Great Western Hospitals NHS Foundation Trust

Meeting:	Board of Directors	**Date:**	4th January 2018
Title:	**Quality Strategy Update**		

Summary of paper:	This paper provides an update on the progress over the past six months on the delivery of the key performance indicators for the Trust Quality Strategy since April 2017. The table in Appendix B provides detailed progress against each Key Performance Indicator.
Consultation / other committee views:	Patient Quality Committee receives regular updates. Individual leads have engaged in the delivery of the key performance indicators.
Assurances:	This information has been obtained from both the monthly Quality Report and the Trust performance reports

Recommendations/ decisions required:	***(a) that Trust board receives this 6 month progress update*** ***(b) that the report be noted***

Link to Trust Priorities	**Link to Quality**
(1) We will make the patient the centre of everything we do. (2) We will work smarter not harder to make best use of existing resource. (3) We will innovate and identify new ways of working. (4) We will build capacity and capability by investing in our staff, infrastructure and partnerships.	(1) Safety (staffing, falls, never events, handover, SI, safeguarding, infection control, environment, medicines, equipment). (2) Effectiveness (HMSR, SHMI, Mortality, Clinical audits, care bundles, deteriorating patient). (3) Caring (patient experience, patient surveys, friends and family test, patient stories, response to call bells). (4) Responsiveness (complaints, waiting times, cancelled operations, ambulance stays, translation services, comfort factors – TV and seating). (5) Well led (staff survey, staffing levels, sickness rates, flu vaccinations rates, board/ward interactions, staff reports, governance and reporting, risk management, financial control).

Risk issues:	**Risk Register Ref No:**	**Risk Score:**
Achieving ED Hour target	823	16
Achieving RTT	1357	12
Achieving AKI screening	1418	8
Achieving Sepsis care bundle	1419	6

Resource Implications: Expenditure / Income net value	**Regulations and legal considerations:**	**Quality consideration and impact on patient and carers:**
Nil	Care Quality Commission Clinical Commissioning Group	The KPIs to the Quality Improvement Strategy sets out to drive improvements in safety and quality for patient care.

Report Sign Off:		
Financial	**Operational**	**HR**
N/A	N/A	N/A

Confidentiality

This report does not contain any confidential information.

Equality Impact Assessment

Great Western Hospitals NHS Foundation wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt.
This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.

Lead Executive Director:	Hilary Walker	Title:	Chief Nurse
Report Author:	Lisa Hocking	Title:	Quality Lead

Introduction

The Trusts Quality Improvement Strategy refresh was agreed in October 2016. This paper provides the second six month summary of progress against the Key Performance Indicators (KPI's).

Quality Improvement Strategy

The Quality Improvement Strategy eight domains are:

- Delivering Safe, Effective Care; Delivering Excellence.
- Leading the Best Patient Experience
- Releasing Time to Care
- Visible Inspirational Leadership
- Culture of Innovation and Continuous Quality Improvement
- Measurement of Essential Quality Standards, Providing Assurance of Patient Safety and Clinical Effectiveness
- Staff Will Understand Their Contribution to the Organisation
- Quality Services Across Systems

Progress against the strategy since April 2017

22 Key Performance Indicators have been achieved, Key areas of success are:

- Trust's mortality rates have been consistently below the nationally expected value. This score makes the Trust one of the best performing in the country for lower than expected Mortality rates.
- Championing the use of a PDSA QI methodology for all the change and transformation projects.
- Mortality rates for sepsis have dropped from 38% to around 11%.
- 30% of the Medical take goes direct to the Ambulatory Care Unit.
- 13 patient safety walkabouts have been conducted since April 2017.
- Specialties and departments have all commenced their Clinical Governance self-assessments and gap analysis.

8 Key performance indicators have been partially achieved. Areas of improvement:

- Delivering an improving picture on 'lives saved' has proved a challenge; 33 lives have been counted as saved. Our aim was to achieve 50 during each six month period. We have so far saved extra 249 lives since the saving 500 lives campaign launched.
- 81% of patients with a NEWS score of 5 or more were appropriately escalated against a target of 85%.
- 83% of patients with a NEWS score of 5 or more had a management plan in place against a target of 85%.
- On average 25% of patients are discharged before lunch, against a target of 30%.
- 76% of Sepsis patients have had Antibiotics administered within 60 minutes of presentation against a target of 80%.

12 Key performance indicators were not achieved as intended. The narrative can be found within Appendix B, the key risks identified are:

- Delivering key national performance targets continues to be a significant challenge including achieving access targets such as cancer, RTT and ED 4 hour wait (please see Appendix B).
- The quality team have not been successful in expanding the QI network as initially planned, due to the quality lead leaving the organisation and subsequent delays in recruiting a suitable replacement. However existing projects have continued to be supported and new projects are being initiated by clinical staff.
- 14 complaint cases were reopened due to poor response letters in the six month period, against a target of one a month. The month of July saw a particular peak with eight responses needing to be reinvestigated. Letters sent during April, May and August all achieved or exceeded the required standard.

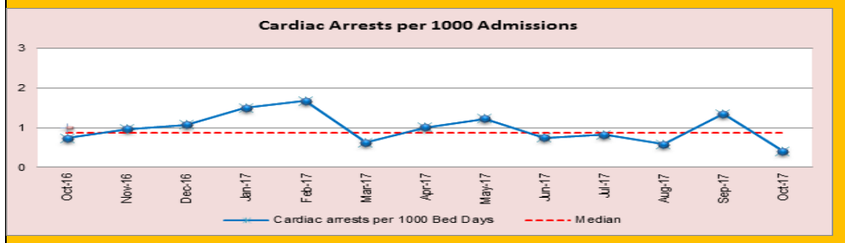
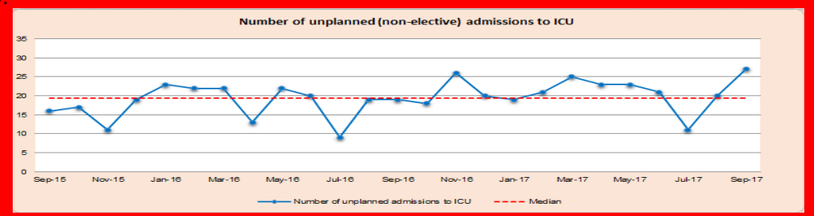
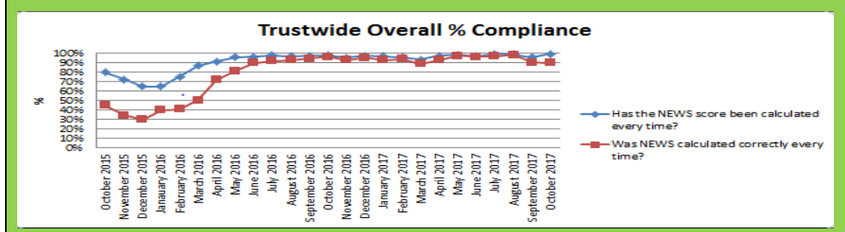
3 indicators were not due a milestone update this review.

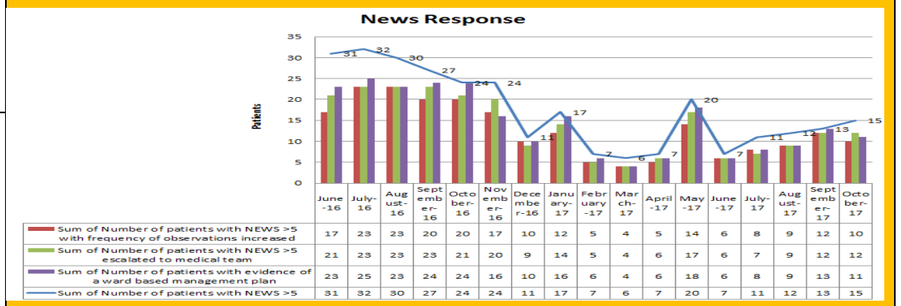
Next steps:

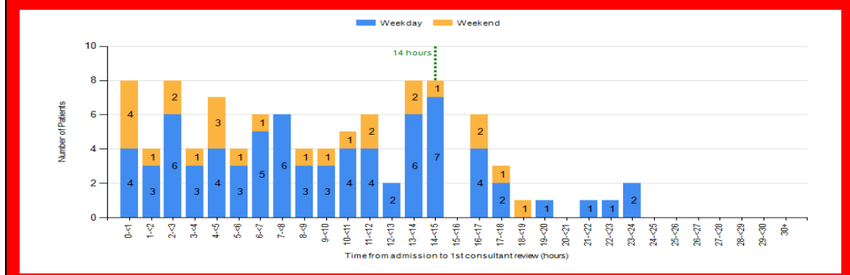
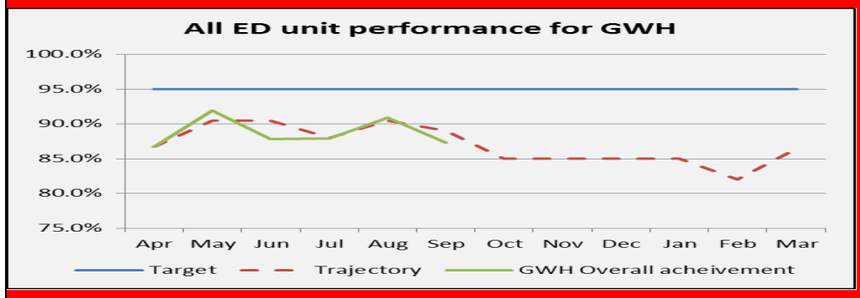
The Strategy objectives will continue to inform the Patient Quality Committee and performance agendas, both standing and rolling. Supportive plans are in place with the leads for each indicator to make further progress with the KPIs which have not delivered within the expected timeframe. A further review and assessment of progress will be reported to the Patient Quality Committee, Executive Committee, the Quality and Governance Committee and through to Trust Board as part of the Trust Quality Accounts in April 2018.

Appendix B

AREA OF WORK	SUCCESS MEASURES	MILESTONES FOR ACHIEVEMENT		NOMINATED LEAD	COMMENTARY
		Oct-17	Mar-18		
Saving an Extra 500 Lives	HMSR below 100 and extra 100 lives saved per year	HMSR below 100	HMSR below 100	Mark Juniper	**October 17 Milestone achieved:** April – July 2017 HSMR = 90.09
	Extra 100 lives saved per year	50 lives saved April 17 to Oct 17	50 lives saved Oct 17 to April 18	Mark Juniper	**October 17 Milestone Partially achieved:** Spells: 18156 Observed deaths (%): 5.94 = 1079 Expected deaths (%): 6.12 = 1111 **April-March Lives saved**: 33 **To date 249 Lives Saved**
Sepsis 6	Reduce mortality at 30 days following an admission with severe sepsis to 23% by April 2018.	Sustain mean mortality below 23%	Sustain mean mortality below 23%	Amanda Pegden / Nic DeVeaux	**October 17 Milestone achieved:** 30 day Mortality for patients admitted with sepsis remained below 23% Mortality rates for sepsis have dropped from 38 % to around 11 %
		90% of patients have documented evidence of use of the sepsis six pathway	90% of patients have documented evidence of use of the sepsis six pathway	Amanda Pegden / Nic DeVeaux	**October 17 Milestone achieved:** Compliance with sepsis screening remains above 90% overall. Admission to ICU has fallen from 14% to 5% for Sepsis
		80% of patients have had Antibiotics administered within 60 minutes of presentation	85% of patients have had Antibiotics administered within 60 minutes of	Amanda Pegden / Nic DeVeaux	**October 17 Milestone Partially achieved**: Compliance in Q1 2017/18 is at **76% -** an improvement from the previous quarter.
AKI	Reduce all cause mortality from AKI to 16% per annum by April 2018	Sustain mean mortality at 18%	Sustain mean mortality at 18%	Tanaji Dasgupta / Nic DeVeaux	**October 2017: milestone not achieved:** Regionally collated data for AKI crude mortality at discharge puts GWH at 20.7% (against a regional position of 18.7%)
AKI	Reduce all cause mortality from AKI to 16% per annum by April 2018	80% of patients with AKI have a completed care bundle	95% of patients with AKI have a completed care bundle	Tanaji Dasgupta / Nic DeVeaux	**October 2017: Milestone not achieved**: Snapshots from April-June and June/July show the compliance with completing the AKI care bundle (including paper tool) is at 36%. Compliance with completing the elements of the care bundle (without the paper tool) is at 85% Audits from 2017/18 are limited (this has been due to the ASK note on Medway, which has limited the data capture).

AREA OF WORK	SUCCESS MEASURES	MILESTONES FOR ACHIEVEMENT			COMMENTARY
		Oct-17	Mar-18	NOMINATED LEAD	
Rescue and respond	1. To reduce avoidable in hospital cardiac arrests by 10% each year by March 2018	**Reduce avoidable cardiac arrests**	Reduce avoidable cardiac arrests	Mark Juniper/Sarah Canfield	**October 2017: milestone partially achieved** A review of cardiac arrests continues to be undertaken to determine whether they were avoidable or unavoidable.  (Lower is better)
	2. Reduce number of avoidable unplanned admissions to ITU from inpatient adult wards	**Reduce avoidable unplanned ITU admissions**	Reduce avoidable unplanned ITU admissions (tbc)	Mark Juniper/Sarah Canfield	**October 2017: Milestone Not Achieved** There has not been a sustained improvement in the number of unplanned admissions into ICU.  **(Lower is better)**
		Sustain Trustwide average of 95% for accurate use of NEWS	Sustain Trustwide average of 95% for accurate use of NEWS	Mark Juniper/Sarah Canfield	**October 2017: milestone achieved:** **On Average news scores are calculated accurately achieving a 95% accuracy rate.** 
AREA OF WORK	SUCCESS MEASURES	MILESTONES FOR ACHIEVEMENT			COMMENTARY

		Oct-17	Mar-18	NOMINATED LEAD	
Rescue and respond	**3 Improve NEWS Scoring**	**Trustwide average of 85% for escalation of patients with NEWS 5 or more**	Trustwide average of 90% for escalation of patients with NEWS 5 or more	Mark Juniper/Sarah Canfiled	**October 2017: milestone partially achieved – with an average of 81%.** (4 months of data have been 85% and above) and demonstrates an improvement since the previous update provided. 
		Trustwide average of 85% for appropriate response including written plan for patients with NEWS 5 or more.	Trustwide average of 90% for appropriate response including written plan for patients with NEWS 5 or more	Mark Juniper / Sarah Canfield	**October 2017: milestone partially achieved – with an average of 83%.** **(**4 months of data have been 85% and above) and demonstrates an improvement since the previous update provided.
WHO Checklist	**1.Reduction in patient safety incidents and harm as a result of errors during invasive procedure**	**Zero Never Events**	Zero Never Events	Adam Brooks	**October 2017**: **milestone not achieved** One never event reported in September 2017 relating to a dental case in April 2017 in which a wrong tooth was extracted, this was identified as a Never Event in September 2017 when the patient was followed up by the dentist.
WHO Checklist	**2. Improved culture for safety within the department undertaking invasive procedures**	**Trustwide average of 90% for accurately completed checklists**	Trustwide average of 95% for accurately completed checklists	Adam Brooks	**October 2017: milestone achieved** Since April 2017, the Trust Wide percentage of correctly completed checklists has been 90%+, with September 2017 data showing 96% compliance. Continued work with NatSSIPs and LocSSIPs is ongoing. Four Human Factors training sessions have now been held by NHS Elect, across these sessions, 77 staff have attended. Following feedback from staff who attended previous sessions, the content and flow has been adapted to provide more case studies, tools and scenarios to work through, alongside the theory. Four more sessions have been booked for 2018, which will result in a further 80 staff being trained.
AREA OF WORK	**SUCCESS MEASURES**	**MILESTONES FOR ACHIEVEMENT**			**COMMENTARY**
		Oct-17	Mar-18	**NOMINATED LEAD**	

Reduction in Complaints and Incidents about poor clinical hand-over	**Significant reduction in number of incidents and complaints about poor clinical hand over**	**Commence improvement plan**	tbc April '17	Sue Day/ A Kerry	**October 2017: milestone Achieved** Improvements with clinical handover includes: • SWICC handover process and safety briefs • Discharge letters • Pre-assessment documentation, including safeguarding and LD assessments Next steps: look at a handover script for when patients are moved from one ward area to another to prompt staff to provide a comprehensive and relevant handover.
Consultant Review for urgent care medical patients	All patients admitted to the Trust as an emergency admission for a physical health problem **have initial consultant review within 14 hours**	All patients **have initial consultant review within 15 hours**	100% patients within 14 hours	Guy Rooney	**October 2017**: **milestone not achieved** The overall proportion of all patients seen and assessed by a suitable consultant at GWH within 14 hours of admission was 70%. However the survey the data analysis demonstrates a positive increase of 46%. 
Access targets	**ED 4hr target**	**95%**	95%	Linda Power	**October 2017**: **milestone not achieved** Overall Achievement for Q1 was 88.9% and Q2 is reported as 88.7%. Q2 breakdown demonstrates: ED achieved 78.9%, Urgent Care Centre 94.8% and GWH Walk in Centre 95.7% The ED position continues to be impacted by Bed delays and First assessment breaches which are occurring at times when the department is overcrowded 
AREA OF WORK	**SUCCESS MEASURES**	**MILESTONES FOR ACHIEVEMENT**			**COMMENTARY**
		Oct-17	Mar-18	**NOMINATED LEAD**	

<table>
<tr><td rowspan="3">Access targets</td><td>Cancer targets</td><td>All national targets achieved</td><td>All national targets achieved</td><td>Linda Power</td><td>October 2017: milestone not achieved

2ww target: The Trust failed to meet the target for 5 out of the 6 months during Q 1 & 2.

The Target was achieved (95.1%) in July and missed in August at 92.8%

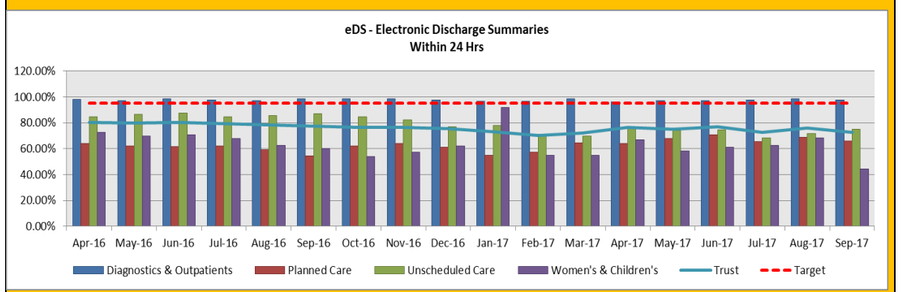
31 day target: The Trust has met all 31 day targets for Q 1 & 2
62 day target: The Trust has not achieved the 85% target during Q 1 & 2 with 81.3% being the highst scored duringthis period.</td></tr>
<tr><td>RTT incomplete standard</td><td>92%</td><td>92%</td><td>Linda Power</td><td>October 2017: milestone not achieved

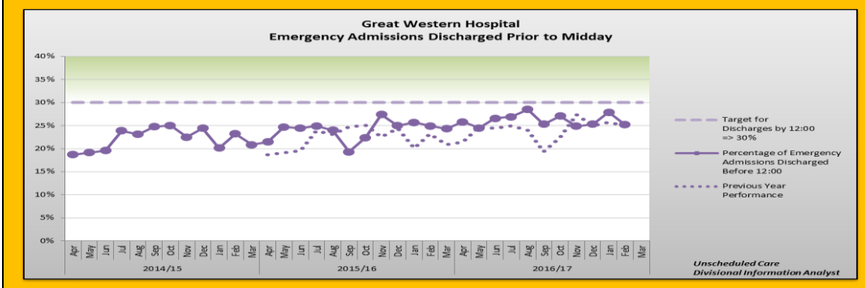
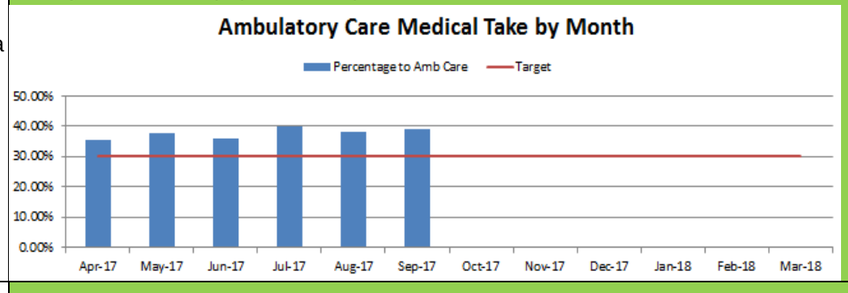
The Trust achieved the target in June; however there was a deterioration of performance, which was not able to be recovered. This was due to some reduced activity in specialties as a result of vacancies and pressure on cancer pathways.

<table><tr><th>Standard</th><th>M1 (Apr 17)</th><th>M2 (May 17)</th><th>M3 (Jun 17)</th><th>M4 (Jul 17)</th><th>M5 (Aug 17)</th></tr><tr><td>Incomplete pathways (standard 92%)</td><td>91.17%</td><td>91.60%</td><td>92.09%</td><td>91.06%</td><td>90.94%</td></tr></table></td></tr>
<tr><td>Electronic discharge summaries</td><td>95% completed within 24hrs of discharge</td><td>95%</td><td>95%</td><td>Linda Power</td><td>October 2017: milestone partially achieved

The Trustwide average is just under 80%

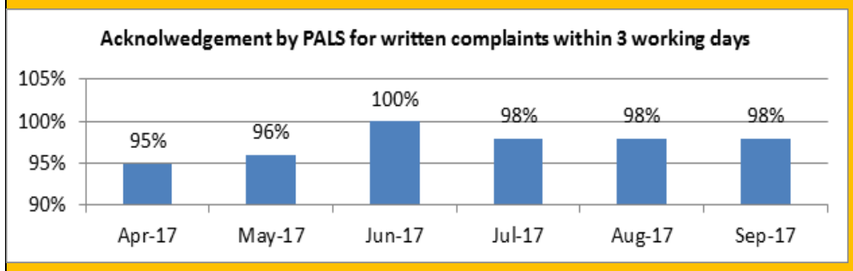
Diagnostic and Outpatients Division: Continues to achieve EDS performance indicators with 98.9% compliance

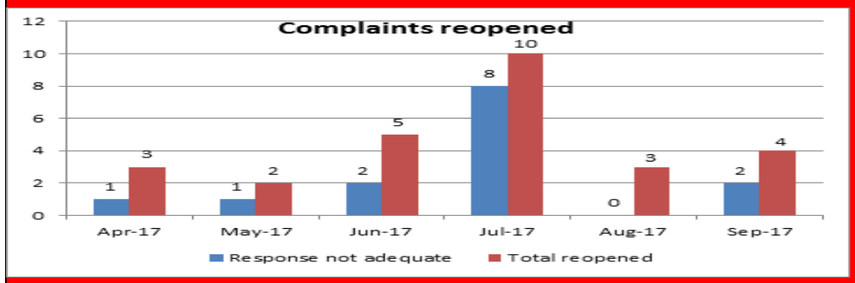
 
</td></tr>
<tr><td>AREA OF WORK</td><td>SUCCESS MEASURES</td><td colspan="3">MILESTONES FOR ACHIEVEMENT</td><td>COMMENTARY</td></tr>
<tr><td></td><td></td><td>Oct-17</td><td>Mar-18</td><td>NOMINATED LEAD</td><td></td></tr>
</table>

Electronic observations implementation	**Establish an electronic observations system across acute hospital site**	**Progress report on commencement date and progress against implementation plan**	Trustwide Rollout update	Julie Parish/Caroline Tandy	**October 2017: milestone achieved** The contract with Nerve Centre was signed on the 12th October 2017 and the kick-off meeting held on the 25th October. • Contract now signed and project starting up • Kick off meeting held • Focus of project confirmed as delivering eObservations, escalations and eHandover. • Aiming for testing to start in January, trialling on two adult wards in February, and full rollout to start in March • Expecting to aim for full rollout complete by end of May/beginning of June • Recruitment of the project team commenced • Analysis and tracking of project benefits has started and will be on-going throughout the project and up to one year following delivery.
Right patient right bed KPIs	**Early discharges facilitate effective patient flow**	**30% discharges before lunch**	30% discharges before lunch	Linda Power	**October 2017 Update: milestone partially achieved:** The Trust is consistently achieving 25% of discharges before lunch; work continues to achieve the 30% target.  *Data from the monthly operational report.*
		30% Medical take direct to Ambulatory Care	30% Medical take direct to Ambulatory Care	Tobenna Onyirioha/ Linda Power	**October 2017 Update: Achieved** *Data from the monthly operational report.* 
Patient Safety Walkabouts	**Executive and non-executive directors actions to improve patient safety are informed by front line staff**	**6 patient safety walkabouts conducted. Evidence of impact of visit**	6 patient safety walkabouts conducted. Evidence of impact of visit	Julie Marshman	**October 2017 Update: Achieved** 13 patient safety walkabouts have been conducted since April 2017. Monthly summaries have been provided within the Quality reports. Visits have also included Swindon community services.
AREA OF WORK	**SUCCESS MEASURES**	**MILESTONES FOR ACHIEVEMENT**			**COMMENTARY**
		Oct-17	Mar-18	**NOMINATED LEAD**	

Ward to Board quality measures	**Key quality measures are considered in regular clinical governance meetings across all wards and departments**	**Quality Governance framework to be ratified and division to commence self-assessments/gap analysis**	All divisions to have started their self-assessments /gap analysis – aim to complete by Aug 18	Julie Marshman	**October 2017 Update: Achieved** Quality Governance framework ratified at Executive Committee in July 2017 Specialties and departments have commenced self-assessments and gap analysis. This will be repeated annually.
Training and development in achieving consistent standards and QI methodology	**1. Increased capacity and capability in the knowledge and use of QI tools and methodologies across the Trust**	**Expanded network of QI coaches.**	Evaluation of QI framework and infrastructure	Rachel Taylor / Mark Juniper	**October 2017 Update: Not Achieved** Capacity and capability plan developed. There have been no further new QI coaches recruited within the Trust network since the initall signup. The Quality Improvement project lead post has been vacant since August 2017. The recruitment process has to date been unsuccessful. A review of the rolw and post is under review by the team. Exisiting QI project continue to be supported.
	2. Directory of QI projects	**Trustwide, divisional and local projects registered on QI project directory**			**October 2017 Update: Not Achieved** Trustwide projects listed, local projects not registered on a central data base. Currently impacted by vacancy in QI lead role. Increasing operational pressures and vacancies in key roles has resulted in unforeseen delays.
Working with AHSNs	**The Trust adopts best practice through working with the AHSN**	**No of AHSN led work programmes GWH is involved with**	No of AHSN led work programmes GWH is involved with	Julie Marshman	**October 2017 Update: Achieved** We continue to be engaged in the following regional AHSN quality collaborative's:- Falls Deteriorating Patients/Sepsis AKI SHINE Maternity Tele-health
Quality Dashboards	**Quality dashboards are in use on every inpatient area**	**100%**	100%	Julie Marshman	**October 2017 Update: Partially Achieved** Quality dashboards are available in every inpatient area; embedded use by all clinical teams is currently variable. This is being addressed as part of divisional governance reviews. Swindon Community Services dashboard continues to be enhanced with the support of the clinical leaders.
QIA process for service developments and cost improvement schemes	**All cost improvement schemes have quality impact assessments completed. All QIAs are reviewed in accordance with Trust protocol**	**100%**	100%	Adam Dougherty	**October 2017 Update: Achieved** All PMO managed QIAs have been reviewed in line with trust policy, All QIAs are reviewed every quarter and reports are presented to Executive Committee and Quality Governance
AREA OF WORK	**SUCCESS MEASURES**	**MILESTONES FOR ACHIEVEMENT**			**COMMENTARY**
		Oct-17	Mar-18	**NOMINATED LEAD**	

Ward Accreditation	**Achieve consistent standards across inpatient wards**	**100% wards self / peer assess against standards**	Formal validation of self / peer assessment for 100% wards.	Toni Lynch	**October 2017 Update: Achieved** Pilot completed against all standards, updates being made to document. Wards will enter implementation phase of first standard (deteriorating patient) in November 2017
Learning from incidents	**SWARM/post incident huddles for all serious incidents reported**	**100%**	100%	Rachel Taylor / Daniel Boden	**October 2017: milestone achieved** SWARMS are used for 100% of our Serious Incidents that are raised by the Trust. The process is not suitable for incidents that are significantly delayed in being reported.
	Proportion of incidents where any learning form the situation was communicated to the reporter	**100%**	1005		**October 2017: milestone achieved** 100% of reporters raising incidents are notified of the outcome of the incident raised through the Incident notification system via email. All learning from RCA investigations are shared within the Trust to support learning and feedback is offered to all staff who were involved within an incident investigation. Incidents are also discussed at individual learning groups.
	Proportion of incidents where any learning from the situation was communicated to other staff in the organisation	**Quarterly divisional newsletters**	Quarterly divisional newsletters		**October 2017: milestone achieved** All learning from RCA investigations and high level departmental Themes and Trends of incidents are shared within the Trust to support learning. The Governance Facilitators are still creating and sharing quarterly newsletters to share learning. Woman's and Children's have started a monthly Patient Safety meeting where incidents, and learning from incidents are shared with the clinical teams within the divisions.
		Improvement activity to be in progress for all departments where invasive procedures are performed			**October 2017: milestone achieved** Out of the initial 22 Departments Identified as undertaking invasive procedures all 22 have completed their individual Self-Assessments and have identified key priorities, and there has been significant developments in areas where SOPs have been created, ratified and are being embedded in practice.
	Zero Serious Incidents reported with evidence of failure to learn from previous events	**Zero Serious Incidents reported with evidence of failure to learn from previous events**	Zero Serious Incidents reported with evidence of failure to learn from previous events	Rachel Taylor	**October 2017: milestone achieved** We have not had any Serious Incidents raised that directly correlate with learning from previous Serious Incidents. We do however; continue to see general themes where we are not learning from incidents that cover, but are not limited to, handover, communication, escalation and recognition of the deteriorating patient. These themes are all part of our current Quality Improvement Projects.
AREA OF WORK	**SUCCESS MEASURES**	**MILESTONES FOR ACHIEVEMENT**			**COMMENTARY**
		Oct-17	Mar-18	**NOMINATED LEAD**	

Incident Reporting rates	**For GWH incident reporting rate to improve and to lie within the middle 50% of comparable Trusts**	**Improve incident reporting rate by 5%**	Improve incident reporting rate by 5%	Daniel Boden	**October 2017: milestone achieved** Our Reporting rate has increased from 38.44 to 42.51 per 1000 bed days. The current median reporting rate for the cluster is 40.14 incidents per 1000 bed days. We have moved from the middle 50% of reporters, to near the top of the middle 50% of reporting Trusts within the Cluster.
Effective clinical governance measures across Divisions	**Annual audit demonstrates effective clinical governance arrangements**	**All specialties commence a self-assessment**	All self-assessments completed with action plans for any gaps identified	Julie Marshman	**October 2017 Update: Achieved** Specialties and departments have commenced self-assessments and gap analysis. This will be repeated annually (planned care are on year two of the process)
Complaints	**Complainants feel their complaints are taken seriously**	**80% of complainants are contacted within 48 working hours of complaint being received by Investigation Manager.**	95% of complainants are contacted within 48 working hours of complaint being received by Investigation Manager.	Deborah Tapley	**October 2017: milestone partially achieved**  The acknowledgment letters (within 3 working days) sent by PALS remains consistent and above the KPI. 80% of complainants being contacted within 48 working hours by the investigating manager has not been achieved 
AREA OF WORK	**SUCCESS MEASURES**	**MILESTONES FOR ACHIEVEMENT**			**COMMENTARY**
		Oct-17	Mar-18	**NOMINATED LEAD**	

Complaints		**Maximum of 1 complaint reopened a month due to inadequate investigation / response.**	Zero complaints reopened a month due to inadequate investigation / response.		**October 2017: Not achieved**  14 cases were reopened in the six monthe period. (During April, May and August 2017 the standard was achieved) July saw a significant increase in cases reopened due to complainants not happy with their response letter [8]. During September, two complaints were reopened.
Staff recommend the Trust as a good place to work/receive care	**The national staff survey identifies that GWH has above average numbers of staff that recommend the Trust as a place to work or receive treatment**	**The percentage of staff who would recommend their organisation to friends and family as a place to work is above the national average**	The percentage of staff who would recommend their organisation to friends and family as a place to work is above the national average	Claire Inglis	**October 2017: Not achieved** The national staff survey identified that 56% of the 1333 employees who completed the Q2 survey would recommend the Trust as a place to work, this is a decrease of 2% from Q1 survey. The national average for Q1 was 64% which decreased nationally to 63% in Q2
AREA OF WORK	**SUCCESS MEASURES**	**MILESTONES FOR ACHIEVEMENT**			**COMMENTARY**
		Oct-17	Mar-18	**NOMINATED LEAD**	

Applications/ nominations for care/ practice awards	**GWH is recognised for services and practices that are outstanding and / or innovative**	**Service quality recognition reported through the Quality Improvement Strategy update**	Service quality recognition reported through the Quality Improvement Strategy update	Julie Marshman	**October 17 milestone: Achieved** STAR award nominations are presented monthly to our staff members along with a Pride of Mental Health award. The eighth annual Staff Excellence Awards took place in June. Nine awards were handed out on the night, with prizes celebrating the work of staff across a range of areas, such as fundraising, patient safety and innovation and partnership working Staff success are celebrated in the Trust news communications, posters in the streets and celebrated at the annual staff awards. Trust celebrates achievements within the bi monthly staff room newsletter, and intranet news bulletins. The Endoscopy team at GWH received national recognition in June for the high standard of care being offered to patients. Inspectors from the Joint Advisory Group on Gastrointestinal Accreditation awarded the team accreditation after they saw the team's excellent work in areas such as clinical quality, patient safety, governance and training. Staff working across the Outpatients department at GWH have been congratulated by the Health Secretary for their recent strong performance in the Friends and Family Test The Mayor of Swindon was guest of honour at a special awards ceremony in July, which celebrated the efforts of staff in achieving formal qualifications in academic subjects related to their career at the Trust. Healthcare staff from GWH showed what they were made of when they took on the gruelling South West NHS Military Challenge. The three-day event saw staff from hospitals across the region take part in a range of military exercises that were designed to push them to their physical, mental and emotional limits.
Quality measures across Swindon Adult Community Services	**Appropriate and robust reporting on key quality indicators for community services are established**	**Systems and reporting well established with improvement demonstrable against priority measures**	Quality improvement goals showing continuous improvement	Julie Marshman	**October 17 milestone: Achieved** Quality reporting for SCHS and the Community Quality Oversight Group well established. Quality measures for SWiCC and Community Nursing agreed and demonstrate improvements. Measures for all Community services are in development.