NHS
Great Western Hospitals
NHS Foundation Trust

Quality Accounts

2017-2018

Service Teamwork Ambition Respect

Contents

1 Our Commitment to Quality – Statement from Nerissa Vaughan Chief Executive dated 17th May 2018

I am pleased to present our Quality Accounts for 2017/18.

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.

This has been a year of continued transformation and hard work by our staff to meet the pressure of increasing demand alongside improvements in the quality of care we provide to patients and working to build a more integrated approach to health and care in Swindon.

Over the last year the response to improvement work following our Care Quality Commission inspection in 2015 was evident in the positive feedback received during our follow-up inspection in 2017. There remain a number of areas to improve on but we continue to move in the right direction, with nearly two thirds of our services now rated as good or outstanding, as we rightly place patient safety at the centre of everything we do. There is much to celebrate and many examples of exemplary and innovative care.

These achievements are testament to the efforts and commitment of our 4,500 dedicated staff working at the Great Western Hospital and across the community in Swindon.

We have continued good work helping us to identify deteriorating patients sooner, implementing and embedding the national Early Warning Score across the Trust, including community areas.

We've had zero hospital MRSA blood stream infections during 2017/18 and we've seen a 13% reduction in hospital attributable E.coli blood stream infections. A gram negative reduction plan has been implemented across both acute and community services with the intention of reducing risk factors associated with the development of all gram negative blood stream infections.

Looking forward, as the population of Swindon, as well as surrounding areas, continues to grow at pace and above the national average we are constrained by the size, capacity and flexibility of our estate and face a considerable equipment replacement programme. Therefore addressing our capacity gaps from both a physical space and a workforce perspective are top priorities to continue to deliver high quality care for local people.

Continuing as we are is not an option so we are prioritising opportunities to further develop the Integrated Care System model in Swindon, following local development of an operating model during 2017. As is the case across the UK, health, social care and community services in Swindon are currently being delivered within a fragmented and complex system, which is as a result of a complex web of services developing not as a system but independently. While good progress has been made in terms of understanding the gaps in service, the challenge to redesign services to ensure a more integrated and efficient approach to the delivery of care across the health and social care system will feature as a key aim for 2018/19.

Following stabilisation of the Swindon Community Health Service during 2017/18, greater collaboration is now required with the acute hospital with particular regard to integrating urgent and ambulatory care, older people and stroke pathways.

Demand in our Emergency Department continues to be high, particularly over the winter months, but despite this our performance against the 4 hour standard was better in the first three months of 2018 compared to same period in 2017, February was 9% better and placed us 26th in country out of 133 Trusts, this was largely due to the hard work and commitment from our staff.

Our Brighter Futures team have worked incredibly hard over the last few years and have now raised £2.2 million of the £2.9 million needed to help bring radiotherapy to Swindon.

This service, to be run by Oxford University Hospitals on the GWH site, will massively improve patient care and we aim to reach our target by the end of the summer which we hope will coincide with the start of the building work for the centre.

As we move into 2018/19 we will increase the capability for quality improvement within the organisation so that it becomes an embedded way of working across everything we do. We will continue to look at new ways of working and how technology can help, such as improving translation services. We will be engaging with our communities at a number of listening groups and working with other partners in the health and care system to further integrate services and improve patient experience.

Nerissa Vaughan

Chief Executive

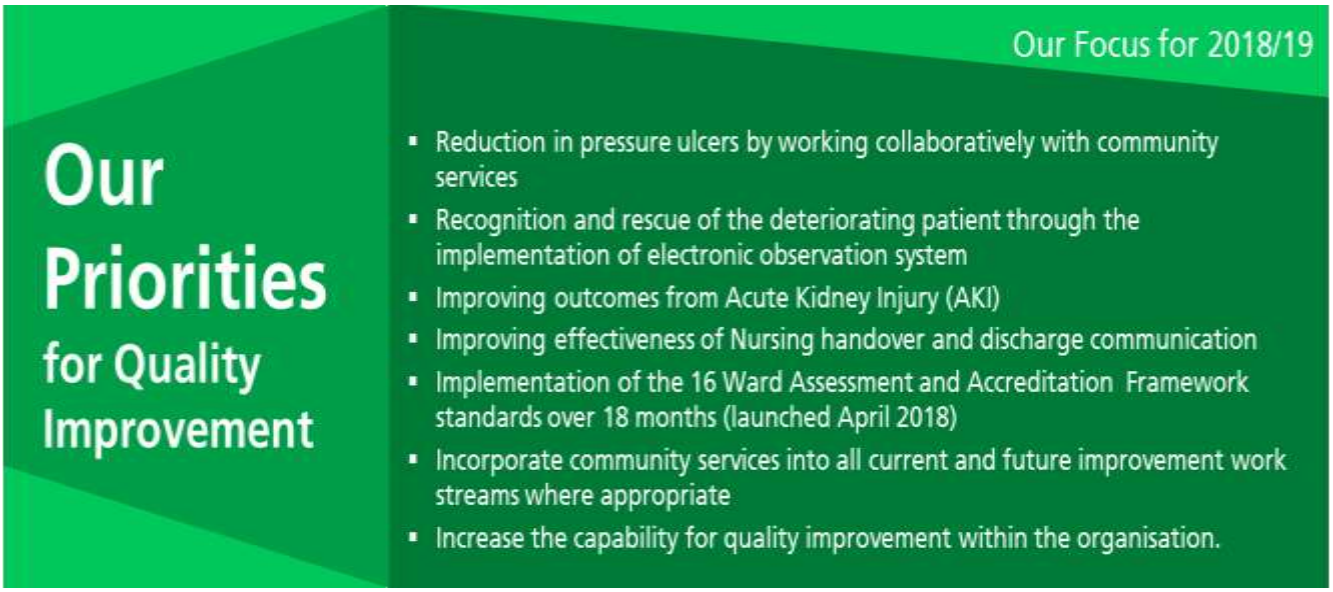
2 Priorities for Improvement & Statements of Assurance

2.1 Priorities for Improvement 2018/2019

This section reflects on the priorities for improvement we will set for 2018/2019 and progress made since the publication of 2016/2017 quality report.

2.1.1 Our Priorities for 2018/19

Our 2018/19 priorities are informed by both national and local priorities including the Sign up to Safety Campaign, learning from incidents, projects supported by external NHS and professional bodies. 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 shaped using feedback, comments and learning through investigation processes. This practice includes our patients, carer's, service users and staff. 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 which continues to be measured through our quality improvement steering groups and monitored and reported through our Patient Quality Committee, Quality Governance Committee and Trust Board.

As part of this over-arching campaign the Trust has continued in its commitment to the national Sign Up To Safety programme. During 2017/18 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)

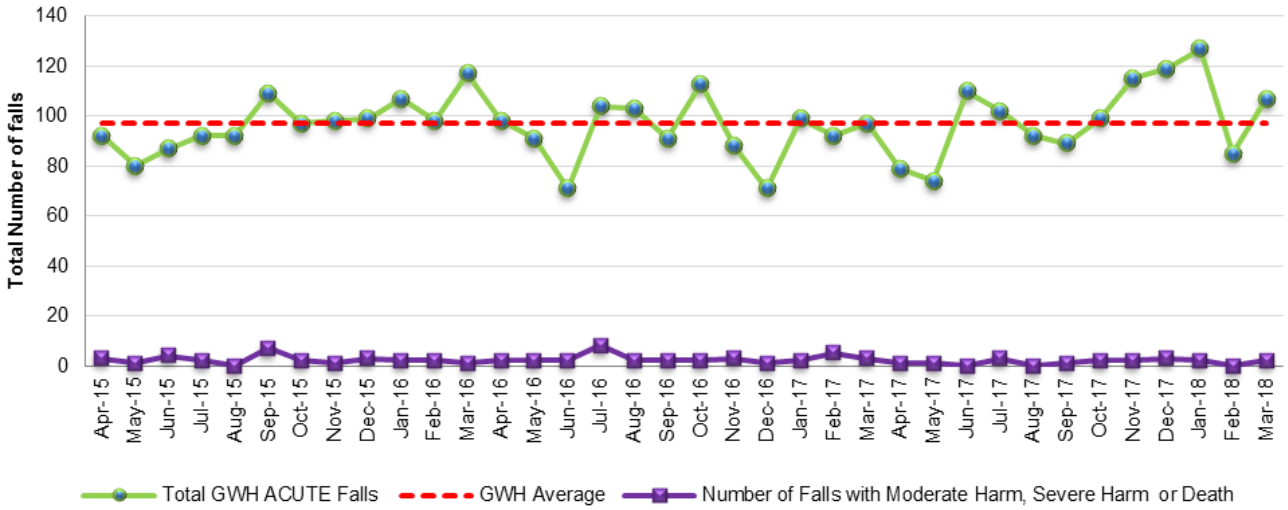
Reducing falls

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

- On average 99 falls were reported within the Trust each month during 2017/2018. This is an increase on the previous year where we reported an average of 93 falls for 2016/2017.
- Our level of harm has reduced by 50% during 2017/2018 where we reported 18 falls resulting in moderate or severe harm compared to 34 falls during 2016/2017.

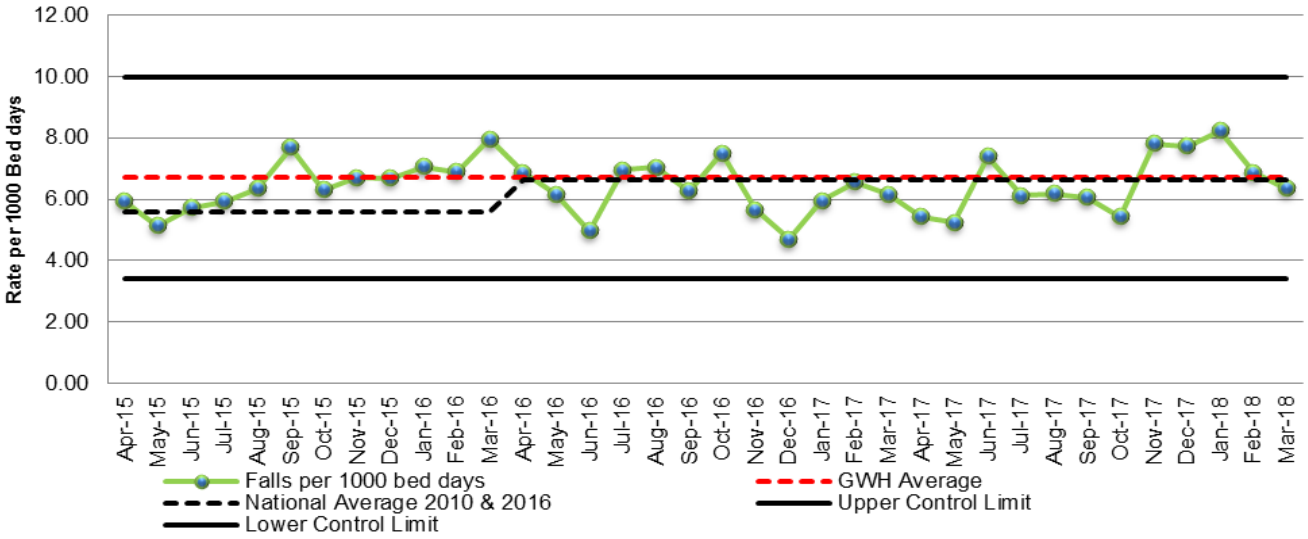
Although the Trust has experienced an increase in the number of falls the level of harm reported for 2017/18 has reduced by 50%. In July 2017 the Trust merged with Swindon Community Health Services which included the reporting of two rehabilitation wards.

Total falls across the Trust



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

Falls Rate per 1000 Bed Days



The chart above demonstrates the Trusts fall rate per bed days with an average rate of 6.56 for 2017/2018.

What improvements have we achieved?

In 2017/18 we reported 8 falls as moderate harm, 50% less than last year (16 falls), 10 as severe harm, 33% decrease on the previous year (15 falls) and zero deaths (2 were reported during 2016/17).

Drivers for improvement

- The Trust made improvement in 6 out of 7 indicators of the National Falls Audit for the Royal College of Physicians in May 2017, work will continue during 2018/19 to further improve against these indicators.
- Revision of the post falls incident form providing valuable data by identifying time, location and patterns of falls along with identification of factors causing falls. This information allowed staff to change and improve on how they care for patients at risk of falling.
- All Ward Managers/Allied Health Professionals are attending our monthly Falls Operational Group meetings to share learning.
- Joint working with Swindon CCG and Bone Health Collaborative.
- Digital Reminiscence Therapy (Interactive multimedia to stimulate personalised memories) equipment was used across the Department of Medicines for the Elderly (DOME) wards.
- Quality improvement projects for preventing deconditioning syndrome (an improvement project to get patients up, get dressed and keep moving) in various wards.

Further Improvements identified and our priorities for 2018/19:

- Review and update Falls Avoidance and Safety Rails Policy
- Review national falls audit from Royal College of Physicians and adopt recommendations
- Falls prevention measures form part of Ward Assessment and Accreditation Framework

Reducing avoidable pressure ulcers

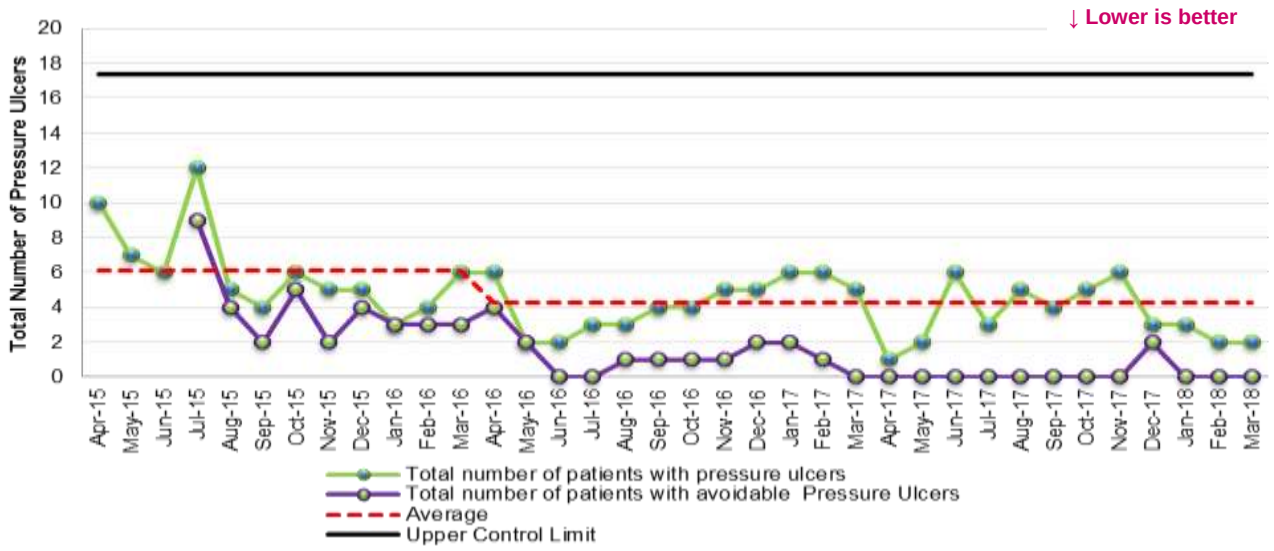
Pressure ulcers typically affect patients with health conditions that make it difficult to move, in particular patients sitting for long periods of time or confined to lying in bed.

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

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

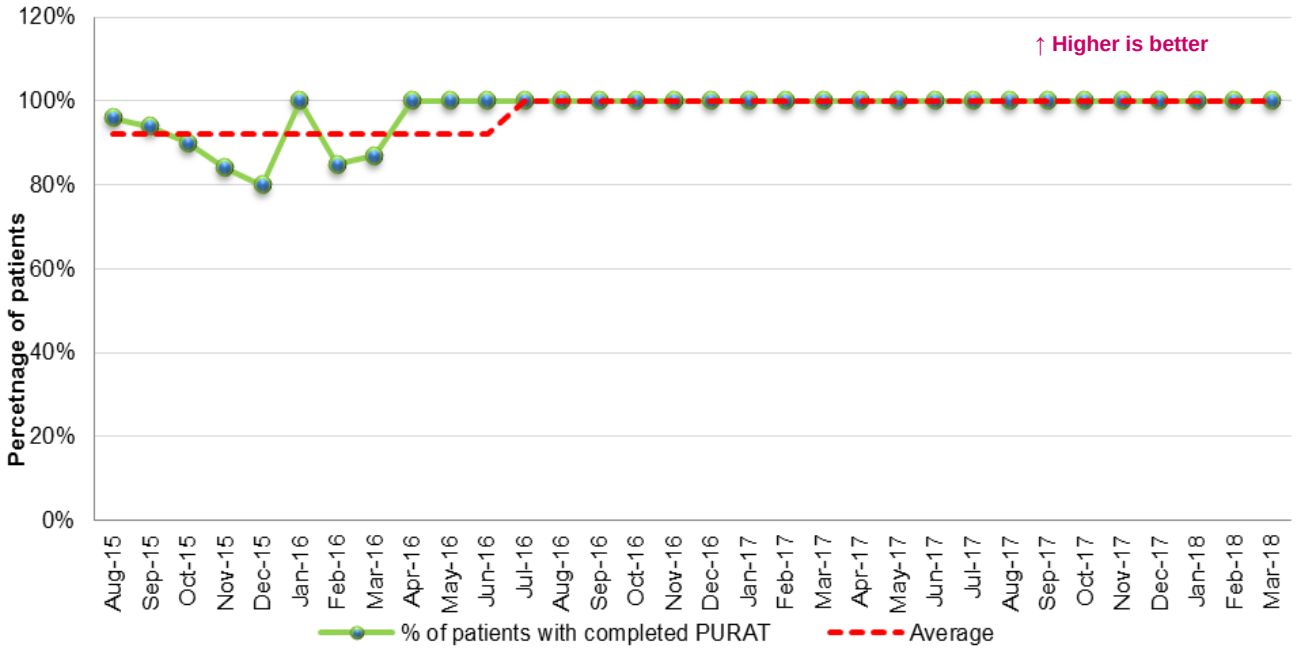
- We reported an average of 3 patients per month with pressure ulcers during 2017/2018 which is a slight increase on 2016/2017 where we reported 1. This still remains below our objective and on target. Of these pressure ulcers 2 were avoidable (1 Category III and 1 Category IV) pressure ulcers in acute inpatients per month'.

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.

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



The graph above shows the percentage of at risk inpatients that have had a pressure ulcer prevention core care plan completed. Since April 2016, 100% of acute at risk inpatients in a sample of 25 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 5 hot spot wards which are wards where pressure ulcers are most frequently reported.

What improvements have we achieved?

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

  These audits include:

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

- 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 July 2018

Further improvements identified and priorities for 2018/19

- Joint working - with acute and community TVN's to develop wound management course for community services

- Review of the discharge documentation - support the review of the discharge paperwork (Led by Acute and Community Matrons) and on-going referrals on discharge from acute care to community and GP practice nursing teams.

- Trial and roll out E-referral - to the Tissue Viability Service along with springboard pointers (prompts within e-referral system)
- Education and learning from incidents - Educational poster raising pressure ulcer awareness to be printed and distributed Trust wide.
- Educational sessions to continue supporting the Academy with on-going programmes - Health Care Assistant mandatory training; the Stepping up programme; Care of the older person's course; Accelerated return to learning and Trainee Assistant Practitioner course.
- Pressure Ulcer Working Group to be established with TVN's from both the Community and Acute services.

Acute Kidney Injury (AKI)

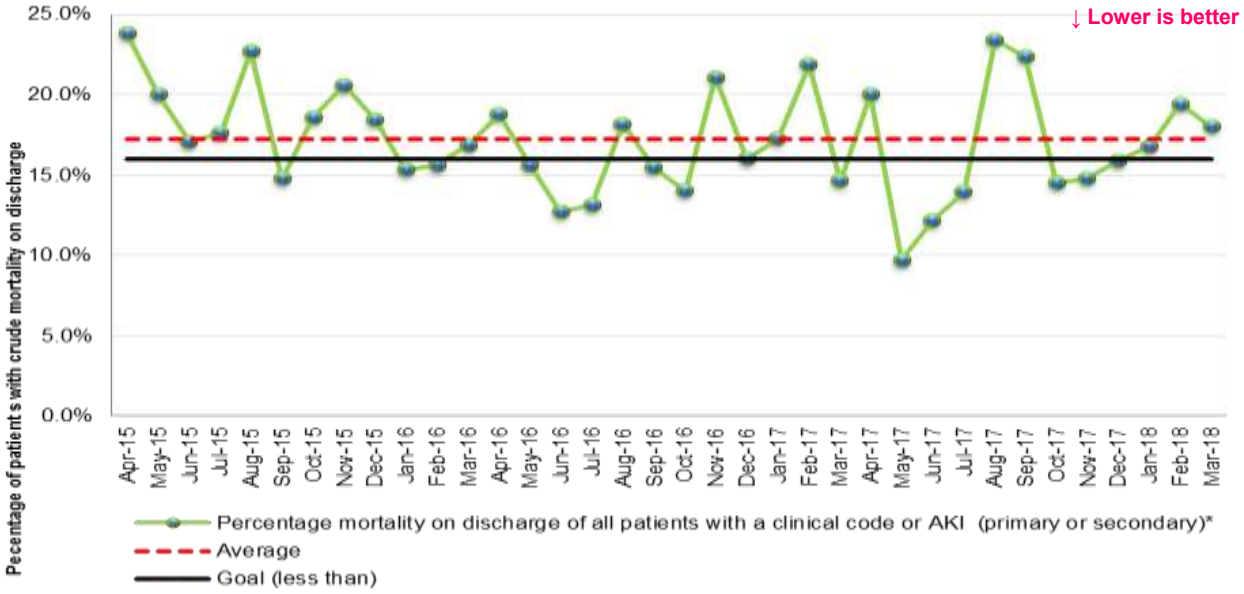
Acute Kidney Injury (AKI) is a sudden deterioration in kidney function that affects up to 20% of patients (1 in 5) admitted to hospital. It can range from minor loss of kidney function to complete kidney failure, and in the most serious cases can lead to death.

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.

- During 2017/18 we reported an average of 16% of our patients die each year in our hospital with Acute Kidney Injury. This is a decrease on last year where we reported an average of 16.6% and have sustained our objective.

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.

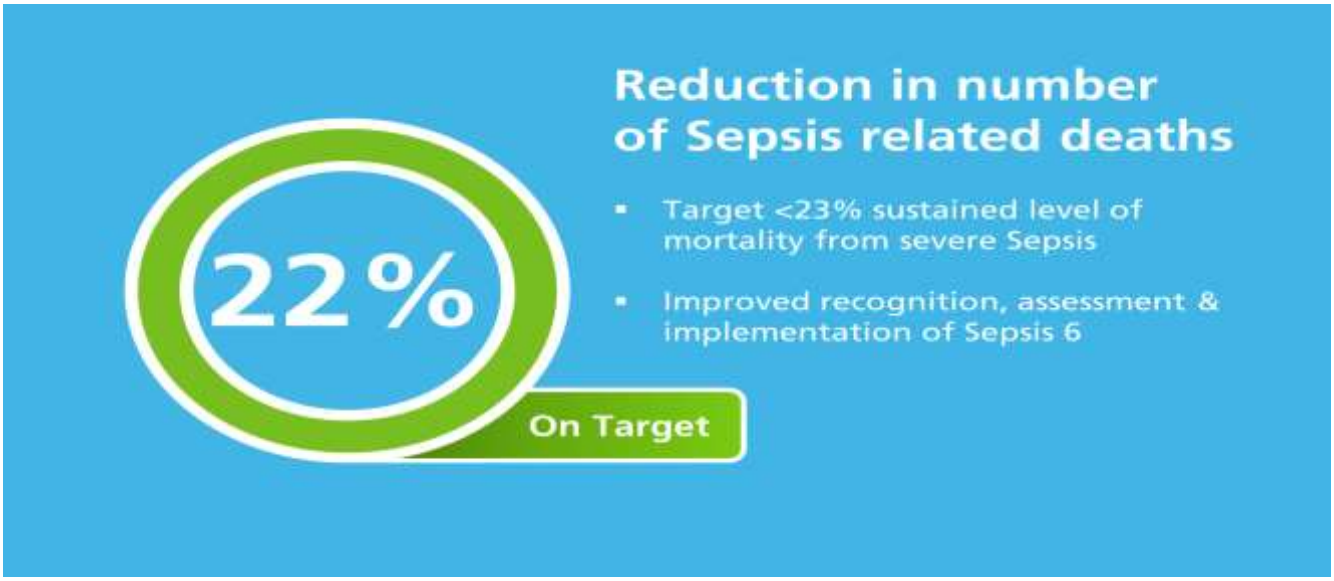
What improvements have we achieved?

- 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 which focuses on early treatment of Sepsis, Hypovolaemia, Obstruction, Urine Analysis and review for nephrotoxins (SHOUT). Patients flagged with AKI receive five standard elements of care proven to be effective in managing AKI and complex patients are managed with input from our on-site Nephrologist Dr Tanaji Dasgupta (Project Lead) so that patients with tertiary care are identified for timely transfer.
- Ward pharmacists carry out medicine reviews of all patients flagged with AKI to determine the most appropriate medication to manage their AKI and aid recovery.
- A new Acute Sepsis and Kidney Injury (ASK) Team was recruited and launched in October 2016 with support of Brighter Futures and charitable funds. 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. Funded by Brighter Futures the team also work with staff across the organisation and healthcare partners such as GPs to raise awareness of the signs and symptoms.
- Data from our Trust is shared with the Renal Registry as part of national benchmarking and we are also participating in regional quality improvement initiatives in collaboration with the Oxford Academic Health Science Network.

Further improvements identified and priorities for 2018/19

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

Sepsis



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

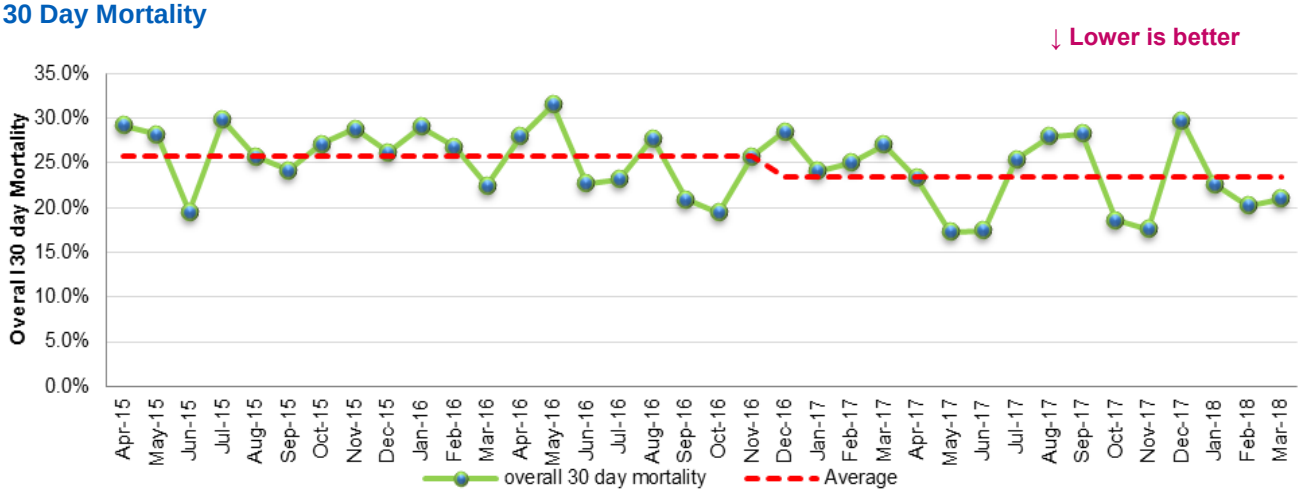
Each year in the UK, it is estimated that more than 250,000 people are admitted to hospital with sepsis and at least 46,000 people will die as a result of the condition. (UK Sepsis Trust 2017).

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

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

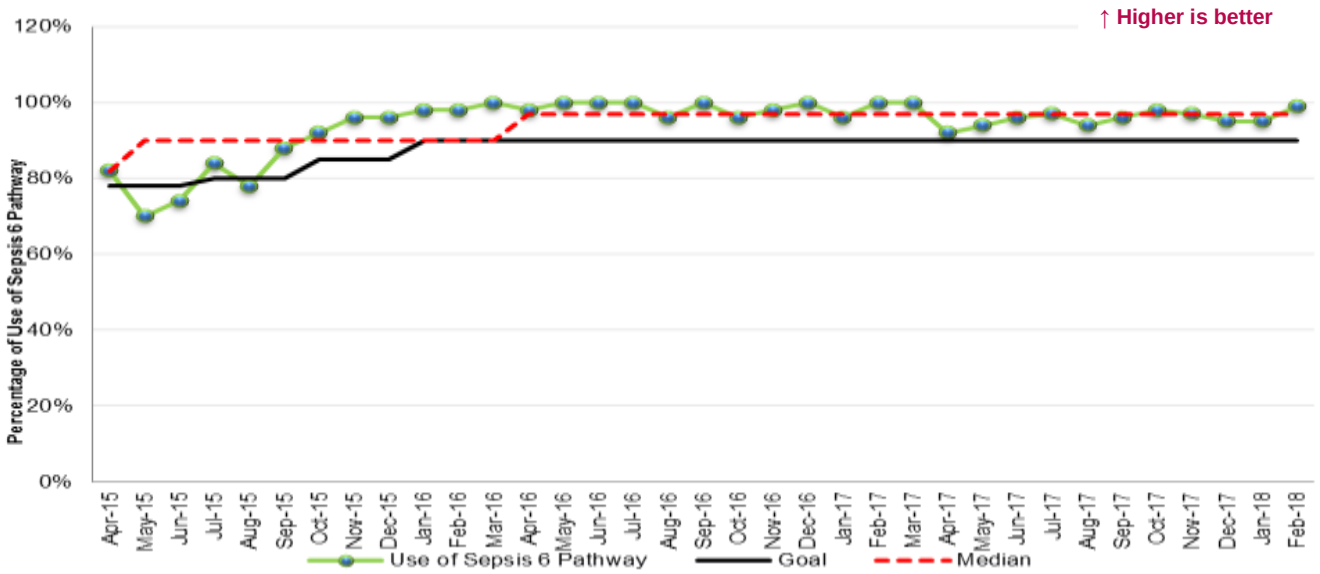
Throughout 2017/18 we reported an average of 22% patients admitted with severe sepsis died within 30 days of discharge. Whilst this is an increase on the previous year, where we reported an average of 15%, the percentage remains under our target of <23%.

30 Day Mortality



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

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



What improvements have we achieved?

- ASK Specialist Nurses Team have now been fully recruited. Seven-day service has been running since November 2017.
- Focussed teaching around Sepsis Management and Sepsis Tools is on-going and was recently delivered to our gynaecology and acute stroke wards.
- 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 Trust.
- 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 2018/19

- Adapt our sepsis working group to incorporate AKI and the patient perspective.
- Continue to provide ward-based simulation training on the management of Sepsis and use of Sepsis 6 Care Bundle
- Continue our trial of an antibiotic review at 72 hours on acute 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.
- Expand the trial with the use of antibiotic grab bags (pre-prepared fully inclusive sepsis package) to reduce the time taken to administer antibiotics. In addition we are also planning a grab-bag for penicillin allergic patients.

Recognition and Rescue of the Deteriorating Patient

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

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

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

- During 2017/2018 we reported an average of 0.79 cardiac arrests per 1000 Bed Days. This is an improvement on last year where we reported an average of 0.88 cardiac arrests per 1000 Bed Days.

What improvements have we achieved?

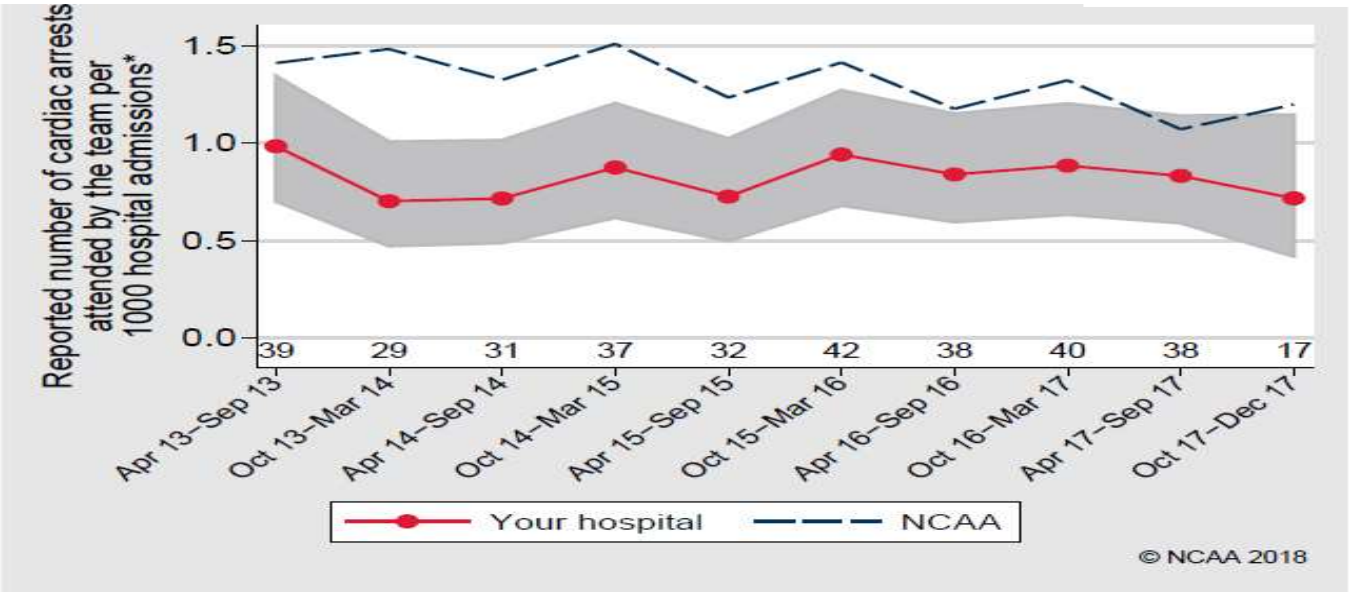
- Fully implemented and embedded the standardised National Early Warning Score (NEWS) Trust Wide, including community areas – monthly audits continue to provide assurance on compliance and accuracy
- Imminent introduction of Nervecentre – Electronic Observations (Summer 2018) Electronic capture, calculations of NEWS, and automated cascading escalations to ensure recognition is followed by rescue.
- Simple Observation Capture (A hand held device for easy capture of observations that automatically calculates News scores)
- Immediate Alerts
- Due and Overdue Reminders
- Adults and Paediatrics
- Cascading Escalations
- Once Electronic-Observation has been introduced the Trust will switch over to NEWS2 by end of September 2018. (NEWS2 is the next evolution of early warning scoring)
- New Matron lead for 24/7 Critical Care Outreach Team
- All cardiac arrest within the Trust are reviewed to assess if they were avoidable / unavoidable
- Introduction of the Ward Assessment and Accreditation framework, which rates each clinical area on their effectiveness in responding to the deteriorating patient.
- Hospital at Night – As of January 2018 an advanced clinical practitioner (ACP) has been rostered every night to support medical ward work until the end of March 2018. This supported the Foundation Year 1 Doctors (FY1) to manage their work load and provide support on the wards.
- The following tasks were allocated to the ACP, which allowed the FY1 to review the more unwell and deteriorating patients on the wards:

- Escalating NEWS score / deteriorating patient
- Cannulation / venepuncture
- Review of Intravenous fluids
- Confirmation of death
- Catheterisation
- NG tube insertion

A case for permanent ACP to provide Hospital at Night cover has been established and results from this current trial will be collated.

Rate of Cardiac Arrests per 1000 hospital admissions

↓ Lower is better

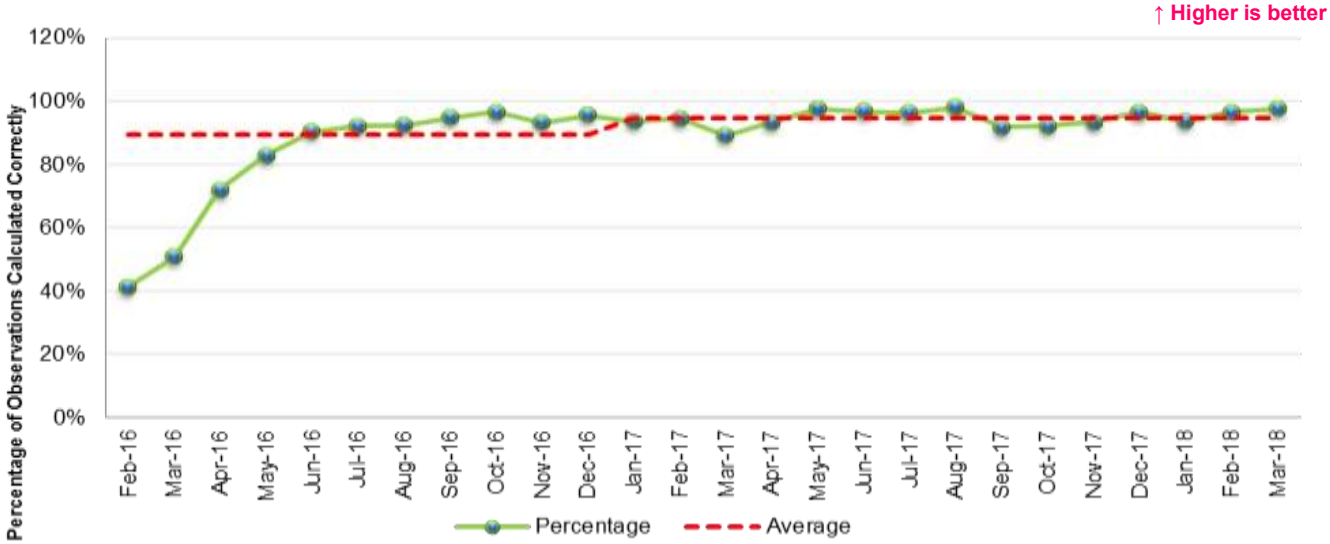


The chart above shows our cardiac arrests per 1000 hospital admissions for the period of 01 April 2017 – 31 December 2017 in comparison to National Cardiac Arrest Audit (NCAA).

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. The Trust's average rate of cardiac arrest per 1000 admissions is 0.79 for April 2017 – March 2018.

Percentage of Observations with NEWS Score Calculated Correctly

↑ Higher is better



The chart above shows the percentage of patients Trust wide with a NEWS Score calculated correctly. We have achieved an average of 95% and above from January 2017.

Further improvements identified and priorities for 2018/19

- Joint medical & nursing lead to continue to lead the deteriorating patient project
- To introduce and embed Electronic -Observations into the acute Trust

- To move to the next stage of electronic observation (NEWS2) by the end of September 2018
- Business case for Advanced Clinical Practitioner to support 'hospital @ night' project to be presented
- Continuation of ward-based simulation training & introduction of short trolley teaching rounds carried out on ward area's planned.

Quality Improvement Capability and Capacity

Quality improvement skills are beginning to develop within the organisation; Staff are actively sign posted to external providers such as the Academic Health Science Networks for formal QI training. Quality Improvement toolkits have been developed and are available on the Trust Intranet site.

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

Six members of staff have joined the Health Foundations Q Community, gaining access to regional networks and training opportunities.

Further improvements identified for 2018/19

A business case setting out proposals to increase capacity to develop and deliver a plan to build the organisations quality improvement capability and capacity has been drafted.

Progression of this business case during 2018/19 will be a key to achieving the following priorities:-

- Development, delivery and evaluation of a strategy and plan to build organisation wide knowledge and skills in quality improvement;
- Assessment of organisational quality improvement capability and capacity;
- Delivery of a coordinated programme of training to provide staff with the skills and knowledge to use QI methodology in practice
- Provision of coaching support to individuals and teams undertaking quality improvement projects;
- Project leadership for high risk Trust wide projects such as Handover, delaying change and improvement

Identify key members of staff to apply for membership of the Health Foundations Q Community during the next application round.

Celebrating Success

Due to the success of our first Speak out on Safety Event held in September 2016 where 75 members of staff and external stakeholders attended the event and Martin Bromley, Chair of the Clinical Human Factors Group was a guest key speaker, we are holding our 2nd Speak out on Safety Event on 8th June 2018.

This full day event with have guest key speakers Adrian and Emma Plunkett 'Learning from Excellence' and Jonathan Peach @Art of Brilliance'.

This event will also cover key quality improvement work streams under our Sign up to safety campaign and opportunities for staff to share 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.

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

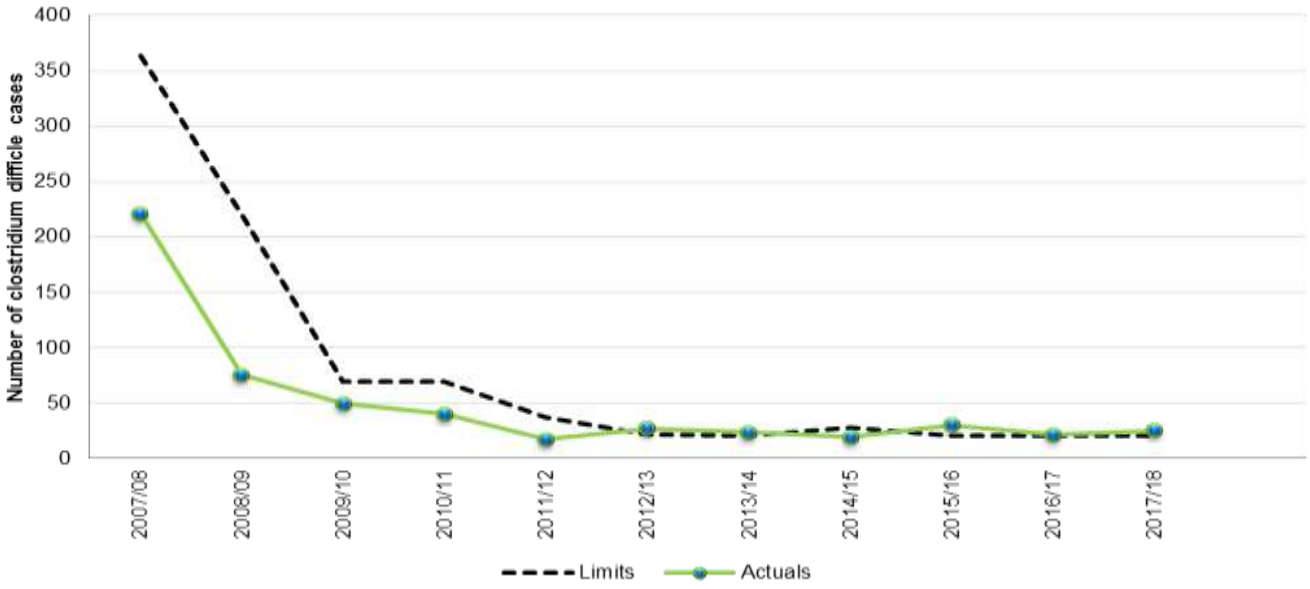
The nationally mandated goal for 2017/2018 was to report no more than 20, Acute or Community Hospital, cases of C.diff. We have reported 25 cases, 4 more than 2016/2017. Each case has been investigated in conjunction with our Commissioners. Of the 25 cases, 16 have been deemed unavoidable and five have been deemed as avoidable and care improvement recommendations made. 4 cases remain pending an investigation outcome.

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

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

Number of *clostridium difficile* cases 2017/2018

↓ Lower is better



The graph above shows the numbers of reported *Cdiff* cases in from 2007 through to 2017/18.

Our priorities for 2018/19

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

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

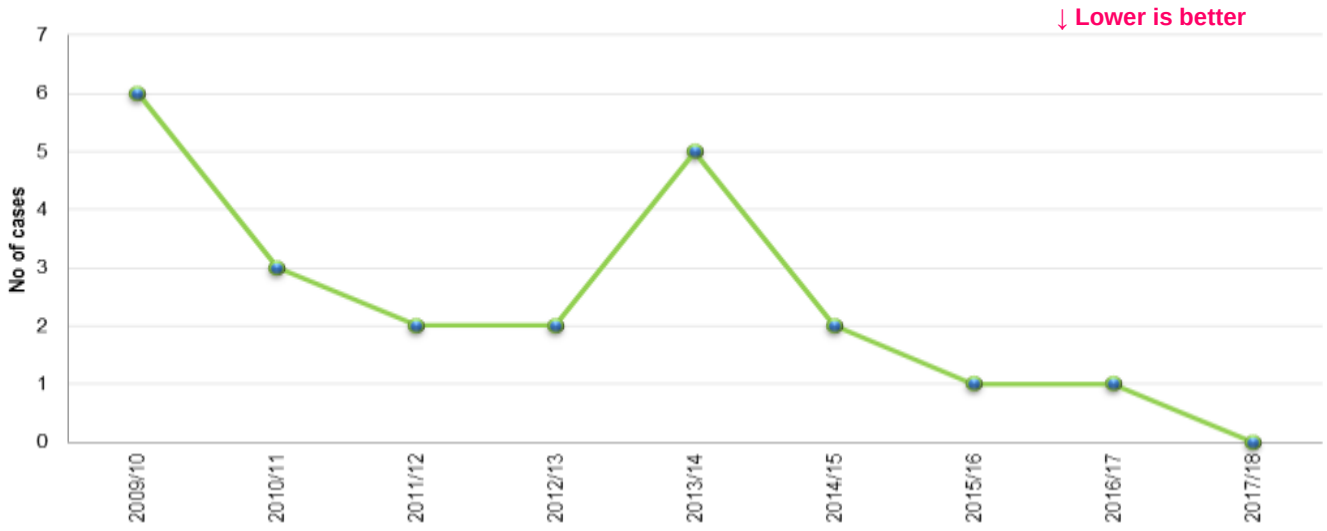
Methicillin Resistant Staphylococcus Aureus (MRSA)

During 2017/18, the Trust met the national target of reporting zero cases of MRSA bloodstream infections.

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

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

Acute Cases of Trust Apportioned MRSA Bacteraemia



The graph above shows the number of cases of Trust apportioned MRSA bacteraemia to Great Western Hospitals NHS Foundation Trust up until 2017/18**.**

Our priorities for 2018/19

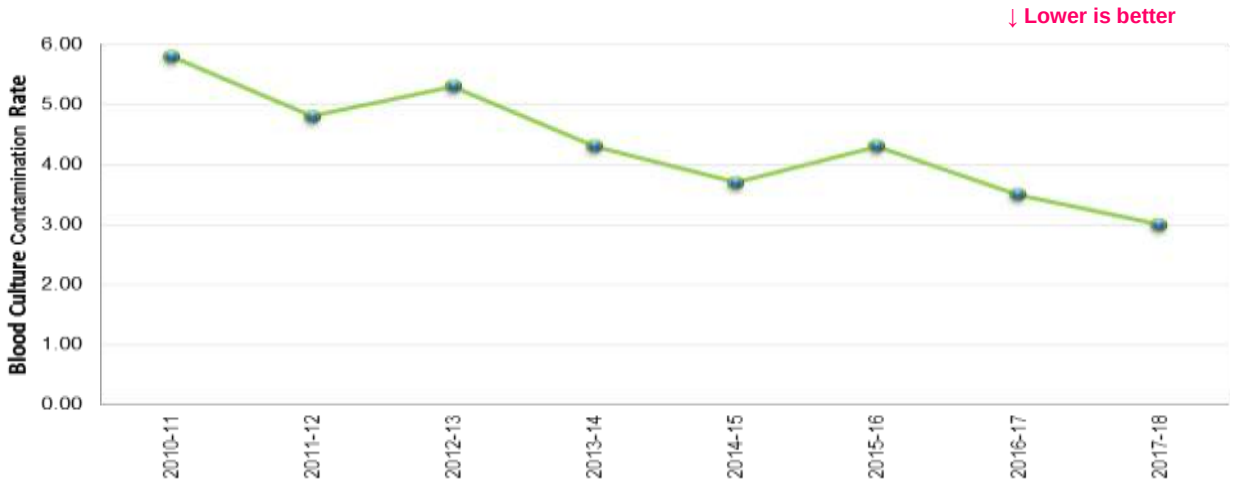
We plan to continue prompt management of patients displaying red flags for sepsis.

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

The focus for 2018/19 will be on sustaining the reduction in blood culture contamination rates which is recommended to be below 3%.

In 2017/18 the average contamination rate was 3%. Rates have been reducing on a year on year basis since 2012/13.

Trust-wide Blood Culture Contamination Rate 2010 -2018



The graph above demonstrates the Trust's blood culture contamination rate from 2010 through to 2017/18 where the Trust achieved the recommend rate of 3%.

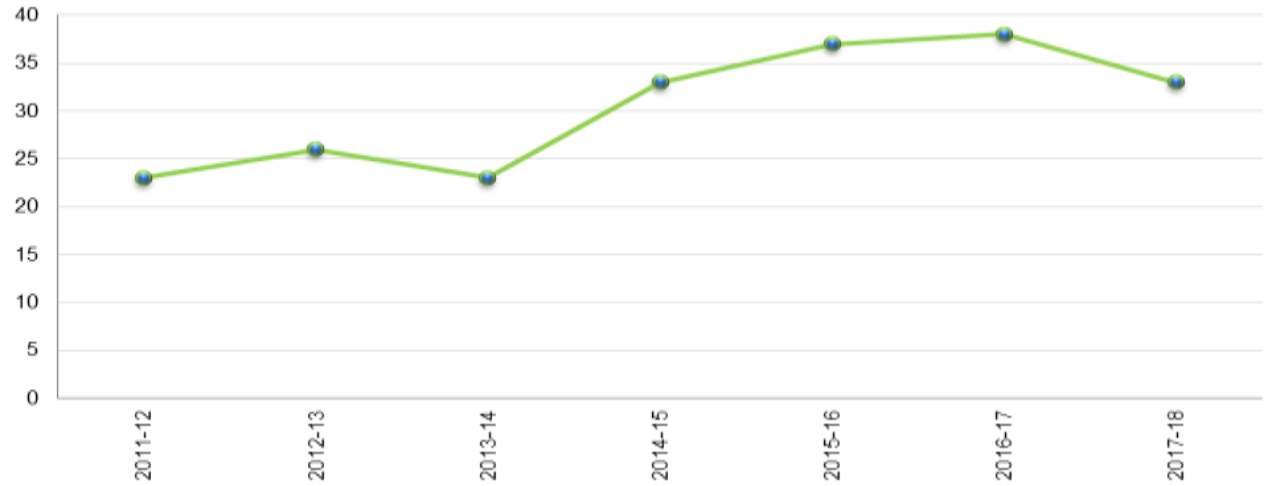
In line with national requirements, the submission of E.coli data to Public Health England (PHE) has become mandatory. From April 2017, it became mandatory to report data on other gram negative blood stream infections, Klebsiella spp and Pseudomonas aeruginosa.

During 2017/18, no targets were set for E.coli, Klebsiella spp and Pseudomonas aeruginosa blood stream infections (BSI).

A total of 33 E.coli BSI, eleven Klebsiella spp BSI and 18 Pseudomonas aeruginosa BSI have been reported in acute trust patients, this encompasses patients in whom the specimen was taken 48 hours after admission to hospital, during 2017/18.

Number of Trust Apportioned E.Coli Blood Stream Infections

↓ Lower is better



The graph above shows the number of cases of Trust apportioned E.coli BSI to Great Western Hospitals NHS Foundation Trust up until 2017/18.

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

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

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

Our priorities for 2018/19

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

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

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

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm, or death, does not have to be the overall outcome of an incident for it to be categorised as a Never Event under the NHS Never Events framework.
We have reported one never event between April 2017 to March 2018. We see no significant variance in the reporting of Never Events as we reported one Never Event for the same time period in 2016/2017. The following Never Event was reported in April 2017:

- Wrong site surgery

The incident has been reported and investigated and managed through the Trusts Incident Management and Clinical Governance process. An action plan was developed, with implementation of recommendations monitored by our Patient Quality Committee. The final incident report was also shared with the patient, 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 2017;

- Current methods of tooth identification prior to dental extraction was reviewed. Where it was not practicable to mark tooth or teeth, then alternative marking processes were considered.
- A pause and check process has been implemented immediately prior to each individual extraction. Allowing the dental surgeon time to concentrate and confirm the exact tooth for extraction.
- The pause and confirmation step is a verbal read back from a second person (Normally Dental Nurse) to confirm the location of the tooth for extraction according to the Radiological investigations available, and as per the patient's signed consent.
- The WHO Surgical Safety checklist has been reviewed, and amended to include a pictorial diagram of a jaw, and is completed during "Time Out" to confirm the location and number of the teeth to be extracted.

Continually learn - Reduce Incidents and Associated Harm

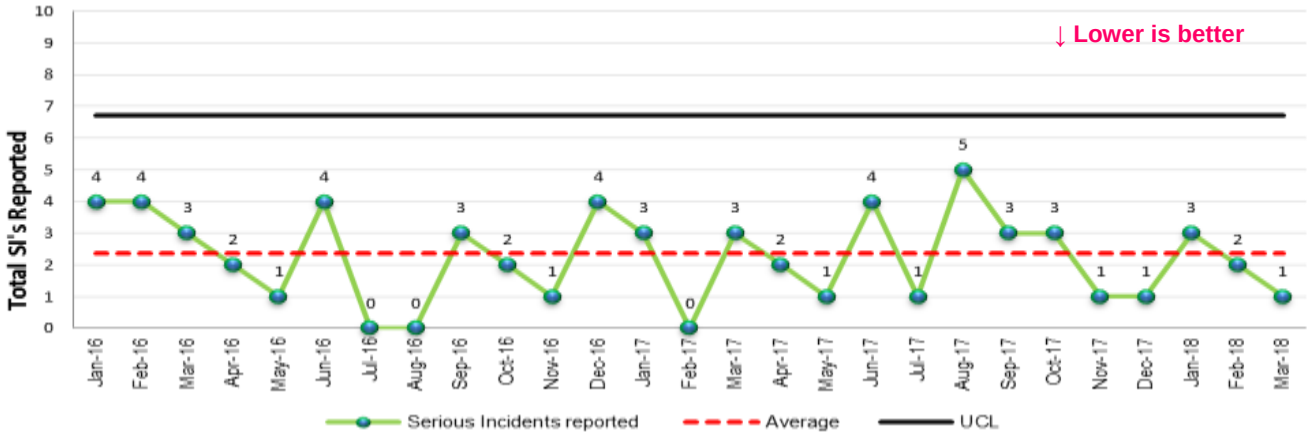
Serious incident reporting

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 27 serious incidents were reported and investigated during the period April 2017 to March 2018. This is an increase of 1 serious incident compared to 2016/17.

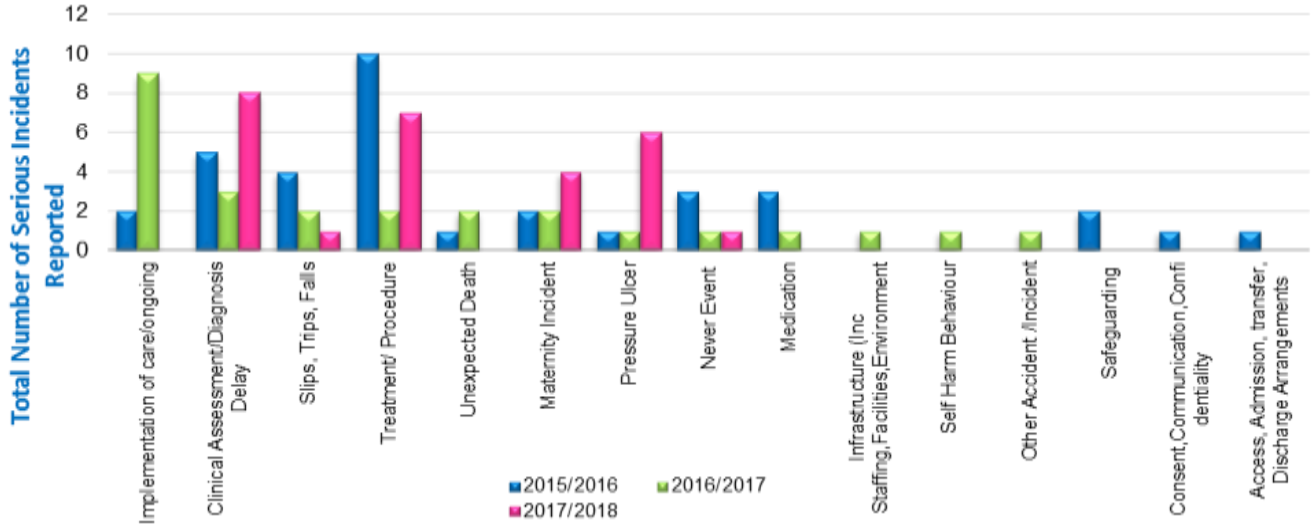
- All patient safety incidents that were reported within the Trust were submitted to the National Reporting and Learning System. Our reporting performance is evaluated against other medium acute Trusts within the cluster group biannually following the publication of the NRLS Organisational reports.
- All Serious Incidents were reported to our Clinical Commissioning Groups and to the Strategic Executive Information System (STEIS) system.

Serious incidents reported 2017/18



The graph above shows the number of serious incidents reported in 2017/18.

Serious incidents reported by type in from 2015/16 – 2017/18



The graph above shows the Trust's serious incidents reported by in 2017/18 compared to previous years broken down by category.

The most frequently reported types of serious incident are:-

Problems with Clinical Assessment which includes delays in Diagnosis, Interpretation and response to diagnostic procedures and tests;

- Treatment Procedure
- Pressure Ulcer's

The increased number of incidents involving problems with Clinical Assessment which includes delays in Diagnosis, Interpretation and response to diagnostic procedures and tests is due in part to improved reporting of incidents and Human Factors.

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

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve the number of Never Events reported and the quality of its services, the actions specifically relate to clinical assessment, delays in diagnosis and interpretation and response to diagnostic procedures and tests:

- Develop a Child and Adolescent Therapeutic Holds and Restraint Policy, to include advice in relation to children and the use of therapeutic holds to enact treatment plans.
- Recruitment of 2 further consultant radiologists, this will support a reduction of work load per consultant.
- Radiology plan to work in line with the Royal Collage of Radiologists recommendations in the Clinical radiology workload: Guidance. The department will have a plan in place to meet the requirements regarding image review by June 2018.
- To revise process for removal of dressings used in Negative Pressure Wound Therapy Management.

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

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

- Continue to theme incidents to identify key trends that could influence change which will be shared through all quality improvement work streams to inform work stream initiatives.

- We will continue to share recommendations and learning from serious incidents Trust-wide which inform improvements to systems and processes within specialities.

Incident reporting and benchmarking

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

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

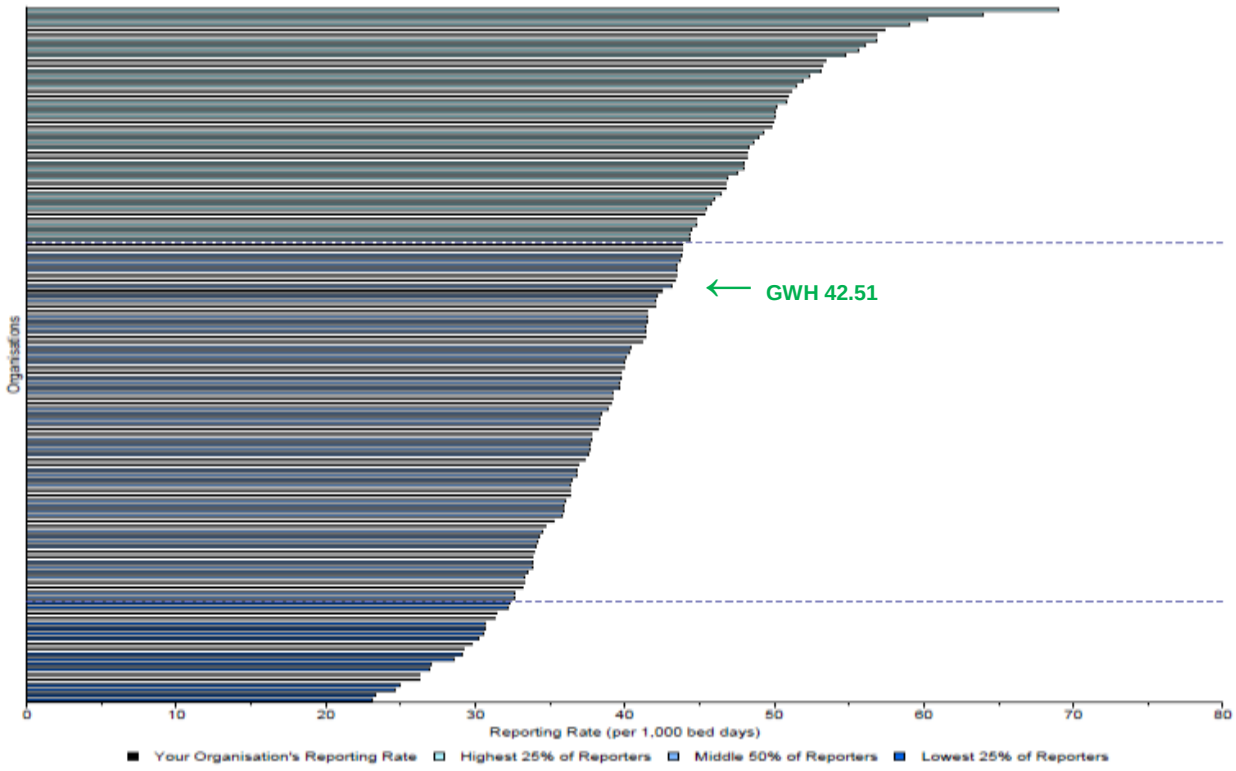
Reporting Year	Non clinical incidents / Health and Safety	Patient Safety Incidents reported to NRLS	Total
2011/2012	2493	6513	9006
2012/2013	2405	6928	9333
2013/2014	3596	6967	10563
2014/2015	4164	6678	10842
2015/2016	4801	6274	11075
2016/2017	4457	8373	12830
2017/2018	3627	7632	11259

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.

Comparative reporting rate per 1000 bed days for 134 acute (non-specialist) organisations

01 October 2016 – 31 March 2017



The Trust reported 3831 incidents between 1st October 2016 to 31st March 2017 with a rate of 42.51 per 1000 bed days. The median reporting rate for this cluster is 40.14 incidents per 1000 bed days.

The Trusts reporting rate has increased from the previous reporting period 01 April 2017 30 September 2017 when 38.44 incidents per 1000 bed days were reported .

During 2017/18 our focus was on improving our reporting culture throughout the Trust through our rebranding of incident reporting from IR1's to Safety Incident Forms. 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.

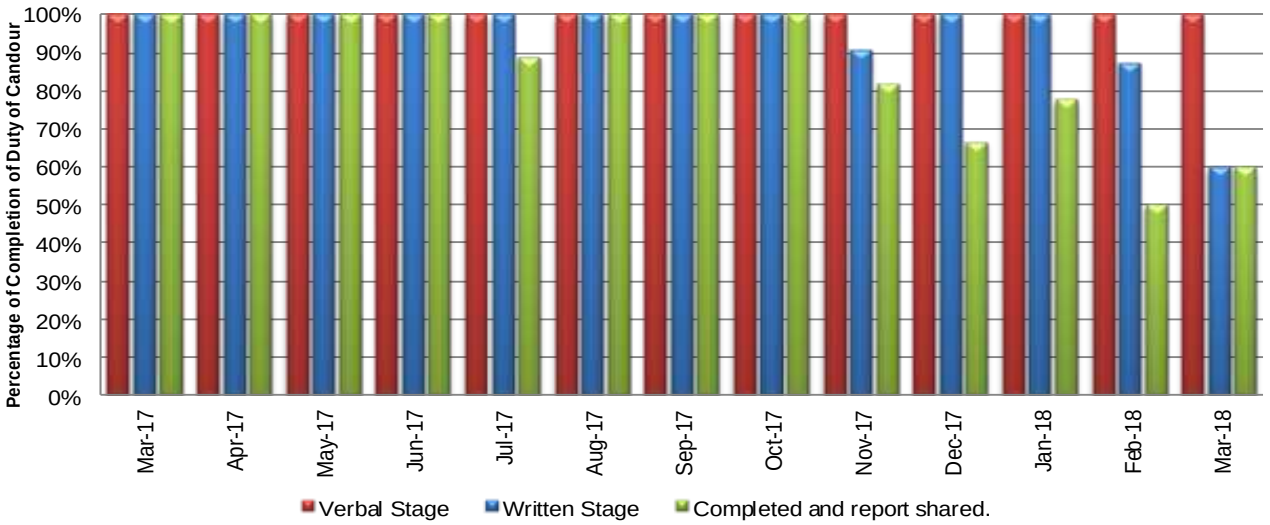
Duty of Candour

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.

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 2018/19

- To continue our modular training programme for Root Cause Analysis (RCA) 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.

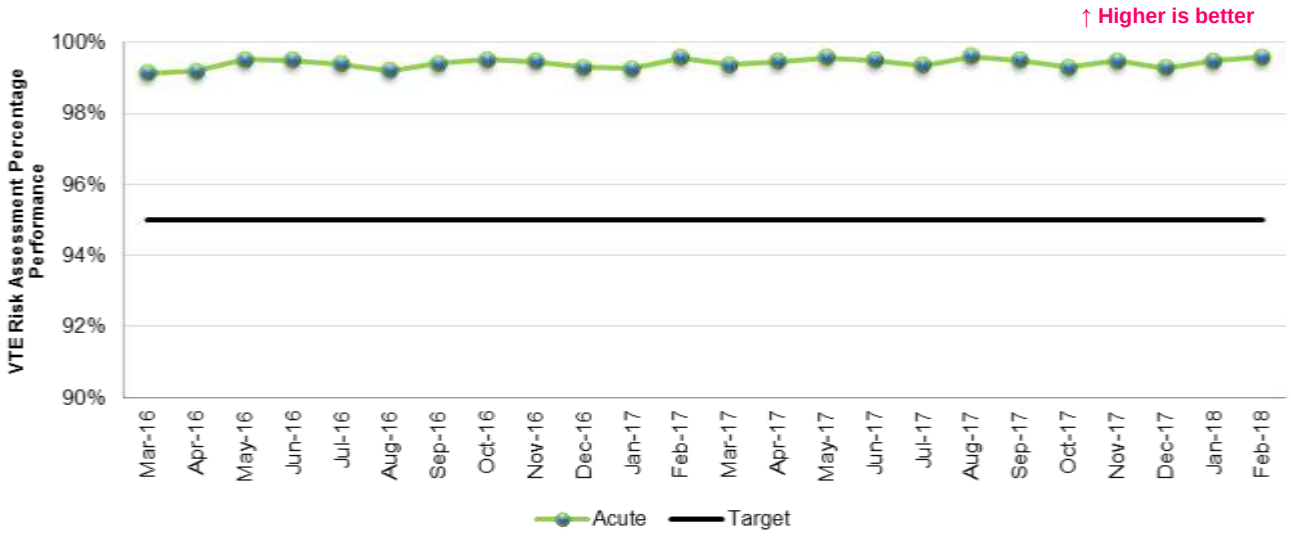
This validation is undertaken bi-monthly and information disseminated to all clinical areas so that any performance requiring review is highlighted.

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.

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

VTE risk assessment performance March 2016 – March 2018



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

Appropriate Prevention and Hospital Acquired Thrombosis Events

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

- Once patients have had a risk assessment we want to ensure that they receive the appropriate preventative treatment. We monitor this using 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

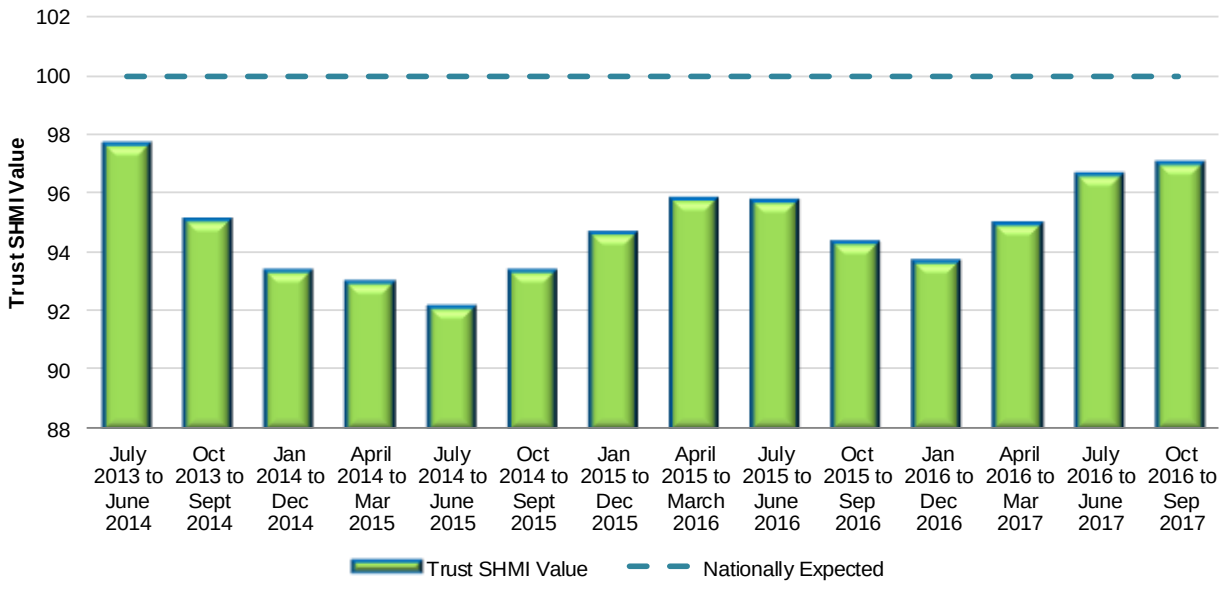
Summary Hospital Mortality Indicator (SHMI)

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 2016 to September 2017 is 97.04, with the confidence limits 92.59 to 101.64 giving the Trust an 'As 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 (January 2016 to December 2016). This is showing a similar trend to the HSMR figures.

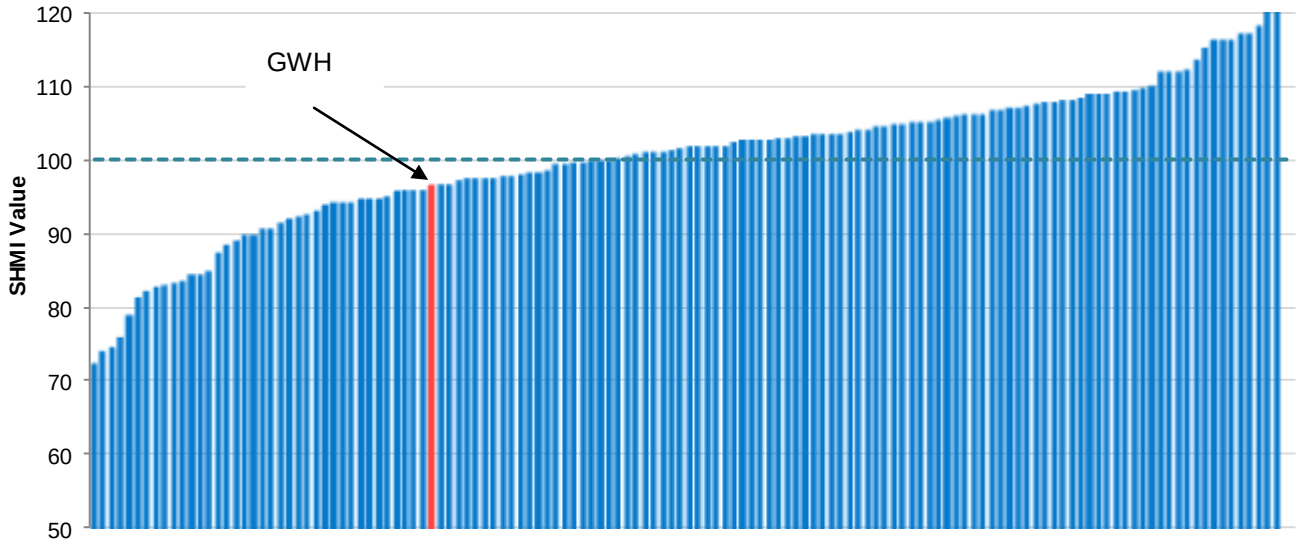
Summary Hospital Mortality Indicator (SHMI) GWH



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

National SHMI October 2016 – September 2017

↓ Lower is better



The chart above shows how the Trust's SHMI compares nationally and demonstrates the Trust was positioned within the lower (better) half overall between October 2016 to September 2017 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 HSCIC

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 January 2017 January 2018

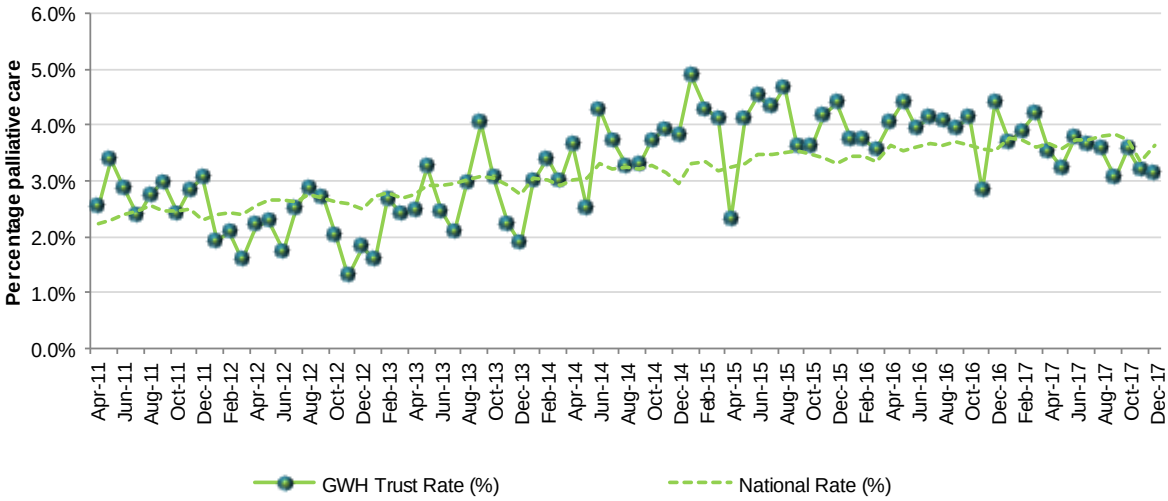
↓Lower is better

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 2017



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. Within the southern region the Trust is just below average for the twelve month period January 2017 to December 2017.

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

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

Priorities for 2018/19

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

Learning from Deaths

During 2017/18, the Trust has introduced a new process for mortality reviews. This has been as part of a collaborative with all hospitals in the West of England. The trusts all worked with the Royal College of Physicians (RCP) as pilot sites for introduction of the Structured Judgement Review (SJR) methodology for undertaking mortality reviews.

At the Great Western Hospital, a new database was established for SJR data entry, for reporting and monitoring and to allow analysis of global data. Reports are produced monthly for both the mortality surveillance group and the patient quality committee. Mortality review performance has been reported at trust board since quarter two. This is reported a quarter in arrears (as reviews cannot be completed until after a patient has died. The data presented below is therefore only for the first three quarters of the 2017/18 year.

As part of the SJR assessment process, in the pilot, the Royal College of Physicians included a scale of avoidability of death. This was subsequently removed from the methodology as published evidence shows that each death needs to be reviewed by five separate reviewers before there is enough agreement to make this judgement valid.

As the reporting requirements include the number of deaths judged to be more likely than not to have been due to problems in care, the data collection tool includes a rating for each death of whether it was more than 50% avoidable. The policy at the Great Western Hospital is that deaths judged to be avoidable are treated as a serious incident. Where care is rated as poor or very poor, this is also treated as a reportable incident.

During 2017/2018 1220 of Great Western Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 212 in the first quarter; 355 in the second quarter; 332 in the third quarter; 362 in the fourth quarter. By 28/03/2018, 294 case record reviews and investigations have been carried out in relation to 1220 of the deaths.

In 4 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 67 in the first quarter; 112 in the second quarter; 71 in the third quarter; 11 to date in the fourth quarter.

These numbers have been estimated using the Structured Judgement Review as recommended in guidance issued by the National Quality Board.

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified. As the SJR process has only been introduced in this financial year, no strong themes have been identified. Now that there are about 300 cases in the database, the mortality surveillance group is starting to explore themes at the monthly meeting.

The collaborative work across the West of England has identified end of life care as an area for improvement and wider work on this is being taken forward by the West of England Academic Health Science Network (WEAHSN)

A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period.

The theme around end of life care has been picked up locally by the end of life working group, which is chaired by the Medical Director. A collaborative event organised by the West of England Academic Health Science Network is due to take place on 7th June to take this work forward on a wider scale.

An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period. As the process has only recently been introduced, a measurable impact on patient outcomes is yet to be seen.

Great Western Hospitals NHS Foundation Trust has made a decision not to use the avoidably scale which was originally set out by the RCP within the National Mortality Case Record Review Programme but removed as it was not appropriate to use rates of avoidability to compare organisations. Alternatively we have asked reviewers if they considered a death was more than 50% avoidable.
So far Great Western Hospitals NHS Foundation Trust has reported 0 deaths due to problems in care.

Implementation of Priority Clinical Standards for Seven day Hospital Services.

Currently the Trust is focussed on the 4 priority clinical standards for 7 Day Services. These have been actively monitored through the twice yearly national audits. A focus is currently underway on the key standard for review in 14 hours, with a review of the rota of the Acute Medical Physicians.

GWH already performs reasonably well on National figures for inpatients being seen as appropriate either once or twice a day throughout the 7 day period.

There is still some work to go for providing routine ultra sonography over the weekend; this is limited by the availability of radiographer staff. Pathways also still need to be confirmed regarding some interventional radiology. However, in summary when benchmarked nationally the Trust services perform reasonably well. Whilst the Trust has a plan to implement 7 day services this is not without cost and the Trust would need to work with Commissioners in order to explore funding routes.

Patient Reported Outcome Measures (PROMS)

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

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

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

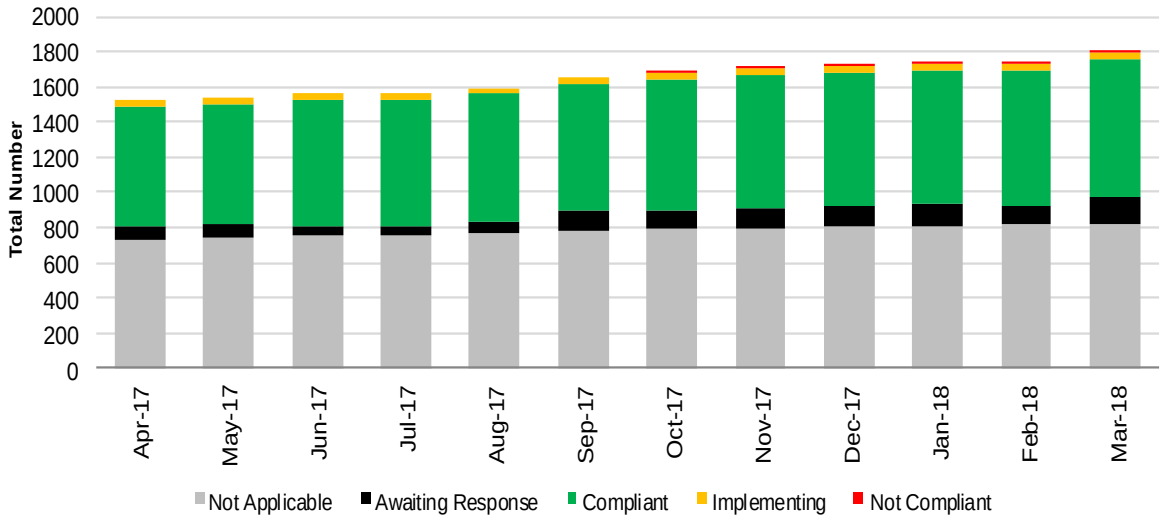
We have currently received a provisional PROMS report for Hip and Knee Replacement which covers the period April 2016 – March 2017. This shows that we were slightly below the average scores in two of the measures. However, this data is un-validated and we have yet to receive detailed data in order to review and understand if there are any specific concerns.

Continue to Monitor and Maintain NICE Compliance

NICE publish evidence based recommendations and standards which healthcare organisations are required to assess and implement where required. Overall, the trust has been assessing NICE guidelines since August 2007 from which time, up to 830 guidelines were assessed as relevant and of which, up to789 have been assessed as compliant (95%).

This year, the trust has received up 297 published guidelines, of which, up to 103 responses (35%) have confirmed they are not relevant to the services, up to 73 guidelines have been confirmed relevant, of which, 65 (89%) guidelines have been assessed and confirmed compliant.
Up to 3 guidelines have action plans in place, bringing the overall number of guidelines being implemented to 33.
Up to 5 guidelines this year have been assessed and found that the Trust are not following recommendations, bringing the overall number of non-compliant guidelines to 8. There are up to 121 guidelines which are still in the process of waiting to be assessed and responded to.

NICE Monthly Status



Referral to Treatment 18 weeks (RTT)

The first three months of 2017/18 saw gradual improvement in the Referral to Treatment standard, with the 92% target met in June 2017. However, performance since then has declined. As a result of vacancies and increased demand in some specialities, performance dipped during the summer months but began to stabilise above 90%. However, significant site pressures in December 2017 coupled with the national steer to cancel routine elective activity in January 2018, which continued in to February 2018 for some specialities, resulted in further deterioration in performance.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because RTT performance had significantly increased and the 92% target had been achieved until June 2017. Variances had been identified from October 2017 to December 2017 as a result of an internal audit mostly due to a system issue which was rectified internally.

In February 2018, an RTT recovery programme was launched across the Trust. This coincided with the change to national guidance which states that the waiting list should be no higher in March 2019 than in March 2018 and, where possible, should be reduced and that the number of patients waiting more than 52 weeks for treatment should be halved by March 2019 and eliminated where possible. As such, plans will focus on the delivery of these metrics in 2018/19. To support this, detailed demand and capacity modelling will be carried out in Q1 for specialities requiring improvement to inform the capacity required to deliver a sustainable waiting list.

Draft activity and performance trajectories have been completed for the year and focus on maximising capacity ahead of winter, whilst also aiming to maintain a greater level of activity over the winter period than was achieved in 2017/18.

Additional capacity through outsourcing, short term increased workforce and efficiencies are also considered as part of this.

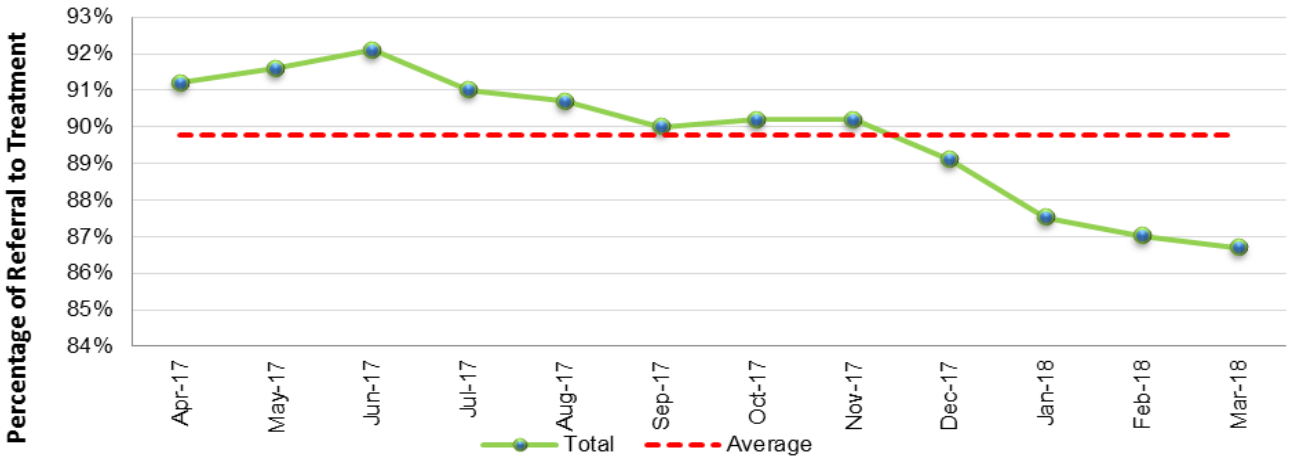
The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this performance and so the quality of its services by;

- An RTT recovery programme has been launched across the Trust since February 2018 which coincides with the change to national guidance.

This guidance states that the waiting list should be no higher in March 2019 than in March 2018 and, where possible, should be reduced and that the number of patients waiting more than 52 weeks for treatment should be halved by March 2019 and eliminated where possible.

- Detailed demand and capacity modelling will be carried out in Q1 for specialities requiring improvement to inform the capacity required to deliver a sustainable waiting list.

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 2017/18 Accident and Emergency Department achieved 87.2% of patients having a maximum of 4 hours wait. Our agreed trajectory with NHS Improvement was 87.1%. We validate our data daily and utilising our re-validation standard operating procedures further validation takes place for each submission of data.

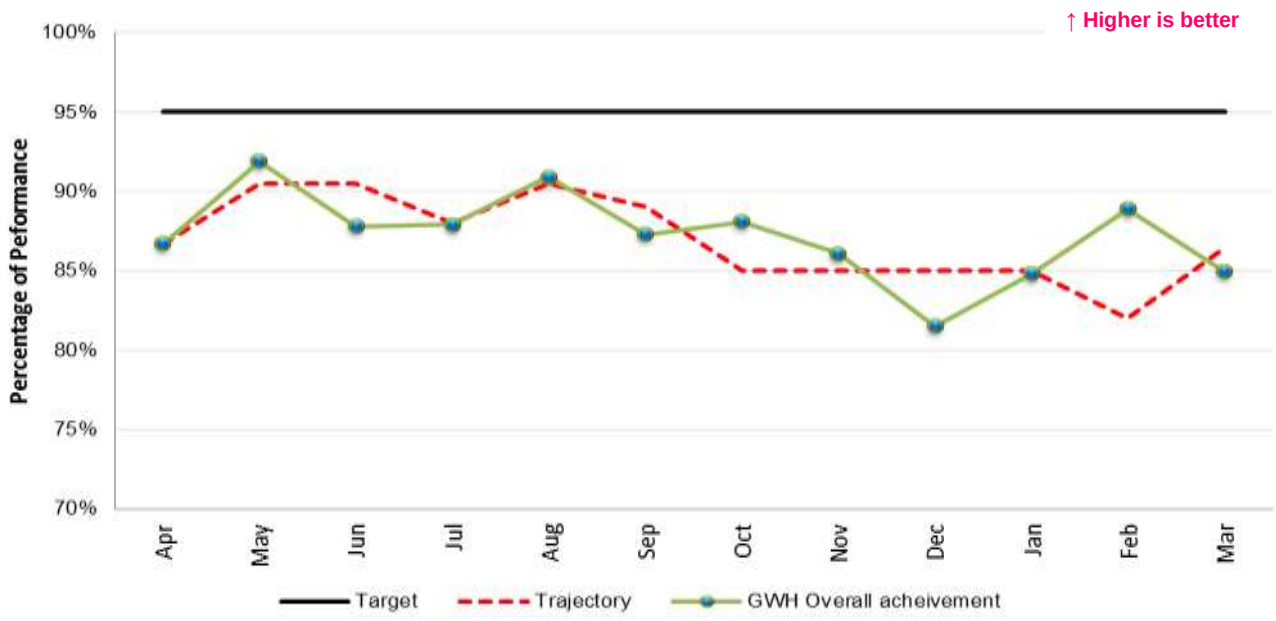
During 2017/18 the Trust built on the initiatives implemented the previous year as these are nationally recognised approaches to improve flow of patients through the hospital which should improve performance against the 4 hours Emergency Department Target. Health and Social Care services across Swindon and Wiltshire are under great pressure and this is recognised by health regulators NHS Improvement.

In the previous Quality Accounts the Trust committed to implementing effective patient streaming using all front door departments to ensure patients are seen by the appropriate teams on arrival to the organisation and improvements to the back door discharge process to ensure earlier safe discharge.

The Trust implemented the following initiatives to deliver the commitments made in our 2016/17 report:

- Introduction of our Ambulatory Care Unit (which was opened in Q4 of 2016/17).
- Implemented a Medically Expected Unit (MEU) so that GP referred patients did not have to attend the Emergency Department if they had already been accepted by the Acute Medical Team
- Completed the re-design of the ED Observations Unit
- Commenced Management of the Urgent Care Centre and harmonising working practices and skills with the Emergency Department.
- Commenced caretaker management of the Walk In Centre in the centre of Swindon.
- Implemented an Integrated Discharge Service which is a team of staff dedicated to improving back door flow.
- Opened a new 10 bed unit for Medically Fit patients awaiting onward care.

All Emergency Department performance for GWH



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 a number of initiatives that were trialled during 2017/18 which will be reviewed and where appropriate implemented to improved Emergency Department performance.

An example of the initiatives trailed are provided below, this is not an exhaustive list;

- Re-alignment of capacity within the Urgent Care Centre to match demand
- Supported additional ED Registrar at night to ensure better management of patient flow
- Revised process for the streaming of patients who arrive in the Emergency Department to all services
- Developed criteria led discharge on medical wards to support improved weekend discharge
- Green Chest Pain Pathway further development to reduce delays in ED and LOS
- Redesign and Development of the ED Observation Unit to support improved pathways for Mental Health and Low Risk Chest Pain Patients
- Golden Patient Initiative (Identification of patients who are fit and ready to go home the following day with everything in place for discharge) to support early morning flow
- Protected appointments within Neurology/Cardiology Clinics (hot clinics) have been implemented to support earlier discharge of patients to be then followed up in these clinics.
- ED consultant rota changes to provide greater senior presence at evenings and weekends
- High Sensitivity Troponin (a test for cardiac muscle damage) implemented to expedite the cardiac pathway

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.

An audit was undertaken during 2017/18 and readmission within 30 days of discharge overall has increased from the previous year from 9.8% to 11.2%. In 2014/15 and 2015/16 the majority of patients had readmissions due to the same diagnoses. However the 2017/18 review has identified that more patients have been presenting with new episodes and deterioration of existing conditions. An audit was not completed in 2016/17.

There were 2 recommendations from the 2017/18 audit:

1. Consideration given to the validity of rerunning this audit until front door revamp is complete and a locally agreed tariff (and thus means of identification) is arrived at for Ambulatory Care activity

2. A specific audit on Treatment, Escalation Plan (TEP) forms – focusing on appropriateness and adherence to treatment plan re: decision to admit or not

And 2 learning points:

1. Coding of Ambulatory Care activity may have a negative impact on the accuracy/relevance of this audit
2. Front Door revamp is an essential component of driving down non-elective readmission rate

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 17	834	5489	6323	75	576	651	9.0%	10.5%	10.3%
May 17	950	6171	7121	92	604	696	9.7%	9.8%	9.8%
Jun 17	869	6045	6914	89	619	708	10.2%	10.2%	10.2%
Jul 17	895	6067	6962	80	667	747	8.9%	11.0%	10.7%
Aug 17	825	5942	6767	71	618	689	8.6%	10.4%	10.2%
Sep 17	927	5908	6835	119	645	764	12.8%	10.9%	11.2%
Oct 17	980	6114	7094	91	774	865	9.3%	12.7%	12.2%
Nov 17	1034	6260	7294	95	784	879	9.2%	12.5%	12.1%
Dec 17	985	5971	6956	100	766	866	10.2%	12.8%	12.4%
Jan 18	922	6332	7254	75	807	882	8.1%	12.7%	12.2%
Feb 18	823	5981	6804	84	746	830	10.2%	12.5%	12.2%
Mar 18			0			0			0.0%
2017/18	**10044**	**66280**	**76324**	**971**	**7606**	**8577**	**9.7%**	**11.5%**	**11.2%**

Medicines Safety

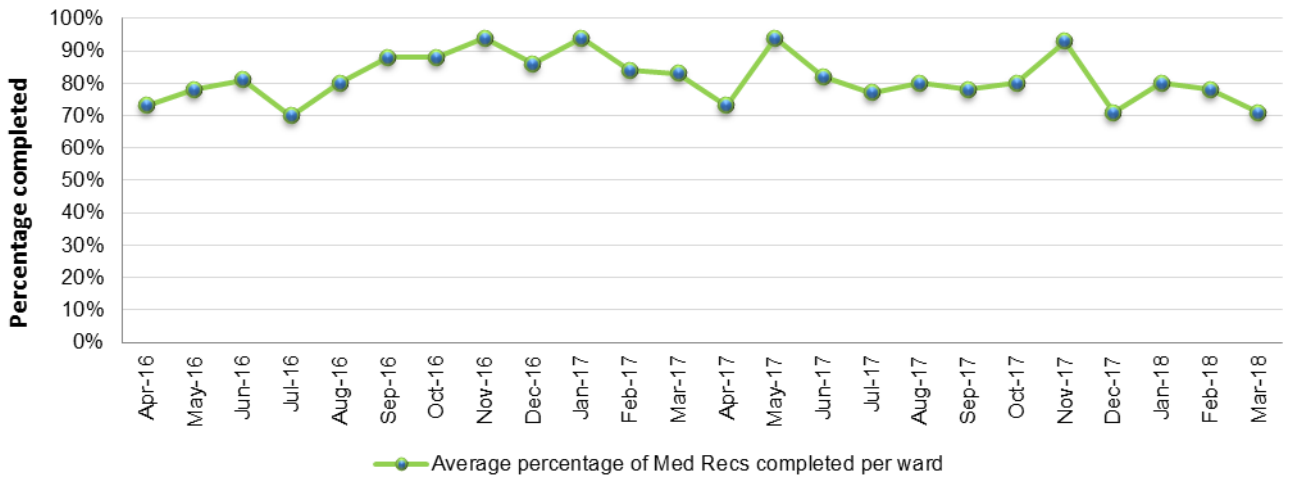
Develop & utilise medicines safety audits to improve practice.

The graph below shows the monthly data reported to clinical areas from an Electronic Prescribing and Medicines Administration system (EPMA) report regarding medicines reconciliation.

Data over the last 2 years has shown a sustained level of patients with completed medicines reconciliations.

Percentage Medicines Reconciliations completed

↑ Higher is better



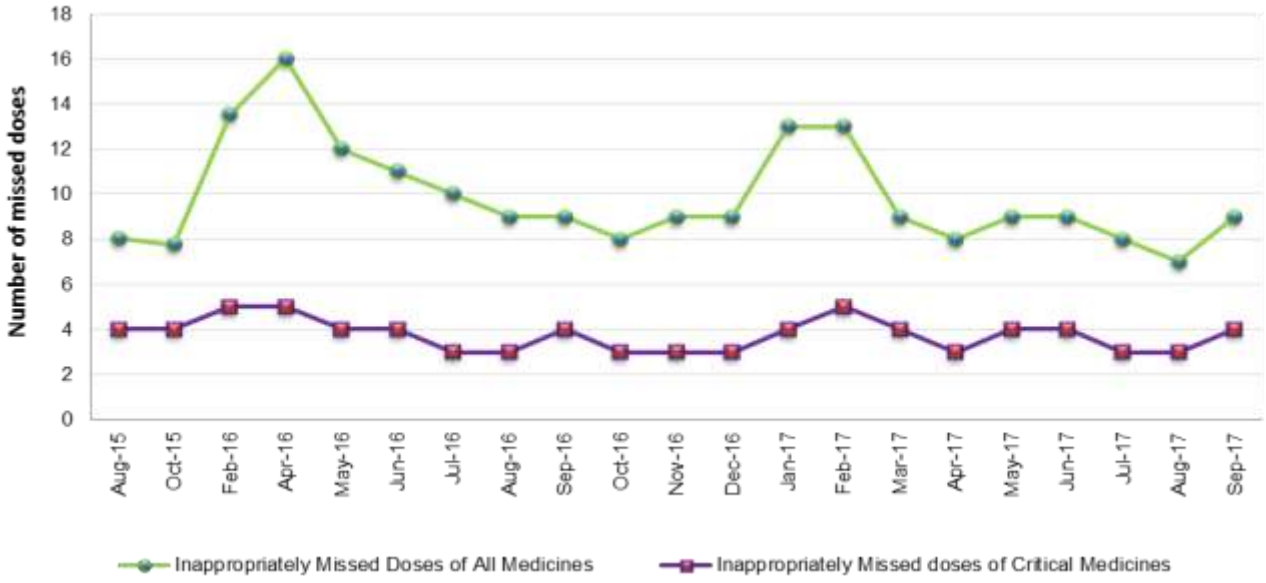
Missed/Omitted Doses

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

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

Average Inappropriately Missed Doses

↓Lower is better



The chart above shows the number of inappropriately missed doses per ward over time.

Data has not been available since late Q3 due to problems with the complex Electronic Prescribing and Medicines Administration system report. The missed dose process has been made simpler for clinical staff and reporting, and is anticipated to provide full data during 2018/19.

Percentage of inappropriate omitted doses of total number of administrations by ward

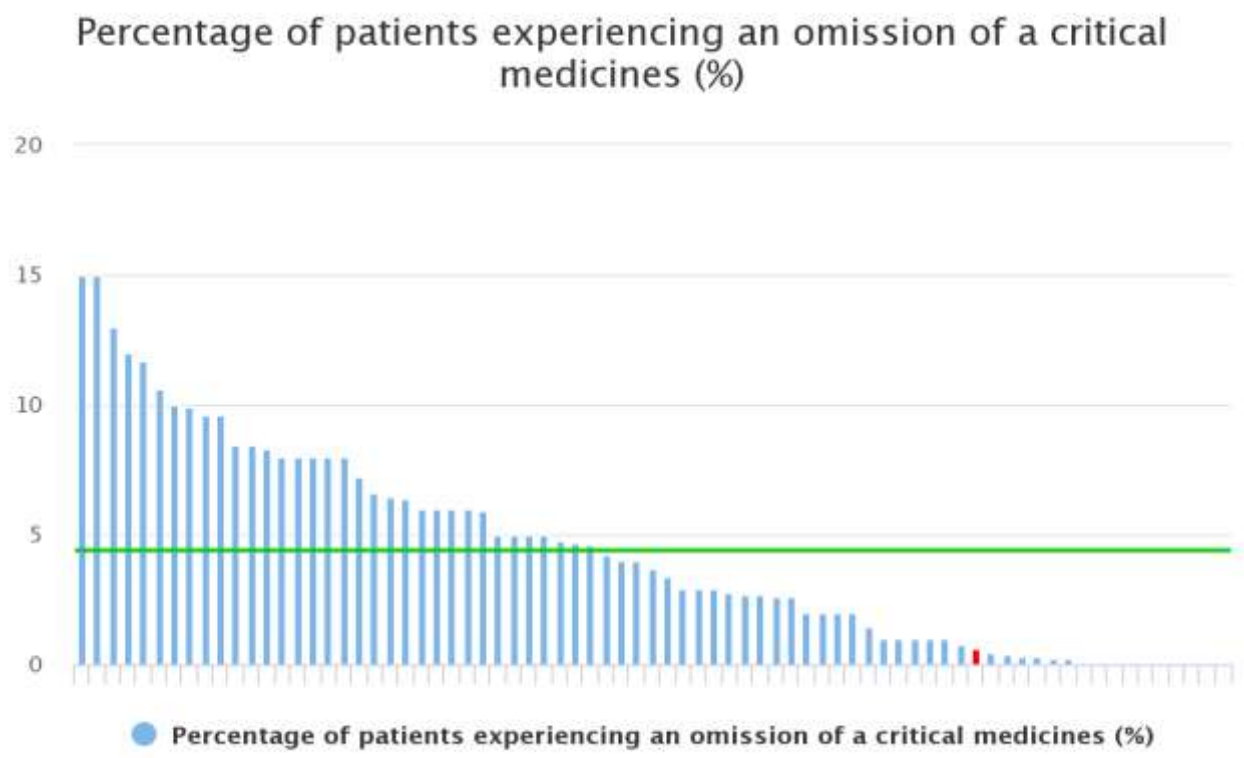
Ward	Total number of administrations	Number of inappropriately omitted doses	Number of inappropriately omitted doses of critical medicines	Percentage of inappropriately omitted doses (%)	Percentage of inappropriately omitted doses of critical medicines (%)
Aldbourne	305	1	1	0.33	0.33
Ampney	465	1	1	0.22	0.22
Beech	196	4	3	2.04	1.53
Cardiology	235	0	0	0.00	0.00
Dove	258	5	0	1.94	0.00
Falcon	265	3	0	1.13	0.00
Jupiter	1153	12	9	1.04	0.78
LAMU	650	33	13	5.08	2.00
Meldon	629	11	10	1.75	1.59
Mercury	1130	13	7	1.15	0.62
Neptune	721	9	4	1.25	0.55
Saturn	771	7	1	0.91	0.13
SAU	191	17	6	8.90	3.14
Shalbourne	215	2	0	0.93	0.00
Teal	684	3	2	0.44	0.29
Trauma	1783	6	2	0.34	0.11
Woodpecker	914	23	7	2.52	0.77
Trust Wide Average	**621**	**8.82**	**4**	**1.76**	**0.71**

The table above 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.

Results from figures 2 & 3 compare favourably with the National Data from the NPSA medicines Safety Thermometer where GWH has a lower rate of missed doses of 1.76% compared to the 8.3% national figure.

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

Medications Safety Thermometer Dashboard



The chart above shows national data from the NPSA Medicines Safety Thermometer through national benchmarking data that the percentage of GWH patients experiencing an omission of a critical medicines is significantly lower than the national average. The red line depicits GWH agains all other organisations

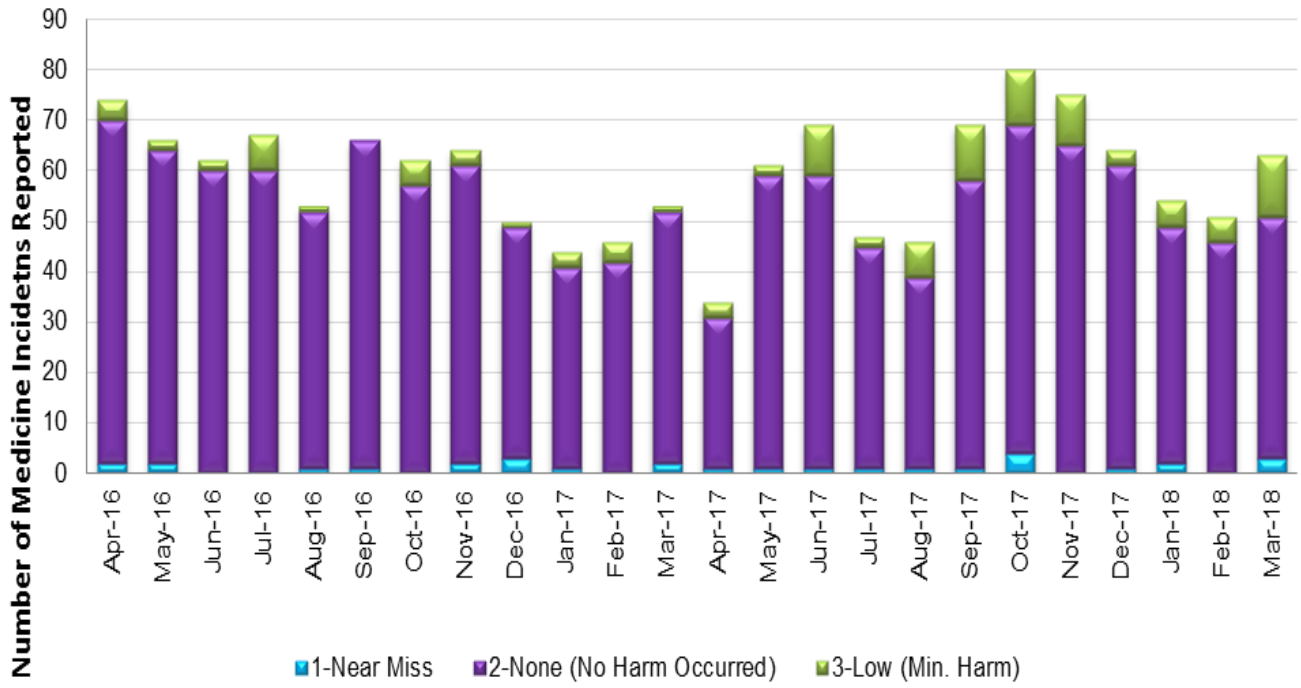
Learning from Incidents and Reduce Harm from Medication Incidents

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

Learning from incidents are shared through Medicines Safety bulletins. Examples of bulletins issued:

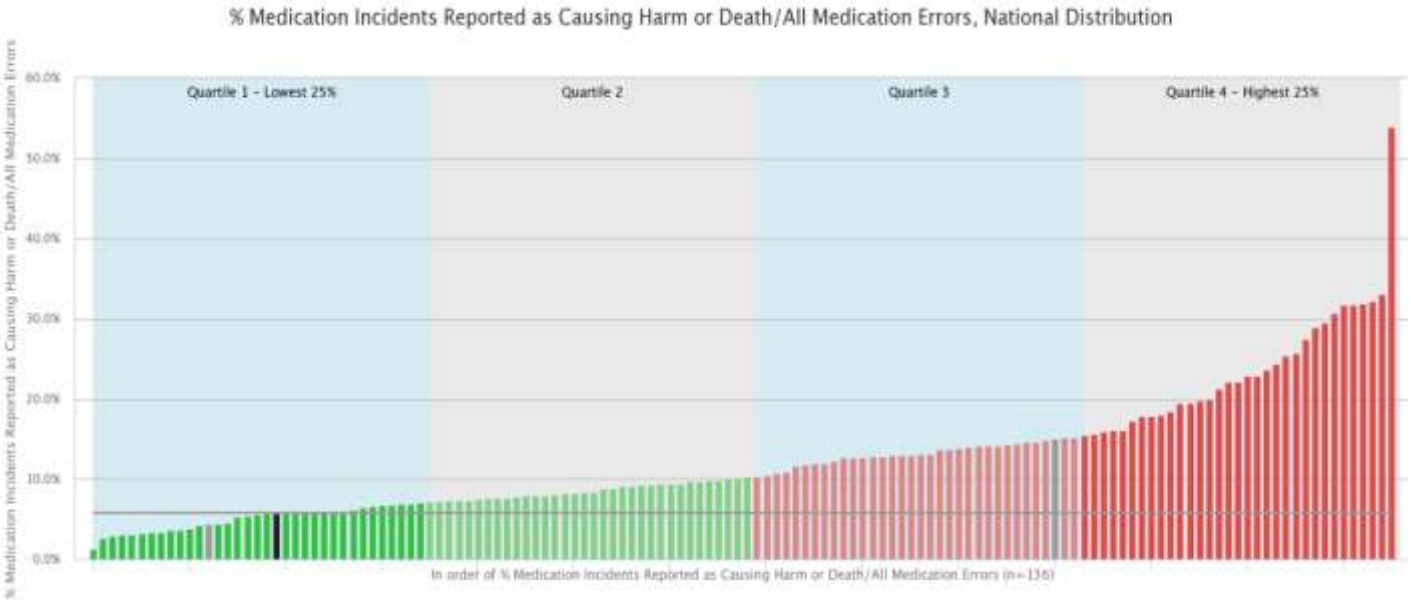
- Safe Storage of Medicines
- Oral Steroid Treatment
- Allergy Fact Sheet
- Withdrawing Insulin From Pen Devices

Number of Medicines Incidents Reported Including Level of Harm



The chart above shows the number of medicines incidents reported at GWH and the level of harm.
Percentage of medication incidents reported as causing harm or death (GWH vs. national distribution)

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



The chart above demonstrates that GWH (black line) is in the lowest quartile in terms of a national distribution of medication incidents causing harm, which provides assurance that for medicines safety GWH is both safe and learns from incidents.

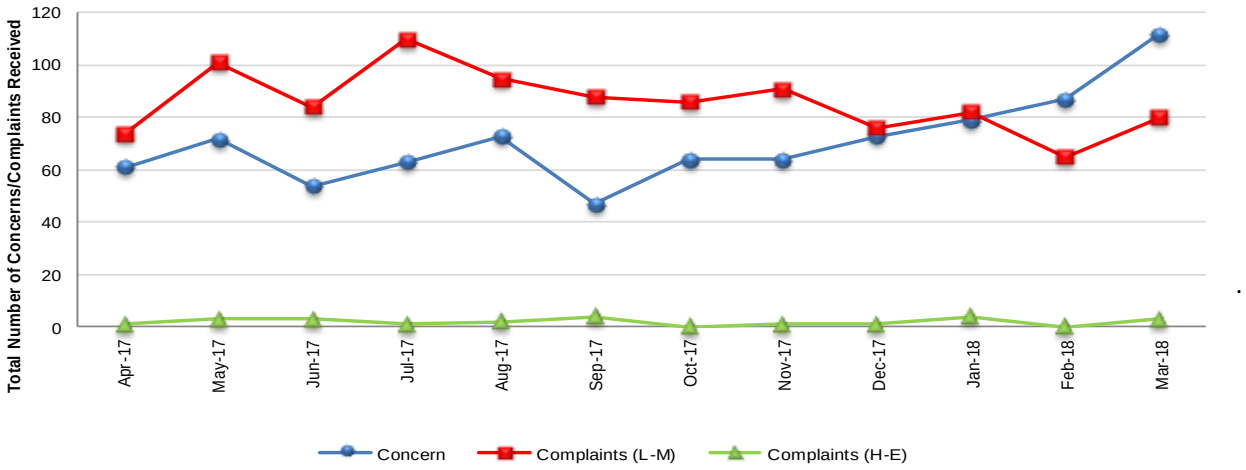
Improving Patient Experience & Reducing Complaints

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.

We are aware that sometimes patients want to receive their care and return home as quickly as possible particularly in the Emergency Department (ED). Text messaging (SMS) for FFT feedback was introduced in April 2017 giving all consenting patients the opportunity to provide feedback once in their home environment. Although this has seen a limited amount of feedback, despite it an effective method for other organisations, text messaging has positively contributed to the overall ED response rate.

Feedback from Friends and Family is shared with all service areas, themes and trends identified are passed to the relevant committees for discussion and implementation of changes to service. Changes and improvements to services have been made as a direct result of the feedback received and reported in the format of "you said, we did " for example changes to cleaning rotas, information detailing the ward routines, extra fruit available on tea rounds and options for decaffeinated drinks.

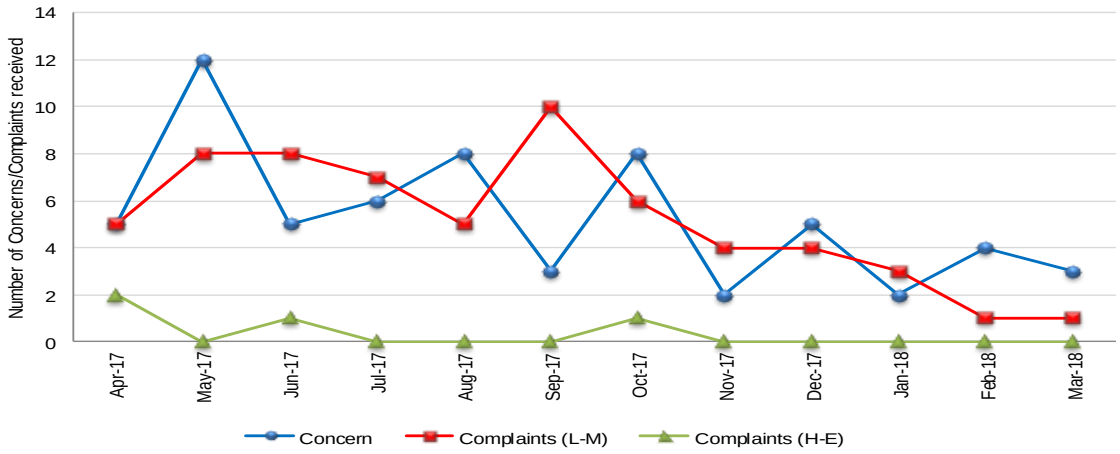
Concerns and Complaints received in 2017/18 Acute Services



The graph above gives a comparison on concerns/complaints received for acute services over a 12 month period for 2017/18.

Low/Medium cases are complaints where service or patient experience is below reasonable expectations, but not causing lasting problems. High/Extreme cases are complaints where significant issues regarding standards, quality of patient care issues that may cause long-term damage to an individual, such as grossly substandard care, professional misconduct or death. This level of complaint will require immediate and in-depth investigation.

Concerns and Complaints received in 2017/18 Community Services



The graph above gives a comparison on concerns/complaints received for our community services over a 12 month period for 2017/18.

Patient Experience

The Trust's Patient Engagement strategy was launched in September 2017; engagement with specific user groups has taken place throughout 2017/2018 and will continue throughout 2018/19 to hear the views of service users. Focusing on building on existing work, the Trust Board is committed to improving patient experience by:

- Role modelling and consistently applying the Trust STAR values
- Having quality champions throughout the Trust
- Recognising the link between staff and patient experience
- Engaging with patients, their carers and key stakeholders
- Using patient feedback meaningfully
- Ensuring that the Trust collects and reports high quality patient information
- Delivering reliable, safe, high quality care seven days a week
- Promoting wellbeing for both staff and patients
- Empowering people at all levels to drive change and value innovation
- Adequately resourcing service redesign that improves experience

National Inpatient Survey

Questionnaires were sent out to patients who had recently stayed at the Great Western Hospital NHS Foundation Trust, the initial mailing was sent out in October 2017. 531 patients responded, 25% of patients were on a waiting list/planned in advance and 72% came as an emergency or urgent case. The overall response rate was 42.7%.

The Trust reviewed the survey results of 2016 and introduced changes following feedback from the 2016 results, with the review and re-launch of bedside guide for the inpatient wards, detailing key information our patients said they wanted to know.

On-going work is being undertaken to improve the discharge process, which has seen the development of revised community nurse and practice nurse letter, this has been developed with the support of all stakeholders.

Providing timely communication to patients, about their progress and discharge plans following the morning board rounds has started not made a marked difference to the results seen in the 2017 survey, however the on-going work during 2018 to improve discharge planning will aim to develop this further, aiming to ensure the patient feels more involved.

The Trust has responded to feedback on the 2016 survey in the way it orders and provides patient meals, with the reintroduction of the menu cards. Finger foods have been introduced, alongside a red tray system to identify patients who need extra support at mealtimes. Carers are encouraged and support to assist at mealtime if they wish, and protected mealtimes are endorsed, to ensure no unnecessary clinical procedures occur during meal times.

The results for 2017 are detailed below against the key objectives agreed to benchmark each year to monitor performance

Lower scores are better

	Communication	2015	2016	2017	Position from 2016 results
Q33	Staff contradict each other	38%	32%	32%	Same
Q38	Could not always find staff member to discuss concerns with	67%	68%	65%	Better
Q37	Not enough (or too much) information given on condition or treatment	23%	22%	21%	Better
Q39	Not always enough emotional support from hospital staff	50%	44%	44%	Same
Q35	Wanted to be more involved in decisions	48%	49%	45%	Better
Q36	Did not always have confidence in the decisions made	32%	28%	27%	Better
Q25	Doctors: did not always give clear answers to questions	39%	31%	34%	Worse
Q27	Doctors: talked in front of patients as if they were not there	27%	25%	24%	Better
Q28	Nurses: did not always give clear answers to questions	37%	37%	30%	Significantly Better
Q76	Did not receive any information explaining how to complain	65%	68%	58%	Significantly Better

Lower scores are better

Discharge Planning		2015	2016	2017	Position from 2016 results
Q53	Did not feel involved in decisions about discharge from hospital	50%	44%	46%	Worse
Q55	Discharge was delayed	48%	45%	42%	Better
Q61	Not given any written/printed information about what they should or should not do after leaving hospital	41%	40%	43%	Worse
Q62	Not fully told purpose of medications	35%	29%	30%	Worse
Q63	Not fully told side-effects of medications	70%	65%	61%	Better
Q64	Not told how to take medication clearly	34%	26%	26%	Same
Q65	Not given completely clear written/printed information about medicines	34%	29%	27%	Better
Q66	Not fully told of danger signals to look for	65%	64%	61%	Better
Q68	Family not given enough information to help	57%	54%	52%	Better
Q69	Not told who to contact if worried	25%	24%	25%	Worse

Lower scores are better

Hospital, Care, Overall		2015	2016	2017	Position from 2016 results
Q23	Not offered a choice of food.	27%	28%	23%	Better
Q38	Could not always find staff member to discuss concerns with.	67%	68%	65%	Better
Q75	Not asked to give views on quality of care	77%	75%	72%	Better

The 2017 survey results have highlighted the many positive aspects of the patient experience:-

- Clearer communication given by Nurses
- Communication and information of complaints process was made clearer to patients
- Choice of food was given to patients
- Patients could locate staff easily.

Our Priorities 2018/19

- Analyse our National Inpatient Survey results for 2017 in the same format as previous years, working with the relevant service areas in the Trust to allow improvements to be made from patient's feedback.
- Engagement with Community Groups, listening events to be held throughout 2018/2019 & 2019/2020.
- Working in line with the Patient Experience and Engagement Strategy, ensuring that I statements are in place and displayed in public areas.
- The introductions of IPads and other technology for interpreting and translation i.e. Skype for patients who require support with communication needs.
- Project with NHS Resolution - Learning from aggregated analysis of complaints, claims and incidents.
- Review the Friends and Family Test improvement plan to improve the Trust response rate.

Staff Survey 2017/18

The NHS Staff Survey is an important source of information allowing the Trust to gather the views on staff experience about what it is like to work in the Health Service in England. The Trust is 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 2017 survey involved 309 NHS Organisations from across the country and achieved 487,227 responses. The NHS Staff Survey results are utilised by Trusts to support local improvements in staff experience and well-being.
They are also examined by external organisations such as the CQC and NHS Improvement and widely publicised on the dedicated staff survey website.

As one of the 309 participating NHS organisations, in October 2017 the Trust made the decision that all staff employed would be given the opportunity to participate in the 2017 Staff Survey. This was also the first year Swindon Community Health Division took part in the Trust's survey.

A total of 2446 employees returned a completed questionnaire giving the Trust a response rate of **46.5%**. This was a decrease in last years (49%) but above the average response rate for Combined Acute and Community Trusts in England (43%).

National and Regional comparisons

National

The latest NHS Staff Survey result is reflective of the current pressures and challenges facing the NHS and its workforce. Despite the extreme pressures, 75% of GWH staff continues to remain enthusiastic about their job and 85% feel that the organisation acts fairly regarding career progression. These scores are significantly better than other similar organisations.

The Trust results are below average in relation to staff feeling that there were enough staff within the organisation to carry out their job properly (24% compared to the National Result 30%)

However, results were significantly better than other similar organisations in "staff confidence and security in reporting unsafe clinical practice" 3.74 compared to national average 3.67 and the "percentage of staff/colleagues reporting most recent experience of violence" 72% compared to the 67% national average.

As to be expected in such a pressured working environment, the survey does highlight some areas of staff concern and scores are below the national average on the percentage of staff experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months (31%) compared to 27% national average and the percentage of staff working additional extra hours (75%) compared to 71% national average.

Regional

Whilst the Trust's response rate was high, the Trusts overall position has declined compared with last year. This year the Trust is ranked 16th out of 21 Trusts when benchmarking performance against organisations from across the South West.

The Trust was ranked 12th out of21 Trusts in 2016 and 10th out of 21 Trusts in 2015, University Hospitals Bristol NHSFT, Royal Berkshire NHSFT and Royal United Hospital Bath NHS Trust have all improved their performance this year and moved ahead of the Trust. Oxford University Hospital NHSFT, Gloucestershire Hospital NHSFT and North Bristol NHS Trust remain below the Trust.

When compared against local STP groups**,** the organisation's performance is ranked 3rd out of 4 other Trust.

This year, the Trust performed above average in 3 of the 32 key findings of the survey results, average in 18 and worse than average in 11 areas. The Trusts results for performing better than average has decreased since last year however, the number of areas where the Trust has performed worse than average has also reduced. It can be identified that overall the Trust's results are primarily within the average range of other Combined Acute and Community Trusts in 2017.

There has been a decline in the National results in relation to staff engagement from 3.80 in 2016 to 3.78 in 2017; this is comparable to the Trusts results of 3.78 in 2016 to **3.77 in 2017.** Overall, the staff engagement score continues to be high with the Trust scoring marginally below the national average. The areas used to measure the staff engagement score is based on staff recommending the organisation as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work.

The Trust's staff engagement score has reduced this year (previously 3.84 in 2016), this result is within the national average for Acute and Community Trust's and is higher than the results of six other Trusts in the South West region.

Key Findings

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.

There was one key area where staff experiences have improved since the 2016 staff survey.

Key Area	2016 Score	2017 Score	Change
Disability – organisation made adequate adjustment (s) to enable me to carry out my work	62%	77%	15%

The key areas where staff experiences have deteriorated since the 2016 staff survey is illustrated below, the data highlights an overall decline in staff satisfaction whilst at work, staffs motivation at work and an increase of staff feeling unwell due to work related stress.

The Trust's recruitment challenges are likely to have impacted on these scores.

Key Area	2016 Score	2017 Score	Change
Staff motivation at work *(the higher the score the better)*	4.02 (out of 5)	3.93 (out of 5)	0.09
Percentage of staff feeling unwell due to work related stress in the last 12 months *(the lower the score the better)*	33%	38%	5%
Percentage of staff able to contribute towards improvements at work *(the higher the score the better)*	74%	69%	5%
Staff satisfaction with level of responsibility and involvement *(the higher the score the better)*	3.95 (out of 5)	3.88 (out of 5)	0.07
Staff satisfaction with the quality of work and care they are able to deliver *(the higher the score the better)*	3.88 (out of 5)	3.75 (out of 5)	0.13

Summary of staff survey response rates

2016		2017		Trust Improvement / Deterioration
Trust	National Average	Trust	National Average	2.5% Deterioration
49%	44%	46.5%	43%	

Our priorities for 2018/2019

Short Term: Each Division develops a local action plan focusing on **3** key areas which will make the most impact based on the results for the Division. For Divisions to promote a 'listening into action' approach, empowering staff to be involved and contribute towards improvements in their Divisional staff survey results. It is recommended that Divisional action plans are developed and owned by key members of the Division and identified through listening groups to encourage staff involvement.

Long Term: The development of a Trust wide approach focusing on the big themes, **working with staff** to identify what actions need to be taken through 'big conversations. The key areas are:

- **Senior Management/Staff Engagement** – improving communication between senior management and staff, enabling and empowering staff to be involved and contribute towards improvements in patient experience and their own working environments

- **Resources** – continue to develop our recruitment and retention strategy to support with the vacancy position and to address the general equipment/resources issues identified by staff. Develop our communication strategy to ensure there is a clear understanding of establishments and temporary staff usage and a link to safer staffing.

- **Health and Wellbeing** (including Bullying and Harassment from Patient and members of the public/staff) – engaging staff in creating new initiatives to improve staff health and wellbeing and taking action against those who bully or harass staff

A positive improvement in these areas will have a direct impact on improving staff engagement and morale.

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 2017/18, 76 national clinical audits and 14 national confidential enquiries were conducted which covered relevant health services provided by Great Western Hospitals NHS Foundation 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.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

No.	Title	Work stream	Relevant	Participation	% Data Submission
1	Adult Cardiac Surgery	N/A	No	NA	NA
2	British Association of Urological Surgeons (BAUS) Urology Audits - Female Stress Urinary Incontinence Audit	N/A	Yes	Yes	Still in progress
3	BAUS Urology Audits - Radical Prostatectomy Audit	N/A	No	NA	NA
4	BAUS Urology Audits - Cystectomy	N/A	No	NA	NA
5	BAUS Urology Audits - Nephrectomy audit	N/A	Yes	Yes	100%
6	BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	N/A	No	NA	NA
7	BAUS Urology Audits - Urethroplasty Audit	N/A	No	NA	NA
8	Cardiac Rhythm Management (CRM)	N/A	Yes	Yes	Still in progress
9	Case Mix Programme	N/A	Yes	Yes	100%
10	Child Health Clinical Outcome Review Programme	Chronic Neurodisability	Yes	Yes	100%
11	Child Health Clinical Outcome Review Programme	Young People's Mental Health	Yes	Yes	100%
12	Child Health Clinical Outcome Review Programme	New Topic - Long-term ventilation in children, young people and young adults	Yes	Yes	Still in progress
13	Elective Surgery (National PROMs Programme)	N/A	Yes	Yes	100%

No.	Title	Work stream	Relevant	Participation	% Data Submission
14	Endocrine and Thyroid National Audit	N/A	Yes	Yes	100%
15	Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	No	NA	NA
16	Falls and Fragility Fractures Audit programme (FFFAP)	Inpatient Falls	Yes	Yes	100%
17	Falls and Fragility Fractures Audit programme (FFFAP)	National Hip Fracture Database	Yes	Yes	100%
18	Fractured Neck of Femur (care in emergency departments)	N/A	Yes	Yes	100%
19	Head and Neck Cancer Audit	N/A	Yes	Yes	100%
20	Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	N/A	Yes	Yes	100%
21	Learning Disability Mortality Review Programme (LeDeR)	N/A	Yes	Yes	100%
22	Major Trauma Audit	N/A	Yes	Yes	100%
23	Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance (reports annually)	Yes	Yes	100%
24	Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality and Morbidity confidential enquiries (reports every second year)	Yes	Yes	100%
25	Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Yes	Yes	100%
26	Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity confidential enquiries (reports every second year)	Yes	Yes	100%
27	Medical and Surgical Clinical Outcome Review Programme	Non-invasive ventilation	Yes	Yes	100%
28	Medical and Surgical Clinical Outcome Review Programme	Acute Heart Failure	Yes	Yes	100%
29	Medical and Surgical Clinical Outcome Review Programme	Cancer in Children, Teens and Young Adults	Yes	Yes	100%
30	Medical and Surgical Clinical Outcome Review Programme	Perioperative diabetes	Yes	Yes	100%
31	Medical and Surgical Clinical Outcome Review Programme	Pulmonary embolism	Yes	Yes	100%
32	Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction	Yes	Yes	Still in progress
33	Mental Health Clinical Outcome Review Programme	Suicide by children and young people in England(CYP)	No	NA	NA
34	Mental Health Clinical Outcome Review Programme	Suicide, Homicide & Sudden Unexplained Death	No	NA	NA
35	Mental Health Clinical	Safer Care for Patients	No	NA	NA

No.	Title	Work stream	Relevant	Participation	% Data Submission
	Outcome Review Programme	with Personality Disorder			
36	Mental Health Clinical Outcome Review Programme	The Assessment of Risk and Safety in Mental Health Services	No	NA	NA
37	Myocardial Ischaemia National Audit Project (MINAP)	N/A	Yes	Yes	100%
38	National Audit of Breast Cancer in Older People (NABCOP)	N/A	Yes	Yes	100%
39	National Audit of Care at the End of Life (NACEL)	N/A	Yes	Yes	100%
40	National Audit of Dementia (in General Hospitals)	Dementia care in general hospitals	Yes	Yes	100%
41	National Audit of Intermediate Care (NAIC)	The project has both a Commissioner level audit and a Provider level audit where organisational level metrics are collected. The Provider level audit also has a service user audit and a Patient Reported Experience Measure (PREM).	No	NA	NA
42	National Audit of Percutaneous Coronary Interventions (Coronary Angioplasty)	N/A	Yes	Yes	100%
43	National Audit of Pulmonary Hypertension	N/A	No	NA	NA
44	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	N/A	This audit did not run in 2017. Data collection commences in April 2018.		
45	National Bariatric Surgery Registry (NBSR)	N/A	No	NA	NA
46	National Bowel Cancer (NBOCA)	N/A	Yes	Yes	100%
47	National Cardiac Arrest Audit (NCAA)	N/A	Yes	Yes	100%
48	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	No	NA	NA
49	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Secondary Care	Yes	Yes	100%
50	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Primary Care (Wales)	No	NA	NA
51	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis .	N/A	This audit did not run in 2017. Data collection commences in April 2018.		
52	National Clinical Audit of Anxiety and Depression	Core audit	No	NA	NA
53	National Clinical Audit of Anxiety and Depression	Psychological Therapies for Anxiety and Depression	No	NA	NA
54	National Clinical Audit of	Core audit	No	NA	NA

No.	Title	Work stream	Relevant	Participation	% Data Submission
	Psychosis				
55	National Clinical Audit of Psychosis	EIP spotlight audit	No	NA	NA
56	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Specialist rehabilitation level 1 and 2	No	NA	NA
57	National Comparative Audit of Blood Transfusion programme	Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	Yes	100%
58	National Comparative Audit of Blood Transfusion programme	2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	Yes	100%
59	National Comparative Audit of Blood Transfusion programme	Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016 (see weblink in column L for 2015 report)	Yes	Yes	100%
60	National Congenital Heart Disease (CHD)	Paediatric, Adult	No	NA	NA
61	National Diabetes Audit - Adults	National Diabetes Foot Care Audit	Yes	Yes	100%
62	National Diabetes Audit - Adults	National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	Yes	Yes	100%
63	National Diabetes Audit - Adults	National Core Diabetes Audit	Yes	No	0%
64	National Diabetes Audit - Adults	National Pregnancy in Diabetes Audit	Yes	Yes	100%
65	National Emergency Laparotomy Audit (NELA)	N/A	Yes	Yes	100%
66	National Heart Failure Audit	N/A	Yes	Yes	100%
67	National Joint Registry (NJR)	N/A	Yes	Yes	100%
68	National Lung Cancer Audit (NLCA)	Lung Cancer Clinical Outcomes Publication	Yes	Yes	100%
69	National Maternity and Perinatal Audit (NMPA)	N/A	Yes	Yes	100%
70	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	N/A	Yes	Yes	100%
71	National Oesophago-gastric Cancer (NOGCA)	N/A	Yes	Yes	100%
72	National Ophthalmology Audit	Adult Cataract surgery	Yes	Yes	100%
73	National Paediatric Diabetes Audit (NPDA)	N/A	Yes	Yes	100%
74	National Prostate Cancer Audit	N/A	Yes	Yes	100%
75	National Vascular Registry	N/A	No	NA	NA
76	Neurosurgical National Audit Programme	N/A	No	NA	NA
77	Paediatric Intensive Care Audit Network (PICANet)	N/A	No	NA	NA
78	Pain in Children	N/A	Yes	Yes	100%

No.	Title	Work stream	Relevant	Participation	% Data Submission
	(care in emergency departments)				
79	Prescribing Observatory for Mental Health (POMH-UK)	Use of depot/LA antipsychotics for relapse prevention	No	NA	NA
80	Prescribing Observatory for Mental Health (POMH-UK)	Prescribing antipsychotics for people with dementia	No	NA	NA
81	Prescribing Observatory for Mental Health (POMH-UK)	Assessment of side effects of depot and LA antipsychotic medication	No	NA	NA
82	Prescribing Observatory for Mental Health (POMH-UK)	Monitoring of patients prescribed lithium	No	NA	NA
83	Prescribing Observatory for Mental Health (POMH-UK)	Prescribing for bipolar disorder (use of sodium valproate)	No	NA	NA
84	Prescribing Observatory for Mental Health (POMH-UK)	Rapid tranquilisation	No	NA	NA
85	Prescribing Observatory for Mental Health (POMH-UK)	Prescribing high-dose and combined antipsychotics on adult psychiatric wards	No	NA	NA
86	Prescribing Observatory for Mental Health (POMH-UK)	Prescribing Clozapine	No	NA	NA
87	Procedural Sedation in Adults (care in emergency departments)	N/A	Yes	Yes	100%
88	Sentinel Stroke National Audit programme (SSNAP)	N/A	Yes	Yes	100%
89	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	Yes	Yes	100%
90	UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)	N/A	Yes	Yes	100%

The reports of 65 national clinical audits were reviewed by the provider in 2017/18. As a result of these audits Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Stroke Services – improve direct admission to stroke unit, nursing and consultant levels to cover primary stroke prevention clinics and weekend cover.

Neonatal services – improve the quality of recording data onto electronic systems; particularly elements of records during admission and upon discharge, for example, completion of daily summaries, culture results and type of feeding at discharge etc.

Maternity Services – to implement a quality improvement project 'Maternity Connections' which is aimed at building bridges from women in our care and Maternity Services to other specialities, including Endocrinology, with consideration of how referral/review may be achieved quicker and how pathways for referral can be publicised to Primary Care in particular those offering community support to those with Diabetes (e.g. General Practitioners, Local Surgery Nurse Lead Clinics).

For patients with Acute Pancreatitis -Enhance service and capacity to improve compliance with Early Warning Scores; Identify urgent patients during out of hours requiring ultrasound scan, Explore feasibility of Hot Gallbladder lists, Implementation of e-prescribing (part of trust wide service development).

For patients with a GI haemorrhage - Establish a working group to the implementation of an action plan incorporating NCEPOD, NICE CG141, SIGN 2008 standards and recommendations to improvement the management of Upper and Lower GI bleeds.

Emergency Laparotomy services - monitor the care of elderly patients, monitor key processes to look for sustainability, introduce generic boarding card for all emergency cases.

Monitor the effect on emergency laparotomy information. Embedding data entry in trainee surgeons. FLO-E:A trial should improve cardiac output monitoring.

Vision Assessment: GWH is to approach the best performing Trusts in relation to vision assessments to evaluate if good practice can be shared between Trusts. Actions going forward will be based on this evaluation

Delirium: Although a significant improvement has been achieved since 2015 (+18%) the documentation and assessment require further improvement to achieve the national average.

The Delirium work stream is clinically led by the Trust lead for Dementia and there are plans to introduce practice guidance to medical and other clinical staff in 2018.

To continue to educate and support junior doctors and nursing staff, while also developing and testing new systems to reduce prescribing and medication management errors Trust-wide.

Revise the hemoglobin threshold for active pre-operative anaemia investigations and treatment to 120g/l for females and 130g/l for males. IV iron can potentially be given to more patients hopefully reducing the number and volume of post-operative transfusion, thus reducing hospital stays. Consider ways to obtain pre-operative Hbs earlier in the pathway for orthopaedic patients in order to ensure supportive investigation and therapy can be carried out in a timely fashion reducing wasted appointments and resulting in less delays in surgery.

Consider the use of TXA in patients with #NOF – this will need to be risk assessed and research studied on the possible adverse effects of this - benefits must outweigh the risks. A protocol change should be considered in conjunction with the Orthopaedic teams and anaesthetics.

The reports of 209 local clinical audits were reviewed by the provider in 2017/18 and Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

New assessment tool to be considered for trial for patients in Labour, explore and possibly develop a care bundle for ‘at risk’ women to include measures like Sorbsan or PICO.

This technique used in evidence based practice , Negative Pressure Wound Therapy (NPWT) or Hibiscrub wash prior to transfer to Theatre and for quarterly rates of post-operative infection to be displayed where appropriate in close location to Maternity Theatre or notice board in sitting room where morning meeting takes place.

To implement TEP becoming a clinical note with mandatory fields, at each stage, and if possible allow an Alert to be raised automatically on Medway at the time the document is raised.

Include TEP on any discharge check list so that it can be reviewed and communication confirmed prior to discharge.

Documentation audit - Raise further awareness within Quality Reports and Newsletter around the requirement to ensure that the patient identifiers (name, D.O.B, hospital number) are clearly recorded on all pages within the notes and to raise awareness around the need to time and date all entries, and to sign and print your name.

Ensure new doctors and locums are fully aware of the electronic mental health assessment and referral process. Deliver the MCA training strategy to ensure a consistent application of safeguarding and MCA.

Communication to antenatal clinic staff to raise awareness of the importance of plotting SFH measurement on designated graph once measured via SMART News feature and team meetings.

Community midwives to be reminded of the importance of documenting Assessments of VTE, booking bloods, to be taken, taken or results, Vitamin D discussed, Downs Screening Result, IOL leaflet given and Antenatal Risk Assessments at 28 weeks.

All relevant team members should be reminded of the Neutropenic sepsis pathway and the use of MASCC scoring and consider a revision in admissions from triage line referrals. Admittance to the hospital through the proposed Triage bay should be given a target date for completion and to achieve better compliance with the `Golden Hour`; currently, just under half of patients (48%) receive an antibiotic within the first hour of admission, rising to 55% when allowed an extra 6 minutes for flexibility.

A new electronic tracking system is being tested and validated. This will enable blood components to be administered using an electronic process more frequently than is currently possible. It is anticipated that this will increase compliance with fating the blood components and reduce workload in tracing components not fate

All Non-Medical Prescribing (NMP) to have a yearly appraisal; All staff to clearly document scope of prescribing intent within their yearly appraisal, at their 1:1, or using the NMP scope of practice document with a copy forwarded to the pharmacy administrator and NMP lead and administrator to review the NMP database and ensure that all staff have attended an annual update or can provide evidence of maintenance of professional development (prescribing) within the last year.

Continue to raise staff awareness of dementia tools and promote staff engagement with the tools. Develop business case for the appointment of Dementia Specialist Nurse at GWH to facilitate on-going staff education and implementation of gold standard care for patients with dementia whilst they are in hospital. Weekly check of tool use within all clinical areas has been implemented and we have incorporated the use of the tools into the ward admission document and into nursing handover paperwork.

SAU to be a protected area, Only 3 days out of 28 SAU assessment area had patient flow, due to being bedded down with medical outliers.

Patients in pain / unwell that ED sent to SAU who would usually have access to a trolley required to lay down in SAU clinic rooms this reduced the number of triage rooms for nursing staff and medical staff to examine patients

In reviewing patients with Type 1 diabetes in the clinical setting at GWH, particularly those with a high Body Mass Indicator (BMI) or high insulin requirements, consider checking C-peptide to clarify diagnosis.

In reviewing patients with Type 2 diabetes with suboptimal glycaemic control on multiple medications, consider C-peptide to help guide to the next stage in treatment whether it be insulin or further insulin sensitising medication.

In some patients with Type 2 diabetes who are difficult to engage or motivate, C-peptide may be used to demonstrate insulin resistance and persuade them to change their lifestyle. Or conversely, those who you feel require insulin but are reluctant to start; C-peptide can demonstrate insulin deficiency and persuade them of the clinical need to start insulin. Improvements required in C-peptide sample handling - find out whether modern immunoassay is a possibility to collect samples for C-peptide in EDTA tubes which is stable in room temperature for 24-48 hours.

Continue tracking NIPE checks for all babies 3 times weekly and follow SOP to address any concerns where required. Report any babies without NIPE check close to breaching 72hr to area responsible and reporting any breach via an incident form..

Education to all staff on the Standard operating procedure for HIV testing in the Intensive Care Unit, Nurse video teaching via non-mandatory training, Highlighted as a key topic at message of the day/week at daily risk assessments and Posters in staff areas.

A sticker to be placed in the medical notes for all community acquired pneumonia patients indicating the requirement for compliance with the Standing Operating Procudure on HIV testing. .

To review the dissemination, monitoring and reporting of National Institute of Clinical Excellence (NICE) Guidance Policy and Assessment Proforma To undertake a re-audit once policy review and actions have been embedded.

Divisions are to design a uniformed factual report for NICE guidance which shows clearly all outstanding NICE Guidance requiring attention on a month by month basis.

To educate staff in Swindon Intermediate care Centre (SwICC) to correctly complete the 'MUST' tool; educate staff in SwICC on how to correctly interpret the results of the 'MUST' tool; highlight the importance of completion of the 'MUST' tool as per NICE and CQC regulations; highlight the importance of weekly weights to be completed to ensure completion of the 'MUST' tool; adapt the 'MUST' pathway and Nutrition Care Plans to make them more applicable for SwICC inpatients; educate staff in SwICC on how to correctly document in and use Nutrition Care Plans and train staff to understand when referrals need to be made to the dietetic service.

Provide learning to all ED clinicians regarding the need to code patients appropriately and in a detailed manner. This will be done in the weekly doctors teaching sessions and in handovers daily as a reminder. To explore with IT whether the mental health diagnosis recorded on the Mental Health Risk Assessment and Referral Form in Medway, where it is a mandatory field, can be included in the discharge coding.

All newly appointed and existing junior and senior medical staff should be provided with targeted training at induction and mandatory training on the need to consider the least restrictive legal frame work when considering need to detain a patient in hospital against their permission and clearly document in medical records all decision making principles regarding patient care.

All consideration involving consideration for the use of MCA or MHA must be clearly recorded in the patient's notes.

To improve patient meal times, operating procedures for mealtimes are to be displayed on wards by Ward Managers by end of April 2018.

Ward Managers are to also implement bell ringing 15 minutes prior to mealtimes to alert patients, staff and carers to get ready for meals by end of April 2018.

Research & Development (R & D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1207 to end March 2018. Another year in which we successfully met and even exceeded our set target.

We currently have 67 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.

We continue to attract commercial companies and our reputation, particularly within cardiology and rheumatology remains strong.

Every effort is made to ensure we achieve recruitment to time and target.
Research continues to gives our patients more opportunities to participate in 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 NHS Foundation Trust income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between Great Western Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Details of proportion of payments achieved is available on request

Further details of the agreed goals for 2017-18 and for the following 12-month period are available electronically on request.

Financial Summary of CQUIN (£m)									
	Plan	Actual	%	Plan	Actual	%	Plan	Forecasted Actual	%
	2015-2016			2016-2017			2017-2018		
Total CQUIN	£6,007	£4,507	75%	£4,845	£3,973	82%	£5,566	£4,762	86%

Care Quality Commission Registration

The Great Western Hospital NHS Foundation Trust has an overall rating of requires improvement since the last inspection that took place during 2017. 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 November 2017 to add the following service - Swindon Walk in Centre.

Periodic/Special Reviews 2017/18

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 and 23 March 2017

In response to the CQC must do- should do actions and to support the Trust in co-regulation, Key Line of Enquiry (KLOE) Compliance assurance frameworks were developed to provide a mechanism for continuous self-assessment of the KLOE indicators by the core service leads, to ensure the monitoring of the quality of care as viewed by the CQC.

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

The table below identifies the Compliance Actions identified form our December 2017 inspection.

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	August 2017	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Compliance Action	August 2017	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Compliance Action	August 2017	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Compliance Action	August 2017	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints
Compliance Action	August 2017	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
Compliance Action	August 2017	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

Our Ratings for the Great Western Hospital from 2017

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:

99.9% for admitted patient care;
99.9% for outpatient care; and
99.9% 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 (IGSG) undertakes an Information Governance Work Programme covering the full range of information governance elements, and ensures that appropriate policies and management arrangements are in place. The IGSG, reviews a data quality and completeness report, including the results of data accuracy tests on a quarterly basis.

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 2017/18 was 77% and was graded 'Not Satisfactory' ('red').

The 'Not Satisfactory' rating was solely due to a failure to reach the required level in respect of one requirement, i.e. that at least 95% of all employees and volunteers have completed their Information Governance 'annual refresh' training within the current financial year (the actual training figure at the end of the year being 81%).

It should be noted that the Trust has produced an improvement plan to rectify this deficiency during 2017/18, in line with the new Data Security and Protection Toolkit which has replaced the Information Governance Toolkit.

It is confirmed that all new staff receive the appropriate Information Governance training when they join the Trust.

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 2017/18 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 has completed the following in the last year towards 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 be taking the following actions forward to continue with our improvement around data quality

- Review of the Trust data quality strategy (to ensure relevance)
- Establish regular Trusts Data Quality group meetings
- Review communicate and education of staff on their responsibilities around data quality
- Explore areas of data quality with the aim to identify areas that need some dedicated improvements with key benefits

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	2017/ 2018	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	5	2	2	1	0	0.96	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.Diff	23	19* *combined previously acute/	30 Trust-wide	21	25	N/A	Zero is aspirational	Low-0; High-121	IP&C	National definition

		2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
			community split								
	C.Diff 100,000 bed days	12.5	9.60	14.7	11.1	11.8	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	10	Not available	Lower is better	--	Incident form	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers		28 Category II & Category IV	51 Category I & Category IV	8 Category III 6 Category IV	50 Cat II	40 Category II 2 Category III	4% incidence	Lower is better	--	Incident form	National Definition (from Hospital database)
6 – Never Events that occurred in the Trust		4	2	3	1	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)	97 (Oct 16 to Sep 17 – 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)	98.3 (Apr 17 – Dec 17 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%	Average 95%	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%	Average 85%	N/A	Higher number is better	--	Audit	Audit criteria (5 patients per month)

		2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
18– Patient Reported Outcome Measures	**Varicose Vein surgery**	100%	90.9%	100% HSCIC Provisional data	100% HSCIC Provisional data	Currently Un available	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	Currently Un available	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	96.7% 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	95.3% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
19 – Readmissions – 30 days	7.9%	9.4%	9.7%	9.8% (Apr 16 to Feb 17)	11.2%	Local target (7.1%)	Lower is better	--		National Definition	
19 – Readmissions – 28 days	7.7%	9.2%	9.6	9.8% (Apr 16 to Sep 16)	10.9% Apr 17 – Feb 18	SW Region 6.9%	Lower is better	Low: 5.12; High:1 0.91	Dr Foster	Dr Foster	
19 – 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 – Re-admissions 28 days** **Ages 0-15** **Ages 16+**
20 – The Trusts responsiveness to the personal needs of its patients during the reporting period.	**Were you involved as much as you wanted to be in decisions about your care and treatment?**	53.2%	51.4%	51.8%	51.1%	55.4%	57.1%	Higher is better	Low: 6.1 High: 9.2 GWH: 7.1	Picker Survey	National definition
	Did you find someone on the hospital staff to talk to about your worries and fears?	37.1%	28.6%	33.0%	32%	34.6%	39.3%	Higher is better	Low: 4.3 High: 8.2 GWH: 4.9	Picker Survey	National definition
	Were you given enough privacy when discussing your conditions or treatment?	70.8%	74.2%	72.6%	75.6%	72.5%	77.0%	Higher is better	Low: 7.5 High: 9.4 GWH: 8.5	Picker Survey	National definition
	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%	38.6%	39.3%	Higher is better	Low: 3.7 High: 7.6 GWH: 4.3	Picker Survey	National definition
	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67.2%	66.2%	68.0%	65.6%	65.9%	70.8%	Higher is better	Low: 6.4 High: 9.7 GWH: 7.6	Picker Survey	National definition
21 – Percentage of staff employed by or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their		58%	70%	68%	68%	68%	69.8%	Higher is better	-	NHS Staff survey	National Definition

family or friends											
23 - VTE	4 Percentage of VTE Risk Assessments completed	95.5%	97.1%	98.3%	99.4%	99%	90%	Higher number better	Low - 91.3; High - 100	EPMA and manually for those areas not using the electronic prescribing system	National Definition (from Hospital database)
	5 Percentage of patients who receive appropriate VTE Prophylaxis	95%	91.6%	95.2	97.4%	94.9%	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)
25 - The number andwhere available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death	Number of Incidents per 100 Bed Days	4.55	4.98	5.9	6.7	5.1	--	Lower is better	--	Informatics & Clinical Risk	-
	Number of Patient Safety Incidents per 100 Bed Days	3.00	3.07	3.3	4.4	3.6	--	Lower is better	--	Informatics & Clinical Risk	-
	Number of Incidents resulting in Severe Harm or Death per 100 Bed Days	0.03	0.04	0.01	0.01	0.02	--	Lower is better	--	Informatics & Clinical Risk	-
	Percentage of Combined Severe Harm and Death	0.56%	0.80%	0.55%	0.26%	0.41%	--	Lower is better	--	Informatics & Clinical Risk	-

		2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition	2013/ 2014
25 - The number and where available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death	Number of Incidents per 100 Bed Days	4.55	4.98	5.9	6.7	5.1	--	Lower is better	--	Informatics & Clinical Risk	-	
	Number of Patient Safety Incidents per 100 Bed Days	3.00	3.07	3.3	4.4	3.6	--	Lower is better	--	Informatics & Clinical Risk	-	
	Number of Incidents resulting in Severe Harm or Death per 100 Bed Days	0.03	0.04	0.01	0.01	0.02	--	Lower is better	--	Informatics & Clinical Risk	-	
	Percentage of Combined Severe Harm and Death	0.56%	0.80%	0.55%	0.26%	0.41%	--	Lower is better	--	Informatics & Clinical Risk	-	
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period		26.0%	26.5%	31.7 % Oct	31.1% (Oct 15 to Sep 16, most	30.8% (Oct 16 to Sep 17,	25.3%	Lower is better	Low:0; High: 49.4	HSCIC	National Definition	

			14-Sept 15 Most recent data availab le	recent data availab le)	most recent data availa ble)					

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 2017/18 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**	**2017/ 2018 Target**	**2017/ 2018 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%	92%	86.7%	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%	90%	69.1%	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%	95%	89.3%	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%	95%	87.2%	Not Met
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	98.4%	99%	94.%	94%	94%	100%	94%	98.7%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	100%	98%	99.7%	98%	98%	99.6%	98%	100%	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%	85%	82%	Not Met
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%	90%	97.6%	Achieved
Cancer 31 day wait from diagnosis to first treatment	98.8%	98.6%	98.00%	96.00%	96%	97.1%	96%	98.4%	Achieved

Indicator	2013/ 2014 Trust	2014/ 2015 Trust	2015/ 2016 Trust	2015/2016 Target	**2016/ 2017 Target**	**2016/ 2017 Trust**	**2017/ 2018 Target**	**2017/ 2018 Trust**	Achieved/ Not Met
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%	93%	93.4%	Achieved
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%	93%	78.5%	Not Met
Maximum 6-week wait for diagnostic procedures	99.7%	99.5%	99%	99.1%	99%	97.0%	99%	96.2%	Not Met

Statement from the Council of Governors dated 9th May 2018

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 the percent of persons attending A & E seen within 4 hours against the target of 95% but were pleased to see that in March 2018 the figure reached 85%, the trajectory figure agreed with NHS I and in April reached 91.9%. Governors consider these figures to be consistent with those of the vast majority of other Trusts and are reflective of the pressures brought about by increased attendance.

The Governors are aware that the Trust continues to take action to address this issue and the consequential effects on other performance indicators. Nonetheless we are 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 a 50% reduction in moderate harm falls and a 53.3% reduction in severe harm falls, a below average mortality rate and in many other areas. These achievements are noted by the Governors and combine to help achieve an improving experience for our service users.

The Governors have had opportunities to undertake safety and quality visits across the hospital, enabling Governors to meet and talk directly to staff and patients in clinical areas, gaining an insight in how the Governor role can support the business of the Trust. The visits provided Governors with direct oversight of patient care and improvements made throughout the year, plus added to the Governors knowledge and understanding of patient experience, along with staff and patient feedback. A continuing programme of visits has been set up for 2018/19.

The Governors Patient Quality and Operational Performance Working Group is working very well and there are detailed presentations and reports and Governors have the opportunity to consider in detail specific issues and areas of improvement.

During the last year Governors have worked with staff to build on the good work within the Quality Accounts and focussed on safeguarding, food hygiene, winter pressures preparation, e-rostering and the management of overseas patients. The Governors are looking forward to continuing to build on this good work in the coming year, focusing on a number of areas including Risk Management, Activity Planning and Increasing Demand and Equality and Diversity. In addition the Local Governors selected Indicator for 2018/19 was Falls (Medicines Reconciliation on admission and after a fall has taken place).

Roger Stroud

Lead Governor on behalf of the Council of Governors

Statement from Swindon Clinical Commission Group dated 16th May 2018

Swindon Clinical Commissioning Group (CCG), as lead co-ordinating commissioner for the Great Western Hospitals NHS Foundation Trust (GWHFT) welcomes the opportunity to review and comment on the GWHFT Quality Account for 2017/2018. Swindon CCG has also sought the view of NHS Wiltshire CCG in order to provide a joint commissioner response. In so far as the CCG has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the CCG via contractual monitoring and quality visits and is presented in the format required by NHS Improvement 2017/2018 presentation guidance.

In June 2017, the GWHFT were commissioned to provide community health services for the population of Swindon (SCHS) and this has resulted in the Trust reporting data for additional services within its quality accounts for 2017/18.

A key priority for the Trust during 2017/2018 was to build on the success of the Sign up to Safety programme. The CCG acknowledges the sustained progress that has been made within these important quality improvement workstreams, focusing on the key priorities relating to inpatient falls; pressure ulcers; reduction in the number of deaths relating to acute kidney injury (AKI), management of sepsis and recognition of the deteriorating patient. The CCG's have a sepsis commissioning for quality and innovation (CQUIN) scheme in contract for 2017-2019 which will support continued focus on reducing the sepsis 30-day mortality rate.

Although the Trust has reported an increase in the number inpatient falls, the CCG notes the reported 50% reduction in the level of harm experienced. During 2017/18 the Trust also reports it has exceeded its target to reduce the number of avoidable pressure ulcers to less than 5 per month. The CCG will continue to monitor the quality improvement workstreams aimed at preventing inpatient falls and pressure ulcers, including the SCHS inpatient wards, but would also welcome more detailed information within the quality accounts of the lessons learned as a result of the individual and thematic reviews of the Trust's investigations into all reported falls and pressure ulcers.

As identified in both national and local learning from incidents, the Trust has continued to build on education and training plans aimed at recognising the deteriorating patient and ensuring timely treatment. The Trust has fully implemented and embedded the standardised National Early Warning Score (NEWS) Trust Wide (including community areas). The CCG notes the delay in the Trust being able to introduce the E-Observations system during 2017/18, but now awaits the outcomes of its planned introduction in the summer of 2018.

During 2017/18, the Trust experienced a sustained increase in elective and non-elective demand, resulting in delays within the Emergency Department (ED) and the Trust having continued difficulties in achieving the 18-week referral to treatment target. These NHS constitutional targets continue to be a national challenge across NHS organisations and are regularly monitored by the CCG. The CCG will continue to work with the Trust to monitor the quality of care and treatment for patients, including outcomes of plans to improve performance, safety and patient experience and quality assurance visits.

The Trust reported a breach in the numbers of Clostridium difficile infections reported during 2017/18 (25 against a trajectory of no more than 20) but was able to demonstrate no outbreaks of infection during this period.

5 of the 25 cases were assessed as avoidable and learning has been shared with the relevant CCGs and infection prevention and control committees, in order to support year on year reductions. Of note, no hospital acquired meticillin resistant staphylococcus aureus blood stream infections (MRSA) were reported during the year.

The CCG welcomes the Trusts' continued focus on reducing reported gram negative bloodstream infections (GNBSI) across the wider hospital and community settings during 2018/19, where there is now a national initiative aimed at ensuring a 50% reduction in the number of GNBSIs reported by 2021.

The CCG is aware that during 2017/18 the Trust has introduced a new process for mortality reviews, which has been developed as part of a collaborative with all hospitals in the West of England. The Trusts have all worked with the Royal College of Physicians (RCP) as pilot sites for the introduction of the Structured Judgement Review (SJR) methodology for undertaking mortality reviews. The CCG welcomes the priority for 2018/19 to now increase the number of reviews taking place, whereby thematic analysis and narrative collected for each case will be used to ensure learning from deaths continues to be shared within the organisation and more widely.

We recognise the ongoing work by the Trust to monitor and improve patient experience and note the outcomes of the 2017 patient survey, demonstrating that a number of survey questions have had an improved score from the previous year. Going forward, the CCG will continue to work with the Trust to gain assurance on actions being taken to improve those areas where feedback scoring has worsened, particularly regarding discharge planning.

The results of the NHS Staff Survey for 2017, demonstrates the Trusts overall position in the region has declined compared with last year. A total of 2446 employees returned a completed questionnaire giving the Trust a response rate of 46.5%. This was a decrease in last years (49%) but above the average response rate for Combined Acute and Community Trusts in England (43%). With 75% of GWH staff continuing to remain enthusiastic about their job and 85% feeling that the organisation acts fairly regarding career progression, it is recognised that these scores are significantly better than other similar organisations. However, overall, the staff engagement score shows the Trust is marginally below the national average. The areas used to measure the staff engagement score is based on staff recommending the organisation as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work. The CCG welcomes the Trust's commitment to achieving its identified short and long term priorities aimed at improving staff engagement and morale and will work with the Trust to monitor progress during 2018/19.

The CCG is pleased to note that the Trust has reported progress within the field of research and development and that the Trust successfully met it's set target for 2017/18. To support these statements further, the CCG would welcome additional information with regards to the positive impact and outcomes that are being achieved through the research and development workstreams.

Swindon CCG welcomes the quality priorities outlined by GWHFT for 2018/19, including the commitment to increase quality improvement (QI) capability within the organisation and incorporate all community services into all current and future improvement workstreams. In addition, the CCG will be seeking further assurances during 2018/19 in relation to the quality impact of any cost improvement plans (CIPs), including impact on workforce. Monitoring of the actions identified within both the Trust's sepsis workstreams and patient experience feedback regarding discharge will also be a key focus for the CCG.

Going forward, NHS Swindon CCG would request that more detailed information is provided for all community services as part of future GWHFT Quality Accounts.

As the lead co-ordinating commissioner, Swindon CCG is committed to sustaining its strong working relationship with GWHFT, together with local clinical commissioning groups and wider stakeholders, ensuring continued collaborative working that can support achievement of the identified priorities for 2018/19 across the whole health and social care system.

Gill May

Executive Nurse, NHS Swindon CCG

Statement from Healthwatch Swindon and Healthwatch Wiltshire dated 8th May 2018.

This statement is provided on behalf of Healthwatch Wiltshire and Healthwatch Swindon and together they welcome the opportunity to comment on the Great Western Hospitals NHS Foundation Trust's quality account for 2017/18. The role of Healthwatch is to promote the voice of patients and the wider public with respect to health and social care services. 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 coming year have been drawn from local learning and national concerns, and that patient/public Governor representatives have been involved in the process.

We are pleased that the Trust only reported one never event during the period of 2017/18 and that they have clearly laid out how they intend to ensure learning from the incident will be used to ensure such similar events don't happen in the future.

We recognise the work that the Trust has done to improve the Emergency Department (A&E) 4 hour wait target and acknowledge that the percentage of patients having a maximum of 4 hours wait is above their agreed trajectory target of 87.1%. We understand that the breaches in the Emergency Department (A&E) wait times are a national issue and we would encourage local people to share their experiences of using the Emergency Department (A&E) services with us to enable their continued engagement with patients.

For parts of this year the Trust's performance in meeting referral to treatment within 18 weeks has declined. The Trust started the year on target but performance dipped during the summer due to vacancies and a demand on specialities. We recognise that the Trust continued to experience a decline in performance during the winter period but that this was partly due to the national steer to cancel routine elective activity to meet demand over during the period of 2017/18 this period. We would again encourage local people to share their experiences of receiving routine elective surgery so that the impact of long waits for services can be identified.

We are pleased to see the continued progress made by the Trust on the areas highlighted by the Care Quality Commission's inspection dated December 2017 and we recognise the Trust's ambition to save an extra 500 lives by their engagement in the 'Sign up to Safety' initiative.

It is reassuring to see that patients are being given a variety of options to complete the national Friends and Family Test questionnaire including a text messaging service for all consenting patients to provide feedback once they are back home. The Trust have also been able to demonstrate improvements which have been implemented as a result of feedback shared through Friends and Family Test.

Healthwatch Wiltshire and Healthwatch Swindon are pleased that the Trust launched their engagement strategy this year and that they worked with various groups to inform the strategy. We would be pleased to work with the Trust in the future on the strategy action plan and implementation across the Trust. We look forward to working with the Trust over the coming year to ensure that the experiences of patients, their carers, and families are heard and taken seriously.

Lucie Woodruff
Manager
Healthwatch Swindon

Statement from Swindon Health Overview & Scrutiny Committee dated 23rd May 2018

I welcome the production of the Quality Account for Great Western Hospital Foundation Trust and the opportunity to comment. We commend you on implementing policies to reduce falls in hospital and despite a small increase; the number of falls resulting in severe harm has reduced. We also note good performance in relation to MRSA and reducing Health Care acquired Pressure Ulcers. It is also pleasing that there has been a small rise in patients saying they are involved in decisions about care and treatment.

We acknowledge the challenges the Trust faces in further reducing falls, the continued improvement needed in infection control and the increase in re-admission rates. We would welcome a further breakdown of admissions rates amongst older people rather than a measure of 16+.

We note that there is no mention of the work of the Trust in relation to safeguarding children and adults and would encourage the Trust to cover this in future

Swindon Adults, Health and Housing Scrutiny Committee welcomes the active engagement of the Trust in its meetings and the regular reports the Committee receives.

Sue Wald

Corporate Director of Adult Social Services

Statement from Wiltshire Health Overview & Scrutiny Committee dated 17th May 2018

The Wiltshire Health Select Committee has been given the opportunity to review the draft Quality Account for Great Western Hospital Trust 2017/18.

On 5 September 2017, the committee considered the CQC report following the re-inspection of Great Western Hospital Trust and noted that the trust had been rated as Good for being effective, caring and well led, and as Requires Improvement for being safe and responsive to people's needs. It was also noted that CQC had not changed the overall rating of the trust following this focused inspection – which remained at Requires Improvement.

The committee last received a report from Great Western Hospital in November 2016 and overall the committee was satisfied with the improvement plan put in place by the Trust.

In early 2019, the committee would welcome an update from Great Western Hospital on the delivery of their priorities for improvement 2018/2019.

Cllr Christine Crisp

Chairman of the Wiltshire Health Select Committee

2017/18 Statement of Directors' Responsibilities in Respect on the Quality Report dated 24th May 2018

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 2017/18 and supporting guidance

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

- Board minutes and papers for the period **1st April 2017 to 24th May 2018**.
- Papers relating to quality reported to the board over the period **1st April 2017 to 24th May 2018.**
- Feedback from Swindon and Wiltshire commissioners dated: **16th May 2018**
- Feedback from governors dated: **9th May 2018**
- Feedback from local Healthwatch organisations dated: **8th May 2018**
- Feedback from Swindon Overview and Scrutiny Committee dated: **23rd May 2018**
- Feedback from Wiltshire Overview and Scrutiny Committee dated: **17th May 2018**
- 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 inpatient survey **February 2018**
- The [latest] national staff survey **March 2018**
- The Head of Internal Audit's annual opinion over the trust's control environment dated: **May 2018.**
- CQC inspection report dated **March 2017.**

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered 2017/18.

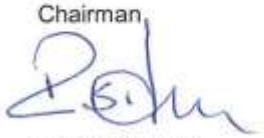
The performance information reported in the Quality Report is reliable and accurate

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 24 May 2018

Chief Executive

Date 24 May 2018

Independent Auditors report to the Council of Governors of Great Western Hospitals NHS Foundation Trust, on the Annual Quality Report dated 23rd May 2018

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 Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 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; and
- 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 trusts 2017/18 ('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 2017/18 (the Guidance).

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

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

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners, dated 16 May 2018;
- feedback from governors, dated 7 May 2018;
- feedback from local Healthwatch organisations, dated 17 May 2018;
- 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 October 2017;
- the latest national staff survey, dated October 2017;
- Care Quality Commission Inspection, dated 4 August 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the Trust's control environment, dated April 2018.

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 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

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

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read

the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

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

Basis for qualified conclusion on the 18 week RTT indicator

Our sample testing on the 18 week RTT indicator identified four issues from a sample of 20 pathways:

- One case where the service was nurse-led and therefore shouldn't have been included as a pathway;
- One case where no date stamp on the referral letter was identified for the clock start date;
- One case where an incorrect stop date was identified;
- One case where a duplicate pathway was identified.

Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the 18 week RTT indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and

  the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance

KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
25 May 2018

Glossary of Terms

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

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