NHS
Great Western Hospitals
NHS Foundation Trust

Quality Accounts

2016-17

Service Teamwork Ambition Respect

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1 Our Commitment to Quality

1 Our Commitment to Quality – Statement from Nerissa Vaughan Chief Executive dated 30th May 2017

I am pleased to present our Quality Account for 2016/17.

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

It is clear that to provide safe and high quality care to a rapidly growing and ageing local population we need to think differently, plan differently and do things differently. That is what this year has been all about.It is also clear that adapting to meet the changing needs of patients must remain our focus for the next few years.

The addition of community healthcare to our services in Swindon has given us great opportunities for better collaboration and to provide more joined up care between services in hospital and at home.

We have already learnt a huge amount from our community colleagues and over the next year we will be looking for more opportunities to standardise best practice across our hospital and community services.

We are now also in a better position to improve the care we provide for patients in their own homes, especially those with long term conditions, such as diabetes, arthritis and hypertension. This means helping patients to better manage their conditions, stay well and out of hospital.

Although we must transform our services, our priorities must remain the same - to provide safe, high quality and effective care.

Our ambitious goal, to save an extra 500 lives by 2020, is here to stay. This means we are focused on saving more patients from life threatening conditions, compared to what would be expected according to national survival rates.

To do this we must deliver the very best care to each patient, by using nationally recognised best practice, standardising care and supporting a culture where we learn from our mistakes.

We continue to focus on our Sign up to Safety Priorities, among other quality improvement work, to achieve our 500 lives goal. These priorities are conditions where lives can be saved or the condition can be prevented through good care. They include sepsis, deteriorating patients, acute kidney injury, falls and pressure ulcer prevention. You can read about our progress throughout the report.

Our most important achievements for 2016/17 include our life saving work on sepsis, with nearly 90 per cent of patients making a full recovery from this potentially fatal condition

The introduction of a specialist Acute Sepsis and Kidney Injury Team, who are building on our expertise in sepsis to tackle acute kidney injury, which accounts for one in five of emergency medical admissions.

I am also proud to report the lowest incidence of pressure ulcers in the south west, with the number of patients experiencing this painful condition falling by 30 per cent in the last year.

We are now looking to cutting edge technologies to improve the outcomes and quality of life for our patients.

The latest 3D printing technology was recently used to help a patient with a rare hip deformity walk without pain, we successfully implanted the UK's first four lead pacemaker in November and we are using state-of the-art simulation technology to provide staff with innovative true to life training.

As you read through this report you will find many more examples of how we are making improvements to the safety and quality of care we provide to our patients.

Despite leading the way in many areas of quality improvement, we are not without our challenges and this report also provides an honest account of the difficulties we face.

The sheer volume of patients needing our care, delays in discharging patients, a tight financial position and staff shortages, are challenges we face every day. But they do not stop us from providing compassionate care. This is thanks to the commitment of our 4,500 caring, professional and highly skilled staff.

As we work towards a more unified healthcare system in Swindon, I am particularly proud of the strong partnerships we already have. They bring a wealth of specialist care to our patients and I'm keen to further expand this collaborative approach.

They include our end of life care service provided by Prospect Hospice, our Macmillan nurses, helping older patients settle back home with the Royal Voluntary Service's Home from Hospital Service and brightening the days of younger patients with Pets As Therapy, among many others.

Looking forward, our work with Oxford University Hospitals NHS Foundation Trust to bring radiotherapy to Swindon is progressing well and the new facility is expected to be available from 2019, making a difference to hundreds of local families.

I hope your enjoy reading about our work and our plans to further enhance the experience of our patients in 2017/18.

Nerissa Vaughan

Chief Executive

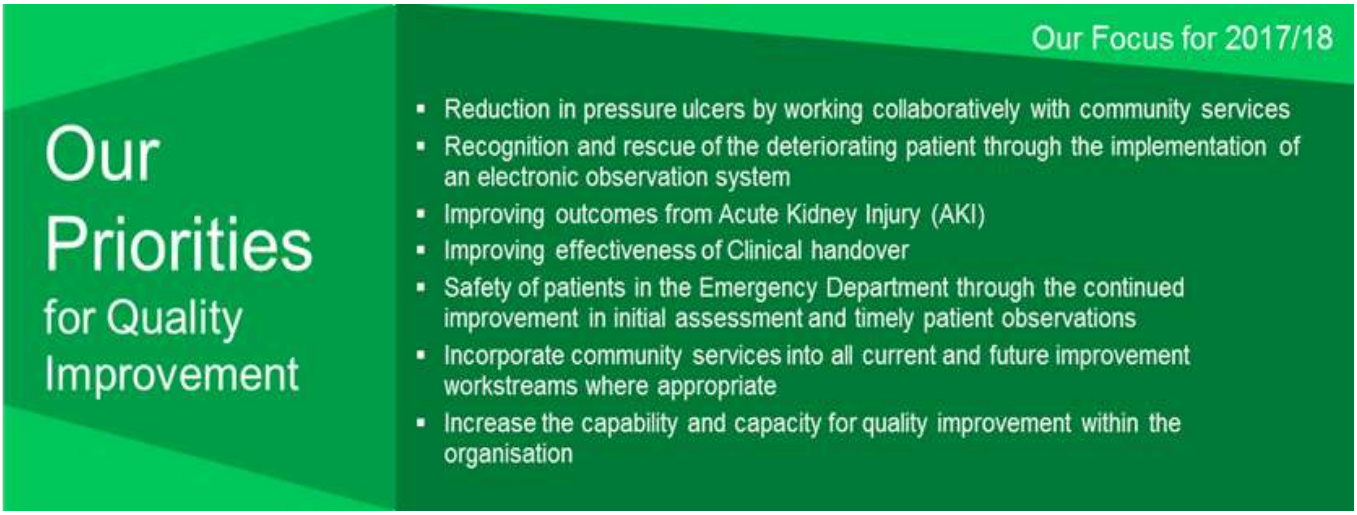
2 Priorities for Improvement & Statements of Assurance

2.1 Priorities for Improvement 2017/2018

This section reflects on the priorities for improvement we will set for 2017/2018 and progress made since the publication of 2016/17 quality report.

2.1.1 Our Priorities for 2017/18

Our 2017/18 priorities are informed by both national and local priorities including the Sign up to Safety Campaign, learning from incidents, projects supported by the Academic Health Science Networks. These priorities are also agreed through our quality contracts with our local Clinical Commissioning Groups, taking into consideration the data available on the quality of care relevant to all of our health services we provide. These priorities have been shared with agreement sought from the Trust Governors as patient/public representatives, Local Healthwatch organisations and other key external stakeholders.



Saving 500 Lives and Quality Improvement

Sign up to Safety

The Trust continues to deliver its ambition to save an extra 500 lives over 5 years, we have continued to progress our safety improvement plans through projects to improve quality and safety. As part of this over-arching campaign the Trust has continued in its commitment to the national Sign Up To Safety programme. During 2016/17 this covered the following key areas of focus, a combination of national aspirations and our own specific improvement areas:

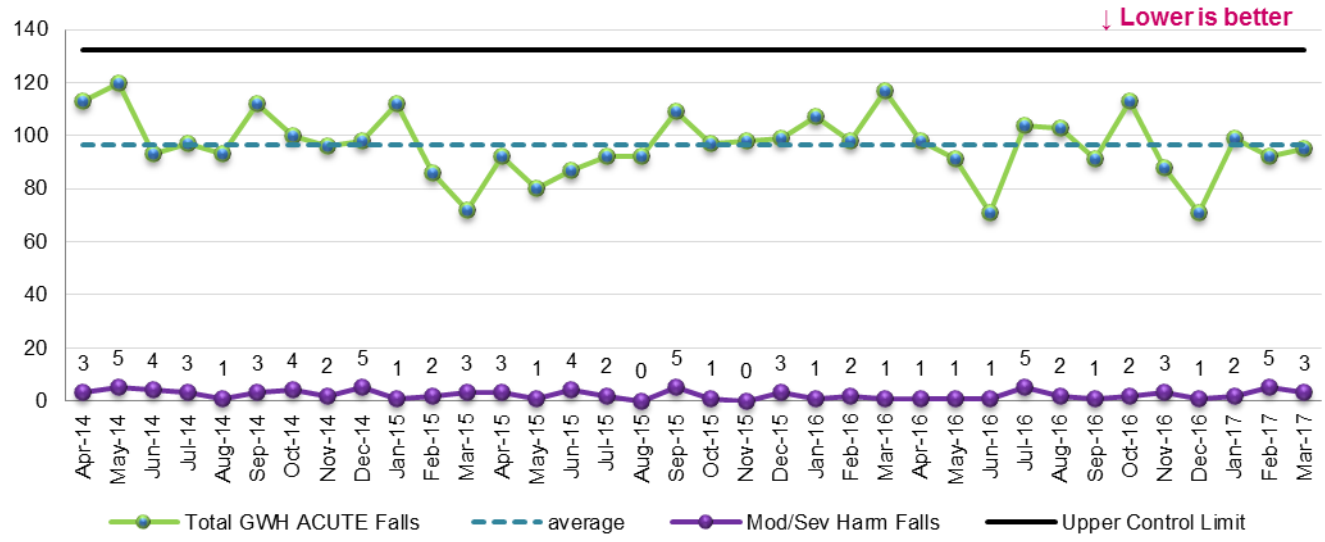
- Reducing falls
- Reducing pressure ulcers
- Management of sepsis
- Recognition of the deteriorating patient
- Acute Kidney Injury (AKI)

Reducing falls

Falls are one of the leading causes of harm in hospitals. They can lead to injury, loss of confidence, independence, and prolonged hospital stays.

During 2016/17 we have seen a 4% reduction in the number of falls on the previous year 2015/16.

Total falls across the Acute 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 from falls.

What improvements have we achieved?

In 2016/17 we reported 27 falls as moderate or severe harm, an average of 2 a month, sustaining the same number reported throughout 2015/16.

Drivers for improvement

- Revision of the falls assessment document in line with Royal College of Physicians recommendations, included in the Trust-wide roll out of the updated Nursing Documentation.
- Junior Doctors receive simulation training on falls during induction.
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- Piloting of non-slip Anti-Embolism socks on Trauma Unit.
- Front-door Physiotherapy Team are identifying and managing the re-admission of multiple fallers.
- All Ward Managers attending the monthly Falls Operational Group to share learning and change ideas from their areas.
- Joint working with Swindon CCG and Bone Health Collaborative
- Revised Post Falls SWARM completed within 24 hours of the fall taking place.

Further Improvements identified and our priorities for 2017/18:

- Implement Digital Reminiscence Therapy (Interactive multimedia to stimulate personalised memories) equipment for use across acute high use wards where falls are frequently reported
- Review and update Falls Avoidance and Safety Rails Policy
- Review national falls audit from Royal College of Physicians and adopt recommendations
- Recruitment of a Falls Specialist Nurse
- Ward based simulation training to improve post falls care
- 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.

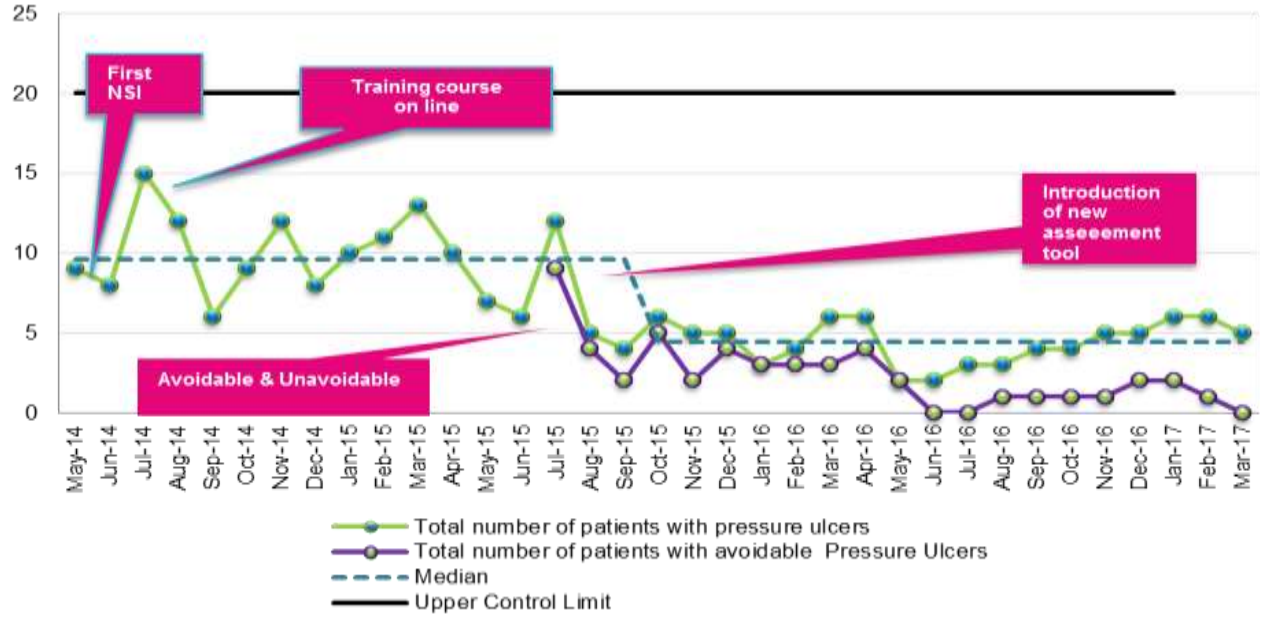
The development of a pressure ulcer can have a negative impact on our patient's quality of life by causing pain, emotional distress and loss of independence. They also increase the risk of infection and prolong hospital stays. In the most serious of cases pressure ulcers increase a patient's risk of 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 have reduced the average number of patients with pressure ulcers from 3.8 to 1.25 per month. We have achieved our target, in 2016/17 we reported an average of 4.25 pressure ulcers per month

Target: **<5 per month** sustained to April 2018.
Improved risk assessment, care of patients at risk & effective care planning.

Total number pressure ulcers (category II, III, IV for all acute inpatients)

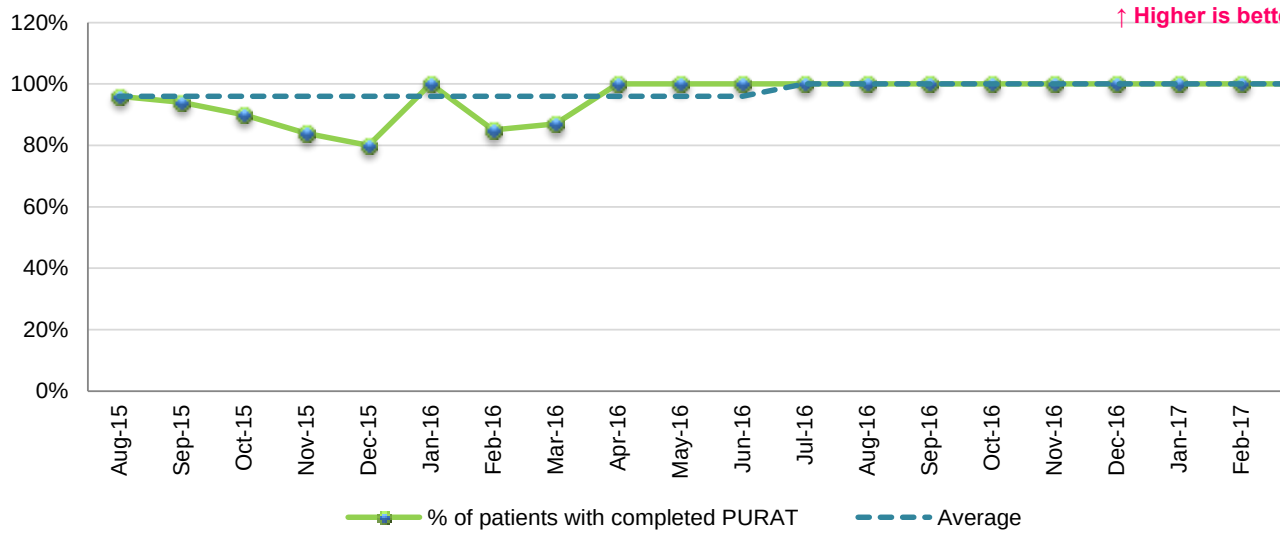


The chart above demonstrates the total number of avoidable and unavoidable category II, III and IV Pressure Ulcers in acute inpatients.

During 2016/17 we exceeded our target to reduce the number of avoidable pressure ulcers to less than 5 per month. We reported an average of 4 unavoidable and 1 avoidable pressure ulcers in acute inpatients per month'.

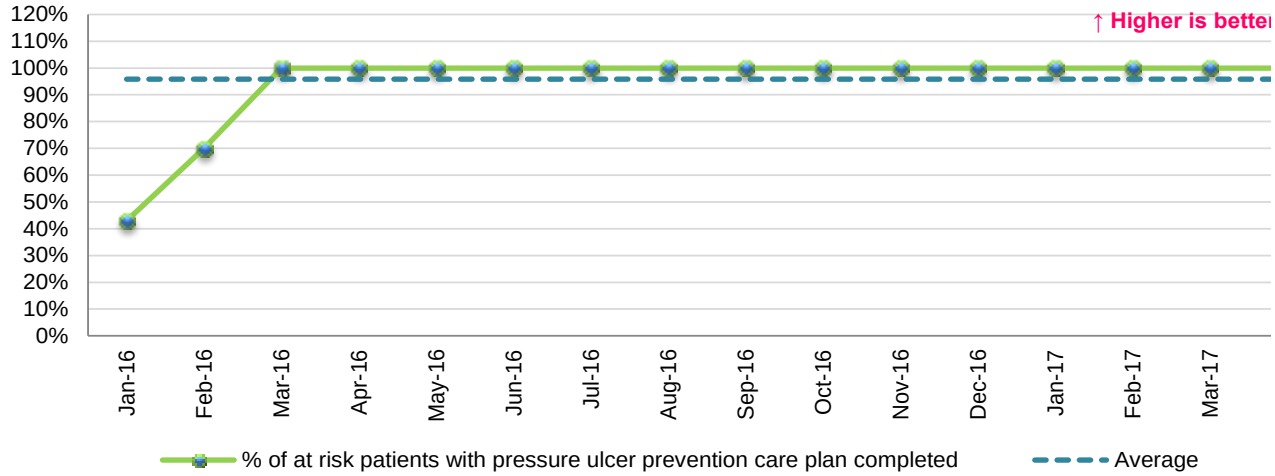
We have achieved this through a number of interventions:-

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



The graph above shows the percentage of patients with a completed Pressure Ulcer Risk Assessment Tool (PURAT). Since April 2016 100% of inpatients in a sample of 20 patients records reviewed per month have had a completed PURAT. This data is taken from our monthly audits of the 4 hot spot wards where pressure ulcers are most frequently reported.

Percentage of at risk acute inpatients with a pressure ulcer prevention core care plan completed



The graph above shows the percentage of at risk inpatients that have had a pressure ulcer prevention core care plan completed. Since March 2016, 100% of acute at risk inpatients in a sample of 20 patients records reviewed per month have had a pressure ulcer prevention core care plan in place. This data is taken from our monthly audits of the 4 hot spot wards.

What improvements have we achieved?

- Tissue Viability Nurses (TVNs) conduct monthly audits for Hot Spot Wards. These audits include:
  - Percentage of patients that have a PURAT completed within 2 hours of admission to the ward.
  - Percentage of patients with a Pressure Ulcer Prevention Core Care Plan completed
  - Percentage of patients with the correct pressure relieving mattress
  - Percentage of patients that have a Wound Assessment and Management Care Plan completed
  - Percentage of patients with the frequency of repositioning documented on the Pressure Ulcer Prevention Core Care Plan
  - 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
- TVN's investigate 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.
- Annual wound audit
- TVN's reviewed and updated Hot Spot Wards in January 2017

Further improvements identified and priorities for 2017/18

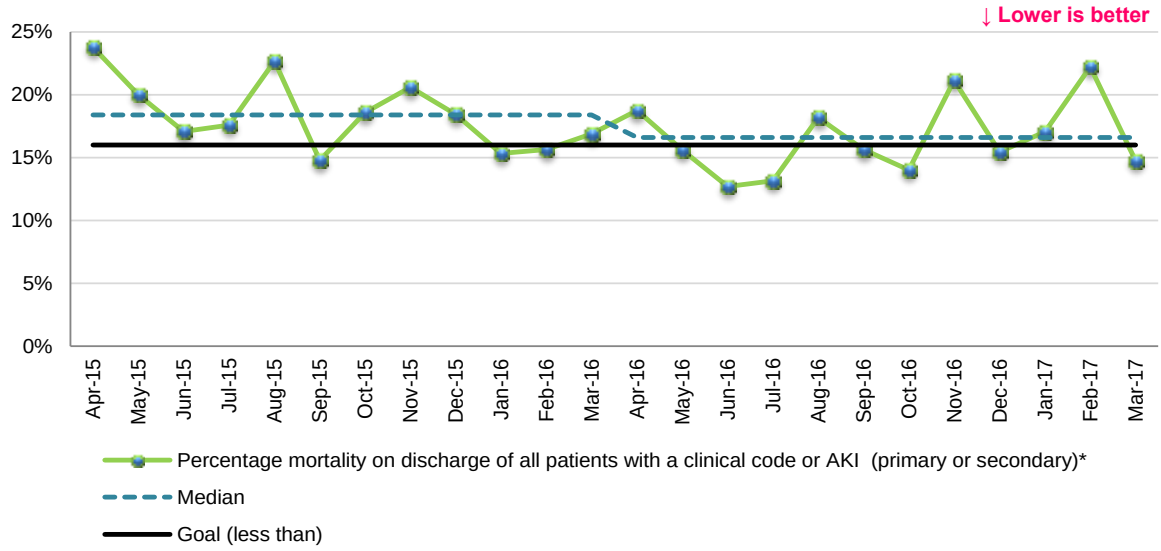
- Joint working with acute and community TVN's to develop wound management course for community services
- Review of the discharge documentation and the referral process from acute care to community and GP practice nursing teams.
- Teaching on the prevention of heel ulcers, i.e. Educational slides on pressure ulcer care to be trialled on one ward before rolling out Trust wide.
- Pressure Ulcer Working Group to be established with TVN's from both the Community and Acute services.

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.

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). In 2016/17 we reported an average of16.6% of patients who had crude mortality on discharge that had a clinical code of AKI. This is a significant improvement on 2015/16 where we reported an average of 18.4%.

What improvements have we achieved?

- Developed online AKI training modules for nursing and medical teams to equip clinical staff with the knowledge and skills to improve recognition and treatment of AKI.
- Implemented the AKI Kidney 5 Care Bundle, Sepsis, Hypovolaemia, Obstruction, Urine Analysis, Toxins (SHOUT). Patients flagged with AKI receive five standard elements of care proven to be effective in managing AKI.
- 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.
- Funded by Brighter Futures, a new Acute Sepsis and Kidney Injury (ASK) Team was recruited and launched in October 2016. Made up of five specialist nurses the ASK team are responsible for ensuring all patients with acute kidney injury are treated using the same set of clinical interventions which are based on international best practice. The team also work with staff across the organisation and healthcare partners such as GPs to raise awareness of the signs and symptoms.

Further improvements identified and priorities for 2017/18

- Supported by the ASK team continue to improve on the use of the AKI care bundle
- We will develop care pathways with GPs and community healthcare providers to improve prevention of AKI of our patients before coming into hospital and support appropriate care to aid their recovery once home.

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.

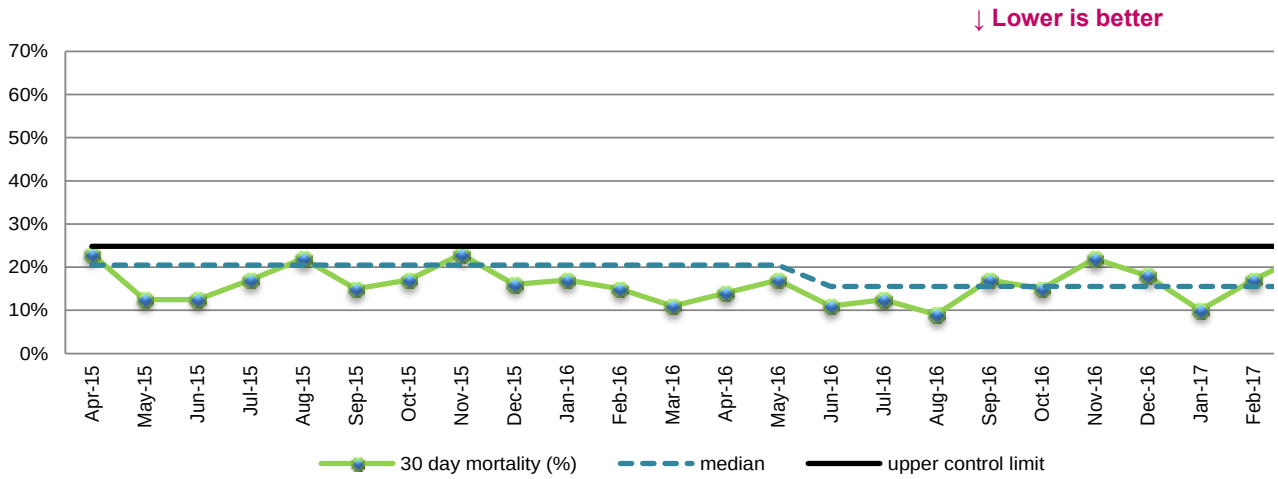
Each year in the UK, it is estimated that more than 100,000 people are admitted to hospital with sepsis and around 44,000 people will die as a result of the condition.

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)

In 2014/2015 we reported an average of 25% 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.

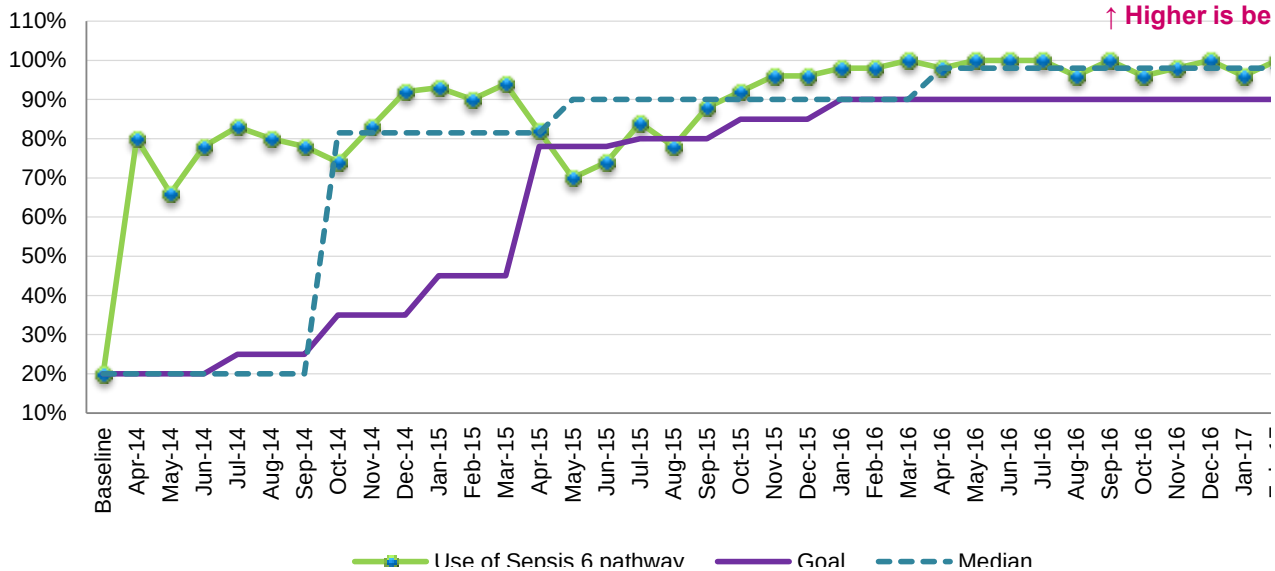
Throughout 2016/17 we reported an average of 15% of patients admitted with severe sepsis die within 30 days of discharge, a decrease on the previous year and remaining below our 23% target.

30 Day Mortality



The chart above shows 30 day crude mortality from severe sepsis and the sustained improvements achieved since April 2015 through to February 2017.

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



What improvements have we achieved?

- ASK Specialist Nurses Team have now been fully recruited.
- Producing a quarterly ASK Team Newsletter which is circulated Trust-wide.
- Focussed teaching around Sepsis Management and Sepsis Tools is on-going and currently more than 90% of clinical staff across 4 wards have been trained.

- Our sepsis campaign has had significant success in the early identification and response to this life threatening condition. This has brought both local and national recognition with our Sepsis Team winning a national Patient Safety Award in December 2015.
- 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 acute hospital.
- Sepsis education programme to all new junior doctors.
- Audit of all patients in our Surgical Assessment Unit (SAU) receiving Sepsis Screening.
- Extended sepsis screening to surgical patients having an emergency laparotomy.

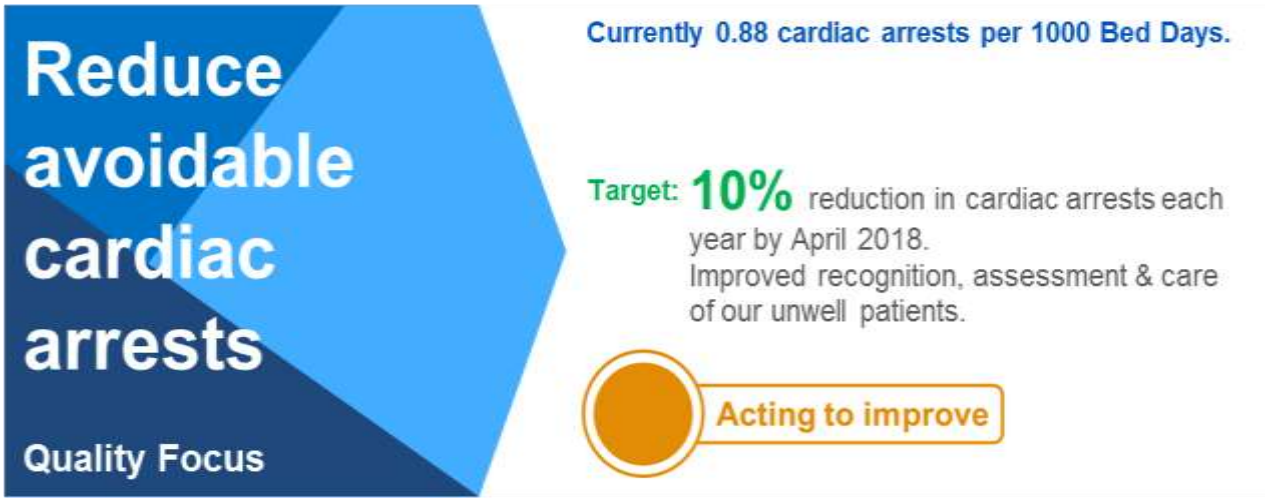
Further improvements identified and priorities for 2017/18

- Incorporate patient and public involvement into our monthly Sepsis Working Group
- Continue to provide ward-based simulation training on the management of Sepsis and use of Sepsis 6 Care Bundle
- Perform trial of antibiotic review at 72 hours stickers on an acute inpatient ward, we will review this before we expand the use to other inpatient wards.
- Increase compliance with the Sepsis 6 Care Bundle to continue to improve early recognition and management of severe sepsis and septic shock.
- We will develop care pathways with GPs and our community services to improve prevention of sepsis of patients before coming into hospital and appropriate care to aid recovery once home
- Trial the use of antibiotic grab bags to acute areas to reduce the time taken to administer antibiotics

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.

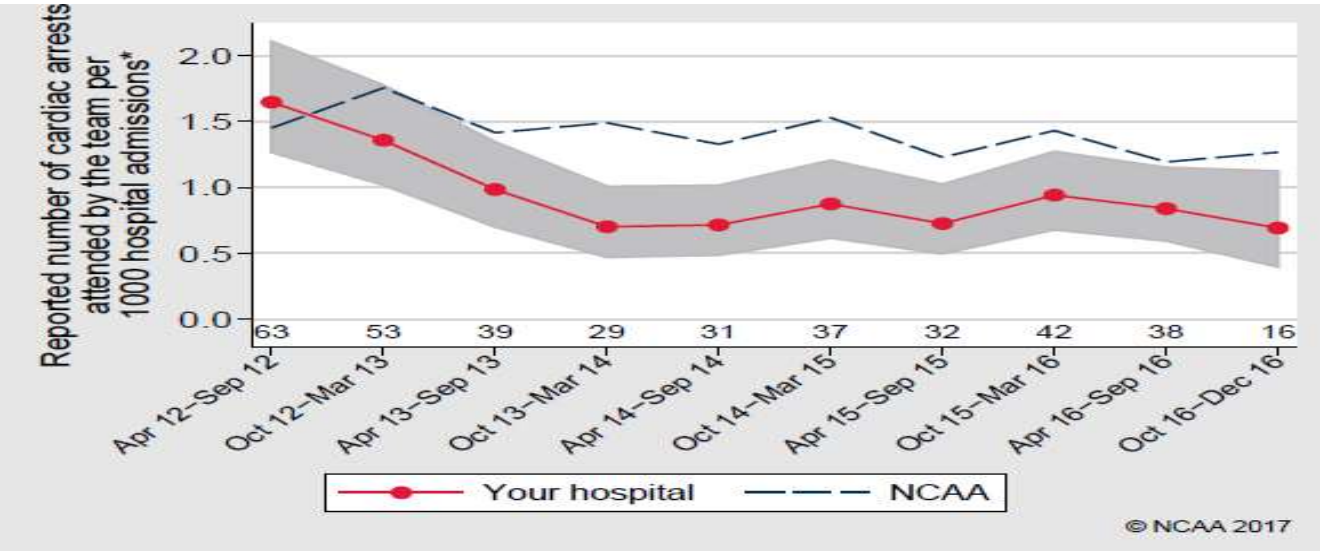


What improvements have we achieved?

- Fully implemented and embedded the standardised National Early Warning Score (NEWS) tracker and trigger tool Trust-wide to help determine and prioritise patients' level of illness
- ABCDE (Recognition and management of the deteriorating patient) video produced and published

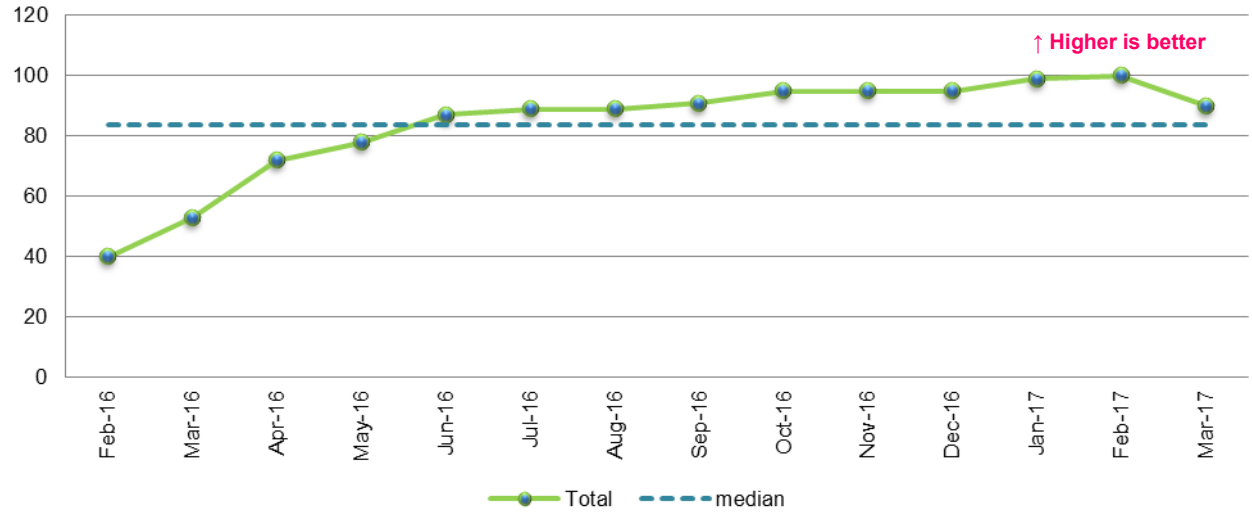
- Introduction of a mandatory on line training tracker module on National Early Warning Score (NEWS) in September 2016, so far have achieved 70% clinical staff who are required to complete this.
- NEWS ward champions identified and trained
- Programme of ward-based simulation training focusing on enhancing skills and knowledge in use of NEWS.
- 24/7 Critical Care Outreach Team launched and trained in January 2017.
- Revised the Deteriorating Patient Policy and Observation Policy

Rate of Cardiac Arrests per 1000 hospital admissions



The chart above shows our cardiac arrests per 1000 hospital admissions in comparison to National Cardiac Arrest Audit (NCAA). Whilst we continue to work to reduce the number of cardiac arrests, the chart demonstrates that the Trust's cardiac arrest numbers are fewer than the number that is reported nationally through the NCAA.

Percentage of Observations with NEWS Score Calculated Correctly



The chart above shows the percentage of patients Trust wide with a NEWS Score calculated correctly. We have achieved a median of 84% and above from September 2016.

Further improvements identified and priorities for 2017/18

- The Trust has commenced a project to introduce an electronic observation system for monitoring patients' vital signs/observations.
- Resuscitation team to analyse each cardiac arrest and determine whether the arrest was avoidable or unavoidable.
- Further ward-based simulation training to include training on use of arrest trolleys
- Improved fluid balance monitoring
- Improved application of Treatment Escalation Plans, for patients where cardiopulmonary resuscitation is considered inappropriate.

Quality Improvement Capability and Capacity

Quality improvement methodology is being used for both Sign up to Safety and Trust wide safety projects. Service improvement skills are beginning to develop within the organisation; we are actively sign posting staff to external providers such as the Academic Health Science Networks for formal QI training.

Many more staff are doing online training and are developing QI skills and expertise through involvement in projects at local and regional level. Six members of staff successfully completed the Improvement Coach training and Quality Improvement Leadership provided by the West of England and Oxford AHSN's respectively.

Four members of staff have completed the Innovating in Healthcare Settings MSC module run by Buckinghamshire University in September 2016.Quality Improvement toolkits have been developed and are available on the Trust Intranet

We are working collaboratively with Oxford Brookes University and the Deanery where health professionals in training are now undertaking service improvement projects whilst on placement within the organisation. We are continuing to develop and implement a coordinated process to ensure that whilst students achieve their objective the organisation benefits from the projects completed. Capturing the change ideas and not losing improvements that can be taken forward.

Further improvements identified for 2017/18

- Develop a five year plan for organisational QI capability and capacity.

Celebrating Success

In September 2016 we held our first Speak out on Safety Event. This was a full day event where Martin Bromley, Chair of the Clinical Human Factors Group was a guest key speaker.

The event also covered key quality improvement work streams under our Sign up to safety campaign including Sepsis, Acute kidney Injury and simulation.

Over 75 members of staff and external stakeholders attended the event where staff shared their success stories, safety pledges and the amazing work that they are doing every day.

2.2 Reporting against core indicators

Continue to reduce our numbers of healthcare associated infections

Clostridium difficile

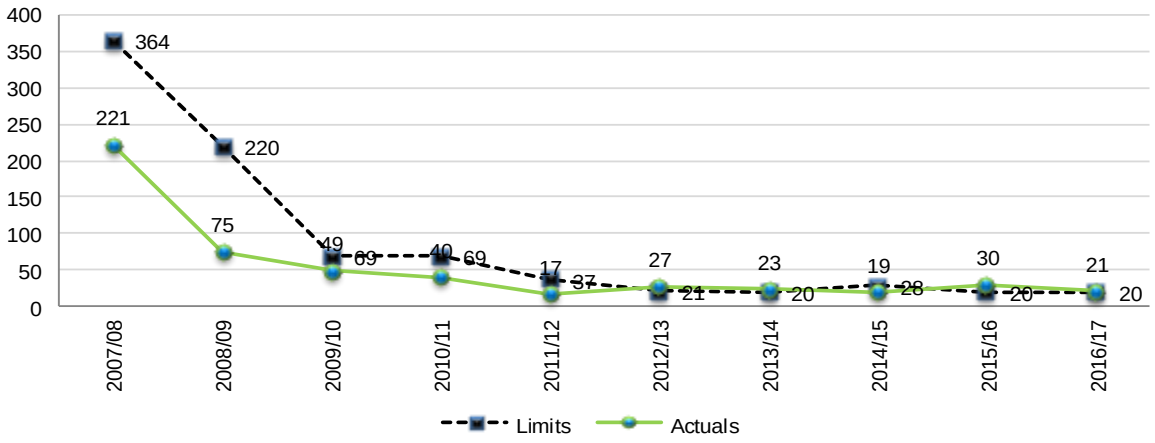
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA, in England it's mandatory for Trusts to report all cases of *Clostridium difficile (Cdiff)* to Public Health England.

The nationally mandated goal for 2016/2017 was to report no more than twenty cases of *C.diff*. We have reported twenty one cases, nine less than 2015/2016. Each case has been investigated in conjunction with our Commissioners. Of the twenty one cases, one has been deemed unavoidable with care improvements recommended and nine cases remain pending an investigation outcome.

We have taken the following actions to improve patient safety throughout 2016/2017 including improvements as a result of learning from our investigations and so the quality of its services with the following local initiatives:

- Continuous monitoring of antibiotic prescribing through audit which includes adherence to antibiotic guidelines, recording the duration of the course and indication for their use. The importance of this is to ensure extended courses of antibiotics do not occur as this increases a patients risk to developing C.*diff*.
- Conducting a root cause analysis on each case to identify areas of improvement and sharing the lessons learnt with staff concerned.
- A multi-disciplinary team reviews each inpatient on a *C.diff* ward round weekly to ensure appropriate management.
- Working with 'front door' services for prompt actions when patients attend with unexplained diarrhoea on admission.
- Ensuring our patients are 'isolated' within 2 hours of unexplained diarrhoea being reported
- We have fully implemented our cleaning strategy and the environmental cleaning standards group triangulates housekeeping audits, matron inspections and ward audits, friends and family feedback and managerial audits. This ensures consistency of cleanliness throughout the Trust.
- The assurance framework for cleaning to meet national requirements established with our business partner, Carillion, has ensured that cleaning is delivered at the correct frequency and level for each area. Audit scores are discussed at the environmental cleaning standards group.
- The importance of standard infection control precautions has been reinforced through link worker meetings and IP&C nurse feedback whilst in clinical areas.

Number of *clostridium difficile* cases 2016/2017



The graph above shows the number of reported *clostridium difficile* cases in 2016/17.

Our priorities for 2017/18

We plan to continue monitoring and reducing risk factors for Clostridium *difficile*. This includes promoting antibiotic stewardship, rapid isolation and sampling needs to continue with ward/department ownership of local cleaning standards, including patient care equipment all of which is specifically aimed at preventing avoidable cases of clostridium *difficile*.

Methicillin Resistant Staphylococcus Aureus (MRSA)

During 2016/2017 we reported one case of MRSA (acute site attributable) against a national target of zero cases. This was a case where a patient was admitted due to community acquired pneumonia, their admission screen was negative to MRSA colonisation however went on to develop an MRSA bacteraemia.

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:

- Blood culture contamination rates are reviewed monthly and individual staff practice and competency reassessed when appropriate.
- Management plans for patients with a new positive MRSA result or a history of MRSA.
- Clear focus on preventing any cross contamination between patients and families and investigating cases where necessary.
- Working with our Occupational Health and Wellbeing team to support staff working in high risk areas
- The Sepsis programme continues to provide early diagnosis and management of patients suffering from blood stream infections.

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 2016/17.

Our priorities for 2017/18

The focus for 2017/18 will be on reducing the numbers of blood culture contamination rates which is recommended to be below 3%. In 2016/17 our rates ranged from 2.4% to 4.5%. We will evaluate the effectiveness of a multidisciplinary approach using Plan, Do, Study, Act (PDSA) aimed at reducing blood culture contamination rates in Emergency Department and across the Trust.

Patient Safety

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 that are wholly preventable. There is guidance or safety recommendations that provide strong systemic protective barriers available at a national 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 outcome for an incident to be categorised as a Never Event.

We have reported one never event between April 2016 to March 2017 which is a decrease of two never events reported during the same period in 2015/2016. The following never event was reported in April 2016

- Wrong site surgery – reported in April 2016

The incident has been reported and investigated and managed through the Trusts Incident Management and Clinical Governance structures. An action plan was developed, with implementation monitored by our Patient Quality Committee. A final report for the incident was also shared with our Commissioners, the CQC and Monitor.

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 the wrong site surgery never event reported in April 2016

- Upgraded all imaging computers to enable clinicians to view MedVIEW in all locations
- An Multi-Disciplinary standard operating procedure describing referral process
- Generic tumour specific email account to ensure appropriate management of onward urgent referrals to guarantee they are acted upon on in a timely manner.

Continually learn - Reduce Incidents and Associated Harm

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.

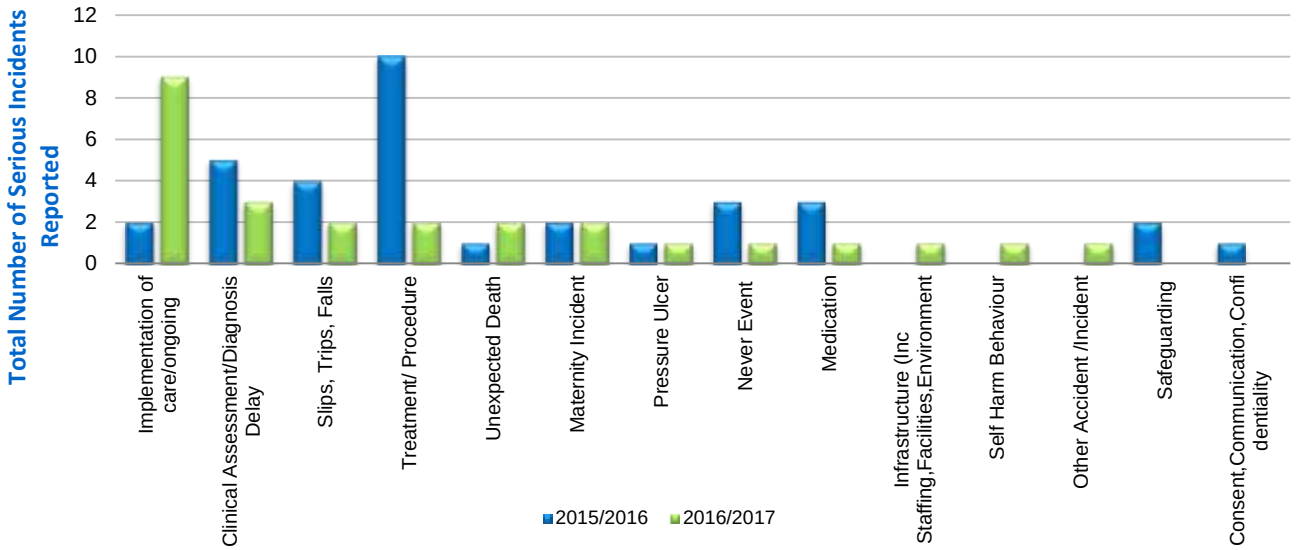
A total number of 26 serious incidents were reported and investigated during the period April 2016 to March 2017. This is a reduction of 9 serious incidents reported on the previous year.

- 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 2016//17

The graph above shows the number of serious incidents reported in 2016/2017.

Serious incidents reported by type in 2015/2016 and 2016/2017.



The graph above shows the Trust's serious incidents reported by in 2016/17 compared to 2015/2016 broken down by category.

The most frequently reported types of serious incident are:-

- Implementation of Care and treatment and Procedure, which includes recognition and rescue of the deteriorating patient
- Problems with clinical assessment, which includes delays in diagnosis, interpretation and response to diagnostic procedures and tests

The increased number of incidents involving recognition and recue of the deteriorating patient is due in part to improved reporting. The Trust-wide campaign to improve the use of National Early Warning Score (NEWs) has raised awareness of the deteriorating patient. During 2016/17 we reviewed serious incidents and incidents that had contributing factors involving recognition and management of the deteriorating patient to identify commonalities which directly informed the Deteriorating Patient Quality Improvement project.

We disseminated learning from incidents involving clinical assessment, diagnosis, and treatment 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 5 years are as follows:

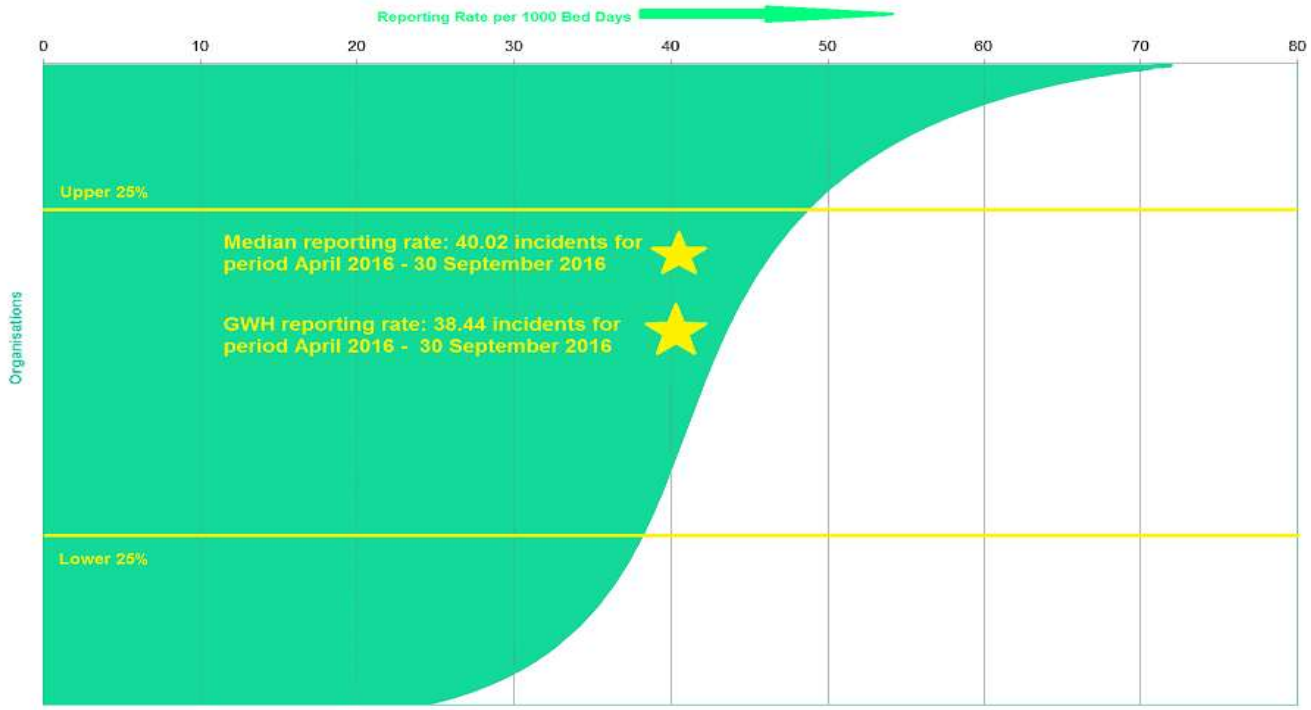
Reporting Year	Non clinical incidents / Health and Safety	Patient Safety Incidents reported to NRLS	Total
2011/2012	2493	6513	9006
2012/2013	2405	6928	9333
2013/2014	3596	6967	10563
2014/2015	4164	6678	10842
2015/2016	4801	6274	11075
2016/2017	4457	8373	12830

How do we compare with other organisations?

NHS England National Reporting and Learning System (NRLS) release an Organisational Patient Safety Incident report twice a year providing organisational and comparative incident data. The report from NRLS containing incident data from 1st April 2016 to 30th Sept 2016 was published on 31st March 2017.

Comparative reporting rate per 1000 bed days for 136 acute (non-specialist) organisations

1st April 2016 – 30th September 2016



The Trust reported 3657 incidents between 1st April 2016 to 30th September 2016 with a rate of 38.44 per 1000 bed days. The median reporting rate for this cluster is 40.02 incidents per 1000 bed days.

The Trusts reporting rate has increased from the previous reporting period 1st October 2015 to 31th March 2016 when 28.52 incidents per 1000 bed days were reported and we were located within the lower 25% of reporters. During 2016/17 we foccussed acivity on improving our reporting culture with rebranding our incident reporting fron IR1's to Safety Incident Forms. We reviewed feedback mechanisims ensuring learning is shared with individual reproters and Trust-wide.

We also devloped a safety video involving a range of staff across the Trust on the benefits and importance of reporting safety incidents and obtaining feedback to aid learning with individual reporters and trust-wide.

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

- Delivering incident awareness road shows throughout the year Trust-wide, to promote the benefits of incident reporting which can have positive impacts on improving patient safety.
- To continue to review and embed all types of feedback mechanisms which aids the sharing of learning from all incidents to individual reporters as well as teams and trust-wide.
- Safety incident video's about individual investigations to aid shared learning and promote awareness Trust-wide.

Duty of Candour

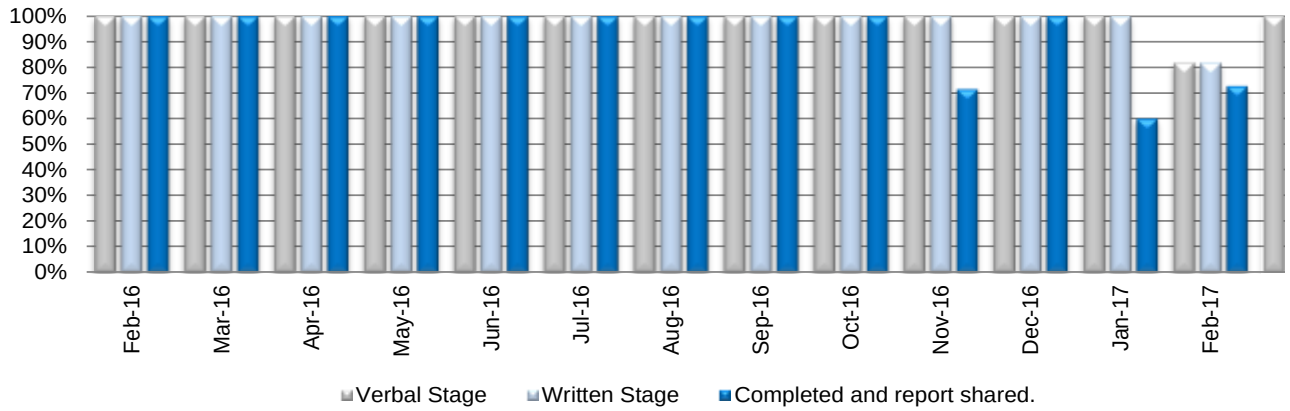
Duty of Candour is a legal duty which came into force in April 2015. As a trust we are legally obliged to inform and apologise to our patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help our patients receive accurate, truthful information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

How are we implementing Duty of Candour?

Compliance with each stage of Duty of Candour



The graph above shows the compliance at each of the three stages of Duty of Candour. Some cases are still currently under investigation and will be shared with the patient, family or relatives upon completion.

To continue to improve on Duty of Candour and the support we provide to our patients, their family and relatives following errors, the following improvements have been put in place:-

- Revised Duty of Candour (Being Open Policy)
- Duty of Candour E-Learning training tracker released in June 2016, all new employees are required to complete the training after induction. The Trust's compliance is currently recorded as 88.88%.
- The Trust's incident reporting system allows us to record Duty of Candour against individual incidents
- Template letters embedded into the incident reporting system to support managers.
- Data extraction facility within the Trust's incident reporting system, which enables us to record and monitor compliance with all significant harm cases. This facility helps to identify any areas of non-compliance.
- The Duty of Candour leads and division are then supported to complete the required elements
- Duty of Candour compliance is monitored at divisional level and within the Patient Safety and Clinical Risk Team with any exceptions reported to divisional boards and our Patient Quality Committee.

Priorities for 2017/18

- Four one day Root Cause Analysis training sessions including Duty of Candour training.

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

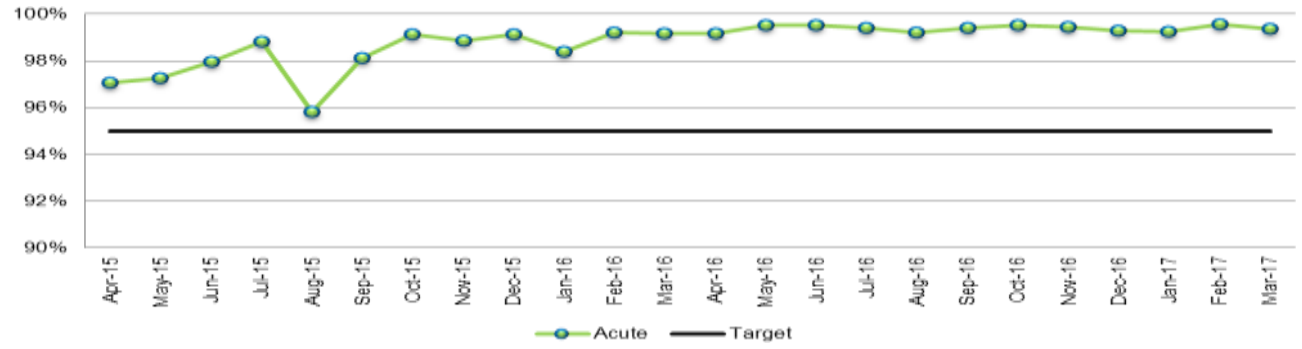
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because data is collated in a variety of ways including the electronic prescribing system and compared to the total number of admissions during any given month. For clinical areas that do not use the electronic 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 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.

A weekly bulletin has been implemented which enables clinical teams to have more up-to-date information to look closely at the performance of individual areas and support them in achieving the target. We can now 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 produce reports that can identify which patients have had a risk assessment and what time this was undertaken.

VTE risk assessment performance April 2015 – March 2017



The graph above shows the Trust's VTE Risk Assessment performance, we have consistently achieved above 99% for 12 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 a national audit tool called the "safety thermometer". This looks at all patients in the hospital on one day each month and checks for a number of patients on each ward that have a VTE risk assessment and how many patients receive the appropriate preventative treatment. We currently give appropriate preventative treatment to 90-95% of patients.

- 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

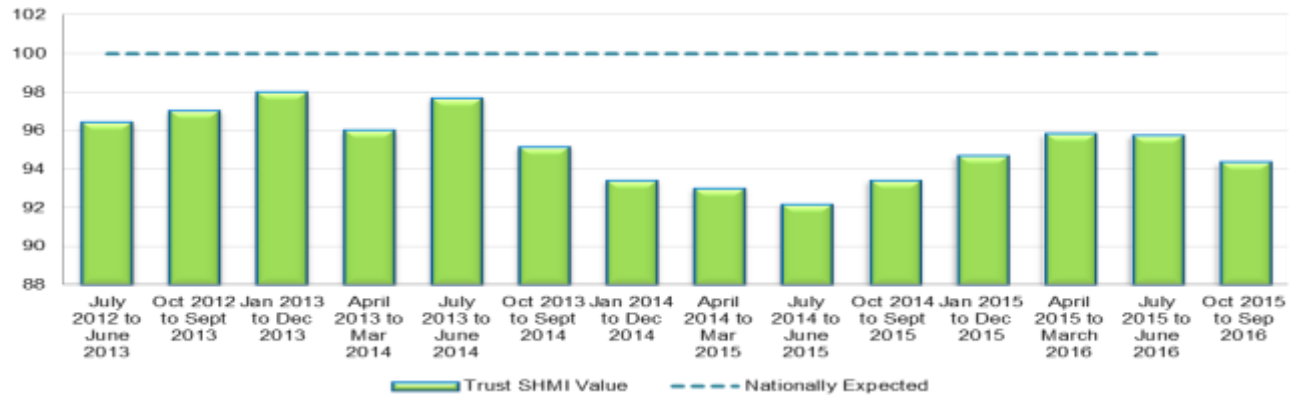
Summary Hospital Mortality Indicator (SHMI)

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.

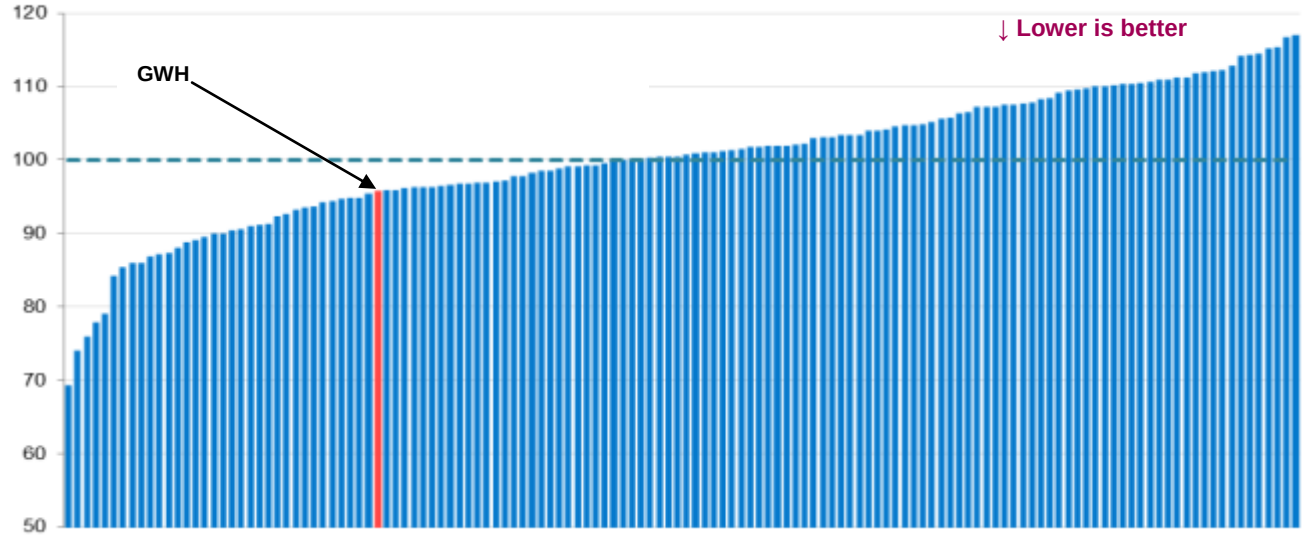
The Trust's SHMI for the rolling 12 month period of October 2015 to September 2016 is 94.34, giving the Trust a 'Better Than Expected' rating. The SHMI for this period is lower (better) than the nationally expected value of 100, and is similar to the previous 12 month period (April 2015 to March 2016). This is showing a similar trend to the HSMR figures.

Summary Hospital Mortality Indicator (SHMI) GWH



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

National SHMI October 2015 to September 2016



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 2015 and September 2016. The red line depicts GWH, and the green 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 HSCI

Hospital Standardised Mortality Rate (HSMR)

The Hospital Standardised Mortality Rate (HSMR) is an external validated method of calculating and comparing mortality rates. This information is analysed and presented to all Trusts 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.

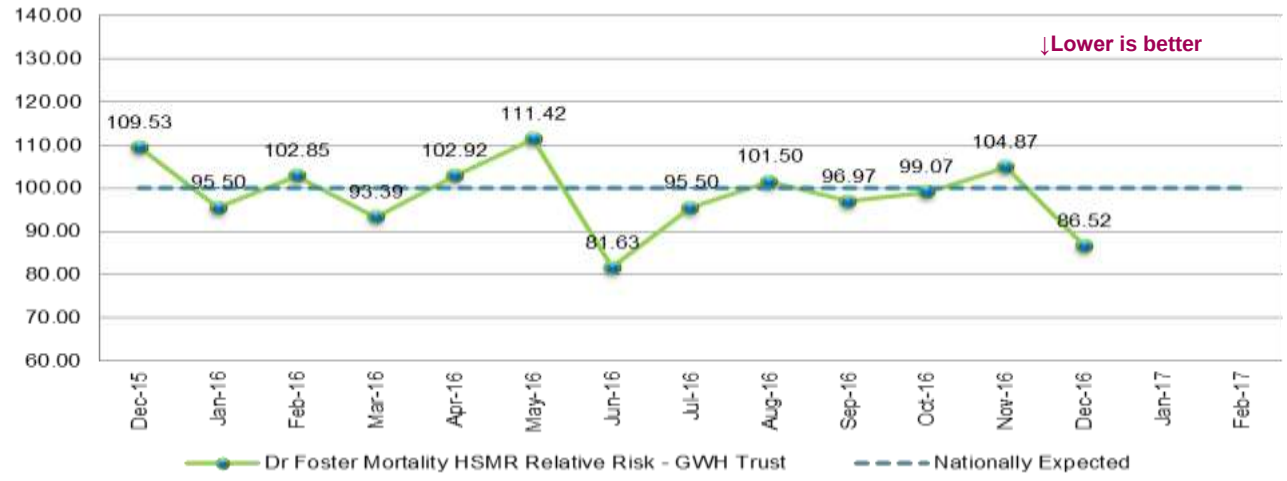
In 2014 the Trust set a target to reduce our mortality rates measured by HSMR (Hospital Standardised Mortality ratio) and to be one of the Trusts with the lowest HSMR value. We remain on our schedule to deliver this improvement. Our continued work has resulted in a lower number of deaths and we have 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 2015 December 2016

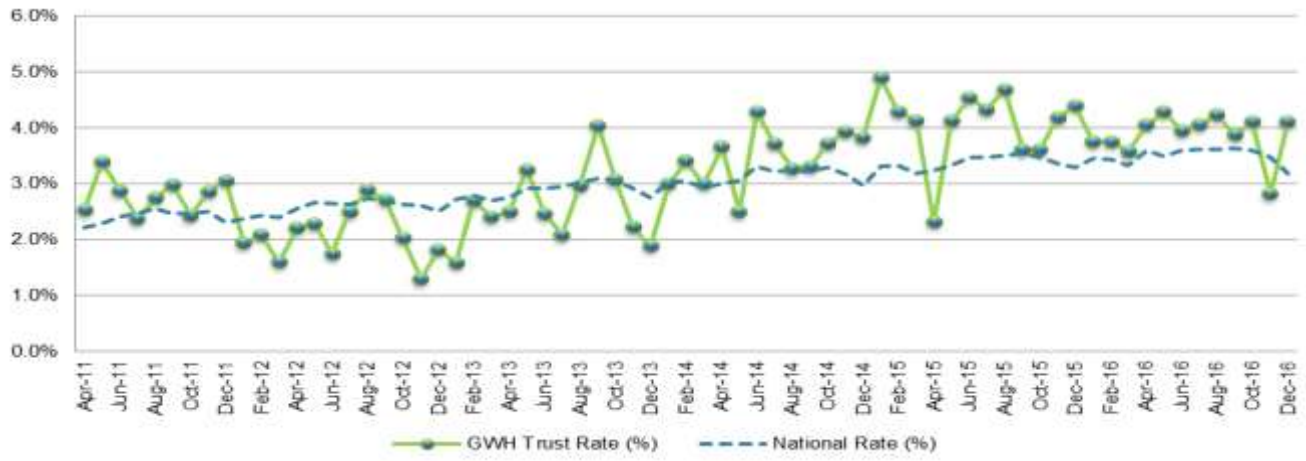


The graph above shows the year on year HSMR following rebasing. This shows a general improvement over time.

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 2016



The charts above shows the levels of Palliative Care coding against the national average since April 2011. 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, but since early 2014 there has been a marked improvement in the levels of coding and the Trust is now above the national average.

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 2017/18

- 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.
- The Trust will introduce the new National process of standardised mortality reviews which was launched in April 2017. This will include the development of a local policy for mortality review and quarterly reporting to the Trust Board from October 2017
- We will continue to develop our work on sepsis and acute kidney injury which is estimated to save approximately 100 lives per quarter. We will also introduce electronic recording of vital signs to improve recognition of deteriorating patients and escalation of treatment. This type of system has improved mortality rates by up to 10% in other hospitals. The aim of this work is to improve care in ways that reduce HSMR and SHMI values and to help deliver our ambition to save an additional 500 lives by 2019.

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 their 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.

Our provisional PROMS report shows that there has been an overall improvement on the scores for 2016/17 in particular hip and knee replacement surgery.

It is a recognised challenge within the Trust to report on contemporary data; this is due to the verification process for PROMS data, which results in finalised data being reported 12 months in arrears.

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

- Reviewing other formats and processes for recording and measuring patient outcomes to support on-going improvements.

Referral to Treatment 18 weeks (RTT)

During 2016/17 the Trust's performance for waiting times for planned surgery has continued to be a focus and has built on the significant work undertaken during 2015/16. The Referral to Treatment national standard for patients waiting for treatment is that at least 92% of patients should have been waiting for 18 weeks or less from referral to definitive treatment; this takes into account that some patients will have complex treatments or choose to wait longer.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because RTT performance has significantly increased and the 92% target has been achieved for seven out of twelve months during 2016/17.

From April 2016 around 90% of patients were waiting less than 18 weeks. Throughout the year there has been a sustained effort to improve this position. This has included undertaking increased clinic and operating activity in a range of specialties where waiting times were longer than required. This activity has included some patients being treated by other providers.

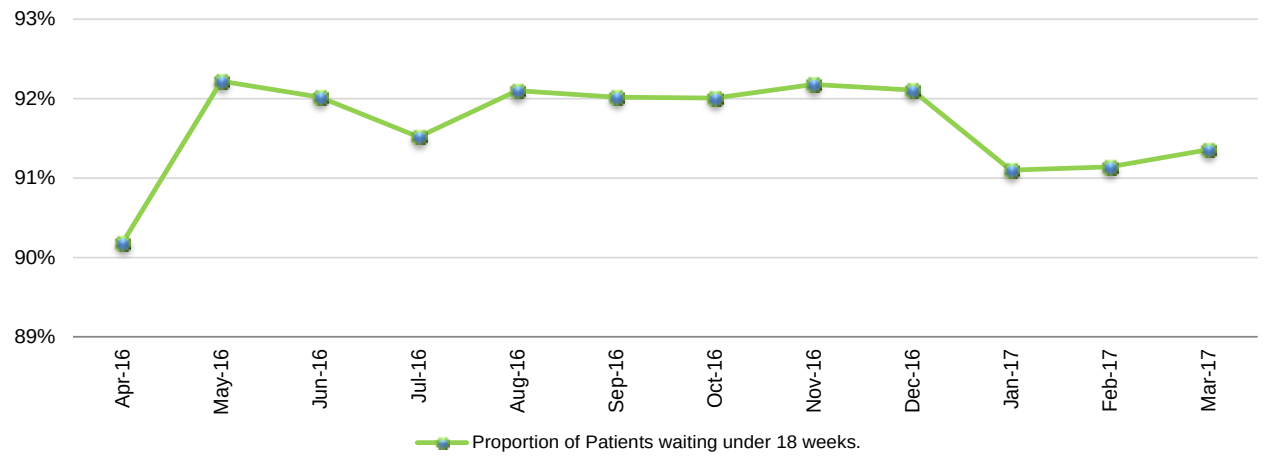
The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this performance and so the quality of its services by;

- Increased collaborative working between the operational and informatics teams, with new monthly validation processes introduced to ensure robust and accurate data reporting.

- An updated Elective Access Policy has been released and is continuing to be embedded with the teams to ensure standardised booking and choice processes are followed throughout the Trust.

Although performance reduced to just above 91% in January 2017 as a result of pressures related to escalation, the Trust is anticipating that the 92% position will be recovered and the sustainable achievement of the 92% standard will continue during 2017/18.

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 2016/17 Accident and Emergency Department achieved 75.9%, of patients having a maximum of 4 hours wait. The target was also not achieved as a Trust at 83.5% or as a Trust including the Urgent Care Centre (UCC) at 86.6%

The Trust has adopted nationally recognised approaches to improve the flow of patients through the hospital, which should help to improve performance against the 4 hour Accident and Emergency Department target. Health and Social Care services across Swindon and Wiltshire are under great pressure and this is recognised by health regulators NHS Improvement.

The Trust has proposed the levels of achievement it expects to deliver in 2017/2018 and a trajectory has been submitted to NHS Improvement but this has not yet been confirmed.

- **Q1 – 85.7%**
- **Q2 – 88.3%**
- **Q3 – 80.0%**
- **Q4 – 78.3%**

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this performance and so the quality of its services by delivery of the GWH 4 Hour Acute Service Remedial Action Plan (RAP) incorporating recommendations made by the Care Quality Commission with actions being assigned to the following project areas;

- Effective patient streaming using all front door departments to ensure patients are seen by the appropriate teams on arrival to the organisation
- Better back door discharge processes to ensure patients are clinically optimised for discharge as soon as possible with better support both internally and externally to support that discharge

Through the 4 hour RAP and investment into resources to improve front door services of the organisation we anticipate to be able to sustain an acceptable 4 hour position throughout 2017/18 as well as reducing times of extreme escalation for the Accident and Emergency Department and the Trust as a whole.

Review of patients readmitted to hospital within 30 days of discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because in previous years we have carried out annual audits on patient readmissions within 30 days of being discharged in order to identify if anything could have been done to better prevent patients being re-admitted, especially if their readmission is related to their previous condition.

The Trust has not undertaken an annual audit in 2016/17. However we have continued to audit readmissions via a monthly dashboard. The current readmission data for 2016/17 suggests that the Trust position in relation to readmission remains relatively static when compared to the previous year.

Previous audits have suggested that certain specialities have a higher readmission rate than others in particular endocrinology and cardiology. However, this data and that of all specialities has yet to be compared to national averages which could provide better comparison of the Trust's position. Therefore, the annual audit is due to be reinstated with revised methodology in 2017/18.

The revised annual audit methodology will allow for a more rigorous quality improvement project and focused actions on specific cohorts of high risk patients.

Monthly 28 day readmission by age group

Outline: These figures are based on the crude emergency re-admissions within 28 days of the original date of discharge. These figures are considered to be crude as they take no account of 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 28 Days			Readmissions Percentage Within 28 Days		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 16	971	5536	6507	90	497	587	9.3%	9.0%	9.0%
May 16	951	5779	6730	84	560	644	8.8%	9.7%	9.6%
Jun 16	982	5903	6885	94	590	684	9.6%	10.0%	9.9%
Jul 16	900	5840	6740	66	571	637	7.3%	9.8%	9.5%

Aug 16	830	5878	6708	76	563	639	9.2%	9.6%	9.5%
Sep 16	936	5881	6817	86	592	678	9.2%	10.1%	9.9%
Oct 16	1074	5986	7060	110	545	655	10.2%	9.1%	9.3%
Nov 16	1081	6025	7106	108	585	693	10.0%	9.7%	9.8%
Dec 16	962	5612	6574	77	530	607	8.0%	9.4%	9.2%
Jan 17	953	5794	6747	115	585	700	12.1%	10.1%	10.4%
Feb 17	897	5260	6157	75	484	559	8.4%	9.2%	9.1%
Mar 17	949	6125	7074	85	583	668	9.0%	9.5%	9.4%
2016/17	**11486**	**69619**	**81105**	**1066**	**6685**	**7751**	**9.3%**	**9.6%**	**9.6%**

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
Apr 16	971	5536	6507	91	502	593	9.4%	9.1%	9.1%
May 16	951	5779	6730	89	570	659	9.4%	9.9%	9.8%
Jun 16	982	5903	6885	94	607	701	9.6%	10.3%	10.2%
Jul 16	900	5840	6740	67	583	650	7.4%	10.0%	9.6%
Aug 16	830	5878	6708	77	572	649	9.3%	9.7%	9.7%
Sep 16	936	5881	6817	88	602	690	9.4%	10.2%	10.1%
Oct 16	1074	5986	7060	111	558	669	10.3%	9.3%	9.5%
Nov 16	1081	6025	7106	112	594	706	10.4%	9.9%	9.9%
Dec 16	962	5612	6574	80	541	621	8.3%	9.6%	9.4%
Jan 17	953	5794	6747	115	596	711	12.1%	10.3%	10.5%
Feb 17	897	5260	6157	75	492	567	8.4%	9.4%	9.2%
Mar 17	949	6125	7074	86	591	677	9.1%	9.6%	9.6%
2016/17	**11486**	**69619**	**81105**	**1085**	**6808**	**7893**	**9.4%**	**9.8%**	**9.7%**

Medicines Safety

Inappropriate Omitted Medication

When patients are admitted to our wards an electronic prescription is provided to cover the majority of the patient's requirements. This includes both medicines for the acute episode of treatment and those which they would take routinely, prior to their admission. During the patient's stay these medicines will be administered as appropriate for the patient's immediate condition. This means that not all medicines which are prescribed will be administered. The omitted dose audit looks at the number of doses that have been omitted, to check if a reason for the omission has been provided and the actions taken to mitigate the issue. Critical medicines are those medicines with a higher risk of causing harm if omitted and in these circumstances the doctor should always be informed.

Missed Dose Audit April 2017

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.

It is intended as an aid to support a local list and is not intended as a replacement.

The NPSA also provides a series of actions which may help Trusts to reduce the number of omitted doses.

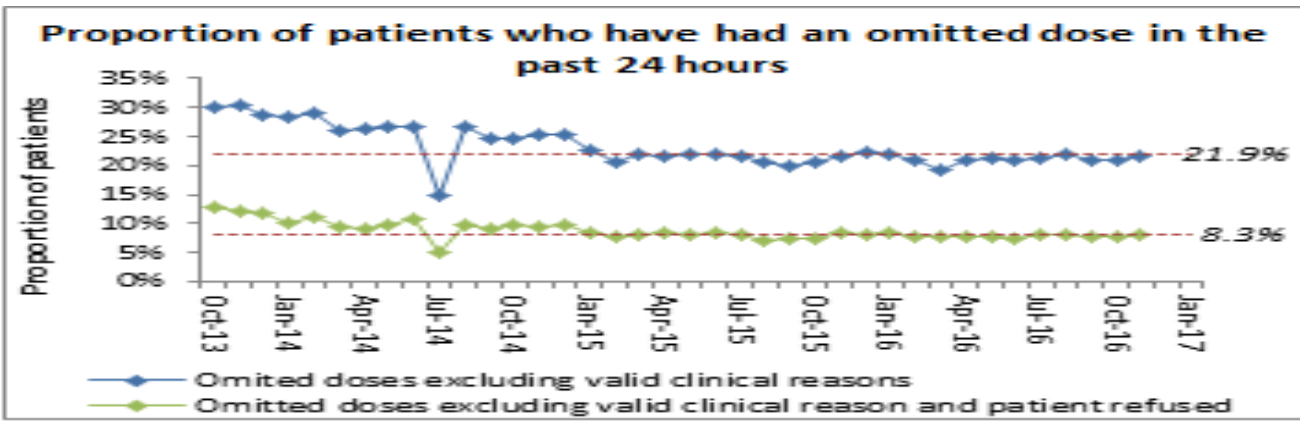
The chart below shows the number of medication administrations that have been prescribed for patients on the ward for a single day as captured on the electronic prescribing system (EPMA) . The third column gives the number of medicine doses which have been omitted for a 24hr period and the fourth column the percentage of which were for critical medicines.

Ward	Total number of administrations	Number of inappropriately omitted doses	Number of inappropriately omitted doses of critical medicines	Percentage of inappropriately omitted doses (%)	Percentage of inappropriately omitted doses of critical medicines (%)
Aldbourne	445	2	0	0.45	0.00
Ampney	491	4	2	0.81	0.41
Beech	363	7	3	1.93	0.83
Cardiology	228	3	2	1.32	0.88
Dove	201	7	5	3.48	2.49
Falcon	473	2	0	0.42	0.00
Jupiter	2226	9	4	0.40	0.18
LAMU	746	14	8	1.88	1.07
Meldon	643	10	6	1.56	0.93
Mercury	1146	5	2	0.44	0.17
Neptune	738	2	2	0.27	0.27
Saturn	682	10	2	1.47	0.29
SAU	334	0	0	0	0.00
Shalbourne	251	12	3	4.78	1.20
Teal	906	4	2	0.44	0.22
Trauma	1310	11	0	0.84	0
Woodpecker	583	30	4	5.15	0.69
Trust Wide	11766	132	45	**1.12%**	0.38%

These results compare favourably with the National Data given in the graph below from the NPSA medicines Safety Thermometer **1.12%** versus 8.3% nationally.

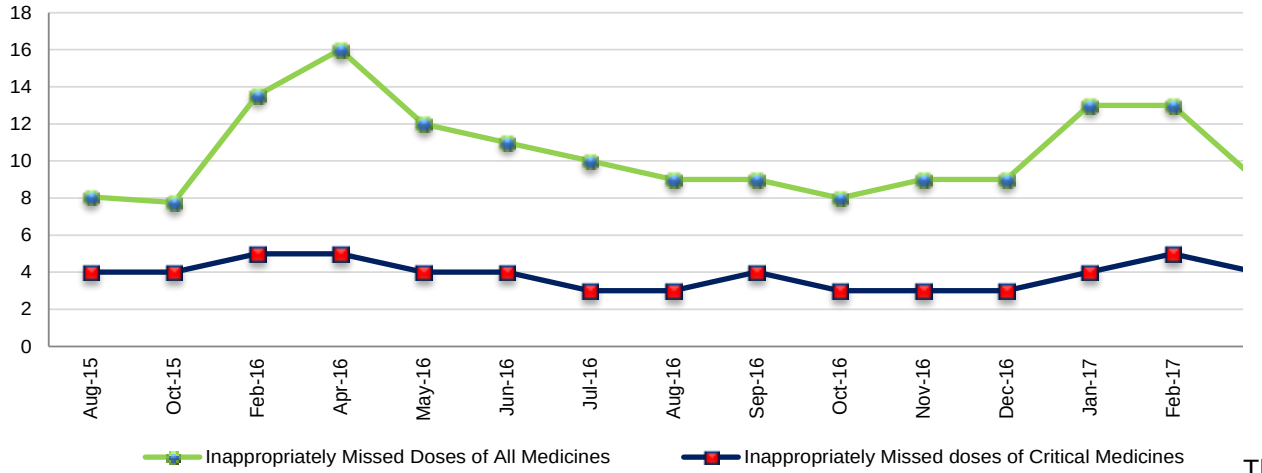
The National Data is provided below on the medication Safety Thermometer Dashboard.

Medications Safety Thermometer Dashboard



The graph above shows national data from the NPSA Medicines Safety Thermometer

Average Number of Inappropriatley Missed Doses per ward (24hr Snap Shot)



The chart above shows the average number of Inappropriately Missed Doses per Ward (24 snap shot)

Activities that are highlighting and reducing missed doses include

- Prompt feedback from the audit to the ward manager providing the name on the patient, medicine and nurse administering medication during the session. This has encouraged immediate training and support on appropriate actions to reduce omitted doses
- Provision of a missed dose action card attached to the medicine trolley keys to aid the appropriate action and support the reduction in missed doses.

Missed dose toolkit on intranet to aid administration and support nurse training

A series of tools have been shared through the Specialist Pharmacy Service Patient Safety Sub-committee from NHS Improvement and we work through these to identify those that would be appropriate to test within GWH

Improving patient experience & reducing complaints

The Friends and Family Test is commissioned nationally by NHS England. All providers of NHS-funded services are required to offer the Friends and Family Test (FFT) to all patients that have been cared for or have used a GWH service at the point of discharge from hospital.

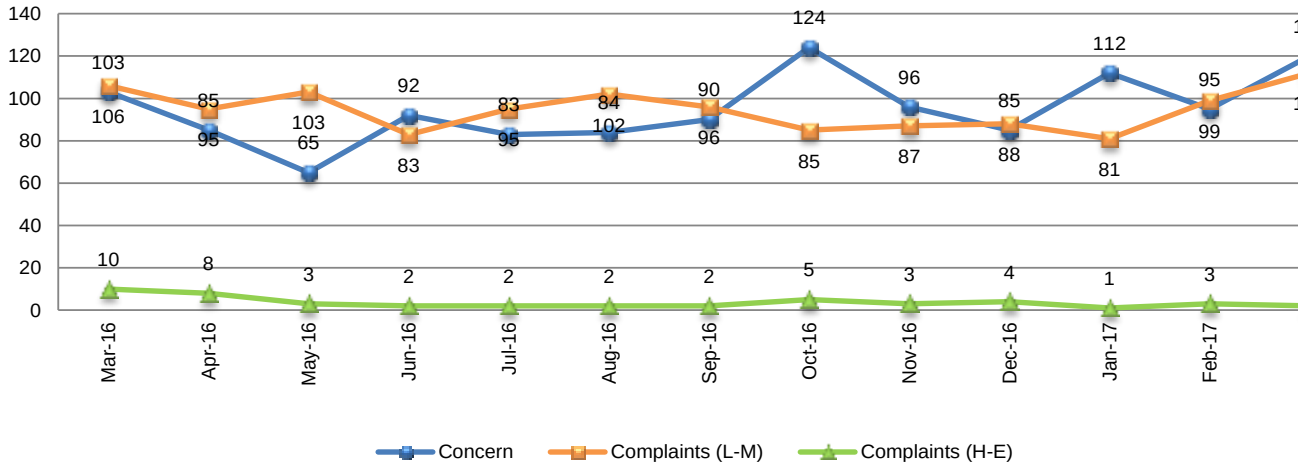
Throughout 2016/2017 95%-97% of patients responding would recommend our services to their Friends and Family if they required hospital treatment. Fewer patients are given the opportunity to provide feedback via FFT than we would like. During 2017/2018 we plan to make improvements by offering alternative methods, i.e. text messaging and feedback kiosks

We have improved our communication and services provided to patients where English is not their first language, we have enhanced our services provided to the deaf community ensuring that information and interpreters are available to assist.

We have reviewed our Patient Information Leaflets ensuring that the information provided is easy to understand and also is also available in various languages at request. We have achieved this by having a patient focused reading group to ensure that information is accessible and up to date at all times.

We aim to resolve any concerns and complaints satisfactorily and in a timely manner. Every effort is made for any worries or fears to be resolved through the concerns process within 48 working hours by the PALS team.

Complaints received in 2016/17



The graph above gives a comparison on concerns/complaints received over a 12 month period towards the end of 2015/16 and 2016/17

Changes throughout 2016/2017 included:

- New approaches ensure that learning takes place and changes are made as an overall outcome to complaints raised.

National Inpatient Survey

Following the National Inpatients Survey 2015 results, published in 2016, the Trust agreed priorities for focussed improvement including

- Communication,
- Discharge Planning,
- Hospital, Care, Overall

Clinical Divisions developed plans to drive improvements in these areas. The subsequent National Inpatient Survey 2016 showed improvements were achieved in some areas.

Results of the Picker Inpatient Survey 2016 against the Trust Priorities agreed from the 2015 Picker Inpatient results and presentation are set out below.

Lower scores are better

Communication		**2015**	**2016**	**Status**
Q34	Staff contradict each other	38%	32%	Improved
Q38	Could not always find staff member to discuss concerns with	67%	68%	Worse
Q37	Not enough (or too much) information given on condition or treatment	23%	22%	Improved
Q39	Not always enough emotional support from hospital staff	50%	44%	Improved
Q35	Wanted to be more involved in decisions	48%	49%	Worse
Q36	Did not always have confidence in the decisions made	32%	28%	Improved
Q51	Anaesthetist / other member of staff did not fully explain how would put to sleep or control pain	19%	12%	Improved
Q52	Results not explained in clear way	37%	30%	Improved
Q25	Doctors: did not always get clear answers to questions	39%	31%	Improved

Q27	Doctors: talked in front of patients as if they were not there	27%	25%	Improved
Q28	Nurses: did not always get clear answers to questions	37%	37%	Same
Q75	Not asked to give views on quality of care	77%	75%	Improved
Q76	Did not receive any information explaining how to complain	65%	68%	Worse

Lower scores are better

Discharge Planning		**2015**	**2016**	**Status**
Q53	Did not feel involved in decisions about discharge from hospital	50%	44%	Improved
Q55	Discharge was delayed	48%	45%	Improved
Q61	Not given any written/printed information about what they should or should not do after leaving hospital	41%	40%	Improved
Q62	Not fully told purpose of medications	35%	29%	Improved
Q63	Not fully told side-effects of medications	70%	65%	Improved
Q64	Not told how to take medication clearly	34%	26%	Improved
Q65	Not given completely clear written/printed information about medicines	34%	29%	Improved
Q66	Not fully told of danger signals to look for	65%	64%	Improved
Q68	Family not given enough information to help	57%	54%	Improved
Q69	Not told who to contact if worried	25%	25%	Same

Lower scores are better

Hospital, Care, Overall		**2015**	**2016**	**Status**
Q23	Not offered a choice of food.	27%	28%	Worse
Q38	Could not always find staff member to discuss concerns with.	67%	68%	Worse
Q75	Not asked to give views on quality of care	77%	75%	Improved
Q76	Did not receive any information explaining how to complain.	65%	68%	Worse

The 2016 survey results have highlighted the many positive aspects of the patient experience:-

Q38, Q75 and Q76 are duplicate questions appearing in Communication and Hospital, Care & overall.

- Overall: 83% rated care 7+ out of 10.
- Overall: treated with respect and dignity 80%.
- Doctors: always had confidence and trust 80%.
- Hospital: room or ward was very/fairly clean 97%.
- Hospital: toilets and bathrooms were very/fairly clean 92%.
- Care: always enough privacy when being examined or treated 90%.

Our Priorities 2017/18

- A Quality Improvement project to commence to reduce the number of patients complaints and incidents in relation to handover of care between clinicians
- Analyse our National Inpatient Survey results for 2016 in the same format, and develop additional Trust Continue to be a voice for patients and be a valuable service to resolve concerns locally avoiding escalation through the complaints handling process.
- There has been on-going work during 2016/2017 to lay the foundations for the Patient Experience strategy. This will be presented to the board by September 2017 This will include a work programme that can be embedded within an agreed timeframe and will have sought engagement with patients, carers, front line staff, and stakeholders.

Staff Survey 2016/17

We recognise that our staff are our greatest asset. Every single person who works for us plays an invaluable role in providing the high quality care and excellent service that we strive for. We know that when our staff have positive experiences at work, our patients also have positive experiences and, therefore, we are keen to hear from our staff about what it is like to work for us and what we can do to make things better.

The NHS Staff Survey is an important source of information about what it is like to work in the health service in England. The survey involves 316 NHS organisations from across the country and achieves over 423,000 responses. The NHS Staff Survey is understood to be the largest workforce survey anywhere in the world and offers unparalleled insight into staff experiences. As one of the 316 participating NHS organisations, in October 2016 the Trust randomly selected 1250 employees to complete the 2016/17 NHS Staff Survey, this is an increased sample size from last year (850 in 2015).

603 of those employees selected, returned a questionnaire giving the Trust a 49% response rate which is an improvement from last year (43% in 2015) and above the national average for combined acute and community Trusts in England.

National and Regional comparisons

National

The latest NHS Staff Survey results demonstrate a positive improvement in terms of staff experience and engagement despite the numerous challenges currently facing the NHS and its workforce.

Nationally, staff engagement has improved continuously over the last five years and this year has also seen an improvement in the overall willingness of staff to recommend the NHS as a place to work or be cared for.

Despite the extreme pressures that the NHS is under, nearly three quarters of the Trust staff remain enthusiastic about their job, the majority of frontline staff (80%) report that they are able to do their job to a standard they are personally pleased with and 90% of staff stated that their job makes a difference for patients. Generally staff reported feeling that managers are invested in their health and wellbeing with a significant proportion of staff stating that their immediate manager takes an interest in their health and wellbeing (67%).

The majority of our staff feel that their organisation takes positive action on the health and wellbeing of staff (90%). In addition to this, the percentage of staff witnessing potentially harmful incidents is at its lowest in five years and the percentage of staff able to report those concerns is at its highest in six years.

As is to be expected in such pressured working environments, the survey does highlight some areas of staff concern, with only 52% of staff feeling satisfied with the opportunities for flexible working and 11.9% of staff reporting that they have experienced discrimination at work. Whilst progress has been made, levels of bullying and harassment still remain unacceptably high nationally. The Trust's results a similar picture with 53% of staff feeling satisfied with the opportunities for flexible working and 9% have experienced discrimination at work.

Regional

Whilst the Trust's response rates remain one of the highest in the region, the Trust's overall position has declined slightly compared with last year. This year the Trust is ranked **12th when benchmarking performance against organisations from across the South West.** Last year the Trust was ranked 10th, Oxford University Hospitals NHS Trust and Torbay and South Devon Healthcare NHS Trust have both improved their performance this year and moved ahead of the Trust.

When compared against local Trust's, the organisation's performance has declined by one place this year and is ranked 3rd.

The results from this year's Staff Survey provide some very encouraging findings regarding the experiences of staff, however it also highlights some areas that are experiencing challenges and some that need improvement. Whilst this year's results have not significantly changed from last year, there has been continued progress overall since 2014.

The six areas where the Trust has seen a difference in results since 2014 are illustrated in the table below. All have been positive improvements with the exception of % appraised in the last 12 months.

Key area	2016 score	2015 score	2014 score	Change
% Appraised in last 12 months	84	86	91	-7
Staff confidence and security in reporting unsafe clinical practice	3.75	3.79	3.58	0.18
Staff recommendation of the organisation as a place to work or receive treatment	3.71	3.73	3.55	0.16
Staff motivation at work	4.01	4.09	3.88	0.14
% able to contribute towards improvements at work	74	77	67	6
Staff satisfaction with level of responsibility and involvement	3.95	3.97	3.83	0.12

This year, the Trust performed above average in 12 of the 32 key findings of the survey results, average in 14 and worse than average in only 6 areas. Whilst we are pleased that there have been improvements this year, there is further work to do in areas such as staffing levels and the number of staff experiencing harassment, bullying or abuse at work from patients or service users.

Overall, staff engagement at GWH continues to be high with the Trust scoring above the national average for staff motivation. This is measured by the fact that the majority of staff felt they could contribute to improvements at work, would recommend the Trust as a place to work or receive treatment and feel motivated at work.

Whilst the Trust's staff engagement score has reduced slightly this year (previously 3.88 in 2015), this result remains above the national average for acute and community Trust's and is higher than the results of 10 other Trusts in the South West region.

Although the results show an improvement in the number of staff who have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, this is still higher than the average score in similar organisations. To ensure our staff are protected at work, our 'Never OK' campaign was launched in October 2016 and will continue this year to reassure our staff that we take this very seriously

During a very busy year at the Trust, which has placed additional pressures on our staff, everyone has gone above and beyond what is expected of them to ensure the best possible experience for our patients.

To ensure our patients receive the highest quality of care, we must ensure that the health and wellbeing of our staff is a priority. Despite this additional pressure on the system, during 2016 fewer staff reported experiencing stress due to work and fewer staff have felt pressured to come to work when they are unwell.

In addition to this, fewer staff are working extra hours and staff satisfaction with opportunities for flexible working has improved

Summary of staff survey results

Table - Response Rate

2015		2016		Trust Improvement / Deterioration
Trust	National Average	Trust	National Average	6% improvement
43%	41%	49%	44%	

Table – Summary of Performance

Those areas where the Trust has performed highly in comparison to the National results can be seen in the table below as well as those areas where further improvement is required.

Top Five Ranking Scores	2016		2015	
	Trust	National	Trust	National
Staff motivation at work *(the higher the score the better)*	4.01	3.94	4.09	3.92
% of staff feeling unwell due to work related stress in the last 12 months *(the lower the score the better)*	33%	36%	36%	36%
% of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the score the better)*	93%	91%	92%	90%
% of staff / colleagues reporting most recent experience of harassment, bullying or abuse *(the higher the score the better)*	48%	45%	34%	38%
Staff confidence and security in reporting unsafe clinical practice *(the higher the score the better)*	3.75	3.68	3.79	3.64

Bottom Five Ranking Scores	2016		2015	
	Trust	National	Trust	National
Staff satisfaction with resourcing and support *(the higher the score the better)*	3.22	3.28	3.20	3.30
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months *(the lower the score the better)*	30%	26%	35%	27%
Staff satisfaction with the quality of work and care they are able to deliver *(the higher the score the better)*	3.88	3.92	3.91	3.94
Effective team working *(the higher the score the better)*	3.74	3.78	3.83	3.77
% of staff witnessing potentially harmful errors, near misses or incidents in the last month *(the lower the score the better)*	30%	29%	25%	29%

Our priorities for 2017/18

- We will be analysing Staff Survey results at sub specialty level and feedback will be presented to the relevant committees. Each committee will discuss their specific set of results and agree an appropriate action plan in response to the feedback from the specific professional group to implement improvements.
- Each Committee will undertake a quarterly review of the actions and improvements and the impact that they have had. Quarterly progress reports will also be submitted to the Executive Committee and the Performance, People and Place Committee.

2.3 Statements 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 the reporting period of 2016/2017 the Great Western Hospitals NHS Foundation Trust provided and / or sub-contracted 7 relevant health services.

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

The income generated by the relevant health services reviewed in 2016/2017 represents 98% of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2016/2017.

Participation in Clinical Audits

During 2016/17, 42 national clinical audits and 6 national confidential enquiries were conducted which covered relevant health services provided by the Trust. The Trust participated in **100%** of the national clinical audits and 100% of the national confidential enquiries of which it was eligible to participate in.

No	National Clinical Audit and Clinical Outcome Review Programmes	Work stream	Relevant	Participation	% Data Submission
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		Yes	Yes	Still in Progress
2	Adult Asthma		Yes	Yes	100%
3	Adult Cardiac Surgery		No	NA	NA
4	Asthma - paediatric and adult (care in emergency departments)		Yes	Yes	100%
5	Bowel Cancer (NBOCAP)		Yes	Yes	100%
6	Cardiac Rhythm Management (CRM)		Yes	Yes	Still in Progress
7	Case Mix Programme (CMP)		Yes	Yes	100%
8	Child Health Clinical Outcome Review Programme	Chronic Neurodisability	Yes	Yes	100%
		Young People's Mental Health	Yes	Yes	100%
9	Chronic Kidney Disease in primary care		No	NA	NA
10	Congenital Heart Disease (CHD)	Paediatric	No	NA	NA
		Adult	No	NA	NA

11	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		Yes	Yes	Still in Progress
12	Diabetes (Paediatric) (NPDA)		Yes	Yes	100%
13	Elective Surgery (National PROMs Programme)		Yes	Yes	Still in Progress
14	Endocrine and Thyroid National Audit		Yes	Yes	Still in Progress
15	Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	No	NA	Na
		Inpatient Falls	No National Audit this year		
		National Hip Fracture Database	Yes	Yes	100%
16	Head and Neck Cancer Audit		Yes	Yes	Still in Progress
17	Inflammatory Bowel Disease (IBD) programme	National Clinical Audit of Biological Therapies (adult and paediatric)	Yes	Yes	100%
18	Learning Disability Mortality Review Programme (LeDeR)		Yes	Yes	100%
19	Major Trauma Audit		Yes	Yes	100%
20	Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	Yes	Yes	Still in Progress
		Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	Still in Progress
		Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes	Yes	Still in Progress
		Maternal mortality surveillance	Yes	Yes	Still in Progress
21	Medical and Surgical Clinical Outcome Review Programme	Physical and mental health care of mental health patients in acute hospitals	Yes	Yes	Still in Progress
		Non-invasive ventilation	Yes	Yes	Still in Progress
22	Mental Health Clinical Outcome Review Programme	Suicide by children and young people in England(CYP)	No	NA	NA
		Suicide, Homicide & Sudden Unexplained Death	No	NA	NA
		The management and risk of patients with personality disorder prior to suicide and homicide	No	NA	NA
23	National Audit of Dementia	Care in general hospitals	Yes	Yes	100%
24	National Audit of Pulmonary Hypertension	National outcomes and tertiary care	No	NA	NA
25	National Cardiac Arrest Audit (NCAA)		Yes	Yes	100%

26	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	No	NA	NA
		Secondary Care	Yes	Yes	Still in Progress
		1. Primary Care (Wales)	No	NA	NA
		2. Primary Care (England)	No	NA	NA
27	National Comparative Audit of Blood Transfusion programme	Use of blood in Haematology	Yes	Yes	100%
		Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	100%
		Audit of the use of blood in Lower GI bleeding	Yes	Yes	100%
28	National Diabetes Audit - Adults	National Foot Care Audit	Yes	Yes	Still in Progress
		National Inpatient Audit	Yes	Yes	100%
		National Pregnancy in Diabetes Audit	Yes	Yes	100%
		National Diabetes Transition	Yes	Yes	100%
		National Core	Yes	Yes	100%
29	National Emergency Laparotomy Audit (NELA)		Yes	Yes	Still in Progress
30	National Heart Failure Audit		Yes	Yes	Still in Progress
31	National Joint Registry (NJR)	Knee replacement	Yes	Yes	100%
		Hip replacement	Yes	Yes	100%
32	National Lung Cancer Audit (NLCA)	Lung Cancer Consultant Outcomes Publication	Yes	Yes	100%
33	Neurosurgical National Audit Programme		No	NA	NA
34	National Ophthalmology Audit	Adult Cataract surgery	Yes	Yes	Still in Progress
35	National Prostate Cancer Audit		Yes	Yes	Still in Progress
36	National Vascular Registry		No	NA	NA
37	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)		Yes	Yes	100%
28	Nephrectomy audit		Yes	Yes	100%
39	Oesophago-gastric Cancer (NAOGC)		Yes	Yes	100%
40	Paediatric Intensive Care (PICA Net)		No	NA	NA
41	Paediatric Pneumonia		Yes	Yes	Still in Progress
42	Percutaneous Nephrolithotomy (PCNL)		No	NA	NA
43	Prescribing Observatory for Mental Health (POMH-UK)	Prescribing antipsychotics for people with dementia	No	NA	NA
		Monitoring of patients prescribed lithium	No	NA	NA
		Rapid tranquilisation	No	NA	NA
44	Radical Prostatectomy Audit		No	NA	NA
45	Renal Replacement Therapy (Renal Registry)		No	NA	NA
46	Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Follow-up	No National Audit this year		

		Clinician/Patient Baseline	No National Audit this year		
47	Sentinel Stroke National Audit programme (SSNAP)		Yes	Yes	Still in Progress
48	Severe Sepsis and Septic Shock (care in emergency departments)		Yes	Yes	100%
49	Specialist rehabilitation for patients with complex needs following major surgery	Specialist rehabilitation level 1 and 2	No	NA	NA
50	Stress Urinary Incontinence Audit		Yes	Yes	Still in Progress
51	UK Cystic Fibrosis Registry	Paediatric	No	NA	NA
		Adult	No	NA	NA

The reports of 44 national clinical audits were reviewed by the provider in 2016/17. As a result of these audits the following actions are planned to improve the quality of healthcare provided –

- Plan to improve and formalise the system for consent for those patients who undergo a hip replacement for fractured neck of femur.
- The Resuscitation Team are working closely with the sign up to safety campaign which aims to reduce cardiac arrests by 10% per year for the next 3 years.
- Provision of psychological support offered to patients by Paediatric Diabetes
- 'Ready Steady Go' process for children transitioning to adult care currently used for transition clinics.
- A review of consultant job planning to ensure no elective activity is listed for those individuals on call.
- All patients over the age of 70 to be reviewed within 3 days following laparotomy operation.
- Quality Improvement involving Respiratory Medicine and Radiology to improve the pathway for patients with suspected community acquired pneumonia; this will focus on key areas including time between admission and receiving a chest x-ray and antibiotic management
- A new WHO style checklist will be introduced in the Emergency Department which will include 7 different criteria to reduce risks to patient when undergoing procedural sedation.
- Improve compliance with oxygen prescribing by introducing prompts for prescribers within the electronic prescribing software.

The reports of 152 local clinical audits were reviewed by the provider in 2016/17 and Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided –

- Review and define arrangements for medical oversight of patients admitted under the podiatric surgeons; identify clear lines of responsibility for their medical care in the event the patient's medical condition deteriorates.
- Review and revise current Abbey Pain Assessment guidelines for in-patients with dementia.
- To establish an action group involving the Trust's Dementia Strategy Group and Pain Management Team.
- Develop a formal local guideline for peri-operative management of patients with a fracture neck of femur to standardise practice.
- To improve the management of patients with Chronic Obstructive Pulmonary Disease (COPD), including the design of an admission care bundle proforma in the acute medical unit to be incorporated into medical clerking. Oxygen will be pre-printed on the admission documents with target saturations to ensure it is prescribed.
- Continue to embed personal care plans for the dying.

- Patients will be seen in clinic to be assessed for suitability and consideration of Fluocinolone Acetonide intravitreal implant as an alternative treatment for eyes with chronic Diabetic Macular Oedema (DMO) which did not respond to the standard treatment.

Research & Development (R & D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2016/2017, that were recruited during that period to participate in research approved by a research ethics committee was 1024 to end March 2017 which evidences growth in year that exceeded our targets.

We now have 97 actively recruiting Department of Health endorsed (portfolio) research projects. We also participate in a number of studies which are more difficult to recruit to given the complex nature of the inclusion and exclusion criteria. We believe it is important to have these studies open in order to give our patients the opportunity of participating in such studies should they be eligible. We run observational studies together with interventional studies.

Our reputation in the Commercial sector continues to grow and we are now not only a top recruiter in the UK for more than one of our studies, as a Participating Site we were also the first to recruit to both a Respiratory and Cardiology Trial in the UK.

We continue with our efforts to ensure we recruit the agreed number of patients in the timescales given.

Research continues to grow throughout the Trust, across a wider range of specialities. This in turn gives our patients more opportunities to participate and access to new and innovative treatment pathways.

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

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of Great Western Hospitals Foundation Trust's income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between Swindon Clinical Commissioning Group and Wiltshire Clinical Commissioning Group 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.

Further details of the agreed goals for 2016-17 and for the following 12-month period are available electronically by request

Financial Summary of CQUIN (£m)									
	Plan	Actual	%	Plan	Actual	%	Plan	Actual	%
	2014-2015			2015-2016			2016-2017		
Total CQUIN	£5,722	£4,505	78.72%	£6,007	£4,507	75%	£4,845	£3,973	82%

Care Quality Commission Registration

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 in October 2016 to add the following service - GWH NHS Foundation Trust Swindon Adult Community Services

Periodic/Special Reviews 2016/17
The Care Quality Commission (CQC) issued enforcement action against The Great Western Hospital NHS Foundation Trust during 2015/2016. A warning notice was issued in respect of some aspects of regulated activity requiring significant improvement within a defined timeframe.

In summary:
In December 2015 the CQC issued the Great Western Hospitals Foundation NHS Trust with a warning notice and required the Trust to make significant improvements. The Trust submitted a comprehensive improvement plan.

In April 2016 the CQC carried out an inspection to check progress against the concerns raised in the warning notice. They found that significant progress had been made but the requirements of the warning notice were not fully met.

In October 2016 the CQC conducted a second follow up inspection and found that further and sufficient progress had been made to meet the requirements of the warning notice. In response to the CQC Must do- should do actions, a monthly Improvement Committee was formed, to prioritise, manage and monitor the progress of the Improvement Plan, The Improvement Committee facilitated and supported the implementation approaches to test changes, and to seek assurance improvements are embedded.

What improvements have we implemented?

- Invested in training
- Introduced electronic white boards
- Introduced a new safety check list in the Emergency Department
- Improved initial nurse assessments in the Emergency Department
- Invested in a specialist mental health nursing team in the Emergency Department Observation Unit

The Trust took part in a formal CQC Inspection during March 2017 .The table below identifies the Compliance Actions identified form our December 2015 inspection.

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	19/01/2016	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Compliance Action	19/01/2016	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Compliance Action	19/01/2016	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Compliance Action	19/01/2016	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Compliance Action	19/01/2016	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
Compliance Action	19/01/2016	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Planned Inspection Update

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, 21 March – 7 April 2017 with the Trust awaiting the final report.

Initial verbal feedback from the CQC recognised there had been significant changes and improvements since their last inspection, the verbal feedback also raised some further areas for improvement which the Clinical Divisions have commenced working on.

Our Ratings for the Great Western Hospital from 2015/2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity And gynaecology	Requires Improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires Improvement	Not Rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

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 2016 to March 2017 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
98.9% for accident and emergency care.

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

100% for admitted patient care;
100% for out-patient care; and
99.8% for accident and emergency care

Information Governance Tool Kit Attainment Levels

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information.

There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Performance, People & Place Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality assurance, information security assurance, and legal compliance.

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

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

These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Digital Information Governance Toolkit. These assessments and the information governance measures themselves are regularly validated through independent internal audit. The main Toolkit headings are:

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

The Trust's Information Governance Assessment Report overall score for 2016/2017 was 77% and was graded 'Satisfactory' ('green'), with a satisfactory rating in every heading of the Information Governance Toolkit.

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 2016/17 by the Audit Commission.

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 will be taking the following actions to improve data quality

- Review of the Trust's data quality policy
- Development of a Trust data quality strategy
- Developed a data quality report that focuses on monitoring the national DQ measures and identify actions from areas below national averages
- A role has been assigned responsibility for monitoring data quality within the Trust
- Review of terms of reference for the Trusts Data Quality group

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

		2013/ 2014	2014/ 2015	2015/ 2016	**2016/ 2017**	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	**MRSA Bed Days as well** *provisional as at 02/05/14	5	2	2	1	0.96 *	Zero is aspirational	Low-0; High-11	IP&C	National definition
	C.Diff	23	19* *combined previously acute/ community split	30 Trust-wide	21	N/A	Zero is aspirational	Low-0; High-121	IP&C	National definition
	C.Diff 100,000 bed days*	12.5*	9.60	14.7	11.1	15.01	Lower is better	Regionally Low:8.71 High: 28.02	PHE	National Definition
2 - Patient Falls in Hospital resulting in severe harm		23	16	13	12	Not available	Lower is better	--	Incident form	NPSA

3 – Reducing Healthcare Acquired Pressure Ulcers	28 Category III & Category IV	51 Category I & Category IV	8 Category III 6 Category IV	1 Category III	4% incidence	Lower is better	--	Incident form	National Definition (from Hospital database)
4 – Percentage of VTE Risk Assessments completed	95.5 %	97.1%	98.3%	99.4%	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	95%	91.6%	95.2	97.4%	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)

		2013/ 2014	2014/ 2015	2015/ 2016	**2016/ 2017**	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
6 – Never Events that occurred in the Trust		4	2	3	1	NHS England 2014-15 Average 2.16	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA
Hospital-level mortality indicator (SHMI)	**(SHMI)**	96.00	92.99	95.83	94.34 (Oct 15 to Sep 16 – most recent data available)	-	Lower than 100 is good	-	National NHS Information Centre	National NHS Information Centre
7 – Mortality Rate (HSMR)	**HSMR**	97.3	90.3	89.0	97.97 (Apr 16 – Dec 16 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)**	95% April – Dec 9 months	90%	85% April – Dec 9 months	Average 96%	Not available	Higher number is better	--	Audit	Audit criteria (10 patients per ward per month)
	Paediatric Early Warning Score (Children)	87.75%	92.25% Average yearly compliance	85% April - Sept 6 months	Average 86%	N/A	Higher number is better	--	Audit	Audit criteria (5 patients per month)
11 – Were you involved as much as you wanted to be in decisions about your care and treatment?		53.2%	51.4%	51.8%	51.1%	54.8%	Higher is better	Low: 6.1 High: 9.2 GWH: 7.1	Picker Survey	National definition
12 – Did you find someone on the hospital staff to talk to about your worries and fears?		37.1%	28.6%	33.0%	32%	38.4%	Higher is better	Low: 4.3 High: 8.2 GWH: 4.9	Picker Survey	National definition

13 – Were you given enough privacy when discussing your conditions or treatment?		70.8%	74.2%	72.6%	75.6%	72.7%	Higher is better	Low: 7.5 High: 9.4 GWH: 8.5	Picker Survey	National definition
14 – Did a member of staff tell you about medication side effects to watch for when you went home?		33.7%	32.1%	29.8%	35.3%	40%	Higher is better	Low: 3.7 High: 7.6 GWH: 4.3	Picker Survey	National definition
15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?		67.2%	66.2%	68.0%	65.6%	69.8%	Higher is better	Low: 6.4 High: 9.7 GWH: 7.6	Picker Survey	National definition
18– Patient Reported Outcome Measures	**Varicose Vein surgery**	100%	90.9%	100% HSCIC Provisional data	100% HSCIC Provisional data	80%	Higher is better	Not available (more than one Contractor for this service)	DoH/ HSCIC	National Definition
	Groin Hernia surgery	100%	57.6%	42.9% HSCIC Provisional data	54.5% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Hip Replacement surgery (Oxford Hip Score)	98.5%	61.5%	93.9% HSCIC Provisional data	91.9% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Knee Replacement Surgery (Oxford Knee Score)	97%	94.4%	97% HSCIC Provisional data	95.3% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition

	2013/ 2014	2014/ 2015	2015/ 2016	**2016/ 2017**	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
17 – Readmissions – 30 days	7.9%	9.4%	9.7	9.7% (Apr 16 to Feb 17)	Local target (7.1%)	Lower is better	--		National Definition
18 – Readmissions – 28 days	7.7%	9.2%	9.6	9.8% (Apr 16 to Sep 16)	SW Region 6.9%	Lower is better	Low: 5.12; High:10. 91	Dr Foster	Dr Foster
18 – Re-admissions 28 days **Ages 0-15** **Ages 16+**	9% 7.5%	8.5% 9.2%	9.02 10.02	9.5% 0-15 & 9.9% 16+ (Apr 16 to Sep 16)	Dr Foster	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 -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 available	31.1% (Oct 15 to Sep 16, most recent data available)	25.3%		Low:0; High: 49.4	HSCIC	National Definition

"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"		58%	70%	68%	68%	69.8%	Higher is better	-	NHS Staff survey	National Definition
20 - 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	--	Lower is better	--	Informatics & Clinical Risk	-
	Number of Patient Safety Incidents per 100 Bed Days	3.00	3.07	3.3	4.4	--	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	--	Lower is better	--	Informatics & Clinical Risk	-
	Percentage of Combined Severe Harm and Death	0.56 %	0.80 %	0.55%	0.26%	--	Lower is better	--	Informatics & Clinical Risk	-

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

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 2016/17 against the key national priorities from the Single Oversight Framework. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2013/ 2014 Trust	2014/ 2015 Trust	2015/ 2016 Trust	2015/2016 Target	**2016/ 2017 Target**	**2016/ 2017 Trust**	Achieved/ Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	94.8%	90.5%	88.9%	92.0%	92.0%	91.1%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	94.9%	88.6%	82.5%	90%	90%	61.6%	Not Met

Indicator	2013/ 2014 Trust	2014/ 2015 Trust	2015/ 2016 Trust	2015/2016 Target	**2016/ 2017 Target**	**2016/ 2017 Trust**	Achieved/ Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	96.3%	95.6%	89.2%	95%	95%	89%	Not Met
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95%	94.1%	91.9%	91.1%	95.0%	95.0%	86.6%	Not Met
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	98.4%	99%	94.%	94%	94%	100%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	100%	98%	99.7%	98%	98%	99.6%	Achieved
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	89.0%	88.4	87.70%	85.00%	85%	86.5%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	98.9%	98.4	98.10%	90.00%	90%	96.7%	Achieved
Cancer 31 day wait from diagnosis to first treatment	98.8%	98.6	98.00%	96.00%	96%	97.1%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	94.7%	94.0	94.30%	93.00%	93%	88.4%	Not Met
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	95.6%	96.8	95.50%	93.00%	93%	91.8%	Not Met

Statement from the Council of Governors dated 12th May 2017

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 86.6% of persons attending A & E were seen within 4 hours against the target of 95%. This is a decrease against the 91.1% attained in the previous year however 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.

The Governors are aware that the Trust is continuing to take action to address this issue and the consequential effects on other performance indicators nonetheless we are also aware that several proposed actions are dependent on partner organisations delivering on their commitments. Within the Quality Report the Trust has reported a number of achievements such as the continual reduction in the occurrence of avoidable pressure ulcers a reduction in Sepsis related deaths and a below average mortality rate. These achievements combine to help achieve an improving experience for our service users and are noted by the Governors.

The Governors have also had opportunity to undertake safety and quality visits across the hospital which enabled Governors to meet and talk directly to staff and patients in the clinical areas, gaining an insight in how the Governor role can support the business of the Trust. The visits have provided the Governors with direct oversight of patient care and improvements made throughout the year, plus added to the knowledge and understanding of Governors around patient experience and quality and staff and patient feedback. A programme of further visits has been set up for 2017/18.

The Governors have established a Patient Quality and Operational Performance Working Group where detailed presentations and reports are made and Governors have the opportunity to consider in detail specific issues and areas of improvement.

The Governors are looking forward to working with staff to build on the good work within the Quality Accounts and have identified areas for focus around Safeguarding, food hygiene, winter pressures preparation, e-rostering and management of overseas patients.

Margaret White

Lead Governor on behalf of the Council of Governors

Statement from Swindon Clinical Commission Group dated 16th May 2017

Swindon Clinical Commissioning Group (CCG) has reviewed the Great Western Hospital NHS Foundation Trust (GWHFT) Quality Accounts for 2016/2017. In so far as we have been able to check the factual details, our 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 the NHS England 2016/2017 presentation guidance.

Swindon CCG welcomes the quality priorities outlined by GWHFT for 2017/18 which look to build on the success of the 'Sign up to Safety' quality improvement work streams established during 2016/17. The Trust quality improvement work streams have reduced the number of inpatient falls to below the national average and has sustained a reduction in the number of hospital category III and IV pressure ulcers. As identified within the quality account, problems with identification and escalation of a deteriorating patient is a key theme identified in the Trust's serious incident reporting. Swindon CCG welcomes a continued focus on this area, including the role out of e-observations aimed at improving safety, together with a review of clinical handover.

During 2016/17, The Trust has experienced increasing demand on the Emergency Department (ED) which has resulted in the Trust not achieving the 4-hour treatment target. This includes some patients spending longer than 12 hours within the department which can impact both patient experience and safety. In response to this, the commissioners requested the Trust developed an ED quality dashboard to provide assurance of safety within the department, which is also aligned to the CQC inspection recommendations. Swindon CCG is actively supporting the Trust to implement both local and national programmes of work.

Swindon CCG recognise that the Trust has experienced difficulties in achieving the 18-week referral to treatment target, resulting in some patients having to wait longer for their elective treatment. This is a national challenge across NHS organisations and is regularly monitored by the CCG who work closely with the Trust to understand the impact on both patient safety and experience resulting from increased wait time.

The Trust has made good progress in reducing hospital acquired infections over recent years, however, the Trust reported a breach in the numbers of *Clostridium difficile* infections reported (21 against a target of 20) and Methicillin Resistant Staphylococcus Aureus blood stream infections (MRSA, 1 against a target of 0) targets during 2016/17. It is recognised that The Trusts' infection prevention and control (IP&C) annual plan for 17/18 will support a continued focus on further reducing these infections within the hospital setting. Moving forward, the CCG is also committed to working with the Trust to achieve a reduction in reported gram negative bloodstream infections.

We recognise the on-going work by the Trust to monitor and improve patient experience and noted areas of improvement over the year from the results of the PICKER survey. It is also positive to note that 95%-97% of patients would recommend to the Trust to friends and family. We look forward to receiving the Trust's Patient Experience Strategy during 2017/18. Swindon CCG would encourage the Trust to report on complaint themes and trends, including associated learning in future quality accounts and look to strengthen the Friends and Family Test response rate.

We note the national and local clinical audits that have been completed in year. Swindon CCG will seek assurance of completion of the planned actions to implement the learning from clinical audit and improve the quality of healthcare, including Ready, Steady, Go for children in transition, implementation of the recommendations from the UK Parkinson's Audit and implementation of the WHO style checklist in the ED.

Swindon CCG note the CQUIN payment framework. The 2016/17 CQUIN's have focused on key clinical pathways including Children in Transition, Frailty, Diabetes and COPD. In future Quality Accounts, Swindon CCCG would request that the Trust reflect on the improved quality outcomes achieved as a result of CQUIN.

Swindon CCG is pleased to see the results of the NHS Staff Survey, which demonstrates a positive improvement in terms of staff experience and engagement despite the numerous challenges currently facing the NHS and its workforce.

The survey has identified some significant areas of improvement over the year, including the level of confidence that staff have in reporting unsafe practice, the effectiveness of communication from senior managers and job satisfaction. However, areas for further improvement have been correctly identified with a focus on bullying and harassment through the 'Never OK' campaign. The Trust has also actively engaged in a CQUIN during 2016/17 to focus on improving staff health and wellbeing.

Swindon CCG is committed to ensuring continued collaborative working with Great Western Hospitals NHS Foundation Trust to achieve identified goals going forward and support the provision of high quality care across the whole health and social care system.

Gill May Executive Nurse, NHS Swindon CCG

Statement from Healthwatch, Swindon and Healthwatch Wiltshire dated 15th May 2017

This statement is provided on behalf of Healthwatch Wiltshire and Healthwatch Swindon. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment. Local Healthwatch have continued to meet regularly with the Trust over the past year and remain committed to continuing this relationship and working with the Trust over the coming year. We are happy to see the priorities for the year have been drawn from local learning and national concerns, and that patient/public Governor representatives have been involved.

We are pleased to see that the number of Never Events are decreasing over time and that full investigations are leading to changes in practice within the hospital. Likewise, we welcome the reduction in the number of serious incidents, alongside the increase in the use of the patient safety incident reporting, to ensure that incidents and near misses are used as learning opportunities.

The Trust has put in place additional developments to improve their compliance with Duty of Candour and to ensure that patients and relatives are fully supported following errors. We note that there were some dips in compliance over the winter period and will be monitoring the situation going forward to ensure that system improvements have a positive impact on compliance over the coming year.

The Trust has continued to miss its target for a maximum wait of 4 hours in the Accident and Emergency Department. Whilst we are appreciative of system wide pressures that exist, we remain concerned that current initiatives do not appear to be achieving the aim of reducing this wait time. We note that a remedial action plan is in place and we welcome this development.

However, we would like to know what measures are being taken to ensure the wellbeing of the patients, their relatives and friends who are waiting longer than 4 hours in the department. As local Healthwatch we are committed to ensuring that local people can speak out about their experiences of receiving care.
We would therefore encourage local people to speak to us about their experience of using the A&E department and offer support to the Trust in their continued engagement with patients.

It is reassuring to see that of those patients who have completed the Friends and Family test, many would recommend the services of the Trust to others. We are pleased to see that the Trust is committed to increasing accessibility of services for those with English as an additional language and members of the Deaf community. We appreciate the use of the National Inpatient Survey data in setting improvement priorities for the coming year. We also welcome the work towards a patient experience and engagement strategy and would be happy to work with the Trust to support this.

We encourage the proposed incorporation of patient and public involvement into the Sepsis Working Group, and offer our assistance with this.

The staff survey has shown some positive results and it is reassuring that staff report that feel able to report concerns, are motivated and feel able to contribute to improvements at work and that the majority would recommend the Trust as a place to work or receive treatment. However, it is concerning to see that the levels of bullying and harassment remain higher than national levels.

Healthwatch Swindon congratulate the trust on winning the community health contract in Swindon and look forward to seeing joined up services and opportunities for patient and resident feedback shaping future service provision.

The Trust continues to face challenges as a result of the required actions put in place by the Care Quality Commission and NHS Improvement following the CQC's initial inspection of the Trust in September/October 2015 as well as subsequent follow-up inspections in 2016/17. We very much hope that the work being done impacts positively to reduce the pressures on staff and hence improve the experience of care for patients. We will be closely monitoring the progress of the Trust and will continue to raise concerns should we feel that the quality of care is being compromised.

Healthwatch Wiltshire and Healthwatch Swindon look forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Dr. Sara Nelson

Head of Research and Insight

healthwatch Swindon
healthwatch Wiltshire

Statement from Wiltshire Clinical Commissioning Group dated 19th May 2017

Wiltshire Clinical Commissioning Group (CCG) has reviewed the Great Western Hospital NHS Foundation Trust (GWH) Quality Accounts for 2016-17. In doing so, the CCG reviewed the Account in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Quality Review Meetings attended by GWH and Commissioners. This evidence is triangulated with information and is further informed through Quality Assurance visits to GWH, which encompass clinician to clinician feedback and reviews. Wiltshire CCG endorses the Trusts identified quality priorities for 2017-18.

It is the view of the CCG that the Quality Account reflects the Trusts' on-going commitment to quality improvement and addressing key issues in a focused way. The Account summarises the achievements against the 2016-17 Trust quality priorities and identifies the 2017-18 priorities. The Trust priorities for 2016-17 have outlined achievement in the Sign Up To Safety Quality Improvement workstreams which has been evidenced through a reduction in the number of category III and IV pressure ulcers, and a reduction in the number of inpatient falls.

The Trust has reported twenty one (21) cases of C.*difficile* in 2016-17 which has exceeded their trajectory of twenty (20), however, following investigation, only one (1) of the cases has been identified as avoidable, with a further nine (9) cases pending investigation outcome. The CCG welcomes the continued focus on the monitoring and reducing the risk factors of C.*difficile* including the promotion of antibiotic stewardship. The CCG is committed to working with the Trust to reduce rates of Gram Negative Blood Stream Infections. Building on the 2016-17 Sepsis workstream, which was supported through CQUIN funding, the CCG anticipates that further improvement will be made through the embedding of early identification and treatment of Sepsis. This will continue as national CQUIN scheme in 2017-18.

The CCG welcomes the Trusts' continued focus on the recognition and rescue of the deteriorating patient in 2017-18, and the further embedding of the standardised National Early Warning Score (NEWS) through the roll out the e-observation system and a focus on improving clinical handover.

Wiltshire CCG acknowledges that the Trust has experienced increasing demand on the Emergency Department (ED) which has resulted in the 4 hour target not consistently being achieved and some patients spending longer than 12 hours on a trolley before a decision has been made to admit. The Commissioners have requested that the Trust develop an ED quality dashboard to provide assurance of safety within the department, which is also aligned to the CQC Inspection recommendations. The CCG will continue to work with the Trust to support improvements.

One of the Trusts' priorities in 2016-17, 'improving patient experience and reducing complaints' has shown results from the national Friends and Family Test that 95-97% of patients would recommend the Trust services.

The CCG welcome the development of the patient experience and engagement strategy in 2017-18, and look forward to receiving this in September 2017. It is positive to see that the Trust is keen to receive and respond to staff feedback. In particular, the 'Never OK' campaign will focus on addressing the findings within the national staff survey regarding bullying and harassment.

Wiltshire CCG is committed to ensuring collaborative working with Great Western Hospital NHS Foundation Trust to achieve continuous improvement for patients in both their experience of care and outcomes.

Yours sincerely

Tracey Cox
Interim Accountable Officer, NHS Wiltshire Clinical Commissioning Group

Statement from Swindon Health Overview & Scrutiny Committee dated 19th May 2017

We welcome the opportunity to comment on the quality account for Great Western Hospital. Adult and Children's services have been working closely with Great Western Hospital staff in offering care and support to patients.

There are many older people who have benefited from our joint working in improving the discharge of patients into adult social care. We welcome the actions the Trust has taken to improve the health and care of patients, particularly the reduction in serious incidents, incidents of Clostridium difficult (Cdiff) and MRSA

It is positive that nearly all patients would recommend the hospital to family and friends. In future we would welcome a section in the quality accounts that focus on how Great Western Hospital safeguards patients, both children and adults alike and the joint work with adult services as part of the Local Safeguarding Adult Board and Local Safeguarding Childrens Board.

The hospital is a member of the Local Safeguarding Children's Board. It would have been helpful if mention could be made about the work GWH have done to address the findings of local and serious case reviews. Also mention of the specific needs of children as patients.

We congratulate Great western Hospital as the new provider of some community health services in Swindon. We believe this is a unique opportunity to work together on prevention and early intervention as well as improved support to adult and children living in the community'

Cllr Claire Ellis and Cllr Gary Sumner

Chair of Adults services and Chair of Children Services

Statement from Wiltshire Health Overview & Scrutiny Committee dated 23rd May 2017

The Health Select Committee has been given the opportunity to review the draft Quality Account for Great Western Hospital Trust 2016/17. The response below provides a record of the Committee's work relating to GWH during 2016-17:

On 27th September 2016 Health Select Committee considered:

- The CQC inspection report of the Trust, following the inspection undertaken in September 2015, the result of which was a grading of 'Requires Improvement'
- The Trust's improvement plan for addressing issues identified by the CQC.

Wiltshire CCG's Director of Quality attended to provide an overview of the report's findings.

In the course of the presentation and discussion, the issues highlighted included: that some areas require improvement; that good multi-disciplinary working had been identified; that a good culture existed for reporting serious incidents; the culture of good, caring, compassionate staff; that occupancy rates were running high and impacting on safety and effectiveness; the warning notice in relation to A&E; that some staffing levels were of concern; that some safeguarding training needed improvement; that some concerns over the way that risk registers linked together, and how can share issues be addressed properly; that Trust was re-inspected in April to address warning notice issues; that the action plan was acknowledged as being comprehensive but that improvements needed to be quicker.

The Committee resolved to ask GWH to come to its next meeting and provide further detail on its improvement programme:

On 15th November, GWH's Director of Nursing attended the Committee and provided a presentation on progress with the action plan devised following the inspection report. Specific issues discussed included how workforce issues were being addressed and which areas were progressing well and which required more focused attention.

Following a proposal from the Chair, the meeting resolved:

To note the information provided on GWH's improvement programme following their CQC inspection report published in August 2016.

Henry Powell
Senior Scrutiny Officer, Performance Risk and Scrutiny

2016/17 Statement of Directors' Responsibilities in Respect on the Quality Report dated 30th May 2017

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 arrangements 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 2016/17 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 **April 2016 to 30 May 2017.**
- Papers relating to quality reported to the board over the period **April 2016 to 30 May 2017.**
- Feedback from Swindon commissioners dated: **16th May 2017**
- Feedback from Wiltshire Commissioners dated: **19th May 2017**
- Feedback from governors dated: **12th May 2017**
- Feedback from local Healthwatch organisations dated: **15th May 2017**
- Feedback from Swindon Overview and Scrutiny Committee dated: **19th May 2017**
- Feedback from Wiltshire Overview and Scrutiny Committee dated:**23rd May 2017**
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Board monthly.
- The [latest] national patient survey **26th October 2016**
- The [latest] national staff survey **10th October 2016**
- The Head of Internal Audit's annual opinion over the trust's control environment dated: **24 April 2017.**
- CQC inspection report dated **January 2016.**

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered 2016/2017.

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

Chairman: Date 30 May 2017

Chief Executive: Date 30 May 2017

Independent Auditors report to the Council of Governors of Great Western Hospitals NHS Foundation Trust, on the Annual Quality Report dated 30th May 2017

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 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;

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 frosts 201617* ('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 *Detailed Requirements for external assurance for quality reports for foundation trusts 201617.*

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 April 2016 to May 2017;
- papers relating to quality reported to the board over the period April2016 to May 2017;
- feedback from commissioners, dated 16 May 2017;
- feedback from governors, dated 12 May 2017;
- feedback from local Healthwatch organisations, dated 15 May 2017;
- feedback from Overview and Scrutiny Committee, dated 19 May 2017;

- 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 February 2017;
- the latest national staff survey, dated April 2017 ;
- Care Quality Commission Inspection, dated December 2015; and
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting 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 2017, 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 ('!SAE 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 characterist ics 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 percentage of incomplete pathways indicator
Our sample testing for the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways for the year ended 31 March 2017 identified nine issues within a sample of 25 pathways. These related to four cases where the pathway had been stopped incorrectly, three cases where clock start dates could not be reconciled to supporting evidence, one duplicated pathway and one patient that should not have been on an incomplete pathway.

Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the percentage of incomplete pathways indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:
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

KPMG LLP
Chartered Accountants 66 Queen Square Bristol
BS1 4BE

30 May 2017

Glossary of Terms

A&E/ED	Accident & Emergency/Emergency Department
AHSN	Academic Health Science Network
AKI	Acute Kidney Injury
C.diff	Clostridium Difficile
CAUTIs	Catheter Associated Urinary Tract Infections
CCG	Clinical Commissioning Groups
CLRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Clinical Quality & Innovation
DTOC	Delayed Transfer of Care
DOC	Duty of candour
DVT	Deep Vein Thrombosis
E&D	Equality & Diversity
EDD	Estimated Date of Discharge
EDS	Equality Delivery System
EPMA	Electronic Prescribing and Medicine Administration
FFT	Friends and Family Test
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
ICHD	Integrated Community Health Division
IP&C	Infection, Prevention & Control
KLOE	Key Lines of Enquiry
LCRN	Local Clinical Research Network
Monitor	The NHS Foundation Trusts Regulator
MRSA or MRSAB	Meticillin-Resistant Staphylococcus Aureus Bacteraemia
MUST	Malnutrition Universal Screening Tool
NEWS	National Early Warning System
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NRLS	National Reporting & Learning System
PbR	Payment by Results
PDSA	Plan, Do, Study , Act
PE	Pulmonary Embolism
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
RR	Relative Risk
RTT	Referral to Treatment
SAFE	Stratification and Avoidance of Falls
SAFER	Patient Flow Bundle
SBAR	Situation, Background, Assessment, Recommendation

SEQOL	Social Enterprise Quality of Life
SHMI	Summary Hospital Level Mortality Indicator
SHOUT	Sepsis, Hypovolemia, Obstruction, Urine Analysis, Toxins
SOPs	Standard Operating Procedures
SOS	Swindon Outreach Scoring System
SSNAP	Sentinel Stroke National Audit Programme
STEIS	Strategic Executive Information System
TEP	Treatment Escalation Plan
TV	Tissue Viability
TVNC	Tissue Viability Nurse Consultant
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WHO	World Health Organisation
WRES	Workforce Race Equality Standard