NHS
Great Western Hospitals
NHS Foundation Trust

Quality Accounts

2018-2019

Service Teamwork Ambition Respect

Contents

1 Our Commitment to Quality – Statement from Nerissa Vaughan Chief Executive

I am pleased to present our Quality Accounts for 2018-2019

This report provides a clear account of our work over the past 12 months to improve the quality of care we provide and shares our priorities for the year ahead.

A huge amount of work has taken place in the last year to better integrate hospital and community services across Swindon, so whether in hospital, in a community facility or at home, our goal is for care to feel well-coordinated and joined-up at every stage of a person's journey.

Our new pathway of care designed to meet the unique and often complex needs of older patients, is a good example of how quality of care has improved through health and social care professionals working together in a more structured way. Patients attending the Emergency Department are starting treatment sooner, are more likely to leave hospital the same day and are receiving specialist older person's care throughout their stay in hospital and beyond.

We are now exploring further opportunities to work more closely with GP practices, social care and voluntary organisations. This work aims to remove organisational barriers, improve communication and introduce more joint working, while improving the experience of patients and their families and creating a more rewarding working life for staff.

Like the rest of the NHS, we must transform local services to ensure we can consistently meet the needs of local people and maximise the value of every pound we receive. The golden thread of this work is quality, which remains at the heart of every decision we make and everything we do.

Our life saving work on sepsis continues and we're proud to be one of the top trusts in the country for identifying and treating this life threatening condition, with 80 per cent of patients making a full recovery. The work of our Acute Sepsis and Kidney Injury Team means we are also spotting the signs of acute kidney injury sooner and so more patients are surviving. These are just a couple of examples of how we are adopting international best practice, standardising processes and focusing on education to provide care which is safer and more effective than ever before.

Over the last year, quality improvement has become an integral part of our everyday work, alongside a culture of openness and learning from mistakes. As we look forward, this will form an even stronger focus, as a key theme throughout our new Trust strategy.

This approach to improvement was reflected in the results of our latest inspection by the Care Quality Commission. While we received a rating of 'requires improvement' overall, the vast majority (80 per cent) of our services were rated as 'good', with a number receiving 'good' across the board, including children's and young people's, outpatients and community. This shows the progress we're making, with just 50 per cent of services rated as 'good' three years ago.

As we look to the future, the expansion of some of our emergency and urgent care services will be a major part of our quality improvement work, helping us to meet the needs of a rapidly growing population, particularly at our busiest times. This is why we were delighted with our successful bid for £30 million national funding to support our new Way Forward Programme, which will help to address these challenges over the coming years.

This programme of work, together with developments like the new Radiotherapy Centre, made possible through the incredible fundraising achievements of local people, will result in a number of exciting changes on the Great Western Hospital site, helping to save more lives.

It is not only major developments like these that make a difference to patient care, there are many smaller scale initiatives designed to improve quality.

We are the first trust in the country to introduce the Hidden Disability Lanyard Scheme, which helps staff to recognise when someone has a hidden disability such as autism.

Our Red Bag Scheme is ensuring that care home residents experience a smoother arrival and discharge from hospital, with their belongings stored in one place.

As the proud winner of the ‘Golden Hip Award’, we have seen hip fracture patients recovering more quickly and fewer deaths, following significant improvements to nutrition, surgery and mobilisation.

The CardioMEMS™ Heart Failure system is enabling doctors to remotely monitor cardiology patients and detect early signs of heart failure. This technology means changes to medication and other interventions can happen sooner, so patients are less likely to need hospital treatment and are experiencing a better quality of life.

As you read through this document, you will see many more examples of innovation, transformation and standardisation, all with safety and quality at the heart.

Looking ahead, our integrated approach to care means there will be more opportunities to help people stay healthy, do more to keep long-term conditions such as diabetes under control and prevent ill health, ultimately helping people to stay well.

I hope you enjoy reading about our progress and our plans to further improve the quality of care we provide across Swindon.

Nerissa Vaughan

Chief Executive

2 Priorities for Improvement & Statements of Assurance

2.1 Priorities for Improvement 2019/2020 & Review of 2018/2019 Priorities

This section sets out our priorities for improvement during 2019/2020. Two of these priorities were identified in our 2018/19 Quality Accounts ('Improving effectiveness of nursing handover and timely discharge communication' and 'Increase Quality Improvement (QI) capacity through implementing a Trust-Wide programme of QI training'). For this reason a review of the previous year's progress as well as plans for 2019/20 are detailed in this section of the report.

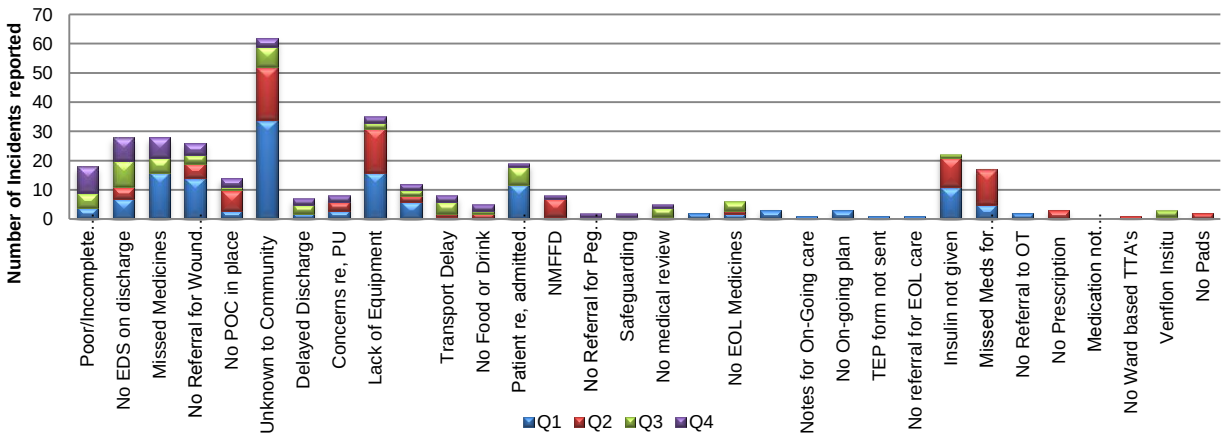
Our priorities for the forthcoming year have been influenced by national and local agenda's, our internal learning from experience, feedback from our staff and stakeholders (including partner organisation, patients and carers). Our priorities are also agreed through our quality contracts with our local Clinical Commissioning Groups (CCG's) and take in to account intelligence we have from available data.
These priorities have been consulted on with the Trust Governors as patient/public representatives, Healthwatch and other key external stakeholders. Progress will be closely monitored and reported through our Patient Quality Committee, Quality Governance Committee and Trust Board.

Our Priorities for Quality Improvement – Our Focus for 2019/20

- Improving effectiveness of nursing handover and timely discharge communication
- Improve patient experience and engagement and improve complaint response timescales
- Increase Quality Improvement capacity through implementing a Trust-Wide programme of Quality Improvement training
- Develop the support provided to carers of a persons living with dementia
- Reduce our rates of Clostridium Difficile infection

Improving effectiveness of nursing handover and timely discharge communication

This priority was identified within the 2018/19 Quality Accounts and remains a key priority given on-going challenges in ensuring safe discharges which have been identified internally and by external partners. In quarter one, two and three our Patient Advice and Liaison Service highlighted that they were receiving a high number of calls relating to concerns around discharges. In quarter four the number has reduced and this has been evidenced by two recently undertaken audits.



The chart above demonstrates the number of handover and discharge related incidents each quarter during 2018/19 with 'unknown to community' associated incidents being the highest number reported. This data is reviewed as part of our Discharge Transformation Steering Group and alongside other evidence informs areas for improvement. Workstreams have been established to lead on improvements in key areas of concern during 2018/19 which will continue in to 2019/20. The work streams are:

- The Safer Discharge Project
- Community Referral Improvement Project
- Electronic Discharge Summary (EDS) Improvement Project

- Nurse Documentation Review

Safer Discharge Project

The safer discharge project has focused on ensuring that key safety milestones are achieved from the beginning of a patient's admission until the end. In the past year a Safer Discharge Checklist has been implemented on all in-patient areas across the acute and community settings. Towards the latter part of the year the checklist was reviewed and a decision was made to provide the assessment areas, excluding the Emergency Department, with a more tailored version of the checklist, to ensure it met the needs of those patients who are only with us for a very short period of time. In line with our adopted Quality Improvement (QI) Methodology this will be evaluated following a further period of testing.

Community Referral Improvement Project

During the previous year a revised community referral form has been implemented across the organisation. This has resulted in a recent drop in the number of clinical incidents reported, relating missed referrals to community services. Despite this our ambition is to reduce such incidents further and during the next year we will continue to closely monitor missed referrals to community services and use identified issues as opportunities to learn and further develop the safety of our services.

A key success story has been the reduction in the number of missed referrals to community services for those patients that require insulin administration. To take this further there is QI project underway within the community looking at the delivery service for those patients requiring insulin. The project is in its infancy stage at the moment.

Electronic Discharge Summary (EDS) Improvement Project

During the past year there we have received feedback from partner organisations (including G.P's) relating to the timely completion and quality of our EDS. In response to this a working group has been established with key people from the organisation and the community to review the process and manage compliance.

With the support of the trust QI Lead a Quality Improvement Project has been instigated to drive and support sustainable change. The project has had input from a wide range of professions and roles within the organisation and from external partners, including Consultants, Ward Administrators and G.P's. A number of processes were changed (including clarification of roles and responsibilities) and training was provided. Tests of change were implemented and improvements were seen on the wards involved. These improvements have been shared across the organisation and we have begun to see a ripple effect in the timeliness of EDS's being sent.

Despite the improvements described above we are committed to further improvements going in to the next year. To support this, the trust Medical Director has recently established an EDS Task and finish group to bring further focus on improvement going in to the next year.

Nurse Documentation

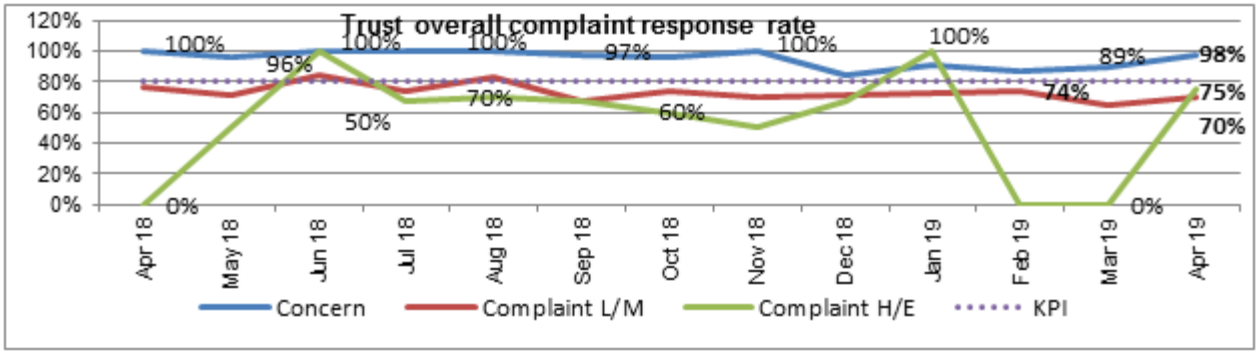
During 2019/20 we plan on further review nursing documentation used within the hospital. This is a key area to support not only safety during admission but also discharge planning and implementation.

Improve patient experience and engagement and improve complaint response timescales

During 2019/20 we plan on enhancing our approaches to engaging with patients and involving them in the development of the quality of our services, to ensure that we fully learn from the positive and negative experiences they have had, A key part of this will be to further refine our management of complaints to ensure that they are appropriately responded to in a timely manner. Key areas for improvement for 2029/20 are:

- Increase Friends and Family Response Rate
- Collaboratively develop and launch new Patient and Carer Involvement Strategy
- Further review processes to improve timeliness of responses to complaints

The table below shows the GWH Complaint response compliance for 2018/19. A complaint is considered as being responded to within timeframe when it is responded to within 25 working days. The exception to this is if an extension is applied in agreement with the complaint.



Increase Quality Improvement capacity through implementing a Trust-Wide programme of Quality Improvement training

This priority was identified during the 2018/19 Quality Accounts and remains a priority going in to 2019/20. Over the course of the past year QI skills have begun to develop across the organisation. Bronze level training has commenced and a training plan is in place to ensure increasing numbers of staff are given the opportunity to develop QI skills. Bronze training has also been incorporated into the leadership course (3 Cohorts per year) and the stepping up programme (Bi-Monthly). We are working with NHS Elect and they are providing us with a number of courses over the next 12 months that will develop our QI coaches. These sessions include Human Factors, difficult conversations and conflict resolution, leadership and coaching.

Fifteen members of staff have now joined the Health Foundation Q community, gaining access to regional networks and training opportunities.

A QI on line registration form and data base have now been developed which shows at a glance the number of projects, where they are taking place and who is leading on those projects.

We have joined a Delivery Improvement Network engaging with other organisations that are at different stages of the Quality Improvement journey. This enables us to network and bench mark ourselves with other organisations and learn from their experiences.

There are a number of NHSI projects in progress within the organisation these include Maternity and Neonates, Nutrition, Oral care, Frailty, Pressure Ulcers and Criteria Led Discharges.

Following the approval of the business case the QI Lead is now in post focusing on developing the Training plan, Trust wide Projects and supporting/coaching teams undertaking QI projects.

Staff are actively sign posted to external providers, such as the Academic Health Science Networks, for formal QI training QI toolkits have been developed and are available on the Trust Intranet site.

Many more staff are developing QI skills and expertise through involvement in projects at local and regional level.

On the 5th of November 2018 we held a QI day. All staff that have QI projects underway were invited to produce a poster to celebrate their projects. The aim of the poster day was to advertise the projects and the outcomes either achieved or potential outcomes and benefits.

Over 70 posters were on display with as many staff dropping in to talk about new ideas and fill our innovation tree. The trust Clinical Lead for Quality also presented at the Grand Round, inspiring our clinical teams to become involved with QI projects. We are planning a future event in June but opening it to the wider Quality Team.

Further improvements identified for 2019/20

- Continue to develop, deliver and evaluate the strategy and to build organisation wide knowledge and skills in quality improvement;
- Continue to develop and review the coordinated programme of training to provide staff with the skills and knowledge to use QI methodology in practice
- Provision of coaching support to individuals and teams undertaking quality improvement projects;
- Project leadership for high risk Trust wide projects
- Identify key members of staff to apply for membership of the Health Foundations Q Community during the next application round.

Develop the support provided to carers of a persons living with dementia

During 2018/19 we have been working closely with Dementia UK who have part funded two Admiral nurses to work with our in patients and their carers and continue to support the patient and their carers when they are discharged in to the community. This is a two year pilot project and was officially launched on 21/01/19. The Admiral Nurses are also a valuable support to the ward teams sharing their knowledge and expertise in order to improve the safety and experience of our patients with dementia.
Going in to 2019/20 our admiral nurses and dementia leads will be continue to review the support available to carers, of people living with dementia, to ensure that they are well supported.

Reduce our rates of Clostridium Difficile infection

During 2018/19 we have introduced and maintained a number of initiatives to improve patient safety that are detailed in the core indicator section of these accounts. Despite this we have reported 27 cases of Clostridium Difficile, 2 more than 2017/18 and 8 above our nationally mandated goal for 2018/19. Each case has been investigated in conjunction with our Commissioners. Of the 27 cases, 15 have been deemed unavoidable and 11 have been deemed as avoidable and care improvement recommendations made. The review of the final episode is outstanding.

Moving in to 2019/20, we plan to continue monitoring and reducing risk factors for C.diff including promoting antibiotic stewardship, rapid isolation and sampling. Recommendations identified through the 2017/18 time to isolation & specimen taking audit will be implemented through quality improvement methodology. In addition, ward/departmental ownership of local cleaning standards, including patient care equipment, antibiotic prescribing needs to continue with the aim of preventing avoidable cases of C.diff.

Review of 2017/18 Quality Account Priorities

This section provides a review of progress against the priorities identified in our 2017/18 Quality Accounts (excluding those which are included in this year's priorities, which are detailed in section 2.1)

Saving 500 Lives

The trust remains committed to deliver its ambition to save an extra 500 lives over 5 years, commenced in 2015, with the continuation of this ambition for 2019/20. We will continue to progress our safety improvement plans through projects to improve quality and safety which continues to be measured, monitored and reported through our Patient Quality Committee, Quality Governance Committee and Trust Board.

The overarching project plan, for delivery of Sign up to Safety, finished in March 2018. During 2017/18 this covered the following key areas of focus, a combination of national aspirations and our own specific improvement areas. The Trust is committed to continue to drive and continually improve these key areas during 2019/20.

- Reducing falls
- Reducing pressure ulcers
- Management of sepsis
- Recognition and rescue of the deteriorating patient
- Acute Kidney Injury (AKI)

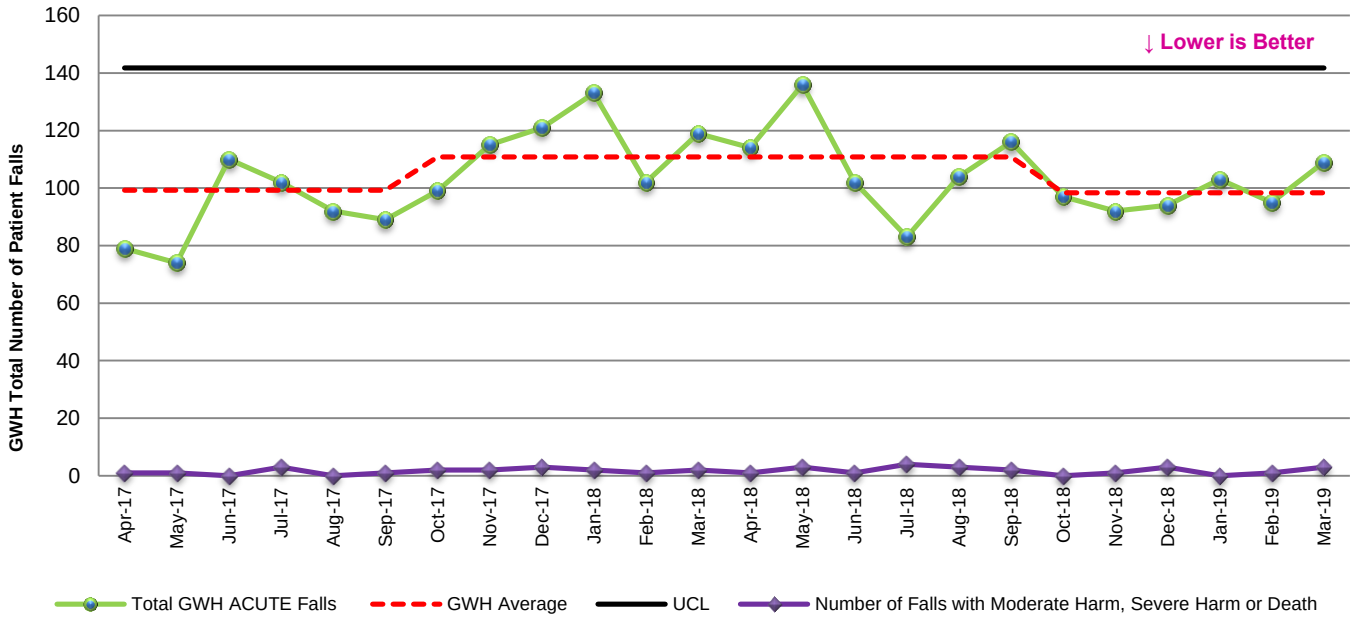
Reducing falls

Falls are one of the leading causes of harm in hospitals. The human cost of falling includes distress, pain and injury, loss of confidence and increased morbidity and mortality.

- On average 103 falls were reported within the Trust each month during 2018/2019 which is comparable to the previous year.
- During 2018/19 we reported 22 falls resulting in moderate or severe harm, averaging fewer than 2 a month, sustaining the average compared to previous years, despite the increase in the number of admissions into the Trust.
- The Trust has not reported any patient deaths following a fall since 2016/17.

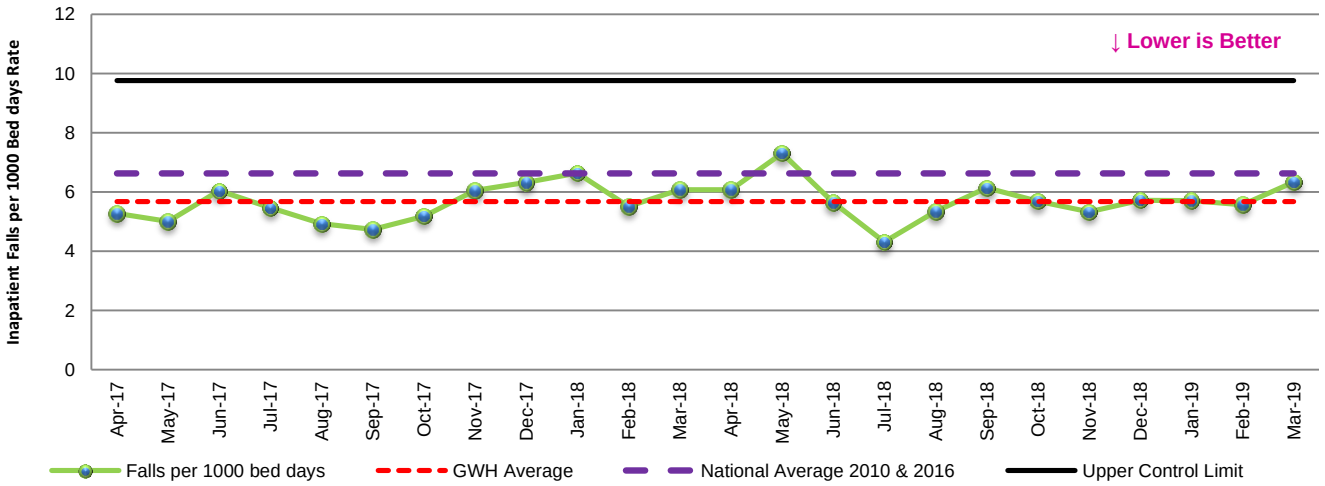
In February 2018, the Trust also opened an eight bedded area (Dorcan Unit) for additional capacity which is included in our reporting of Trust wide falls to ensure appropriate oversight.
Year on year our target is to continue to reduce the number of falls and in particular the number of falls which result in significant harm.

Total falls across the Trust



The chart above shows the total number of falls reported by the Trust each month and the number of falls resulting in moderate or severe harm.

Falls Rate per 1000 Bed Days



The chart above demonstrates the Trusts inpatient falls rate per bed days sits below the national average.

What improvements have we achieved?

We have been consistently below the national average rate for falls per 1000 bed days for 11 out of 12 months in 2018/2019.There have been no deaths caused from inpatient falls reported in 2017/18 and in 2018/19

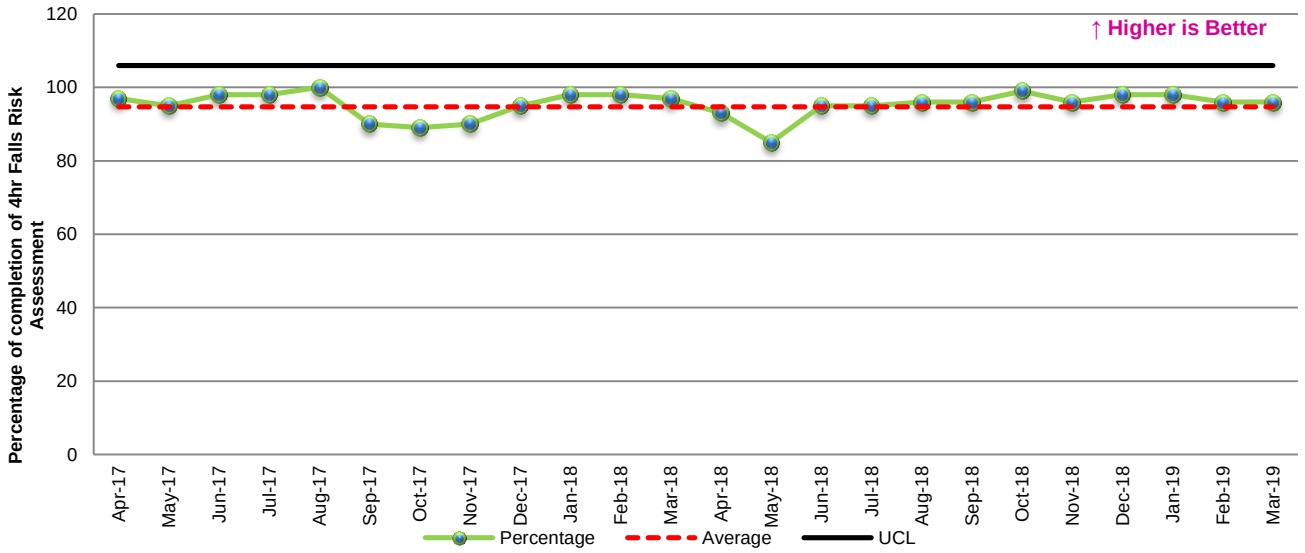
Over the last twelve months, our focus has been to embed an analytical approach to preventing falls based on clinical data and observations to help identify where we can improve our practice. The old post falls incident form design meant that there were numerous missing variables which made looking at patterns of falls very difficult. Many fields, such as the bed number, are now mandatory to ensure effective communication of hot spots on specific wards. The data obtained from the new post falls incident form has already allowed us to focus more on interventions that will help reduce falls and harm from falls, for example, looking at the effect of medication on falls, looking at environmental obstacles, looking at the type of footwear patients have on when they fall as well as the use of bedrails in patients who have fallen. All of this information is fed back to the Falls Operational Group and used to aid discussions on safety.

All Ward Managers/Allied Health Professionals are attending the monthly Falls Operational Group meetings to share learning Trust wide. The primary purpose of the Group is to identify, pilot, measure, implement, embed and sustain practices and processes that promote a safety culture around falls avoidance and reducing harm from falls. The Group regularly review falls trend analysis and reviews incidents resulting in harm from a fall, and any incident where there is learning.

The Trust made improvement in 6 out of 7 indicators of the National Falls Audit for the Royal College of Physicians (RCP) in May 2017, work continues during 2018/19 to further improve against these indicators. The organisation is participating in the RCP National Audit which commenced in January 2019 (results not yet issued).

The Trust completes regular snap shot audits every month to ensure every patient is assessed for their risk of a fall within 4 hours of admission or transfer to a ward. The compliance rate for the completion of the risk assessments has increased over the past 12 months, with a sustained improvement.

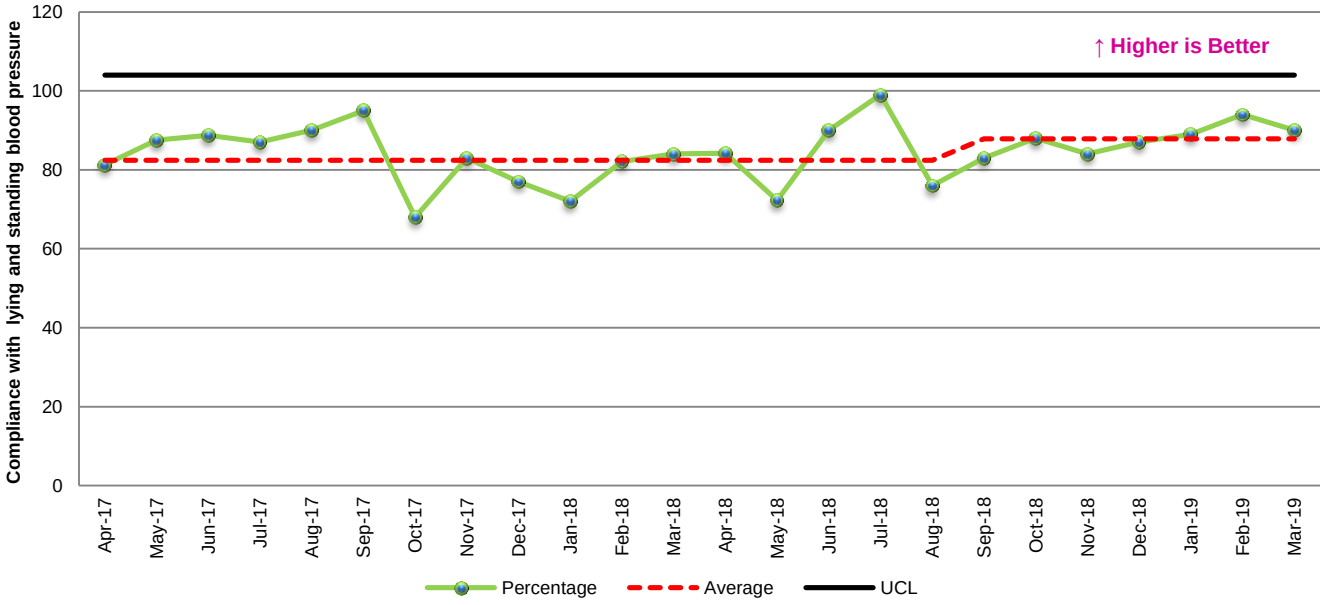
Falls Risk Assessment



The chart above demonstrates the Trusts percentage of completion of falls risk assessment with an average of 95% completion over the last 12 months. Assessment for a postural drop by taking a lying and standing blood pressure is also monitored via this snap shot audit.

The compliance rate for the completion of the lying and standing blood pressures and the identification of a postural drop have also both increased over the past 12 months with a sustained improvement.

Compliance with lying and standing blood pressure



This chart demonstrates the sustained improvement for the completion of a lying and standing blood pressure during the completion of the falls assessment, with the new average being 88.0%, and increase from 82.4%.

The identification and assessment for Delirium was an area when we scored lower than expected in the RCP audit of 2017, it has also been identified as one of the more common causes of inpatient falls. We have amended the post falls proforma completed by the medical staff which now includes assessing for delirium as a contributing factor to the fall. Identifying delirium in post fall assessments will inform the forward medical plan and allow us to better manage our confused patients, reducing the risk of a patient having multiple falls, reducing multiple admissions and prolonged stays in hospital.

The Trusts Safety Rails policy has also been amended in line with best practice. Compliance for this will be monitored in the coming year.

Drivers for improvement

- Post Fall Proforma - designed by the junior doctors to ensure a standardised proforma provides consistency of documentation between doctors and increases confidence when dealing with a fall
- EDS to inform GP of a fall during the admission
- Joint working with Swindon CCG and partner organisations as part of Swindon Falls and Bone Health Collaborative
- Digital Reminiscence Therapy (Interactive multimedia to stimulate personalised memories) equipment is being used across the Department of Medicines for the Elderly (DOME) wards.
- Quality improvement projects for preventing deconditioning syndrome (an improvement project to get patients up, get dressed and keep moving) in various wards.

Further Improvements identified and our priorities for 2019/20

- Review and update Falls Avoidance Policy and Falls Strategy.
- Participate in the Royal College of Physicians National Audit which commenced January 2019 looking at patients who have sustained a hip fracture while in hospital.
- Falls prevention measures form part of Ward Assessment and Accreditation Framework

Reducing avoidable pressure ulcers

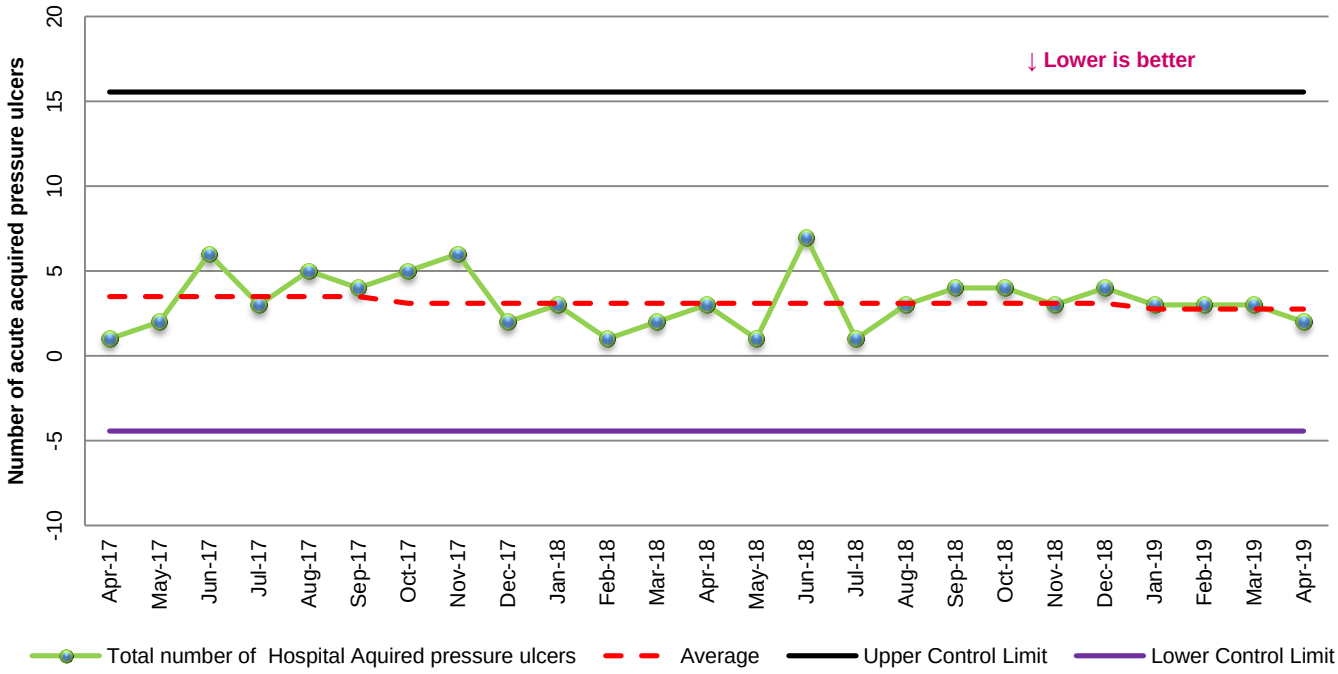
Pressure ulcers typically affect patients with health conditions that make it difficult to move, in particular patients sitting for long periods of time or confined to lying in bed.

The development of a pressure ulcer can have a negative impact on our patient's quality of life by causing pain, emotional distress and loss of independence. They also increase the risk of infection and prolong hospital stays. In the most serious of cases pressure ulcers increase a patient's risk of death.

Many pressure ulcers can be prevented through effective risk assessment and care planning for our patients, and ensuring our patients are kept mobile, changing positions wherever possible.

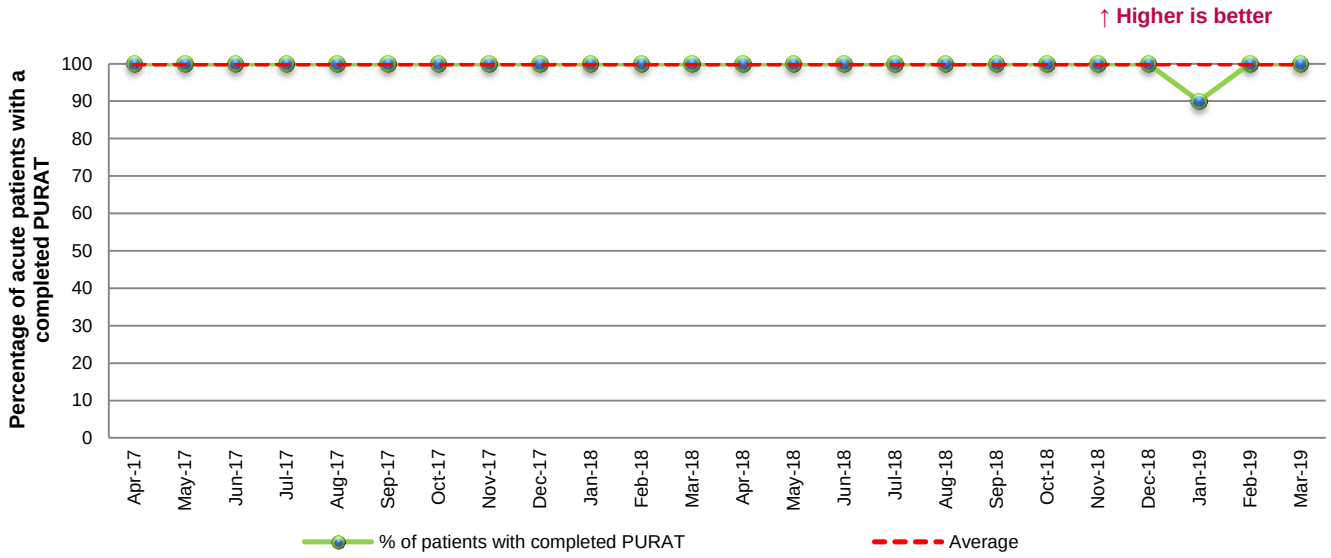
- We reported an average of 3 acute patients per month with pressure ulcers during 2018/2019 sustaining the average on previous years. 1 category 3 pressure ulcer was reported during 2018/19, this remains the same as 2017/2018.

Total number of acute inpatient pressure ulcers (category 2, 3, 4 for all acute inpatients)



The chart above demonstrates the total number of avoidable and unavoidable category 2, 3 and 4 Pressure Ulcers in acute inpatients.

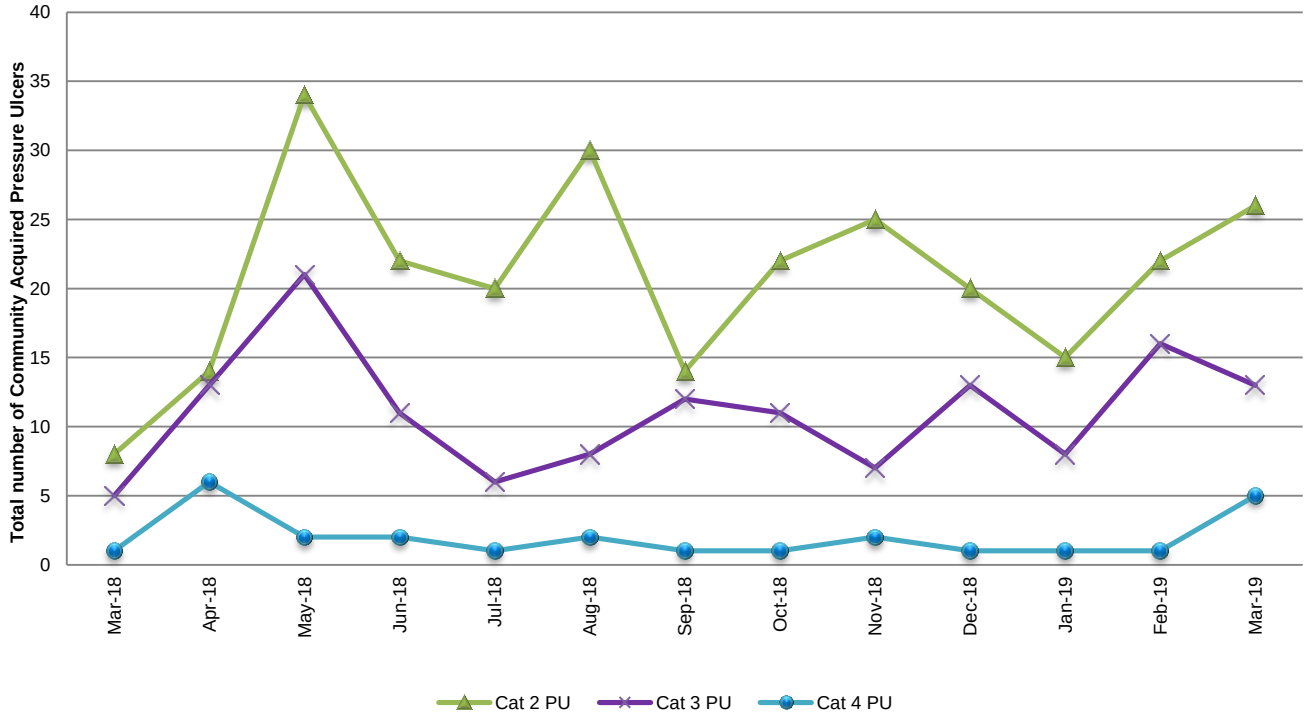
Percentage of acute patients on hotspot wards with a completed Pressure Ulcer Risk Assessment Tool (PURAT)



The chart above shows the percentage of at risk inpatients that have had a pressure ulcer prevention core care plan completed. We consistently achieved 100% for acute, at risk inpatient's who have had a pressure ulcer prevention core care plan in place (in samples of 25 patients records reviewed per month). There was one month where this reduced to 90%.

This data is taken from our monthly audits of the 5 hot spot wards which are wards where pressure ulcers are most frequently reported.

Total number of community acquired pressure ulcers (category 2, 3, 4)



The chart above shows the number of acquired pressure ulcers reported within community services during 2018/19 with category 2 being the highest.

What improvements have we achieved?

- New E-referral process to the Tissue Viability Service has been developed in conjunction with Nerve centre and is about to evaluated on two wards prior to distribution to all clinical areas. The aim is to improve timely referrals and safeguard the process, reducing errors.
- Tissue Viability Nurses (TVN's) investigate complex wounds and pressure ulcers incidents. For each category II pressure ulcer and above, the TVN's work with the relevant ward manager to review the patient journey.
- Following the guidance in June 2018 from NHSi re the standardisation of terminology, documentation and the reporting process of all Pressure Ulcers a quality improvement plan across the organisation was commenced. Being an integrated trust and Tissue Viability team has improved this process, offering standardised approaches, seamless working and a consensus approach, this has also been re-enforced with the consensus approach across the Tissue Viability Teams within the STP.

  Tissue Viability Nurses (TVNs) conduct monthly audits for Hot Spot Wards (wards where pressure ulcers are most frequently reported)

These audits include:

1. Percentage of patients that have a Pressure Ulcer Risk Assessment (PURAT) completed within 2 hours of admission to the ward.
2. Percentage of patients with a Pressure Ulcer Prevention Core Care Plan completed
3. Percentage of patients with the correct pressure relieving mattress
4. Percentage of patients that have a Wound Assessment and Management Care Plan completed
5. Percentage of patients with the frequency of repositioning documented on the Pressure Ulcer Prevention Core Care Plan
6. Percentage of patients who have the Intentional Rounding Tool (an assessment tool to determine a patients level of risk of pressure ulcer development) in place

- An Annual wound audit is conducted.
- Successful Integration of a Tissue Viability service across both acute and community division's joint meetings and training are taking place with joint working on pathways and seamless patient journeys.
- Educational sessions continue supporting the Academy with on-going programmes - Health Care Assistant mandatory training; the Stepping up programme; Care of the older person's course; Accelerated return to learning and Trainee Assistant Practitioner course.
- Re-implementation of the wound care link nurse meetings to champion knowledge on the wards, with dissemination of updates and new dressings. The meetings are quarterly.

Further improvements identified and priorities for 2019/20

- Integration of the link group with community link nurses (community and practice nursing)
- Development of 2 databases one for the reporting of hospital acquired pressure ulcers, the patient journey and if there are any missed opportunities in care, and one for the reporting of patients who have been discharged into Swindon Community with skin integrity issues, we look and reflect on each IR1 individually and update each incident accordingly. The data bases are updated monthly.
- Implementation of the E referral process across the organisation (acute division) following completion of trial - this will ensure referrals are more efficient between the ward and the Tissue Viability Service.
- Quarterly newsletter designed and sent out trust wide to keep staff updated about the service
- Educational sessions to continue supporting the Academy with on-going programmes - Health Care Assistant mandatory training; the Stepping up programme; Care of the older person's course; Accelerated return to learning, Trainee Assistant Practitioner course and medical staff.
- Implementing and embedding of the NHSI new categorisation of pressure ulcers, to include unstageable, moisture associated skin damage, device related and deep tissue Injuries which will be reported on monthly.

- Education on the use of Kerrapro to all wards and departments which is a silicone pressure relieving aid can be applied in strips, squares, sacrum and heel shaped and assists in relieving pressure on pressure points such as heels, sacrum, spine, hips and any other pressure areas. The strips can also be used under medical devices such as oxygen behind the ears, or over the nose for example.
- Mattress Audits are carried out prior to bank holidays to ensure the appropriate use of dynamic mattresses across the trust. Every ward is audited to see whether a patient could be stepped down, thus ensuring sufficient resources and effective use of equipment.

Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) is a sudden deterioration in kidney function that affects up to 20% of patients (1 in 5) admitted to hospital. It can range from minor loss of kidney function to complete kidney failure, and in the most serious cases can lead to death.

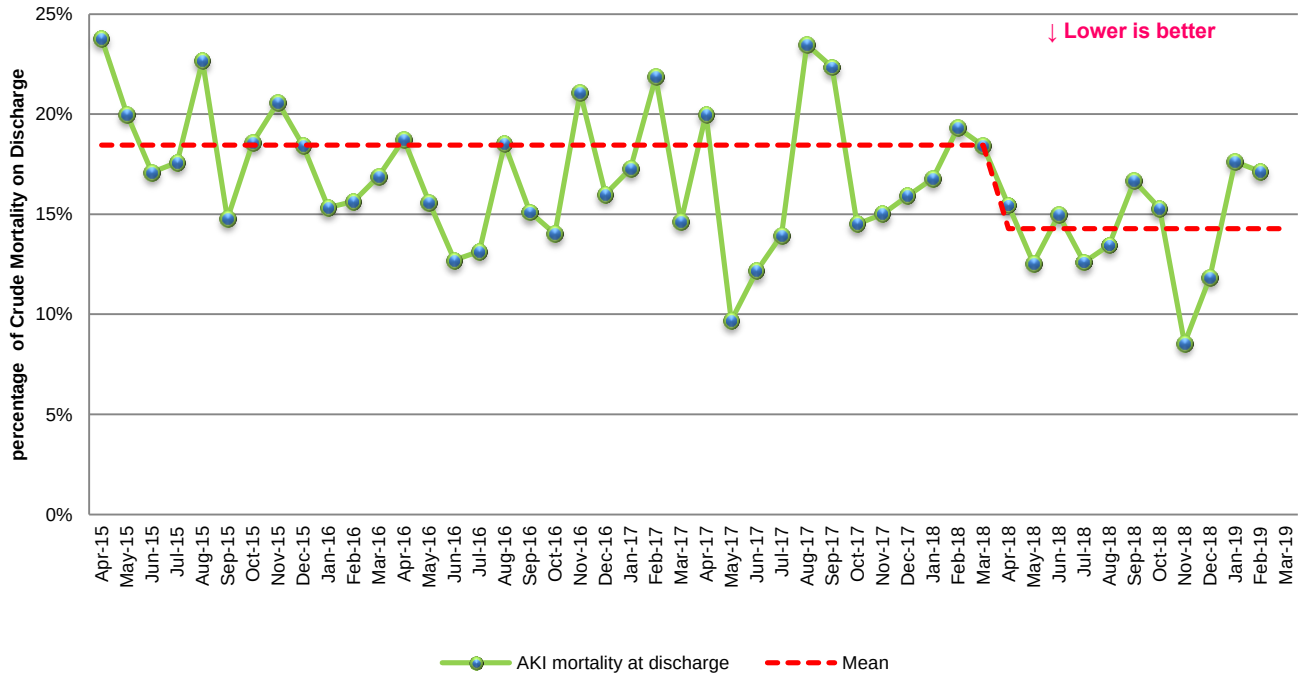
With early detection and the right care at the right time, both the risk of death and long term damage to the kidneys is greatly reduced.

As a common and potentially life threatening condition, we are passionate about proactively improving care and saving lives.

- During 2018/19 we reported an average of 14.7% of our patients die each year in our hospital with Acute Kidney Injury. This is a decrease on last year where we reported an average of 16%.

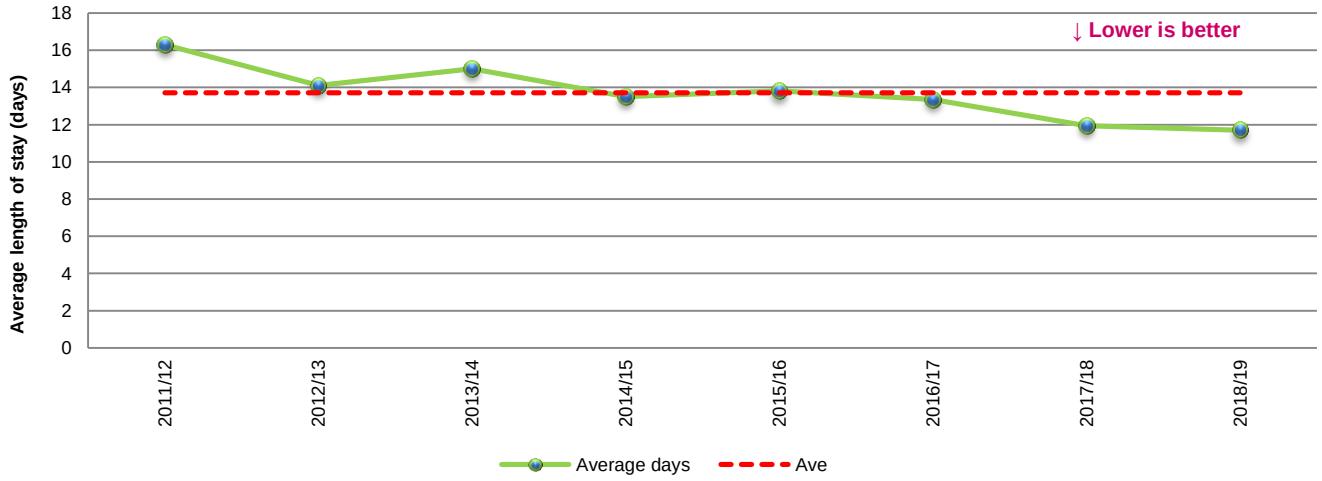
Time period	Average mortality at discharge with AKI
April – Dec 2015	19.28%
2016/17	16.58%
2017/18	16.79%
2018/19	14.69%

Crude mortality on discharge: patients with a clinical code of AKI (primary or secondary)



The chart above shows the crude mortality on discharge with patients who have a clinical code of AKI (Primary or secondary.

Average length of stay (days)



The chart above demonstrates average length of stay a patient stays in hospital with a diagnosis of AKI. A decrease in length of stay can be seen from 2013/2014 since awareness work started demonstrating that early recognition and treatment of AKI results in a shorter stay in hospital.

What improvements have we achieved?

- Implemented the AKI Kidney 5 Care Bundle which focuses on early treatment of Sepsis, Hypovolaemia, Obstruction, Urine Analysis and review for nephrotoxins (SHOUT). Patients flagged with AKI receive five standard elements of care proven to be effective in managing AKI and complex patients are managed with input from our on-site Nephrologist Dr Tanaji Dasgupta (Project Lead) so that patients with tertiary care are identified for timely transfer.
- Ward pharmacists carry out medicine reviews of all patients flagged with AKI to determine the most appropriate medication to manage their AKI and aid recovery.
- The Acute Sepsis and Kidney Injury (ASK) Team continue with their responsibility for ensuring all patients with AKI are treated using the same set of clinical interventions which are based on international best practice. The team work with staff across the organisation and healthcare partners to raise awareness of the signs and symptoms.
- Data from our Trust is shared with the Renal Registry as part of national benchmarking and we are also participating in regional quality improvement initiatives in collaboration with the Oxford Academic Health Science Network.
- AKI flagging direct to GP surgeries commenced in early 2019.

Further improvements identified and priorities for 2019/20

- To continue to improve on the use of the AKI care bundle with the support of the ASK Team.
- We will develop care pathways with GPs and community healthcare providers to improve prevention of Acute Kidney Injury with our patients before coming into hospital and support appropriate care to aid their recovery once home.
- We will bring electronic flagging of AKI into real-time alerting using the NerveCentre e:observations system. This will ensure increased awareness amongst clinical staff and should encourage timely delivery of the Kidney 5 SHOUT care bundle.

Sepsis

Sepsis is a common and life threatening condition caused by the body's own response to infection. Sepsis occurs when severe infection in the body triggers widespread inflammation, swelling and organ failure.

Each year in the UK, it is estimated that more than 250,000 people are admitted to hospital with sepsis and at least 52,000 people will die as a result of the condition. (UK Sepsis Trust 2018).

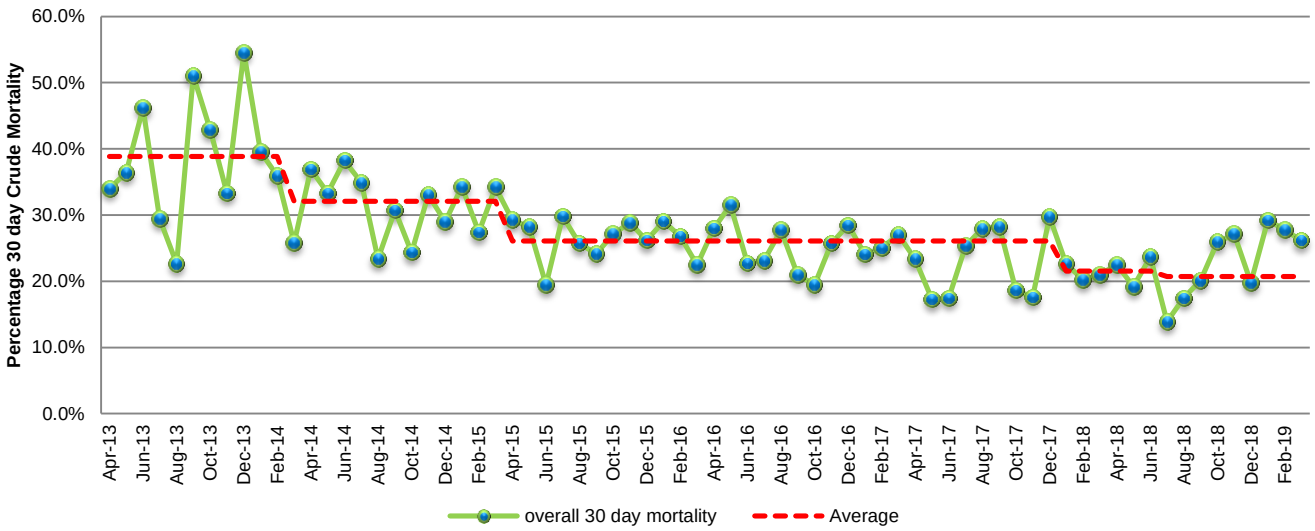
Effective delivery of the Sepsis Care Bundle (Sepsis 6 UK Sepsis Trust) increases patients' chance of survival by up to 30%. Overall national mortality rate for patients admitted with severe sepsis is 35%. (UK Sepsis Trust 2014) Changes to the way we diagnose and classify sepsis came into use during 2016, and is likely to continue to adapt and develop over the coming years.

In 2014/2015 we reported an average of 25% of patients admitted with severe sepsis that die within 30 days of discharge. We used this first year of data collection to set our annual mortality target to less than 23% sustained level of mortality from severe sepsis until 2018.

In 2018 we revised the way we collected data on Sepsis which widened the category of patients included. This has led to the data showing an increase in our percentage of patients admitted with sepsis who died within 30 days of discharge, from 15% (2016/17) to 22% (2017/28). Despite the change to the way the data is collected 22% remains below our initial annual mortality target of 23%, which was set using the previous data collection method. This achievement is as a result of the significant service developments described below .

30 Day Mortality

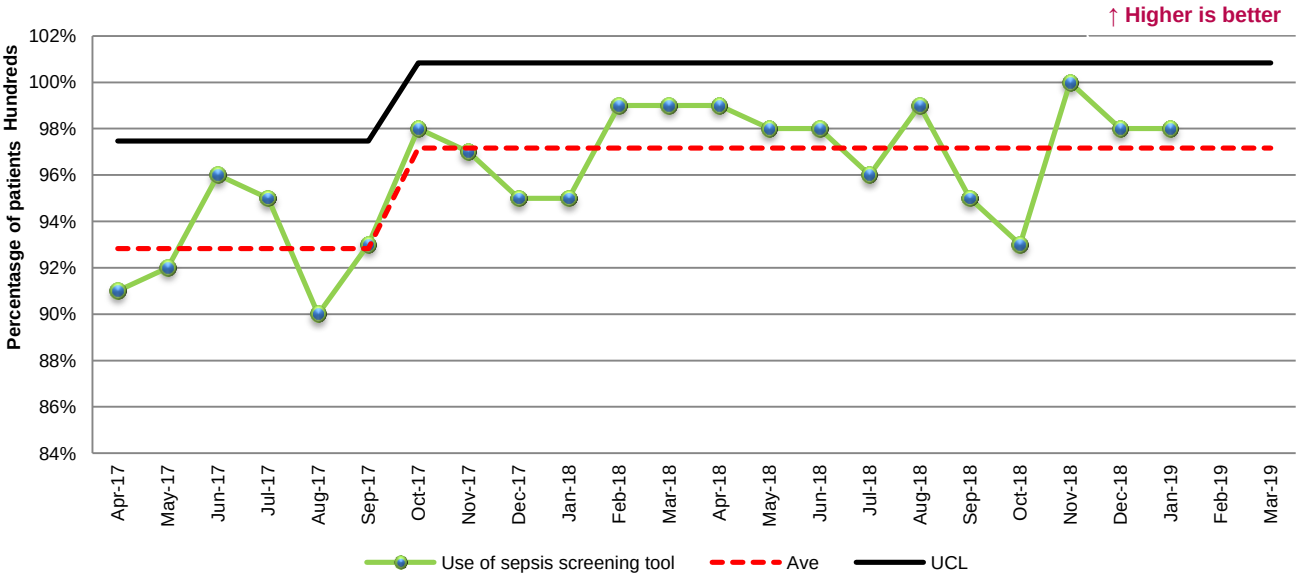
↓ Lower is better



The chart above shows 30 day crude mortality from severe sepsis.

Percentage of patients who have documented evidence of the use of the sepsis six pathway

↑ Higher is better



What improvements have we achieved?

- ASK Specialist Nurses Team has achieved a seven-day service consistently running since November 2017.

- Individual ward focussed/ simulation teaching. Training has been recently delivered to Falcon Ward, Shalboure Ward and Teal Ward in February.
- Sepsis Grab Bag trial currently running on Beech, Neptune, SWICC and Meldon using the red (penicillin) and blue (penicillin allergy) bag. The grab-bag trial has been extended to ACAT within the medical admissions service.
- Physical presence of ASK Team daily in ED, SAU and ACAT/ AMU
- We have continued to monitor and improve usage of our standardised Sepsis screening tool and Sepsis 6 Care Bundle for all emergency admissions to the Trust.
- Audit of all patients in our Surgical Assessment Unit (SAU) receiving Sepsis Screening.
- NEWS2 rollout has completed, with ED moving onto Eobs during October 2018.

Further improvements identified and priorities for 2019/20

- Planned to launch in May of 2019 will be the sepsis module of our electronic observations system NerveCentre.
- ALL patients observations will be screened for the presence of "red-flags" according to the NICE 2016 guidelines for sepsis (https://www.nice.org.uk/guidance/ng51)
- Linking out to Community services – Training commenced/planned for 2019: Swindon Community Teams, Goatacre Nursing Home.
- Education sessions for Oxford Brookes Nursing students, now planning further sessions in 2019.

Recognition and Rescue of the Deteriorating Patient

Recognition and appropriate timely management of the deteriorating patient has been recognised nationally as an area of concern. Numerous reports since the 1990s have identified patients are physiologically deteriorating, however that deterioration is not recognised appropriately or acted on as required, resulting in potential harm to the patient. In the worst case scenario this can result in the patient having an avoidable cardiac arrest.

Our improvement work aims to identify the range of contributory factors underpinning this aspect of patient care and implement changes in practice to improve patient outcomes.

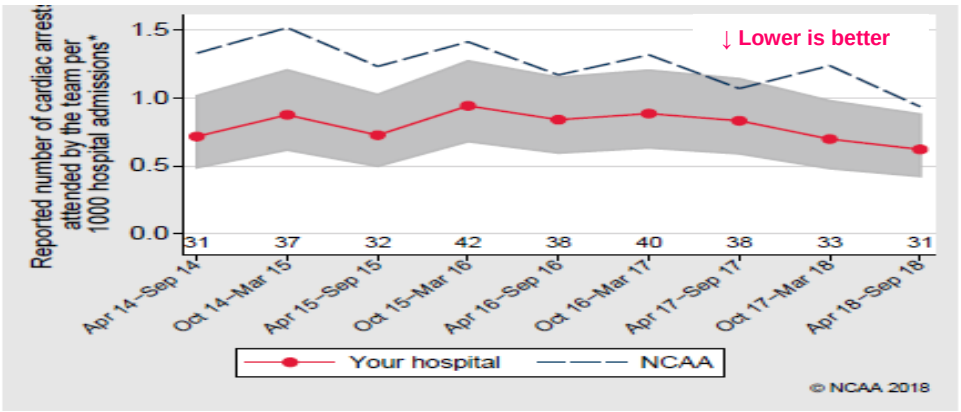
A Deteriorating Patient working group to reduce harm from failures to recognise and respond to acute physical deterioration has been established and leads for individual projects are identified.
A nursing and medical lead jointly leads the group. Monthly meetings have been arranged and each project group have an assigned date and time to feed back their progress.

Key points from the National Cardiac Arrest Audit (NCAA) (2018/2019) Quarter 2 report 01/04/2018 – 30/06/2018

Please note Quarter 3 and year end was not available at the time of this report being finalised.

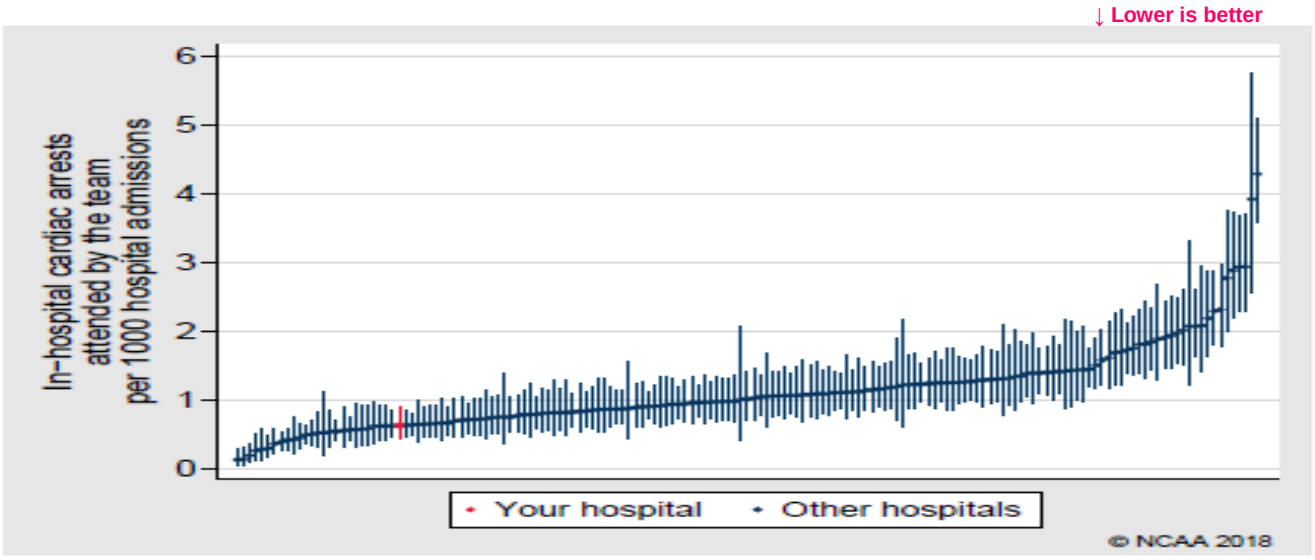
- Number of incidents for quarter 2 = 15 (Q1:16)
- Incidence (per 1000 admissions) for quarter 2 = 0.67 (Q1:0.64)
- Number of potential non-arrests for quarter 2 = 0 (Q1:0)
- Survival to hospital discharge for quarter 2 = 14.2% (Q1:13.3%)
- National survival rate 2016 = 20.1%

Rate of Cardiac Arrests per 1000 hospital admissions



The chart above shows our cardiac arrests per 1000 hospital admissions for the period of 01 April 2018 – September 2018 in comparison to National Cardiac Arrest Audit (NCAA).

Rate of in-hospital Cardiac Arrests



The chart shows the reported number of in-hospital cardiac arrests attended by the team per 1000 hospital admissions for adult, acute hospitals in NCAA with the red line depicting Great Western Hospitals FT.

The data overall shows that the Trust continues to reduce the number of cardiac arrests per 1000 admissions, and demonstrates that the Trust's cardiac arrest numbers are fewer than the number that is reported nationally through the NCAA. The Trust's average rate of cardiac arrest per 1000 admissions is 0.67 for April 2018 – June 2018 compared to 0.79 for April 2017 – March 2018.

NEWS 2

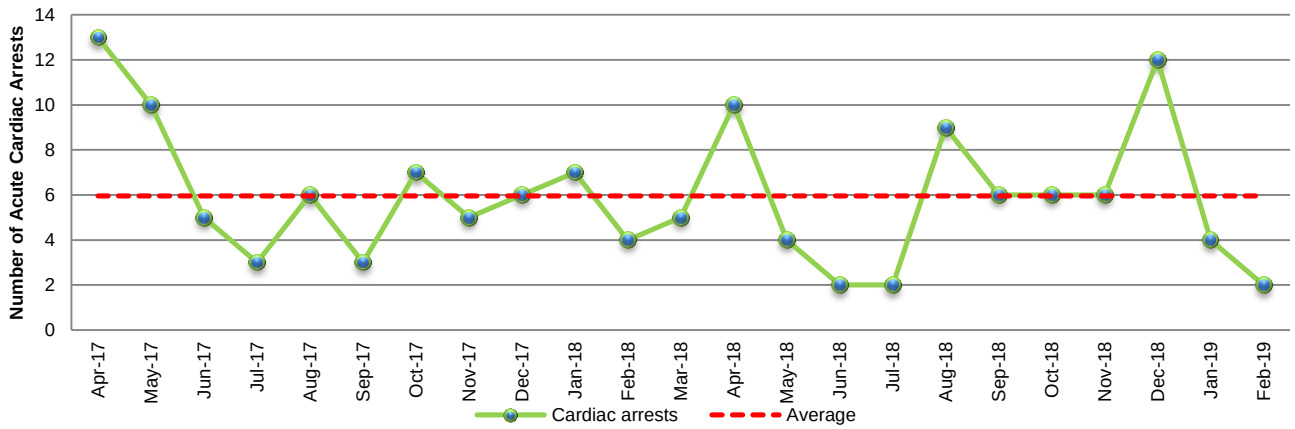
The Trust introduced Nerve-centre; an electronic-Observations (E-Obs) system has been introduced. NEWS2 has been incorporated into software and now the GWH is fully NEWS 2 compliant. The Trust has stopped the monthly audits of Percentage of Patients with a NEWS score calculated correctly due to the introduction of E-Obs

Nerve-centre data on frequency of observations and escalation will now be collected and presented monthly at the Deteriorating Patient board meeting.

Although MET calls have increased since October 2017, the overall rate of actual cardiac arrests have remained below the median rate of 0.87 cardiac arrests per 1000 admissions, 6 cardiac arrests occurred in January, equating to a rate of 0.77 per 1000 bed days.

As part of the deteriorating patient project inpatient cardiac arrests within the Trust are now being reviewed routinely to ascertain if avoidable or unavoidable. For the period May – September 2018, 0 cardiac arrests were found to be avoidable.

Number of Acute Cardiac Arrests –Excluding ED and Outpatient areas



The graph above shows the number of acute cardiac arrests excluding the Emergency Department and Outpatient areas, demonstrating no significant change to previous years.

What improvements have we achieved?

- Fully implemented and embedded the standardised National Early Warning Score 2 (NEWS2) Trust Wide, including community areas
- Introduction of Nerve-centre – Electronic Observations. Electronic capture, calculations of NEWS2, and automated cascading escalations to ensure recognition is followed by rescue.
- All cardiac arrest within the Trust are reviewed to assess if they were avoidable / unavoidable
- Introduction of the Ward Assessment and Accreditation framework, which rates each clinical area on their effectiveness in responding to the deteriorating patient.
- Hospital at Night – introduction of Advanced Clinical Practitioners (ACP)to Hospital at Night (H@N) to allow a multidisciplinary team based approach to managing the escalating care needs of adult inpatients overnight, 7 days a week.

Percentage of Observations with NEWS Score Calculated Correctly

All observations are now performed via the E-Obs system which automatically calculated the NEWS 2 score

Further improvements identified and priorities for 2019/20

- Joint medical & nursing lead to continue to lead the deteriorating patient project
- To continue to learn from events and develop care
- To promote TEP within the Trust
- Continuation of ward-based simulation training & introduction of short trolley teaching rounds carried out on ward area's planned.
- Hospital at night system which will manage all patient tasks out of hours to support staff and ensure all work is triaged by the hospital at night practitioner.

Ward Assessment and Accreditation Framework (WAAF)

The Ward Accreditation and Assessment Framework is a way of ensuring patients receive consistently safe and high quality care, and will enable wards to be inspected and graded against a range of quality standards, with each one representing a different aspect of patient care. It was one of our key priorities for 2018/19 and will remain a key tool to drive improvement during 2019/20. The Framework is based on our Trust values and incorporates best practice Quality Improvement Priorities), national guidance (NICE), including but not limited to: Leading Change, Adding Value (National Nursing Strategy), Care Quality Commission Core Standards and key

There are 16 separate standards included in the framework, covering areas such as:

- Governance
- Leadership
- Person-centred care
- Harm-free care
- Communication
- End of life care

Performance against each standard is assessed, with the scores then added together to give a ward a rating of red, amber, green or gold. The journey towards reaching gold is expected to take anything up to three years, with the top rating only being awarded when all 16 standards have been met.

Achievements 2018/19

- All acute wards have now completed standard 10 'Recognising and managing the deteriorating patient'
- All acute wards have commenced Standard 5: 'Management of Sepsis' Standard 6: 'Diagnosis and Treatment of Acute Kidney Injury AKI' Standard 12; 'Pressure ulcer avoidance' Standard 9: 'Contribute to reducing avoidable falls' and Standard 11: 'Medicines management'
- Commencement of Standard 16: 'Effective patient flow commenced autumn and winter 2018/19 and it is anticipated that this standard will continue for a number of months whilst work streams are imbedded.

Our priorities for 2019/20

- WAAF being supported by our new Deputy Chief Nurse, and put on hold in February 2019 whist ward undertake their self-assessments for co regulation of the KLOE quality indicators.
- WAAF will need to be aligned or integrated with quality governance framework (departmental self-assessment and peer assessment)to reduce duplication and improve outcomes

2.3 Statement of Assurance

This section provides nationally requested content to provide information to our public which will be common across all Quality Accounts.

Information on the Review of Services

During 2018-19 the Great Western Hospitals NHS Foundation Trust provided and/or subcontracted 6 relevant health services.

The Great Western Hospitals NHS Foundation Trust has reviewed all the data available on the quality of care in 100% of the relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 98% of the total income generated from the provision of relevant health services by the [Great Western Hospitals NHS Foundation Trust] for [2018-19].

Participation in Clinical Audits

During 2018/19, 56 national clinical audits and 2 national confidential enquiries were conducted which covered relevant health services provided by Great Western Hospitals NHS Foundation Trust. The Trust participated in **98%** of the national clinical audits and 100% of the national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2018/19 are as follows:

No.	Project Name	Relevant	Participation	% Data Submission
1	Adult Cardiac Surgery	No	Na	Na
2	Adult Community Acquired Pneumonia	Yes	Yes	In Progress
3	BAUS Urology Audit - Cystectomy	No	Na	Na
4	BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Yes	Yes	In Progress
5	BAUS Urology Audit - Nephrectomy	Yes	Yes	In Progress
6	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	No	Na	Na
7	BAUS Urology Audit – Radical Prostatectomy	No	Na	Na
8	Cardiac Rhythm Management (CRM)	Yes	Yes	In Progress
9	Case Mix Programme (CMP)	Yes	Yes	100%
10	Child Health Clinical Outcome Review Programme : Long Term Ventilation in Children, Young People and Young Adults	Yes	Yes	100%
11	Elective Surgery (National PROMs Programme)	Yes	Yes	100%
12	Falls and Fragility Fractures Audit Programme (FFFAP)* - Inpatient Falls	Yes	Yes	100%
13	Falls and Fragility Fractures Audit Programme (FFFAP)* - Hip Fracture Database	Yes	Yes	100%
14	Falls and Fragility Fractures Audit Programme (FFFAP)* - Fracture Liaison Service	No	Na	Na
15	Feverish Children (care in emergency departments)	Yes	Yes	100%
16	Inflammatory Bowel Disease programme / IBD Registry	Yes	Yes	100%
17	Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%

18	Major Trauma Audit	Yes	Yes	100%
19	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	100%
20	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	Yes	Yes	100%
21	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	100%
22	Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance	Yes	Yes	100%
23	Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity and mortality confidential enquiries	Yes	Yes	100%
24	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Review Tool	Yes	Yes	100%
25	Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism 2018/19	Yes	Yes	100%
26	Medical and Surgical Clinical Outcome Review Programme - Acute Bowel Obstruction 2018/19	Yes	Yes	100%
27	Mental Health Clinical Outcome Review Programme	Yes	Yes	100%
28	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%
29	National Asthma and COPD Audit Programme*	Yes	Yes	100%
30	National Audit of Anxiety and Depression	Yes	Yes	100%
31	National Audit of Breast Cancer in Older People	Yes	Yes	100%
32	National Audit of Cardiac Rehabilitation	Yes	Yes	100%
33	National Audit of Care at the End of Life (NACEL)	Yes	Yes	100%
34	National Audit of Dementia	Yes	Yes	100%
35	National Audit of Intermediate Care	Yes	Yes	100%
36	National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	100%
37	National Audit of Pulmonary Hypertension	No	Na	Na
38	National Audit of Seizures and Epilepsies in Children and Young People	Yes	Yes	100%
39	National Bariatric Surgery Registry (NBSR)	No	Na	Na
40	National Bowel Cancer Audit (NBOCA)	Yes	Yes	100%
41	National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
42	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Yes	100%
43	National Clinical Audit of Psychosis	No	Na	Na
44	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	National Audit Did Not Commence	Na
45	National Comparative Audit of Blood Transfusion programme*: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients 2018/19	Yes	National Audit Did Not Commence	Na
46	National Comparative Audit of Blood Transfusion programme*: Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016 (see weblink in column L for 2015 report) 2018/19	Yes	National Audit Did Not Commence	Na
47	National Comparative Audit of Blood Transfusion programme*: Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	Yes	No - Not enough patients for inclusion	0%
48	National Comparative Audit of Blood Transfusion programme*: Management of massive haemorrhage	Yes	Yes	100%
49	National Congenital Heart Disease (CHD)	No	Na	Na
50	National Diabetes Audit – Adults*: National Diabetes Foot Care Audit 2018/19	Yes	Yes	100%
51	National Diabetes Audit – Adults* : National Diabetes Audit Transition 18/19 (17/18 data)	Yes	No	Na

52	National Diabetes Audit – Adults* :National Diabetes Audit – Adults -NaDIA-Harms - reporting on diabetic inpatient harms in England 2018/19	Yes	Yes	In Progress
53	National Diabetes Audit – Adults*: National Pregnancy in Diabetes 2018	Yes	Yes	100%
54	National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
55	National Heart Failure Audit	Yes	Yes	100%
56	National Joint Registry (NJR)	Yes	Yes	100%
57	National Lung Cancer Audit (NLCA)	Yes	Yes	100%
58	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
59	National Mortality Case Record Review Programme	Yes	Yes	
60	National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
61	National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100%
62	National Ophthalmology Audit	Yes	Yes	100%
63	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
64	National Prostate Cancer Audit	Yes	Yes	100%
65	National Vascular Registry	No	Na	Na
66	Neurosurgical National Audit Programme	No	Na	Na
67	Non-Invasive Ventilation - Adults	Yes	Yes	In Progress
68	Paediatric Intensive Care (PICANet)	No	Na	Na
69	Prescribing Observatory for Mental Health (POMH- UK)*	No	Na	Na
70	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Yes	Yes	100%
71	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%
72	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	100%
73	Seven Day Hospital Services	Yes	Yes	100%
74	Surgical Site Infection Surveillance Service	Yes	Yes	100%
75	UK Cystic Fibrosis Registry	No	Na	Na
76	Vital Signs in Adults (care in emergency departments)	Yes	Yes	100%
77	VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	100%

The reports of 41 national clinical audits were reviewed by the provider in 2018/19. As a result of these audits the following actions are planned to improve the quality of healthcare provided –

In Respiratory Services – Consideration is going to be given to recruiting additional admin support with the aim of achieving best practice tariff; achieving this is a surrogate marker for Chronic Obstructive Pulmonary Disease (COPD) patients receiving best practice evidence based interventions. Improvements also include: Provision of respiratory review within 24hours, improve provision of Non-Invasive ventilation (NIV) and the implementation of national recommendations from the National Confidential Enquiries Patient Outcome Programme (NCEPOD). The service also intends to scope the utility of introducing clinical risk scoring i.e. Stratifying risk and identification of early discharge (DECAF) and predicting 90 day readmission risk or death without readmission to best target post discharge intervention (PEARL).

In Ophthalmology Services – Although the assessment of overall local results from the national audit provided reasonable assurance, the service has agreed to peer review data collection of key fields and outcomes of key metrics in order to share and learn from best practice. Improvements will continue to be monitored and any reoccurring gaps to be actioned accordingly.

In Hip Fracture Services – Although the service was awarded the “Golden Hip Award” for the most impressive and sustained improvements in Hip Fracture Care, the team are going to continue their on-going involvement in the National Audit and review of national data. There will also be a continuation of local Quality Improvement (QI) and priorities for the forthcoming year include: Embedding reduced pre-operative starvation times and pre-operative carbohydrate loading, Increase the number of patients operated within <36hrs to 90%, and to improve the best practice tariff achievements in 2018.

In Acute Medical Unit Services – There is to be a prolonged evening consultant presence on the Acute Medical Unit, thus managing ‘today’s take’ today; a physician of the day will be present from 10.00-22.00hours to

improve on the current 49% consultant review time within the 14hour target time. There will also be an on-call physician starting earlier to reflect the influx of patients coming through later on the day. The 'medically expected' unit (MEU) will have a dedicated nursing assistant to monitor early warning scores on patient arrival within 30mins to improve the early warning score current level of compliance of around 57%. There is also to be a dedicated Junior Doctor to review direct admissions to the medically fit unit; the service is currently split across admissions situated on the ground floor and the MEU situated on the 3rd floor.

The reports of 134 local clinical audits were reviewed by the provider in 2018/19 and Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided –

Results from the Blood Observation Audit – improvements recommended include, that all registered practitioners administering blood components must hold a 'once only' competency. Those who currently have a 'renewable three yearly' competency must convert to the 'once only' competency. There is to be an improved awareness of the poor recording of observations at 15 minutes in and the end of transfusion should be highlighted to matrons, ward managers and all practitioners administering blood transfusions.
The lack of use of 'Bloodhound' system for recording these observations are also be highlighted. There will also be a bedside checklist card which is to be issued to staff administering blood impresses on them the legal requirement to record traceability of the component. Measures to improve compliance with the documentation of consent is another focus for improvement; it is intended for this to become part of the work being undertaken to comply with the CAS alert (Central Alerting System) issued from the Department of Health in November 2017 concerning a bedside checklist. Prescribers will also be required to continue to be educated on the nationally recommended haemoglobin (Hb) thresholds for red cell transfusion in non-bleeding patients. Alternatives to transfusion, particularly in iron deficient patients are to be highlighted and a pathway for referring these patients for treatment created.

Results from the Safeguarding Adults Audit – Whilst compliance demonstrated extremely good results, there are plans to deliver the Mental Capacity Act (MCA) training strategy; this also includes a structured work plan to improve the consistent application of safeguarding and MCA, improving documentation around respect and informed consent, utilising documentation in respect of 'best interests' decisions and ensure consistency and alignment of trust wide processes for adults unable to consent to care and treatment. There is also to be a focus on the appropriateness of referrals to IMCA service 100% of the time with a further audit to be undertaken in 2019 to measure success of improvements and identification of further improvements required.

Results from the Neutropenic Sepsis Audit – Teaching sessions for both medical and nursing staff are to be carried out frequently, with the aim to provide monthly sessions; mainly on the acute medical unit but also to include Emergency Department (ED), where patients who have suspected Neutropenic sepsis also attend. This will focus on the importance of: Patients receiving antibiotics within an hour of arriving at hospital; Use of the Patient Held Prescription for First Line Antibiotics for Adult Patients presenting with Suspected Neutropenic Sepsis (PANTS) Policy and Procedure card and ensuring when this is used, it is documented in the clerking notes. Locally, it is also aimed to review the Neutropenic Sepsis data on a monthly basis; to enable us to monitor: If our teaching sessions are effective in ensuring patients are receiving antibiotics within an hour; Greater accuracy in collating the data. There are also plans to work more closely with the medical team on Ambulatory Care Unit (AMU) to discuss/review the Neutropenic Sepsis (NS) pathway.

Results from Outpatient Parenteral Antibiotic Therapy (OPAT) Service - The service is focussing on reducing the inpatient stay by aiming to review and assess patients sooner and discharge once medically fit for discharge (MFFD). Improvements also include keeping the readmission rate below 5% by continuing to provide robust management plan and follow up every patient who is discharged with Outpatient Parenteral Antimicrobial Therapy (OPAT). Patients will also receive an OPAT management plan-when an OPAT nurse is not available, this will be send to the patients at the earliest date possible, and development of the service with additional staff to cover absences in order to aim for 7 days service and to avoid delays in discharge at weekends.

Results from Discharge Experience of Patients with Dementia from the Acute Trust Audit – Improvements include the early initiation of discharge planning, ideally within 24 hours of admission; including discharge dates, plans and medically fit for discharge status, which are to be discussed widely with the multidisciplinary team (MDT) at the board round and recorded in the patient's medical and nursing notes. A health/social care needs assessment will be completed when requested to support discharge planning and where appropriate, a referral to an Independent Mental Capacity Advocate (IMCA) to be undertaken when the person is unbefriend and decisions are being made in relation to serious treatment, changes to accommodation arrangements, or if there is a dispute in relation to the medical and/or care plans between clinical staff and family members. There will be a focus on the documentation of the 'medically fit' status in the patient's medical notes and also the communication with relatives/carers; advising of the discharge date and time to ensure that suitable arrangements are in place to facilitate a safe discharge and with conversations to be documented in nursing notes. The Mental Capacity 2 stage Assessments are to be undertaken to ascertain mental capacity for all in-

patients for whom this in doubt; this will ensure all steps are taken to ensure the person is as involved as they can be in decision making for their care.

Research & Development (R & D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was over 1,000 to 31st March 2019

During the 2018/19 financial year over 1,000 patients were recruited to 55 open studies, overseen by 43 individual Principal Investigators. There were a further 2,500+ patients being 'followed up' in studies now closed to recruitment.

Research activity at the Trust has grown steadily over the past 10 years, involving increasing numbers of doctors, nurses, allied health professionals and others. Over 20 clinical areas are currently involved in the delivery of clinical studies. Active participation in research continues to give our patients the opportunity to access new and innovative treatment pathways.

With funding received from the Department of Health via our Local Clinical Research Network (LCRN), R&I have and will continue to provide strong research support throughout the Trust.

Use of the CQUIN payment framework

A proportion of Great Western Hospitals NHS Foundation Trust income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between Great Western Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Details of proportion of payments achieved is available on request. While the CQUIN has been achieved from a financial perspective, the achievement rate from a quality/patient outcome perspective is yet to be finalised.

Financial Summary of CQUIN (£m)

	Plan	Actual	%	Plan	Actual	%	Plan	Forecasted Actual	%	Plan	Forecasted Actual	%
	2015-2016			2016-2017			2017-2018			2018-2019		
Total CQUIN	£6,007	£4,507	75%	£4,845	£3,973	82%	£5,566	£4,762	86%	£5,804	£5704	98%

Care Quality Commission Registration

The Great Western Hospital NHS Foundation Trust has an overall rating of requires improvement since the last inspection that took place during August & September 2018. A quarterly review of our CQC registration is undertaken across the acute and community sites to ensure that our CQC registration is adequate for the regulated activities undertaken across the sites.

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.

By law all Trusts must be registered with the CQC under section 10 of the Health and Social Care Act 2008 - to show they are meeting essential quality standards.

NHS Trusts have to be registered for each of the regulated activities they provide at each location from which they provide them.

The Trust is registered for all of its regulated activities, without conditions. Without this registration, we would not be allowed to see and treat patients.

The Great Western Hospitals NHS Foundation Trust registration was updated and reviewed in January 2019. No changes.

The Great Western Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission (CQC) inspected The Great Western Hospitals Foundation Trust as part of its routine inspection programme. The inspection was carried out between, August & September 2018

In response to the CQC must do- should do actions and to support the Trust in co-regulation, a Quality Governance Framework was developed to provide a mechanism for continuous self-assessment of the KLOE indicators by the core service leads, to ensure the monitoring of the quality of care as viewed by the CQC.

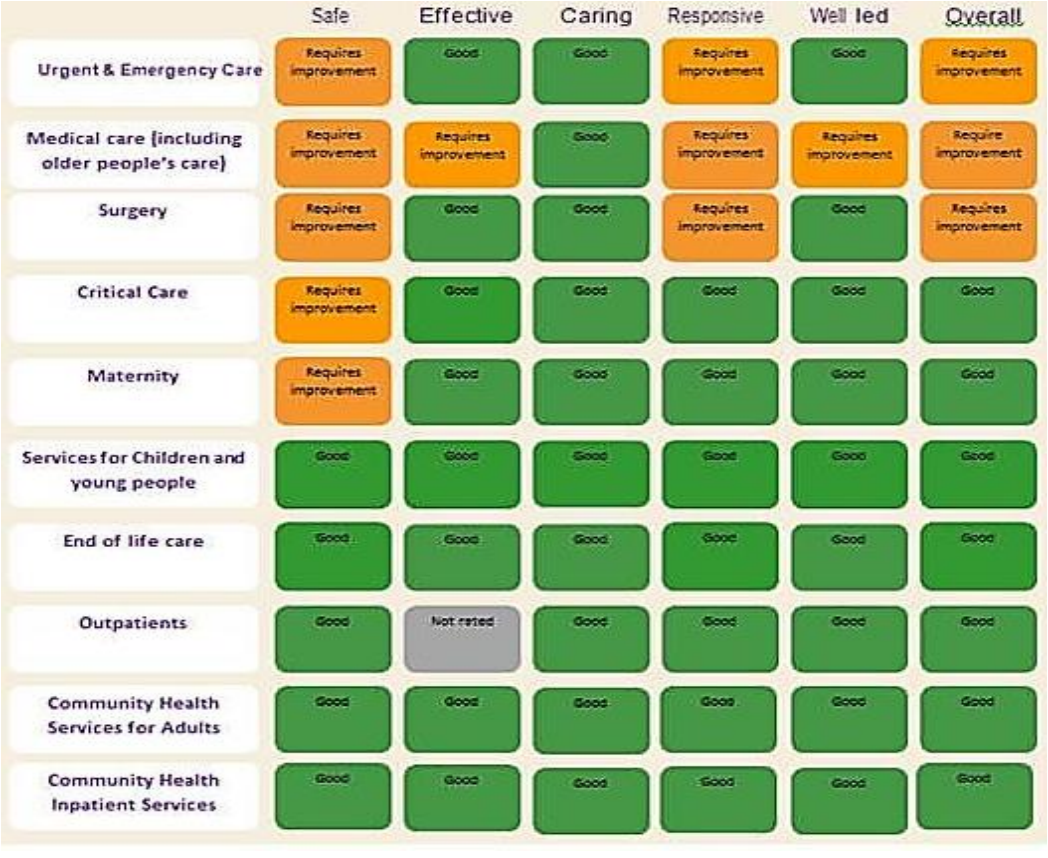
A monthly KLOE Committee was formed, to prioritise, manage and monitor the progress of the KLOE compliance assurance frameworks, The committee facilitates and supports the implementation approaches to test changes, and to seek assurance improvements are embedded.

The table below identifies the Compliance Actions identified from our December 2018 inspection.

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	August 2018	Regulation 12 Safe care & treatment
Compliance Action	August 2018	Regulation 10 Dignity & respect
Compliance Action	August 2018	Regulation 15 Premises & equipment
Compliance Action	August 2018	Regulation 17 Good governance

Feedback from the CQC recognised there had been significant changes and improvements since their last inspection, feedback also raised some further areas for improvement which the Core Service leads have commenced action groups.

Our Ratings for the Great Western Hospital from 2018



Copies of the full reports for the Trust and each individual location inspected by the CQC are available publicly online here: http://www.cqc.org.uk/provider/RN3/reports.

Hospital Episode Statistics

The Great Western Hospitals NHS Foundation Trust submitted records during 1st April 2018 to January 2019 (the most recent data available) 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
98.8% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

99.9% for admitted patient care
99.9% for outpatient care and
99.6% for accident and emergency care.

Data Security & Protection Toolkit 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.

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 and lawful manner, which ensures that 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.

There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group (IGSG) oversees information governance issues, and monitors all IG activities and performance with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

The IGSG 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 Trust's Information Governance Policy sets out best practice in data protection and confidentiality and is based on four key principles which are openness, information quality assurance, information security assurance, and legal compliance.

These corporate and operational arrangements ensure that information governance is 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 NHS Digital Data Security & Protection (DSP) Toolkit. These assessments and the information governance measures themselves are regularly validated through independent internal audit.

For 2018-19, the Toolkit underwent a significant update to incorporate legislative changes such as the introduction of the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018), as well as integrating more data and cyber security elements. The DSP Toolkit assessment is based on the National Data Guardian's Security Standards, which at a heading level are:

- Personal Confidential Data
- Staff Responsibilities

- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was graded as 'Standards Met'.

- 100 of 100 mandatory evidence items provided
- 40 of 40 assertions confirmed

Clinical Coding Error Rate

Great Western Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period of 2018/19.

Data Quality

Data quality is essential for the effective delivery of patient care. For improvements to patient care we must have robust and accurate data available.

Great Western NHS Foundation Trust has completed the following in the last year towards improve data quality

- Annual review of the Trust data quality strategy
- Review awareness of key staff on their responsibilities around data quality and propose approach to achieve improvement if necessary
- Monitoring monthly of national DQ measures
- Reviewed specific data sets (Referral to Treatment PTL & Maternity Services Dataset) with specific regard to data quality.

Great Western NHS Foundation Trust will be taking the following actions forward to continue with our improvement around data quality

- Annual review of the Trust data quality strategy (to ensure relevance)
- Establish quarterly Trust Data Quality group meetings, a sub group of the Information Governance Steering Group.
- Review awareness of key staff on their responsibilities around data quality and propose approach to achieve improvement if necessary
- Review scope of material internal data sets with specific regard to data quality and summarise those known with their main characteristics, any known DQ issues and owners in overview.

Great Western NHS Foundation Trust will continue to monitor and work to improve data quality by using the above mentioned data quality report, with the aim to work with services /staff to educate and improve data quality, which in turn improves patients records thus patient care.

2.2.3 Reporting against Core Indicators

The table below shows core quality data for 2018/19 and the previous 4 years.

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	MRSA	2	2	1	0	3	0.96	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.Diff	19* *combined previously	30 Trust-wide	21	25	27	N/A	Zero is aspirational	Low-0; High- 121	IP&C	National definition

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
		acute/ community split									
	C.Diff 100,000 bed days	9.60	14.7	11.1	11.8	14.2	15.01	Lower is better	Regionally Low:8.71 High: 28.02	PHE	National Definition
2 - Patient Falls in Hospital resulting in severe harm		16	13	12	10	12	Not available	Lower is better	--	Incident form	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers		51 Category III & Category IV	3 Category III 5 Category IV	50 Cat II	40 Category II 2 Category III	38 Category 2 1 Category 3	4% incidence	Lower is better	--	Incident form	National Definition (from Hospital database)
6 – Never Events that occurred in the Trust		2	3	1	1	9	NHS England 2014-15 Average 2.16	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA
Hospital-level mortality indicator (SHMI) (SHMI)		92.99	95.83	94.34 (Oct 15 to Sep 16 –)	97 (Oct 16 to Sep 17 –	85.6(Oct 17 to Sept 18) most recent available	-	Lower than 100 is good	-	National NHS Information Centre	National NHS Information Centre
7 – Mortality Rate (HSMR) HSMR		90.3	89.0	97.97 (Apr 16 – Dec 16 provisional figure)	98.3 (Apr 17 – Dec 17 provisional figure)	90.1(Apr 18 – Dec 18) Provisional Figure	100	Lower than 100 is good	Low -74.2; High -128.8	Dr Foster	National NHS Information Centre
8 – Early Management of deteriorating patients - % compliance with Early Warning Score	**Early Warning Score (Adults)**	90%	85% April – Dec 9 months	Average 96%	Average 95%	Average 97%	Not available	Higher number is better	--	Audit	Audit criteria (10 patients per ward per month)
	Paediatric Early Warning Score (Children)	92.25% Average yearly compliance	85% April - Sept 6 months	Average 86%	Average 85%	Average 95%	N/A	Higher number is better	--	Audit	Audit criteria (5 patients per month)

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
18– Patient Reported Outcome Measures	**Varicose Vein surgery**	90.9%	100% HSCIC Provisional data	100% HSCIC Provisional data	Currently Un available	No longer measured as part of PROMs	80%	Higher is better	Not available (more than one Contractor for this service)	DoH/ HSCIC	National Definition
	Groin Hernia surgery	57.6%	42.9% HSCIC Provisional data	54.5% HSCIC Provisional data	Currently Un available	No longer measured as part of PROMs	80%	Higher is better		DoH/ HSCIC	National Definition
	Hip Replacement surgery (Oxford Hip Score)	61.5%	93.9% HSCIC Provision	91.9% HSCIC	96.7% HSCIC Provisional	96.6% HSCIC Provisional	80%	Higher is better		DoH/ HSCIC	National Definition

			al data	Provisional data	data	data					
	Knee Replacement Surgery (Oxford Knee Score)	94.4%	97% HSCIC Provisional data	95.3% HSCIC Provisional data	95.3% HSCIC Provisional data	95.4% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
19 – Readmissions – 30 days	7.9%	9.7%	9.8% (Apr 16 to Feb 17)	11.2%	Local target (7.1%)	10.2%	Lower is better	--		National Definition	
19 – Readmissions – 28 days	7.7%	9.6	9.8% (Apr 16 to Sep 16)	10.9% Apr 17 – Feb 18	SW Region 6.9%	9.68%	Lower is better	Low: 5.12; High:10.91	Dr Foster	Dr Foster	
19 – Re-admissions 28 days **Ages 0-15** **Ages 16+**	9% 7.5%	9.02 10.02	9.5% 0-15 & 9.9% 16+ (Apr 16 to Sep 16)	-	Dr Foster	0-15 8.91% 16+ 9.79%	Lower is better	0-15 yrs: Low: 0.8; High: 15.8 16+ yrs: Low: 5.0; High: 11.1	Dr Foster	Dr Foster	**19 – Re-admissions 28 days** **Ages 0-15** **Ages 16+**
20 – The Trusts responsiveness to the personal needs of its patients during the reporting period.	**Were you involved as much as you wanted to be in decisions about your care and treatment?**	51.4%	51.8%	51.1%	55.4%	54.4%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition
	Did you find someone on the hospital staff to talk to about your worries and fears?	28.6%	33.0%	32%	34.6%	17.3%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition
	Were you given enough privacy when discussing your conditions or treatment?	74.2%	72.6%	75.6%	72.5%	75%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition
	Did a member of staff tell you about medication side effects to watch for when you went home?	32.1%	29.8%	35.3%	38.6%	23.1%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition
	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	66.2%	68.0%	65.6%	65.9%	65.3%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition
21 – Percentage of staff employed by or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends		70%	68%	68%	68%	69.9%	69.8%	Higher is better	-	NHS Staff survey	National Definition

23 - VTE	4 Percentage of VTE Risk Assessments completed	97.1%	98.3%	99.4%	99%	99%	90%	Higher number better	Low - 91.3; High - 100	EPMA and manually for those areas not using the electronic prescribing system	National Definition (from Hospital database)
	5 Percentage of patients who receive appropriate VTE Prophylaxis	91.6%	95.2	97.4%	94.9%	89%	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)

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
25 - The number and where available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death	Number of Incidents per 100 Bed Days	4.55	4.98	5.9	6.7	5.2	5.1	--	Lower is better	--	Informatics & Clinical Risk
	Number of Patient Safety Incidents per 100 Bed Days	3.00	3.07	3.3	4.4	3.8	3.6	--	Lower is better	--	Informatics & Clinical Risk
	Number of Incidents resulting in Severe Harm or Death per 100 Bed Days	0.03	0.04	0.01	0.01	0.02	0.02	--	Lower is better	--	Informatics & Clinical Risk
	Percentage of Combined Severe Harm and Death	0.56%	0.80%	0.55%	0.26%	0.24%	0.41%	--	Lower is better	--	Informatics & Clinical Risk
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period		26.0%	26.5%	31.7 % Oct 14- Sept 15 Most recent data availab le	31.1% (Oct 15 to Sep 16, most recent data availab le)	30.1% (Feb 18 to Jan 19, most recent data availa ble)	30.8% (Oct 16 to Sep 17, most recent data availa ble)	25.3%	Lower is better	Low:0; High: 49.4	HSCIC

Clostridium Difficile

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA, in England it's mandatory for Trusts to report all cases of *Clostridium difficile (C.diff)* to Public Health England.

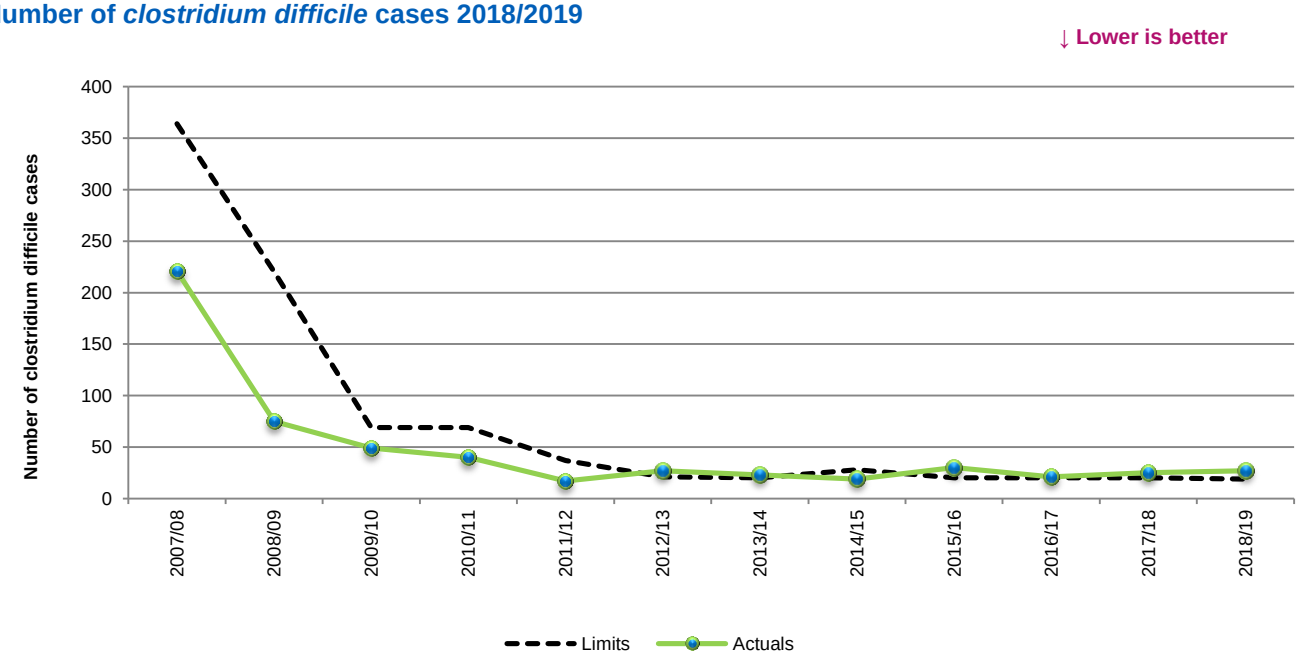
In England, it is mandatory for Trusts to report all cases of *C.diff* and MRSA bloodstream infections to Public Health England (PHE).

The nationally mandated goal for 2018/19 was to report no more than 19, Acute or Community Hospital, cases of C.diff. We have reported 27 cases, 2 more than 2017/18. Each case has been investigated in conjunction with our Commissioners. Of the 27 cases, 15 have been deemed unavoidable and 11 have been deemed as avoidable and care improvement recommendations made. The review of the final episode is outstanding.

We have introduced and maintained a number of initiatives and taken the following actions to improve patient safety, including improvements as a result of learning from our investigations throughout 2017/2018.
These include:

- Development of a C.diff infection reduction plan – this is monitored on a regular basis to ensure it reflects identified areas of concern
- A multi-disciplinary team reviews each inpatient on a C.diff ward round weekly to ensure appropriate on-going management.
- Periods of observed practice undertaken on wards to gain assurance that staff consistently comply with standard infection control precautions the C.diff policy, which had in particular focused on hand hygiene and cleaning patient care equipment
- Wards ensuring compliance with Infection Prevention and Control (IPC) mandatory training attains a minimum of 85%, this includes the nurse bank
- Auditing the time to isolation of patients and the timeliness of specimen taking patients when loose stools develop. For patients with known C.diff, this includes keeping side room doors closed and completion of C.diff care bundle daily
- Close monitoring of the use of higher risk antibiotics by the prescriber with support from the microbiologist and pharmacy team
- Commencing an early huddle type multi-disciplinary review which is underpinned by root cause analysis conducted on each C.diff case. This enables clinicians involved in the patients care to identify areas of improvement and ensure prompt and timely lessons learnt that are shared with all staff concerned

Number of *clostridium difficile* cases 2018/2019



The graph above shows the numbers of reported *C.diff* cases in from 2007 through to 2018/19.

Our priorities for 2019/20

We plan to continue monitoring and reducing risk factors for C.diff including promoting antibiotic stewardship, rapid isolation and sampling.

Recommendations identified through the 2017/18 time to isolation & specimen taking audit will be implemented through quality improvement methodology. In addition, ward/departmental ownership of local cleaning standards, including patient care equipment, antibiotic prescribing needs to continue with the aim of preventing avoidable cases of C.diff.

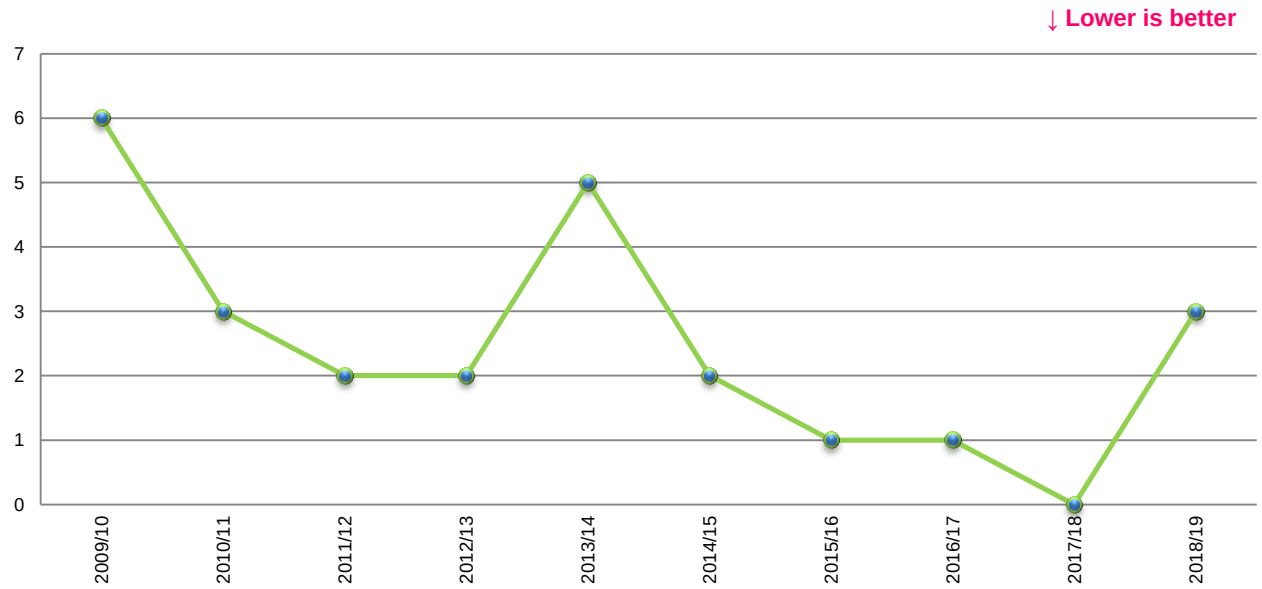
Methicillin Resistant Staphylococcus Aureus (MRSA)

During 2018/19, the Trust reported three MRSA bloodstream infections, above the national target of zero.

In addition to the standard practice of screening all emergency and specific categories of elective patients for MRSA, isolating and decolonising patients with positive results, the Trust has taken the following actions to improve patient safety:

- On-going monitoring of compliance to hand hygiene, standard precautions and MRSA policy across all professions
- Timely application of appropriate decolonisation regimes through education and introduction staff friendly instruction leaflets. Compliance with decolonisation is monitored through audit
- Blood culture contamination rates are reviewed monthly and a quality improvement initiative implemented in the Emergency Department which has reduced blood culture contaminant rates
- Prompt management of patients displaying red flags for sepsis.

Acute Cases of Trust Apportioned MRSA Bacteraemia



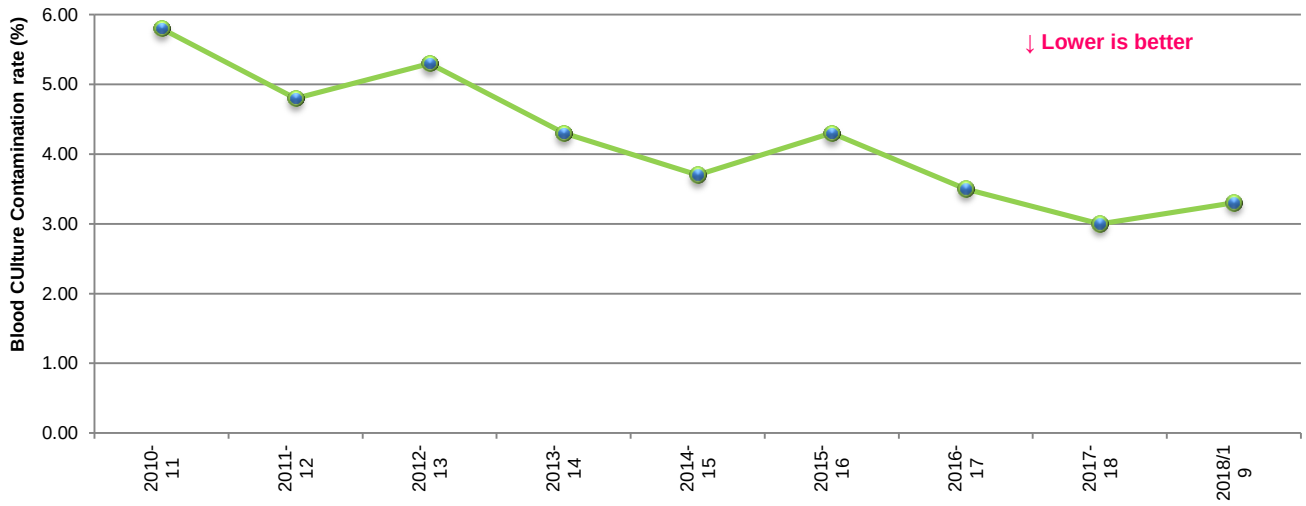
The graph above shows the number of cases of Trust apportioned MRSA bacteraemia to Great Western Hospitals NHS Foundation Trust up until 2018/19.

Our priorities for 2019/20

We plan to continue prompt management of patients displaying red flags for sepsis.

In addition, we will monitor the screening regime currently in place to provide assurance that all MRSA positive patients are managed appropriately. Ward/departmental ownership of local cleaning standards, including patient care equipment, will also continue.

Trust-wide Blood Culture Contamination Rate 2010 -2019



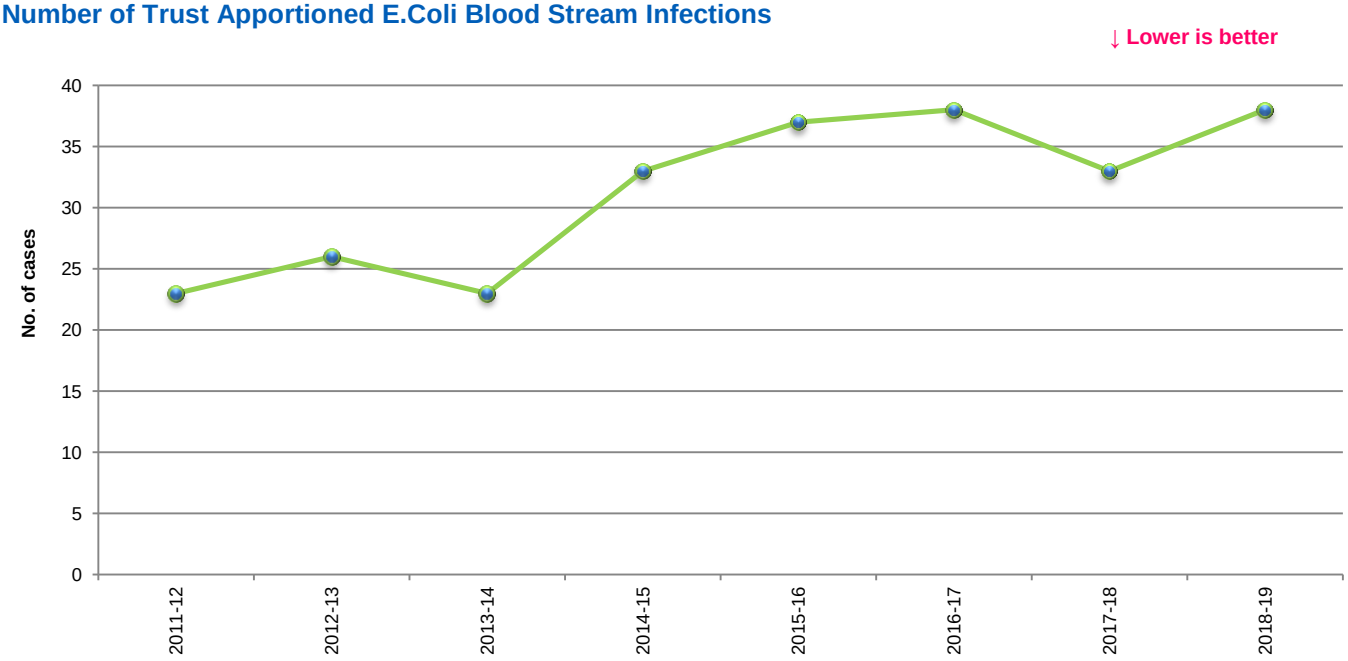
The graph above demonstrates the Trust's blood culture contamination rate from 2010 through to 2018/19, where the Trust achieved a rate of 3.3% (1st April 2018 – 17th March 2019). The recommended rate is 3.0% and this was achieved in 2017/18, however, this year has shown a small increase.

In line with national requirements, the submission of E.coli data to Public Health England (PHE) has become mandatory. From April 2017, it became mandatory to report data on other gram negative blood stream infections, Klebsiella spp and Pseudomonas aeruginosa.

During 2018/19, no targets were set for E.coli, Klebsiella spp and Pseudomonas aeruginosa blood stream infections (BSI).

A total of 38 E.coli BSI (2017/18 = 33), 18 Klebsiella spp BSI (2017/18 = 11) and 2 Pseudomonas aeruginosa BSI (2017/18 = 18) have been reported in acute trust patients. This encompasses patients in whom the specimen was taken 48 hours after admission to hospital.

Number of Trust Apportioned E.Coli Blood Stream Infections



The graph above shows the number of cases of Trust apportioned E.coli BSI to Great Western Hospitals NHS Foundation Trust up until 2018/19.

Following the introduction of a Commissioners quality premium to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021, the Trust has worked with our commissioners to review local data and compare this against the national picture of known healthcare associated risk factors.

In order to reduce preventable gram negative blood stream infections across both acute and community services provided by Great Western Hospital a gram negative reduction plan has been implemented, with the intention of reducing, where safe to do so, risk factors associated with the development of GNBSI.

Progress is monitored through the Infection Control Committee and surveillance continues to identify risk factors and key areas for improvement. The Catheter associated UTI work stream underpins much of the reduction plan and involves close links with the Oxford Academic Health Science Network

Our priorities for 2019/20

We plan to continue monitoring the gram negative reduction plan and increasing our understanding of risk factors associated with GNBSI, through surveillance and reporting, as we work towards a 50% reduction by March 2021.

Specific programmes of work across acute and community services commenced in 2017/18 will continue including effective surveillance, prudent antibiotic prescribing in line with guidelines, promotion of hydration, CAUTI work stream, reaffirming best practice in Infection Prevention and Control policies, and enhancing patient education and information when discharged with invasive devices.

Continually learn - Reduce Incidents and Associated Harm

Never Events

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all Never Events to NHS Improvement, National Learning and Reporting System (NRLS) and local commissioners in line with the Never Events Policy and Framework.

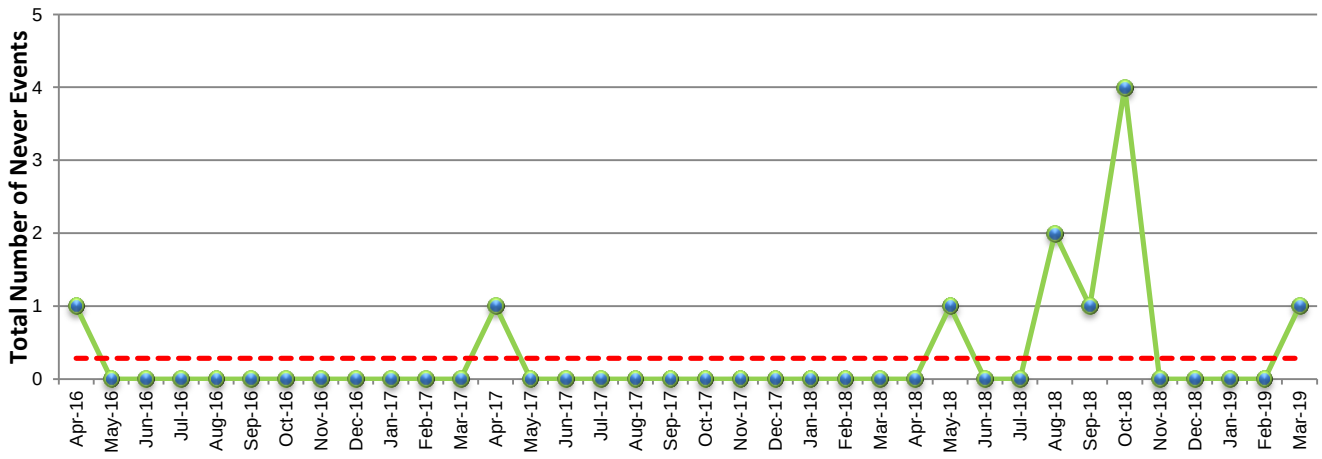
Never Events are Serious Incidents are wholly preventable. There is guidance (Never Events Policy and Framework) which was recently updated in April 2018 that provides strong systemic protective barriers that are available at a national and local level and should be implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm, or death, does not have to be the overall outcome of an incident for it to be categorised as a Never Event under the NHS Never Events framework.

We have reported 9 Never Events between April 2018 to March 2019. The following categories of Never Events have been reported:

- Wrong Site Surgery. 1
- Wrong Implant/Prosthesis 7
- Retained Foreign Object Post Surgery 1

Total number of Never Events reported



The chart above shows the total number of Never Events reported by Great Western Hospitals Foundation Trust during 2018/19 by month.

Following the Never Events reported in August and September 2018 with regards to an implant/plate used for forearm fractures a review took place of all completed forearm implants/plates over the last 12 months. This showed a further 5 cases where the same incorrect fixation used. In total 7 cases have been reported. Action plans were developed, with implementation closely monitored by our Patient Quality Committee. Final reports for the Never Events are also shared with the patients, Commissioners, the CQC and Monitor.

Furthermore the Trust has worked closely with NHSi and a Patient safety Alert which was published in early 2019 to aid/support other organisations to not repeat the same or similar incidents. The Trust has been praised and thanked for its proactive response to the initial concern, investigation and transparency.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve the number of Never Events reported and the quality of its services, the actions specifically relating to wrong site surgery and wrong implant/prosthesis:

Key Learning Points and Actions taken:

- Surgical Planning Group and theatre coordinator to ensure x-rays are always available when required. Additional training for theatre staff to support radiographer enabling theatre staff to use image intensifiers.
- On a new operator joining a procedure a pause should take place so site and procedure can be re, confirmed. A standard operating procedure has been written and is in place.
- Sterile cockpit concept to be applied and followed and to include a time out when if a new operator joins a procedure. Regular audit of the WHO checklist completed and shared at governance meetings.
- Surgical Site marking policy amended to reflect recommendations
- Recon plates removed from fragment sets.
- Multidisciplinary working group to review and agree a standard safety process to be introduced to provide further assurance that any surgical plate intended to be retained and part of a clinical plan is correctly selected and confirmed as correct.
- Swab, instrument and needle Counts Policy to be reviewed and updated to reflect changes.

Serious incident
Serious incident reporting

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all serious incidents their local commissioners and the NRLS in line with the Serious Incident Framework.

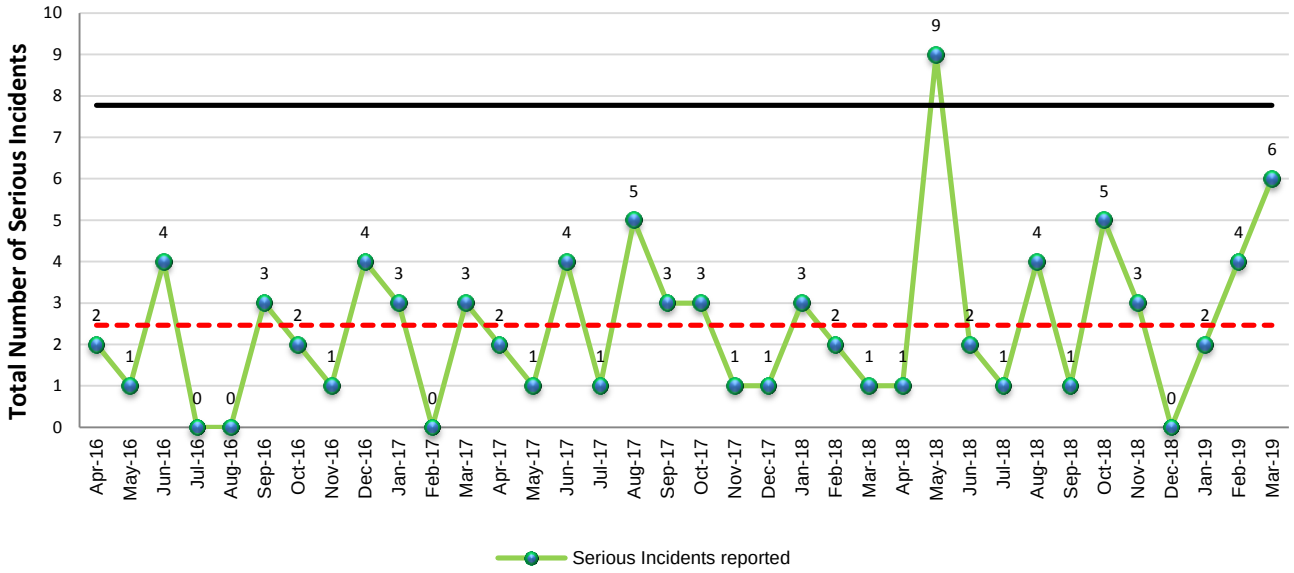
A total number of 38 serious incidents were reported and investigated during the period April 2018 to March 2019. This is an increase of 9 serious incident compared to 2017/18.

- All patient safety incidents that were reported within the Trust were submitted to the National Reporting and Learning System. Our reporting performance is evaluated against other medium acute Trusts within the cluster group biannually following the publication of the NRLS Organisational reports.

- All Serious Incidents were reported to our Clinical Commissioning Groups and to the Strategic Executive Information System (STEIS) system.

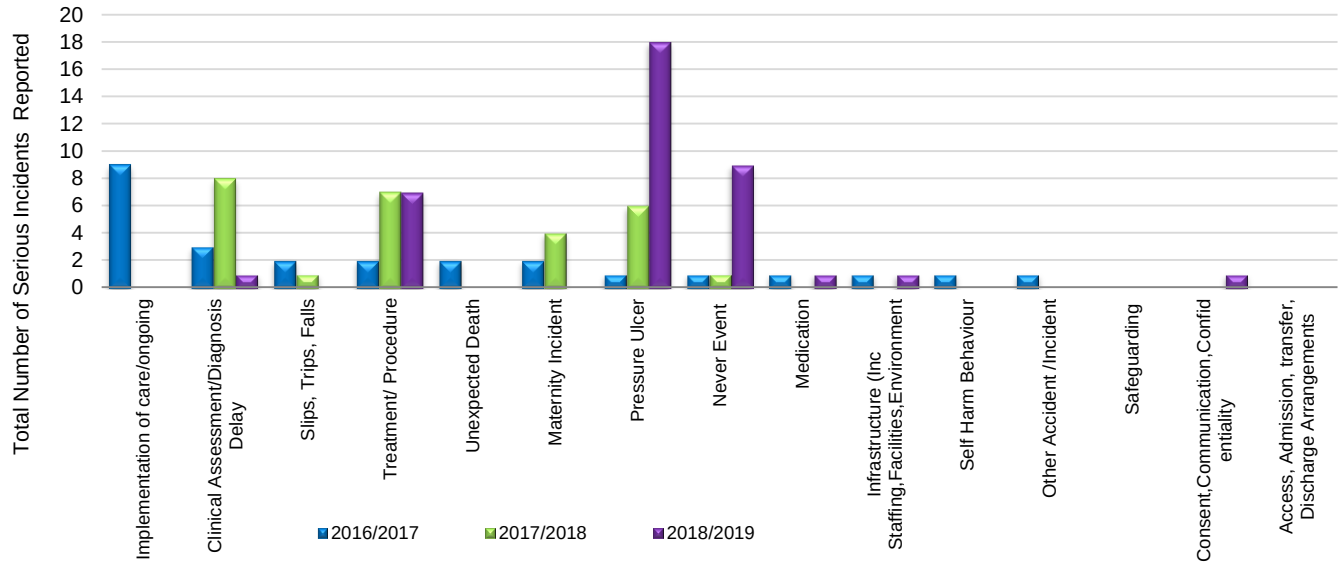
Serious incidents reported 2018/19

↓ Lower is better



The graph above shows the number of serious incidents reported in 2016/19.

Serious incidents reported by type in from 2015/16 – 2018/19



The graph above shows the Trust's serious incidents reported broken down by category in 2018/19 compared to previous years.

The most frequently reported types of Serious Incidents including Never Events are:-

- Pressure Ulcer's
- Never Events
- Implementation of care/on-going

The increased number of serious incidents involving problems with Clinical Assessment which includes delays in Diagnosis, Interpretation and response to diagnostic procedures and tests is due in part to improved reporting of incidents and Human Factors. It should be noted that the increase in pressure also is attributable to the inclusion on Swindon Community Health Service data and the spike in Never Events is attributable to 7 Never Events relating to the same failure in process.

We reviewed all Serious Incidents and incidents with contributing factors involving problems with clinical assessment which includes delays in diagnosis to identify commonalities directly informed Patient Quality Improvement projects relating to improved Clinical Assessment, Diagnosis and interpretation of diagnostics.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve the number of Never Events reported and the quality of its services, the actions specifically relate to

- Created and embedded new processes in Theatres to support with identification, selection and placement of Trauma and Orthopaedic plates.
- Updated key policies and procedures to support change.
- Ensured and tracked NatSSIPs and LocSSIP activity across the Trust

We disseminated learning from serious incidents to all speciality groups and Clinical Governance Leads where assessment and relevance of recommendations from all incidents have been shared to ensure that appropriate actions were taken to improve similar processes in their own departments.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the number of serious incidents reported and the quality of its services, by

- Continue to theme incidents to identify key trends that could influence change which will be shared through all quality improvement work streams to inform work stream initiatives.
- We will continue to share recommendations and learning from serious incidents Trust-wide which inform improvements to systems and processes within specialities.

Incident reporting and benchmarking

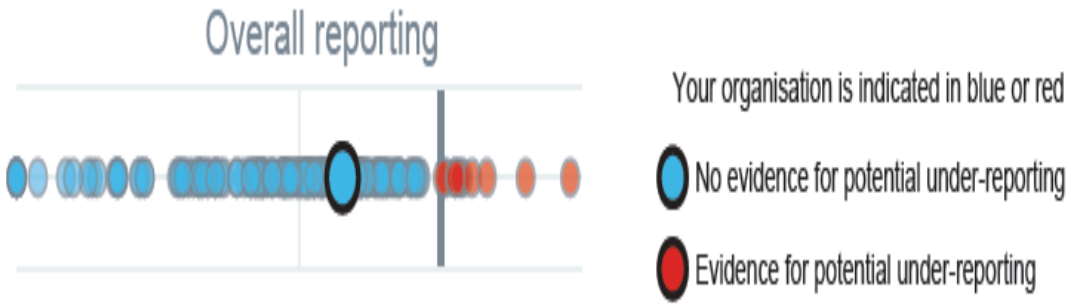
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all patient safety incidents to the National Reporting and Learning System (NRLS).

The Trust uploads all reported patient safety incident forms to the (NRLS) on a daily basis. The number of incidents we have reported in the last 7 financial years are as follows:

Reporting Year	Non clinical incidents / Health and Safety	Patient Safety Incidents reported to NRLS	Total
2011/2012	2493	6513	9006
2012/2013	2405	6928	9333
2013/2014	3596	6967	10563
2014/2015	4164	6678	10842
2015/2016	4801	6274	11075
2016/2017	4457	8373	12830
2017/2018	3627	7632	11259
2018/2019	3022	8398	11420

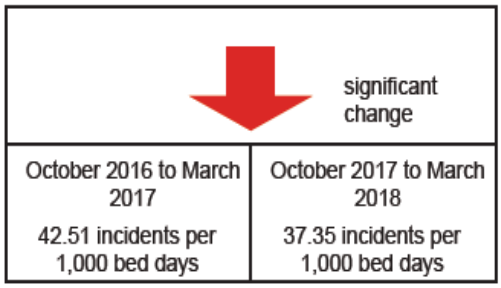
NHS Improvement National Reporting and Learning System (NRLS) release an Organisational Patient Safety Incident report twice a year providing organisational and comparative incident data. NHSI and the NRLS revised their incident summary report during 2018 so that organisations can better understand the incidents we report and if we could be more effective in improving our safety culture.

Potential under-reporting of incidents to the NRLS October 2017 – March 2018



The graph above demonstrates potential under-reporting of incidents during the reporting period of October 2017 – March 2018. Currently GWH FT is placed within the BLUE suggesting that there is no evidence of potential under reporting at our Trust.

GWH FT reporting rate per 1000 bed days comparison



Actions for your organisation

- Investigate the reasons for any significant change in reporting using your more detailed local incident data.
- Is this a general change, or are certain types of incidents being reported more or less frequently?

The chart above demonstrates reporting rate per 1000 bed days comparison year on year and suggests that there has been significant change. Our reporting rate has decreased to 37.35 per 1000 bed days compared to 42.51 Oct 16 to March 17. The median reporting rate for the acute cluster comprising of 134 organisations is 42.0.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the reporting of all safety incidents and the quality of its services, by

- Providing incident management and awareness sessions throughout the year. These sessions will continue to promote the benefits of incident reporting, and how they make positive impacts on improving patient safety.
- To work with key managers and their deputies across the Trust to support with grouping, theming and trending incidents as to identify key Quality Improvement activity.
- Promote a ‘You Said’ ‘We Did’ approach to learning from incidents.

Duty of Candour

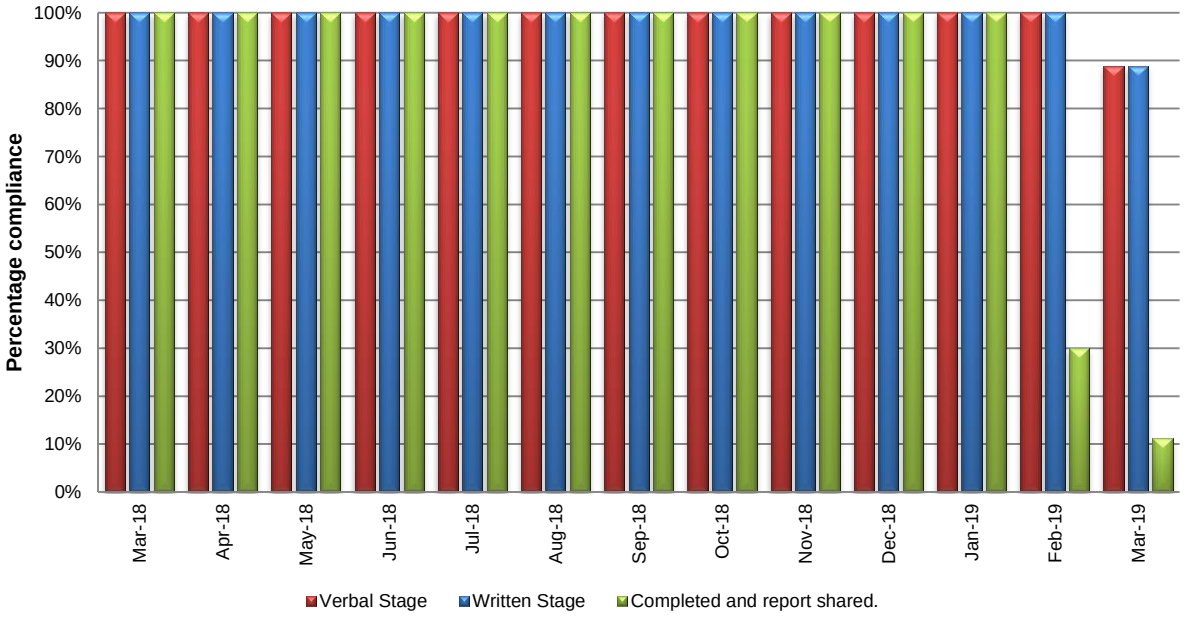
Duty of Candour is a legal duty which came into force in April 2015. As a trust we are legally obliged to inform and apologise to our patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help our patients receive accurate, truthful information and providing reasonable support and

an apology when things go wrong. Errors occur at the best hospitals and clinics - despite the best efforts of talented and dedicated professionals.

Duty of candour means 'being open' as soon as possible after an incident:

- Informing the patient or their family that an incident has occurred
- Acknowledging, apologising and explaining the incident – and confirming this in writing
- Providing information
- Providing reasonable support
- Inform the patient in writing of the original notification and the results of any further enquiries.
- Saying sorry is not an admission of liability and is the right thing to do.

Compliance with each stage of Duty of Candour



The graph above depicts the Trusts Duty of Candour compliance at each of the three stages of Duty of Candour, this being 1, a formal apology 2, formal written apology from the Trust and 3, sharing of the incident investigation. Some cases are still currently under investigation and will be shared with the patient, family or relatives upon completion. All outstanding Duty of Candour cases are currently due to be completed within the deadline of 60 working days from reporting the incident on STEIS.

To continue to improve staff recognition of what level of 'harm' initiates the need for full formal Duty of Candour, how this is applied to support our patients and staff and to ensure that patients and their families are fully informed, and to promote 'Candour' we support our staff, patients, their family and relatives following errors, the following improvements have been completed:-

- Duty of Candour training is included in all investigation, Human Factors and RCA training courses.
- The Duty of Candour E-Learning training tracker was released in June 2016 whereby the expectations are that all new employees are required to complete the training after induction. The Trust's compliance is currently recorded as 95.69%
- The Trust's incident reporting system allows us to record Duty of Candour against individual incidents
- There is a data extraction facility within the Trust's central incident reporting system, which enables the Trust to record and monitor formal Duty of Candour compliance. This facility also helps to identify any areas of non-compliance reported on a monthly basis that can then be operational rectified.
- Duty of Candour compliance is monitored at Divisional and Trust level by the Patient Safety and Clinical Risk Team. All Duty of Candour exceptions are reported at all Divisional boards and via the Trusts Patient Quality Committee.
- Duty of Candour leads receive coaching from the Clinical Risk Team who also provide support and oversight of the process to ensure that stage1,2 and 3 are completed.
- Revised Duty of Candour (Being Open Policy) – This policy has been reviewed (February 2019)

Priorities for 2019/20

- To develop a Trust wide Human Factors Training programme for the organisation.
- The Trust will continue to develop a 'Just Culture'.
- Ensure that we as an organisation are 'Reporting' and 'Celebrating Excellence' across the Acute and Community Services.
- Continue to work in conjunction with the Trusts Academy as to effectively deliver Root Cause Analysis (RCA) and Duty of Candour training for staff.

Venous Thromboembolism (VTE) risk assessment and hospital acquired thrombosis events

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because data is collated in a variety of ways including the electronic prescribing 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.

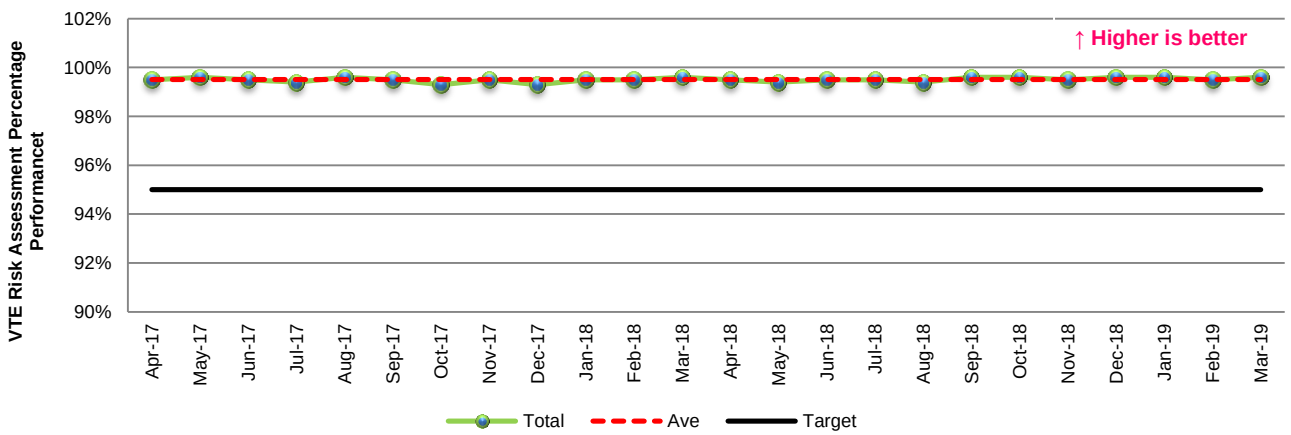
This validation is undertaken bi-monthly and information disseminated to all clinical areas so that any performance requiring review is highlighted.

All adult patients (over 16 years) who are admitted to our trust should undergo a risk assessment to determine their risk of developing a VTE related episode (For example a blood clot such as deep vein thrombosis (DVT) or pulmonary embolus (PE)).

The national target is set at 95%, which means that at least 95% of patients admitted to hospital should be risk assessed on admission.

We can now more easily access data via our electronic prescribing system which is in place on the majority of the wards at our acute site. The system allows us to audit the process more easily and can identify which patients have had a risk assessment and what time this was undertaken. The name of the clinician completing the assessment is clear which enables us to inform clinical leads in a timely manner when parts of the assessment have not been fully completed.

VTE risk assessment performance April 2017 – March 2019



The graph above shows the Trust's VTE Risk Assessment performance, we have consistently achieved above 99% for 24 months.

Appropriate Prevention and Hospital Acquired Thrombosis Events

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to maintain this score and so the quality of its services, by continuing to ensure that the processes in place that help us to achieve our target are maintained and provide high quality care for our patients in preventing blood clots whilst they are hospitalised.

Once patients have had a risk assessment we want to ensure that they receive the appropriate preventative treatment. We monitor this using an audit tool similar to the previously used "safety thermometer" data
This looks at 10 patients on each ward in the hospital on one day each month and checks if they have had a VTE risk assessment and how many patients receive the appropriate preventative treatment. Since the implementation of this we have had some difficulty with the completion of the form and are currently looking at ways to improve the data collection form to ensure we are getting accurate information. It is hoped that we will be able to link it to one of the electronic systems in place to save duplication of information. Whilst we can't provide an accurate figure at the moment we can be reassured that the number of patients who develop a hospital acquired thrombosis has not increased.

For all hospital acquired thrombosis events we carry out a root cause analysis first to make sure that a risk assessment has been carried out and also if the patient received the treatment they should have. If part or either of these points have not been done then a more detailed root cause analysis is carried out to determine why and to make sure that we learn from the findings to help prevent the same thing happening again. Some cases are unavoidable and these are documented which allows us to look at certain specialities where we need to consider providing more preventative treatment for longer.

Effective Care

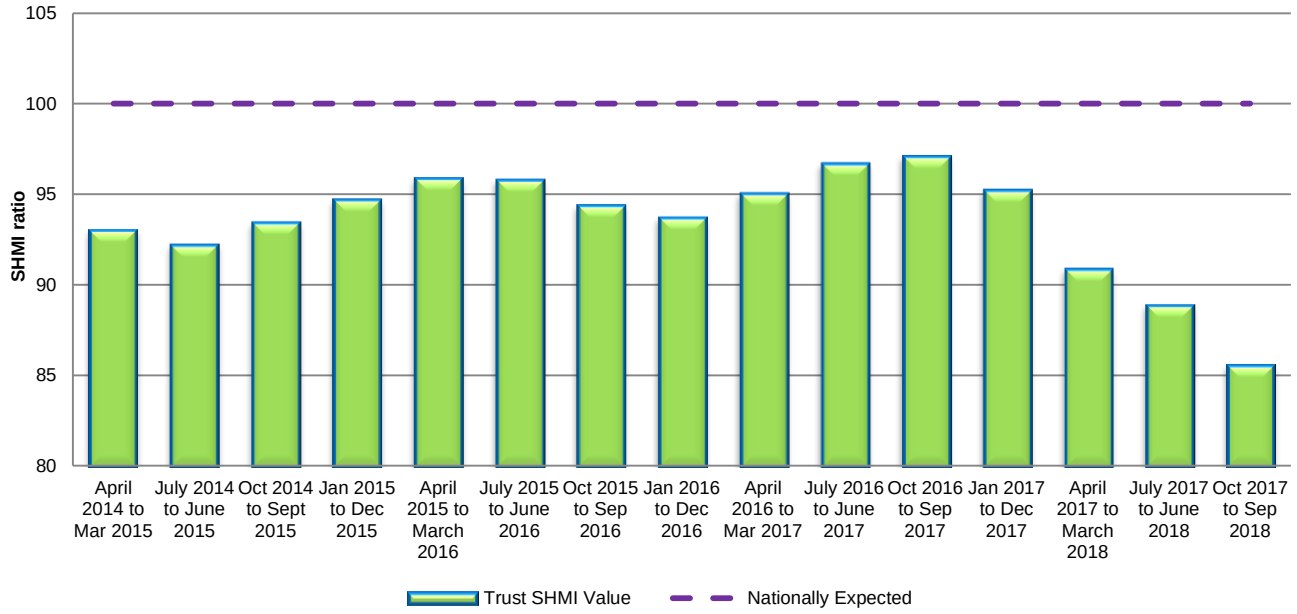
Summary Hospital Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. This indicator is produced and published quarterly as an experimental official statistic by the Health and Social Care Information Centre (HSCIC).

The SHMI is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The Trust's SHMI for the rolling 12 month period of October 2017 to September 2018 is 85.56, with the confidence limits 81.62 to 89.64 giving the Trust a 'Better than Expected' rating. The SHMI for this period is lower (better) than the nationally expected value of 100, and is similar to the previous 12 month period (July 2017 to June 2018).

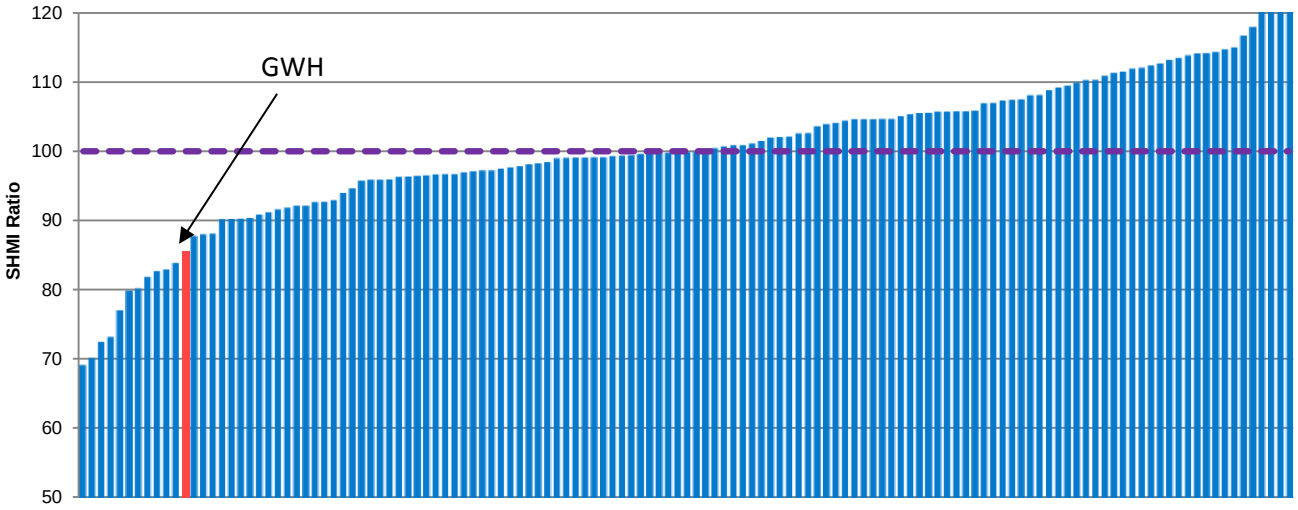
Summary Hospital Mortality Indicator (SHMI) GWH



NB the SHMI is always at least 6 -9 months in arrears

National SHMI October 2017 – September 2018

↓ **Lower is better**



The chart above shows how the Trust's SHMI compares nationally and demonstrates the Trust was positioned within the lower (better) half overall between October 2017 and September 2018. The red line depicts the GWH, and the dotted horizontal line is the nationally expected norm.

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

- The data is reviewed on a monthly basis by the Trust Mortality Group and the Patient Quality Committee
- 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
- This indicator is produced and publicised by the HSCIC

Hospital Standardised Mortality Rate (HSMR)

The HSMR is an external validated method of calculating and comparing mortality rates. This information is analysed and presented to all Trusts through Dr Foster; an independent benchmarking organisation specialising in healthcare analysis including mortality rates. HSMR 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.

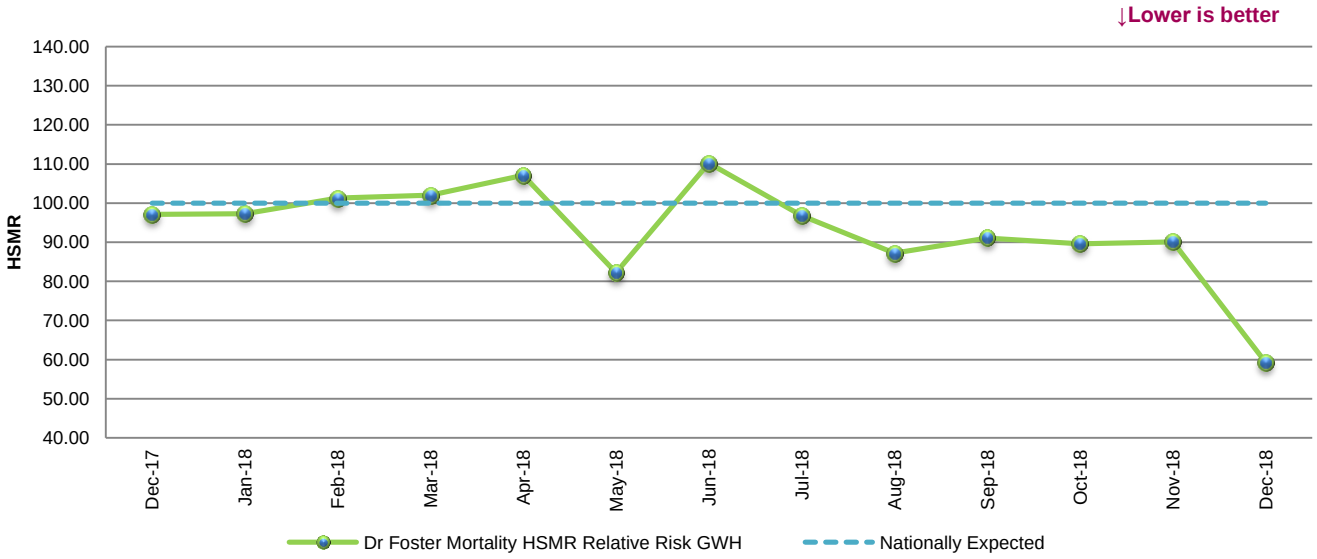
A local RR figure of 100 indicates that the mortality rate is exactly as expected; whilst a local figure of less than 100 indicates a mortality rate lower (better) than expected. The Care Quality Commission (CQC) uses HSMR values to monitor performance of hospitals and identify areas of practice where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

In 2014 the Trust set a target to reduce our mortality rates measured by HSMR (Hospital Standardised Mortality ratio) and to be one of the Trusts with the lowest HSMR value. We remain on our schedule to deliver this improvement. Our continued work has resulted in a lower number of deaths and we have one of the lowest HSMR values in Southern England.

The Great Western Hospitals NHS Foundation Trust 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 and the Patient Quality Committee
- 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

Trust HSMR Trend December 2017 December 2018

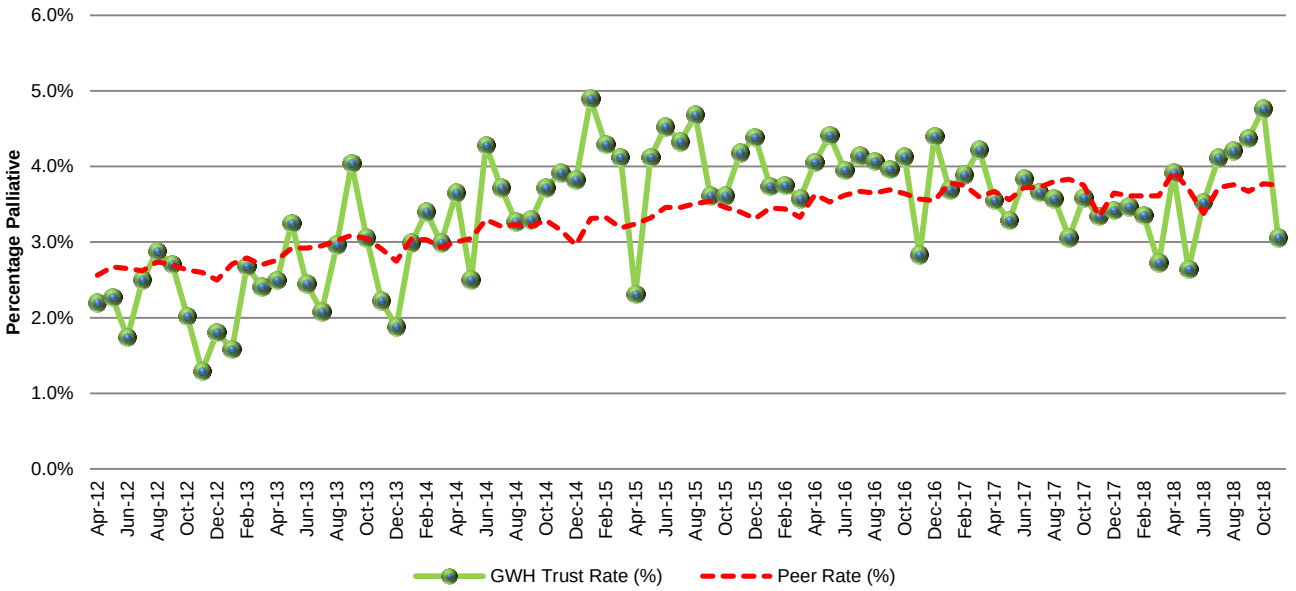


The graph above shows the Trust HSMR December 2017 – December 2018 following rebasing. This shows a general improvement over time with HSMR remaining under the nationally expected since July 2018.

Palliative Care – Coding Levels

Palliative care is the holistic care of a patient who has been diagnosed with a life limiting illness with the goal of maintaining a good quality of life until death. By definition patients receiving palliative care have a higher risk of in-hospital death than that of non-palliative patients. Trusts which provide specialist palliative care services have a higher proportion of patients admitted purely for palliative care rather than treatment compared to Trusts without specialist services. To account for this, the Hospital Standardised Mortality Ratio (HSMR) adjusts for patients who have received specialised palliative care when calculating the expected risk of death of a patient.

Percentage palliative care Coded Spells (HSMR Basket Only) to December 2018



The chart above shows the levels of Palliative Care coding against the national average since April 2012. The GWH Trust rate is expected to follow the national rate.

For the period December 2012 through to the end of 2013 the level of Palliative Care coding was generally below the national rate, from early 2014 there was an increase in the levels of coding although the Trust is now reporting just around or above the national average. Within the southern region the Trust is only slightly below average for the twelve month period January 2018 to December 2018.

Note that the data for the most recent month should be considered as provisional.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to continue to improve the effectiveness of care and so the quality of its services by:

Priorities for 2019/20

- Our Trust Mortality Group will continue to review a range of Dr Foster mortality indicators each month and investigate Dr Foster mortality alerts as well as agreeing any other investigations or initiatives prompted by the data and trends.
- Having introduced the new National process of Structured Judgement Review, the priority is to increase the number of reviews taking place. Thematic analysis of the areas with low rating scores as well as the narrative collected for each case will be used to ensure lessons are learned and shared within the organisation and more widely.

Learning from Deaths

During 2018/19, the Trust has continued to use the Structured Judgement Review (SJR) process for mortality reviews that was introduced in 2017/18. The lessons learned from this have been shared with all hospitals in the West of England as part of a collaborative group that was used to introduce the new process.

National guidance lists a number of categories (for example, deaths following elective surgery, and where families have raised concerns) where a review must be undertaken. At the Great Western Hospital, between 7 and 14% of deaths fall into these 'mandatory' categories. Data on mortality reviews is reported quarterly at Trust Board meeting.

All deaths are screened to identify which fall into the mandatory categories. Overall, approximately 25% of all deaths are subject to SJR. The numbers reported are always three months in arrears as the review process can take place up to three months after a death occurs.

Monthly reports have been in place to report mortality rates at both the mortality surveillance group and the patient quality committee for the last ten years. Mortality review performance has been added to these reports.

A database developed to collect information on mortality reviews and for reporting purposes is used to produce reports at departmental and trust level. These are used at the mortality surveillance group to share lessons learned from mortality reviews and to identify any themes where improvement work is required.

During 2018/19, 1,269 of the Great Western Hospital's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 306 in the first quarter; 281 in the second quarter; 342 in the third quarter; 340 in the fourth quarter.

By 31st March 2019, 245 case record reviews and one investigation have been carried out in relation to 245 of 1,269 deaths. In one case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 79 in the first quarter; 71 in the second quarter; 78 in the third quarter; 17 in the fourth quarter.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review process. There were two deaths initially identified as more likely than not to have been due to problems in the care provided to the patient. Both have been investigated as serious incidents. After investigation, one case was no longer considered to be due to problems in care. The other case is still under investigation.

0 case record reviews and 0 investigations completed after April 2018 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review process.

0 representing 0% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Implementation of Priority Clinical Standards for Seven day Hospital Services.

The Trust remains focussed on the 4 priority clinical standards for 7 Day Services. Until recently these have been actively monitored through the twice yearly national audits. However, going forward they will be monitored more in real time and from regular reports to the Trust Board

Over the last 6 months the Trust has seen a big improvement in the number of patients seeing a consultant within 14 hours of emergency admission. In addition it shows good reporting of those patients who need to be seen once or twice a day once admitted to the inpatient wards.

The diagnostic and interventional access is also good; with extra MRI and US sessions being available since the report last year.
The only real issue is the availability of cardiac echocardiography over the weekend. Part of the issue here is national lack of staff able to do this. The Trust is still on track to achieve compliance by March 2020.

Freedom to Speak Up

NHS staff across the country are being encouraged to speak up and raise concerns following the introduction of a new policy launched by NHS Improvement: Freedom to speak up: raising concerns (whistleblowing) policy for the NHS.

The nationwide policy aims to help make raising concerns the norm in NHS organisations and standardise how NHS organisations support staff when concerns are raised. It's also one of a number of outcomes from the review by Sir Robert Francis into the NHS which aims to improve the experience of staff who speak up.

At Great Western Hospital we want our staff to feel confident, safe and

supported to say something if they have a concern.

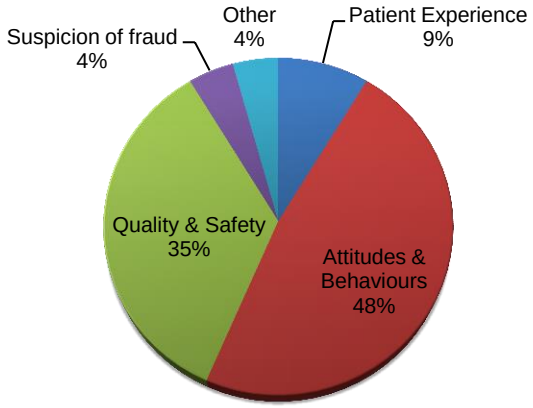
Another key outcome from the Sir Robert Francis included the appointment of Freedom to Speak Up Guardians in trusts.

The Guardian's Role

Led by an allocated Executive Director and Non-Executive Director the Trust's Guardians are responsible for providing confidential advice and support to staff in relation to any concerns about patient safety. They can also offer advice and support to ensure concerns raised are handled professionally and result in a clear outcome. We currently have 7 Freedom to Speak Guardians within the Trust with different backgrounds and experiences and a Freedom To Speak Up Co-ordinator supporting staff across the trust with their concerns and feedback and outcomes. Staff can raise a concern via an online form, by phone or in writing. They can also contact one of the guardians directly. All concerns raised are treated confidentially and thoroughly investigated, and action taken where necessary.

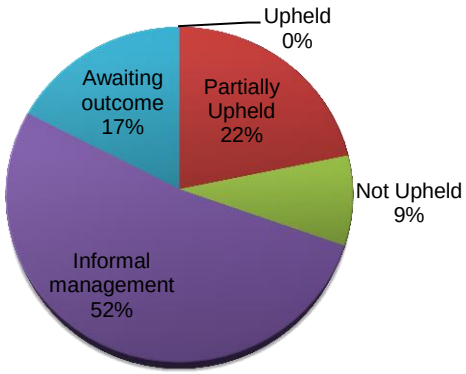
Freedom to Speak Up concerns, trends and themes are closely monitored by Patient Quality Committee, Governance and Trust Board.

Key themes arising from cases reported since April 2018 to March 2019



The chart above shows the number of cases and themes of cases received April 2018 – March 2019

FTSU Alert Outcomes April 2018 to March 2019



The chart above shows the outcomes of cases during April 2018 – March 2019.

GWH continues to raise the profile of Freedom to Speak Up through various communications channels including:

- Increased awareness via regular communication to all staff
- FSUG regularly meet up to develop understanding of speaking up
- Quarterly FTSU updates for all staff via communications team / intranet
- Recruitment - Increased number of Guardians 7 now recruited across the Trust from various staff groups
- F2SU screensavers across the organisation
- Freedom to speak up posters in every Staff room
- Freedom to speak up drop in sessions
- Business cards for each F2SU guardian
- Regional network meeting to be held at GWH in October

Patient Reported Outcome Measures (PROMS)

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

The Trust takes part in PROMS which measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England. This data and information is gathered via responses to questionnaires before and after surgery to assess patient's condition following surgery and whether it has improved.

An independent company analyses the questionnaires and reports the results to NHS Digital; this data is then benchmarked against other Trusts.

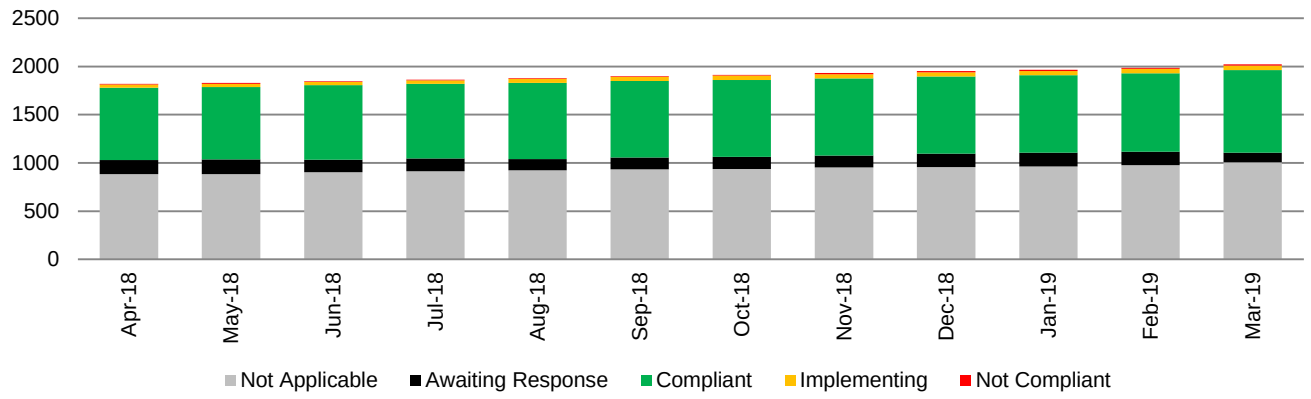
We have currently received a provisional PROMS report for Hip and Knee Replacement which covers the period April 2018 – March 2019. This shows that we are above the average scores in two of the measures. However, it needs to be recognised that this data is un-validated and we have yet to receive detailed data in order to review and understand specifics within this.

Continue to Monitor and Maintain NICE Compliance

NICE publish evidence based recommendations and standards which healthcare organisations are required to assess and implement where required. Overall, the trust has been assessing NICE guidelines since August 2007 from which time, up to 922 guidelines were assessed as relevant and of which, up to 861 have been assessed as compliant (93.38%).

During 2018/19, the trust has received up 224 published guidelines, of which, up to 91 responses (40.63%) have confirmed they are not relevant to the services, up to 76 guidelines have been confirmed relevant, of which, 62 (81.58%) guidelines have been assessed and confirmed compliant. Up to 13 guidelines have action plans in place, bringing the overall number of guidelines being implemented to 49. Following assessment, there have been no guidelines identified as not complying with recommends which means the overall number of non-compliant guidelines remains at 11. There are up to 57 guidelines which are still in the process of waiting to be assessed and responded to.

NICE Monthly Status



Referral to Treatment 18 weeks (RTT)

The waiting list size trajectory (which stated that the waiting list size should be no higher in March 2019 than in March 2018) was not achieved at the end of 2018/19. The Trust reported 21,558 patients on the RTT incomplete PTL, against a trajectory of 20,790 (+768).

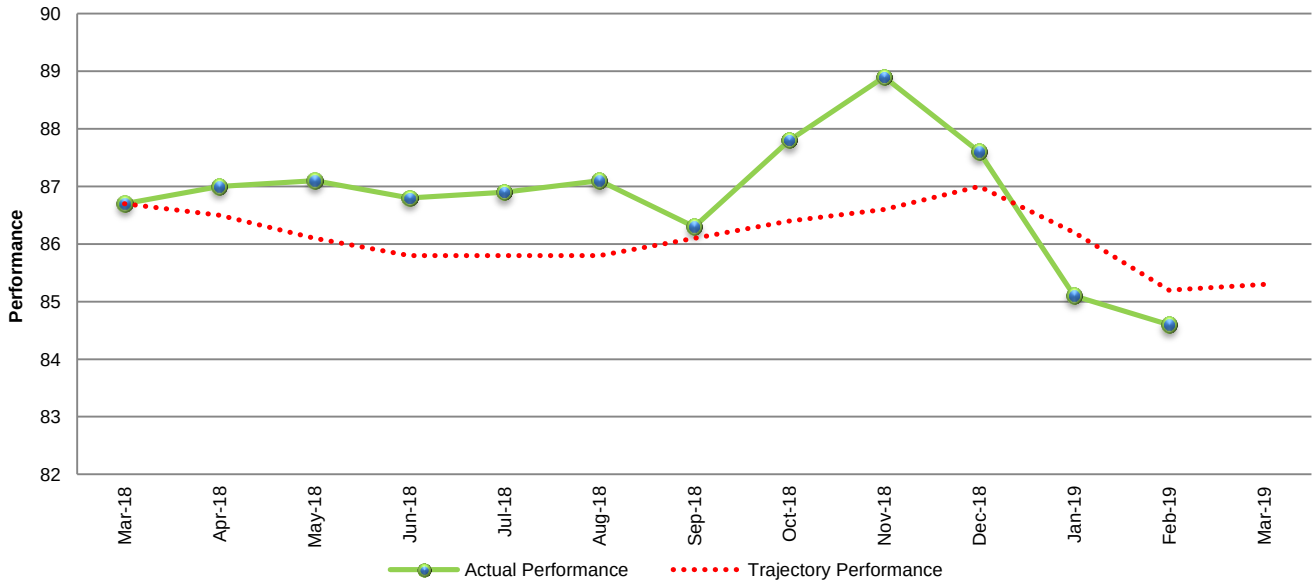
Following an increase in waiting list size in the first quarter, specialty trajectories were put into place, which resulted in a reducing waiting list size between July and November, and the position remaining below trajectory in December and January, despite winter pressures. The main reason for not achieving the trajectory in March was significant operational deterioration in waiting list size in February. Through internal analysis we have identified opportunities to improve the way that we predict waiting lists sizes which will enable us to be more responsive to demand going forward.

In quarter 4 the Trust also made several reporting changes on RTT counting following discussion with the NHSI/E Intensive Support Team in February 2019. Whilst this did not materially impact on missing the waiting list trajectory it was an additional consideration for teams at this time.

The 2018/19 guidance to halve and where possible eliminate patients waiting over 52 weeks was achieved; 10 patients were reported as waiting over 52 weeks in March 2018, and none were reported as waiting over 52 weeks in March 2019. There was an increased number of patients waiting over 52 weeks throughout the year due to a combination of the temporary cessation of corneal graft operating, reporting issues related to the Appointment Slot Issue list and patient choice at the end of long pathways, but these were cleared by the end of March 2019.

In response to the deterioration in waiting list size over quarter 4, the Trust has commissioned NHS Elect to undertake an external review on why this happened. An internal action plan is also in place between operational and informatics teams to resolve the issues identified to date.

RTT Performance waiting time for patients still waiting (incomplete pathways)



A&E: Maximum waiting time of 4 hours from arrival to admission/transfer/discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because for the period 2018/19 Accident and Emergency Department achieved 89.6% of patients having a maximum of 4 hours wait. Our agreed trajectory with NHS Improvement was 90.42% and the national target still remains at 95%. We validate our data daily and utilising our re-validation standard operating procedures further validation takes place for each submission of data.

40% of the GWH's overall performance is attributable to WH&C performance, which relates to Chippenham and Trowbridge Minor Injury Units (MIUs). In April 2018 WH&C staff moved from sitting under GWH payroll system to sitting under their own. As per 4 hour rules this took the MIU's performance out of GWH performance. In response to this it was agreed with both NHSI and NHSE that instead of the GWH losing this performance, 40%

would be attributed to GWH and 60% would be attributed to Royal United Hospitals Bath, based on the geographical location of both of the units.

Delivery of the 4 hour target remains challenging for the Trust however type 1 performance over the last year has improved with a number of initiatives supporting this. The Trust was supported with capital funding from NHSi to redevelop the Clover Building which previously housed Ambulatory Care and the Urgent Care Centre (UCC). The development has increased the foot print of the Urgent Care Centre, improved the layout of the Ambulatory Care Centre and created Ambulatory Care and Triage (ACAT) which is now the initial triage space for all medically expected patients. This reduces clinical risk for patient who were previously arriving directly onto Linnet ward our Ambulatory Care Unit (LAMU).

• The Medically Expected Unit reported in the last version of this report remains open reducing crowding within the Emergency Department (ED). It has been enhanced to include a sitting area for patients offering greater flexibility of the space.

• Since the Unscheduled Care Division has taken ownership of the Urgent Care Centre (UCC) a trial of working hours successfully proved the need to change the opening hours to align with the demand profile for the service. This change has been substantively adopted and resulted in a reduction in the number of patients waiting longer than 4 hours in the UCC.

• The Trust has continued caretaking management of the Walk In Centre (WIC) embedding best practice working policy and procedures. The challenge will be during 2019/20 when the WIC is closing the walk in element of the service and reconfiguring how patients access the services. It will no longer be operated by the Trust but has the potential to increase demand on the Acute site.

• It has been identified that 1st assessment breaches are a contributor to the current under performance, in response the Trust has realigned the staffing costs from UCC to ED providing a 24/7 ENP service for the minors stream to prevent non admitted breaches. Also this realignment has provided band 7 streaming nurses 4 days a week to ensure patients are treated in the right place and increase streaming to the UCC. There has also been an adjustment to the consultant rota to ensure increased consultant capacity at the weekends.

The Trust has been operating Dorcan Ward (8 beds) for medically fit patients. The purpose is to crease acute bed capacity for ED flow whilst the final arrangements for a patients discharge are completed.

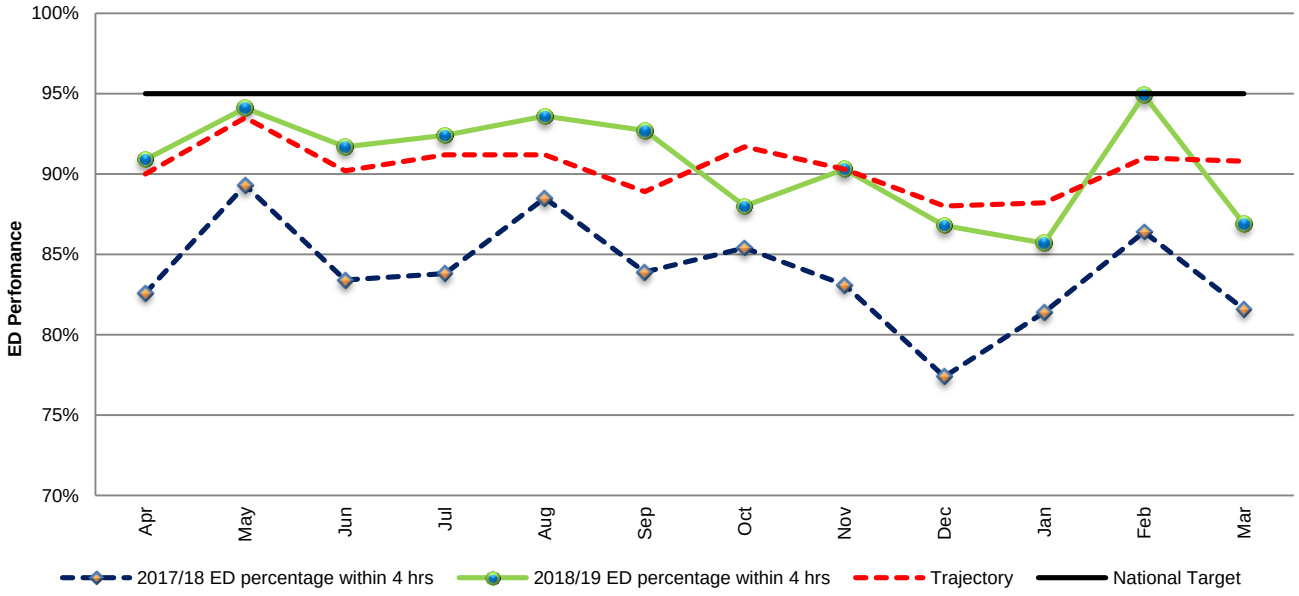
The Trust acknowledges that flow of patients out of the ED, especially early morning flow, is critical in managing performance, patient experience and safety.
Audits have demonstrated that when the ED becomes crowded the ability of the clinical teams to assess and treat patients is impacted, resulting in further crowding of the department due to exit block and caring for patients that should be in an inpatient areas. Referred patients are then discharged from ED as they have had a significant amount of treatment improving their condition that should be provided as an inpatient. In support of the need to improve flow the Trust is driving the Emergency Care Intensive Support team (ECIST) principles of identifying a patients Predicted Date Medically Stable (PDMS) for discharge.

This is a new initiative to the Trust but is targeting at making sure all patients have a target discharge date and actions are taken to remove all blocks to the patient achieving the planned discharge date. This process also supports identification of the next day's discharges so that preparations can be made to achieve the discharge early in the day.

In addition the Trust was successfully awarded £30M to invest in a redevelopment of the ED and bringing some of the 'front door' services located around the hospital to the ground floor creating a truly integrated front door service and providing the capacity for onward flow of patients. Planning for this work has commenced and construction work is planned to start by the beginning of 2021.

All Emergency Department performance for GWH

↑ Higher is better



The chart above demonstrates Emergency Department performance for 2018/19 in comparison to 2017/18 against the national target of 95%.

The Great Western Hospitals NHS Foundation Trust intends to take the work carried out this year and enhance this for 19/20 alongside the preparation work for the 'front door' redevelopment project.

62 day national cancer standard

The Great Western Hospitals NHS Foundation Trust considers that this data is as described as there are strong governance processes in place within the trust that monitor and manage this data.

The cancer waiting times service standards include a maximum 62 days from receipt of urgent GP referral for suspected cancer to 'First Definite Treatment' of cancer as per Operational Standard of 85%.

Performance Indicator	Standard	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer 62 Days	≥85%	89.2%	80.8%	86.9%	93.1%	76.7%	84.0%	81.7%	90.9%	92.4%	83.6%	77.1%	86.4%	88.7%

Actions across all Divisions to support 62 day cancer performance

1. Delivery of National "10 High Impact Actions". Work continues on delivery of timed pathways by tumour site with breach analysis identifying risks to pathway delivery and where required inter trust referral by day 37 in a patient pathway.
2. Executive Oversight of Cancer performance with weekly meetings with teams demonstrating actions to manage each identified risk.
3. Breach analysis for all patients who have breached 62 day treatment target
4. Proactive management of Cancer Patient Tracking List (PTL), meeting with Heads of Service and Diagnostic teams
5. Proactive review of 72day+ patients on PTL by clinical lead and weekly oversight by Medical Director to reduce risk of 104 day breaches
6. With increasing cancer activity; review of treatment numbers for cancer trajectory for 2019
7. Collaborative working with CCG & Macmillan GP to support GP training and audit on use of 2WW referral
8. Working with tertiary providers on managing PTL and dating patients for treatment.
9. Development of Cancer Dashboard following successful bid to TVCA innovation bid to monitor performance of timed pathway by tumour site.
10. Thames Valley Cancer Alliance (TVCA) Transformation projects including pathway redesign project manager to support development for lung, colorectal, urology and Upper GI pathways.
11. Review of internal audit process of 62 day performance and Cancer Access Policy (e-RS /2ww referrals management in Booking Centre)

National standard achieved in March with performance of **88.7%** with 106 treatments and 12 breaches. Breaches were noted in Colorectal (5), Gynae (0.5), Haematology (2), Lung (1.5) and Urology (3).

5 breaches related to GWH pathway, 2 breaches related to OUH PET scanning delays; 2 breaches had tertiary involvement in pathway (2 ITR in time); 3 breaches related to the tertiary "all options" urology patients. We have seen an increase in 2ww referrals for breast, breast symptomatic, colorectal and gynaecology. Outpatient and diagnostic capacity has been under pressure to deliver requirements with additional clinics arranged to meet demand.

PET scanning delays of at least 4 weeks due to FDG stability (National issue). The impact of these delays has been raised with NHSE.

Review of patients readmitted to hospital within 30 days of discharge

For the 18/19 position the audit with the local CCG has yet to occur and will be carried out in May 2019. On terms of the current position the trust is showing an improvement on 17/18 position of 10.1% readmission rate at 30 days compared to 11.2% the previous year. This remains high when benchmarked through Dr Foster with a low position being 5.12% and a high position being 10.91%.

There still remains a challenge within the data set with Ambulatory Care still remaining within the numbers as well as a number of planned readmission's being coded incorrectly. In order to ascertain the true impact of readmissions a local audit was conducted by the Unscheduled Care Division in October 2018 reviewing all readmissions where the admitting ward had been an Unscheduled Care ward. This was done using all patients 'classified' as a readmission during September 2018 with 1 clear questions asked of the team when carrying out the audit.

'Was the first admissions clinically related to the readmission'

297 patient's notes were reviewed as part of the audit with the following findings

- 188 patients first admission was related clinically to their second admission (45%)
- 103 patients first admission was NOT related clinically to their second admission (52%)
- 6 Patients had complex conditions where it was unclear if the admissions were clinically related

This is in contrast to the contractual position where we assume that 70% of readmissions are accurate. A further audit is to commence in April 2019 based on January readmission data covering Unscheduled Care, Planned Care and Women's and Children's.

Monthly 30 day readmission by age group

Outline: These figures are based on the crude emergency re-admissions within 30 days of the original date of discharge.

These figures are considered to be crude as they take no account of 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			Readmission Within 30 Days			Readmissions Percentage Within 30 Days		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
2017/18	**10906**	**72653**	**83559**	**1042**	**8476**	**9518**	**9.6%**	**11.7%**	**11.4%**
Apr 18	920	6268	7188	77	768	845	8.4%	12.3%	11.8%
May 18	962	6608	7570	78	824	902	8.1%	12.5%	11.9%
Jun 18	873	6611	7484	77	787	864	8.8%	11.9%	11.5%
Jul 18	890	6630	7520	60	697	757	6.7%	10.5%	10.1%
Aug 18	821	6686	7507	64	676	740	7.8%	10.1%	9.9%
Sep 18	929	6315	7244	78	650	728	8.4%	10.3%	10.0%
Oct 18	1017	6719	7736	109	710	819	10.7%	10.6%	10.6%
Nov 18	1110	6784	7894	126	656	782	11.4%	9.7%	9.9%
Dec 18	935	6594	7529	85	670	755	9.1%	10.2%	10.0%
Jan 19	971	6929	7900	83	678	761	8.5%	9.8%	9.6%
Feb 19	888	6197	7085	97	609	706	10.9%	9.8%	10.0%
Mar 19	1003	6802	7805	71	404	475	7.1%	5.9%	6.1%
2018/19	**11319**	**79143**	**90462**	**1005**	**8129**	**9134**	**8.9%**	**10.3%**	**10.1%**

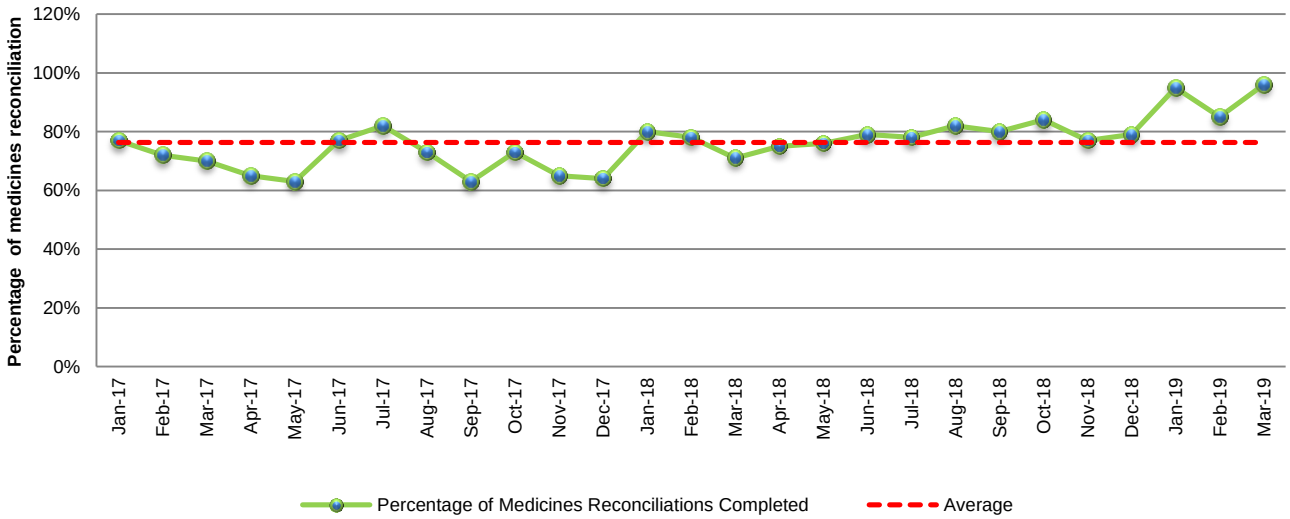
Medicines Safety

Develop & utilise medicines safety audits to improve practice.

The graph below shows the monthly data reported to clinical areas from an Electronic Prescribing and Medicines Administration system (EPMA) report regarding medicines reconciliation. Data over the last 2 years has shown a progressive increase in patients with completed medicines reconciliations, which is an important marker in ensuring patient and medication safety.

Percentage Medicines Reconciliations completed

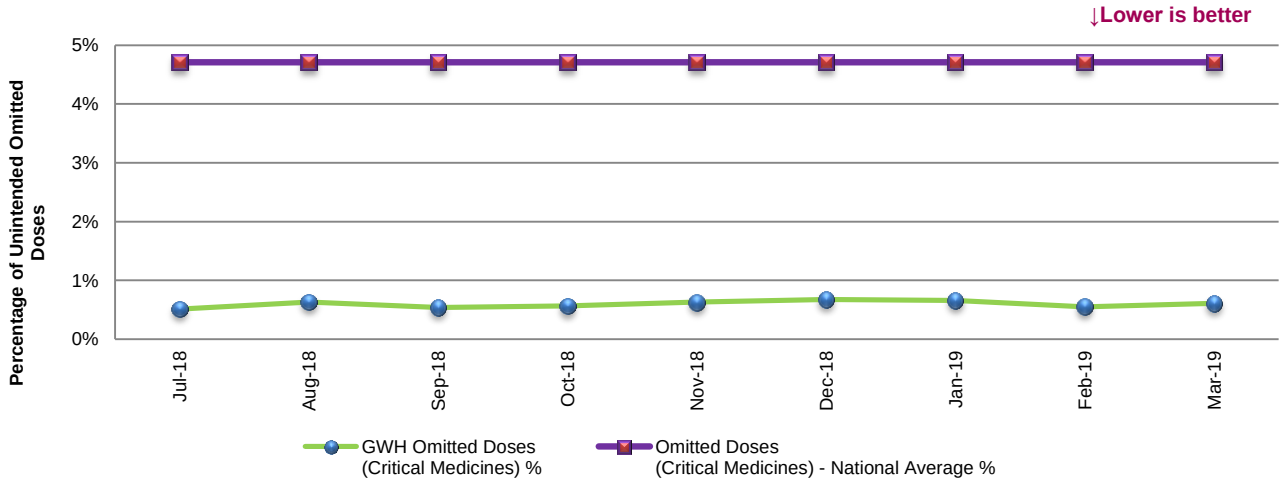
↑ **Higher is better**



Missed/Omitted Doses

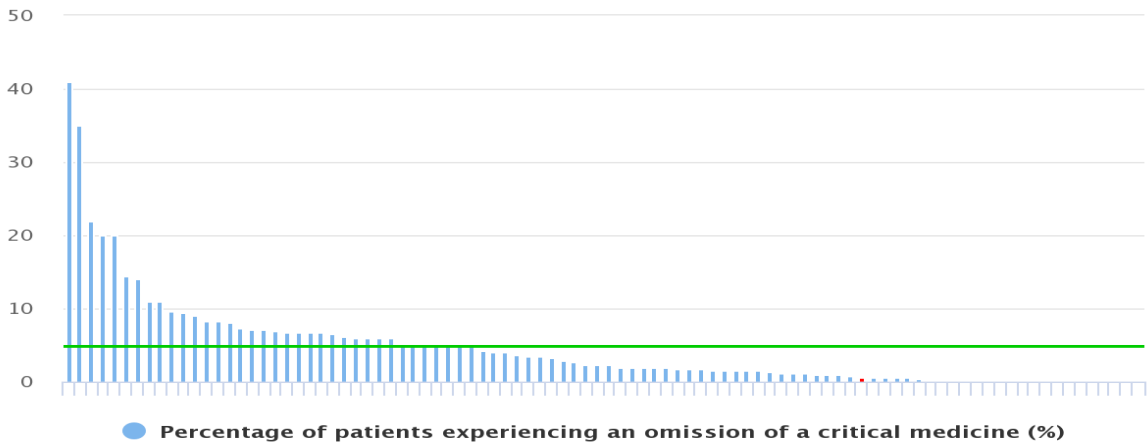
The National Patient Safety Agency (NPSA) rapid response report on omitted and delayed medicines in hospitals guides organisations to identify a list of critical medicines where timeliness of administration is crucial.

Percentage of Omitted Doses (Critical Medicines) against National Benchmarking



The chart above shows the percentage of unintended omitted critical medicines, as a percentage the total number of administrations of all medicines per month, at GWH is lower than the national average of acute hospital trusts

Percentage of patients experiencing an omission of a critical medicine



The chart above (GWH as the red line) shows that through national benchmarking data that the percentage of GWH patients experiencing an omission of critical medicines is significantly lower than the national average.

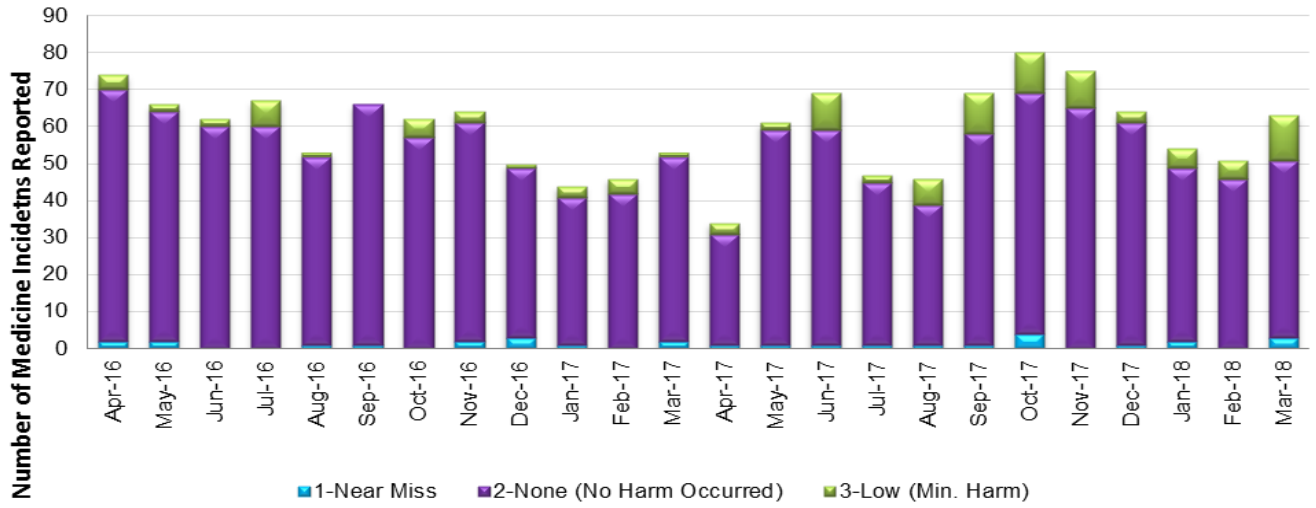
Learning from Incidents and Reduce Harm from Medication Incidents

Medication incidents reviewed and reported through Medicines Safety Group (MSG) meetings to ensure lessons are learnt & shared. MSG meets every 2 months as a direct report to the Medicines Assurance Committee (MAC).

Learning from incidents shared through Medicines Safety bulletins. Examples issued in 18/19:

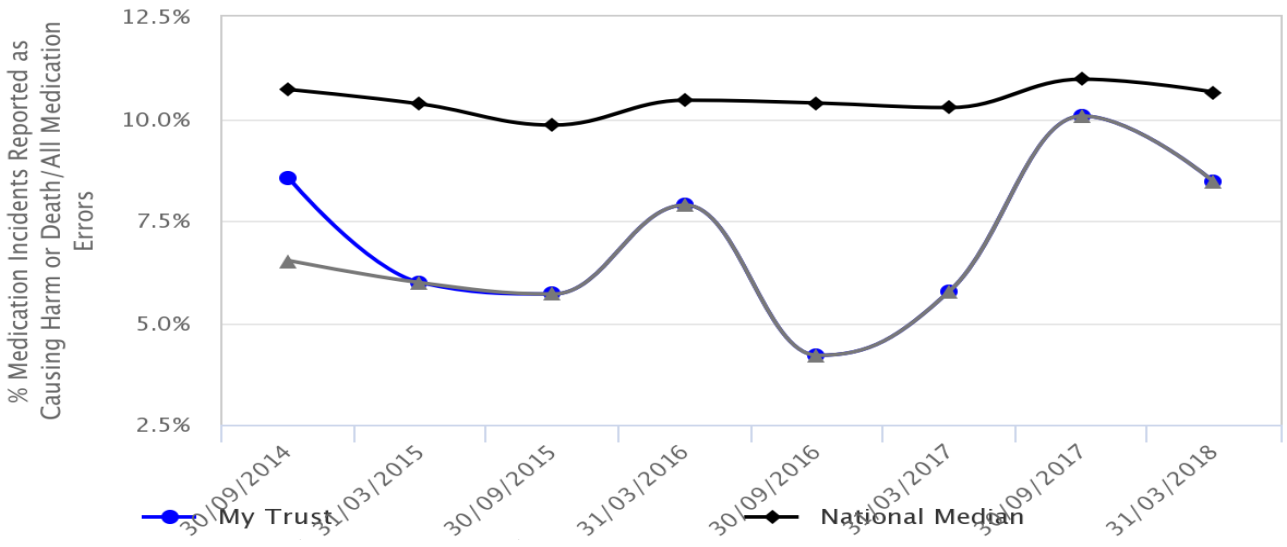
- Safe Storage of Medicines
- Ensuring Patients get their Medicines in a timely manner
- Correct Use of Oxygen Cylinders
- Urgent Antibiotics

Number of Medicines Incidents Reported Including Level of Harm



The chart above shows the number of medicines incidents reported at GWH with the level of harm along with consistency in reporting.

Percentage of medication incidents reported as causing harm or death (GWH vs. national distribution)



The chart above demonstrates that GWH (blue line) continues to report medication incidents well, and remains below the national average of medication incidents causing harm.

Together this data provides assurance that for medicines safety GWH is safe, has good systems in place for medicines safety and importantly learns from incidents.

Improving Patient Experience & Reducing Complaints

The Friends and Family Test is commissioned nationally by NHS England as a form of data collection for patients to provide feedback on our services who have been discharged from our care.

Our overall response rate remains low for the Friends and Family Test; however feedback that is received is acted on and highlights areas of excellence and areas where improvements can be made.

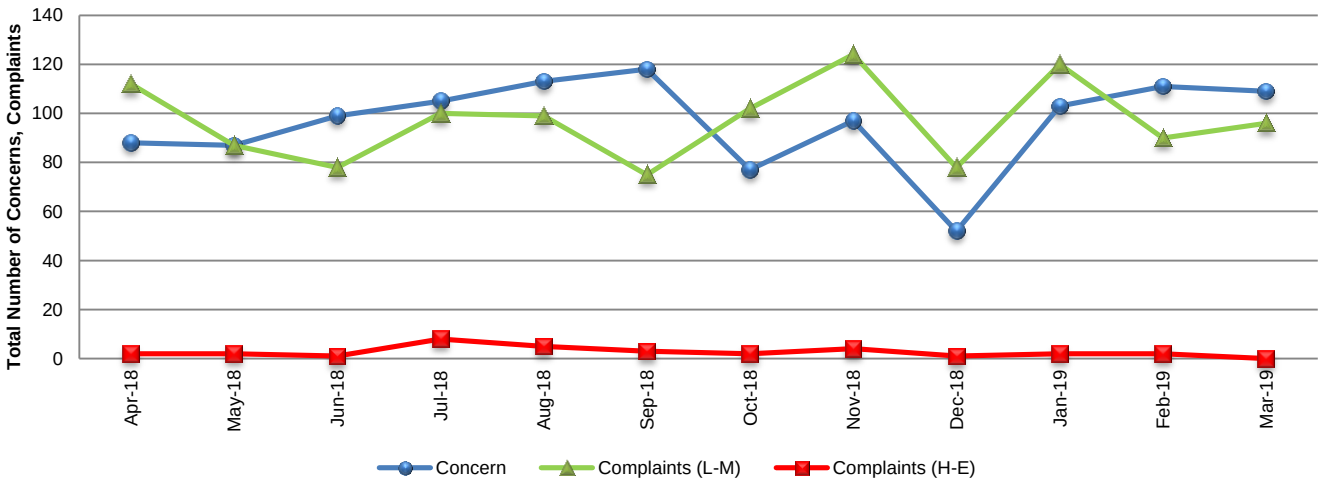
Feedback from the Friends and Family Test includes changes to tea rounds, ward routines in the format of bedside guides, changes in the Childrens food menus, prompt repairs and cleaning to seating clinic areas/waiting areas.

Percentages of patient recommendation scores are high and have remained consistent in the high 90% throughout 2018/2019.

Cards are available for patients to complete; these cards are also available in other formats to include Large Print, Child friendly and Easy Read.

Every aim is to improve the overall response rates for completed cards. We are aware within some areas once a patient has been discharged they are wanted to return home as soon as possible, therefore a text messaging service is in place for the Emergency Department patients, plans are in place to introduce this into all Inpatient areas throughout 2019/2020.

Concerns and Complaints received in 2018/19 Trust-Wide



The graph above gives a comparison on concerns/complaints received Trust-Wide services over a 12 month period for 2018/19.

Low/medium cases are complaints where service or patient experience is below reasonable expectations. High/extreme cases require a more in-depth investigation.

Themes from complaints are highlighted and actions developed and implemented in the format of “you said, we did”.

Patient Experience and Engagement

Engagement with patient groups has taken place throughout 2018/2019 gaining views on our services and changes made to enhance service delivery. Plans are in place for this worked to continue throughout 2019/2020.

National Inpatient Survey

Questionnaires were sent out to patients who had recently stayed at the Great Western Hospital, the initial mailing was sent out in October 2018. 539 patients responded. The overall response rate was 46%.

The results for 2018 are detailed below against the key objectives agreed to benchmark each year to monitor performance.

Communication	2014	2015	2016	2017	2018
Care: Staff did not contradict each other	66%	62%	68%	68%	65%
Care: Was involved as much as wanted in decisions	88%	88%	88%	91%	91%
Care: Had confidence in the decisions made	92%	92%	92%	94%	94%
Care: Right amount of information given on condition or treatment	77%	77%	78%	78%	76%
Enough emotional support from hospital staff	81%	82%	84%	82%	84%
Doctors: Got clear answers to questions	95%	92%	96%	93%	94%
Doctors: Not talked in front of patients as if they were not there	74%	73%	75%	76%	77%
Nurses: Got clear answers to questions	95%	94%	94%	95%	95%
Received information explaining how to complain	23%	23%	18%	26%	14%

Discharge Planning	2014	2015	2016	2017	2018
Discharge: Given clear written/printed information about medicines	85%	83%	88%	88%	80%
Discharge: Family given enough information to help care	72%	67%	70%	72%	70%
Discharge: Told who to contact if worried	74%	73%	73%	73%	73%
Discharge: Felt involved in decisions about discharge from hospital	86%	84%	88%	85%	84%
Discharge: Was not delayed	56%	52%	55%	58%	56%
Discharge: Patients given written/printed information about what they should or should not do after leaving hospital	65%	59%	60%	57%	54%
Discharge: Told purpose of medications	90%	87%	89%	87%	91%
Discharge: Told side-effects of medications	52%	49%	55%	56%	51%

Hospital, Care, Overall	2014	2015	2016	2017	2018
Hospital: Offered a choice of food	93%	92%	92%	94%	93%
Found staff member to discuss concerns with	67%	70%	75%	70%	71%
Asked to give views on quality of care	18%	15%	14%	17%	9%

Our Priorities 2019/20

- Continue with the recruitment of Trust Bank Interpreters.
- The introduction of IPads for Skype Interpreting for deaf patients.
- The introduction of using an app for language interpreting on trust iPod's/tablets.
- Review finance for changes to PALS Structure.
- Review of National Surveys to change provider.
- Slicker and escalation processes to be in place for improved complaint handling.
- Complaint themes and outcomes to link with QI projects to ensure learning takes place and shared trust wide.
- Scoping exercise for Easy Read documents to be produced in house.
- Procurement for the Friends and Family Test.
- Considerations for a Patient Experience team to be formed.
- Engagement with Community Groups, listening events to be held throughout 2019/2020/2021.
- Review process for gathering real time patient experience and engagement feedback

Staff Survey 2018/19

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 44% (2017: 46%). Scores for each indicator together with that of the survey benchmarking group Combined Acute and Community Trusts are presented below.

	2018		2017		2016	
	GWH	Benchmarking Group	**GWH**	Benchmarking Group	**GWH**	Benchmarking Group
Equality, diversity and inclusion	**9.1**	9.2	**9.2**	9.2	**9.3**	9.3
Health and wellbeing	**5.8**	5.9	**6.0**	6.0	**6.2**	6.1
Immediate managers	**6.8**	6.8	**6.8**	6.8	**6.8**	6.8
Morale	**6.1**	6.2	**-**	-	**-**	-
Quality of appraisals	**5.2**	5.4	**5.3**	5.3	**5.5**	5.4
Quality of care	**7.2**	7.4	**7.1**	7.5	**7.4**	7.5
Safe environment – bullying and harassment	**8.1**	8.1	**7.9**	8.1	**8.0**	8.2
Safe environment – violence	**9.5**	9.5	**9.4**	9.5	**9.5**	9.5
Safety culture	**6.7**	6.7	**6.7**	6.7	**6.8**	6.7
Staff engagement	**6.9**	7.0	**6.9**	7.0	**7.1**	7.0

The Trust was one of the 304 participating NHS organisations, and one of the 43 Combined Acute and Community Trusts that participated in the National Staff Survey in October 2018. There were 1,250 (25% of the workforce) randomly selected and given the opportunity to participate in the 2018 Staff Survey by an online staff survey through their NHS email. A total of 534 employees returned a completed questionnaire giving the Trust a response rate of **44%**. This was a slight decrease in last years (46%, 2017) but above the average response rate for Combined Acute and Community Trusts in England (40%, 2018).

National and regional response comparisons

National

NHS England released the results of the 2018 NHS Staff Survey on Tuesday 26 February 2019. Over 497,000 NHS staff took part in the survey with a National response rate of 45.7 per cent and just fewer than 10,000 more people shared their views compared to the 2017 survey. GWH demonstrated a similar trend to the national results with a reduction in response rates.

2018 Results Analysis

Areas of Improvement from 2017
The top five areas where the results have improved from the 2017 survey are;

- Q4f. Have adequate materials, supplies and equipment to do my work 46% (42%, 2017)
- Q4h. Team members have a set of shared objectives 75% (70%, 2017)
- Q5g. Satisfied with level of pay 31% (26%, 2017)
- Q5h. Satisfied with opportunities for flexible working patterns 56% (51%, 2017)
- Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public 74% (68%, 2017)

Areas that have deteriorated from 2017
The top five areas where the results have declined from the 2017 survey are;

- Q8b. Immediate manager can be counted on to help with difficult tasks 67% (72%, 2017)
- Q11a. Organisation definitely takes positive action on health and wellbeing 22% (27%, 2017)
- Q11c. Not felt unwell due to work related stress in last 12 months 57% (61%, 2017)
- Q13d. Last experience of harassment/ bullying/ abuse reported 43% (49%, 2017)
- Q22b. Receive regular updates on patient/s service user feedback in my directorate/department 51% (60%, 2017)

Regional

The Trust was ranked 16th out of 21 Trusts in 2018 when benchmarking against the ten National Staff Survey themes against organisations from across the South West. Gloucestershire Hospitals NHS Foundation Trust, Oxford University Hospital NHS Trust and North Bristol NHS Trust remain below the Trust.

When compared against the STP group, Salisbury NHS Foundation Trust ranked 9th and Royal United Bath Hospital ranked 14th.

Due to the changes in the way the national results are reported we are unable to obtain a regional comparison against last year's results.

Staff Engagement

The staff engagement score for the Trust has remained the same at 6.9 and is scoring marginally below the national average of 7.0. The areas used to measure the staff engagement score is based on staff recommending the organisation as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work. Whilst the Trusts staff engagement score has remained the same this year, against a regional comparison the Trust engagement score is higher than three other Trusts and scored the same as four other Trusts in the South West region.

Staff engagement levels across the Trust are variable and range from 6.6 to 7.2 out of a possible 10. Corporate Services and Diagnostic and Outpatients report the lowest levels of engagement at 6.6 with Planned Care and Swindon Community Health Services reporting the highest at 7.2.

Our priorities for 2019/2020

The development of a Trust wide approach will be implemented on four key focus areas, the Trust will work with staff through listening events and focus groups to identify relevant and meaningful actions.

The key priority areas for focus are;

Staff Engagement (led by HRD and OD lead)
- Refresh and re-launch of the People Strategy
- Implement Engage to Change within agreed departments
- Leadership Development
- 'You Said' and 'We Did' communication to be done Trust Wide and Locally

Quality of Care (led by Head of Quality)
- Develop a new Quality Strategy
- Implement a communication plan to support the Quality Strategy
- Utilise the engage to change methodology for employee led improvements

Quality of Appraisals (led by Head of Learning and Development)
- Review Appraisal Policy and Training
- Consider the implementation of an appraisal period (Summer)
- Implement bespoke training for hotspot departments

Health and Wellbeing (led by Head of Health and Wellbeing)
- Review Health and Wellbeing strategy as part of the People strategy review
- Implement wellness events utilising charitable funds
- Review of staff benefits and how this is communicated to staff (Staff App)
- Improving health and wellbeing guidance for managers

Divisional
Each Division will develop a local action plan focusing on three key areas which will make the most impact based on the results for the Division. The results will be shared through a 'listening into action' approach, empowering staff to be involved and contribute towards improvements in their Divisional staff survey results. Updates on the progress of the Divisional action plans will be presented quarterly at Executive Committee.

Monitoring arrangements
The Trust and each of the Divisions have commenced developing action plans aligned to the areas where their scores have deteriorated. Each of the priority areas will have named the three lowest scoring questions. The areas will be measured by an improvement on the score for these questions following the 2019 survey.

All Divisions will provide updates on the progress of the Divisional action plans quarterly at Executive Committee.

Trade Union Facility Time – New for 2018/19

In 2017 the government passed The Trade Union (Facility Time Publication Requirements) Regulations 2017 requiring public bodies to report each year on the agreed time off Trade Union Representatives who are employees have taken to carry out their trade union role.

As at 31 March 2019 there are 27 Trade Union Representatives who are employed by the Trust and the current data shows that employees have 244.5 hours on paid Trade Union Activities and 405.5 hours on paid Trade Union Facility Time. This is expected to rise with the Q4 information and at that point cost and % of employee time will also be calculated for 2018/19. The data is published by 31 July each year.

NHS Doctors and Dentists- Rota Gap and Improvement Plan

In August 2017 there were 30 junior doctor vacancies with a further 16.5 pending starters appointed, this was reduced significantly to just 14.5 vacancies in August 2018 with 2 pending starters appointed. This has remained at a low level throughout this year but increased slightly in April and May 2019, there are currently 9.84 junior doctor vacancies across the Trust with a further 5 pending starters.

The reduction in vacancies for junior doctors has been achieved, despite an overall increase in posts, by using a number of different methods; all have contributed in different ways.
Internal factors:
We conduct an annual recruitment trip to a European university that has now been running for 4 years. We recruit F1 level clinical fellow doctors directly during this trip that are of a high standard. These doctors often then stay on for a 2nd year to work at F2 level before either taking on training roles with HEE or continuing to work for the Trust in more senior clinical fellow roles. This is of significant importance, as whilst we don't struggle to recruit F1 level doctors, having them stay on to work at F2 level has been of great value to the Trust and helped reduce our vacancies at this level.

In 2018 we took out a BMJ subscription meaning we can advertise all our medical vacancies through their online portal which has a large number of views Nationally and Internationally by doctors looking for work. We also have access to use their printed journal for advertising but this is reserved for Consultant recruitment campaigns since usage is limited.

For the last 4-5 years we have also recruited additional teaching roles through the Academy, these doctors work in teaching or innovation roles but also undertake clinical duties on a 50/50 split. Funding comes from the

Academy for the increase in headcount needed to support the reduction in clinical capability from each of the appointed doctors.

Vacancies are reviewed regularly at monthly Medical Staffing Group meetings and in Quarterly Guardian reports. We also take the opportunity to work with the Junior Doctors forum to promote roles that might interest their members and gain feedback on improvements that could be made to make roles more attractive.

External factors:
HEE introduced a payment for GP trainees in the area for specific roles to boost recruitment and encourage doctors to take on those roles. These payments are funded by HEE and have no financial impact on the Trust other than positive by filling more of the roles.

All remaining vacancies are covered by internal bank locums or agency locums, however the fill rate for bank locums is high.

3 Other Information

3.1 Other Information

This section provides information about other services we provide, through a range of selected quality measures. These measures have been selected to reflect the organisation and shows data relevant to specific services as well as what our patients and public tell us matters most to them.

Performance against key national priorities

An overview of performance in 2018/19 against the key national priorities from the Single Oversight Framework. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2014/ 2015 Trust	2015/ 2016 Trust	2015/ 2016 Target	2016/ 2017 Target	2016/ 2017 Trust	2017/ 2018 Target	2017/ 2018 Trust	2018/ 2019 Target	2018/ 2019 Trust	Achieved/ Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	90.5%	88.9%	92.0%	92.0%	91.1%	92%	86.7%	86.7%	83.45%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	88.6%	82.5%	90%	90%	61.6%	90%	69.1%	69.1%	66.33%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95.6%	89.2%	95%	95%	89%	95%	89.3%	89.3%	89.45%	Not Met
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95%	91.9%	91.1%	95.0%	95.0%	86.6%	95%	87.2%	National 95%	89.6%	Not Met
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	99%	94.%	94%	94%	100%	94%	98.7%	94%	97.6&	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	98%	99.7%	98%	98%	99.6%	98%	100%	98%	100%	Achieved

Indicator	2014/ 2015 Trust	2015/ 2016 Trust	2015/ 2016 Target	2016/ 2017 Target	2016/ 2017 Trust	2017/ 2018 Target	2017/ 2018 Trust	2018/ 2019 Target	2018/ 2019 Trust	Achieved/ Not Met
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	88.4%	87.70%	85.00%	85%	86.5%	85%	82%	85%	85.7%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	98.4%	98.10%	90.00%	90%	96.7%	90%	97.6%	90%	95.1%	Achieved
Cancer 31 day wait from diagnosis to first treatment	98.6%	98.00%	96.00%	96%	97.1%	96%	98.4%	96%	98.4%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	94.0%	94.30%	93.00%	93%	88.4%	93%	93.4%	93%	94.8%	Achieved
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	96.8	95.50%	93.00%	93%	91.8%	93%	78.5%	93%	93.6%	Achieved
Maximum 6-week wait for diagnostic procedures	99.5%	99%	99.1%	99%	97.0%	99%	96.2%	99%	92.77%	Not Met

Statement from the Council of Governors dated 12/05/19

The Governors are of the opinion that the Quality Account is a realistic representation of the Trust's performance as presented to the governors over the past year. The Governors have acknowledged that unfortunately the Trust did not achieve some targets, notably 89.6% of persons attending A&E were seen within 4 hours, was marginally below the agreed trajectory with NHS Improvement of 90.42% and the national target of 95%. The Governors consider these figures to be consistent with those of the majority of other Trusts and are reflective of the pressures brought about by increased attendance.

It should be noted that these figures are an improvement on last year and that a number of improvement initiatives were introduced this year. The Trust intends to take the work carried out this year and enhance this for 2019/2020, alongside the preparation work for the 'front door' redevelopment project, for which the Trust was successfully awarded £30M to invest in a redevelopment of the ED and to bring some of the 'front door' services located around the hospital to the ground floor creating a truly integrated front door service and providing the capacity for onward flow of patients.

Within the Quality Report the Trust has reported a number of achievements including-

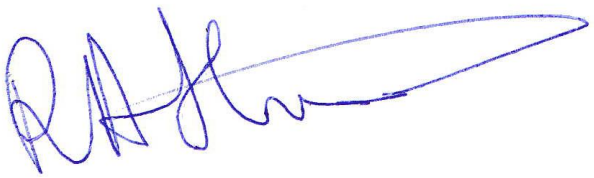
The Venous Thromboembolism (VTE) risk assessment, carried out on adult patients who are admitted to the Trust, to determine their risk of VTE related episode has for the last two years been consistently greater than 99%, against the national target of 95%.

The Trust's Summary Hospital-level Mortality Indicator (SHMI), October 2017 to September 2018 is 85.56, lower than the nationally expected value of 100 and nationally falls in the first decile.

Acute Kidney Injury (AKI) Average Mortality Rate at Discharge – During 2018/19 14.7% of patients died in GWH with Acute Kidney Injury. This is a decrease on the previous year where the figure was 16.8% and over the last four years has decreased from 19.28% to 14.69%.

Medicine Safety – The Electronic Prescribing and Medicines Administration System (EPMA) report regarding medicines reconciliation, shows that data over the last 2 years has shown progressive increase in patients with completed medicine reconciliations, which is an important marker in ensuring patient and medication safety. In addition, the percentage of unintended omitted doses of critical medicine, as a percentage of the total number of administrations of all medicines per month, at GWH, -0.7% is lower than the national average of acute hospital trusts of -4.8%.

These achievements combine to help achieve an improving experience for our service users and are noted by the Governors.



Roger Stroud

Lead Governor on behalf of the Council of Governors

Statement from Swindon Clinical Commission Group dated 17/05/19

Swindon Clinical Commissioning Group (CCG), as lead co-ordinating commissioner for the GWHFT, welcomes the opportunity to review and comment on the GWHFT Quality Account for 2018/2019. In so far as the CCG has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the CCG via contractual monitoring and quality visits and is presented in the format required by NHS Improvement 2018/2019 presentation guidance.

The CCG recognises and commends the Trust's commitment to delivering its safety improvement plans, which has evidenced a reduction in acute kidney injury (AKI) mortality, the number of unexpected cardiac arrests and improved compliance with key sepsis management processes. It is also positive to note that the number of reported inpatient falls remains below the national average, supported by demonstrable improvements in compliance with falls risk assessments and lying and standing blood pressure monitoring. This work will be further supported by the national falls CQUIN (commissioning for quality and innovation) for 2019/20. A continued focus on preventing deconditioning of frail patients during their hospital stay is welcomed and will be monitored in year to ensure patients maintain independence in hospital. GWH (acute and community) are a valued contributor to the Swindon Falls and Bone Health Collaborative, which has implemented a number of improvement initiatives across the wider falls pathway.

GWHFT reported a breach in the numbers of Clostridium difficile infections (CDI) during 2019/19, reporting 27 against a trajectory of no more than 19. Reviews involving GWHFT, Swindon CCG and Wiltshire CCG determined 11 to be avoidable. With reporting definitions changing nationally during 2019/20, it is essential that the Trust continues its aim in reducing the incidence of CDIs in the hospital and community setting. The CCG also welcomes the Trusts' continued focus in supporting plans to reduce reported gram-negative bloodstream infections (GNBSI) across the wider health and social care economy during 2019/20, which will contribute towards meeting both the national and local 50% reduction target by 2021.

During 2019/20 the SCCG will continue to monitor the prevalence of pressure ulcers, with a particular focus on prevention and management of those pressure ulcers reported for patients cared for in their own home.

The Care Quality Commission's (CQC) inspection of GWHFT during August and September 2018 resulted in an overall rating of requires improvement. During 2018/19, a key focus for the CCG has been the quality and safety of care within the emergency department, particularly when attendances increased within the department during the winter period. The CCG would therefore request that these safety workstreams provided by GWHFT to the commissioner are also evidenced within future quality accounts. The CCG would also request that an additional element for the quality account going forward would be the inclusion of reported mixed sex accommodation breaches. The CCG is in receipt of the Trust's CQC Improvement Plan and will continue to monitor progress via formal contract quality review meetings and quality visits throughout 2019/20.

The CCG recognises the increased number of 9 never events reported during 2018/19, with the majority (7) related to incidents categorised as 'wrong implant'. A number of these cases were identified as a result of the full review into the first reported case. The commissioners commend the Trust for conducting a proactive and transparent investigation, which has enabled this patient safety issue to be highlighted nationally to support wider learning. The CCG has sought and received assurance from the Trust on the actions being taken to prevent reoccurrence and will continue to monitor progress and patient outcomes.

The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR) are key indicators of the quality of care provided. The CCG is assured by the SHMI data for the rolling 12-month period of October 2017-September 2018, giving the Trust a 'better than' expected rating. In addition, the Trust is meeting its target to reduce mortality rates measured by hospital standardised mortality rate (HSMR), demonstrating one of the lowest HSMR rates in Southern England. The CCG welcomes the Trust's priority for 2019/20 to increase the number of structured judgement reviews aimed at supporting thematic analysis and further learning.

GWHFT has evidenced full implementation of the Freedom to Speak Up requirements following the learning identified in The Gosport War Memorial Hospital Independent Panel report. The account specifies how staff are able to raise concerns and details key themes arising from concerns raised. In line with national requirements, the CCG would request more information regarding learning and actions taken and that this is provided within future quality accounts.

Patient experience and engagement has been identified as a priority for the Trust and the outcomes of the 2018 patient survey are noted. In order to ensure the patient voice is heard and acted upon, the CCG will continue to work with the Trust to gain assurance on actions being taken to improve those areas where feedback scores

have worsened, particularly regarding 6 out of the 8 specific questions relating to discharge planning; information explaining how to complain (14%) and the number of patients asked to give views on quality of care (9%).

It is recognised that during 2018/19 GWHFT experienced a sustained increase in non-elective demand, resulting in the Trust having continued difficulties in achieving the 18-week referral to treatment target. These NHS constitutional targets continue to be a challenge across NHS organisations and are regularly monitored by the CCG. The CCG will continue to work with the Trust to monitor the quality of care and treatment for patients.

The CCG notes the GWHFT's priorities for 2019/20 and will work with the Trust to support the achievement of better outcomes for patients as a result of improving nursing handover and timely discharge; reducing rates of clostridium difficile; improving patient engagement, increasing support for carers of a person living with dementia and implementing a Trust wide programme of quality improvement training. The CCG would also request that nationally set CQUINS are also prioritised, with outcomes described in the GWHFT annual account for 2019/20.
Swindon CCG, together with associated co-commissioners, is committed to sustaining strong working relationships with GWHFT and together with wider stakeholders, aims to continue collaborative working that can support achievement of the identified priorities for 2019/20 across the whole health and social care system.

Gill May

Director of Nursing and Transformation, NHS Swindon CCG

Statement from Healthwatch Swindon and Healthwatch Wiltshire dated 17/05/19

Healthwatch Swindon and Healthwatch Wiltshire welcome the opportunity to comment on the draft Quality Account again this year. We are pleased to see the proposals for improvement in 2019/20 and have some comments on the past year based on the feedback we have received from local residents.

Complaint handling

We look forward to seeing the outcome of the review of processes to improve timeliness of responses to complaints. We met with GWH colleagues to discuss some of the issues local people raise with us and will be happy to cooperate with the review. One commentator asking us for advocacy support said, "I have ongoing NHS complaints which are not being investigated properly."

Support to carers

We welcome the initiative to review the support available to the carers of those living with dementia. We have begun a discussion with the GWH carers lead about gaining more feedback from carers about their experience with the Trust and expect to pursue with the Trust during 2019/20.

End of Life Care

We have received feedback about the use of the Treatment Escalation Plan (TEP) during 2018/19 and hope that the promotion of the TEP within the Trust during 2019/20 and clear public understanding of its use will be beneficial.

Research

The number of patients and staff involved with current or closed research studies is impressive, but we were concerned to read an article in Swindon Advertiser in March 2019 where, "in a report to GWH's executive board, research and innovation director Dr Badri Chandrasekaran and team manager Catherine Lewis-Clarke said they were not getting enough help from the hospital's top table."

Waiting List

It is regrettable that, "the 92% standard and stable waiting list size were not achieved at the end of 2018/19". We look forward to seeing the results of the action to improve performance as delays (and cancellations) are undoubtedly of concern. One commentator told us, "There was a long wait for referral but the experience was good once we got there".

Patient Experience and Engagement.

We are pleased that consideration is being given to establishing a patient experience team. We would like to see which specific patient groups have been engaged with during 2018/19 and we can support work to increase engagement. Some of our volunteers have contributed at the nutrition and hydration group, the eye care reference group, the cancer services group and the falls collaborative.

During 2018/19 Healthwatch Swindon received 60 negative and 30 positive comments from local people about the Trust's services. The range of feedback we receive from patients is wide and includes both the acute and community services provided by the Trust.

For example one commentator said, "online booking works well. It is ironic that it's people with hearing problems who can't use it for audiology at GWH because only telephone booking is possible". One said, "when my husband was in hospital he needed his tablets at certain times; he was often kept waiting an hour before he got his pain relief because they needed two doctors to sign off to get it, and very often one doctor was elsewhere". Another referred to the effective integration of acute and community services: "I had great service from GWH even though it was a lengthy wait I felt well cared for by all the nurses and surgeon. My aftercare was a concern. I needed to have my leg re-dressed every two days and it was a complete nightmare trying to see a nurse at my GP surgery. I regularly went to the Walk-in Centre which I received outstanding care from but some days it was a very very long wait…."

We hope that the "slicker and escalation processes to be in place for improved complaint handling" will bear fruit given the experience of some patients we have supported through our independent health advocacy service.

Healthwatch Wiltshire received few comments about the acute trust in this period, and most of these were related to difficulty in getting to appointments. We also received some comments relating to delayed discharges: "After being told ready to be discharged my friend was waiting a further 2 hours to be discharged. This included a long delay waiting at the pharmacy for medication."

Conclusion

We acknowledge the work undertaken by all those involved with the Trust at all levels and often in very difficult circumstances. One commentator told us, "I have so much praise for GWH and all the staff that were very professional and helpful. I can't thank them enough from the paramedics to the nurses and doctors that work for the NHS keeping up the fantastic work"

Healthwatch Swindon and Healthwatch Wiltshire look forward to helping to contribute to continued improvements in the delivery of the Trust's services.

Carol Willis
Team Manager
Healthwatch Swindon

Stacey Plumb
Manager
Healthwatch Wiltshire

Statement from Swindon Health Overview & Scrutiny Committee dated 08/05/19

We welcome the focus on improving safe discharges from hospital and reduce re-admission rates. We also congratulate the Trust on the improvements which have been made.

We look forward to working with the Trust on the Quality Improvement work and believe we can make a contribution to the methodology given our transformation in adult social care.

We would recommend an executive summary of achievements and continued areas of development in future reports

Sue Wald
Corporate Director of Adult Social Services

Statement from Wiltshire Health Overview & Scrutiny Committee dated 20/05/2019

Overall the committee felt that this was a detailed report, although at the time members of the committee met to review the Quality Accounts the document was incomplete (version 5 was considered). Version 8 was sent to Wiltshire Council on Friday 17 May.

For ease of access for members of the public the committee would suggest that a simple executive summary is included with the quality accounts, which would offer an overview of the improvements achieved in the past year against the trust's priorities for that same year, as well as the areas requiring more work. Both would include numbers, i.e. showing the rate of improvement(s) achieved against the measures selected. The executive summary could also list the quality priorities identified by the trust for the year ahead and the proposed measurements.

Members also felt that it was difficult to establish the severity of some of the issues highlighted as there were no local or national comparator offered. For example, it is hard to weigh the significance of the figures for pressure ulcers without national comparator / average.

It would also be helpful if figures such as number of admissions were included, especially where there has been an increase reporting of an issue. For example, the total falls across the trust; it is mentioned in the text above the table that there had been an increase in the number of admissions to the trust, but this is not reflected in the graph.

The committee noted that the number of Clostridium Difficile cases were higher than the previous year (2017/18) and 8 above the trust's mandated goal for 2018/19; and was therefore glad to see that reducing the rate of Clostridium Difficile infection remained a priority for 2019/20.

The committee appreciated that the trust had participated in 56 national clinical audits (98% of relevant clinical audits) and 2 national confidential enquiries covering health services provided by the trust and that actions had been agreed to improve the quality of healthcare provided based on the reports from the audits.

The committee also noted that the December 2018 CQC inspection had resulted in many of the Core Services being rated as good but that three had been rated as Requires improvement: Urgent & Emergency Care, Medical care (including older people's care) and Surgery.

The committee noted that the trust's number of patients safety incidents was either the same as national average or marginally above.
It was also noted that there had been 3 cases of MRSA bloodstream infections in 2018-19, above the national target of 0.

It was noted that 1 wrong site surgery, 7 wrong implant/prosthesis and 1 retained foreign object post surgery had been reported as Never Events between April 2018 and March 2019. Although concerned about the Never Events, the committee was pleased to see that the trust had been proactive in ensuring that other organisations did not repeat the same or similar incidents with regards to the wrong implant / plate used for forearm fractures.

It was also noted that there had been an increase of 9 serious incidents from the previous year, with a total of 38 serious incidents reported and investigated in 2018-19; with the most frequently reported serious incidents being:

- Pressure ulcers,
- Never Events,
- Implementation of care / on-going.

The committee hoped that the awarded £30M to be invested in the Emergency Department and into creating an integrated front door service would help the trust achieve its 4 hours maximum waiting time from arrival to admission / transfer / discharge (89.6% achieved for 2018-19 against a set target of 90.42% and a national target of 95%).

The committee would be grateful for an update to be provided in 6 to 9 month time, detailing:

1. progress on the priorities for Quality Improvement identified by the trust for 2019-20:
    a. Improving effectiveness of nursing handover and timely discharge communication,
    b. Improve patient experience and engagement and improve complaint response timescales,
    c. Increase Quality Improvement capacity through implementing a trust-wide programme of Quality Improvement training,
    d. Develop the support provided to carers of a person living with dementia,
    e. Reduce the rates of Clostridium Difficile infection.

2. Actions implemented to address issues highlighted by the December 2018 CQC inspection, in particular for:
    a. Urgent & Emergency Care,
    b. Medical care (including older people's care), and
    c. Surgery

3. Implementation of key learning points and actions taken with regards to Never Events (if possible number of Never Events reported to date) and serious incidents.

4. Developments to the Emergency Department and integrated front door service (£30M funding awarded).

Signature Required

Cllr Howard Greenman
Chairman of the Wiltshire Health Select Committee

2018/19 Statement of Directors' Responsibilities in Respect on the Quality Report dated 20/05/19

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement 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 arrangement that NHS 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 2018/19 and supporting guidance.

The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period 1st May 2018 to 4th May 2019
- Papers relating to quality reported to the board over the period 1st May 2018 to 4th May 2019
- Feedback from Swindon and Wiltshire commissioners dated: 17th May 2019.
- Feedback from Governors dated: 12th May 2019.
- Feedback from local Healthwatch organisations dated: 17th May 2019.
- Feedback from Swindon Overview and Scrutiny Committee dated: 8th May 2019.
- Feedback from Wiltshire Overview and Scrutiny Committee dated: 20th May 2019
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, report to Board monthly.
- The [latest] national inpatient survey: March 2019
- The [latest] national staff survey February 2019
- The Head of Internal Audits annual opinion over the Trust's control environment dated: May 2019
- CQC inspection report dated: 21st December 2018

The Quality Report presents a balances picture of the NHS foundation Trust's performance over the period covered 2018/19.

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 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.

Liam Coleman **5 June 2019**
Chairman

Nerissa Vaughan **5 June 2019**
Chief Executive

Independent Auditors report to the Council of Governors of Great Western Hospitals NHS Foundation Trust, on the Annual Quality Report dated 24/05/19

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 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

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

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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 NHS Improvement.

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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2018/19 ('the Guidance'); 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 Guidance.

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 and papers for the period 1 April to 4 May 2019
- papers relating to quality reported to the board over the period 1 May 2018 to 4 May 2019.
- feedback from Swindon and Wiltshire commissioners, dated 17 May 2019;
- feedback from Governors, dated 12 May 2019;
- feedback from local Healthwatch organisations, dated 17 May 2019;
- feedback from Swindon Overview and Scrutiny Committee, dated 8 May 2019;
- feedback from Wiltshire Overview and Scrutiny Committee, dated 20 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated March 2019;

- the latest national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated 21 December 2019
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019; and
- any other information included in our review.

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 the 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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, except 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 indicator;
- 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; and
- 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 affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Great Western Hospitals NHS Foundation Trust.

Basis for qualified conclusion on the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator

As a result of our procedures performed in relation to the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator, we have not been able to gain assurance over the six dimensions of data quality as required by NHS Improvement. We identified 9 issues from a sample of 25.

- One case where the clock start date recorded was incorrectly, based on the underlying records;
- One case where the clock stop date recorded was incorrect based on the underlying records;
- One case where there was no evidence to support the clock start date;
- Four cases where no date stamp on the referral letter was identified for the clock start date; and
- Two cases where patients had been incorrectly included on the pathway following upgrades.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 Guidance; 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 and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
5 June 2019

Glossary of Terms

A&E/ED	Accident & Emergency/Emergency Department
ACP	Advanced Clinical Practitioner
AHSN	Academic Health Science Network
AKI	Acute Kidney Injury
ASK	Acute Sepsis and Kidney Injury Team
BAUS	British Association of Urological Surgeons
BMI	Body Mass Indicator
BSI	Blood Stream Infections
C.diff	Clostridium Difficile
CAUTIs	Catheter Associated Urinary Tract Infections
CCG	Clinical Commissioning Groups
CLRN	Comprehensive Local Research Network
CRM	Cardiac Rhythm Management
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Clinical Quality & Innovation
DTOC	Delayed Transfer of Care
DOC	Duty of Candour
DOME	Department of Medicines for the Elderly.
DVT	Deep Vein Thrombosis
E&D	Equality & Diversity
EDD	Estimated Date of Discharge
EDS	Equality Delivery System
EDTA	Ethylene-Diamine-Tetra-Acetic
EPMA	Electronic Prescribing and Medicine Administration
FFT	Friends and Family Test
FFFAP	Falls and Fragility Fractures Audit programme
FY1	Foundation Year Doctor
GP	General Practitioner
GNBSI	Gram Negative Blood Stream Infections
GWH	Great Western Hospitals NHS Foundation Trust
HAT	Hospital Acquired Thrombosis
HPA	Health Protection Agency – now NHS England
HSCA	Health & Social Care Act
HSCIC	Health & Social Care Information Centre
HSMR	Hospital Standardised Mortality Rates
IBD	Inflammatory Bowel Disease
IOL	Induction Of Labour
IGSG	Information Governance Steering Group
IP&C	Infection, Prevention & Control
KLOE	Key Lines of Enquiry
LCRN	Local Clinical Research Network
MASCC	Multinational Association of Supportive Care in Cancer
MCA	Mental Capacity Act
MEU	Medically Expected Unit
MHA	Mental Health Act
Monitor	The NHS Foundation Trusts Regulator
MRSA or MRSAB	Meticillin-Resistant Staphylococcus Aureus Bacteraemia
MUST	Malnutrition Universal Screening Tool
NACEL	National Audit of Care at the End of Life
NAIC	National Audit of Intermediate Care
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEWS	National Early Warning System
NEWS2	National Early Warning System (Next phase)
NG	Nasogastric Tube
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NMP	Non-Medical Prescribing

NPSA	National Patient Safety Agency
NPWT	Negative Pressure Wound Therapy
NOF	Neck of Femur
NRLS	National Reporting & Learning System
NSI	Nurses with Special Interest
PbR	Payment by Results
PCNL	Percutaneous Nephrolithotomy
PDSA	Plan, Do, Study , Act
PE	Pulmonary Embolism
PICO	Technique Used in Evidence Based Practice
PHE	Public Health England
POMH-UK	Prescribing Observatory for Mental Health
PROMS	Patient Reported Outcome Measures
PURAT	Pressure Ulcer Risk Assessment Tool
QI	Quality Improvement
RAP	Remedial Action Plan
R&D	Research & Development
RCA	Root Cause Analysis
RCP	Royal College of Physicians
RR	Relative Risk
RTT	Referral to Treatment
SAFE	Stratification and Avoidance of Falls
SAFER	Patient Flow Bundle
SAU	Surgical Assessment Unit
SBAR	Situation, Background, Assessment, Recommendation
SJR	Structured Judgement Review
SHMI	Summary Hospital Level Mortality Indicator
SHOUT	Sepsis, Hypovolemia, Obstruction, Urine Analysis, Toxins
SMART	Specific, Measurable, Assignable, Realistic, Time Related
SMS	Text Messaging
SOPs	Standard Operating Procedures
SOS	Swindon Outreach Scoring System
SSNAP	Sentinel Stroke National Audit Programme
STEIS	Strategic Executive Information System
STP	Sustainability and Transformation Partnerships
SwICC	Swindon Intermediate Care Centre
TACO	Transfusion Associated Circulatory Overload
TEP	Treatment Escalation Plan
TV	Tissue Viability
TVN	Tissue Viability Nurse
TXA	Tranexamic Acid
UCL	Upper Control Limit
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WEAHSN	West of England Academic Health Science Network
WHO	World Health Organisation
WRES	Workforce Race Equality Standard

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