Quality Report
January 2015*

*All data relevant to December 2014, unless otherwise specified
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Executive Summary

Effective
The HSMR for August 2014 (the most recent data available from Dr Foster) is 84.91.

Safe
There have been two cases of *Clostridium difficile* reported during December 2014 (quarter 3). The cases are attributed to Unscheduled Care and Planned Care Divisions.
The Trust remains below the Q3 trajectory by two cases and year to date trajectory by five cases.
There have been no cases of MRSA bacteraemia during December 2014

During December nine cases of influenza were confirmed within the Trust, previous month no cases were detected.

One potential Ebola case was seen and assessed in the Emergency Department on the 22nd December 2014. The case was managed well by staff, following procedures and escalated to the on call microbiologist by the ED team. The case was subsequently stood down by Imported Fevers, Public Health, Porton Down

There were 10 Serious Incidents reported by the Trust in December 2014, there are 11 Serious Incident action plans in progress four of which are overdue.
At time of reporting there were 559 incident reports overdue, the Clinical Risk Team is working with individual managers to support them to develop processes within their own departments for timely investigation of incidents.

Overall New Harm Free Care is at 96.8% for December, this is against a target of 95% harm free care

There has been a gradual decrease in the number of falls per 1000 bed days since June 2014 in the acute setting. From June to December 2014, the median shifted from above 8.3 to a median of 6.6. The target is to reach or be better than national average of 5.6 per 1000 bed days.
The Community is currently reporting 9.59 falls per 1000 bed days against a national target of 8.6 per 1000 bed days.
The Trust reported two moderate harm falls in December 2014, all initial assessments and safety measures had been in place for these patients. Following RCA investigations these falls were considered unavoidable.

Vacancy rates remain a challenge for the Trust, with high levels of recruitment across all divisions. Although Nursing remains the professional group with the highest number of vacancies, this has reduced by approximately 25 posts since October 2014. The Trust continues to place significant emphasis on recruitment and the Trust will undertake an international recruitment campaign in January 2015 for an additional 25 qualified nurses. A recruitment event for Healthcare Assistants is also planned for January 2015

Caring
The number of complaints received has reduced again this month with a total of 69 complaints being processed via the complaints procedure, alongside this there has been an increase in concerns to 154, these are resolved within 48 hours and handled by the Customer Service team.
Themes for concerns are: communication, waiting times and appointment waiting times
Themes for complaints are: clinical care, behaviour and attitude and communication

Nine cases are currently being investigated by the Parliamentary Health Service Ombudsman

Friends and Family response rate for ED has dropped significantly during December 2014 with a response rate of 12.7%. Inpatients response rate was 28.8% however the target has increased to 35% and therefore increased focus is required to meet this.
Responsive
CQC light touch visits have continued with 6 visits completed to date

Well Led
There were no patient safety executive walkabouts in December

Review of the current PALS & Customer Service provision is underway and will be completed at the end of January
The revised Quality Governance arrangements are moving forward with recruitment for Divisional Quality Governance Facilitators taking place during January and early February.

‘Sign Up to Safety’ patient quality improvement priorities: Falls, Sepsis, Pressure Ulcers, Deteriorating Patient and Acute Kidney Injury. All safety improvement plans (SIPs) have been completed and will be published onto our Trust website and NHS England Patient Safety Collaborative site, ‘Sign up to Safety’ during January. Key staff meetings and all appropriate opportunities will be used to spread the message of the Trust safety improvement priorities to ensure all professional groups and levels of staff are aware of these key priorities and the associated quality improvement work.
Updated Dr Foster data is not available for December

There has been no update of the Dr Foster data this month. As a result the previous month’s data is presented and the updated crude mortality rate (in green).

The number of deaths in the trust rose in November and December. HSMR often tracks the crude mortality rate (as can be seen from the previous year’s data) but the number of admissions also rose during December.

For the previous two years a mortality review of all deaths in the trust over the Christmas period has been undertaken to identify themes and areas for improvement. A further review is planned this year. This will provide further information on areas for improvement and will help to identify if the previous reviews have resulted in improvements in care.

This graph shows the HSMR performance for 35 Acute Trusts in the former South West SHA and in the South of England area for the period September 2013 to August 2014.

With the HSMR at 96.47 for the rolling 12 month period, the Trust is now established in the main group of 25 trusts with a value between 89 and 100.

When looking at the first five months of this financial year, the Trust is performing better than expected within the region, being in the lower (better) half of all Southern trusts.
Summary Hospital Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. This indicator is produced and published quarterly as an experimental official statistic by the Health and Social Care Information Centre (HSCIC).

The SHMI is the ratio between the actual number of patients who die following treatment at the Trust (and up to 30 days post discharge) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The Trust’s SHMI for the rolling period April 2013 to March 2014 is 96.0. This is lower (better than) the expected value of 100, and is a decrease from 97.97 for the previous period (January 2013 to December 2013). This is showing a similar trend to the HSMR figures.

NB The SHMI is always at least 6-9 months in arrears

The chart below shows how the Trust’s SHMI compares nationally and demonstrates we were positioned within the lower (better) half overall between April 2013 and March 2014. The red line depicts the GWH, and the green horizontal line is the nationally expected norm.

The chart below shows how the Trust’s SHMI compares nationally and demonstrates we were positioned within the lower (better) half overall between April 2013 and March 2014. The red line depicts the GWH, and the green horizontal line is the nationally expected norm.
Clinical Audit & Effectiveness

National Audits

There are 31 National Projects that are currently in progress and a further seven are planned to start in 2015.

Of the completed projects, there are 16 National reports that are awaited to be published. Of the most recent reports received, for one project, the national recommendations are currently being assessed against current practice, five are awaiting a report summary of local findings and for one project, and a local action plan is awaited to be formulated.

Due to changes in the National Dementia Audit, the Audit Leads have decided to run a pilot for 2014, for which, only 10 sites were required to participate. GWH are planned to participate in the next annual audit once it has been fully developed. For this reason the audit has now been withdrawn from the audit plan.

Clinical Audit Compliance Rates

<table>
<thead>
<tr>
<th>Clinical Audit Title</th>
<th>Number of Standards</th>
<th>Range</th>
<th>Overall Compliance</th>
<th>Key Assurances</th>
<th>Key Areas to Develop</th>
<th>Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Not Attempt Resuscitation (DNAR) Audit 2013</td>
<td>11</td>
<td>63-100%</td>
<td>91%</td>
<td>Increased compliance from 2012</td>
<td>Improve completion of Pt NHS no and signature of senior Dr; Introduce new paperwork and intensive training; Work with GPs</td>
<td>Trust wide</td>
</tr>
<tr>
<td>Antibiotic Prescribing Audit 13/14</td>
<td>3</td>
<td>81-90%</td>
<td>87.5%</td>
<td>Increased compliance over the last four quarters 81% to 87.5%</td>
<td>Train/educate Prescribers; improve current practice in Children’s Ward, Gynae &amp; Delivery; pilot of new system on Meldon ward.</td>
<td>D&amp;O</td>
</tr>
<tr>
<td>Infant, Children and Young People Nutrition Clinical Guideline Audit</td>
<td>11</td>
<td>0-100%</td>
<td>45%</td>
<td>Menus were provided to meet allergy and cultural needs and referrals appropriately made to dieticians for fluid/food concerns.</td>
<td>Growth charts to be filed in Pt notes, completed with current weight, height &amp; head circumference recorded to avoid missed referral to dietitian.</td>
<td>D&amp;O</td>
</tr>
<tr>
<td>Re-audit on Insulin prescribing at GWH</td>
<td>9</td>
<td>50-100%</td>
<td>92.3%</td>
<td>Overall compliance has risen from 79.7% to 92.3%; improvements following changes to drug chart</td>
<td>Recording date by prescribing Dr and missed doses during I/p stay</td>
<td>D&amp;O</td>
</tr>
<tr>
<td>Dr Foster - Mortality Review Other drainage of peritoneal cavity</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>There were no avoidable deaths identified.</td>
<td>Continue Sepsis Six pathway and improve palliative care provisions</td>
<td>UC</td>
</tr>
<tr>
<td>Sepsis Audit Q2</td>
<td>3</td>
<td>50-88%</td>
<td>45%</td>
<td>Average time to diagnosis fallen by &gt;50 min since May 2014; Length of stay reduced by over 4 days, treatment given to more patients each month, improved antibiotic administration time now 98min (previously &gt;10hrs = 7%)</td>
<td>Still some cases not being identified in a timely manner, support for Nursing staff to feel confident to seek immediate medical attention, Continue On-going teaching, Continue monthly feedback</td>
<td>UC</td>
</tr>
<tr>
<td>NCEPOD – Care of Patients with Tracheostomy</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>The trust meets or partially meets 23/25 recommendations.</td>
<td>Overall pathway to be reviewed; documentation and processes to be improved and implemented; working group identified</td>
<td>PC</td>
</tr>
</tbody>
</table>
The Trust’s blood culture contamination rate for December was 5.6%, which is an increase in the last two months reported. We saw a significant increase in the number of blood cultures taken, namely 1171. This increase was particularly apparent in the week leading up to Christmas.

There were two cases of *Clostridium difficile* reported during December (Quarter 3). These cases are attributed to Ampney and Jupiter wards.

At the end of Q3 the Trust reported two cases below the quarter trajectory of seven, which are five below the annual trajectory of 21 cases year to date.
### Clostridium Difficile

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Accumulative (Q1 &amp; Q2)</th>
<th>Quarter 3</th>
<th>Accumulative (Q1, Q2 &amp; Q3)</th>
<th>Quarter 4</th>
<th>Accumulative total to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. diff trajectory</td>
<td>7</td>
<td>7</td>
<td>14</td>
<td>7</td>
<td>21</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>GWH Reported cases</td>
<td>3</td>
<td>8</td>
<td>11</td>
<td>5</td>
<td>16</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>CCG C. diff Reviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unavoidable</td>
<td>3</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Meeting to be arranged</td>
</tr>
<tr>
<td>Avoidable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Influenza

During December nine cases of influenza were confirmed within the Trust, previous month no cases were detected. Cases continue to be reported during the first week of January.

<table>
<thead>
<tr>
<th>Department</th>
<th>Month</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>December</td>
<td>0</td>
</tr>
<tr>
<td>MSSA</td>
<td>December</td>
<td>1</td>
</tr>
<tr>
<td>Ecoli</td>
<td>December</td>
<td>2</td>
</tr>
<tr>
<td>GRE Bacteraemia</td>
<td>December</td>
<td>0</td>
</tr>
</tbody>
</table>

### Acute Cases of Trust Apportioned MRSA Bacteraemia

There were no new cases of Trust attributed MRSA Bacteraemia for December.
MSSA Bacteraemia attributed to Dove ward
- Positive day 11 of admission
- Transfer from Oxford on 29 December 2014 following surgical treatment of a sub-dural haematoma
- Probable PVC infection – arm swollen and sore
- Likely cause PVC infection – PVC care had not been audited during December on Dove

E coli attributed to:
Meldon Ward
- Positive urine sample for E coli
- Positive on day 3 of admission
- Diabetic only predisposing risk factor

Aldbourne Ward
- Positive urine sample for E coli
- Positive day 3
- No risk factors
**E Bola**

One potential Ebola case was seen and assessed in the Emergency Department on the 22nd December 2014. The case was managed well by staff, following procedures and escalated to the on call microbiologist by the ED team. The case was subsequently stood down by Imported Fevers, Public Health, Porton Down.

Another case was subsequently seen and assessed by the Emergency Department on Saturday the 3rd January 2015. Bloods were sent to Porton Down and the patient tested negative to Ebola in the early hours of Sunday morning. Lessons learnt are being collated from all involved. The action cards have been updated to reflect the learning. Further staff training is taking place for ED and other staff likely to become involved; this training will be following the Public Health England’s PPE Guidance dated December 2014. There was considerable media round this case very early on, which caused great anxiety to staff.

**Environment**

**Cleanliness standards**

![Housekeeping Performance Improvement chart]

All Housekeeping audits completed during December have achieved above the 95% pass rate for each risk category.

The average cleaning score for the site is 95%, which is a decline on the previous month, however remains at the target rate, which is a reflection of on-going concerns raised and being managed within radiology.

Below is a table showing the % split of clinical/non clinical areas audited based on a year's data.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Rooms</td>
<td>75%</td>
</tr>
<tr>
<td>Non-Clinical Rooms</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical Walkways</td>
<td>11%</td>
</tr>
<tr>
<td>Non Clinical Walkways</td>
<td>4%</td>
</tr>
</tbody>
</table>
## GWHFT Data – Including Clinical Equipment

### Executive/IP&C Inspections

<table>
<thead>
<tr>
<th>Ward</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dove</td>
<td>4.12.14</td>
<td>95.6% - one dusty drip stand. Patients happy with the cleaning.</td>
</tr>
<tr>
<td>Cardiac Catheter Lab</td>
<td>11.12.14</td>
<td>90% - high dust on equipment (responsibility of the radiographer). Advised to obtain a new bin. Plugs requiring PAT testing in kitchen. Requested improved cleaning of the kitchen.</td>
</tr>
<tr>
<td>Cherwell</td>
<td>18.11.14</td>
<td>76% - some dust on shelving. Tape on procedure trolley. Leaking window resulting in damage to wall, broken blinds; escalated to Estates. Water fountain to be de-scaled</td>
</tr>
</tbody>
</table>

### Matron spot checks – clinical equipment focus

<table>
<thead>
<tr>
<th>Ward</th>
<th>Date</th>
<th>Compliance Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturn</td>
<td>23.12.14</td>
<td>70%</td>
<td>Dirty window sill. Dusty areas identified. Patient lockers not always clean, curtain changing required. ECG machine dusty.</td>
</tr>
</tbody>
</table>

### Patient Feedback

- **Complaints regarding Catering**: 3
- **Complaints/Concerns regarding Cleanliness**: 0

### F&FT feedback regarding Cleanliness

30 comments received in total
- 2 negative comments
- 28 positive comments

### F&FT Comments received regarding Food:

42 comments received
- 8 commented that improvements to food would be recommended
Patient Care Equipment – Departmental self-audits

Trust Wide Patient Equipment

A number of areas failed to complete their audits during December. Therefore, the above details do not show a complete picture. Areas, which haven’t completed audits:
- SAU
- Trauma
- Theatres (some audits)
- Discharge Lounge
- ED
- Mercury (some audits)
- Beech

Clinical Incidents

Never Events

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(PAW)

Serious Incidents Reported December 2014

<table>
<thead>
<tr>
<th>Incident number</th>
<th>Division</th>
<th>Area/Department</th>
<th>Incident type</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>73792</td>
<td>Women’s and Children’s</td>
<td>Paediatrics</td>
<td>Unexpected death</td>
<td>1</td>
</tr>
<tr>
<td>74352</td>
<td>Integrated Community Health</td>
<td>Warminster/Westbury/Mere CT</td>
<td>Pressure Ulcer Category III</td>
<td>1</td>
</tr>
<tr>
<td>74177</td>
<td>Unscheduled Care</td>
<td>Woodpecker</td>
<td>Safeguarding Allegation</td>
<td>2</td>
</tr>
<tr>
<td>74085</td>
<td>Integrated Community Health</td>
<td>Malmesbury</td>
<td>Pressure Ulcer Category III</td>
<td>1</td>
</tr>
<tr>
<td>74105</td>
<td>Integrated Community Health</td>
<td>Mulberry</td>
<td>Safeguarding Allegation</td>
<td>2</td>
</tr>
<tr>
<td>74089</td>
<td>Unscheduled Care</td>
<td>ED</td>
<td>Fall resulting in #NOF</td>
<td>1</td>
</tr>
<tr>
<td>74319</td>
<td>Integrated Community Health</td>
<td>Chippenham CT</td>
<td>Pressure Ulcer Category IV</td>
<td>1</td>
</tr>
</tbody>
</table>
Serious Incidents Reported Year on Year Comparative 2013/14 & 2014/15

There were 10 Serious Incidents reported by the Trust in December 2014, this takes the amount of cases reported since April 2014 to 64. There has been an increase of 10 incidents when compared to December 2013.

Overdue Serious Incident Action Plans

There are currently 11 Serious Incident Action Plans in progress, four of which are overdue (displayed in graph).

The current target is to review action plans approaching their deadlines.
<table>
<thead>
<tr>
<th>Incident Number</th>
<th>Due Date</th>
<th>Ward</th>
<th>Incident Description</th>
<th>Action/Issue</th>
<th>Lead</th>
</tr>
</thead>
</table>
| 65984           | 30/11/2014   | Meldon                    | Rescue of Deteriorating patient             | 1. Documentation of medical plan  
2. Handover of abnormal observations  
3. Training for the Ward staff. Measuring how safe practice is now with regard to SOS scoring, observations and fluid balance. | Urology Consultant Matron for Meldon Consultant Nurse – Outreach       |
| 67848           | 01/10/2014   | Gynaecology               | Delayed Diagnosis/treatment                 | Automated reminder function disabled due to medical staff preference on the electronic request system for laboratory and radiology tests. Agreed the process to ensure that Radiology tests are always reviewed. | Issue: Appropriate Lead needs to be identified                        |
| 68489           | 31/10/2014   | Saturn Ward               | Pressure Ulcer Category III                 | 1. Confirm that monitoring of practice and data review is happening in these areas, with actions in place to develop practice  
2. Teaching sessions for senior nursing team on Saturn first two weeks in September  
3. Letter to all staff discussing outcome of this investigation and need to refer to TVN at end of life  
4. Remaining staff to complete education session on pressure ulcer prevention and management utilising divisional wide rota of session run by different wards  
5. Take to Matrons Care Quality Group for discussion to agree Lead and identify actions that need to be taken. As part of a ‘harm free culture’ Clinical Risk Lead and Matron for Saturn to review investigatory process and recommend changes to format to facilitate investigation at point of incident  
6. Planned programme of review by Matron/Sr Sister/NSI) of patients on Saturn at high risk or with pressure ulcers on Red Wednesday August/September/October  
7. Review and amend referral form, ensuring updated version uploaded | Interim Divisional Director of Nursing for USC Ward Manager USC Matron Specialist Nurse Senior Sister Tissue Viability Nurse |
| 72684           | 31/12/2014   | Melksham Community Team   | Pressure Ulcer Category III                 | 1. To ensure timely referral to the team caseload when a need is identified and admission and discharge from the caseload recorded as required on EPEX. | Neighbourhood team administrator Bradford on Avon and Melksham Integrated Team Leader |
Managers have 14 days to investigate incidents from the date the incident is reported. On the 5th of January, 559 IR1s were over the 14 days investigation time frame.

Throughout December 2014, the average number of days that IR1s were overdue was 93; this is something that the Clinical Risk Team is working on to reduce by providing support and guidance to reporting managers and staff.

### Top Overdue IR1 Departments

<table>
<thead>
<tr>
<th>Department</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturn Ward</td>
<td>38</td>
</tr>
<tr>
<td>Linnet Ward - Acute Medical Unit</td>
<td>24</td>
</tr>
<tr>
<td>Childrens Unit</td>
<td>23</td>
</tr>
<tr>
<td>A&amp;E/ED</td>
<td>20</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>17</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>16</td>
</tr>
<tr>
<td>Ailesbury Ward</td>
<td>14</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>14</td>
</tr>
<tr>
<td>Woodpecker Ward</td>
<td>14</td>
</tr>
<tr>
<td>Surgical Assessment Unit</td>
<td>13</td>
</tr>
<tr>
<td>Beech Ward (GWH)</td>
<td>13</td>
</tr>
</tbody>
</table>

### Safety Thermometer

The Safety Thermometer is a national initiative that records the presence of four harms on all patients on one day every month. The rationale for focusing on the four harms is because they are common and because clinical consensus is that they are largely preventable through appropriate patient care.

### New Harm Free Care (Now in numbers rather than percentages)

December 2014 - 96.8% new harm free care

The harm free care has reduced by 0.3% this month compared to November 2014. The focus this month will be on quality of data being submitted to the trust from the clinical areas.

The Trust has seen a rise in the incidents of missing information being submitted on completed data collection tools across various wards.

The safety thermometer Lead Matron met with the safety thermometer administrator in December to advise which areas are of most concern (top 5 wards) and the data collection tool is being revised to make it easier for the clinical staff to use.

This has also been raised at the Matrons meeting so they are aware of the areas submitting incomplete forms.

It has been planned to visit some of these wards on the next red Wednesday to also offer face to face support to the clinical staff collecting the data. We will then review the completeness of the forms on the next data collection day and report back to the Lead Matron for further consideration.
The Acute setting has seen a gradual decrease in the number of falls per 1000 bed days since June 2014.

The decrease has seen a downward median shift from the previous median. From June to December 2014, the median shifted from above 8.3 to a median of 6.6.

In December 2014 the falls per 1000 bed days have gone below the current median (6.6) to 6.35 falls per 1000 bed days.

Though the Acute setting has not met the national average of 5.6 falls per 1000 bed days, there is evidence of sustained improvement.

The Community setting had a median shift down to the national average of 8.6 falls per 1000 bed days since November 2013. However there has been no consistence on monthly performance.

In September and October the Community setting was better than the national average, however in November and December there was an increase in the number of falls which took them above the national average.
Falls - Harm by Division
(Rolling three months to November 2014) (Note: Missing months/Directorates denote no occurrences)

Harm from falls has reduced. From October – December 2014 the Trust had one severe harm incident from Planned Care Division. The fall occurred on one of the wards which record very few falls. Following a RCA investigation, this fall was unavoidable.

The Trust reported two moderate falls in December 2014 and all initial assessments and safety measures had been in place for these patients. Again these falls were unavoidable.

Pressure Ulcers

Pressure Ulcers – Acute Inpatients GWH Data (Rate per bed days)

The total number of pressure ulcers developed in December was nine, all of which are Category II therefore superficial pressure ulcers. The hot spot is Jupiter with four pressure ulcers while Trauma, Hazel, Mercury and Saturn all had one pressure ulcer develop.

The Tissue Viability Nurse Consultant (TVNC) is leading a new safety collaborative to reduce pressure ulcers with Think Skin: Your Actions Relieve the Pressure. The Fact Finding day on 13.11.2014 resulted in Driver diagram and action plan and the first action strategy group met on 5 December. The actions include increasing the number of pressure relieving mattresses, which have been increased by 28 mattresses. A consignment stock is being trialled on LAMU throughout January to ensure that At Risk patients are put on a pressure relieving mattress within 2 hours of admission. A new initiative will also be trialled in ED by the end of January.

A new education programme will commence in January 2015 including all aspects of the patient journey including Tissue Viability continence and dietetics.

Additional work to protect heels is also underway, the funding stream is being resolved with the ward managers and the TVNC.
The total number of pressure ulcers in December has remained the same at 13, although this data is still being verified.

Therefore the Tissue Viability Consultant nurse is leading a new proactive safety collaborative called THINK SKIN: YOUR ACTIONS RELIEVE THE PRESSURE – HARM FREE CARE. This will start with a harm free care collaborative day on 5 February 2015. This has been delayed as the ICHD Leads wanted the day in a different format. This session will involve all community clinical staff including GP’s, ICHD locality leads and team leads, nursing staff and allied health professionals to review the patient journey, to highlight where we can improve our services to patients. The risk assessments and documentation have all been reviewed and updated and ready for roll out in January 2015.

Of the 1030 patients assessed during December, seven patients were identified as being treated for a UTI, with a urinary Catheter, which had occurred during their stay. Through a desk top validation process it seems the number of reported catheter associate UTIs may have been reported slightly higher than it should have been by two cases.

The data collection tool is currently under review, to ensure staff fully understand how to collect the required data to ensure the data is an accurate reflection of what is occurring during the audit period.
% of patients receiving a VTE risk assessment on admission to hospital

GWH is maintaining our agreed target of >95% across both the acute and community settings.

Updated figures are shown within the graph.

The majority of the data is collated from the electronic nursing care system (crescendo), however there are certain areas within the acute sector that do not use this system due to the large volume of patients being admitted and have so far have relied on manual data collection.

% of Patients Receiving Appropriate Thromboprophylaxis

(this is taken from the safety thermometer data which is a snapshot of one day each month, all wards)

This looks at the total number of patients in on a set day per month so it is snap shot data and the GWH VTE Lead is working with the safety thermometer team to help validate the VTE data as there have been some discrepancies with the interpretation of the data collection form.
For the sixth consecutive month the data is demonstrating a shortfall in registered nurse day hours, against those planned and an increase in unregistered staff day and night hours.

The most common themes remain the same as those reported previously, some of which are outside of the influence of safer staffing reporting alone. These include:

- The ratio of registered nurses to care staff falling below that planned. There are a number of factors contributing to this. Such as, RN vacancies; financial recovery temporary staffing/skill mix plans; staff redeployment to winter ward; RNs awaiting professional registration’ patients requiring close support.
- Some shifts remain unfilled shifts, following risk assessment/professional judgement, and a decision made jointly between the senior nurses.
- Despite more robust processes for decision making around providing close support (formerly known as 1:1 care), the impact continues to drive a significant proportion of the use of temporary care staff.
### Issues

| Number of complaints featuring staff | 314 comments made related to staff from Friends and Family cards for December (positive and negative). One complaint in December with a specific staff name mentioned, processed via Complaints process. |

| Number of F&FT mentioning poor staffing levels | 31 | 19 | 6 |

### Staffing Vacancies

<table>
<thead>
<tr>
<th>% of whole</th>
<th>Number of</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctors</strong></td>
<td>9.83%</td>
</tr>
<tr>
<td><strong>AHPs</strong></td>
<td>6.45%</td>
</tr>
<tr>
<td><strong>Admin &amp; Clerical</strong></td>
<td>6.76%</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>6.03%</td>
</tr>
</tbody>
</table>

Vacancy rates remain a challenge for the Trust, with high levels of recruitment across all divisions. Although Nursing remains the professional group with the highest number of vacancies, this has reduced by approximately 25 posts since October 2014. The Trust continues to place significant emphasis on recruitment and the Trust will undertake an international recruitment campaign in January 2015 for an additional 25 qualified nurses. A recruitment event for Healthcare Assistants is also planned for January 2015.

### Staff F&FT Response Rate – This is quarterly information and will not be available until the end of Quarter 4

### Safeguarding Adults

There were 17 Safeguarding Adults at Risk Alerts recorded on the GWH.
Safeguarding Adults At Risk Team’s database as being raised by Trust staff during December. Twelve of these alerts were raised by the Acute Services; the remaining five were raised by ICHD.

There were seven Safeguarding Adults at Risk Alerts raised against the Trust during December, 5 of the alerts were against Acute Services, the remaining 2 were against Community Hospital Wards.

Acute – 5 alerts
Three relate to one staff member’s care towards 3 patients on the same ward. Alert raised by internal ward staff.
One relates to lack of discharge information from GWH to care home.
One due to medication errors on discharge and bruising to patient; raised through PALS.

Community – 2 alerts
One alert raised by a member of staff concerning the care provided to patient by another team member.
One alert raised by staff at GWH concerning an unknown member of staff within a Community Hospital Ward. Patient transferred from ICHD community ward to an GWH Inpatient ward and revealed to staff his concerns of care provided at night at an ICHD ward.

Institutional harm was the highest alerted category in December (4 out of 7)
Neglect continues to be the highest alerted category of harm reported by the Trust in December with Psychological & Emotional being the second highest category.

The GWH Safeguarding Adults Team are not regularly receiving copies or notification of the safeguarding alerts being made across the Trust. Awareness raising and system modifications are being undertaken by the team to address this. This may account for the downturn in reporting figures for the previous 3 months.

Safeguarding Children
The Trust continues to show commitment to improving work to safeguard children.

The Quality Data/Dashboard and what it will look like to inform reporting was discussed at the Safeguarding Children’s Forum on 12 December 2014. Work is now underway to progress reporting on areas such as strategy discussions, participation in case conferences, and safeguarding incidents. Data collation will need to be reviewed in some areas to ensure this reporting is robust but in the interim we will report on those areas where data is secure.
A Strategy Discussion is called after receipt of a child protection referral and should involve local authority children’s social care, the police, health and other bodies as appropriate. The purpose of the discussion is to share information, ascertain what action is required immediately and whether a Section 47 investigation needs to be undertaken.

In January 2014 GWH NHS FT Children and Young People’s Community Health Services joined with the police and Wiltshire Council to implement the Multi-agency Safeguarding Hub (MASH). For GWH, one of our safeguarding specialist nurses is now permanently sited in the MASH during the day time on a rotational basis, and strategy meetings on cases not open to social care now take place within the MASH.

Strategy meetings on children who are already open to social care continue within the locality teams and community staff, such as health visitors and school nurses, attends these meetings. A central referral point for these meetings was set up in July 2014 and attendance is being managed and monitored through this point.

Our aspiration is to attend all strategy meetings but this is challenged by the short notice that is sometimes given for strategy meetings held within the community.

Deprivation of Liberties Safeguard (DoLS)

There were 19 DoLS applications made during December, an increase in 9 applications from November. This could possibly be due to reporting variations with not all applications being copied to the Safeguarding Adults at Risk Team. The Safeguarding Adults at Risk Team are working with the Divisional Directors of Nursing, Matrons and Ward Managers in raising awareness of the reporting process.

Death while Patient under a DoLS:

Community: Two deaths on a Community Hospital Ward:

- Supervisory Body in breach no standard authorisation in place, therefore did not die under DoLS authorisation.
- Confirmation from GWH Legal Team, Coroner’s Inquest was opened and closed so no further action is required.

Acute: No deaths occurred whilst patient under a DoLS.
Death under a Detention of Mental Health Act:

No deaths occurred in the Trust whilst patient detained under the Mental Health Act.

Explanations of Sections:

**Section 2:** Admission for Treatment – Detention for a period not exceeding 28 days including the day the patient was detained.

**Section 2 Other Hospital.** Inpatient at GWH, receives mental health assessment and detained under Section 2 of MHA to another hospital. Patient transferred to the other hospital.

**Section 3:** Admission for Treatment. Detention for up to six months including the day the patient was detained.

**Section 5(2):** Report on Hospital In-Patient. Doctors holding order that lasts for up to 72hrs during which time the patient should receive a full Mental Health Act assessment.

**Section 17:** Authorised Leave of Absence – Patient is detained to another hospital under the Mental Health Act and attending GWH for medical assessment/treatment.

**Section 19:** Authority to transfer patient detained under the Mental Health Act from Hospital to another under Different Managers.

**Section 23:** An Order for Discharge. Registered Responsible Clinician assesses patient under the MHA and discharges patient from their Detention Order.

Mandatory Training for Safeguarding, MHA, MCA and DoLS

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act &amp; Deprivation of Liberties (MCA &amp; DoLS)</td>
<td>89.85%</td>
<td>89.60%</td>
<td>89.42%</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>83.12%</td>
<td>82.06%</td>
<td>82.46%</td>
</tr>
<tr>
<td>Adult Safeguarding</td>
<td>97.16%</td>
<td>96.99%</td>
<td>96.98%</td>
</tr>
<tr>
<td>Child Protection Level 1</td>
<td>96.88%</td>
<td>96.81%</td>
<td>96.92%</td>
</tr>
<tr>
<td>Child Protection Level 2*</td>
<td>65.20%</td>
<td>42.88%</td>
<td>44.31%</td>
</tr>
<tr>
<td>Child Protection Level 3</td>
<td>**</td>
<td>14.77%</td>
<td>23.28%</td>
</tr>
</tbody>
</table>

The Child Protection training needs analysis has just been reviewed based on changes to the Royal College of Paediatrics and Child Health Intercollegiate document. All staff with patient contact must now complete Level 2 training and staff with regular contact with children and young people must complete Level 3. This means a lot more of our staff are required to complete Level 2 than previously, which is why the compliance has dropped. A Level 2 e-Learning module is to be introduced in January 2015.
83 Incidents of ‘No Harm’
An example of:
One report where a patient’s PE was linked to missed doses of dalteparin. An internal RCA has been requested, even though it may not be possible to ascertain that the development of the PE was as a result of the missed doses.

6 Incidents of ‘Low Harm’
An example of:
One report of a patient who suffered acute bradycardia requiring reversal with atropine as a result of receiving 300mg of diltiazem immediate release tablets instead of the modified release preparation. An internal RCA has been requested to facilitate learning and avoid similar incidents.

1 Incident of ‘Moderate Harm’
One report of a patient who developed acute kidney injury after receiving incorrect doses of intravenous aciclovir over a period of time. An internal RCA has been requested to facilitate learning and avoid similar incidents.

Three missing CD incidents reported in December
- Two on Linnet ward - one was accounted for as a documentation error, and one could not be accounted for.
- One reported from Trowbridge Neighbourhood Team. (Patient’s own). Yet to be investigated.
- Two outstanding CD incidents on Saturn ward yet to be investigated.
All CD incidents are recorded as part of the IR1 system. Pharmacy are working with the Deputy Chief Nurse to ensure incidents are investigated appropriately by relevant ward staff and closed in a timely manner. Pharmacy will work with wards on any issues raised as a result of the investigation.
154 concerns were received and resolved by the Customer Service team for December 2014. 69 complaints were rated as Low to Moderate risk, 11 complaints received rated as High to Extreme. We are starting to see a decline in complaints being processed via the complaints procedure and an increase in concerns which are resolved within 48 hours handled by the Customer Service team.

Concern themes:
- Communication
- Telecommunication
- Issues related to appointment Waiting times.

Complaint themes:
- Clinical Care
- Behaviour
- Attitude and Communication

Top Areas:
- ED,
- Booking Centre
- Orthopaedics OPD
- ENT
- Physiotherapy

One Complaint was reopened within Planned Care. The Complainant was not happy with the original response and wanted to raise further questions. The original complaint related to his clinical care. An earlier outpatient has been arranged for clinical advice.
Response times

<table>
<thead>
<tr>
<th>Concern</th>
<th>L-M</th>
<th>H-E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carillon</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Corporate</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>D&amp;O</td>
<td>97%</td>
<td>65%</td>
</tr>
<tr>
<td>ICH</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>Planned</td>
<td>95%</td>
<td>44%</td>
</tr>
<tr>
<td>Unscheduled</td>
<td>88%</td>
<td>21%</td>
</tr>
<tr>
<td>W&amp;C</td>
<td>80%</td>
<td>38%</td>
</tr>
</tbody>
</table>

The overall trust response rate for both Low - Moderate Cases closed in December and High to Extreme cases was 45% for each rating. Improvements in response rates are required in both Planned and Unscheduled Care. Both of these Divisions are concentrating on reducing their backlogs and responding to old complaints which are now outside of timeframe, this is impacting in low monthly response rates being reported. Trigger points have now been implemented by the Customer Service team at day 20 asking for updates so that the complainant can be kept informed of progress of the investigation.

9 cases are currently being investigated by the Parliamentary Health Service Ombudsman
ICH - Provision of services for head injury in 2012, rehabilitation not implemented
ICH - Failed to treat gangrene in 2012, lack of communication from the Trust
PC - Care provided to late mother in 2012, request for medical photography, inappropriate care provided
USC - Advice provided due to relating to another organisation
USC - Inappropriate discharge in 2011, managed mainly by AWP
USC - Lack of basic care and poor understanding of Dementia, lack of compassion and appropriate communication 2014
W&C - Lack of Speech & Language Therapy provision provided to son in 2011 - (original complaint was with WHCS transferred over)
W&C - Delay in receiving Hysteroscopy result in 2013
W&C - Complications during birth in 2014 - Birth Reflection meeting offered

3 cases have been investigated by the Parliamentary Health Service Ombudsman, upheld and Action Plans required
PC - Inappropriate discharge from ITU 2013, no clear handover of clinical responsibility for patient who was clearly unwell
USC - Care and treatment of late wife suffering with Pancreatic Cancer 2013. Failure in care during second admission and division complaint handling
USC - Delays in condition being diagnosed and treated in 2013. Communication between staff, patients and families, fluid balance monitoring, IV administration. MRI scans and Neurology reviews carried out in a timely manner.
Backlog in responding to complaints have increased for December. Emphasis should be made in responding to complaints which are due prior to October. The Customer Service team will be working with Planned Care and Unscheduled Care to ensure that these complaints are responded to and closed by the end of January. Backlogs will be monitored by ward/clinic area in more detail.

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>2</td>
</tr>
<tr>
<td>Diagnostics and Outpatients</td>
<td>4</td>
</tr>
<tr>
<td>Finance (including IT and Estates)</td>
<td>1</td>
</tr>
<tr>
<td>Integrated Community Health</td>
<td>0</td>
</tr>
<tr>
<td>Planned Care</td>
<td>48</td>
</tr>
<tr>
<td>Unscheduled Care</td>
<td>34</td>
</tr>
<tr>
<td>Women's and Children's</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
</tr>
</tbody>
</table>

Patient comments received regarding catering:

"Not provided with any dairy free meals and I found the trolley lady very rude. We ended up having to go out and bring our own food which he could eat".

"The Food was excellent, try not to give patients with heart conditions butter or white bread".
<table>
<thead>
<tr>
<th>You Said</th>
<th>You said</th>
<th>We did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Unit recorded child’s weight wrong, hence administered incorrect dose based on guidelines.</td>
<td>Contact made with National Patient Safety Agency to inform them of the likelihood of this error occurring again whilst there are two forms of measurement commonly in use in the UK. This has been discussed at the Divisional Directorate Board meeting to highlight to all clinicians including midwives and health visitors the importance of communicating and accurately recording weight in kilograms.</td>
<td></td>
</tr>
<tr>
<td>Mum and baby discharged but that night baby was not feeding so ended being brought back in to SCBU.</td>
<td>Need to review process for admittance of babies from SCBU; establish if SCBU or Children’s unit can alert the Community Midwife when a baby is re-admitted.</td>
<td></td>
</tr>
<tr>
<td>Phone calls into the Children’s Unit are not documented.</td>
<td>Implementing a system to document and audit the phone calls received to ensure that correct advice is given. Also looking at Consultant led advice service for GP's.</td>
<td></td>
</tr>
<tr>
<td>After the stem cell transplant G had a NG tube inserted to feed him during this very painful and difficult period. The nurse who did the procedure removed the metal insert which was meant to stay in the tube, so that when x-rayed, it would confirm that it was in the correct position. The absence of this metal insert now meant that when x-rayed it was not possible to determine if the tube was still in the correct place. This caused considerable stress to G, as he was told that it needed to be removed and re-inserted. This was a very traumatic experience. An air test was carried out and believed it was indeed in the correct position. Nurses instructed to proceed with the feeding procedure. Every day the patient was sent to x-ray and was sent back again as his metal insert had been removed.</td>
<td>Direct action to ensure that the system for the maintenance of naso-gastric tubes on the Dove Unit has been revised, with a new system currently being trialled.</td>
<td></td>
</tr>
<tr>
<td>P’s date of birth written down incorrectly and that the GWH post mortem reference number shows 12P943 instead of 12P(0)43 though this number is correctly place on the sample boxes/slides. Concerns for the integrity of the staff who are responsible for handling such important ‘items’ as incorrect labelling of tissue samples could, undoubtedly, lead to misdiagnosis at post mortem”.</td>
<td>As a result of this incident, mortuary processes are being reviewed by one of our senior managers and adjustments made as required. Furthermore, the purchase and use of a sequential numbering stamp for numbering patient records in the Mortuary Register will remove the possibility of accidentally using the same number for two patients’ in the future.</td>
<td></td>
</tr>
<tr>
<td>&quot;Discharge was arranged for that day with transport booked for 2pm. When there was no sign of patient arrival, I rang the hospital at 5.15pm to be told there was a 4 hour window on transport. I explained that the carers would be back at 7.30pm. The ward rang me back at 6.15pm saying transport would be another hour. Again with no sign of Mum at 7.30, I rang back and again was told it would be another hour. Finally at 8.30 with the carers gone again, I agreed with the ward to postpone the whole thing until the following day. The whole experience was very frustrating and upsetting for both my Mum and my Dad who had been looking forward to her coming home on the Monday. The discharge went to plan on the Tuesday.&quot;</td>
<td>Ensure transport is booked the day before to reduce the risk of transport turning up late.</td>
<td></td>
</tr>
<tr>
<td>Endoscopy carried out, nothing identified more tests required family not informed. Patient passed away; cause of death was “Aspiration Gastric Contents sticking on the Lungs.”</td>
<td>Review of existing process for requests for OP referrals following Endoscopy and identify an electronic solution for recording OP requests.</td>
<td></td>
</tr>
</tbody>
</table>
Patient left for 9 hours in the SAU waiting room with no pain relief and no monitoring from staff.

The ward has started monitoring more rigorously and has improved and adapted the proforma to reflect this. The SOS tool is being used to highlight how often patients require checking and identifying which patients require more frequent checks. Work has been carried out with SOS scoring and highlighting potential patients. Ward Clerks are helping to support this.

Friends & Family Test

The Trust sees a slight decrease in star values for December recording a score of 4.75 stars out of 5. The overall top three areas are (with 5 reviews or more) Intensive Care Unit, Physiotherapy-Savernake and Audiology. Bottom three services (with 5 reviews or more) SAU, Mercury Ward, Woodpecker. A total of 2093 reviews were made for December.

December has seen a huge decrease from 29.3% in November to 12.7% for December. The target for ED remains as 20%. Tokens will remain until the end of March. ED will be monitored weekly on responses received; volunteers will be used to support completion of cards. Further actions will be drawn up to ensure that the response rate increases in January.

The Inpatient response for December was 28.8% which is under our predicted target to reach the CQUIN of 40% for the month of March and 30% for quarter 3. Further work is required in ensuring that cards are given out in each area to ensure that the CQUIN will be met. The Customer Service team are weekly monitoring response rates in each area and support will be provided to ensure that January sees an increase.

PALS Review

A review of PALS and Customer Service is nearing conclusion and will be reported in February’s Report. This will include the results of Internal Audit’s (TIAA) review of practice.
### Responsive

#### CQC Position/Update

<table>
<thead>
<tr>
<th>CQC Outliers (from national team)</th>
<th>1st submission to CQC</th>
<th>2nd submission to CQC (following CQC queries)</th>
<th>3rd submission to CQC (following action plan request)</th>
<th>4th submission (CQC receipt)</th>
<th>Copies of all sent to Swindon &amp; Wiltshire CCG</th>
<th>Latest update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity outlier alert: Maternal non-elective readmissions within 42 days</td>
<td>20 June 2014</td>
<td>30 July 2014</td>
<td>1 Sept 2014</td>
<td>CQC confirmed receipt on 1st Sept 2014</td>
<td>5 August 2014</td>
<td>Closed by Local Team – no further action required</td>
</tr>
<tr>
<td>Maternity outlier alert: Neonatal non-elective readmissions within 28 days of delivery</td>
<td>20 June 2014</td>
<td>30 July 2014</td>
<td>1 Sept 2014</td>
<td>5 August 2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### CQC Outliers (follow up of previous outliers from CQC local area team)

<table>
<thead>
<tr>
<th>CQC Outliers (follow up of previous outliers from CQC local area team)</th>
<th>1st submission to CQC</th>
<th>2nd submission to CQC</th>
<th>Latest update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality outlier alert 2013: Acute myocardial infarction Nov 2013</td>
<td>27th October 2014</td>
<td>None</td>
<td>CQC confirmed on 11th Dec 2014 that this outlier is now closed by the Local team and no further follow up required.</td>
</tr>
<tr>
<td>Mortality outlier alert 2013: Patients admitted with diagnosis of pathological fracture Nov 2013</td>
<td>27th October 2014</td>
<td>None</td>
<td>Closed by Local Team – no further action required</td>
</tr>
</tbody>
</table>

#### Outstanding Actions from CQC visit in October 2013

<table>
<thead>
<tr>
<th>CQC Action</th>
<th>Action requirement</th>
<th>Update</th>
<th>Actions now closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consistent environmental cleanliness; to national specification</td>
<td>An update was provided to the Governance Committee in September 2014. The committee endorsed the actions taken by the IP&amp;C team and highlighted that cleanliness has consistently been improving.</td>
<td>Weekly compliance with cleaning standards is reported on weekly by Carillion. They are reviewed monthly at the cleaning standards meeting along with other audits completed by nursing and IP&amp;C staff. Currently there is an issue with the contract with Semperian and Carillion around the 95% cleaning standard across the wards. Currently ward and department cleanliness is reported to be meeting our expectations.</td>
</tr>
<tr>
<td>22</td>
<td>Observational assurance for safe medicine administration</td>
<td>The wards are participating in a rolling audit program with approximately 600 audit forms returned to date. Each form represents 1 nurse/day. These results are being presented to the next Medicines Governance Group</td>
<td>Medicines Management audit of 1100 drug administrations has been completed. The audit was discussed at the Medicines Governance Group on 15th October 2014 and the decision was made to continue with an on-going audit using the same format. Results will be reported to matrons, ward</td>
</tr>
</tbody>
</table>
managers and the Medicines Governance Group. Areas of poor performance/compliance being followed up by individual ward managers. 17 areas were audited in total. The results demonstrated between 80-100% compliance. 7 at 100%, 3 at 96%, 1 at 95%, 2 at 93%, 4 at 80-89%.

<table>
<thead>
<tr>
<th>29</th>
<th>Call bell response &gt;95% within 5 minutes</th>
<th>Improvement noted Heads of Nursing are continuing to monitoring progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Carillion had previously informed the Trust that call bell reporting is not part of the contract and they were not able to undertake this work. The first call bell data has been received for November 2014 with an overall response rate of 83.4% which is a drop from our last records of 86%</td>
<td></td>
</tr>
</tbody>
</table>

**Well Led**

**Staff Survey**
The next update will be the 2014 Staff Survey; results are out around March 2015.

**Executive Patient Safety Walkabouts**
There were no programmed Executive Patient Safety Walkabouts in December.

**Quality Governance Structure**
The review and changes proposed for Quality Governance are:

- New style quality report for board – commenced November 2014
- Divisional Quality Governance Facilitators to be recruited during February 2015
- Patient Experience and Patient Safety committees to reform into Patient Quality Committee, this meeting to report into Governance Committee and to have a greater profile with CQUINs, quality strategy KPI’s, quality impact assessments and organisational learning and sharing of best practice
  - The first Patient Quality Committee will be April 2015
- Divisional Performance Meetings to incorporate quality metrics for overview and scrutiny alongside finance and workforce performance

**Sign up to Safety**

![Sign up to SAFETY LISTEN LEARN ACT](image)
Recognition of the Deteriorating patient:
Aim for zero incidence of avoidable deaths as a result of failure to recognise / escalate care of a deteriorating patient in a timely manner

- Standardise procedures
- Observations
- Education
- Equipment
- Audit

**PRIMARY DRIVERS**

- Adopt one EWS - modified NEWS (work with West of England Patient Safety Collaborative Board)
- Review Escalation procedures – ensure consistency from point of identification of issue through to who responds
- 24/7 Critical Care Outreach service

**SECONDARY DRIVERS**

- Write and implement a Trust wide observation policy
- Ward based observation champions to monitor and train team in observation and fluid balance chart completion
- Write and implement a mandatory Training Tracker section on observations for all clinical staff
- Set a minimum standard of training for each level of nursing staff e.g. all clinical staff to have REACT, ward Sister / charge nurse ILS and REACT
- Increase training availability, including ward based

- Increase number of sphygmomanometers / stethoscopes in ward areas
- Increase number of monitored beds
- Introduce an electronic data collection system to remove ‘human’ factor

- Wards to audit own observation / fluid balance charts Focus groups to discuss results
- Route cause analysis of IR1s where failure to identify and escalate identified – identify common causal factors between incidents
- Quarterly Trust wide chart audit
‘Driver Diagram’ - Falls

To reduce the rate of falls and avoidable harm due to falls by 20% within 3 years (Dec 2017/Jan 2018)

Zero avoidable harm resulting from falls