Great Western Hospitals NHS

NHS Foundation Trust

Quality Accounts 2010-2011

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PART 1- Chief Executives statement

We continue to focus our energies on improving safety and patient and carer satisfaction by providing the highest quality care. The past year has been an extremely positive one and we have improved care in a number of areas and delivered some significant service improvements and developed our services.

On safety we made a number of changes and we have seen our Hospital Standard Mortality Rates (HSMR) fall from 95 in 2009/10 to 88.2 in 2010/11. We now undertake regular Methicillin-Resistant Staphylococcus Aureus (MRSA) screening for emergency and elective patients and through rigorous attention to hygiene, hand washing and antibiotic prescribing, we have seen a fall in hospital acquired infection rates – both MRSA and Clostridium Difficile. For MRSA we saw a fall from 5 hospital acquired cases in 2009/10 to 3 in 2010/11 and for Clostridium Difficile a fall from 49 to 40. Our staff have led improvements in many other areas of safety and improved care, including Venus Thromboembolisis (VTE), Ventilator Acquired Infections, patient falls and a significant reduction in pressure ulcers. 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 were scored “excellent” again by an external assessment of the hospital by the Patient Environment Action Team (PEAT). The hospital design means that we can deliver single sex accommodation and bathrooms. Our nursing teams have eliminated mixed sex bays and all ward areas are compliant with this important aspect of privacy and dignity. Further work is underway to segregate the sexes in our Acute Assessment Unit (AAU), which cares for patients requiring urgent medical treatment

We are still seeing the benefits of the Dragon’s Den initiative which we set up in 2009. Following bids from staff, money was invested in services and equipment to help improve safety, patient care and provide more cost effective services. Evaluation of the schemes funded showed demonstrable improvements, for example investing in avoiding Musculoskeletal Disorder injuries to staff has helped to significantly reduce the number of work days lost to injuries and our staff sickness rates fell so that more nurses were able to work during the year, providing invaluable care to patients. In the Breast Centre the Trust was one of the first places in the Europe where patients can now be tested to assess their risk of Lymphodaema prior to Breast Surgery which is helping improve their quality of life after their operation. These examples, and many more, were the result of the creativity and innovation of staff and something which grows ever more important as we tackle the financial challenges of the years ahead.

As a Foundation Trust not only do we ensure that we provide consistently safe, high quality care but we also have to meet the terms of our authorisation which are set out by Monitor (the Regulator of Foundation Trusts) through its Compliance Framework. This covers a range of areas including national requirements such as ensuring patients with cancer receive their diagnosis and treatment in a timely manner and people are seen promptly for both emergency and elective treatment. We are delighted that each quarter we were “Green” for all these important indicators.

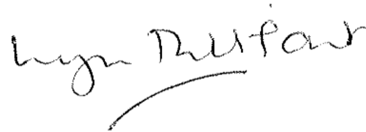
We also have to make sure that we are using public money wisely and manage within the resources that we have obtained through our contracts with Primary Care Trusts (PCTs). Once again this year we saw more patients than we were contracted to see. This is a very important issue for us going forward as we need to support Primary Care in ensuring that patient’s referred to the hospital are similar to the numbers of patients we are commissioned to treat. If we do not do this then it causes both operational and financial problems for the hospital. We ended the year with a b*reakeven* position. Further information on these issues is provided in the annual accounts at the back of this annual report.

The year has been very significant in that we are proud to have been selected as preferred provider for Wiltshire Community Health Services and we plan to take on the responsibility for management of these services. Not only will these services increase the population we serve from 340,000 to approximately 750,000 but it will mean we have delivered an important element of our strategic aim which is to increase the population we serve.

Through our Governors, our members have said they wanted us to improve the patient experience from General Practitioner, hospital and community and social care services. We believe that in becoming responsible for Community Services we have a unique opportunity, not only to improve patient and carer satisfaction, but to reduce duplication and cost. We will continue to work effectively with other health, local authority and voluntary provider services to ensure that we use public funding wisely and provide the best services we can.

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



Bruce Laurie
Chairman

Lyn Hill-Tout
Chief Executive

1.2 - 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 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 for the preparation of the Quality Report

In preparing the Great Western Hospitals NHS Foundation Trust's 2010/11 Quality Report, the directors have satisfied themselves that:

- The Quality Report presents a balanced picture of the 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 subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the quality report.

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

PART 2 Quality Improvement Plan (QIP) 2011 - 2012

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.

This quality and safety strategy explains the key measures against which the Trust will assess that this objective is met and the detailed plans for how these measures will be delivered. Delivery of this strategy will provide both internal and external assurances that robust clinical governance structures and systems are in place, monitored and appropriately managed and that there is a continuous drive to improve the quality of care provided for our patients.

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 enhancing the patient experience.

The Trust proposes four priorities for quality improvement:

1. To improve patient safety and reduce harm.
2. To deliver effective, evidence based care.
3. To improve the patient experience.
4. To comply with governance and regulatory obligations.

The Trust proposes the following areas for reporting on quality performance and improvement within the four priorities indentified:

Priority Area for Quality Improvement	Quality Matrix for measuring and monitoring quality performance	Primary Drivers
1. To improve patient safety and reduce harm	**1.1** Reduce hospital acquired infection • MRSA bacteraemias • *Clostridium difficile* infection	DH CQC regulations Monitor Health Act Commissioning contract Local priority QRP
	1.2 Reduce harm associated with incidents • drug errors • blood transfusion • patient falls	SW Quality and Patient Safety Improvement Programme CQC Monitor Commissioning Contract SHOT NSFs Local priority
	1.3 Reduce Grade 3 and Grade 4 pressure ulcers	CQC Regulations Local priority

	1.4 NPSA – reducing avoidable harm to patients using the key risk categories advised by the NPSA	NPSA – never events Commissioning contract Local priority CQC regulations
	1.5 Reduce preventable hospital mortalities	CQC regulation Commissioning Contract Local priority Patient Safety First campaign
2. To deliver effective, evidence based care	**2.1** Compliance with VTE guidance and action plan	CQC regulations Regional and commissioning contract National priority QRP
	2.2 Improvement in Nutritional assessments and care	CQC regulations Regional and commissioning contract National priority QRP
	2.2 Implementation of the Stroke action plan to ensure compliance with the stroke care pathway	CQC regulations Regional and commissioning contract National priority QRP
	2.3 Review hospital readmissions within 14 days	Commissioning Contract Local priority
	2.4 18 weeks RTT (also defined within the national performance targets).	CQC regulations Regional and commissioning contract National priority QRP Monitor
	2.5 Cancer national priorities (also defined within the national performance targets).	CQC regulations Regional and commissioning contract National priority QRP Monitor
	2.6 Review patient return to theatres within 2 weeks	Commissioning Contract Local priority
	2.7 #NOF – review and monitor timescales to theatre	National and local priority CQC regulations Commissioning contract

	2.8 Compliance with NICE guidance	National and local priority CQC regulations Commissioning contract
	2.9 Compliance with CAS	National and local priority CQC regulations Commissioning contract
3 To improve the patient experience	**3.1** Patients who would recommend the hospital to family and friends	CQC regulations Regional and commissioning contract National priority QRP Picker survey
	3.2 Patients treated with dignity and respect	CQC regulations Regional and commissioning contract National priority QRP Picker survey
	3.3 Patient information on discharge	CQC regulations QRP Picker survey
	3.4 Response times to call bells	QRP Picker survey
4 To comply with governance and regulatory obligations	**4.1** Compliance with CGC regulations and CQC registration	CQC regulations and registration Monitor
	4.2 Improve the Trusts Quality and Risk profile	CQC regulations and registration Monitor
	4.3 NHSLA acute standards – work toward Level 3	CQC regulations QRP Commissioning contract
	4.4 NHSLA maternity standards – sustain Level 3	CQC regulations QRP Commissioning contract
	4.5 Staff survey	CQC regulations QRP Commissioning contract
	4.6 Mental Health/Capacity	CQC regulations QRP Commissioning contract
	4.7 Vulnerable children/adults	CQC regulations QRP Commissioning contract

2.2 Review of services

During 2010/11 the Great Western Hospitals NHS Foundation Trust provided 7 NHS services and or sub-contracted 7 NHS services

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

The income generated by NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Great Western Hospitals NHS Foundation Trust for 2010/11.

The Trust has registered with the CQC as a provider of the following services:

- 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

As part of the merger with Wiltshire Community Health Services (WCHS), the Trust has applied to the Care Quality Commission (CQC) to alter the conditions of its existing registration from June 1st 2011. The Trust has applied to be registered as a provider of an additional regulated activity, namely nursing care, which is carried out at two locations within WCHS. The Trust has also applied to vary its registration with the CQC by adding an additional 21 sites/locations

The quality of care was considered across each of the services delivered, paying particular attention to the feedback of our patients and their experiences, from feedback from our governors and staff, from local themes from complaints and incidents and from data from national centre's and regulatory bodies

2.3 Participation in Clinical Audits

National Clinical Audit's for inclusion in Quality Accounts 2011

During 2010-2011, 38 national clinical audits and 3 national confidential enquiries covered NHS services that GWHFT, Swindon provides.

During that period GWHFT, Swindon participated in 82% 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 GWHFT, Swindon was eligible to participate in during 2010-2011 are listed in the table below along with the national clinical audits and national confidential enquiries that GWHFT, Swindon participated in during 2010-2011.

Audit Title	Eligible	Participated
Adult Asthma	Yes	Yes
Adult Cardiac Surgery	Not	NA

Audit Title	Eligible	Participated
	Eligible	
Adult Community Acquired Pneumonia	Yes	No
British Cardiovascular Intervention Society	Yes	Yes
Bronchietasis	Not Eligible	NA
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No
Cardio- Thoracic NHS Blood & Transplant: UK Transplant Registry	Not Eligible	NA
Carotid Interventions Audit	Yes	Yes
DAHNO - Data for Head and Neck Oncology	Yes	Yes
Depression & anxiety (National Audit of Psychological Therapies)	Not Eligible	NA
Emergency use of Oxygen	Yes	No
European Chronic Obstructive Pulmonary Disease audit	Yes	No
Familial Hypercholesterolemia	Not Eligible	NA
Heart Failure Audit	Yes	Yes
Heavy Menstrual Bleeding	Yes	Yes
Intensive Care National Audit & Research (ICNARC) 2010	Yes	Yes
Liver Transplantation NHSBT UK Transplant Registry	Not Eligible	NA
LUCADA - National Lung Cancer Audit-2010	Yes	Yes
Myocardial Ischemia National Audit Project 2010	Yes	Yes
National Audit of Pharmacological Treatment of Schizophrenia	Not Eligible	NA
National Childhood Epilepsy Audit	Yes	Yes
National Comparative Re-Audit of the use of Platelets	Yes	Yes
National Elective Surgery PROMs - Four Operations	Yes	Yes
National Inflammatory Bowel Disease 3rd Round-2010	Yes	Yes
National Joint Registry	Yes	Yes

Audit Title	Eligible	Participated
National Neonatal Audit Programme 2010	Yes	Yes
National Paediatric Diabetes Audit	Yes	Yes
National Pain Database Audit	Yes	Yes
National Pleural Procedures Audit	Yes	Yes
National Re-audit of Falls and Bone Health	Yes	Yes
National Sentinel Stroke Audit - Round 7	Yes	Yes
National Vascular: Peripheral Vascular Surgery	Yes	Yes
NBOCAP - National Bowel Cancer Audit Project-2010	Yes	Yes
NHFD (National Hip Fracture Database)	Yes	Yes
Non Invasive Ventilation (NIV)	Yes	No
Paediatric Asthma	Not Eligible	NA
Paediatric Cardiac Surgery & Congenital Heart Disease	Not Eligible	NA
Paediatric Fever	Yes	Yes
Paediatric High Dependency Audit	Yes	Yes
Paediatric Pneumonia	Yes	Yes
Parkinson's UK - National Parkinson's Audit	Yes	No
POMH: Prescribing Topics in Mental Health Services	Not Eligible	NA
Potential Donor Audit	Yes	Yes
Prescribing in mental health services (POMH)	Not Eligible	NA
Pulmonary Hypertension Audit	Not Eligible	NA
Re-Audit of the use of Group ORh D Neg Red Cells-2010	Yes	Yes
Renal Colic	Yes	Yes
Renal replacement therapy (Renal Registry)	Not Eligible	NA

Audit Title	Eligible	Participated
Renal Services (Vascular Assess: Patient Transport)	Not Eligible	NA
Renal transplantation (NHSBT UK Transplant Registry)	Not Eligible	NA
Stroke Improvement National Audit Programme	Yes	No
TARN: Severe Trauma	Yes	Yes
CEMACH-Peri natal Mortality	Yes	Yes
Vital Signs in Majors	Yes	Yes
NCEPOD - Cardiac Arrest Procedures Study	Yes	Yes
NCEPOD - Peri-operative Care Study	Yes	Yes

GWHFT withdrew from some of the audits as confirmation received from the audit project organisers that it was a data collection tool and not an audit.
A local audit was recently undertaken to provide assurance with NICE Guidance and hence the Trust did not participate in the Parkinson's UK - National Parkinson's Audit.
The Trust could not participate in BTS audits as there were numerous audits requested by British Thoracic Society at the same time. The Trust is reviewing data capture for the next round of audits.
GWHFT is not currently participating in the Cardiac arrest (National Cardiac Arrest Audit) project. Unlike the other audits listed above, the audit requires local funding - not only in terms of registration but also in terms of administrative support for data collection and data entry. The Trust is currently reviewing how future participation in the project might be funded.

The Trust is currently participating in the Network Stroke Audit which looks at the wider stroke pathway compared to Stroke Improvement National Audit Programme. The Network decided to continue with the current practice.

Participation in other National Clinical Audits

The Trust participated in a number of other national audits during 2010-2011 that were considered vital in promoting the quality and effectiveness of patient care. These are outlined below:

Other National Clinical Audits
Asthma in Emergency Department
BRONJ - National study on avascular necrosis of the jaw including bisphosphonate related osteo necrosis
Care Feedback Following Antenatal Clinic Restructuring
Diabetes Pump Audit
Efficiency of Outpatient Appointments

Other National Clinical Audits
Fractured NOF's in ED
Incidences of problematic stomas
Information Giving in Antenatal Clinics
Inpatient Audit of Children with Diabetes
National Audit of Cardiac Rehabilitation
National Audit of Emergency Department Discharge Data on GP Letters
National Audit of Services for People with Multiple Sclerosis 2011 - Service Providers
National Cancer Patient Survey (as mandated by the National Cancer Reform Strategy)
National Care of Dying Audit - 3rd Round 2011
National Comparative Audit of the use of Red Cells in Neonates & Children
National Confidential Enquiry Head Injury in Children
National Diabetes Inpatient Day Audit-2010
Negative Wound Pressure Therapy
Paediatric Consent - Are we following the guidelines
Pain in Children in Emergency Department
UK wide audit of all colonoscopies
UKONS 24 hour Triage Assessment Tool

Data Submission

The national clinical audits and national confidential enquiries that GWHFT, Swindon participated in, and for which data collection was completed during 2010-2011, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Submitted/Required (%)
Adult Asthma	10/10 (100%)
British Cardiovascular Intervention Society	368/368 (100%)
Carotid Interventions Audit	22/22 (100%)

Audit Title	Submitted/Required (%)
DAHNO - Data for Head and Neck Oncology	18/ 18 (100%)
Heart Failure Audit	207/207 (100%)
Heavy Menstrual Bleeding	Ongoing submission
Intensive Care National Audit & Research (ICNARC) 2010/11	818/818 (100%)
LUCADA - National Lung Cancer Audit-2010	155/155 (100%)
Myocardial Ischaemia National Audit Project 2010	518/700 (74%)
National Childhood Epilepsy Audit	In planning stages-awaiting data submission.
National Comparative Re-Audit of the use of Platelets	20/20 (100%)
National Elective Surgery PROMs - Four Operations	1223/1223 (100%)
National Inflammatory Bowel Disease 3rd Round-2010	40/40 (100%) -Ongoing
National Joint Registry	1178/1178 (100%)
National Neonatal Audit Programme 2010	366/366 (100%)
National Paediatric Diabetes Audit	148/148 (100%)
National Pain Database Audit	25/25 (100%)
National Pleural Procedures Audit	30/30 (100%)
National Re-audit of Falls and Bone Health	60/60 (100%)
National Sentinel Stroke Audit - Round 7	30/30 (100%)
National Vascular: Peripheral Vascular Surgery	22/22 (100%)
NBOCAP - National Bowel Cancer Audit Project-2010	17/ 17 (100%)
NHFD (National Hip Fracture Database)	382/382 (100%)
Paediatric Fever	50/50 (100%)
Paediatric High Dependency Audit	169/300 (63%) (Approx figures)
Paediatric Pneumonia	32/32 (100%)
CEMACH-Perinatal Mortality	28/28 (100%)

Audit Title	Submitted/Required (%)
Potential Donor Audit	276/276 (100%)
Re-Audit of the use of Group ORh D Neg Red Cells-2010	29/29 (100%)
Renal Colic	50/50 (100%)
TARN: Severe Trauma	179/179 (100%)
Vital Signs in Majors	50/50 (100%)
NCEPOD - Peri-operative Care Study	3/3 (100%)
NCEPOD - Cardiac Arrest Procedures Study	2/2 (100%)

Review of Clinical Audit Reports
National Audits

The reports of 12 national clinical audits were reviewed by the Trust in 2010-2011 and GWHFT, Swindon 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 Trust Board via Patient Safety and Quality Committee.

Adult Asthma

The audit aims to identify areas around the early management of asthma, assessment of severity of the condition and more particularly discharge arrangements. Audit results demonstrate the need for a Respiratory Specialist Nurse. Although most of the results are comparable, the outcome shows poor performance when taking peak flow readings and doing unnecessary blood gases. Improvement plan includes presentation of results to Unscheduled Care Clinical Governance and Respiratory Meeting, highlighting importance of non-compliant areas.

British Cardiovascular Intervention Society-2009

The results demonstrate increase in number of procedures performed locally and good care quality reflected by reduction in mortality. There is high compliance with data completeness. Actions include continue with delivery of high standard of care and ongoing participation in the national audit.

DAHNO - Data for Head and Neck Oncology-2009

The trust participated in this national audit, submitting > 85% of expected cases. 95% of patients were seen at multi disciplinary team (MDT). Internal validation reflected that 52% of patients to have interval of less than 21 days from referral to diagnosis and 67 % to have interval of less than 30days between diagnosis & MDT. Most of the key data items relate to treatment activity that takes place in Oxford. Our patients' treatment is recorded under Oxford's audit submission. To facilitate improved data contribution, the Trust is looking into the possibility of promoting data input on our behalf. Clinical Nurse Specialists contact is now routinely recorded on our Cancer Database and is projected to be around 95% for next audit period. Trust will continue to participate in the national audit.

Intensive Care National Audit & Research 2009

Results demonstrate good accurate data input with local performance comparable to national benchmarking and reflects clear improvement in some areas e.g. Night discharge. The trust aims to sustain and monitor performance.

National Lung Cancer Audit-2009

Trust demonstrates high compliance to data completeness & quality, processes of care in place and clinical outcomes. It was apparent from the 2008 report that the figures did not include patients who have not been diagnosed in person. These figures are picked up through other pathways where scans have shown abnormalities. In these cases the results are sent to GPs asking them to re-refer the patient as appropriate.

Myocardial Ischemia National Audit Project 2009

The Trust performance is better than or in line with the national targets. Results demonstrate that the Trust is compliant with the national standards i.e. administering clot busting drugs within 60 minutes (of calling for professional help) in over 86% of patients and within 30 minutes in 100% of arriving through the hospital doors. Percentage of patients discharged on secondary prevention medication is >90%.The trust endeavors to maintain high quality performance, with close monitoring of service delivery including primary percutaneous coronary intervention by reviewing each case on an individual basis.

National Neonatal Audit Programme 2009

The aim of this audit is to assess whether babies requiring neonatal care received consistent care across England and Wales. Results show that our neonatal intensive care unit has achieved high rates of compliance in a number of areas.100% of all infants with gestational ages 26-28 weeks received surfactant (allowing them to breathe more easily). 100% of all infants with a birth weight of <1250g, underwent 1st Retinopathy of Prematurity (ROP) screening whilst still an inpatient and between 42 and 49 days after birth.100% of babies born < 33 weeks gestation receive their mother's milk whilst an inpatient. 57% of babies <28 weeks gestation (up to 27+6) had their blood pressure is measured within 1 hour of birth.71% of babies <28 weeks gestation (up to 27+6) had their temperature measured within 1 hour of birth. We aim to improve data quality.

UK Inflammatory Bowel Disease-2009

The UK Inflammatory Bowel Disease (IBD) Audit is performed within gastroenterology and seeks to improve the quality and safety of care for IBD patients in hospitals throughout the UK. The audit investigates individual patient care, service resources and organisation against national standards. Report demonstrates that the Trust performs above average in nearly all aspects audited.

NATIONAL AUDITS - OTHER

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)-Caring to the End

This NCEPOD report highlights the process of care of patients who died in acute hospitals within four days of admission. It takes a critical look at areas where the care of patients might have been improved. The Trust is almost compliant with the NCEPOD recommendation from this study. The compliance report was presented at Patient Safety & Quality Committee along with action plan to achieve full compliance. Action plan includes further plan to monitor actions through End of Life Strategy Group and local audits to monitor compliance with the standards.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)-Acute Kidney Injury

This NCEPOD report highlights the process of care of patients who died in hospital with a primary diagnosis of acute kidney injury (AKI). It takes a critical look at areas where the care of patients might have been improved. The trust is compliant with the recommendations made by NCEPOD. Further Clinical Audits are underway incorporating criteria from NCEPOD and Society of Acute Medicine.

National Health Promotion in Hospitals-2009

Health promotion and health education are currently a top priority for hospitals in England. The audit aims to assess the proportion of adult hospitalised patients assessed for a risk factor (Smoking, Alcohol, Obesity and Physical Inactivity) and identify the percentage of patients with a risk factor who were delivered a form of health promotion.(Verbal advice, Written advice, Referral to a Specialist or Service). The results from the National audit demonstrate that the Trust compares well with the national average. 100% of patients were assessed for smoking and 42% of smokers were delivered health promotion locally as compared to 35% nationally. 95% were assessed for alcohol.14% patient were found to be obese. Further more advice regarding Physical activity was given to all the patients identified to be physically inactive. Recommendations include implementation of health promotion Integrated care pathways, commitment to delivering it to the patients and re-audit.

National Diabetes Inpatient Day Audit -2009

In September 2009 the first national audit of inpatients with diabetes was undertaken. This has been the largest survey of inpatient diabetes care. It has been immensely valuable in informing health care professionals and managers of the burden of inpatient diabetes, patient experiences and the levels of care provided. Local results show that 88% had experienced appropriate blood glucose testing during the last seven days, compared to 86% of all patients nationally.45% of patients required insulin as an inpatient and 27% received an intravenous insulin infusion, compared to 45% and 23%, respectively.38% reported that they had been visited by a member of a diabetes specialist team (26% for all audit inpatients). 34% of patients reported to have a physical examination of their feet during their inpatient stay, compared to 31% nationally.15% of patients included in the audit had a prescription error compared to 19% or all patients. Actions include undertaking a gap analysis to improve compliance with areas showing care deficiencies and currently comparing our performance after participating in 2010 audit.

<u>Summary</u>

The Patient Safety and Quality Committee (PSQC) takes a methodical approach and examines all national audits reports including that provide good compliance and reflect high quality clinical practice. The Trust takes account of clinical areas that deficit high standard. The Trust actively implement on actions from recommendations made by national audits or national confidential enquiries. Gap Analysis is conducted to close any service deficiency and action plans are drawn up to facilitate improvement.

The Trust Board is meticulous in keeping Clinical Audit as the key component of clinical governance in its efforts to promote patient safety, patient experience and to promote effectiveness of care delivered to the patients.

Key performance indicators stated by the Care Quality Commission, litigation authorities (National Health Services Litigation authority), Royal College's, National Institute of Clinical Excellence (NICE) are managed through the PSQC and directorate clinical governance forums. This ensures full participation in all the relevant nationally recommended audits. This enables the Trust to benchmark against national recommendations and in turn ensures delivery of care at the different contributing specialities. More importantly, it ensures delivery of high quality care to the patients.

The Trust Board promotes active dissemination and implementation of audit results to ensure its effective usage by all stakeholders.
The Trust works closely with the local Primary Care Trust to ensure delivery of high standard of care across patient pathways.

Regional Audits

The Trust is committed to participation in multi-disciplinary/interface audits within the organization and in partnership with other organizations. Interface/Joint audit are used to examine different aspects of care. It concentrates on the interface itself or/and on the experiences of patients as they are transferred from one part of the service to another. The following list represents a selection of the actions the Trust has taken/will be taking in response to recent completed regional clinical audits:

Audit of compliance with Self Harm - NICE Standards

The audit aimed at measuring trust compliance with key aspects of the NICE self harm clinical guidelines. This project has identified consistent adherence to the majority of the NICE standards audited.

South West BASHH Audit on HIV Resistance and HLA B5701

The audit aimed at measuring compliance with national standards. 100% had a resistance test done and were tested for HLAB5701.Continue with current performance.

TSSG Squamous cell Carcinoma Audit

Retrospective audit of all excised cutaneous SCC's was undertaken. Results demonstrate that rates of complete excision at GWH are good. There are areas for improvement that includes documentation of risk factors and, in particular, individual risk factors needs to be improved, documentation of tumour characteristics, documentation of clinical excision margins.

Thames Valley Cancer Network -TVCN Consent Audit

High compliance was demonstrated in other key areas i.e. clinician taking the consent, intended risks and benefits. However, there are some areas that need to be improved -compliance with information leaflet given to the patient. The plans include training and education of health care professionals taking consent and avoid the use of abbreviations and clear documentation of the name of procedure.

Local Audits

The reports of 126 local clinical audits were reviewed by GWHFT, Swindon in 2010-2011. *Summary outcomes and actions reports of completed audits are routinely reviewed by the* PSQC. The following list represents a selection of the actions the Trust has taken/will be taking in response to recent completed local clinical audits in order to improve the quality of healthcare provided to patients:

Productive Theatres

Improve efficiency and effectiveness within Theatres - part of the productive ward initiative. There are no agreed procedures in place for preparing patients for operating theatres or regular process for communicating with wards to allow them to know that specific patients will be collected for operating

theatres. Implementation of a flow chart of the process, education to all ward and theatre staff, liaising with all ward staff to agree on realistic patient transfer times will help promote efficiency. Re-audit is planned for this year.

Parkinson's disease NICE-CG35

Outcome of this audit has shown that, whilst we are compliant with most of the criterias, we fail to provide adequate continuing support for patients once they have been discharged from hospital and in between outpatient appointments. Key recommendations include the design and introduction of patient information leaflets and the introduction of a dedicated Parkinson's Nurse to provide support for patients and families on the ward, outpatients department and on the telephone. Re-audit is anticipated in 1yr.

Primary Percutaneous Coronary Intervention

GWH PPCI service has performed well in 2010 – robust 9-5 service timings improved with learning curve. Ongoing changes have been made on a rolling basis throughout the year. We will continue to monitor action when necessary.

Prescribing & Complications of Fondaparinux

Prescribing of Fondaparinux is a safe method and demonstrates good clinical outcomes. Education of indications and contra-indications has been given to all staff in Cardiology at Clinical Governance.

Time to Surgery for Fracture Neck of Femur (#NOF)

In February and March 2010, 75% of hip fractures presenting to Great Western Hospital received surgery within 36hrs from arrival in Accident & Emergency, or time of diagnosis in an inpatient, to the start of anaesthesia. An anaesthetic flow chart was introduced for patients with hip fractures with operation slots and the option to cancel elective surgery to avoid delay in hip fracture surgery. The reasons for delay and targeted improvements are discussed at the monthly hip fracture care meeting.

Uni-compartmental - Knee replacement - Rapid Recovery

The rapid recovery programme for patients undergoing uni-knee replacement has not been effective as pathway not followed. As a result of the audit, the anaesthetic protocol has been reviewed with a dedicated theatre slot agreed. Patients will be better informed prior to surgery by being offered the opportunity to discuss the procedure individually with the surgeon and physiotherapist and also by having access to a video currently being produced.

Management of Cord Prolapse after Viable Age of Gestation at GWH

Results show 74% compliance to Royal College Obstetricians & Gynaecologists guidelines for the management of Cord Prolapsed. Action Plan include improve documentation of attending team, avoidance of artificial ruptures, new protocol for management cord prolapsed with normal continuous electronic fetal monitoring to avoid general anaesthesia, increase paired cord blood samples. Re-audit.

Outcomes in Macular Hole Surgery

The results show that combined procedure of Phaco/Intra-ocular Lenses (IOL)/Vitrectomy/Internal Limiting Membrane (ILM) peel/Gas for macular hole repair has comparative benefits over vitrectomy alone of: Improved visual outcome and shorter hospital in-patient stay. Monitor compliance.

Lumbar Puncture Documentation

To ensure that when a lumbar puncture is performed it is documented in the patients clinical case notes and includes a minimum data set of criteria as outlined in the standards. The results show that we are compliant for indication for the procedure but showed poor compliance with documentation guidelines in the health record. The department has enrolled use of stickers to assist with including all necessary information in the health record when doing lumbar puncture.

Service Provision in Surgical Assessment Unit (SAU)

This was a patient satisfaction survey with the service and care they receive in SAU. The improvements will focus on promoting patient dignity and produce a patient information leaflet which patients would be given on admission to the unit. Re-audit to take place in 6 months after implementation of above results.

Re-audit of Patients Re-admitted to Acute Assessment Unit (AAU) within 30 days of discharge

The review demonstrated that 70% admissions were related and 14% were avoidable. Measures include improving communication of management with patients, families/carers & GPs, improve documentation, clarify services provided by AAU with GPs, and ensure adequate outpatient support available and education of results to AAU staff.

Audit of step 3 of the baby friendly initiative. 'Giving information to pregnant women'

The baseline audit aimed to check if the correct breastfeeding information has been given to women by 34 weeks of pregnancy. Women demonstrate poor retention of information regarding breastfeeding and there was poor documentation regarding completed information about breastfeeding checklist in notes. Improvement aims at educating each midwife in the Trust to ensure they are delivering effective information to expectant mothers.

Alvarado Score a useful tool in the diagnosis of acute appendicitis?

Aim to assess the validity of the Alvarado score in the diagnosis of acute appendicitis. Implementing or educating doctors about the modified Alvarado score is recommended to aid diagnosis of acute appendicitis. The different aspects of the modified Alvarado score should all be included when clerking a patient presenting with right iliac fossa pain.

Audit of the Blood Collection Process

The GWH NHS Foundation Trust is required to show compliance with the Trust's Blood Transfusion Guidelines for all staff who have received training and competency assessment in the blood administration process. Although almost compliant, transfusion training is now incorporated in the mandatory Trust induction and standing agenda item at Clinical Managers Meeting. The transfusion team will raise and monitor incidents and report on any exceptions.

Re-Audit -Compliance to Health Records Keeping Policy

Aim was to determine the Trust’s current compliance to Medical Record Keeping/filing Policy. Generally most areas are not compliant and need to be improved. Actions include stamps printed with the Name and Grade of each clinician when taking post at the Trust. The wards need to ensure addressograph labels are always available for use in medical records. Provide education sessions to all clinical staff to highlight the importance of maintaining the health record. Re-audit in one year to allow time for action plans to become embedded in practice.

Re-Audit of New GWH Drug Charts

To audit aimed to ensure that the new drug charts are being used safely and appropriately. Partial compliance led to improvements in the new drug chart. It will be re-audited with the up dated version of the new drug charts.

Surviving Sepsis Campaign First Six Hours Compliance

To determine the extent to which the Trust emergency and acute medical departments adhere to international guidelines in the resuscitation of the septic patient - admitted to Intensive Care with sepsis. Trust compliance for the elements audited reflect areas for improvement. A proforma approach to managing these patients may be beneficial that would ensure these bundle criteria are adhered to in a timely manner. This approach should include the doctor giving the first does of the antibiotics.

Summary

The Trust Clinical Audit Department, with the support of Trust PSQC, ensures that the full cycle of clinical audit is maintained, a particular focus is ensured on improving the quality of care to patients. The aim is to affect real change and improvement and not just the provision of unutilised data. The Trust promotes participation in clinical audit and quality improvement initiatives. Members of the different health care professions are encouraged to undertake audits. Patients and other service users are engaged in this undertaking. This optimises the impact of clinical audit in creating partnership between multidisciplinary teams.

The results are actively disseminated to relevant governance groups. Action plans are addressed to facilitate change and identify those tasked to implement service improvement. Re-audits are ensured to ascertain whether improvements in care have been implemented as a result of clinical audit activity.

For areas showing compliance or sustainability of implemented changes, systems are put in place to monitor service improvements once the clinical audit cycle has been completed.

Dr Foster Reviews

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. The alerts are investigated to identify areas for improvement and explain the reason for deviation in clinical care or processes at GWHFT beyond apparent.

The following list outlines Dr Foster investigation summary with actions implemented:

Day Case Rates - Termination of Pregnancy

Cohort of 17 patients reviewed and no cause of concern identified. The Trust aims to monitor & sustain performance.

Extended Length of Stay (LOS)- Coronary Angiography

There is a higher level of acute cases as opposed to elective cases. The results reflect that extended LOS was justified in majority of patients. LOS will be monitored via Myocardial Ischemia National Audit Project database. Furthermore, the performance will improve with the opening of second Catheter lab.

Extended Length of Stay - Normal Pregnancy/Delivery

No cause of concern was identified in the care of these cases. Delayed discharges due to Neonatal complications will be addressed.

Extended Length of Stay - Pneumonia

No instance of prolonged LOS was identified due to delay in diagnosis or delay in institution of medical treatment.

Extended Length Of Stay - Hip Replacement

Most patients in high risk group – complex co-morbidities. No common themes found. The Trust aims to monitor & sustain practice.

Extended Length Of Stay - Endoscopic Resection of Male Bladder

57 % patients were Trial without Catheter (TWOC'd) successfully and went home the following day, 43% either failed TWOC or had medical issues. The improvement plans include development of guidelines for improving processes to facilitate TWOC and discharge of patients with potential of catheter removal in the community.

Day Case Rates - Operation on Vitreous body

The investigation report suggested that it is a complex surgery with high risk of visual disability. No cause of concern identified. Continue monitoring. Discuss with the ophthalmologist the proposal of ways to reduce post operative stay and coding to improve data input.

Day Case Rates - Other destruction of hemorrhoid

The investigation report suggested that the patients are not discharged because of surgery performed in afternoon list and indication to surgery not clearly indicated in operation notes. Improvement plans include discussion with the surgeons the proposal of clearly annotating the indication to discharge on the operation notes and admitting patients for am theatre list.

Mortality outlier for Acute and Unspecified Renal Failure

Having carried out this review with recommendations made by Care Quality Commission, there do not appear to be concerns regarding the clinical care of these patients and areas where quality of clinical care could be improved. The cohorts of patients were elderly with multiple co-morbidities that appeared to be managed appropriately during the patient's admission. This review has provided evidence that clinical care has not been compromised.

Length of Stay - Cardiac Pacemaker

The main preventable delay was from referral to implantation. There are actions in progress. Length of Stay will decrease when the new Catheter lab is open. It is expected that the new cardiology database will, with IT support, allow electronic referral and listing for these patients.

Maternal Re-Admissions following Normal Delivery

The majority of re-admissions were attendances. No clinical concerns were identified in the management of the patients. The plans include working with NHS Swindon to encourage attendance at walk in centre's rather than emergency department, ensure better signposting at delivery to encourage patients to see their family doctor and review coding at point of entry to hospital.

Readmissions within 28 days - Transurethral Resection of Bladder Tumour (TURBT).

No trends identified as a result of the review.

Readmissions within 28 days - Cancer of Breast

Following a triggered alert from Dr Foster, the following area was investigated to ascertain the reason for high readmission rate. The results of the review demonstrated that re-admissions was unrelated, therefore, no cause of concern was identified.

Readmissions within 28 days - Inguinal Hernia Repair

Following a triggered alert from Dr Foster, the following area was investigated to ascertain the reason for high readmission rate. The results of the review demonstrated that re-admissions was unrelated, therefore, no cause of concern was identified.

Mortality Review - Operation on Peptic Ulcer

This review has provided evidence that clinical care has not been compromised.

<u>Conclusion</u>

Other activities include promoting work-based learning and support to healthcare professionals. This promotes learning from the best audits and encourages participation in audits in areas of reduced audit activity.

The Trust provides support to enhance the audit network. It has a wide range of resources, including books, web site links, and skills to set up databases and guidance to help local teams deliver local audit activity.

2.4 Research

The Trust carries out its own research within the Academy, principally in the areas of Cancer studies, Pediatrics, Orthopedics, Anaesthetics, Rheumatology, Dermatology, Hematology and two pandemic flu studies. The Trust follows the research governance standards set out by the Department of Health.

Within the Academy, the Trust has a small Research and Development Team with responsibility for providing advice, support and leadership on matters relating to R&D. The team comprises a clinical lead, R&D Manager and a R&D Coordinator. Detailed below are some of areas where significant progress has been made in 2009/10:

1483 patients were recruited during 2010/11 to participate in research approved by a research ethics committee. This is a slight increase from last year.

The following have been areas of priority for Research and Development over the last 12 months:-

- Increasing the breadth of the portfolio within the Trust to include ICU, Diabetes, Stroke, Rheumatology, Cancer, Orthopaedics, Dermatology, and Sexual Health. We continue to pursue quality research projects for the areas of Cardiology and Diabetes.
- R&D fund research posts within Cancer, Rheumatology, Dermatology, Orthopaedics, ICU, Sexual Health and Stroke to support the research activity, increased the recruitment and set up new projects.
- Funding research roles in support departments like Pharmacy, Pathology, Day Therapy and Radiology to enable them to support research activity within the Trust.

- Support for these research roles is key. We are developing a set of competencies for the research nurses and an induction pack for all new staff. Holding team meetings and training sessions where necessary.

- Developing our processes to further support Trust-Sponsored activity following our first Good Clinical Practice Inspection from the MHRA.

- Working closely with our Comprehensive Local Research Network to streamline our processes, utilise their training packages and for general support and advice.

- Monitoring our funding allocation closely to ensure financial probity and targeted spending in key areas.

2.5 Goals agreed with Commissioners

A proportion of the Trust's contracted income in 2010/11 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 2010/11

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

Expected financial value of Scheme ￡2.3m (approx)

The payment of 1.5% CQUIN in 2011/12 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.'

2.6 What others say about the Provider

NHS Swindon as lead commissioner has reviewed the Quality Account produced by Great Western Hospitals Foundation Trust

The Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered with no requirements.

NHS Swindon has taken the opportunity, to review the Quality Account prepared by the Great Western Hospitals NHS Foundation Trust for 2010 -2011. Associate commissioners from Wiltshire PCT have been involved in the review of the quality of services during the year.

In a shared vision to maintain and continually improve the quality of services, NHS Swindon and Great Western Hospitals NHS Foundation Trust have worked in collaboration to establish a quality framework is in place that includes nationally mandated quality and performance indicators alongside locally agreed quality improvement targets.

The quality account provides information covering the elements of quality. NHS Swindon is satisfied that the Quality Account incorporates all of the mandated elements of a Quality Account.

There are clear arrangements in place with Great Western Hospitals NHS Foundation Trust to agree, monitor and review the quality of its services, covering the key quality domains of safety, clinical & cost effectiveness, patient experience and governance arrangements. This is managed through the Clinical

Quality and Patient Safety Group that meet monthly, with representation from senior clinicians from NHS Swindon, to review, monitor and provide assurance in relation to quality of care.

The national performance targets were routinely managed through a separate performance group.

NHS Swindon agrees that the Quality Account for Great Western Hospitals Foundation Trust contains information that is consistent with data received throughout the year. The Trust has faced challenges during 2010 - 2011 that arose from concerns regarding quality of care in relation to additional beds on wards and privacy and dignity of patients, as well as eliminating same sex accommodation. NHS Swindon has worked in partnership with the Trust to identify, and respond to these concerns and there is further work to be completed in achieving the standards.

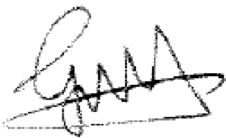
Although the Trust has performed well against most of its quality indicators it is recognised that there are areas where improvement has been slower than expected. The PCT and Trust will work together to address these issues in 2011 - 2012.

The priorities for 2011 - 2012 have been developed in partnership and NHS Swindon endorses the proposals set out in the Quality Account.

Heather Mitchell
Interim Chief Executive
NHS Swindon
3rd June 2011

Governors

During the year the Governors have received regular Quality updates and have had the opportunity to ask questions and have input as necessary. This Quality Report presents a balanced and accurate account of the performance of the Trust over the period 2010/11"



Godfrey Fowler
Lead Governor

2.7 Data Quality

The Trust has a Data Quality Group that has a programme of work that is informed by external and internal audits, regular external and internal data quality reports, national comparative reports as well as data issues raised by Commissioners. This work programme is progressed by the Data Quality Group who report progress and issues to the Trust's Information Governance Steering Group.

The Trust submits patient level data to the Secondary Users Service (SUS) for inclusion in Hospital Episode Statistics and data quality reports are published on a monthly basis from this submitted data and made available to Providers and Commissioners. Performance is generally very good. One of the

key data items is NHS Number which is included as an NHS priority data item. In the SUS flows for April – January 2010/11 the completeness for valid NHS number was:

99.2% for admitted care (compared to 98.5% nationally)
99.6 for outpatient care (98.6 nationally)
97.0 for accident and emergency care (91.1 nationally)

Each year the Trust completes its rating against the requirements of the NHS Information Governance Toolkit. Three components of this relate closely to data quality and consist of several measures in each. The Trust's performance was rated as satisfactory in each (two ratings exist – unsatisfactory or satisfactory, with 70% being the attainment level for satisfactory). The performance levels were:

Information Quality and Health Records Management – 80%
Secondary Use Assurance – 83%
Corporate Information assurance – 77%

In 2009/10 the Trust had two Payment by Results Assurance Audits carried out by the Audit Commission as part of the PbR Assurance Programme. These covered admitted patients and outpatients. In 2010/11 these national audits were targeted at Trusts who were perceived as having ongoing issues and Great Western Hospitals was not in this group.

The Trust did however undertake three audits of admitted patient clinical coding to meet the criteria for the Information Governance Toolkit and to ensure Clinical Coding is regularly audited. Each audit included 200 case notes. The summary performance is shown in the table below.

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
External	88.0%	67.6%	91.7%	88.5%
Internal	90.5%	87.6%	93.0%	79.1%
Internal	94.5%	94.9%	97.5%	93.1%
Overall Average	91.0%	83.4%	94.1%	86.9%
Level 2 Attainment requirement	90.0%	80.0%	90.0%	80.0%

The level 2 attainment requirement is from the Information Governance Toolkit which has four levels ranging from 0 to 3. The poor performance in Secondary Diagnosis in the external audit was affected by new requirements to collect secondary diagnosis such as historical smoking status for the first time and the external audit covered the first month that this data collection was introduced and some coders were still adjusting to the requirements. These requirements themselves have been reviewed by the NHS and many of the extra codes have been dropped for the 2011/12 year.

The clinical coding audits are used to target any additional training requirements and as feedback mechanism to the coding department and individual coders where errors or omissions are seen. The Clinical Coding department is also increasing its feedback to clinicians and this is planned to be rolled out via the Trust data warehouse development 2011/12. The combination of better feedback and more targeted audit should contribute to increased accuracy with the aim of moving towards the performance levels required for level 3 attainment in the Information Governance Toolkit.

A further NHS data quality priority during 2010/11 has been the Psuedonymisation Project. The project aims to reduce access to patient identifiable data to NHS staff using data and information for "secondary use" which is broadly defined as not being for direct patient care. The Trust has a project that is developing better compliance with the requirements and has included work on reviewing data flows and data use not connected to direct patient care (for example Commissioning) and also

reviewing the use of identifiable data within data made available within the Trust for, for example, management and review of performance. The Project reports to the Information Governance Steering Group.

PART 3 - Quality Improvement Plan 2010/11 – Executive Summary

KEY

Below target
On target or better
1 2 3 4 – Refers to Quarterly Reporting

Patient Safety

Item	1	2	3	4
1. To reduce our number of MRSA Bacteraemias	Green	Green	Green	Green
2. To reduce our number of Clostridium difficile infections	Green	Green	Green	Green
3. Medication errors – Reduce harm associated with med errors	Green	Green	Green	Green
4. Zero patients receiving incorrect blood transfusions and safer transfusions	Green	Green	Green	Green
5. Reduce patient falls in hospital	Red	Red	Red	Red
5b Reduce associated harm	Red	Green	Green	Green
6. To reduce our hospital acquired Grade 3 pressure ulcers	Green	Green	Green	Green
7. To reduce our hospital acquired Grade 4 pressure ulcers	Green	Green	Green	Green
8. NPSA –reducing harm – never events.	Green	Green	Green	Green
9. HSMR- reduce preventable hospital mortalities	Green	Green	Green	Green
10. South West SHA Quality and Patient Safety Improvement Programme				

Clinical Effectiveness

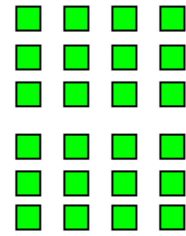
Item	1	2	3	4
11. Increase risk assessment completion for adult patients for VTE	Green	Green	Green	Green
12. Administer appropriate VTE thromboprophylaxis	Green	Green	Green	Green
13. Nutritional assessments and care	Green	Red	Red	Red
14. New Stroke patients spending 90% or more of their time in the hospital on the Acute stroke ward (Falcon) – Q4 only	Green	Green	Green	Green
15. Reduce the rate of emergency re-admissions within 28 days of discharge and 14 days of discharge	Red	Red	Empty box	Empty box
16. 18 weeks Referral to treatment (RTT)	Green	Green	Green	Green
17. Cancer national priorities	Green	Green	Green	Green
18. Return to theatre within 2 weeks	Empty box	Empty box	Empty box	Empty box
19. Fractured neck of femur timescales to theatre	Red	Red	Red	Red
20. Compliance with NICE guidance	Green	Green	Green	Green
21. Compliance with CAS	Green	Green	Green	Green
22. New and Revised Clinical Guidelines and Policies				

Patient Experience

Item	1	2	3	4
23. Patient Recommendations	Green	Red	Red	Green
24. Patients treated with Dignity and Care		Red	Red	Empty box
25. Patient Information on discharge		Red	Red	Empty box
26. Patient call bells responded to within 5 mins				Green

Regulatory Measures

27. Compliance with CQC
28. NHSLA Acute standards.
29. NHSLA Maternity standards
30. Staff survey
31. Mental Health Capacity Act
32. Safeguarding Children



Source Key

CQC –Care Quality Commission
M – Monitor
PC – Primary care

PART 4 - Patient Safety and Reducing Harm

1 To reduce our number of MRSA Bacteraemias

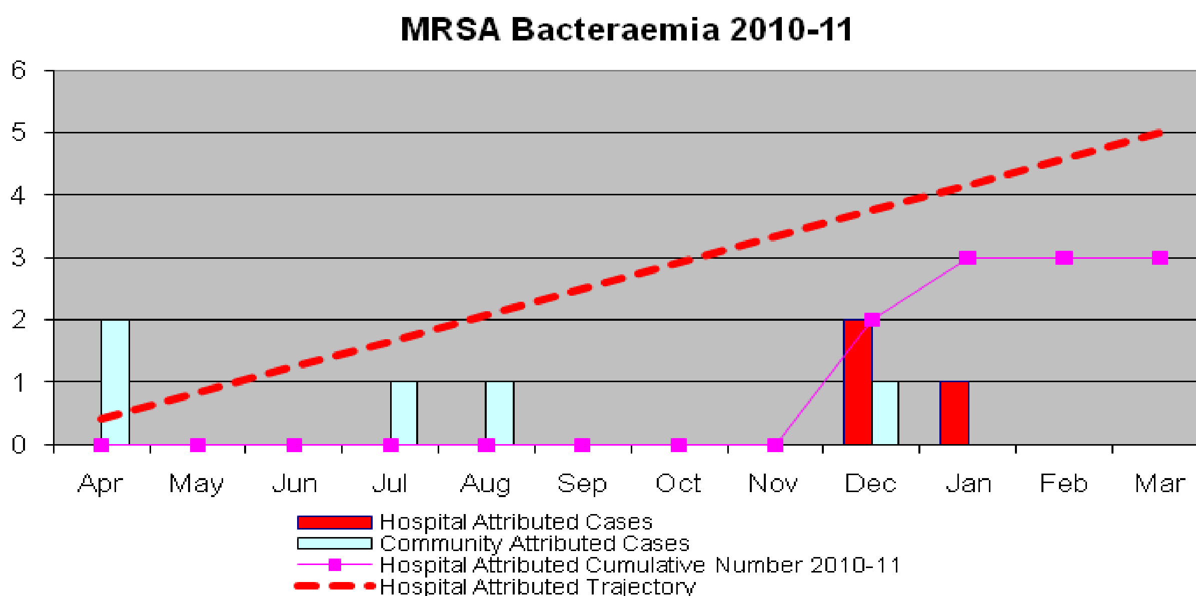
Monitoring	Monthly	**09/10 Target**	6 or less
Source	CQC,M,	**10/11 Target**	5 or less
PC Contract	Yes	**Target achieved**	**Yes (3)**
Leads	Dr Alf Troughton – Medical Director Dr Susan Dawson – Consultant Microbiologist Lisa Hocking – Lead Nurse Practitioner for Infection Prevention & Control		

During 2008/09 and 2009/10 rates of MRSA bacteraemias continued to be low, however the Trust still felt that further measures could be implemented to continue to reduce these numbers in line with national priorities. The goal for 2010/11 was to reduce the number of hospital acquired MRSA bacteraemias to five or less.

Although our MRSA bacteraemia rate per 10,000 bed days was 0.33 during 2009/10, this has increased to 0.59 (October to December 2010), this is because Non-Acute Trust apportioned MRSA bacteraemias are included with Acute Trust data to calculate this rate.

This Trust reported three MRSA bacteraemias for 2010/11, thus showing a 50% reduction in Acute Trust reported MRSA bacteraemias when compared to 2009/10.

Table 1



Local initiatives included:

- Sustained improvement whilst striving for increased compliance with care bundles for peripheral lines and urinary catheters.
- Undertake risk assessments for all patients admitted to GWH aiming for 100% compliance.
- MRSA screening of elective and emergency patients aiming for 100%
- All results reported through the IP&C Forum and the Clinical Governance and Risk Committee (now the Patient Safety and Quality Committee).
- Utilise a rapid process for MRSA screening.
- Core training programmes for nurses, doctors and pharmacists to include antibiotic prescribing

2 To reduce our number of Clostridium difficile infections

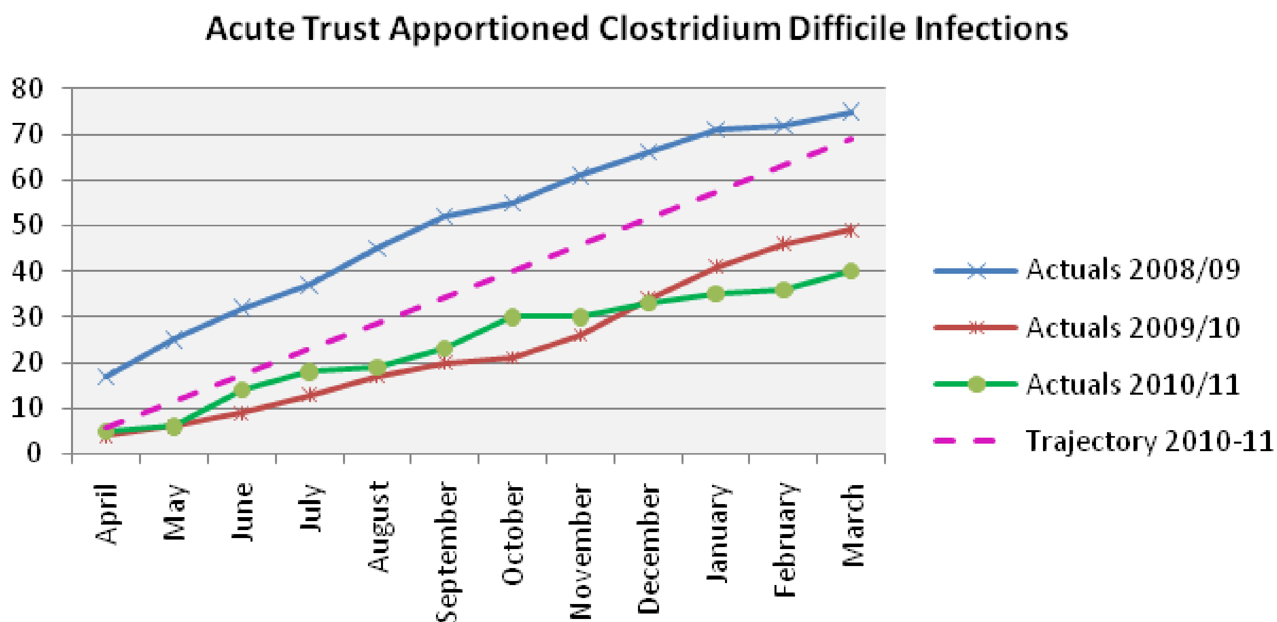
Monitoring	Monthly	**09/10 Target**	69 or less
Source	CQC,M,	**10/11 Target**	69 or less
PC Contract	Yes	**Target achieved**	**Yes (40)**
Leads	Dr Alf Troughton – Medical Director Dr Susan Dawson – Consultant Microbiologist Lisa Hocking – Lead Nurse Practitioner for Infection Prevention & Control		

The goal for 2010/11 was to report 69 Acute Trust apportioned cases or less. This is a locally agreed trajectory with the commissioning PCT and the SHA. The total number of cases reported during 2010/11 was 40, thus showing a reduction of 18% when compared to 2009/10.

Local initiatives to maintain our reduction included:

- Prompt isolation of patients with suspected infective diarrhoea within two hours.
- Rapid testing of suspected norovirus, which allows early identification of norovirus outbreaks and aid appropriate management of outbreaks of diarrhoea.
- Introduction of a weekly ward round for patients with *Clostridium difficile.*

Table 2



During October to December 2010 the rate of Acute Trust apportioned cases per 1000 bed days for GWH was 0.21, which is lower than both the national (0.27) and regional rates (0.24).

Health & Social Care Act 2008

Following the unannounced visit in 2009 the Trust has the action plan has satisfactorily been completed and the Trust continues to audit, review and sustain improvements made and collated as evidence against the Health and Social Care Act.

3 Medication errors – Reduce harm associated with medication errors

Monitoring	Monthly	**09/10 Target**	N/A
Source	Regional	**10/11 Target**	15% or less
PC Contract	Yes	**Target achieved**	**Yes (8.6%)**
Leads	Dr Alf Troughton – Medical Director Jane Coleborn – Chief Pharmacist Mike Lewis – Deputy Chief Pharmacist		

In 2010 – 11 there were a total of 514 medicine related incidents, and of these 7.8% were reported as causing low harm, 0.5% moderate harm and the remainder (91.7%) with no harm or a near miss. There were no medicine incidents causing severe harm or worse. An increase in number of reports in 2010-2011 is a positive sign as the need to report near miss incidents is widely promoted at staff induction and other training as a means of improving safety.

All medicine related incidents were reviewed by a medicines governance pharmacist, assessed for severity, and further investigated when necessary. Where appropriate action plans were put in place to reduce the risk of reoccurrence. Trends around medicines were investigated and reported to the Medicines Governance Group.

Table 3

Medicine Incidents by Harm 2010 – 2011

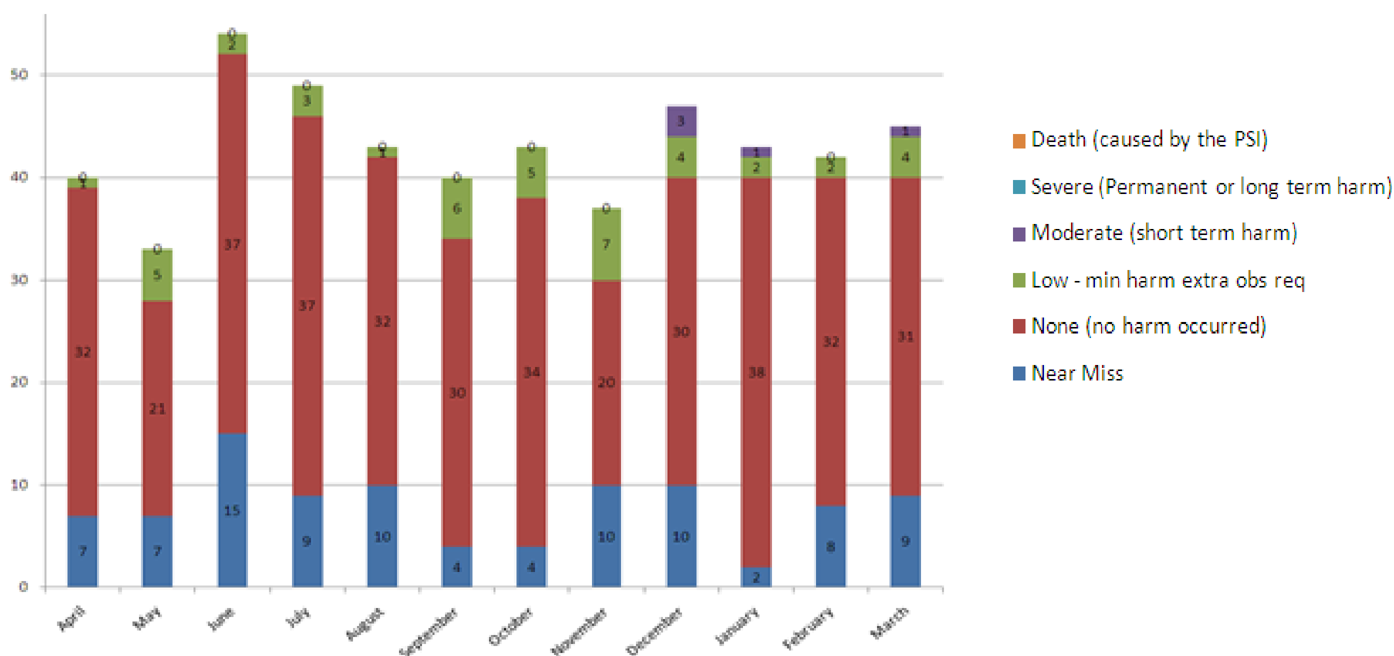
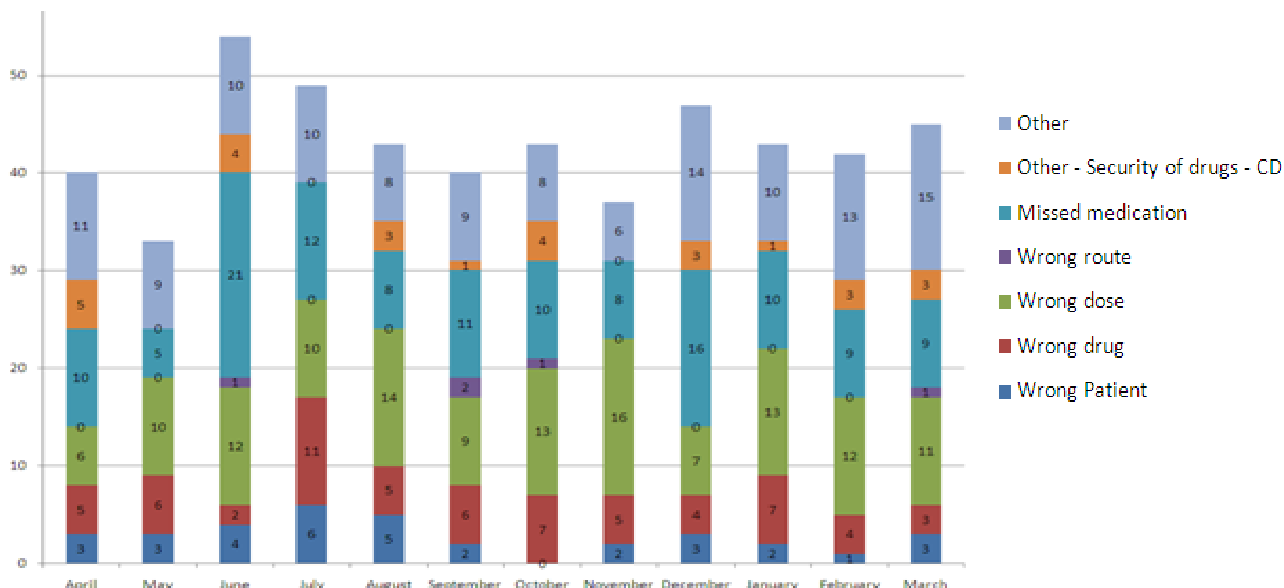


Table 4

Medicine Incidents by Type 2010 – 2011



Regional Quality Improvement Program

Work continued as part of active involvement with the Regional Quality improvement program. A weekly rolling audit program using a sample of charts was initiated and this information was fed into the Regional program dataset. In addition many changes were made as part of this program to progress the NPSA alert on missed doses.

These activities included:

- two wards receiving more intensive intervention with cycles of change and review
- a more comprehensive monthly audit program of missed doses to cover all wards over a 12 month period
- the development of a critical list to guide staff in identifying medicines that must not be missed
- review of all incidents of over-anticoagulation with warfarin with an INR greater than 6
- a redesign of the pharmacy intranet front page with a particular emphasis on missed doses and the development of a set of tools to aid nursing staff – see illustration below . This front page was accessed approximately 50,000 times in 2010.

Missed dose resources on the pharmacy Intranet

Discharge Team

In 2010-2011 the pharmacy further developed a discharge team service to wards. This is an afternoon senior pharmacist led process involving an experienced pharmacist visiting unscheduled care wards and planned care wards, and clinically screening discharge prescriptions at ward level. This allows the pharmacist to process discharge prescriptions whilst on the ward and resolve any queries on the prescription (medication missed off, incorrect doses etc) in a timely manner using both the patient's medical notes and asking the patients doctor hence improving patient safety. This service has enabled the pharmacy department to process TTA (To Take Away) prescriptions in faster turnaround time's thus improving patient satisfaction.

Discharge Process

The discharge process has been further streamlined throughout 2010-2011 in a number of ways. Pharmacists and pharmacy technicians are now able to upload medication on to the patients electronic discharge summary (EDS) provided the drug chart has a doctors signature to state drug is to continue on discharge. This has allowed the medication on TTA prescriptions to be dispensed in a much more timely manner. By providing each ward with a one stop dispensing service (supplying all medication for each patient with directions for discharge), there is often no need for prescriptions to be sent to pharmacy for dispensing as the patient already has all items on the ward thus again improving discharge time. The pharmacy robot has also allowed a more streamline dispensing process which has further improved the turnaround time of TTAs.

Medical Gases

Safety issues around medical gases were addressed by the development of new ward based storage racks for oxygen cylinders to ensure appropriate storage and labeling, and by the start of a medical gas cylinder 'milk round' that topped up wards to an agreed level every night to ensure cylinders were always available and to reduce the amount of clinical time needed to manage cylinders.

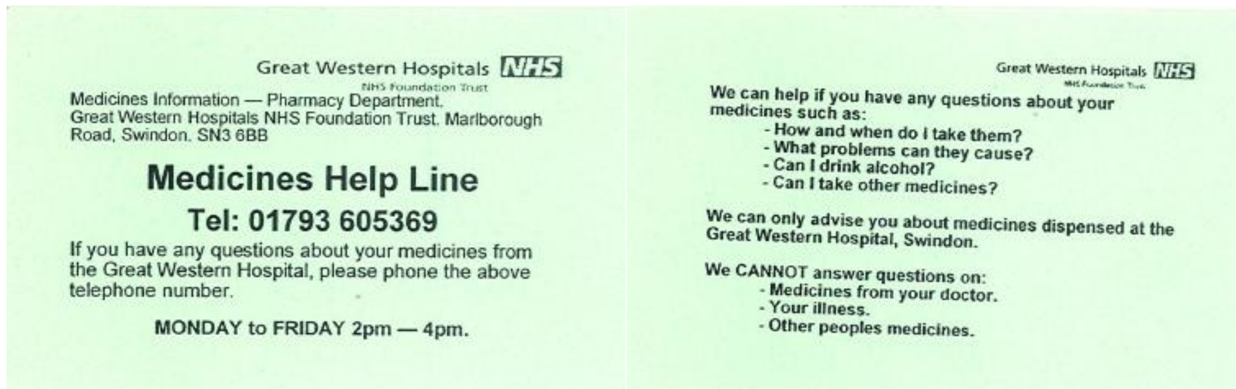
New Medicine Chart

In June 2010 after extensive trials and consultation, a new inpatient medicine prescribing chart was introduced to the Trust. This chart was a 16 sided 'booklet' style and replaced the old 'blue' six side charts. It drew together many of existing additional charts and forms which were often present as loose pages stapled to the main blue chart. It also allowed several clinical guidelines to be included as an integral part of all inpatient stays notably venous thromboembolic prophylaxis. The chart also created a structured approach to short and long term antibiotic prescribing and review, and created more space for regular and when required medicines, so that fewer patients required a second chart.

Patient helpline and information

In 2010 a patient medicine information helpline was trialed and then introduced fully to the Trust. This consists of a dedicated telephone number which is staffed by an experienced medicines Information pharmacist or pharmacy technician during certain hours to answer patients' questions about their outpatient or discharge medications. A copy of the card advertising the service is shown in the illustration below. This information will also be included in the enhanced discharge information given to inpatients.

Medicine Helpline Information Card



Training

Training is an important part of medicine safety, and in 2010 – 11 there was further development of the training program.

- Induction of clinical staff consisted of workbooks or face to face training on the major issues related to medicines safety. In addition all junior medical staff coming in to the Trust received additional sessions on safe prescribing and antibiotic prescribing, and the good principles associated with the provision of information to patients about their medicines (Medicines Adherence).

- Medical Students had a significant amount of extra training around medicines safety including shadowing of pharmacy staff and preparation for practice sessions looking at prescribing issues with worked examples and problem solving.

Medicine Reconciliation

Pharmacy led medicine reconciliation (recording an accurate medicine history on admission) continued in 2010-11 and this was audited on a rolling basis as part of the Regional Quality Improvement Program. Overall compliance was 90% with an increased pharmacy input into the Acute Admissions Unit at weekends and bank holidays, although further work is needed in the surgical admission unit.

Pharmacy Robot

The pharmacy ‘robot’ (an automated dispensing system) was installed in April to May 2010 and commissioned in June 2010. This system has several advantages from a patient safety point of view

- Reallocation of staff to ward based activities
- Bar coded issue of medicines for dispensing, reducing the risk of wrong drug / wrong dose errors
- A redesign of the dispensary, allowing more efficient and safer workflow

After 6 months of usage the robot has had a major effect on workflow in pharmacy, leading to a more efficient, better structured process.

Antibiotic Team

Throughout the year April 2010 - 11 the antibiotic management team (pharmacists, microbiologists and IC nurses) have been continuing to see an improvement in the quality of antibiotic prescribing. The team continuously monitors the use of antibiotics by auditing prescribing on every ward each week and regularly discusses these results with nursing and medical staff on the wards and feed this information back formally to prescribers every three months.

There has been a further reduction in numbers of *C.difficile* associated diarrhoea (CDAD) cases in the Trust this year. The team manages care of all patients with CDAD and has introduced a weekly antibiotic team ward round which also includes a dietician and a consultant gastroenterologist. The team also visits selected patients with severe infections who benefit the specialist advice.

The antibiotic pharmacists have launched an antibiotic blood level monitoring service this year which aims to ensure safer use of certain antibiotics.

We continue to ensure all of our antibiotic usage policies are updated regularly and are available on our hospital intranet for easy access by prescribers.

Air Tube

The hospital air tube transport system was extended to all wards in 2010. This allows a rapid transit of prescription requests from wards to pharmacy, and return of items from pharmacy to ward. The system is in place and working, and pharmacy is working with the Productive Ward initiative to develop standard ways of using the air tubes most effectively and ensuring that medicines are available and doses are not missed.

National Patient Safety Agency (NPSA) Alerts

In 2010 action plans were developed and followed for all NPSA alerts. In addition the NPSA identified to Trusts an increased number of 'Never' events and also developed 'Signals' designed to highlight safety issues, many related to medication. The Trust medicines Governance team has started to develop work plans around these notifications.

4 Zero patients receive incorrect blood transfusions and safer transfusions

Monitoring	Monthly	**09/10 Target**	0 errors
Source		**10/11 Target**	0 errors
PC Contract	No	**Target achieved**	**Yes**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Alex Sternberg – Consultant Haematologist Sally Caldwell – Blood transfusion Practitioner		

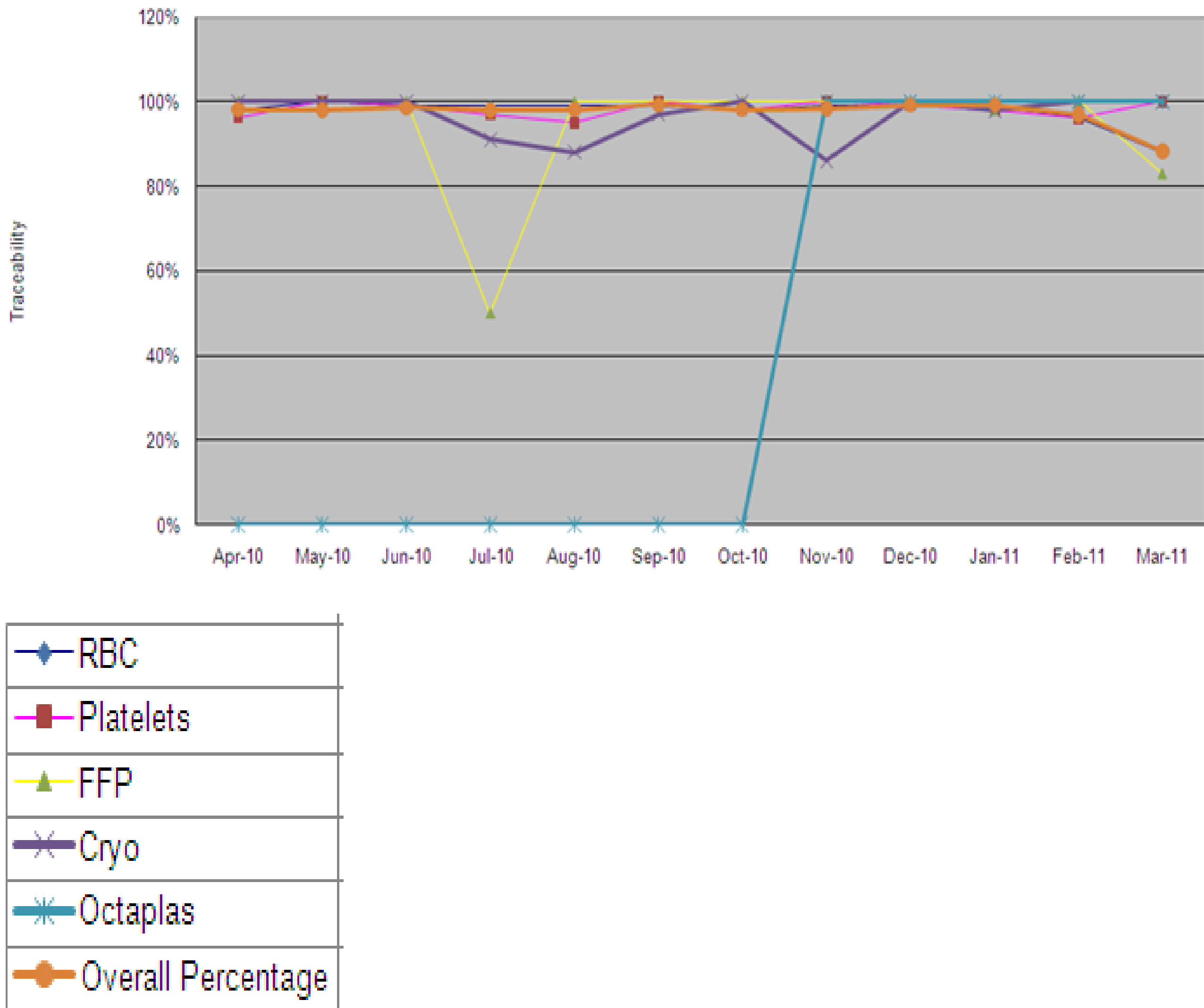
During the 2010 - 2011 reporting year there have been no 'wrong blood to wrong patient' incidents and no 'near miss' incidents within this category. There have also been no 'handling & storage' incidents this year. There have been two delayed hemolytic transfusion reactions due to immunological complications, **not** human error. One has been reported to SABRE (Serious Adverse Blood Reactions & Events) and SHOT (Serious Hazards of Transfusion) and one is about to be reported.

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 Hospitals NHS Foundation Trust uses the Blood Audit & Release System (BARS) which is an electronic blood

tracking system. Traceability is constantly monitored and month by month has on average been running at 98.041% with a mode of 98.59%. There has been a marked improvement over the last two years. Traceability for January, February and March 2011 is still to be completed.

Table 5

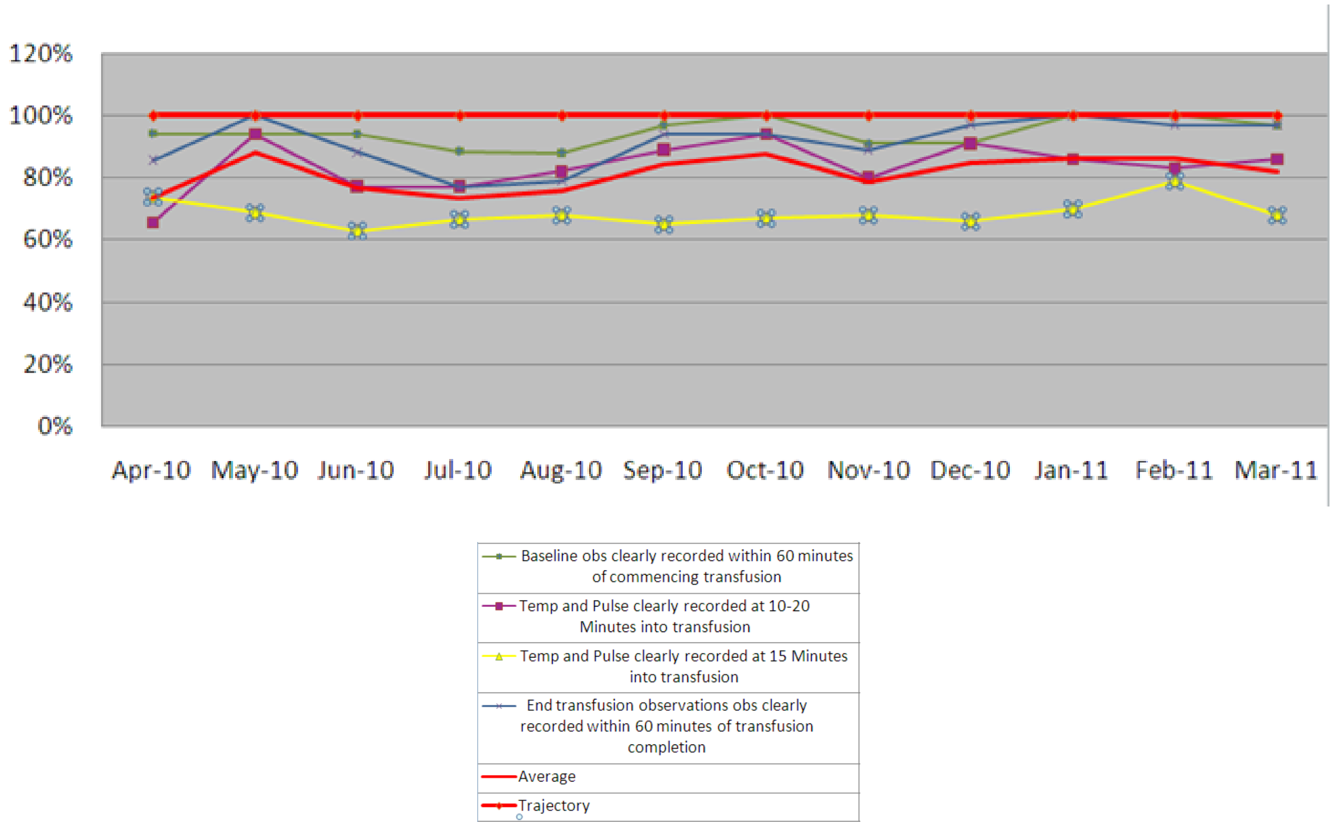
Blood Component Traceability April 2010 – March 2011



Safe care of the patient receiving blood component transfusions is regularly monitored via monthly auditing 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.

Table 6

Blood Transfusion Observations April 2010 – March 2011



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 this process. The Trust is currently at 79.8% (not including doctors). All staff undertaking these tasks must hold a current Trust competency, any staff without the relevant competencies are no longer permitted to take part in the blood transfusion process. A clear process of action was approved at February's Clinical Managers meeting utilising the Matrons actively in policing and managing this; a transfusion breech form has been devised to identify any concerns. Any concerns or issues regarding staff competencies will be monitored through the Clinical Managers Group held monthly.

5a Reduce patients' falls in hospital

Monitoring	Monthly	09/10 Target	1156 or less
Source	Local	**10/11 Target**	909 or less
PC Contract	Yes	**Target achieved**	**No (1090)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Attoti – Consultant Physician (DOME) Amy Walsh – Falls Co-ordinator		

5b Reduce associated harm

Monitoring	Monthly	09/10 Target	NA
Source	Local	**10/11 Target**	24 or less incidents of severe harm
PC Contract	Yes	**Target achieved**	**Yes (15)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Attoti – Consultant Physician (DOME) Amy Walsh – Falls Co-ordinator		

The Trusts aim for falls reduction during 2010/11 has not been achieved. The 6% decrease in reported falls was exceeded by 17% to a total of 1090. We have however surpassed the 10% reduction aim in severe harm falls by 38% from our target of 24 to our total of 15 reported incidents. The falls investigation group commenced at the beginning of last year have worked together in reducing this number through learning from the serious incident investigation process and sharing their learning between wards. This work will continue through the GWH falls working group.

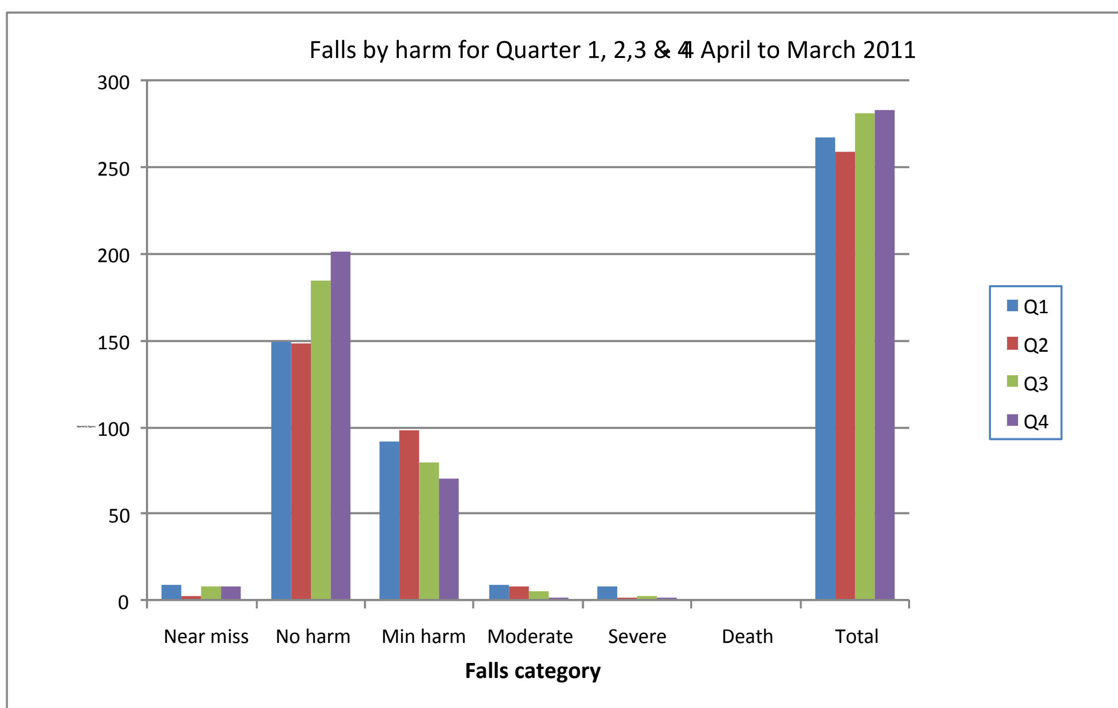
The Swindon falls and bone health strategic group work together across council services and primary and secondary care organisations. The action plan from this group have enabled us to work together to review and improve the integrated falls and bone health pathway, to ensure a seamless journey of service delivery to all service users. As a result of this we have audited the first stage of the inpatient falls pathway to measure its effectiveness and drawn up improvement measures to be re audited in 2011/12. We have also taken part in the second national falls and bone health audit from the Royal College of physicians, the results of which will be released soon. This information will further aid us in reviewing and progressing within our service.

Within the integrated falls and bone health team over the last year there has been new key professionals welcomed. Dr Ipe is the new Falls consultant lead, Amy Walsh is the new Clinical nurse – falls avoidance and Julia Bradbury is the new Community falls and bone health lead for care and support partnership in Swindon.

Weekly audit reports show that on average 60% of patients over 65 years old have the current falls risk assessment completed within 24 hours of admission. Those wards in the transitional period of using new the new risk assessment audit their compliance manually, for which they are achieving 80% on average.

The patient safety campaigns aim to improve staff compliance with the care pathway continues this year. Through efforts to ensure the inpatient falls pathway is accessible and easy to use in practice. The trial of the new tool in two adult wards will become the new pathway and will be implemented throughout the hospital during the coming year.

Table 7



6 To reduce our hospital acquired Grade 3 Pressure Ulcers

Monitoring	Monthly	**09/10 Target**	24
Source	Local	**10/11 Target**	22
PC Contract	Yes	**Target achieved**	**Yes (2)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Hocken – Vascular Surgeon Stephanie Carpenter – Tissue Viability Nurse Specialist		

With the introduction of the Pressure Ulcer Focus Forum (PUFF) we have targeted areas where It has been identified through RCA ,the learning outcomes to improve on patient care. This year focusing upon the learning outcomes has resulted in a combined improvement by 75% in the number of Grade 3 and Grade 4 hospital acquired pressure ulcers.

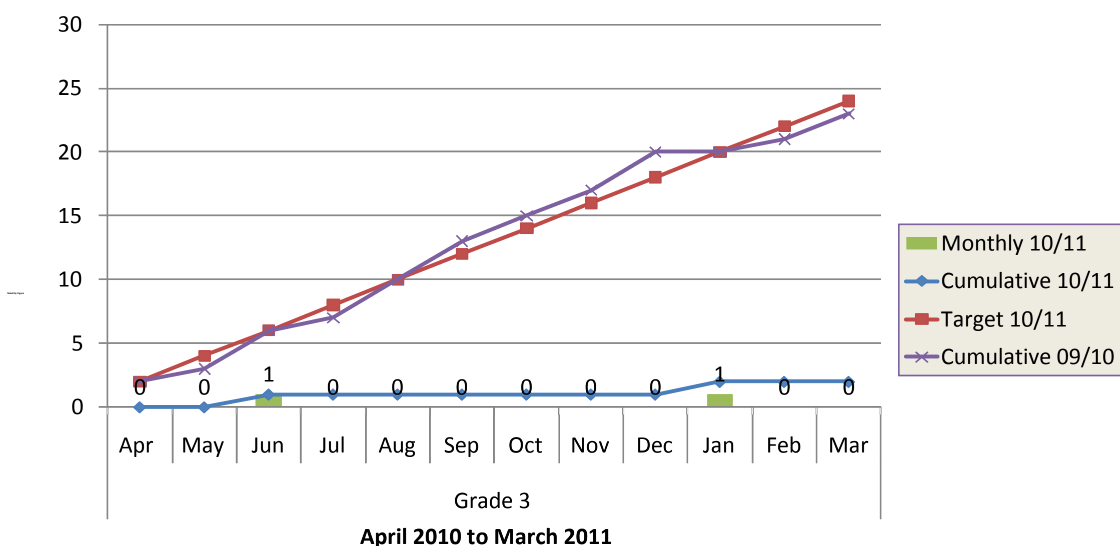
The Trust has made a dramatic improvement of 91% to the target for Grade 3 pressure ulcers and 59% improvement to the number of Grade 4 pressure ulcers.

An audit tool has been developed for the designated areas to take ownership of these patient focused outcomes.

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 Grade 3 and Grade 4 hospital acquired pressure ulcers has been exceeded.

The reduction in grade 3 and 4 pressure ulcers has been achieved through the employment of a specialist nurse who reports fortnightly to the Deputy Director of Nursing and Midwifery. A specialist assessment tool "waterlow" is used on admission and throughout a patient's stay. The results sit on the ward dashboard so that they are visible at all times. This is particularly important during ward handover so that staff are aware of who is at risk. Specialist equipment is used depending on the outcome of the assessment such as mattresses, negative pressure ulcer machines, gels, protectors and dressings. Photographs are taken of any ulcers to observe how they improve or worsen. There is a pressure ulcer forum which monitors activity.

Table 8



7 To reduce our hospital acquired Grade 4 Pressure Ulcers

Monitoring	Monthly	**09/10 Target**	30
Source	Local	**10/11 Target**	27
PC Contract	Yes	**Target achieved**	**Yes (11)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Hocken – Vascular Surgeon Stephanie Carpenter – Tissue Viability Nurse Specialist		

- Grade 4 pressure ulcers to be formally investigated using an adapted Department of Health RCA Data Gathering Tool

- Increase compliance with skin status assessments of all patients on admission

- Sustained compliance with the skin status assessments weekly using the electronic nursing record, crescendo

- Probably the most influential elements for this achievement has been sustained compliance of the skin status/pressure ulcer risk assessments via Crescendo and the use of the adapted Department of Health Root Cause Analysis Data Gathering Tool to identify any learning

outcomes

- From April 2010, Grade 3 pressure ulcers were formally investigated using the RCA information collection tool and reported as serious incidents.

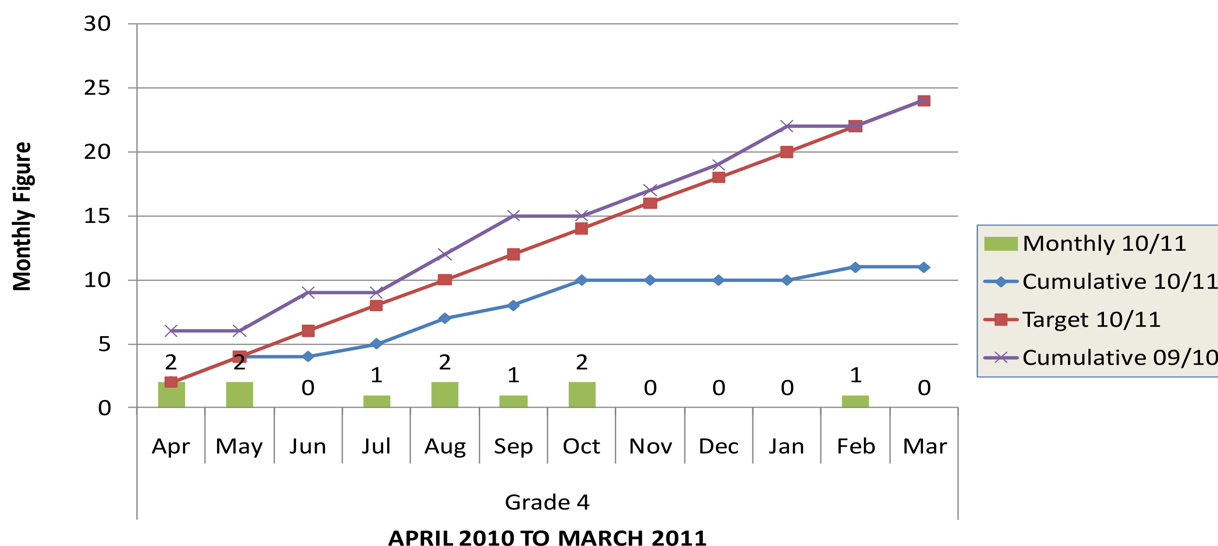
- The findings assisted the PUFF action plans and reviews. All patients will also have a re-assessment of skin status/Waterlow score on a weekly basis.

- All Grade 4 pressure ulcers were formally investigated using the RCA information collection tool; and reported as serious incidents. Ward Managers are able to identify the numbers of pressure ulcers within their areas using the daily/weekly pressure ulcer audit tool. This can be completed on a daily basis and a copy forwarded to the Tissue Viability Nurse Specialist (TVNS).

Wards have had educational sessions by the TVNS and comfort rounds have been implemented

Table 9

Hospital acquired Grade 4 Pressure Ulcers
April 2010 - March 2011



8 NPSA – *reducing harm – never events.*

Monitoring	Monthly	**09/10 Target**	NA
Source	National	**10/11 Target**	0 errors
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Associate Medical Directors Rachel Jefferies – Clinical Risk Manager		

The Trust has reported no never events from April 2010 to March 2011. In February 2011, the Department of Health published an updated list of never events for 2012. The list has expanded from a previous set of 8 never events to 25. Leads have been identified for each never event to ensure that an action plan is in place to reduce the risk of an event occurring.

9 HSMR- reduce preventable hospital mortalities

Monitoring	Monthly	09/10 Target	100 or less
Source	National	**10/11 Target**	100 or less
PC Contract	Yes	**Target achieved**	**88.2% YTD (data 3 mths in arrears)**
Leads	Dr Alf Troughton – Medical Director Mark Juniper Consultant respiratory Medicine Ruth McCarthy – Associate Director for Clinical Governance Peter 'O' Driscoll – Head of Informatics		
Monitoring	Monthly	**09/10 Target**	N/A
Source	Local	**10/11 Target**	To monitor and progress our plan to reduce mortalities
PC Contract	No	**Target achieved**	
Leads	Dr Alf Troughton – Medical Director Mark Juniper Consultant respiratory Medicine Ruth McCarthy – Associate Director for Clinical Governance Peter 'O' Driscoll – Head of Informatics		

The Trust has maintained an aggregate Hospital Standardised |Mortality Rate (HSMR) below 100 for the year to date (April – January). The rate of 88.2 is a significant improvement on the previous year.

As reported previously Dr Foster updates its benchmark following the end of year and when this was done for the year 2009/10 performance the HSMR increased from being 95.0 to a final rebased position of 106.4. Dr Foster's explanation is that the in-hospital mortality rates are declining rapidly and so that HSMRs fall accordingly. As a result the national average expected level would no longer be 100 and that recalibration when actual annual data is available is necessary to re-baseline performance. Dr Foster currently predicts that the re-based outturn for the Trust would be 97.0, which would be a significant improvement on 2009/10 final position.

Table 10 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 four years the Trust has reduced its HSMR and in the current year is broadly tracking around the SHA average (89.2 April – January) with two months where higher peaks are seen.

Table 10 – HSMR Mortality GWH and SHA

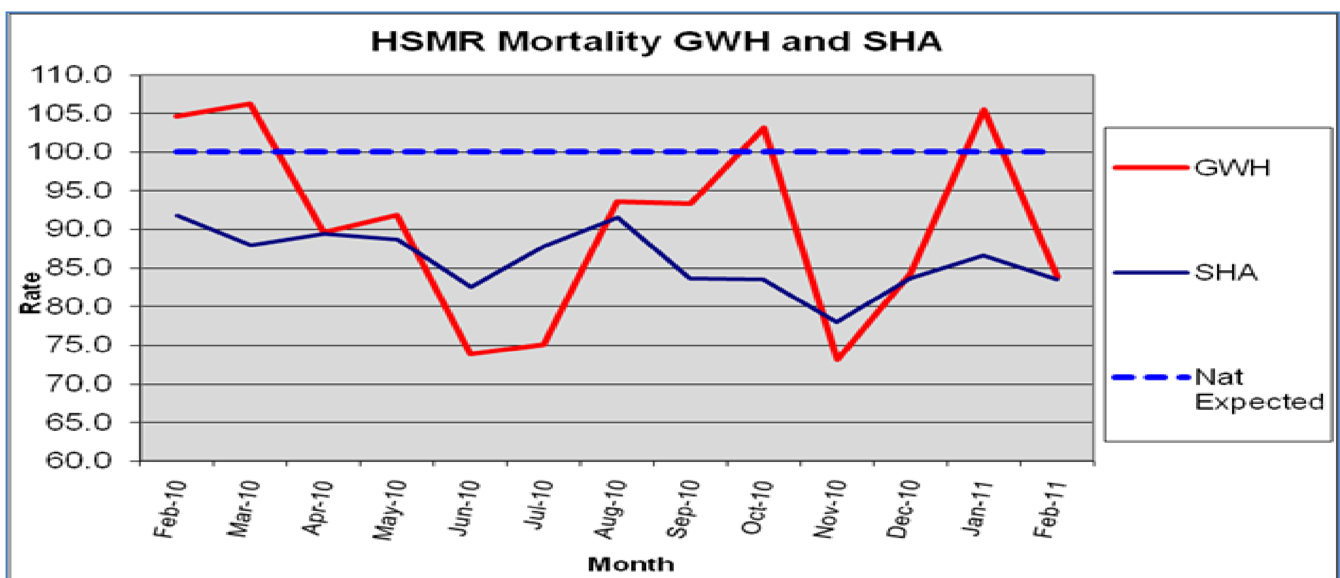
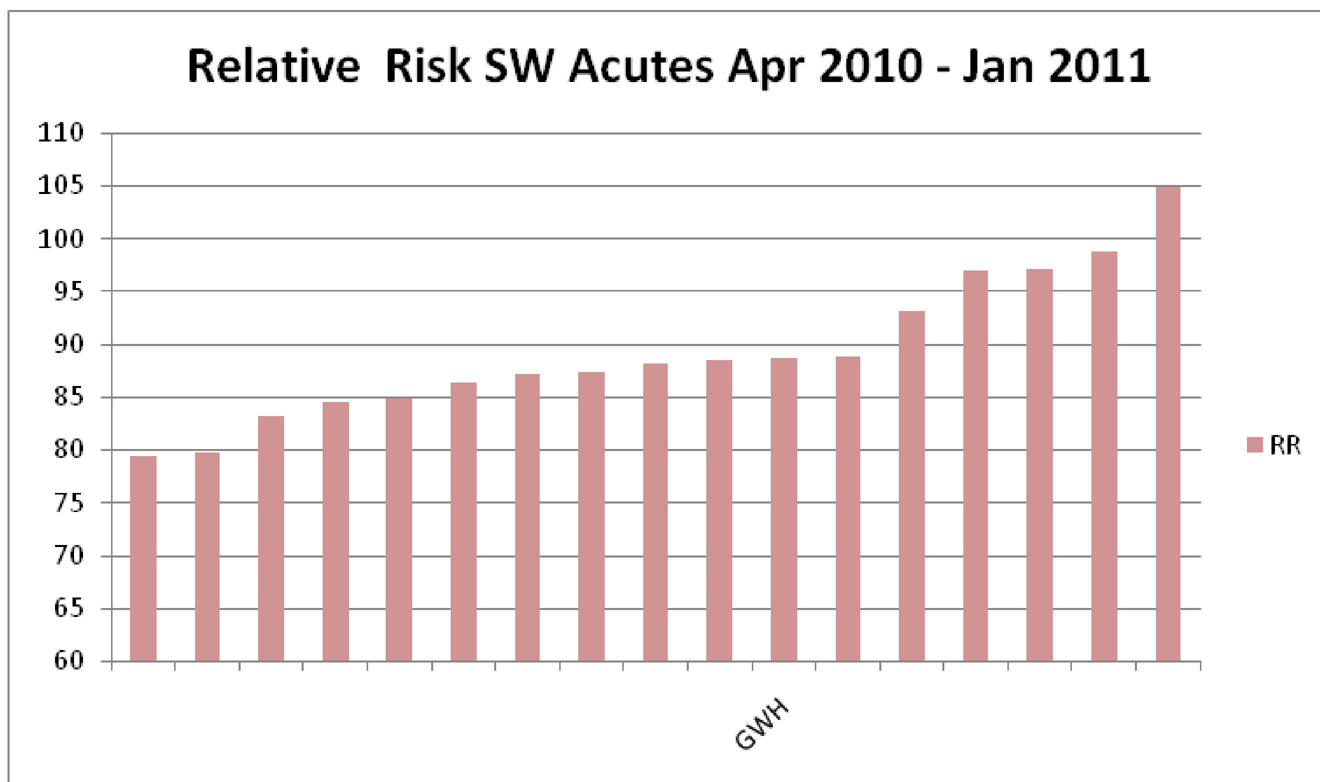


Table 11 shows in more detail how the Trust compares against the other Acute Trusts in the SHA for HSMR relative risk for the current year. It can be seen that performance is good and significantly better than several Trusts in the SHA.

Table 11 – Relative risk SW Acute Trusts April 2010 – January 2011



The Trust has developed a 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, Information and Clinical Coding. The group receives monthly reports on mortality centred on Dr Foster analysis and investigates areas where performance is showing lower than expected, often including a clinical audit or review by the lead clinician of the area concerned. The results of investigations are reported back to the group and the group also reports regularly on its work to the Trust Quality Group. The Mortality Group also develops work strands on any issues concerned with mortality that are brought to it.

10 South West SHA Quality and Patient Safety Improvement Programme

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care (NPSA)

The Trusts reports all incidents which relate to patient safety to the National Patient Safety Agency (NPSA) via the Reporting and Learning System (NRLS) on a weekly basis.

The NPSA is now required to send all incidents resulting in moderate harm, severe harm or death to the Care Quality Commission (CQC). Since February 2011, to comply with CQC regulatory requirements, the Trust includes the incident description and outcome of the investigation with all incidents uploaded to the NPSA.

Incidents reported to the NPSA during 2010/11

The NPSA encourages reporting of incidents and recognises that high reporting organisations usually have a better and more effective safety culture.

The number of patient safety incidents reported within the Trust has increased from 3759 incidents reported during 2009/10 to 4613 during 2010/11. The Trust's organisational report received from the NPSA for the period April 2010 to September 2010 confirmed this improvement, the Trust's reporting rate had increased to 5.45 per 100 admissions compared to 4.8 per 100 admissions for the period between October 2009 to March 2010. This indicates that awareness of the requirement to report patient safety incidents has improved and that staff feel confident to report incidents. The CQC 2010 staff survey supports this, the Trust was placed in the best 20% of Trusts for fairness and effectiveness of their incident reporting procedures.

The CQC staff survey results revealed that the Trust scored better than average for the percentage of staff who said they had witnessed a harmful error in the last month (fewer staff had witnessed a harmful error). Table 13 demonstrates that although incident reporting to the NPSA increased during 2010/11, a higher percentage of incidents reported than in 2009/10, were either a near miss incident or resulted in no harm to a patient, indicating that although a more incidents were reported this did not equate to higher numbers of incidents resulting in harm.

Table 12 Actual harm resulting from patient safety incidents

Actual harm	Number of incidents 2009/10	% of incidents 2009/10	Number of incidents 2010/11	% of incidents 2010/11
Near miss	255	6.8%	345	7.5%
No harm	2095	55.7%	2859	62%
Low harm	1048	27.9%	1246	27%
Moderate harm	344	9.15%	139	3%
Severe harm	10	0.27%	20	0.4%
Death	7	0.19%	7	0.15%
Total	3759	100%	4613	100%

In April 2010 the Trust fully adopted the NPSA National ***Framework*** for Reporting and Learning from Serious ***Incidents Requiring Investigation***. This may account for the slightly higher percentage of incidents resulting in severe harm, all Grade 4 pressure ulcers are now graded as severe harm, along with any fall which results in a fractured neck of femur, a number of these types of incident would previously have been reported as moderate harm.

Timeliness of reporting

The time between an incident occurring and being reported to the NPSA is important for the information to be useful for identifying and acting on patient safety incidents quickly. Year end 2009/10 the NPSA reported that fifty percent of all incidents reported from all organisations were submitted to the NRLS more than 44 days after the incident occurred, whilst in our organisation, 50% of incidents were submitted more than 20 days after the incident occurred. The Trust maintained a consistently good reporting time in 2010/11, with an average of 21 days from date of incident occurring to date of report to NPSA.

Table 13
Type of incident reported

Cause Group	2008/09	2009/10	2010/11
Access, Admission, transfer, discharge	348	269	274
Clinical Assessment	281	222	206
Consent, Communication, Confidentiality	179	97	93
Disruptive, Aggressive Behaviour	37	26	9
Documentation (Inc Records, patient identification)	241	227	376
Fire	3	0	0
Implementation Of Care/ongoing	309	291	399
Infection Control Incident	96	91	320
Infrastructure (Incl. Staffing)	302	128	137
Manual Handling	16	9	15
Maternity incident	N/A	N/A	61
Medical Device, Equipment	268	165	322
Medication	302	447	512
Other Accident/incident	134	113	160
Physical Abuse	13	8	15
Security	26	9	13
Self-Harming Behaviour	34	32	16
Sexual Abuse	2	0	0
Slips, trips And Falls	1297	975	1108
Treatment/procedure	708	650	565
Verbal Abuse	3	0	4
Total	4599	3759	4613

Most notably an increase has been seen in the reporting of documentation and infection control related incidents. This is likely to be as a result of an improved reporting culture, a reduction in actual harm from Clostridium Difficile and MRSA has been consistently achieved during 2010/11, however further evaluation and monitoring of the increase in documentation errors will be required during 2011/12 to establish trends.

A new cause group for maternity specific errors was added by the NPSA in Quarter 3 of 2010/11, the Trust is now coding and uploading incidents to the NPSA against this new cause group.

During 2011/12 analysis of themes, cause groups and learning will form part of developing trust wide aggregated analysis of incidents, claims and complaints data required for NHSLA assessment.

Serious Incidents

The Trust reported 44 serious incidents during the period April 2010 to March 2011, an increase from 27 reported during April 2009 to March 2010. In April 2010 the Trust fully adopted the NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, which set clear criteria for the types of incident which should be reported as a serious incident. All Grade 3 and 4 pressure ulcer incidents and falls resulting in a fractured neck of femur are

now classified as a serious incident, 21 incidents of this type were reported by the Trust in 2010/11, increasing our total number of serious incidents.

All serious incidents were investigated following the principles of Root Cause Analysis, with progress monitored by the previous Clinical Governance and Risk Committee, the newly formed Patient Safety and Quality Committee and appraised by the Trust Board through the monthly Patient Safety and Quality report.

Learning from incidents this year has resulted in many recommendations to improve care and patient safety throughout the Trust. The completion of action plans to implement the advised recommendations has been monitored by the previous Clinical Governance and Risk Committee and now the Patient Safety and Quality Committee, 35 serious incident action plans have now been completed, out of the 44 incidents reported. Improvements in practice, systems and processes which are now either completely implemented or in the process of being implemented include:

- Clearly defined use of the discharge unit, with agreed plan for opening as an additional area to admit inpatients;
- Introduction of PCR Norovirus testing on site;
- Implementation of the South West Norovirus checklist;
- Current Intensive Care Unit practice of routine MRSA suppression for all patients included in Trust policy;
- All patients identified as having a pressure ulcer will have a clear preventative and management plan completed;
- Reassessment will be completed twice weekly on a Wednesday and Sunday for those patients who have been identified as at a high risk of development of pressure ulcers;
- Review of falls care plan and risk assessment process, to ensure a comprehensive record of interventions put in place to reduce risk of falls;
- Traceable and auditable programme for maternal screening programme, the screening team to implement a blood tracking form;
- Maternity bloods need to be identifiable - all maternity blood forms will be marked with a sticker until electronic requesting is implemented;
- In maternity, all out of area women will be attending GWH for their booking blood tests.

Quality and Patient Safety Improvement Programme

Since March 2010 the 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 programme consists of 5 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.

Leadership Since June 2011, as part of the SW SHA Quality and Patient Safety Programme, GWH has been conducting patient safety walk rounds, visiting various areas throughout the Trust to establish first hand patient safety concerns from frontline staff.

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 will now be taking part in a patient safety walk round on a monthly basis.

Since implementing patient safety walk rounds within the Trust executive teams have visited 11 clinical areas, with a further 19 programmed for 2011. 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 45 actions raised 30 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 will be incorporated into the Trusts developing aggregated analysis process alongside incidents, claims, complaints and Global Trigger tool (case note review) data.

As a method of providing assurance that change is taking place, NEDs and Governors will be undertaking biannual meetings to review progress, discuss common themes and resolution of actions that have been identified. In addition the Chief Executive's quarterly report will be including the main themes and actions identified, ensuring that patient safety concerns are raised directly to the Trust Board.

General Ward The general ward teams have successfully implemented daily safety briefings in ward areas across the Trust in conjunction with the Productive ward handover module. The safety briefing is delivered at handover to all ward staff at the start of each shift, ensuring that the team is fully aware of risks on the ward, such as patients at risk of falling, infection control issues or highly dependent patients. During 2011/12 the team will be continuing to monitor compliance with this new process and assessing its impact on the improvement of patient safety within the ward areas.

In February 2011 the team delivered a training programme and the launch of SBAR (Situation-Background-Assessment-Recommendation), a tool to improve communication between professionals in the healthcare setting. A plan is in place to roll out and monitor the effectiveness of the SBAR communication tool across the Trust in 2011/12.

Medicines Management The teams have continued to expand on the action plan developed for the NPSA alert Reducing Harm from Omitted and Delayed Medication (2010), a critical medication list has been now developed and implemented across the Trust. The teams have commenced twice monthly audits and have been working with ward managers to implemented actions to resolve the issues as they are identified. In addition, as part of the patient safety programme, during 2011/12 the team will be sharing expertise and working jointly with the peri-operative team to identify the incidence and reduce occurrence of missed doses of betablockers in surgical patients.

Peri operative The team have been working on improving compliance with the WHO safer surgical checklist first implemented in 2009/10, the two pilot areas identified have successfully demonstrated sustained compliance of 100%. The team will now be validating these results before spreading the improvement process across all theatres in the department. In addition the maternity safer surgical checklist has been introduced to the maternity theatre; audits of compliance will begin in April 2011.

Critical Care The intensive care team have successfully implemented multidisciplinary ward rounds and daily goal setting for their patients, helping to improve communication between all team members, patients, carers and relatives.

The Southwest SHA Patient Safety Team visited the hospital in September 2010 to assess the Trust's progress and commitment to implementing the Quality and Patient Safety Improvement Programme, the Trust was extremely pleased with the positive feedback that was received. The SHA felt that we had taken time to consider how to integrate the programme into the operational work of the trust, that

each team was accelerating and demonstrating real enthusiasm, and that the programme was well linked with Trust objectives with progress reported to Clinical Governance meetings and Trust board.

11 Increase risk assessment completion for adult patients for VTE

Monitoring	Monthly	**09/10 Target**	45%
Source	National Local	**10/11 Target**	90% (end of year) 90%
PC Contract	Yes	**Target achieved**	**Yes (93%)**
Leads	Dr Alf Troughton – Medical Director Sue Rowley – Director of Nursing and Midwifery Dr Sarah Green – Consultant Haematologist Sue Rhodes – VTE Nurse		

VTE risk assessment has continued to improve and we reached 92% for December 2010, 91.7% for January and 93% for February 2011. (To put this in context we were at 25% in February 2010 and 33% in March 2010) This is within trajectory and achieves the national target of >90% by end of Q3 and sustaining for Q4.

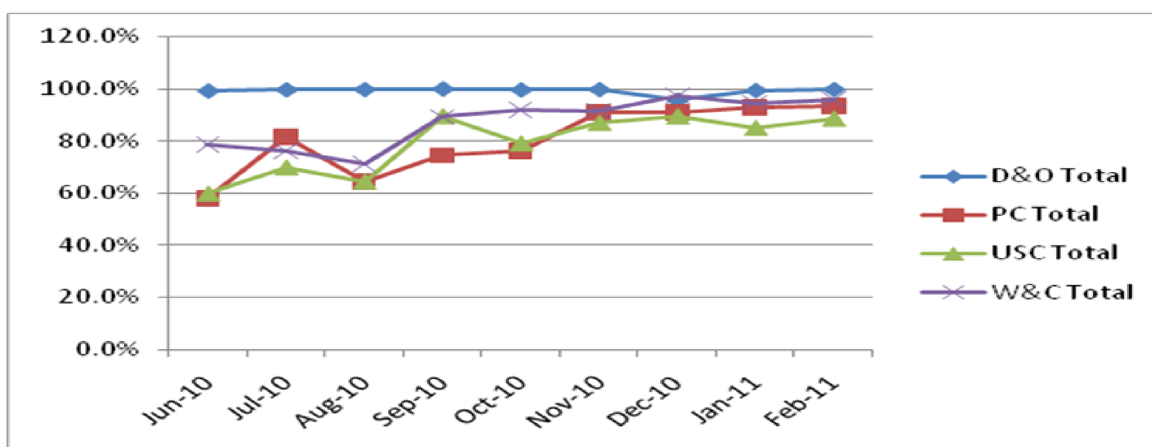
This has been achieved with:

- On-going training for both nursing and medical staff via Trust Induction, clinical skills framework, Training tracker workbook and E-learning available soon
- Implementation of an audit trail through the nursing crescendo system
- The incorporation of the risk assessment into the new drug chart which has significantly improved completion of the form.
- Raising awareness with patients and relatives by means of information boards and displays during national thrombosis week
- Patient information leaflet developed and available on intra-net, wards have copies and supply in discharge lounge. All patients to receive information either in pre-admission pack or on discharge from hospital

Note – the VTE measure started in June 2010. There is no data (as it was not a requirement) prior to June 2010

Table 14

% VTE Risk assessment completion by directorate since submission to DoH which commenced in June



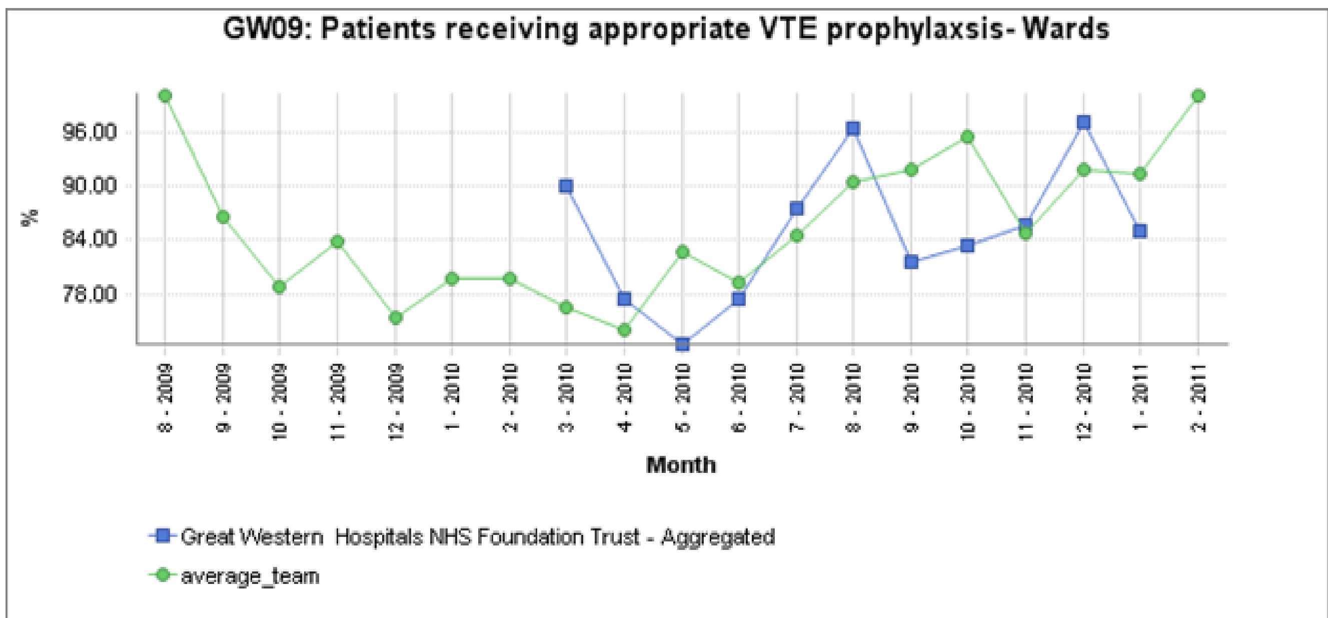
12 Administer appropriate VTE thrombophylaxis

Monitoring	Monthly	09/10 Target	45%
Source	National Local	**10/11 Target**	90%
PC Contract	Yes	**Target achieved**	**Yes (90%)**
Leads	Dr Alf Troughton – Medical Director Sue Rowley – Director of Nursing and Midwifery Dr Sarah Green – Consultant Haematologist Sue Rhodes – VTE Nurse		

The informatics team have been instrumental in ensuring that the data we submit to the DoH is robust and wards are notified daily of the number and names of patients without a VTE risk assessment to enable them to identify the patients more easily.

The administration of appropriate thromboprophylaxis is displayed in the chart below and shows compliance between 80%-90% for the last 6 months. We will continue to monitor compliance for both indicators and hope to sustain the levels achieved so far.

Table 15



13 Nutritional assessments and care

Monitoring	Monthly	**09/10 Target**	NA
Source	Local	**10/11 Target**	95% compliance with completion of MUST tool by Mar 2011
PC Contract	Yes	**Target achieved**	**No (70.2%)**
Leads	Sue Rowley – Director of Nursing and Midwifery Carole Crocker- Deputy Director of Nursing Linda Webb – Dietetics and Service Manager		

Good nutrition and hydration are fundamental to well-being and recovery from illness or trauma. A high proportion of individuals admitted to hospital are vulnerable to malnutrition.

- 70% of those admitted are elderly
- 40 - 50% of all hospital in-patients may be malnourished

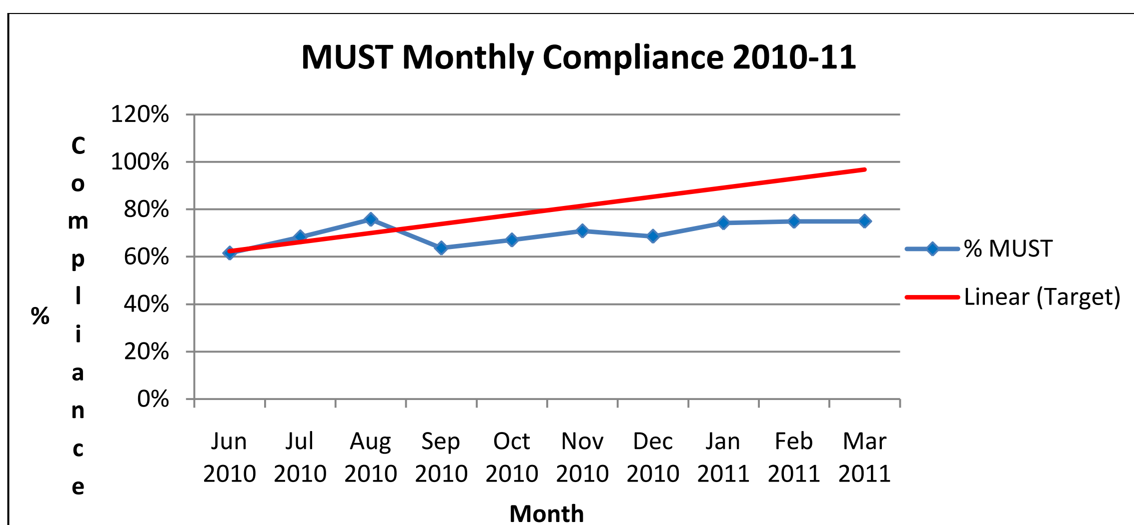
In hospital, nutritional status and hence general health and well-being can rapidly deteriorate for a variety of reasons often with serious consequences.

There have been significant improvements in a number of areas at GWH.

- Nationally validated screening tool (MUST) customised for local use and implemented in all appropriate areas along with supporting info e.g. user guide and patient record forms
- Training programme includes Volunteers and Nursing Assistants and on-going training of staff to use MUST (& wards based Nutrition Resource Nurses & MUST champions cascade training)
- E-learning version of MUST now available
-
- MUST average compliance has increased from 33% to 75%
- Improvements to meal quality (portion sizes, presentation, temp & patient satisfaction)
- Introduction of new allergy aware menu & green tray system for people with food intolerance/coeliac disease. Complaints have reduced significantly.
- New Children's menu introduced
- Positive PEAT feedback regarding food provision in 2010 and again 2011
- Positive Essence of Care (RSM Tenon) audit report Aug 2010

Overall there have been notable improvements with the numbers of patients receiving nutritional assessments on admission to hospital and the Trust has plans in place to further improve in this over the next 12 months. The 2010/11 Trust wide nutritional plan has been significantly progressed during the year as demonstrated above. A recent visit from the CQC and assessment of Outcome Five (meeting the nutritional needs of our patients) has resulted in the Trust being assessed as compliant in this important element of care. . Suggestions for sustaining and further strengthening compliance will be included and implemented within the 2011/12 quality improvement plans.

Table 16 – MUST monthly compliance 2010 -11



14 New acute stroke patients spending 90% or more of their time in the Hospital on the Acute Stoke Ward (Falcon) – Q4 only

Monitoring	Monthly	**09/10 Target**	NA
Source	National	**10/11 Target**	Q1,2,3 60% Q4-80%
PC Contract	Yes	**Target achieved**	**Yes (83.9%)**
Leads	Dr Alf Troughton – Medical Director Dr Elizabeth Price – Consultant Rheumatologist Mark Canwell – DGM Unscheduled Care		

- Q1 Performance April to June 2010: 74 out of 114 patients (64.9%) spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 60%)

- Q2 Performance July to Sept 2010: 88 out of 127 patients (69.1%) spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 60%)

- Q3 Performance October to December 2010: 93 out of 117 patients (79.5%) spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 60%)

- Q4 Performance January to March 2011: 73 out of 87 patients (83.9%) have spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 80%)

The Trust has completed the changes required by the Care Quality Commission in the last year, delivering significant improvements in the quality of care provided fro stroke patients. Patient s receive dedicated treatment and rehabilitation in line with national standards, which enables a quicker and better recovery in the majority of cases. In the year ending 1 April 2011, 73.6% of all stroke patients spent 90% or more of their stay in the hospital on the Acute Stoke Unit. This represented a significant improvement on the previous year (34.5%).

The South West Stroke Review team undertook a second inspection of the service in July 2010. The Review Team complimented the Trust and staff involved in stroke care, on the work that had

been undertaken supporting the creation of a service that was unrecognisable from their previous visit.

Thrombolysis 24x7 was introduced in the early part of April 2011. This extended the service from 9-5 Monday to Friday

The most significant current issue is maintaining direct admission particularly when there is significant pressure on beds

Table 17 - Treatment

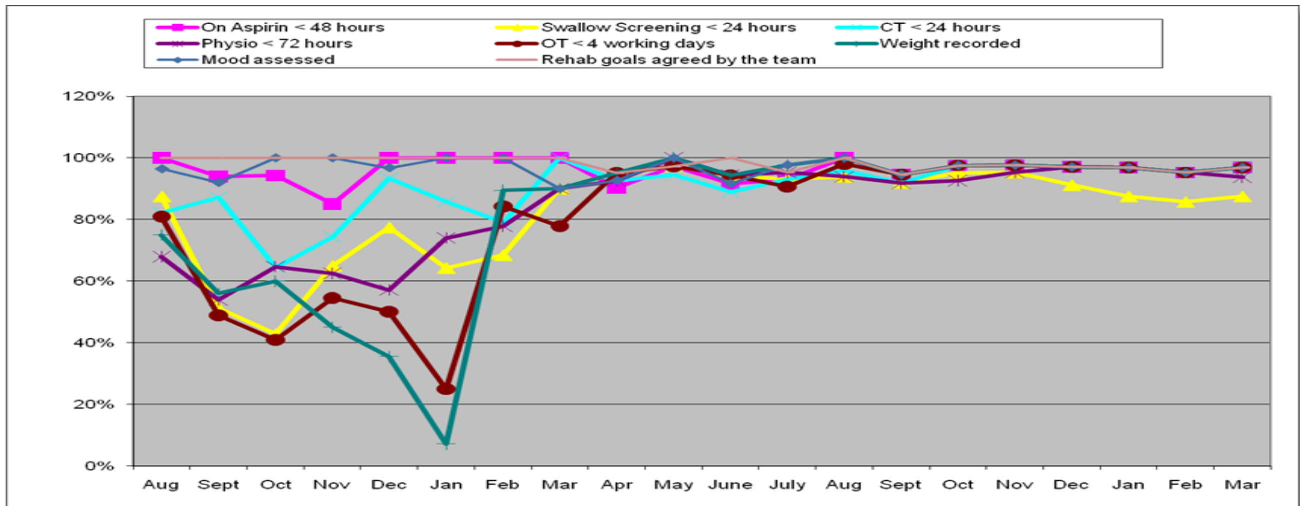


Table 18

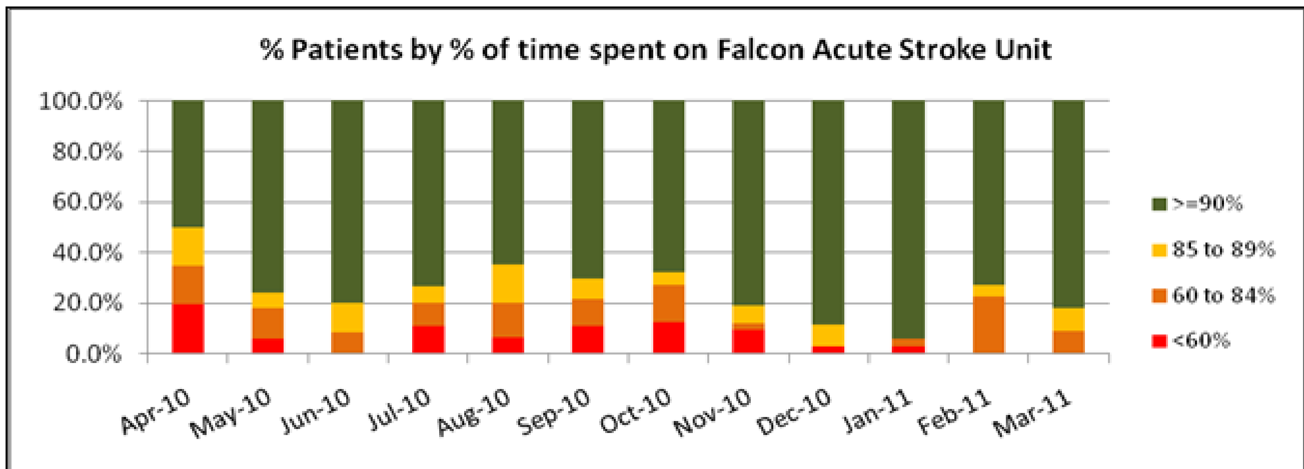
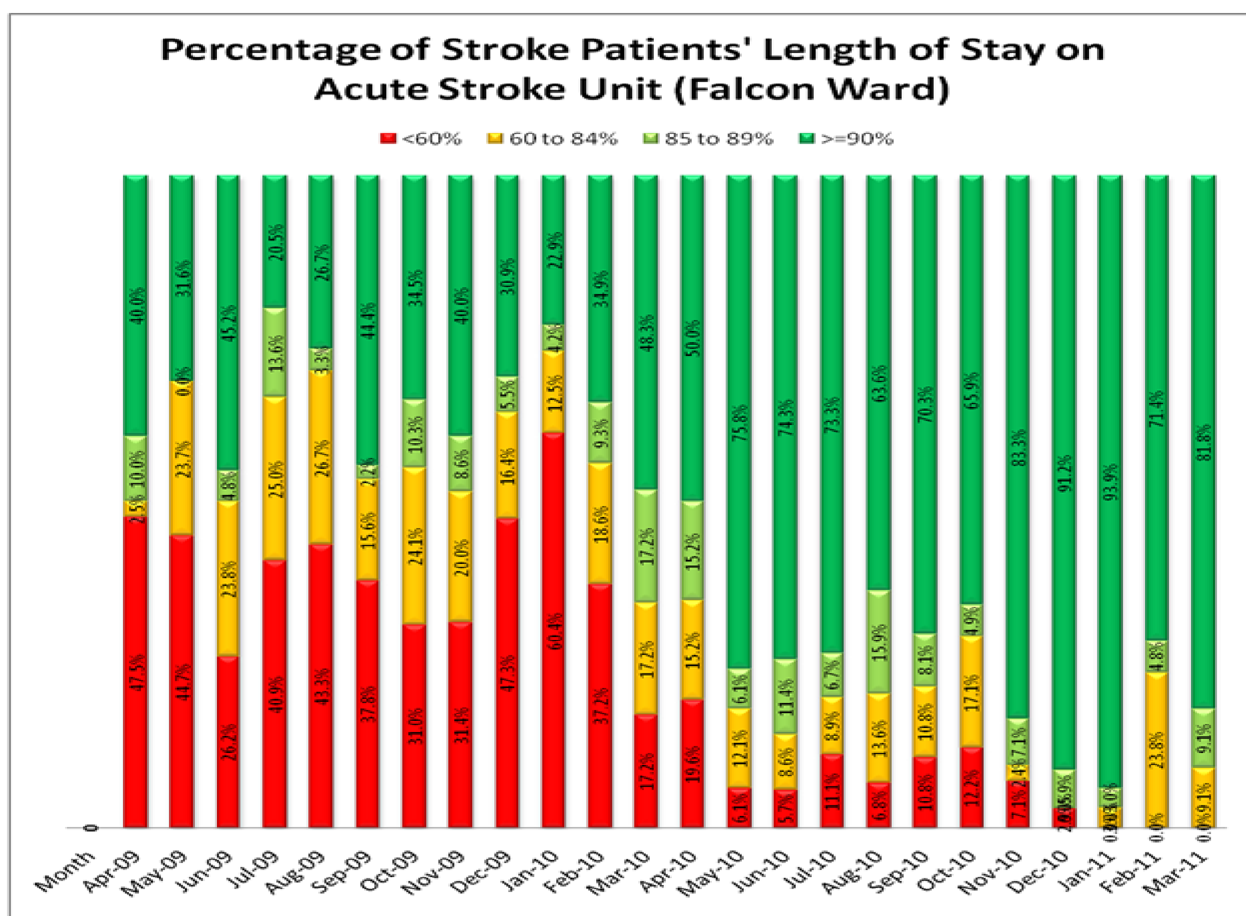


Table 19 - Percentage of stroke patients length of stay on acute stoke unit (Falcon Ward



15 Reduce the rate of emergency re-admissions within 28 days of discharge and 14 days of discharge

Monitoring	Monthly	**09/10 Target**	6.6% or less (28 days)
Source	Local	**10/11 Target**	6.6% or less (28 days)
PC Contract	Yes	**Target achieved**	**No**
Leads	Dr Alf Troughton – Medical Director Ranju Gopal – Clinical Audit & Effectiveness Manager John Palmer – Information Project Specialist		
Monitoring	Monthly	**09/10 Target**	4.3% or less (14 days)
Source	Local	**10/11 Target**	4.3% or less (14 days)
PC Contract	Yes	**Target achieved**	**No**
Leads	Dr Alf Troughton – Medical Director Associate Medical Directors Ranju Gopal – Clinical Audit & Effectiveness Manager John Palmer – Information Project Specialist		

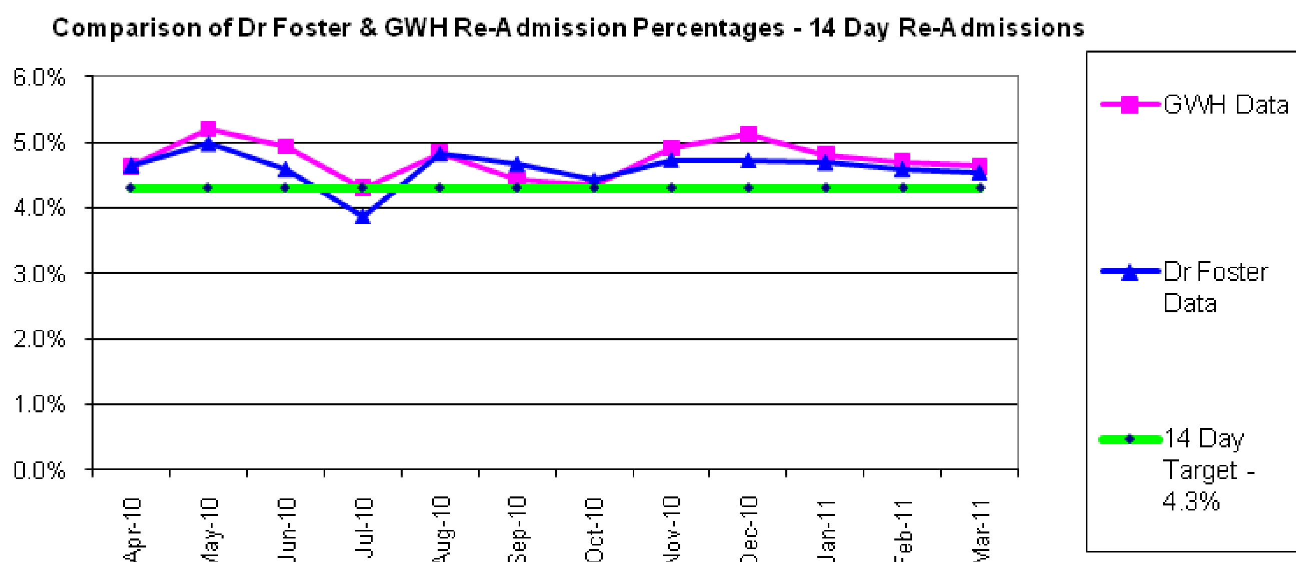
The rate of readmission is a vital monitoring tool to review delivery of care provided locally. The information extracted from Dr Foster data (Imperial College) demonstrates the percentage of patients re-admitted as emergencies within 14 days of discharge. However, the data does not differentiate

between related and unrelated re-admissions to the original episode. Furthermore the information is also only available with a five month time lag. The records cannot be replicated locally because of differences in data methodology.

Dr Foster is currently building the facility for Trusts to access National and SHA data for comparison of re-admission rates within 14 days.

In order to reduce the rate of emergency re-admissions, local data is being produced monthly by the Trust Informatics Team and is disseminated to the Associate Medical Directors and General Managers. The aim of the review is to capture facets of care that might influence the outcome and identify areas where delivery of care can be improved locally. This is shared with the Patient Safety & Quality Committee via the Trust Length of Stay Project Group. The percentage of patients readmitted with 14 days (April 2010- Jan 2011- Table 19) remains very close to the trajectory with an average performance this year of 4.9% (target-4.3% by end of year)

Table 20



Local Reviews and Outcomes

The following list represents a selection of the actions the Trust has taken/will be taking in response to recent completed re-admission reviews in order to improve the quality of healthcare provided to patients and reduce re-admission rates.

Audit of Readmissions to the Unscheduled Care

The review clearly demonstrated that many readmissions are not preventable despite best medical practice. However, identified possible factors that impact on patients being readmitted to the unscheduled care directorate within 14 days, are most notably in the area of discharge planning. Improvement plans include identification of those patients that need assessment by allied health professionals, improved documentation with adequate explanation.

Maternal Re-Admissions following Normal Delivery

The majority of re-admissions were attendances. No clinical concerns were identified in the management of the patients. The plans include working with NHS Swindon to encourage attendance

at walk in centres rather than emergency department, ensure better signposting at delivery to encourage patients to see their family doctor and review coding at point of entry to hospital.

Readmissions within 28 days - Cancer of Breast
Following a triggered alert from Dr Foster, the following area was investigated to ascertain the reason for high readmission rate. The results of the review demonstrated that re-admissions was unrelated, therefore, no cause of concern was identified.

Readmissions within 28 days - Inguinal Hernia Repair
Following a triggered alert from Dr Foster, the following area was investigated to ascertain the reason for high readmission rate. The results of the review demonstrated that re-admissions was unrelated, therefore, no cause of concern was identified.

Readmissions within 28 days - Transurethral Resection of Bladder Tumour (TURBT).
No trends identified as a result of the review.

Further plans to reduce hospital readmissions include:

- Develop a robust system of identifying related re-admissions.
- Set up audit as per specialities, prioritising according to highest related readmission rate.
- Set up regular reporting back to the Patient Safety & Quality Committee quarterly through Quality Accounts and the Trust Length of Stay Project Group.

16 18 Weeks Referral to Treatment (RTT)

Monitoring	Monthly	**09/10 Target**	90% admitted pathways, 95% non-admitted
Source	CQC, PCT	**10/11 Target**	90% admitted pathways, 95% non-admitted
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Hilary Shand?		

Overall in 2010/11 the Trust has performed well in referral to treatment measures and consistently exceeded the overall all specialty targets of 90% for admitted patients being treated within 18 weeks, 95% for non-admitted patients and 95% for audiology patients. For admitted specialties each specialty has met or exceeded the target for each month. For non-admitted three specialties missed the target for individual months – Ophthalmology in February, Oral Surgery in April and May and Plastic Surgery in April and May.

17 Cancer National Priorities

Monitoring	Monthly	09/10 Target	Same as 2010/11 as below
Source	Monitor, PCT	10/11 Target	See Table below
PC Contract	Yes	Target achieved	Yes
Leads	Dr Alf Troughton – Medical Director Michael Wilson – Lead Manager Cancer services		

The National Institute for Health and Clinical Excellence (NICE) provides guidance and sets quality standards to improve people's health and prevent and treat ill health. NICE make recommendations to the NHS on new and existing medicines, treatments and procedures and NICE Technology Appraisals (TAs) are of significant importance within Cancer Services as they often introduce new chemotherapy drugs that require considerable resource to implement.

However, being able to demonstrate compliance with published NICE TAs is an indicator of a quality service and as a result of the robust NICE process that exists within Cancer Services we have successfully implemented each relevant new NICE TA that has been published during the financial year, these have included:

TA	Description	Fully Compliant?
TA129	Bortezomib monotherapy for relapsed multiple myeloma	✓
TA190	Pemetrexed for the maintenance treatment of non-small-cell lung cancer	✓
TA191	Capecitabine for the first-line treatment of inoperable advanced gastric cancer	✓
TA192	Gefitinib for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer	✓
TA193	Rituximab for the treatment of relapsed or refractory chronic lymphocytic leukaemia	✓
TA202	Ofatumumab for the treatment of chronic lymphocytic leukaemia refractory to fludarabine and alemtuzumab	✓
TA208	Trastuzumab for HER2 positive metastatic gastric cancer	✓
TA209	Imatinib for the treatment of unresectable and/or metastatic gastrointestinal stromal tumours	✓
TA216	Bendamustine for the first-line treatment of chronic lymphocytic leukaemia	✓

Performance Indicators

The Trust has exceeded each of the various cancer operational standards for the 2010/11 financial year as shown in table 21 below.

Table 21

	Operational Standard	2010/11 Year End*
Two Week Wait	93%	96.9%
Symptomatic Breast Two Week Wait	93%	97.2%
31 Day First Treatment	96%	99.2%
62 Day First Treatment	85%	92.2%
62 Day First Treatment (Screening Service)	90%	100%
31 Day Subsequent Treatment (Surgery)	94%	99.4%
31 Day Subsequent Treatment (Drug)	98%	100%

During the 2010/11 financial year the Trust saw some 7,230 patients being referred via the Two-Week Route (guaranteed first appointment with a responsible specialist within 14 calendar days of GP referral for a suspected cancer) – an increase of some 11.5% on the previous year.

National Cancer Patient Experience Survey 2010

Certainly one of the largest to have been undertaken anywhere in the world, the national cancer patient experience survey provides insights into the care experienced by cancer patients across England who were treated as day cases or inpatients during the first three months of 2010. 158 NHS Trusts providing cancer services identified patients and 67,713 patients chose to respond. The high national response rate (67%) shows how willing patients are to report on their care and thereby help to improve future service quality.

The Great Western Hospitals NHS Foundation Trust fully embraced the National Survey and some 512 eligible patients from this Trust were sent a survey, and 352 questionnaires were returned completed. This represents a response rate of 72% (higher than the national response rate) once deceased patients and questionnaires returned undelivered had been accounted for.

Local Comparative Performance

The national report includes benchmark data that stratifies local responses into red, amber and green categories to represent local indicators in comparison with the lowest 20% of Trusts, the middle 60%, and the highest 20% of Trusts.

Local Cancer Patient Surveys

National Cancer Quality Indicators (National Peer Review Measures) first introduced by The Manual of Cancer Services [1] establishes the requirement for providers of services to cancer patients to periodically survey relevant patient groups and to ensure observations made by patients are considered and acted upon by relevant multi-disciplinary cancer teams.

- A survey of patients attending Nurse-Led Clinical Trial Clinics, June 2010
- A survey of Paediatric Oncology Services, May 2010

- A TVCN survey of patients with Testicular Cancer, September 2010
- A survey of Stem Cell Transplant Services, December 2010
- A survey of Inpatient Environment, Dove Ward, February 2011
- A survey of patient experience, Two-Week Referral system, February 2011

18 Return to theatre within 2 weeks

Monitoring	Quarterly	**09/10 Target**	NA
Source	Local	**10/11 Target**	Establish baseline
PC Contract	Yes	**Target achieved**	
Leads	Dr Alf Troughton – Medical Director Dr Helen Jones – AMD Planned Care Lucy Baker - GM Planned Care		

Outcome for 2010/11 was to establish baseline figures for patient returns to Theatre within 2 weeks.

Table 22

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Total returns to theatre	9	8	3	20	4	7	8	19	13	13	8	34	5	5	6	16	89
Total cases	1853	1619	1693	5165	1671	1532	1698	4901	1593	1792	1528	4913	1609	1477	1840	4926	19905
%	0.5	0.5	0.2	0.4	0.2	0.5	0.5	0.4	0.8	0.7	0.5	0.7	0.3	0.3	0.3	0.3	0.4

- There appears to be a significant reduction in returns from 2009/10. This may be due, in part, to improved validation criteria developed in collaboration with the Informatics Team and the Theatre Coordinating Managers.
- There continues to be monthly monitoring of specialty trends. Theatre Coordinating Managers validate the monthly figures collated by the Informatics Team.
- 2011/12 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.

19 Fractured neck of Femur timescales to theatre

Monitoring	Monthly	**09/10 Target**	24hrs
Source	Regional	**10/11 Target**	36hrs (95% end of March 2011)
PC Contract	Yes	**Target achieved**	No (89%)
Leads	Dr Alf Troughton – Medical Director Dr Helen Jones – AMD Planned Care Gillian Taylor – DGM Trauma & Orthopaedics John Ivory – Consultant Orthopaedics		

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 has been amended from 24 hours to 36 hours. The Trust set an indicator to work toward 95% of patients who are fit for surgery, waiting less than 36 hours for surgery.

Local initiatives to attain this improvement have included:

- 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 fractured NOF
- Increased bank holiday/weekend trauma lists

Compliance has improved during the year and in January, February and March 2011 the target was met or bettered. In December 2010 during the excessively bad weather 94% of patients with NOF fracture were operated on within 36 hours.

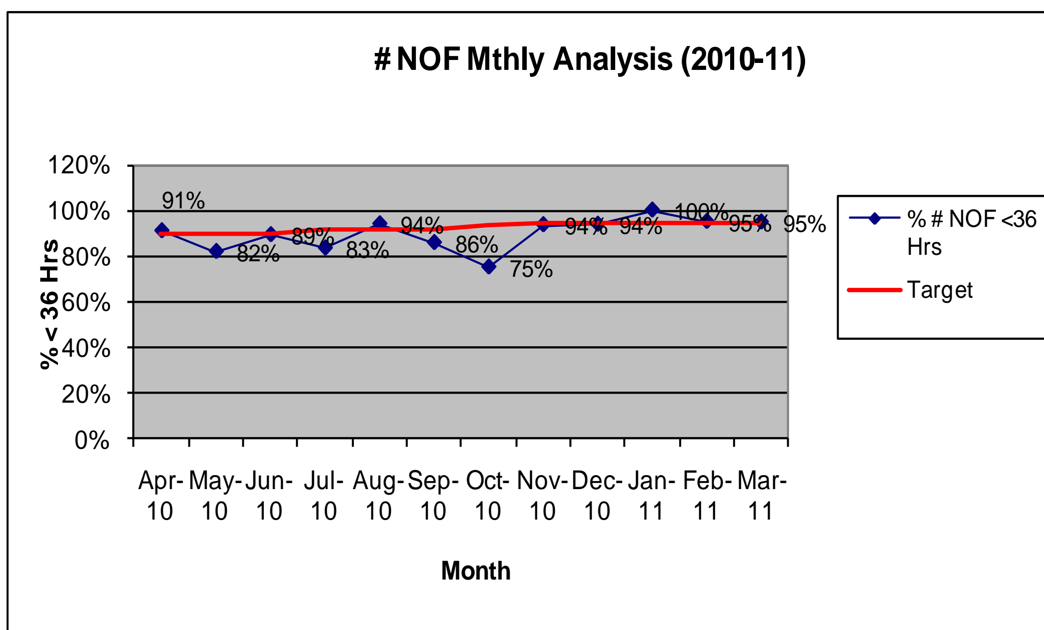
October was a particularly difficult month as the data shows we had 19 patients admitted in 1 week with hip fracture. On average we would expect one patient per day to be admitted with a hip fracture. This led to delays in surgery due to time and availability of theatre equipment. Since then we have developed an escalation plan fro such occurrences.

There was an improvement in quarter 4. We receive regular data on our time to theatre and analysis it carefully, putting plans in place to manage the process to provide the best outcome for patients

The target will continue to be monitored closely.

Overall the trust has made noted improvements in this area and compares favourably benchmarked with other Trusts within the South and West.

Table 23



20 Compliance with NICE guidance

Monitoring	Monthly	**09/10 Target**	95%
Source	Regional	**10/11 Target**	95%
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Associate Medical Directors Ranju Gopal – Clinical Audit & Effectiveness Manager Sharon Edwards – Clinical Audit Facilitator & NICE Lead		

The National Institute for Health and Clinical Excellence (NICE) is an established 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 Department has been responsible for the dissemination pathway for National Institute for Clinical Excellence (NICE) Guidance since September 2007.

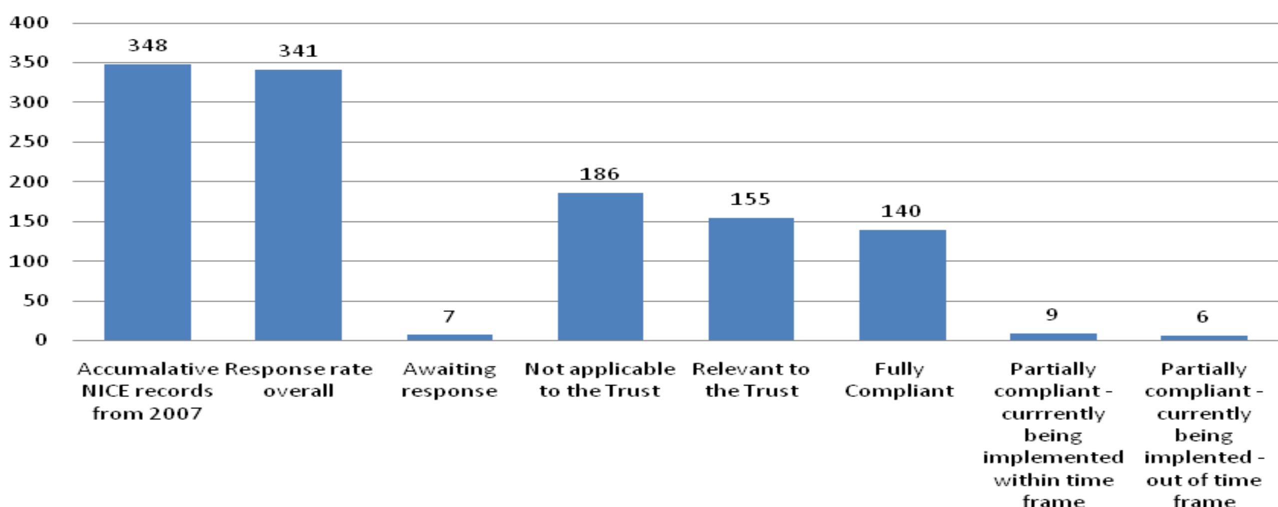
The NICE process includes identifying, disseminating, monitoring the implementation and reporting, of all NICE published guidance is managed by the NICE Lead, based in the Clinical Audit department.

The creation of dedicated database in 2010, has enable the accurate recording and monitoring of all 231NICE records, including the responses and progress with directorate and Trustwide compliance.

At the close of 2009/10 the trust demonstrated 100% compliance with 96/102 guidance fully implemented, and 6/102 that were partially compliant with actions to implement to attain full compliance.

During 2010/11, the Trust has been in receipt of an additional 117 published guidelines in the following areas; Technology Appraisals, Clinical Guidelines, Interventional Procedures, Public Health, and Cancer Services.

Table 24



All guidelines have been disseminated to the relevant clinicians and directorates. A response rate of 93% or above has been maintained throughout the year, which have confirmed that 60/117 (51%) of the publications are relevant to the Trust, of which, full compliance has been assured with 44/60 (73%).
Of the remaining guidance, 7 have only recently been published so are considered within the time frame, for assessment and responding.

To date, 9 guidance's are within the time frame allowed to become implemented and embedded within clinical practice. There are 6 guidance's from 2009/10 which remain partially compliant, and are now out of time frame (pass the deadline for implementation).

Trust wide compliance of 96-100% has been attained throughout this year which meets the Trust's contractual obligation with NHS Swindon.

Table 25

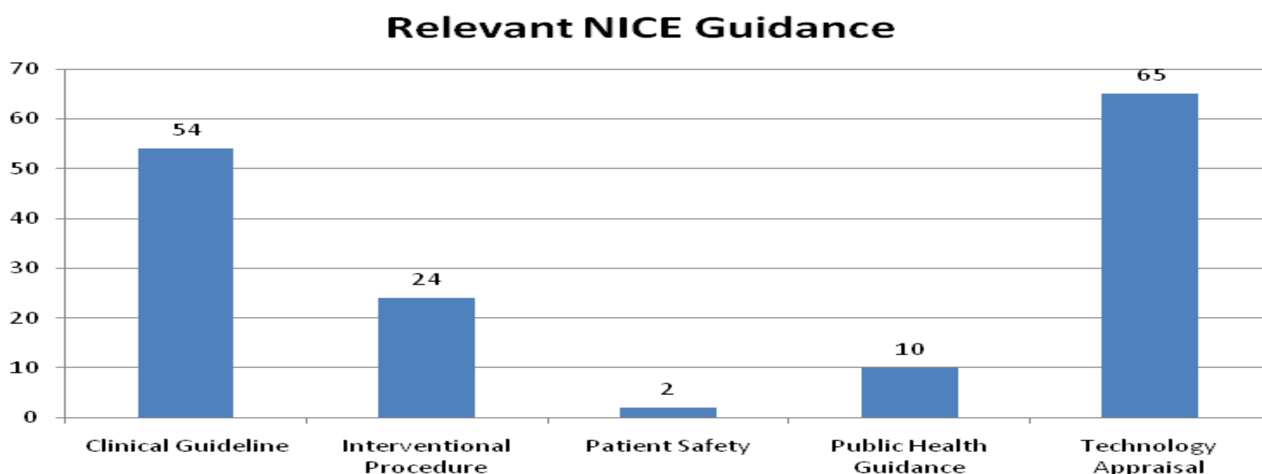
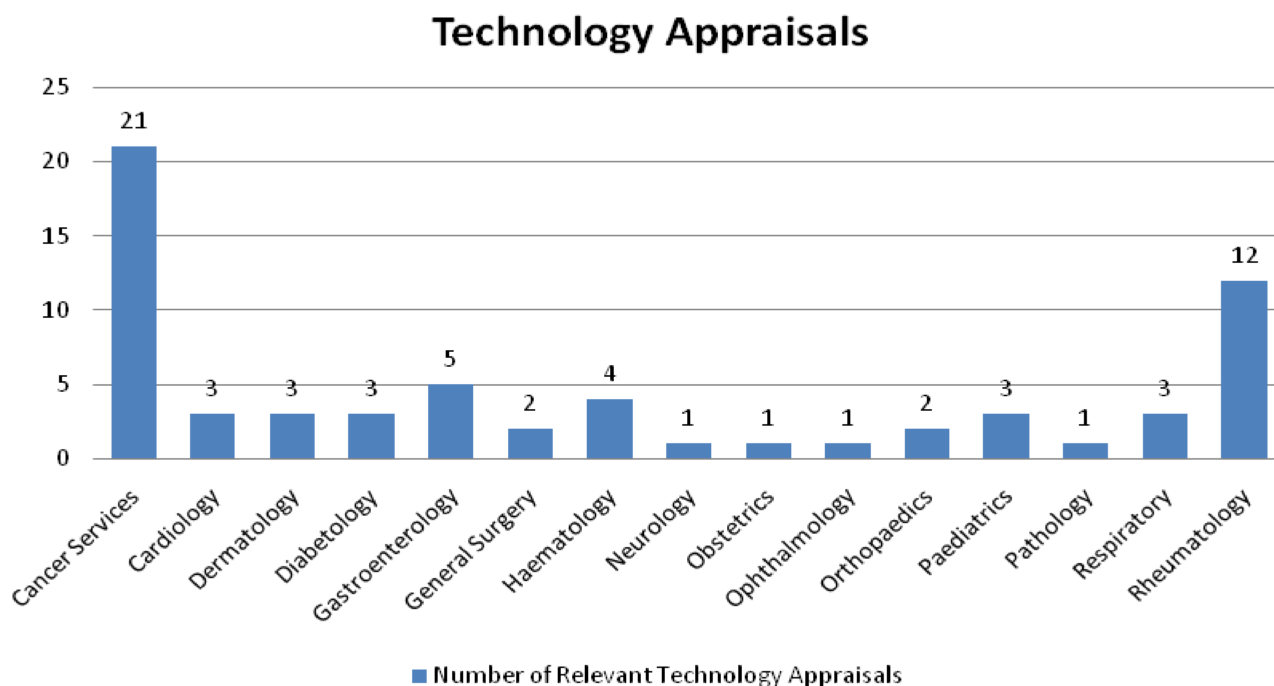


Table 26

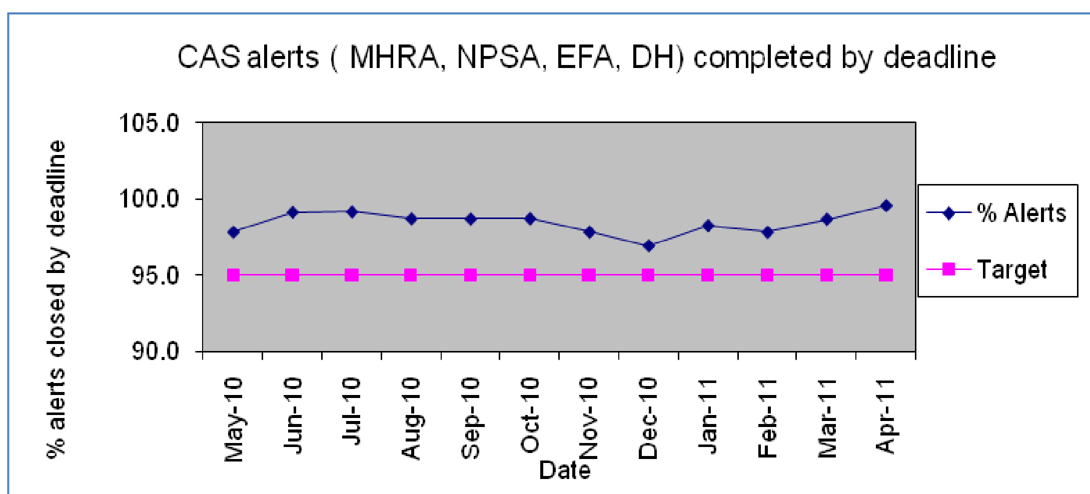


21 Compliance with CAS

Monitoring	Monthly	**09/10 Target**	95%
Source	National	**10/11 Target**	95%
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director John McGinty – Trust Equipment Manager Rachel Jefferies – Clinical Risk Manager		

The CAS (Central Alerting System) publishes medical device, hospital equipment and clinical alerts from the MHRA, the DH Estates and Facilities department and the NPSA. Responses and the completion of actions are monitored to defined deadlines via a web based system. Between April 2010 and the end of March 2011 the Trust received a total of 130 alerts from the CAS system.

Table 27



The standard of at least 95% compliance with no significant exceptions has been maintained throughout 2010/2011. 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.

Currently there is one alert outstanding, NPSA 2010/RRR015, concerning the prevention of over infusion of fluids in neonates. An action plan is in place, which is underway in Pharmacy and Pediatrics.

Table 28

Date of deadline (in date order)	**Reference and Alert description**	**Exec lead**	**Trust lead**	**Action awaited by, Directorate responsible**	**Estimated Date closing**	**Risk - to be completed by Trust lead**
28/02/2011	**NPSA 2010-RRR015 Prevention of overinfusion of intravenous fluids and medicines in neonates**	AT	Rachel Jefferies	Mike Lewis/Joanne Smith	15/04/2011	8(4 x 2)

22 New and Revised Clinical Guidelines and Policies

The principal function of the Clinical Development Group (CDG) is to co-ordinate the assessment, implementation and monitoring of Clinical Guidelines and Policies within the Trust.
In September 2010, the way in which the Trust managed its policies and procedures changed with the introduction of EDRMS (Electronic Discharge and Record Management System). The new system provides a single store for all Trust wide policies and procedures. Document numbers are no longer required as EDRMS automatically controls the versioning of all the documents. Guidelines and competencies still remain on the intranet for the foreseeable future.
All staff are able to view all the documents but only the approved versions of these will be visible. The documents that have been ratified at the CDG from April 2010 to March 2011 (a total of 29) are listed in table 29 below:

Table 29

Document Name	Date ratified
Clinical Guideline for oxygen prescribing in adults	25.5.10
Clinical Guideline for the Management of Adult Patients At risk of re-feeding syndrome	22.6.10
Policy for the requesting of Clinical imaging procedures By non-medical referrers	22.7.10
Competency for the use of intra-aortic balloon counterpusation therapy (IABP) for nursing staff	22.7.10
Competency in the safe and appropriate use of temporary pacing single chamber external pulse generators for nursing staff	22.7.10
Clinical trials nurse led patient assessment protocol for patients receiving treatment or follow-up within the context of a breast cancer clinical trials	22.7.10
Guideline for the application of Transcutaneous nerve stimulation (TENS) machine for inpatients	22.7.10
Clinical Guideline for non-discordant radiographer only reading of mammograms	24.8.10
Clinical competency for the safe preparation and collection of venous blood sample – medical staff	28.9.10
Last Offices - Adults	30.9.10
Mortuary Viewing Policy	30.9.10
Nurse led supply of TTA Medication incorporating the use of TTA packs	26.10.10
Swindon Outreach Score (SOS)	26.10.10
Medical Devices Training Policy	26.10.10
Management of Acute pain in adult patients taking long-term opioids (non-obstetric)	26.10.10
Organ Donation Policy	23.11.10
Clinical Competency for the safe management of patients receiving blood component transfusions	23.11.10
Near Patient Testing Policy and Procedure	23.11.10
Policy Document for the Emergency plan for the Management of Blood and Platelet Shortages	23.11.10
Nutrition Policy for Infants, Children and Young People	23.11.10
Procurement of Medical Consumables Policy	25.1.11
Clinical Guideline for Elective Surgical Blood ordering Schedule	25.1.11
Clinical Competency for Laryngeal Mask airway insertion	22.3.11
Clinical Competency for automated external defibrillation	22.3.11
Clinical Competency for Defibrillation	22.3.11

Clinical Guideline for Massive Haemorrhage – Obtaining Blood and Blood products	22.3.11
Clinical Guideline for requesting a Blood Transfusion	22.3.11
Clinical Guideline for Blood issue and distribution from the Blood Transfusion Laboratory	22.3.11
Clinical Guideline for the Administration of Blood components and Blood products	22.3.11

The terms and conditions of the group are currently under revision. There has also been a change made to the meeting structure to ensure that the main focus of the group is the ratification of policies and procedures. A new draft ratification form is being developed which will ensure that all policies and procedures can be monitored more effectively throughout the Trust.

23 Patient Recommendations

Monitoring	Monthly	**09/10 Target**	95%
Source	National	**10/11 Targets**	Q1 70%, Q2 75%, Q3 80%, Q4 90%
PC Contract	Yes	**Target achieved**	**No (83.5%)**
Leads	Sue Rowley – Director of Nursing and Midwifery Kevin Mcnamara – Head of Marketing & Communications Liz Daly – Head of Patient Experience		

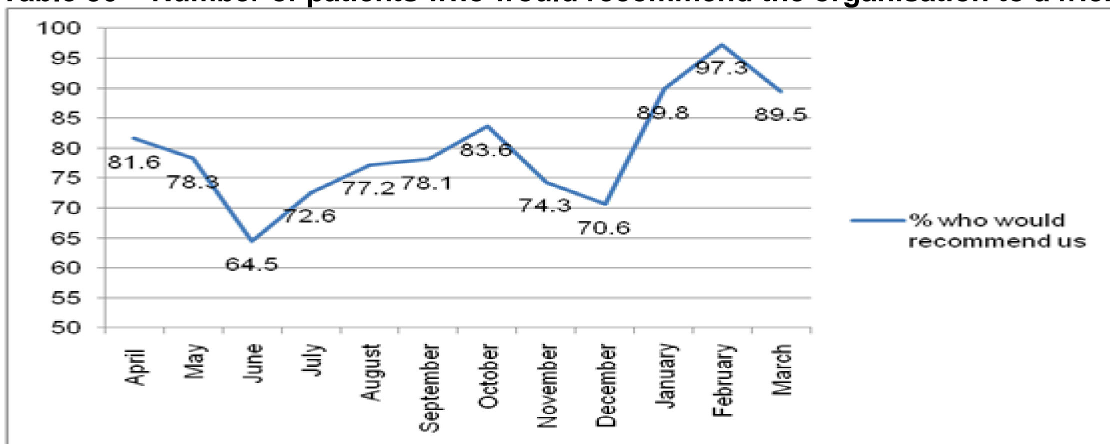
- Q1 Performance April to June 2010: 77.3% vs target of 60% - Achieved
- Q2 Performance July to September 2010: 73.7% vs target of 75% - Not Achieved
- Q3 Performance October to December 2010: 77.4% vs target of 80% - Not Achieved
- Q4 Performance January to March 2011: 90.5% vs target of 80% - Achieved (Notable improvement)
- Annual Performance April 2010 to March 2010: 83.5%

Tell us how we're doing' comment cards are available throughout the hospital and ask four questions to gain a snapshot into the satisfaction of our service users and their relatives.
These questions are:

- What was good about your visit?
- Was there anything that we could do better?
- Would you recommend us to a friend and why?
- Please tell us about any person or team who provided you with excellent care

Table 30 below shows the number of patients who would recommend the organization to a friend for 2010/11.

Table 30 – Number of patients who would recommend the organisation to a friend for 2010/11



During 2010/11 there have been a number of volunteers who have visited wards and departments to get feedback from the patients using the comment cards.

Patient feedback is also actively collected from the NHS Choices website and during 2010/11 the following surveys were commissioned by the Trust:

Quarterly Inpatient
Maternity Services
Paediatric Inpatient
Paediatric Outpatient

Annual Inpatient – results from this survey are used for national benchmarking purposes by the CQC

24 Patients treated with Dignity and Care

Monitoring	Quarterly	**09/10 Target**	90%
Source	National	**10/11 Target**	80%
PC Contract	Yes	**Target achieved**	**No (75.4% - Q4 data still o/s)**
Leads	Sue Rowley – Director of Nursing and Midwifery Carol Black – Matron Planned Care		

The Trust commissioned quarterly in-patient surveys during 2010/11 from the PICKER Institute.

Question 72 in the questionnaire asks 'Overall, did you feel you were treated with respect and dignity while you were in hospital?' This question has also been adopted as a question for monitoring purposes from 2012/13 under the NHS Outcomes Framework.

22% of patients felt that they were not treated with dignity and care compared with 23% of patients who completed the 2009 survey.

25 Patient Information on discharge

Monitoring	Quarterly	**09/10 Target**	NA
Source	National	**10/11 Target**	80%
PC Contract	Yes	**Target achieved**	**No (59.9% - Q4 data still o/s)**
Leads	Sue Rowley – Director of Nursing and Midwifery Liz Daly – Head of Patient Experience		

The Trust collects the views of patients about information on discharge from the quarterly inpatient survey. Q42 asks 'How much information about your condition or treatment was given to you?' The Trust measures the response rate for 'the right amount' for reporting.

23% of patients felt that they were not given enough (or given too much) information about their condition or treatment. In 2009 22% felt this way which means that there has been a slight decrease in the number of patients who were given the right amount of information.

The NHS Outcomes Framework and CQUIN highlight the importance of effective discharge planning and communication with patients.

The General Manager of Unscheduled Care is leading the Trust lead on discharge and a Discharge Lead Nurse was recruited during 2010/11 with a focus on reviewing and improving the discharge process. A discharge pack is being formulated in collaboration with the Pharmacy team and the comment cards will be included within this pack.

It is important to note that the number of comment cards completed by patients each month is quite low, only representing feedback from approximately 75-100 patients each month. The Trust has been seeking more reliable and robust methods of capturing feedback from the experiences of our patients and this is now being obtained by undertaking internal PICKER surveys quarterly. Hence future reports will be considered more reliable and informative.

26 Patient call bells responded to within 5 mins

Monitoring	Monthly	**09/10 Target**	80%
Source	National	**10/11 Target**	80%
PC Contract	No	**Target achieved**	**Yes (80% Feb/March data only)**
Leads	Sue Rowley – Director of Nursing and Midwifery Liz Daly – Head of Patient Experience		

Responding promptly to call bells is really important to our patients. As such we have worked very closely with our partners in health care provision. Carillion Health Care to determine an effective way of monitoring this element of care. Carillion are now able to monitor response times to call bells using an electronic system which is robust and reliable. We are an organisation that is leading the way in capturing this data and are proud that we have been able to focus on and demonstrate some real improvements in this area.

27 Compliance with CQC

Monitoring	Quarterly	**09/10 Target**	100%
Source	National	**10/11 Target**	100% by October 2010
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Ruth McCarthy – Associate director of Clinical Governance & IP&C		

Regulatory Monitoring

The Clinical Standards Group was set up by the Trust to specifically monitor performance against a variety of regulatory standards. The Group acts as a scrutinizing body and therefore provides assurance to the Trust Board.

It is tasked with enabling the Trust to meet its responsibilities in complying with the Care Quality Commission's essential standards of quality and safety as well as other regulations such as the Hygiene Code, the NHSLA risk management standards and others.

The Group meets monthly and draws upon a membership of Trust wide senior staff, reporting any perceived risks to its parent body the Patient Safety and Quality Committee.

Compliance with the various regulations is monitored at the Clinical Standards Group via an agreed rolling monitoring programme, with attendance of the appropriate regulation leads invited to aid the discussion. Monthly and quarterly summaries of the regulations discussed are fed back to the Executive Committee and Trust Board via the Patient Safety and Quality Report.

Table 31

CQC Compliance

Health & Social Care Act 2008 / (CQC Registration Regulations 2009)
Regulations Assessed for Compliance as at March 2011

Reg. No.	Outcome No.	Regulation Title	Compliance
17	1	Respecting & Involving People Who Use Services	Fully Compliant
18	2	Consent to Care & Treatment	Fully Compliant
(19)	3	Fees	Fully Compliant
9	4	Care & Welfare of People Who Use Services	Fully Compliant
14	5	Meeting Nutritional Needs	Fully Compliant
24	6	Co-operating With Other Providers	Fully Compliant
11	7	Safeguarding People Who Use Services From Abuse	Fully Compliant
12	8	Cleanliness & Infection Control	Fully Compliant
13	9	Management of Medicines	Fully Compliant
15	10	Safety & Suitability of Premises	Fully Compliant
16	11	Safety, Availability & Suitability of Equipment	Fully Compliant
21	12	Requirements Relating to Workers	Fully Compliant
22	13	Staffing	Fully Compliant
23	14	Supporting Workers	Fully Compliant
(12)	15	Statement of Purpose	Fully Compliant
10	16	Assessing & Monitoring the Quality of Service Provision	Fully compliant
19	17	Complaints	Fully Compliant
(16)	18	Notification of Death of a Person Who Uses Services	Fully Compliant
(17)	19	Notification of Death or Unauthorised Absence of a Person Who Is Detained or Liable to be Detained Under the Mental Health Act 1983	Fully Compliant
(18)	20	Notification of Other Incidents	Fully Compliant
20	21	Records	Fully Compliant
5	23	Requirement Where the Service Provider is a Body Other Than a Partnership	Fully Compliant
7	25	Registered Person: Training	Fully Compliant
(13)	26	Financial Position	Fully Compliant

(15)	28	Notifications: Notice of Changes	Fully Compliant

A concern was raised at the Clinical Standards Group with regard to providing sufficient detailed analysis of reporting trends for claims. Following the merger with WCHS from the 1st of June 2011 some additional resources for this area of work will become available, so further feedback with regard to this will be available.

With regard to the other parts of the regulation such as risk management, serious incident investigation, analysis and learning, the Group felt that the Trust can be confident that it has robust processes in place and is compliant with the regulation.

This concern and the overall compliance with the regulations were presented to the April meeting of the Patient Safety and Quality Committee**. .** The PSCQ agreed the internal review of full compliance with all CQC regulations and outcomes

CQC Registration

The following summary applies to the registration of the enlarged organisation as from June 1st 2011.

As part of the merger with Wiltshire Community Health Services (WCHS), the Trust is required to apply to the Care Quality Commission (CQC) to alter the conditions of its existing registration as from June 1st 2011. The CQC require 120 days notice of any variance to an organisation's registration.

The Trust has applied to be registered as the provider of an additional regulated activity, namely nursing care, which is carried out at two locations within WCHS. The cost of this variance is a one-off flat fee of £5,000 which is payable on application.

The Trust has also applied to the CQC to vary its registration in relation to locations at which the regulated activities will be carried out from June 2011. In total the Trust has submitted to register 21 sites, (20 additional sites). This has involved declaring compliance in relation to all the CQC essential standards of quality and safety, and details relating to the security of records and premises, any other business carried out and compliance with the Disability Discrimination Act 2005 in relation to access. As these locations were previously registered with the CQC by WCHS, we have been advised that there is no charge for this change to our registration, although we await confirmation.

All the applications required an updated version of the Trust's Statement of Purpose, detailing all services and locations that will be part of the enlarged organisation post 1st of June 2011. Once finalised, this will be accessible on the Trust's website.

28 NHSLA Acute standards.

Monitoring	Quarterly	**09/10 Target**	Level 2
Source	Local	**10/11 Target**	Work toward level 3
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Rachel Jefferies - Clinical Risk Manager		

Since March 2010 the Great Western Hospital NHS Foundation Trust has recruited an NHSLA project co-ordinator.

The co-ordinator has been helping the trust to prepare for NHSLA assessment level 3, this has involved:

- Revised and aligned policies to reflect the revised assessment standards for 2010/2011
- Completed a gap analysis
- Produced a programme of the works for each criterion lead for progression towards level 3
- Provided guidance on implementation of monitoring systems
- Assisted in revising audit criterions for level 3 evidence
- Prepared and undertook an informal assessment during 2010

During the 3rd quarter of 2010 GWH were successful in their bid in acquiring the Wiltshire Community Health Services (WCHS). This meant that GWH and WCHS would become a merge organisation and would be assessed as one.

The NHSLA standards stipulated that organisations undergoing significant restructuring will be allocated an assessment level by the NHSLA immediately post event.

New organisations and those which have undergone significant restructuring must choose either a formal assessment or an informal visit within the first twelve months of their establishment or the restructuring. The acute merge was classified as large but not significant, therefore NHSLA as a compromise in February 2011 allowed the merged organisation to retain its current NHSLA acute Level 2 accreditation following the merger but the date of its next assessment must take place within 1 calendar year of the merge.

To determine which level the organisation should next be assessed at the NHSLA project co-ordinator has been undertaking an options appraisal, this will be presented to the Trust's Clinical Standards Group and Patient Safety Quality Committee with recommendations of the preferred option of assessment at level 1 or 2.

GWH have been liaising with WCHS to establish their current position and to help build relations prior to the merger.

The NHSLA project co-ordinator is working with the GWH criterion leads establishing what work is required, community leads and understanding of processes ahead of the forthcoming assessment. Over the forthcoming months the NHSLA project co-ordinator will be helping the trust to prepare for its next assessment for 2012.

29 NHSLA Maternity standards

Monitoring	Quarterly	09/10 Target	Sustain Level 3
Source	Local	10/11 Target	Sustain Level 2 (transition)_
PC Contract	Yes	Target achieved	Yes
Leads	Dr Alf Troughton – Medical Director Dr Helen Price – Consultant Paediatrician Teresa Harding – GM Women's and Children's Christina Rattigan – Head of Midwifery		

The Maternity unit was due for CNST reassessment at Level 3 in November 2011, however, due to the imminent merger of Wiltshire Maternity Services with GWH Hospitals NHS Trust on the 1st of June, NHSLA have assessed the new service at Level 2.. This will therefore be reflected as green

Monthly meetings have been set up with the risk management team from Wiltshire and Swindon to progress the agenda of reviewing all policies, audits and monitoring process. Level 2 will apply for 2 years and within this time a formal assessment must take place.
Monitoring of CNST Standards progress is in place via the Directorate Patient Safety and Quality group and Trustwide Patient Safety and Quality group.

30 Staff Survey

Monitoring	Quarterly	09/10 Target	N/A
Source	National	10/11 Target	Implement improvement plan
PC Contract	Yes	Target achieved	
Leads	Oonagh Fitzgerald – Director of Workforce & Education Lesley Maiden – Deputy Director of Workforce & Education		

Sickness absence – supporting staff to remain at work

The Trust has put a number of measures in place to support staff to remain at work and to remain productive. These include a fast track policy for staff that need treatment at GWH, support from Staff Support services and health assessments and advice from Occupational Health staff. The Trust also implemented a new policy for managing sickness absence to ensure that managers were proactively managing attendance at work.

To measure the outcome of these initiatives, the upper threshold for sickness absence was set at 4% for the Trust for 2010/11. At the year end, the actual rate of absence was 3.85%, this compares to a year end figure of 4.64% for 2009/10. The improvements are due to the implementation of a new sickness absence policy. As a result the Trust had an additional 7750 days available from its workforce: the equivalent of 21.23 whole time equivalents.

Medical Workforce

In 2009/10 a programme of work has been implemented to ensure we were making best use of the pay bill. In total £5.2 million was spent on temporary medical staffing during 09/10. This spend was high due to the implementation of the European Working Time Directive and also our inability to appoint substantive medical staff when gaps arise. In 2010/11, this has been reduced to £3.9 million. This was achieved through the introduction of a new Locum policy, review of agency terms and

conditions, the implementation of standardised locum rates and proactive management of locum booking requests.

This proactive work has been recognised as the Medical Workforce teams have reached the final of the Healthcare Personnel Managers Association (HPMA) awards for best practice HR.
Savings have also been made on the agency spend of nursing staff.

Learning and Development

The Academy continues to offer high quality learning and development interventions linked to Trust and departmental business plans. The Academy prospectus has been developed in order to ensure that all staff, external stakeholders and other organisations are aware of the range and availability of programmes. Regional and national study days continue to be organised to raise the profile of the Academy.

Staff engagement

The Trust is committed to engaging with staff at all times but particularly during periods of organisational change. Briefing meetings have been held across the Trust to ensure that staff are aware of the implications of the WCHS transition and integration. Over 300 staff attended these sessions.

Team brief continues to be cascaded monthly to ensure that staff are aware of other developments and news and Horizon (quarterly magazine) is also distributed.

The influencing group continues to meet to discuss how what changes the organisation needs to make to maximise the contribution of our workforce.

In total the Trust received 12 grievances during 10/11 and appeals were received for 1.58% of cases, both a reduction on the previous year. This is a result of a close working relationship between HR, line mangers and trade union colleagues.

Health and Safety

Members of the Executive team continue to visit sites where RIDDORs occur to ensure that when accidents happen they are investigated thoroughly and lessons are learnt and shared across the organisation. In 09/10 the Trust had 16 RIDDORS however in 10/11; there were 9, which is a 40% reduction. This is a result of robust health and safety management systems in place including the annual audit programme and an improved training regime.

31 Mental Health Capacity Act

Monitoring	Quarterly	**09/10 Target**	100% in awareness training at Trust Induction
Source	Local	**10/11 Target**	Sustain current level
PC Contract	No	**Target achieved**	**Yes**
Leads	Sue Rowley – Director of Nursing and Midwifery Carole Crocker – Deputy Director of Nursing		

We are pleased to report that there have been significant improvements in the last 12 months regarding Mental Health, Mental Capacity, Deprivation of Liberties and overall vulnerable adult's needs. We are compliant within the legal framework and this is monitored at our MHA (Mental Health Act) and MCA (Mental Capacity Act) committee which is chaired by the Trust Chairman. An Annual

report regarding Mental Health and Mental Capacity is submitted to the Trust Board and this offers assurance and re-assurance that compliance is in place.

An audit carried out by Bentley Jenison has shown that the Board and the organisation can be assured that there are mechanisms and processes in place to care for and manage this group of patients attending GWH. In addition the Deputy Director of Nursing (GWH) and the Deputy Director of Operations (AWP) have carried out a scope of services provided by AWP. This has directed and influenced the development of a SLA between AWP and GWH. The two way SLA between AWP and GWH, specifications 4-9 have been agreed and signed off. Specifications 1-3 are currently under review due to the services modernisation and re-design within AWP. GWH is a key member of the Swindon Mental Development Board which ensures that all services are fit for the purpose.

Key points in place include:

Mental Health Act policy
Mental Capacity Act Policy
Deprivation of Liberties Policy
Protocol - Visiting or Admission to hospital for people with learning disabilities
Carers Policy
Guidelines for Carers and Staff
External Audit of GWH as Demonstrator Site for Carers
Action Plans and Work Plans for - Learning Disabilities, Carers, Dementia, Mental Health, Mental Capacity including the Deprivation of Liberty Safeguards (DoLS) –

All this information is accessible through a dedicated Vulnerable Adults Intranet site for all Trust staff

Internal groups in place to ensure continued improvement:
Mental Health Act and Mental Capacity Act Committee (Chaired by Chair of the Trust)
Mental Health Act and Mental Capacity Act Operational Group (Chaired by Deputy Director of Nursing)
Learning Disabilities Action Group - Chair - Matron for Un-Scheduled Care
Carers Committee - Chair -Matron for Un-Scheduled Care
Carers Leads Forum - Chair - Deputy Director of Nursing
Dementia Care Group – Chair – Deputy Director of Nursing

External Groups:
Deputy Director of Nursing is a member of external groups:
Local Safeguarding Adults Board – Swindon and Wilts
Policy and Procedures Group for Vulnerable Adults
Dementia Partnership Group - SHA, PCT, AWP & GWH
Dementia Expert Referencing Group
Mental Health Act Steering Group
Mental Capacity Steering Group
Veterans Support Network
Pro-active members of PREVENT

Future developments include a Transfer Action Plan for Vulnerable Adults. This is a joint working Group between GWH and WCHS (Wiltshire Community Health Service) which will ensure that vulnerable adults are safeguarded through the transfer of services.

32 Safeguarding Children

Monitoring	Quarterly	09/10 Target	Compliance at level 1 training
Source		10/11 Target	Improve compliance at level 2 & 3 training
PC Contract	Yes	Target achieved	
Leads	Sue Rowley – Director of Nursing & Midwifery Teresa Harding – GM Women's and Children's Joanne Smith – Senior Nurse Children's Services		

Child Protection and Safeguarding continues to have a high profile on the national agenda. In June 2010 the Department for Education announced Professor Eileen Munro would conduct an independent review to improve child protection this was despite the fact that the new 'Working Together guidance' was only published in March 2010.
We are currently awaiting the publication of the final report of the Munro Review of Child Protection in England due in April 2011. This review of Child Protection is part of a national drive to improve the quality of child protection services. The final report will contain recommendations for safeguarding children which will need to be incorporated into our practice

TRAINING

The revised 'Working Together' guidance (Mar 2010) completely changed the levels of child protection training and instead of levels referred in its recommendations to groups. Within Swindon the LSCB decided that there would be no change to child protection training until Munro had published her recommendations to prevent any confusion and unnecessary change. We have this past year remained with the 3 levels but this is different to other local Trusts within the South West including Wiltshire. The LSCB training sub-group will following Munro decide on the new levels and present to the LSCB board for ratification. Following this it is likely that we will make changes within our Trust.

The Intercollegiate Document "Safeguarding Children and Young People: Roles and Competencies for Health Care Staff has also been revised in 2010, and this has significant implications in respect of staff groups who require specific levels of safeguarding training.

A significant amount of safeguarding training is provide by the Named Nurse and the designated doctor has this year introduced shortened Level 2 training for medical staff which has had a good uptake.

In addition, the Named Nurse has provided dedicated Level 2 training to departments including Ophthalmology, Radiology, Obstetrics and the Emergency Department. Despite this the Academy report that staff are still not accessing the training provided either online or face to face (which is recommended for Level 2 and above)

Currently Level 1 stands at 72.54% (amber) and Level 2 at 65.34% (red). The actual numbers are

LEVEL	NUMBER ATTENDED	NUMBER STILL TO ATTEND
Level 1	2346	888
Level 2	545	288
Level 3	32	Not applicable

N/B Level 3 training is multi-agency and there is no set number that must attend, generally it is paediatric medical staff, community midwifery, community paediatrics, co-ordinators in ED and leads in depts. where children are seen on a regular basis. Or staff that need to attend additional training e.g. Safer Recruitment/Allegations/case conferences & core groups etc.

STRATEGY MEETINGS/CASE CONFERENCES

As always the Named Nurse/Dr, Paediatricians/Children's Outreach Nurses/Community Midwifery Manager & Midwives attend numerous meetings to ensure the safety of unborn baby/children child and the sharing of information across all agencies.

AUDITS

This year audits have been undertaken by the ED dept in relation to the documentation relating to parents who attend ED with their children (this was required from a Serious Case Review perspective)
An audit was done in relation to 'Missed diagnosis of fractures in children' (NPSA Signal Alert).
Another audit was done by one of the paediatric registrars on 'Reviewing of children with suspected abuse'.
Additional audits are done by the Named Nurse as part of the LSCB Quality assurance Sub-group)

NEW GUIDANCE

Working Together to Safeguard Children (2010)
NICE PH29 - prevent unintentional injuries children under 15
Transitions Policy for Disabled Children (launched Feb 2011)

OFSTED/CQC

In Feb 2011 Ofsted did another 2 day unannounced inspection and Swindon LSCB have received a good report. In particular a special note was made of the CP leads meet which the Named Nurse attends on behalf of the Trust (Ofsted also recognised excellent partnership working including monthly multi-agency meetings to discuss cases of concern)

SECTION 11

This is our report which ensures our arrangements are compliant to Safeguard and Promote the Welfare of Children
We submitted the 2009-2010 report and received good feedback with the independent panel agreeing our scores all except one which they felt was better than our score. They requested more details of our evidence (which we had ready, but was unfortunately not requested until after the review)
For this year (2010-2011) the General Manager for W&C has asked the directorates to complete the audit form to gain ownership of the safeguarding agenda. The evidence will then be collated into the report and submitted. This is due to be sent middle of April.

GOOD PRACTICE

Continues to be good sharing of information where there are concerns regarding children from key staff in certain departments to the Named Nurse, particularly Ophthalmology, ENT and Fracture Clinic. Child Protection clinical supervision sessions are held every 2 weeks by the designated Doctor and anyone is welcome to attend.

Planned care have ensured that with the automated patient cancellation process that for children there is an exception and that no child can be cancelled without checks.

The Ophthalmology DNA guidance flowchart has been revised following an LSCB audit and the Sister in ENT is producing a similar flowchart.

All nursing staff in the Children's unit have received training on sexual health this year which will enable them to focus on the particular concerns re sexual exploitation, the need for Chlamydia screening and undertaking sexual health assessments on all young people who are sexually active.

We now have excellent representation from ED and Midwifery at the local MARAC (Multi-agency Risk Assessment Conferences). This is to ensure that we highlight the high risk Domestic Abuse cases and

ensure that patients are protected and that information is shared. Those discussed at the MARAC meetings will now have an alert put on the hospital Medway system so we can highlight any concerns

In addition to this the ED department are introducing the DASH (Domestic Abuse, Stalking and Honour Based Violence) assessment and our midwifery team will also start later on in the year after training has been provided. This training has been done in liaison with the police and is a national initiative to highlight potential high risk cases and save lives.

SAFER RECRUITMENT

This will be covered in the HR report but Swindon LSCB continues to provide training sessions on Safer Recruitment and Allegations and this is essential under our statutory duties.

In February the Coalition Government published the findings of its Review into the Vetting and Barring Scheme. These are the recommendations most pertinent to us as an organisation.

- the merging of the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) to form a streamlined new body providing a proportionate barring and criminal records checking service;

- A large reduction of the number of positions requiring checks to just those working most closely and regularly with children and vulnerable adults;

- Portability of criminal records checks between jobs to cut down on needless bureaucracy;

The Coalition Government has confirmed that until all the appropriate legislation has been introduced and the new arrangements are established, the existing responsibilities of employers and the ISA will remain.

AREAS TO IMPROVE

We need to increase the number of staff to undertake Level 1 & Level 2 CP training. And this needs to be led by each directorate.

The Named Nurse had hoped to set up a dedicated intranet site for safeguarding but this has not been achieved and so will be brought forward to this year (2011-2012)

Directorates need to raise more awareness of the ‘See the Adult See the Child ‘ protocol within adult areas to ensure that for those children whose parents have mental illness, learning disabilities or substance misuse there is an assessment to ensure their needs are being met.

There are still areas of the NSF for Children and Maternity that need to be reviewed within the Directorates e.g. dedicated out-patients lists for children, dedicated paediatric theatre lists and recovery, an adolescent area within paediatrics.

PLANS/OBJECTIVES FOR 2011-2012

Address the Munro recommendations when published.

Develop Trust intranet for Child Protection.

Increase the level 1 CP training to >90%.

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Increase Level 2 CP training to >75%.

Trial of Paediatric ED (starting Sept 2011). This will address the needs of children & families and address some of the gaps that we have in sharing information and reporting safeguarding concerns.

Community Paediatrics has moved into GWHFT this past year and in the coming year we will be integrating the Named Doctor role and improving communication to conference reporting and implementation of the CAF (Common Assessment Process).

The safeguarding requirements are increasing at a time when service provision from partner agencies is decreasing, due to the need for financial constraints. Like with all departments this will require vigilance to ensure the needs of children are met and that the safeguarding agenda remains high on everyone's agenda.

Part 5 Glossary of Terms

MRSA - Methicillin-resistant Staphylococcus Aureus, which is a common skin bacterium that is resistant to a range of antibiotics.

Clostridium difficle – Bacteria naturally present in the gut

IP&C – Infection Prevention and Control

NPSA – National Patient Safety Agency - leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

HSMR – Hospital Standardised Mortality Rate - an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

VTE – Venous Thromboprophylaxis – refers to a blood clot

NHSLA - National Health Service Litigation Authority – Handles negligence claims and works to improve risk management

DoH – Department of Health

SHA – Strategic Health Authority – Manages the NHS locally and provides important link between the DoH and the NHS

CQC – Care Quality Commission – Independent regulator of health and social care in England

WCHS – Wiltshire Community Health Services

NOF – Neck of femur

IC – Intensive Care

RCA – Root cause analysis – problem solving methods

Falcon – Acute Stroke Ward

ED – Emergency Department

AAU – Acute Assessment Unit

Dove – Cancer Unit

Dr Foster - Provider of healthcare information in the UK, monitoring the performance of the NHS and providing information to the public

CQUIN - The Commissioning for Quality and Innovation payment framework was introduced in 2009 to make a proportion of providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of care.

RIDDOR - The Reporting of Injuries, Diseases and Dangerous Occurrences