Great Western Hospitals NHS
NHS Foundation Trust

Quality Account 2012/2013

PART ONE

Our Commitment to Quality - Chief Executive's View

Patient safety continues to be at the heart of everything we do. We continue to focus our energies on improving safety and patient and staff satisfaction by providing the highest quality care.

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

We have regularly monitored our quality improvement plans during 2012/13 through our Patient Safety and Quality Committee through to Trust Board. We have presented progress to our Council of Governors and the local Health Overview and Scrutiny Committee. We have also ensured our quality improvements plans have been informed by national priorities and our locally agreed quality contracts with our commissioners.

The priorities for quality improvement set out in the Quality Accounts have been chosen to reflect our goals in improving the safety of our patients and prevent avoidable harm, to ensure the care we provide is clinically effective and in the best interest of our patients and to improve the experiences and satisfaction of our patients. We have improved care in many areas and delivered some significant service improvements and continued to develop our services.

We have continued to reduce hospital acquired infections and we have achieved our MRSA improvement (reduction) goals for both the acute and community settings. Although our numbers of clostridium infections remains low, we did not achievement our improvement goal within the acute hospital setting and have implemented plans to improve in this area.

Due to the early recognition and prompt management of patients presenting with Norovirus we have also reduced the number of ward closures due to outbreaks and hence reduced the number of beds we have not been able to fully utilise due to ward closures.

We are proud of our achievements in reducing the numbers of pressure ulcers developing in patients within our care and have significantly reduced the numbers of the more serious pressures ulcers developing within the acute hospital. We have reduced the numbers of patients who fall in hospital by proactively managing their care and providing specialist equipment to reduce these incidents. Whilst we recognise these improvements, we are mindful that they remain the most commonly reported to our Clinical Risks Team and plan to keep these key elements of safe care as top priority within our quality improvement plans during 2013/14.

2012/13 has seen the implementation of a planned programme of care led by our Matrons to ensure the nutrition and hydration need of our patients are being met and continuously assessed. We have also continued to closely monitor our mortality rates and implement actions to reduce preventable mortalities where improvements can be made. As a result of this, our Hospital Standard Mortality Rate (HSMR) has remained below 100 which is an accepted and reliable national benchmark for the effective care we provide.

We have listened to our patients, heard their experiences and continue to share and use this information and the learning from incidents, complaints and audits to continuously improve the quality of care we provide and improve our patient satisfaction. Our in-patient survey shows we have improved in many areas however we are aware that we still need to improve the way we communicate with our patients and their families.

I am delighted with our recent 2012/13 staff survey results. Feedback from staff indicated that they felt highly motivated at work and placed GWH within the top three Trusts in the South West of England. Whilst the outcome of the Survey continues to improve year on year, we continue to strive to make further improvement particularly in the areas of communication, staff engagement and Health and Well Being. We have also undertaken a staffing skill mix review to ensure we have the right numbers of staff in post to deliver high quality care.

During 2013/14 we will be developing and consulting on our Quality Strategy 2013-2018. This will be informed by national reviews i.e. the Francis Report, national and local drivers and the local contractual agreements with our local Clinical Commissioning Groups and will be used to progress and monitor our long term quality improvement plans and future Quality Accounts.

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

Date: 27 June 2013

Signature

Nerissa Vaughan
Chief Executive

PART TWO

This section provides a review of the progress we have made in our 2012/13 priorities as published in the last Quality Account and sets out our priorities for 2013/14

Priorities for improvement

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

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

Priorities 2012/13:

Safe Care

- Continue to reduce healthcare associated infections including MRSA and *Clostridium* difficile (Commissioning for Quality & Innovation) (CQUIN contract)
- Continue to reduce harm associated with patient falls
- Continue to reduce hospital and community acquired pressure ulcers
- Continue to reduce avoidable mortality, disability and chronic health through improved assessment and management of venous thromboembolism (CQUIN contract)

Effective Care

- Improve the care and management of patients through progressing implementation of the Trusts Nutrition and Hydration action plans
- Continue to sustain our Hospital Standardised Mortality Ratio (HSMR) to below 100
- Improve the management of the deteriorating patient by full completion of the Early Warning Score

Patient Experience

- Continue to improve the quality of end of life care for patients and improve access to palliative care services (CQUIN contract)
- Improve care and access to services for patients with dementia (CQUIN contract)
- Improve patient satisfaction by improving upon the Trust's outcome measures within the National Patient Experience (PICKER) survey (CQUIN contract)

Priorities 2013/14

Our commitment to quality will continue through a number of priorities for 2012/13 which are informed by both national and local priorities and as such, are driven through the Commissioning for Quality Improvement Contracts agreed with our local Clinical Commissioning Groups. These priorities will be shared with and agreement sought from the Trust Governors, Local Healthwatch Organisations and other key external stake holders.

Priorities for 2013/14 are summarised below and they have been set out in the NHS Outcomes Framework which focuses on patient outcomes and experience. We are developing detailed plans to ensure we deliver these improvement priorities.

NHS Domain	Darzi Element	Focus	Priority	Driver
1	Effective care	Preventing people from dying prematurely	• Hospital Standardised Mortality Ratios (HSMR)/Summary Hospital-level Mortality Indicator (SHMI)	Contract
			• Early recognition of the deteriorating patient	Contract

2	Effective care	Enhancing quality of life for people with long term conditions	• Dementia	CQUIN/Contract
			• Safeguarding adults and children	Contract/Regulation
			• Review of patients who are being readmitted to hospital within 30 days of discharge	National/Contract
3	Effective Care	Helping people to recover from episodes of ill health or following injury	• Nutrition and hydration	Contract/ Regulation
			• Stroke care	National/Contract/ Regulation
			• Compliance NICE Publications	Contract
4	Patient Experience	Ensuring people have a positive experience of care	• Friends and family test – patient recommendations	CQUIN/Contract
			• Reducing complaints	Local
			• Equality and Diversity	Contract/Regulation/ Local
5	Safe care	Treating and caring for people in a safe environment and protecting them from avoidable harm	• Reduce Healthcare Infections	National/Contract/ Regulation/Local
			• Never events • Reduce Incidents and associated harm	Contract/ Local/ Regulation
			• Patient safety thermometer - continue to reduce pressure ulcers, falls, Catheter Associated Urinary Tract Infections (CAUTIs), VTE	CQUIN/Contract/ Local

During 2013/14 we will report upon our performance against these patient focused outcomes and we will also continue to explore new measures by which we can enhance and improve upon the quality of care we provide.

Review of Quality Performance 2012/13

Priority 1 – To continue to reduce our numbers of Healthcare Associated Infections

MRSA Bacteraemia

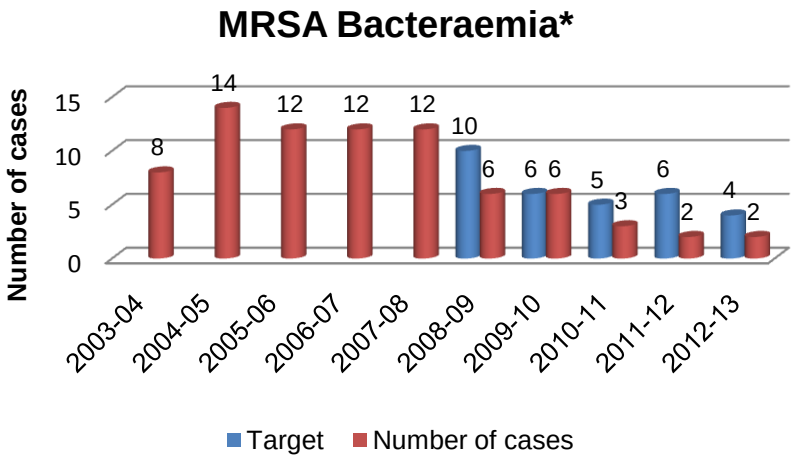
Reducing healthcare associated infection remains an important priority for us and our patients at both local and national level. Our nationally mandated goal for 2012/13 was to report no more than two acute cases of Meticillin-Resistant Staphylococcus Aureus Bacteraemia (MRSAB) and no more than two community cases.

During 2012/13 we reported one acute and one community case, two in total.

In 2008, all NHS Acute and Foundation Trusts had trust specific targets set by the Department of Health to reduce the number of health care acquired infections year on year. You can see our trajectories in the chart below. The chart demonstrates our year on year improvements since 2004. The total number of cases also includes our community beds from 2011-12

Local initiatives to ensure MRSA bloodstream infections remain minimal included:

- Sustained improvement with care bundles, (which is a method of measuring and improving clinical care), for peripheral intravenous lines and urinary catheters. These have also been introduced to and have been completed by the community staff during the year
- Ensuring Infection Control admission risk assessments are completed on all patients and acted upon, including the community inpatient beds
- Daily monitoring of MRSA admission screening of elective and emergency patients, with follow up isolation and decolonisation regimens. This has ensured that over 95% of patients are screened for MRSA skin colonisation on or prior to admission
- Continued improvement of care for patients with diabetes thus helping to reduce complications such as infected ulcers that are often associated with MRSAB's



***Including community since 2011/12**

Clostridium *difficile*

The nationally mandated goal for 2012/13 was to report no more than twenty one acute trust apportioned cases and no more than nine Community apportioned cases. We reported twenty seven *Clostridium difficile* infections within the acute hospital and six within the community. This means that although we continue to report low numbers of *Clostridium difficile* infections, we did not achieve the Acute Trust improvement goal of 21 but we did achieve the community reduction goal.

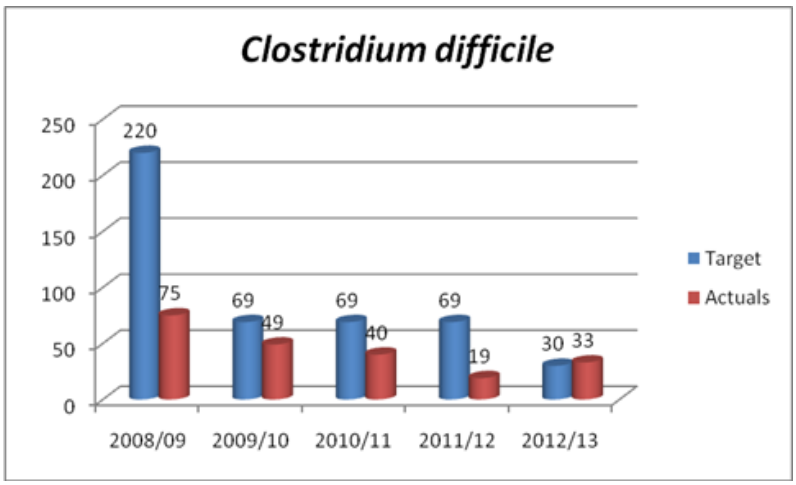
Local initiatives to ensure we continue to reduce these infections have included:

- Promotion of prompt isolation of patients with suspected infective diarrhoea
- Continuation of weekly ward round for patients with Clostridium *difficile* infections, including teleconferences for any positive patients in community beds with the wards staff to monitor and advise
- An external review of the management and prevention of Clostridium *difficile*

The Trust requested an external peer review as we were concerned about the number of Clostridium *difficile* cases being reported within our acute services. The review was conducted in December 2012 by a Senior Infection Control Nurse from the Royal Wolverhampton NHS Trust. During this visit the assessor inspected our levels of cleanliness on the wards and patient care equipment. She met with senior staff and looked at how we report internally on a monthly basis to our staff. An action plan has been agreed since the visit to address the recommendations made and is being progressed.

The pharmacy antibiotic team are proactively monitoring antibiotic prescribing and promoting the Department of Health's 'Start Smart and Focus' actions, thus engaging staff to reduce antibiotic usage and the incidence of Clostridium *difficile*.

Clostridium *difficile* numbers for 2012/13 have increased this year within the Swindon and local community and we are working closely with our partners in healthcare to ensure all elements of healthcare provided are giving a real focus toward driving down these infections.

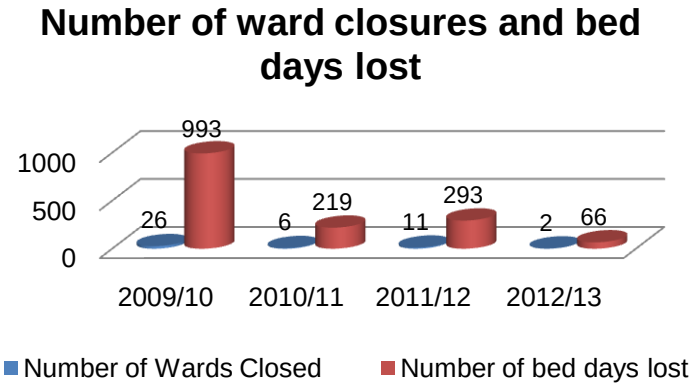


***Including community since 2011/12**

Ward Closures due to Outbreaks of Norovirus

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

The chart below shows the number of ward closures each year and the associated impact on the number of empty bed days accumulated during these closures. The winter of 2009/10 was particularly difficult with many wards being closed for long periods of time. Since 2011-12 the data also includes the GWH community wards and it can be seen that due to the proactive management and isolation of patients, and early bay closures, the numbers of wards we have needed to close has reduced considerably along with the number of bed days lost due to full ward closure.



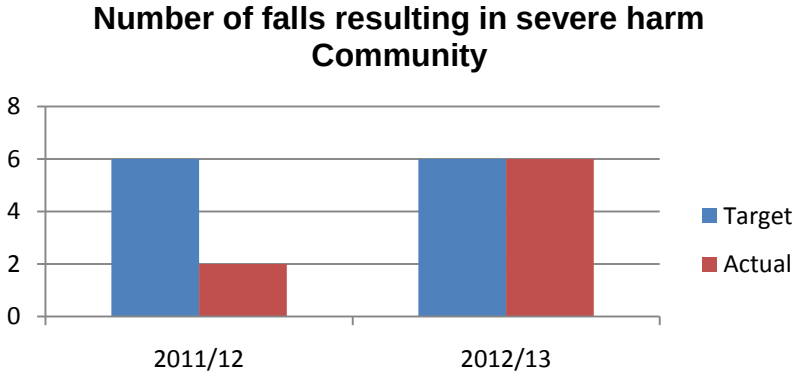
Priority 2 - To reduce harm arising from patient falls

Patients who fall in hospital are at significant risk of sustaining injuries and fractures and it is a real priority for us to not only prevent these falls occurring, but also to reduce the harm to patients following such incidents. This summary provides information on all patient falls resulting in severe harm which have occurred within our acute and community services. The key findings and learning from these incidents have been combined.

For the year 2012/13 our goal was to reduce the number of patients who sustain severe harm from a fall by 10%. This equated to <20 for the acute hospital and <6 for the community services we provide.

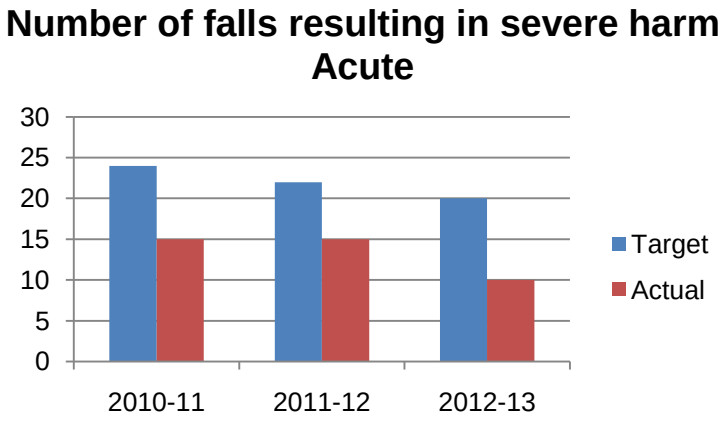
Definitions

Moderate Harm: The fall resulted in harm that was likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital
Severe Harm: Where permanent harm, such as disability, was likely to result from the fall.



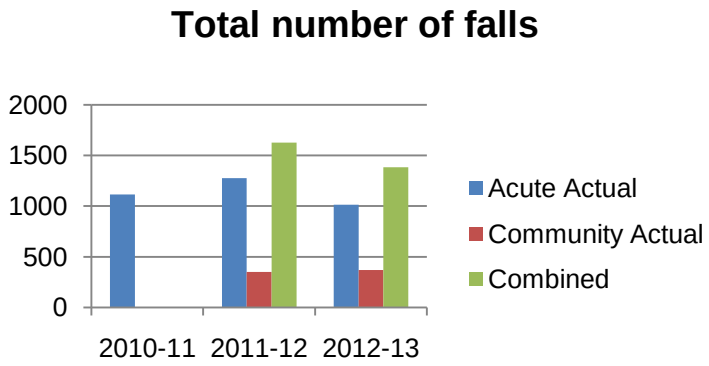
The above graph shows that the Trust reported four more, severe harm falls in 2012/13 compared with 2011/12. Unfortunately we do not have any community data prior to 2011/12 so we cannot be sure if this is a transient increase.

Following investigation, a theme started to arise in that the patients were attempting to mobilise without seeking support. Another observation, plus Nursing Establishment Review was that in one ward the layout does not promote good visibility of all the beds. We have aimed to alleviate this by introducing intentional rounding, establishing a guideline for when 1:1 nursing is appropriate, and ultimately renting a sensor alarm to alert staff when a patient is attempting to mobilise. Intentional Rounding is a method of systematically reviewing all patients on a regular basis to ensure and document that fundamental care needs are met. The check includes Pressure Ulcer Prevention intervention, continence care, prevention of falls and support regarding nutrition and hydration



The graph above shows that during 2012/13, we reported 10 falls which resulted in severe harm in the acute setting. This is a 33% reduction compared with 2011/12 figure and has exceeded our improvement goal.

As a whole, the Trust has seen an overall reduction in the total number of patient falls this year compared with 2011/12, as well as a reduction in the number of severe harm from falls if the figures are combined. The strengthening of investigations and prompt learning which support the reduction in falls strategy have accounted for the improvements made during the year.



The above graph shows there is a combined total reduction (green bar) of 16% of all patient falls compared with 2011/12. 2012/13 will see focused work on reducing falls in the community, such as purchasing more low beds and developing guidance for staff on when it is appropriate to request one to one supervision for high risk fallers.

The trust will continue to strive to achieve the standards set within the Falls Strategy, including aiming for every adult patient to have a falls risk assessment within 4 hours of admission and a comprehensive falls prevention care plan in place for those patients identified as at risk of falling. This practice is being audited monthly at ward level and data collated to a central spreadsheet for monitoring at directorate level.

Priority 3 - To Reduce Healthcare Acquired Pressure Ulcers

Preventing the development of pressure ulcers is an important element of the care we provide for our patients, especially for those who have reduced mobility and those who, due to serious illness and increasing age, may have delayed recovery.

The GWH acute hospital combined reduction goal for both Category III and Category IV hospital acquired avoidable pressure ulcers was 18 or less. Grade III and IV category pressure ulcers are the most serious ones. The actual total number reported during 2012/13 was 2 (Category IV = 1; Category III = 1). This is a significant improvement and achievement and shows a reduction in severe pressure ulcers of 60% from the previous year

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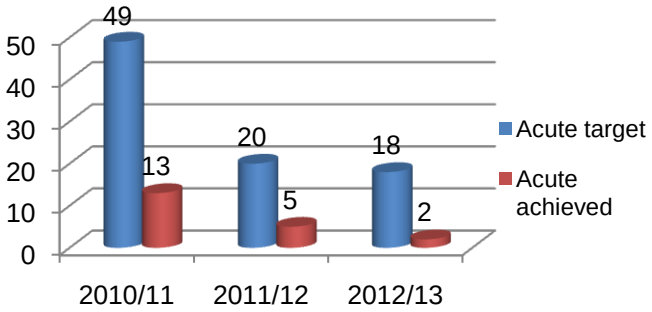


During 2012/2013 we also aimed to reduce the number of hospital acquired Category II pressure ulcers.

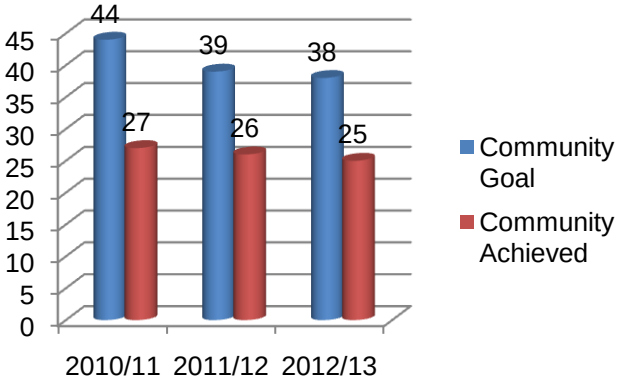
	Acquired Category II pressure ulcers GWH Hospital
2011/2012	**157**
2012/2013	**138**

In 2011/12, 157 hospital acquired category II pressure ulcers were reported and at end of year 2012/13, 138 had been reported. This is a reduction of 12%

A pressure ulcer risk assessment tool is used when patients are admitted to hospital to determine the risk of them developing a pressure ulcer and re-assessments are undertaken as conditions change. This enables care to be individualised and planned appropriately for each patient. The reassessment results are placed on a ward dashboard so that they are highly visible at all times.

The introduction of Ward Safety briefings ensures that our staff are aware of the patients who are at risk of developing pressure ulcers i.e., those patients whose skin integrity is already compromised and/or those whose skin is vulnerable.

Within our community setting, the combined reduction goal of both Category III and Category IV community acquired avoidable pressure ulcers was 38 or less. The actual total number reported end of year 2012/13 was 25(Category IV = 12; Category III = 13). This shows that we have made a small reduction in these patient safety incidents over the last 3 years and will remain a continuing priority for us during 2013/14.



The tissue viability team have also focused on reducing the numbers of community acquired Category II pressure ulcers; which have also been monitored for every neighbourhood team. This relates to patients who are being cared for in their own homes.

	Acquired Category II pressure ulcers Community hospital	Acquired Category II pressure ulcers Neighbourhood teams	Acquired Category II pressure ulcers Total
2011/2012	23	217	**240**
2012/2013	31	123	**181**

The table above shows that we have also reduced our healthcare associated Category II pressure ulcers by 25% over the last year.

The Tissue Viability Team has put many measures in place to optimise the reduction of pressure ulcers:

- Implementation of an intentional rounding tool within Great Western hospital and the community hospital sites
- This includes the Surface Skin Keep Moving Incontinence Nutrition (SSKIN) Bundle which is a national tool used for pressure ulcer assessment and reduction
- Developing an information leaflet for all patients at home and in hospital on how to prevent pressure ulcers
- Providing specialist equipment where appropriate such as the provision of dynamic mattresses, negative pressure wound therapy, protectors and dressings
- Utilising the services of the medical photography department take photographs of pressure ulcers to support the monitoring of how they improve or worsen to inform further care
- Implementing actions following investigations when Category III or Category IV pressure ulcers develop

A new Pressure Ulcer Prevention Strategy has been developed and will be fully implemented during 2013/14 and includes:

- Utilising the SSKIN Bundle in every patient's home in the community and working in partnership with Social Service agencies
- Instigating a pressure ulcer review panel to investigate and learn from each incident
- Education on pressure ulcer prevention will become mandatory from 2013
- A pressure ulcer and wound care group will commence from May 2013

Priority 4 - To ensure patients are assessed for the risk of developing venous thromboembolism and that these risks are managed appropriately.

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

VTE Risk Assessments

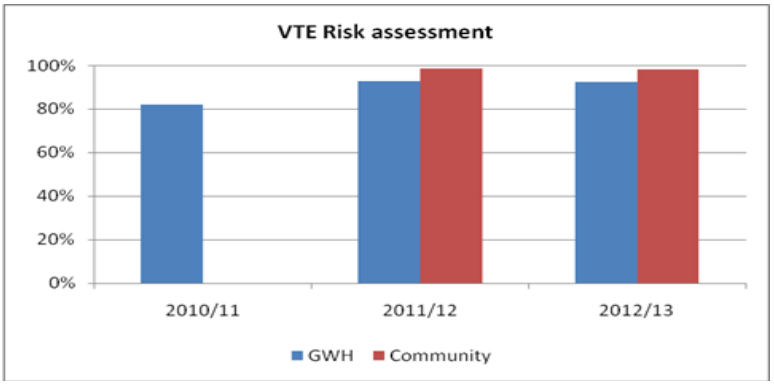
During 2012/13 our goal of completing VTE risk assessments for all patients has been maintained at over 90%. This includes data from our community settings since June 2011.

This has been achieved by:

- Continued education sessions at Trust Induction for both the acute and community settings
- Making VTE training available electronically on the Trust's intranet site
- Daily monitoring of the completion of VTE risk assessments through the nursing Crescendo documentation system providing daily reports to each ward
- Raising awareness with patients and relatives by means of information boards and displays
- We have also worked closely with our community partners in healthcare provision to introduce VTE risk assessments into the community for patients who are discharged home with VTE prophylaxis. This will

also enable patients who deteriorate at home to be reassessed and for them to receive appropriate VTE prophylaxis, if at risk. This is not mandated in the NICE clinical guideline (CG92) but is good clinical practice and has been embraced by the community

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

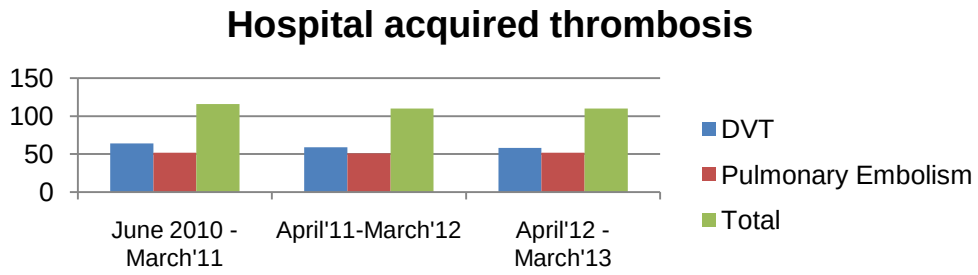


Administering appropriate VTE thromboprophylaxis

Compliance with VTE prophylaxis has been maintained between 90-100% for the last 12 months. Audits evaluating the quality of the risk assessments and appropriate thromboprophylaxis are undertaken each month looking at one surgical ward and one medical ward.

Hospital Acquired Thrombosis

We also look at the number of Hospital Acquired VTE events (HAT) which relates to a thrombosis (either deep vein thrombosis or pulmonary embolism) that occurs within 90 days of a hospital admission. The chart below shows the total number of hospital acquired thromboses since June 2010 and includes data for our community services since April 2012. There is no national bench mark for this data but it is good clinical practice to monitor this and enables us to see if we are improving and to learn. The number of events has not gone down this year however the total number of admissions throughout the year has increased by over 2000 for the same period in 2011-12.



Priorities for 2013/14 are:

- To increase the percentage of patients who have a VTE risk assessment from 90% to 95% by November 2013
- To ensure a root cause analysis is carried out for all hospital acquired thrombosis events where a VTE risk assessment and/or received appropriate prophylaxis have not been observed
- To set an achievable and sustainable reduction goal

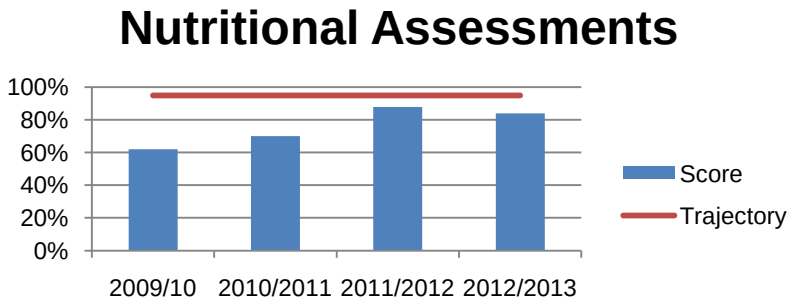
Priority 5 - To meet the nutritional/hydration needs of patient

Nutritional screening is essential to identify those requiring nutritional support to sustain their nutritional and hydration needs. This includes the quality of the food being offered and the meals service including providing assistance and an appropriate environment.

Many of our inpatients are elderly and frail; require assistance with their eating and drinking and consequently are at additional risk of clinical deterioration. Many of these patients will be nutritionally compromised and/or dehydrated on admission. Additional stresses from any acute illness or trauma and the unfamiliarity of their surroundings and foods can further impact adversely on their nutrition and hydration status.

All patients should have a nutritional screen on admission and an appropriate and individualised nutritional care plan initiated. At Great Western Hospital NHS Foundation Trust the Malnutrition Universal Screening Tool (MUST) is used, which has been nationally validated for screening adults. Patients' nutritional status (regular weights and MUST re-screening) and nutritional intake, as well as fluid input/output must be monitored. Clear and timely recording with effective bed-side handover is essential to ensure any issues are raised early.

Not all nutritionally vulnerable patients are elderly and frail; many are at risk due to complex chronic conditions such as inflammatory bowel disease or cancer and these patients may need additional and specific support from dietetics.



Our priorities this year have been to focus on:

- Improving (or maintaining) compliance with and accuracy of MUST, nutrition care plans and documentation of fluid balance
- Improving in-patients meal-time experience including meal quality, appropriate choice and assistance with meals as required
- Ensuring ward staff (including hostesses, Nursing Auxiliaries and volunteers) and catering staff undergo training appropriate to their roles and areas of work (GWH & Community) through training programmes, workbooks and/or e-learning
- Providing twice yearly reports, to the Clinical Standards Group, showing progress with the action plan and assessments

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

To improve (or maintain) compliance with and accuracy of MUST, nutrition care plans and documentation of fluid balance

- Matrons continue to audit ward hydration and nutrition documentation and individualised care planning monthly to ensure accurate completion and compliance with standards
- Year to date figures show MUST compliance rate of 85%
- Ward performance is a standing agenda item at the Matrons Care Quality Operational Group (MCQOG). Audit results are regularly reviewed and actions agreed for each individual ward and Matron to improve compliance rates and quality of results
- Results of ward performance are discussed at the Directorates' ward review meetings and at senior sisters meetings
- Awareness training for Nutrition and Hydration is mandatory for all relevant ward staff, Compliance is monitored by the Trust's "Academy" Team and staff Line Managers.
- Internal inspections are conducted by the Trust Quality and Safety Team
- Spot Checks conducted by the Deputy Director of Nursing; Executives and Matrons (Peer Review)

To improve in-patients meal-time experience including meals quality, appropriate choice and assistance with meals as required.

- The "protected meal times" initiative: avoiding interruptions at mealtimes and supporting patients that require assistance
- Ensuring that all patients identified as being nutritionally at risk and requiring assistance with food and drinks are easily identifiable to staff through the use of a red trays and a red jug lids

- Dietetics Team are working to strengthen individualised care planning for patient nutrition and hydration which will include guidance to improve efficiency of the meal time's processes and experience. A pilot project is underway on Saturn ward
- Ward staff have access to the Nutrition Resource Folder which includes guidance on ordering meals or specific items for special diets such as allergen free
- Information on the above is also accessible via the Dietetics intranet site
- Band 6 ward nurses lead on embedding effective bed-side handover which includes a review of fluid and food charts
- Patient feedback sought via patient food questionnaire ("diary") completed in March 2013. Feedback generated provides areas for improvement with food quality and choice which is being reviewed with Carillion as providers of meals and with the matrons. Good feedback was received regarding the levels of assistance at mealtimes. Also other satisfaction surveys e.g., new Friends and Family Test and Senior Managers walkabouts and complaints.
- The current menu does meet the existing standards; the dieticians have completed checks to confirm this. More detailed analysis is planned for later in 2013/14

Education, training and information

- Hydration and nutrition awareness is now included on the Trust nursing and (Nursing Auxiliary) NA induction
- The majority of wards have a Nutrition Resource Nurse many of whom were also involved with the productive ward meals projects
- Volunteer staff receive information and training on assisting patients with hydration and nutrition
- Relevant ward staff involved in direct patient care undertake mandatory training on hydration and nutrition. Training is delivered through an e-learning programme and work books
- Information leaflets on hydration and nutrition are available to patients, carers and the public in ward clinical areas
- Ward staff have access to Hydration Information and Nutrition Resource Folders
- Dietetics intranet pages include guidance on nutritional screening, nutrition care planning and therapeutic diets. Also includes information about ordering meals or specific items for special diets such as allergen free or modified textures.

Assurance Framework

- Ward performance is a standing agenda items at the Matrons Care Quality Operational Group (MCQOG). Audit results are regularly reviewed and actions agreed for each individual ward and Matron to improve compliance rates and quality of results. Current audits identify overall compliance at 80-100% against all indicators, which has risen from 60% when audits commenced in March 2012. Individualised care planning has proven the most challenging with overall compliance at 80%, improvement in this is a component of the 'Saturn Ward Project'
- Trust Nutrition & Hydration Steering Group (NHSG) monitors activities relating to quality standards and ensures work plans are updated as required. NHSG reports to the Clinical Standards Group and informs compliance with the relevant CQC regulations

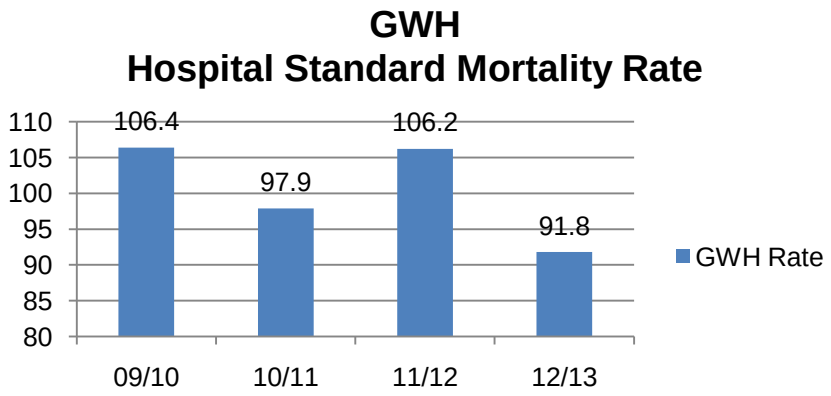
Priority 6 - To Reduce Preventable Hospital Mortalities

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

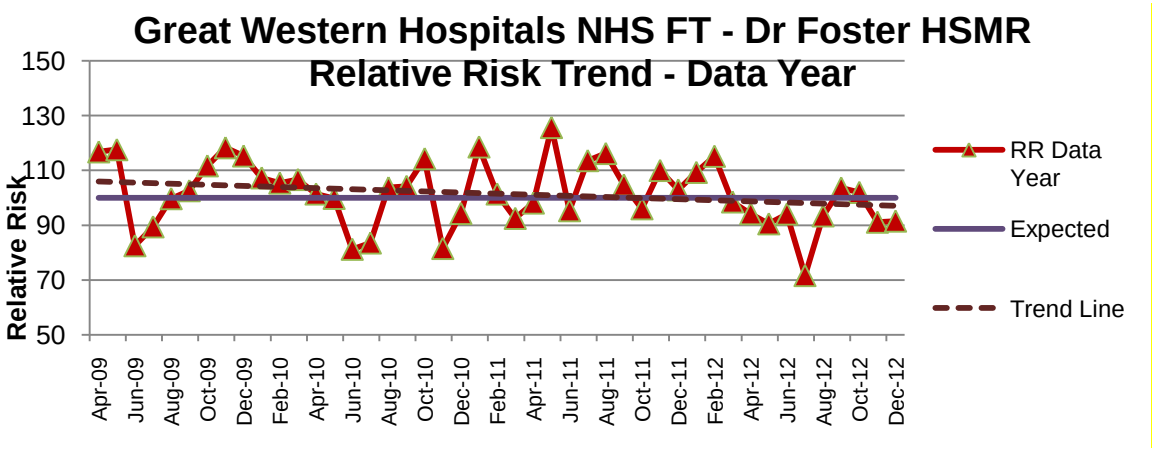
Therefore when comparing a local RR figure of 100 it would indicate that the mortality rate is exactly as expected, whilst a local figure of less than 100 would indicate a mortality rate lower (better than) than expected.

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

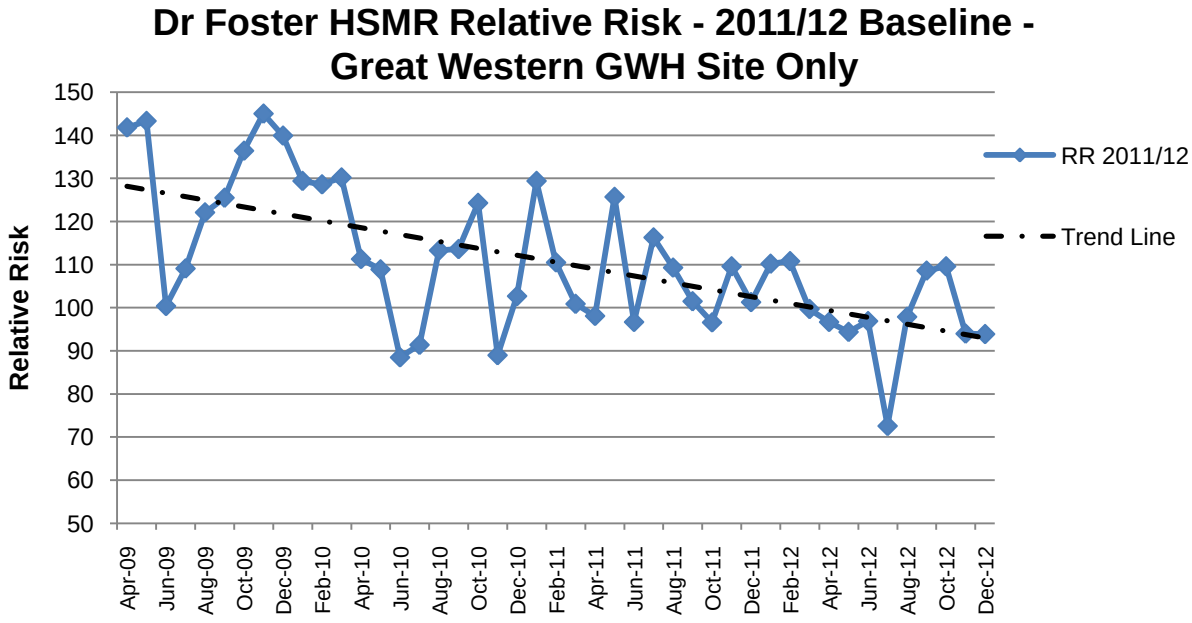
The Table below shows the year on year HSMR following rebasing which denotes a continued improvement and reduction in mortality rates over the last 3 years



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



It is clear from the chart below that by comparing the RR trend for the Trust over the last 3 years using the current base year of 2011/12 across the whole period that major improvements in the RR score for mortality have been made. That said, because the baseline is being recalculated every year it means that the benchmark is always being lowered (albeit by smaller amounts year on year) so the Trust can never be complacent about the RR performance. This chart is not available for the Community due to figures being base lined on the previous year (2010/11), which was not available.



Priority 7 - Monitor Compliance with the Early Warning Score (EWS for Adults and PEWS for Paediatrics)

Early Warning Score - Adults

It is important whenever a critically unwell patient presents that they are identified quickly and care escalated appropriately. For staff to do this they need to use a system that all members of the Multi Disciplinary Team are familiar with, use effectively and respond to in a recognised manner. Much in the same way that resuscitation is universal across the country, the current drive is to standardise the process for recognising critically unwell patients through the rollout of a National Early Warning Scoring system (NEWS). This should ensure that wherever staff work in different hospitals, and wherever patients present, they will have exposure to the same standard system, hopefully reducing risk or errors with lack of familiarity of different systems and also allowing comparison of different Trusts data, with the aim to drive national standards up.

With the official sign up of the Royal College of Physicians in July 2012 of the National Early Warning Scoring system (NEWS) it was agreed to continue with the current SOS system and unmodified charts with a view to moving over to the NEWS system when launched. This system uses a very different style of chart but does include 'frequency of observations'. The SOS system in its current format has a high compliance rate of completion and works well across the Trust. However, it is a local scoring system so will not give comparative data against other Trusts; the long term plan is to move over to NEWS. The annual audit of 200 charts completed between Jan and Mar 2013 again shows compliance with the NEWS monitoring process of over 90%.

For 2013-2014, the plan is to continue to use the SOS scoring system, with quarterly audits, and plan a staged change over to NEWS within 12 months.

The SOS observation charts were introduced across Wiltshire in 2012. The audit completed in Jan – Mar 2013 showed compliance above 90%. It was agreed to mirror the GWH processes and continue with the SOS scoring on the current unmodified charts and move over to the National Early Warning Scoring system (NEWS) during 2013/14.

Paediatrics Early Warning Scores (PEW)

A universal PEW score for the whole organisation was not introduced as planned due to the variations of assessment/monitoring tools across the various disciplines.

However a PEW audit was undertaken during a 10 week period on the children's unit, this involved reviewing 5 charts weekly. Compliance improved over the 10 week period though appeared to decrease during busy periods. The main concerns were frequency of observations not being documented and observations being missed. The ward manager and ward sisters have raised this with staff and it is now part of their daily monitoring to ensure compliance.

For 2013-2014, the plan is to introduce a Trust wide PEW tool that meets the demands of the various areas within the Trust where children are assessed and monitored. Once introduced, each area will be audited at least once to obtain a percentage base line compliance with completion. We will seek to ensure at least 90% compliance during 2013/14.

Priority 8 - To improve the quality of End of Life Care for patients

End of Life Care is provided by staff throughout the Trust. Staff are supported in delivering this care by the Palliative Care Team. This in-reach team is provided Prospect Hospice and is contracted to support the needs of patients in the Acute Trust. This is achieved in 2 ways:

- By supporting clinical staff throughout the Trust in their provision of care. This is demonstrated in the Quality Accounts by the education provision, the support of the Liverpool Care Pathway, work to flag patients on the Adastra electronic register (see below) and work to increase understanding and participation in advance care planning
- By providing direct care, for example with advice on more complex symptom control, supporting rapid discharges home, supporting the decision making for the more complex patients. The direct care also provides opportunity to up-skill the wider clinical teams informally.

Improve education and awareness in End of Life care for clinical staff.

Education provision is an important component of the In-reach Palliative Care Team's activity. Education provided over the past year:

- Formal sessions (68 hours provided to 1087 attendees)
- Informally whilst providing direct clinical advice and care (130 hours to 83 staff members)

Nursing staff are required to complete an e-learning module about the Liverpool Care Pathway. Participation is closely tracked electronically. The **Liverpool Care Pathway for the Dying Patient** (**LCP**) is a UK care pathway covering palliative care options for patients in the final days or hours of life. It has been developed to help doctors and nurses provide quality end-of-life care. The Liverpool Care Pathway was developed by Royal Liverpool University Hospital and Liverpool's Marie Curie Hospice in the late 1990s for the care of terminally ill cancer patients. Since then the scope of the LCP has been extended to include all patients deemed dying.

A series of educational study days around enhancing the skills and confidence of ward nurses in the delivery of End of Life Care are underway. This was a single funded initiative by the Strategic Health Authority and provided by the Palliative Care Team and the Education Facilitator at Prospect Hospice.

Improve data capture of patients who are approaching end of life admitted to GWH and in community.

In Swindon and Wiltshire, an electronic register enables primary care teams to generate a register of patients who are likely to be within the last year of life. Patients must consent to be included. The register facilitates the communication of information between care providers with the aim of enabling the most appropriate care to be offered to patients. Work is now underway to identify these patients on the hospital's electronic information system so that the information recorded on the register is available to hospital clinicians.

Promote conversations involving Advance Care Planning

Advance Care Planning is a voluntary process of discussion about future care between an individual and their care providers, in the context of anticipated future deterioration in individuals condition (NHS End of Life Care Programme, 2008)

To support such conversations the Advance Care Planning booklet 'Planning for your future care,' published by the National End of Life Care Strategy is available for patients and their carers in key clinical areas and distributed when appropriate by the Palliative Care Team.

The Palliative Care Team has been involved in 759 conversations about Advance Care Planning over the last year. This was also a theme incorporated into educational events.

It is important that patients expressed preferences are reflected in their care. Over the last year, 87 patients who were known to the Palliative Care Team and who died in the hospital expressed a preference to have their End of Life Care provided in the hospital. The discharge from hospital to home or care home of 352 patients was supported by the team. 102 patients were transferred to Prospect Hospice.

Involvement in National Care of the Dying (Liverpool Care Pathway) Audit

The most recent round of twice yearly audits took place during the summer of 2011. It is anticipated that the audit will be repeated in 2013. The audit is directed nationally. It enables benchmarking of the local use of the pathway against other hospitals across the country.

Work has been undertaken in response to the very adverse publicity that the Liverpool Care Pathway has received in the media, to ensure that high quality care is available to dying patients and their families. This has involved the Palliative Care Team working alongside ward teams and patients/families to provide support and the development of an additional information leaflet

The substantial educational activity of the team has incorporated issues around the Liverpool Care Pathway in many events.

The outcome of the independent review of the Liverpool Care Pathway is expected in summer 2013

Priorities for 2013/2014

In accordance with the National End of Life Care Programme's guidance for acute hospitals, work will continue to embed and develop the key enablers which support good End of Life Care. These include Advance Care Planning, the End of Life Register, Rapid Discharge Home pathways and the Liverpool Care Pathway. This will be facilitated by the mechanisms above, by building on the well developed clinical care and education delivered over the last year and by close collaborative working with End of Life Care providers in other sectors.

Priority 9 – Improve care and access to services for patients with Dementia

On 8 February 2013, Gloucestershire Hospitals NHS Foundation Trust visited GWH hospital to review the development made so far in the care and support for people with dementia and their carers. This review is part of an ongoing programme across the South West area hospitals to improve standards through a process of networking and Peer Review, giving organisations an opportunity to showcase their good work, share experiences and support each other to meet the challenges. The reviewers commented on the significant improvement the Trust made since the review of November 2011.

Positive Practices identified during the visit

- The implementation of Dementia Training for staff and volunteers
- The dementia champion forum was launched in November 2012 and over 100 staff from across the organisation volunteered to support the Trust aspiration to improve patient experience and care
- The visiting team liked the process which enables the Dementia Environment Group to be involved in any planned works including public areas within the hospital, and the use of Charitable Funds to buy small equipment/clocks etc
- The Team were impressed with the close working between GWH hospital and the Prospect In-reach Palliative Care Team who provide timely support to patients in hospital including expediting discharge planning arrangement. The Prospect also provide education and training to GWH staff
- Development made in ensuring that patients' hydration and nutrition needs were met using a range of initiatives. They liked the idea of 'Weigh Wednesday' programme and the way it has been extended into the community hospitals. There has been introduction of soft menu for dementia patients and a system that enables a choice of meal from the trolley
- The visiting team were impressed by the thoroughness of the work targeted at falls prevention
- GWH was commended for attracting, supporting and retaining 590 volunteers across the organisation Staff on wards welcomed the support they receive and the evident benefits for patients
- The visiting team liked the concept of learning from patients' stories through a process referred to as 'Goldfish Bowl' where patients or relatives/carers are able to come to the hospital to share with staff their positive or negative experiences
- The visiting team heard of the steps the hospital was taking to address better management of pain for people with dementia

Work expected in 2013/14

- Continue to develop staff knowledge and skills in caring for people with dementia through the dementia training programme
- Develop an integrated dementia pathway to ensure that patients have a seamless journey from community to hospital and back to community
- Continue to increase the number of dementia champions that will help to raise awareness locally and support the embedding of standards
- To develop a GWH Dementia Care Strategy clearly outlining the Trust's ambitions and priorities

Priority 10 – To improve patient experience and satisfaction

Patient Experience focuses on inpatients because the data historically used to satisfy some CQUIN questions and this section of the Quality Account has been based on the mandatory inpatient survey.

We are aware that the CQUIN questions do not provide enough information on the views of some patients, particularly outpatients, and we plan to change this in the future. The Trust has already gone further than needed with the Friends and Family Test now in place in Inpatients, MIUs, A&E and Maternity services. We are also hoping to roll it out to Outpatient areas by late summer and onto the remaining areas later in the year.

In the future, this simple test will give a much clearer impression of the views of all patients, not just inpatients.

A change in survey provider (from Picker to Quality Health) has resulted in a difference to the analysis of the in-patient survey. In past surveys a 'problem score' was used which focused on the negative results. With the change in provider and with a positive outlook, we are now focusing on top scores.

Previous surveys, which focused on the 'problem score' outcome also had targets attributed to a reduction of the negative or 'no' answer; for example, '40% or less'. With the change in focus, we have used the 'yes, definitely' answer to re-frame to target to become a measurement of the positive; 'more than 60%'.

The table below shows the results for the Great Western Hospital, and the Community. It should be noted that the response rate for the community was significantly smaller in quarter two and this has resulted in some unbalanced figures when calculating the percentage.

The Trust closed the year with some mixed results; achieving or surpassing its targets in five areas, but falling short in the other five. The areas for improvement mostly relate to communication with our patients, which is a priority for us to address in 2013/14.

Question	Target	Q1 %	Q2 %	Q3 %	Q4 %
Were you involved as much as you wanted to be in decisions about your care and treatment?	**GWH** GWH target 52% or more responding 'Yes, definitely'	**45**	**49**	**51**	**50**
	Community GWH target 42% or more responding 'Yes, definitely'	**42**	**18**	**45**	**49**
Did you find someone on the hospital staff to talk to about your worries and fears?	**GWH** GWH target 43% or more responding 'Yes, definitely'	**37**	**37**	**37**	**32**
	Community GWH target 41% or more responding 'Yes, definitely'	**41**	**0**	**43**	**41**
Were you given enough privacy when discussing your condition or treatment?	**GWH** GWH target 73% or more responding 'Yes, definitely'	**71**	**72**	**73**	**72**
	Community GWH target 73% or more responding 'Yes, definitely'	**73**	**55**	**64**	**61**
Did a member of staff tell you about medication side effects to watch for when you went home?	**GWH** GHW target 40% or more responding 'Yes, completely'	**31**	**31**	**30**	**28**
	Community GWH target 31% or more responding 'Yes, completely'	**31**	**20**	**13**	**21**
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?	**GWH** GWH target 63% or more responding 'Yes'	**63**	**69**	**67**	**67**
	Community GWH target 67% or more responding 'Yes'	**67**	**10**	**53**	**55**

To improve patient satisfaction through more involvement with decisions about care

Results from the National Inpatient Survey have remained fairly static over the last few years. Although around 50% were 'definitely' happy with the level of involvement about their care, we need to work harder to reach the other 50%.

Further actions being taken include:

- Implementation of bedside handovers with patient involvement, to ensure patients are involved in their care
- We are aiming for bedside handover audits by matrons and senior sisters monthly to ensure robust processes in place
- Maintenance of senior sister/matron posters visible in ward/departments ensuring patients and visitors know who to contact if they have concerns or questions
- Provision of patient information prior to admission and on discharge regarding care and treatment
- Implementing actions arising from a recent nursing skill mix review. Roll out of adjusted staffing establishments commenced April 2013 with the introduction of supervisory roles for the senior ward Sisters. This will increase visibility and a core part of the Sisters' role will be daily reviews of all

patients, meeting and greeting visitors to ensure that there is good communication and opportunities to ask questions and raise concerns regarding treatment and care plans

To improve patient satisfaction through more discussions regarding any concerns

- The Trust has worked hard to maintain many of the high clinical standards we pride ourselves on, however visibility and availability of staff still concerns some of our patients
- The provision of posters denoting the senior sisters/matrons is a key area to address these concerns so that patients and visitors know who to speak to and contact. There will also be pictures of staff uniforms in the new 'Bedside Guide' to help patients recognise know who is looking after them in terms of staffing grade and competency
- We are also recruiting additional nurses which will help with staffing availability (see section above).
- In the Children's Ward, a designated co-ordinator visits every bed space twice a day to check that enough information has been given to children and their families. There are also initiatives to promote nurses as advocates to help families understand medical information
- Implementation of bedside handovers also ensures that staff visit each bedside at least three times a day

To improve patient satisfaction through ensuring privacy when discussing care or treatment

Privacy has been a key development area, and the results of the survey show that the hard work had improved patient experiences. Staff are more focused on confidentiality, especially at bedside handovers and more care is taken to reflect the needs of the patient. Safety briefs and handover of confidential information is conducted away from the patient's bedside.

In the Children's Ward, an office has now been allocated for confidential phone calls by professionals. The option to pull curtains is also now in place for all families unless close observation is required.

Some wards now have sitting rooms available for private discussions with patients and their relatives.

To improve patient satisfaction by providing more explanation of the side effects of medication

Progress has been made to resolve some of the issues regarding communication on medication prescribed. This has included:

- Provision of information leaflets on discharge regarding side effects of medication dispensed from pharmacy
- Provision of, and advertising a helpline number for patients to ring if there are concerns about medication

The Trust is also reviewing admission, discharge and transfer documents to ensure standardised discharge checklists are completed. This includes an explanation about medication and side effects. Clinical handover of care documents have been developed and all staff should complete them on discharge for patients receiving additional support when at home; this includes a section on medication. The admission discharge and transfer document was launched and is now under review again, led by the Chief Nurse and includes a checklist for staff to follow which includes explaining medication to patients.

Community Hospital wards will be adopting the admission, discharge and transfer documents to ensure standardised discharge checklists are completed. This includes an explanation about medication and side effects. The policy is the same for acute and community.

To improve patient satisfaction through more contact after discharge, should any concerns arise

The GWH closed the year above its goal of 63%, which is an encouraging sign that the work started during the year is having an impact in this area.

Work continuing into 2013/14 includes:

- Discharge workshop training. Plans in place to progress these workshops during 2013 and will include all clinical staff. A mandatory training package for the Training Tracker is also being discussed.

- Reviewing discharge and transfer documentation. This work has been completed and is now under review with the Chief Nurse.

The Friends and Family Test (CQUIN)

One of the biggest changes regarding the measurement of the patient experience is the introduction of the Friends and Family Test. Although not mandatory until 1 April 2013, the Trust proactively introduced it into many areas in December 2012.

Working in partnership with an external company iWantGreatCare, the Trust launched the test in all inpatient areas, maternity and A&E. Although it is too early to obtain full and meaningful data, early indications show a positive view of the Trust, and with many patients expressing the view that they would be extremely likely to recommend us if their friends and family needed care or treatment.

The Trust has adopted a paper based and on-line approach to the test. At the point of discharge, every patient should be given a small A5 card which currently asks:

- what was good about their care, and;
- how likely they are to recommend us should a friend or family member need care

Patients can either complete the card in the hospital on at home on-line.

The Trust is expected to achieve a 15% – 20% response rate for these cards and plans to roll this test out across outpatients so that we have a comprehensive view of patient experience.

Each week, the completed cards are sent to iWantGreatCare who produce management reports down to ward level. These are shared with staff as soon as possible and reflect an overall score, based on the recommendation, and a scan of any hand written comments.

From July 2013 onwards, the results from the test will be published on-line.

Clinical Incidents- Never Events, Serious Incidents and Incidents

Never Events

A total of three never events were reported recorded by the Trust between April 2012 to March 2013:

1. Wrong site surgery
2. Wrong drug dosage of methotrexate
3. Retained foreign object post-operation

These events have been investigated, reported and managed through the Trust Clinical Risk Management and Clinical Governance Structures. Action plans have been developed and fully implemented to ensure such events do not re occur. This work has been shared with and approved by the CQC. Continuous monitoring of practices within the theatre and maternity departments is observed. Details of the action plans can be found in the Incident Investigation Report. The key learning and actions implemented include:

- Implementation of the WHO safer surgery checklist throughout the theatre department
- Continuous audit of compliance with the WHO safer surgical checklist implemented
- Introduction of a single method of checking lens power which is adopted by all surgeons performing cataract surgery at GWH
- Amendment of the Medicines Management policy to reflect guidance on Methotrexate prescribing
- The Swab, Instrument and Needle Count Policy and Processes to be amended and ratified following review
- “Silent cockpit” is to be strictly observed while the swab count is in progress. Therefore, there should be total silence in theatre whilst the checklist and counts are being audibly read

In January 2013, the Clinical Risk Department commenced a scheduled audit programme, testing compliance with the recommended control measures described within the national Never Event framework, identifying gaps and making recommendations to strengthen controls. The programme of audits will continue during 2013/14, to ensure that adequate control measures are in place to reduce the risk of all 25 of the listed never events.

In March 2013, the Clinical Risk Department commenced a review of previously closed serious incident investigations, including the never events which occurred in 2012/13, seeking assurance that action plans had been implemented and evidence of sustained changes in practice.

Serious Incidents

Previous to March 2010, reporting of serious incidents was described within regional and local policies, there was no national consistency and local policies were open to interpretation. The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation was published by the National Patient Safety Agency (NPSA) in March 2010. The framework provided a consistent approach to reporting and management of Serious Incidents, and a clear definition for serious harm. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

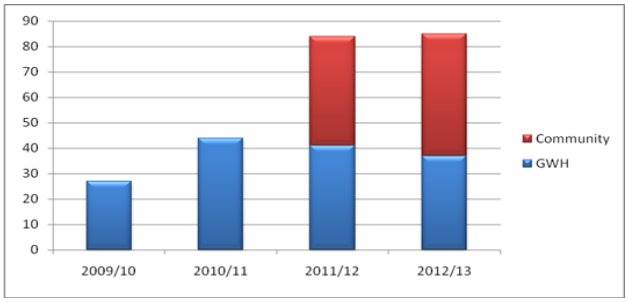
1. Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
2. Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten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

Serious harm was clearly defined within the framework as "harm where the outcome requires life saving intervention or major medical/surgical intervention". This increased our reporting rate because falls resulting in fractured Neck of Femur and all Category III and IV pressure ulcers now clearly met the reporting requirements. This accounts for the increase in serious incidents from 27 in 2009/10 to 44 in 2010/11

The Trust acquired Wiltshire Community Health Services and Wiltshire Maternity Services in June 2011, which increased the number of serious incidents reported from 44 in 2010/11 to 84 in 2011/12.

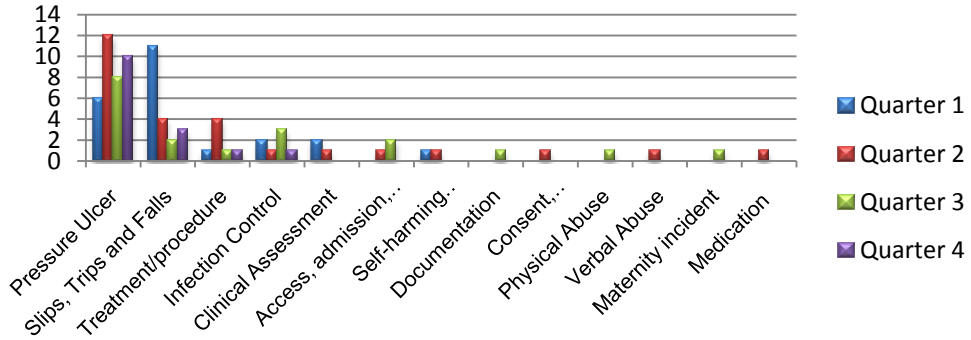
A total number of 85 serious incidents were reported and investigated during the period April 2012 to March 2013.

Total number of serious incidents April 2009 – March 2013



NB The chart depicts all SIs reported since integration with our community services 2011/12.

Serious Incident by Type 2012/13



Category 3 and 4 pressure ulcers and slips, trips and falls have continued to be the highest reported cause of serious incidents during 2012/13.

To ensure effective investigation and learning from pressure ulcer incidents the Tissue Viability Nurse Specialist and Clinical Risk Department have instigated a Pressure Ulcer Investigation review group to analyse and critique investigations. Outcomes from pressure ulcer investigations now contribute to a Trust wide pressure ulcer action plan to ensure that learning is shared throughout the organisation. Improvements in practice included on the Trust wide action plan include:

- Process to flag requirement to repeat routine pressure ulcer and other required patient risk assessments within the Neighbourhood teams;
- All occupational therapists and physiotherapists in the community will have access to pressure ulcer risk assessment training;
- Pressure ulcer patient information leaflet to be included in all assessment packs, with section added to the assessment pack for documenting that information leaflet has been provided.

The Deputy Chief Nurse and Falls Avoidance Team have launched a Trust Wide Falls Strategy and implemented a Falls Prevention Working Group to monitor implementation, review falls data and improvement measures. Serious incidents resulting from falls have reduced during 2012/13, from 11 reported in quarter 1, to 4 incidents in quarter 2, with the improvement remaining consistent until quarter 4 where 3 incidents were reported.

Incidents

National Reporting and Learning System Organisational Patient Safety Incident Report 1 Apr 2012 to 30 Sept 2012

The Trust reports all reported patient safety incident forms to the National Reporting and Learning System on a weekly basis.

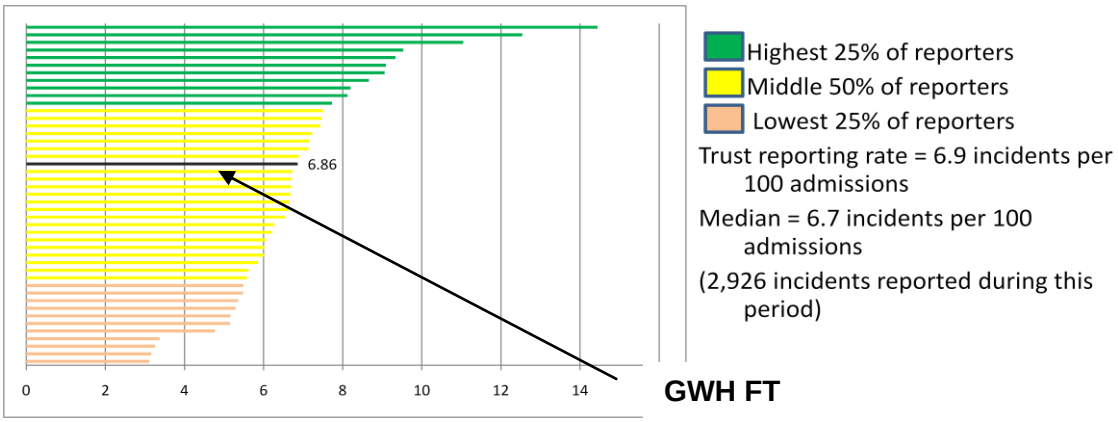
The ninth release of the Organisation Patient Safety Incident Reports data for NHS organisations in England and Wales was released on Wednesday 20 March 2013.

The data release included details of patient safety incidents in England and Wales that occurred between 01 April 2012 and 30 September 2012. The report also provides comparative data comparing Great Western Hospitals NHS Foundation Trust with 45 other medium acute Trusts.

National Incidents/Comparative data

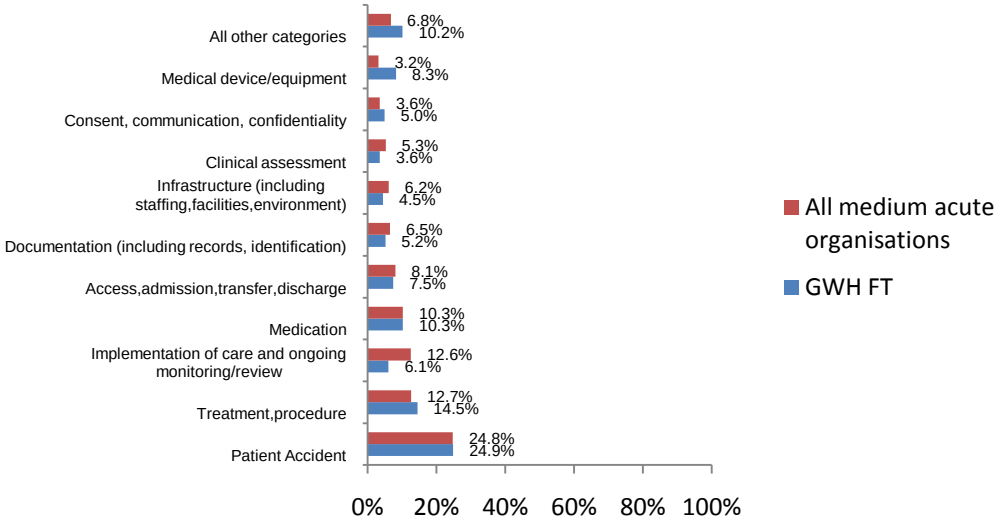
Are we actively encouraging reporting of incidents?

The Trust reported 6.86 incidents per 100 admissions.
Comparative reporting rate per 100 admissions, for 45 medium acute organisations.



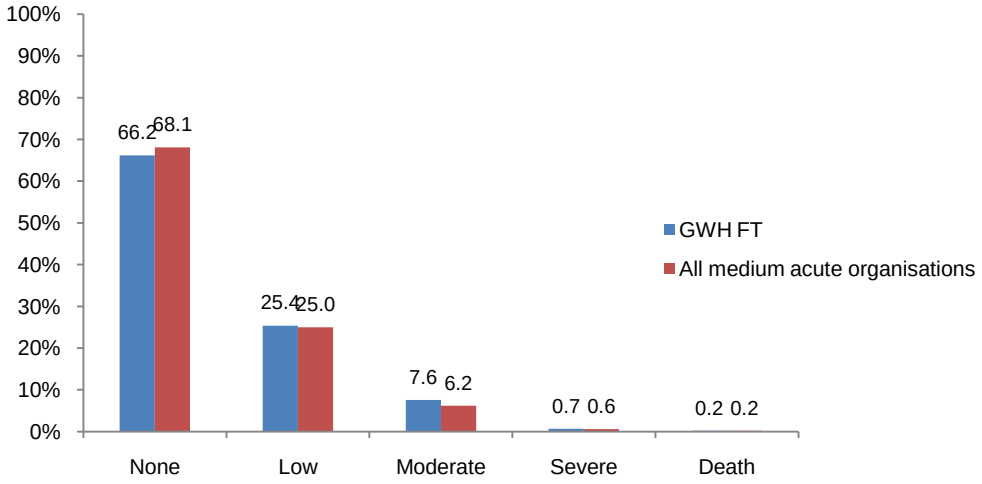
What type of incidents are reported in our organisation?

The report demonstrated that our reporting profile is similar to other reporting organisations within our reporting cluster.

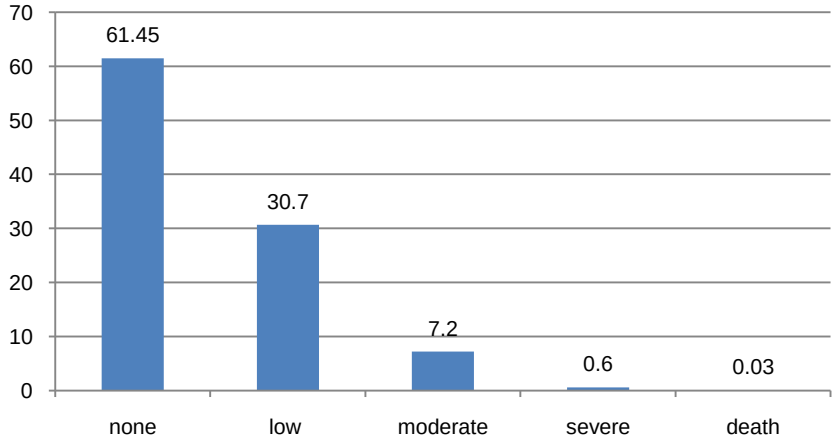


Incidents reported by degree of harm for medium acute organisations

Nationally, 67 per cent of incidents are reported as no harm, and just under one per cent as severe harm or death. The Trust is not an outlier in comparison to the other Trusts within our cluster group.



Incidents by degree of harm Oct 2012 to March 2013 for Great Western Hospital only (national data not published for this period until Sept 2013)



Degree of Harm following an Incident – 2012-13

2012/13	None	Low	Moderate	Severe	Death
April 2012 to September 2012 (6 months)	**1936** (66.2%)	**742** (25.4%)	**222** (7.6%)	**21** (0.7%)	**5** (0.2%)
October 2012 to March 2013 (6 months	**1881** (61.45%)	**941** (30.7%)	**219** (7.2%)	**19** (0.6%)	**1** (0.03%)
Full 12 months data 2012/13	**3817** **(**63.8%)	**1683** (28.1%)	**441** (7.4%)	**40** (0.67%)	**6** (0.1%)

The chart above shows the degree of harm following all incidents. It shows that moderate/severe harm has reduced over the 2nd twelve months of the year. National data is not yet available to benchmark against for the second twelve months of the year (see previous two charts).

Priorities for 2013/14

1. Compliance with Incident Management Policy and implementation of sustainable changes as a result of serious incident investigations
2. Compliance with the Being Open Policy for all serious incidents to demonstrate commitment to Duty of Candour
3. Development and delivery of patient safety related training programmes
4. To monitor compliance with all recommended control measures described within the Never Event Framework
5. To ensure that all recommended control measures described within the Never Event Framework are in place within the organisation
6. To describe the process for supporting staff involved in an incident, complaint or claim within a revised policy document. To monitor compliance with this document, to provide assurances of an effective process which meets both the needs of Trust's Staff and the NHSLA.

Participation on the Regional Patient Safety Programme

During July 2012, the Trust began to use the NHS Safety Thermometer. This is a tool developed by the NHS to be used as a point of care survey instrument and was first introduced in 2012 and now used nationally. All Trusts have been encouraged to use this tool with a CQUIN incentive target running alongside.

The Safety Thermometer allows teams to measure harm and the proportion of patients that are "harm free" at the point of measurement. At present, the four harms measured are:

- Pressure Ulcers
- Falls
- Catheter related urinary tract infections (CAUTIs)
- VTEs

Reports in the form of charts, graphs and percentages are available as soon as the data is entered into the Safety Thermometer which then allows the teams to monitor their progress in the four areas.

Survey measurements are uploaded onto a national monitoring tool which then allows organisations to benchmark against others.

Since April 2012, over 1 million patients have been surveyed with figures for The Trust as follows:

- 6362 patients surveyed
- 182 surveys completed and submitted

Expected Outcomes from the on-going use of the Safety Thermometer are as follows:

- Providing support to areas that require help to complete ST from on time
- Continuing to ensure that the data validation time scales are met and not exceeded
- Generic email boxes now in use so that final data submission can be made by more than one person
- Ward Managers to review their data monthly and ensure that action plans for improvement to their specific areas are set. Matrons to support with this process

- Ward Managers/Sisters and all other staff can feel supported and assisted to implement positive changes of practice in their ward areas
- To update the Safety Thermometer link which is available on the Trust intranet so all staff have access to the relevant information for the Safety Thermometer
- A Patient Safety Thermometer group is currently being established to review the data and determine how and where trust wide reports will be shared and learning shared

Review of Services

During 2012/13 the Great Western Hospitals NHS Foundation Trust provided and/or sub-contracted 7 relevant health services.

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

The income generated by the relevant health services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2012/13.

Registration with Care Quality Commission and Periodic/Special Reviews

Care Quality Commission Registration

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

The Care Quality Commission has not taken enforcement action against The Great Western Hospitals NHS Foundation Trust during 2012/13.

Following integration with Wiltshire Community Health Services, the Trust submitted a variance to the conditions of its existing registration from June 1st 2011 with the Care Quality Commission (CQC). This included nursing care as an additional community based activity and the addition of 21 community sites/locations.

All registered sites/locations and activities were reviewed again during 2012 and registration variation applications have been confirmed and completed (in direct liaison with the CQC) to reflect the changes. A new certificate of registration was then dated 18th October 2012 and subsequently issued by the CQC on 2 November 2012.

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

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

The regulated activities per location (as per certificate of registration) are shown in the table below:

Activity/Location	Amesbury Health Clinical	Central Health Clinic	Chippenham Community	Frome Victoria	Great Western	Hillcote	HMP Earlestoke	Melksham Community	Paulton Memorial	Princess Anne Wing	Savernake	Shepton Mallet Community	Southgate House	Swindon Health Centre	Tidworth Clinic	Trowbridge Community	Warminster	West Swindon Health Centre	Westbury Community
Assessment or medical treatment for persons detained under the Mental Health Act 1983					✓														
Diagnostic and Screening procedures	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Management of supply of blood and blood derived products					✓														
Maternity and Midwifery Services			✓	✓	✓				✓	✓		✓				✓			
Nursing care						✓							✓						
Surgical procedures					✓														
Termination of Pregnancy *NOTE: ONLY FOR MEDICAL REASONS*					✓														
Treatment of Disease/Disorder or Injury	✓	✓	✓		✓		✓	✓			✓		✓	✓	✓	✓	✓	✓	✓

Periodic/Special Reviews

The Great Western Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13 (see table below).

The CQC undertook two unannounced inspections at the GWHFT during 2012/13

CQC External Regulatory Compliance March 2013				
Great Western Hospital	**5 July 2012 Review of Compliance**	4 Care & Welfare	GWH site - Theatres	Compliant
		5 Meeting Nutritional Needs	GWH site	Compliant
Great Western Hospital **Princess Anne Wing (PAW)** **Trowbridge Birthing Unit (BU)** **Maternity Service Inspection**	**11th, 12th, 13th and 18th December 2012** Unannounced Inspections	1 Respecting & Involving People	GWH	Compliant
			PAW	Compliant
		4 Care & Welfare	GWH	Compliant
			Trowbridge Birthing Unit	Compliant
		8 Cleanliness & Infection Control	PAW	Non Compliance Moderate Impact
		13 Staffing	Trowbridge Birthing Unit	Compliant
		13 Staffing	GWH	Non Compliance Minor Impact
			PAW	Non Compliance Minor Impact
		16 Assessing & Monitoring the Quality of Service Provision	GWH	Compliant
			PAW	Compliant
			Trowbridge Birthing Unit	Compliant

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to address the conclusions or requirements reported by the Care Quality Commission.

Cleanliness and Infection Control

- A redecoration programme of the Maternity Unit at Princess Ann Wing, which will include the Delivery rooms in the Central Delivery Suite
- Quality improvements to the cleaning schedule (as provided by the Royal United Hospital under contract), to ensure adequate numbers of cleaning staff and the delivery of expected quality cleaning standards
- An active cleaning audit programme to monitor and improve the standards of cleaning
- A review of current Infection Control audits in place, to support robust monitoring of care delivery and ensure that actions are taken when required

Staffing

- A staffing review and phased plan completion which will increase the numbers of midwives (in line with midwife to birth national guidelines ratio) within the Maternity Services at both GWH and PAW sites. Although staffing levels were deemed below national guidance, the resulting impact on care patient care was deemed to be 'minor' by the CQC

The Great Western Hospitals NHS Foundation Trust has made the following progress by 31 March 2013 in taking such action:

Cleanliness and Infection Control

- £400,000 Department of Health finance secured to support required redecoration programme
- Redecoration plans drawn up and contract under negotiation
- Continued negotiations with the Royal United Hospital to improve the standard of cleaning
- Great Western Hospitals NHS Foundation Trust cleaning audit programme reviewed and continues to monitor and improve the standards of cleaning
- Equipment storage improvements reviewed and actions progressing
- Infection control audit review completed and amendments made to the process

Staffing

- Validation of the submitted Birth Rate Plus report including numbers of Midwives
- Drawing up of a phased plan to increase the numbers of Midwives at both GWH and PAW sites
- Executive approval to finance additional recruitment of Midwives
- Recruitment drive planning commenced and progressing

CQC Special Reviews - Dr Foster alerts and subsequent investigations

Pneumonia Mortality Outlier

On 19 October 2012, the CQC notified the Trust about a mortality outlier alert for Pneumonia.

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

- Identified a group of patients who have particularly complex medical problems. This leads to significant difficulty in allocating accurate diagnostic codes for complex medical problems
- Reviewed the coding process to improve coding in complex medical cases
- To progress work across the local community to improve advance care planning and the use of end of life pathways

Acute myocardial infarction-investigation

On 2 November the CQC notified the Trust about a mortality outlier alert for Myocardial Infarction which occurred in July 2012.

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

- Undertaken a case by case review identifying reasons for the apparent increase in mortality to identify any issues related to clinical coding and the quality of clinical care. No avoidable mortality was identified
- Coding improvements were implemented as a result of the review
- Work within the South West Cardiac Network continues to ensure that all patients who are candidates for cardiac intervention following out of hospital cardiac arrest have access to this service
- Future submission of a regional out of hospital MI Protocol to be submitted in September 2013 once ratified

Neonatal non elective readmissions – Maternity Services, Royal United Hospital, Bath

The CQC identified the subsequent increase in rates of neonatal non-elective readmissions within 28 days of delivery from July 2011 to December 2011 as an outlier and an internal investigation was commenced.

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

A report was created following internal investigation and this identified and led a review of and improvement in:

- The coding process for documenting readmissions
- Discharge checks for feeding of babies
- Breast feeding support pre discharge

Maternal non-elective readmissions within 42 days of delivery – Maternity Services, Royal United Hospital, Bath

The CQC identified an increase in rates of maternal non-elective readmissions within 28 days of delivery from July 2011 to December 2011 as an outlier and an internal investigation was commenced.

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

- A Trust review of how healthy mothers are now recorded/coded when accompanying an unwell baby
- Staff education on accurate documentation and coding

Other External Reviews

The following non CQC external reviews which have taken place during 2012/13 are listed in the Table below.

External Review	Review area/service	Site	Date
Prison Health Performance & Quality Indicators (PHPQI) Review	Prison Services HMP Earlestoke	HMPE	Took place 16 May 2012
Accreditation	GWH Endoscopy Department	GWH	End April 2012
Cancer Peer Review	GWH Oncology	GWH	2 July 2012
Verifier Visits	GWH The Academy	GWH	26 January 2012 16 February 2012 5 May 2012 10 May 2012
Breast Screening Review	Breast Screening/ Breast Screening Centre	GWH	w/c 8 May 2012
NHSLA	Trust wide	GWH based	22-23 November 2012
Stroke Network	Stroke Services (at the request of GWH)	GWH	5 November 2012
Commissioners Quality Walkabout	Maternity	Princess Anne Wing	6 December 2012
Infection Control Peer Review	Trust wide	GWH	12 & 13 December 2012
Departmental Accreditation in Echo	Cardiology	GWH	9 January 2013
Diabetic Foot Service Peer Review	Diabetic Foot Surgery	GWH	11 January 2013
Commissioners Quality Walkabout	MIU and Mulberry Ward	Chippenham Hospital	7 February 2013
Dementia Care in Hospital Peer Review	Trust wide – Dementia Care	GWH	8 February 2013

NHSLA Risk Management Standards - Acute and Maternity Standards

NHSLA Acute and Community

The Trust successfully achieved compliance at Level 1 in May 2012 based upon the revised NHSLA Acute Standards for 2012/13 followed by compliance at Level 2 in November 2012 with a score of 49/50.

The assessments went well with members of staff attending to support evidence of implementation throughout the assessment. The assessor reported that the staff were knowledgeable in the processes and had ownership of their areas of responsibility. The assessors commended the Trust on the management of the health records reviewed.

Following the Level 2 Assessment, an action plan has been developed and is being monitored to address recommendations made by the NHSLA assessor.

The Trust is undertaking a gap analysis to establish any shortfalls and gaps between level 2 and 3. The findings of the gap analysis will inform the Trust's decision regarding future assessments.

The NHSLA will be releasing a statement in May 2013 regarding the new way forward, proposed/new/revised standards and the structure of future assessments.

Maternity Clinical Negligence Scheme for Trusts (CNST)

On 1 June 2011 Great Western Hospitals NHS Foundation Trust acquired the Wiltshire Community Health Services and became a merged organisation. The Maternity Services in the Bath clinical area joined the Directorate of Women and Children's. The Maternity Teams have continued to monitor and progress compliance with the CNST Standards as a formal assessment is required within 24 months of transition. A level 2 assessment is booked for 23 and 24 May 2013.

Staff Survey Summary 2012/13

Between October and December 2012, 800 questionnaires were sent out to staff seeking their views on what the Trust is doing well and where improvements could be made. A total of 511 questionnaires were returned, equating to a return rate of 63%.

Overall the responses to the Survey were very encouraging, with the scores benchmarking the Trust as third across the 23 Trusts in the South West of England. Whilst the outcome of the Survey continues to improve year on year, the Trust continues to strive to make further improvements, particularly in those areas identified as the lowest ranking within the Survey namely;

- *Staff felt communication could be improved between senior management and staff*
- *Staff felt pressured to attend work, when feeling unwell*
- *Staff did not always feel satisfied with the quality of work and patient care they are able to deliver*
- *Staff felt they were not always able to contribute towards improvements at work*
- *25% of Staff stated that they had experienced harassment, bullying or abuse from staff in last 12 months*

In response, a number of areas of work have been identified for the Trust to focus upon over the next 12 months;

Improving Communication between Senior Management and Staff

The Trust has built on the success of quarterly magazine, Horizon. In each issue the Trust ensures there is a wide selection of features from across the Trust providing representation from both the acute and community settings. The magazine also provides a good source of news items for the local media. Similarly a quarterly "Voluntary Service Matters" newsletter is sent to all volunteers and twice a year we hold "Volunteer Social Events" (including Long Service Awards) to ensure that the volunteers are well communicated with and have an opportunity to share their ideas with us too.

The new Trust Intranet was launched in February 2012 and continues to provide greater opportunities to reach staff across the organisation. The new intranet features web chat and video Podcasts to provide important information in a more easily digestible format, and empowers staff to take control of their own areas of the site to share information with colleagues.

Our Chief Executive, Nerissa Vaughan continues to hold Open Meetings with staff across the Trust sites, whilst a feedback process called 'Ask Nerissa' continues to enable staff to email her directly about their concerns and questions on issues affecting them.

Chief Executive 'road shows' are held across the Trust to provide staff with an opportunity to meet the Chief Executive and ask questions. Whilst the monthly Team Brief continues to be used as a key source of information for staff offering the Chief Executive's personal view on issues affecting the Trust.

Supporting Health and Wellbeing

Our approach to our staff's health and wellbeing is to ensure we are putting in place preventative measures so that we can keep our staff healthy and well. The proactive work includes supporting every member of staff to have an assessment to look at all aspects of their health and lifestyle and specialist advice is offered to design a bespoke programme to make changes which will improve and enhance their health and wellbeing both at work and at home. The Occupational Health Team now has an OH nurse advisor who is also a Registered Mental Health Nurse. This nurse complements the nurses already in post who can offer Cognitive Behavioural Therapy, and also works alongside the Staff Support Service, who offer the full range of counselling and support therapies.

Helping Staff to contribute to improvements at work

The Trust continues to be committed to encouraging and supporting staff with their ongoing learning and development. With this aim in mind, the Academy has extended its excellent training facilities during the year such that it not only boasts an excellent suites of seminar rooms and lecture facilities in Swindon but has extended across the Wiltshire area improving facilities in Warminster and opening new, fully equipped training rooms at Chippenham and Savernake Hospitals.

The Academy works to support the current and future workforce of all disciplines to gain knowledge, skills and understanding which will enable them to deliver empathetic care of the highest quality to our service users, now and in the future. The Academy listens to feedback from service users and firmly links educational aims to service delivery, striving for excellence in both delivery of clinical care and overall patient experience.

We are also investing in improving our management capability and have commissioned Ashridge Business School to design and deliver a bespoke leadership programme for 93 of our nursing and midwifery leaders. The Transforming Leadership, Transforming Care Programme aims to ensure that our managers are well equipped to support staff through change as we improve pathways and efficiencies in the way we work.

The Trust employed its first Staff Engagement Manager, Jane Keep in June 2012. Jane conducted 400 interviews with staff to understand, in depth, what their issues, ideas and suggestions were. This feedback culminated in a Staff Engagement Plan which was presented and approved by Executive Committee in September 2012.

In addition, the Trust has implemented a "Dragon's Den" initiative to encourage staff to bring their ideas about how to improve the Services into practice. This event took place on 21 March 2013, with 24 ideas being put forward demonstrating the push to improve services and the care we provide.

Ensuring we have the right numbers of staff in all areas so that staff can feel they can deliver high standards of care.

The requirement to have the right number of staff in post is well recognised and was highlighted in the Skill Mix Review work undertaken by the Chief Nurse, Hilary Walker. This supports the Nursing Strategy which demonstrated that the Trust needs to invest in our qualified nursing workforce. In response to this, a Centralised Recruitment process has been launched to assist in timely recruitment of Band 5 nurses across the Trust. The first Assessment Day took place in April and was a great success; these will continue throughout the year.

We have also invested in our midwifery workforce to ensure that our staffing levels meet the needs of our patients. At the beginning of May 2013, eight additional midwives were recruited to work within GWH, and it is hoped this and further investment within the Community will improve our staff's confidence so that they feel more satisfied with the quality of work and patient care they are able to deliver.

Supporting and Building effective Working relationships

The Trust continues to embed the STAR organisation values, which are Service, Teamwork, Ambition and Respect (STAR). These values underpin the work undertaken within the Trust and are embedded in our HR and development policy framework, recognition schemes and support recruitment decisions.

Through the launch of a new Performance Review (Appraisal) process in April 2013, the importance of ensuring effective working relationships are cited as everyone's responsibility. It is intended that every performance review will be an opportunity to remind staff of their responsibility to engage whilst they work, as well as to remember that everyone has a responsibility for living the Trust's STAR values.

Participation in Clinical Audits

During 2012/13, 39 National Clinical Audits and 8 National Confidential Enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During 2012/13 Great Western Hospitals NHS Foundation Trust, participated in 37/39 (95%). Exceptions to the National Audits are as follows:

- For one audit the trust does not capture diagnostic codes on outpatient attendees so was unable to identify patients with Bronchiectasis in order to participate in this audit. Coding outpatient diagnosis is not observed locally as part of the data collection for coding and there is not currently a facility to record this on Medway. This is being reviewed
- For one audit the Trust chose not to participate in the annual audit of "National Health Promotion in Hospitals" as the Trust was compliant with the audit in the previous year, and at the time, initiated internal measures to monitor compliance

National Clinical Audits and 8/8 (100%) National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries, which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Great Western Hospitals NHS Foundation Trust, was eligible and participated in during 2012/13 are as follows: (below is listed each data set completed 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 - Eligible	Participated	% Data Submission
1	Acute Coronary Syndrome or Acute Myocardial Infarction	Yes	100%
2	Adult Asthma	Yes	100%
3	Adult community acquired pneumonia	Yes	100%
4	Adult Critical Care	Yes	100%
5	Bowel cancer	Yes	100%
6	Bronchiectasis	No	N/A
7	Cardiac Arrest	Yes	100%
8	Cardiac Arrhythmia	Yes	Data submission still in progress
9	Carotid interventions	Yes	100%
10	Comparative audit of blood transfusion	Yes	100%
11	Coronary Angioplasty	Yes	Data submission still in progress
12	Diabetes (Adult)	Yes	100%
13	Diabetes (Paediatric)	Yes	100%
14	Emergency use of oxygen	Yes	100%
15	Epilepsy 12 (Childhood Epilepsy)	Yes	Data submission still in progress
16	Fever in children	Yes	100%
17	Fractured neck of femur	Yes	Data submission still in progress
18	Head and neck oncology	Yes	100%
19	Heart failure	Yes	Data submission still in progress
20	Health promotion in hospitals	No	NA
21	Heavy menstrual bleeding	Yes	100%
22	Hip fracture database	Yes	100%
23	Inflammatory bowel disease	Yes	100%
24	Lung cancer	Yes	100%
25	National joint registry	Yes	100%
26	Neonatal intensive and special care	Yes	100%
27	Non-invasive ventilation	Yes	100%
28	Oesophago-gastric cancer	Yes	100%
29	Paediatric asthma	Yes	100%
30	Paediatric pneumonia	Yes	100%
31	Pain Database	Yes	100%
32	Parkinson's disease	Yes	100%

33	Potential donor	Yes	100%
34	Renal colic	Yes	100%
35	Renal Registry	Yes	100%
36	Renal transplantation (NHSBT UK Transplant Registry)	Yes	100%
37	National Stroke (Sentinel and SINAP)	Yes	Data submission still in progress
38	Trauma (TARN)	Yes	100%
39	National Audit of Dementia	Yes	100%
	Confidential Enquiries		
1	Asthma Deaths	Yes	Data submission still in progress
2	Child Health	Yes	100%
3	Maternal infant and perinatal	Yes	100%
4	Patient Outcome and Death - Subarachnoid Haemorrhage	Yes	100%
5	Patient Outcome and Death - Alcohol Related Liver Disease	Yes	100%
6	Patient Outcome and Death - Bariatric Surgery	Yes	100%
7	Patient Outcome and Death - Cardiac Arrest Procedures	Yes	100%
8	Elective surgery (National PROMs Programme)	Yes	100%

The reports of 24 National Clinical Audits were reviewed by the provider in 2012/13 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- To set up a new multidisciplinary working group for heavier patients to ensure the Trust has the correct equipment and procedures in place. A scoping exercise is currently underway to identify gaps in provision and updates to the trust policy accordingly
- For post-op fracture care, lying & standing blood pressure readings are to be added to the existing proforma and to employ a Fracture Liaison Nurse
- To continue with excellent rates of pacing achieved in our catchment areas, which have been recognised and congratulated by the Cardiac Network Director, Dr T Cripps, Consultant Electophysiologist
- The recruitment of an Epilepsy Specialist Nurse
- To review the management of patients admitted with heart failure and develop a heart failure care pathway involving cardiology, general medicine and care of the elderly
- To provide education sessions which focus on the use of the Liverpool Care Pathway, co-existing alongside interventions such as hydration, in order to build confidence in health care professionals and their discussions with patients
- A Parkinson's Nurse Specialist will be recruited which will help with the waiting times. This will allow more time for the doctors to see new patients which will reduce referral times and extra clinics can be introduced
- Appoint a Respiratory Nurse Specialist
- Continue to participate in National Clinical Audits and Confidential Enquiries and assess recommendations and implement actions where appropriate
- Continue to monitor compliance with National Clinical Audits and Confidential Enquiries

The reports of 224 local clinical audits were reviewed by the provider in 2012/13 and the Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- To re-design the child protection paper work in the A&E department to ensure that it is clear for staff to see and complete. To educate staff the importance of the new documentation
- To guarantee a geriatrician assessment, a senior anaesthetist and senior surgeons for all patients coming to theatre with a fracture neck of femur
- To educate junior doctors on renal colic with the inclusion of information on investigation of renal colic in the Junior Doctor's Surgical Handbook
- Introduce an Epistaxis (nose bleed) management protocol in the A&E department

- Develop an agreed pathway and database for patients with Rheumatoid Arthritis with a focus on compliance with: Monthly monitoring, patient and GP education, and monthly appointment for patients with early rheumatoid arthritis
- To work with the Specialist Special Educational Needs Services (SSENS) team to create a screening tool for Special Educational Needs Co-ordinators (SENCO's) which will help them to spot hidden language needs in children and create intervention programmes for schools to help them support children
- To have earlier communication between the medical team and nurses to ask Urologists about follow-up plans especially for patients receiving bladder instillation
- GWH NHS FT to contribute to the review and update of the current Escalation Policy and Flow Chart being undertaken by Wiltshire Local Safeguarding Children's Board
- To educate junior doctors about the importance of Glasgow Scoring in acute pancreatitis and produce a Glasgow Scoring proforma in the form of a sticker which can be used to score all admissions
- Develop a proforma enabling healthcare professionals to document in line with the key recommendations for sedation in children and young people, and to improve the awareness amongst the medical staff of the NICE guidance
- Increase awareness of the stop smoking services available within maternity and for all patients who smoke or are affected by smoking, to be referred to the stop smoking specialist midwife
- Agree a pathway in the primary care for cows milk allergy and the appropriate prescription of specialist formulas with the Paediatricians at Salisbury District Hospital and roll out education programme supporting local GP's and Health Visitors once pathway has been introduced
- Continue to provide training and education of clinical audit results and outcomes to all clinical staff where required
- Continue to monitor and re-audit projects where the results and outcomes have demonstrated good compliance
- Continue to identify areas for improvement and key learning and implement changes where appropriate

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

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

To provide additional assurance to the Trust Board, a total of 22 reviews were undertaken as a result of the Trusts internal monitoring process for increased inpatient mortalities, readmissions and length of stays, of which, 3 reviews provided assurances to the Care Quality Commission.

Research & Development

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 826.

We currently have 61 actively recruiting Department of Health endorsed (portfolio) research projects. 11% of these are straight forward Band1 studies with 43% being the more complex Band 2 studies and 46% are highly complex Band 3 studies.

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

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

Cancer research accounts for approximately 50% of our activity, and this remains our most heavily supported area with 6 full time staff supporting research here. Progress continues to be made in other key topic areas such as Rheumatology and Orthopaedics with 10% of activity and 1.2 full time staff in these areas. Dementia research has taken off this year with 5% of our activity happening in this growing area.

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

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

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

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

Goals agreed with Commissioners

The monetary total for the amount of income in 2012/13 conditional upon achieving Quality Improvement and Innovation Goals, and a monetary total for the associated payment in 2011/12 is summarised in the table below.

Financial Summary of CQUIN							
		Plan	Actual		Plan	Actual	
		2012-13			2011-12		
TOTAL CQUIN		£6,064k	£5,036k	83%	£3,750k	£3,088k	82%

Data Quality

Great Western Hospitals NHS Foundation Trust submitted records during 2012/13 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: 99.4% for admitted patient care; 99.9% for outpatient care; and 92.1% for accident and emergency care. The lower performance in accident and emergency care is attributed to the completeness of this data item at the minor injury units in Wiltshire and the Trust's data quality group is working on improving this.

- which included the patient's valid General Practitioner Registration Code was 99.7% for admitted patient care; 99.6% for outpatient care; and 100% for accident and emergency care.

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2012/13 was 77% and was graded satisfactory / green.

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

- The Trust Data Quality Group will continue to manage and monitor a work programme that targets identified areas of poor data quality and progress will be reported to the Trust's Information Governance Steering Group
- Proactive review of data quality will be integral to the Patient Administration Project being undertaken by the Trust in 2012/13
- The actions from internal and external audits and benchmark reports associated with data quality will be acted on and monitored by the Trust Data Quality Group
- Data quality reports and issues raised by Commissioners will be reviewed and any required action taken
- Development of refresher training programmes for staff involved in data collection and data entry will continue

Great Western Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The summary results of the audit were

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
PbR Audit Commission	90.0%	91.1%	94.6%	100.0%

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

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

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 Finance Director 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, information security 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 for the sharing of patient information with healthcare organisations and other agencies in a controlled manner, which ensures the patients' and public interest 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 NHS Information Governance Toolkit. The main Toolkit headings are:

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

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The Trust's Information Governance Assessment Report overall score for 2012/13 was 77% and was graded Green/Satisfactory, with a satisfactory rating in every heading of the Information Governance Toolkit.

Clinical Coding Error Rate

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

PART 3

		2009/ 2010	2010/ 2011	2011/ 2012 Data includes Comm'ty	2012/ 2013	National Average	What does this mean	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	MRSA	6	3	2	2	Not available	Zero is aspirational	IP&C	National definition
	C.*Diff*	49	40	17	33	Not available	Zero is aspirational	IP&C	National definition
	C.Diff 100,000 bed days*	23.7	20.1	7.3	13.4				
2 - Patient Falls in Hospital resulting in severe harm		24	15	17	16	Not available	Low number is excellent	IR1's	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers			40	31	28	Not available	Low number is better	IR1's	National definition (from Hospital database)
4 – Percentage of VTE Risk Assessments completed		N/A	85.1%	92.7%	95.3%	90%	Higher number better	Crescendo nursing care plan and manual data collection from LAMU, Day surgery, and ICU	National definition (from Hospital database)
5 – Percentage of patients who receive appropriate VTE Prophylaxis	Figures awaited	-	90% (No audit for Surgical actioned in Q2 & Q3 therefore YTD based on Medical only)	94.5%	93.9% (Apr-Oct)	N/A	Higher number better	One day each month whole ward audit for one surgical ward and one medical ward	National definition (from Hospital database)
6 – Never Events that occurred in the Trust		0	0	3	3	SW Regional never events 2009 -7 2010-17 2011-33 2012-32	Zero tolerance	IR1's	NPSA
7 – Mortality Rate (HSMR)	HSMR	106.4	97.9	106.2	91.8	100	Lower than 100 is good	Dr Foster	National NHS Information Centre
8 – Early Management of Deteriorating Patients - % compliance with Early Warning Score	Early Warning Score (Adults)	90% GWH only	93% GWH only	96% GWH only	91%	Not available	Higher number is better	Audit	Audit criteria
	Paediatric Early Warning Score (Children)	Not available						Audit	Audit criteria
10 – Percentage of Nutritional Risk Assessments	Using MUST	62% Acute only	70% Acute only	87.8% Combined	84%	Not available	Higher % is better	Crescendo	National definition

11 – Were you involved as much as you wanted to be in decisions about your care and treatment?		47.8%	48.1%	46.9%	51%	Not available	Higher is better	Picker Survey	National definition
12 – Did you find someone on the hospital staff to talk to about your worries and fears?		23.8%	23%	22.5%	37%	Not available	Higher is better	Picker Survey	National definition
13 – Were you given enough privacy when discussing your conditions or treatment?		68.7%	68.5%	66.8%	73%	Not available	Higher is better	Picker Survey	National definition
14 – Did a member of staff tell you about medication side effects to watch for when you went home?		24.4%	22.9%	24.3%	30%	Not available	Higher is better	Picker Survey	National definition
15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?		62.1%	65.6%	66.6%	67%	Not available	Higher is better	Picker Survey	National definition
16 – Patient Reported Outcome Measures	Varicose Vein surgery	Not available	Awaited	Awaited	100%	80%	Higher is better	DoH	National Definition
	Groin hernia surgery	Not available	Awaited	Awaited	96.9%	80%	Higher is better	DoH	National Definition
	Hip Replacem't Surgery	Not available	Awaited	Awaited	96%	80%	Higher is better	DoH	National Definition
	Knee Replacem't Surgery	Not available	Awaited	Awaited	95.6%	80%	Higher is better	DoH	National Definition
17 – Readmissions – 30 days		n/a	n/a	7.4%	8.1%	Local target (7.1%)	Lower is better	Where from – POD?	National Definition
18 – Readmissions – 28 days	To be monitored from 2013/14								

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

Performance against Key National Priorities

An overview of performance in 2012/13 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	2009-10 GWH	2010-11 GWH	2011-12 Trust	2012-13 Trust	2012-13 Target	Achieved/ Not Met
Clostridium Difficile -meeting the C.Diff objective	49	40	19	33	30 or less	Not Met
MRSA - meeting the MRSA objective	6	3	2	2	4 or less	Achieved
Cancer 31 day wait for second or subsequent treatment - surgery	97.4%	98.5%	98.4%	98.4%	94.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments	99.8%	100.0%	100.0%	100.0%	98.0%	Achieved
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	90.3%	92.4%	89.3%	90.0%	85.0%	Achieved
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	98.9%	100.0%	98.4%	96.2%	90.0%	Achieved
Cancer 31 day wait from diagnosis to first treatment	97.4%	99.0%	98.7%	98.1%	96.0%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected)	92.6%	97.0%	97.1%	95.3%	93.0%	Achieved
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected)	96.0%	97.2%	97.1%	96.0%	93.0%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	95.0%	95.1%	96.1%	95.3%	90.0%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	97.5%	97.9%	98.2%	98.3%	95.0%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways				96.1%	92.0%	Achieved
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95.3%	97.4%	97.0%	95.6%	95.0%	Achieved

NHS
Wiltshire
Clinical Commissioning Group

Statement from Wiltshire Clinical Commissioning Group for Great Western Hospital Foundation Trust. Quality Account

NHS Wiltshire CCG have reviewed the information provided by Great Western Hospital NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

Provider organisations are expected to put in place arrangements for the involvement of service users in the development of their Quality accounts and there is no evidence of this in the Quality report for GWHFT. This needs to be addressed in future Quality Reports

Our view is that Great Western Hospital NHS Foundation Trust provides, overall, high-quality care for patients. The results from the National Inpatient Survey have remained fairly static over the last few years. One of the biggest changes regarding the measurement of the patient experience in 2013/14 will be the introduction of the Friends and Family Test. Although not mandatory until 1st April 2013, the GWHFT have proactively introduced it into many areas in December 2012, and to maternity Service prior to the national implementation date for maternity of October 2013

Great Western Hospital Foundation Trust will need to consider the implications of the Francis report and on-going actions from the Winterbourne View Report, both of which will form a key part of our assurance in 2013/14.

Wiltshire CCG welcome the specific priorities for 2013/14 which the Trust has highlighted in this report all are appropriate areas to target for continued improvement and link with the Clinical Commissioning priorities.

The Community Transformation Programme is a high local priority for Wiltshire in 2013/14 in terms of developing an integrational model of care for community health services ensuring the right clinical balance of services between Primary care, hospital care, community settings and patients' homes .NHS Wiltshire is fully committed to continuing its close co-operation with the Trust over the coming year on these important issues.

Signed.....

Date... 24/6/13.

Statement from Swindon Clinical Commissioning Group (Lead Commissioner) dated 15 May 2013

Summary Statement for GWHNHSFT Quality Account 2012/13

The Quality Account provides information across a wide range of quality measures and gives a comprehensive view of the quality of care provided by the Trust. Swindon Clinical Commissioning Group (CCG) has reviewed the Great Western Hospitals NHS Foundation Trust Quality Account against the three domains of quality:

Safe care: which demonstrates the good progress made relating to the prevention of healthcare associated infections, falls and pressure ulcers.

Effective care: highlighting notable progress within two key outcome measures, i.e., the Trust's nutrition and hydration action plan to address their priority in meeting the nutritional/hydration needs of patients and the reported major improvements in the relative risk score for mortality.

Patient experience: GWHNHSFT clearly demonstrates that it values feedback about the patients' experience and uses this to help shape improvements for the future. We are pleased that the Trust has made significant improvement in the development in the care and support for people with dementia and their carers and will monitor progress in 2013/14.

The report provides a balanced overview of the Trust and clearly identifies their achievements to date, but also sets out areas within their service delivery where improvements could be made. The CCG welcome the openness and transparency of this approach and are committed to supporting the Trust in achieving improvement in the areas identified within the Quality Account through existing contract mechanisms and collaborative working. The CCG welcomes the benefits this will bring to service users and their families/carers.

Gill May
Executive Nurse
NHS Swindon CCG

Statement from Wiltshire Council dated 25 April 2013

It has not been possible for the Health Select Committee to comment of the GWH Quality Account this year due to the timing of local government elections. However, the Committee looks forward to being able to comment next year.

Cllr Peter Hutton
Chair of the last Health Select Committee
Wiltshire Council

Statement from Governors dated 16 May 2013

As in previous years, the Governor Group have had regular presentations and involvement in the Quality updates through the Council of Governor and Patient Experience meetings, the latter offering the opportunity for more detailed scrutiny. The PEWG is also open to visits from the local CQC officials.

The Patient Experience Group has the opportunity to update on an ongoing basis trends that it picks up with regards patient issues. In the past year it has been closely involved with the reorganisation of the Patient Advise

& Liaison Services (PALs) structure and also receives regular updates on the formal complaints coming into the Hospital and where necessary resolutions that are achieved. This group ensures that the experience of the Hospital delivered to patients is a constant focus at all levels within the Hospital.

Harry Dale – Lead Governor
Great Western Hospitals NHS Foundation Trust

Statement from Local Healthwatch Organisations dated 15 May 2013

Statement written by the Local Healthwatch

It falls to the Local Healthwatch in the area of an NHS Trust's main offices to co-ordinate a response to a draft Quality Account. Swindon Local Involvement Network (LINk) closed on 31 March and Healthwatch Swindon was established on 1 April 2013. Local Healthwatch in adjacent areas were not in a position to comment on the draft and nor, formally, was Healthwatch Swindon.

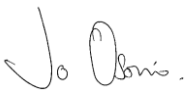
During 2012/13 Swindon Local Involvement Network participants continued to work in a variety of ways with Trust staff, governors and board members - to reflect the views of local people in working groups to achieve change or improvement where possible, and to pass on comments, suggestions or complaints. The Quality Account for 2012/13 demonstrates the breadth and complexity of the Trust's work and of its geographical spread. Healthwatch Swindon will look forward to working with Local Healthwatch in adjacent areas and with the Trust during 2013/14 to ensure that the voices of local people are heard and the best quality health care is provided in the most appropriate setting.

Jo Osorio
Healthwatch Swindon
Wat Tyler House, Swindon SN1 2GH

Statement written by Healthwatch on behalf of Bath and North East Somerset (B&NES) Local Involvement Network disbanded 31st March 2013

Bath and North East Somerset (B&NES) LINk welcomed the opportunity to contribute to the Quality Report prepared by Great Westerns Hospitals NHS Foundation Trust (GWHFT). The LINk had a positive and constructive working relationship with the Trust and recommended that this relationship is continued. They recommended that Healthwatch responds to the NHS Quality Accounts (QA) and where necessary applies pressure to ensure that Quality Account documents are received in good enough time for Healthwatch to develop a thorough response and that information relevant to the QA is available, discussed and consulted on with Healthwatch throughout the year.

Healthwatch B&NES began in April 2013, and they are not in a position to provide a comprehensive response to this year's Quality Account. They look forward to submitting a comprehensive response in 2014.



Jo Osorio
Healthwatch Swindon
Wat Tyler House, Swindon SN1 2GH

Statement from Swindon Health Overview & Scrutiny Committee dated 13 May 2013

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

The Health Overview & Scrutiny Committee is committed to having a good working relationship with the Great Western Hospital NHS Foundation Trust and, based on the Committee's knowledge, endorses the Quality Account for 2012/13.

The Committee welcomes attendance and regular reporting at its committee meetings and hopes that this will continue throughout 2013/14.

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

Sally Smith
Overview & Scrutiny Officer
Swindon Borough Council

Statements of Directors' responsibilities in respect of the Quality Report

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- 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 2012 to June 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
  - Statement from Wiltshire County Council dated 24 April 2013
  - Feedback from the Wiltshire Clinical Commissioning Group dated 13 May 2013
  - Feedback from the Swindon Clinical Commissioning Group dated 15 May 2013
  - Feedback from the Swindon Health Overview & Scrutiny Committee dated 13 May 2013
  - Feedback from governors dated 16 May 2013
  - Feedback from Local Healthwatch organisations dated 15 May 2013
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to the Board monthly
  - The national patient survey dated April 2013
  - The national staff survey 28 February 2013
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2013
  - Care Quality Commission quality and risk profiles dated April 2012 – March 2013
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

23/5/2013 ..... **Date** ..... **Chairman**

23.5.13 ..... **Date** ..... **Chief Executive**

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

Independent Auditor's Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

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

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

Respective responsibilities of the Directors and auditors

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

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

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

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

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

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from the Commissioners dated May 2013;
- Feedback from Governors dated 16 May 2013;
- Feedback from local Healthwatch organisations dated 15 May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;
- The 2012/13 national patient survey;
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles 2012/13; and
- The 2012/13 Head of Internal Audit's annual opinion over the Trust's control environment dated 17 May 2013.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Great Western Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit

the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

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

Jonathan Brown

Jonathan Brown, for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

23 May 2013