Great Western Hospitals NHS
NHS Foundation Trust

Annual Quality Account 2014/2015

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PART ONE

Our Commitment to Quality - Chief Executive's View

I am pleased to present our Quality Account for 2014/15. This is an honest account of recent improvements which affect the quality of care our patients experience and our priorities for the coming year.

Safety and quality is at the heart of everything we do. Our number one priority is to provide safe, high quality and effective care, offering the best possible experience and outcome for patients.

As you read about our progress over the last 12 months you will see there is much to be positive about. Every achievement is testament to our hardworking staff who put patients at the centre of every decision we make and everything we do.

Despite a challenging year financially, we have achieved some fantastic improvements in the quality of care we provide of which I am very proud.

We have seen a significant improvement in our mortality rates, meaning that more patients are surviving their illness than would be expected. To save more lives we are now focusing on making changes to how we treat conditions with typically high mortality rates. Notably, we have reduced the likelihood of dying from severe sepsis, with almost 80 per cent of patients now surviving, which is significantly better than the national average.

We've embraced the national Sign up to Safety pledges, to put safety first, continually learn, honesty, collaborate and support. Over the coming year we will be focusing on five areas to apply those principles and make a significant improvement to the quality of patient care. The areas we have identified are sepsis, falls prevention, rescue of deteriorating patients, acute kidney injury and pressure ulcer prevention. These are important priorities for us and you will find details of the work we are doing in each of these areas in our Quality Account.

I am delighted that our performance has been recognised nationally by CHKS, the country's leading provider of healthcare intelligence and quality improvement services, who nominated the Trust for the prestigious Patient Safety Award at their annual Top Hospital Awards. The award highlights outstanding performance from Trusts which have provided patients with a safe hospital environment.

I have seen first-hand some of the fantastic work which is taking place and recent feedback from the Friends and Family Test shows patients are noticing a difference, with the vast majority saying they would recommend our services.

I hope you enjoy reading about the progress we are making and our plans to further improve the quality of care for all of our patients.

Nerissa Vaughan
Chief Executive

Quality of Care

At Great Western Hospitals NHS Foundation Trust we ensure the provision of safe, high quality, patient care is our number one priority.

We are passionate about getting things right and meeting the expectations of our patients and their families, for patients to have the right care at the right time in the right place provided by appropriately trained individuals. The Trust Board takes full responsibility for the quality of care and service provided to patients and fosters a culture that encourages people to take pride in their work. There are clear links to improved patient outcomes when there is consistent quality care.

Our aim is to set out clear quality improvement plans, building on current local and national quality improvement initiatives to meet quality and safety objectives and to provide the safest and most effective care to enhance the experiences of our patients.

Our Patient Quality Committee agrees the priorities that will help us improve the quality of care we provide to our patients. Some of the priorities agreed are important to our regulators and/or commissioners, all the priorities are discussed and agreed with our Council of Governors.

In March 2014 the Trust launched a Quality Strategy, which outlines the quality goals and ambitions the Trust aims to achieve. Our seven priorities for improvement are:

1. Delivering safe, effective care, delivering excellence
2. Leading the best patient experience
3. Releasing time to care
4. Visible inspirational leadership
5. Culture of innovation and embracing of continuous Quality Improvement
6. Measurement of essential quality standards, providing assurance of patient safety and clinical effectiveness
7. Staff will understand their contribution to the whole organisation

Going forward we will use the Quality Accounts to report against progress of the Quality Strategy, in addition to reporting against the Quality Accounts priorities.

The Great Western Hospitals NHS Foundation Trust provides acute hospital services (at the Great Western Hospital) and community health services across Wiltshire. Acute is generally defined as Inpatient beds within the Great Western Hospital site and Community is generally defined as Community inpatient beds and patients treated within their own homes.

PART TWO

2.1 Review of Quality Performance 2014/2015

How well have we done in 2014/2015?

This section reflects on our priorities during 2014/2015 and whether we have achieved our goals. Where performance was below what we expected we explain what we are doing to improve in 2015/16

The areas identified for improvement during 2014/2015 were:

Safe Care

- Falls
- Pressure Ulcers
- Reduce Healthcare Infections
- To report zero Never Events
- Reduce Incidents and associated harm
- Patient Safety Thermometer, continue to Reduce:
    - Catheter Associated Urinary Tract Infections (CAUTIs)
    - Venous Thromboembolism (VTE)
- To reduce Medication Errors

Effective Care

- Hospital Standardised Mortality Ratios (HSMR)/Summary Hospital Level Mortality Indicator (SHMI)
- Early recognition of the deteriorating patient
- Dementia
- Safeguarding adults and children
- Review of patients who are being readmitted to hospital within 30 days of discharge
- Nutrition and hydration
- Stroke care
- Compliance NICE Publications

Patient Experience

- Implement a new Complaints System in April 2014
- National Inpatient Survey
- Staff Survey
- Equality and Diversity

SAFE CARE

Continue to Reduce Severe Harm Arising from Patient Falls

One of our priorities for 2014/2015 was to continue to support the highest risk wards in identifying learning from all reported falls incidents, not just those that result in requiring increased treatment due to a fall or actual permanent harm such as a fracture from a fall. (Moderate or severe harm)

The Trust Launched a Fall Safe Operational Group on 1st June 2014, which had a mandatory attendance of Ward Managers to further strengthen its importance.

This group's objectives were to reduce the number of falls in each individual ward, to put in place local falls reduction initiatives, and to learn from each other on what worked well on wards that experienced

less falls. The group shared the learning from serious falls incident investigations, for instance, the identification of the root cause of each individual fall, including lessons learned and actions to prevent recurrence of similar causes.

Each month the five wards with the highest number of falls, presented their findings and learning at the Fall Safe Operational Group meeting. The highest wards also presented the number of patients with dementia who had fallen. The group discussed and supported these wards on what else could have been done to reduce the number of falls. This included sharing initiatives that were successfully trialled on other wards.

Examples of the ward based initiatives are:

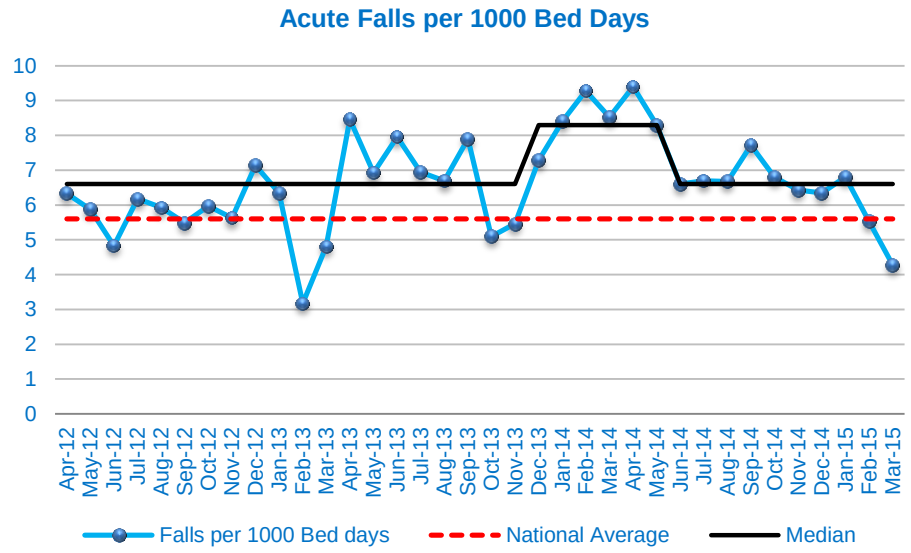
- A local initiative trialled this year on the Trauma Unit was an After Action Review; this is where every fall was immediately looked at by the team and lessons learned were shared immediately to prevent the recurrence of a fall from similar causes
- Finishing tasks was tested on Jupiter Ward. This meant that staff stayed close by/with patients until they finished the task that they were carrying out with the patient, for example, when patients were assisted into the bathroom, the nurse was expected to stay outside and continued to reassure the patient that they were nearby and ready to assist when they were ready and if required
- Neptune Ward increased the frequency of monitoring patients (care rounding) at night, this is more frequent monitoring of patients who were at increased risk of falls, and ensured that they were assisted with their toileting/personal hygiene needs at regular intervals.
- We offered and assisted patients with their toileting needs at critical times, such as before going to bed at night, before meals, after visiting times and according to known individual patient's toileting patterns
- Use of red Zimmer Frames – A red Zimmer frame means that a patient was at risk of falls and needed assistance with their mobility. Therefore members of the Multi-Disciplinary Team would stop and assist those patients if they were seen to be moving independently

Another Trust wide initiative was to provide close support for patients deemed as very high risk of falls, particularly those with mental health, mental capacity concerns or acute confusion. Processes have been agreed to identify when additional staff are needed to provide close support.

Our Quality Improvement Plan for 2014/2015 was to be below (better than) the national average number of falls per 1000 occupied bed days, which is 5.6 for Acute and 8.6 for Community inpatients. This year's average was 7.3 for Acute and 10.6 for Community. The quality improvement plan has been driven by the newly formed Fall Safe Operational Group.

The Trust did not meet the national benchmarking standard of <5.6 falls per 1000 bed days, however, the Trust continues to strive towards reducing falls and harm resulting from a fall. Work has focussed on transformational change via Sign up for Safety campaign and Falls Safe Operational group. The principles of the programme is to empower ward based staff to improve their standards of care, systems, process and team culture to continually reduce harm. The Falls Safe Operational group applies learning from literature and good practice from other Trusts. It should be noted the national average of 5.6 falls per 1000 beds days was set in 2009 by the National Patient Safety Association, given the ageing population and increase in dementia since this date it's unlikely this figure represents a realistic benchmark for acute Trusts.

Graph 1

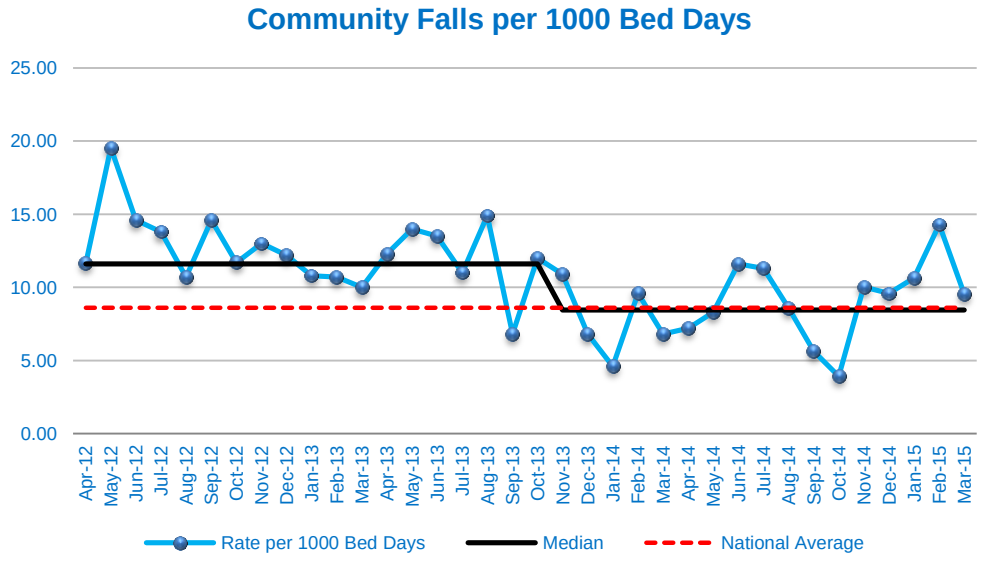


Graph 1 above shows the number of falls per 1000 bed days in the Acute hospital inpatient beds With the setup of the Fall Safe Operational Group on 1 June 2014 the number of falls per 1000 bed days within the Acute (GWH hospital inpatient beds) setting began to show a downward trend.

In March 2015, the Acute setting recorded 4.28 falls per 1000 bed days which is below a national average of 5.6 falls per 1000 bed days.

This achievement was mostly due to the Ward Managers working with their local teams in identifying root causes of falls incidents in their clinical areas and putting actions and processes in place to prevent recurrences.

Graph 2



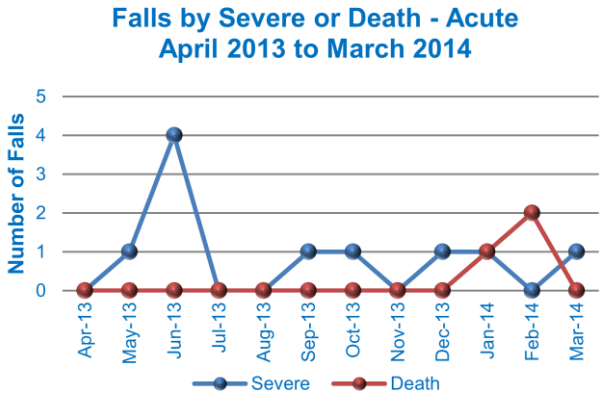
Graph 2 above shows the number of falls per 1000 bed days within the Community wards.

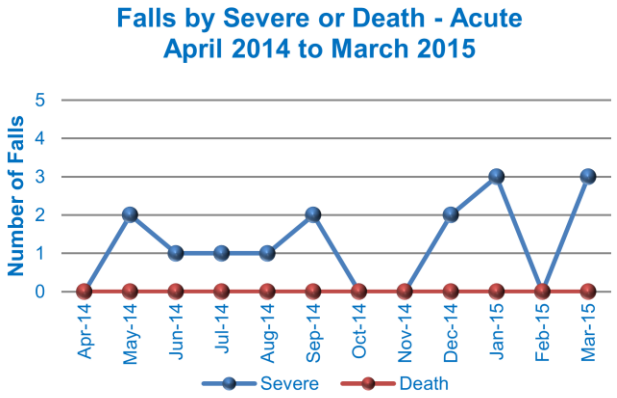
From April 2014 to March 2015, there were six months that the Community wards performed at or below the national average of 8.6 falls per 1000 bed days (April, May, June, August, September and October 2014). The other six months of the year, the Community wards performed above the national average.

The Community wards are also part of the Fall Safe Operational Group and we are working hard to support efforts to reduce the number of falls within the Community wards.

Reduce Severe Harm Arising from Patient Falls

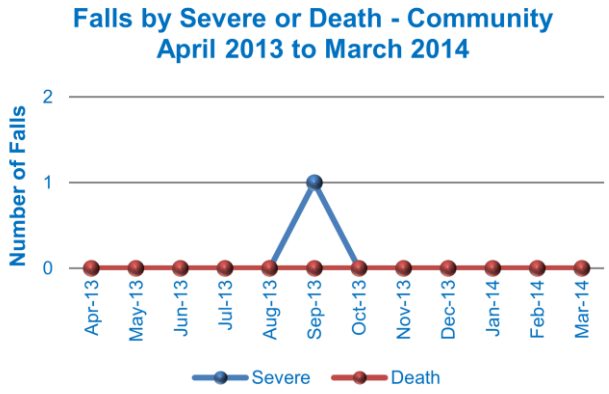
We are very keen to see a reduction in severe harm suffered by patients falling while in hospital across both the acute and community services.

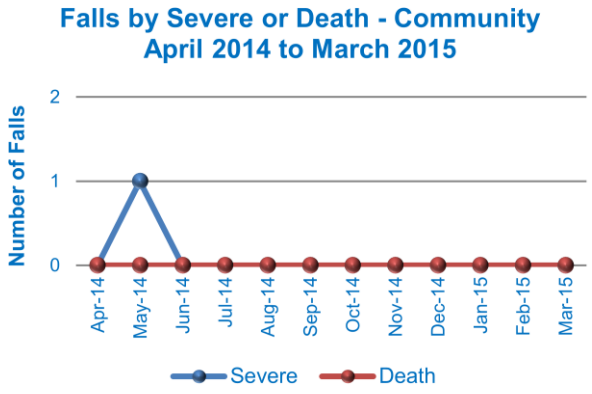




Though the number of falls per 1000 bed days within the Acute setting had significantly reduced for the year 2014/2015 as compared to year 2013/2014, the number of severe harm from falls has not seen the same reduction.

In 2013/2014, the Trust had 13 severe harm incidents including two deaths as a result of falls. There was a slight increase to 16 severe harm falls in the year 2014/2015 overall for Acute & Community. Though the number of severe harm from falls was slightly higher in 2014/2015, it is important to note that there were no deaths associated with falls within the Acute setting.





The Community saw less severe harm in both 2014/14 and 2014/215 as compared to the Acute setting. In 2013/2014, the Community wards had one fall which resulted in severe harm as well as in 2014/2015. There were no deaths associated with falls for either year.

Key Actions from serious incidents

- Continue with appropriate falls assessments within 4 hours of patient admission
- Appropriate frequency of care for patients at risk of falls
- Ward Managers continued working with their teams to identify times of the day that falls occur on their wards and to establish initiatives that they could put in place to reduce falls during those times.
- Use of close (individual) support where patients were at high risk of falls
- Appropriate use of low beds following SAFE assessments, as low beds are more appropriate and safer for those patients who are at risk of falling whilst getting into or out of bed

Our Priorities to further reduce falls in 2015/2016 are:

- Collaborative working roll out across all ward areas (involvement of the Multi-Disciplinary Team)
- Continue with Fall Safe Operational Group initiatives, which have contributed to the reduction of falls last year
- Use of close support for high risk patients
- Both Acute and Community falls per 1000 bed days to be at national average or better
- Review of care rounding tool to match the needs of patients at risk of falls
- Improvement in call bell answering times.

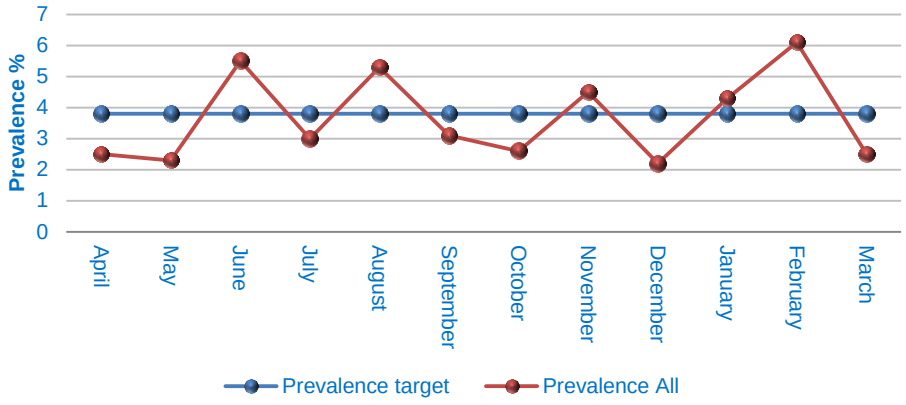
Continue to Reduce Healthcare Acquired Pressure Ulcers

As an organisation we had two Commissioning for Quality and Innovation framework (CQUIN) targets for the reduction of healthcare acquired pressure ulcers:

The two CQUIN targets were:

1. NHS Swindon

The acute and community providers were required to develop a joint programme of delivering the 15% reduction in all old and newly acquired pressure ulcers within the system. To demonstrate an improvement we had to achieve a median of three consecutive monthly data points on the national 'Safety Thermometer' tool up to 31st December 2014.



Graph 1: To show the prevalence of pressure ulcers using the Safety thermometer data.

Safety Thermometer data includes all wards within the Acute Trust, Community Hospitals and the patients within the community (at home/care homes etc).

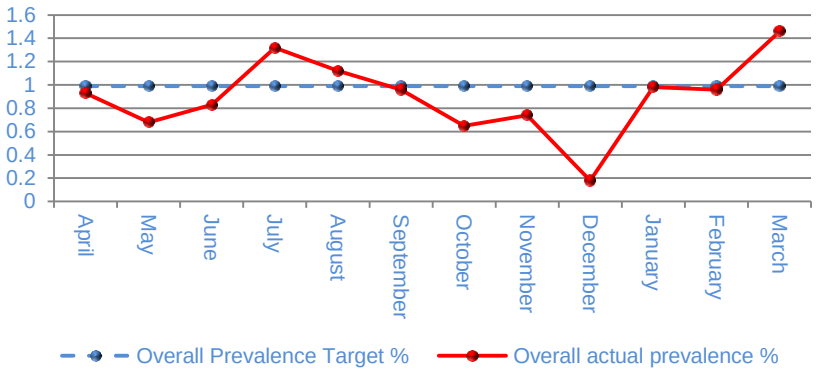
The Tissue Viability (TV) teams in both GWHFT and SEQOL worked closely on the following improvement plan:

- Joint care pathway to ensure safe, timely and consistent referral to appropriate community service in Swindon for patients with complex wounds and Negative Pressure Wound Therapy.
- Raised awareness with all carers and patients across Swindon and Wiltshire communities with a Carers conference which was planned for May 2014 and involved Carer's charities offering support, education and advice.
- Developed a joint pressure ulcer investigation process with shared learning to include the investigation of any patient readmissions with a pressure Ulcer who had used both GWH and SEQOL services.
- To help reduce admissions to GWH of patients with pressure ulcers from Nursing Homes we took part in a joint 5 day Tissue Viability Course for nursing staff in Wiltshire and Swindon, which was run by the GWH TV team
- Pressure ulcer prevention education across GWH across acute and community services and available across SEQOL community services

2. NHS Wiltshire:

To reduce the prevalence of pressure ulcers, categories II, III and IV by 10% in the three consecutive months for October, November and December. This equated to a median prevalence of 0.99% across both acute and community services. For each month the total should not exceed 3.78 patients in the acute and 9 patients in the community service. This gave a monthly organisation total of 12.78 (13) patients and this was not a cumulative target.

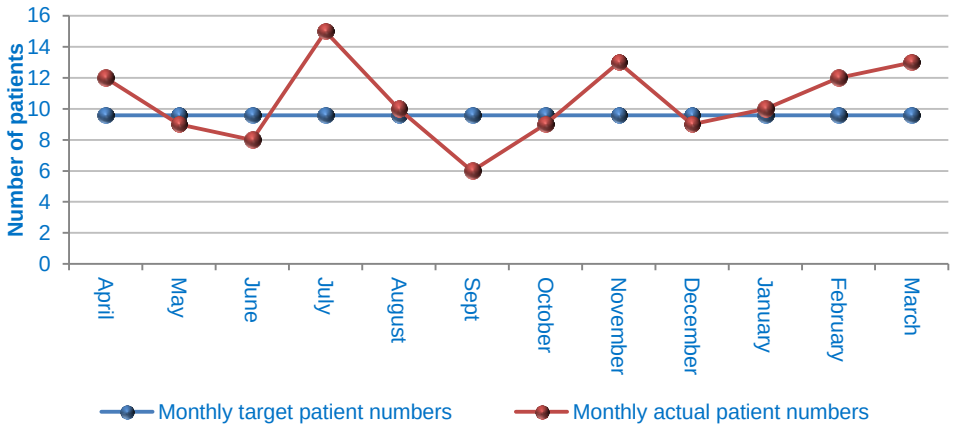
Graph 2: To show the prevalence of pressure ulcers using the Safety Thermometer data.



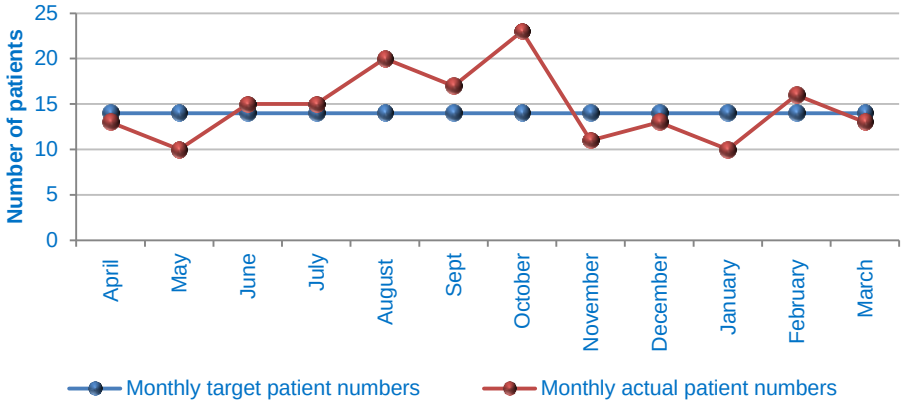
The target was achieved in October, November and December.

A further quality target was set by NHS Wiltshire to reduce the incidence of pressure ulcers by 10% across the organisation, the target was less than 286 patients who would go on to develop a pressure ulcer. This was divided up in the acute and community (ICHD) services with a target of less than 9.58 per calendar month in the acute wards and less than 14 in the community services.

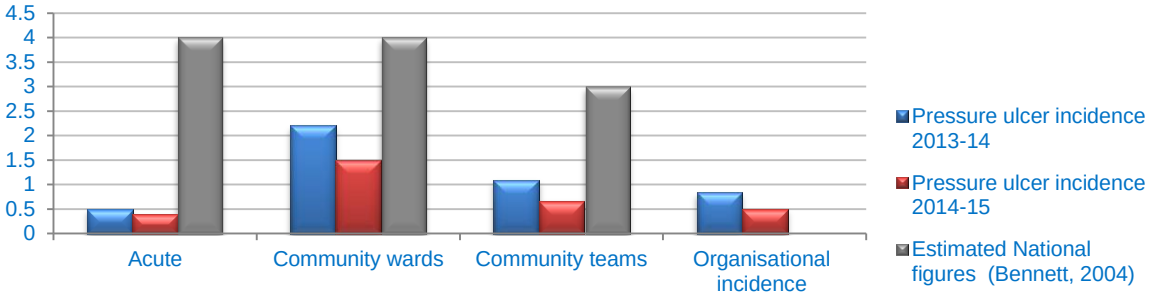
Graph 3: The number of patients who developed a pressure ulcer per month in the acute wards.



Graph 4: The number of patients who developed a pressure ulcer per month in the Integrated Community Health Division



However, the number of patients admitted in the organisation was significantly higher in the last year and there was a reduction in the percentage of patients who developed a health care acquired pressure ulcer from 0.84% to 0.5%, this means that 99.5% of patients who were admitted into the Trust did not develop a pressure ulcer and the incidence was lower than the estimated national average.



Organisational incidence is the overall combined figure for Acute & Community

The results show that as a Trust there were 51 Category III and Category IV pressure ulcers during 2014/2015 across both acute and community this gave a 0.5% incidence rate.

Priorities for 2015/2016 are:

The Tissue Viability Nurse Consultant (TVNC) is leading a Harm Free Care action plan to reduce pressure ulcers with 'Think Skin: Your Actions Relieve the Pressure'.

The actions include:

In-patient wards:

- Roll out of the Pressure Ulcer Risk Assessment Tool (PURAT), which is a new pressure ulcer prevention core care and wound documentation plan, is complete across the organisation and is being audited weekly by the TV team
- Provision of pressure relieving mattresses from point of entry (admission) within two hours of the risk assessment. This provision is being monitored with the Equipment Library Manager
- Completion of PURAT from all areas of admission including the Emergency Department
- Stepping down to a foam mattress for patients no longer requiring an air mattress in an attempt to use the equipment more effectively; this was linked to the 'Spring to Green' initiative and is being monitored with the Equipment Library Manager and audited by the Tissue Viability team in a new TV patient pathway audit
- Focus group for heel protectors took place on 30 March and a trial of new heel protectors is being organised for May 2015 on the wards with higher risk profiles.
- STOP, the pressure education programme will take place on 9 and 10 April in conjunction with the continence team, dietetics, medical photography and equipment library
- Cluster Root Cause Analysis investigations (RCA's) will commence from April 2015 for all hot spots
- Harm Free Care Collaborative is being planned with the Deputy Chief Nurse to work with the wards with higher risk profiles to establish why pressure ulcers are still occurring

For Integrated Community Head Division (ICHD):

- Embedding revised PURAT and wound documentation throughout ICHD. Measuring success of role of new documentation using the Tissue Viability Pathway audit. The first audit will take place during May 2015 across ICHD
- Focus group with Help to Live at Home care agencies is set up for 14 April 2015 to review the use of the SSKIN bundle tool across ICDH
- A cluster Root Cause Analysis will be carried out for the teams above with more than five pressure ulcers in one quarter
- Development of a comprehensive "Introduction to the community programme" with the aim for staff members to attend as soon as possible after start date. This will include training from experts from the clinical risk team, Tissue Viability etc., to set standards and expectations and support new team members
- The TV Lead to meet with the Therapy Lead to review the therapist input into patients at risk or with pressure ulceration
- Continue to work with patients who make their own choices with care, ensuring these are well informed choices.

Continue to Reduce Our Numbers of Healthcare Associated Infections

MRSA Bacteraemia

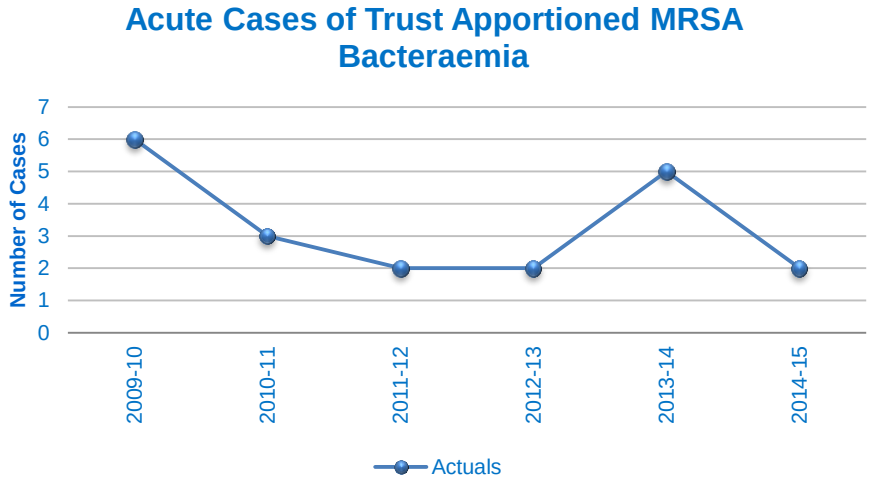
Reducing healthcare associated infection remains an important priority for us.

During 2014/2015 we reported two cases in total (both acute site attributable) against a national target of zero cases.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it's mandatory for health Trusts to report all cases of blood stream infection caused by Meticillin resistant *Staphylococcus aureus* (MRSA) to Public Health England.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve patient safety, and so the quality of its services, by implementing the following initiatives.

- Use of awareness poster for staff and enhanced training to improve communication for all members of staff at all levels.
- Management plans for patients with a history of a previous MRSA
- Clear focus on preventing any cross contamination between patients and families
- Working with our Occupational health team to support staff working in high risk areas
- Sepsis Six was implemented across the organisation. The programme provides early diagnosis and management of patients suffering from blood stream infections, and so far has saved 70 lives since the project started.



Clostridium difficile

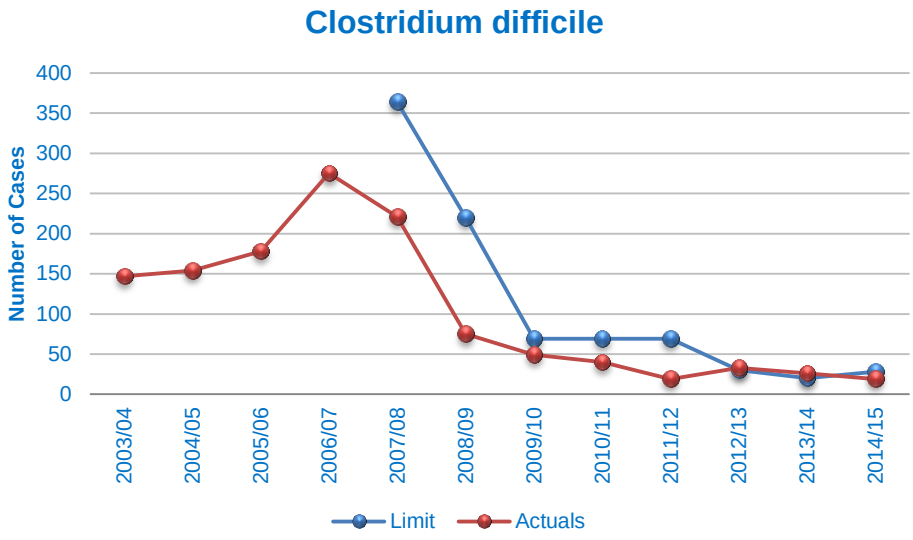
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA above, in England it's mandatory for Trusts to report all cases of *Clostridium difficile (Cdiff)* to Public Health England.

The nationally mandated goal for 2014/2015 was to report no more than twenty eight cases of C.diff We reported nineteen cases in total; seventeen *C.diff* infections were attributed to the Acute Hospital and two cases to the Community Hospitals. This was a great improvement for our patients.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve patient safety, and so the quality of its services with the following local initiatives:

- Working with 'front door' services for prompt actions when patients attend with unexplained diarrhoea on admission.
- Ensuring our patients were 'isolated' within 2 hours of unexplained diarrhoea being reported

- We strive to achieve 100% for environmental cleaning, this remains a priority for 2015/2016
- We are trialling the use of hand hygiene/wipes for patients to use prior to meal, this will be rolled out trust wide during 2015/16
- We strived to improve antibiotic audit scores, which included adherence to antibiotic guidelines, recording the duration of the course and indication for their use; this improved in all areas, there were improvements still to be made and it is anticipated electronic prescribing will improve our work on this even further in 2015/16
- We fully implemented our cleaning strategy and also set up an environmental cleaning standards group. This group focused on ensuring consistency of cleanliness through the triangulation of housekeeping audits, matron inspections and ward audits, friends and family feedback and managerial audits.
- With our business partner, Carillion, we have developed an assurance framework for cleaning to meet National requirements and cross referenced all high risk rooms within lower risk departments, such as procedure rooms within outpatients departments. This was to ensure the cleaning was delivered at the correct frequency and audit expectations were set appropriately to capture this.



Priorities for 2015/2016

The focus for the coming year will be on the Clostridium difficile improvement plan, which focuses ward/department ownership of local cleaning standards. This includes patient care equipment and promoting antibiotic stewardship, all of which is specifically aimed at preventing avoidable cases of Clostridium difficile.

Patient Safety

Report Zero Never Events

Never Events are serious, largely preventable Patient Safety Incidents that should not occur if the available preventative measures have been put in place. The NHS England Never Event Framework 2012 includes 25 specific incidents that are considered to be 'Never Events'

Our aspiration for 2014/2015 was to report zero never events.

We reported a total of two never events between April 2014 to March 2015, a decrease from 4 reported during the same period in 2013/14.
They were:

- Wrong site surgery – reported in October 2014
- Retained foreign body – reported in March 2015

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

Our Priorities for 2015/2016 to reduce the risk of further 'never Events' are:

- As a direct result of these incidents a Trust wide review of the use of the WHO check list will be completed during the early part of 2015/16
- Ensure all recommended measures are in place to mitigate the risk of each of the 'Never Events' identified in the Revised Never Events Policy and Framework (March 2015).

Reduce Incidents and Associated Harm

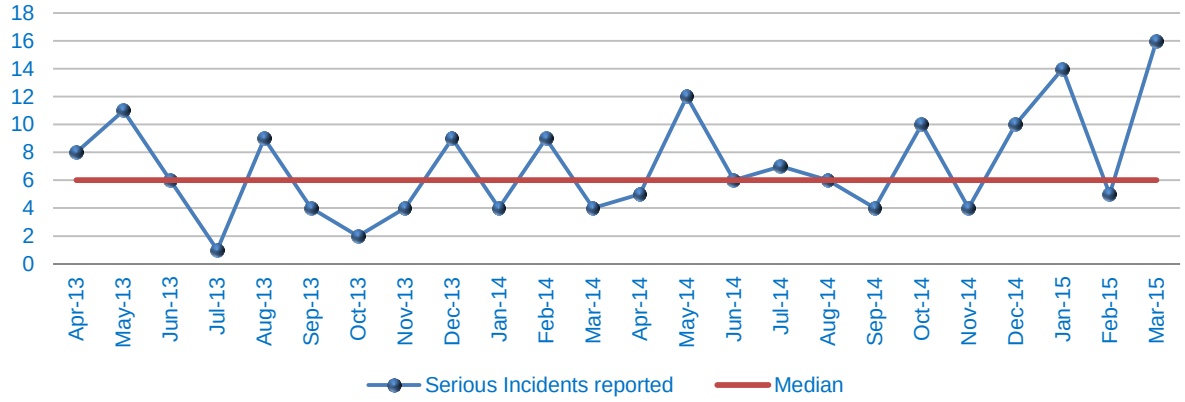
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because:

- All incidents reported were reviewed on a daily basis by the Clinical Risk and Health and Safety Departments
- All patient safety incidents that were reported within the Trust were submitted to the National Reporting and Learning System, reporting performance is evaluated against other medium acute Trusts within the cluster group biannually following the publication of the NRLS Organisational reports
- All Serious Incidents were reported to our Clinical Commissioning Groups and to the Strategic Executive Information System (STEIS) system

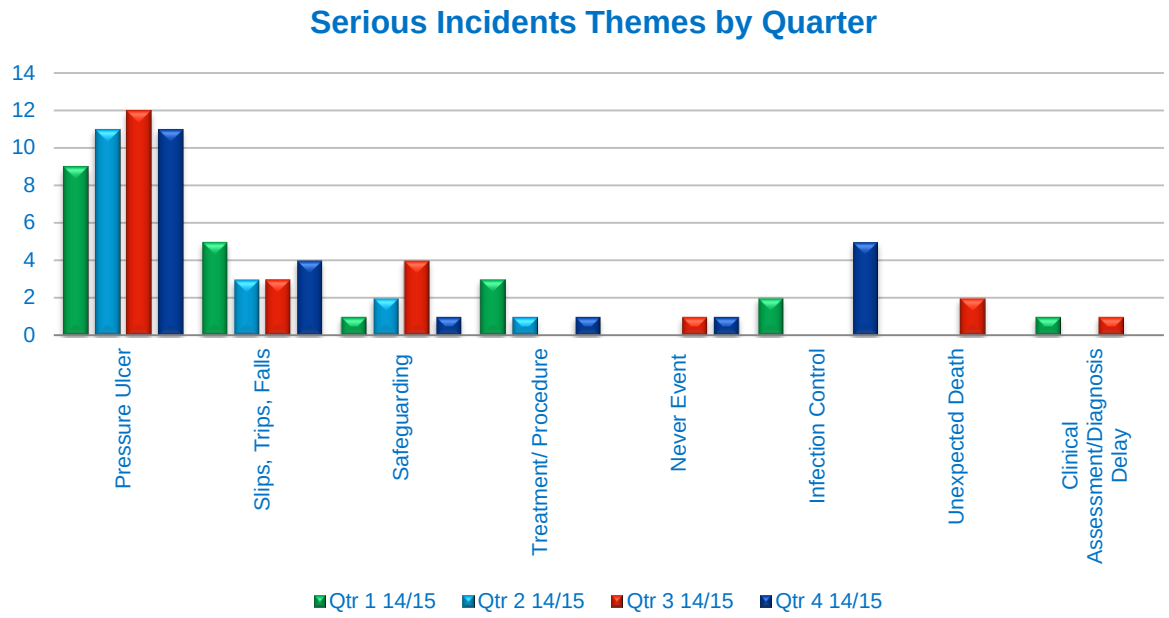
Serious Incident Reporting

A total number of 99 serious incidents were reported and investigated during the period April 2014 to March 2015; an increase of 28 from 2013/14.The increase in serious incidents resulted in part due to enhanced reporting and an increased level of patients seen and treated across the Trust in 2014/2015.

Serious Incidents Reporting April 2013 to March 2015



Serious Incidents by type per Quarter 2014/2015



Review of 2014/2015

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

- Delivering a mechanism to measure the safety culture within the organisation (safety culture analysis/ culture barometer)
- To support the delivery of measurable improvement activities relating to the NHS Safety Thermometer Harm Free Care
- Support the delivery of the Quality Improvement Strategy

Priorities for 2015/2016

As an organisation we officially 'signed up' to the national campaign Sign up for Safety on 20th November 2014. Sign up for Safety is a national campaign that aims to make the NHS safer, building on the recommendations of the Berwick Advisory Group; Sign up for Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives.

Our priority during 2015/16 is to support clinical collaborative teams to progress quality improvement in these areas, demonstrating change in practice through the use of methodology and measurement and building capability and capacity in quality improvement for frontline clinicians and teams.

The NHS Safety Thermometer

This is a national initiative that records the presence of four harms on all patients on one day every month. The rationale for focusing on the four harms is because they are common and because clinical consensus is that they are largely preventable through appropriate patient care. Whilst all four harms are equally important we agreed as part of our indicators for the Quality Accounts to report in 2014/2015 on Catheter Associated Urinary Tract Infections (CAUTI) and Venous Thromboembolism, which are below. The other harms, falls and pressure ulcers have been reported as separate indicators.

Continue to Reduce Catheter Associated Urinary Tract Infections

Urinary tract infection (UTI) is the most common hospital acquired infection with many attributable to having a urinary catheter inserted. This can lead to delays in recovery and discharge home for some patients.

We have been working with the Oxford Academic Health Science Network to look at some benchmarking across organisations. We are aiming to raise standards across the organisation with the use of 'The High Impact Intervention Care Bundle tool'. Overall results of how well we are doing are reported through the Infection Control Committee and were used by the Trust CAUTI group to benchmark improvements as the project progressed.

We will continue to work with the Oxford Academic Health Science Network project throughout 2015/16.

Continue to Reduce Healthcare Acquired Venous Thromboembolism and that these Risks are Managed Appropriately

People who are unwell, frail and have reduced mobility are at increased risk of developing venous thromboembolism (VTE). This is the development of small blood clots in the veins, 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

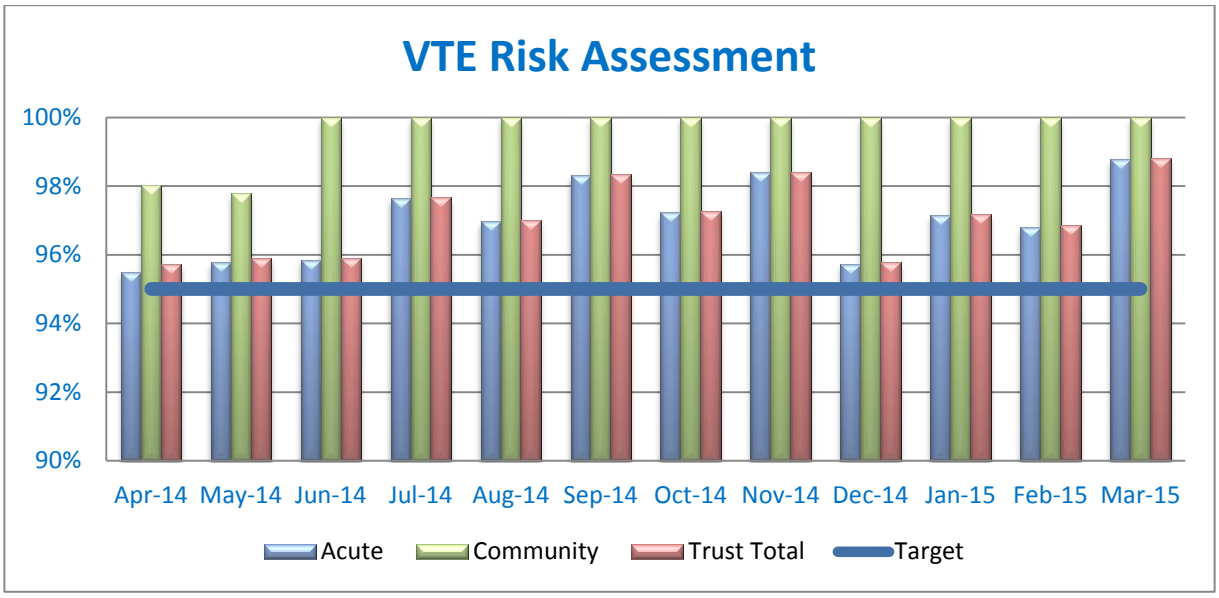
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because data is collated from the electronic nursing care system and compared to the total number of admissions during any given month. For clinical areas that do not use the electronic system, manual collation is used and validated by the lead for VTE and the informatics team. This validation is undertaken weekly and information disseminated to all clinical areas so that any under performance is highlighted and able to be rectified.

We have achieved the target set by the Department of Health of 95% across the whole year.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, 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
- Monitoring progress throughout the month ensuring that any performance concerns can be highlighted and action plans put in place
- 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.

The chart below shows the total percentage of patients that have had a VTE risk assessment on admission to hospital for 2014/2015



Acute: Acute Inpatient beds
Community: Community Inpatient beds

Hospital Acquired Thrombosis

We also looked at the number of Hospital Acquired VTE events (HAT) which related to a thrombosis (either deep vein thrombosis or pulmonary embolism) that occurs within 90 days of a hospital admission. Data has been collected since 2010 and the number of VTE events has reduced by 10% in GWH Community.

Reduce Medication Errors

There are approximately 500,000 prescriptions written each year in the Trust, and around 2.5 million doses administered each year. Sometimes there are errors in the prescribing, supply or administration of these medicines, and although nationally it is estimated that 97% of these errors result in little or no harm, the Trust has clearly defined processes for reporting incidents and learning from any medicine incidents to reduce the risk of harm, or reoccurrence of the incident in the future. The main parts of this process are:

- Having a comprehensive medicine policy, medicine administration procedures and training about medicine usage
- investigation of, and learning from incidents, both locally and nationally
- audit of medicine usage to identify possible problems
- the use of new technology to minimise risk

The group within the Trust that focuses on medicines safety is the Medicines Governance Group. This is a Multi-Disciplinary group that has membership consisting of nurses, doctors, pharmacists. It met regularly during the year, and is the group where medicine safety issues were discussed. Although all reported medicine incidents were investigated at the time of their occurrence, the Medicines Governance Group reviewed any common themes or trends, and also reviewed any incidents which either had, or could have had a major risk of harm.

The development of a Medicines Safety Officer post was part of a national initiative to develop medicine safety by improving the reporting of incidents, and the communication of medicine safety

messages within the organisation. The Trust has had a designated Medicine Safety Officer for the last two years, who is part of the national information sharing network. The Medicines Safety Officer role also ensured that there is a prompt response to national medicine alerts, and medicine recalls and hazards.

New Technology

The Trust began implementing an Electronic Prescribing and Medicine Administration (EPMA) system in which the paper medicine charts used for the prescribing and recording the administration of medicines on wards is replaced by an electronic system. This was a huge change to how medicines are used within the Trust, and the project, which started early in 2014, is expected to be in use on all the main wards at the Great Western Hospital by the end of June 2015. Many of the areas where medicine errors could occur will be resolved by this change, including unclear handwriting, ambiguous dosing, and unclear abbreviations.

Review of 2014/2015

During 2014/2015 there were 876 reported medicine incidents, which included all areas of the Trust. This included acute and community wards, community nursing, the prison. Of these incidents 870 were reported as causing either no harm or minor harm. Six incidents were categorised as moderate harm there were no reported incidents of severe harm or death

Priorities for 2015/2016

The main priorities for 2015/2016 in relation to medicine safety:-

- To ensure that the EPMA system is fully embedded in the prescribing and administration of medicines within the Trust
- To use the data that is available from the EPMA system to create a comprehensive program of medicine safety audits
- To fully participate in Regional and National Medicine Safety network activity, and to ensure that messages and processes that result in risk reduction in relation to medicines are fully implemented within the Trust
- To continue to learn from medicine safety incidents. The Trust does not want to see a reduction in the number of reports as the reporting of incidents is fundamental to improving medicine safety.
- To see a reduction in the number of incidents that cause harm, or significant risk of harm.

EFFECTIVE CARE

Preventing People from Dying Prematurely

Continue to Sustain our Hospital Standardised Mortality Ratio (HSMR)

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

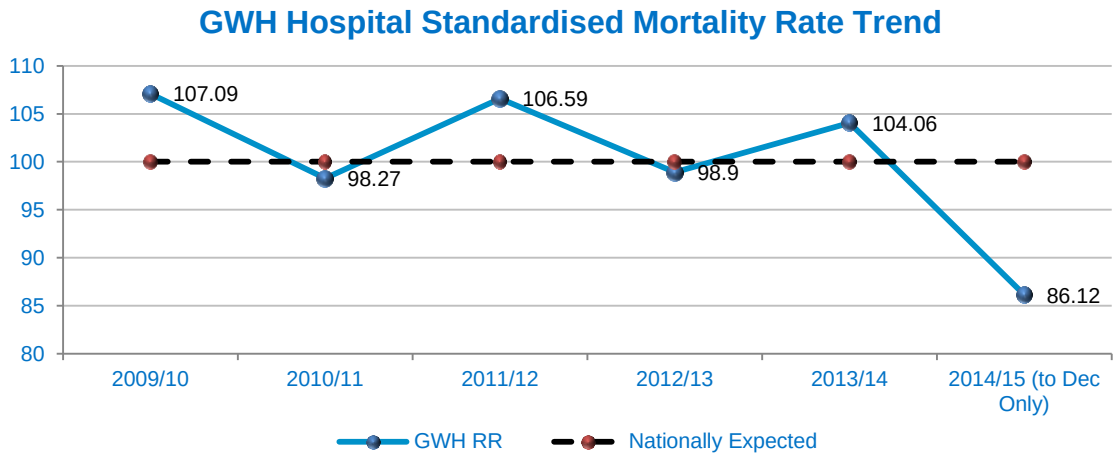
Therefore a local RR figure of 100 indicates that the mortality rate is exactly as expected; whilst a local figure of less than 100 indicates a mortality rate lower (better) than expected. The Care Quality Commission (CQC) uses HSMR values to monitor performance of hospitals and identify areas of practice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

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

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

- The data is sourced from Dr Foster and is widely used in the NHS
- The data is refreshed on a monthly basis
- The data is reviewed on a monthly basis by the Trust Mortality Group
- The data is included in the Trust quality and performance dashboards which are reviewed by the Trust Executive Committee and Board as well as relevant CCG Committees
- It is a key indicator of the quality of care we provide

The Graph below shows the year on year HSMR following rebasing. This shows a general improvement over time.



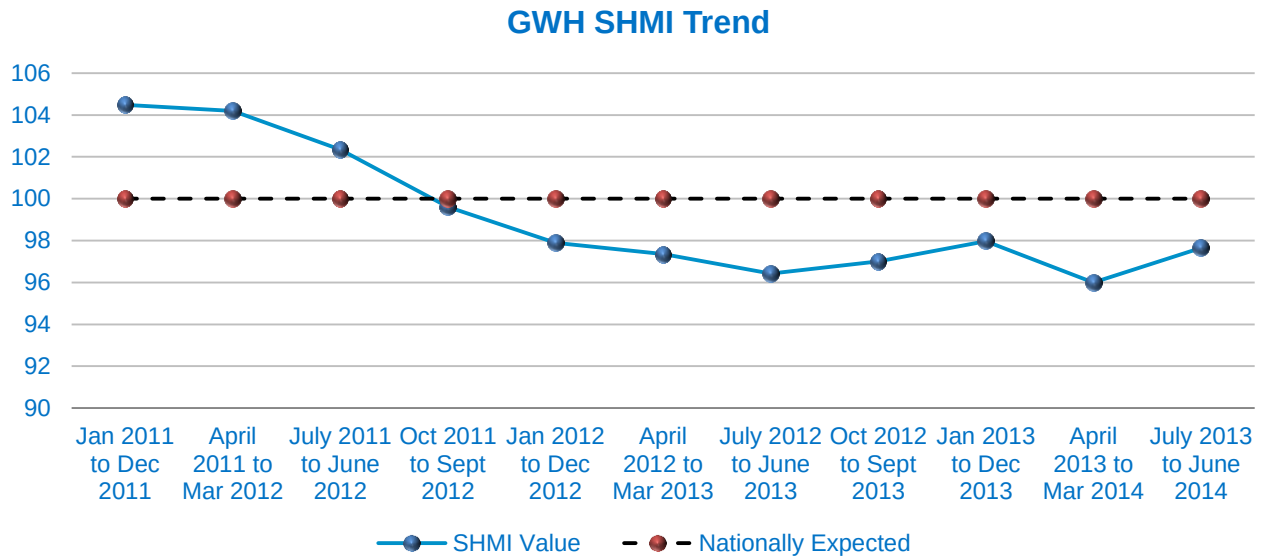
CQC Mortality Alerts

The CQC identified two mortality alerts for the Trust in 2014/2015 based on figures that suggested there may be an excess of deaths in two different categories. These were deaths due to myocardial infarction (heart attack) and deaths due to pathological fracture (a broken bone where the bone was weak to start with). As a Trust we therefore investigated both of these alerts by reviewing the care of patients who had died from these conditions. No avoidable deaths were identified in either category. Together with CQC we have continued to monitor mortality rates in these categories and there have been no further alerts. On-going monitoring shows improved mortality rates (HSMR) in these groups to lower than expected levels suggesting that the actions taken following investigation were effective. The CQC has notified us that they are satisfied that there is no longer a concern in these areas.

Standardised Hospital Mortality Indicator (SHMI)

We also monitor the SHMI performance and this is reported to the Trust Mortality Group. The indicator is produced by the Health and Social Care Information Centre. It is similar to HSMR but counts deaths both in hospital and those patients that die within 30 days post discharge from hospital. The Great Western Hospitals NHS Foundation Trust considers that this data is as described because SHMI is the ratio of observed number of deaths to the expected number of deaths by provider. The trend closely follows the Trust HSMR figures and is published with a longer time lag on a quarterly basis.

The graph below shows our latest published performance in rolling year periods. Our performance shows an improving trend with the rate being below the expected national average. Given its similarity to HSMR the SHMI performance is likely to continue to be below expected in the latter part of the year.



Priorities for 2015/2016

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

- The Trust Mortality Group will continue to review a range of Dr Foster mortality indicators each month and investigate Dr Foster mortality alerts as well as agreeing any other investigations or initiatives prompted by the data and trends
- The Trust has put plans in place to take a more proactive approach to reviewing the care of patients who die.
- The Trust also plans to feedback to clinical teams the lessons learned from mortality reviews to ensure that there is continuous improvement in the quality of care delivered to our patients
- For 2015/2016, the “Sign up to Safety” work programme, which we have joined, is targeting five key areas with the potential to improve mortality rates. These areas are sepsis, acute kidney injury, falls, pressure ulcers and recognition of deteriorating patients. Work streams are linked with the work of the Mortality Group and should contribute to further improvement in HSMR and SHMI values.

Early Recognition of the Deteriorating Patient (SOS/NEWS for Adults and PEWS for Paediatrics)

Early identification of the deteriorating patients and patients whose condition may be worsening plus early escalation of care and appropriate treatment is vital to ensure good outcomes for patients.

Currently for adults we use a ‘tool’ called the Swindon Outreach Scoring System (SOS); an early warning scoring system, to help members of the multidisciplinary team to identify deteriorating patients. The SOS system has been used throughout all our adult inpatient areas. Within our ‘front door services’ (the emergency department and acute assessment wards) we use a different scoring system, the ‘National Early Warning Scoring system’ (NEWS), which is more appropriate to these acute areas. The Patient Quality Committee recommended that one system should be used across the Trust, and a

system that is recognised nationally. Therefore we are changing our early warning scoring system to NEWS for all our clinical areas.

For the children we care for we will be using the national 'Paediatric Early Warning Scoring System' (PEWS). The triage process in our new purpose built Children's Emergency Department will include the new PEW score to improve the early intervention and recognition of the sick child.

Continue to Enhance the Quality of Life for Patients with Dementia

Our Dementia Strategy focuses on six key priorities as shown below. Delivery of the key objectives is overseen by the Dementia Strategy Group. Since the new Clinical Lead for Dementia came to post in July 2014, the Dementia Strategy Group has increased the frequency of meetings; the full committee now meets every two months. In addition, the Dementia Strategy Group has a lead person for each of the six key priorities; these work stream leads meet every two months. A huge amount of progress has been made with regards to our dementia priorities in 2014.

1. Raising Awareness

We held Dementia Champion Forums in April and October and these were well attended. Work took place to increase the number of attendees, to maintain momentum and effect change at ward level. A 'reasonable adjustments' alert has been created on the hospital Medway computer system, which alerts staff to an individual's specific requirements. This allowed the delivery of personalised care for patients with dementia.

A recent audit into the use of specific dementia tools 'This is Me' document and Forget-Me-Not Flowers (both advocated by the Alzheimer's Society) highlighted areas for improvement in their use and the actions from this audit continue to be implemented throughout 2015.

2. Education & Training

We provide dementia training to all hospital staff in accordance with Health Education England's requirements. A dedicated Dementia Training Lead coordinated and implemented this extensive training programme. The new SCOPE course, which was introduced in 2014, included advanced dementia care training on topics such as challenging behaviours, delirium and appropriate environments.

3. Dementia Friendly Environments

GWH opened the first dementia friendly ward in November 2014 after a £98,000 refurbishment project, which was funded by a grant from the Brighter Futures Charity. This specialist ward enables patients with dementia to be cared for in an environment which supports their complex needs and improves their hospital experience. A programme to introduce meaningful activities for inpatients with dementia is underway e.g., music therapy and sociable meal times.

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

4. Dementia Care Pathway

A key priority for 2015 is the development of a whole hospital pathway for patients with dementia from admission to discharge. The aim was to dovetail this work within the acute trust with the community dementia services to ensure continuity of care for patients with dementia between the hospital and community settings.

5. Valuing Carers

The GWH Dementia Strategy Group continues to work in close collaboration with the Trust's Carers Committee to improve support for carers of people with dementia. The Dementia Strategy Group has carer representation within the attendees. A new carer feedback survey was introduced to ensure that we understand the needs of those who care for individuals with dementia so that we can support them in the most appropriate way. Our new Outpatient Welcome & Liaison Service (OWLS) helps people with dementia and their carers to navigate their outpatient appointments with greater ease.

6. Benchmarking Services

GWH continues to ensure that all our dementia services and work adhere to national and regional standards and recommendations. We are due to participate in the National Dementia Audit in 2016.

Safeguarding for Adults & Children

Safeguarding Adults at Risk

During 2014/2015 we have further strengthened our Safeguarding Team to ensure the greater well-being and safety of our patients through Safeguarding procedures.

The recruitment of a Safeguarding Adults at Risk Lead for the Acute Services in January 2015 has enabled the Safeguarding Adults Team to support both the Integrated Community Health Directorate (ICHD) and the Acute Services in awareness raising and supporting the raising of multi-agency safeguarding adults referrals. The Safeguarding Adults Leads provide training at Day 1 of the Trust Induction programme, bespoke training to staff/areas and undertake quality assurance on incidents raised with relevant feedback as required.

Neglect is the highest alerted category of harm reported by the Trust during the year with Physical, Financial, Psychological and Emotional being the next highest reported categories.

Safeguarding Children

We take the safeguarding of children very seriously; we have a dedicated Safeguarding Children Team who provides training, advice and support to all services both in the hospitals and across the community. We have continued to work in partnership with Local Authorities to safeguard children. Each Local Authority has its own Local Safeguarding Children's Board (LSCB) made up of nominated Lead Officers from key organisations and GWH had senior representation on Swindon and Wiltshire LSCBs. We also have a statutory duty under Section 11 of the Children's Act 2004 to protect children from harm as part of the wider work of safeguarding and promoting their welfare.

This means we work in partnership with other agencies to: protect children; identify health and development needs early to ensure the right level of support to safeguard children and young people; ensure children grow up in circumstances consistent with provision of safe and effective care; and ensure processes are in place to learn from events.

We aimed to fulfil our commitment to safeguarding and promoting the welfare of children by:

- Ensuring there was Senior Management commitment
- Ensuring there were clear lines of accountability and structures

- Supporting a culture that enables safeguarding issues and promotion of children's welfare to be addressed and ensuring that accurate records are made
- Ensuring staff receive adequate training to safeguard children

Review of 2014/2015

The following priorities for safeguarding children were identified in the 2014/2015 work plan:

- Improve staff access to safeguarding children training
- Ensure support and safeguarding supervision is in place for staff that have a particular responsibility to safeguard children
- Ensure a robust audit programme is in place to oversee safeguarding practice and learning

Progress was achieved in all 3 of these priority areas.

- The organisational Safeguarding Children & Young People Training Strategy was reviewed to ensure that the organisation fully met the requirements of the "Intercollegiate Document: 'Safeguarding Children & Young People: Roles and Competencies for Health Care Staff. Intercollegiate Document' published in March 2014. The review identified that a substantial cohort of staff (1,400), particularly within the acute setting, needed Level 3 training and these staff would have previously only accessed Level 2 training. A realistic work plan was developed to reflect how the Organisation will achieve the necessary compliance over 2015-16.
- The Trust supervision policy was reviewed and a supervision model developed to ensure that staff working with children had access to a framework of support and supervision. A model of group and individual supervision is now embedding within community services. Training for supervisors within acute services is completed and supervision was in the process of being implemented.
- The organisational safeguarding audit programme was implemented for 2014-15 and included an audit of social care referrals, safeguarding supervision and understanding and knowledge of escalation policy.

Priorities for 2015/2016

- Ensure that compliance for level 1, 2 and 3 safeguarding training increases to 90%.
- Embed safeguarding supervision model across the Trust.
- Develop a robust safeguarding children performance dashboard across Trust and monitor at safeguarding forum.

Learning Disabilities

Access to Healthcare for people with a Learning Disability

This was a new target for 2014/15 and was mandated by Monitor, for Foundation Trust regulation, for completion from quarter 3, 2014. The target relates to six indicators six criteria for meeting the needs of people with a learning disability, based on recommendations set out in 'Healthcare for all' (DH, 2008). The following targets have been met:

- Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?
- Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?
- Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?

- Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?

The following targets are partially achieved.

- Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria:
    - treatment options
    - complaints procedures
    - appointments

The Trust will be fully compliant with these standards by quarter 1, 2015/16.

- Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?

The Trust has protocols in place and will be publishing reports publically via Trust Board annually from quarter 1 in 2015/16

Review of Patients who are being re-admitted to Hospital within 28/30 Days of Discharge

We carry out audits on patient re-admissions to highlight any gaps in care for patients who have been readmitted within 28 and 30 days respectively to find out if there was anything that we could have done better to prevent patients being re-admitted, especially if their re-admission is related to their previous condition.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described as we have undertaken a review of all patients (74 in total) over the age of 18 who had an emergency admission with a discharge date during two specific time periods in the year and who subsequently had an emergency readmission within 28 days.

- Pneumonia acquired whilst in the Community was highlighted as the most common initial diagnosis. Overall 86% of patients had multiple illnesses. The patients' length of stay (LOS) varied from less than 24 hours to 59 days with an average of seven days per admission.

- Most of the patients were readmitted having attended the Emergency Department (ED) and in 50% the re-admitting diagnosis was the same as that for the original admission.

- The readmission LOS averaged six days. Many of the patients had repeated readmissions with nineteen patients having more than four admissions within the previous six months, a proportion of these readmissions were for mental health concerns.

- Overall 63% of the readmissions were felt to be unavoidable; 18% may have been prevented by actions in secondary care, 10% by actions in the community and 9% would have required a combination of acute and community actions to prevent their re-admission.

The actions that might have prevented re-admission within the secondary care sector included:

- Arranging for bloods to be rechecked and acted upon in a timely fashion;
- Better communication with primary care;
- Ensuring an advanced care plan in place;
- Ensuring mental health and/or an alcohol liaison review was in place prior to discharge.

The community actions that might have prevented readmission included:

- GP review,
- Community nurse review
- Mental health input.

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

30 Day Readmission Comparative Data 2014/2015

	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	March 15
Emergency Re-admission within 30 days of discharge	7.8%	8.0%	9.8%	9.6%	9.8%	10.2%	9.8%	9.1	8.9%	8.9%	9.5%	10%

28 Day Readmission Comparative Data 2014/2015

Month of Original Discharge	Total Spells			Crude Re-Admission Numbers			Crude Re-Admissions Percentage		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 13	782	5612	6394	58	422	480	7.4%	7.5%	7.5%
May 13	632	5740	6372	42	475	517	6.6%	8.3%	8.1%
Jun 13	644	5493	6137	50	440	490	7.8%	8.0%	8.0%
Jul 13	667	5830	6497	37	454	491	5.5%	7.8%	7.6%
Aug 13	634	5652	6286	52	478	530	8.2%	8.5%	8.4%
Sep 13	701	5666	6367	61	442	503	8.7%	7.8%	7.9%
Oct 13	804	6164	6968	48	461	509	6.0%	7.5%	7.3%
Nov 13	727	5827	6554	55	445	500	7.6%	7.6%	7.6%
Dec 13	771	5671	6442	74	411	485	9.6%	7.2%	7.5%
Jan 14	748	6215	6963	77	460	537	10.3%	7.4%	7.7%
Feb 14	618	5443	6061	70	364	434	11.3%	6.7%	7.2%
Mar 14	690	5776	6466	68	423	491	9.9%	7.3%	7.6%
Year 2013/14	**8418**	**69089**	**77507**	**692**	**5275**	**5967**	**8.2%**	**7.6%**	**7.7%**
Apr 14	706	5794	6500	50	451	501	7.1%	7.8%	7.7%
May 14	865	6136	7001	53	493	546	6.1%	8.0%	7.8%
Jun 14	680	5608	6288	62	530	592	9.1%	9.5%	9.4%
Jul 14	685	6120	6805	49	583	632	7.2%	9.5%	9.3%
Aug 14	566	5553	6119	39	550	589	6.9%	9.9%	9.6%
Sep 14	728	5897	6625	62	605	667	8.5%	10.3%	10.1%
Oct 14	707	6021	6728	66	579	645	9.3%	9.6%	9.6%
Nov 14	715	5374	6089	65	481	546	9.1%	9.0%	9.0%
Dec 14	877	5398	6275	76	505	581	8.7%	9.4%	9.3%
Jan 15	698	5385	6083	72	454	526	10.3%	8.4%	8.6%
Feb 15	699	4868	5567	74	447	521	10.6%	9.2%	9.4%
Mar 15	692	5642	6334	67	550	617	9.7%	9.7%	9.7%
Year 2014/15	**8618**	**67796**	**76414**	**735**	**6228**	**6963**	**8.5%**	**9.2%**	**9.1%**

Helping People to Recover from Episodes of Illness or Following Injury

Nutrition & Hydration

All in-patients must be screened for nutritional risk on admission to hospital using an approved and validated tool. We use the Malnutrition Universal Screening Tool ("MUST") which is the most commonly used nutritional screening tool in England and recommended by a number of national bodies. Exclusions to this include those who are under 18 years, at the end of life or within maternity.

Since we started using a tool to screen for malnutrition in 2010 the amount of screening performed has increased from 33% and has been maintained at about 81%. On-going audits and screening reviews have shown the prevalence of malnutrition at GWH is 39% which is similar to national figures. These patients are found to be at risk on admission to hospital so this means factors affecting nutritional status are largely occurring in the community. A screening programme using "MUST" and pathway was introduced across Wiltshire & Swindon focussing initially on community hospitals community teams and care homes

Progress and areas for improvement have been captured in the Nutrition & Hydration Steering Group annual work plan/strategy and will be used as a basis for quality and service improvements.

Review of 2014-2015

- Improving (or maintaining) compliance with and accuracy of the "MUST", nutrition care plans and documentation of fluid balance
- Streamlining admission documentation: "MUST" is only one of a number of screening and assessment tools ward staff are required to complete on admission and a new admission document combining these is being piloted to help to streamline their workload. This should help to improve compliance and accuracy of "MUST".
- Improving in-patients meal-times experience including meals quality, appropriate choice and assistance with meals as required. This includes observational "audits" of meal times with feedback to ward manager and matrons in relation to the protected meal time standards by the dietetic assistant.
- Mandatory training for ward and other key staff now includes Nutrition, Food Hygiene and Hydration

Stroke Care

The National Stroke Strategy was published in 2007, outlining best practice standards for stroke care in hospitals and the community for rehabilitation; we are audited by the Sentinal Stroke National Audit Programme [SSNAP].

A specialist stroke unit was established on Falcon Ward in 2009 with stroke specialist nurses and therapists [provided by SEQOL, an external organisation]. Partnership working with commissioners and other service providers has been established to develop pathways of care for these patients and their carers'.

The British Association of Stroke Physicians states that *"All stroke patients benefit from immediate admission to a Stroke Unit. The target is > 90% of patients with stroke to be admitted directly to the Stroke Unit from the ED or home, and to spend 90% of their length of stay in specialist stroke bed.*

Patients are to be admitted to the Stroke Unit within 4 hours of hospital arrival." The demands and pressures on the Emergency Department have meant this has been difficult to achieve, but wherever possible and appropriate Stroke patients have taken a priority with recent performance being an average of 72.8% of patients going direct to our stroke care ward, Falcon. The percentage average achieved is not as hoped and a reflection of inpatient pressures and demands for beds. Improvement of this performance continues to be a top priority.

The challenges for the future are to create a 7 day therapy service, which includes a clinical psychologist.

Continue to Monitor and Maintain NICE Compliance

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

Every month, NICE publish their guidelines for healthcare organisation to assess and/or put into place. Since 1 April 2014, we have received 117 published NICE guidelines; all of which have been sent to the relevant clinical leads and divisions to check against their current practice.

To date, 39 out of the 117 guidelines have been deemed not applicable to the organisation, and full compliance has been confirmed with at least 36 guidelines. Of the recent publications, a response is awaited for 20 guidelines; and a further 15 are in the process of being reviewed to check prescribing protocols, pathways or where funding is to be confirmed. There are action plans currently being implemented or are in the process of being formulated for the remaining 7 guidelines

We have maintained a compliance rate of 98.6%, and this is based on the initial assessment of all relevant guidelines.

PATIENT EXPERIENCE

Friends & Family Test

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because the Friends and Family Test is commissioned nationally by NHS England. All providers of NHS-funded services are required to offer the Friends and Family Test (FFT) to their patients.

We first introduced FFT in early 2013 in our acute inpatient services, A&E and our maternity services in line with the national timetable. In October 2014, it was extended into our outpatient services and the day case services, and then in January 2015 we completed the roll-out to include community services.

The Friends and Family Test was also part of our Commissioning for Quality and Innovation (CQUIN) framework that aims to secure improvements in the quality of services and better outcomes for patients

The wealth of patient information received from this source is invaluable for improving services and quality of care to our patients. With the introduction of Friends and Family Champions throughout the Trust towards the end of this financial year, Friends and Family has received a refreshed approach into the collection of patient feedback. It has been encouraging to see the positive feedback about the services we strive to provide and we have met our targets, which we set out at the beginning of this

financial year. We will continue with this approach and hope to make further improvements using the patient feedback we receive.

We have maintained a standard of 4.72 - 4.8 stars out of 5 throughout the whole year which reflects how well our patients and users rate the services we provide

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, as follows:

- To continue to promote Friends and Family Champions throughout the Trust.
- To display “you said; we did” feedback in all of our areas throughout GWH and Community Sites.
- To look at other methods of collection of Friends and Family comments for Outpatients and the Emergency Department areas.
- To fully engage and collate comments from Children and Young on their overall Patient Experience.

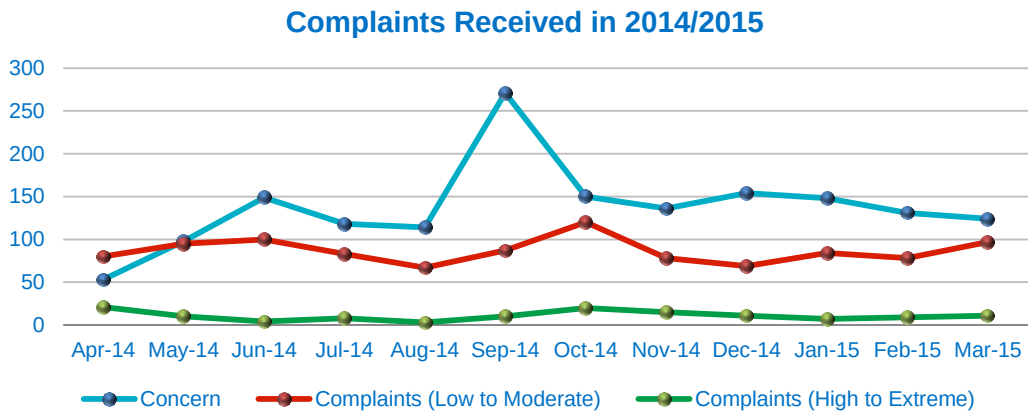
During 2014/2015 a total of 6380 comments were received through the Friends and Family Test from Acute and Community Inpatients against a total of 20852 total discharges. There were also 8450 comments received from the Emergency Department against a total of 41901 patients who were seen and discharged the same day.

Improving Patient Experience & Reducing Complaints

Improving Patient Experience is a key priority for us; we have robust methods of collating Patient Feedback and want to build on this throughout 2015/2016. ‘Listening to Patients’ and understanding their concerns is very important to us and we have held two “Listening Events” throughout 2014/2015 in Swindon and Devizes. We plan throughout 2015/2016 to hold further events and look to introduce additional Patient Participation Groups.

We want to improve on patient information provided so we are reviewing all the information we currently use with our aim to have all documents produced and published in a Plain English format throughout 2015/2016.

Throughout the year we have made changes to the way that we respond to complaints, the majority of comments made are answered within 24/48 working hours as a concern rather than escalating through the complaints process. The graph below gives a comparison on concerns/complaints received for 2013/2014 and 2014/2015.



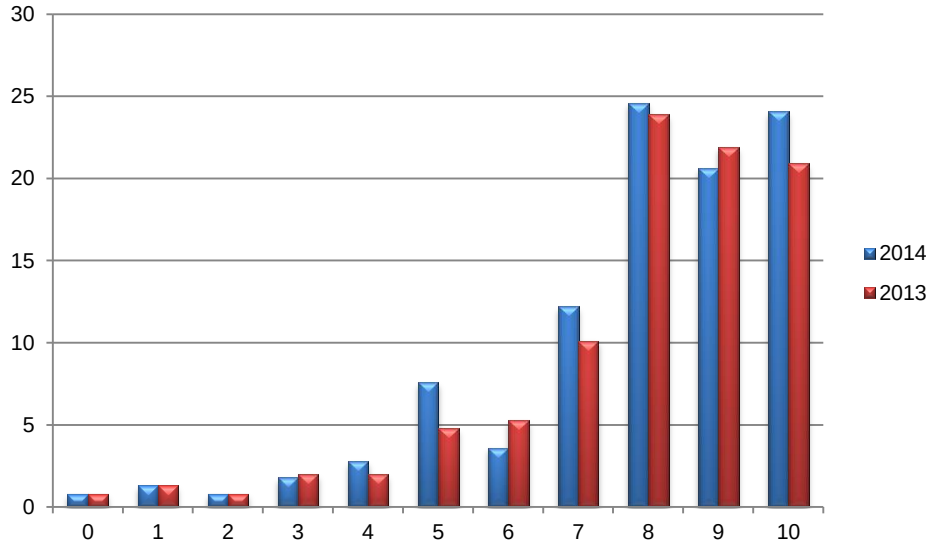
Further changes include:

- Improving response times to complaints.
- Ensuring that learning and changes to services take place.
- A service available to all which offers support and guidance to patients.

National Inpatient Survey

The National Inpatient Survey was carried out in quarter three of 2014 by the Picker Institute. The chart below shows the year on year comparison of how those who took part in the survey rated the quality of the care they received.

Chart - National Inpatient Survey, question H2 - (Please rate your experience on a scale of 0 – 10)



The chart above shows that, overall, patients have continued to rate their experiences highly with ten being the highest rating.

This Patient Experience rate also reflects in our Friends and Family score which remain at 4.7 stars out of a possible 5 stars at the end of 2014/2015.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is a reliable, externally validated measure reflecting the experience of our patients, it is objective and provides an annual snapshot telling us how we are doing from our patients perspectives and where we have improved and where we need to focus further improvements.

Question	Target	2012/13 %	2013/14 %	2014/2015 %
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'	**51**	**53.2**	**51.4**
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**	**37.1**	**28.6**
Were you given enough privacy when discussing your condition or treatment?	**GWH** GWH target 73% or more responding 'Yes, definitely'	**73**	**70.8**	**74.2**
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'	**30**	**33.7**	**32.1**
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'	**67**	**67.2**	**66.2**

Implement Plans to Improve Results of the National Inpatient Survey

Our aims for 2014/2015 were:

- Implement a new feedback system and improve the quality of customer feedback
- Develop a new Patient Information policy
- Develop a robust Trust wide action plan to address the areas within the National Inpatient Survey report, where improvements are required.
- Significantly improve the individual score for patients not being asked to give views on the quality of care (Question H3).

Throughout 2014/2015 our focus has been the collection of patient feedback on the services we provide. Detailed analysis is reported monthly on Patient Experience, for example comments from Friends and Family cards, Voicebook messages. Engagement/Listening events have been held throughout the year working in partnership with Healthwatch within the Swindon and Wiltshire area. This information has been shared with the relevant areas for improvements to be made to services.

We have commenced work on reviewing all of our Patient Information Leaflets and now have a Lay Readership Panel who will review all leaflets before being published. 'Plain English' training has been made available to staff to help with the creation of new patient information leaflets.

Friends and Family Champions have been introduced in each ward/clinic area; this has contributed to the increase in cards received and provides more detailed feedback of what patients are saying about the care they have received. Throughout the year we have maintained a consistent star rating (Friends

& Family national rating system). We are especially proud of the feedback we have received during a time of increased challenges and pressures across the NHS.

Work has been carried out on areas that were identified in the Inpatient Survey results 2013 particularly related to food; call bell answering within a set timeframe; patient feedback and information being made available on how to make a complaint.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this patient feedback, and so the quality of its services, by introducing 'Patient User Groups'.

During 2015/2016 we will also:

- Continue to improve feedback via Friends and Family cards.
- Create a robust Trust wide action plan in response to priorities identified in the National Inpatient Survey report published in 2015/2016, with close monitoring of progress.
- Explore other methods of Patient Feedback particularly in Outpatient and Emergency Department settings.
- Introduction of Patient User Groups.
- The completion of the Patient Information project.

Staff Survey Summary 2014-2015

We want our Trust to be a place that people want to work and would recommend to their family and friends. Our People Strategy sets out our journey of cultural change, ensuring that compassion and care are at the heart of our organisation, both for patients and our staff.

Every single person who works in our organisation plays an invaluable role in providing the high quality care and excellent service we strive for and we are committed to supporting our staff to achieve this through the six commitments outlined in our People Strategy.

As a Trust we are committed to developing our staff and strive to ensure that all our employees reach their full potential at work and are happy and motivated to do their job and contribute to our success as an organisation. We also continue to work towards improving how we recognise the hard work, loyalty, commitment and successes of our workforce and have raised the profile of achievement through the monthly and annual award scheme and in putting staff forward for national awards**.**

At the end of February 2015 we had 5,212 staff in the organisation. The breakdown by professional group is listed below.

	Headcount of Staff
Admin and Clerical	1139
Allied Health Professionals	502
Medical and Dental	521
Non-Clinical Support	169
Registered Nursing and Midwifery	1770
Scientific, Therapeutic & Technical	445
Unregistered Nursing and Midwifery	666
Grand Total	**5212**

The sample size was 828 surveys sent to staff with a return rate of 456 (55%).

We recognise that a more satisfied and motivated workforce provides better patient care. And therefore we place significant emphasis on exploring ways to improve and enhance motivation so that staff are satisfied in their work whether they are looking after patients in our hospitals, schools, community centres or in patients' homes.

To help us understand how staff are feeling, the results of the annual staff survey are examined by the Trust to identify any areas for improvement, to share good practice and implement changes

Our staff scores received in March 2015 benchmarks the Trust as thirteenth across twenty-two Trusts in the South West of England, including Royal Berkshire. Last year the Trust benchmarked in fifth position so this is a downward trend.

Through our 'You Said We Did' programme, The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve in the areas identified within last year's staff survey:

You Said: Only 5 out 10 staff felt the Trust treats staff involved in an error or incident fairly.
We Did: In August 2014, we launched the Respect Us campaign, a reminder to the public that any form of verbal or physical abuse against staff will not be tolerated and abusive patients, relatives or other members of the public will face tough penalties. In or 2014 Staff Survey, we saw improvements in each of these areas.

You Said: 24% of staff feel there are enough staff in the organisation to do their job properly.
We Did: over the last year the Trust has continued to place significant focus on recruitment. The 2014 Staff Survey showed a slight improvement to 27% in this area.

You Said: 61% would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.
We Did: This year saw the introduction of the Staff Friends & Family Test (SFFT) giving staff the opportunity every quarter to tell us what it is like to work here. Since last year's survey, we have asked our Staff this question on three occasions; the results from the SFF show a positive improvement, with around 70% of staff saying they would recommend GWH to friends and family if they needed treatment. However this year's staff survey saw a slight decrease to 58%.

You Said: Improvements are needed in the sharing of team objectives and closer communication between teams to achieve objectives.
We Did: 96% of you in this year's Staff Survey said that they work as part of a team and 74% agreed that their teams had a shared set of objectives. Further improvements are still needed in this area and this will be one of the key priorities for the Trust this year.

Overall, the Trust is measured against the four staff pledges from the NHS Constitution with an additional theme of staff satisfaction. These indicators break down into 29 key findings and results show that staff at GWH report that their experience of working at GWH places us in the Top 20% of Acute Trusts in UK for 1 out of 29 indicators regarding the amount of staff who have received an appraisal in the last 12 months.

Staff Survey Scores 2014	Answers
Top 20%	1
Above (Better than) Average	9
Average	9
Below (Worse than) Average	7
Bottom 20%	3
Total	29

We are better than average for 9 out of 29 indicators including training, support from managers and staff motivation at work. We are average for 9 out of 28 indicators relating to job satisfaction and staff feeling able to contribute towards improvements at work.

The Trust are worse than average in 7 out of 28 indicators including staff being unsatisfied with the quality of work and patient care they are able to deliver, pressure of work and extra hours being worked. All these areas are connected to our staffing levels which we have a plan to improve.

Our staff survey results will be presented to the Executive Committee and Trust Board to enable us to determine which areas to focus on so that we could improve the experience of our staff. Each division will be provided with a staff survey information pack which sets out the key priorities for the Trust and division and how these are aligned to the People Strategy.

Development and training opportunities

The vast majority of staff said that they had received training, learning or development opportunities over the past 12 months however our results in this section have decreased slightly since last year.

It has been an incredibly busy year which has made it difficult for some of our staff to attend training, however we recognise the importance of this and we will make this a priority for the coming year.

This year, it was great to see that 91 per cent of staff said they had taken part in a Performance Review (appraisal); this is compared to the national average of 84 per cent. We acknowledge that we still have further development to do in this area to ensure that our appraisals are helping our staff to improve how they do their job, and most importantly leave them feeling valued. We are currently reviewing this process to make sure it is adding value to our staff and is providing them with the support they need.

Working together and making a difference

The majority of staff (96 per cent) agreed that they work as part of a team in their roles, with 74 per cent agreeing that they have a set of team objectives. This is a great start but we need to do more to support our staff to work together and to give them the opportunities to meet regularly to discuss team effectiveness and ideas for improvements.

Over the past year we have placed significant emphasis on recruitment and have been working hard to increase our staffing levels in many areas. This has been reflected in our results this year, with more of our staff agreeing that there are enough people in the organisation to do their job properly. We have also seen an increase the number of staff feeling that they are able to do their job to a standard that they are personally pleased with which is really positive.

Feeling supported

We have seen a slight decrease in the number of staff feeling senior managers are involving them in important decisions and acting on feedback. We have also seen a decrease in the amount of staff who feel that the communication between senior management and staff is effective. All our staff should experience the right level of support and involvement from both the Trust and their manager and we need to make sure this is happening in practice.

Health, well-being and safety at work

Our staff's health and wellbeing is really important to us and we recognise that our people can only provide high quality care if they feel supported in their own health and well-being. We have seen improvements in this area with less of our staff experiencing harassment, bullying or abuse whilst at work and more staff reporting incidents if they do occur. This is following the successful 'Respect Us' campaign that was launched in August last year which reminded the public that any form of verbal or physical abuse against staff will not be tolerated.

The Great Western Hospitals NHS Foundation Trust considers that the data is as described from the national staff survey and information provided by Quality Health.

Table - Response Rate

2013		2014		Trust Improvement/ Deterioration
Trust	**National Average**	**Trust**	**National Average**	
67%	49%	55%	42%	12% deterioration

	Table – Summary of Performance	2013		2014	
		Trust	**National Average**	**Trust**	**National Average**
Top 5 Ranking Scores	Question: KF7. Percentage of staff appraised in the last 12 months *(the higher the score the better)*	92%	84%	91%	85%
	Question: KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the score the better)*	88%	90%	93%	90%
	Question: KF10 Percentage of staff receiving health and safety training in last 12 months *(the higher the score the better)*	82%	76%	81%	77%
	Question: KF9. Support from immediate managers *(the higher the score the better)*	3.75	3.64	3.69	3.65
	Question: KF26. Percentage of staff having equality and diversity training in the last 12 months (*the higher the score the better)*	74%	60%	68%	63%
Bottom 5 Ranking Scores	Question: K29. Percentage of staff agreeing that feedback from patients / service users is used to make informed decisions in their directorate / department *(the higher the score the better)*	-	-	49%	56%
	Question: KF2. Percentage of staff agreeing that their role makes a difference to patients (*the higher the score the better)*	92%	91%	88%	91%
	Question: KF6. Percentage of staff receiving job-relevant training, learning or development in the last 12 months *(the higher the score the better)*	79%	81%	78%	81%
	Question: KF3. Work pressure felt by staff *(the lower the score the better)*	3.16	3.06	3.17	3.07
	Question: KF21. Percentage of staff reporting good communication between senior management and staff (*the higher the score the better)*	30%	29%	25%	30%

The four key areas of concern from this year's Staff Survey results are personal development and training opportunities for staff, performance appraisal, staff engagement and communication between senior management and staff. These will form the Trust's key priorities for 2015/16.

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

Summary of Actions:

- Review the provision of training to all staff, as appropriate to job role and responsibilities, in relation to health and safety; equality and diversity; violence and aggression management; and infection control.
- Undertake further work on the quality of training and its relevance to staff, particularly in relation to patient/service user experience and assisting staff to do their job more effectively.
- Check on the coverage of appraisals and reviews, particularly amongst hard to reach groups, and take steps to increase coverage and to monitor the provision of appraisals.
- Assess the way in which appraisals and reviews are conducted in order to ensure staff leave the review feeling that their work is valued by their organisation.
- Put in place specific arrangements in each work group to ensure that staff receive regular, clear feedback on how well they have performed their work, outside of the appraisal system. Ensure this is linked to planned goals and objectives.
- Review work planning and scheduling in order to reduce conflicting work demands on staff.
- Where appropriate, ensure that senior managers involve staff in important decision making processes.
- Work directly with staff to understand why some would not recommend the organisation as a place to work – and take action accordingly.
- Identify the location of spikes in violent incidents from patients and the public, by drilling down into your data where possible.
- Improve awareness of the need to report bullying and harassment in a confidential fashion

Priorities for 2015/2016

Review of Appraisal process
Review of Trust Induction and provision of training
Review of Staff Survey Provider, size of sample and accessibility for completion of survey
Three Key priorities defined for each division with quarterly review against progress
Increase response to amongst top 5 and in line with national average
Improve overall results so in line with or above national average

Friends and Family

This year also saw the introduction of the Staff Friends and Family test. This survey provides our staff with an opportunity to submit feedback regarding whether they would recommend the Trust as a place for treatment and a place of work.

Table – Staff Friends & Family Response Rate

Would you recommend the Trust as a place for treatment	Extremely Likely or Likely
Staff Friends & Family Test Quarter 1 (April – June 2014)	70%
Staff Friends & Family Test Quarter 2 (July – September 2014)	76.4%
Staff Friends & Family Test Quarter 3 (October – December 2014)	N/A
Staff Friends & Family Test Quarter 4 (January – March 2015)	80%

Equality & Diversity within the organisation

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

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

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

2.2 Our Priorities for 2015/2016

Our commitment to quality will continue through a number of priorities for 2015/2016 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 have been shared with agreement sought from the Trust Governors as patient/public representatives, Local Healthwatch Organisations and other key external stakeholders.

Priorities for 2015/2016 are summarised below and they have been set out in the NHS Outcome Framework which focuses on patient outcomes and experience. We are developing detailed plans with timescales and targets to ensure we deliver these improvement priorities.

Implementing a Safety Improvement Plan – Sign Up to Safety

Set within the strategic aims of the Quality Strategy the Trust Board has committed to ensuring quality and safety remains the focus of everything we do. As part of this commitment the Trust formally signed up to the National Sign Up to Safety Campaign.

A Safety Improvement Plan has been developed which builds on the campaign's five key pledges, below:

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.
2. Continually learn. Make our organisation more resilient to risks by acting on the feedback from patients and by constantly measuring how safe our services are.
3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patient uses.
5. Support. Help people understand why things go wrong and how to put them right.

As part of this plan a number of safety priorities have been agreed, which are aligned to the national topic areas within the Sign Up to Safety campaign. These safety priorities have clear objectives, against which we will measure progress and as such will form our priorities for 2015/16.

2015/2016 Priorities

1. **Reducing Falls - to reduce the rate of falls and avoidable harm due to falls by 20% within 3 years (2017/2018)**
2. **Reducing Pressure Ulcers - Reducing avoidable pressure ulcers to <5 per month**
3. **Management of Sepsis - Reduction of mortality from severe sepsis to 23% by 2017.**
4. **Recognition of The Deteriorating Patient - To reduce 'in hospital' cardiac arrests by 10% each year by 2018**
5. **Acute Kidney Injury - Reduction of avoidable AKI by 30% in the next two years**

2.3 Statements of Assurance

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

Information on the Review of Services

During this reporting period of 2014/2015 the Great Western Hospitals NHS Trust provided and /or sub-contracted 7 relevant health services.

The Trust has reviewed all the relevant data available to them on the quality of care in all of these services through its performance management framework and quality governance processes.

The income generated by the relevant health services reviewed in 2014/2015 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2014/2015.

Participation in Clinical Audits

During 2014/2015, 34 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that The Great Western Hospitals NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that The Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2014/2015 are as follows:

The national clinical audits and national confidential enquiries that The Great Western Hospitals NHS Foundation Trust participated in and for which data collection was completed during 2014/2015 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits		Participated	% Data Submission
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Data collection/submission still in progress
2	Adult Community Acquired Pneumonia	Yes	Data collection/submission still in progress
3	British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	NA	NA

4	Bowel cancer (NBOCAP)	Yes	100%
5	Cardiac Rhythm Management (CRM)	Yes	Data collection/submission still in progress
6	Case Mix Programme (CMP)	Yes	Data colle7ction/submission still i8n progress
7	Chronic Kidney Disease in primary care	NA	9NA
8	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	NA	10NA
9	Coronary Angioplasty/National Audit of PCI	Yes	Data collection/submission still in progress
10	Diabetes (Adult)	NA	No Data Collection required during 14/15
11	Diabetes (Paediatric) (NPDA)	Yes	100%
12	Elective surgery (National PROMs Programme)	Yes	Data collection/submission still in progress
13	Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
14	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
15	Fitting child (care in emergency departments)	Yes	100%
16	Head and neck oncology (DAHNO)	Yes	100%
17	Inflammatory Bowel Disease (IBD) programme	Yes	Data collection/submission still in progress
18	Lung cancer (NLCA)	Yes	100%
19	Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%
20	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
21	Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Data collection/submission still in progress
22	Mental health (care in emergency departments)	Yes	100%
23	National Adult Cardiac Surgery Audit	NA	NA
24	National Audit of Dementia	NA	National Audit did not proceed during 14/15
25	National Audit of Intermediate Care	Yes	100%
26	National Cardiac Arrest Audit (NCAA)	Yes	100%
27	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	NA	NA
28	National Comparative Audit of Blood Transfusion programme	Yes	100%
29	National Emergency Laparotomy Audit (NELA)	Yes	Data collection/submission still in progress
30	National Heart Failure Audit	Yes	Data collection/submission still in progress
31	National Joint Registry (NJR)	Yes	Data collection/submission still in progress
32	National Ophthalmology Audit	NA	National Audit did not commence
33	National Prostate Cancer Audit	Yes	Data collection/submission still in progress
34	National Vascular Registry	NA	NA

35	Neonatal Intensive and Special Care (NNAP)	Yes	100% (missing information which is being inputted by 2nd March 2015)
36	Non-Invasive Ventilation - adults	NA	National Audit did not commence
37	Oesophago-gastric cancer (NAOGC)	Yes	Data collection/submission still in progress
38	Older people (care in emergency departments)	Yes	100%
39	Paediatric Intensive Care Audit Network (PICA Net)	NA	NA
40	Pleural Procedure	Yes	100%
41	Prescribing Observatory for Mental Health (POMH)	NA	NA
42	Renal replacement therapy (Renal Registry)	Yes	100%
43	Pulmonary Hypertension (Pulmonary Hypertension Audit)	NA	NA
44	Rheumatoid and Early Inflammatory Arthritis	Yes	Data collection/submission still in progress
45	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection/submission still in progress
46	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection/submission still in progress
47	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection/submission still in progress
48	Specialist rehabilitation for patients with complex needs	NA	National Audit did not commence

Confidential enquiries			
1	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Sepsis	Yes	100%
2	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Acute Pancreatitis	Yes	Data collection/submission still in progress
3	Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NA	NA
4	Child health clinical outcome review programme (CHR-UK)	Yes	100%
5	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%

The reports of 20 national clinical audits were reviewed by the provider in 2014/2015 and The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- For Diabetes inpatient care - Collaborative working with the catering services to review and improve the menu choices available for diabetic inpatients. Promote the profile of the podiatry services and review the training and education provided for staff; with a view of incorporating this within mandatory training.

- Improve the provision of Stroke services within the Integrated Community Health Division, improved involvement of specialist therapies (physiotherapy and speech and language) and improved screening, reviews and multidisciplinary rehabilitation goals.
- There are improvements to be made in the pathway for women with heavy menstrual bleeding by having appropriate treatment being undertaken in both primary and secondary care. The pathways will be revised as required to support the guidelines, which will be done collaboratively with all the appropriate teams.
- For the management of asthma in children, it has been agreed to implement a patient information leaflet for 'wheezy' children which will be provided on discharge, furthermore, a 'discharge sticker' to place on the front of the patient notes will help prompt effective discharge advice.
- There are proposed plans to review the current cardiac rehabilitation services; looking at all the relevant stages of the patient pathway to ensure all standards and core components are fully met, this will ensure patients attending cardiac rehabilitation are fully supported and thereby reducing the risk of associated readmission.
- There are plans to increase the capacity of the epilepsy service in order to support patients with chronic epilepsy and who frequently attend the emergency department. The development of care plans, and improvements in the referral process to the alcohol liaison services will help prevent recurrent emergency attendances and reduce the need for admission.
- There is to be an appointment of a designated, named, clinical lead for asthma services, who will be responsible for formal training in the management of acute asthma. Planned improvements for patients who have attended the emergency department two or more times with an asthma attack in the previous 12 months are to have a follow-up appointment after every attendance at an emergency department (or out-of hour's service) and follow-up care to be arranged after every hospital admission for asthma.

The reports of 46 local clinical audits were reviewed by the provider in 2014/2015 and The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

- **Community Patients have an Estimated Date of Discharge (EDD) in their care plans (4th Re-audit):** To ensure the estimated date of discharge (EDD) as set within 24hours of admission, to ensure the EDD was recorded on the contact assessment page within the patient notes, to ensure a MDT/Nursing Team meeting has discussed the appropriate options to timely discharge.
- **Treatment of Hypoglycaemia:** The results from this audit identified the need to update current hypoglycaemia protocol to ensure it is in line with the new national guidelines.
- **Counting of Swabs/Needles/Tampons Before and After Perineal Suturing (4th Re-Audit - March 2014):** Weekly spot check, swab audits and monthly reporting to continue to ensure improved practice continues. Any non-compliance found on spot check to be reported to Department Manager and/or supervisor so further training support can be given.
- **WHO Safety Checklist – Cardiology June/July 2014:** Improve documentation to avoid misinterpretation to the various questions that are sometimes not applicable to the procedure or the patient's recovery; adapt current form and implement a checklist for specific procedures. The audit results were disseminated to the Cardiology department to highlight the areas of non-compliance and address the improvements required.
- **Audit of the management and documentation of gram negative bacteraemias:** Sepsis 6 charts are to be completed within the trust. Improve adherence to the Sepsis 6 protocol and monitor by the Trust's sepsis nurse; Monitor gram negative organism's resistance pattern over 6 months to ensure that empirical sepsis antibiotic protocol appropriate.
- **NICE CG149 Antibiotics for early-onset neonatal infection:** Advice letters for parents to be made available on the postnatal wards. A tick box is to be developed within the documentation to indicate when parents have been provided with a letter at discharge and to ensure they fully understand the information. Actions also include developing a discharge summary on babies at discharge through the BADGER system (neonatal/patient administration system).

- **Mortality Reviews Q1 - 2014/2015:** Actions include, all patients having their Resuscitation Status reviewed on admission and when their condition changes (improves or deteriorates). The quality of documentation is to be monitored by spot checks/audit as part of the 'walkabout'.

Research & Development (R&D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2014/2015, that were recruited during that period to participate in research approved by a research ethics committee was 934 to end March 2015.

We currently have 85 actively recruiting Department of Health endorsed (portfolio) research projects. 1.5% of these are straight forward Band 1 studies with 52% being the more complex Band 2 studies and 23.5% are highly complex Band 3 studies. 23% of studies are commercially sponsored.
In addition to these tasks the focus has changed to incorporate more in depth support to recruitment of on-going studies. We are also focusing on ensuring we recruit the number of patients we agreed to recruit, in the timescales given.

Progress continues to be made across the Trust to promote further research activity. We now have 3.5 Trust-Wide Research Nurses who oversee research in key areas such as Obstetrics and Gynaecology and Cardiology and work to actively engage new areas in research. We also have a new research nurse in the Emergency Department.

Commercially funded research has grown within the Trust with research posts continuing to be funded from this income. This money will also be used moving forward to cover any excess treatment costs incurred from important studies we feel we should participate in.

With funding received from the Department of Health through our Local Clinical Research Network (LCRN), R&D have been able to continue funding key research posts across the Trust in Cancer, Rheumatology, Dermatology and Orthopaedics. 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 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

Use of the CQUIN payment framework

A proportion of The Great Western Hospitals NHS Foundation Trust's income in 2014/2015 was conditional on achieving quality improvement and innovation goals agreed between The Great Western Hospitals NHS Foundation Trust and the agreements and contracts for the provision of NHS services, through the Swindon and Wiltshire Clinical Commissioning Groups for Quality and Innovation payment framework.

Further details on the agreed goals for 2014/2015 and the following twelve month period are available electronically by request

The monetary total for the amount of income in 2014/2015 is conditional upon achieving Quality Improvement and Innovation Goals, and a monetary total for the associated payment in 2014/2015 is summarised in the table below.

Financial Summary of CQUIN						
	Plan	Actual	%	Plan	Actual	%
	2013-2014			2014-2015		
TOTAL CQUIN	£5366	£4353	81%	£5,722	£4,505	78.72%

Registration with Care Quality Commission and Periodic/Special Reviews

Care Quality Commission Registration

An extensive review of our CQC registration was undertaken across the acute and community sites in June 2014 to ensure that our CQC registration is adequate for the regulated activities undertaken across the sites.

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

The Care Quality Commission has not taken enforcement action against The Great Western Hospital during 2014/2015.

Periodic/Special Reviews 2014/2015

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

Due to the new CQC Inspection Process there has not been a further GWH CQC New Style Inspection as yet. The last CQC Unannounced Inspection at the GWH Site took place in October 2013 for which there are no outstanding actions.

CQC Intelligence Monitoring Tool (IMT) Report

In October 2013 the Trust received its first quarterly CQC Hospital Intelligent Monitoring Report which incorporated 84 out of the 118 surveillance indicators and were assigned a Band 3 Trust summary banding. The indicators reviewed relate to the five key domains asked of all services (safe, effective, caring, responsive and well-led).

An overall summary risk banding of 1 to 6 is given to the Trust, with band 1 representing highest risk and band 6 with the lowest. These bands have been assigned based on the proportion of indicators that have been identified as ‘risk’ or ‘elevated risk’, if there are known serious concerns (e.g. trusts in special measures) trusts are categorised as band 1.

Since the report was published the Trust has received a total of four CQC IMT reports which has highlighted various risks (see the table below).

From October 2013 to October 2014, we have been rated as follows:

Indicator category	CQC KLOE (safe, effectiveness, caring, responsive or well led)	Key Risk Indicators	CQC Report October 2013	CQC Report March 2014	CQC Report June 2014	CQC Report October 2014

Banding 1 = High Risk (worst) to 6 = Low Risk (best)	N/A	3	6	3	5

All risks highlighted within the CQC IMT Report have been investigated; reported on and if appropriate have been put on the risk register.

During May 2015 the CQC published their latest Intelligent Monitoring Tool, in which the Trust was rated as Band 2. This report is being reviewed by the Trust with an action plan being drawn up. This will be monitored throughout the coming year and acted upon as required.

Patient Reported Outcome Measures (PROMs)

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

Our PROMS report shows that there has been a reduction in the overall scores for 2014/2015 in all areas but particularly for groin hernia surgery and hip replacement surgery. The Great Western Hospitals NHS Foundation Trust will take the following actions to improve this percentage, and so the quality of its services by the Planned Care Division reviewing the data to understand why there has been such a reduction in patient reported outcomes. We will review our services, patient pathways and our own patient experience data to understand what further investigation is required, in order to fully understand this drop in standards.

Data Quality

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

The Great Western Hospitals NHS Foundation Trust submitted records during 2014/2015 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:

- 99.2% for admitted patient care
- 99.3% for outpatient care
- 95.2% 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 Information Department is working to ensure improvement with this.

Also included the patient's valid General Practitioner Registration Code this was:
99.9% for admitted patient care
99.9% for outpatient care
99.5% for accident and emergency care.

The Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall rating for 2014/2015 was **"Satisfactory 77%"**

The 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. The Trust Data Quality Group has increased the Operational Division's representation and is re-focussing on how it can provide support for operational staff to improve data quality.
- The actions from internal and external audits and benchmark reports associated with data quality will be reviewed by the Data Quality Group and acted on and monitored by the Trust Data Quality Group where appropriate.
- Data quality reports and issues raised by Commissioners will be reviewed and any required action taken.
- Training programmes associated with the implementation of the new Medway PAS have allowed a general refresher training of users and training will continue as the system is implemented and upgraded during the year.
- Development of refresher training programmes for staff involved in data collection and data entry will continue.

Information Governance Tool Kit Attainment Levels

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information. There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

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

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

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the HSCIC Information Governance Toolkit. 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 2014/2015 was 77% and was graded Satisfactory ('green'), with a satisfactory rating in every heading of the Information Governance Toolkit.

Clinical Coding Error Rate

Explanatory Note of Clinical Coding

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

The Great Western Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
PbR Audit Commission	95.0%	91.2%	93.8%	89.3%

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

Great Western Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period as part of the national Data Assurance Framework. However an Information Governance coding audit was undertaken, the error rates reported in this latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
Information Governance- External auditors	94.0%	89.3%	90.4%	81.8%

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

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

- Day surgery
- Endoscopy
- ENT
- General Medicine
- General Surgery
- Paediatrics

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

2.4 Reporting against Core Indicators

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	MRSA Bed Days as well *provisional as at 02/05/14	3	2	2	5	2	0.96*	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.*Diff*	40	17	33	23	19* *combined previously acute/ community split	Not applicable	Zero is aspirational	Low-0; High-121	IP&C	National definition
	C.Diff 100,000 bed days*	20.1*	7.3*	13.4*	12.5*	9.60	15.03	Lower is better	Regionally Low:7.46 High: 24.19	HPA	National Definition
2 - Patient Falls in Hospital resulting in severe harm		15	17	16	23	16	Not available	Low number is excellent		IR1's	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers		40	31	28	28 (Category III & Category IV)	51 (Category III & Category IV)	4% incidence	Low number is better	--	IR1's	National Definition (from Hospital database)
4 – Percentage of VTE Risk Assessments completed		85.1%	92.7%	95.3%	95.5%	97.1%	90%	Higher number better	Low - 91.3; High - 100	Crescendo nursing care plan and manual data collection from LAMU, Day Surgery, and ICU	National Definition (from Hospital database)
5 – Percentage of patients who receive appropriate VTE Prophylaxis		90% (No audit for Surgical actioned in Q2 & Q3 therefore YTD based on Medical only)	94.5%	93.9% (Apr-Oct)	95%	91.6%	N/A	Higher number better	--	One day each month whole ward audit for one surgical ward and one medical ward	National Definition (from Hospital database)

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
6 – Never Events that occurred in the Trust		0	3	3	4	2	**NHS England** 2014-15 Average 2.16	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA
7 – Mortality Rate (HSMR)	HSMR	97.9	106.2	91.8	97.3	90.3	100	Lower than 100 is good	Low -74.2; High - 128.8	Dr Foster	National NHS Information Centre
8 – Early Management of Deteriorating Patients - % compliance with Early Warning Score	Early Warning Score (Adults)	93% GWH only	96% GWH only	91%	95% (April – Dec (9 months)	90%	Not available	Higher number is better	--	Audit	Audit criteria (50 patients per month)
	Paediatric Early Warning Score (Children)	--	--	74.2%	87.75%	92.25% (Average yearly compliance)	Not applicable	Higher number is better	--	Audit	Audit criteria (5 patients per month)
10 – Percentage of Nutritional Risk Assessments	Using MUST	70% Acute only	87.8% Combined	84%	82%	81%	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?		48.1%	46.9%	51%	53.2%	51.4%	54.8%	Higher is better	Low: 6.1 High: 9.2 GWH: 7.1	Picker Survey	National definition
12 – Did you find someone on the hospital staff to talk to about your worries and fears?		23%	22.5%	37%	37.1%	28.6%	38.4%	Higher is better	Low: 4.3 High: 8.2 GWH: 4.9	Picker Survey	National definition
13 – Were you given enough privacy when discussing your conditions or treatment?		68.5%	66.8%	73%	70.8%	74.2%	72.7%	Higher is better	Low: 7.5 High: 9.4 GWH: 8.5	Picker Survey	National definition
14 – Did a member of staff tell you about medication side effects to watch for when you went home?		22.9%	24.3%	30%	33.7%	32.1%	40%	Higher is better	Low: 3.7 High: 7.6 GWH: 4.3	Picker Survey	National definition
15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?		65.6%	66.6%	67%	67.2%	66.2%	69.8%	Higher is better	Low: 6.4 High: 9.7 GWH: 7.6	Picker Survey	National definition
16 – Patient Reported Outcome Measures (Average Health Gain [score])	Varicose Vein surgery	--	--	100%	100%	90.9%	80%	Higher is better	Not available (more than one Contractor for this service)	DoH/HSCIC	National Definition
	Groin Hernia surgery	--	--	96.9%	100%	57.6%	80%	Higher is better		DoH/HSCIC	National Definition
	Hip Replacement surgery (Oxford Hip Score)	--	--	96%	98.5%	61.5%	80%	Higher is better		DoH/HSCIC	National Definition
	Knee Replacement Surgery (Oxford Knee Score)	--	--	95.6%	97%	94.4%	80%	Higher is better		DoH/HSCIC	National Definition

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
17 – Readmissions – 30 days		n/a	7.4%	8.1%	7.9%	9.4%	Local target (7.1%)	Lower is better	--		National Definition
18 – Readmissions – 28 days		6.9%	7.3%	7.9%	7.7%	9.2%	SW Region 6.9%	Lower is better	Low: 5.12; High:10.91	Dr Foster	Dr Foster
18 – Re-admissions 28 days Ages 0-15 Ages 16+					9% 7.5%	8.5% 9.2%		Lower is better	0-15 yrs: Low: 0.8; High: 15.8 16+ yrs: Low: 5.0; High: 11.1	Dr Foster	Dr Foster
19 - SHMI – The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the trust for the reporting period		22.5%	20.6%	18.4%	26.0%	26.5%	25.3%	Lower is better	Low:0; High: 49.4	HSCIC	National Definition
20 - The number and where available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death	Number of Incidents per 100 Bed Days	3.32	4.05	4.22	4.55	4.98	--	Lower is better	--	Informatics & Clinical Risk	
	Number of Patient Safety Incidents per 100 Bed Days	2.45	2.93	3.13	3.00	3.07	--	Lower is better	--	Informatics & Clinical Risk	
	Number of Incidents resulting in Severe Harm or Death per 100 Bed Days	0.03	0.04	0.04	0.03	0.04	--	Lower is better	--	Informatics & Clinical Risk	
	Percentage of Combined Severe Harm and Death	0.93%	1.08%	0.85%	0.56%	0.80%	--	Lower is better	--	Informatics & Clinical Risk	

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

PART THREE

3.1 Other Information

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

Performance against Key National Priorities

An overview of performance in 2014/2015 against the key national priorities from the Department of Health's Operating Framework is set out below. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2010/2011 GWH	2011/2012 Trust	2012/2013 Trust	2013/2014 Trust	2014/2015 Trust	2014/2015 Target	Achieved/ Not Met
Clostridium Difficile - meeting the *Clostridium Difficile* objective	40	19	33	23	17 Acute 19 All	28 or less (Acute)	Achieved
MRSA - meeting the MRSA objective	3	2	2	5	2	0 or less Contract Monitor de minimis 6	Monitor de minimis achieved
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	98.5%	98.4%	98.4%	98.4%	99.0	94.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	100%	100%	100%	100%	99.7	98.0%	Achieved
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	92.4%	89.3%	90.0%	89.0%	88.4	85.0%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	100%	98.4%	96.2%	98.9%	98.4	90.0%	Achieved
Cancer 31 day wait from diagnosis to first treatment	99.0%	98.7%	98.1%	98.8%	98.6	96.0%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	97.0%	97.1%	95.3%	94.7%	94.0	93.0%	Achieved

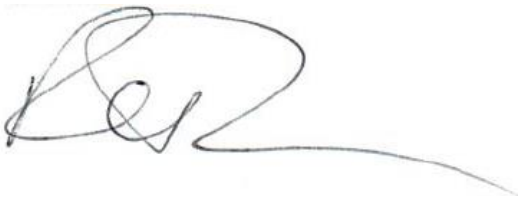
Indicator	2010/2011 GWH	2011/2012 Trust	2012/2013 Trust	2013/2014 Trust	2014/2015 Trust	2014/2015 Target	Achieved/ Not Met
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	97.2%	97.1%	96.0%	95.6%	96.8	93.0%	Achieved
Maximum time of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

Statement from the Council of Governors dated 27 May 2015

In the opinion of Governors, the Quality Account represents a fair reflection of the information received by governors over the year on the Trust's performance. The Governors have acknowledged that the Trust did not achieve the 95% target for a maximum waiting time of 4 hours in A&E (91.9% against a target of 95%) and Referral to Treatment Times, but are satisfied with the efforts being undertaken towards addressing these and note that the Trust's performance is not dissimilar to many other Trusts.

The Governors noted that the Trust has experienced an increase in attendance in A&E compared with last year and this undoubtedly impacted on the performance indicators.

The Trust has made a number of achievements as set out in the Quality Account, notably around infection control and cancer waits. In addition other achievements which contribute towards improved patient experience, clinical outcome and patient care are noted by the Governors.



Ros Thomson
Lead Governor on behalf of the Council of Governors

Statement from Swindon Clinical Commissioning Group dated 27 May 2015

NHS Swindon Clinical Commissioning Group (CCG) has reviewed the information provided by Great Western Hospital NHS Foundation Trust in its 2014-2015 Quality Account. In so far as we have been able to check the factual details, our view is that the Quality Account is materially accurate and is presented in the format required by the NHS England 2014/2015 Presentation Guidance.

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, as set out within the three quality domains of safe care, effective care and patient experience.

Safe Care

Swindon CCG fully supports the Trust's commitment to ensuring quality and safety of care is at the heart of everything it does. During 2014/15 a number of quality improvement initiatives aimed at preventing avoidable harm and improving quality of life have been successfully implemented, with key achievements noted in the reduction of mortality rates and reduction in the incidence of *clostridium difficile* infections, falls and pressure ulcers. There has also been a noted improvement in the number of patients receiving appropriate VTE assessments.

Following the key successes demonstrated in 2014/15, the CCG notes the five priorities identified within the Trust's safety improvement plan for 2015/16, which builds on the national Sign Up to Safety Campaign's five key pledges. A continued focus on reducing falls and pressure ulcers is welcomed, together with ensuring further improvements in the care and management of patients with a diagnosis of sepsis and acute kidney injury. These key priorities are also being driven by national CQUINs during 2015/16, and the CCG will continue to work collaboratively with the Trust in order to improve patient care and ensure better outcomes.

Effective Care

A skilled workforce with robust leadership is key to delivering services safely and effectively. In response to the 2014/15 staff survey, Swindon CCG notes the challenges in relation to available workforce and the continued need to focus on recruitment and retention of staff. Therefore in 2015-2016, a continued emphasis will be placed on monitoring medical, nursing, midwifery and other clinical skill mixes in light of the impact that staff shortages have on patient experience, safety and outcomes.

During 2014/15 the CCG continued to monitor the Trusts ability to deliver an effective stroke care service. This included the need for appropriate patients to be admitted directly to the dedicated stroke ward (Falcon Ward). As illustrated within the quality account the CCG notes the challenges experienced due to bed pressures and will continue to work with the Trust in order to resolve issues and improve care for patients.

Provision of high quality care for people with a diagnosis of dementia is a key priority for the CCG. Given the ageing population and increasing numbers of people with a diagnosis of dementia, the CCG commends the good progress made with regards to dementia care within the Trust, including the investment in staff training and creation of a dementia friendly ward. Ensuring an understanding of these interventions, including an improvement in reported patient outcomes, remains a key priority in 2015/16.

Patient Experience

The Trust has set out a number of feedback mechanisms aimed at collating patient experience feedback. The CCG is pleased to note the increase in uptake of the Friends and Family Test which reflects how well patients and service users rate the quality of services. However, the results of the annual inpatient survey has allowed the Trust to identify areas for improvement and the CCG welcomes the Trust's approach to ensuring this work stream is a priority for 2015/16.

Monitoring in regards to equality and diversity and patient engagement across the nine protected characteristics will also be a focus in the coming year; to reflect both new statutory requirements and NHS Swindon Clinical Commissioning Group's objectives to promote inclusion and monitoring of actions as required.

We welcome the Trust's focus for 2015/16 as set out in the identified priorities aimed at improving safe, effective care that improves patient experience. Going forward, the CCG will also be seeking assurance against the achievements of the conversation project; aimed at improving engagement and care for patients at the end of their life. This builds on the work already implemented as part of CQUIN during 2014/15. In line with national guidance, the CCG will also monitor the Trust's Safeguarding Children action plan, developed in recognition of the need to increase uptake of level 2 and 3 safeguarding training for all relevant staff.

Swindon CCG is committed to ensuring continued collaborative working with Great Western Hospitals NHS Foundation Trust in order to achieve these goals and support the provision of high quality care across the whole health and social care economy.

Gill May
Executive Nurse
NHS Swindon CCG

Dr Peter Mack
Clinical Vice Chair
NHS Swindon CCG

Statement from Wiltshire Clinical Commissioning Group dated 27 May 2015

NHS Wiltshire Clinical Commissioning Group has reviewed the 2014/2015 Quality Account provided by Great Western Hospital NHS Foundation Trust. In doing so, we have reviewed the factual details and our view is that the report is materially accurate and is presented in the format required by the NHS England 2014/2015 Presentation Guidance. This information supports key quality indicators and assurances sought at monthly Clinical Quality Review Meetings. Our contract covers two key areas: Acute services and Community services in Wiltshire. The trust also provided community maternity services for April and May 2014, prior to transfer to another provider. Although this report contains intelligence related to community services, the predominant area of focus is on the inpatient services at Great Western Hospital.

The Trust has embraced the national Sign up to Safety pledges, focusing on five identified areas. The CCG is supportive of the priorities and are keen to see improvements in all areas, specifically pressure ulcer prevention in the community, which the CCG are supporting through a local CQUIN scheme for 2015/2016. In addition, Sepsis and Acute Kidney Injury have been identified as national priorities and are also included as a national CQUIN scheme across acute providers.

The CCG acknowledge that during 2014/2015 the trust have reported challenges in recruitment and staffing levels. Therefore, continued emphasis will be placed on monitoring safer staffing levels, clinical skill mix and the impact that staff shortages have on patient

safety and experience. In addition, the CCG notes the importance of exit interviews and will continue to seek and review assurance with regards to staff and patient feedback.

The CCG recognises the challenges in demand faced by the trust, but welcomes the commitment to continue to prioritise access for stroke patients to the specialist ward. The CCG will continue to monitor this and other important stroke indicators, looking for significant improvement through the SSNAP audits and trust improvement plan.

The CCG support the actions that the trust has highlighted in relation to preventing re-admissions for inpatients and patients in the community. This will be further strengthened through the implementation of the 2015/2016 avoidable admissions CQUIN scheme.

Over the next year, the CCG look forward to supporting the trust to further explore trust wide learning and embed improvements from safety incidents, patient contacts and complaints and the development of ambulatory care services.

The CCG will increase the frequency of Quality Assurance visits to the trust to enable the trust to showcase improvements and identify areas on which to focus improvements and embed learning trust wide.

Deborah Fielding
Chief Officer
NHS Wiltshire Clinical Commissioning Group

Statement from Swindon Health Overview & Scrutiny Committee dated 26 May 2015

The Swindon Health, Adult and Children's Services Overview & Scrutiny Committee is encouraged by the work that is already being undertaken to improve services for quality improvement.

The Health, Adult and Children's Services 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 2014/15. The Committee welcomes attendance and regular reporting at its committee meetings and hopes that this will continue throughout 2015/16.

The Committee 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, Scrutiny Officer
On behalf of the Chair of the Health, Adults and Children's Services Overview & Scrutiny Committee

Statement from Wiltshire Overview & Scrutiny Committee dated 27 May 2015

Wiltshire Council Health Select Committee Response to the Great Western Hospital Quality Account 2014/15

The Wiltshire Council Health Select Committee would like to thank the Great Western Hospital for readily communicating and attending meetings as appropriate, this has proved to be most useful.

The Committee wish to highlight that it is felt that GWH have identified too many priorities which could be detrimental to their success and achievement of targets.

The areas that were identified in the Quality Account for improvement are supported by the Committee as key areas that require due care and attention in order to achieve sufficient improvements for patients. However, the Committee would like to highlight the following issues and concerns:

- The number of falls that resulted in severe harm to a patient went from 13 last year to 15 this year, however it is noted that the number of deaths from such falls were reduced from 2 to 0;
- The target for preventing pressure ulcers and in particular the escalation of the severity of ulcers has not been achieved;
- Further improvements are required to ensure better results in the national inpatient survey, it is commended that GWH strives to provide care that patients and staff would want to receive themselves and recommend to others. It is noted that the results of the staff survey were much poorer resulting in GWH falling by 8 places in the ranking system;
- A focus on improving mortality ratios is certainly deemed appropriate
- It is commended that a new complaints system has been put in place, the Committee wish to emphasise the importance of the patient voice.

The Committee noted that there have been only 2 cases of MRSA and a reduction in the number of cases of C. difficile as well as good results from the sepsis 6 campaign enabling 70 lives to be saved.

The Committee is concerned that the Quality Account reports only 2 never events for the period when it has previously been listed as 4, it is said that this is due 2 occurring in maternity services which have been awarded to the Royal United Hospital.
Concern was also raised in respect of an increase of 28 additional serious incidents from last year.

Finally, the Committee wish to congratulate GWH on the opening of their dementia friendly ward in November last year. This work is highly commended by the Committee and was endorsed by the Review of Dementia Services Task Group who did detailed work on the topic.

Adam Brown
Democratic Services Officer for the Health Select Committee

Statement from Healthwatch, Bath and North East Somerset, Healthwatch Swindon and Healthwatch Wiltshire dated 22nd May 2015.

This statement is provided on behalf of the local Healthwatch organisations that exist in the areas in which the Great Western Hospital Foundation Trust operates or serves. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment.

During the past year, we have continued to work with the trust to ensure that patients and the wider community are appropriately involved in providing feedback and that feedback is taken seriously by the trust. As well as being represented at a number of its forums, we welcomed the opportunity to co-host listening events in Swindon and Wiltshire and look forward to supporting further activities throughout the coming year.

We acknowledge the progress made against the priorities identified for improvement last year but note that there are still a higher number than average falls both in the acute and community ward setting and, although it is reassuring to see that there is a downward trend in the acute setting, no such trend is as yet occurring in the community setting. In addition to this, whilst we recognise the impact of initiatives such as the Fall Safe Operational Group, we would welcome expanded insight into the learning's made and outcomes of the initiatives to reassure the public and patients, particularly as the figures for severe harm from falls has not improved since last year (in the acute setting).

Similarly with Pressure ulcers, although improvements have been made, further work is required to achieve consistently low numbers of healthcare acquired pressure ulcers particularly in the community setting.

We do recognise that a number of actions and new initiatives have been put in place and welcome the introduction of further initiatives, which we hope brings about improvements for patients. We will be closely monitoring the situation over the coming year and glad to see that the trust continues to prioritise on reducing falls and reducing pressure ulcers.

We welcome all of the work that is being done in respect of improving care for patients who have dementia and their relatives and carers. In particular, the opening of the first dementia friendly ward in November 2014 and the introduction of a whole hospital dementia pathway from admission to discharge that aims to ensure continuity of care for patients between the hospital and community settings.

In addition, we applaud the increased focus on carers through their representation on the dementia strategy group and the Jupiter Dementia project to explore learning for inpatients with dementia to receive appropriate nutrition and hydration care. We will be interested to understand patient and family experiences of these initiatives and how learning will be shared across the organisation.

We note that the prevalence of malnutrition at GWH is 39% (similar to national figures) but recognise that the patients' poor nutritional status occurs largely before admission. We therefore applaud the introduction of nutritional screening across the community areas (community hospitals, by community teams and in care homes). We hope that this action impacts positively on malnutrition rates, particularly in community settings and therefore on patient care. We continue to receive feedback regarding inpatient mealtimes experience and welcome the invite to be involved in the Nutrition and Hydration Steering Group as a platform to raise these concerns.

We welcome the introduction of champions for the Friends and Family Test throughout the trust and are pleased to see that the Trust has achieved and maintained a consistent standard throughout the year. It would be beneficial to know the percentage of responses received to understand any requirement and initiatives to increase the completion rate. We are also encouraged to note that the Trust plan to fully engage with children and young people on their overall patient experience.

Although some results from the national patient survey show that patients rate their experiences highly, it is concerning to see that only 28.6% of patients responded 'yes definitely', to the question 'did you find someone on the hospital staff to talk to about your worries and fears?' We are therefore glad to see that a trust-wide action plan to address the areas within the national inpatient survey that require improvement, is part of an agreed improvement plan for the coming year.

Patient experience is key and we were pleased to see a review of a new complaints procedure during 2014. However our own work on complaints and direct feedback suggests that further work needs to be done around the complaints procedure to raise awareness and make it easier for patients to understand and request support without fear of impact on current or future heath care.

We are concerned to see that the patient reported outcomes measures that look at perceived improvements in a patient's condition post-surgery have dropped in all measured areas but particularly for groin hernia surgery and total hip replacement surgery. We would like to see an improvement over the coming year and will be monitoring the situation.

Considering the crucial role that staff play in the patient experience, it is also a concern that there are some downward trends in results of the national staff survey, especially the reduction in response rate. This may be expected given the difficult year that the Trust has experienced and we note key areas for improvement have been identified and prioritised and hope that improvements in these area will impact positively on patient care.

We acknowledge the Care Quality Commission (CQC) summary and note that the CQC undertook an extensive review of the Trust's registration, which revealed gaps. We see that the Trust have now notified the CQC of the variations required to current registered sites and is awaiting revised registration from the CQC.

We are aware that the Trust has had a challenging year both financially and in terms of meeting national targets for patient care. We note the efforts made by the trust to improve this situation but feel that there is still more to be done if the Trust is to achieve its targets. We very much hope that the work that is being done impacts positively on patient care over the coming year. We will be closely monitoring the progress of the Trust and will continue to raise concerns should we feel that the quality of patient care is being compromised.

Pete Rowe
Manager
Healthwatch Swindon

On behalf of:

healthwatch Bath and North East Somerset
healthwatch Swindon
healthwatch Wiltshire

2014/2015 Statement of Directors' Responsibilities in Respect on the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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:

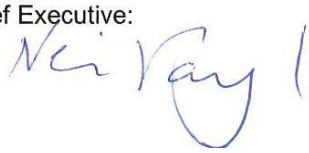
- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual;*
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to 27 May 2015;
    - Papers relating to Quality reported to the Board over the period April 2014 to 27 May 2015;
    - Feedback from the Swindon Clinical Commissioning Group dated 27 May 2015;
    - Feedback from the Wiltshire Clinical Commissioning Group dated 27 May 2015;
    - Feedback from Governors – dated 27 May 2015;
    - Feedback from Swindon Healthwatch dated 22 May 2015;
    - Feedback from Wiltshire Healthwatch dated 22 May 2015;
    - Feedback from Bath & North East Somerset Healthwatch dated 22 May 2015;
    - Feedback from Swindon Overview & Scrutiny Committee dated 26 May 2015;
    - Feedback from Wiltshire Overview & Scrutiny Committee dated 27 May 2015
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Trust Board monthly;
    - The September 2014 national patient survey dated February 2015;
    - The 2014 national staff survey dated October 2015;
    - The Head of Internal Audit's annual opinion covering the 2014/2015 period;
    - Care Quality Commission Intelligent Monitoring tools from April 2014 to April 2015

- 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 Account 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/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report

By order of the Board

Chairman:  Date 27 May 2015

Chief Executive:  Date 27 May 2015

Independent Auditors report to the Council of Governors of Great Western Hospital NHS Foundation Trust, on the Annual 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 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways ("Referral to Treatment – incomplete pathways"); and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers ("62 day cancer waits").

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 2014/15 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2014 to May 2015;

- Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
- Feedback from the Commissioners dated May 2015;
- Feedback from Governors dated May 2015;
- Feedback from local Healthwatch organisations dated May 2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Trust Board monthly;
- The 2014/15 national patient survey dated February 2015;
- The 2014/15 national staff survey dated October 2014;
- Care Quality Commission intelligent monitoring reports 2014/15; and
- The 2014/15 Head of Internal Audit's annual opinion over the Trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the 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; and
- reading the documents.

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

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

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

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

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 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the "62 day cancer waits" indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We identified weaknesses in the design of the control environment in regard to the "referral to treatment – incomplete pathways" indicator. As a result of our testing of this indicator we also identified data errors, where data included within the indicator could not be agreed to supporting patient records. As a result we are not able to issue a limited assurance opinion in respect of the "referral to treatment – incomplete pathways" indicator.

Jonathan Brown
KPMG LLP
100 Temple Street
Bristol
BS1 6AG
28 May 2015

Glossary of Terms

A&E/ED	Accident & Emergency/Emergency Department
C.diff	Clostridium Difficile
CAUTIs	Catheter Associated Urinary Tract Infections
CCG	Clinical Commissioning Groups
CLRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Clinical Quality & Innovation
Crescendo	An NHS IT system
DVT	Deep Vein Thrombosis
E&D	Equality & Diversity
EDD	Estimated Date of Discharge
EPMA	Electronic Prescribing and Medicine Administration
FFT	Friends and Family Test
GWH	Great Western Hospitals NHS Foundation Trust
HAT	Hospital Acquired Thrombosis
HPA	Health Protection Agency – now NHS England
HSCIC	Health & Social Care Information Centre
HSMR	Hospital Standardised Mortality Rates
ICHD	Integrated Community Health Division
IP&C	Infection, Prevention & Control
KLOE	Key Lines of Enquiry
LCRN	Local Clinical Research Network
LOS	Length of stay
LSCB	Local Safeguarding Children's Board
Monitor	The NHS Foundation Trusts Regulator
MRSA or MRSAB	Meticillin-Resistant Staphylococcus Aureus Bacteraemia
MUST	Malnutrition Universal Screening Tool
NEWS	National Early Warning System
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NRLSA	National Reporting & Learning System Agency
PbR	Payment by Results
PROMS	Patient Reported Outcome Measures
PURAT	Pressure Ulcer Risk Assessment Tool
R&D	Research & Development
RCA	Root Cause Analysis (analyses)
RCA	Root Cause Analysis
RR	Relative Risk
SAFE	Stratification and Avoidance of Falls
SEQOL	Social Enterprise Quality of Life
SHMI	Summary Hospital Level Mortality Indicator
SOPs	Standard Operating Procedures
SOS	Swindon Outreach Scoring System
SSNAP	Sentinel Stroke National Audit Programme
TV	Tissue Viability
TVNC	Tissue Viability Nurse Consultant
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WHO	World Health Organisation