Great Western Hospitals NHS
NHS Foundation Trust

Quality Accounts 2011-2012

Our Values
Service Teamwork Ambition Respect

1.1 Chief Executives Statement

Patient safety continues to be at the heart of everything we do. We continue to focus our energies on improving safety and patient and staff satisfaction by providing the highest quality care. The past year has been extremely challenging due to the mergence with Wiltshire Community Health Services on 1st June 2011. However, it has also been an extremely positive and rewarding year and provided opportunity for us to develop and improve the quality of care provided for the new enlarged organisation.

We have regularly monitored our quality improvement plans during 2011/12 via our Patient Safety and Quality Committee through to Trust Board and through our external reporting and monitoring arrangements with our commissioners and key stake holders including LINks and local Health Overview Scrutiny Committees. The priorities for quality improvement set out in the quality Accounts have been chosen to reflect our goals to improve patient safety, clinical effectiveness and the experiences of our patients. We have improved care in many areas and delivered some significant service improvements and continued to develop our services.

We have seen our Hospital Standard Mortality Rates (HSMR) remain below (better than) 100. We have continued to reduce hospital acquired infections and more specifically we have achieved our MRSA and *Clostridium difficile* improvement (reduction) targets. Our staff have led improvements in many other areas of safety and improved care, including Venous Thromboembolisis (VTE), Ventilator Acquired Infections and shown a significant reduction in pressure ulcers and harm associated with patient falls. All of these have contributed to better patient outcomes and experience.

Delivering safe, high quality care relies on a clean and fit for purpose environment and good equipment. We were delighted that we have received excellent verbal feed back again following our external assessments of all of our hospital (inpatient sites) by the Patient Environment Action Teams (PEAT). Formal written reports are awaited. The hospital design and reconfiguration of ambulatory care and transfer of the AAU department onto Linnet ward has also enabled us to achieve ZERO mixed sex breaches since December 2011. We consistently aim to follow and implement best practice in accordance with national recommendations and alerts and I am delighted to say that we are over 95% compliant with all published NICE guidance and Central Alert System (CAS) alerts.

We have used the published Annual Inpatient (PICKER) survey results to focus on improving the experiences of our patients and we have used our day to day reporting processes to ensure we learn from complaints, incidents, clinical audits and claims.

We have progressed with the implementation of the regional acute patient safety programme and we have implemented Executive led quality and safety walkabouts as part of the leadership module within this programme. These walkabouts now include representation from Non Executive Directors and Governors. We have also commenced implementation of the community patient safety programme.

I am delighted with our recent 2011/12 staff survey result. Great Western Hospitals NHS Foundation Trusts position has improved significantly and no indicators are in the bottom 20% and nearly 50% are in the top 20%.None of the above would have been possible without the hard work and dedication of our staff and volunteers, along with colleagues working in other allied organisations. Change is needed and is inevitable if we are to continue to improve what we do both inside and outside hospitals and deliver better care for the population we serve at lower cost. However, we are confident that our staff will continue to meet the challenges ahead.

Yours sincerely

Nerissa Vaughan
Chief Executive

Current Priorities 2011/12 and Priorities for 2012/13

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

The Trusts aim is to set out a clear quality improvement plan building on current local and national quality improvement initiatives to meet its patient quality and **safety** objectives and provide the safest and most **effective** care to enhance the experiences of our patients.

Our 2011/12 priorities as published in the last Quality Account were:

Safe care

To reduce harm through the monitoring and reducing:

1. Healthcare Associated Infections (HCAIs)
2. Medication errors
3. Patients falls
4. Pressure ulcers
5. Blood transfusion errors
6. Reducing preventable hospital mortalities year on year i.e. Hospital Standardised Mortality Rates (HMSR)
7. Participating on the Regional Patient Safety Programme

Effective care

1. Complying with best practice guidance (NICE) and Central Alert Bulletins
2. Reviewing the clinical care of patients who need to return to theatre within a two week period
3. Ensuring that patients who have sustained a fractured neck of femur are operated upon within 36 hours of sustaining their injury if medically fit
4. Ensuring patients are assessed for the risk of developing Venousthromboembolisms and managing the risk appropriately
5. Undertaking nutritional assessments on patients on admission to hospital to ensure we meet their nutritional and hydration needs
6. Achieving the sentinel stoke audit indicators

Patient Experience

1. To involve patients more in decisions about their care
2. To ensure privacy when discussing treatment and care with patients
3. To improve upon the information given to patients on medication and it side effects
4. To ensure patients know who to contact after discharge if they have concerns

Regulation

1. To sustain compliance with the CQC regulations
2. To sustain NHSLA and Maternity Standards and develop longer term plans to achieve Level 3
3. To implement plans to improve results of the national staff survey
4. To sustain compliance with the Mental Health Capacity Act
5. To sustain compliance with Safeguarding Children

Priorities 2012/13

Our commitment to quality will continue through a number of priorities for 2012/13 which have been agreed in accordance with the views and comments from clinical staff commissioners, the Trust Governors and key external stake holders and the PSQC. Our priorities will be:

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

Effective Care
Improve the care and management of patients through implementation of the Trust Nutrition and Hydration strategy
Improve our Hospital Standardised Mortality Ratio (HSMR) year on year (100 or below)
Improve the management of the deteriorating patient by full completion of the Early Warning Score

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

Statement of Directors Responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended 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 2011/12;
- 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 2011 to May 2012
    - Papers relating to Quality reported to the Board over the period April 2011 to May 2012
    - Feedback from the commissioners dated 18/05/2012
    - Feedback from Governors dated 18/05/2012
    - Feedback from LINks dated 18/05/2012
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15th May 2012 (Quality report)
    - The national patient survey dated April 2012
    - The national staff survey dated March 2012
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 14th May 2012
    - Care Quality Commission quality and risk profiles dated September 2011 – March 2012

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

24-5-12 Date ..... Chairman

24-5-12 Date ..... Chief Executive

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Review of Quality Performance 2011/12

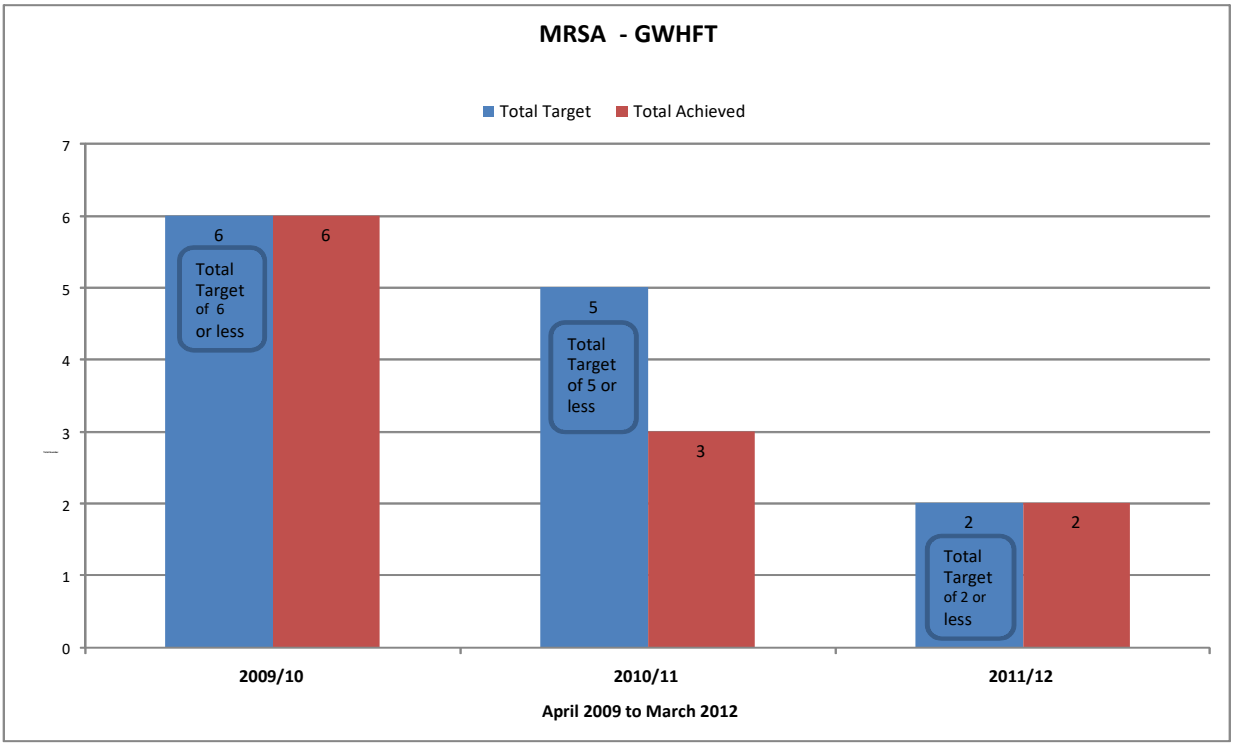
Safe Care

Priority 1: To reduce our numbers of Healthcare Associated Infections

MRSA: The goal to reduce the number for 2011/12 was achieved with only two cases reported as Trust attributed. No cases of MRSA bacteraemia (MSRAB) were reported within the Community following its merger with Great Western Hospitals NHS Foundation Trust on 1st June 2012.

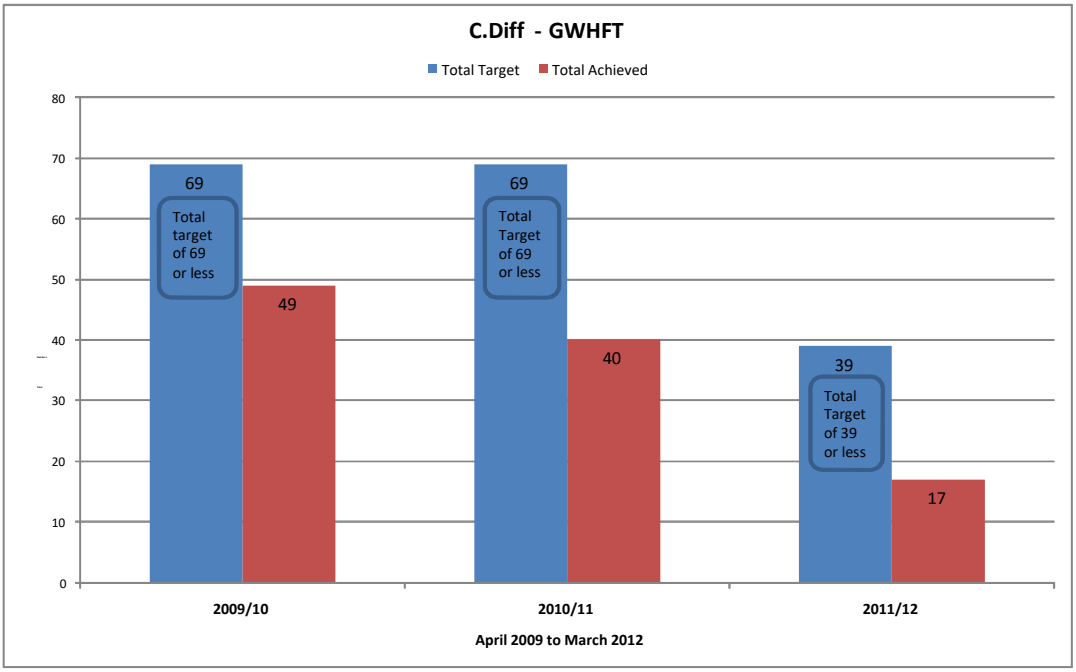
Local initiatives to ensure MRSA infection remain minimal have included:

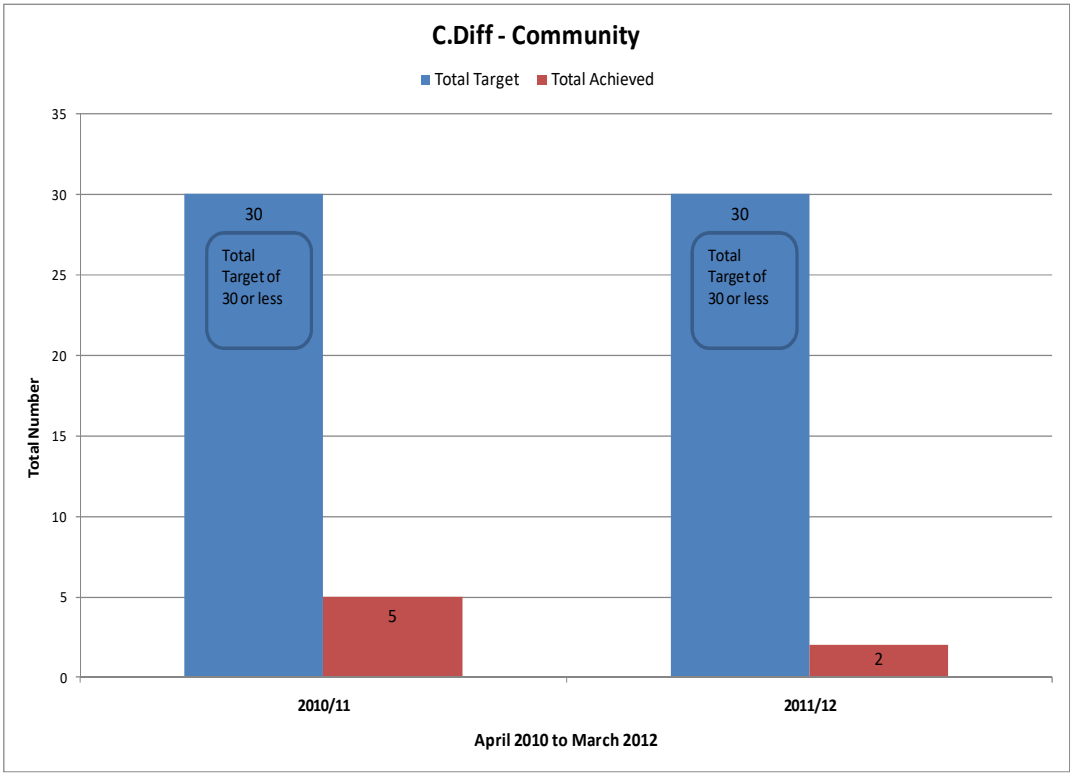
- Sustained improvement with care bundles, (which is a method of measuring and improving clinical care), for peripheral lines and urinary catheters
- Ensuring admission risk assessments are completed on all patients and acted upon
- Daily monitoring of MRSA admission screening of elective and emergency patients
- Development of a core training programmes for nurses, doctors and pharmacists which has included key information on antibiotic prescribing
- Improving care for diabetic patients in Swindon thus helping to reduce the complications that are often associated in MRSABs



Clostridium Difficile: The goal for 2011/12 was to report no more than 39 Acute Trust apportioned cases and no more than 30 Community apportioned cases. We reported 17 Clostridium *difficile* infections within GWHFT and two within the Community
Local initiatives to ensure we continue to reduce these infections have included:

- Promotion of prompt isolation of patients with suspected infective diarrhoea
- Rapid testing of suspected norovirus (GWHFT only), which allows early identification of norovirus outbreaks and aids prompt management of outbreaks of diarrhoea
- Inclusion of a gastroenterologist and dietician to the weekly ward round for patients with *Clostridium difficile* infections
- Review and harmonisation of GWHFT and Community *Clostridium difficile* policy
- Increased surveillance and investigation of inpatients with a history of *Clostridium difficile*



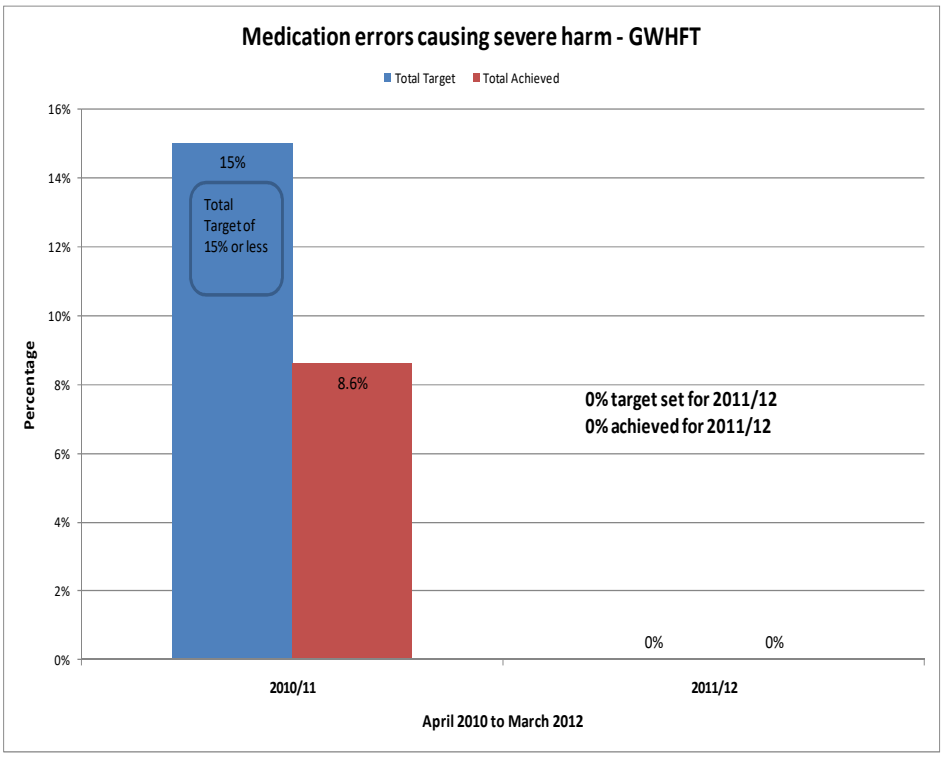


In January 2012's volume of the Journal of Hospital Infection, an article was published by the *Clostridium difficile* ward round team from GWH. The ward round is attended by a Consultant Microbiologist, Antibiotic Pharmacist or Technician, an Infection Prevention and Control Nurse, a Consultant Gastroenterologist and a Dietician. The article concluded that the *Clostridium difficile* ward rounds have helped improve patient care by enabling expertise in management to be brought to the patient. Audit results show that despite the fact that a *Clostridium difficile* protocol was in place, additional interventions were made during the majority of team visits which further improved the quality of patient care and also provided educational opportunities for ward staff.

Priority 2: To reduce harm associated with medication errors

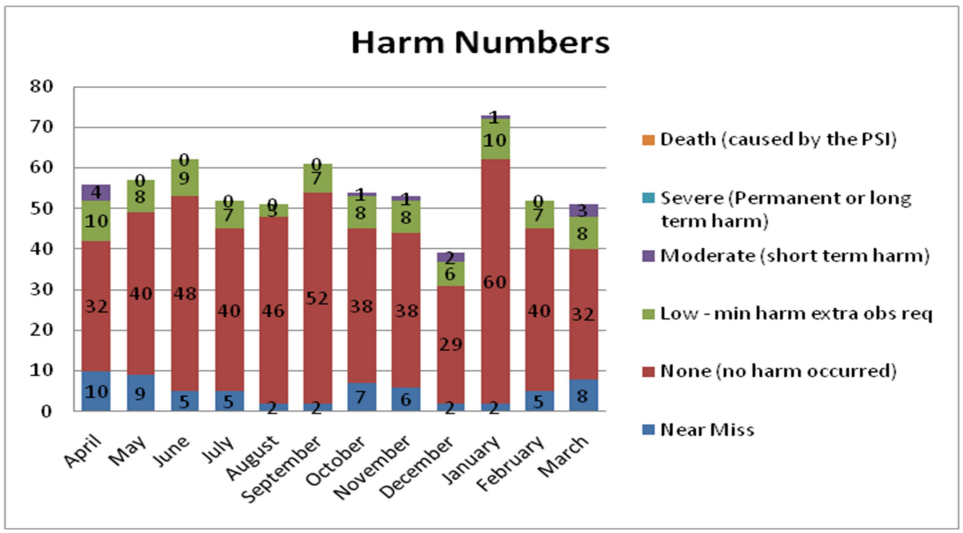
In 2011/12 there were a total of 661 medicine related incidents. Of these 12 (1.8%) were classified as causing moderate harm. Moderate harm is classed as an event that may impact on a small number of patients and could require professional intervention. No medicines incidents caused severe harm or worse.

The number of reported incidents has increased from 514 in the previous year. This is a positive indication of increased reporting and also reflects the assimilation of the Community Unit incident reporting system.

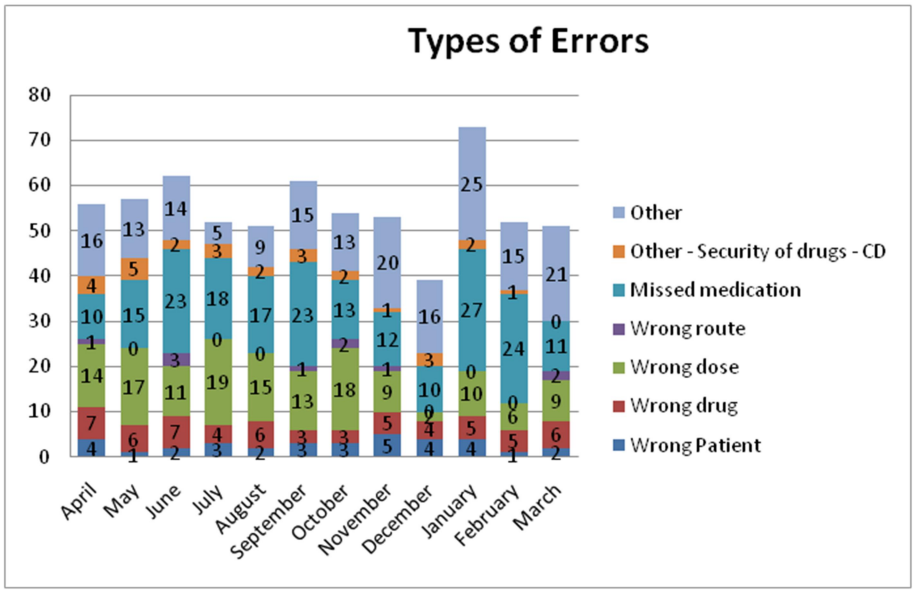


Analysis of Errors

Medicine incidents by harm - 2011/12.



Medicine incidents by type 2011/12



Medicine incident trends and types are reviewed as part of the work program of the Medicines Governance Group. The main incident type is missed doses, and this reflects the increased awareness around this issue. The number of missed doses is audited on a regular basis and there are work plans in place for several areas

All medicine related incidents were seen and reviewed by a Medicines Governance Pharmacist and assessed for severity and further investigated when necessary. Trends and reoccurring incidents were discussed at the Medicines Governance Group. This group was significantly changed in 2011/12. The membership was extended to include Wiltshire Community representation and also to widen the membership to all directorates and to include both senior and junior medical staff. The Medicines Governance Group also added membership from the training department to ensure safety messages were integrated as part of Trust training.

During the year, the Pharmacy Medicines Governance Team produced a series of medicines safety bulletins to highlight particular issues within the Trust. Training was provided at induction to nursing and medical staff and this was modified to include learning from recent incidents and near misses.

Regional Quality Improvement Programme

The Trust continued to participate in the Regional Quality Improvement Programme and in 2011/12 the principal activities associated with medicines were:-

- Further activity on missed doses with regular programme of ward audits, feedback to clinical managers, improved ward intranet resources
- Further reviews and investigation of over anticoagulation
- Development of a rolling 10 charts per week audit programme to cover main inpatient clinical areas. This weekly audit covers various aspects of prescribing medicines reconciliation and administration and the results fed back to Clinical Managers and Medicines Governance Group.

Medicines security audits

The Trust has an existing programme of medicine security and storage audits which was run for several years. This was maintained in 2011/12 with a further 114 audits being completed during the

year and action plans being created for each audit. The Trust also prepared a response to CQC which summarised the medicines security measures in place.

Medical Gas Cylinder Management

The improved ward based medical gas storage has been in place for over a year and has prevented situations where emergency supplies of cylinders were required at short notice, and has reduced the amount of nursing time needed to manage the cylinders. In addition the overall level of medical gas cylinders held by the Trust is being reduced with benefits for stock, storage and also cylinder rental costs.

Discharge information and improved patient medicine information.

The emphasis on medicines information for patients has led to a number of pharmacy initiatives being developed and extended. The Medicines Helpline which started in 2010 has been more widely publicised to patients being discharged, and has received an increasing number of calls. A printed discharge medication summary and reminder card, which can be generated from the existing electronic discharge summary is being issued with all discharge medication supplied from pharmacy, although it is recognised that further work is needed with the EDS team to streamline this process.

Patient's own medicine 'Green Bag'

The Trust is part of a wider initiative, also encompassing the ambulance service and GP practices, to have a standard patients own medicine 'green bag' which will allow patients medicines to be kept together in a standard container and should improve patients own medicines being brought into the Trust, ensuring they are available during inpatients stay, and providing better control of medicines on discharge.

The pharmacy also has representation on the PCT Shared Care Record committee which should provide a record of medicines, adverse effects and allergies for patients within the PCT. In 2012/13 there will be a need to understand how this information is provided and how it is used within the Trust.

Pharmacy Robot

The pharmacy robot has many benefits in terms of stock holding and control, but has also produced a significant reduction in medication errors arising within the pharmacy. These are reduced by 50% from 46 errors in 2010/11 to 23 in 2011/12. In particular this is related to the unique bar coding on each drug pack which ensures correct supply when a pack is selected during the dispensing process.

Pharmacy Training

The pharmacy team have a number of training initiatives to promote safe use of medicines. Internal to the department are regular training sessions for technical staff on clinical and safe practice issues. In addition there is regular attendance at ward managers meetings to highlight issues of medicines safety. Pharmacy staff are also involved in induction and mandatory medicine training for clinical staff and in 2011/12 these have been updated to include learning arising from local and national incidents and alerts.

Clinical Pharmacy Services and Key Performance Indicators

Although the pharmacy has been providing a comprehensive clinical service to wards and clinical areas for many years, these have only been benchmarked on an annual or bi-annual basis. From November 2011 a detailed recording and key performance indicator recording system has been put in place. In the 4 months since its initiation 40,000 prescriptions have been seen and 5,000 medicine reconciliations have been completed. There have also been 4,000 clinical interventions made with 150 felt to be of major importance.

During 2011/12 there was an enhanced clinical service to Aylesbury ward at Savernake Hospital, this was to support medicine reconciliation and generally improve clinical services to the unit and came at a time when the role of the ward and the average length inpatient stay reduced very significantly.

Amalgamation with Wiltshire Community Health Service Units

During the year the various medicines safety and performance processes have been amalgamated with the Wiltshire Community Units. The incident reporting and medicines governance processes follow the same processes and the relevant Trust Committees have community unit representation, the Trust Prescribing Committee and the Medicines Governance Group. The medicine incident process uses the same recording method and follow up process.

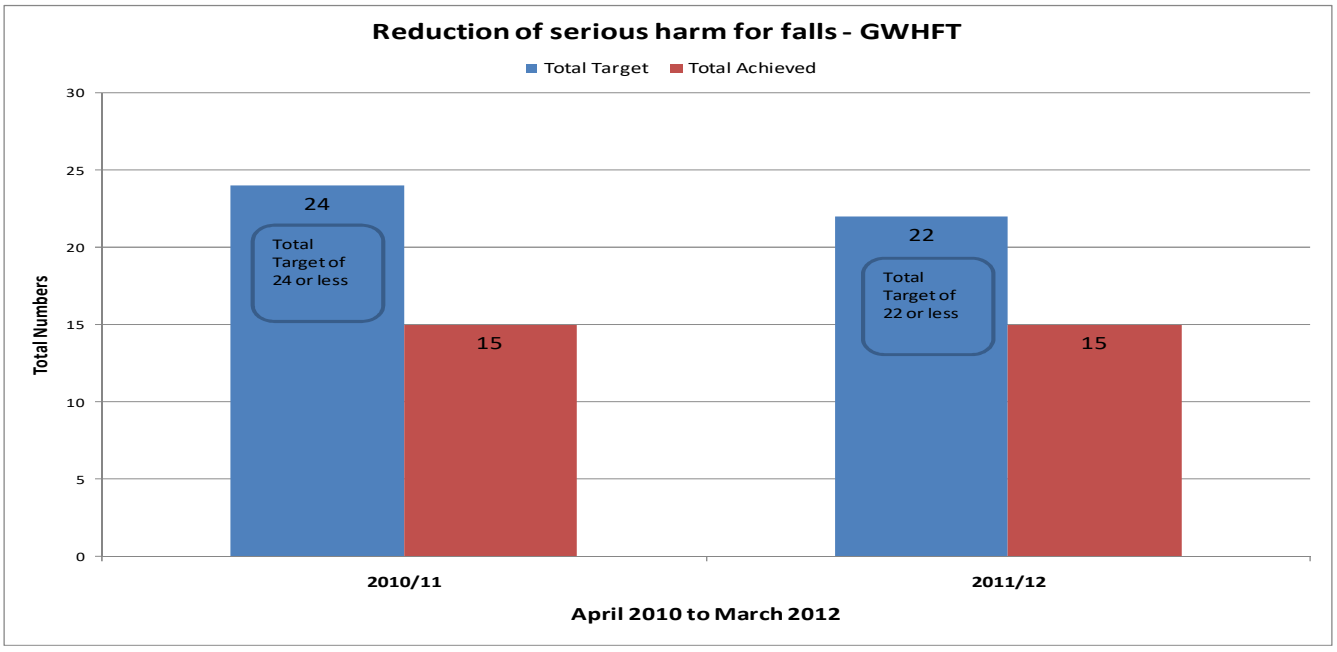
The community unit medicines policy has been re-written and formalises the revised links around security, storage and governance and this is now in use in the community units. There has been significant work to amalgamate the non-medical prescribing and patient group directives and it is anticipated that this will be complete mid 2012.

Priority 3: To reduce harm associated with patient falls

GWHFT: This year the trust has focused on a 10% reduction in severe harm and death from falls in the acute setting, as categorised by the NPSA (National patient safety agency).

The figures indicate that the Trust performance exceeded the target by 32% for the year.
The Acute Trust has an implementation programme for rolling out a new Falls care bundle to all adult wards by April 2012, supported by a training workbook. The care bundle named by the trust as SAFE (Stratification and Avoidance of Falls in the Environment) is in line with the latest evidence based guidance on falls prevention in hospitals, as produced by the Royal College of Physicians in 2011.

As part of the implementation programme there will be a monitoring tool developed by April 2012 to audit compliance across the trust of the falls care bundle. The focus going forward this year will be to facilitate the Acute Wards to effectively implement this new care bundle, working towards 95% or greater compliance by November 2012. This aims to ensure we are providing the best possible standards of care for patient at risk of falls.



COMMUNITY: It was not possible to set a target for the reduction in numbers falls resulting in severe harm and death, as there was not a robust system in place to record the level of harm from reported falls prior to 2011/12. Since the community services merged with GWHFT in June, there have been two recorded severe harm incidents across the four community wards. There has not been any death directly caused by falls in the same period of time.

The previous Community Falls Policy has been updated; it now shares much of its contents with the revised acute falls policy, this is prior to the proposed full integration of both the community and acute polices later this year.

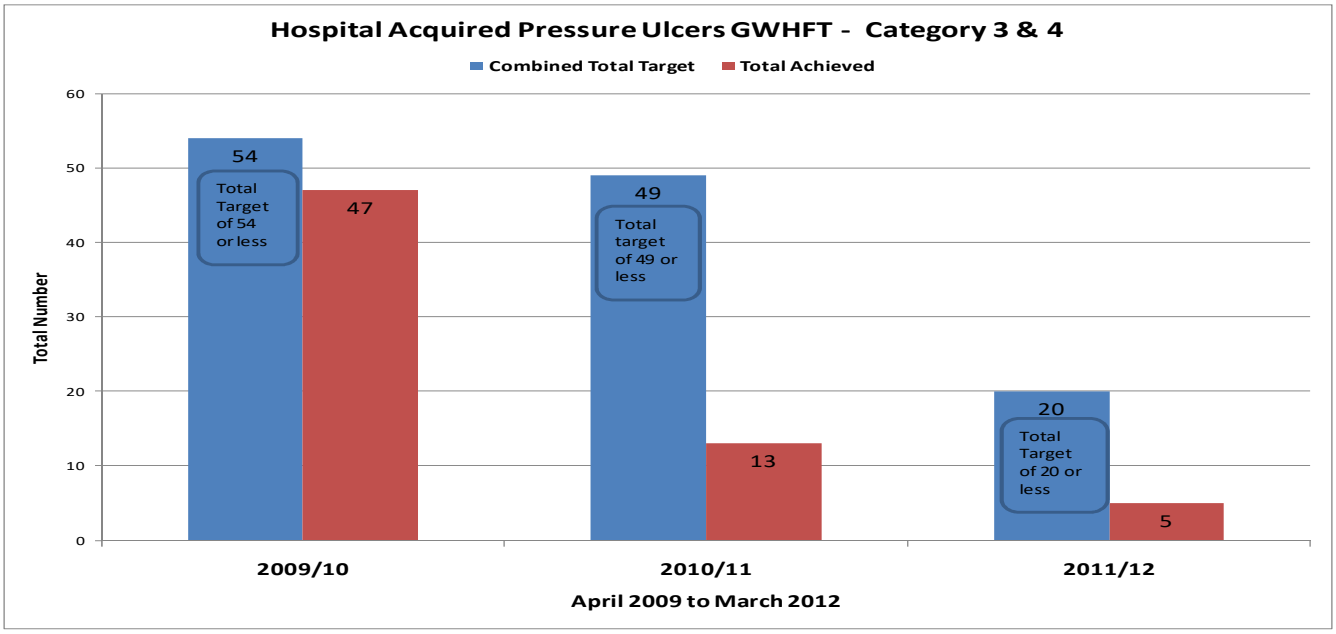
Across the community hospital wards, the SAFE care bundle is being introduced and will be fully implemented by the end of March 2012.

Priority 4: To reduce healthcare acquired pressure ulcers.

GWHFT: The combined target of both Category 3 and Category 4 hospital acquired pressure ulcers was 20 or less. The actual total number reported during 2011/12 was 5 (Grade 4 = 1; Grade 3 = 4).

Comparing the total numbers for 2010/2011 Category 4 and Category 3 hospital acquired pressure ulcers (13) with 2011/2012 figures we have a 61.5% reduction on the previous years total numbers

Where we have achieved our greatest improvement is on the actual total numbers of pressure ulcers that have developed year on year. This year our strongest achievement has been in the reduction of Category 4s.



Pressure ulcers are key quality care indicators within the Essence of Care patient-focused framework for clinical effectiveness and are included in the South West Key driver programme; the aim 80% reduction in hospital acquired pressure ulcers by 2014. The planned reduction of both Category 3 and Category 4 hospital acquired pressure ulcers has been exceeded.

An assessment tool "Waterlow" is used on admission and throughout a patients stay. The results sit on the ward dashboard so that they are visible at all times.

The Productive Ward has supported the improvement programme by use of visual aids the safety cross identifies pressure ulcers that are inherited and those that are hospital acquired, the ward safety briefing verbalises to the healthcare staff the patients whose skin integrity is already compromised

and/or those whose skin is vulnerable. This is particularly important during ward handover so that staff is aware of who is at risk.

Specialist equipment is used depending on the outcome of the individuals' assessment such as the provision of dynamic mattresses, negative pressure wound therapy, protectors and dressings. The medical photography department is used to take photographs of pressure ulcers to support the monitoring of how they improve or worsen.

Since 2010 the serious incident actions from the root cause analysis identified following the development of a hospital acquired Category 3 or Category 4 pressure ulcer, have been monitored through the Pressure Ulcer Focus Forum; this Forum's activity has changed to monitor the Falls serious incident actions too, and forthwith will be called the Pressure Ulcer & Falls Forum.

2012/2013 we will strive to strengthen the reduction of hospital acquired Category 2 pressure ulcers; monitoring is to be defined by ward and directorate

Education on pressure ulcer prevention is to become mandatory during 2012. Meanwhile wards have had educational sessions provided by the TVNS.

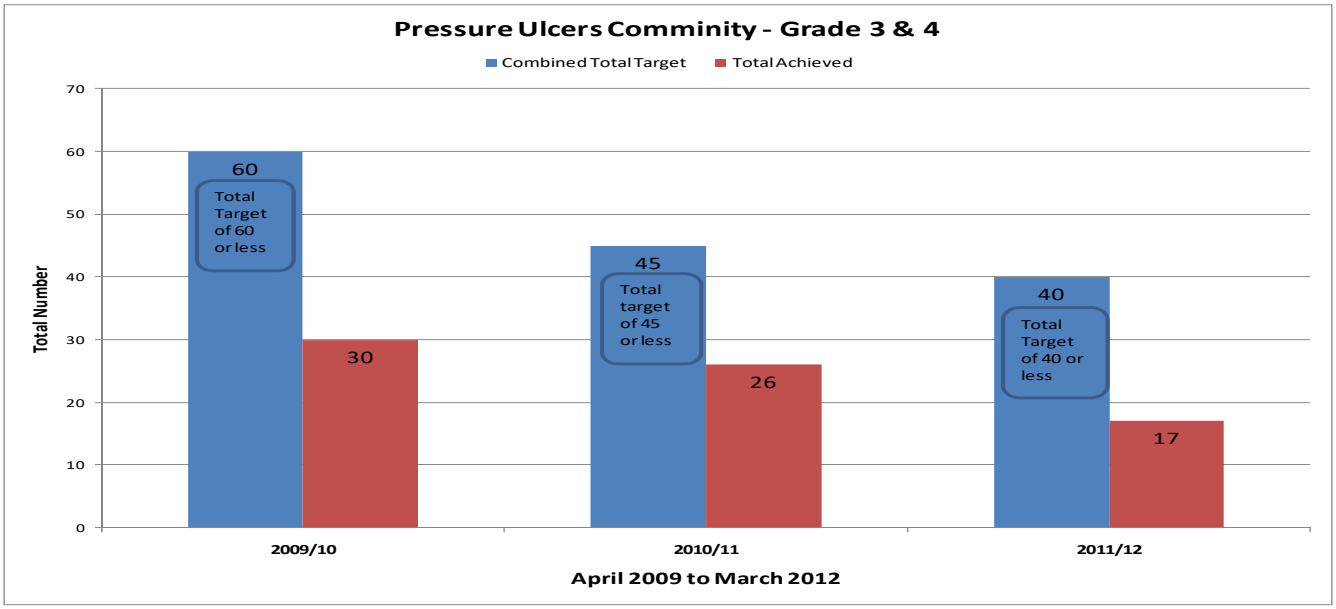
The Great Western Hospital has also commenced Intentional Rounding; a role out programme commenced end of January 2012.

Community: The community Tissue Viability Team has a monthly reporting mechanism in which all patients who develop a pressure ulcer, while in the care of the community nursing team, are reported, using a paper based audit tool to the tissue viability office. There has been 100% reporting for the last 12 months.

The data is formatted into a quarterly report which is then distributed to all of the Neighbourhood team Co-ordinators and has been presented at the Quality Meetings with managers and commissioners.

The pressure ulcer risk assessment tool used within community teams is the Pressure Ulcer Risk Assessment Tool (PURAT) and has been used successfully for five years and has won a national award for innovation. The pressure ulcers are put into Categories in accordance with the 2009 European Pressure Ulcer Advisory Panel which advises NICE and the Department of Health.

The target combined number of category 3 and 4 pressure ulcers is 40 and the number developed is 23. This is 17 below target (57%).



The reduction in pressure ulcers has been achieved through some of the following initiatives:

- Provision of pressure relieving alternating air mattresses to high risk community patients within 4 hours of referral
- Community in-patient units use the white board and handover sheets for every shift to highlight patients at high risk. There has been one category IV pressure ulcer developed on the community hospital ward in the last 12 months
- The Tissue Viability team respond to referral regarding a patient with a category 3 or 4 within one working day
- Rolling educational programme with community staff to which all staff attend
- Developed Link Nurse group (33% of qualified nurses within each team) who have regular pressure ulcer educational updates and training with equipment
- Development of the RCA's investigation form in line with the NPSA Investigation report to identify any patient focused learning outcomes
- Completion of RCA's for every Category 3 and 4 pressure ulcer with regular feedback given to the NT's at all staffing levels and the Community Operations meeting. This feedback is patient focused and informs the educational program
- Educational program with social service and agency staff working with patients within Wiltshire community to ensure that all new and existing staff can recognise and respond appropriately to their client group who are at risk of developing pressure ulcer and the early signs of pressure damage

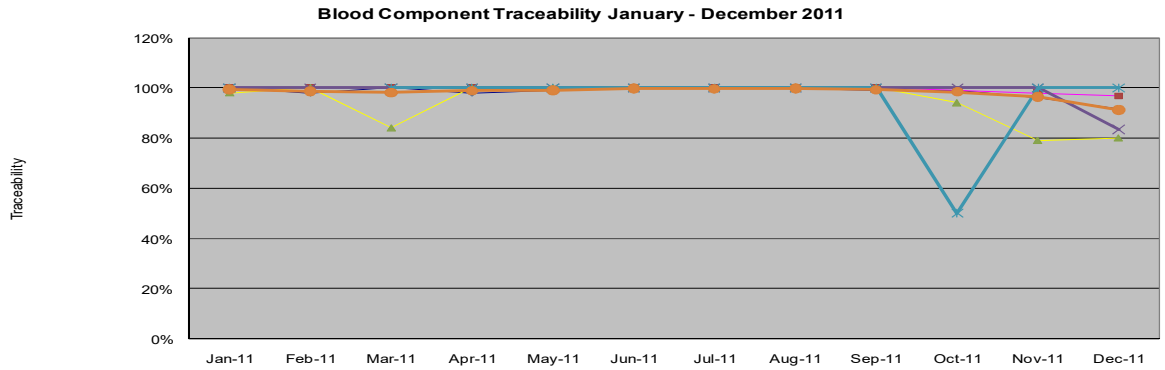
Priority 5: To Provide Safe Blood Transfusions

During 2011 - 2012 there have been no 'wrong blood to wrong patient' incidents within the Great Western Hospital, Savernake, Chippenham and Warminster Community Hospitals.

Under the Blood Safety & Quality Regulations (2005) there is a legislative requirement for all blood and blood components to be fully traceable from donor to recipient. The Great Western Hospital uses the Blood Audit & Release System (BARS) which is an electronic blood tracking system. We are also responsible for the traceability of blood components at SwICC (Swindon Intermediate Care Centre) Prospect Hospice and Savernake Hospital.

For these areas we use a paper system. Blood component traceability is constantly monitored on a monthly basis and has on average been running at 98.20%. Chippenham and Warminster Community Hospitals and the Princess Anne Wing have their blood provided by the Royal United Hospital, Bath which is responsible for the traceability.

Blood Component Traceability Jan 2011 – Dec 2011



	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
RBC	100%	98%	100%	98%	99%	100%	100%	100%	99.08%	99.00%	96.00%	91%
Platelets	100%	100%	100%	100%	99%	100%	100%	100%	100.00%	99.00%	98.00%	97%
FFP	98%	100%	84%	100%	100%	100%	100%	100%	100.00%	94.00%	79.00%	80%
Cryo	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	83%
Octaplas	100%		100%	100%	100%	100%	100%	100%	100.00%	50.00%	100.00%	100.00%
Overall Percentage	99.44%	98.65%	98.15%	98.86%	98.95%	99.75%	99.62%	99.74%	99.21%	98.35%	96.46%	91.21%

Safe care of the patient receiving blood component transfusions has been regularly monitored via audit of transfusion observations. Minimum monitoring of the patient should include temperature, pulse, blood pressure and respiration rate. These should be recorded no more than 60 minutes prior to commencing the unit, 15 minutes into the unit (this includes observations undertaken within a 5 minute window either side of the 15 minutes) and no more than 60 minutes after completion of the unit. This is stipulated within the Trust's transfusion guidelines and will be monitored via audit at least once a year.

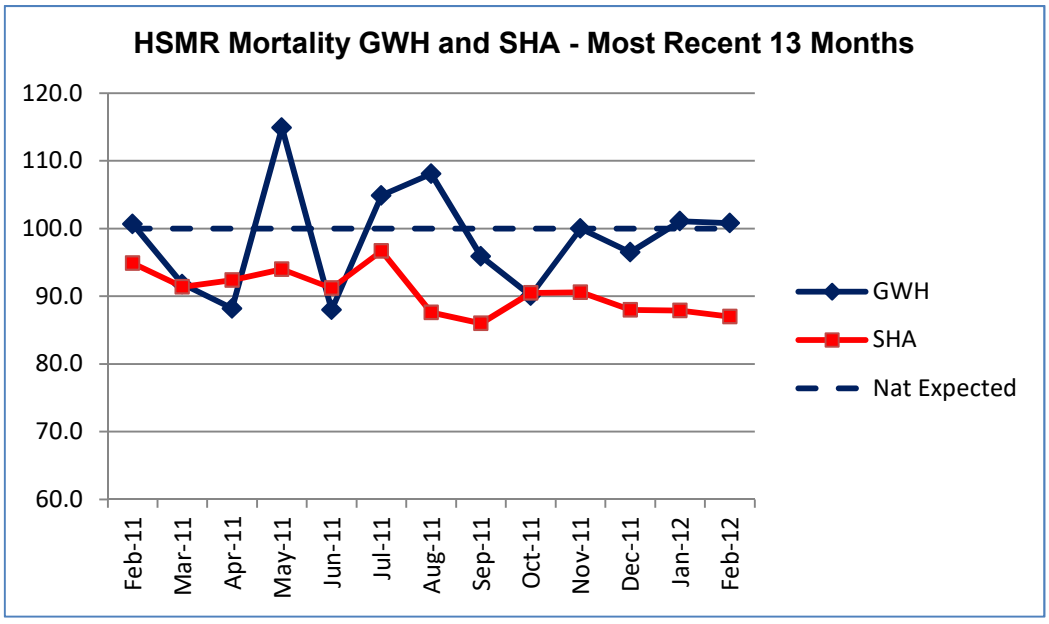
The National Patient Safety Agency (NPSA) competency based training for blood administration and venepuncture continues. The Trust is working towards achieving the set target of 100% for all staff involved in transfusion. However this is a very fluid process due to staff leaving and joining the organisation, maternity leave, long term sick leave etc. Staff who do not have a current relevant competency can no longer perform the procedure.

Work is ongoing with trying to utilise ESR for the monitoring of transfusion related competencies. A clear process of action was approved at the Clinical Managers meeting in February 2011, utilising the Matrons actively in policing and managing staff competencies. A 'transfusion breach form' is generated whenever blood is administered by someone who, according to our records, does not have the relevant competency. The number of breaches is falling month on month which shows that we are making good progress.

Priority 6: To Reduce Preventable Hospital Mortalities

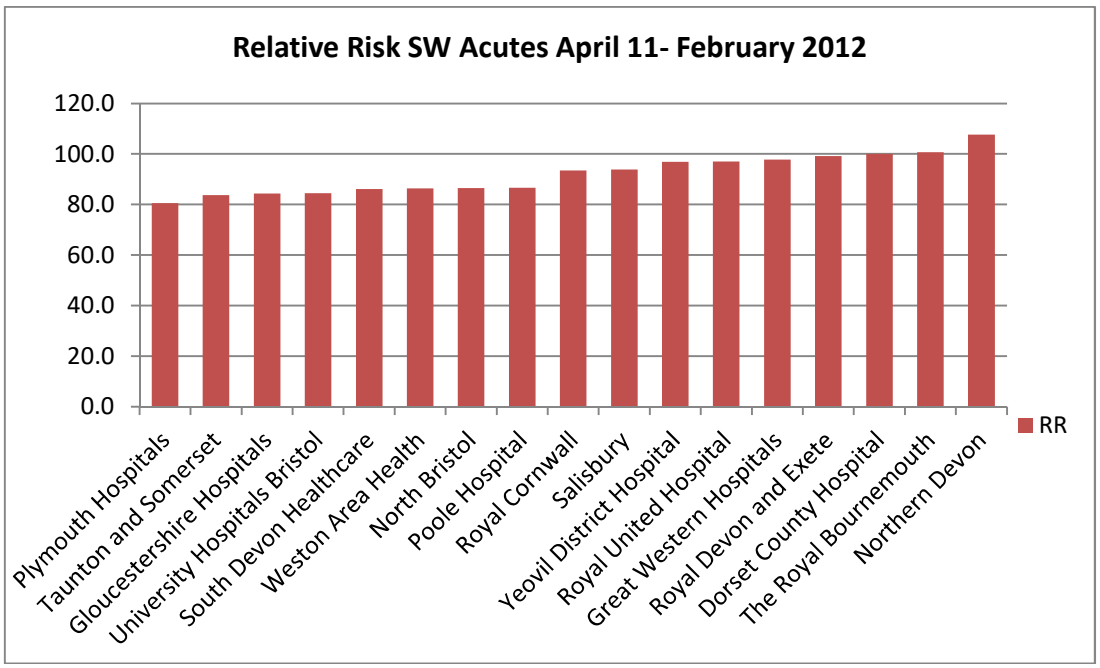
The Trust has maintained an aggregate 98.7 Hospital Standardised Mortality Rate (HSMR) below 100 (better than) for the year to date (April – February).

The graph below shows how the Trust is performing when compared to the average for the South West SHA and against the national expected level of 100. It can be seen that over the last 13 months the Trust's trend has broadly followed that of the SHA average although at a higher level with some peaks.



The table below shows in more detail how the Trust compares against the other Acute Trusts in the SHA for HSMR relative risk for the current year. It can be seen that performance is generally good in the SHA.

Relative risk SW Acute Trusts April 2011 – February 2011



The Trust has an established Trust Mortality Group that meets on a monthly basis and includes clinician representation from each Clinical Directorate as well as representatives from Quality, Clinical Audit, Risk, Informatics and Clinical Coding.

The work of this group includes monthly reports on mortality produced by the information department and centred on Dr Foster tools. Red bell alerts from Dr Foster are investigated with review of coding and clinical care. CUSUM reports (Cumulative Sum Control Chart) also produced by Dr Foster are being used to identify areas for proactive investigation where mortality appears to be increasing prior to a red bell alert.

This tool has also been introduced to monitor areas which have previously alerted to give assurance that improved performance is maintained. Audits have been presented back to the Patient Safety and Quality Committee. Action plans arising from these audits which have the potential to improve patient care, reduce the risk of preventable deaths or improve Dr Foster HSMR performance include a review of processes in the obstetric department to improve coding and investigation of stillbirths, review of pathways in urology for the care of patients with obstructed kidneys and a revised cancer MDT proforma also in the urology department to improve assessment of patients with bladder cancer.

The group is also monitoring the work led by the audit department to establish a trust wide database to record departmental mortality and morbidity meetings. Progress reports in this area have been introduced. Other work has included the introduction of guidance for death certification (including consultant involvement), development of a new notice of death form (containing key information to be included in mortality reviews) for use by mortuary staff and an information pack is in development for inclusion in the induction of the August 2012 foundation trainees.

The Mortality Group also develops work strands on any issues concerned with mortality that are brought to it and links with the end of life working group.

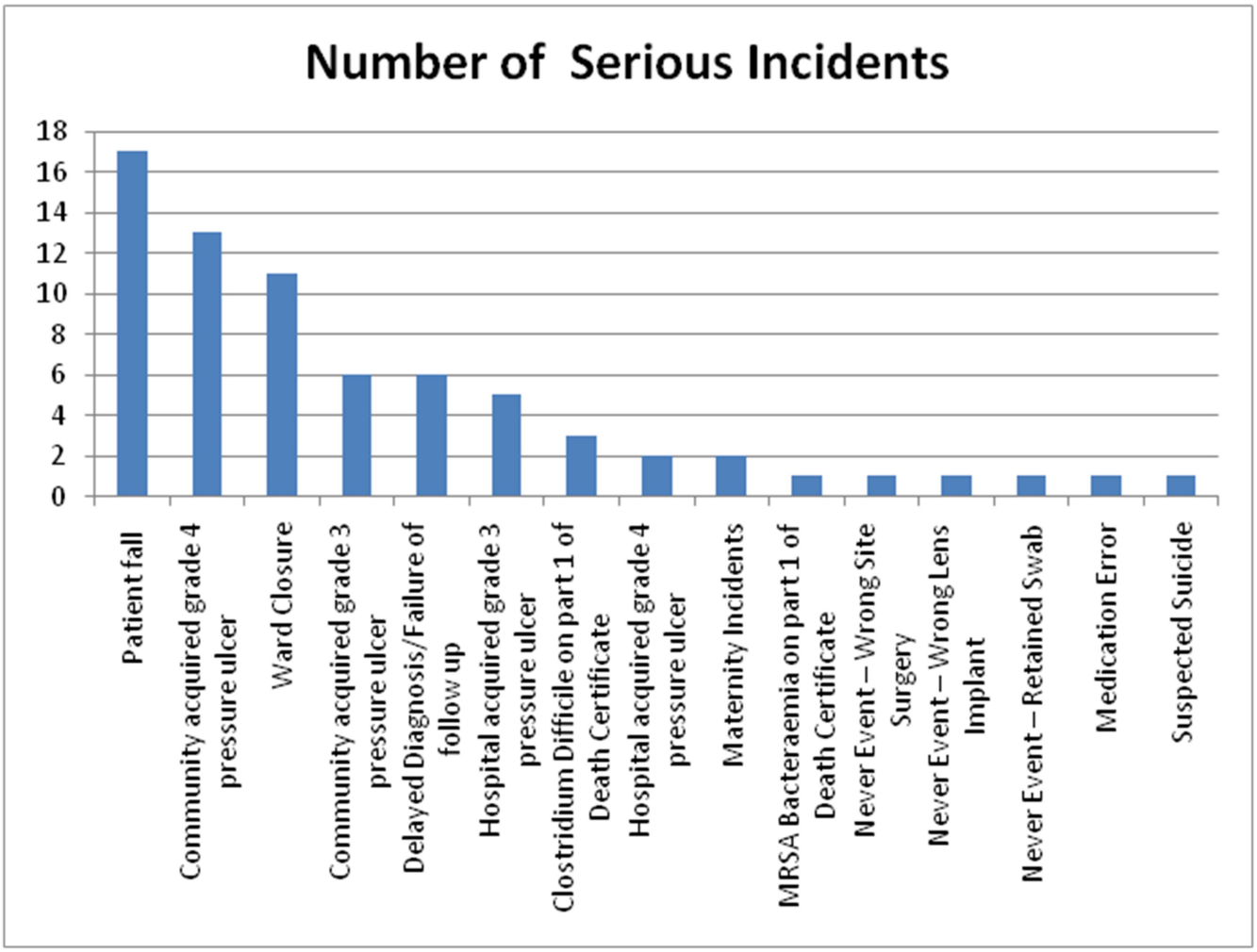
Clinical Incidents – Never Events, Serious Incidents and Incidents

Never Events: A total of three never events have been recorded in the Trust between April 2011 to March 2012. All three were surrounding surgery;

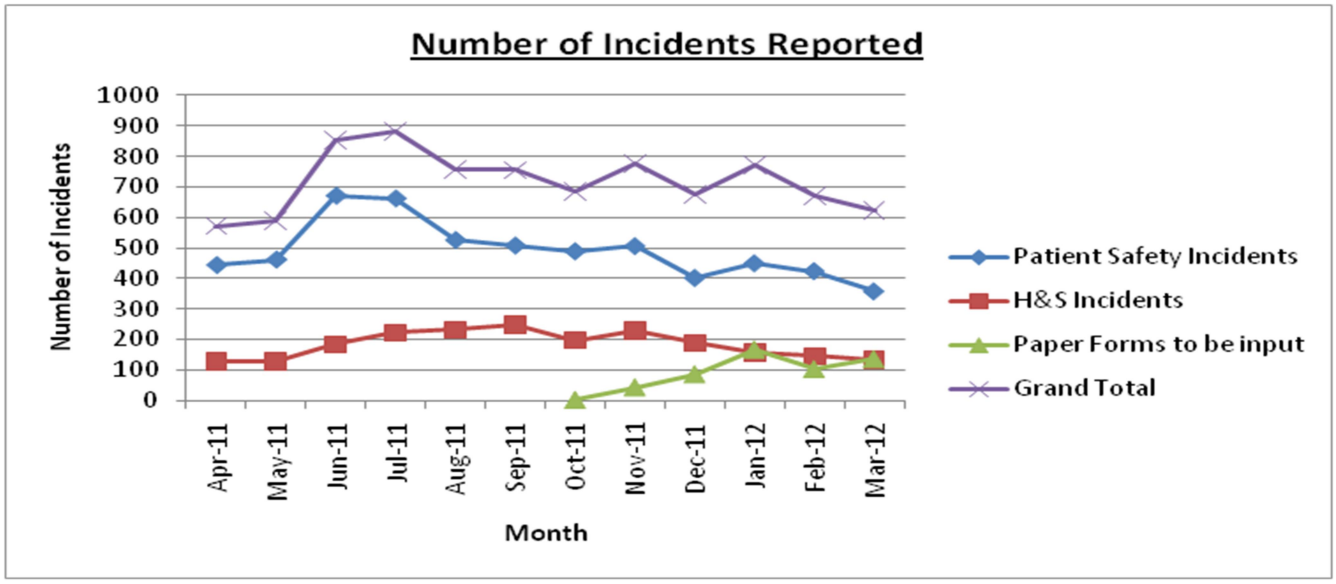
1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation

These events have been reported and managed through the trust Clinical Risk management and Governance systems. Action plans have been developed and fully implemented to ensure such events do not re occur. This work has been shared with and approved by the CQC. Continuous monitoring of practices within the theatre and maternity departments is observed. Details of the Action Plans can be found in the Incident Investigation Report.

Serious Incidents: All serious incidents are investigated to identify the care and service delivery problems which contributed to the root cause of the incident. These are addressed in an action plan which is then communicated within Directorate meetings and reports across the Trust to ensure learning is shared. 71 serious incidents were reported and investigated across the merged Trust during the period April 2011 to March 2012. This was a decrease from the previous year April 2010 to March 2011 of 100 (44 GWHFT and 56 COMMUNITY incidents added to quantify the figures). The graph below demonstrates the number of Serious Incidents grouped by type of incident.



Incidents: The Clinical Risk Team was responsible for managing 84% of incidents which occurred at the Trust over the last year. The Health and Safety Team investigate the non-clinical incidents. The graph below demonstrates the numbers of incidents reported.



Following the Trust's merger in June, the community arm of GWHFT is still reporting a large quantity of their incidents on paper incident reporting forms which are subsequently input to the GWHFT electronic system. Whilst all incidents reported in this manner are reviewed and reported within accepted timescales, there is currently a three month backlog of inputting the data from these forms which is reflected in the graph above. There is an ongoing community rollout of access, and training to the GWHFT electronic reporting system. Community users will be integrated onto the GWHFT incident reporting system by September 2012.

Top five clinical incident causes 2011-2012

Incident Cause	Grand Total
Fall - Found On Floor	933
Pressure Ulcer	607
Fall - Slip Or Trip	418
Equipment/Device - Contamination	258
Med Error - Missed Medication	226

NB. *Equipment/Device – Contamination* relates to damaged packaging on sterile equipment stored for use in DSDU. These are mainly '*near miss*' incidents where the damaged packaging was found on routine checks and alternative sets supplied for use.

Patient Falls and Pressure Ulcers are included in the ***South West SHA Patient Safety and Quality Improvement Programme,*** which the Trust is currently participating in order to embed process focussed on reducing harm from these events.

Last year it was reported that there had been an increase in documentation errors but this trend does not appear to have continued in 2011/12. The previous rise may have been due to the increase in total reporting figures; the NPSA agree that organisations reporting more incidents generally have a better and more effective safety culture. In the most recent *NPSA Organisation Patient Safety Incident*

Report, the GWH was in the highest 25% of reporters. Timeliness of reporting is also an indication that the organisation is able to identify and act efficiently on incidents. The NPSA Report from April to Sept 2011 recognised the Trust continued to submit 50% of incidents fewer than 20 days after the incident occurred, ahead of the average of fifty percent of all incidents submitted to the NRLS more than 36 days after the incident occurred.

The volume of reporting within the Trust has continued to increase year on year:

- 3759 reported during 2009/10
- 4613 reported during 2010/11
- 5547 reported during 2011/12* *this includes the merged organisation from June 2011.

The NPSA Organisation Patient Safety Incident Report demonstrates that our rate of moderate harm, severe harm and incidents resulting in death is over 50% lower than that of comparable trusts.

The three top serious incident causes and their report recommendations are;

- Patient Falls
    - Variance on audit compliance - Falls risk assessment and SAFE tool. Monthly audits undertaken to monitor compliance;
    - Reinforcement of the importance of implementing care plans following identification of at risk patients;
    - Improving and cascading information to all members of the Multidisciplinary team
- Community acquired grade 4 pressure ulcer
    - Immobile patients to receive multi-disciplinary care planning;
    - Regular review of nutritional status;
    - Improve recognition, and subsequent referral when patients current pain-relief regime is not sufficient;
    - Patients identified as being at risk of or who have pressure ulcers will have core care plans that are implemented and regularly evaluated;
    - Monitoring accuracy of assessments; additional training identified and accessed
- Ward Closure
    - Improve staff awareness of procedure and policy surrounding isolation, control and investigative procedures of possible outbreaks of infection;
    - When outbreak identified, check possibility of cross contamination of patients exposed and discharged from affected area;
    - Ensure full and accurate patient details are given when transfers are planned.
    - Hand hygiene audit completed weekly
    - Personal protective equipment to be available and staff reminded of when to wear.

Presentations of the reports of these investigations are made to Directorate Leads at the monthly Patient Safety and Quality Committee meeting; learning from this including action plans is then cascaded to Directorate teams to share good practice. Utilising this system of reporting enables the Trust to learn from incidents, complaints and claims and act in a proactive way to try and prevent similar events occurring.

National Patient Safety Thermometer

During 2012-2013 the Trust will adopt the NHS Safety Thermometer; developed for the NHS by the NHS as a point of care survey instrument. The survey allows teams to measure harm and the proportion of patients that are 'harm free' within their care. Survey measurements will be uploaded onto a national monitoring tool to allow organisations to benchmark against others.
The four areas being measured are:

- Pressure ulcers;
- Falls;
- Urinary catheters and associated infections;

- VTE assessments.

Priority 7: Participation on the Regional Patient Safety Programme

Since March 2010 the acute services for Great Western Hospital NHS Foundation Trust, alongside many of the acute Trusts in the South West region, has been actively involved in the Quality and Patient Safety Improvement Programme. The programme, led by the South West Strategic Health Authority (SHA) in collaboration with the Institute for Healthcare Improvement (IHI), aims to achieve a 30% reduction in adverse events and a 15% reduction in mortality by September 2014.

The Acute Programme consists of five work stream packages: leadership, general ward, medicines management, peri-operative care and critical care. Each incorporating a number of high risk topics, for example preventing venous thromboembolism, use of the Safer Surgical checklist, and reducing complications from ventilators in intensive care units. Work stream leads and teams have been established within the Trust to deliver improvement in each of these areas, supported by our recently appointed Patient Safety Project Coordinator.

The Acute and Community programmes within the trust run in parallel

The Community programme consists of six measures and one work stream package, Average length of stay for inpatients, Patients with Observations complete, patient falls, pressure ulcers, urinary catheters, venous thromboembolism and leadership. Each measure and work stream has a Trust Lead.

Leadership since June 2010, as part of the SW SHA Quality and Patient Safety Programme, GWHFT has been conducting patient safety walk rounds within the acute services, visiting various areas throughout the Trust to establish first hand patient safety concerns from frontline staff. The walk rounds for the community are planned to be rolled out during 2012.

Non Executive Directors (NEDs) and Governors are now actively involved in this process, the first NED joined the executive team walk round for the visit to the Mortuary in January 2011 helping to develop actions and solutions to concerns raised. A NED or Governor now takes part in a patient safety walk round on a monthly basis. Since implementing patient safety walk rounds within the Trust Executive Teams have visited 18 clinical areas, most having had two visits; with up to a further 16 programmed for 2012,

During the walk round, actions are identified to resolve issues that are raised by staff, the Patient Safety Coordinator within the Clinical Risk Team monitors completion of actions, of the 90 actions raised to date 67 have now been completed and resolved. The most common themes that have been identified are communication, treatment/care delivery problems and equipment related issues. In continuing to develop the process, themes that are being identified are now being incorporated into the Trusts aggregated analysis and improvement report which is produced on an annual basis alongside incidents, claims and complaints data.

As a method of providing assurance that change is taking place, NEDs and Governors will be undertaking bi- annual meetings to review progress, discuss common themes and resolution of actions that have been identified. In addition the Chief Executive's report will include the key themes schedule which identifies key and common concerns raised on the walk rounds, this ensures that patient safety concerns are raised directly to the Trust Board.

General Ward: During 2011/12 the general ward teams have successfully implemented and rolled out the hydro bottles across the Trust in conjunction with the productive ward handover module. The bottles aid with hydrating patients and help to provide more independence to those who are less able.

The Tissue Viability Nurse Specialist (TVNS) presented on Pressure Ulcers at the SW SHA learning session in June 2011. The work undertaken to reduce the Trust's pressure ulcers was so inspirational

that she was invited by the SHA and Improvement for Healthcare Improvement (IHI) to host a South West conference call in August 2011 on pressure ulcers. The conference call was a success and the pressure ulcer tools have been loaded onto the IHI for other SW trusts to use.

The community have commenced developing a EWS (Early Warning System) in the community settings. It entails utilising the observation chart (currently used at GWHFT) for the Community (to replace their current Obs Chart).

The process is split into three phases: trailing chart on a community ward, roll out to inpatient areas and roll out to neighbourhood teams.

Medicines Management: The team have worked across the trust with omitting the abbreviations for insulin prescribing. The prescribing will now be written as 'unit' rather than 'u, this will help to reduce the number of errors associated with insulin prescribing.

Peri operative: The team have been working on improving compliance with normothermia to ensure that the patient's body temperature is normal throughout the operation. A traffic light system has been introduced by the team to help identify patients who are at risk of becoming cold throughout an operation. The system scores the patient and identifies what the risk is of the patient not being able to maintain a normal body temperature. The theatre team are able to proactively provide interventional methods to keep the patients warm.

Critical Care: The intensive care team are now successfully collating data and recording Ventilated Acquired Pneumonia (VAP) rates in patients. A lot of hard work and effort has been invested in this project (measure) and the team are now investigating specific trends in the VAP rates.

Institute Multi-Disciplinary Rounds where introduced during 2011 and are now embedded into practice, there is regular attendance by the physio, pharmacy and dietician. Multi-disciplinary ward rounds are taking place on a daily basis (Monday – Friday) and are helping to improve communication between all team members, patients, carers and relatives.

As part of the SW SHA programme the Trust are involved a number of improvement projects which includes, improving the use of the surgical safety check list, patient falls protocol, patient comfort rounds, theatre pre list meetings, medication reconciliation and many more.

Effective Care

Priority 8: Compliance with best practice guidance (NICE) and Central Alert Bulletins

NICE: The National Institute for Health and Clinical Excellence (NICE) is an organisation that publishes evidence based guidelines and recommendations for patients and healthcare organisations. Service providers are expected to consider and implement NICE guidelines where relevant, when developing and delivering their services for their patients. Regulatory bodies such as the Care Quality Commission (CQC) and the NHS Litigation Authority (NHSLA) can use these standards as a monitoring tool to measure the quality and safety the organisation provides.

At the Great Western Hospital, the Clinical Audit & Effectiveness Department has been responsible for the dissemination pathway for National Institute for Clinical Excellence (NICE) Guidance since September 2007.

The NICE process includes identifying, disseminating, monitoring the implementation and reporting, of all NICE published guidance and is managed by the NICE Lead, based in the Clinical Audit & Effectiveness department.

NICE published 82 guidelines during 2011/12.

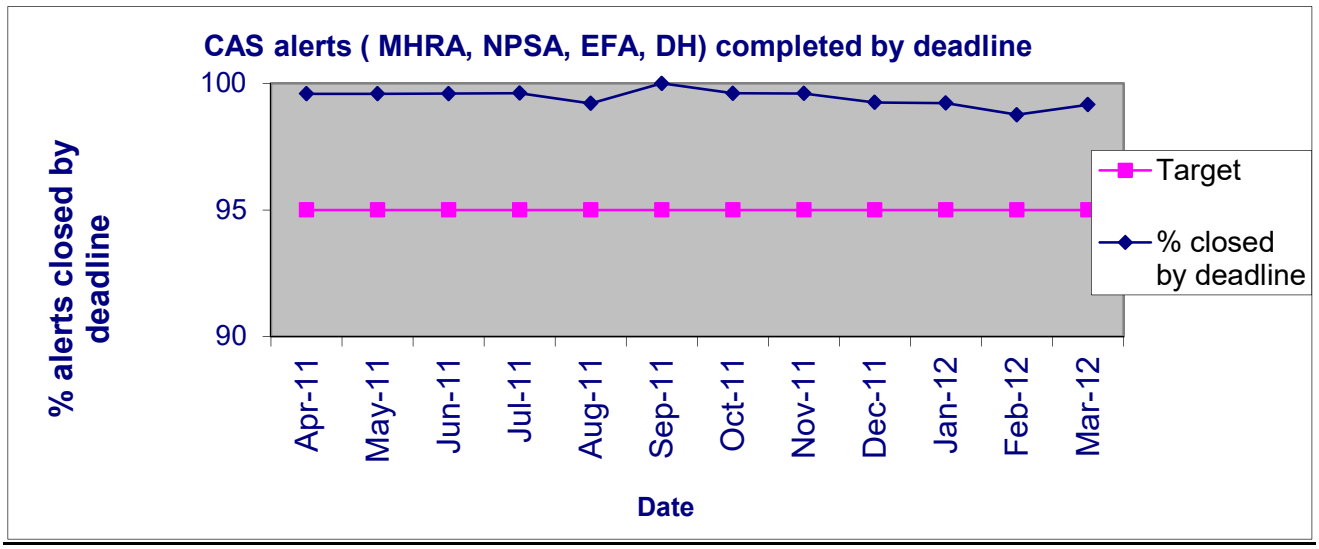
All the guidelines have been disseminated to the relevant clinicians and directorates including Wiltshire Community Health Services. A response rate of 96 % or above has been maintained throughout the year.

35/82 (41.5%) of the publications have been confirmed they are relevant to the Trust.
Out of this 35:

- 22 guidance have been assured of full compliance
- 4 guidance's are currently being implemented
- 6 have only recently been published and are within time frame to respond
- 1 Technology Appraisal is under discussion
- 2 Guidance's have been reported as an exception as the Trust has other provisions to implement the guidance.

Thus Trust wide compliance of 98-100 % has been attained this year.

CAS: The CAS (Central Alerting System) publishes Safety Alerts, emergency alerts, Dear Doctor letters and Medical Device Alerts on behalf of the Medicines and Healthcare products Regulatory Agency, the National Patient Safety Agency, and the Department of Health. These relate to medical devices, hospital facilities, equipment and clinical incidents. Responses and actions are monitored to defined deadlines via a web based system. Between April 2011 and March 2012 the Trust received 112 alerts from the CAS system.



The standard of at least 95% compliance with no significant exceptions has been maintained throughout the 2011/12. Any alert that has failed to achieve full compliance within the prescribed deadline is reviewed monthly at the PSQ meeting to ensure that progress is being made to address outstanding actions and that no significant risks exist.

All alerts that are past, or within one month of, their deadline have an allocated lead manager and associated responsible member of the executive, and outstanding actions are listed against expected resolve dates. These alerts are risk assessed to indicate the level of risk associated with non compliance.

The NPSA alert, 2010 RRR019: Safer ambulatory syringe drivers, is outstanding, awaiting confirmation of a training programme in the community. Clinical Risk assesses the risk of non completion to be low. There is one Estates alert past its deadline, EFA 2011/002, concerning the management of refilling liquid Oxygen VIE plants. The outstanding actions concern approval of documentation. Estates and Facilities Management assess the risk to be low.

Priority 9: To review the clinical care of patients who need to return to theatre within a two week period

The aim for 2011/12 was to establish baseline figures for patient returns to Theatre within 2 weeks.

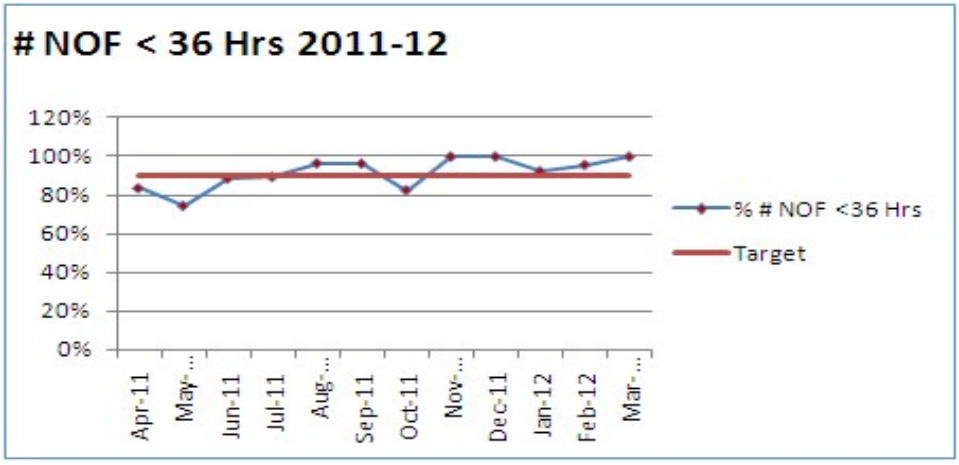
Total returns to Theatre for YTD = 41
Total cases YTD = 18.468
Overall % YTD = 0.2%

- There continues to be monthly monitoring of specialty trends. Theatre Coordinating Managers validate the monthly figures collated by the Informatics Team.
- 2012/13 we will continue to collate, monitor and validate on a monthly basis.
- We will continue to highlight any trends and report these to the appropriate specialty Clinical lead in the first instance.
- Any trends or areas of concern will be discussed at the Directorate & Clinical Governance meeting on a monthly basis where appropriate.

Priority 10: To ensure that patients who have sustained a fractured neck of femur are operated upon within 36 hrs of sustaining their injury if medically fit

Hip fracture is a common, costly and well-defined injury, which occurs mainly in older people. As the number of elderly people and age-specific incidence of hip fracture continue to rise, orthopaedic and rehabilitation services face growing pressures and a multidisciplinary working group meets bi-monthly to review all aspects of care for these patients.

Early surgical intervention is associated with better patient outcome. In accordance with best practice tariff, the quality indicator contract time to theatre is 36 hours. The Trust indicator requires that 90% of patients who are deemed medically fit require surgery within 36 hours of admission. The average percentage of patients who achieve this is 91% for the year.



This has been achieved by:

- Monthly reporting of percentage of patients having surgery within 36 hours
- Monthly trend analysis to close any gaps identified
- Monthly reporting of reasons for non-operation within 36 hours
- Changes to processes to improve compliance
- Prioritisation of operating slots for patients with hip fracture

- Increased bank holiday/weekend trauma lists

Priority 11: To ensure patients are assessed for the risk of developing Venousthromboembolisms and that these risks are managed appropriately

Compliance with completing VTE risk assessment has been maintained at over 90%
This achievement includes data from Wiltshire since June 2011.

This has been achieved with:

- Continued education sessions at Trust Induction
- VTE update training now available on Training tracker and via a workbook
- VTE sessions provided specifically for Health Care assistants which was very successful and enabled recruitment of additional VTE link HCA's who have made significant improvements to the quality of VTE assessments in their areas. This is also being rolled out in Wiltshire to enable VTE link staff to have the same level of access
- Implementation of an audit trail through the nursing crescendo system and daily reports provided by Informatics to each ward area which allows them to easily identify any patients who have not been risk assessed
- Raising awareness with patients and relatives by means of information boards and displays during National Thrombosis week, the winner of last year's event is permanently displayed in the Cherwell pre-assessment unit
- A second patient information leaflet developed specifically for patients who are being discharged home with VTE prophylaxis which gives information for the patient and also the community health care provider.
- We have also worked closely with Swindon PCT to establish VTE risk assessment in the community for patients who are discharged home with VTE prophylaxis. This will also enable patients who deteriorate at home to be assessed and for them to receive appropriate VTE prophylaxis if at risk.

Administer appropriate VTE thromboprophylaxis

Compliance with VTE prophylaxis has been maintained between 88%-100% for the last 12 months. Audits are proposed to evaluate the quality of the risk assessments and ensure appropriate thromboprophylaxis is prescribed and that patients who require extended prophylaxis in the community receive it.

Priority 12: To undertake nutritional assessments on patients on admission to hospital to ensure we meet their nutritional and hydration needs

Good nutrition & hydration are fundamental to well being and recovery from illness or trauma. A high proportion of individuals admitted to hospital or requiring support via the neighbourhood teams are vulnerable to malnutrition

Targets, compliance and audit methodology & frequency for the 3 key locations vary:

- **GWHFT site: Target 95%; Compliance 87.8%**
- **Community Hospitals: Target 100%; Compliance 77.5%**
- **NHT: Target 100%; compliance 44.4%**

Despite not yet meeting the target, significant improvements in other aspects of nutritional care have been achieved. At GWHFT site "MUST" completion is assessed via Crescendo on a daily basis to provide weekly and monthly compliance rates. (See CQC report in Regulation section)

The Community conducts a qualitative audit 6 monthly. For the purposes of this report an average of all wards is used for the key parameters of the audit.

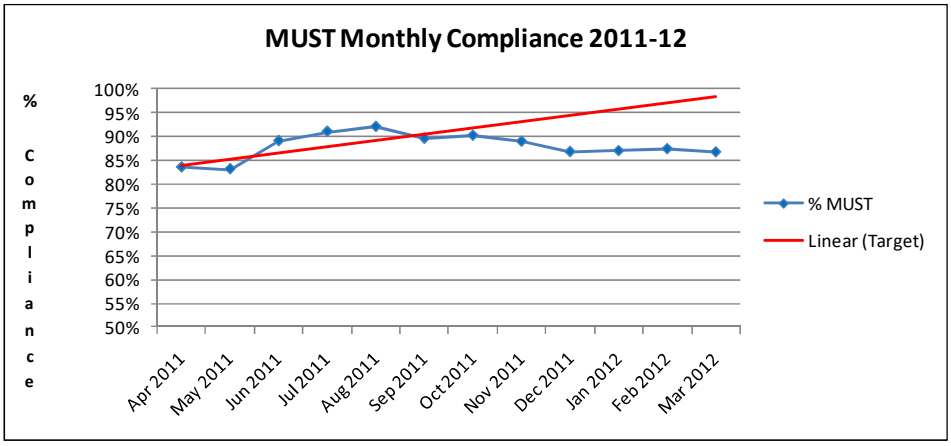
GWHFT site:

- Prior to MUST implementation there was no consistent or validated screening tool in place and compliance was measured at 33%
- In 2010 MUST was implemented with a training programme carried out by the dietetic team. Compliance was improved to 75% by Feb 2011
- The improved MUST compliance resulted in a >100% increase in referrals to the dietetic team resulting in a lack of time available for on-going training
- During 2011 refinements were made to compliance audits, including improving the identification of exclusions and supporting wards with lower levels of compliance
- Compliance has further improved to 87% with 3 areas achieving 95%; 6 areas 85 – 94% and 5 areas at or below 84% (range 78 – 84%)
- An on-going training programme is in place for NAs and volunteers including MUST and nutrition care.

Additional and existing activities to improve MUST accuracy and compliance are being introduced and strengthened.

- To support accurate MUST completion a new E- learning package and workbook for MUST are being introduced via the academy. The Nursing Auxiliary & Volunteer training programme is to be updated to incorporate the needs of Wiltshire Community staff and changes to meals service such as the menu-less meals project
- An additional dietician has now been funded by industry (commenced in post 20th Feb 2012 until March 2013) to support the MUST and Nutrition Care Plan programme and to identify ways of managing the resultant referral demand. The post holder will be required to identify and pilot alternative ways of working to achieve this once the funding ceases
- Ward dieticians will be targeting their lower compliance wards with additional training and support Regular comfort rounds (intentional rounding) instituted to provide more proactive and timely care
- Matrons weekly inspections have recently started with a more specific and consistent approach to monitoring and improving compliance issues with MUST, nutrition care pans and documentation of fluid balance
- As a result of complaints and concerns regarding meals' quality on-going weekly checks of meals service is carried out. This has improved resulting in positive PEAT reports
- A pilot project to improve patient's meals experience and reduce wastage was introduced in 2010 through the Productive ward meals module. Due its success the, menu-less meals programme is being rolled out to the rest of the GWHFT site, as appropriate
- Dieticians identified a significant amount of food wastage and dissatisfaction from patients with diabetes and ward staff regarding the diabetic snack provision. Subsequently a new snack choice has been introduced which has been well received by patients and staff and is predicted to reduce wastes and produce some cost savings
- The Productive ward team identified a system designed to improve patients' hydration needs. The trial of the "Hydrant" in 2011 was so successful it is being rolled out to other areas
- It was identified mid 2011 that the menus did not fully cater for patients with dysphagia. The dieticians, Speech and Language Therapists and Carillion are working on the development of a separate soft menu to improve choice and suitability of texture for these patients. An interim menu is currently in place prior to introduction of the finalised version
- Women & Children's Directorate and Paediatric dieticians, identified that MUST is not appropriate for children and no other equivalent screening tool exists. The paediatric dieticians have developed a nutritional screening tool for 0-5 year olds
- Update of pictorial menu complete

GWH Site - MUST



Community Sites*:*

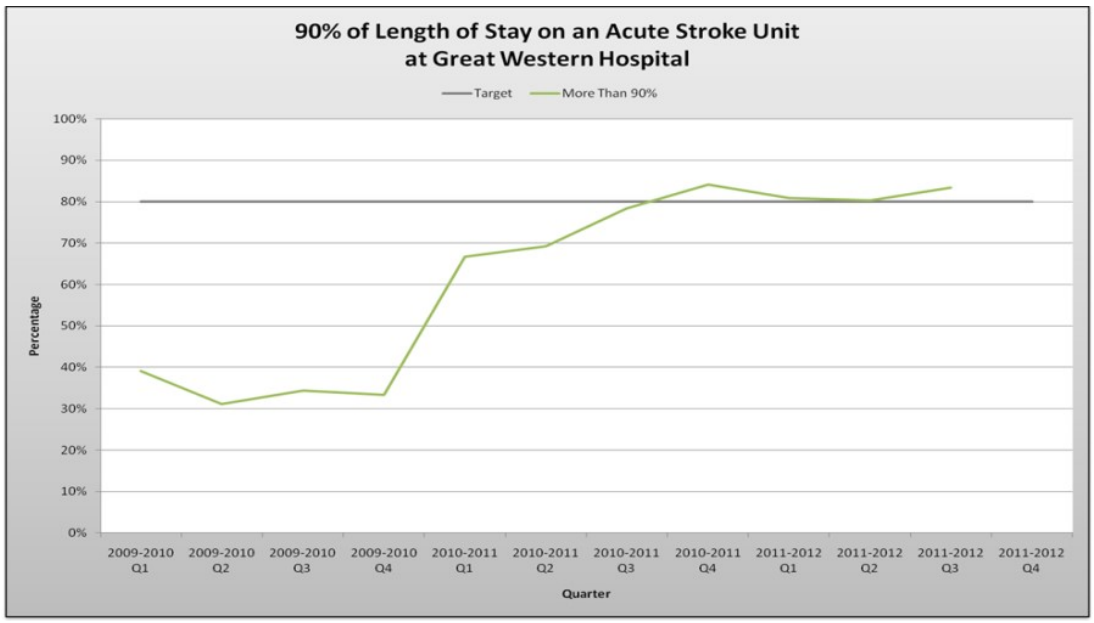
Community were being integrated with GWHFT throughout 2011. Both elements of the Trust were using MUST but training programmes, targets and audit methodology have been different. The Nutrition Steering Groups have been merged and a new integrated Trust Nutrition & Hydration Steering Group has been established which is developing a comprehensive work plan. This should ensure more consistent reporting and activity in the coming year

Wiltshire conducts a qualitative audit 6 monthly. For the purposes of this report an average of all wards is used for the key parameters of the audit.

- A regular ongoing training programme ("MUST" & nutrition action planning) for all Neighbour Hood teams and community Hospitals to ensure accuracy and improve compliance rates.
- Overarching action plan developed for NHT to support local planning
- 6 monthly audits undertaken for NHT and community hospitals
- Introduction of Nutrition Link Workers; role to include audits
- Development of matrons observational audit
- On-going review of "MUST" screening documentation across all localities
- Review of "Food First" nutrition information booklet
- "MUST" training provided in care homes

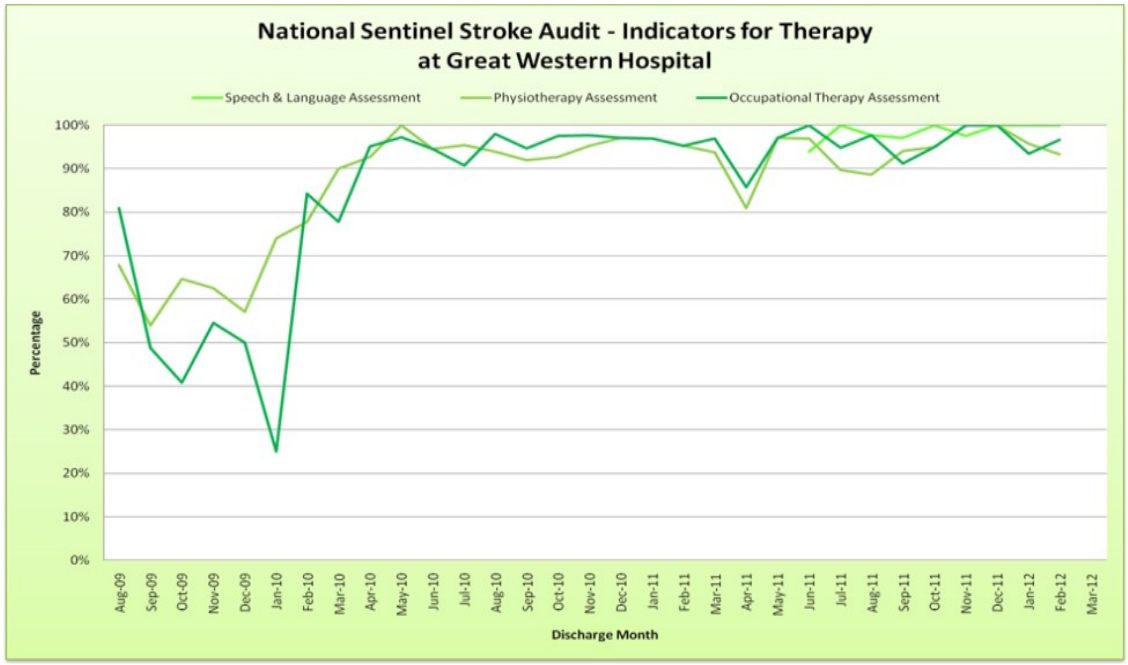
Priority 13: To attain the national Sentinel Stroke Targets

The Acute Stroke Unit at the Great Western Hospital has consistently delivered quality care for stroke patients over the last year. The quarterly target for 80% of patients to spend at least 90% of their length of stay in hospital on an Acute Stroke Unit was first achieved in the last quarter of 2010-2011, and has been achieved for all quarters of 2011-2012.



Patients treated on the Acute Stroke Unit received dedicated treatment and rehabilitation from a multidisciplinary team with specialist stroke skills, patients are consistently:

- assessed within 72 hours of admission, if required, by the Speech and Language Therapist
- assessed within 72 hours of admission by the Physiotherapists
- assessed within 4 working days of admission by the Occupational Therapists



The Great Western Hospital has delivered significant improvements for stroke patients with the 24/7 thrombolysis service. Since the extended service was introduced this financial year in April 2011, 47 patients have been thrombolysed compared to 7 patients in the previous financial year
This is an increase of 60% on from the number of patient's thrombolysed during the limited working hours service (09:00 to 17:00, Monday to Friday).
In addition, the door-to-needle times (from the moment a patient enters A&E to assessment and receiving treatment) are continuing to decrease with less variability between patients.

Patient Experience

Priority 14: To involve patients more in decisions about their care

GWHFT: Overall Target 50% or less

- Q1 Performance April to June 2011: 45.1% - Achieved
- Q2 Performance July to September 2011: 46.6% - Achieved
- Q3 Performance October to December 2011: 46.8% - Achieved
- Q4 Performance January to March 2012: 52% - Not Achieved

The Great Western Hospital collects the views of patients about information on discharge from the Quarterly Inpatient Survey. The National Inpatient Survey 2010 showed that 50% of patients wanted to be more involved with decisions about their care, which demonstrates a slight improvement during 2011/12.

Further actions required:

- Roll out of Ward Managers Surgeries to encourage patients and their carers to ask questions and query care whilst on the ward
- Bedside handovers to keep patients aware of their care and to be informed of any tests or procedures to be carried out during that shift

Community: Overall target 35% or less

- Q1 Performance April to June 2011: 31% - Achieved
- Q2 Performance July to September 2011: 31% - Achieved
- Q3 Performance October to December 2011: 4% - Achieved
- Q4 Performance January to March 2012: 3% - Achieved

Satisfaction surveys are given to all patients upon discharge from the Trust's Community Inpatient areas. Community inpatient services are provided from four wards across three sites, Longleat Ward - Warminster Hospital, Aylesbury Ward - Savernake Hospital, and two wards at Chippenham Community Hospital, Cedar Ward and Beech Ward which is a Stroke rehabilitation Unit.
There are currently low numbers of participants in the surveys. The Community Inpatient Survey will be incorporated within the Patient Survey tender in quarter one 2012/13.

The Community Inpatient Survey results demonstrate that the Community Inpatient areas are consistently achieving this measure.

Priority 15: To ensure staff are available to discuss care concerns with patients and their carers

GWHFT: Overall target 59% or less

- Q1 Performance April to June 2011: 40.7% - Achieved
- Q2 Performance July to September 2011: 54.5% - Achieved
- Q3 Performance October to December 2011: 61.6% - Not achieved
- Q4 Performance January to March 2012: 37.0% - Achieved

The National Inpatient Survey 2010 showed that 59% of patients could not always find a member of staff to discuss concerns with. During quarters one and two 2011/12, there has been an increase in patient satisfaction in this measure, which decreased in quarter three.
Posters showing photographs of the Ward Managers and Matrons have been displayed during March 2012, to inform patients of the Clinical Managers in the ward should they wish to speak with some one. The introduction of bedside handovers will also increase the availability of nursing staff to speak with patients about their care.

Community: Overall target 3% or less

- Q1 Performance April to June 2011: 10.1% - Not achieved
- Q2 Performance July to September 2011: 6.2% - Not Achieved
- Q3 Performance October to December 2011: 9% - Not achieved
- Q4 Performance January to March 2012: 5% - Not Achieved

The results of the Community Inpatient Survey show that there is further work required to improve patient satisfaction in this area.
Further actions required:

- Roll out of Ward Managers surgeries to encourage patients and their carers to ask questions and query care whilst on the ward
- Bedside handovers to keep patients aware of their care and to be informed of any tests or procedures to be carried out during that shift
- Posters showing photographs of the Ward Manager and Matron to be displayed

Priority 16: To ensure patients are given sufficient privacy when discussing care and concerns

GWHFT: Overall target 31% or less

- Q1 Performance April to June 2011: 27.4% - Achieved
- Q2 Performance July to September 2011: 24.8% - Achieved
- Q3 Performance October to December 2011: 29.1% - Achieved
- Q4 Performance January to March 2012: 28.0% - Achieved

The National Inpatient Survey 2010 showed that 31% of patients felt that there was not enough privacy when discussing their care or treatment. The quarterly survey results for 2011/12 show an increase (2%) in patient satisfaction in this area.
A matron within the Planned Care Directorate carried out a privacy audit in November 2011 to collect information on the different ways that privacy notices are used when discussions are taking place around the bedside. As part of the bedside handover, confidential information about patients is discussed away from the bedside. Safety briefings have also been introduced to share information with staff on handover and are carried out away from the bedside.
Further actions required:

- Standardised privacy notices to be rolled out to wards as part of the hygiene module of the Productive Ward

Community: Overall target 20% or less

- Q1 Performance April to June 2011: 6.3% - Achieved
- Q2 Performance July to September 2011: 3.2% - Achieved
- Q3 Performance October to December 2011: 1% - Achieved
- Q4 Performance January to March 2012: 1% - Achieved

There has been an improvement of patient satisfaction in this area during 2011/12.
Further actions required:

- Audit of curtain peg and privacy notice use across community inpatient areas with a view to introducing the Trustwide standardised privacy notices

Priority 17: To improve upon the information given to patients on medication and it side effects

GWHFT: Overall target 49% or less

- Q1 Performance April to June 2011: 30.8% - Achieved
- Q2 Performance July to September 2011: 42.9% - Achieved
- Q3 Performance October to December 2011: 65% - Not achieved
- Q4 Performance January to March 2012: 52% Not achieved

There are a number of ways that side effect information could be provided, and a number of developments have been made over the last year by the Pharmacy department to enable this information to be given to patients. These include, information leaflets included with all discharge medicines, patient information available via the internet and a patient medicines information helpline which is publicised via Outpatients.
The survey results demonstrate that clear guidance needs to be given to both staff and patients.

Further actions required:

- Provision of medicine reminder card with all discharges via pharmacy
- A multidisciplinary meeting including nursing and medical representation to review the process and information sharing of medication on discharge

Community: Overall target 10% or less

- Q1 Performance April to June 2011: 7.3% - Achieved
- Q2 Performance July to September 2011: 21.5% - Not achieved
- Q3 Performance October to December 2011: 21% - Not achieved
- Q4 Performance January to March 2012: 12% - Not Achieved

As with the measure for GWH, there is work around information of medication to be undertaken in Community Inpatient areas. The Community Inpatient areas receive their discharge medication in a different way, however the way that this information is shared with patients can be replicated from GWH.

Further actions required:

- Review of the way medications are given to patients discharged from Community Inpatient areas

Priority 18: To ensure patients know who to contact after discharge if they have concerns about their care

GWHFT: Overall target 26% or less

- Q1 Performance April to June 2011: 34.5% - Not achieved
- Q2 Performance July to September 2011: 21.8% - Achieved
- Q3 Performance October to December 2011: 23.20% - Achieved
- Q4 Performance January to March 2012: 26.0% - Achieved

The National Inpatient Survey 2010 showed that 26% of patients were not told who to contact if they were worried after they were discharged. The Unscheduled Care Directorate has led on the Discharge Policy review and the introduction of discharge leaflets. This links with the work that Pharmacy has been undertaking to improve patient information on discharge. The Unscheduled Care Directorate has facilitated a number of workshops on improving the pathway to discharge.

Community: Overall target 20% or less

- Q1 Performance April to June 2011: 30% - Not achieved
- Q2 Performance July to September 2011: 23.7% - Not achieved
- Q3 Performance October to December 2011: 25% - Not achieved
- Q4 Performance January to March 2012: 19% - Achieved

Community Inpatient areas are managed by the Unscheduled Care Directorate. As the Directorate are leading the work on discharge, it gives an ideal opportunity for good practice to be replicated.

Regulation

Compliance with the CQC Regulations

The Clinical Standards Group (CSG) was set up by the Trust with the remit of monitoring performance against regulatory standards. The group acts as a scrutinizing body for evidence and gap analysis to provide assurance to the Trust Board.

Compliance with the CQC Regulations is assessed and monitored by the CSG and monthly compliance reports inform the PSQC, Executive Committee and Trust Board. Since the Trust merger with Wiltshire Community Health Services, a formal review of assessment methodology has been undertaken by the CSG and a consistent and robust internal compliance assessment process has now been agreed and implemented across the merged organisation.

CQC Inspections

Since April 2010 there have been a total of eight external inspections by the CQC and a schedule of work has been developed to monitor progress with the action plans arising following each inspection

Following the eight inspections, a CQC judgement of not fully compliant for the following three outcomes at Great Western Hospital site has been made:

- **Outcome 1 Respecting and Involving people who use services**
  In April 2011, the Trust was judged as none compliant with Outcome 1 due to its inability to demonstrate the provision of adequate and consistent patient privacy and dignity An action plan was developed and completed by September 2011. In December 2011 a follow up inspection by the CQC deemed the Trust as compliant with some improvement actions.
- **Outcome 4 Care & Welfare of people who use services**
  On December 8th 2011, the CQC specialist inspection for Theatres judged the site as non compliant due to inconsistency of WHO checklist completion.
  Completion of an action plan and subsequent regular internal audits and inspections for assurance has provided clear evidence of compliance and the Trust has declared compliance with outcomes four as from 30th April 2012 with the CQC.
- **Outcome 5 Meeting nutritional needs**
  On December 8th 2011, the CQC inspectors focussed on hydration and after finding three incomplete fluid charts on one ward, judged the site as non compliant.
  Completion of action plans, a Hydration Strategy Internal Review, Productive Ward improvements and subsequent weekly internal audits and inspections has provided clear evidence of compliance and the Trust has declared compliance with Outcomes five as from 30th April 2012 with the CQC.

Other External Reviews

A dynamic database system has been created to enable tracking of all external reviews and inspections. This system enables the Trust to track progress, actions and compliance status and is reported to the Patient Safety and Quality Committee.

CQC Registration & Review of Services

The Great Western Hospitals NHS Foundation Trust is registered with the CQC and its current registration status is "registered" without conditions. The CQC has not taken enforcement action against the Trust during 2011/12

During 2011/12 the Great Western Hospitals NHS Foundation Trust provided seven NHS services and or sub-contracted seven NHS services.

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

The income generated by NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by the Great Western Hospitals NHS Foundation Trust for 2011/12.

The Trust is currently registered with the CQC as a provider of the following regulated activities:

- Treatment of disease, disorder and injury
- Surgical procedures
- Assessment or medical treatment for people detained under Mental Health Act 1983
- Diagnostic and Screening procedures
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Termination of pregnancies
- Nursing care

As a result of the merger with the Community, the Trust submitted a variance to the conditions of its existing registration from June 1st 2011 with the Care Quality Commission (CQC). This included nursing care as an additional community based activity and the addition of 21 community sites/locations. All registered sites/locations and activities have since been re reviewed post merger and registration variation applications are currently underway to reflect the changes.

Subsequent to this and following a lengthy consultation process beginning in September 2011, a final revised version of our CQC registration variance was presented to the PSQC on 1st May 2012. The proposal was also shared with our CQC inspector who recommended submission to the CQC registration department.

The proposal will reduce the number of sites registered with the CQC from 22 sites to 10 sites. Of the removed 12 sites, one would be de-registered as it is no longer part of Adult Services. The remaining 11 sites would be classed as satellite services as per the CQC guidance i.e. registered under GWH as the main provider of the extended satellite services.

Prior to finalising this piece of work and submitting the variance forms to the CQC, Trust board approval will be sought in May 2012.

NHSLA Risk Management Standards - Acute and Maternity Standards

Acute

From June 2011 The Great Western Hospital NHS Foundation Trust merged with the Community.

Prior to merger, the Great Western Hospital had attained NHSLA Level 2 and the Community had attained Level 1. As a merged organisation the NHSLA allocated the Trust NHSLA Level 2. The Trust is required by the NHSLA to undergo a formal Acute Assessment prior to June 2012.

The Trust is to be assessed at Level 1 in May 2012 which will be based upon the revised NHSLA Standards for 2012/13.

Following the Level 1 assessment the Trust will be assessed at Level 2 in November 2012 and will be planning for Level 3.

Maternity

On 1st June 2011 Great Western Hospitals NHS Foundation Trust acquired the Community Health Services and became a merged organisation. The Maternity Services in the Bath clinical area joined the Directorate of Women and Children's.

The Patient Safety Manager was allocated as CNST project coordinator, to lead a combined assessment process and as stipulated in the NHSLA CNST Maternity Standards formal assessment is required within 24 months of transition.

To determine which level the Maternity service should next be assessed at, the Project Co-ordinator produced an options appraisal to determine the risks and benefits of assessment at level 1 or 2. This was presented to Trust Patient Safety and Quality and the decision was made to proceed with a level 2 assessment.

In preparation for assessment:-

- Maternity services staff has been engaged in the joint assessment process.
- Expertise and resources required have been identified including allocating standard and criterion leads.
- A business case has been produced to recruit staff to support the process.
- An informal visit by the CNST Assessor has taken place and another is arranged.
- Governance arrangements and processes have been clarified.
- A joint Maternity Risk Management Strategy is currently under development.
- A project plan has been produced and monthly meetings take place to monitor progress.

The Project Co-ordinator is working with the criterion and standard leads to prepare and ensure that all level 1 documentation for the formal level 2 assessment which is in 2013, is compliant.

National Staff Survey

The year in the run up to the staff survey in 2011 was a challenging one for the Trust. In late 2010, the Trust put in a bid for the Adult Community Services and Maternity services run by NHS Wiltshire and Wiltshire Community Health Services (COMMUNITY). The resources required to support the bid were large and no additional resources were made available to line managers: this presented significant challenges to those involved.

The Trust was named as preferred provider in early 2011 and a programme was set up with a series of work streams to ensure the transition would happen seamlessly. In February, the transition was delayed from 1st April due to the requirements of Monitor. The transition subsequently took place on June 1st: Approximately 1900 employees transferred from COMMUNITY on this date.
Throughout the run up to transition a considerable amount of effort had been put into ensuring that COMMUNITY staff were engaged with the process: Senior Executives visited community sites to explain the Vision; work was started on integrating the two Employee Partnership forums so that by April a joint forum was in place and COMMUNITY and GWH employees were part of the work stream teams. In addition, some Wiltshire Managers were invited to attend the GWH Staff Excellence Awards ceremony in June 2011.

On transition, the key challenge was to integrate the Corporate Back office (CBO) services and deliver a savings programme of £1.3 million in this area. The CBO services covered Finance, Recruitment, Infection Control and Informatics, Estates and facilities, HR, Patient Advice and Liaison Services and the bank and 'e' roster teams.
In the clinical areas, the initial integration only impacted on handful of Senior Managers. Throughout the summer, Line Managers in the CBO reviewed their structures and change papers were prepared for sign off by the Executive Committee and the Employee Partnership forum. A 90 day period of consultation started in September, with team meetings being held followed up by individual meetings with all affected employees.

Throughout the process a sub group of EPF (Employee Partnership forum) ensured that the process was consistent and that issues were addressed quickly. The process ran very smoothly and 45 people were put at risk, although 10 people were successfully re-deployed in the organisation. The savings targets were achieved.

In the autumn, Adult Community services were integrated into the main Directorates: as before a project team was set up to review all the key services and decide which Directorate provided the best fit for the team. The second phase of the integration was completed by the end of October 2010.

In addition to challenges around the working arrangements of GWH and COMMUNITY teams, there was a major challenge on the GWH site with car parking arrangements. Patients were having difficulty to park on site at peak times and so were staff. A consultation process had been put in place and a new policy agreed in late 2010 which would result in restricted access to parking for staff and increased payments. Although the arrangements were due to go live, due to the feedback from staff and technical difficulties, the implementation was delayed until the autumn whilst appeals were held and the infrastructure put in place. There were initial teething problems with the system, however, it has now bedded in and a review is taking place to consider any outstanding issues and lessons learnt.

Engagement Strategy

The prime strategy was to integrate the Community organisation and ensure there was clarity on reporting lines and how to get things done. A transition pack was provided to all employees with details on what was changing for them and what stayed the same. Prior to and after the transition, Community employees were fully engaged in the work streams and conversations about the shape of future services. Community employees were invited to join the Influencing group - a key group in GWHFT that had developed new values for the Trust which were being rolled out.

The GWHFT has a strong relationship with the Employee Partnership forum (EPF) and work on integration with the Wiltshire Workforce Partnership forum started in January 2010, so that a new agreement was in place and joint meetings being held from April 2011. All major change papers that affect organisational structures are presented to this forum before the organisation starts consultation, an example of the effectiveness of the process is that we have no appeals or employment tribunal claims as a result of the CBO re-structure programme.

Subsequent to the transfer, Executive meetings such as Trust Board and Executive Committee have been held in the Community and the EPF alternates between Swindon and Devizes.

As part of embedding the Values, the Trust has implemented a monthly Staff recognition programme in addition to the yearly Staff Excellence award ceremony. The winners of these awards are recognised in the monthly team brief: winners have been from both the Community and Acute settings.

Other parts of the engagement strategy have been to ensure that all organisational communications, such as the Team brief and Horizon have coverage of issues and news across the whole organisation. Another initiative has been to ensure that we have Employee Governors from the Community and that membership of the Trust is widened to ensure that it includes a good proportion of individuals in Wiltshire.

In addition to the Staff survey feedback, in early 2012 the Trust asked for feedback in the form of a questionnaire from key employees involved in the pre and post transition phase and a workshop was held, facilitated by NHS Elect to understand what went well and what could be done differently next time. A feedback questionnaire has also been designed which will go out to the wider community to understand key issues around the transition and what improvements can be introduced.

Staff Engagement – Staff survey results

The Trust's score for 2012 was 3.66, this compares with our score last year of 3.59 and an average for acute trusts in 2011 of 3.62. This score means that we are better than average when compared with other acute trusts in 2012. This compares with our score of last year being worse than average compared with acute trusts. The average for acute trusts between 2011 and 2012 did not change from 3.62. We are in the top three Trust's for the South West.

There are three elements that make up the overall staff engagement score, KF 31 (contributing to improvements at work), KF34 (recommendation of the trust as a place to work) and KF 35 (staff motivation). The only indicator that has changed is staff motivation which is better than 2010; we are now in the best 20% of Trust's for staff motivation. Whilst this is down to improvements in our scores it also shows that we have managed to increase this indicator when other trusts have seen reductions.

Key priorities and targets

One of the key areas that GWHFT will be focussing on in 2012 will be the introduction of a new performance review process which will be the same across the Community and Acute sites. The current appraisal process in GWHFT is not well structured and development is not clearly linked to the current role; the new process will address this.
This initiative will address three of the bottom four ranking scores, KF13 (% having well structured appraisals), KF14 (% appraised with personal development plans in last 12 months) and KF10 (feeling there are good opportunities to develop their potential at work). The target would be that the survey results next year shows that we are average compared with other Acute Trusts on these indicators.

In terms of other priorities that the Trust has identified to improve this year include:-

- KF 1- Feeling satisfied with the quality of work and patient care they are able to deliver (worse than average)
- KF 34 - Staff recommendation of the trust as a place to work or receive treatment (Average)
- KF3 - % feeling valued by their work colleagues (Better than average)
- KF31- % feeling able to contribute towards improvements at work (Better than average)

It is felt that these indicators are particularly relevant for our Values and we want to target these areas.

Details of the key findings from the latest NHS staff survey:

- The response rate for 2011 was 66% compared with 59% last year. The average rate for Acute Trusts in 2011 was 53%. This response rate puts GWHFT in the highest 20% of Acute Trusts.

Areas of improvement from the previous year

Indicator	Average for acute trusts 2010	Trust score 2010	Average for acute trusts 2011	Trust score 2011	Trust improvement /deterioration	Ranking
KF 23. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	8%	8%	8%	4%	4% improvement	Best 20%
KF 2. Percentage of staff agreeing that their role makes a difference to patients	90%	89%	90%	93%	4% improvement	Best 20%
KF 35. Staff motivation at work	3.83	3.76	3.82	3.88	0.12 improvement	Best 20%
KF 38. Percentage of staff experiencing discrimination at work in last 12 months	13%	13%	13%	9%	4% improvement	Best 20%

Areas of deterioration from the previous year

No indicators have deteriorated since last year. 34 indicators have not changed since the last survey and 4 indicators have improved since last year.

Top four ranking scores

Indicator	Average for acute trusts 2010	Trust score 2010	Average for acute trusts 2011	Trust score 2011	Trust improvement /deterioration	Ranking
KF 23. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	8%	8%	8%	4%	4% improvement	Best 20%
KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	15%	13%	15%	10%	3% improvement	Best 20%
KF 16. Percentage of staff receiving health and safety training in last 12 months	80%	92%	81%	92%	No change	Best 20%
KF 38. Percentage of staff experiencing discrimination at work in last 12 months	13%	13%	13%	9%	4% improvement	Best 20%

Bottom four ranking scores

Indicator	Average for acute trusts 2010	Trust score 2010	Average for acute trusts 2011	Trust score 2011	Trust improvement /deterioration	Ranking
KF 13. Percentage of staff having well structured appraisals in last 12 months	33%	34%	31%	34%	No change	Worse than average
KF 8. Percentage of staff working extra hours	66%	70%	65%	68%	2% improvement	Worse than average
KF 14. Percentage of staff appraised with personal development plans in last 12 months	66%	66%	68%	66%	No change	Worse than average
KF 10. Percentage of staff feeling there are good opportunities to develop their potential at work	41%	39%	40%	37%	2% deterioration	Worse than average

Mental Health Capacity Act

The Mental Health Act Administrator provides a three monthly report on the application of the Mental Health Act in the Trust. The report is considered by the Mental Health Act and Mental Capacity Act Committee at each meeting.
From April 2011 – 7th March 2012, the use of the Mental Health Act was applied on 75 occasions in regard of 30 patients.
The 75 occasions relate to 30 inpatients at the Great Western Hospital which include those patients on Section 17 authorisation of leave from other organisations.

Safeguarding Children

Child Protection and Safeguarding continues to have a high profile on the national and local agenda The aim of the proposed reform is to move from 'a system that is over bureaucratised and focused on compliance to one that values and develops professional expertise and is focused on the system and welfare of Children and Young People.

The independent review into Child Protection in England by Eileen Munro was published and 15 recommendations were made. The government responded to these on the 14th July 2011.

- They agreed that the recommendations need to be considered in the round and that they offer the opportunity to deliver holistic reform of the Child Protection system.
- The government will oversee a radical reduction in the amount of regulation through the revision of the statutory framework.
- There will be greater emphasis to work directly with Children, Young People and families.
- There will be a new inspection framework with Children, Young People and families at the centre.
- Greater transparency and co-ordination of local arrangements to deliver early help. Creation of a Chief Social Worker to advise government.
- To be a co-produced work programme between Department of Education, Department of Health, NHS bodies, local authorities and professional bodies to ensure improvement of safeguarding arrangements in healthcare reform.
- That future system review Local Safeguarding Children's Board methodology when serious case reviews are undertaken.

- Munro said no compelling case for national database re children being subject to a plan or Looked After and Government accepted this but will keep under review.

Impact for Great Western Hospitals Foundation Trust

- Swindon is moving to the Signs of Safety and Strengthening Families Model which Munro sites as good practice. This will impact on those professionals working closely with families by increasing time for Strategy Meetings and case conferences (specific impact for Community Midwives, and Named Nurse/Dr and Children's Outreach Nursing Service).
- Need to await any actions from the changes produced by the healthcare reform (no timescale yet).

Training

GWHFT Staff who completed the training on or after 1st April 2011:

CP1 = 2,512 (will include some staff who did the update before the 12 months was up so they'll be counted twice)
CP2 = 303
CP3 = 21

GWHFT Staff still requiring training;

CP1 = 922
CP2 = 401
CP3 = 9

As for the last years a significant amount of training across the Trust is provided by the Named Nurse and the designated doctor – the shortened Level 2 training for medical staff has proved very popular.

Level 1 training has improved significantly across the Trust with each Directorate taking responsibility for ensuring this happens for their staff – this is via a workbook on line so much easier than attending a training session.

Level 2 training is a little more difficult and some areas are still struggling to achieve compliance with this however, the Named Nurse has linked with the majority of departments around putting on additional sessions at various times during the day to make this easier for staff to attend.

Wiltshire community staff link to Wiltshire Local Safeguarding Children's Board (LSCB) and the training arrangements are delivered in a different way to that agreed for Swindon LSCB.
Level 1 - Awareness of Child Abuse and Neglect. This is an e-learning module for all staff which has been reviewed to meet the needs of both hospital and community staff.

Level 2 - Inter Agency Foundation Child Protection. This is a one day course for those who work regularly with children and young people, and with adults who are carers. Update every 3 years. This will include staff from Minor Injury Units, dental services and dietetics.

Level 3 - Inter Agency Advanced Child Protection. This is a two day course for those with a particular responsibility for safeguarding children. Update every 3 years.

Both level 2 and 3 training is delivered by the Wiltshire LSCB training group.

Community staff:
CP1 – data being merged to GWHFT data base. An accurate figure is not currently available.
CP2 – 210 (94%)
CP3 – 154 (99%) for children and young people's services. Data caption on uptake of training for maternity services has been challenging as the workforce access training from two Local

Safeguarding Children's Boards but plans are in place to ensure that all midwives access this training. Data information on Level 1 training is good and indicates an uptake of above 90%.

Strategy Meetings/Case Conferences

The Named Nurse/Dr, Paediatricians/Children's Outreach Nurses/Community Midwifery Manager, Health Visitors, School nurses, community health staff & Midwives attended numerous meetings as in previous years to ensure the safety of unborn babies/children and share relevant information across all the agencies.

Section 11

This is the report which ensures our arrangements are compliant to Safeguard and Promote the Welfare of Children. For 2010-11 we trialled a different way of capturing the information from all Directorates by getting them more involved in the completion of the document and giving an insight into what the Section 11 was all about with more ownership placed on them.

This worked well and the General Manager for Women's & Children's along with the Named Nurse met with the various teams across the Trust in order to complete the audit. We had very good feedback from this audit and we are again planning the same way of organising this for 2011-12 with all Directorates being involved in the completion and ownership.

The document is due to be submitted mid April 2012. The new organisation now links with 2 Local Safeguarding Children's Boards – Wiltshire and Swindon- and GWH will now submit the section11 report to both Boards to ensure compliance with safeguarding requirements.

Good Practice

There is various good practice being shared Trustwide. There has been an ENT DNA flowchart introduced as is already available for Ophthalmology. There continues to be good sharing of information where there are concerns regarding children from key staff in certain departments to the Named Nurse, Ophthalmology, ENT and fracture clinic being very good at this and highlighting any concerns to the Named Nurse as soon as is possible.

Working Together to Safeguard Children states that all Health Professionals working with children should have access to effective supervision from a named professional, who has up to date knowledge of the legislation, policy and research relevant to safeguarding, and promoting the welfare of children (*2010:4.48.*)
An audit of supervision was undertaken on Health visitors and school nurses to evaluate the effectiveness of supervision delivered by the Named Nurses for Safeguarding Children and its effect on supporting practitioners holding a child caseload. The results show that 98% of staff accessed child protection supervision with one staff member saying she could not respond as she had just come into post. All staff were very positive about the supervision seeing it as a good opportunity to reflect on practice and discuss current cases.

Safer Recruitment

Swindon LSCB continues to provide training sessions on Safer Recruitment and Allegations and this is essential under our statutory duties. Staff from the Trust who will play a role in recruitment of staff working with children are asked to attend this training and within the HR section details will be provided of the numbers of these and plans for future.

Within the Wiltshire LSCB the training is recommended as part of overall Recruitment training so there will need to be a review now that both organisations are working together.

Areas to Improve

With the introduction of the new intranet the Named Nurse has worked closely with the Marketing & GP Liaison Manager to get up and running the Safeguard section on the intranet which was an area that was down for improvement in last year's report.

For this year we want to continue to raise awareness of the need for dedicated out-patient lists for children, dedicated paediatric theatre list and recovery and an adolescent unit within the Children's Unit.

The Paediatric ED should be up and running in October 2012 – this will be an area of improvement for children attending the Emergency Department who would usually sit with adults. This area will be both visually and audibly separate, both waiting area and assessment area.

The Children's Unit will work towards a Paediatric Assessment Unit on the ward, this will be for children who do not necessarily need an inpatient bed and are not sick enough to be in ED. The aim is that children will be assessed on the unit within 6 hours and discharged home with our Community Outreach Nursing team phoning the parents the following day to ensure everything is ok.

Within the Children's Unit we have purchased a child friendly questionnaire on a tough book style gadget – called 'Fabio the Frog'. This will enable us to gain feedback from children on the unit.

Bath and North East Somerset (B&NES) and Wiltshire have both had CQC/Ofsted inspections of safeguarding children's services in the last quarter of 2011 -12 and these inspections have included our Community and Maternity services. The reports are currently being drafted and recommendations from these reports will be included in an improvement plan for 2012-13 once they have been finalised.

Dementia Care

The Healthcare Quality Improvement Partnership (HQIP) commissioned the National Audit of Dementia (Care in Hospitals) conducted during the period March 2010 to April 2011.
89% of eligible hospitals representing 99% of Trust/Health Boards in England and Wales participated in the audit. The audit incorporated a review of three wards at Great Western Hospital namely Jupiter, Kingfisher and Ampney wards.

The review focussed on the ward environment, structure and support, the physical environment, experiences of patients and carers on the ward and feedback from ward staff about the awareness of dementia and the support offered to patients with dementia. The Trust performed in the middle quartile against the national average which meant that there were some areas of good practices and areas that require further development.

Hospitals in the South West are working collaboratively to improve standards for people with dementia across the region through a process of developing and monitoring of 8 standards that are reflected in the National Dementia Strategy.

The South West Dementia Partnership peer review was conducted in November 2011 and included areas such as Care of the Elderly, Accident and Emergency, Medical Assessment Unit, Outpatients Department for care of the Elderly, PALS Voluntary Services and the Pre-Operative Assessment Unit. The Trust had positives responses from the review such as the productive ward; introducing 'This is Me' and the trial of hydrant bottles. The Trust Dementia plan for 2012/13 includes the following:

- Expanding the role of Dementia Champions
- Establish a Dementia Strategy Group that would progress actions towards compliance with the National Dementia Strategy

- Strengthen training on Dementia
- Focus on providing a Dementia friendly environment

Cancer National Priorities

	Operational Standard	2011/12 Year End*
Two week wait from urgent GP referral to date first seen for all cancers	93%	✓ 97.1%
Symptomatic Breast Two Week Wait	93%	✓ 97.6%
31 day wait from decision to treat to first treatment for all cancers	96%	✓ 98.4%
31 day wait for second or subsequent treatment - Surgery	94%	✓ 98.4%
31 day wait for second or subsequent treatment - Anti Cancer Drug treatments	98%	✓ 100%
62 day wait for first treatment from Urgent GP Referral to treatment for all cancers	85%	✓ 89.3%
62 day wait for first treatment from Screening Service to treatment for all cancers	90%	✓ 98.4%

Achievement of JACIE Accreditation

The Trust's high dose chemotherapy and Stem Cell Transplant Service received International Accreditation during 2011/12. JACIE (founded by the European Group for Blood and Marrow Transplantation (EBMT) and the International Society for Cellular Therapy (ISCT), the two leading scientific organisations involved with stem-cell transplantation in Europe) is a quality and governance framework that underpins this complex area of medicine.

Following an inspection late in 2011 a report was submitted to the JACIE head office in December and by January 2012 our services were awarded JACIE Accreditation Status which will be valid for four years.

The preparations for accreditation has required a huge amount of work and commitment by numerous members of staff, including Dove Ward, Day Therapy, Clinical Nurse Specialists, Haematology Consultants, Quality and Data Manager, Dietician and Pharmacists.

JACIE accreditation is of great importance to the Trust and to patients as it allows them to be treated in a familiar environment, close to home and to a pre determined Standard of care as set out by JACIE standards.

Participation in National Cancer Clinical Audits

During the last year, GWH Cancer Services have fully participated in the following National Cancer Clinical Audits:

- NBOCAP (National Bowel Cancer Audit)
- DAHNO (National Head & Neck Oncology Audit)
- NLCA (National Lung Cancer Audit)
- NAOGC (National Oesophago-Gastric Cancer audit)

National Cancer Peer Review Programme

GWH has continued to participate in the Cancer Peer Review Programme, in order to provide assurance against national cancer quality standards to patients and commissioners (Peer Review results are in the public domain). All cancer MDTs and services are subject to a rolling programme of

Peer Review, although in 2011-12 a review amnesty was given to the Breast, Colorectal, Lung, Skin and Upper GI teams based on previous good performance. Results of the 2011-2012 Programme are provided below:

MDT or Service	Self Assessment	Internal Validation	External Verification
MDT measures			
Acute Oncology MDT	66.7%	66.7%	n/a
Chemotherapy Clinical Service	75.6%	92.7%	Confirmed
General Acute Oncology	90.9%	90.9%	n/a
General Acute Oncology (inpatients)	50.0%	50.0%	n/a
Gynaecology	86.2%	86.2%	Confirmed
Intrathecal Chemotherapy	100%	100%	Confirmed
Oncology Pharmacy	100%	100%	Confirmed
POSCU Level 2*	97.9%	n/a	87.8%
POSCU MDT*	94.7%	n/a	89.5%
Urology	89.7%	84.6%	Confirmed
Locality measures			
Brain/CNS	100%	100%	n/a
Colorectal	100%	n/a	n/a
Complementary Therapies	100%	n/a	n/a
Head & Neck	100%	n/a	n/a
Sarcoma	100%	100%	n/a

*The POSCU team received an external Peer Review visit in 2011

All teams discussed above will undertake Self Assessment in 2012, along with the teams previously given an amnesty. Internal Validation will also be performed for the following teams/services:

- Upper GI
- Colorectal
- Skin
- Gynaecology
- Specialist Palliative Care

There will be an external Peer Review of the Acute Oncology service this year. No immediate risks or serious concerns are anticipated.

In 2012-13, publication of Peer Review measures for Haematology, Cancer of Unknown Primary and Specialist Palliative Care is expected.

National Cancer Patient Survey

In its second year, GWH continues to fully participate in certainly one of the largest cancer patient surveys to be undertaken anywhere in the world. The national cancer patient experience survey provides insights into the care experienced by cancer patients across England and the 2011/12 survey has been sent to approximately 114,000 NHS patients who have been seen for treatment in hospital during the Autumn of 2011.

Still in progress, early indicators show that the overall national response rate is at 23% (as at March 2012), at the same time the local GWH response rate was at 47%.

Local Cancer Patient Surveys

National Cancer Quality Indicators (National Peer Review Measures) require that provides of services to cancer patients periodically survey relevant patient groups and to ensure observations made by patients are considered and acted upon by relevant multi-disciplinary cancer teams. During the last year the following local surveys have been conducted in addition to the National Cancer Patient Survey:

- Participation in the Royal College of Physician's Survey of Cancer Patients and their experience of urgent/emergency admission to hospital care, April 2011
- Patient & Carer Experience of participating in a Haematology/Oncology Genetic or Quality of Life Study (RCT and Non-RCT), May 2011
- Chemotherapy Pathway Service Improvement Questionnaire, April 2011
- Dermatology Skin Cancer Patient Experience Survey, May 2011
- Breast Screening Survey, August 2011
- Patient satisfaction Survey of Nurse Led Telephone PSA Clinic, August 2011

Participation in Clinical Audits

During 2011-2012, 42 out of 51 National Clinical Audits listed for inclusion in the Quality Accounts 2011-12, and 4 National Confidential Enquiries, covered NHS services that Great Western Hospitals NHS Foundation Trust Swindon provides.

During this period the Great Western Hospital Swindon, participated in 36/42 (86 %) of National Clinical Audits and 100% National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries, which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Great Western Hospital was eligible to participate in during 2011-2012, are listed in the table below along with the National Clinical Audits and National Confidential Enquiries that the Great Western Hospital participated in during 2011-2012.

Name of Audit	Eligible	Participated
Peri-and Neo-natal		
Perinatal mortality (MBRRACE-UK)	Yes	No
Neonatal intensive and special care (NNAP)	Yes	Yes
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes
Pain management (College of Emergency Medicine)	Yes	Yes
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Yes
Paediatric intensive care (PICANet)	No	NA
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	NA
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	Yes
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes
Non invasive ventilation -adults (British Thoracic Society)	Yes	Yes
Pleural procedures (British Thoracic Society)	Yes	Yes
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No

Severe sepsis & septic shock (College of Emergency Medicine)	Yes	No
Adult critical care (ICNARC CMPD)	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes
Seizure management (National Audit of Seizure Management)	Yes	No
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	No
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis & Crohn's disease (UK IBD Audit)	Yes	Yes
Parkinson's disease (National Parkinson's Audit)	Yes	Yes
Adult asthma (British Thoracic Society)	Yes	Yes
Bronchiectasis (British Thoracic Society)	Yes	No
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Elective surgery (National PROMs Programme)	Yes	Yes
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	NA
Liver transplantation (NHSBT UK Transplant Registry)	No	NA
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes
Carotid interventions (Carotid Intervention Audit)	Yes	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	No	NA
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes
Heart failure (Heart Failure Audit)	Yes	Yes
Acute stroke (SINAP)	Yes	Yes
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes
Renal disease *		
Renal replacement therapy (Renal Registry)	No	NA
Renal transplantation (NHSBT UK Transplant Registry)	No	NA
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes
Head & neck cancer (DAHNO)*	Yes	Yes
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	Yes
Severe trauma (Trauma Audit & Research Network)	Yes	Partly
Psychological conditions		
Prescribing in mental health services (POMH)	No	NA

Schizophrenia (National Schizophrenia Audit)	No	NA
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	Yes
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	Yes
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	No
End of life		
Care of dying in hospital (NCDAH)	Yes	Yes
National Confidential Enquiries into Patient Outcome & Death		
Cardiac arrest	Yes	Yes

The Great Western Hospital is not currently participating in the National Cardiac Arrest Audit project; however the Trust has subscribed and made arrangements to participate in the next round of the National Audit.

The Trust chose not to contribute to the repeat audit of National Health Promotion in Hospitals as the Trust was compliant with the standards audited in the initial project and has other internal measures in place to monitor compliance.

In addition the Trust has now signed up to participate in severe trauma (Trauma Audit & Research Network).

Participation in other National Clinical Audits

The Trust participated in a number of other National Audits during 2011-2012 that were considered vital in promoting the quality and effectiveness of patient care. Few of these are outlined below:

Other National Audits
National Cancer Patient Survey (as mandated by the National Cancer Reform Strategy)
College of Emergency Medicine (CEM) - Fractured Neck of Femur's (NOF) in Emergency Department
College of Emergency Medicine (CEM) - Asthma in Emergency Department
CEM - National Audit of Emergency Department Discharge Data on GP Letters
Inpatient Audit of Children with Diabetes (SWPDN)
National Mastectomy and Breast Reconstruction Audit-(4th Round-Final)
National Comparative Audit of the use of Red Cells in Neonates & Children
National Diabetes Inpatient Day Audit
Major Complications of Airway Management

Data Submission

The National Clinical Audits and National Confidential Enquiries that the Great Western Hospital participated in, and for which data collection was completed during 2011-2012, are listed below alongside the percentage of cases submitted to each audit as required by the terms of that audit or enquiry.

Name of audit	Submitted (%)
Peri-and Neo-natal	
Perinatal mortality (MBRRACE-UK)	Ongoing internal review
Neonatal intensive and special care (NNAP)	100%
Children	
Paediatric pneumonia (British Thoracic Society)	Ongoing- data submission deadline- Mar 2012
Paediatric asthma (British Thoracic Society)	100%
Pain management (College of Emergency Medicine)	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	100%
Acute care	
Emergency use of oxygen (British Thoracic Society)	100%
Adult community acquired pneumonia (British Thoracic Society)	Ongoing- data submission deadline- May 2012
Non invasive ventilation -adults (British Thoracic Society)	Ongoing- data submission deadline- May 2012
Pleural procedures (British Thoracic Society)	100%
Adult critical care (ICNARC CMPD)	100%
Potential donor audit (NHS Blood & Transplant)	100%
Long term conditions	
Heavy menstrual bleeding (RCOG National Audit of HMB)	100%
Chronic pain (National Pain Audit)	100%
Ulcerative colitis & Crohn's disease (UK IBD Audit)	100%
Parkinson's disease (National Parkinson's Audit)	100%
Adult asthma (British Thoracic Society)	100%
Elective procedures	
Hip, knee and ankle replacements (National Joint Registry)	100%
Elective surgery (National PROMs Programme)	100%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	100%
Carotid interventions (Carotid Intervention Audit)	100%
Cardiovascular disease	
Acute Myocardial Infarction & other ACS (MINAP)	100%
Heart failure (Heart Failure Audit)	100%
Acute stroke (SINAP)	100%
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	100%
Cancer	
Lung cancer (National Lung Cancer Audit)	100%
Bowel cancer (National Bowel Cancer Audit Programme)	100%
Head & neck cancer (DAHNO)	100%

Name of audit	Submitted (%)
Oesophago-gastric cancer (National O-G Cancer Audit)	100%
Trauma	
Hip fracture (National Hip Fracture Database)	100%
Blood transfusion	
Bedside transfusion (National Comparative Audit of Blood Transfusion)	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	100%
End of life	
Care of dying in hospital (NCDAH)	100%

Review of Clinical Audit Reports

National Audits

The reports of 21 National Clinical Audits were reviewed by the Trust in 2011-12 and the Great Western Hospital intends to take the following actions to improve the quality of healthcare provided. It should be noted that National Clinical Audits may not necessarily report on an annual basis. The key finding, recommendations and actions from these audits are reported to the Directorate Governance meetings and the Trust Board via the Patient Safety and Quality Committee.

No.	Audit Title	Key Learning and Actions Arising from The Project
1.	National Cancer Patient Survey	Actions include- Focussed survey to assess service opportunities in Day therapy centre. Local survey was undertaken and the report is covered under "Local Audits".
2.	National Audit of Dementia 2010	The Trust performed in the middle quartile. The audit demonstrated a few areas of good practice. The action plan has been incorporated into the Trust Dementia Strategy. The Trust has signed up to participate in the next round of National Audit of Dementia.
3.	National Mastectomy and Breast Reconstruction Audit	The Trust performance is in the upper 25% centiles in terms of satisfaction. The time that the clinical nurse specialists take with these patients needs to be recognised for future increase in caseload. The trust must continue to provide patients with sufficient time in their consults to discuss reconstructive issues. It is recommended that those involved in the development of future guidelines on mastectomy and breast reconstruction should refer to the results of high achieving organisations.
4.	College of Emergency Medicine (CEM) - Asthma in Emergency Department (ED)	The audit demonstrated that there is a great improvement with the performance. Areas that need to improve are recording of peak flow, better recording of discharge plans, use of proforma and promote local education and training.
5.	College of Emergency Medicine (CEM) - Fractured Neck Of Femur's in Emergency Department (ED)	The pain scores are not always recorded on NOF proforma and there are delays in analgesia, X-Rays & fast tracking admission. Improvement plan focuses on better recording/education, improvements in ED flow.
6.	College of Emergency Medicine (CEM) - Pain in Children in Emergency Department (ED)	There is improvement in pain scoring, analgesia recording & reassessment.
7.	National Pleural Procedures Audit 2010	The results reflect that 40% of chest drains with pleural effusions are being carried out by Ultrasound guidance. There is no bedside ultrasound is being carried out. High numbers of drains are being put in for undiagnosed effusions. Ultrasound machine has been purchased, local pleural effusion guidelines have been developed, pneumothorax guidelines updated. Teaching and education is done regularly. Other plans include producing a chest drain proforma.
8.	Myocardial Ischaemia National Audit Project-2010	The Trust has demonstrated high compliance with the key performance indicators. The area that needs to improve is time of transfer of patients with nSTEMI (acute coronary syndrome) to cardiac beds on admission.
9.	NCEPOD- An Age Old Problem- Elective and Emergency Surgery in the Elderly	Current practice is in line with most of the national recommendations. There are no recommendations to implement,
10.	College of Emergency Medicine CEM	The project organisers have not provided individual

	– National Audit of Emergency Department Discharge Data on GP Letters.	hospital reports. Local actions include implementation of recommendations from the college.
11.	Data for Head and Neck – DAHNO 6th Round	The Trust is compliant with the majority of the criteria and has shown significant improvement since the last audit in intervals from referral to established diagnosis. Areas for improvement include documentation of chest imaging onto the local database.
12.	Inpatient Audit of Children with Diabetes (SWPDN)	Participation rates were low, however positive with regard to paediatric diabetes staff but critical of other health professional's knowledge. Patients and parents were happy with amount of contact with Dr, paediatric diabetes specialist nurse (PDSN) and Dieticians. Patients and parents felt there was a need for psychological services to be made available (particularly at diagnosis). Over half of the Parents and patients said they visited the clinic 4+ times. Majority of patients and parents felt they had enough choice re: insulin regime. Over 80% of patients and parents felt they could contact their PDSN or Dr outside of their appointment, and this that service was valued and useful.
13.	The National Oesophago-Gastic Cancer Audit (NOGCA)	The aim of the audit is to look at the diagnosis, staging, and treatment planning process, curative treatment outcomes, palliative oncological treatment (chemotherapy / radiotherapy) and endoscopic / radiological palliative therapies. The Trust is compliant with the recommendations made by the national audit. The surgical treatment is offered in Oxford. The Trust aims to continue with the current practice and participate in the next round of the national audit.
14.	National Lung Cancer Audit (LUCADA) -2009/10	The Trust is compliant with all the standards covered under this project in 2009/10.
15.	Consultant Sign Off – College of Emergency Medicine (CEM) Audit 2011	This audit was to review of selected patient groups by a consultant in Emergency Medicine prior to discharge from the Emergency Department (ED) or admission to hospital. The results showed that there is limited consultant availability in ED in the evenings and at night. Consultants in the department have started to cover shifts from 3pm to 7pm. There should be teaching of all ED staff to underline the importance of review of these patients prior to discharge. Results of the national audit will be taken forward by the College to look at national guidance on staffing levels in emergency departments.
16.	Major Complications of Airway Management	The project aimed at focusing on the complications of airway management in the NHS hospitals across the UK. Although the Trust did not have any eligible patients for the audit, the trust is compliant with the recommendations made by the Royal College of Anaesthetists.

17.	Carotid Interventions Audit 2010	The trust has demonstrated excellent clinical outcomes. The next steps include, a planned patient experience questionnaire from August 2011, further joint working with stroke team to streamline pathway, and improved data submission.
18.	National Diabetes Inpatient Day Audit-2010	This Audit was to asses the care received by diabetic patients. Actions include raising awareness of the Think Glucose Initiative across the whole of the trust to improve patient care.
19.	National Comparative Audit of the use of Red Cells in Neonates & Children - 2010	Participation in the National Audit reflected that the Trust is compliant with the majority of the recommendations. Action plans include drawing up new guidelines and policies for the use of red cell transfusions to all children and not just neonatal groups, promote education about safe prescribing and administration of transfusions. Re-audit with a focus on pre and post transfusions Hb levels and the recommendations around documentation and prescriptions.
20.	College of Emergency Medicine (CEM)- Paediatric Fever	There is a need for training and supervision for medical and nursing staff so that the guideline is both understood and becomes part of the normal practice of our departments.Actions include: Dissemination of the results and revision of paediatric proforma to capture all elements required on admission with fever.
21.	National Paediatric Diabetes Audit 2010	This National report is two years out of date and changes have already been made to the service. Recent data suggests that the Trust is performing equal to or above the National Average. Actions that have been completed include increase in diabetes support nurse.

Regional Audits

The following list represents a selection of the actions the Trust has taken/will be taking in response to recent completed regional clinical audits:

No.	Audit Title	Learning From The Project
1.	South West Regional Microbiologists – Malaria Audit	Results showed that the majority of patients receive treatment compliant with recommended methods. Only action is to include the British Infection Summary of Malaria Treatment on the Hospital Antibiotic webpage.
2.	Germ Cell Audit-Thames Valley Cancer Network (Testicular Cancer)	The audit focussed on information capture specific to testicular cancer patients and ensures they receive adequate/appropriate information and support. Improvement needs to focus on more visibility of Cancer Nurse Specialist (CNS) in follow ups and change in CNS contact written information. Consider offering prosthesis at time of surgery and

		whether sample prosthesis should be available in clinic. Website address to be written in front of testicular booklet.
3.	Hepatitis B uptake and completion rates (South West BASHH Audit)	The standards were based on BASHH Guidelines. The results were based on feedback received from 10 different Trusts in the region. Overall, the local department at GWH was one of the best performing clinics in the South West. Regional recommendations include devising standardising risk proforma for the region, discuss pre and post vaccination results and discuss how to improve vaccination course completion and learn from the best performing clinics.
4.	Gas bacteraemias in South west (invasive Group A streptococcal bacteraemia)	This review aimed to determine mortality from GAS bacteraemia in the South West region of England. The Trust's current antibiotic guidelines are satisfactory and do not need amending.

Local Audits

The reports of 273 local clinical audits were reviewed by GWHFT, Swindon in 2011-2012. Summary outcomes and actions reports of completed audits are routinely reviewed at the Directorate Governance Meetings with exception reporting to Patient Safety Quality Committee. The following list represents a selection of the actions the Trust has taken/will be taking in response to recently completed local clinical audits in order to improve the quality of healthcare provided to patients:

No	Audit Title	Audit Summary/Learning and Action
1.	Antibiotic Missed Doses	The audit was aimed identify the reasons behind missed antibiotic doses and to try to see any trends or eductional issues with an aim to address these issues and look at the need for a possible change in procedure or for futher education. The results demonstrated partial compliance. Actions include- Antibiotic working group to promote training for staff groups.Look into possibility of adding a feature to the antibiotic newsletter. Ward stock lists to be made available on the pharmacy intranet.
2.	Image Guides Musculo-Skeletal Injection Review	The overall patient experience is good and results demonstrate patient satisfaction with information provided regarding the procedure in majority of cases. Actions include- Continue with the practice and work on improved explanations of procedure and re-survey.
3.	Surviving Sepsis	The results demonstrate that there are areas for improvement Trustwide. Actions include- Developing & implementing sepsis proforma, change in practice with first dose of antibiotic, information dissemination and education.
4.	Compliance to In-Patient Consent Policy	Audit results demonstrate that there is a high level of compliance in areas of practice i.e. stating demographics, intended benefits, risks. However

		lower levels of compliance can be seen in respect of consenting children compared both to consenting adults. Actions include inserting “check box” into Consent Form 1-4 to require a positive affirmation from the health professional that they are either competent to do the procedure or have undertaken procedure specific training. Raising targeted awareness amongst paediatric surgeons to improve compliance with consenting children. These actions have been impleted and the reaudit is planned in June 2012.
5.	Compliance to Out Patient Clinic Letters (10-11)	Audit results demonstrate that there are only a few areas for improvement pertaining to quality of Outpatient Clinic letters. Areas of good practice include secretaries within the directorates are now pooling the work to enable speedier transcription, voice recognition has proved really successful although cost implications if taken forward for all specialties, letters being sent ‘unsigned to hasten delivery’ to speed up the process.Actions include monthly monitoring on timeliness of clinic letter, continue work on improving timeliness of clinic letters and re- audit.
6.	Compliance with In- Patient discharge letters (10-11)	Audit results demonstrate that there are only a few areas for improvement pertaining to quality of Discharge Summaries. The area that needs to be largely improved is the time frame the discharge summary is sent to the general practitioner.Actions include appropriate changes to eDS system to allow automatic population of ‘source of admission’, colour coding to inspire timely completion, monthly monitoring on timeliness of eDS, education for junior doctors. Encourage clinical engagement within Directorates at each stage of the audit, review data collection proforma and re-audit.
7.	Stem Cell Transplant-Patient Satisfaction Survey	The survey was designed to obtain information about the patient experience of stem cell transplantation, including follow-up support. 100% of patients felt involved in decisions about their treatment and felt comfortable to ask questions. They were all able to meet the dietician prior to their transplant. There were positive responses with regard to the role of clinical nurse specialist. 50% of patients felt they would benefit from seeing a clinical psychologist. There were some issues with cleanliness and standard of meals. Extremely positive results received for standard of care post discharge.Actions include changes to patient information leaflet to emphasise the details of support available for the relatives. A clinical psychologist is now in post. Cleaning is being monitored by the ward and fed back to Carillion.
8.	Diabetes Ketoacidosis (DKA) Management	Majority of patients are managed according to the guidelines however capillary ketone measurement to confirm diagnosis is not done well and there is lack of awareness and over reliance on urinary ketones. Actions include: To add a new sheet to the DKA

		protocol for nurses to check, as well as clear indication for stopping insulin infusion .To ask Emergency Department Assistants to ensure that ketones strips are always available.
9.	Re-Audit Use of Troponin Test	The reaudit illustrated a large improvement in performance. The initial audit results showed poor compliance with only 28% of test fully complying with guidelines. The guidelines were updated in order to clarify when the tests should be used. After a period of education the reaudit showed 94% of patients now fully complying with guidelines. This process has saved the trust over £4000 per year. Updated guidelines have clarified usage; this is reflected in a reduction in the number of tests ordered.Action Summary-Ward troponin education needs to be incorporated into the induction program for Acute Assessment Unit and Emergency Department.
10.	NICE Self Harm in Emergency Department	Performance is significantly short of NICE guidelines Action Summary- Dissemination of results to encourage better documentation and referral rate for this group of patients. Work with the Mental Health Service to identify what is achievable and to ensure this group of patients are receiving adequate care. Re-Audit following implementation.
11.	Laparoscopic Cholecystectomy (LC)- Patient satisfaction - Important factors to patients	The review aimed at assessing the importance of cosmesis v's other factors in gall bladder surgery.93% of patients were happy or extremely happy with the current procedure. 48% experienced some wound related issues (pain, infection) and 65% of those were at the umbilicus. Cosmesis was rated less important than other factors in gall bladder surgery. Action Summary-Given patients are generally satisfied by the current procedure, the aim is to invest in improving day case rates for LC.
12.	Obstetric Haemorrhage (Midwifery Led Unit)	This audit demonstrated good compliance with the correct management of Post Partum Haemorrhage within the setting of the midwifery led unit or if transfer to an acute unit was required, however it highlighted some areas for improvement in documentation. Actions include - All staff to be made aware of the need to: - Document discussion of events and discussion with parents of reasons for transfer and consent. Respirations and fluid balance charts should be documented where appropriate and revise audit tool.
13.	Client Identification at Hillcote	The audit demonstrated 100% compliance. Hillcote have improved greatly on recording the NHS number or any appropriate number of their photo pages. The service will aim to continue with this high level of performance.
14.	Provision of Information about Prescribed Medicines	The audit aimed to gather baseline data on patient's perceptions of the quality and quantity of information they received about medicines newly started at GWH. Majority of patients reported being given information on what medicine was prescribed, why it was prescribed and how to take it, during their hospital stay. Furthermore, the results demonstrate a very low

		compliance around information provided on what side effects patients might experience and what to do in that case. A large proportion of patients did not know how long to continue new medicines for. 70% patients were satisfied or very satisfied with the surveyed aspects of information given. This represents a mis-match between what Health Care Professionals and patients believe constitutes appropriate information.Action plan includes developing a "Provisions of Medicines Policy" detailing a list of MUST and SHOULD actions for provision of information. "Patient information leaflet" must be given with all supplied medicines. Electronic discharge summaries to be standardised. Implementation of "Patient Medicines Information Helpline". Ward Pharmacists to use available opportunities to speak to patients about newly prescribed medicines and relevant information in a timely manner. Re-audit is planned when actions have been implemented.
15.	Non Invasive Ventilation (NIV)	In general, NIV is being used appropriately. The key learning is to modify NIV Nursing chart to include record of blood gases.
16.	Vaginal Birth after C- Section	The audit has demonstrated excellent performance in the implementation of recommendations for intrapartum care and antenatal records. The works needs to focus on improvement in documentation of counselling, management and planning required.
17.	The time taken by Emergency Department X-ray to complete X-ray requests made by Acute Assessment Unit (AAU)	A low number (23%) of cases had a delay in having the X-rays performed. The main reasons identified were- No nurse escort and/or Patient not ready.There are discussions planned at inter-departmental steering group and the results will be referred to AAU.
18.	Service Improvement: Chemotherapy treatment on Day Therapy Centre (DTC)	The key actions to improve service include- Promote patient information regarding avoiding same day bloods unless there is a clinical reason to do so, Poster to be produced, Proposal to separate out different chemotherapy types to streamline process and C-PORT chemotherapy capacity tool to be introduced to streamline pathway and increase efficiency to maximise DTC capacity.
19.	Prescribing of Oral Nutritional Supplements (ONS) for Adults at Three Swans Surgery.	There are identified areas for improvement around “advice given to the patients, recording of BMI’s, and documentation of treatment plan. Use of ONS has risen since 2008. Targeted work around each individual patient with recording of essential information and timely periodic review of patients to ascertain continuation of ONS.
20.	Compliance to Patient Group Directions (PGD)	Areas for improvement include amalgamation of PGD policies and agreement on training and competency for PGD’s across the merged Trusts.
21.	Audit of the Prescribing, Monitoring and Administration of Therapeutically Monitored Antibiotics	Overall, the results demonstrate improvements (of various magnitudes) in the indicators of interest relating to antibiotic level monitoring. The plans are to continue with the service and re-audit using the same methodology.
22.	Evaluation of Sedation Practice on	Actions include analgesia and sedation protocol

	Intensive Care Unit	discussion by a multi-disciplinary working group.
23.	Hip Resurfacing	This Review was undertaken following Medicines and Healthcare products Regulatory Agency (MHRA) Alert- Revision of MoM (Metal on Metal) hip replacements. The concerns involved soft tissue reactions which may be associated with unexplained hip pain. The Orthopaedic Department categorised the affected patients with plans to follow-up patients.
24.	NICE CG56 - Ordering of Scans in Paediatrics Incorporating Head Injury	Results demonstrate compliance with the NICE guidance and that there is appropriate ordering and undertaking of CT Scans.
25.	Neonatal Readmissions to the Children's Ward 0-28 Days of Age	Results reflect good communication of breastfeeding care. Actions include- Infant co-ordinator to continue in-house training. Use of Breastfeed observation charts to pick up ineffective feeding at an earlier stage.
26.	SALT (Speech and Language Therapy) - Service Evaluation of the interface between agencies supporting children with Autistic Spectrum Disorders (ASD).	Actions include improved sharing of information using Communication Assessment Form and better communication between the SALT Service and other multi-agencies.
27.	Venous Thromboembolism (VTE)	The results demonstrated that overall compliance was very high. Actions include possibility of using a sticker stating the VTE assessment at each ante natal admission.
28.	Induction of Labour	There was low compliance with documentation of the discussion with the mother about induction of labour in the maternal records. Actions include- Remind all midwives of the importance of discussion of prolonged pregnancy and induction of labour and giving leaflet to supplement these discussions.
29.	VTE Assessment of Screening Prophylaxis	The results reflected very high compliance with the majority of criterion.
30.	Delayed and Omitted Medicines Audit	Actions include all blank missed doses to be reported to the Ward Manager and investigated.
31.	Death Certificate Completion	Areas for improvement identified were recording of Doctor's grade and name, training and education and guidance notes that include clarification on confirmation and certifying deaths.
32.	End of Life	Base line audit results demonstrate that the Trust performance is better that the nationally published data. Actions include- discussion of results with the Commissioners to agree a CQUIN target.
33.	Compliance with Joint Guidelines in Regard to Antibiotic Prescribing	Overall compliance is excellent. Further actions include educating prescribers to ensure patients are switched from Intravenous to oral antibiotics.
34.	Health Records Audit Q2 – Warminster Neighbourhood Team.	Audit demonstrates a very high compliance.
35.	Health Records Audit Q2 – Bradford on Avon, Trowbridge and Melksham Neighbourhood Team's	Audit demonstrates compliance with majority of standards. Areas for improvement include encouraging recording of name and designation of each signatory.
36.	NICE CG124 – Hip Fracture	Audit demonstrated an improvement since 2008. Actions include further teaching sessions to improve

		further compliance. There is ongoing monitoring of this practice to monitor compliance.
37.	Audit on Causes of Delays in Theatre Start Times	There is considerable room for improvement. This includes identification of poor risk patients in advance and receiving the patients into a dedicated holding bay.
38.	Parenthood Education with COMMUNITY	The re-audit demonstrates high satisfaction rates.
39.	Privacy and Dignity at Hillcote	There is improvement since the previous audit in 2009/10. Further actions include checks on induction process and protocol review to promote this further.
40.	Health Records Audit – Minor Injury Unit (MIU) Health Records Audit – Wilton and Amesbury Neighbourhood teams	There are some areas for improvement including improving documentation, recording NHS numbers and ensuring that there are no spaces between entries.
41.	Omitted and Delayed Medicines Audit – Beech Omitted and Delayed Medicines Audit - Longleat	Areas for action include reporting of blank missed doses and drug availability appropriately.
42.	Privacy and Dignity Mixed Sex Accommodation Neighbourhood Teams	Majority of criteria was compliant. Only action was to ensure staff wear ID badges visible on their uniforms and are easily identified by patients. .
43.	Services in the Swindon Community for Children with Continuing Healthcare Needs	Excellent practice demonstrated around identifying acting upon and documenting the children's clinical need. Further work includes improved documentation of care for children with complex healthcare needs and development of local guidelines.
44.	Management of Suspected Cardiac Chest Pain in the Emergency Department	Very high compliance. Actions include changes to a few sections of the "Chest Pain Proforma".
45.	Compliance with Discharge Summaries Audit Report-Quality & Timeliness 2011-12	The reaudit showed that the Trust has demonstrated high compliance with the vast majority of the standards. ALL electronic discharge summaries currently submitted now have values for the data on: Action by GP requested / For GP info, Urgent / Routine, Medication Changed (Y/N). Finally, compliance with the timeliness of inpatient discharge summaries to be with GPs within 1 working day of discharge was 73% (Target-90%). Actions include: dissemination of results, weekly monitoring on timeliness of eDS and educating all clinicians to ensure discharge summaries include all relevant information.
46.	Compliance with Out Patient Clinic Letters-2011-12	The reaudit demonstrated that the vast majority (94%) of the patient records checked reflect a high standard of compliance. Considering that changes to the OP clinic template were implemented on 12th Jan 2012, the compliance with data on: Action by GP requested / For GP info, Urgent / Routine, Medication Changed (Y/N), is 80% (Target-98%).Furthermore, it was observed that the actions in the boxes did match the content/sense of the OP clinic letter. Even though

		there is some improvement with the availability of clinic letter on Medway within 2 working days, there is further improvement required to achieve compliance (% Achieved- 71%, Target-90%). Actions include: Dissemination of results, continue work on improving timeliness of clinic letters and re-evaluate the effectiveness of the mandatory boxes.
47.	Continuing Health Care (CHC) Review Process	Audit identified that, although improvements have been made, further work is required in order that all documents are completed ensuring that all areas of patient need are being met.
48.	Community Patients have an Estimated Date of Discharge (EDD) in their Care Plans (Re-Audit)	7 Neighbourhood Teams have achieved 100% compliance with EDD set and documented within 24 hours. Action includes, non-compliance NT's to benchmark against each other to improve compliance.
49.	Congenital Hypothyroidsm	There is clear evidence of good documentation and institution of treatment and investigation in children born with CHD. In addition, the follow-up is also managed regularly.
50.	NICE CG111 – Nocturnal Enuresis	Although the Children's Continence Service has achieved 100% compliance against the majority of the criteria, the Care Pathway needs to be revised to include the latest published NICE Guidance.
51.	Readmission Review –Unscheduled Care	The review results demonstrate that there is no evidence that suggests any gaps in delivery of care. None of the readmissions were preventable or avoidable.
52.	Readmission Review –Planned Care	The review results demonstrate that there is no evidence that suggests any gaps in delivery of care. Relevant information was provided to all of the patients on discharge. Furthermore, there is no evidence of failure to communicate between acute care and primary care. 100% of patients reviewed showed no evidence of any issues concerning community care prior to readmission. It is recommended that further audits are undertaken to raise any clinical areas of concern and to ensure appropriate financial credits with commissioners. It is also recommended that this work links in with the ongoing Surgical Site Infection (SSI) audit work to identify and potential areas of concern regarding infection rates.

Dr Foster Reviews

All inpatient hospital data is sent to Dr Foster Intelligence based at Imperial College London. The data is analysed to generate case-mix adjusted figures for the following clinical quality and safety indicators:

- Mortality rates
- Re-admissions rates
- Length of stay rates
- Day case rates
- Patient Safety indicators and
- Service Line Indicators

These are then grouped into different diagnoses and procedures group. The data is benchmarked against national and peer averages. When the rate is higher than expected a 'Red Bell' is generated.

Local Audits including reviews flagged as "Red bells" by Imperial College (Dr Foster) are vital in measuring and benchmarking clinical practice against agreed national and local standards. All red bells are investigated by a Lead Clinician which involves going through a sample of patient case notes during the data period to undertake a clinical and a coding review.

The alerts are investigated to identify areas for improvement and explain the reason for deviation in clinical care or processes at the Great Western Hospital.

The following list outlines Dr Foster investigation summary results with actions implemented. The majority of investigations found that clinical care was excellent. In areas where possible improvements were identified these were actioned through business cases, education and other change management methods.

No.	Type And Area Of Alert	Review Synopsis
1.	Day Case Rates -Hydrocele Sac	There were no concerns identified during the review.
2.	Day Case Rates – • Spinal Nerve Root • Adenoid Surgery	Review has recognized improvement around recording of management intent that needs to correlate the recorded outcome.
3.	Extended Length of stay (LOS) Rates- Short Gestation/ Low Birth Weight	The results demonstrate that no babies stayed beyond their full gestational age and the mean gestation prior to discharge was on the lower threshold.
4.	Extended Length of stay (LOS) Rates- • Angioplasty • Coronary Atherosclerosis • Acute Myocardial Infarction	There was no evidence of clinical care being compromised and the updated reports reflect improvement in performance.
5.	Extended Length of stay (LOS) Rates- Knee Replacement	There were significant contributing factors to evidence extended LOS. Furthermore, current performance is in line with expected. Other initiatives have been set up to promote delivery of care.
6.	Extended Length of stay (LOS) Rates- Non Hodgkin's Lymphoma	Review demonstrates that clinical pathways are followed. The cohort of patients was complex, with justified extended LOS. No coding issues identified.
7.	Patient Safety Indicator- Obstetric Trauma	No Areas of clinical concern. Coding issues identified. Actions include - amend coding on MDS3 so that accurate data is collated and providing more specificity regarding the type of tear on MDS3 to ensure the most appropriate codes are assigned .
8.	Mortality Rate - Acute renal Failure	Actions include- Promote working between clinical coders and clinicians to reduce coding errors, Increase use of physiological monitoring plan and timely review on admission. Further input into coding of these episodes has helped reflect our practice more appropriately and the current performance is being reported as better than expected.
9.	Mortality Rate- Aspiration Pneumonitis , Food/Vomitus	This may have been caused by a data upload error - Dr Fosters re-loaded the data on 15 June and the issue is no longer alerting.

10.	Mortality Rate- Peptic Ulcer	Review did not reveal any areas of clinical/coding concerns.
11.	Mortality Rate- Cancer of Colon	No themes emerged concerning delivery of clinical care. No coding issues identified
12.	Patient Safety Indicator- Post Op Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE)	There were coding issues identified. Area for improvement includes reinforcing consistency in assignment of codes for DVT/PE.
13.	Readmission Rates- Percutaneous Puncture of Kidney	Review did not reveal any areas of concerns.
14.	Readmission Rates- Epilepsy-Adults	The review demonstrated that a low number of readmissions were related to the first admission and were unavoidable. Further actions include Junior Doctors' education on recording of specific diagnosis.
15.	Readmission Rates- Delivery	Review did not reveal any areas of concern. Further input into coding of these episodes will help reflect local practice more appropriately.
16.	Re-admission Rates- Epilepsy	The evidence from this data suggests the readmissions were in the patient's best interest and were unavoidable. Recurrent seizures are usually not predictable.
17.	Re-admission Rates- Cancer of brain & Nervous system	The re-admissions were unavoidable in all the cases reviewed. Review demonstrated areas of good practice. Actions include- discharge summaries to specify follow up and monitor performance via Dr Foster.

Research

The number of patients receiving NHS services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 793

Under the direction of the R&D Director and Academic Dean the R&D department continues to increase research activity at the Great Western Hospitals NHS Foundation Trust.
The team has increased to include an R&D Administrator to ensure tight deadlines for approval of research projects are met.

Cancer research remains our largest topic area, accounting for approximately 50% of our activity, however substantial progress has been made in other key topic areas such as Rheumatology and Orthopaedics. Cardiology is now participating in a commercially funded research project and further projects are being considered.

Commercially funded research has grown within the Trust which will allow us to self-fund some research posts in the coming year.

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

All research staff in the Trust are supported with training and guidance through R&D and the CLRN's. All research nurses receive an induction pack and competency pack in addition to their standard induction information.

R&D also fund 0.2 WTE for a trainee accountant to ensure funding allocated to us is utilised effectively and our department can offer transparent accounting. R&D and Finance are always looking for smarter and more efficient ways of working to ensure our funding allocation and income is used in key areas to support research activity, allowing us to offer patient choice in as many areas as possible.
All SOPs (standard operating procedures) within the Research Support Services National Initiative are being implemented to ensure we are compliant with all governance standards.

Recruitment of patients into research studies has decreased this year from 1680 in 2010/11 to approximately 700 this year. This is due to the closure of an observational study that recruited over 800 patients last year. Recruitment into more complex research projects has increased by 5% this year which is an excellent achievement.

Goals agreed with Commissioners

A proportion of the Trust's contracted income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Trust and its commissioners for the provision of NHS services, through the Commissioning for Quality and Innovation payment frame work (CQUIN).
CQUIN 2011/12

Coordinating Commissioner: NHS Swindon
Associate Commissioners: NHS Wiltshire, NHS Oxfordshire, NHS Gloucestershire, NHS Berkshire West, Southwest Specialised Commissioning Group

The financial plan associated with CQUIN in 2011-12 was 2,584k. The Trust achieved £1,624k (estimate based on Q3 position)

The CQUIN proportion of the Trusts contract values will increase from 1.5% to 2.5% from 2012-13. The payment of CQUIN in 2012/13 will be linked to locally agreed quality improvement schemes. CQUIN enables commissioners to reward excellence by paying a quality increment to providers using NHS Standard Contracts if they achieve agreed quality improvement goals.

Nationally Determined performance Targets

	2009-2010	2010-11	Annual 2011-12				
	GWH	GWH	Merged	Merged Target	GWH	WCHS	Achieved / Not Met
Clostridium Difficile year on year reduction^	49	40	19	69	17	2	Achieved
Incidence of MRSA bacteraemia	6	3	2	2 or less	2	0	Achieved
Two week wait from urgent GP referral to date first seen for all cancers	92.6%	97.0%	97.1%	93%	97.1%	N/A	Achieved
Symptomatic Breast two week wait	96.0%	97.2%	97.1%	93%	97.1%	N/A	Achieved
31 day wait from decision to treat to first treatment for all cancers	97.4%	99.0%	98.7%	96%	98.7%	N/A	Achieved
31 day wait for second or subsequent treatment - Surgery	94.7%	98.5%	98.4%	94%	98.4%	N/A	Achieved
31 day wait for second or subsequent treatment - Anti Cancer Drug treatments	99.8%	100%	100.0%	98%	100%	N/A	Achieved
62 day wait for first treatment from Urgent GP Referral to treatment for all cancers	90.3%	92.4%	89.3%	85%	89.3%	N/A	Achieved
62 day wait for first treatment from Screening Service to treatment for all cancers	98.9%	100%	98.4%	90%	98.4%	N/A	Achieved
For admitted patients - Referral to treatment 18 weeks maximum waiting time	95.0%	95.1%	96.1%	90%	96.1%	N/A	Achieved
For non admitted patients - Referral to treatment 18 weeks maximum waiting time	97.5%	97.9%	98.2%	95%	98.2%	99.8%	Achieved
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	95.3%	97.4%	97.0%	95%	95.5%	99.9%	Achieved
The Trust has fully met the National core standards	Compliant	Compliant	Not Fully Compliant	CQC Compliance	Not fully Meeting Outcomes 4 and 5	Compliant	Not Fully Met
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Not measured	Not measured	Compliant	Maintain compliance	Compliant	Compliant	Achieved

What Others Say About us?

Commissioning PCTs Statements

NHS Wiltshire

NHS Wiltshire, as lead commissioner for Wilshire Community Health Services, is pleased to assure the merged Community's second Annual Quality Account. The document is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

This has been a year of transition for the Community; on 1 June 2011 Great Western Hospitals NHS Foundation Trust acquired Wiltshire Community Health Services and became a merged organisation. The Community have joined the Unscheduled and Community Care directorate, Children's and the Bath Clinical Area Maternity Services have joined the Directorate of Women and Children's Services.

The Community provides a range of general and specialist services, and it is right that these services should aspire to make year on year improvements in the standards of care they can achieve. We believe the specific priorities for 2012/13 which the trust has highlighted in the report are appropriate areas to target for continued improvement.

NHS Wiltshire's strategy for improving health and health care services in Wiltshire set out clear priorities for ensuring that wherever possible patients can be looked after in their own home and that they have access to services which offer excellence in terms of clinical outcomes and patient experience. The Quality Account acknowledges the level of the challenge posed in some 2011/12 priorities, particularly in relation to patient falls. We support the Trust's decision to continue to improve patient safety, ensure effective care and continue to improve the patient experience.

We welcome the inclusion of success measures within the Quality Account, providing a gauge upon which service users, carers and commissioners can appraise the Trust's achievements in the coming year. NHS Wiltshire looks forward to continuing to work with Great Western Foundation Trust as they fulfill their commitment to continuously improve the quality of care for our local health service users, their families and carers.

Deborah Rigby
Quality Development and Performance Manager

NHS Swindon

NHS Swindon as lead commissioner has reviewed GWFT Quality Accounts report for 2011/12. The Quality Accounts were reviewed by the Commissioning for Quality group which includes Clinical Commissioning group representation. NHS Swindon can confirm that, in their view, the Quality Accounts complies with the guidelines for application for the trust QA report.

Commissioners monitor performance and the quality of services routinely each month with the Trust. Commissioners can confirm that, to the best of our knowledge, the Trust QA 2011/12 contains accurate information in relation to the services provided.

The Trust has set their priorities by exploring multiple sources ranging from patient feedback to local intelligence collected via incident reporting and complaints, as well as consulting staff and commissioners. The approach to setting priorities is commended by NHS Swindon and we are happy to endorse the targets that have been set. The monitoring of each priority is deemed to be set at appropriately timed intervals for each priority, allowing a timely response to address issues that may cause the target to be missed.

It is good to see the improvements for quality of end of life care for patients and improve access to palliative care services. NHS Swindon would encourage the further integration and collaboration of health and social care community services as a driver to achieve this improvement.

Overall, the Trust has good plans to improve quality during 2012/13, and with the impending transition from Primary Care Trusts to Clinical Commissioning Groups we look forward to working together to ensure that quality of care and services remains key..

Gill May
NHS Swindon Quality Commissioning Lead

Health Overview and Scrutiny Committee Statements

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

The Health Overview & Scrutiny Committee is committed to having a good working relationship with the Great Western Hospital NHS Foundation Trust and, based on the Committee's knowledge, endorses the Quality Account for 2011/12.
The Committee is grateful to the Chief Executive and her team for the regular updates at Committee meetings on what is working well, and in some cases, what is not working so well within the Foundation Trust. The Foundation Trust has been open and transparent throughout the overview and scrutiny process and the committee hopes that this continues through to the next municipal year.

The Committee looks forward to continuing to work with The Great Western Hospital NHS Foundation Trust to continue to improve acute hospital care and community care for the residents of Swindon and the region.

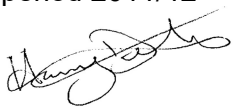
Sally Smith
Overview & Scrutiny Officer for HOSC
Swindon Borough Council

Governors Statement

Over the course of the past year the Governor Group have had the opportunity to receive regular Quality updates at both the Council of Governors Meetings and in the more focused Patient Experience Working Group, which has an open invitation to the local CQC officials,

This group has the opportunity to feed in on a regular basis on matters of Patient Care and is regularly updated on new initiatives. It also on occasions, calls for reports on areas that have been highlighted which are of potential concern. It is a highly motivated group which helps to keep Patient Experience at the top of the Hospitals agenda.

This Quality Report presents a balanced and accurate account of the performance of the Trust over the period 2011/12"



Harry Dale – Lead Governor

Local Involvement Networks' statement (LINks)

Local Involvement Network (LINks) welcomes the opportunity to comment on the draft Quality Account from Great Western Hospital. Swindon has responsibility for co-ordinating responses from other LINks because the Trust's head office is in Swindon. The first draft QA was circulated to LINks in Gloucestershire, Oxfordshire, West Berkshire and Wiltshire. The Trust responded to the initial comments made by LINks and this commentary has been amended accordingly.

Combined LINk comments
In making this composite response we have considered the Department of Health published guidance which includes this statement, "year-round stakeholder engagement during the process of producing a Quality Account and the opportunity for local scrutiny is seen as an important feature to ensure that Quality Accounts are locally meaningful and reflect local priorities."
There is an expectation that GWHFT will demonstrate in this QA that patients and the public have been involved in its production. The Chief Executive's statement clarifies this point as does the Governors' statement.
Ruth Lockwood, GWHFT Associate Director for Quality and Patient Safety attended the October 2011 Swindon LINk steering group to present information to the group about service improvements at GWH mid-year.

Specifically referring to the published draft Quality Account,
The QA appears to reflect the priorities of the local population in broad terms, – patient care, safety, involvement, dignity and nutrition. It was not apparent that any important issues have been missed out. However many of the graphs in the original draft were felt to be confusing particularly with the added dimension of the merger of GWHFT with the Community. We understand that the graphs will be clearer in the final version of the QA.

The use of abbreviations and jargon is often a major problem for people not familiar with the language regularly used in health and care services. We hope that some significant editing between draft and final versions will have added to the document's clarity for a wider readership; as will the addition of the glossary.

The three month backlog of data transfer from paper to electronic systems (incident reporting) may cause doubt over the accuracy of some of the other performance data. However we understand from GWHFT that the backlog should now be in the process of being cleared and that all data is readily available.

We refer to the 2011/12 priority about patient experience "to ensure privacy when discussing treatment and care with patients". People with hearing loss tend to talk and need to listen to people who talk a little louder than normal. We understand that patients are asked if they are happy for their treatment or care to be discussed at the bedside and that they will be moved to a private area if they have concerns about the privacy

.

Whilst there are references to end of life care, there are no specific references to the Liverpool Pathway (LCP) being used when appropriate. We understand that the LCP will be included in the 2012/13 QA.

Care Quality Commission (CQC)

We noted in their October 2011 report on Dignity at 100 UK hospitals the CQC reported that they had moderate concerns at GWHFT. We are pleased to hear that the Annual Report clarifies the position.

Review of Priorities

We are pleased to note that GWHFT have developed the 2012/13 plan to continue to improve in key patient areas such as falls, ulcer and infection. We also welcome the information that the Trust has considered important patient improvement measures where it is felt there is local need and priority and is including dementia as a key quality measure. This also links with the CQC's quality and risk profile.

Jo Osorio
Swindon LINk development officer
22 May 2012
LINk/GWH

Glossary of Terms

BARS – Blood Audit and Release System

Care Bundle – A method of measuring & improving clinical care.

Clostridium Difficile – Bacteria naturally present in the gut

CQC – Care Quality Commission

CQUIN – Commissioning for Quality and Innovation Payment

CUSUM – Cumulative Sum Control Chart

EDS – Electronic Discharge Summary

EPF – Employee Partnership Forum

HCAIs – Healthcare Associated Infections

NHT – Neighbourhood Teams

HSMR – Hospital Standardised Mortality rate

JACIE – Joint Accreditation Committee

MRSA – a common skin bacterium that is resistant to a range of antibiotics

MUST – Malnutrition Universal Screening Tool

NEDs – Non executive Directors

NICE – National Institute for Health and Clinical Excellence

NHLSA – National Health Service Litigation Authority

NPSA – National Patient Safety Agency

PCT – Primary care Trust

PEAT – Patient Environment Action Team

PSQC – Patient Safety and Quality Committee

PURAT – Pressure Ulcer Risk Assessment Tool

RCA – Root Cause Analysis

SAFE – Stratification and Avoidance of Falls in the Environment

SHA – Strategic Health Authority

SWICC – Swindon Intermediate Care Centre

TVNS – Tissue Viability Nurse Specialist

VTE - Venous Thromboprophylaxis (Blood clot)

WHO – World Health Authority