety culture analysis/ culture barometer)
- To provide a programme of patient safety education which includes Root Cause Analysis, Being Open/Duty of Candour, Quality Improvement methodology and tools
- To provide directorates with the systems to analyse incident trends and themes
- To support the delivery of measurable improvement activities relating to the NHS Safety Thermometer Harm Free Care
- Support the delivery of the Quality Improvement Strategy
- To continue to develop the programme of Executive Patient Safety Visits, to include reporting mechanisms and measurable outcomes to demonstrate impact
- To continue to develop Trust wide mechanisms for sharing learning from patient safety incidents and communication of other patient safety related topics

- To improve serious incident investigations, increasing assurance that root causes have been identified, and SMART actions agreed
- To support individual managers and directorates to implement action plans arising from serious incident investigation
- To ensure that Trust Policy enables the organisation and its clinical staff to achieve their responsibilities with regard to Duty of Candour

## Review of Services

During 2013/2014 the Great Western Hospitals NHS Foundation Trust provided and/or sub-contracted 7 relevant health services.

The Great Western Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 7 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2013/2014.

## Participation in Clinical Audits

Clinical audit is a quality improvement process that looks to improve patient care and outcomes by regularly reviewing current practice against specific standards and implementing change where required.

During 2013/2014, 32 National Clinical Audits and 5 National Confidential Enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During that period Great Western Hospitals NHS Foundation Trust, participated in 32/32 (100%) national clinical audits and 5/5 (100%) of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Great Western Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/2014 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

The reports of 258 local clinical audits were reviewed by the provider in 2013/2014 and the Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Introduction of a Deep Vein Thrombosis risk assessment form to be completed by clinicians to ensure patient risk factors have been clearly identified
- Introduce mandatory training to ensure thorough knowledge and understanding of the Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-CPR) policy is embedded amongst all staff
- Introduction of a chest pain pro-forma in the Acute Medical Unit to ensure patients are clearly identified; treated appropriately and referred to specialist teams where appropriate
- It is planned for all 29 state senior schools in Wiltshire to have a weekly school nurse drop in/open access session during term time
- It is planned to revise the paper incident forms to include a section for documenting ‘being open’ communication, additionally, instructions will be included on the electronic incident form to prompt staff to document accordingly. Exploration of options to include ‘Being Open’ as part of clinical staff induction
- To introduce a new Serious Incident reporting checklist to ensure all reporting requirements are completed by the Clinical Risk Team within a required timeframe. To monitor department level investigations to ensure they are completed within 14 days, reporting exceptions to Patient Safety Committee and Directorate Management. To review and amend induction/mandatory training for all Trust staff

As a Department of Health directive towards driving quality, safety and evidence through Clinical Audits, the Trust aims to ensure that it meets all professional, regulatory, monitory and national requirements. This includes

the assessment and implementation of all National Institute for Health and Care Excellence (NICE) guidance where relevant to the organisation.

The Clinical Audit and Effectiveness department continues to see an increasing number of registered audits which are fundamental in promoting the quality, safety and effectiveness of patient care, for example, to avoid incidents that should never happen, reviewing the management and clinical care for patients who die in hospital, avoiding unnecessary length of stays for inpatients and avoiding readmissions into hospital after discharge.

The varied number of projects registered with the department is a reflection of the organisation and health care professional's dedication to providing assurances with evolving evidence based practices and promoting patient safety and outcomes with a remarkable 116 service evaluation projects and 73% of clinical audits leading to change in practice.

To provide additional assurance to the Trust Board, a total of 18 reviews were undertaken as a result of the Trust's internal monitoring process for increased inpatient mortalities, readmissions and length of stays, furthermore, additional 3 reviews provided assurances to the Care Quality Commission.

The results of clinical audits will continue to be presented when required and activity reports will continue to be produced by the department summarising audit outcomes. All key learning, recommendations and actions from these audits will continue to be reported to the Directorate Clinical Governance meetings, Executive Committee, and any exceptions will continue to be reported to the Patient Safety Committee.

The Clinical Audit and Effectiveness department has an established robust process for audit activity and providing evidence for assurances within the Trust and will continue to strengthen these processes and reporting systems.

| National Clinical Audits | | Participated | % Data Submission |
|---|---|---|---|
| 1 | Acute coronary syndrome or Acute myocardial infarction | Yes | 100% |
| 2 | Adult cardiac surgery audit | NA | NA |
| 3 | Adult critical care (Case Mix Programme) | Yes | 100% |
| 4 | Bowel cancer | Yes | 100% |
| 5 | Cardiac arrhythmia | Yes | 100% |
| 6 | Chronic Obstructive Pulmonary Disease | Yes | Commences Jan 14 |
| 7 | Congenital heart disease (Paediatric cardiac surgery) | NA | NA |
| 8 | Coronary angioplasty | Yes | Data collection/submission still in progress |
| 9 | Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) | Yes | 100% |
| 10 | Diabetes (Paediatric) | Yes | Data collection/submission still in progress |
| 11 | Elective surgery (National PROMs Programme) | Yes | Data collection/submission still in progress |
| 12 | Emergency use of oxygen | Yes | 100% |
| 13 | Epilepsy 12 audit (Childhood Epilepsy) | Yes | Data collection/submission still in progress |
| 14 | Falls and Fragility Fractures Audit Programme, includes National Hip Fracture Database | Yes | Data collection/submission still in progress |
| 15 | Falls and Fragility Fractures Audit Programme (FFFRAP) - Pilot audit of inpatient falls. Feasibility study | Yes | Data collection/submission still in progress |
| 16 | Falls and Fragility Fractures Audit Programme (FFFRAP) - Pilot audit of Fracture liaison service | NA | NA |
| 17 | Head and neck oncology | Yes | 100% |
| 18 | Heart failure | Yes | 100% |
| 19 | Inflammatory bowel disease | Yes | 100% |
| 20 | Lung cancer | Yes | 100% |
| 21 | Moderate or severe asthma in children (care provided in emergency departments) | Yes | Data collection/submission still in progress |

| | | | |
|---|---|---|---|
| 22 | National audit of schizophrenia | NA | NA |
| 23 | National Audit of Seizure Management (NASH) | Yes | 100% |
| 24 | National Cardiac Arrest Audit | Yes | Data collection/submission still in progress |
| 25 | National comparative audit of blood transfusion | Yes | 100% |
| 26 | National emergency laparotomy audit | Yes | Data collection/submission still in progress |
| 27 | National Joint Registry | Yes | Data collection/submission still in progress |
| 28 | National Vascular Registry, including CIA and elements of NVD | NA | NA |
| 29 | Neonatal intensive and special care | Yes | 100% |
| 30 | Oesophago-gastric cancer | Yes | 100% |
| 31 | Paediatric asthma | Yes | Data collection/submission still in progress |
| 32 | Paediatric bronchiectasis | NA | NA |
| 33 | Paediatric intensive care | NA | n/a |
| 34 | Paracetamol Overdose (care provided in emergency departments) | Yes | Data collection/submission still in progress |
| 35 | Prescribing Observatory for Mental Health (POMH-UK) (Prescribing in mental health services) | NA | NA |
| 36 | Pulmonary hypertension | NA | NA |
| 37 | Renal replacement therapy (Renal Registry) | Yes | 100% |
| 38 | Rheumatoid and early inflammatory arthritis | Yes | Commences Feb 14 |
| 39 | Sentinel Stroke National Audit Programme (SSNAP), includes SINAP | Yes | Data collection/submission still in progress |
| 40 | Severe sepsis & septic shock | Yes | Data collection/submission still in progress |
| 41 | Severe trauma (Trauma Audit & Research Network) | Yes | Data collection/submission still in progress |
| **Confidential enquiries** | | | |
| 1 | Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Tracheostomy Care | Yes | 100% |
| 2 | Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Lower Limb Amputation | Yes | 100% |
| 3 | Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Gastrointestinal Haemorrhage | Yes | 100% |
| 4 | Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) | NA | NA |
| 5 | Child health clinical outcome review programme (CHR-UK)* | Yes | 100% |
| 6 | Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) | Yes | 100% |

The reports of 37 national clinical audits were reviewed by the provider in 2013/2014 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- GWH Laboratory staff routinely aim to provide group specific blood issued within fifteen minutes which, national results show that hospitals able to provide group specific blood within this time use up to 50% less emergency 'O Rhesus D negative' red cells
- The appointment of three extra Gastro-Intestinal Surgeons to facilitate next day referral to specialist care to avoid out of hours emergencies. This will also increase the provision of specialist on call surgeons. It is planned to provide a provision for colonic stenting at GWH

- All rectal cancer patients will have a pre-operative appointment and made aware of the potential outcomes of a temporary ileostomy with a Clinical Nurse Specialist
- Laparoscopic surgery is to be considered in all suitable cases by two additional colorectal surgeons accredited in colorectal laparoscopic techniques, strengthening the current team to five colorectal surgeons
- Within the Stroke Services, there are two areas which are currently being improved upon; the percentage of patients who are directly admitted from the Accident and Emergency department to the Acute Stroke Unit within 4 hours of admission; the national performance for this indicator is 57%. GWH performance at October 2013 was 75%
- The percentage of patients who are achieving 90% length of stay on a Stroke Unit; the national performance for this indicator is 84%. GWH performance at October 2013 was 90%.
- A review of the current services provided for patients with alcohol related liver disease is planned, which includes establishing a new Multi-disciplinary team with clinical lead, and a robust process of joint working with Primary Care services
- Recruitment of specialist clinician/consultant to ensure that all patients admitted with alcohol-related liver disease receive early specialist input and continued management

## Research & Development (R&D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2013/2014, that were recruited during that period to participate in research approved by a research ethics committee was 762 to end March 2014.

We currently have 95 actively recruiting Department of Health endorsed (portfolio) research projects. 6% of these are straight forward Band 1 studies with 42% being the more complex Band 2 studies and 43% are highly complex Band 3 studies. 9% of studies are commercially sponsored.

Under the direction of the R&D Director the R&D department continues to increase research activity at the Great Western Hospitals NHS Foundation Trust.

The team consisting of part time posts of R&D Manager, Facilitator and Administrator continue to ensure tight deadlines for approval of research projects are met. In addition to these tasks the focus has changed to incorporate more in depth support to recruitment of on-going studies.

Progress continues to be made in key topic areas such as Rheumatology and Orthopaedics with 11% of activity and 1.2 full time staff in these areas. Maternity research has grown and we have had our best recruiting study in Delivery Suite.

Commercially funded research has grown substantially within the Trust and some research posts continue to be funded from this income.

With funding received from the Department of Health through our Comprehensive Local Research Network (CLRN), R&D have been able to continue funding key research posts across the Trust in Cancer, Rheumatology, Dermatology, Sexual Health, Orthopaedics and ICU. Support departments continue to receive funding for posts to allow them to carry out any additional tests etc that a research project may require. We have now recruited two generic research nurses to enable us to improve research in less research active areas.

All research staff in the Trust are supported with training and guidance through R&D and the CLRN's. All research nurses receive an induction pack and competency pack in addition to their standard induction information. Further support is also available through mentoring our increasingly experienced team here.

All SOPs (standard operating procedures) within the Research Support Services National Initiative have been implemented to ensure we are compliant with all governance standards

## Goals agreed with Commissioners

Use of the CQUIN payment framework.

A proportion of The Great Western Hospitals NHS Foundation Trusts income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between The Great Western Hospitals NHS

Foundation Trust and the agreements and contracts for the provision of NHS services, through the Swindon and Wiltshire Clinical Commissioning Groups for Quality and Innovation payment framework.

Further details on the agreed goals for 2013/14 and the following twelve month period are available electronically by request

The monetary total for the amount of income in 2013/2014 conditional upon achieving Quality Improvement and Innovation Goals, and a monetary total for the associated payment in 2013/2014 is summarised in the table below.

| **Financial Summary of CQUIN** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Plan** | **Actual** | | **Plan** | **Actual** | |
| | | **2012-2013** | | | **2013-2014** | | |
| **TOTAL CQUIN** | | **£6064k** | **£5036k** | **83%** | **£5366** | **£4353** | **81%** |

## Registration with Care Quality Commission and Periodic/Special Reviews

### Care Quality Commission Registration

The Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered” without conditions.

The Care Quality Commission has not taken enforcement action against The Great Western Hospitals NHS Foundation Trust during 2013/2014.

**CQC Registration update**

All registered sites/locations and activities were reviewed during 2012 and a new certificate of registration was then dated 18 October 2012 and subsequently issued by the CQC on 2 November 2012.

The ten sites currently registered with the CQC are as follows:

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

As a result of the registration review (in consultation with the CQC in 2012 and following CQC registration guidance) some community sites were deemed as satellite services (rather than a designated registered site). The Trust is however registered to provide CQC regulated activities at these community sites and these are contained within table 1.

The satellite sites are as follows:

- HMP Erlestoke
- Melksham Hospital
- Southgate House
- West Swindon Health Centre
- Westbury Community Hospital
- Swindon Health Centre
- Tidworth Clinic
- Central Health Clinic

- Amesbury Health Clinic

Hillcote amendments to registration have been submitted as formally agreed by the Trust Board. These amendments include the removal of the regulated activity for 'Nursing Care' with the addition of 'Accommodation for person who require nursing or personal care' and 'Treatment of Disease, Disorder and Injury' (in line with the CQC inspectors guidance).

The CQC certificated regulated activities per location are shown below (**Table 1**)

| Registered Sites | Regulated Activities | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 Registered sites with satellite services in addition | Treatment of disease, disorder or i | Family Planning Services | Diagnostic and Screening procedure | Maternity and Midwifery Services | Nursing Care | Surgical procedures | Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Management of supply of blood and blood products | Accommodation for people require treatment for substance misuse | Accommodation and nursing or personal care in the further education sector | Accommodation for people who require nursing or personal care | Services in slimming clinics | Personal Care | Transport services, triage and medical advice provided remotely | Termination or pregnancies |
| Warminster Community Hospital | ✓ | | ✓ | | | | | | | | | | | | |
| Trowbridge Community Hospital | ✓ | | ✓ | ✓ | | | | | | | | | | | |
| Chippenham Community Hospital | ✓ | | ✓ | ✓ | | | | | | | | | | | |
| Frome Victoria Hospital | | | ✓ | ✓ | | | | | | | | | | | |
| Shepton Mallet Community Hospital | | | ✓ | ✓ | | | | | | | | | | | |
| Paulton Memorial Hospital | | | ✓ | ✓ | | | | | | | | | | | |
| Princess Anne Wing-RUH (Maternity) | | | ✓ | ✓ | | | | | | | | | | | |
| Hillcote | | | | | ✓ | | | | | | | | | | |
| Savernake Community Hospital | ✓ | | ✓ | | | | | | | | | | | | |
| **GWH Satellite Services** (as documented within Certificate of Registration) | | | | | | | | | | | | | | | |
| HMP Erlestoke | ✓ | | ✓ | | | | | | | | | | | | |
| Melksham Community | ✓ | | ✓ | | | | | | | | | | | | |
| Southgate House | ✓ | | ✓ | | ✓ | | | | | | | | | | |
| West Swindon Health Centre | ✓ | | ✓ | | | | | | | | | | | | |
| Westbury Community Hospital | ✓ | | ✓ | | | | | | | | | | | | |
| Swindon Health Centre | ✓ | | ✓ | | | | | | | | | | | | |
| Tidworth Clinic | ✓ | | ✓ | | | | | | | | | | | | |
| Central Health Clinic | ✓ | | ✓ | | | | | | | | | | | | |
| Amesbury Health Clinic | ✓ | | ✓ | | | | | | | | | | | | |

## Periodic/Special Reviews 2013/2014

The Great Western Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/2014 as below. GWH intends to take the following action to address the conclusions or requirements reported by the Care Quality Commissioner [see below]. GWH has made the following progress by 31 March 2014 in taking such action

## CQC Unannounced Inspection GWH Site (October 2013)

The CQC undertook an unannounced responsive inspection at the Trust in Swindon during October 2013. The visit was conducted over 4 days where they visited 9 different wards and areas at GWH.

CQC also undertook a table top exercise where they reviewed outcomes relating to governance and staffing.

The team of inspectors were very complimentary about the caring staff – particularly the nursing staff they came across.

During the inspectors' time on the wards and departments they found areas which were not meeting the CQC standards, these included Cleanliness and Infection Control Practices, Staffing and Governance.

The CQC have published the formal inspection report in December 2013, the report highlights that GWH was not fully meeting the standards for the following outcomes:

Outcome 8 Cleanliness and infection control
Outcomes 13 Staffing
Outcome 16 Governance (Assessing and monitoring the quality of service provision)

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to address the conclusions or requirements reported by the Care Quality Commission (following October inspection at GWH).

An overarching CQC action plan has been developed to address the areas where standards are not being fully met. This was submitted to the CQC in December 2013. This plan has been approved by the Governance Committee.

Detailed action plans to support the Trust wide plan are being progressed and monitored by the Regulatory Compliance Group and Patient Safety Committee. Formal reporting on progress with these improvement plans informs Trust Board via Trust Governance Committee which meets every other month.

The overarching action plan (improvement actions) is due for completion at the end of May 2014. The Trust would then consider that compliance has been achieved. Monitoring of some actions will continue (within the sub plans) to progress additional internally identified quality improvement measures.

The CQC returned to Princess Ann Wing in July 2013, to review progress on the maternity actions required (as per submitted action plan) post December 2012 inspection.

As a result, the CQC declared all outcomes were compliant as meeting the required standards.
The actions were monitored (as per plan) until declared fully completed in January 2014.

**CQC Special Reviews - Dr Foster alerts and subsequent investigations**

**Acute myocardial infarction alert**

On 11 November 2013, the CQC notified the Trust about a mortality outlier alert for Acute Myocardial Infarction
The Great Western Hospitals NHS Foundation Trust has taken the following action to address the conclusions or requirements reported by the Care Quality Commission:

- Submission of a report based on 12 case notes (already reviewed) of which no avoidable deaths were subsequently identified
- Coding and death certification improvement actions in place were reviewed and will continue, as these cases were complex

**Pathological Fractures Mortality Outlier**

On, 5 November 2013 the CQC notified the Trust about a mortality outlier alert for Pathological Fractures

The Great Western Hospitals NHS Foundation Trust has taken the following action to address the conclusions or requirements reported by the Care Quality Commission:

- A review of case notes was undertaken, to identify any issues related to clinical coding and the quality of clinical care, which demonstrated no clearly avoidable deaths
- Incorrect coding in 14 of the 15 cases reviewed were found to be driven by a change in the local Coroner and their request of death certification practice; subsequent actions included liaison with the Coroner for death certification clarity (and medical staff education update post agreement)
- Updating medical documentation (used to record hip fractures)
- Coding review by Consultants for all patients who are identified as suffering a pathological fracture

**Other External Reviews**
The following non CQC external reviews which have taken place during 2012/2013 are listed in the Table below.

| External Review | Review area/service | Site/sites | Date |
|---|---|---|---|
| MHRA | Blood transfusion inspection | GWH | 3 April 2013 |
| PLACE (previously PEAT) | Environment, Food, Privacy & Dignity | Great Western Hospital, Frome, Paulton Birthing Centre, PAW, Chippenham Community Hospital, Warminster Community Hospital, Hillcote House, Trowbridge, Savernake Hospital | April-June 2013 |
| National Cancer Peer Review | Transition Delivery Partner in the NHS Commissioning Board (NHSCB) (previously the Cancer Peer Review) | GWH | 24 June 2013 |
| HMIP | Health unit | Erlestoke Prison | September/October 2013 |
| Child safeguarding | Community | Various | October 2013 |
| CQC | Various departments | GWH | October and November 2013 |
| Surveillance assessment of Quality Management Systems | Quality Management Systems for Cellular Pathology and Microbiology | GWH | 19 and 20 November 2013 |
| Clinical Pathology Accreditation | Blood Sciences | GWH | 23 May 2013 |
| **CCG visits** | | | |
| Wiltshire CCG | | Savernake Hospital | 29 July 2013 |
| Wiltshire CCG | Birthing Unit | Trowbridge | 20 June 2013 |
| Wiltshire CCG | Birthing Unit | PAW | 19 September 2013 |

## NHSLA Risk Management Standards - Acute and Maternity Standards

### NHSLA Acute

Following the achievement of NHSLA level 1 and 2 Assessment in 2012, a full gap analysis was undertaken and completed to establish any shortfalls and gaps between level 2 and 3.

Following the findings of the gap analysis an options appraisal was provided to Patient Safety Committee and the Executive Committee regarding the option to proceed for a Level 3 assessment either in 2013, 2014 or 2015.

It was decided by the Executive Committee in May 2013 that in light of the NHSLA consultation, and uncertainty about assessments that the NHSLA Working Group should continue to monitor progress with the project plan working towards the minimum standard to achieve Level 3. A further analysis of our position will then be presented again in May 2014.

Currently all the policies relating to NHSLA had their monitoring tables reviewed during 2013 and monitoring against those requirements is being progressed.

The NHSLA are currently undergoing consultation and are reviewing their entire structure and processes. The NHSLA has indicated that there will no longer be risk management standards or formal assessments. Organisational claims history may be analysed in the future to assess service safety and to calculate the Trust's Litigation Authority contributions.

## Maternity Clinical Negligence Scheme for Trust Assessment (CNST) 23 & 24 May 2013

Maternity Services demonstrated compliance passing 46 out of the 50 standards and the Trust attained Level 2 CNST. Level 2 Assessment focused on and examined the implementation of maternity services policies and processes.

There were four areas where compliance was not awarded:

**Shoulder Dystocia**
A new Royal College of Gynaecologists (RCOG) Surgeons pro-forma was introduced in January 2013 and although all required information was documented in the health records this could not be demonstrated in all cases on the new pro-forma.

**Obesity**
The level 1 guideline was not compliant against national recommendation. Areas requiring further work include introduction of management plans, manual handling forms and the use of proformas. Whilst the service does not meet the national guidelines the local policy has been amended to ensure that care is as safe as possible for women who are obese in pregnancy.

**Patient Information**
There was insufficient documentation within the health records of the information given to mothers. The CNST assessor suggested the service had set the bar too high and suggested amending the level 1 guideline to reflect this. This will be completed when the service has finalised the patient information to be given out to mothers.

**Newborn life support**
Gaps were identified in the neonatal resuscitation daily equipment check lists; this indicated a need for more robust checking and the monitoring of this check. This has been actioned and audit results demonstrate this strategy is working.

## Data Quality

Great Western Hospitals NHS Foundation Trust submitted records during 2013/2014 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was: 99.7% for admitted patient care; 99.9% for outpatient care; and 94.1% for accident and emergency care. The lower performance in accident and emergency care is attributed to the completeness of this data item at the minor injury units in Wiltshire and the Trust's data quality group is working on improving this.

- Which included the patient's valid General Practitioner Registration Code was 99.9% for admitted patient care; 99.7% for outpatient care; and 99.4% for accident and emergency care.

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2013/2014 was 77% and was graded satisfactory / green.

Great Western Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust Data Quality Group will continue to manage and monitor a work programme that targets identified areas of poor data quality and progress will be reported to the Trust's Information Governance Steering Group. The Trust Data Quality Group has been re-structured to have a second group made up of operational staff who work through some of the key areas where data quality can be improved by standardising procedures or by identifying blockages to good data quality
- The actions from internal and external audits and benchmark reports associated with data quality will be acted on and monitored by the Trust Data Quality Group
- Data quality reports and issues raised by Commissioners will be reviewed and any required action taken

- Training programmes associated with the implementation of the new Medway PAS have allowed a general refresher training of users and training will continue as the system is implemented and upgraded during the year
- Development of refresher training programmes for staff involved in data collection and data entry will continue

## Information Governance Tool Kit Attainment Levels

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information. There is corporate leadership of information governance, the Director of Finance & Performance having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality assurance, information security assurance, and legal compliance. Confidentiality, security, and data quality play an important role in the safeguarding of information within the Trust. This includes organisational and staff information as well as patient information. The Trust has agreements with healthcare organisations and other agencies for the sharing of patient information in a controlled manner, which ensures the patients' and public interests, are upheld. It is essential for the delivery of the highest quality health care that accurate, timely and relevant information is recorded and maintained. As such it is the responsibility of all staff to promote data quality and confidentiality.

The Trust's Information Governance Steering Group undertakes an Information Governance Work Programme covering the full range of information governance elements, and ensures that appropriate policies and management arrangements are in place. The Data Quality Group, which reports to the Steering Group, provides a quarterly data quality and completeness report, including the results of data accuracy tests. The Data Quality Group also undertakes a Data Quality Work Programme, which includes data quality reporting, training and awareness, clinical coding, and policies and procedures. These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the HSCIC Information Governance Toolkit. The main Toolkit headings are:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance – Health Records and Information Quality
- Secondary Use Assurance
- Corporate Information Assurance – Records Management and Freedom of Information.

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The Trust's Information Governance Assessment Report overall score for 2013/2014 was 77% and was graded Satisfactory ('green'), with a satisfactory rating in every heading of the Information Governance Toolkit.

## Clinical Coding Error Rate

**Explanatory Note of Clinical Coding**

The Clinical Coding Audit carried out by the Audit Commission takes a sample of 100 patients from a selected specialty, in this year's audit, Trauma and Orthopaedics, as well as 100 patients randomly selected across all specialties. The samples are therefore small and the results of the audit should not be extrapolated further than the actual sample audited.

Great Western Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

| Auditor | Primary Diagnosis | Secondary Diagnosis | Primary Procedure | Secondary Procedure |
|---|---|---|---|---|
| PbR Audit Commission | 95.0% | 91.2% | 93.8% | 89.3% |

The results should not be extrapolated further than the actual sample audited.

These results achieved Attainment Level 2 in the Information Governance Toolkit. The audit identified areas for improvement and these have been included in an action plan that will be implemented in the course of the year.

The Trust continues to work towards developing compliance with the pseudonymisation initiative and maintains a log of patient identifiable data flows from key departments. The audit serves both to log the flows and to audit their compliance with pseudonymisation and data protection rules. This work will maintain its level of focus as changes to data flows are requested by Clinical Commissioning Groups.

## Staff Survey Summary 2013/2014

We are very proud of our staff who work incredibly hard and are committed to providing the highest care possible to our patients and their carers'. As a Trust we are committed to being an exemplar employer and strive to ensure that all our employees reach their full potential at work and are happy and motivated to do their job and contribute to our success as an organisation

As an organisation that provides a public service, we have also focused on ensuring that our staff have the right knowledge and skills to provide high standards of care to our patients and their carers' but also the right values so that they provide care in a compassionate way to local people.

We also continue to work towards improving how we recognise the hard work, loyalty, commitment and successes of our workforce and have raised the profile of achievement through the monthly and annual award scheme and in putting staff forward for national awards.

We have been trying to engage with our staff in a different way over the course of the year so that they are more involved in organisational change at an early stage and also so that we are actively getting staff ideas and suggestions on ways to deliver care differently.

Following last year's staff survey the Trust published a Trust-wide staff survey action plan which focused on improving visibility of senior staff, recruiting additional staff as part of the skill mix review work, improving how the Trust designs roles and enhancing leadership capability. Each Directorate also produced their own action plan, based on their Directorate results. These actions plans were reviewed quarterly by the board.

### Summary of Performance

**Table - Response Rate**

| 2012 | | 2013 | | Trust Improvement/ Deterioration |
|---|---|---|---|---|
| **Trust** | **National Average** | **Trust** | **National Average** | |
| 63% | 50% | 67% | 49% | **4% improvement** |

**Table – Summary of Performance**

| Top 4 Ranking Scores | 2012 | | 2013 | | Trust Improvement/ Deterioration |
|---|---|---|---|---|---|
| | Trust | National Average | Trust | National Average | |
| Question: KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months *(the lower the score the better)* | 25% | 24% | 20% | 24% | **5% improvement** |
| Question: KF7. Percentage of staff appraised in the last 12 months *(the higher the score the better)* | 86% | 78% | 92% | 84% | **6% improvement** |
| Question: KF9. Support from immediate managers *(the higher the score the better)* | 3.63 | 3.61 | 3.75 | 3.64 | **0.12 improvement** |
| Question: KF8. Percentage of staff having well-structured appraisals in the last 12 months *(the higher the score the better)* | 37% | 36% | 44% | 38% | **7% improvement** |

| Bottom 4 Ranking Scores | 2012 | | 2013 | | Trust Improvement/ Deterioration |
|---|---|---|---|---|---|
| | Trust | National Average | Trust | National Average | |
| Question: KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months *(the lower the score the better)* | 28% | 30% | 32% | 29% | **4% deterioration** |
| Question: KF3. Work pressure felt by staff *(the lower the score the better)* | 3.03 | 3.08 | 3.16 | 3.06 | **0.13 deterioration** |
| Question: KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the score the better)* | 92% | 90% | 88% | 90% | **4% deterioration** |
| Question: KF6. Percentage of staff receiving job relevant training, learning or development in the last 12 months *(the higher the score the better)* | 81% | 81% | 79% | 81% | **2% deterioration** |

**Response rate compared with prior year**
In the 2013 Staff Survey we saw a 4% increase in our response rate from 63% in 2012 to 67%.

The Trust considers that the staff survey response data is as described as the Trust works with an independent organisation called Quality Health who have undertaken staff surveys in the NHS for over 15 years. Quality Health is the largest provider for the NHS National Staff Survey.

The Trust has taken the following actions to improve in the areas identified within last year's staff survey:

**Areas of improvement from the prior year and deterioration**
Last year the Trust recognised that we need to improve visibility of senior management in the organisation, particularly across community services and a plan is being agreed to ensure that visits have the maximum impact. We also needed to recruit to the additional staff agreed as part of the Skill Mix Review work, which supports the Nursing Strategy and demonstrated that we needed to invest in our qualified nursing workforce. The Trust also agreed to invest in the midwifery workforce to ensure that staffing levels meet the needs of our patients. This investment will improve our staff's confidence so that they feel more satisfied with the quality of work and patient care they are able to deliver and will recommend us more highly as an employer of choice.

The Trust also needed to focus on how we design our jobs and how we deploy our staff to ensure that we are getting maximum benefit from our workforce and so that staff have maximum job satisfaction.

Since last year's staff survey the Trust has also invested in improving our management capability, whereby the commissioned Ashridge Business School designed and delivered a bespoke leadership programme for 93 of our nursing and midwifery leaders. The Transforming Leadership, Transforming Care Programme ensured that our managers were well equipped to support staff through change as we improve pathways and efficiencies in the way we work.

## Key areas of improvement

Our staff scores received in March 2014 benchmarks the Trust as fifth across 23 Trusts in the South West of England, including Royal Berkshire and Oxford hospitals. Last year the Trust benchmarked in third position so this is a small downward trend.

Overall, the Trust is measured against the four staff pledges from the NHS Constitution with an additional theme of staff satisfaction. These indicators break down into 28 key findings and results show that staff at GWH report that their experience of working at GWH places us in the Top 20% of Acute Trusts in UK for 13 out of 28 indicators including staff motivation levels, training, appraisals and equal opportunities for promotion.

| Staff Survey Scores 2013 | Answers |
|---|---|
| Top 20% | 13 |
| Above (Better than) Average | 4 |
| Average | 2 |
| Below (Worse than) Average | 6 |
| Bottom 20% | 3 |
| Total | 28 |

We are better than average for 4 out of 28 indicators including work related stress and agreeing that their role makes a difference to patients. We are average for 2 out of 28 indicators relating to effective team working and reporting good communication between senior management and staff. The Trust are worse than average in 9 out of 28 indicators including staff being unsatisfied with the quality of work and patient care they are able to deliver, pressure of work and extra hours being worked. All these areas are connected to our staffing levels which we have a plan to improve.

## Future priorities and targets

**Statement of key priority areas**
The Trust received the full results and management report for the 2013 Staff Survey at the end of February 2014. From the summary results of 2013 staff survey received to date the Trust's key priorities should be:

Recruiting staff with the qualities we value – service, teamwork, ambition and respect - and ensuring they are fully supported in their roles continues to be a priority.

56% of staff who completed the staff survey said they would recommend the Trust as a place to work. The Trust would like to increase this score in the coming year and will do so by focusing on the following areas:

**Staffing**
Our recruitment drive means we have almost 100 more nursing and midwifery staff than we did this time last year, however we still need more. Recruiting nurses in particular is a real challenge for the whole NHS due to a

national shortage. However, we are doing all we can, even going as far afield as Spain, Portugal and Ireland and this effort will continue until we have the staff we need, in the places we need them.

**Teamwork**
The heart of effective teamwork is communication. Currently only six in every ten staff meet often to discuss team effectiveness. As many staff are not computer based, face-to-face meetings are often the only chance to catch up, discuss the team's effectiveness, ask questions and share ideas.

There has been a slight reduction in teams having a shared set of objectives (76%) which is essential to ensure we are all working towards the same thing. Fewer staff also said that they had to communicate closely with other team members to achieve team objectives (76%).

**Raising concerns and feeling informed about errors, incidents and near misses**
Only half of staff said they are informed when things go wrong (52%). We will encourage our staff to be open and sharing mistakes to enable us to learn and take action to prevent the same thing happening again.

60% of our staff either agreed or strongly agreed that they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. The percentage of staff either agreeing or strongly agreeing with this statement has continued to decline over the last two years. In 2011 66% of our staff either agreed or strongly agreed with this statement, which decreased to 64% in 2012.

In April 2014 the Trust introduced the Staff Friends and Family Test which will monitor the response to this question on a quarterly basis. We will use this information to help us understand the reasons for this decline and what actions we can take to improve this going forward.

## Development of Action Plan and Monitoring arrangements

Following this year's staff survey results, the Executive Committee will agree which areas the Trust should focus on so that the Trust can improve the experience of staff. They will also agree this year's monitoring arrangements, which is likely to follow on from last year's quarterly action plan updates

## PART 3 – Other Information

### Performance against Trust's Selected Metrics

| | | 2010/ 2011 | 2011/ 2012 Data includes Community | 2012/ 2013 | 2013/ 2014 | National Average | What does this mean | Source of measure | Definition |
|---|---|---|---|---|---|---|---|---|---|
| 1 - Reducing Healthcare Associated Infections | MRSA Bed Days as well<br><br>*provisional as at 02/05/14 | 3 | 2 | 2 | 5 | 0.96* | Zero is aspirational | IP&C | National definition |
| | C.*Diff* | 40 | 17 | 33 | 23 | Not applicable | Zero is aspirational | IP&C | National definition |
| | C.Diff 100,000 bed days*<br><br>**Provisional – not published as yet | 20.1% | 7.3% | 13.4% | 12.5% | 12-15%** | Lower is better | HPA | National Definition |
| 2 - Patient Falls in Hospital resulting in severe harm | | 15 | 17 | 16 | 23 | Not available | Low number is excellent | IR1's | NPSA |
| 3 – Reducing Healthcare Acquired Pressure Ulcers | | 40 | 31 | 28 | 28 (grade 3 and 4) | Not available | Low number is better | IR1's | National definition (from Hospital database) |
| 4 – Percentage of VTE Risk Assessments completed | | 85.1% | 92.7% | 95.3% | 95.5% | 90% | Higher number better | Crescendo nursing care plan and manual data collection from LAMU, Day Surgery, and ICU | National definition (from Hospital database) |
| 5 – Percentage of patients who receive appropriate VTE Prophylaxis | | 90%<br><br>(No audit for Surgical actioned in Q2 & Q3 therefore YTD based on Medical only) | 94.5% | 93.9% (Apr-Oct) | 95% | N/A | Higher number better | One day each month whole ward audit for one surgical ward and one medical ward | National definition (from Hospital database) |
| 6 – Never Events that occurred in the Trust | | 0 | 3 | 3 | 4 | SW Regional never events 2009 - 7 2010-17 2011-33 2012-32 | Zero tolerance | IR1's | NPSA |
| 7 – Mortality Rate (HSMR) | HSMR | 97.9 | 106.2 | 91.8 | 97.3 | 100 | Lower than 100 is good | Dr Foster | National NHS Information Centre |
| 8 – Early Management of Deteriorating | Early Warning Score (Adults) | 93% GWH only | 96% GWH only | 91% | 95% (April – Dec (9 months) | Not available | Higher number is better | Audit | Audit criteria (50 patients per month) |

| | | 2010/ 2011 | 2011/ 2012 Data includes Community | 2012/ 2013 | 2013/ 2014 | National Average | What does this mean | Source of measure | Definition |
|---|---|---|---|---|---|---|---|---|---|
| Patients - % compliance with Early Warning Score | Paediatric Early Warning Score (Children) | | | | 87.75% | | | Audit | Audit criteria (5 patients per month) |
| 10 – Percentage of Nutritional Risk Assessments | Using MUST | 70% Acute only | 87.8% Combined | 84% | 82% | | Higher % is better | Crescendo | National definition |
| 11 – Were you involved as much as you wanted to be in decisions about your care and treatment? | | 48.1% | 46.9% | 51% | 53.2% | 54.8% | Higher is better | Picker Survey | National definition |
| 12 – Did you find someone on the hospital staff to talk to about your worries and fears? | | 23% | 22.5% | 37% | 37.1% | 38.4% | Higher is better | Picker Survey | National definition |
| 13 – Were you given enough privacy when discussing your conditions or treatment? | | 68.5% | 66.8% | 73% | 70.8% | 72.7% | Higher is better | Picker Survey | National definition |
| 14 – Did a member of staff tell you about medication side effects to watch for when you went home? | | 22.9% | 24.3% | 30% | 33.7% | 40% | Higher is better | Picker Survey | National definition |
| 15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? | | 65.6% | 66.6% | 67% | 67.2% | 69.8% | Higher is better | Picker Survey | National definition |
| 16 – Patient Reported Outcome Measures | Varicose Vein surgery | Awaited | Awaited | 100% | 100% | 80% | Higher is better | DoH | National Definition |
| | Groin hernia surgery | Awaited | Awaited | 96.9% | 100% | 80% | Higher is better | DoH | National Definition |
| | Hip Replacement surgery | Awaited | Awaited | 96% | 98.5% | 80% | Higher is better | DoH | National Definition |
| | Knee Replacement Surgery | Awaited | Awaited | 95.6% | 97% | 80% | Higher is better | DoH | National Definition |
| 17 – Readmissions – 30 days | | n/a | 7.4% | 8.1% | 7.9% | Local target (7.1%) | Lower is better | | National Definition |
| 18 – Readmissions – 28 days | | 6.9% | 7.3% | 7.9% | 7.7% | SW Region 6.9% | Lower is better | Dr Foster | |
| 18 – Re-admissions 28 days<br><br>Ages 0-15<br>Ages 16+ | | | | | 9%<br>7.5% | | Lower is better | Dr Foster | |

*The above [c.*diff*] rates have been calculated on the Trust's actual bed days. This will of course be different to the rates calculated by the HPA (now Public Health England) over previous years, as their calculations are estimated figures based on the previous year's bed numbers. We do not have these figures to base our calculations on. The HPA rates are provided on a quarterly basis and they do not produce an annual rate per Trust.

## Performance against Key National Priorities

An overview of performance in 2013/2014 against the key national priorities from the Department of Health's Operating Framework is set out below. Performance against the relevant indicators and performance thresholds are provided.

| Indicator | 2010-2011 GWH | 2011-2012 Trust | 2012-2013 Trust | 2013-2014 Trust | 2013-14 Target | Achieved/ Not Met |
|---|---|---|---|---|---|---|
| *Clostridium Difficile* - meeting the *Clostridium Difficile* objective | 40 | 19 | 33 | 23 | 20 or less (Acute) | Not Met |
| MRSA - meeting the MRSA objective | 3 | 2 | 2 | 5 | 0 or less Contract<br><br>Monitor de minimis 6 | Monitor de minimis achieved |
| Cancer 31 day wait for second or subsequent treatment - surgery | 98.5% | 98.4% | 98.4% | 98.4% | 94.0% | Achieved |
| Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments | 100% | 100% | 100% | 100% | 98.0% | Achieved |
| Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) | 92.4% | 89.3% | 90.0% | 89.0% | 85.0% | Achieved |
| Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) | 100% | 98.4% | 96.2% | 98.9% | 90.0% | Achieved |
| Cancer 31 day wait from diagnosis to first treatment | 99.0% | 98.7% | 98.1% | 98.8% | 96.0% | Achieved |
| Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) | 97.0% | 97.1% | 95.3% | 94.7% | 93.0% | Achieved |
| Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) | 97.2% | 97.1% | 96.0% | 95.6% | 93.0% | Achieved |
| Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients | 95.1% | 96.1% | 95.3% | 94.9% | 90.0% | Achieved |
| Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients | 97.9% | 98.2% | 98.3% | 96.3% | 95.0% | Achieved |
| Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways | | | 96.1% | 94.8% | 92.0% | Achieved |
| A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge | 97.4% | 97.0% | 95.6% | 94.1% | 95.0% | Not Achieved |
| Data completeness community services: referral to treatment information | | | 80.0% | 88.2% | 50.0% | Achieved |
| Data Completeness community service information: referral information | | | 80.0% | 81.5% | 50.0% | Achieved |
| Data completeness community services information: treatment activity information | | | 85.0% | 96.0% | 50.0% | Achieved |

**Commentary related to previous table (not within main body of the Report)**

**Patient Reported Outcome Measures (PROMs)**

The Great Western Hospital NHS foundation Trust considers that this data is as described for the following reasons:

This information is derived from Patient Survey forms which are reviewed and analysed by the HSCIC and data is provided nationally.

The Great Western Hospital NHS foundation Trust will take the following actions to improve this percentage, and so the quality of its services;

Performance for Varicose Veins and Groin Hernia Surgery is at 100% for 2013/2014; GWH will continue to monitor these services to ensure the greatest benefit to our patients. Whilst Hips and Knee procedures are also above the national average within the Trust, we will again continue to monitor and improve these percentages throughout the coming year.

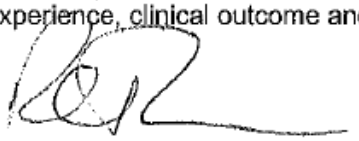
## Statement from the Council of Governors dated 20 May 2014

The Council of Governors has been consulted on the Great Western Hospitals NHS Foundation Trust's Quality Account 2013-14 and is satisfied that the Account includes the priorities identified by the Council of Governors.

In the opinion of Governors, the Quality Account represents a fair reflection of the information received by governors over the year on the Trust's performance. The Governors have acknowledged that the Trust did not achieve the 95% target for a maximum waiting time of 4 hours in A&E (94.1% achieved), but are satisfied with the efforts being undertaken towards addressing this, namely the engagement of the Emergency Care Intensive Support Team (ECIST), which has undertaken a whole system review and has made recommendations for improvement. The Governors have also noted that the Trust experienced an increase in attendance in A&E compared with last year and this undoubtedly impacted on the performance indicator.

Furthermore, the Governors noted that the Trust exceeded the maximum number of Clostridium Difficile cases, (23 cases against a maximum of 20). Governors are aware that each case is reviewed and any learning opportunities are considered and shared. Governors are satisfied with the actions being undertaken to reduce the number of cases, noting that a peer review has been undertaken and recommendations from that review are being progressed.

Despite a busy year, the Trust has made a number of achievements as set out in the Quality Account and in particular, Governors noted the improved performance around cancer waits in some areas and data completeness. In addition other achievements which contribute towards improved patient experience, clinical outcome and patient care are noted by the Governors.



**Ros Thomson**
**Lead Governor on behalf of the Council of Governors**

## Statement from Swindon Clinical Commissioning Group dated 16 May 2014

The Quality Account provides information across a wide range of quality measures and gives a comprehensive view of the quality of care provided by the Trust.

NHS Swindon Clinical Commissioning Group (CCG) has reviewed the information provided by Great Western Hospital NHS Foundation Trust in its 2013-2014 Quality Account. In so far as we have been able to check the factual details, our view is that the Quality Account is materially accurate and is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

In 2013/14 there have been a number of national seminal reports and recommendations that have influenced the quality and safety agenda, most notably the report of Robert Francis QC, the Government's response "Hard Truths Patients first and foremost" and the Berwick Review of patient safety: "A promise to learn – a commitment to act: Improving the safety of Patients in England". The Trust has demonstrated its commitment to continued improvement by embracing the recommendations of the Francis Report, from the implementation of the Friends and Family Test, improving its systems for the identification and monitoring of incident trends and improvements in its processes in managing and responding to complaints. The participation rate on the Friends and Family test across specific areas in the trust continues to be a challenge although we note the marked improvement at the end of year linked to the introduction of a new method of gathering information and engaging the Trust's customers. We will continue to monitor this throughout 2014/15.

A workforce with robust leadership is key to delivering services effectively. Therefore in 2014/15 greater emphasis will be placed on monitoring nursing and clinical skill mix and the impact that staff shortages have on patient experience and outcomes. We are pleased to note that in relation to the staff survey, staffing and teamwork are highlighted as key priorities for the year ahead.

We will continue to support Great Western Hospital to drive improvements in patient safety through areas such as the Pressure Ulcer Strategy with the Trust setting itself a challenging aim of zero healthcare acquired pressure ulcers by 2015.

We note that although the rates of healthcare associated infections are reducing year on year, they remain greater than expected and will continue to be a challenge in the coming year. We support the identified aim to continue to improve clinical practice and environmental cleanliness.

NHS Swindon CCG has a structured monthly quality review meeting with Great Western Hospital using a range of quality measures to help us to support and monitor improvements. We welcome the specific priorities for 2014/15 to improve on patient safety, patient experience and effectiveness which the Trust has highlighted in the Quality Account. All are appropriate areas to target for continued improvement, building on improvements already achieved in 2013/2014.

**Gill May**
**Executive Nurse**
**NHS Swindon Clinical Commissioning Group**

## Statement from Wiltshire Clinical Commissioning Group dated 20 May 2014

NHS Wiltshire CCG have reviewed the information provided by Great Western Hospital NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile. Our contract with Great Western Hospital Foundation Trust covers three key areas: Acute service, Community services in Wiltshire and Maternity services. The Quality report while providing data across the key areas predominantly focuses on the Inpatient services at Great Western Hospital.

Last year we commented on the arrangements for the involvement of service users in the development of their Quality accounts and evidence of this in the Quality report for GWHFT; this still needs to be addressed.

In 2013/14 there have been a number of national seminal reports and recommendations that have influenced the quality and safety agenda, most notably the report of Robert Francis QC, the Government's response "Hard Truths Patients first and foremost" and the Berwick Review of patient safety: "A promise to learn – a commitment to act: Improving the safety of Patients in England".

The Trust has embraced the recommendations of the Francis Report, from the implementation of the Friends and Family Test, the identification and monitoring of trends and early warning signs of changes and workforce review. The participation rate on the Friends and family test across specific areas in the Trust continues to be a challenge as the targets increase in 2014/15.

A workforce with robust clinical leadership is key to delivering services effectively therefore in 2014/15 greater emphasis will be placed on monitoring nursing and clinical skill mix and the impact that staff shortages have on patient experience and outcomes.

The Community Transformation Programme has been a significant local priority for Wiltshire in 2013/14 in terms of developing a model of care for community health services ensuring the right clinical balance of services between primary care, hospital care, community settings and patients' homes. Great Western Hospital foundation Trust has been pivotal in the development of Care Coordinators and the appointment of 23 new roles.

We will continue to support Great Western Hospital to drive improvements in patient safety through projects such as Pressure ulcer Reduction and Harm Free Care. We have a structured monthly quality review meeting with Great Western Hospital using a range of indicators and metrics from a number of sources.

NHS Wiltshire CCG welcomes the specific priorities for 2014/15 which the Trust has highlighted in this report all are appropriate areas to target for continued improvement and link with the Clinical Commissioning priorities

**Name Deborah Fielding**
**Title Chief Officer**
**NHS Wiltshire Clinical Commissioning Group**

## Statement from Swindon Health Overview & Scrutiny Committee dated 13 May 2014

The Swindon Health Overview & Scrutiny Committee is encouraged by the work that is already being undertaken to improve services for quality improvement.

The Health Overview & Scrutiny Committee is committed to having a good working relationship with the Great Western Hospital NHS Foundation Trust and, based on the Committee's knowledge, endorses the Quality Account for 2013/14.

The Committee welcomes attendance and regular reporting at its committee meetings and hopes that this will continue throughout 2014/15, albeit under a new Committee structure.

The Committee supports the areas for Quality Improvement and looks forward to continuing to work with the Great Western Hospital NHS Foundation Trust to provide improving health services for the residents of Swindon and the region.

**Sally Smith**
**Overview & Scrutiny Officer**
**Swindon Borough Council**

## Statement from Wiltshire Overview & Scrutiny Committee dated 30 April 2014

The Scrutiny Committee has been given the opportunity to review the draft Quality Account for GWH NHS Foundation Trust for 2013/2014. As background, the CQC carried out an unannounced inspection in October 2013, the findings of which were published in December 2013. Key areas of concern included cleanliness issues, staffing, and governance and monitoring problems; further concerns involved patient keeping practices.

The Committee was briefed by the Trust on the 19th January 2014 on their action plan to address these issues. These included the appointment of new nursing staff and practice development nurses to support the development of the existing nursing teams. The ratio of nurses to patients was seen as inadequate but, should be mitigated by an £1.2m investment in extra staffing, in the interim we were told that there would be some reliance on agency staff.

Overall, the Committee expressed concern at the findings of the CQC report and suggested that the findings were a 'wake-up call' to the leadership team.

The Committee also noted that the findings identified were made under the old inspection regime and hoped that a better picture of the Hospital might be achieved following an inspection under the new regime which is now in operation. The Committee will continue to support the Trust over the next year and will monitor the progress that is clearly now being made by the Trust to remedy any shortcomings.

**Mrs Christine Crisp**
**Chairman**
**Wiltshire Health Select Committee**

## Statement from Healthwatch Swindon dated 16 May 2014

Healthwatch Swindon is pleased to have worked with the Trust and welcomes the opportunity to comment on the Trust's Quality Account Report for 2013/14.

Healthwatch Swindon has been represented in a number of its forums during 2013/14, including the safeguarding forum, nutrition steering group and cancer users group.

We also established firm working arrangements with the PALS, customer service and communication teams in order to manage our new role as provider of independent complaints advocacy for NHS complaints and to pass on comments and feedback from local people.

We acknowledge the work undertaken by Trust staff to maintain and improve the quality of service provided in the acute hospital. However we have been concerned about a number of communication-related issues brought to our attention during the year.

Healthwatch Swindon will be monitoring progress on the Trust identified priorities for improvement during 2014/15 as well as drawing attention to other issues and comments brought to us.

We will be developing these relationships further during 2014/15 particularly with and through the Governors as elected representatives of local people in Trust membership.

**Pete Rowe**
**Manager**
**Healthwatch Swindon**

## Statement from Healthwatch Wiltshire dated 15 May 2014

Healthwatch Wiltshire welcomes the opportunity to comment on Great Western Hospitals NHS Foundation Trust Quality Account for 2013/2014. During the period Healthwatch Wiltshire was established as a new organisation to promote the voice of patients and the wider public in respect to health and social care services. As such, Healthwatch Wiltshire has sought to develop a relationship with the Trust in order to understand its approach to

patient and carer engagement and to satisfy itself that the Trust takes seriously all feedback from the people it serves.

The Quality Account references the unannounced inspection which was undertaken by the Care Quality Commission in November 2013. The Trust was found not to be fully meeting three of the standards in relation to cleanliness, staff numbers, and checks on quality (to assure health, welfare and safety of patients). Healthwatch Wiltshire notes that the Trust has worked hard to put in place an improvement plan and is currently implementing this (due for completion in May 2014) and is reporting regularly on progress. Healthwatch Wiltshire is pleased to support the Trust in its efforts to check the quality of the environment (particularly in respect to cleanliness) having been invited by the Trust to nominate volunteers to take part in PLACE visits (PLACE stands for 'Patient Led Assessment of the Care Environment').

The Trust reports on four incidents which are called 'never events' on the basis that they should never occur. The first two (which occurred in April and August 2013) resulted in an investigation and a report with recommendations. It is rather troubling therefore that a further two 'never events' occurred in February 2014. All of the 'never events' happened in the maternity department. Following the events in February the Trust has commissioned an external investigator to look into what happened and a report will be published in May 2014. Healthwatch Wiltshire welcomes this approach because it is important that local people feel confident that the Trust is responding to such incidents in a robust manner. We also note and welcome the Trust's 'rolling audit' of previously closed serious incident investigations (including 'never events') in order to ensure that there is a change of practice following learning from such incidents.

The Trust describes its priority for improving patient experience and reducing complaints. In particular Healthwatch Wiltshire is pleased that the Trust has involved customers in the development of a new complaints system which will be put in place in early 2014/2015. There was a target for reducing the number of complaints and this has been achieved. Formal complaints are one way the Trust can find out about patient experience however there are other methods including the Friends and Family test. This is a valuable way to pick up positive and 'mediocre' experiences (i.e. experiences which may not result in a complaint but would nonetheless be of interest to the Trust). Healthwatch Wiltshire notes the 'good' score which the Trust is achieving on its Friends and Family test.

The Trust has set out a number of priorities for 2014/2015 and one of these is in respect to patient experience. Healthwatch Wiltshire will work closely with patients, carers, and the wider community to help support the Trust in meeting its targets against the priority areas. Furthermore, Healthwatch Wiltshire recognises that the wider health care community has a role to play in the Trust's performance and as such will take a particular interest in monitoring the partnership effort to provide patients with a seamless experience of acute and primary health services and social care services.

**Patrick Wintour**
**Director**
**Healthwatch Wiltshire**

## Statement from Healthwatch Bath & North East Somerset dated 20 May 2014

Healthwatch Bath and North East Somerset

Healthwatch Bath and North East Somerset are pleased to endorse the comments by Healthwatch Swindon and the opportunity to comment on the Trust's Quality Account Report for 2013/14.

Healthwatch has been represented in a number of its forums during 2013/14, including the safeguarding forum, nutrition steering group and cancer users group.

Healthwatch also established firm working arrangements with the PALS, customer service and communication teams in order to manage our new role as provider of independent complaints advocacy for NHS complaints and to pass on comments and feedback from local people.

Healthwatch acknowledge the work undertaken by Trust staff to maintain and improve the quality of service provided in the acute hospital. However we have been concerned about a number of communication-related issues brought to our attention during the year.

Healthwatch Bath and North East Somerset will be monitoring progress on the Trust identified priorities for improvement during 2014/15 as well as drawing attention to other issues and comments brought to us.

Healthwatch Bath and North East Somerset hope to develop better relationships with the Trust during 2014/15 particularly with and through the Governors as elected representatives of local people in Trust membership.

**General Manager**
**The Care Forum**

## 2013/2014 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual;*
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2013 to 22 May 2014;
    - Papers relating to Quality reported to the Board over the period April 2013 to 22 May 2014;
    - Feedback from the Swindon Clinical Commissioning Group dated 16 May 2014;
    - Feedback from the Wiltshire Clinical Commissioning Group dated 20 May 2014;
    - Feedback from Governors dated 19 May 2014;
    - Feedback from Swindon Healthwatch dated 16 May 2014;
    - Feedback from Wiltshire Healthwatch dated 15 May 2014;
    - Feedback from Bath & North East Somerset Healthwatch dated 20 May 2014;
    - Feedback from Swindon Overview & Scrutiny Committee dated 13 May 2014;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Trust Board monthly;
    - The September 2013 national patient survey dated February 2014;
    - The 2013 national staff survey dated 27 January 2014;
    - The Head of Internal Audit's annual opinion covering the 2013/2014 period;
    - Care Quality Commission Intelligent Monitoring tools from October 2013 and March 2014

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report

By order of the Board

Chairman: Date 28 May 2014

Chief Executive: Date 28 May 2014

## Independent Auditors report to the Council of Governors of Great Western Hospital NHS Foundation Trust, on the Annual Quality Report

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

### Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

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 Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources - specified in the *Detailed Guidance for External Assurance on Quality Reports; and.*
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission intelligent monitoring reports 2013/14; and

- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those 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 Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Great Western Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). 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.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller 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 which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Great Western Hospitals NHS Foundation Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*

KPMG LLP

**KPMG LLP**

Chartered Accountants

100 Temple Street

Bristol

BS1 6AG

28 May 2014