Great Western Hospitals NHS
NHS Foundation Trust

Quality Accounts
2015/16

Service Teamwork Ambition Respect

Contents

1 Our Commitment to Quality

I am pleased to present our Quality Account for 2015/16. This document provides a clear account of our work to improve the quality of care our patients have experienced over the last year and our priorities for the year ahead.

There is no getting away from the fact it has been an incredibly tough year, with operational pressures, recruitment challenges and financial constraints. However we have ended the year stronger and our priorities have not changed. Providing safe, high quality and effective care, is what we are here to do.

Our focus on quality is now more important than ever before. This is because efficiency and quality go hand in hand. You cannot have one without the other. Over the past 12 months, we have been changing how we do things, adopting international best practice and being smarter with our resources. This has helped us to achieve better value for local taxpayers, while treating more patients and saving more lives than ever before.

I see lives saved every day and our mortality rates continue to reduce. This means that more patients are now surviving their illness than would be expected according to national averages.
This is particularly evident in our survival rates for patients with sepsis, with 120 lives saved last year alone. I am pleased that we have been recognised nationally for leading the way in this area with nominations for prestigious BMJ and Health Business awards.

Building on this life saving work, we have set ourselves an ambitious goal to save an extra 500 lives, over and above what would be expected, over the next five years.
Our focus will therefore remain on our Sign up to Safety Priorities, which alongside sepsis, include deteriorating patients, acute kidney injury, and falls and pressure ulcer prevention. You can read about our progress in these areas in this Quality Account.

I acknowledge that the data quality of the 18 weeks referral to treatment pathway has been identified as needing improvement and I'm confident that in the last six months we have made significant improvements and investment in this area.

With a growing and ageing population the NHS is facing fresh challenges, but it is still important to recognise the fantastic work which is taking place in our local hospitals, communities and in people's own homes.

I am particularly proud of how we are bringing cancer treatment closer to home for hundreds of people across Wiltshire, pioneering mobile chemotherapy with national charity Hope for Tomorrow and working with Oxford University Hospitals NHS Foundation Trust to bring radiotherapy to Swindon. This is just one area where we are making a big difference to people's lives and I'm pleased to able to share many more examples in our Quality Account.

I hope your enjoy reading about our work over the last year and our plans to further improve the quality of care for all of our patients.

Nerissa Vaughan
Chief Executive

2 Priorities for Improvement & Statements of Assurance

2.1 Review of Quality Performance 2015/16

This section reflects on the priorities we set for 2015/16 and whether we have achieved our goals. Where performance was below what we expected we explain what we are doing to improve in 2016/17.

2.1.1 Sign Up To Safety

The Trust committed to a safety improvement plan: Sign Up To Safety. This covered the following key areas of focus:

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

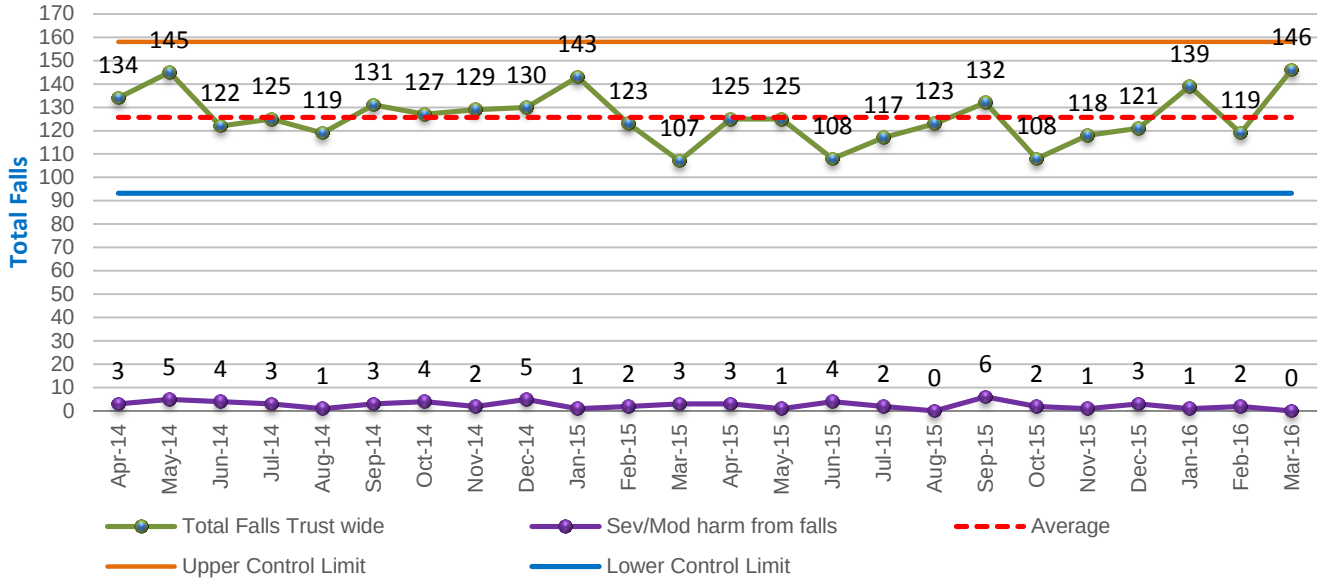
Reducing falls

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

Across the Trust, over the last year, we have seen a 30% reduction in harm from falls even though we have only had a slight reduction in the number of falls

In 2014/15 we were reporting an average of 3 moderate, severe harm or death from falls a month. In 2015/16 this has reduced to an average of 2 moderate, severe harm or death a month.

Total falls across the Trust



The chart above shows the total number of falls reported by month trust wide and the number of moderate, severe or death harm from falls.

What improvements have we achieved?

In 2015/16 we have reported a 30% reduction in harm from falls with. 13 falls were reported as severe harm with the remaining 12 as moderate harm. In total we reported 25 falls experiencing moderate or severe harm against 36 falls suffering moderate or severe harm that were reported in 2014/15.

Drivers for improvement

- We launched our 'Falls Collaboratives' for hotspot wards, bringing together multi-disciplinary teams to identify change ideas and test them in clinical areas.
- Our hotspot wards tested change ideas to reduce falls in clinical areas using PDSA (Plan, Do, Study, Act) methodology: Bedside Handover, Safety Briefs and Board Rounds.
- Trialling post incident safety huddles (SWARM) for early identification of learning after a fall.
- Training on quality improvement methodology for Ward Managers.

Further Improvements identified and our priorities for 2016/17:

- All Ward Managers sharing learning through the monthly Falls Operational Group to share ideas that have worked well on their areas.
- We will work closely with social services to fast track the discharge of our patients who are at greatest risk of a fall who are medically fit for discharge.

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.

Most 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

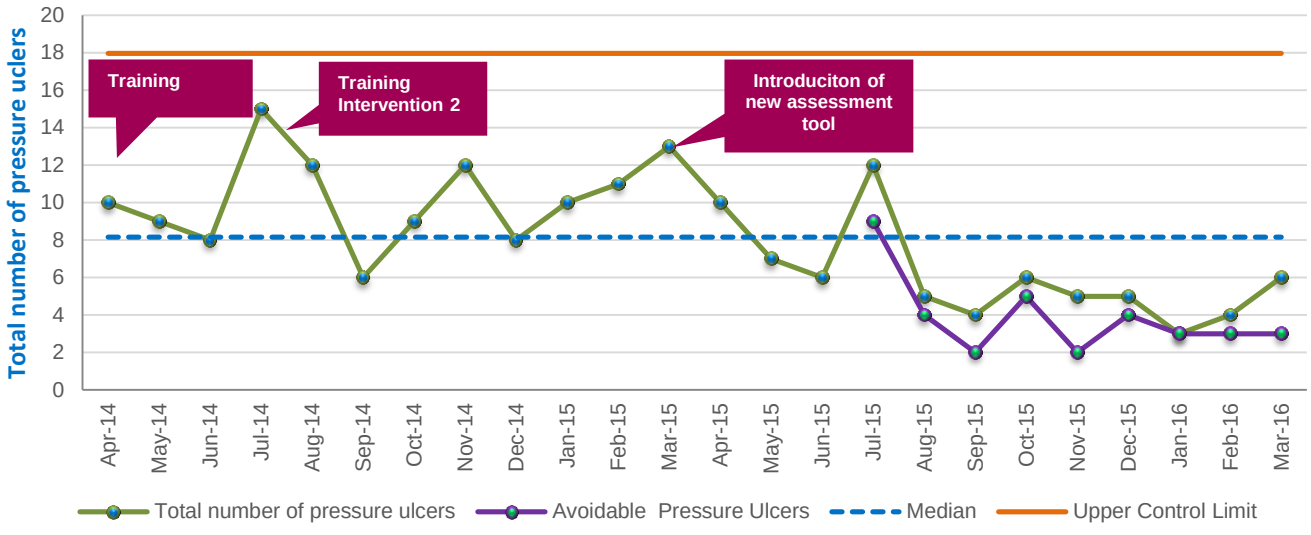
Acute Hospital Performance

We have reduced the number of avoidable pressure ulcers (category II, III & IV) across the acute hospital from nine to four per month.

Target: **<5 per month** sustained to April 2018.

Improved risk assessment, care of patients at risk & effective care planning.

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



The chart above shows the total number of category II, III and IV Pressure Ulcers reported and unavoidable

pressure ulcers reported for all our acute in-patients.

During the reporting period of 2015/16, our acute hospital achieved a reduction in the percentage of patients who developed a health care acquired pressure ulcer from the previous year from 0.84% to 0.5%.

This incidence was significantly lower than the estimated national average of 3-7% (*The cost of Pressure Ulcers in the UK, Oxfordjournals.org).*

Community Hospitals and Integrated Community Health Teams

We have reduced the number of avoidable pressure ulcers (category II, III & IV) across the Wiltshire community to an average of twelve per month.

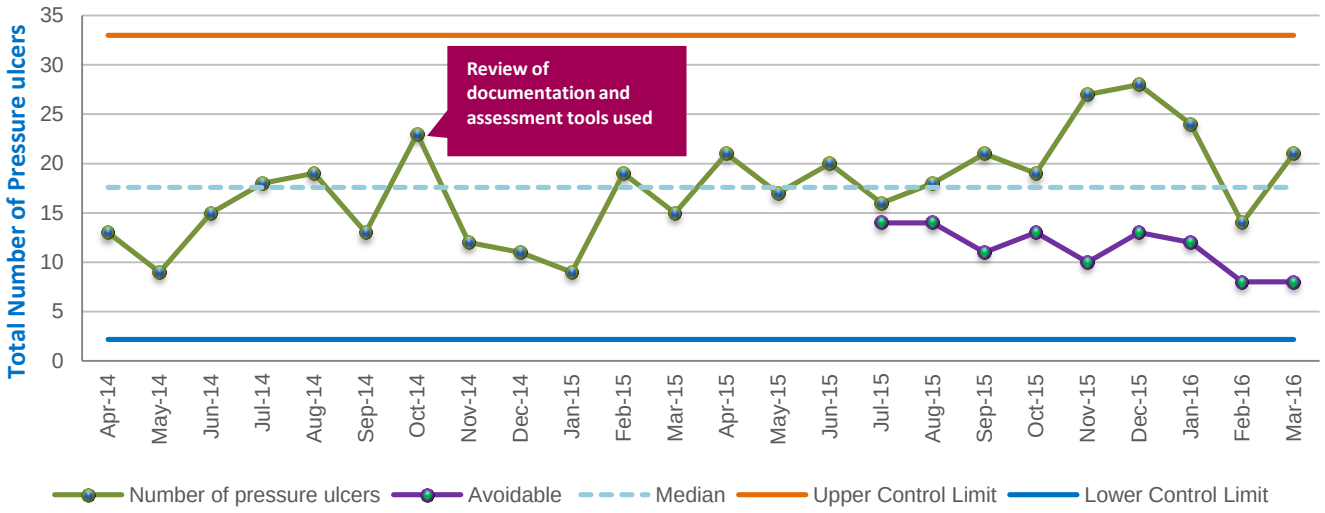
Target: **<14 per month** sustained to April 2018.

Improved risk assessment, care of patients at risk & effective care planning.

On Target

There has been a reduction in the incidence of patients cared for by our community teams who developed an avoidable health care acquired pressure ulcer from 1.25% to 0.57%. This incidence was lower than the estimated national average of 3-7%. *(the cost of Pressure Ulcers in the UK. Oxford journals.org.)*

Total number of pressure ulcers (category II, III, IV for all community patients)



The chart above shows the number of pressure ulcers reported for all community patients 2015/16.

What improvements have we achieved?

We have reduced the number of avoidable pressure ulcers across the Wiltshire community to an average of 12 per month which is below the target we set to achieve by 2018. Since July 2015 we have taken measures to differentiate between avoidable and unavoidable pressure ulcers that we report. This has enabled us to identify that 58% of these pressure ulcers were unavoidable.

Drivers for improvement

- Revised and implemented the Pressure Ulcer Risk Assessment Tool across the acute hospital to ensure timely identification of patients at risk of developing a pressure ulcer.
- Implemented the Wound Assessment and Management Care Plan to ensure patients who develop a pressure ulcer have an effective plan to manage their condition.
- Undertook an assessment of patients receiving pressure relieving air mattresses on our acute wards within two hours of the request.
- Distributed protective heel pads to hot spot wards with training for ward staff.
- Carried out process mapping with wards and community teams where pressure ulcers had been a problem to identify areas for improvement and deliver training to staff.

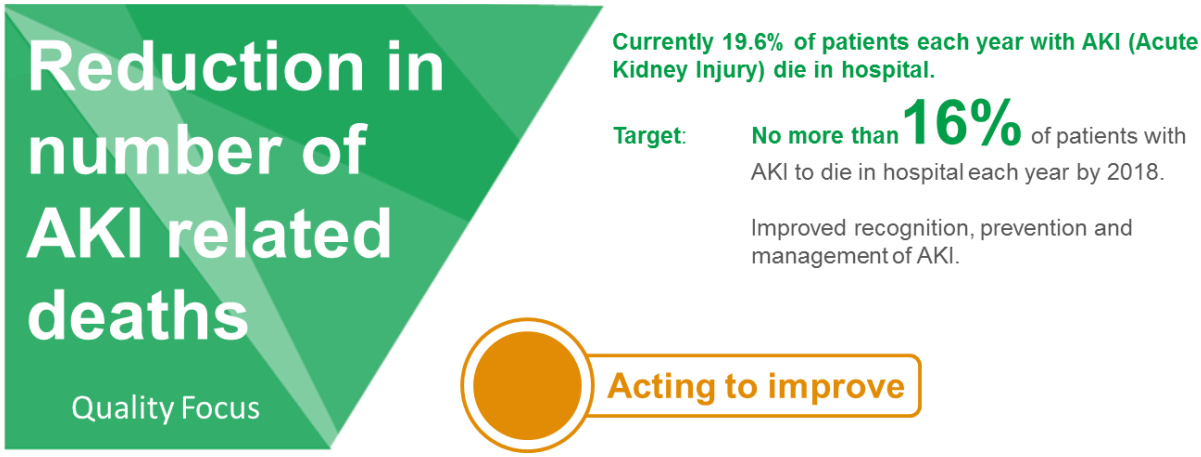
Further improvements identified and priorities for 2016/17

- For every pressure ulcer that develops, our Tissue Viability team will work with the Ward Manager or Community Team Leader to review the patient's care.
- We will continue to deliver training on pressure ulcer prevention and effective care management for our multi-disciplinary teams

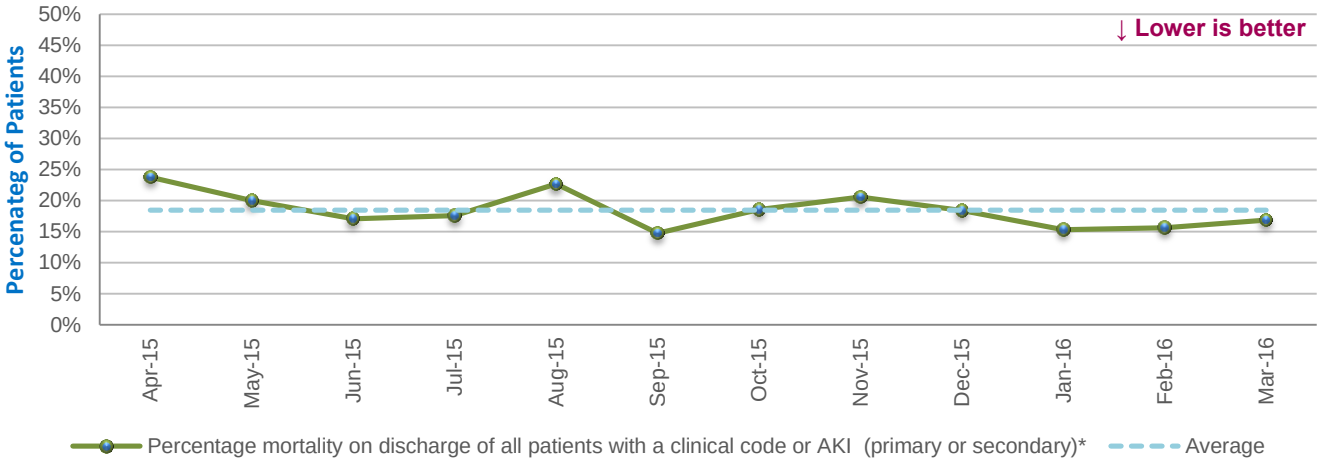
Acute Kidney Injury (AKI)

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

With early detection and the right care at the right time, both the risk of death and long term damage to the kidneys is greatly reduced. As a common and potentially life threatening condition, we are passionate about proactively improving care and saving lives.



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



The chart above shows the crude mortality on discharge with patients who have a clinical code of AKI (Primary or secondary). Since January 2016 we have reported an average of 15.9% in crude mortality on discharge that have a clinical code of AKI. This is below the 16% per annum we are striving to achieve.

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.
- Introduced an electronic flagging system that detects patients who have AKI from blood test results. The flag alerts the doctor that their patient has AKI and its severity.
- Implemented the AKI Kidney 5 Care Bundle, Sepsis, Hypovolaemia, Obstruction, Urine Analysis, Toxins (SHOUT). Patients flagged with AKI receive five standard elements of care proven to be effective in managing AKI.
- Ward pharmacists carry our medicine reviews of all patients flagged with AKI to determine the most appropriate medication to manage their AKI and aid recovery.
- Formed an AKI quality improvement project group of nurses, doctors, pharmacists, clinical coders and data analysts to work collaboratively to improve AKI care processes.

Further improvements identified and priorities for 2016/17

- We will launch an electronic AKI Care Bundle and integrate our IT systems to enable an AKI flag to be transferred across all relevant information systems to aid recognition, early treatment and coding of our patients with AKI.
- We will develop care pathways with GPs and community healthcare providers to improve prevention of AKI of our patients before coming into hospital and support appropriate care to aid their recovery once home.

Sepsis

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

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

Effective delivery of the Sepsis Care Bundle (Sepsis 6 UK Sepsis Trust) increases patients' chance of survival by up to 30%. Overall national mortality rate for patients admitted with severe sepsis is 35%. (UK Sepsis Trust 2014)

Reduce number of Sepsis related deaths

Quality Focus

Currently 17% of patients admitted with severe sepsis die within 30 days of discharge.

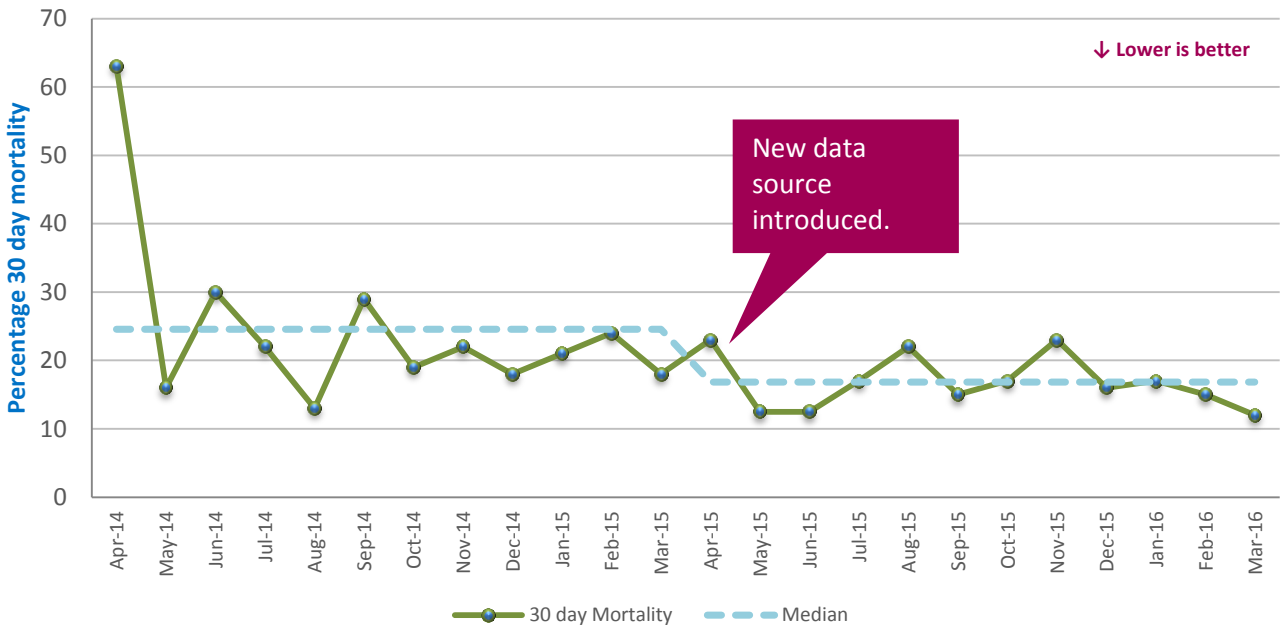
Target: **<23%** sustained level of mortality from severe sepsis.

Improved recognition, assessment & implementation of Sepsis 6.

On Target

In 2014/2015 we reported an average of 25% patients admitted with severe sepsis that die within 30 days of discharge. We used this first year of data collection to set our annual mortality target to less than 23% sustained mortality from severe sepsis until 2018. However in In 2015/2016 we have achieved an average of 17% crude mortality from severe sepsis which is exceeding our current aim of below 23% mortality. Our challenge for 2016/2017 is sustaining this reduction in mortality each month.

30 Day Mortality



The chart above shows 30 day crude mortality from severe sepsis and the improvements achieved since April 2015

What improvements have we achieved?

- 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 ccontinued to monitor and improve usage of our standardised Sepsis screening tool and Sepsis 6 Care Bundle for all emergency admissions to the acute hospital.
- We have rolled out a Sepsis education programme to all new junior doctors.
- Audit of all patients in our Surgical Assessment Unit (SAU) receiving Sepsis Screening.
- We have extended sepsis screening to surgical patients having an emergency laparotomy.

Further improvements identified and priorities for 2016/17

- Our sepsis screening and improvement work will expand to include all inpatient areas of the acute hospital in addition to the existing emergency admission areas.
- We will 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 community healthcare providers to improve prevention of sepsis of patients before coming into hospital and appropriate care to aid recovery once home.

Recognition and rescue of the deteriorating patient

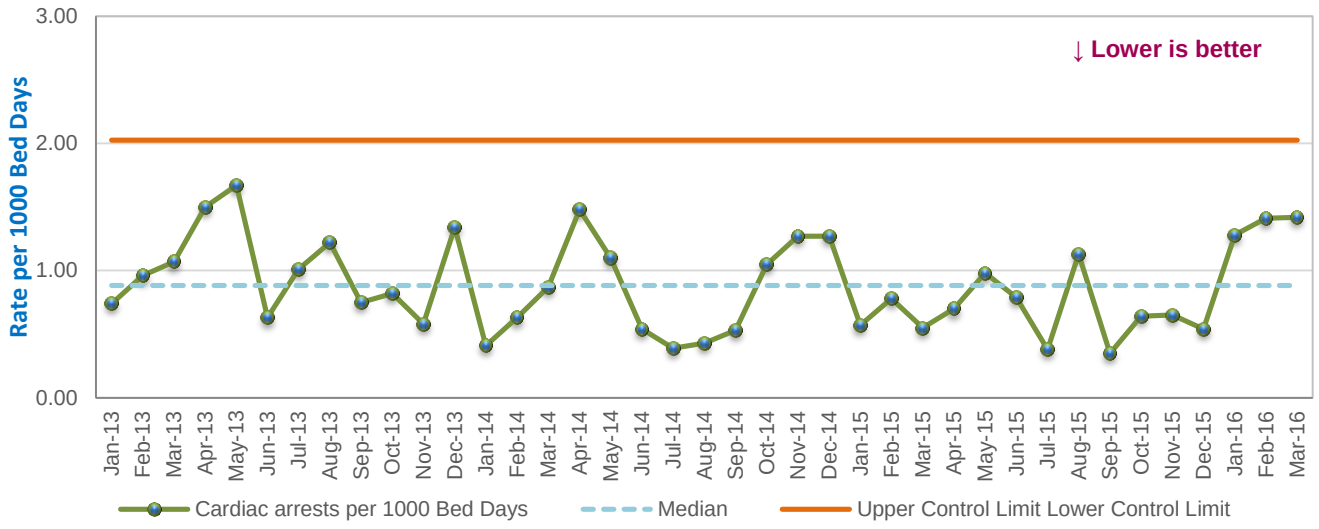
Recognition and appropriate timely management of the deteriorating patient has been recognised nationally as an area of concern. Numerous reports since the 1990s have identified patients are physiologically deteriorating, however that deterioration is not recognised appropriately or acted on as required,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

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

What improvements have we achieved?

- Implemented the standardised National Early Warning Score (NEWS) tracker and trigger tool across our acute inpatient, Day Case and Emergency Department areas to help determine and prioritise patients' level of illness.
- Developed and tested a NEWS education programme with two wards to improve recognition, accuracy of assessment and escalation of unwell patients by nursing teams.
- Recording the NEWS score on above-bed boards in acute admission areas to support prioritisation and identification of unwell patients.
- Launched Treatment Escalation Plans (TEP) in August 2015.
- Revised the Deteriorating Patient Policy in November 2015 and Observation Policy under development

Cardiac Arrests per 1000 Bed days



The chart above shows our cardiac arrests per 1000 bed days. In 2015/2016 we reported an average of 0.86 cardiac arrests per 1000 bed days. Although we have not reached our aim of a 10% reduction in cardiac arrests per 1000 bed days each year we have identified 3 key areas to focus our improvements efforts.

Further improvements identified and priorities for 2016/17

- We will rollout NEWS and simulation training across all wards at our acute hospital.
- Additional training will be rolled out to our ward staff in the use of communication tools (e.g. Situation, Background, Assessment, Recommendation SBAR) to improve timely escalation and review of the deteriorating patient.
- We will work with medical teams to ensure prompt and appropriate care planning for acutely unwell patients.

2.1.2 Other Quality Performance

Continue to reduce our numbers of healthcare associated infections

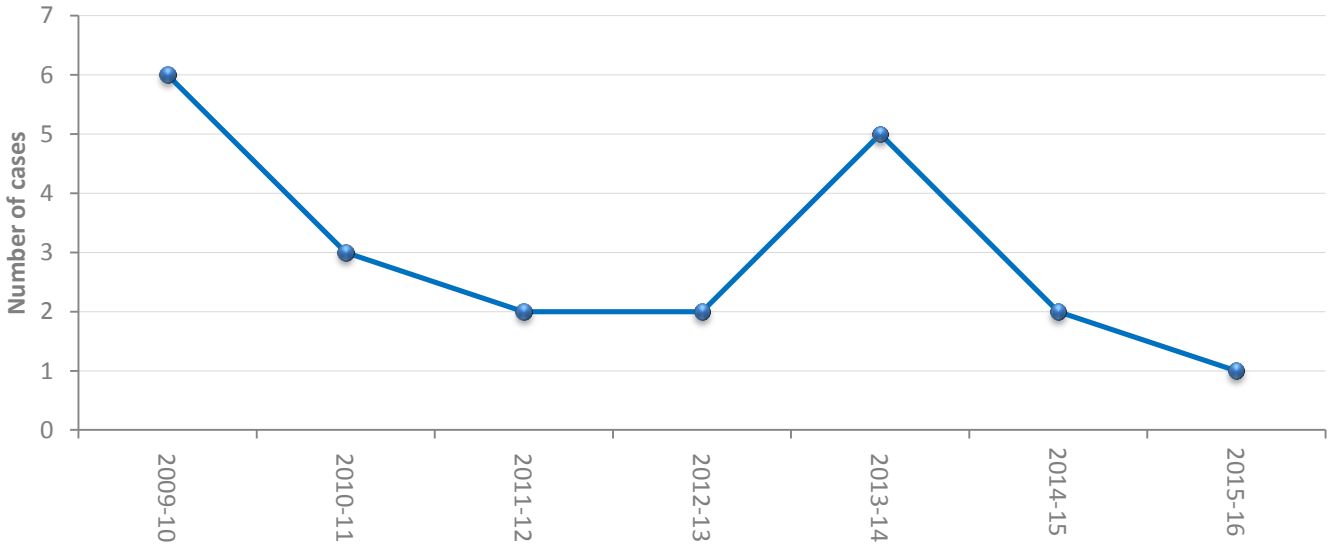
Methicillin Resistant Staphylococcus Aureus (MRSA)

During 2015/2016 we reported one case in total (acute site attributable) against a national target of zero cases. This was a contaminated sample obtained by a Locum Doctor in the Emergency Department rather than a healthcare associated infection.

In addition to expected practice of screening all emergency and categories of elective patients for MRSA, isolating and decolonising patient with positive results, the Great Western Hospitals NHS Foundation Trust has taken the following actions to improve patient safety, and so the quality of its services, by implementing the following initiatives:

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

Acute Cases of Trust Apportioned MRSA Bacteraemia



The graph above shows the number of cases of trust apportioned MRSA bacteraemia to Great Western Hospitals NHS Foundation Trust up until 2015/2016.

Clostridium Difficile

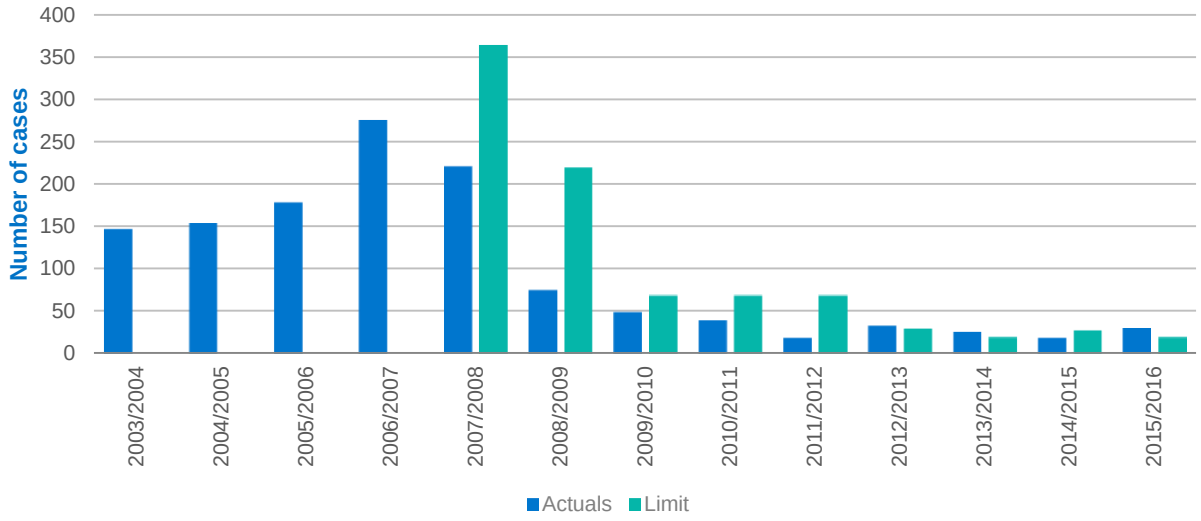
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA above, in England it's mandatory for Trusts to report all cases of *Clostridium difficile (Cdiff)* to Public Health England.

The nationally mandated goal for 2015/2016 was to report no more than twenty cases of *C.diff*. We have reported thirty cases in total which exceeds this goal; twenty five *C.diff* infections were attributed to the Acute Hospital and five cases to the Community Hospitals.
In conjunction with our Commissioners 3 of the 30 cases we reported were declared avoidable with care improvements recommended.

We have taken the following actions to improve patient safety, and so the quality of its services with the following local initiatives:

- Conducting a root cause analysis on each case to identify any areas of improvement
- Sharing the lessons learnt with staff concerned.
- Working with 'front door' services for prompt actions when patients attend with unexplained diarrhoea on admission.
- Ensuring our patients were 'isolated' within 2 hours of unexplained diarrhoea being reported
- We strive to improve antibiotic prescribing audit scores, which included adherence to antibiotic guidelines, recording the duration of the course and indication for their use; the introduction of electronic prescribing allows ease of audit, allowing a focus for improvement to be monitored. Electronic prescribing also allows the IP&C team to monitor antibiotic prescribing.
- We have fully implemented our cleaning strategy and the environmental cleaning standards group triangulates housekeeping audits, matron inspections and ward audits, friends and family feedback and managerial audits. This ensures consistency of cleanliness throughout the Trust.
- The assurance framework for cleaning to meet National requirements established with our business partner, Carillion, has ensured that cleaning is delivered at the correct frequency and level for each area. Audit scores are discussed at the environmental cleaning standards group.
- The importance of standard infection control precautions has been reinforced through link worker meetings and IP&C nurse feedback whilst in clinical areas.

Number of clostridium difficile cases 2015/16



The graph above shows the number of reported clostridium difficile cases in 2015/16. Our goal for 2015/2016 was to achieve no more than 20 cases. We reported 30 cases in total, 10 cases over our goal which equates to 50% above goal, 3 of the 30 cases we reported were declared avoidable with care improvements recommended.

Our priorities for 2016/17

The focus for the coming year will be on reducing the numbers of avoidable clostridium difficile. This includes promoting antibiotic stewardship, rapid isolation and sampling needs to continue with ward/department ownership of local cleaning standards, including patient care equipment all of which is specifically aimed at preventing avoidable cases of clostridium difficile.
To evaluate the effectiveness of a multidisciplinary approach using Plan, Do, Study, Act (PDSA) in reviewing each case of clostridium difficile infection within 24 hours of reporting with departments involved.

2.1.3 Patient Safety

Never Events

Never Events are serious incidents that are wholly preventable. There is guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

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

We reported a total of three never events between April 2015 to March 2016, a decrease of one never event reported during the same period in 2014/15. They were:

- Wrong site surgery – reported in August 2015
- Retained foreign body – reported in February 2016
- Wrong implant / prosthesis – reported in March 2016

The incidents have been reported and investigated, with March 2016 still under investigation, and managed through the Trust Incident Management and Clinical Governance structures. Action plans have been developed, with implementation closely monitored by our Patient Quality Committee.
Final reports for the incidents are also shared with our Commissioners, the CQC and Monitor.

Key learning points to take forward in 2016/17

- We have reviewed the consent process across the organisation, to ensure identification and patient safety is robust.
- The consent form for patients who do not have capacity now includes the best interests' checklist for clinicians to refer to when consenting.
- Revision of the procurement policies and procedures for surgical consumables and equipment within theatres.
- Improving the process to ensure the selection of the correct Lens during cataract surgery operations is closely linked and embedded within the WHO check list process.

Reduce Incidents and Associated Harm

Serious incident reporting

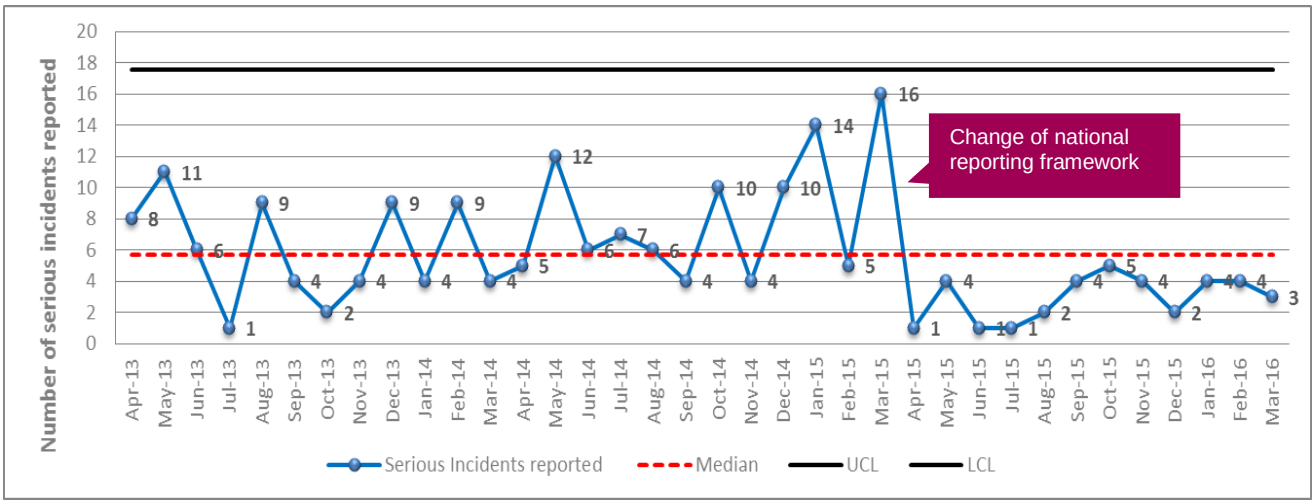
A total number of 35 serious incidents were reported and investigated during the period April 2015 to March 2016.

- 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.

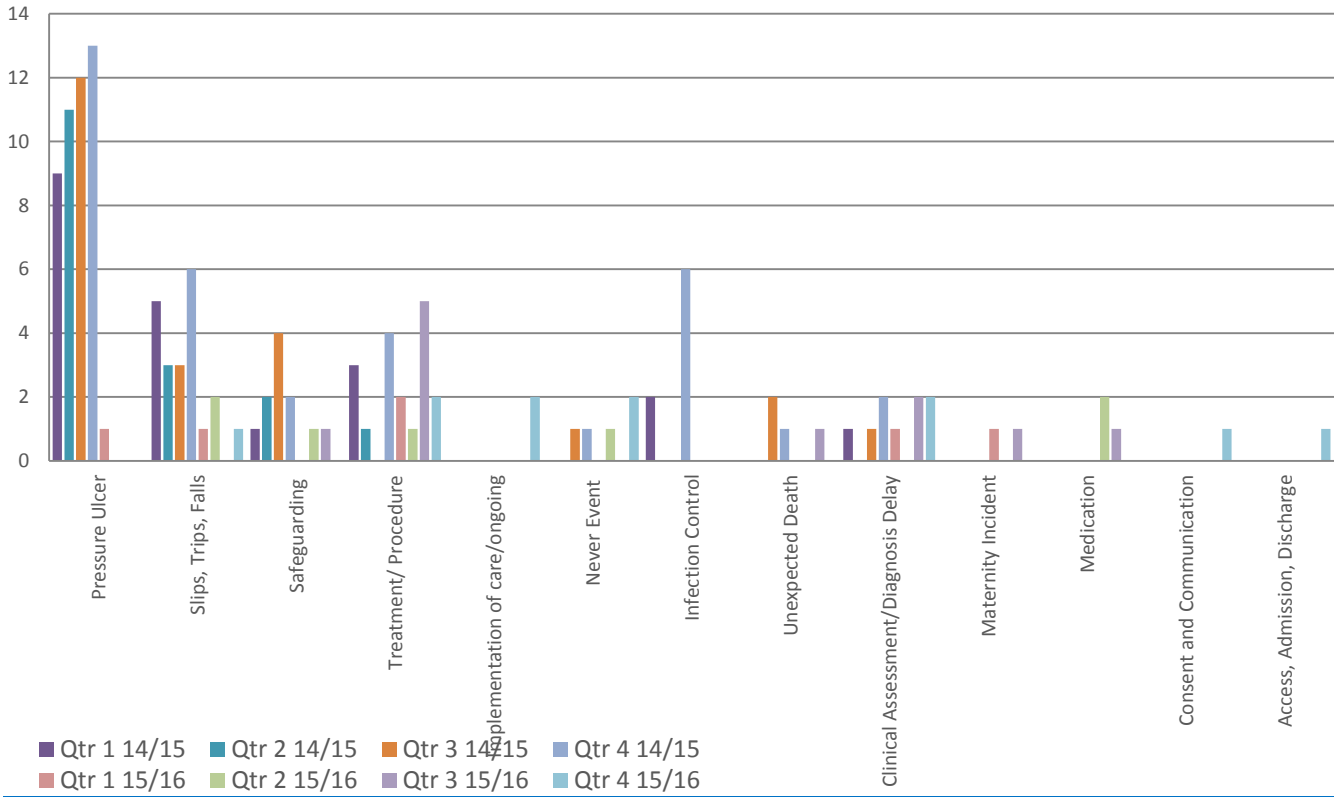
In March 2015 a revised serious incident framework was released by NHS England. The reduction in blanket reporting of pressure ulcers and falls on STEIS reflects this revised Serious Incident Framework allowing us to focus on the most significant risks and opportunity for learning.

Serious incidents reported 2015/16



The graph above shows the number of serious incidents reported in 2015/16. From April 2015 the number of serious incidents reported has remained below the median line.

Serious incidents reported by type per quarter 2015/16



The graph above shows the Trust's serious incidents reported by quarter in 2015/16 compared to 2014/2015 broken down by category. In 2015/2016 we reported a reduction in pressure ulcer and falls serious incidents.

This was in line with the revised national Serious Incident Framework which came into force in April 2015 this saw nationally a decrease in 'blanket reporting' to allow trusts to focus attention on the identification and implementation of quality improvments that will prevent recurrance of serious incidents, rather than simply the completion of a series of tasks.

The most frequently reported types of serious incident are:-

- Pressure ulcers
- Patient falls
- Treatment/Procedure failure, including monitoring rescue of the deteriorating patient
- Problems with clinical assessment, delays in diagnosis, interpretation and response to diagnostic procedures and tests

Incident reporting and benchmarking

The Trust uploads all reported patient safety incident forms to the National Reporting and Learning System (NRLS) on a daily basis. The number of incidents we have reported in the last 5 years are as follows:

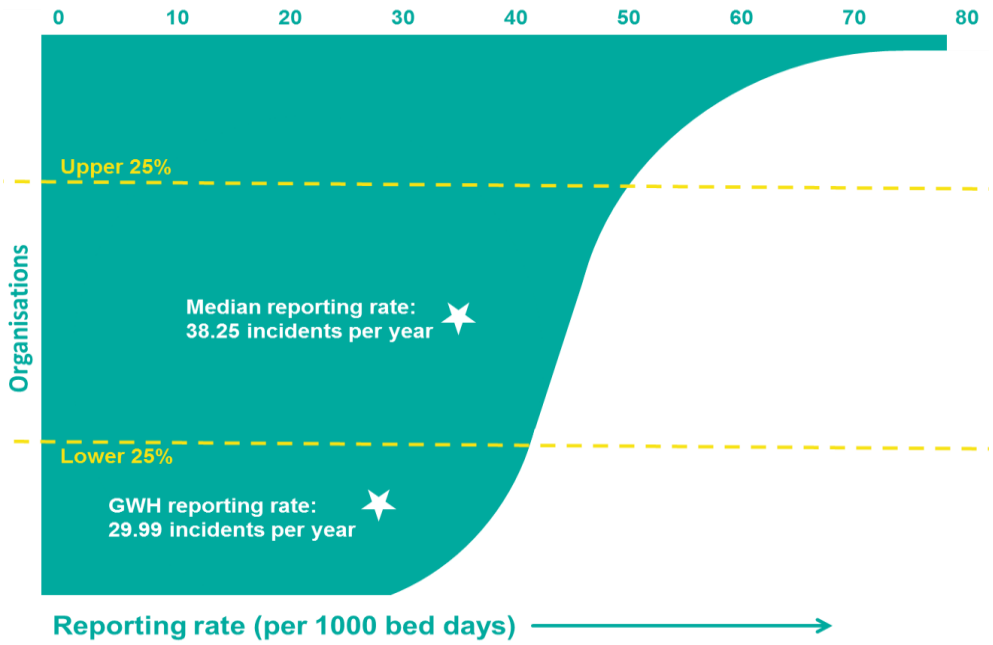
Reporting Year	Non clinical incidents / Health and Safety	Patient Safety Incidents reported to NRLS	Total
2011/2012	2493	6513	9006
2012/2013	2405	6928	9333
2013/2014	3596	6967	10563
2014/2015	4164	6678	10842
2015/2016	4796	6169	10965

How do we compare with other organisations?

NHS England National Reporting and Learning System (NRLS) release an Organisational Patient Safety Incident report twice a year providing organisational and comparative incident data. The next report from NRLS containing incident data from 1st April 2015 to 30th Sept 2015 is due to be published on 31st March 2016.

Comparative reporting rate per 1000 bed days for 137 acute (non-specialist) organisations

1st April 2015 – 30th September 2015



The Trust reported 3055 incidents between 1st April 2015 to 30th September 2015 with a rate of 29.99 per 1000 bed days. The median reporting rate for this cluster is 38.25 incidents per 1000 bed days. The Trust is at the lower end of the scale, falling within the bottom 25%. The Trust's reporting rate has decreased from the previous reporting period 1st October 2014 to 30th March 2015 when 31.5 incidents per 1000 bed days were reported.

Priorities for 2016/17

The Trust is in the lower 25% of reporters, with a reporting rate that has decreased from to 31.5 incidents 29.99% per 1000 bed days. During 2016/17 focussed activity on improving reporting culture will include:

- Rebranding of incident reporting from 'IR1' to 'Safety Incident Forms'
- Review of feedback mechanisms to ensure learning is shared with individual reporters, teams and Trust wide
- Safety videos
- GWH Patient Safety Conference in September 2016

Contributory factors from incidents involving recognition and management of the deteriorating patient will be aggregated to identify commonalities; these priority areas will directly inform the Deteriorating Patient Quality Improvement project.

Learning from incidents involving clinical assessment, diagnosis, and treatment to all speciality groups will be disseminated directly to Clinical Governance Leads who should assess relevance of recommendations from incidents occurring elsewhere and ensure appropriate actions are taken to review and improve similar processes in their own departments.

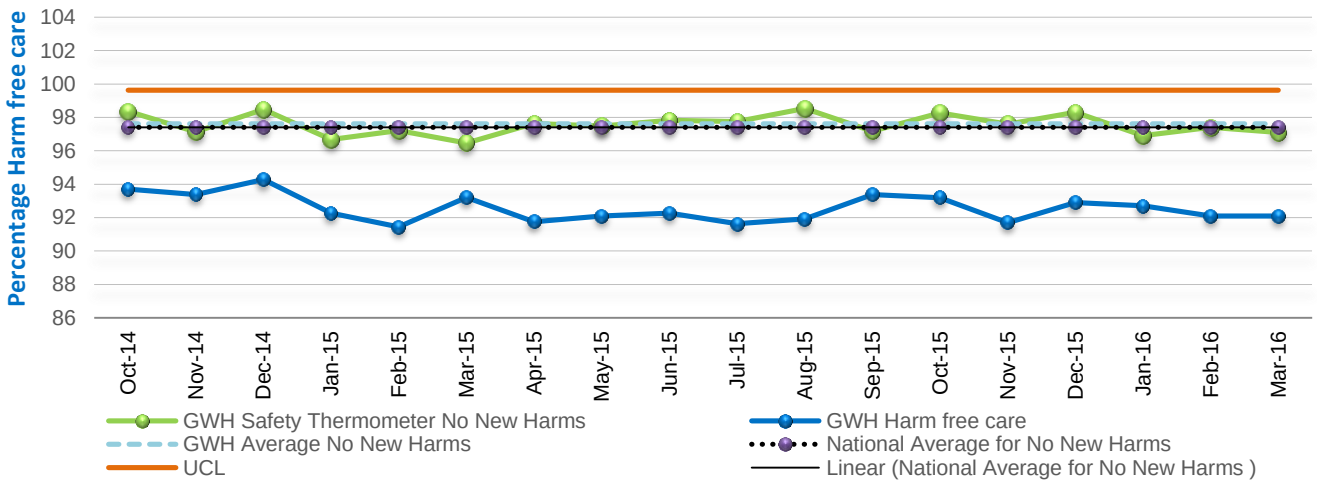
Build Quality Improvement (QI) capability across the organisation to move from an action planning, to a quality improvement approach when implementing change as a result of audit, incident management and risk management activities. Encourage and support Quality Improvement projects as the 'follow on' process from audit and incident management to achieve sustainable improvement;

- Deliver a programme of QI training to provide the skills for frontline teams
- Develop and make available QI resources and tools
- Accessible QI coaching and project troubleshooting
- Build a network of QI coaches within the organisation, with first cohort attending AHSN training in March 2015.

The NHS Safety Thermometer

This is a national initiative that records the presence of four harms on all patients on one day every month. The rationale for focusing on the four harms is because they are common and because clinical consensus is that they are largely preventable through appropriate patient care.

Safety Thermometer performance 2015/16



The graph above shows our Safety Thermometer new harm free care (new harms are those which are evident after admission to hospital). Our average new harm free care for 2015/16 was 97.6%. This is an increase of 0.02% on the previous reporting year 2014/2015.

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 can occur at the best hospitals and clinics - despite the best efforts of talented and dedicated professionals.

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

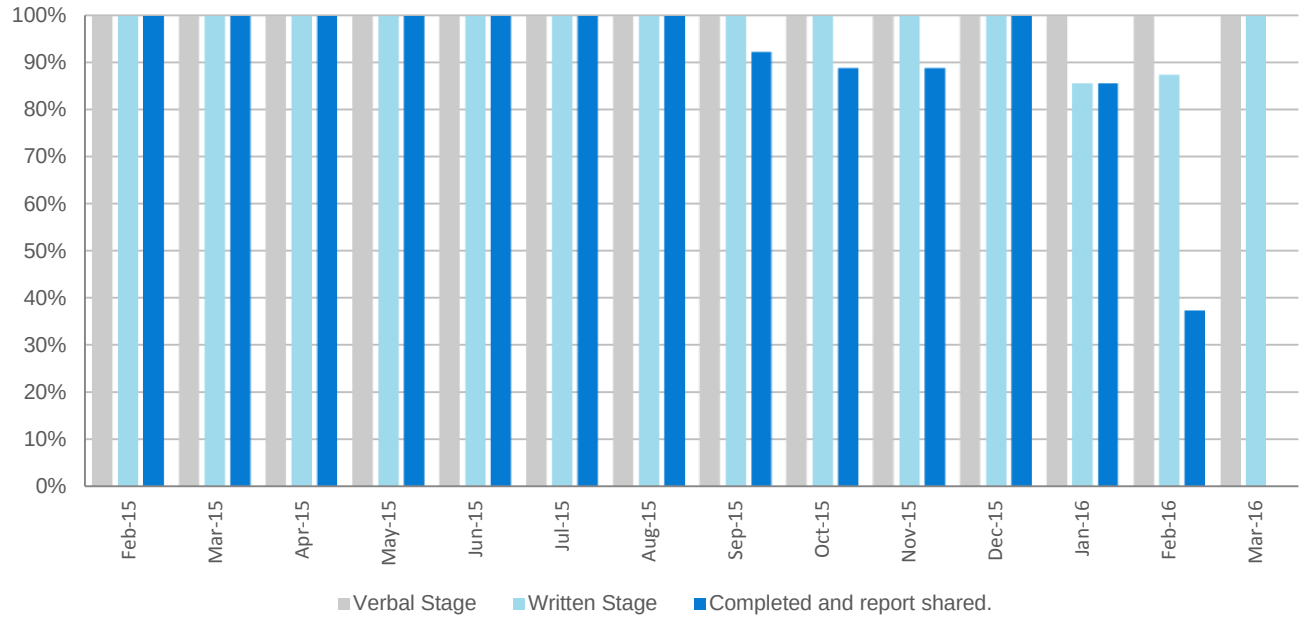
- Informing the patient or their family that an incident has occurred
- Acknowledging, apologising and explaining the incident – and confirming this in writing
- Providing information
- Providing reasonable support
- Inform the patient in writing of the original notification and the results of any further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

How are we implementing Duty of Candour?

We revised our Duty of Candour (Being Open policy) along with implementing education and training which is provided to all clinical staff at our Trust induction with additional e-learning released in August 2015. 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. The Trust's incident reporting system allows us to record Duty of Candour to document the three stages in communication to our patients or other relevant persons. We have also embedded template letters into the incident reporting system to support managers

We have a data extraction facility within the Trust's incident reporting system, which enables us to record and monitor compliance with all significant harm cases and is monitored at divisional level.

Compliance with each stage of Duty of Candour



The graph shows our current full compliance with each stage of Duty of Candour. We have 60 working days to conduct a Root Cause Analysis (RCA) investigation and write a report. This completed report is then shared with the patient/patients representative. The grey bar shows full compliance of verbal stage completed as soon as possible following an incident. The light blue and deeper blue bars representing the written and report stages show a slight lag to completion due to the 60 day full reporting and investigation process.

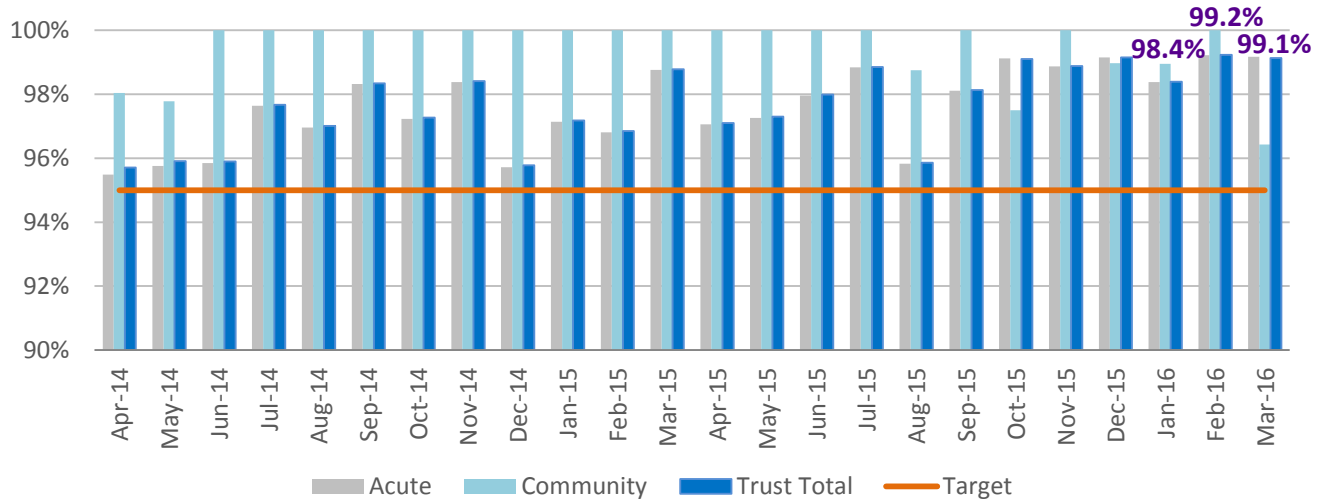
Venous Thromboembolism (VTE) risk assessment and hospital acquired thrombosis events

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 weekly and information disseminated to all clinical areas so that any under performance is highlighted and able to be rectified.
All adult patients who are admitted to GWH 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 95% of patients admitted to hospital should be risk assessed on admission. Across both the acute hospital and the inpatient wards in our community hospitals, we have worked hard to achieve and sustain this target. Data is collected in a variety of ways and we work with individual departments to ensure that the appropriate method is suitable for their needs.

Since the implementation of a weekly email to enable wards to have more up-to-date information we are able to look closely at the performance of individual areas and support them in achieving the target. We can now easily access data via our electronic prescribing system which is in place on the majority of the wards at our acute site, which allows us to produce reports that can identify which patients have had a risk assessment and what time this was undertaken.

VTE risk assessment performance April 2014 – March 2016



The graph above shows the Trust's VTE Risk Assessment. The Trust's average for quarter 4 was 99% which is 4% above the target of 95%.

Appropriate prevention and hospital acquired thrombosis events

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 check 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 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.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to continue to improve this score, and the quality of its services, following recommendations from the "all parliamentary thrombosis group" we are looking at all cases of hospital acquired thrombosis to determine if there are certain specialities where we need to look at providing more preventative treatment for longer.

We will continue 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.

2.1.4 Effective Care

Preventing premature death

Hospital Standardised Mortality Rate (HSMR)

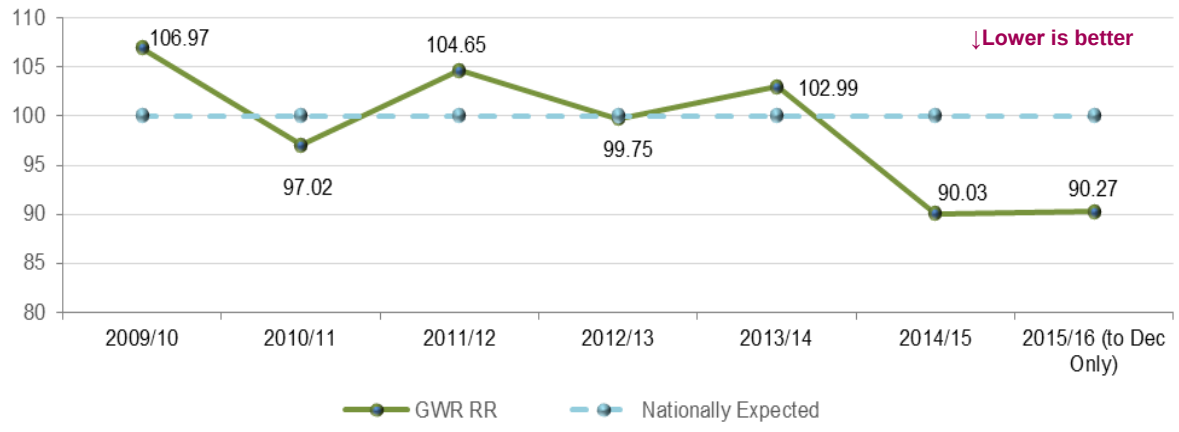
The Hospital Standardised Mortality Rate (HSMR) is an external validated method of calculating and comparing mortality rates. This information is analysed and presented to all trusts through Dr Foster; an independent benchmarking organisation specialising in healthcare analysis including mortality rates. 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 work has resulted in a lower number of deaths and we have one of the lowest HSMR values in Southern England.

The 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 2009 – Dec 2015



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

Mortality Alerts

In 2015/16, there were no mortality alerts identified by the CQC. Red bell alerts identified by the Dr Foster monitoring process were investigated using a standard process. As a result of these investigations there were no alerts where the number of deaths identified any particular themes. No avoidable deaths were identified.

The Trust received an alert via the national hip fracture database of an excess of deaths in these patients. This was not identified by the CQC or the Dr Foster data collection process. A review of these cases was undertaken. This identified that patients had not always been admitted to the trauma unit and suggested that use of sepsis tools could be improved. Sepsis tools have now been added to the documentation for these patients. An external review of the service by the British Orthopaedic Association has been requested and it is anticipated that following this review a quality improvement project will be established in any areas identified as needing improvement. Mortality rates in this patient group have already improved.

We have taken the following actions to improve patient safety, and so the quality of its services with the following local initiatives:

Priorities for 2016/17

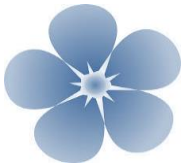
- The Trust Mortality Group will continue to review a range of Dr Foster mortality indicators each month and investigate Dr Foster mortality alerts as well as agreeing any other investigations or initiatives prompted by the data and trends
- The Terms of Reference for the Mortality Group and its membership will be revised this year to improve sharing of lessons learned from mortality reviews across the system.
- The Trust will be participating in a project with the West of England Academic Health Science Network to standardise mortality reviews and to learn from other organisations. This is part of a project across the whole of the NHS in England, led by the Royal College of Physicians. Local hospitals have agreed to act as early adopters of this programme of work
- We estimate that up to 80 lives have been saved each quarter by our work on sepsis. We aim to build on this by delivering a similar programme of work for patients with acute kidney injury which has the potential to save more lives. This is likely to result in further improvements in HSMR and SHMI values to help deliver our ambition to save an additional 500 lives by 2019.

Patient Reported Outcome Measures (PROMS)

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because patients who undergo surgery for, hip, knee, groin hernia and varicose vein surgery are sent questionnaires before and after surgery to assess the improvement in their conditions following their surgery. An Independent company analyses the questionnaires and reports the results to the Health & Social Care Information Centre. This data is then benchmarked against other Trusts.

Our provisional PROMS report shows that there has been an overall improvement on the scores for 2015/16 in particular Varicose Vein Surgery and hip replacement surgery. The Great Western Hospitals NHS Foundation Trust will take the following actions to continue to improve. We will continue to review our services, patient pathways and our own patient experience data to understand what further investigation is required, in order to fully understand this drop in standards.

Continue to Enhance the Quality of Life for Patients with Dementia



Our Dementia Strategy focuses on six key priorities as shown below. Delivery of these key objectives is overseen by the Dementia Strategy Group. The Dementia Strategy Group has a lead person for each of the six key priorities. In 2016 these work stream leads will form the basis of the Dementia Operational Group who will be overseeing improvements in dementia care at a ward based level. Much progress has been made with regards to our dementia priorities in 2015.

1. **Raising Awareness**
   A new lead has been created for the Trust's Dementia Champions, who has re-invigorated the role and activity of the Dementia Champions. A forum for Dementia Champions has been created and the

Champions now meet every 2 months to discuss dementia care in their clinical areas and departments, share best practise and novel approaches with each other and get involved in new dementia projects and initiatives around the Trust. Informed and motivated Champions help to raise awareness of dementia among staff within their respective work areas and are also well informed to help patients and relatives they come into contact with.

During National Dementia Awareness Week the Trust hosted a week of events to raise awareness of issues important to people with dementia. This included educational stalls and stands around the Great Western Hospital on the importance of personalised dementia care; delirium and dementia; supporting carers and dying with dementia. These stalls were aimed at educating both staff and public.

There is much on-going work to ensure dementia care is individualised as much as possible throughout the Trust including the use of 'reasonable adjustment' flags on our computer systems; the use of electronic Forget-Me-Not flowers on our new electronic ward boards and improved accessibility of 'This is Me' documents throughout clinical areas. An annual audit is now conducted into the use of these tools which facilitate our delivery of personalised care.

2. Education & Training

We provide basic dementia training to all hospital staff in accordance with Health Education England's requirements. We also provide a range of advanced dementia training courses for various staff. The Trust Lead for dementia training co-ordinates and regularly updates our dementia training programme.

3. Dementia Friendly Environments

GWH opened the first dementia friendly ward in November 2014 after a £98,000 refurbishment project, which was funded by a grant from the Brighter Futures Charity. A review of the impact of this first dementia friendly ward was carried out in 2015 and revealed a reduction in falls on the ward; a small reduction in length of stay; reduced use of sedating medications; reduced use of close support (one to one supervision of patients) and improved patient experience with fewer complaints. A programme of meaningful activities has also been introduced on the dementia friendly ward including the use of memory boxes which to facilitate reminiscence therapy, regular music therapy and the introduction of sensory bands for distraction in individuals with agitation or anxiety.

We continue to work in close partnership with Carillion, our private sector partner and estates manager, to ensure that routine updates to hospital fixtures and fittings are carried out in accordance with The King's Fund dementia friendly principles.

4. Dementia Care Pathway

During 2015 a new Dementia Care Pathway has been developed in conjunction with multiple specialties and departments throughout the hospital. The aim of this pathway is to ensure that excellent personalised dementia care is delivered throughout the Trust and throughout the patient journey from admission to discharge. It is anticipated that this pathway will be approved and introduced into clinical areas during 2016. In 2015 we have also developed guidelines for the management of pain in dementia as well as guidance on the use of specialist medications in delirium and dementia.

5. Valuing Carers

The GWH Dementia Strategy Group continues to work in close collaboration with the Trust's Carers Committee to improve support for carers of people with dementia. In 2015 we developed and introduced a new carer feedback survey. This has allowed us to collect valuable feedback from over 100 carers using either an online or telephone survey after discharge. Carer feedback is now reviewed every 6 months and recommendations and actions are taken forward in a 'You Said, We Did' spirit.
We have also conducted a Trust wide review of current support and provisions for carers in line with John's Campaign, a National Campaign highlighting how carers can be supported when their loved one is in hospital. Recommendations for improvements following this review are underway.

6. Benchmarking Services

GWH continues to ensure that all our dementia services and work adhere to national and regional standards and recommendations. We are due to participate in the National Dementia Audit in 2016, which will allow us to see how our dementia services compare with other dementia services on a regional and national basis.

Referral to Treatment 18 weeks (RTT)

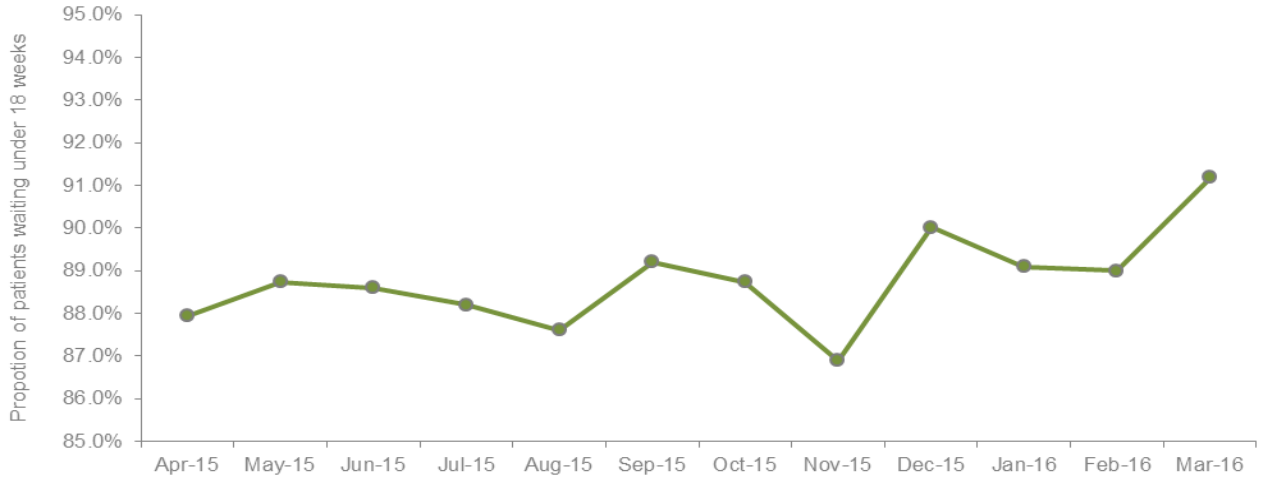
During 2015/16 the Trust's performance on waiting times for planned surgery has been a focus for improvement. The Referral to Treatment national standard for patients waiting for treatment is that at least 92% of patients should have been waiting for 18 weeks or less from referral to definitive treatment;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

At the beginning of the year around 88% of patients were waiting less than 18 weeks. Throughout the year there has been a sustained effort on improving this position. This has included undertaken increased clinic and operating activity in a range of specialties where waiting times were longer than expected. This activity has included some patients being treated at other providers. Waiting time for initial outpatient appointments have reduced as has the waiting time for routine day case and inpatient operations. We have also looked at our processes to ensure that patients are always booked according to clinical priority and then in order of waiting time. The programme has also included improving the quality of data recording and improving training for staff managing the patient journey.

Performance of 91.2% in March 2016 shows significant improvement and this is planned to continue into 2016/17. We feel this improvement is due to the introduction of the revised programme improving the quality of data recorded and focusing on training for staff in order to effectively manage the patient journey.

The Trust is anticipating that it will be back to sustainable achievement of the 92% standard from the end of May 2016.

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



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

For the period 2015/16, the Trust achieved only 90.3% of patients having a maximum of 4 hours wait in A&E. Taking into account SEQOL data, where our patients can attend the urgent care centre this takes our actual to 91.1%. Delivery of the GWH 4 Hour Acute Service Remedial Action Plan (RAP) incorporates the CQC recommendations.

The SAFER bundle and the Right Patient, Right Bed programme, which is designed to improve quality and performance through effective flow management contributing to improved ED performance.

It is underwritten by a performance trajectory that sees the 95% target achieved by July 2016, and sustained for the remainder of 2016/17.

The RAP is a whole system plan and Commissioners and community health and social care provider partner organisations have committed, within the RAP, to reduce the current high levels of DTOC and non-DTOC delays by 50% sustainably from Q2. The Trust achievement of the 95% target in Q4 will be achieved only if partner organisations deliver on their commitment to reduce DTOC and non-DTOC patient delays by 50% sustainably from Q2. This caveat has been fully acknowledged by commissioners.

If the 50% reduction target in DTOCs and other delays is not achieved by Q2, the Trust would therefore seek to see a revision of the ED trajectory, with commissioners, as follows:

- July – November 95%
- December 90%
- January 90%
- February 90%
- March 92%

Review of patients readmitted to hospital within 30 days of discharge

We carry out audits on patient readmissions within 30 days (28 days in 2014/15 as per commissioner request) of being discharged to find out if there was anything that we could have done to better prevent patients being re-admitted, especially if their readmission is related to their previous condition.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described as we have undertaken a review of all patients (144 in total) over the age of 18 who had an emergency admission with a discharge date during two specific time periods in the year and who subsequently had an emergency readmission within 30 days.

The 2014/15 readmission review included 74 patients' case notes; this has increased to 144 in 2015/16 due to including all direct emergency readmission routes (our Surgical Assessment Unit & Linnet Acute Medical Unit) and revising the inclusion criteria from emergency readmission within 28 days of discharge to within 30. A 95% confidence level has been achieved during this review.

In order to allow us to complete a comprehensive comparison with previous readmission audits we reviewed patients over the age of 18 years who had an emergency admission with a discharge date between the 21st and the 27th of September or the 23rd and 29th of November 2015 who subsequently had an emergency readmission within 30 days. 144 patients were highlighted as meeting these criteria by the Trust's Informatics Department.

- The majority were readmitted having self-presented to our Emergency Department (92/144) from their own home (120/144) and in 38% the readmitting diagnosis was the same as that for the original admission.
- In only 2 cases was the readmission attributed to failure of planned community health services.
- In 2 cases it was felt that closer mental health and alcohol support in the community may have prevented the readmission. In 2 cases there was felt to have been inadequate resource for pain management in the community.
- 28 readmissions were identified as potentially being avoidable (19%). The most common intervention which might have prevented a readmission was the provision of mental health services.
- Community acquired pneumonia was highlighted as the most common initial diagnosis in 2014 but in this review, poisoning was highlighted as the most common initial diagnoses. In 2014 86% of patients had multiple comorbidities. In 2015 44% had multiple co-morbidities.
- Mental health support in the community may have prevented 9 readmissions. Mental health support in the emergency department may have prevented 4 readmissions.

- In 4 cases it was felt that better management of the first admission by secondary care would have prevented readmission.
- In 4 cases the readmission was precipitated by the patient's lack of compliance with treatment.
- In 3 cases it was felt that the patient could have been managed in primary care.
- In 2 cases it was felt that the patient could have been better managed by the community hospital.
- In 1 case it was felt that the patient could have received IV antibiotics in the community preventing readmission.
- In 1 patient there was a failure of communication between primary and secondary care.
- In 1 case it was felt that the decision to readmit from ED by secondary care was incorrect.

In summary, 13 readmissions might have been prevented by better mental health support, 4 by better management in secondary care, 3 by primary care and 2 by community care. The provision of IV antibiotics in a Nursing Home resident might have prevented one admission, better communication between primary and secondary care could have prevented another and better decision making in ED might have prevented one more. Four readmissions were related to patient compliance.

19% of the readmissions were felt to be avoidable. Of these, only 7 could have been prevented by improved management of their first admission by secondary care. Although the overall number of readmissions has risen compared to last year (144 vs. 74) this is against a background of increasing admissions overall and a change from 28 to 30 days as a criteria for readmission plus the inclusion of surgical readmissions. The percentage classified as avoidable has decreased from 37% to 19% suggesting that overall management has improved.

Areas for development

The overall findings are similar to those of a previous readmission audit, but the number being readmitted because of lack of community mental health support has risen significantly.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by putting in place a process/plan to highlight the issues identified, educate medical and nursing staff on strategies to reduce readmissions and re-audit to measure progress.

Monthly 28 day readmission by age group

Month of Original Discharge	Total Spells			Readmission Within 28 Days			Readmissions Percentage Within 28 Days		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 14	917	5365	6282	82	403	485	8.9%	7.5%	7.7%
May 14	1018	5707	6725	79	445	524	7.8%	7.8%	7.8%
Jun 14	939	5627	6566	89	489	578	9.5%	8.7%	8.8%
Jul 14	938	6138	7076	75	545	620	8.0%	8.9%	8.8%
Aug 14	820	5557	6377	63	510	573	7.7%	9.2%	9.0%
Sep 14	995	5911	6906	93	555	648	9.3%	9.4%	9.4%
Oct 14	978	6024	7002	96	529	625	9.8%	8.8%	8.9%
Nov 14	961	5417	6378	90	435	525	9.4%	8.0%	8.2%
Dec 14	1081	5429	6510	93	449	542	8.6%	8.3%	8.3%
Jan 15	908	5448	6356	100	423	523	11.0%	7.8%	8.2%
Feb 15	863	4911	5774	99	414	513	11.5%	8.4%	8.9%
Mar 15	943	5677	6620	95	534	629	10.1%	9.4%	9.5%
2014/15	**11361**	**67211**	**78572**	**1054**	**5731**	**6785**	**9.3%**	**8.5%**	**8.6%**
Apr 15	812	5581	6393	91	533	624	11.2%	9.6%	9.8%
May 15	910	5631	6541	94	501	595	10.3%	8.9%	9.1%
Jun 15	891	5924	6815	67	571	638	7.5%	9.6%	9.4%
Jul 15	893	6000	6893	73	536	609	8.2%	8.9%	8.8%
Aug 15	795	5441	6236	84	539	623	10.6%	9.9%	10.0%

Sep 15	927	5902	6829	92	609	701	9.9%	10.3%	10.3%
Oct 15	966	5947	6913	96	560	656	9.9%	9.4%	9.5%
Nov 15	996	5690	6686	110	552	662	11.0%	9.7%	9.9%
Dec 15	1053	5750	6803	100	540	640	9.5%	9.4%	9.4%
Jan 16	941	5375	6316	86	515	601	9.1%	9.6%	9.5%
Feb 16	911	5323	6234	99	499	598	10.9%	9.4%	9.6%
Mar 16	1022	6002	7024			0	0.0%	0.0%	0.0%
2015/16	**11117**	**68566**	**79683**	**992**	**5955**	**6947**	**8.9%**	**8.7%**	**8.7%**

Monthly 30 day readmission by age group

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 14	917	5365	6282	84	410	494	9.2%	7.6%	7.9%
May 14	1018	5707	6725	80	458	538	7.9%	8.0%	8.0%
Jun 14	939	5627	6566	91	508	599	9.7%	9.0%	9.1%
Jul 14	938	6138	7076	76	560	636	8.1%	9.1%	9.0%
Aug 14	820	5557	6377	63	517	580	7.7%	9.3%	9.1%
Sep 14	995	5911	6906	94	563	657	9.4%	9.5%	9.5%
Oct 14	978	6024	7002	98	541	639	10.0%	9.0%	9.1%
Nov 14	961	5417	6378	90	442	532	9.4%	8.2%	8.3%
Dec 14	1081	5429	6510	93	456	549	8.6%	8.4%	8.4%
Jan 15	908	5448	6356	103	438	541	11.3%	8.0%	8.5%
Feb 15	863	4911	5774	101	419	520	11.7%	8.5%	9.0%
Mar 15	943	5677	6620	97	552	649	10.3%	9.7%	9.8%
2014/15	**11361**	**67211**	**78572**	**1070**	**5864**	**6934**	**9.4%**	**8.7%**	**8.8%**
Apr 15	812	5581	6393	93	539	632	11.5%	9.7%	9.9%
May 15	910	5631	6541	94	510	604	10.3%	9.1%	9.2%
Jun 15	891	5924	6815	68	581	649	7.6%	9.8%	9.5%
Jul 15	893	6000	6893	75	543	618	8.4%	9.1%	9.0%
Aug 15	795	5441	6236	84	547	631	10.6%	10.1%	10.1%
Sep 15	927	5902	6829	96	619	715	10.4%	10.5%	10.5%
Oct 15	966	5947	6913	97	568	665	10.0%	9.6%	9.6%
Nov 15	996	5690	6686	111	564	675	11.1%	9.9%	10.1%
Dec 15	1053	5750	6803	103	551	654	9.8%	9.6%	9.6%
Jan 16	941	5375	6316	89	529	618	9.5%	9.8%	9.8%
Feb 16	911	5323	6234	100	509	609	11.0%	9.6%	9.8%
Mar 16	1022	6002	7024			0	0.0%	0.0%	0.0%
2015/16	**11117**	**68566**	**79683**	**1010**	**6060**	**7070**	**9.1%**	**8.8%**	**8.9%**

Continue to Monitor and Maintain NICE Compliance

The National Institute for Health and Care Excellence (NICE) provides national guidance and recommendations which healthcare organisations are expected to follow. This means there is an agreed standard of health and social care which is required to be given to patients and service users, to improve their treatment, recovery and overall experience.

Every month, NICE publish their guidelines for healthcare organisation to assess and/or put into place. Since 1 April 2015, we have received 168 published NICE guidelines. Of the responses received from clinical divisions to date, 19 out of the 168 (11%) guidelines have been deemed not applicable to the organisation, and full compliance has been confirmed with at least 18 (11%) guidelines. Of the publications, a response is awaited for 125 (74%) guidelines, of these at least 30 guidelines were recently published in February 2016. There are action plans being implemented or are in the process of being formulated for the remaining 6 (4%) guidelines.

The Trust has maintained a compliance rate of 98%, and this is based on the initial assessment of all relevant guidelines.

2.1.5 Patient Experience

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 eligible patients at the point of discharge from hospital.
Throughout 2015/16 we have maintained a consistent 4.7 stars out of a possible 5 stars awarded by patients for the care they have received. Changes were made nationally to the reporting process; in line with these changes the Trust has also remained consistent with 90%-95% of patients likely to recommend our services to Friends and Family if they needed similar care or treatment.

FFT feedback from patients has allowed us to implement changes to be made to improve our services and this information is displayed on our ward/service area's noticeboards in the form of **"you said, we did"**.

To ensure that feedback is available to all eligible patients, Friends and Family cards have been produced in Large Print, Child & Young People friendly and Easy Read formats.

During 2015/2016 the Trust collected a total of 16,471 completed Friends and Family cards against a total of 140,166 total discharges throughout 2015/2016. We intend to take the following actions to improve this percentage and the quality of its services, as follows:

- We will continue to display "you said; we did" feedback in all of our areas throughout our hospital and community sites.
- We will continue to promote the Friends and Family Champions on each ward providing them with information and guidance on any changes and provide feedback to them to be shared with staff in their specific areas.
- We will introduce other methods of collection of Friends and Family comments for all areas in the form of real time data collection.

Improving patient experience & reducing complaints

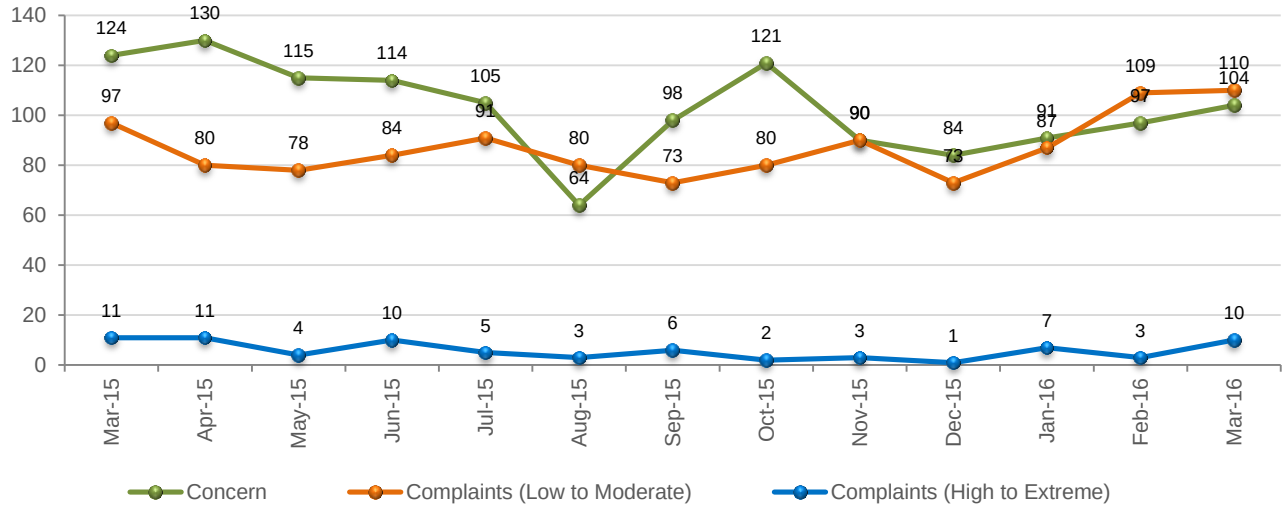
Listening to patients is important to us as it allows us to make changes to the care provided and the services we deliver. Throughout 2015/16 we have worked closely with Healthwatch Swindon and Healthwatch Wiltshire as part of their Engagement Plan to gain valuable feedback from inpatients about their overall patient experience, specifically related to inpatient stay, discharge and after care in the community.

Throughout 2015/16 Patient Experience films have been made to share patient's feedback on their overall patient journey. These short films have been made to share with the general public and trust wide staff. We intend to continue with filming these small films of patient stories throughout 2016/17. We will also continue to receive and use audio clips in the form of "Voicebook" for learning and improvement.

How we communicate with our patients is important to us and we are passionate about ensuring that our patients have detailed patient information in a plain English format to provide details or follow up information about the care patients have received or are about to receive. We are reviewing all of our Patient Information Leaflets and engaging with a "Lay Readership" panel to ensure that the information provided is relevant, helpful and in a format which is easy to understand. We have also made some of our Patient Information leaflets available in other languages and will continue to increase leaflets available in the top five requested languages to ensure that Patient Information is available to all.

We aim to respond to concerns within 24/48 working hours to avoid escalation through the complaints process; this allows for answers to be provided promptly and dealt with effectively. This ensures that the Trusts complaints procedure is accessible to all and easy and clear to follow.

Complaints received in 2015/16



The graph above gives a comparison on concerns/complaints received over a 12 month period towards the end of 2014//2015 and 2015/2016.

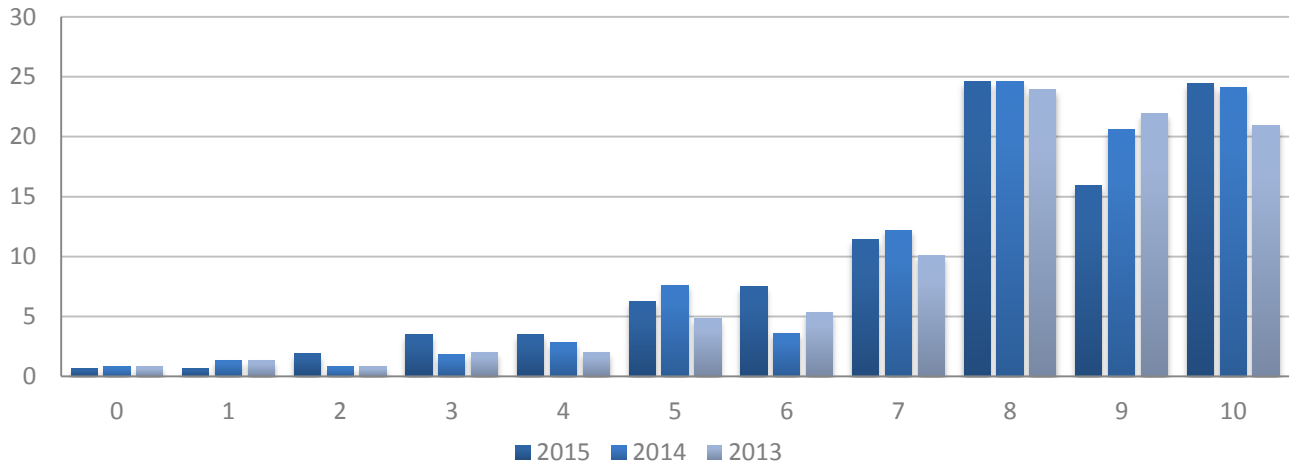
Further changes will include:

- Reducing response times to complaints.
- Ensuring that learning takes place and changes are made as an overall outcome to complaints raised.
- A service available to offer support, advice and guidance to patients, families and carers with an aim to resolve concerns, complaints effectively with an aim to avoid further escalation.

National Inpatient Survey

The National Inpatient Survey was carried out in quarter three of 2015 by the Picker Institute. The chart below shows the year on year comparison of how those who took part in the survey rated the quality of the care they received.

Trust performance in patient experience rating



The chart above shows responses to a question about their experience of care; a score of 0 was aligned to the statement “I had a very poor experience” scaling up to a score of 10 – “I had a very good experience”. The graph shows that overall, patients have continued to rate their experiences highly with scores between 8 and 10 being the most common.

Implement plans to improve results of the National Inpatient Survey

Following the results received from the 2014 picker survey, areas were identified for improvements to be made during 2014/15:

Bothered by noise at night from staff

- To review times of bin and water changes
- To review times of the drink service
- To work with Carillion to address noisy doors
- To implement Matrons' night ward rounds

Could not always find staff member to discuss concerns with

- Re-launched supervisory role of Senior Sister
- To improve call bell response times
- Continuance of six monthly skill mix review

Food was fair or poor

- Trial of menu system took place
- Patient feedback took place Carillion

Not always enough emotional support from hospital staff

- To agree actions at team meetings

Did not always get clear answers to questions

- Addition of 'Has patient understood plan?' to ward round check-list
- Details Included in junior doctor induction

Did not receive any information explaining how to complain

- To ensure posters and leaflets are in clinical areas
- To ensure patient "welcome packs" are used

During 2016/17 we will:

- Analyse the National Inpatient Survey report 2015 to identify further areas for improvement, create a robust Trust wide action plan with close monitoring of progress.

Staff Survey 2015/16

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

The NHS Staff Survey is understood to be the largest workforce survey anywhere in the world and offers unparalleled insight into staff experiences. The survey involves 297 NHS organisations from across the country and achieves just under 300,000 responses. As one of the 297 participating NHS organisations, in October 2015 we randomly selected 850 employees to complete the 2015/16 NHS Staff Survey. Of those, 367 returned a completed questionnaire giving the Trust a 43% response rate which is higher than most of our surrounding trusts.

National and regional comparisons

Despite the numerous challenges currently facing the NHS and its workforce, this year's NHS Staff Survey results demonstrate a positive improvement in terms of staff experience and engagement. Nationally, staff engagement has improved continuously over the last five years and this year the NHS has also seen an increase in staff's willingness to recommend their organisations as places to work or receive treatment. The majority of staff (69%) either agreed or strongly agreed that they would be happy with the standard of care their organisation provided if a friend or relative needed treatment and most (80%) agreed that they feel able to do their job to a standard they are personally pleased with. However, in contrast to this, the survey also highlighted that staff are continuing to experience difficulties with some of the pressures facing them, including inadequate resources and staffing shortages.

When comparing our results with the national results, there are similar themes evident. Our Staff Engagement score has also improved this year, from 3.68 in 2014 to 3.88 in 2015 which is above average when compared with similar trusts (possible scores range from 1 to 5 with 1 indicating that staff are poorly engaged with their work, team and trust, and 5 indicating staff are highly engaged).

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

Top Five Ranking Scores	Trust Score	National Score
Percentage of staff able to contribute towards improvements at work *(the higher the score the better)*	77%	71%
Staff confidence and security in reporting unsafe clinical practice *(the higher the score the better)*	3.79	3.64
Staff motivation at work *(the higher the score the better)*	4.09	3.92
Quality of non-mandatory training, learning or development *(the higher the score the better)*	4.13	4.04
Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(the higher the score the better)*	3.86	3.71

Bottom Five Ranking Scores	Trust Score	National Score
Percentage of staff experiencing harrassment, bullying or abuse from patients, relatives or the public in the last 12 months *(the lower the score the better)*	35%	27%
Percentage of staff working extra hours *(the lower the score the better)*	79%	72%
Staff satisfaction with resourcing and support *(the higher the score the better)*	3.2	3.3
Percentage of staff/colleagues reporting most recent experience of harrassments, bullying or abuse *(the higher the score the better)*	34%	38%
Percentage of staff experiencing physical violence from staff in last 12 months *(the lower the score the better)*	2%	2%

These results simulate the national results with more people (77%) feeling able to contribute towards improvements at work and feeling motivated at work (4.09), however higher levels of staff are working extra hours (79%) and staff are reporting concerns regarding their satisfaction with resourcing and support.

Comparison of 2014 and 2015 results

This year the Trust has seen improvements in a number of areas compared to 2014; a summary of those sections with significant changes can be found below.

Management

This year the Trust has made improvements in all of the questions within the Management section. The most noticeable improvement (+10%) has been in the effectiveness of communication between senior management and staff with only 27% of respondents providing a negative response. There have also been significant improvements in the amount of staff who know who our senior managers are (+ 8%) and who feel involved in making important decisions (+4%).

Communication and visibility of senior management was one of the key priority areas that the Trust identified from last year's survey.

In order to improve our staff's experience of this, we introduced a 'Message of Month' where each month one of our Executive Director's provide staff with an update on a 'hot topic' relating to the Trust. In addition to this, we have also continued the 'In Your Shoes' initiative, with a number of our senior managers working alongside our staff to learn about their jobs and to experience what it is like to work in different departments across the Trust.

Bullying, Harassment and Whistleblowing

The results within this section are varied. Although we have seen improvements in the questions relating to reporting incidents of physical violence or clinical practice concerns, the amount of staff who experience harassment, bullying or abuse at work has increased with less people reporting it. More than half (55%) of those staff who responded stated that their last experience of harassment, bullying or abuse was not reported. We want to ensure our staff feel safe and supported at work and therefore we have identified this as a key priority for improvement over the next year.

Patient / Service User Care

Performance within this section has been strong this year, with more people (+5%) feeling that the care of patients is the organisations top priority. More staff reported that patient / service user feedback is collected within their division or department and that they were provided with regular updates on this feedback. The Trust also saw an increase this year in the amount of staff who feel that feedback from patients or service users is used effectively from 3.55 in 2014 to 3.71 in 2015. Our patients are at the centre of everything we do and therefore we want to continue this good work into the next year.

Appraisals and Your Job

There were small improvements made within all of the questions asked in this section apart from one where there was a significant decrease. Although the quality of our appraisals has improved, the number of staff reporting that they had received an appraisal within the last 12 months has decreased by 5% compared to last year to 86%.

We are committed to supporting our staff's development to help them to perform to the best of their ability in their roles. One of the ways in which we achieve this, is through the Trust's Appraisal process. Earlier this year we reviewed our appraisal processes in order to make sure that they were effective and easy to use. Part of this review included asking employees and managers for their feedback and suggestions on the process, this feedback was then used to inform the changes that we made to the policy and paperwork used. This year's Staff Survey results show that the changes we have made, have improved the quality of our appraisals and that staff who received an appraisal do feel more valued by the organisation. This year, we will work with managers across the Trust to ensure that all our staff receive an appraisal.

Team working and Involvement

This year more staff have reported that they are involved in deciding changes that affect their work (+3%) and feel that they are able to make improvements within their work area (+9%). This is following the introduction of an ideas generation initiative, where staff are encouraged to put forward any suggestions for improvement they have both within their own teams and across the Trust. Since introducing this process, more than 200 ideas have been submitted.

Staff are still however, reporting challenges with the resources available to them at work, both in terms of the number of staff within the organisations and having adequate materials, supplies and equipment to enable them to do their work. The Trust continues its focus on recruitment, exploring and developing innovative ways of recruiting new staff to join our hard working teams. In addition to developing and maintaining positive relationships with local schools and universities, the Trust is also continuing its overseas search for nurses. The Trust has held a number of recruitment events over the year seeking to attract people from all professional groups to come and work with us and this will continue into 2016/17.

Our priorities for 2016/17

Based on the information provided in the responses to this year's survey, the Trust has agreed the following key priorities for 2016/17:

- Protecting our staff against harassment, bullying and abuse from patients and service users
- Continuing to address challenges with the resources available to our staff at work, both in terms of the number staff within the organisation and having adequate materials, supplies and equipment
- Supporting our staff's health and wellbeing and personal development

These priority areas will be used to identify a number of Trust wide schemes which will be developed and implemented to address the key areas for concern.

Next year, the Staff Friends and Family Test will be used to continuously monitor the Trust's performance in these areas. Each quarter we will use the Staff Friends and Family Test to focus on a different key theme highlighted from the report, asking additional questions to gain a better understanding of the concerns raised and actions required to make improvement. Each division will also identify their own key priority areas for the next 12 months and will develop and implement actions to address key areas of concern.

Equality & Diversity within the organisation

Our vision for 2014-2017 is for: "Services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt"
Our trust objectives ensure that in attending to aspects of Equality and Diversity, the results will be: better health outcomes for all; improved patient access and experience; comprehensively empowered and engaged workforce; effective and inclusive leadership at all levels:

The outcomes of our Equality Strategy will support us in the obligation we have to fulfil the Public Sector Equality Duty through; the elimination of discrimination, harassment and victimisation and any other conduct that is prohibited by or under the 2010 Act; advance equality of opportunity for all people; foster good relations between people, no matter how diverse they are from each other.

The Trust has an Equality and Diversity (E&D) Working Group with Health Care representatives from across the Trust's organisation. The purpose of the group is to develop awareness of Equality & Diversity impacts, with an end to support the delivery of the outcomes stated above. To support this we have developed a series of actions to deliver specific objectives over the next 12 months, which are all incorporated into an action plan and monitored and tracked accordingly.

The Trust recognises where we need to achieve excellence through the Equality agenda and, for 2016 – 2017, take into account the need to recognise the changes in legislation, the implementation of the refreshed Equality Delivery System (EDS2) and the new NHS Workforce Race Equality Standard (WRES) and to commit to taking the necessary steps to deliver this beyond our basic statutory duties.

2.1.6 Our Priorities for 2016/17

Our Trust's commitment to quality continues through a number of priorities that we set in 2015/16 which are informed by both national and local priorities, like our Sign up to Safety Campaign, and as such are aligned with our commissioning for Quality Improvement Contracts agreed with our local Clinical Commissioning Groups. These priorities have been shared with agreement sought from the Trust Governors as patient/public representatives, Local Healthwatch Organisations and other key external stakeholders.

We will;

- Commit to save an extra 500 lives through provision of safe, high quality care and treatment.
- Continue to reduce falls and avoidable harm by 20% by 2018
- Reducing avoidable pressure ulcers to under <5 a month
- Continue to manage Sepsis
- Improve recognition and rescue of the deteriorating patient
- Reduce mortality as a result of Acute Kidney Injury to 16% by 2018
- Improve Patient Experience and Engagement
- Improve Learning and Quality Improvement

We have embraced the five Sign up to Safety pledges that we signed up to in 2015/16. These were a combination of national aspirations and our own specific improvement areas:

1. Put safety first

We will continue to commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. We will:

- Provide leadership for quality and safety, our Trust leaders will be highly visible role models/coach's championing quality improvement, empowering staff to continuously improve their services
- Continue to foster a safety culture that is open and fair across the whole organisation
- Aim to be within the 10% of NHS organisations with the lowest risk adjusted mortality
- Save 500 more lives over five years as a direct result of the efforts to improve quality and safety, particularly in relation to the key causes of mortality.
- Identify standards of care and safety measures which are monitored and understood from ward to board.
- Continue to implement the sepsis six care bundle
- Develop care bundles to ensure consistent care is delivered to patients with a high risk of death including those with acute kidney injury and following emergency laparotomy
- Reduce the incidence of pressure ulcers and patient falls by implementing improvements in care identified through incident investigation

2. Continually learn

We will make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are. We will:

- Continually learn and share safety lessons from incidents, complaints and claims
- Celebrate best practice and achievements of individuals and teams
- Develop and improve the learning from the Mortality case note review process
- Develop the use of data for improvement, increasing the knowledge base of our staff about measurement of safety
- Develop quality improvement plans to deliver safer care for patients
- Develop an internal and external network to ensure learning from best practice is implemented across the trust
- Actively seek the views of patients and relatives about areas of care that we can improve

3. Honesty

We will be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. We will:

- Implement the statutory Duty of Candour, supporting staff to build skills in being open with patients when things go wrong
- Engage with service users, their carers and relatives and use their feedback to help us improve quality.
- Continue holding 'spotlight' listening events and turning public feedback into service improvements.
- Reviewing all 'VoiceBook' comments and using the Friends and Family test to inform us of what patients think about our services
- Listen to staff and provide ways for staff to have their say, for example the Staff Friends and Family Test and the ' See Something, Say Something' campaign
- Share progress of projects to improve patient safety with our patients, staff and Trust Board
- Engage with the national safer staffing agenda, displaying staffing levels clearly on our wards and publishing on NHS Choices.

4. Collaborate

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We will:

- Actively participate in local and regional patient safety networks, including the NHS England Patient Safety Collaborative, as an opportunity to share best practice and to develop quality improvement expertise.
- Work with local partner organisations to improve patient pathways across NHS organisations.
- Continue to establish and progress the work of Trust quality improvement groups, developing expertise within these teams. Our key safety priorities as we 'Sign up to Safety' will be:

    - Acute Kidney Injury
    - Falls prevention
    - Pressure ulcer prevention
    - Rescue of deteriorating patients
    - Sepsis

5. Support

We will help people understand why things go wrong and how to put them right. We will give staff the time and support to improve and celebrate the progress. We will:

- Ensure that support is available for staff who have been involved in incidents, complaints and claims, both individually and as teams
- Provide staff with training in quality and safety methodology, and the tools to deliver improvements
- Provide staff with practical quality improvement tools and guidance
- Encourage ownership of safety and quality improvement by all staff , at all levels of the organisation
- Continue to develop the Executive Patient Safety Visits, ensuring these visits meet the needs of the executive and frontline teams.
- Develop clinical leadership and quality expertise within the Trust to champion quality and safety from ward to board.

We will be developing a Patient Experience Strategy, which will set out how the Trust intends to build on and improve how we work with people who access our services, and how we will work in partnership with patients, carers, families, patient groups and forums, CCGs, and professionals. We will strengthen the PALS service in terms of the experience of those accessing it, and the support provided to internal stakeholders. The Trusts patient experience processes and systems, will be reviewed and strengthened in order to support operational divisions to be responsive to our patients, family and carer feedback. A work plan will be developed out of the strategy, with clear actions and timelines.

We are aiming for quality improvement methodology to be used for both Sign up to Safety and all Trust wide safety projects. Build organisational Quality Improvement (QI) capability and deliver a programme of QI coaching and training to provide the skills for frontline teams to apply the theory of QI practice when making changes at departmental level, to lead change from our frontline.

To ensure that all tools and resources are accessible and meet the needs of clinicians undertaking service improvement within their own practice. We will work collaboratively with Universities and the Deanery to support health professionals in training to complete service improvement projects whilst on placement within the organisation. We will implement a coordinated process with the university to ensure that whilst students achieve their objective the organisation benefits from the projects completed. Capturing the change ideas and not losing improvements that can be taken forward. The Trust will develop quality improvement systems, processes and tools to enable a culture of innovation and improvement and will widen our Trust's organisational network and engagement of staff in quality improvement and the Sign up to Safety programme at all levels.

2.2 Statements of Assurance

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

2.2.1 Information on the Review of Services

During the reporting period of 2015/2016 the Trust provided and / or sub-contracted 8 relevant health services.

The Trust has reviewed all the data available on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by the Great Western Hospital NHS Foundation Trust for 2015/2016.

Participation in Clinical Audits

During 2015/2016, 35 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During that period Great Western Hospitals NHS Foundation Trust, participated in 34/35 (97%) national clinical audits and 4/4 (100%) of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that Great Western Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/2016, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

	National Clinical Audits	Participated	% Data Submission	Actions taken
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%	
2	Adult Asthma	No	No National Audit this year	
3	Bowel cancer (NBOCAP)	Yes	100%	
4	Cardiac Rhythm Management (CRM)	Yes	100%	
5	Case Mix Programme (CMP)	Yes	100%	
6	Chronic Kidney Disease in primary care	NA	NA	

7	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	NA	NA	
8	Coronary Angioplasty/National Audit of PCI	Yes	100%	
9	Diabetes (Adult) Inpatient	Yes	100%	
10	Diabetes (Adult) Foot care	Yes	100%	
11	Diabetes (Adult) Pregnancy	Yes	100%	
12	Diabetes (Adult)	No	0%	
13	Diabetes (Paediatric) (NPDA)	Yes	100%	
14	Elective surgery (National PROMs Programme)	Yes	100%	
15	Emergency Use of Oxygen	NA	NA	
16	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%	
17	Inflammatory Bowel Disease (IBD) programme	Yes	100%	
18	Lung cancer (NLCA)	Yes	100%	
19	Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%	
20	National Adult Cardiac Surgery Audit	NA	NA	
21	National Audit of Intermediate Care	Yes	100%	
22	National Cardiac Arrest Audit (NCAA)	Yes	100%	As part of the “sign up to safety” campaign, the Resus team will be monitoring the number of cardiac arrests by working with the lead team for “the deteriorating patient” to jointly identify areas of development. There are trust wide plans for the introduction of a new Treatment Escalation Plan (TEP) to identify patients who are not for cardio-pulmonary resuscitation and to implement the National Early Warning Score (NEWS) to identify deteriorating patients to reduce numbers of unexpected cardiac arrests.
23	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Community Services	Yes	100%	
24	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Acute Services	NA	NA	
25	National Comparative Audit of Blood Transfusion programme	Yes	100%	
26	National Complicated Diverticulitis Audit (CAD)	Yes	100%	
27	National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NA	NA	
28	National Emergency Laparotomy Audit (NELA)	Yes	100%	Whilst the organisation has achieved good results in the National Emergency Laparotomy Audit, there remains a few small areas for improvement; GWH showed less than 50% for a consultant review within 12 hours of emergency admission and an assessment by a Medical Crisis in Older People specialist (MCOP) in patients >70yrs age.

29	National Heart Failure Audit	Yes	100%	
30	National Joint Registry (NJR)	Yes	100%	
31	National Ophthalmology Audit	Yes	100%	
32	National Prostate Cancer Audit	Yes	100%	
33	National Vascular Registry	NA	NA	
34	Neonatal Intensive and Special Care (NNAP)	Yes	100%	Neonatal Intensive & Special Care services are to improve the timeliness of retinopathy screening. All patients are to have a senior review within 24hrs of admission and a developmental assessment of all infants born at gestational age of <30weeks.
35	Non-Invasive Ventilation - adults	No	No National Audit this year	
36	Oesophago-gastric cancer (NAOGC)	Yes	100%	
37	Paediatric Asthma	Yes	100%	
38	Paediatric Intensive Care Audit Network (PICA Net)	NA	NA	
39	Paediatric Pneumonia	No	No National Audit this year	
40	Prescribing Observatory for Mental Health (POMH)	NA	NA	
41	Prescribing Observatory for Mental Health (POMH)	NA	NA	
42	Prescribing Observatory for Mental Health (POMH)	NA	NA	
43	Renal replacement therapy (Renal Registry)	NA	NA	
44	Procedural Sedation in Adults (care in emergency departments)	Yes	100%	
45	Pulmonary Hypertension (Pulmonary Hypertension Audit)	NA	NA	
46	Rheumatoid and Early Inflammatory Arthritis	Yes	100%	
47	Sentinel Stroke National Audit Programme (SSNAP): Community Services	Yes	100%	
48	Sentinel Stroke National Audit Programme (SSNAP): Acute Services	Yes	100%	
49	UK Cystic Fibrosis Registry	NA	NA	
50	UK Parkinson's Audit (previously known as National Parkinson's Audit)	Yes	100%	
51	Vital signs in Children (care in emergency departments)	Yes	100%	The Emergency Department, are planning to develop a simple proforma for recording information about seizures, and a patient information leaflets for febrile seizures and 'first fit'; this will ensure patients/carers of all children who present with seizures receive written advice. Further training and education around the management of hypoglycaemia and advanced paediatric life support (APLS/EPLS) will also be provided.
52	VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%	

Confidential enquiries			
1	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Mental Health Patients in Acute Hospitals	Yes	100%
2	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Child Health Programme (Chronic Neurodisability, focusing on cerebral palsy)	Yes	100%
3	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Child Health Programme (Adolescent Mental Health, focusing on self-harm)	Yes	100%
4	Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NA	NA
5	Maternal, New born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%

The reports of 32 national clinical audits were reviewed by the provider in 2015/2016 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- To improve care in the Emergency Department for older patients, there will be an introduction of a new Risk assessment for all older adults; this will incorporate cognitive impairment, dementia assessment, falls risk, safeguarding and NEWS scoring. Consideration is being given to also incorporate a specific box for recording Early Warning Score (EWS) on Emergency Department (ED) notes. Automatic documentation of cognitive assessment will be provided as a letter to the GP.

- The blood transfusion service will be looking to improve their prescription chart by redesigning and incorporating the name of the person taking consent to encourage ownership of the process; ensure that training for medical staff on blood transfusion consent and documentation is given alongside general consent training; ensure that training on the appropriate use of blood, prescribing and documentation is carried out in a robust format to all medical staff.

- In Maternity services, perinatal mortality remains below the UK national average, and stillbirth rate at GWH was 3.87 per 1,000 births compared to UK national average of 4.64. Although neonatal death rate at 1.49 per 1,000 births compared to UK national average of 2.68 per 1,000 births remains low, regional benchmarking adjusted neonatal death rate shows GWH to be one of the highest. As a result of this, the Maternity Services, are organising a local review into neonatal mortality to examine where any quality improvements could be made, aiming at reducing the overall mortality rate.

The reports of 190 local clinical audits were reviewed by the provider in 2015/16 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Audit	Actions Taken
Mortality Reviews Q4 - 2014/15	Disseminate report to Senior Sisters, for discussion at local team meetings and presented at Harm Free Care Focus Group to identify key learning and examine the barriers to good practice
Diabetes Mortality and Morbidity (M&M) A root cause analysis approach 2014/15	Hold regular mortality and morbidity meetings for diabetes
Epidural Audit in Maternity 2015	Results of this audit presented and at relevant maternity forum. Consideration of integrating audit criteria to any relevant care pathway audits or changes to audit tool to improve condition for data collection.

WHO Checklist - Q1, Q2, Q3, Q4 2015/16	results disseminated to relevant staff within Maternity Services. Continuation with weekly spot checks and compliance trend monitoring presently. Staff to be further reminded via SMART News and Delivery Suite morning meeting of need to complete of all sections of the form especially date and signature.
Annual Sharps Reporting Audit 2015	Continue education with particular emphasis on the assembly of sharp bin containers Continue Education with emphasis on correct labelling of sharps bin containers Promotion and education of the use of temporary closures use on sharps bins Reinforce through education safe sharps practice highlighting the dangers of overfilling and protruding sharps Promote use of brackets or mobile units and ANTT trays when using sharps bins
Resuscitation Trolleys, Grab Bags and Resuscitaires Audit (inc Maternity) 2014	Resuscitation Officers to conduct monthly spot checks of resuscitation equipment in all areas of the Trust that are currently on red status. Areas on amber status will receive quarterly checks. Spot checks will continue until 100% compliance (green status) is achieved. The Resuscitation Department to review the equipment lists of community grab bags/AEDs to bring them into line with current recommendations from the Resuscitation Council UK. Alongside this will be the development of new check record documentation to enable accurate record keeping and appropriate medicines management in accordance with the Trust Medicines in Wiltshire Community Healthcare Unit – Safe and Secure Handling Policy. The Resuscitation Department to work with the Ward Manager on SCBU to identify appropriate equipment and stock levels for the Neonatal Emergency trolleys and facilitate the necessary changes.
Annual Hand Hygiene Audit Q4 2014-15	Clinical/Service Leads have shared audit results with their teams and use as an opportunity to promote and maintain best practice in hand hygiene. The Divisional Quality Governance Facilitator will request electronic evidence to support completion of actions i.e. team minutes where the results were discussed, emails to demonstrate you have achieved your action. Clinical/Service Leads to ensure that Occupational Health Referrals are made for those staff with existing skin problems.
Annual Health Records Audit Q3 2014-15	Acute: Gynaecology 1. Present the results at an educational half day to remind all staff about importance of record keeping Paediatrics 1. To remind all staff to document the date, time, signature, designation and printed name on all written entries. 2. To remind all staff about countersigning any deletions or alterations they make. Community: Speech and Language Therapy 1. To ensure the team are aware that the following need to be completed on the records: • The patient's ethnicity been documented within the notes? • The patient's religion been documented within notes? • The patient's first name, last name and DOB are recorded on each page • The patient's NHS number is recorded on each page Hillcote 2. To ensure the team are aware of the need to complete the following in health records on each occasion; • Legible printed name and designation on each entry • No spaces in between entries • To record time as well as date on each entry 3. To ensure an information sheet is present in each folder 4. To have ethnicity and religion sections added to general information sheet. Learning Disabilities 5. To disseminate the results to all team members 6. To ensure all written records meet audit standards

NHSBT - National Comparative Audit of: Use Anti D Audit (Local Re-Audit)	Audit report to be disseminated and any learning shared with relevant staff. Audit findings to be discussed at relevant forum meetings. Use of blood product in anti-D and the need for clear documentation of informed consent to be further highlighted to staff via SMART News feature. Draft anti-D care pathway proforma which integrates all elements of the care pathway and simplifies approach to be developed potentially in association with SHOT who will offer support. Use of Fetal DNA sampling to determine fetal Rh (D) to be further explored.
Blood Observation Local Audit 2014/15	1.1 Audit findings and key points for learning to be emailed out to all clinical area ward managers and Transfusion Champions for dissemination to clinical staff and display on transfusion notice boards. "Stop time documented" 79% compliance. 2.1 During transfusion training sessions to remind staff of the importance of documented stop time, as legal evidence that the transfusion has been administered over the appropriate time. 2.2 Audit summary and recommendations/ actions to be presented at Transfusion champion meeting "Documentation of informed consent" 70% Compliance 4.1 Key learning points education sheet to be sent out trust wide and displayed on Transfusion notice boards "Leaflet given" 57% compliance 5.1 Remind nursing and medical staff that patients receiving a blood transfusion must receive a patient information leaflet. Trust wide education for all staff on induction, referencing recent audit results and findings.
NICE CG160 - Feverish illness in children (Re-Audit)	Feverish child guideline protocol summary poster in visible place in PAU. Regular education of medical team – Summary of feverish illness guidelines in SHO induction pack. Collect urine (clean catch if possible) in all children under 5 years with fever without obvious source. Urine samples in children under 3 years should be sent for urgent microscopy and culture rather than just dipping
NICE CG149 - Diagnosis and Management of Neonatal Sepsis (Re-Audit)	Educational bundle to increase awareness Doctors at induction Message on the hand over sheet Spot checking "Sepsis Champion" ?Sepsis pack/stickers/printed cards Discharge leaflets made available on PNW as part of discharge check Consultant Board rounds on Hazel Reiterate and check on each baby
Therapeutic cooling for babies with Hypoxic-ischemic encephalopathy (HIE) (Re-Audit)	On-going teaching sessions for doctors and nurses to be arranged and cerebral function monitoring training to ensure the areas for improvement are addressed First page of therapeutic hypothermia guidelines to be printed for each baby considered for cooling to be available at the cot side for reference to ensure appropriate group assignment and subsequent management.
Transition of Children from Health Visiting to School Nursing Service (Re-Audit)	Results to be disseminated to Team Leaders and Teams. Health Visitors need to be reminded of the need to enter a high quality, robust record of all children who require handover and ensure this is entered on to Epex. The audit needs to be repeated in this years 2014/15 format next year

NICE CG154 - Management of ectopic pregnancy (Re-Audit)	Ensure discussions with regard to future fertility take place and are documented at the time of intervention. Appropriate operation can then be arranged if required. Ensure that following 2 Bhcgs and progesterone estimation, the case is discussed with the consultant lead for EPU/EGU or his deputy to ensure management plan in place and documented. To ensure the Unit is compliant with regard to follow up pregnancy tests after salpingectomy and salpingostomy.
NICE CG154 - Management of women diagnosed as having a missed miscarriage (Re-Audit)	All staff should document everything with date, time, and clear name. Confirmation whether patients are offered TVS or not and if yes whether declined or not. Confirmation of failed pregnancy to be documented on scan report with 2nd person identified by name even if the patient had previous scan showing viable pregnancy. To record` in the beginning of the history whether the patient was seen by other HCP or self-referred.
NICE CG98 Neonatal Jaundice (Maternity) (Re-Audit)	Audit report to be disseminated and shared with relevant staff. Audit findings to be discussed at PAG meeting to ensure reviewed by both Maternity and Paediatric Teams. Care pathways associated with referral and treatment of inpatients on the Postnatal Ward with Neonatal Jaundice to be discussed at PAG to identify where quality improvements can be made. Reaudit selection to more selective to ensure minimum of three babies at <36 weeks gestation included in order to examine compliance with different care pathways.
Supervisors Maternal Health Records (Oct14-Mar15)	Cascade results of this audit New approach to 'Supervisee Health Records Audit' to be trialled which will act as a complete audit including a scoring system and recommendations for the individual on how to improve their practice based on their score.
Maternity Swab Count Audit (Q4 2014/15)	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved.
Maternity Swab Count Audit - Q1 2015/16	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved.
Maternity Swab Count Audit - Q2 2015/16	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved. Develop paperwork for reporting non-compliance to department manager formally so evidence of actions taken against any non-compliance available.
Maternity Swab Count Audit - Q3 2015/16	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved.
Neonatal Readmissions Q1 2015/16	Cascade results of this audit to Midwifery and Paediatric Team. Explore need to admit short stay babies onto system causing potential inaccuracy on HES data.
Maternity NICE Smoking Re-Audit	Report to be disseminated as appropriate and staff informed of the key assurances and areas for development via e-mail. Smoking Cessation Midwife to record any care interventions including discussion related to risks and benefits of Nicotine Replacement therapy on Maternity Medway to ensure improved communication and a more seamless care pathway for the woman. Community Midwifery Team to be reminded of the importance of continuing Carbon Monoxide breath testing at each antenatal visit regardless of specialist service intervention and to record any discussion related to smoking in woman's notes.

Maternity Hypertension Pathway Audit	Cascade results of this audit Audit to be presented to appropriate forums to ensure multidisciplinary review of findings. Develop Postnatal Medical Review Proforma for High Risk women to be completed by the reviewing and/or discharging medic.
Maternity Multiple Pregnancy Pathway Audit	Cascade results of this audit Audit to be presented to appropriate forums to ensure multidisciplinary review of findings. Consider changing data collection tool to reduce the difficulty in data collection in future re-audit. Same criteria to be measured but tool to be developed as 'care pathway audit' and other related GWH policy specific criteria could be added and more examination of patient experience may be possible.
DNA-CPR: Decision making and patient discussion	Raise awareness amongst clinical leads and Resuscitation Officers regarding deficiencies in the involvement of patients, their families and carers in DNA-CPR decision making
Stem Cell Transplant Clinical Coding Audit (JACIE)	The issue of recording stem cell transplant dates on the discharge summary to be communicated at the next JACIE meeting (8th April 2015) and cascaded down to all relevant doctors by Ranjeet Babbra. Verification of secondary codes to be requested from the Clinical Coding Manager (E-mail sent on 24th March 2015).
Nutritional Screening (MUST) Compliance for Inpatients	Incorporate MUST into the new dietetic referral pathway Disseminate findings to department Disseminate findings to nutrition steering group and discuss improvement plan Consider adjusting current training
NICE QS44 Atopic Eczema in Children	Consideration of use of the Children's Dermatology Life Quality Index (CDLQI) for children seen with atopic eczema in paediatric dermatology clinics.
Breakthrough's Service Pledge for Breast Cancer	Re-word the Improvement Goals so they outline a clear, strong commitment that the hospital is going to make to patients.
Conversation Project Pre-audit Teal	Education of Teal Ward staff about 'The Conversation Project' including the rationale, objectives and support available. Present this base-line audit data to help identify areas for improvement. Implement the Conversation Project pilot on Teal Ward. To include the package of interventions that has been established on Jupiter Ward. Re-audit patient records on Teal Ward once the project has been introduced.
Conversation Project Teal (Re-audit)	Please note I have met with Dr Arunalantham to discuss the audit findings and to identify ways in which we can facilitate improvement in terms of patient inclusion, conversation topics discussed and communication with Primary Care. Dr Arunalantham felt that over the coming weeks there are a number of expected changes to staffing within the medical team which will impact on continuity, understanding of project objectives and team capacity. He felt that we should take a step back from work on Teal and consider broadening participation through involvement of other wards. In discussions with other Project team members we have decided to maintain a presence on Teal ward to attempt to sustain the improvements achieved thus far while these changes to staffing occur. Once some stability occurs we will then become more proactive in terms of addressing the areas identified for improvement and working with the ward team to improve the numbers of patients included, the scope of conversations and communication with Primary Care

PACE Patient Questionnaire 2014/15	1. To ensure all patients are able to access a PACE programme within 18 weeks of assessment. 2. To ensure all patients who have been offered a place on the programme are motivated to attend sessions in order to increase completion rates. 3. To ensure all patients have a short term (during programme) and long term (reviewed at follow up sessions) goal. 4. Formalise friends and family feedback via the PALS team. 5. To ensure that patients have a bridging exercise programme to carry out between assessment and programme.
Tissue Viability Pathway Audit 2015	1. The dietician will be asked to improve the compliance with nutritional assessment within the next six months. 2. Each team will be asked to improve the numbers of wounds that are measured or photographed 3. Each team will be asked to improve the use of the core care plan for patients reluctant to accept prescribed care / equipment
Fordingbridge Malnutrition Universal Screening Tool (MUST)	1. The MUST resource pack to be put in all patient notes. 2. A stadiometer should be used to measure height for all patients, and use alternative measurements (e.g. ulna, knee height, demi-span) as required and as per BAPEN recommendations. 3. Leaflets to support patients with diet and particular medical issues to be put into a resource folder for staff to have access to. 4. Nursing staff to receive update MUST training (which is logged) to ensure nutrition screening is carried out correctly. 5. Nursing staff should be informed how to use alternative height measures and mid-upper arm circumference during the training session.
Fordingbridge Malnutrition Universal Screening Tool (MUST) Re-Audit	1. To ensure a full, laminated copy of the MUST resource is in all patient notes. 2. To document whether food records are adequate and whether dietetic referral is needed.
Effectiveness of 1st and 2nd Line Dietary Treatment of IBS (Re-Audit)	1. To continue to monitor patient symptoms and PROM to help guide appropriate and tailored advice for the individual 2. To continue to deliver group education sessions, and evaluating and amending these as necessary based on patient experience, reflection and current recommendations 3. To start developing sessions and resource tools for other patient groups
Sepsis Audit Q4	On-going education and training, Meet with neighbouring trusts and Development of a sepsis screening tool for Primary Care Liaise with GP, DN, PN + community staff Reciprocal training and experience between GWH and Paramedic trainees.
2015-16 CQUIN Indicator 2a (sepsis screening) audit report	Agree improvement target with Wiltshire and Swindon CCGs Plan 2015/16 education programme
2015-16 CQUIN Indicator 2a (sepsis screening) audit report	Agree improvement target with Wiltshire and Swindon CCGs Plan 2015/16 education programme
Winter mortality Review 2014/15	DNAR decision making – education of doctors on this via a Grand Round Session Community planning for EOL care – to be raised with EOL group (chaired by Guy Rooney) and with Lorrain Austen to stimulate discussion and debate on improvements to EOL planning in community setting
Postoperative Epidural Analgesia Audit NPSA 2014	There are fewer patients receiving postoperative epidural analgesia therefore nursing staff may struggle to remain competent. This is an important priority for the Pain Specialist nurses who need to identify when additional support is required. The on-call anaesthetist should be aware of patients with epidural infusions on the wards out of hours and at weekends. Investigate why patients are in pain for more than 1 hour and target any common themes
Audiology Patient Satisfaction Survey Q4	To ensure that all staff who send out adult 'first assessment' appointment letters are aware that they must include the information sheet that has been written by the department. Survey questionnaire sheet to be amended to reflect recent changes to service provision.

Audiology Patient Satisfaction Survey May 15	To make staff aware of the new leaflet that has been produced. This should ensure that if patients do not received the initial Choose & Book information sheet they do have this further information. To remind staff at the July staff meeting as to how to advise patients should they wish to make a complaint.
Audiology Patient Satisfaction Survey Nov 15	There appears to be several areas where the department has slipped down by 2%. With a relatively small survey group this could be due to a single patient feeling that the service was not attaining the standard they expected.
Surgical Assessment Unit Pathway Audit	Discussion, Recommendations and actions agreed at the time of reviewing the results: 1. The SAU proforma has since been revised ensuring it is fit for purpose and there is confidence that areas of poor compliance in the clerking section will be improved, for example - a. Removing observations/assessments sections as this is recorded elsewhere b. Removing P-Possum score and include in the EPOCH boarding card – KJ to check c. Replacing sections with more appropriate elements i.e. Sepsis 6 d. Improved clarity around remaining sections i.e. eat/drink/Nil by Mouth (NBM) 2. The introduction of the SAU 'Pack' as previously recommended is considered no longer required as this has been replaced with the revised SAU proforma 3. Affixing Patient identifiers on forms was highlighted at the time of review and this was an immediate action undertaken by the SAU Lead nurse. There is confidence that this should no longer remain a concern. 4. It was agreed that improvements are required around the property checklist and the clarity around the process. It was agreed that this needs to be taken forward to the next Matron's meeting for discussion. 5. It was discussed and agreed that not all Nursing assessments are required to be undertaken again upon arrival to the ward and this may account for the poor level of compliance identified in the results. 6. It was agreed that timely Consultant review remains an area of improvement. What are the actions around this one?? There was discussion around having a local arrangement in place i.e. for a Reg. to see a patient and liaise with the cons via phone and document accordingly in the notes – I can't remember what the final outcome of the discussion was. 7. Patient discharge at 12noon (SAFER Bundle standard) is not possible due to the way the wards operate; the tasks that are required before discharge and the time given to complete them. A 2pm discharge is more achievable. – was this going to be set as a standard for Meldon? 8. Feedback from patients was reviewed and discussion; waiting times in SAU and patient expectations remains an issue. It was agreed that notices are to be displayed in SAU to explain clearly to patients that whilst it is endeavoured to see patients as quickly as possible, delays/long wait may be possible. 9. From reviewing the patient experience were there any further actions to implement around privacy, involving patients in decision making and improved discharge planning???

Research & Development (R&D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2015/2016, that were recruited during that period to participate in research approved by a research ethics committee was 794 to end March 2016.

At this point in time, we currently have 73 actively recruiting Department of Health endorsed (portfolio) research projects. We also participate in a number of studies which are more difficult to recruit to given the complex nature of the inclusion and exclusion criteria. We believe it is important to have these studies open in order to give our patients the opportunity of participating in such studies should they be eligible. We run observational studies together with interventional studies. Our reputation in the Commercial sector continues to grow and we are a top recruiter in the UK for one of our cardiology studies.

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

Progress continues to be made across the Trust to promote further research activity. We now have 4.8 Trust-Wide Research Nurses who oversee research in key areas such as Obstetrics and Gynaecology and Cardiology and work to actively engage new areas in research. We also have the equivalent of 3.8 whole time Research Nurses dedicated to Cancer Research.

With funding received from the Department of Health through our Local Clinical Research Network (LCRN), R&D 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 Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust, Swindon Clinical Commissioning Group and Wiltshire Clinical Commissioning Group and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/2016 and for the following 12 month period is available electronically are available electronically by request

Financial Summary of CQUIN (£m)									
	Plan	Actual	%	Plan	Actual	%	Plan	Actual	%
	2013-2014			2014-2015			2015-2016		
Total CQUIN	£5.366	£4.353	81%	£5.722	£4.505	78.72%	£6.007	£4.507	75%

Care Quality Commission Registration

A quarterly review of our CQC registration is undertaken across the acute and community sites to ensure that our CQC registration is adequate for the regulated activities undertaken across the sites.

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

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

The Trust underwent a planned inspection by the Care Quality Commission (CQC) in September and October 2015. The final report was published in January 2016. The report identifies 28 actions that the Trust must do (including those associated with the warning notice) and 43 that the Trust should do. Additionally, the report identifies areas for improvement that the organisation and local teams would like to address.

Periodic/Special Reviews 2014/15

The Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during the reporting period.

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.

Full Inspection Outcomes

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 29 September - 2 October 2015 and the final report was published on the 19 January 2016.

Trust staff were described by the CQC as being “committed and passionate”. The ratings for both the acute and community aspects are summarised as follows:

Our Ratings for the Great Western Hospital

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

Our Ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Good	Good	Outstanding ★	Outstanding ★	Good	Outstanding ★
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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.

The CQC did raise concerns about the location, design and layout of the Emergency Department Observation Unit, combined with inadequate staffing levels and staff training, presents risks to patients and staff in the Emergency Department (ED) and issued a Warning Notice on 1st December 2015 This service was rated as "requires improvement" within the full inspection report received in January 2016.

In addition 6 Compliance Actions were made, as follows;

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	19/01/2016	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Compliance Action	19/01/2016	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Compliance Action	19/01/2016	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Compliance Action	19/01/2016	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Compliance Action	19/01/2016	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
Compliance Action	19/01/2016	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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 submitted records during April 2015 to February 2016 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
- 89% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100%for admitted patient care;
- 100% for outpatient care; and
- 99.5% for accident and emergency care.

Great Western NHS Foundation Trust will be taking the following actions to improve data quality
A role with in the informatics team has responsibilities to monitor these quality items.

We are currently developing a Data Quality dashboard which will allow us to monitor these areas prior to submission to allow corrective action before submissions

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 Audit, Risk & Assurance Committee on behalf of the Trust Board.

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

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

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the HSCIC Information Governance Toolkit. 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 2015/2016 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 new requirement, i.e. the requirement for at least 95% of all employees and volunteers to have completed their Information Governance 'annual refresh' training within the 2015/2016 year (the actual training figure being 88%). It should be noted that the Trust has produced an Improvement Plan to rectify this deficiency during 2016/2017, and that 100% of new staff receive the appropriate Information Governance training when they join the Trust.

2.2.2 Clinical Coding Error Rate

Explanatory Note of Clinical Coding

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

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.
However an Information Governance coding audit was undertaken, the error rates reported in this latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
Information Governance	95.0%	87.9%	95.6%	91.3%

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

The Clinical Coding Audit carried out by the Audit Commission/Information Governance auditors takes total sample of 200 patients from selected specialities. The samples are therefore small and the results of the audit should not be extrapolated further than the actual sample audited

This year's Information Governance audit, consisted of 200 patients selected from the following specialities/areas

- General Medicine
- General Surgery
- Obstetrics
- Paediatrics
- Trauma & Orthopaedics

These results achieved Attainment Level 2 in the Information Governance Toolkit. The Great Western Hospitals NHS Foundation Trust will be taking the following actions to improve Data Quality: The audit identified areas for improvement and these have been included in an action plan that will be implemented in the course of the year.

2.2.3 Reporting against Core Indicators

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	**MRSA Bed Days as well** *provisional as at 02/05/14	3	2	2	5	2	2	0.96*	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.Diff	40	17	33	23	19* *combined previously acute/ community split	30 Trust-wide	N/A	Zero is aspirational	Low-0; High- 121	IP&C	National definition
	C.Diff 100,000 bed days*	20.1*	7.3*	13.4*	12.5*	9.60	14.7	15.01	Lower is better	Regionally Low:8.71 High: 28.02	PHE	National Definition
2 - Patient Falls in Hospital resulting in severe harm		15	17	16	23	16	13	Not available	Lower is better	--	IR1's	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers		40	31	28	28 Category III & Category IV	51 Category III & Category IV	8 Category III 6 Category IV	4% incidence	Lower is better	--	IR1's	National Definition (from Hospital database)
4 – Percentage of VTE Risk Assessments completed		85.1%	92.7%	95.3%	95.5%	97.1%	98.3	90%	Higher number better	Low - 91.3; High - 100	Crescendo nursing care plan and manual data collection from LAMU, Day Surgery, and ICU	National Definition (from Hospital database)

5 – Percentage of patients who receive appropriate VTE Prophylaxis	90% (No audit for Surgical actioned in Q2 & Q3 therefore YTD based on Medical only)	94.5%	93.9% (Apr-Oct)	95%	91.6%	95.2	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)

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
6 – Never Events that occurred in the Trust		0	3	3	4	2	3	NHS England 2014-15 Average 2.16	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA
7 – Mortality Rate (HSMR)	**HSMR**	97.9	106.2	91.8	97.3	90.3	89.0	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)**	93% GWH only	96% GWH only	91%	95% April – Dec 9 months	90%	85% April – Dec 9 months	Not available	Higher number is better	--	Audit	Audit criteria (50 patients per month)
	Paediatric Early Warning Score (Children)	--	--	74.2%	87.75%	92.25% Average yearly compliance	85% April - Sept 6 months	N/A	Higher number is better	--	Audit	Audit criteria (5 patients per month)
10 – Percentage of Nutritional Risk Assessments	**Using MUST**	70% Acute only	87.8% Combined	84%	82%	81%	Currently not available	Not available	Higher % is better	--	No longer Crescendo	National definition
11 – Were you involved as much as you wanted to be in decisions about your care and treatment?		48.1%	46.9%	51%	53.2%	51.4%	51.8%	54.8%	Higher is better	Low: 6.1 High: 9.2 GWH: 7.1	Picker Survey	National definition
12 – Did you find someone on the hospital staff to talk to about your worries and fears?		23%	22.5%	37%	37.1%	28.6%	33.0%	38.4%	Higher is better	Low: 4.3 High: 8.2 GWH: 4.9	Picker Survey	National definition
13 – Were you given enough privacy when discussing your conditions or treatment?		68.5%	66.8%	73%	70.8%	74.2%	72.6%	72.7%	Higher is better	Low: 7.5 High: 9.4 GWH: 8.5	Picker Survey	National definition
14 – Did a member of staff tell you about medication side effects to watch for when you went home?		22.9%	24.3%	30%	33.7%	32.1%	29.8%	40%	Higher is better	Low: 3.7 High: 7.6 GWH: 4.3	Picker Survey	National definition

15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?		65.6%	66.6%	67%	67.2%	66.2%	68.0%	69.8%	Higher is better	Low: 6.4 High: 9.7 GWH: 7.6	Picker Survey	National definition
16 – Patient Reported Outcome Measures (Average Health Gain [score])	**Varicose Vein surgery**	--	--	100%	100%	90.9%	100% HSCIC Provisional data	80%	Higher is better	Not available (more than one Contractor for this service)	DoH/ HSCIC	National Definition
	Groin Hernia surgery	--	--	96.9%	100%	57.6%	42.9% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Hip Replacement surgery (Oxford Hip Score)	--	--	96%	98.5%	61.5%	93.9% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Knee Replacement Surgery (Oxford Knee Score)	--	--	95.6%	97%	94.4%	97% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition

		2010/ 11	2011/ 12 Data includes Community	2012 / 13	2013/ 14	2014/ 15	2015/ 16	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
17 – Readmissions – 30 days		n/a	7.4%	8.1%	7.9%	9.4%	9.7	Local target (7.1%)	Lower is better	--		National Definition
18 – Readmissions – 28 days		6.9%	7.3%	7.9%	7.7%	9.2%	9.6	SW Region 6.9%	Lower is better	Low: 5.12; High:10.91	Dr Foster	Dr Foster
18 – Re-admissions 28 days **Ages 0-15** **Ages 16+**					9% 7.5%	8.5% 9.2%	9.02 10.02	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 - SHMI – The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the trust for the reporting period		22.5 %	20.6 %	18.4 %	26.0 %	26.5 %	31.7 % Oct 14-Sept 15 Most recent data available	25.3%		Low:0; High: 49.4	HSCIC	National Definition
20 - The number and where available, rate of patient safety incidents and the number	**Number of Incidents per 100 Bed Days**	3.32	4.05	4.22	4.55	4.98	4.9	--	Lower is better	--	Informatics & Clinical Risk	
	Number of Patient Safety Incidents per 100 Bed Days	2.45	2.93	3.13	3.00	3.07	2.8	--	Lower is better	--	Informatics & Clinical Risk	

and percentage of such patient safety incidents that resulted in severe harm or death	**Number of Incidents resulting in Severe Harm or Death per 100 Bed Days**	0.03	0.04	0.04	0.03	0.04	0.01	--	Lower is better	--	Informatics & Clinical Risk	
	Percentage of Combined Severe Harm and Death	0.93 %	1.08 %	0.85 %	0.56 %	0.80 %	0.55%	--	Lower is better	--	Informatics & Clinical Risk	

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

3 Other Information

3.1 Other Information

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

Performance against key national priorities

An overview of performance in 2015/16 against the key national priorities from the Department of Health's Operating Framework is set out below. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2010/ 2011 GWH	2011/ 2012 Trust	2012/ 2013 Trust	2013/ 2014 Trust	2014/ 2015 Trust	2014/ 2015 Target	2015/ 2016 Trust	2015/2016 Target	Achieved/ Not Met
Clostridium Difficile - meeting the *Clostridium Difficile* objective	40	19	33	23	17 Acute 19 All	28 or less (Acute)	25 Acute 30 All	20 or less (All)	Not Achieved
MRSA - meeting the MRSA objective	3	2	2	5	2	0 or less Contract Monitor de minimis 6	1	0 or less Contract Monitor de minimis 6	Monitor de minimis achieved
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	98.5%	98.4%	98.4%	98.4%	99.0	94.0%	99.30%	94.00%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	100%	100%	100%	100%	99.7	98.0%	99.70%	98.00%	Achieved
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	92.4%	89.3%	90.0%	89.0%	88.4	85.0%	87.70%	85.00%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	100%	98.4%	96.2%	98.9%	98.4	90.0%	98.10%	90.00%	Achieved
Cancer 31 day wait from diagnosis to first treatment	99.0%	98.7%	98.1%	98.8%	98.6	96.0%	98.00%	96.00%	Achieved

Indicator	2010/ 2011 GWH	2011/ 2012 Trust	2012/ 2013 Trust	2013/ 2014 Trust	2014/ 2015 Trust	2014/ 2015 Target	2015/ 2016 Trust	2015/2016 Target	Achieved/ Not Met
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	97.0%	97.1%	95.3%	94.7%	94.0	93.0%	94.30%	93.00%	Achieved
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	97.2%	97.1%	96.0%	95.6%	96.8	93.0%	95.50%	93.00%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	95.1%	96.1%	95.3%	94.9%	88.6%	90.0%	82.5%	90%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	97.9%	98.2%	98.3%	96.3%	95.6%	95.0%	89.2%	95%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	--	--	96.1%	94.8%	90.5%	92.0%	88.9%	92.0%	Not Met
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95%	97.4%	97.0%	95.6%	94.1%	91.9%	95.0%	91.1%	95.0%	Not Achieved
Data completeness community services: referral to treatment information	--	--	80.0%	88.2%	88.5%	50.0%	98%	50.0%	Achieved
Data Completeness community service information: referral information	--	--	80.0%	81.5%	81.0%	50.0%	96%	50.0%	Achieved
Data completeness community services information: treatment activity information	--	--	85.0%	96.0%	98.2%	50.0%	100%	50.0%	Achieved

Statement from the Council of Governors dated 17 May 2016

The Governors are of the opinion that the Quality Account is a reasonable 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 90.3% of persons attending A & E were seen within 4 hours against the target of 95%. This is a further decrease against the 91.9% attained in the previous year however Governors consider these figures to be consistent with those of the majority of other Trusts and are reflective of the pressures brought about by increased attendance. The Governors are aware that the Trust is continuing to take action to address this issue and the consequential effects on other performance indicators nonetheless we are also aware that several proposed actions are dependent on partner organisations delivering on their commitments. Within the Quality Report the Trust has reported a number of achievements such as the reduction in the occurrence of avoidable pressure ulcers within acute care, a reduction in Sepsis related deaths and a below average mortality rate. These achievements combine to help achieve an improving experience for our service users and are noted by the Governors.

Margaret White

Lead Governor on behalf of the Council of Governors

Statement from Swindon Clinical Commission Group dated 13 May 2016

NHS Swindon Clinical Commissioning Group (CCG) has reviewed the information provided by Great Western Hospital NHS Foundation Trust in its 2015-2016 Quality Account. In so far as we have been able to check the factual details, our view is that the Quality Account is materially accurate and is presented in the format required by the NHS England 2015/2016 presentation guidance.
The Quality Account provides information across a wide range of quality measures which are monitored through regular Clinical Quality Review Meetings and gives a comprehensive view of the quality of care provided by the Trust, as set out within the three quality domains of safe care, effective care and patient experience.

Safe Care

Swindon CCG fully supports the Trust's commitment to ensuring quality and safety of care is at the heart of everything it does. During 2015/16 a number of quality improvement initiatives aimed at preventing avoidable harm have been successfully implemented through the Sign up to Safety scheme. The Trust has evidenced key achievements such as the reduction of pressure ulcers, harm from falls and mortality. NHS Swindon CCG will continue to work collaboratively with the Trust to deliver quality improvement initiatives such as the Swindon Wide Falls and Bone Health Collaborative and the national Sepsis Commissioning for Quality and Innovation (CQUIN) scheme during 2016/17 in order to improve patient care and ensure better outcomes.

During 2016/17, NHS Swindon CCG will continue to support the Trust to learn from and deliver improvements in response to clinical incidents, including serious incidents and Never Events. It is recognised that the Trust had 3 Never Events during 2015/16 and related action plans are being closely scrutinised to prevent recurrence of these patient safety incidents which should not happen.

The CCG support the Trust's approach in building quality improvement capability across the Trust to move towards a more proactive process to achieve sustainable improvement.
NHS Swindon CCG acknowledge the findings of the CQC inspection completed during 2015/16. It was pleasing to see that staff were found to be "committed and passionate" and providing good end of life care and maternity services. The improvements that the Trust must deliver, particularly related to the warning notice issued for ED will be closely monitored through the Trust's CQC action plan and through the three quality improvement work streams that have been established related to mental health, effective pathways of care and learning and quality improvement.

Effective Care

A skilled workforce with robust leadership is key to delivering services safely and effectively. NHS Swindon CCG notes the continued challenges in relation to availability of staff and the continued need to focus on recruitment and retention of staff. NHS Swindon CCG will continue to monitor medical, nursing, midwifery and other clinical skill mixes during 2016/17 in light of the impact that staff shortages have on patient experience, safety and outcomes. A national CQUIN to support the Health and Wellbeing of staff will be implemented during 2016/17.
NHS Swindon CCG recognises the challenges in demand faced by the trust during 2015/16, particularly relating to waiting times in A&E and the 18 week referral to Treatment (RTT). NHS Swindon CCG will continue to work together with the Trust to deliver improvements in compliance to the national targets through the monitoring and delivery of remedial action plans. During 2016/17 the CCG will focus quality visits in these specific areas to ensure patient safety and experience is maintained.

Patient Experience

The Trust has set out a number of feedback mechanisms aimed at collating patient experience feedback.
During 2015/16, the response rate for the Friends and Family Test has fallen significantly. NHS Swindon CCG will continue to monitor the response rate during 2016/17 to ensure this is improved to capture vital patient comments and appropriately acted upon to improve patient experience.
When comparing year on year data, the number of formal complaints received by the Trust during 2015/16 has remained constant. NHS Swindon CCG recognises the challenges faced by the Trust in meeting complaint response times and implementing the actions that arise as a result of complaints. This will be closely monitored through CQRM's in 2016/17, with a continued focus on trends and themes.

NHS Swindon CCG fully support the Trust's plan to develop a Patient Experience Strategy to improve how they work will work in partnership with patients, carers and their family and deliver improvements to patient experience and would encourage the Trust to ensure that FFT response rates and complaint response times are addressed as part of the work plan.
Swindon CCG is committed to ensuring continued collaborative working with Great Western Hospitals NHS Foundation Trust in order to achieve these goals and support the provision of high quality care across the whole health and social care economy.

Gill May, Executive Nurse, NHS Swindon CCG

Statement from Healthwatch, Swindon and Healthwatch Wiltshire dated 10 May 2016.

This statement is provided on behalf of Healthwatch Wiltshire and Healthwatch Swindon. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment.

Local Healthwatch have worked closely with the Trust over the previous year as part of their on-going engagement work and look forward to continuing this work going forward. We welcome the proposed development of a patient experience strategy and would welcome the opportunity to be involved.

We are concerned that the total number of falls has not reduced over the past year. However, we note that the harm caused by falls has reduced. We welcome the introduction of a number of initiatives that aim to reduce the number and severity of falls and to promote learning across the trust. We hope to see progress made towards meeting the proposed target of a 20% reduction in the rate of falls and avoidable harm by 2018.

We welcome the reported reduction in the number of avoidable pressure ulcers across acute and community settings. We would like to see the maintenance of this downward trajectory over the coming year.

We are concerned to see that the Trust has exceeded the National mandated level of cases of *C. Difficile*. However, we note the introduction of a number of initiatives that seek to improve learning and reduce the numbers of infections over the coming year.

We are pleased that the work carried out by the Trust to reduce mortality rates, has been successful and that the Trust has now has one of the lowest hospital standardised mortality ratio rates in Southern England. We were concerned however that the Trust received an alert for the number of deaths of those with hip fracture. However, we are reassured that following swift actions including improved measures to recognise and treat sepsis, the mortality rates in these patients is already improving.

We welcome the work that the Trust has done to improve the care and experience of those with dementia, their families and unpaid carers. In particular, the creation of dementia friendly environments and the introduction of a new carer feedback survey. We also welcome the proposed introduction of a dementia care pathway and will be monitoring the outcomes of this in relation to patient/relative experience. We would like to see the commitment to dementia continue and also the increased involvement of patients, their relatives and unpaid carers in the development of any new initiatives.

We are concerned to see that the Trust achieved only 90.3% of patients having a maximum of 4 hours wait in the emergency department (ED). We are very concerned about the increase in12 hour breaches in March 2016 and the potential impact on patient safety. However, we note the measures being put in place to achieve an improvement in these times. As ED was an area of particular concern in the recent Care Quality Commission Inspection, we will continue to monitor progress with these targets over the coming year and review impact on other services within the Trust.

We are pleased that 90-95% of patients say that they would be likely to recommend the services of the Trust to their friends and family. In addition, we see that feedback from patients has been used to drive service improvements. However, the completion rate of the Friends and Family Test is low (11%). We note that the Trust has plans in place to achieve a higher completion rate that includes the introduction of real-time feedback mechanisms. We will continue monitor the situation over the coming year.

As Local Healthwatch we know that finding easily accessible, good quality information is a major issue for local people. Therefore, we are pleased that the Trust is reviewing all of their patient information with the help of lay readership panels. We would be happy to assist with this review process.

We note improvements in the handling of issues and concerns at an early stage to avoid escalation through the formal complaints process. Healthwatch Wiltshire welcomes the participation of the Trust's PALS team in our new complaints Liaison group that seeks to bring together managers from all local trusts, Wiltshire CCG and advocacy services with the aim of sharing good practice.

According to the National Inpatient Survey, only 33% of patients said that they found someone to talk about their worries and fears and only 29.8% stated that a member of staff had informed them of possible medication side effects. This raises concerns for patient wellbeing and we would like to see more done improve on these scores. We would also like to see an increase in the patients who reported feeling involved in care and treatment decisions (currently 51.8%).

The staff survey shows that 69% of staff agreed/strongly agreed that they would be happy with the standard of care their organisation provided if a friend/relative needed treatment. However, 79% of staff reported working extra hours.

Access for traffic to the hospital remains a perennial problem and are hopeful that the on-going work to promote alternatives to visiting ED and the development of an additional 400 spaces will go some way to alleviate this.

We recognise that the Trust has had a challenging couple of years both financially and as a result of the required actions put in place by the Care Quality Commission and Monitor following the CQC's inspection of the Trust in September/October 2015. We very much hope that the work being done impacts positively to reduce the pressures on staff and hence improve the experience of care for patients. We will be closely monitoring the progress of the Trust and will continue to raise concerns should we feel that the quality of care is being compromised.

S. J. nelson

Dr. Sara Nelson

Information and Communication Manager

healthwatch Swindon
healthwatch Wiltshire

Statement from Swindon Health Overview & Scrutiny Committee dated 17 May 2016

At the time of submission of the Great Western Hospital's NHS Foundation Trust Annual Quality Account Report, Swindon Health Overview & Scrutiny Committee was appointing a new Chair of their committee. Due to this key vacancy Swindon Health Overview & Scrutiny Committee informed the Trust that they have been unable to provide a statement of Assurance on Great Western Hospitals NHS Foundation Trust Quality Account Report for 2015/16.

Statement from Wiltshire Health Overview & Scrutiny Committee dated 17 May 2016

The Health Select Committee has been given the opportunity to review the draft Quality Account for Great Western Hospital Trust 2015/16.

The Committee has not undertaken any detailed work on the Trust this year. However, we have scheduled an item for its meeting on 27th September to consider:

- The CQC inspection report of the Trust, following the inspection undertaken in September 2015, the result of which was a grading of 'Requires Improvement'

- The Trust's improvement plan for addressing issues identified by the CQC.

Cllr Chuck Berry, Chairman

Wiltshire Health Select Committee

Statement from Wiltshire Clinical Commissioning Group dated 20 May 2016.

Wiltshire Clinical Commissioning Group (CCG) has reviewed the Great Western Hospital (GWH) Quality Accounts for 2015/2016. In so doing, the CCG reviewed the Account in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Outcomes and Quality Assurance (CQRM) meetings attended by the GWH and Commissioners. This evidence is triangulated with information from Quality Assurance Visits to GWH which encompass clinician to clinician feedback and reviews. Wiltshire CCG therefore confirms that the Quality Account appears to be accurate and fairly interpreted.

It is the view of Wiltshire CCG that the 2015/16 Quality Account reflects the ongoing commitment of GWH to quality improvement by tackling key risks and areas of development in a focused and collaborative way. The Account summarises the achievements against quality priorities throughout the year and the CCG acknowledges the progress made by the Trust in these areas. Linked to the 15/16 Quality Priorities, the Trusts 'Sign Up to Safety' improvement plan is on target. The CCG commends the Trust's significant progress in reducing sepsis related deaths which was supported by a 'Sepsis CQUIN' in 2015/16, and congratulates the GWH sepsis team on their National Patient Safety Award in Dec 2015.

The Trust has rightly identified their continued 'better than expected' Hospital Standardised Mortality Ratio (HSMR) as an area of strong performance. As a Trust with one of the lowest HSMR scores in Southern England, the CCG will work with the Trust and the National Mortality Review to identify and share more widely the Trust's good practice in this area.

The CCG recognises the ongoing work by the Trust to monitor and improve patient experience and key to good patient experience are satisfied and engaged staff. The Trust has rightly identified some significant areas of improvement over the year and other areas for further action; this is inclusive of bullying, harassment and whistleblowing. Of note is the reported improvement in management communication.

The final report of the Trust's CQC inspection was published in January. The CCG will work with the Trust and co-commissioners to review and monitor progress against the areas identified within the Trust's formal action plan. The CCG is assured that the Quality Priorities set by the Trust for 16/17 align both to the areas we would wish to see addressed and to the key findings within the CQC report.

The CCG confirms that we believe the accounts are accurate in regard to the service provided to Wiltshire patients and will support the Trust in 2016/17 to embed learning and achieve the identified Quality Priorities. The CCG would be keen to see the GWH further develop its Quality Account into 2016/17 to include more information on work to ensure patient safety during periods of high demand and challenge, collaborative working with community and primary health providers, actions to specifically address patient and staff feedback, and how improvement work is linked to the NHS Outcomes Framework.

Yours sincerely

Deborah Fielding
Accountable officer, Wiltshire Clinical Commissioning Group

2015/16 Statement of Directors' Responsibilities in Respect on the Quality Report dated 26 May 2016

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.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that 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 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2015 to 23 May 2016
- Papers relating to Quality reported to the board over the period April 2015 to 23 May 2016
- Feedback from Swindon commissioners dated 13/05/2016
- Feedback from Wiltshire Commissioners dated 20/05/16
- feedback from governors dated 17/05/2016
- Feedback from local Healthwatch organisations dated 10/05/2016
- feedback from Overview and Scrutiny Committee dated 17/05/2016
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Board monthly.
- The [latest] national patient survey 07/10/2015
- the [latest] national staff survey 09/10/2015
- The Head of Internal Audit's annual opinion over the trust's control environment dated12/05/16

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
The performance information reported in the Quality Report is reliable and accurate
There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
The Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

23 May 2016 Date.....Chairman

23 May 2016 Date.....Chief Executive

Independent Auditors report to the Council of Governors of Great Western Hospitals NHS Foundation Trust, on the Annual Quality Report dated 26 May 2016.

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

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

Respective responsibilities of the directors and auditors

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

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('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 supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance 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 the FT ARM 2015/16 and other documents, listed below:

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;
- feedback from Overview and Scrutiny Committee;
- the Group's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2015 national patient survey, received February 2016;
- the 2015 national staff survey, received March 2016;
- the 2015/16 Head of Internal Audit's annual opinion over the Group's control environment;
- the CQC Report, released in January 2016: and
- the latest CQC Intelligent Monitoring Report.

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 2016, 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

1. 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.

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.

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

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on page 140 of the Group's Quality Report, the Group currently has concerns with the accuracy of data of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (RTT) indicator.

The Group has reported data for the period ending 31 March 2016 for the RTT indicator in line with the national guidance. However, the Group were unable to provide detailed data from April 2015 to October 2015 to allow for sample testing over the whole period. As a consequence we are unable to conclude on the completeness, reliability, validity and accuracy of the RTT indicator included in the published Quality Report. As a result of the issues described above we are unable to conclude that nothing has come to our attention that causes us to believe that the RTT indicator for the year ended 31 March 2016 has been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance (A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge) has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
KPMG
100 Temple Street
Bristol
BS1 6AG

26 May 2016

Glossary of Terms

A&E/ED	Accident & Emergency/Emergency Department
AHSN	Academic Health Science Network
AKI	Acute Kidney Injury
C.diff	Clostridium Difficile
CAUTIs	Catheter Associated Urinary Tract Infections
CCG	Clinical Commissioning Groups
CLRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Clinical Quality & Innovation
DTOC	Delayed Transfer of Care
DOC	Duty of candour
DVT	Deep Vein Thrombosis
E&D	Equality & Diversity
EDD	Estimated Date of Discharge
EDS	Equality Delivery System
EPMA	Electronic Prescribing and Medicine Administration
FFT	Friends and Family Test
GWH	Great Western Hospitals NHS Foundation Trust
HAT	Hospital Acquired Thrombosis
HPA	Health Protection Agency – now NHS England
HSCA	Health & Social Care Act
HSCIC	Health & Social Care Information Centre
HSMR	Hospital Standardised Mortality Rates
ICHD	Integrated Community Health Division
IP&C	Infection, Prevention & Control
KLOE	Key Lines of Enquiry
LCRN	Local Clinical Research Network
Monitor	The NHS Foundation Trusts Regulator
MRSA or MRSAB	Meticillin-Resistant Staphylococcus Aureus Bacteraemia
MUST	Malnutrition Universal Screening Tool
NEWS	National Early Warning System
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NRLS	National Reporting & Learning System
PbR	Payment by Results
PDSA	Plan, Do, Study , Act
PE	Pulmonary Embolism
PROMS	Patient Reported Outcome Measures
PURAT	Pressure Ulcer Risk Assessment Tool
QI	Quality improvement
RAP	Remedial Action Plan
R&D	Research & Development
RCA	Root Cause Analysis
RR	Relative Risk
RTT	Referral to Treatment
SAFE	Stratification and Avoidance of Falls
SAFER	Patient Flow Bundle
SBAR	Situation, Background, Assessment, Recommendation
SEQOL	Social Enterprise Quality of Life
SHMI	Summary Hospital Level Mortality Indicator
SHOUT	Sepsis, Hypovolemia, Obstruction, Urine Analysis, Toxins

SOPs	Standard Operating Procedures
SOS	Swindon Outreach Scoring System
SSNAP	Sentinel Stroke National Audit Programme
STEIS	Strategic Executive Information System
TEP	Treatment Escalation Plan
TV	Tissue Viability
TVNC	Tissue Viability Nurse Consultant
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WHO	World Health Organisation
WRES	Workforce Race Equality Standard