

# Swindon Borough Council

## Children's Health, Social Care and Education Overview and Scrutiny Committee

**Wednesday, 5 July 2017**

Committee Room 6, Civic Offices

At 6.00 p.m.

### **Conservative Councillors**

*Gary Sumner (Chair)*  
*Malcolm Davies*  
*Colin Lovell*  
*Gemma McCracken*  
*Barbara Parry*

### **Labour Councillors**

*Matthew Courtliff*  
*Fay Howard*  
*Carol Shelley*  
*Nadine Watts*

### **Co-opted Representatives**

Steve Colledge, Swindon Association of Secondary Headteachers  
Gary Evans, Swindon Association of Primary School Headteachers  
Steve Henderson, Equalities Advisory Forum  
Doug Morris, Swindon Parent and Carers Group  
Alison Paul, Swindon Association of Special School Headteachers  
Elaine Poulter, Parent Governor  
Liz Townend, Church of England Diocese  
TBC, Healthwatch  
TBC, Catholic Church Diocese

**Committee Officer:** Rita Glen Gallo 463611  
email: [RGlen-Gallo@swindon.gov.uk](mailto:RGlen-Gallo@swindon.gov.uk)

Swindon Borough Council can be contacted at the Civic Offices, Euclid Street,  
Swindon, SN1 2JH (Telephone 01793 445500)

**Access Arrangements** - The venue is wheelchair accessible and an infrared receiver hearing system is provided. If you have any special requirements to enable you to attend the meeting or would like to receive any of the pages contained in this agenda in a larger print size, please contact the Committee Officer as soon as possible prior to the date of the meeting.

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# AGENDA

**1. Apologies for Absence**

**2. Appointment of Vice-Chair**

**3. Declarations of Interest**

Members are reminded that at the start of the meeting they should declare any known interests in any matter to be considered, and also during the meeting if it becomes apparent that they have an interest in the matters being discussed.

**4. Minutes** (Pages 5 - 10)

To receive the minutes of the meeting held on 29<sup>th</sup> March 2017.

**5. Public Question Time**

See explanatory note below. Please phone the Committee Officer whose name and number appears at the top of this agenda if you need further guidance.

**6. Appointment of Co-optees** DLDS (Pages 11 - 14)

**7. NHS Swindon Clinical Commissioning Group**

Please note that this item has been withdrawn and will be submitted at the next meeting of this Committee on 20<sup>th</sup> September 2017.

**8. Annual Quality Accounts 2016-17 - Great Western Hospital** (Pages 15 - 86)

**9. Children Services Performance Summary 16/17 Outturn** DCS (Pages 87 - 110)

**10. Work Programme 2017-18** DLDS (Pages 111 - 138)

**Date of Despatch:** 29 Jun 2017

**Key:**

**Officers**

DLDS	-	Director of Law and Democratic Services
DCS	-	Director of Children's Services

**Public Question Time** - Swindon Borough Council remains committed to increasing its accountability to the public and to promoting active citizenship. 15 minutes will be allowed at the start of all Council meetings for questions to the Chair from the public about the work of the Committee (except for confidential matters, and matters relating to planning and licensing applications). We will give priority to those who submit questions in writing at least two days before the meeting. Questions must be relevant, clear, and concise. You may not use Public Question Time as an opportunity to make speeches or statements.

Questions in writing should be sent to the Committee Officer whose contact details appear on the agenda above or to the Director of Law and Democratic Services, we will publish it, along with the answer, alongside the Minutes. The process associated with asking a public question is set out in the "Public Question Time at Council Meetings Protocol and Guidance" available on the Council's Website.

(<http://www5.swindon.gov.uk/moderngov/ecCatDisplay.aspx?sched=doc&cat=13338&path=0>) or from the Committee Officer named above.

**Terms of Reference:**

To fulfil all the functions of an overview and scrutiny committee as they relate to –

- the review, scrutiny and development of policy recommendations,
  - the management of performance,
  - the monitoring of progress towards delivering relevant strategies and corporate priorities, and
  - the formulation of advice for the Cabinet, Council and other partners and stakeholders.
- 
- To have specific responsibility for (but not limited to) the scrutiny of:–
  - the performance of services for children towards agreed local and national Performance Indicators,
  - the quality of provision and effectiveness of Local Authority strategies to raise standards of education within Swindon,
  - specialist social services and integrated social services for children and young people in Swindon,
  - the delivery of services to children and young people in Swindon generally.

In addition, as these relate to Children and Young People:

- the performance of services seeking to deliver healthy communities towards agreed local and national performance indicators,
- Health, health commissioning and service delivery,
- Public Health, Health promotion and the work of the Health and Wellbeing Board, and
- Health Integration and collaborative working and commissioning with Health agencies and providers and General Practitioners.
- Reducing Domestic Violence and Abuse
- Strategic issues around Licensing

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**CHILDREN'S HEALTH, SOCIAL CARE AND EDUCATION OVERVIEW AND  
SCRUTINY COMMITTEE**

**WEDNESDAY, 29 MARCH 2017**

PRESENT:- Councillors Gemma McCracken (Chair), Malcolm Davies, Fay Howard, Colin Lovell, Teresa Page, Barbara Parry, Carol Shelley, Gary Sumner and Nadine Watts.

Steve Colledge (Swindon Association of Secondary Headteachers), Mark Edwards (Healthwatch), Doug Morris (Swindon Parent and Cares Group), Steve Henderson and Michelle Howard (Equalities Advisory Forum).

Also present: Miss Chloe Townsend, Miss Dani Wells and Mr Jacob Patterson, (elected Members of the Youth Parliament), Paul Dobson (Project Manager, Swindon Ten to Eighteen Project), Fiona Frances (Service Manager for Quality Assurance and Review Service), Lyn Frith (Commissioner, Education), Gill May, (Executive Nurse, Clinical Commissioning Group), Kevin McNamara (Director of Strategy, Great Western Hospital), Peter Nathan (Head of Education), Christina Rattigan (Interim Divisional Director of Nursing and Midwifery), Karen Reeve (Director of Children's Services), Maria Young (Head of Children, Families and Community Health).

Apologies for absence were received from Councillor Fionuala Foley, Cabinet Member for Children's Services and Liz Townend (Church of England Diocese).

**38. Declarations of Interest**

The Chair reminded Members of the need to declare any known interests in any matters to be considered at the meeting.

Councillor Barbara Parry made a personal, non-prejudicial declaration of interest to agenda item 9 (Children's Services Performance Report) in her capacity as an employee at Uplands Educational Trust.

Councillors Carol Shelley and Gary Sumner made personal, non-prejudicial declarations of interest to agenda item 9 (Children's Services Performance Report) in their capacity as governors at Swindon School.

Councillor Gary Sumner made a personal, non-prejudicial declaration of interest to agenda item 9 (Children's Services Performance Report) as his wife was a deputy Headteacher at a Swindon School.

**39. Public Question Time**

No public questions were asked.

**40. Minutes**

Resolved - That the minutes of the meeting held on 18<sup>th</sup> January 2017 be confirmed and signed as a correct record.

**41.**

### **Progress Update of Youth Participation**

The Project Manager, Swindon Ten to Eighteen Project, submitted a report updating the Committee on performance and key issues relating to youth participation, Swindon's Members of Youth Parliament, Swindon Youth Council and the Young Inspectors and Thought Tank. He explained that there was a positive response from schools to the "Emotional Health and Well-being" survey and at the request of the Senior Public Health Manager a mapping exercise would be undertaken to understand the kinds of mental health and support services available in Swindon. It was noted that this would be undertaken through targeted consultation with those dealing with well-being and mental health issues.

The Project Manager, advised of the membership of the Swindon Youth Council, which met three times a year and to the work being undertaken by the Council. The Committee noted the Swindon Youth Council's continued close working relationship with Great Western Hospital to improve the experience of young people receiving treatment at the hospital.

The Project Manager, Swindon Ten to Eighteen Project, and the Youth Parliament members, responded to members' questions and comments in respect of the following matters:

- The results of the Emotional Health and Well-being Survey and the identification of bullying and mental health issues as major issues of concern.
- The inclusion of minority groups in the survey
- The availability of support for all young people in the community.
- The need to refrain from using acronyms when signposting pathways to access support.

Resolved – That the report be noted.

**42.**

### **Swindon Clinical Commissioning Update Report**

The Clinical Commissioning Group (CCG) submitted a report updating the Committee on performance and key issues relating to the service. Ms Gill May, Executive Nurse at NHS Swindon Clinical Commissioning Group (CCG), introduced the report and commented on the Groups' priorities and action being undertaken. Ms May referred to the increase of children diagnosed with Autism Spectrum Disorder (ASD) since 2004 and advised that this national trend was reflected in Swindon. She explained that a review of the ASD pathway was being undertaken due to the increase in the number of patients. Ms May commented on the Children's Services Review and advised that progress had been made with the CCG identifying project management support for two key work streams. These included scrutinising existing funding for contracts and developing performance and outcome reporting tools.

Following her introduction of the report, Ms May responded to the members' questions and comments in respect of the following matters:

- The recruitment of an occupational therapist and community speech and a language therapist.
- Delayed publication of the Children's Services Review and whether funding opportunities had been missed as a result.
- Increased data gathering about children with special education needs and

disabilities in the Joint Strategic Needs Assessment.

- The later in life diagnosis of children with Autism the support available in these cases.

Resolved – (1) That the report be noted.

(2) That an interim report on the outcomes of the Children's Services Review be submitted to the next meeting of the Committee.

(3) That the Commissioner, Education, be requested to liaise with the Executive Nurse at NHS Swindon Clinical Commissioning Group, regarding the Children Services Review.

#### **43. Recruitment of Social Workers**

The Head of Children, Families and Community Health, submitted a report providing an update on a) the recruitment of social workers; b) Government Social Work accreditation; and c) Social Work Health Check and caseload issues. She explained that social workers deliver statutory responsibilities as set out in the Children's Act 1989 and that the need to recruit social workers was still high. To address this, a microsite/ recruitment and induction process has been developed to provide information to potential candidates. Additionally, an academy approach to recruitment and development of newly qualified social workers had been established and this helped them reach the standards required for their year of practice. Career progression scheme and aspiring manager's programmes had also been introduced. The Committee was informed that caseload management aided the delivery of effective social work and that dedicated recruitment would help reduce the number of children per social worker.

Following the introduction of the report, the Head of Children, Families and Community Health, with the Director of Children's Services and the Head of Education, responded to the Committee members' questions and comments in respect of the following matters:

- Reliance on agency social workers to undertake the work.
- An update on the recruitment drive to employ new social workers.
- Engagement with other agencies to provide social services.
- The current number of vacancies, retention and turnover numbers of social workers.
- The recruitment of support staff to assist social workers in their work.
- Support through supervision being provided to social workers.
- The appraisal system for social workers.
- Review of work practices to reduce bureaucracy.
- An update on the graduate programme.

Resolved – (1) That the report be noted.

(2) That the Head of Children, Families and Community Health, advise members of the number of agency social workers currently employed by the Council and also the number of staff appraisals undertaken.

#### **44. Joint Local Area SEND Inspection**

The Head of Education submitted a report updating the Committee on progress made in readiness for the new joint local area SEND (Special Educational Needs and Disability) inspection. The Commissioner, Education, explained that from May 2016, all local areas in England were subject to a joint inspection from Ofsted and the Care Quality Commission (CQC). This was to judge the effectiveness of

the areas in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The Commissioner, Education, explained that the report had been structured to highlight the strengths and challenges of the work that had been undertaken, making specific reference to the recently updated self-assessment tool provided by the Council for disabled children. She advised that a joint improvement plan will be created with Clinical Commission Group, Swindon, that will provide targeted support to children and young people who have special needs and / or disabilities.

Following the introduction of the report, the Commissioner, Education, responded to the members' questions and comments in respect of the following matters:

- How academies were dealing with the increased number of fixed term exclusions in Swindon and the support being provided by the Local Authority.
- The alternative placement of excluded pupils.
- The number of schools actively engaging with the Parents Carer Forum.
- Parental involvement in inspections jointly undertaken by Health Department and the Local Authority.
- The use of the "early help" assessment tool and how this identified those needing a statutory assessment of special educational needs.
- The number of students undertaking internships who then went on to paid employment.
- Narrowing the attainment gap at Key Stage 3.
- Work being conducted at the North Swindon Learning Campus.

Resolved – (1) That the report be noted.

(2) That the Head of Education be requested to submit a report regarding exclusions in Swindon to a future meeting of the Committee.

#### **45. Children's Services Performance Report**

The Head of Children, Families and Community Health, submitted a report providing an update on performance within all service commissioning for the end of quarter three, to end of January 2017. She referred to the strengths and challenges of the work that had been undertaken, making specific reference to the increase in assessments undertaken and to the challenges to complete reviews and visits for children on child protection plans.

The Head of Children, Families and Community Health, advised that a high percentage of children looked after were in family placements and that the number of children coming into care as unaccompanied asylum seekers had also increased. It was noted that more statutory assessments were being completed as there was an increase of children on child protection plans and becoming looked after. However fewer children became the subject of a second or subsequent child protection plan. The Head of Children, Families and Community Health, explained that timely looked after children reviews continued to be a challenge for the department.

Following her introduction of the report, the Head of Children, Families and Community Health, responded to the members' questions and comments in respect of the following matters:

- The reduction of referrals through work being undertaken by the Multi Agency



Safeguarding Hub (MASH)

- The make-up of the MASH team and the expertise all staff bring to their posts.
- An understanding of who represents parents at schools when an exclusion is being considered.
- The increase in the number of children in Swindon waiting to be adopted.

Resolved – (1) That the report be noted.

(2) That the Director of Children Services and the Head of Education be requested to review the feasibility of creating a support officer post in the MASH team.

#### **46. Child Sexual Exploitation, Female Genital Mutilation (GM), Honour Based Violence (HBV) and (DA) Domestic Abuse Update**

The Service Manager for Quality Assurance and Review Service submitted a report updating the Committee on progress made regarding Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Honour Based Violence (HBV) and (DA) Domestic Abuse. It was noted that following a successful bid to One Swindon for funding, leaflets on CSE had been produced and circulated to children, taxi drivers, hotels, leisure centres, bus drivers, parents and professionals. She advised that a CSE e-learning course was available and additional training had been developed through the Children's Workforce Development Team to enhance practitioners' skills.

The Service Manager explained that the Multi-agency Risk Panel (MARP) saw an increase in the number of referrals for children who were criminally exploited. She advised that MARP assessed children who are at risk of CSE, criminal exploitation and missing and its work entailed liaising with the Police to support vulnerable children.

Following the introduction of the report, the Service Manager, responded to members' questions and comments in respect of the following matters:

- Lessons learnt from undertaking CSE work were transferrable to other areas of child exploitation risks.
- The new model for sharing police notifications.
- The collaborative work being undertaken by the police with schools.
- Expanding the work being undertaken to include other partner organisations.
- Assessing the work of a new project to provide a multi-agency support pathway for vulnerable women who lost a child to the care system in preventing a subsequent removal.
- The new data system being introduced for Looked After Children.

Resolved – (1) That the report be noted.

(2) That the Head of Children, Families and Community Health, be requested to include information on the number of "hits" on The Child Sexual Exploitation website (<https://www.swindon.gov.uk/cse>).

#### **47. Work Programme Report**

The Committee received a report from the Director of Law and Democratic Services detailing its updated work programme for the Municipal Year 2016/17. The Committee received a report from the Director of Law and Democratic Services detailing its updated work programme for the Municipal Year 2016/17.

Resolved – (1) That the report be noted.

(2) That contributions received from Councillors and stakeholders for consideration for inclusion in the Committee's Work Programme for the Municipal Year, 2017/18, be welcomed.

## Appointment of Co-optees

### Children's Health, Social Care and Education

#### Overview & Scrutiny Committee

Date: 5<sup>th</sup> July 2017

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Author:	Director of Law & Democratic Services
Wards:	All Wards
Locality Affected:	All Locality Areas
Parishes Affected:	All Parish Area

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#### 1. Purpose and Reasons

- 1.1 The purpose of the report is to confirm the appointment of co-optees to the Children's Health, Social Care and Education Overview and Scrutiny Committee for the Municipal year 2017/18.
- 1.2 The Children's Health, Social Care and Education Overview and Scrutiny Committee is permitted by the Council's Constitution to appoint parent governor and diocese representatives to its membership and may choose to appoint additional co-opted members.

#### 2. Recommendations

##### The Committee is recommended to:

- 2.1 To confirm the appointment of Liz Townend as the Church of England Diocese representative.
- 2.2 To confirm the appointment of Elaine Poulter as Parent Governor Representative.
- 2.3 To consider the appointment of the following non-voting representatives:
  - Alison Paul (Swindon Association of Special School Headteachers).
  - Gary Evans (Swindon Association of Primary Headteachers).
  - Steve Colledge (Swindon Association of Secondary Headteachers).
  - Steve Henderson (Equalities Advisory Forum).
  - Doug Morris (Swindon Parent and Carers Group)
- 2.4 To confirm the appointment of a Catholic Church Diocese representative to the Committee as and when nominations are received.
- 2.5 To confirm the appointment of a Healthwatch representative to the Committee as and when nominations are received.

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Further information on the subject of this report can be obtained from Rita Glen-Gallo, 01793 463611, rglen-gallo@swindon.gov.uk.

# Appointment of Co-optees

## Children's Health, Social Care and Education

### Overview & Scrutiny Committee

Date: 5<sup>th</sup> July 2017

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#### 3. Detail

- 3.1 The Council's Constitution states that the Children's Health, Social Care and Education Overview and Scrutiny Committee will appoint no more than 2 church representatives and 2 parent governor representatives to its membership as full voting members in respect of education matters. If the Children's Health, Social Care and Education Overview and Scrutiny Committee deals with other matters, these representatives shall not vote on those other matters, though they may stay in the meeting and speak.
- 3.2 The Committee is asked to determine whether any additional co-opted representatives should be sought to support its work programme for the year.

#### 4. Alternative Options

- 4.1 The Committee may choose only to appoint co-optees required under the Constitution and to appoint other co-optees to support their work programme on a meeting-by-meeting basis.

#### 5. Implications, Diversity Impact Assessment and Risk Management

##### Financial and Procurement Implications

- 5.1 Co-opted representatives are entitled to claim travel and meal allowances in order to attend Council meetings, the costs of which are met from within the Allowance budget. There are no procurement implications arising from the contents of his report.

##### Legal and Human Rights Implications

- 5.2 Section 21 of the Local Government Act requires every local authority to establish an overview and scrutiny function to hold the Executive to account, undertake policy development and review, monitor and improve performance.

##### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 There are no other direct implications arising as a result of this report. Any further implications will be identified when a topic is reviewed by the Scrutiny Committee and in any recommendations made by the Scrutiny Committee.

##### Diversity Impact Assessment

- 5.4 No Diversity Impact Assessment is required at this stage. Any DIA that is required during review of topics included within the work programme will be identified at the appropriate stage.

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Further information on the subject of this report can be obtained from Rita Glen-Gallo, 01793 463611, rglen-gallo@swindon.gov.uk.

# Appointment of Co-optees

## Children's Health, Social Care and Education

### Overview & Scrutiny Committee

Date: 5<sup>th</sup> July 2017

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#### Risk Management

- 5.5 Any risks arising from the proposals contained within this report will be managed through their implementation taking into consideration feedback from the consultation exercise.

#### **6. Consultees**

- 6.1 The Director of Finance (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

#### **7. Background Papers**

- 7.1 None.

#### **8. Appendices**

- 8.1 None.

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**Annual Quality Accounts 2016/17 – Great Western Hospital  
Children’s Health, Social Care and Education  
Overview and Scrutiny**

**Date: 5<sup>th</sup> July 2017**

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Author:	Kevin McNamara, Director of Strategy
Wards:	Swindon
Locality Affected:	Swindon
Parishes Affected:	Swindon

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**1. Purpose and Reasons**

- 1.1** This report provides the Children’s Health, Social Care and Education Overview and Scrutiny Committee with an update of key issues relating to Great Western Hospitals NHS Foundation Trust.
- 1.2** A key purpose of the Children’s Health, Social Care and Education Overview and Scrutiny Committee is to hold providers of healthcare services to account.

As a provider of healthcare in Swindon, Great Western Hospitals NHS Foundation Trust is required to provide information on the planning and provision of healthcare services within the Borough and consult with the Committee on any planned substantial changes or developments.

**2. Recommendations**

The Committee is recommended to:

- 2.1** Note the report
- 2.2** Identify any areas of concern or interest that require further investigation.

**3. Detail**

- 3.1** This is an opportunity to share Great Western Hospitals NHS Foundation Trust’s annual Quality Account for 2016/17.

A Quality Account is a report about the quality of services offered by healthcare providers, including NHS and non-NHS providers of healthcare.

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Further information on the subject of this report can be obtained from Kevin McNamara, Director of Strategy, Great Western Hospitals NHS Foundation Trust - 01793 604676, [kevin.mcnamara@gwh.nhs.uk](mailto:kevin.mcnamara@gwh.nhs.uk)

# **Annual Quality Accounts 2016/17 – Great Western Hospital**

## **Children’s Health, Social Care and Education**

### **Overview and Scrutiny**

**Date: 5<sup>th</sup> July 2017**

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The Department of Health requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year.

The report provides the public with a clear account of our work over the past 12 months to improve the quality of care we provide to patients and shares our priorities for the year ahead.

The quality of services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

It is applicable to all Trust services and the quality improvement work summarised in the report is applicable to both adult and children’s services.

### **3.2 Great Western Hospitals NHS Foundation Trust’s Quality Account 2016/17**

The report includes many examples of how we are making improvements to the quality of care we provide to our patients and priorities for the year ahead.

Our most important achievements for 2016/17 include our life saving work on sepsis and acute kidney injury, with nearly 90 per cent of sepsis patients making a full recovery from this potentially fatal condition. As well as our work on preventing pressure ulcers, with the number of patients experiencing this painful condition falling by 30 per cent in the last year to the lowest incidence in the south west.

We are now looking to cutting edge technologies to improve the outcomes and quality of life for our patients. The latest 3D printing technology was recently used to help a patient with a rare hip deformity walk without pain, we successfully implanted the UK’s first four lead pacemaker in November and we are using state-of the-art simulation technology to provide staff with innovative true to life training.

Despite leading the way in many areas of quality improvement, we are not without our challenges and this report also provides an honest account of the difficulties we face.

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Further information on the subject of this report can be obtained from Kevin McNamara, Director of Strategy, Great Western Hospitals NHS Foundation Trust - 01793 604676, [kevin.mcnamara@gwh.nhs.uk](mailto:kevin.mcnamara@gwh.nhs.uk)



# **Annual Quality Accounts 2016/17 – Great Western Hospital**

## **Children's Health, Social Care and Education**

### **Overview and Scrutiny**

**Date: 5<sup>th</sup> July 2017**

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The sheer volume of patients needing our care, delays in discharging patients, a tight financial position and staff shortages, are challenges we face every day.

Looking ahead it's clear we must transform our services to meet the changing needs of the local population, however our priorities must remain the same - to provide safe, high quality and effective care to all.

Our ambitious goal, to save an extra 500 lives by 2020, is here to stay. This means we are focused on saving more patients from life threatening conditions, compared to what would be expected according to national survival rates.

We continue to focus on our Sign up to Safety Priorities, among other quality improvement work, to achieve our 500 lives goal. These priorities are conditions where lives can be saved or the condition can be prevented through good care. They include sepsis, deteriorating patients, acute kidney injury, falls and pressure ulcer prevention.

The addition of community healthcare to our services in Swindon has given us greater opportunities to provide more joined up care between services in hospital and at home.

We are now also in a better position to improve the care we provide for patients in their own homes, helping patients to better manage their conditions and stay well and out of hospital.

As we work towards a more unified health and social care system in Swindon, the strong partnerships we already have, provide us with a great platform for further collaboration.

#### **4. Alternative Options**

##### **4.1 None.**

# **Annual Quality Accounts 2016/17 – Great Western Hospital**

## **Children’s Health, Social Care and Education**

### **Overview and Scrutiny**

**Date: 5<sup>th</sup> July 2017**

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#### **5. Implications, Diversity Impact Assessment and Risk Management**

##### Financial and Procurement Implications

**5.1** None.

##### Legal and Human Rights Implications

**5.2** None.

##### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

**5.3** None.

##### Diversity Impact Assessment

**5.4** None.

##### Risk Management

**5.5** None.

#### **6. Consultees**

**6.1** The Director of Finance, (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

#### **7. Background Papers**

**7.1** None.

#### **8. Appendices**

**8.1** Appendix 1 – Annual Quality Accounts 2016/17 Final.

<http://www.gwh.nhs.uk/about-us/publication-scheme/what-our-priorities-are-and-how-are-we-doing/> Please note: Latest version to be uploaded shortly.

# Quality Accounts

2016-17

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## 1 Our Commitment to Quality

### 1 Our Commitment to Quality – Statement from Nerissa Vaughan Chief Executive dated 30<sup>th</sup> May 2017

I am pleased to present our Quality Account for 2016/17.

This report provides the public with a clear account of our work over the past 12 months to improve the quality of care we provide to patients and shares our priorities for the year ahead.

It is clear that to provide safe and high quality care to a rapidly growing and ageing local population we need to think differently, plan differently and do things differently. That is what this year has been all about. It is also clear that adapting to meet the changing needs of patients must remain our focus for the next few years.

The addition of community healthcare to our services in Swindon has given us great opportunities for better collaboration and to provide more joined up care between services in hospital and at home.

We have already learnt a huge amount from our community colleagues and over the next year we will be looking for more opportunities to standardise best practice across our hospital and community services.

We are now also in a better position to improve the care we provide for patients in their own homes, especially those with long term conditions, such as diabetes, arthritis and hypertension. This means helping patients to better manage their conditions, stay well and out of hospital.

Although we must transform our services, our priorities must remain the same - to provide safe, high quality and effective care.

Our ambitious goal, to save an extra 500 lives by 2020, is here to stay. This means we are focused on saving more patients from life threatening conditions, compared to what would be expected according to national survival rates.

To do this we must deliver the very best care to each patient, by using nationally recognised best practice, standardising care and supporting a culture where we learn from our mistakes.

We continue to focus on our Sign up to Safety Priorities, among other quality improvement work, to achieve our 500 lives goal. These priorities are conditions where lives can be saved or the condition can be prevented through good care. They include sepsis, deteriorating patients, acute kidney injury, falls and pressure ulcer prevention. You can read about our progress throughout the report.

Our most important achievements for 2016/17 include our life saving work on sepsis, with nearly 90 per cent of patients making a full recovery from this potentially fatal condition

The introduction of a specialist Acute Sepsis and Kidney Injury Team, who are building on our expertise in sepsis to tackle acute kidney injury, which accounts for one in five of emergency medical admissions.

I am also proud to report the lowest incidence of pressure ulcers in the south west, with the number of patients experiencing this painful condition falling by 30 per cent in the last year.

We are now looking to cutting edge technologies to improve the outcomes and quality of life for our patients.

The latest 3D printing technology was recently used to help a patient with a rare hip deformity walk without pain, we successfully implanted the UK's first four lead pacemaker in November and we are using state-of the-art simulation technology to provide staff with innovative true to life training.

As you read through this report you will find many more examples of how we are making improvements to the safety and quality of care we provide to our patients.

Despite leading the way in many areas of quality improvement, we are not without our challenges and this report also provides an honest account of the difficulties we face.

The sheer volume of patients needing our care, delays in discharging patients, a tight financial position and staff shortages, are challenges we face every day. But they do not stop us from providing compassionate care. This is thanks to the commitment of our 4,500 caring, professional and highly skilled staff.

As we work towards a more unified healthcare system in Swindon, I am particularly proud of the strong partnerships we already have. They bring a wealth of specialist care to our patients and I'm keen to further expand this collaborative approach.

They include our end of life care service provided by Prospect Hospice, our Macmillan nurses, helping older patients settle back home with the Royal Voluntary Service's Home from Hospital Service and brightening the days of younger patients with Pets As Therapy, among many others.

Looking forward, our work with Oxford University Hospitals NHS Foundation Trust to bring radiotherapy to Swindon is progressing well and the new facility is expected to be available from 2019, making a difference to hundreds of local families.

I hope you enjoy reading about our work and our plans to further enhance the experience of our patients in 2017/18.

**Nerissa Vaughan**

**Chief Executive**

## 2 Priorities for Improvement & Statements of Assurance

### 2.1 Priorities for Improvement 2017/2018

This section reflects on the priorities for improvement we will set for 2017/2018 and progress made since the publication of 2016/17 quality report.

#### 2.1.1 Our Priorities for 2017/18

Our 2017/18 priorities are informed by both national and local priorities including the Sign up to Safety Campaign, learning from incidents, projects supported by the Academic Health Science Networks. These priorities are also agreed through our quality contracts with our local Clinical Commissioning Groups, taking into consideration the data available on the quality of care relevant to all of our health services we provide. These priorities have been shared with agreement sought from the Trust Governors as patient/public representatives, Local Healthwatch organisations and other key external stakeholders.

## Our Priorities for Quality Improvement

### Our Focus for 2017/18

- Reduction in pressure ulcers by working collaboratively with community services
- Recognition and rescue of the deteriorating patient through the implementation of an electronic observation system
- Improving outcomes from Acute Kidney Injury (AKI)
- Improving effectiveness of Clinical handover
- Safety of patients in the Emergency Department through the continued improvement in initial assessment and timely patient observations
- Incorporate community services into all current and future improvement workstreams where appropriate
- Increase the capability and capacity for quality improvement within the organisation

### Saving 500 Lives and Quality Improvement

#### Sign up to Safety

The Trust continues to deliver its ambition to save an extra 500 lives over 5 years, we have continued to progress our safety improvement plans through projects to improve quality and safety. As part of this overarching campaign the Trust has continued in its commitment to the national Sign Up To Safety programme. During 2016/17 this covered the following key areas of focus, a combination of national aspirations and our own specific improvement areas:

- Reducing falls
- Reducing pressure ulcers
- Management of sepsis
- Recognition of the deteriorating patient
- Acute Kidney Injury (AKI)





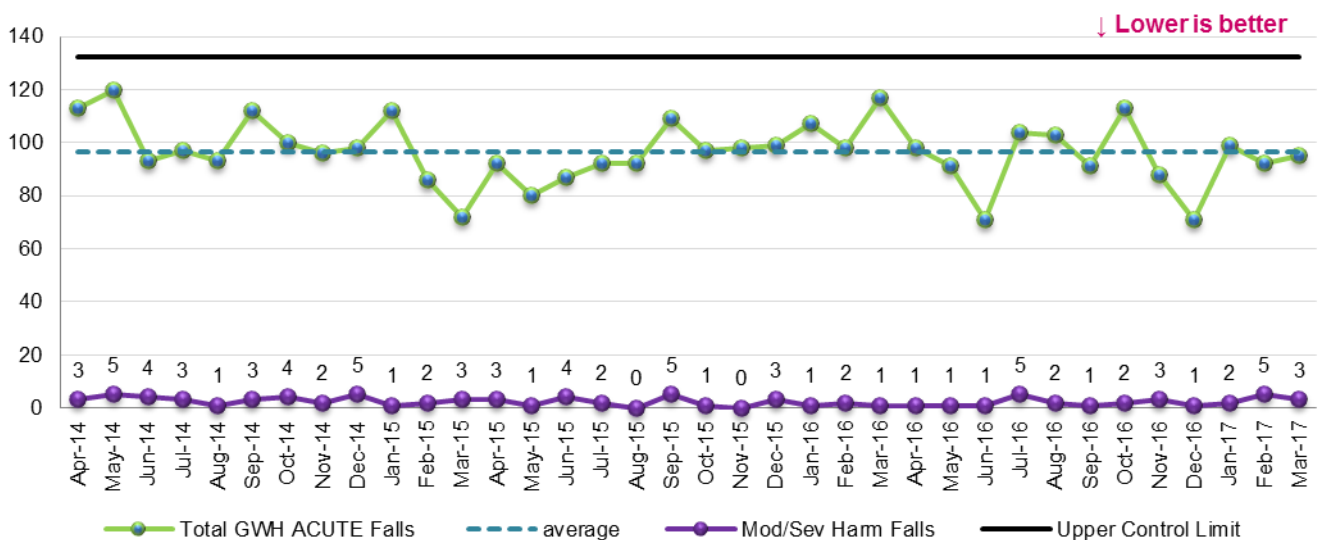
## Reducing falls

Falls are one of the leading causes of harm in hospitals. They can lead to injury, loss of confidence, independence, and prolonged hospital stays.



During 2016/17 we have seen a 4% reduction in the number of falls on the previous year 2015/16.

### Total falls across the Acute Trust



The chart above shows the total number of falls reported by the Trust each month and the number of falls resulting in moderate or severe harm from falls.

### What improvements have we achieved?

In 2016/17 we reported 27 falls as moderate or severe harm, an average of 2 a month, sustaining the same number reported throughout 2015/16.

## Drivers for improvement

- Revision of the falls assessment document in line with Royal College of Physicians recommendations, included in the Trust-wide roll out of the updated Nursing Documentation.
- Junior Doctors receive simulation training on falls during induction.
- Piloting of non-slip Anti-Embolism socks on Trauma Unit.
- Front-door Physiotherapy Team are identifying and managing the re-admission of multiple fallers.
- All Ward Managers attending the monthly Falls Operational Group to share learning and change ideas from their areas.
- Joint working with Swindon CCG and Bone Health Collaborative
- Revised Post Falls SWARM completed within 24 hours of the fall taking place.

## Further Improvements identified and our priorities for 2017/18:

- Implement Digital Reminiscence Therapy (Interactive multimedia to stimulate personalised memories) equipment for use across acute high use wards where falls are frequently reported
- Review and update Falls Avoidance and Safety Rails Policy
- Review national falls audit from Royal College of Physicians and adopt recommendations
- Recruitment of a Falls Specialist Nurse
- Ward based simulation training to improve post falls care
- Falls prevention measures form part of Ward Assessment and Accreditation Framework

## Reducing avoidable pressure ulcers

Pressure ulcers typically affect patients with health conditions that make it difficult to move, in particular patients sitting for long periods of time or confined to lying in bed.

The development of a pressure ulcer can have a negative impact on our patient's quality of life by causing pain, emotional distress and loss of independence. They also increase the risk of infection and prolong hospital stays. In the most serious of cases pressure ulcers increase a patient's risk of death.

Many pressure ulcers can be prevented through effective risk assessment and care planning for our patients, and ensuring our patients are kept mobile, changing positions wherever possible.

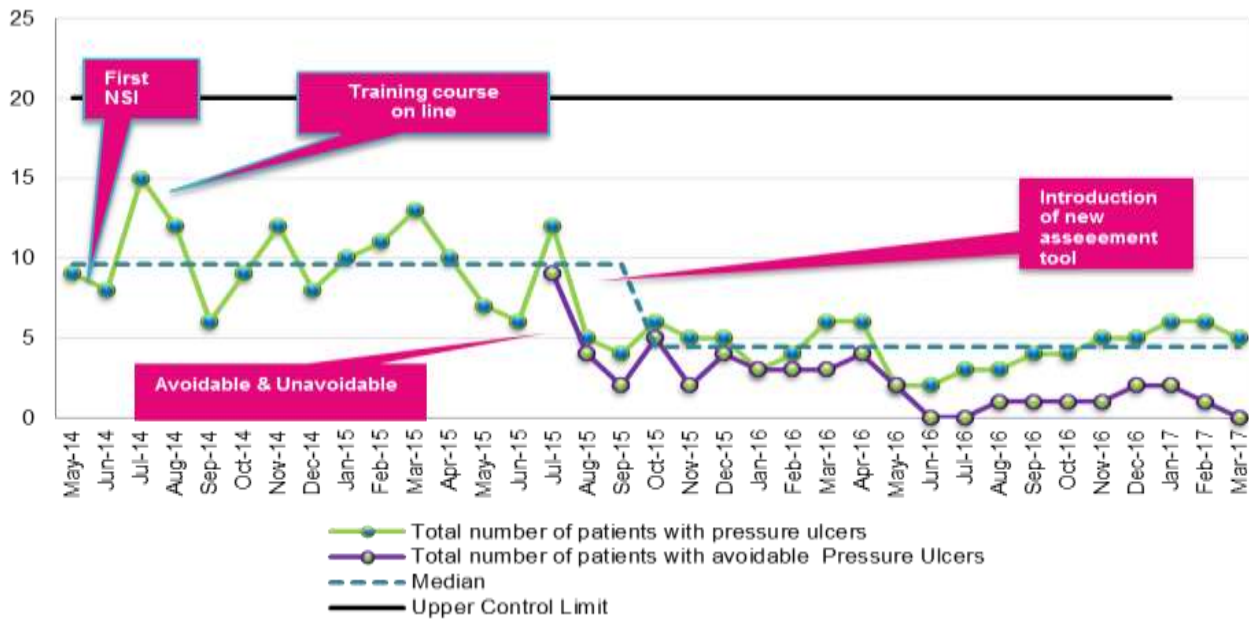


We have reduced the average number of patients with pressure ulcers from 3.8 to 1.25 per month. We have achieved our target, in 2016/17 we reported an average of 4.25 pressure ulcers per month

Target: **<5 per month** sustained to April 2018.  
Improved risk assessment, care of patients at risk & effective care planning.



### Total number pressure ulcers (category II, III, IV for all acute inpatients)

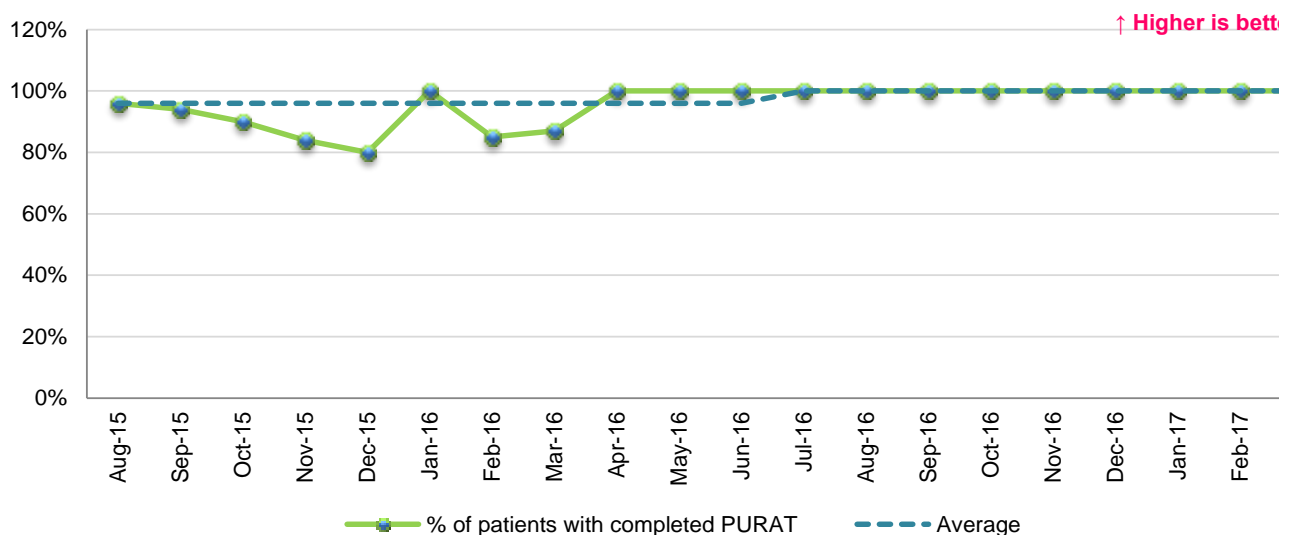


The chart above demonstrates the total number of avoidable and unavoidable category II, III and IV Pressure Ulcers in acute inpatients.

During 2016/17 we exceeded our target to reduce the number of avoidable pressure ulcers to less than 5 per month. We reported an average of 4 unavoidable and 1 avoidable pressure ulcers in acute inpatients per month'.

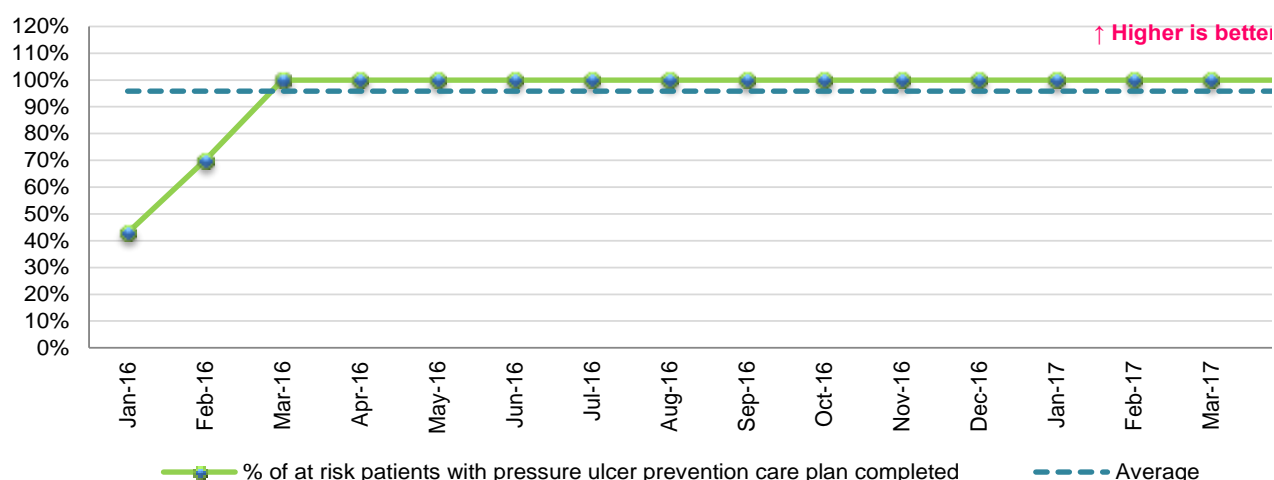
We have achieved this through a number of interventions:-

### Percentage of acute patients with a completed Pressure Ulcer Risk Assessment Tool (PURAT)



The graph above shows the percentage of patients with a completed Pressure Ulcer Risk Assessment Tool (PURAT). Since April 2016 100% of inpatients in a sample of 20 patients records reviewed per month have had a completed PURAT. This data is taken from our monthly audits of the 4 hot spot wards where pressure ulcers are most frequently reported.

## Percentage of at risk acute inpatients with a pressure ulcer prevention core care plan completed



The graph above shows the percentage of at risk inpatients that have had a pressure ulcer prevention core care plan completed. Since March 2016, 100% of acute at risk inpatients in a sample of 20 patients records reviewed per month have had a pressure ulcer prevention core care plan in place. This data is taken from our monthly audits of the 4 hot spot wards.

### What improvements have we achieved?

- Tissue Viability Nurses (TVNs) conduct monthly audits for Hot Spot Wards. These audits include:
  - Percentage of patients that have a PURAT completed within 2 hours of admission to the ward.
  - Percentage of patients with a Pressure Ulcer Prevention Core Care Plan completed
  - Percentage of patients with the correct pressure relieving mattress
  - Percentage of patients that have a Wound Assessment and Management Care Plan completed
  - Percentage of patients with the frequency of repositioning documented on the Pressure Ulcer Prevention Core Care Plan
  - Percentage of patients who have the Intentional Rounding Tool ( an assessment tool to determine a patients level of risk of pressure ulcer development ) in place
- TVN's investigate wounds and pressure ulcers incidents. For each category II pressure ulcer and above, the TVN's work with the relevant ward manager to review the patient journey.
- Annual wound audit
- TVN's reviewed and updated Hot Spot Wards in January 2017

### Further improvements identified and priorities for 2017/18

- Joint working with acute and community TVN's to develop wound management course for community services
- Review of the discharge documentation and the referral process from acute care to community and GP practice nursing teams.
- Teaching on the prevention of heel ulcers, i.e. Educational slides on pressure ulcer care to be trialled on one ward before rolling out Trust wide.
- Pressure Ulcer Working Group to be established with TVN's from both the Community and Acute services.

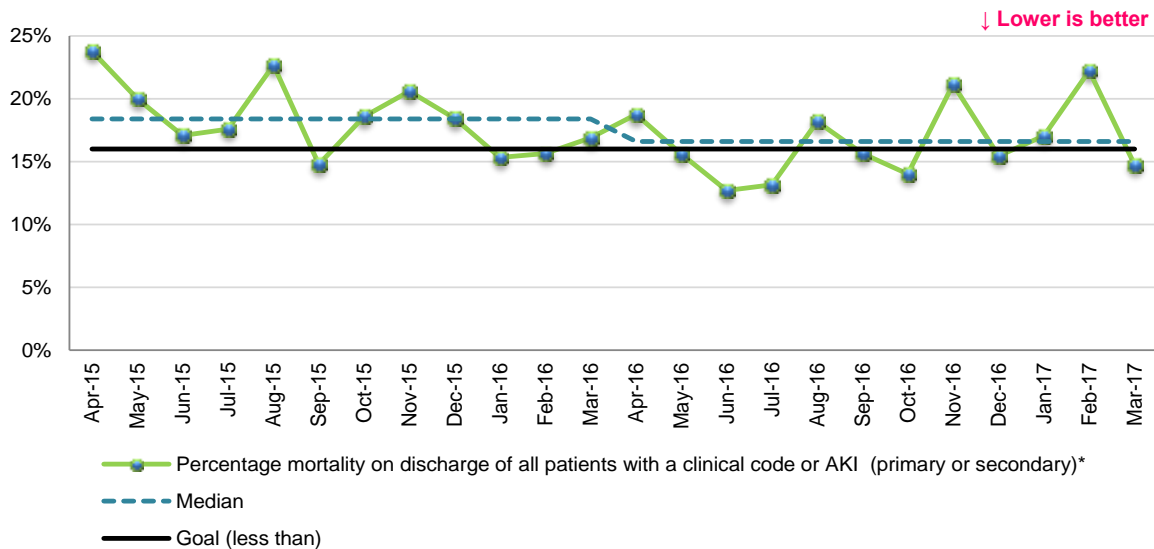
## Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) is a sudden deterioration in kidney function that affects up to 20% of patients (1 in 5) admitted to hospital. It can range from minor loss of kidney function to complete kidney failure, and in the most serious cases can lead to death.

With early detection and the right care at the right time, both the risk of death and long term damage to the kidneys is greatly reduced. As a common and potentially life threatening condition, we are passionate about proactively improving care and saving lives.



### Crude mortality on discharge: patients with a clinical code of AKI (primary or secondary)



The chart above shows the crude mortality on discharge with patients who have a clinical code of AKI (Primary or secondary). In 2016/17 we reported an average of 16.6% of patients who had crude mortality on discharge that had a clinical code of AKI. This is a significant improvement on 2015/16 where we reported an average of 18.4%.



## What improvements have we achieved?

- Developed online AKI training modules for nursing and medical teams to equip clinical staff with the knowledge and skills to improve recognition and treatment of AKI.
- Implemented the AKI Kidney 5 Care Bundle, Sepsis, Hypovolaemia, Obstruction, Urine Analysis, Toxins (SHOUT). Patients flagged with AKI receive five standard elements of care proven to be effective in managing AKI.
- Ward pharmacists carry out medicine reviews of all patients flagged with AKI to determine the most appropriate medication to manage their AKI and aid recovery.
- Funded by Brighter Futures, a new Acute Sepsis and Kidney Injury (ASK) Team was recruited and launched in October 2016. Made up of five specialist nurses the ASK team are responsible for ensuring all patients with acute kidney injury are treated using the same set of clinical interventions which are based on international best practice. The team also work with staff across the organisation and healthcare partners such as GPs to raise awareness of the signs and symptoms.

## Further improvements identified and priorities for 2017/18

- Supported by the ASK team continue to improve on the use of the AKI care bundle
- We will develop care pathways with GPs and community healthcare providers to improve prevention of AKI of our patients before coming into hospital and support appropriate care to aid their recovery once home.

## Sepsis

Sepsis is a common and life threatening condition caused by the body's own response to infection. Sepsis occurs when severe infection in the body triggers widespread inflammation, swelling and organ failure.

Each year in the UK, it is estimated that more than 100,000 people are admitted to hospital with sepsis and around 44,000 people will die as a result of the condition.

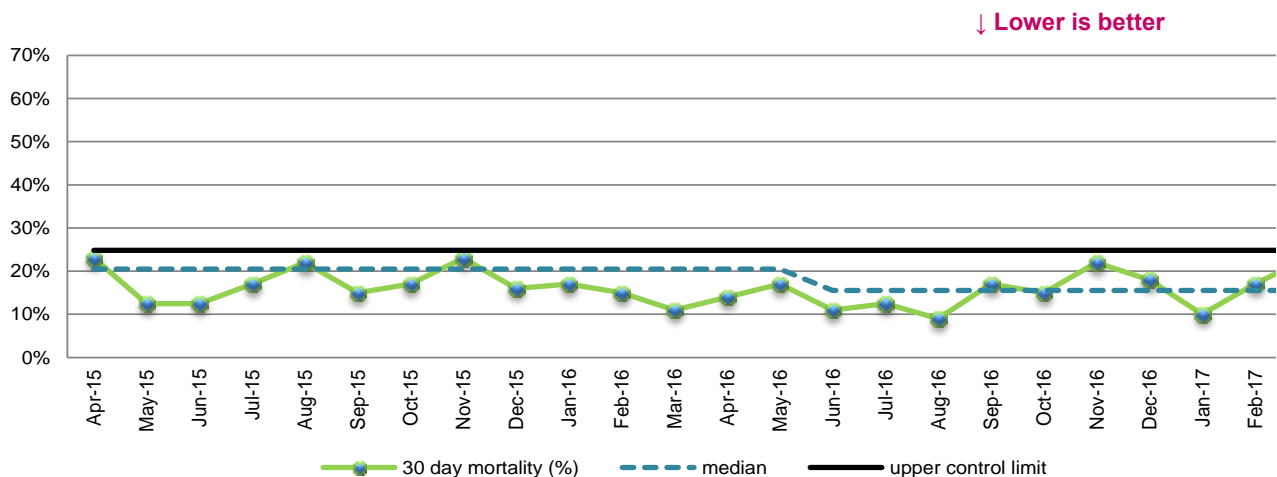
Effective delivery of the Sepsis Care Bundle (Sepsis 6 UK Sepsis Trust) increases patients' chance of survival by up to 30%. Overall national mortality rate for patients admitted with severe sepsis is 35%. (UK Sepsis Trust 2014)



In 2014/2015 we reported an average of 25% patients admitted with severe sepsis that die within 30 days of discharge. We used this first year of data collection to set our annual mortality target to less than 23% sustained level of mortality from severe sepsis until 2018.

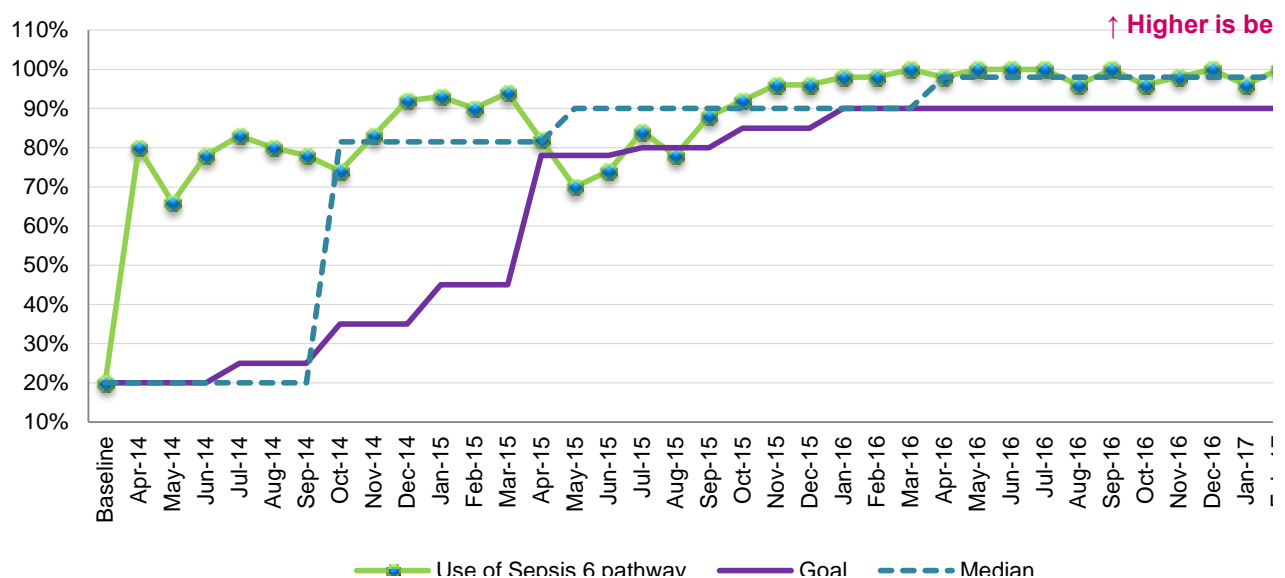
Throughout 2016/17 we reported an average of 15% of patients admitted with severe sepsis die within 30 days of discharge, a decrease on the previous year and remaining below our 23% target.

### 30 Day Mortality



The chart above shows 30 day crude mortality from severe sepsis and the sustained improvements achieved since April 2015 through to February 2017.

### Percentage of patients who have documented evidence of the use of the sepsis six pathway



### What improvements have we achieved?

- ASK Specialist Nurses Team have now been fully recruited.
- Producing a quarterly ASK Team Newsletter which is circulated Trust-wide.
- Focussed teaching around Sepsis Management and Sepsis Tools is on-going and currently more than 90% of clinical staff across 4 wards have been trained.

- Our sepsis campaign has had significant success in the early identification and response to this life threatening condition. This has brought both local and national recognition with our Sepsis Team winning a national Patient Safety Award in December 2015.
- We have continued to monitor and improve usage of our standardised Sepsis screening tool and Sepsis 6 Care Bundle for all emergency admissions to the acute hospital.
- Sepsis education programme to all new junior doctors.
- Audit of all patients in our Surgical Assessment Unit (SAU) receiving Sepsis Screening.
- Extended sepsis screening to surgical patients having an emergency laparotomy.

#### Further improvements identified and priorities for 2017/18

- Incorporate patient and public involvement into our monthly Sepsis Working Group
- Continue to provide ward-based simulation training on the management of Sepsis and use of Sepsis 6 Care Bundle
- Perform trial of antibiotic review at 72 hours stickers on an acute inpatient ward, we will review this before we expand the use to other inpatient wards.
- Increase compliance with the Sepsis 6 Care Bundle to continue to improve early recognition and management of severe sepsis and septic shock.
- We will develop care pathways with GPs and our community services to improve prevention of sepsis of patients before coming into hospital and appropriate care to aid recovery once home
- Trial the use of antibiotic grab bags to acute areas to reduce the time taken to administer antibiotics

#### Recognition and rescue of the deteriorating patient

Recognition and appropriate timely management of the deteriorating patient has been recognised nationally as an area of concern. Numerous reports since the 1990s have identified patients are physiologically deteriorating, however that deterioration is not recognised appropriately or acted on as required, resulting in potential harm to the patient. In the worst case scenario this can result in the patient having an avoidable cardiac arrest.

Our improvement work aims to identify the range of contributory factors underpinning this aspect of patient care and implement changes in practice to improve patient outcomes.



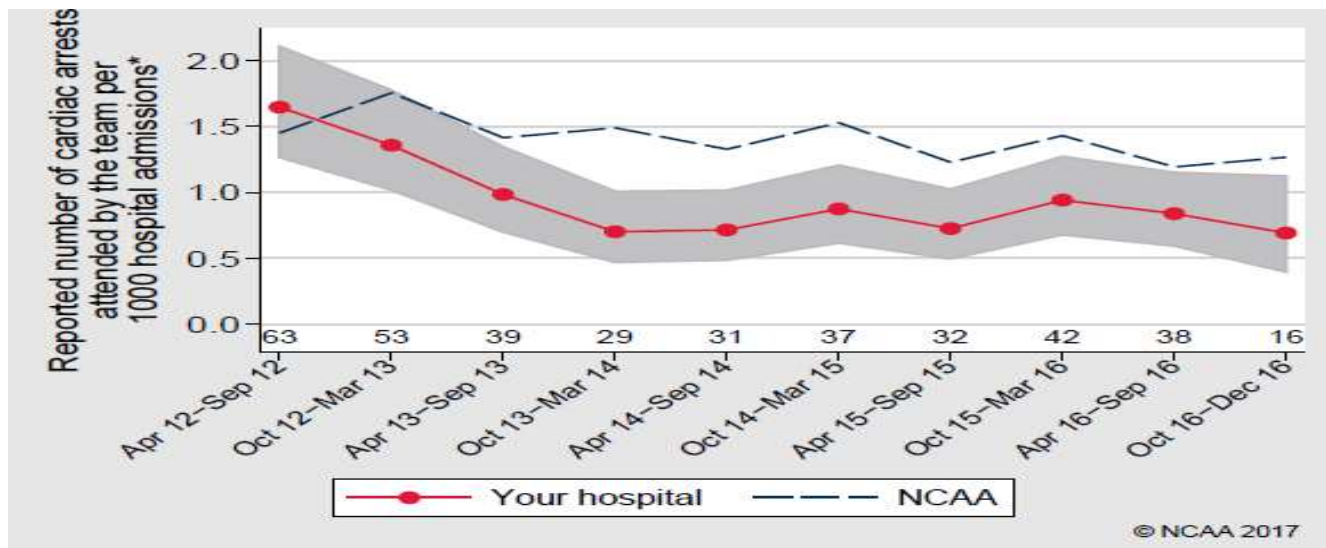
#### What improvements have we achieved?

- Fully implemented and embedded the standardised National Early Warning Score (NEWS) tracker and trigger tool Trust-wide to help determine and prioritise patients' level of illness
- ABCDE (Recognition and management of the deteriorating patient) video produced and published



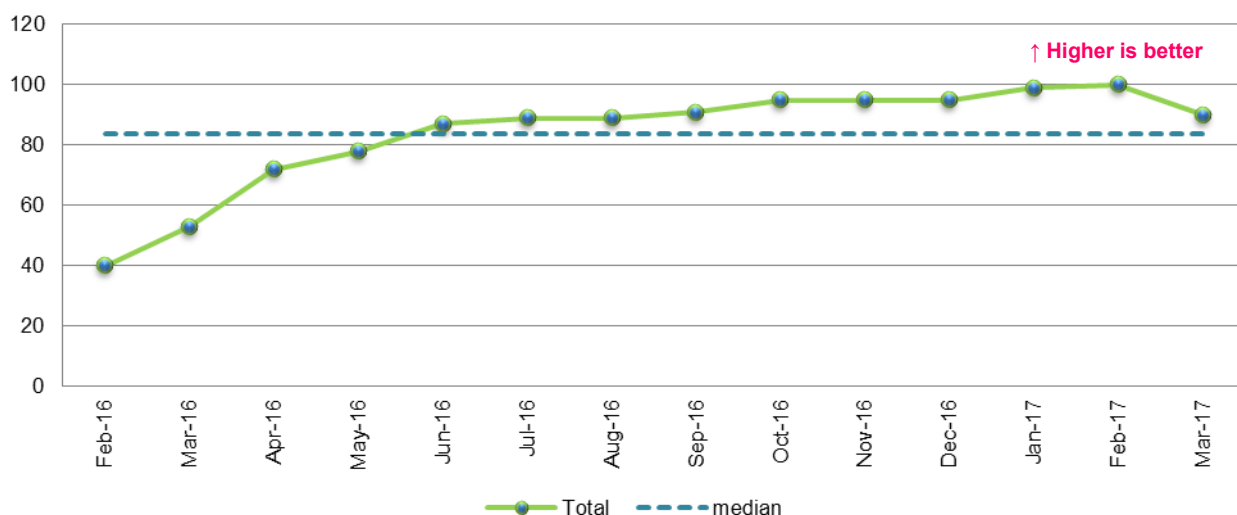
- Introduction of a mandatory on line training tracker module on National Early Warning Score (NEWS) in September 2016, so far have achieved 70% clinical staff who are required to complete this.
- NEWS ward champions identified and trained
- Programme of ward-based simulation training focusing on enhancing skills and knowledge in use of NEWS.
- 24/7 Critical Care Outreach Team launched and trained in January 2017.
- Revised the Deteriorating Patient Policy and Observation Policy

#### Rate of Cardiac Arrests per 1000 hospital admissions



The chart above shows our cardiac arrests per 1000 hospital admissions in comparison to National Cardiac Arrest Audit (NCAA). Whilst we continue to work to reduce the number of cardiac arrests, the chart demonstrates that the Trust's cardiac arrest numbers are fewer than the number that is reported nationally through the NCAA.

#### Percentage of Observations with NEWS Score Calculated Correctly



The chart above shows the percentage of patients Trust wide with a NEWS Score calculated correctly. We have achieved a median of 84% and above from September 2016.

### Further improvements identified and priorities for 2017/18

- The Trust has commenced a project to introduce an electronic observation system for monitoring patients' vital signs/observations.
- Resuscitation team to analyse each cardiac arrest and determine whether the arrest was avoidable or unavoidable.
- Further ward-based simulation training to include training on use of arrest trolleys
- Improved fluid balance monitoring
- Improved application of Treatment Escalation Plans, for patients where cardiopulmonary resuscitation is considered inappropriate.

### Quality Improvement Capability and Capacity

Quality improvement methodology is being used for both Sign up to Safety and Trust wide safety projects. Service improvement skills are beginning to develop within the organisation; we are actively sign posting staff to external providers such as the Academic Health Science Networks for formal QI training.

Many more staff are doing online training and are developing QI skills and expertise through involvement in projects at local and regional level. Six members of staff successfully completed the Improvement Coach training and Quality Improvement Leadership provided by the West of England and Oxford AHSN's respectively.

Four members of staff have completed the Innovating in Healthcare Settings MSC module run by Buckinghamshire University in September 2016. Quality Improvement toolkits have been developed and are available on the Trust Intranet



We are working collaboratively with Oxford Brookes University and the Deanery where health professionals in training are now undertaking service improvement projects whilst on placement within the organisation. We are continuing to develop and implement a coordinated process to ensure that whilst students achieve their objective the organisation benefits from the projects completed. Capturing the change ideas and not losing improvements that can be taken forward.

### Further improvements identified for 2017/18

- Develop a five year plan for organisational QI capability and capacity.

### Celebrating Success

In September 2016 we held our first Speak out on Safety Event. This was a full day event where Martin Bromley, Chair of the Clinical Human Factors Group was a guest key speaker.

The event also covered key quality improvement work streams under our Sign up to safety campaign including Sepsis, Acute kidney Injury and simulation.

Over 75 members of staff and external stakeholders attended the event where staff shared their success stories, safety pledges and the amazing work that they are doing every day.





2.2 Reporting against core indicators



## Continue to reduce our numbers of healthcare associated infections

### *Clostridium difficile*

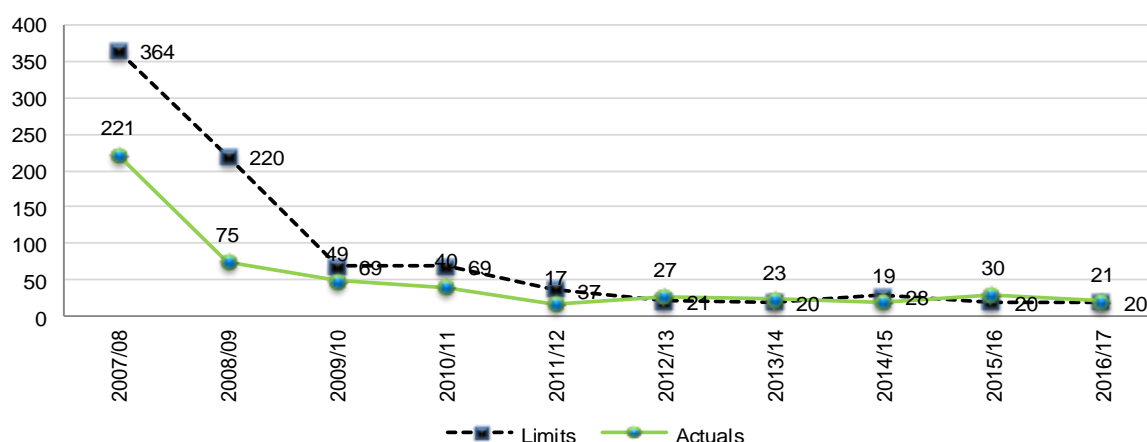
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA, in England it's mandatory for Trusts to report all cases of *Clostridium difficile* (*Cdiff*) to Public Health England.

The nationally mandated goal for 2016/2017 was to report no more than twenty cases of *C.diff*. We have reported twenty one cases, nine less than 2015/2016. Each case has been investigated in conjunction with our Commissioners. Of the twenty one cases, one has been deemed unavoidable with care improvements recommended and nine cases remain pending an investigation outcome.

We have taken the following actions to improve patient safety throughout 2016/2017 including improvements as a result of learning from our investigations and so the quality of its services with the following local initiatives:

- Continuous monitoring of antibiotic prescribing through audit which includes adherence to antibiotic guidelines, recording the duration of the course and indication for their use. The importance of this is to ensure extended courses of antibiotics do not occur as this increases a patients risk to developing *C.diff*.
- Conducting a root cause analysis on each case to identify areas of improvement and sharing the lessons learnt with staff concerned.
- A multi-disciplinary team reviews each inpatient on a *C.diff* ward round weekly to ensure appropriate management.
- Working with 'front door' services for prompt actions when patients attend with unexplained diarrhoea on admission.
- Ensuring our patients are 'isolated' within 2 hours of unexplained diarrhoea being reported
- We have fully implemented our cleaning strategy and the environmental cleaning standards group triangulates housekeeping audits, matron inspections and ward audits, friends and family feedback and managerial audits. This ensures consistency of cleanliness throughout the Trust.
- The assurance framework for cleaning to meet national requirements established with our business partner, Carillion, has ensured that cleaning is delivered at the correct frequency and level for each area. Audit scores are discussed at the environmental cleaning standards group.
- The importance of standard infection control precautions has been reinforced through link worker meetings and IP&C nurse feedback whilst in clinical areas.

## Number of *clostridium difficile* cases 2016/2017



The graph above shows the number of reported *clostridium difficile* cases in 2016/17.

## Our priorities for 2017/18

We plan to continue monitoring and reducing risk factors for *Clostridium difficile*. This includes promoting antibiotic stewardship, rapid isolation and sampling needs to continue with ward/department ownership of local cleaning standards, including patient care equipment all of which is specifically aimed at preventing avoidable cases of *clostridium difficile*.

## Methicillin Resistant *Staphylococcus Aureus* (MRSA)

During 2016/2017 we reported one case of MRSA (acute site attributable) against a national target of zero cases. This was a case where a patient was admitted due to community acquired pneumonia, their admission screen was negative to MRSA colonisation however went on to develop an MRSA bacteraemia.

In addition to the standard practice of screening all emergency and specific categories of elective patients for MRSA, isolating and decolonising patients with positive results, the Trust has taken the following actions to improve patient safety:

- Blood culture contamination rates are reviewed monthly and individual staff practice and competency reassessed when appropriate.
- Management plans for patients with a new positive MRSA result or a history of MRSA.
- Clear focus on preventing any cross contamination between patients and families and investigating cases where necessary.
- Working with our Occupational Health and Wellbeing team to support staff working in high risk areas
- The Sepsis programme continues to provide early diagnosis and management of patients suffering from blood stream infections.

### Acute Cases of Trust Apportioned MRSA Bacteraemia



The graph above shows the number of cases of Trust apportioned MRSA bacteraemia to Great Western Hospitals NHS Foundation Trust up until 2016/17.

### Our priorities for 2017/18

The focus for 2017/18 will be on reducing the numbers of blood culture contamination rates which is recommended to be below 3%. In 2016/17 our rates ranged from 2.4% to 4.5%. We will evaluate the effectiveness of a multidisciplinary approach using Plan, Do, Study, Act (PDSA) aimed at reducing blood culture contamination rates in Emergency Department and across the Trust.

### Patient Safety

### Never Events

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all Never Events to NHS Improvement, National Learning and Reporting System (NRLS) and local commissioners in line with the Never Events Policy and Framework.

Never Events are serious incidents that are wholly preventable. There is guidance or safety recommendations that provide strong systemic protective barriers available at a national level and should be implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not have to be the outcome for an incident to be categorised as a Never Event.

We have reported one never event between April 2016 to March 2017 which is a decrease of two never events reported during the same period in 2015/2016. The following never event was reported in April 2016

- Wrong site surgery – reported in April 2016

The incident has been reported and investigated and managed through the Trusts Incident Management and Clinical Governance structures. An action plan was developed, with implementation monitored by our Patient Quality Committee. A final report for the incident was also shared with our Commissioners, the CQC and Monitor.



The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve the number of Never Events reported and the quality of its services, the actions specifically relate to the wrong site surgery never event reported in April 2016

- Upgraded all imaging computers to enable clinicians to view MedVIEW in all locations
- An Multi-Disciplinary standard operating procedure describing referral process
- Generic tumour specific email account to ensure appropriate management of onward urgent referrals to guarantee they are acted upon in a timely manner.

## Continually learn - Reduce Incidents and Associated Harm

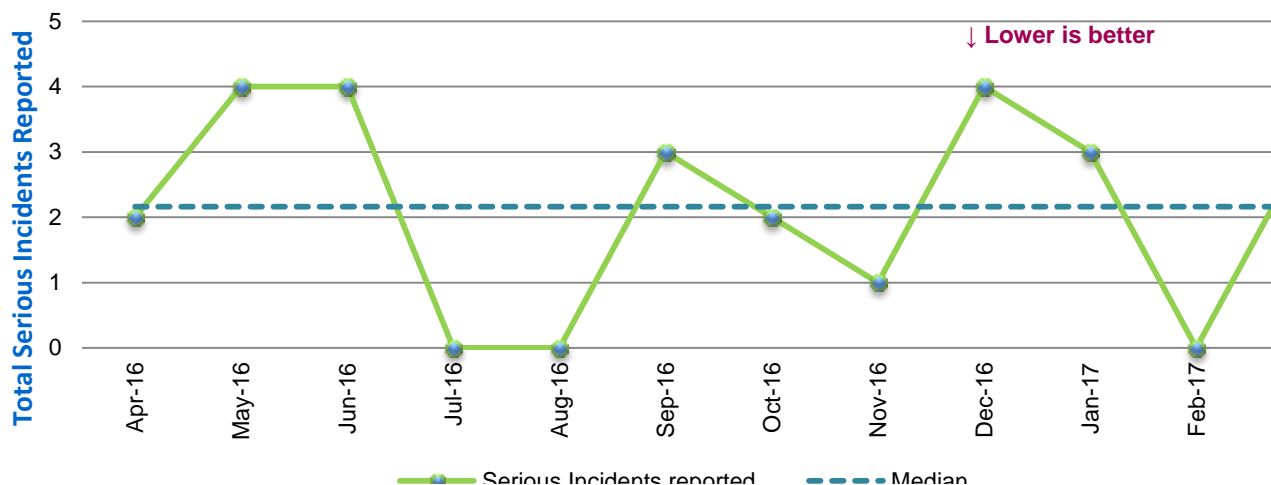
### Serious incident reporting

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all serious incidents their local commissioners and the NRLS in line with the Serious Incident Framework.

A total number of 26 serious incidents were reported and investigated during the period April 2016 to March 2017. This is a reduction of 9 serious incidents reported on the previous year.

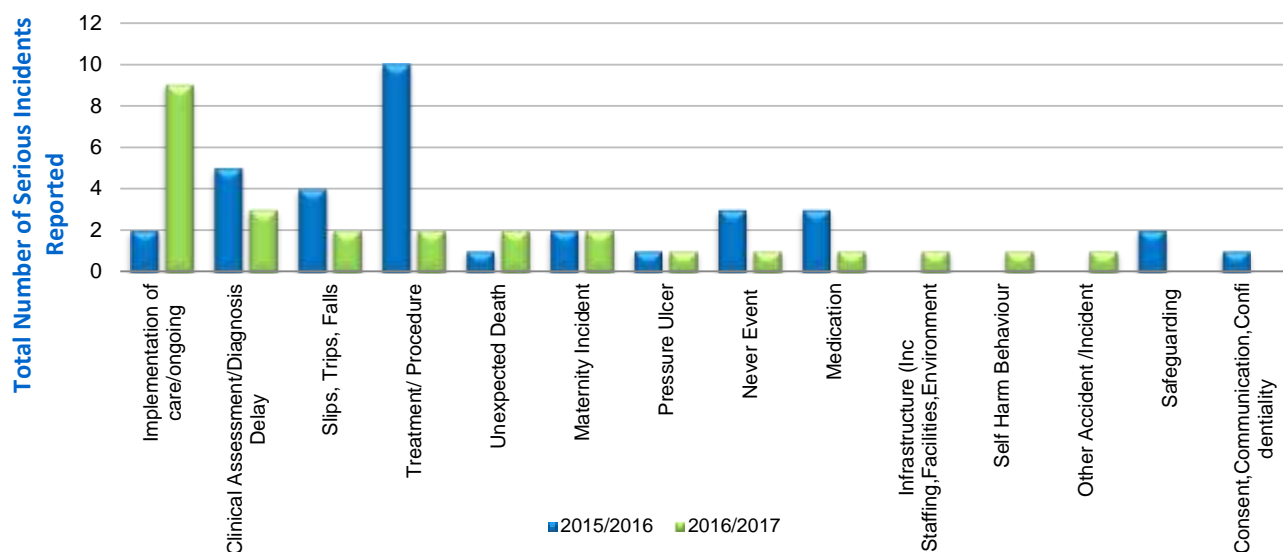
- All patient safety incidents that were reported within the Trust were submitted to the National Reporting and Learning System. Our reporting performance is evaluated against other medium acute Trusts within the cluster group biannually following the publication of the NRLS Organisational reports.
- All Serious Incidents were reported to our Clinical Commissioning Groups and to the Strategic Executive Information System (STEIS) system.

### Serious incidents reported 2016//17



The graph above shows the number of serious incidents reported in 2016/2017.

### Serious incidents reported by type in 2015/2016 and 2016/2017.



The graph above shows the Trust's serious incidents reported by in 2016/17 compared to 2015/2016 broken down by category.

The most frequently reported types of serious incident are:-

- Implementation of Care and treatment and Procedure, which includes recognition and rescue of the deteriorating patient
- Problems with clinical assessment, which includes delays in diagnosis, interpretation and response to diagnostic procedures and tests

The increased number of incidents involving recognition and rescue of the deteriorating patient is due in part to improved reporting. The Trust-wide campaign to improve the use of National Early Warning Score (NEWS) has raised awareness of the deteriorating patient. During 2016/17 we reviewed serious incidents and incidents that had contributing factors involving recognition and management of the deteriorating patient to identify commonalities which directly informed the Deteriorating Patient Quality Improvement project.

We disseminated learning from incidents involving clinical assessment, diagnosis, and treatment to all speciality groups and Clinical Governance Leads where assessment and relevance of recommendations from all incidents have been shared to ensure that appropriate actions were taken to improve similar processes in their own departments.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the number of serious incidents reported and the quality of its services, by

- Continue to theme incidents to identify key trends that could influence change which will be shared through all quality improvement work streams to inform work stream initiatives.
- We will continue to share recommendations and learning from serious incidents Trust-wide which inform improvements to systems and processes within specialities.

## Incident reporting and benchmarking

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all patient safety incidents to the National Reporting and Learning System (NRLS).

The Trust uploads all reported patient safety incident forms to the (NRLS) on a daily basis. The number of incidents we have reported in the last 5 years are as follows:

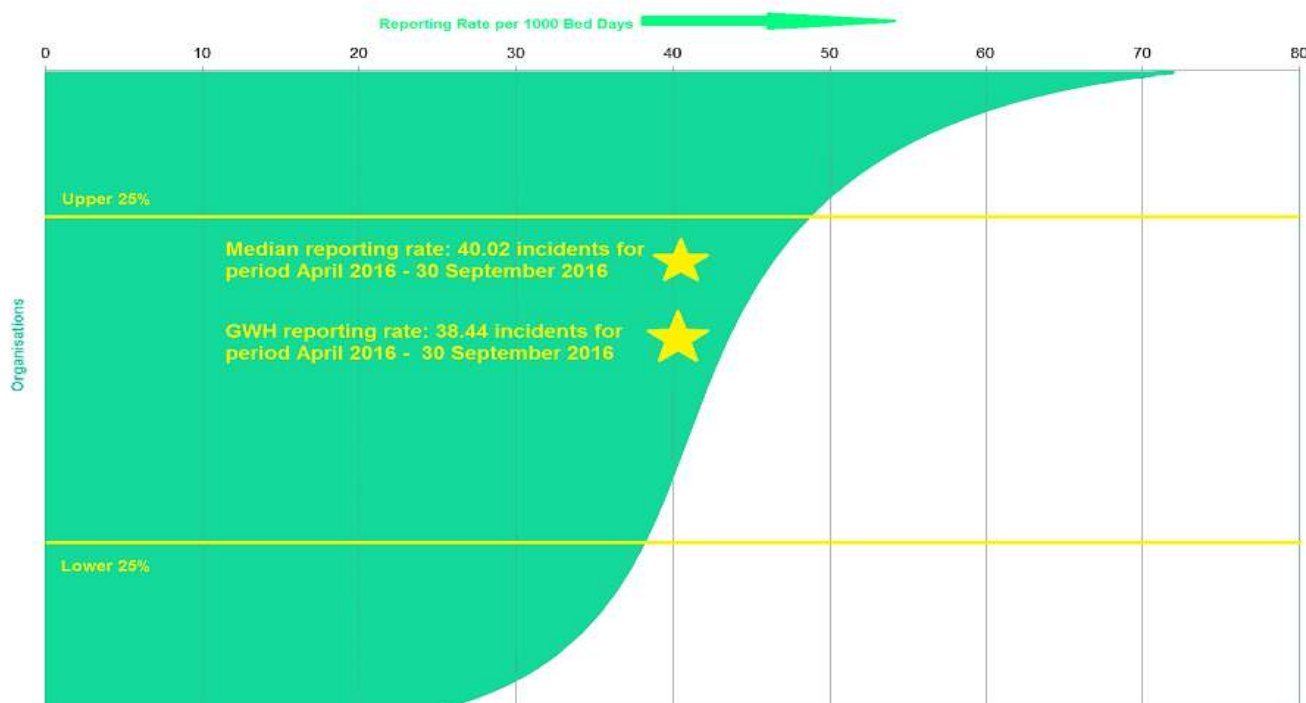
Reporting Year	Non clinical incidents / Health and Safety	Patient Safety Incidents reported to NRLS	Total
2011/2012	2493	6513	9006
2012/2013	2405	6928	9333
2013/2014	3596	6967	10563
2014/2015	4164	6678	10842
2015/2016	4801	6274	11075
2016/2017	4457	8373	12830

## How do we compare with other organisations?

NHS England National Reporting and Learning System (NRLS) release an Organisational Patient Safety Incident report twice a year providing organisational and comparative incident data. The report from NRLS containing incident data from 1st April 2016 to 30th Sept 2016 was published on 31st March 2017.

## Comparative reporting rate per 1000 bed days for 136 acute (non-specialist) organisations

1<sup>st</sup> April 2016 – 30<sup>th</sup> September 2016



The Trust reported 3657 incidents between 1st April 2016 to 30th September 2016 with a rate of 38.44 per 1000 bed days. The median reporting rate for this cluster is 40.02 incidents per 1000 bed days.



The Trusts reporting rate has increased from the previous reporting period 1st October 2015 to 31st March 2016 when 28.52 incidents per 1000 bed days were reported and we were located within the lower 25% of reporters. During 2016/17 we focussed activity on improving our reporting culture with rebranding our incident reporting from IR1's to Safety Incident Forms. We reviewed feedback mechanisms ensuring learning is shared with individual reporters and Trust-wide.

We also developed a safety video involving a range of staff across the Trust on the benefits and importance of reporting safety incidents and obtaining feedback to aid learning with individual reporters and trust-wide.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the reporting of all safety incidents and the quality of its services, by

- Delivering incident awareness road shows throughout the year Trust-wide, to promote the benefits of incident reporting which can have positive impacts on improving patient safety.
- To continue to review and embed all types of feedback mechanisms which aids the sharing of learning from all incidents to individual reporters as well as teams and trust-wide.
- Safety incident video's about individual investigations to aid shared learning and promote awareness Trust-wide.

## Duty of Candour

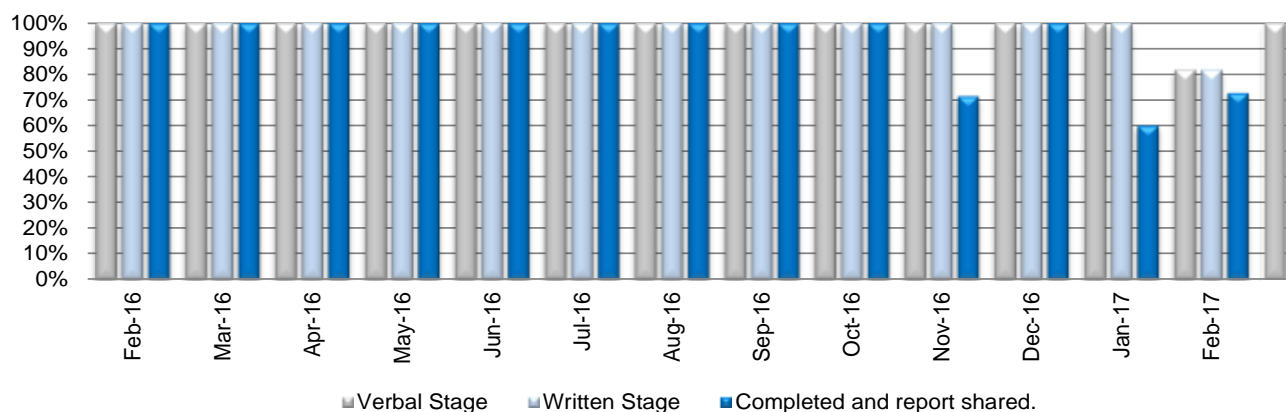
Duty of Candour is a legal duty which came into force in April 2015. As a trust we are legally obliged to inform and apologise to our patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help our patients receive accurate, truthful information and providing reasonable support and an apology when things go wrong. Errors occur at the best hospitals and clinics - despite the best efforts of talented and dedicated professionals.

Duty of candour means 'being open' as soon as possible after an incident:

- Informing the patient or their family that an incident has occurred
- Acknowledging, apologising and explaining the incident – and confirming this in writing
- Providing information
- Providing reasonable support
- Inform the patient in writing of the original notification and the results of any further enquiries.
- Saying sorry is not an admission of liability and is the right thing to do.

## How are we implementing Duty of Candour?

### Compliance with each stage of Duty of Candour



The graph above shows the compliance at each of the three stages of Duty of Candour. Some cases are still currently under investigation and will be shared with the patient, family or relatives upon completion.

To continue to improve on Duty of Candour and the support we provide to our patients, their family and relatives following errors, the following improvements have been put in place:-

- Revised Duty of Candour (Being Open Policy)
- Duty of Candour E-Learning training tracker released in June 2016, all new employees are required to complete the training after induction. The Trust's compliance is currently recorded as 88.88%.
- The Trust's incident reporting system allows us to record Duty of Candour against individual incidents
- Template letters embedded into the incident reporting system to support managers.
- Data extraction facility within the Trust's incident reporting system, which enables us to record and monitor compliance with all significant harm cases. This facility helps to identify any areas of non-compliance.
- The Duty of Candour leads and division are then supported to complete the required elements
- Duty of Candour compliance is monitored at divisional level and within the Patient Safety and Clinical Risk Team with any exceptions reported to divisional boards and our Patient Quality Committee.

### Priorities for 2017/18

- Four one day Root Cause Analysis training sessions including Duty of Candour training.

### Venous Thromboembolism (VTE) risk assessment and hospital acquired thrombosis events

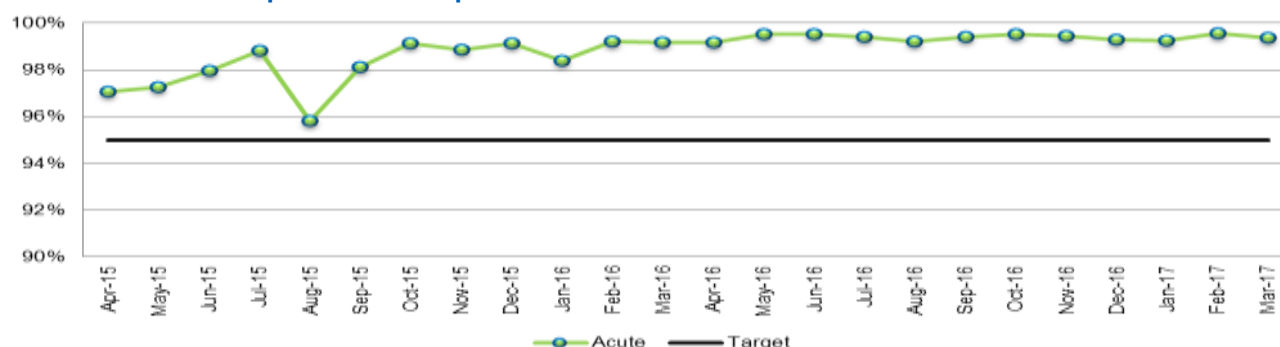
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because data is collated in a variety of ways including the electronic prescribing system and compared to the total number of admissions during any given month. For clinical areas that do not use the electronic system, manual collation is used and validated by the lead for VTE and the informatics team. This validation is undertaken bi-monthly and information disseminated to all clinical areas so that any performance requiring review is highlighted.

All adult patients who are admitted to our trust should undergo a risk assessment to determine their risk of developing a VTE related episode (For example a blood clot such as deep vein thrombosis (DVT) or pulmonary embolus (PE)).

The national target is set at 95%, which means that at least 95% of patients admitted to hospital should be risk assessed on admission.

A weekly bulletin has been implemented which enables clinical teams to have more up-to-date information to look closely at the performance of individual areas and support them in achieving the target. We can now easily access data via our electronic prescribing system which is in place on the majority of the wards at our acute site. The system allows us to produce reports that can identify which patients have had a risk assessment and what time this was undertaken.

### VTE risk assessment performance April 2015 – March 2017



The graph above shows the Trust's VTE Risk Assessment performance, we have consistently achieved above 99% for 12 months.

### Appropriate prevention and hospital acquired thrombosis events

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to maintain this score and so the quality of its services, by continuing to ensure that the processes in place that help us to achieve our target are maintained and provide high quality care for our patients in preventing blood clots whilst they are hospitalised.

- Once patients have had a risk assessment we want to ensure that they receive the appropriate preventative treatment. We monitor this using a national audit tool called the "safety thermometer". This looks at all patients in the hospital on one day each month and checks for a number of patients on each ward that have a VTE risk assessment and how many patients receive the appropriate preventative treatment. We currently give appropriate preventative treatment to 90-95% of patients.
- For all hospital acquired thrombosis events we carry out a root cause analysis first to make sure that a risk assessment has been carried out and also if the patient received the treatment they should have. If part or either of these points have not been done then a more detailed root cause analysis is carried out to determine why and to make sure that we learn from the findings to help prevent the same thing happening again.
- Some cases are unavoidable and these are documented which allows us to look at certain specialities where we need to consider providing more preventative treatment for longer.

## Effective Care

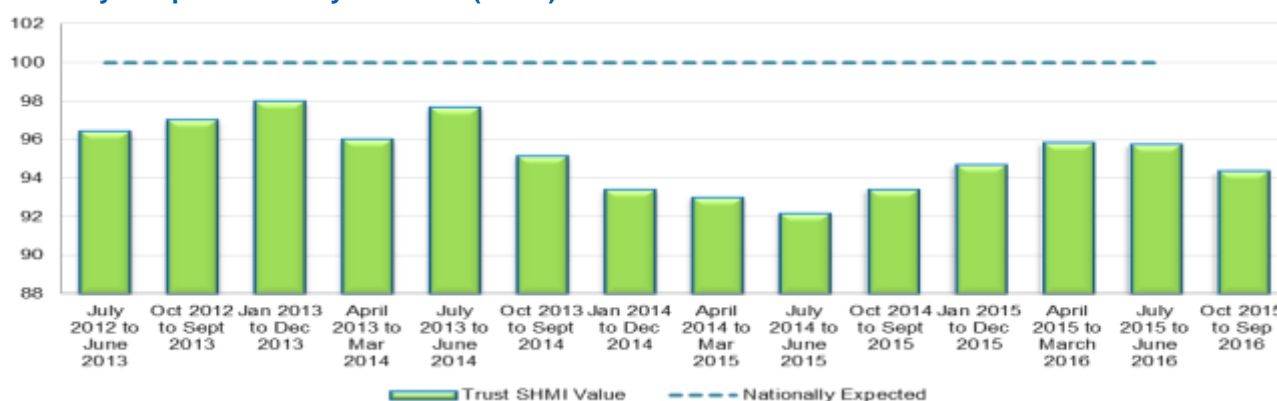
### Summary Hospital Mortality Indicator (SHMI)

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 the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

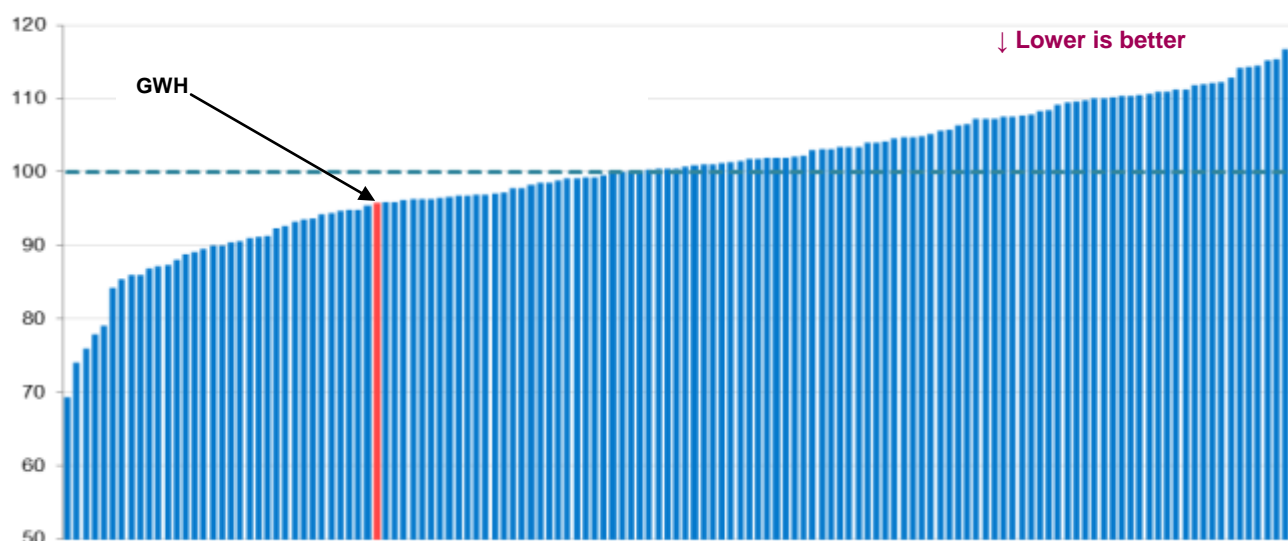
The Trust's SHMI for the rolling 12 month period of October 2015 to September 2016 is 94.34, giving the Trust a 'Better Than Expected' rating. The SHMI for this period is lower (better) than the nationally expected value of 100, and is similar to the previous 12 month period (April 2015 to March 2016). This is showing a similar trend to the HSMR figures.

### Summary Hospital Mortality Indicator (SHMI) GWH



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

## National SHMI October 2015 to September 2016



The chart above shows how the Trust's SHMI compares nationally and demonstrates the Trust was positioned within the lower (better) half overall between October 2015 and September 2016. The red line depicts GWH, and the green horizontal line is the nationally expected norm.

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

- The data is reviewed on a monthly basis by the Trust Mortality Group and the Patient Quality Committee
- The data is included in the Trust quality and performance dashboards which are reviewed by the Trust Executive Committee and Board as well as relevant CCG Committees
- It is a key indicator of the quality of care we provide
- This indicator is produced and publicised by the HSCI

## Hospital Standardised Mortality Rate (HSMR)

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

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

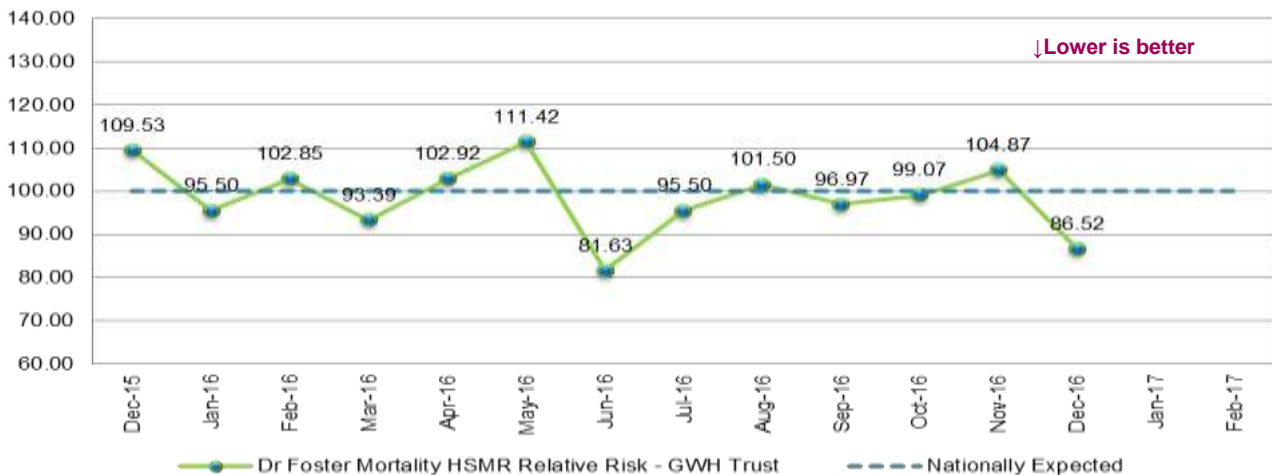
In 2014 the Trust set a target to reduce our mortality rates measured by HSMR (Hospital Standardised Mortality ratio) and to be one of the Trusts with the lowest HSMR value. We remain on our schedule to deliver this improvement. Our continued work has resulted in a lower number of deaths and we have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

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

- The data is sourced from Dr Foster and is widely used in the NHS
- The data is refreshed on a monthly basis

- The data is reviewed on a monthly basis by the Trust Mortality Group and the Patient Quality Committee
- The data is included in the Trust quality and performance dashboards which are reviewed by the Trust
- 
- Executive Committee and Board as well as relevant CCG Committees
- It is a key indicator of the quality of care we provide

### Trust HSMR Trend December 2015 December 2016

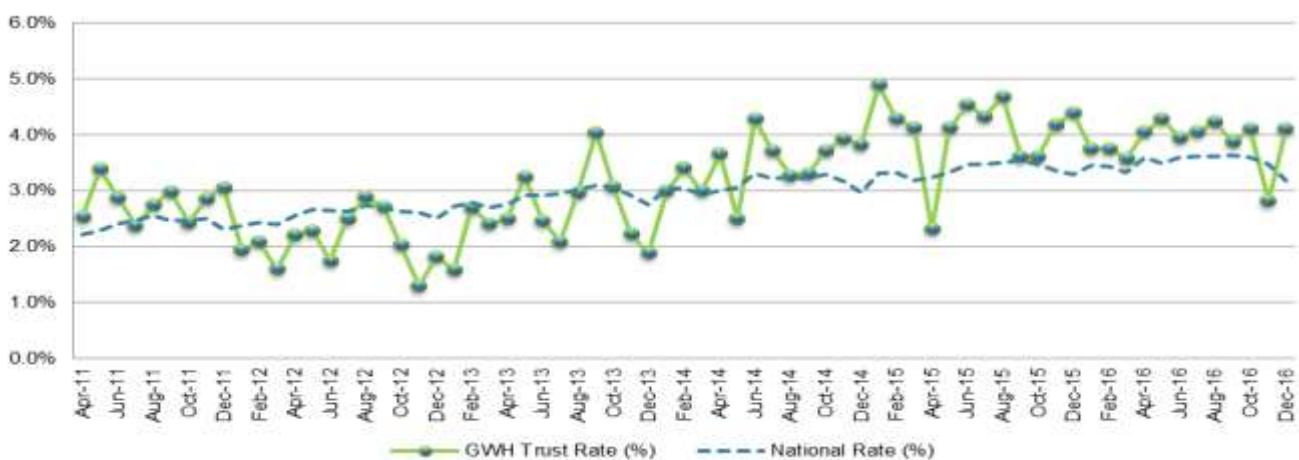


The graph above shows the year on year HSMR following rebasing. This shows a general improvement over time.

### Palliative Care – Coding Levels

Palliative care is the holistic care of a patient who has been diagnosed with a life limiting illness with the goal of maintaining a good quality of life until death. By definition patients receiving palliative care have a higher risk of in-hospital death than that of non-palliative patients. Trusts which provide specialist palliative care services have a higher proportion of patients admitted purely for palliative care rather than treatment compared to Trusts without specialist services. To account for this, the Hospital Standardised Mortality Ratio (HSMR) adjusts for patients who have received specialised palliative care when calculating the expected risk of death of a patient.

### Percentage palliative care Coded Spells (HSMR Basket Only) to December 2016



The charts above shows the levels of Palliative Care coding against the national average since April 2011. The GWH Trust rate is expected to follow the national rate.

For the period December 2012 through to the end of 2013 the level of Palliative Care coding was generally below the national rate, but since early 2014 there has been a marked improvement in the levels of coding and the Trust is now above the national average.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to continue to improve the effectiveness of care and so the quality of its services by:

### Priorities for 2017/18

- Our Trust Mortality Group will continue to review a range of Dr Foster mortality indicators each month and investigate Dr Foster mortality alerts as well as agreeing any other investigations or initiatives prompted by the data and trends.
- The Trust will introduce the new National process of standardised mortality reviews which was launched in April 2017. This will include the development of a local policy for mortality review and quarterly reporting to the Trust Board from October 2017
- We will continue to develop our work on sepsis and acute kidney injury which is estimated to save approximately 100 lives per quarter. We will also introduce electronic recording of vital signs to improve recognition of deteriorating patients and escalation of treatment. This type of system has improved mortality rates by up to 10% in other hospitals. The aim of this work is to improve care in ways that reduce HSMR and SHMI values and to help deliver our ambition to save an additional 500 lives by 2019.

### Patient Reported Outcome Measures (PROMS)

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

The Trust takes part in PROMS which measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England. This data and information is gathered via responses to questionnaires before and after surgery to assess their condition following surgery and whether it has improved. An independent company analyses the questionnaires and reports the results to NHS Digital; this data is then benchmarked against other Trusts.

Our provisional PROMS report shows that there has been an overall improvement on the scores for 2016/17 in particular hip and knee replacement surgery.

It is a recognised challenge within the Trust to report on contemporary data; this is due to the verification process for PROMS data, which results in finalised data being reported 12 months in arrears.

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

- Reviewing other formats and processes for recording and measuring patient outcomes to support on-going improvements.

### Referral to Treatment 18 weeks (RTT)

During 2016/17 the Trust's performance for waiting times for planned surgery has continued to be a focus and has built on the significant work undertaken during 2015/16. The Referral to Treatment national standard for patients waiting for treatment is that at least 92% of patients should have been waiting for 18 weeks or less from referral to definitive treatment; this takes into account that some patients will have complex treatments or choose to wait longer.



The Great Western Hospitals NHS Foundation Trust considers that this data is as described because RTT performance has significantly increased and the 92% target has been achieved for seven out of twelve months during 2016/17.

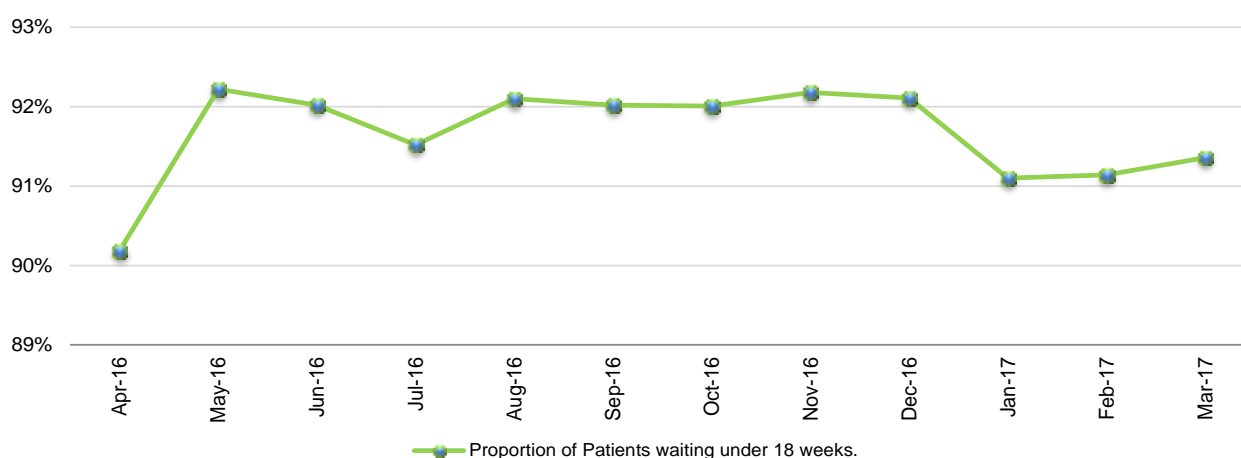
From April 2016 around 90% of patients were waiting less than 18 weeks. Throughout the year there has been a sustained effort to improve this position. This has included undertaking increased clinic and operating activity in a range of specialties where waiting times were longer than required. This activity has included some patients being treated by other providers.

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

- Increased collaborative working between the operational and informatics teams, with new monthly validation processes introduced to ensure robust and accurate data reporting.
- An updated Elective Access Policy has been released and is continuing to be embedded with the teams to ensure standardised booking and choice processes are followed throughout the Trust.

Although performance reduced to just above 91% in January 2017 as a result of pressures related to escalation, the Trust is anticipating that the 92% position will be recovered and the sustainable achievement of the 92% standard will continue during 2017/18.

#### RTT Performance waiting time for patients still waiting (incomplete pathways)



#### A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because for the period 2016/17 Accident and Emergency Department achieved 75.9%, of patients having a maximum of 4 hours wait. The target was also not achieved as a Trust at 83.5% or as a Trust including the Urgent Care Centre (UCC) at 86.6%

The Trust has adopted nationally recognised approaches to improve the flow of patients through the hospital, which should help to improve performance against the 4 hour Accident and Emergency Department target. Health and Social Care services across Swindon and Wiltshire are under great pressure and this is recognised by health regulators NHS Improvement.

The Trust has proposed the levels of achievement it expects to deliver in 2017/2018 and a trajectory has been submitted to NHS Improvement but this has not yet been confirmed.

- Q1 – 85.7%
- Q2 – 88.3%
- Q3 – 80.0%
- Q4 – 78.3%

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this performance and so the quality of its services by delivery of the GWH 4 Hour Acute Service Remedial Action Plan (RAP) incorporating recommendations made by the Care Quality Commission with actions being assigned to the following project areas;

- Effective patient streaming using all front door departments to ensure patients are seen by the appropriate teams on arrival to the organisation
- Better back door discharge processes to ensure patients are clinically optimised for discharge as soon as possible with better support both internally and externally to support that discharge

Through the 4 hour RAP and investment into resources to improve front door services of the organisation we anticipate to be able to sustain an acceptable 4 hour position throughout 2017/18 as well as reducing times of extreme escalation for the Accident and Emergency Department and the Trust as a whole.

## Review of patients readmitted to hospital within 30 days of discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because in previous years we have carried out annual audits on patient readmissions within 30 days of being discharged in order to identify if anything could have been done to better prevent patients being re-admitted, especially if their readmission is related to their previous condition.

The Trust has not undertaken an annual audit in 2016/17. However we have continued to audit readmissions via a monthly dashboard. The current readmission data for 2016/17 suggests that the Trust position in relation to readmission remains relatively static when compared to the previous year.

Previous audits have suggested that certain specialities have a higher readmission rate than others in particular endocrinology and cardiology. However, this data and that of all specialities has yet to be compared to national averages which could provide better comparison of the Trust's position. Therefore, the annual audit is due to be reinstated with revised methodology in 2017/18.

The revised annual audit methodology will allow for a more rigorous quality improvement project and focused actions on specific cohorts of high risk patients.

## Monthly 28 day readmission by age group

**Outline:** These figures are based on the crude emergency re-admissions within 28 days of the original date of discharge. These figures are considered to be crude as they take no account of the original discharge specialty (or condition, diagnoses & procedures) nor the reason (or specialty & diagnoses) for re-admission. The age is calculated from the date of the original discharge

Month of Original Discharge	Total Spells			Readmission Within 28 Days			Readmissions Percentage Within 28 Days		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 16	971	5536	6507	90	497	587	9.3%	9.0%	9.0%
May 16	951	5779	6730	84	560	644	8.8%	9.7%	9.6%
Jun 16	982	5903	6885	94	590	684	9.6%	10.0%	9.9%
Jul 16	900	5840	6740	66	571	637	7.3%	9.8%	9.5%



Aug 16	830	5878	6708	76	563	639	9.2%	9.6%	9.5%
Sep 16	936	5881	6817	86	592	678	9.2%	10.1%	9.9%
Oct 16	1074	5986	7060	110	545	655	10.2%	9.1%	9.3%
Nov 16	1081	6025	7106	108	585	693	10.0%	9.7%	9.8%
Dec 16	962	5612	6574	77	530	607	8.0%	9.4%	9.2%
Jan 17	953	5794	6747	115	585	700	12.1%	10.1%	10.4%
Feb 17	897	5260	6157	75	484	559	8.4%	9.2%	9.1%
Mar 17	949	6125	7074	85	583	668	9.0%	9.5%	9.4%
<b>2016/17</b>	<b>11486</b>	<b>69619</b>	<b>81105</b>	<b>1066</b>	<b>6685</b>	<b>7751</b>	<b>9.3%</b>	<b>9.6%</b>	<b>9.6%</b>

### Monthly 30 day readmission by age group

**Outline:** These figures are based on the crude emergency re-admissions within 30 days of the original date of discharge. These figures are considered to be crude as they take no account of the original discharge specialty (or condition, diagnoses & procedures) nor the reason (or specialty & diagnoses) for re-admission. The age is calculated from the date of the original discharge

Month of Original Discharge	Total Spells			Readmission Within 30 Days			Readmissions Percentage Within 30 Days		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 16	971	5536	6507	91	502	593	9.4%	9.1%	9.1%
May 16	951	5779	6730	89	570	659	9.4%	9.9%	9.8%
Jun 16	982	5903	6885	94	607	701	9.6%	10.3%	10.2%
Jul 16	900	5840	6740	67	583	650	7.4%	10.0%	9.6%
Aug 16	830	5878	6708	77	572	649	9.3%	9.7%	9.7%
Sep 16	936	5881	6817	88	602	690	9.4%	10.2%	10.1%
Oct 16	1074	5986	7060	111	558	669	10.3%	9.3%	9.5%
Nov 16	1081	6025	7106	112	594	706	10.4%	9.9%	9.9%
Dec 16	962	5612	6574	80	541	621	8.3%	9.6%	9.4%
Jan 17	953	5794	6747	115	596	711	12.1%	10.3%	10.5%
Feb 17	897	5260	6157	75	492	567	8.4%	9.4%	9.2%
Mar 17	949	6125	7074	86	591	677	9.1%	9.6%	9.6%
<b>2016/17</b>	<b>11486</b>	<b>69619</b>	<b>81105</b>	<b>1085</b>	<b>6808</b>	<b>7893</b>	<b>9.4%</b>	<b>9.8%</b>	<b>9.7%</b>

## Medicines Safety

### Inappropriate Omitted Medication

When patients are admitted to our wards an electronic prescription is provided to cover the majority of the patient's requirements. This includes both medicines for the acute episode of treatment and those which they would take routinely, prior to their admission. During the patient's stay these medicines will be administered as appropriate for the patient's immediate condition. This means that not all medicines which are prescribed will be administered. The omitted dose audit looks at the number of doses that have been omitted, to check if a reason for the omission has been provided and the actions taken to mitigate the issue. Critical medicines are those medicines with a higher risk of causing harm if omitted and in these circumstances the doctor should always be informed.

### Missed Dose Audit April 2017

The National Patient Safety Agency (NPSA) rapid response report on omitted and delayed medicines in hospitals guides organisations to identify a list of critical medicines where timeliness of administration is crucial.

It is intended as an aid to support a local list and is not intended as a replacement.

The NPSA also provides a series of actions which may help Trusts to reduce the number of omitted doses.

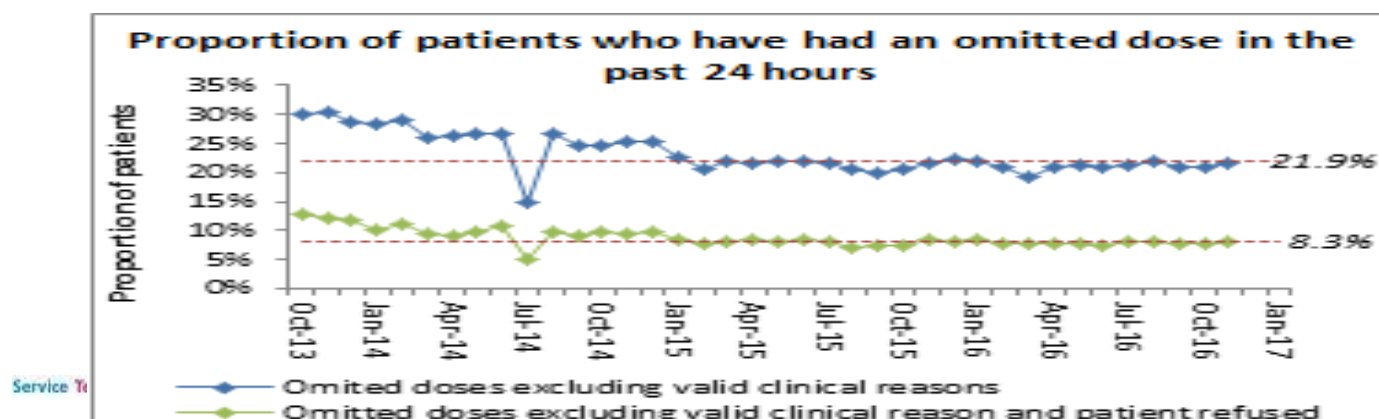
The chart below shows the number of medication administrations that have been prescribed for patients on the ward for a single day as captured on the electronic prescribing system (EPMA) . The third column gives the number of medicine doses which have been omitted for a 24hr period and the fourth column the percentage of which were for critical medicines.

Ward	Total number of administrations	Number of inappropriately omitted doses	Number of inappropriately omitted doses of critical medicines	Percentage of inappropriately omitted doses (%)	Percentage of inappropriately omitted doses of critical medicines (%)
Aldbourn	445	2	0	0.45	0.00
Ampney	491	4	2	0.81	0.41
Beech	363	7	3	1.93	0.83
Cardiology	228	3	2	1.32	0.88
Dove	201	7	5	3.48	2.49
Falcon	473	2	0	0.42	0.00
Jupiter	2226	9	4	0.40	0.18
LAMU	746	14	8	1.88	1.07
Meldon	643	10	6	1.56	0.93
Mercury	1146	5	2	0.44	0.17
Neptune	738	2	2	0.27	0.27
Saturn	682	10	2	1.47	0.29
SAU	334	0	0	0	0.00
Shalbourne	251	12	3	4.78	1.20
Teal	906	4	2	0.44	0.22
Trauma	1310	11	0	0.84	0
Woodpecker	583	30	4	5.15	0.69
Trust Wide	11766	132	45	<b>1.12%</b>	0.38%

These results compare favourably with the National Data given in the graph below from the NPSA medicines Safety Thermometer **1.12%** versus 8.3% nationally.

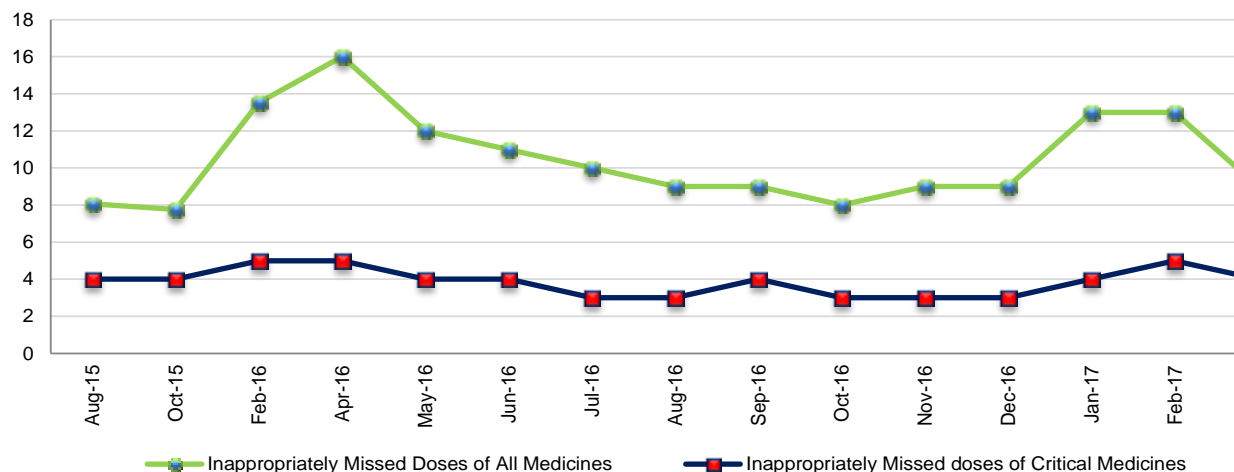
The National Data is provided below on the medication Safety Thermometer Dashboard.

#### Medications Safety Thermometer Dashboard



The graph above shows national data from the NPSA Medicines Safety Thermometer

### Average Number of Inappropriately Missed Doses per ward (24hr Snap Shot)



The chart above shows the average number of Inappropriately Missed Doses per Ward (24 snap shot)

Activities that are highlighting and reducing missed doses include

- Prompt feedback from the audit to the ward manager providing the name on the patient, medicine and nurse administering medication during the session. This has encouraged immediate training and support on appropriate actions to reduce omitted doses
- Provision of a missed dose action card attached to the medicine trolley keys to aid the appropriate action and support the reduction in missed doses.

### Missed dose toolkit on intranet to aid administration and support nurse training

A series of tools have been shared through the Specialist Pharmacy Service Patient Safety Sub-committee from NHS Improvement and we work through these to identify those that would be appropriate to test within GWH

### Improving patient experience & reducing complaints

The Friends and Family Test is commissioned nationally by NHS England. All providers of NHS-funded services are required to offer the Friends and Family Test (FFT) to all patients that have been cared for or have used a GWH service at the point of discharge from hospital.

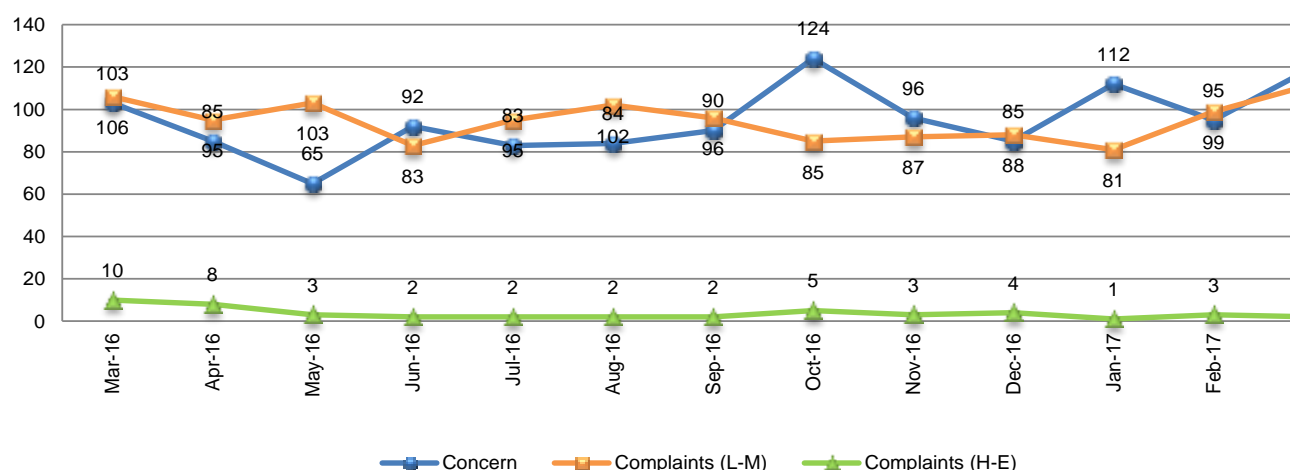
Throughout 2016/2017 95%-97% of patients responding would recommend our services to their Friends and Family if they required hospital treatment. Fewer patients are given the opportunity to provide feedback via FFT than we would like. During 2017/2018 we plan to make improvements by offering alternative methods, i.e. text messaging and feedback kiosks

We have improved our communication and services provided to patients where English is not their first language, we have enhanced our services provided to the deaf community ensuring that information and interpreters are available to assist.

We have reviewed our Patient Information Leaflets ensuring that the information provided is easy to understand and also is also available in various languages at request. We have achieved this by having a patient focused reading group to ensure that information is accessible and up to date at all times.

We aim to resolve any concerns and complaints satisfactorily and in a timely manner. Every effort is made for any worries or fears to be resolved through the concerns process within 48 working hours by the PALS team.

### Complaints received in 2016/17



The graph above gives a comparison on concerns/complaints received over a 12 month period towards the end of 2015/16 and 2016/17

Changes throughout 2016/2017 included:

- New approaches ensure that learning takes place and changes are made as an overall outcome to complaints raised.

### National Inpatient Survey

Following the National Inpatients Survey 2015 results, published in 2016, the Trust agreed priorities for focussed improvement including

- Communication,
- Discharge Planning,
- Hospital, Care, Overall

Clinical Divisions developed plans to drive improvements in these areas. The subsequent National Inpatient Survey 2016 showed improvements were achieved in some areas.

Results of the Picker Inpatient Survey 2016 against the Trust Priorities agreed from the 2015 Picker Inpatient results and presentation are set out below.

*Lower scores are better*

Communication		2015	2016	Status
Q34	Staff contradict each other	38%	32%	Improved
Q38	Could not always find staff member to discuss concerns with	67%	68%	Worse
Q37	Not enough (or too much) information given on condition or treatment	23%	22%	Improved
Q39	Not always enough emotional support from hospital staff	50%	44%	Improved
Q35	Wanted to be more involved in decisions	48%	49%	Worse
Q36	Did not always have confidence in the decisions made	32%	28%	Improved
Q51	Anaesthetist / other member of staff did not fully explain how would put to sleep or control pain	19%	12%	Improved
Q52	Results not explained in clear way	37%	30%	Improved
Q25	Doctors: did not always get clear answers to questions	39%	31%	Improved

Q27	Doctors: talked in front of patients as if they were not there	27%	25%	Improved
Q28	Nurses: did not always get clear answers to questions	37%	37%	Same
Q75	Not asked to give views on quality of care	77%	75%	Improved
Q76	Did not receive any information explaining how to complain	65%	68%	Worse

Lower scores are better

Discharge Planning		2015	2016	Status
Q53	Did not feel involved in decisions about discharge from hospital	50%	44%	Improved
Q55	Discharge was delayed	48%	45%	Improved
Q61	Not given any written/printed information about what they should or should not do after leaving hospital	41%	40%	Improved
Q62	Not fully told purpose of medications	35%	29%	Improved
Q63	Not fully told side-effects of medications	70%	65%	Improved
Q64	Not told how to take medication clearly	34%	26%	Improved
Q65	Not given completely clear written/printed information about medicines	34%	29%	Improved
Q66	Not fully told of danger signals to look for	65%	64%	Improved
Q68	Family not given enough information to help	57%	54%	Improved
Q69	Not told who to contact if worried	25%	25%	Same

Lower scores are better

Hospital, Care, Overall		2015	2016	Status
Q23	Not offered a choice of food.	27%	28%	Worse
Q38	Could not always find staff member to discuss concerns with.	67%	68%	Worse
Q75	Not asked to give views on quality of care	77%	75%	Improved
Q76	Did not receive any information explaining how to complain.	65%	68%	Worse

The 2016 survey results have highlighted the many positive aspects of the patient experience:-

Q38, Q75 and Q76 are duplicate questions appearing in Communication and Hospital, Care & overall.

- Overall: 83% rated care 7+ out of 10.
- Overall: treated with respect and dignity 80%.
- Doctors: always had confidence and trust 80%.
- Hospital: room or ward was very/fairly clean 97%.
- Hospital: toilets and bathrooms were very/fairly clean 92%.
- Care: always enough privacy when being examined or treated 90%.

### Our Priorities 2017/18

- A Quality Improvement project to commence to reduce the number of patients complaints and incidents in relation to handover of care between clinicians
- Analyse our National Inpatient Survey results for 2016 in the same format, and develop additional Trust Continue to be a voice for patients and be a valuable service to resolve concerns locally avoiding escalation through the complaints handling process.
- There has been on-going work during 2016/2017 to lay the foundations for the Patient Experience strategy. This will be presented to the board by September 2017 This will include a work programme that can be embedded within an agreed timeframe and will have sought engagement with patients, carers, front line staff, and stakeholders.

## Staff Survey 2016/17

We recognise that our staff are our greatest asset. Every single person who works for us plays an invaluable role in providing the high quality care and excellent service that we strive for. We know that when our staff have positive experiences at work, our patients also have positive experiences and, therefore, we are keen to hear from our staff about what it is like to work for us and what we can do to make things better.

The NHS Staff Survey is an important source of information about what it is like to work in the health service in England. The survey involves 316 NHS organisations from across the country and achieves over 423,000 responses. The NHS Staff Survey is understood to be the largest workforce survey anywhere in the world and offers unparalleled insight into staff experiences. As one of the 316 participating NHS organisations, in October 2016 the Trust randomly selected 1250 employees to complete the 2016/17 NHS Staff Survey, this is an increased sample size from last year (850 in 2015).

603 of those employees selected, returned a questionnaire giving the Trust a 49% response rate which is an improvement from last year (43% in 2015) and above the national average for combined acute and community Trusts in England.

### National and Regional comparisons

#### National

The latest NHS Staff Survey results demonstrate a positive improvement in terms of staff experience and engagement despite the numerous challenges currently facing the NHS and its workforce.

Nationally, staff engagement has improved continuously over the last five years and this year has also seen an improvement in the overall willingness of staff to recommend the NHS as a place to work or be cared for.

Despite the extreme pressures that the NHS is under, nearly three quarters of the Trust staff remain enthusiastic about their job, the majority of frontline staff (80%) report that they are able to do their job to a standard they are personally pleased with and 90% of staff stated that their job makes a difference for patients. Generally staff reported feeling that managers are invested in their health and wellbeing with a significant proportion of staff stating that their immediate manager takes an interest in their health and wellbeing (67%).

The majority of our staff feel that their organisation takes positive action on the health and wellbeing of staff (90%). In addition to this, the percentage of staff witnessing potentially harmful incidents is at its lowest in five years and the percentage of staff able to report those concerns is at its highest in six years.

As is to be expected in such pressured working environments, the survey does highlight some areas of staff concern, with only 52% of staff feeling satisfied with the opportunities for flexible working and 11.9% of staff reporting that they have experienced discrimination at work. Whilst progress has been made, levels of bullying and harassment still remain unacceptably high nationally. The Trust's results a similar picture with 53% of staff feeling satisfied with the opportunities for flexible working and 9% have experienced discrimination at work.

#### Regional

Whilst the Trust's response rates remain one of the highest in the region, the Trust's overall position has declined slightly compared with last year. This year the Trust is ranked **12th when benchmarking performance against organisations from across the South West**. Last year the Trust was ranked 10th, Oxford University Hospitals NHS Trust and Torbay and South Devon Healthcare NHS Trust have both improved their performance this year and moved ahead of the Trust.



**When compared against local Trust's**, the organisation's performance has declined by one place this year and is ranked 3rd.

The results from this year's Staff Survey provide some very encouraging findings regarding the experiences of staff, however it also highlights some areas that are experiencing challenges and some that need improvement. Whilst this year's results have not significantly changed from last year, there has been continued progress overall since 2014.

The six areas where the Trust has seen a difference in results since 2014 are illustrated in the table below. All have been positive improvements with the exception of % appraised in the last 12 months.

Key area	2016 score	2015 score	2014 score	Change
% Appraised in last 12 months	84	86	91	-7
Staff confidence and security in reporting unsafe clinical practice	3.75	3.79	3.58	0.18
Staff recommendation of the organisation as a place to work or receive treatment	3.71	3.73	3.55	0.16
Staff motivation at work	4.01	4.09	3.88	0.14
% able to contribute towards improvements at work	74	77	67	6
Staff satisfaction with level of responsibility and involvement	3.95	3.97	3.83	0.12

This year, the Trust performed above average in 12 of the 32 key findings of the survey results, average in 14 and worse than average in only 6 areas. Whilst we are pleased that there have been improvements this year, there is further work to do in areas such as staffing levels and the number of staff experiencing harassment, bullying or abuse at work from patients or service users.

Overall, staff engagement at GWH continues to be high with the Trust scoring above the national average for staff motivation. This is measured by the fact that the majority of staff felt they could contribute to improvements at work, would recommend the Trust as a place to work or receive treatment and feel motivated at work.

Whilst the Trust's staff engagement score has reduced slightly this year (previously 3.88 in 2015), this result remains above the national average for acute and community Trust's and is higher than the results of 10 other Trusts in the South West region.

Although the results show an improvement in the number of staff who have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, this is still higher than the average score in similar organisations. To ensure our staff are protected at work, our 'Never OK' campaign was launched in October 2016 and will continue this year to reassure our staff that we take this very seriously

During a very busy year at the Trust, which has placed additional pressures on our staff, everyone has gone above and beyond what is expected of them to ensure the best possible experience for our patients.

To ensure our patients receive the highest quality of care, we must ensure that the health and wellbeing of our staff is a priority. Despite this additional pressure on the system, during 2016 fewer staff reported experiencing stress due to work and fewer staff have felt pressured to come to work when they are unwell.

In addition to this, fewer staff are working extra hours and staff satisfaction with opportunities for flexible working has improved

### Summary of staff survey results

**Table - Response Rate**

2015		2016		Trust Improvement / Deterioration
Trust	National Average	Trust	National Average	6% improvement
43%	41%	49%	44%	

**Table – Summary of Performance**

Those areas where the Trust has performed highly in comparison to the National results can be seen in the table below as well as those areas where further improvement is required.

Top Five Ranking Scores	2016		2015	
	Trust	National	Trust	National
Staff motivation at work <i>(the higher the score the better)</i>	4.01	3.94	4.09	3.92
% of staff feeling unwell due to work related stress in the last 12 months <i>(the lower the score the better)</i>	33%	36%	36%	36%
% of staff reporting errors, near misses or incidents witnessed in the last month <i>(the higher the score the better)</i>	93%	91%	92%	90%
% of staff / colleagues reporting most recent experience of harassment, bullying or abuse <i>(the higher the score the better)</i>	48%	45%	34%	38%
Staff confidence and security in reporting unsafe clinical practice <i>(the higher the score the better)</i>	3.75	3.68	3.79	3.64

Bottom Five Ranking Scores	2016		2015	
	Trust	National	Trust	National
Staff satisfaction with resourcing and support <i>(the higher the score the better)</i>	3.22	3.28	3.20	3.30
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months <i>(the lower the score the better)</i>	30%	26%	35%	27%
Staff satisfaction with the quality of work and care they are able to deliver <i>(the higher the score the better)</i>	3.88	3.92	3.91	3.94
Effective team working <i>(the higher the score the better)</i>	3.74	3.78	3.83	3.77
% of staff witnessing potentially harmful errors, near misses or incidents in the last month <i>(the lower the score the better)</i>	30%	29%	25%	29%



## Our priorities for 2017/18

- We will be analysing Staff Survey results at sub specialty level and feedback will be presented to the relevant committees. Each committee will discuss their specific set of results and agree an appropriate action plan in response to the feedback from the specific professional group to implement improvements.
- Each Committee will undertake a quarterly review of the actions and improvements and the impact that they have had. Quarterly progress reports will also be submitted to the Executive Committee and the Performance, People and Place Committee.

## 2.3 Statements of Assurance

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

### Information on the Review of Services

During the reporting period of 2016/2017 the Great Western Hospitals NHS Foundation Trust provided and / or sub-contracted 7 relevant health services.

The Great Western Hospitals NHS Foundation Trust has reviewed all the data available on the quality of care in 100% of the relevant health services.

The income generated by the relevant health services reviewed in 2016/2017 represents 98% of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2016/2017.

### Participation in Clinical Audits

During 2016/17, 42 national clinical audits and 6 national confidential enquiries were conducted which covered relevant health services provided by the Trust. The Trust participated in **100%** of the national clinical audits and 100% of the national confidential enquiries of which it was eligible to participate in.

No	National Clinical Audit and Clinical Outcome Review Programmes	Work stream	Relevant	Participation	% Data Submission
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		Yes	Yes	Still in Progress
2	Adult Asthma		Yes	Yes	100%
3	Adult Cardiac Surgery		No	NA	NA
4	Asthma - paediatric and adult (care in emergency departments)		Yes	Yes	100%
5	Bowel Cancer (NBOCAP)		Yes	Yes	100%
6	Cardiac Rhythm Management (CRM)		Yes	Yes	Still in Progress
7	Case Mix Programme (CMP)		Yes	Yes	100%
8	Child Health Clinical Outcome Review Programme	Chronic Neurodisability	Yes	Yes	100%
		Young People's Mental Health	Yes	Yes	100%
9	Chronic Kidney Disease in primary care		No	NA	NA
10	Congenital Heart Disease (CHD)	Paediatric	No	NA	NA
		Adult	No	NA	NA

11	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		Yes	Yes	Still in Progress
12	Diabetes (Paediatric) (NPDA)		Yes	Yes	100%
13	Elective Surgery (National PROMs Programme)		Yes	Yes	Still in Progress
14	Endocrine and Thyroid National Audit		Yes	Yes	Still in Progress
15	Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	No	NA	Na
		Inpatient Falls	No National Audit this year		
		National Hip Fracture Database	Yes	Yes	100%
16	Head and Neck Cancer Audit		Yes	Yes	Still in Progress
17	Inflammatory Bowel Disease (IBD) programme	National Clinical Audit of Biological Therapies (adult and paediatric)	Yes	Yes	100%
18	Learning Disability Mortality Review Programme (LeDeR)		Yes	Yes	100%
19	Major Trauma Audit		Yes	Yes	100%
20	Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	Yes	Yes	Still in Progress
		Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	Still in Progress
		Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes	Yes	Still in Progress
		Maternal mortality surveillance	Yes	Yes	Still in Progress
21	Medical and Surgical Clinical Outcome Review Programme	Physical and mental health care of mental health patients in acute hospitals	Yes	Yes	Still in Progress
		Non-invasive ventilation	Yes	Yes	Still in Progress
22	Mental Health Clinical Outcome Review Programme	Suicide by children and young people in England(CYP)	No	NA	NA
		Suicide, Homicide & Sudden Unexplained Death	No	NA	NA
		The management and risk of patients with personality disorder prior to suicide and homicide	No	NA	NA
23	National Audit of Dementia	Care in general hospitals	Yes	Yes	100%
24	National Audit of Pulmonary Hypertension	National outcomes and tertiary care	No	NA	NA
25	National Cardiac Arrest Audit (NCAA)		Yes	Yes	100%

26	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	No	NA	NA
		Secondary Care	Yes	Yes	Still in Progress
		1. Primary Care (Wales)	No	NA	NA
		2. Primary Care (England)	No	NA	NA
27	National Comparative Audit of Blood Transfusion programme	Use of blood in Haematology	Yes	Yes	100%
		Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	100%
		Audit of the use of blood in Lower GI bleeding	Yes	Yes	100%
28	National Diabetes Audit - Adults	National Foot Care Audit	Yes	Yes	Still in Progress
		National Inpatient Audit	Yes	Yes	100%
		National Pregnancy in Diabetes Audit	Yes	Yes	100%
		National Diabetes Transition	Yes	Yes	100%
		National Core	Yes	Yes	100%
29	National Emergency Laparotomy Audit (NELA)		Yes	Yes	Still in Progress
30	National Heart Failure Audit		Yes	Yes	Still in Progress
31	National Joint Registry (NJR)	Knee replacement	Yes	Yes	100%
		Hip replacement	Yes	Yes	100%
32	National Lung Cancer Audit (NLCA)	Lung Cancer Consultant Outcomes Publication	Yes	Yes	100%
33	Neurosurgical National Audit Programme		No	NA	NA
34	National Ophthalmology Audit	Adult Cataract surgery	Yes	Yes	Still in Progress
35	National Prostate Cancer Audit		Yes	Yes	Still in Progress
36	National Vascular Registry		No	NA	NA
37	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)		Yes	Yes	100%
28	Nephrectomy audit		Yes	Yes	100%
39	Oesophago-gastric Cancer (NAOGC)		Yes	Yes	100%
40	Paediatric Intensive Care (PICA Net)		No	NA	NA
41	Paediatric Pneumonia		Yes	Yes	Still in Progress
42	Percutaneous Nephrolithotomy (PCNL)		No	NA	NA
43	Prescribing Observatory for Mental Health (POMH-UK)	Prescribing antipsychotics for people with dementia	No	NA	NA
		Monitoring of patients prescribed lithium	No	NA	NA
		Rapid tranquilisation	No	NA	NA
44	Radical Prostatectomy Audit		No	NA	NA
45	Renal Replacement Therapy (Renal Registry)		No	NA	NA
46	Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Follow-up	No National Audit this year		

		Clinician/Patient Baseline	No National Audit this year		
47	Sentinel Stroke National Audit programme (SSNAP)		Yes	Yes	Still in Progress
48	Severe Sepsis and Septic Shock (care in emergency departments)		Yes	Yes	100%
49	Specialist rehabilitation for patients with complex needs following major surgery	Specialist rehabilitation level 1 and 2	No	NA	NA
50	Stress Urinary Incontinence Audit		Yes	Yes	Still in Progress
51	UK Cystic Fibrosis Registry	Paediatric	No	NA	NA
		Adult	No	NA	NA

The reports of 44 national clinical audits were reviewed by the provider in 2016/17. As a result of these audits the following actions are planned to improve the quality of healthcare provided –

- Plan to improve and formalise the system for consent for those patients who undergo a hip replacement for fractured neck of femur.
- The Resuscitation Team are working closely with the sign up to safety campaign which aims to reduce cardiac arrests by 10% per year for the next 3 years.
- Provision of psychological support offered to patients by Paediatric Diabetes
- 'Ready Steady Go' process for children transitioning to adult care currently used for transition clinics.
- A review of consultant job planning to ensure no elective activity is listed for those individuals on call.
- All patients over the age of 70 to be reviewed within 3 days following laparotomy operation.
- Quality Improvement involving Respiratory Medicine and Radiology to improve the pathway for patients with suspected community acquired pneumonia; this will focus on key areas including time between admission and receiving a chest x-ray and antibiotic management
- A new WHO style checklist will be introduced in the Emergency Department which will include 7 different criteria to reduce risks to patient when undergoing procedural sedation.
- Improve compliance with oxygen prescribing by introducing prompts for prescribers within the electronic prescribing software.

The reports of 152 local clinical audits were reviewed by the provider in 2016/17 and Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided –

- Review and define arrangements for medical oversight of patients admitted under the podiatric surgeons; identify clear lines of responsibility for their medical care in the event the patient's medical condition deteriorates.
- Review and revise current Abbey Pain Assessment guidelines for in-patients with dementia.
- To establish an action group involving the Trust's Dementia Strategy Group and Pain Management Team.
- Develop a formal local guideline for peri-operative management of patients with a fracture neck of femur to standardise practice.
- To improve the management of patients with Chronic Obstructive Pulmonary Disease (COPD), including the design of an admission care bundle proforma in the acute medical unit to be incorporated into medical clerking. Oxygen will be pre-printed on the admission documents with target saturations to ensure it is prescribed.
- Continue to embed personal care plans for the dying.

- Patients will be seen in clinic to be assessed for suitability and consideration of Fluocinolone Acetonide intravitreal implant as an alternative treatment for eyes with chronic Diabetic Macular Oedema (DMO) which did not respond to the standard treatment.

## Research & Development (R & D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2016/2017, that were recruited during that period to participate in research approved by a research ethics committee was 1024 to end March 2017 which evidences growth in year that exceeded our targets.

We now have 97 actively recruiting Department of Health endorsed (portfolio) research projects. We also participate in a number of studies which are more difficult to recruit to given the complex nature of the inclusion and exclusion criteria. We believe it is important to have these studies open in order to give our patients the opportunity of participating in such studies should they be eligible. We run observational studies together with interventional studies.

Our reputation in the Commercial sector continues to grow and we are now not only a top recruiter in the UK for more than one of our studies, as a Participating Site we were also the first to recruit to both a Respiratory and Cardiology Trial in the UK.

We continue with our efforts to ensure we recruit the agreed number of patients in the timescales given.

Research continues to grow throughout the Trust, across a wider range of specialities. This in turn gives our patients more opportunities to participate and access to new and innovative treatment pathways.

With funding received from the Department of Health through our Local Clinical Research Network (LCRN), R&I have and will continue to provide strong research support throughout the Trust.

## Goals agreed with commissioners

### Use of the CQUIN payment framework

A proportion of Great Western Hospitals Foundation Trust's income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between Swindon Clinical Commissioning Group and Wiltshire Clinical Commissioning Group and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016-17 and for the following 12-month period are available electronically by request

Financial Summary of CQUIN (£m)									
	Plan	Actual	%	Plan	Actual	%	Plan	Actual	%
	2014-2015			2015-2016			2016-2017		
Total CQUIN	£5.722	£4.505	78.72%	£6.007	£4.507	75%	£4.845	£3.973	82%

## Care Quality Commission Registration

A quarterly review of our CQC registration is undertaken across the acute and community sites to ensure that our CQC registration is adequate for the regulated activities undertaken across the sites.

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

By law all Trusts must be registered with the CQC under section 10 of the Health and Social Care Act 2008 - to show they are meeting essential quality standards. NHS Trusts have to be registered for each of the regulated activities they provide at each location from which they provide them. The Trust is registered for all of its regulated activities, without conditions. Without this registration, we would not be allowed to see and treat patients.

The Great Western Hospitals NHS Foundation Trust registration was updated in October 2016 to add the following service - GWH NHS Foundation Trust Swindon Adult Community Services

### Periodic/Special Reviews 2016/17

The Care Quality Commission (CQC) issued enforcement action against The Great Western Hospital NHS Foundation Trust during 2015/2016. A warning notice was issued in respect of some aspects of regulated activity requiring significant improvement within a defined timeframe.

#### In summary:

In December 2015 the CQC issued the Great Western Hospitals Foundation NHS Trust with a warning notice and required the Trust to make significant improvements. The Trust submitted a comprehensive improvement plan.

In April 2016 the CQC carried out an inspection to check progress against the concerns raised in the warning notice. They found that significant progress had been made but the requirements of the warning notice were not fully met.

In October 2016 the CQC conducted a second follow up inspection and found that further and sufficient progress had been made to meet the requirements of the warning notice. In response to the CQC Must do- should do actions, a monthly Improvement Committee was formed, to prioritise, manage and monitor the progress of the Improvement Plan, The Improvement Committee facilitated and supported the implementation approaches to test changes, and to seek assurance improvements are embedded.

### What improvements have we implemented?

- Invested in training
- Introduced electronic white boards
- Introduced a new safety check list in the Emergency Department
- Improved initial nurse assessments in the Emergency Department
- Invested in a specialist mental health nursing team in the Emergency Department Observation Unit

The Trust took part in a formal CQC Inspection during March 2017 .The table below identifies the Compliance Actions identified from our December 2015 inspection.

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	19/01/2016	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Compliance Action	19/01/2016	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Compliance Action	19/01/2016	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Compliance Action	19/01/2016	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Compliance Action	19/01/2016	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
Compliance Action	19/01/2016	Regulation 18 HSCA (RA) Regulations 2014 Staffing

### Planned Inspection Update

The Care Quality Commission (CQC) inspected The Great Western Hospitals Foundation Trust as part of its routine inspection programme. The inspection was carried out between, 21 March – 7 April 2017 with the Trust awaiting the final report.

Initial verbal feedback from the CQC recognised there had been significant changes and improvements since their last inspection, the verbal feedback also raised some further areas for improvement which the Clinical Divisions have commenced working on.

### Our Ratings for the Great Western Hospital from 2015/2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity And gynaecology	Requires Improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires Improvement	Not Rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Copies of the full reports for the Trust and each individual location inspected by the CQC are available publicly online here: <http://www.cqc.org.uk/provider/RN3/reports>.

### Hospital Episode Statistics

The Great Western Hospitals NHS Foundation Trust submitted records during 1st April 2016 to March 2017 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.



The percentage of records in the published data which included the patient's valid NHS number was:

99.7% for admitted patient care  
99.9% for outpatient care and  
98.9% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;  
100% for out-patient care; and  
99.8% for accident and emergency care

### Information Governance Tool Kit Attainment Levels

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information.

There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Performance, People & Place Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality assurance, information security assurance, and legal compliance.

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

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

These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Digital Information Governance Toolkit. These assessments and the information governance measures themselves are regularly validated through independent internal audit. The main Toolkit headings are:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance – Health Records and Information Quality
- Secondary Use Assurance
- Corporate Information Assurance – Records Management and Freedom of Information.

The Trust's Information Governance Assessment Report overall score for 2016/2017 was 77% and was graded 'Satisfactory' ('green'), with a satisfactory rating in every heading of the Information Governance Toolkit.

## Clinical Coding Error Rate

Great Western Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period of 2016/17 by the Audit Commission.

## Data Quality

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

Great Western NHS Foundation Trust will be taking the following actions to improve data quality

- Review of the Trust's data quality policy
- Development of a Trust data quality strategy
- Developed a data quality report that focuses on monitoring the national DQ measures and identify actions from areas below national averages
- A role has been assigned responsibility for monitoring data quality within the Trust
- Review of terms of reference for the Trusts Data Quality group

Great Western NHS Foundation Trust will continue to monitor and work to improve data quality by using the above mentioned data quality report, with the aim to work with services /staff to educate and improve data quality, which in turn improves patients records thus patient care.

### 2.2.3 Reporting against Core Indicators

		2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	Nati onal Aver age	What does this mean	Trusts with the highe st and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	MRSA Bed Days as well  *provisional as at 02/05/14	5	2	2	1	0.96 *	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.Diff	23	19* *combined previously acute/ community split	30 Trust-wide	21	N/A	Zero is aspirational	Low-0; High- 121	IP&C	National definition
	C.Diff 100,00 0 bed days*	12.5*	9.60	14.7	11.1	15.0 1	Lower is better	Regionall y Low:8.71 High: 28.02	PHE	National Definition
2 - Patient Falls in Hospital resulting in severe harm		23	16	13	12	Not avail able	Lower is better	--	Incident form	NPSA

<b>3 – Reducing Healthcare Acquired Pressure Ulcers</b>	28 Category III & Category IV	51 Category I & Category IV	8 Category III 6 Category IV	1 Category III	4% incidence	Lower is better	--	Incident form	National Definition (from Hospital database)
<b>4 – Percentage of VTE Risk Assessments completed</b>	95.5 %	97.1%	98.3%	99.4%	90%	Higher number better	Low - 91.3; High - 100	EPMA and manually for those areas not using the electronic prescribing system	National Definition (from Hospital database)
<b>5 – Percentage of patients who receive appropriate VTE Prophylaxis</b>	95%	91.6%	95.2	97.4%	N/A	Higher number better	--	One day each month whole ward audit for one surgical ward and one medical ward	National Definition (from Hospital database)

		2013/2014	2014/2015	2015/2016	2016/2017	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
<b>6 – Never Events that occurred in the Trust</b>		4	2	3	1	NHS England 2014-15 Average 2.16	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA
<b>Hospital-level mortality indicator (SHMI)</b>	<b>(SHMI)</b>	96.00	92.99	95.83	94.34 (Oct 15 to Sep 16 – most recent data available)	-	Lower than 100 is good	-	National NHS Information Centre	National NHS Information Centre
<b>7 – Mortality Rate (HSMR)</b>	<b>HSMR</b>	97.3	90.3	89.0	97.97 (Apr 16 – Dec 16 provisional figure)	100	Lower than 100 is good	Low -74.2; High -128.8	Dr Foster	National NHS Information Centre
<b>8 – Early Management of deteriorating patients - % compliance with Early Warning Score</b>	<b>Early Warning Score (Adults)</b>	95% April – Dec 9 months	90%	85% April – Dec 9 months	Average 96%	Not available	Higher number is better	--	Audit	Audit criteria (10 patients per ward per month)
	<b>Paediatric Early Warning Score (Children)</b>	87.75%	92.25% Average yearly compliance	85% April - Sept 6 months	Average 86%	N/A	Higher number is better	--	Audit	Audit criteria (5 patients per month)
<b>11 – Were you involved as much as you wanted to be in decisions about your care and treatment?</b>		53.2%	51.4%	51.8%	51.1%	54.8%	Higher is better	Low: 6.1 High: 9.2 GWH: 7.1	Picker Survey	National definition
<b>12 – Did you find someone on the hospital staff to talk to about your worries and fears?</b>		37.1%	28.6%	33.0%	32%	38.4%	Higher is better	Low: 4.3 High: 8.2 GWH: 4.9	Picker Survey	National definition

13 – Were you given enough privacy when discussing your conditions or treatment?		70.8%	74.2%	72.6%	75.6%	72.7%	Higher is better	Low: 7.5 High: 9.4 GWH: 8.5	Picker Survey	National definition
14 – Did a member of staff tell you about medication side effects to watch for when you went home?		33.7%	32.1%	29.8%	35.3%	40%	Higher is better	Low: 3.7 High: 7.6 GWH: 4.3	Picker Survey	National definition
15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?		67.2%	66.2%	68.0%	65.6%	69.8%	Higher is better	Low: 6.4 High: 9.7 GWH: 7.6	Picker Survey	National definition
18– Patient Reported Outcome Measures	Varicose Vein surgery	100%	90.9%	100% HSCIC Provisional data	100% HSCIC Provisional data	80%	Higher is better	Not available (more than one Contractor for this service)	DoH/ HSCIC	National Definition
	Groin Hernia surgery	100%	57.6%	42.9% HSCIC Provisional data	54.5% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Hip Replacement surgery (Oxford Hip Score)	98.5%	61.5%	93.9% HSCIC Provisional data	91.9% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Knee Replacement Surgery (Oxford Knee Score)	97%	94.4%	97% HSCIC Provisional data	95.3% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition

	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
17 – Readmissions – 30 days	7.9%	9.4%	9.7	9.7% (Apr 16 to Feb 17)	Local target (7.1%)	Lower is better	--		National Definition
18 – Readmissions – 28 days	7.7%	9.2%	9.6	9.8% (Apr 16 to Sep 16)	SW Region 6.9%	Lower is better	Low: 5.12; High: 10.91	Dr Foster	Dr Foster
18 – Re-admissions 28 days Ages 0-15 Ages 16+	9% 7.5%	8.5% 9.2%	9.02 10.02	9.5% 0-15 & 9.9% 16+ (Apr 16 to Sep 16)	Dr Foster	Lower is better	0-15 yrs: Low: 0.8; High: 15.8 16+ yrs: Low: 5.0; High: 11.1	Dr Foster	Dr Foster
19 -The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period	26.0 %	26.5 %	31.7 % Oct 14- Sept 15 Most recent data available	31.1% (Oct 15 to Sep 16, most recent data available)	25.3%		Low: 0; High: 49.4	HSCIC	National Definition

"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"		58%	70%	68%	68%	69.8%	Higher is better	-	NHS Staff survey	National Definition
20 - The number and where available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death	Number of Incidents per 100 Bed Days	4.55	4.98	5.9	6.7	--	Lower is better	--	Informatics & Clinical Risk	-
	Number of Patient Safety Incidents per 100 Bed Days	3.00	3.07	3.3	4.4	--	Lower is better	--	Informatics & Clinical Risk	-
	Number of Incidents resulting in Severe Harm or Death per 100 Bed Days	0.03	0.04	0.01	0.01	--	Lower is better	--	Informatics & Clinical Risk	-
	Percentage of Combined Severe Harm and Death	0.56 %	0.80 %	0.55%	0.26%	--	Lower is better	--	Informatics & Clinical Risk	-

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

## 3 Other Information

### 3.1 Other Information

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

#### Performance against key national priorities

An overview of performance in 2016/17 against the key national priorities from the Single Oversight Framework. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2013/2014 Trust	2014/2015 Trust	2015/2016 Trust	2015/2016 Target	2016/2017 Target	2016/2017 Trust	Achieved/ Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	94.8%	90.5%	88.9%	92.0%	92.0%	91.1%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	94.9%	88.6%	82.5%	90%	90%	61.6%	Not Met

Indicator	2013/ 2014 Trust	2014/ 2015 Trust	2015/ 2016 Trust	2015/2016 Target	2016/ 2017 Target	2016/ 2017 Trust	Achieved/ Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	96.3%	95.6%	89.2%	95%	95%	89%	Not Met
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95%	94.1%	91.9%	91.1%	95.0%	95.0%	86.6%	Not Met
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	98.4%	99%	94.4%	94%	94%	100%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	100%	98%	99.7%	98%	98%	99.6%	Achieved
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	89.0%	88.4	87.70%	85.00%	85%	86.5%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	98.9%	98.4	98.10%	90.00%	90%	96.7%	Achieved
Cancer 31 day wait from diagnosis to first treatment	98.8%	98.6	98.00%	96.00%	96%	97.1%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	94.7%	94.0	94.30%	93.00%	93%	88.4%	Not Met
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	95.6%	96.8	95.50%	93.00%	93%	91.8%	Not Met

## Statement from the Council of Governors dated 12<sup>th</sup> May 2017

The Governors are of the opinion that the Quality Account is a realistic representation of the Trust's performance as presented to the governors over the past year. The Governors have acknowledged that unfortunately the Trust did not achieve some targets, notably 86.6% of persons attending A & E were seen within 4 hours against the target of 95%. This is a decrease against the 91.1% attained in the previous year however Governors consider these figures to be consistent with those of the majority of other Trusts and are reflective of the pressures brought about by increased attendance.

The Governors are aware that the Trust is continuing to take action to address this issue and the consequential effects on other performance indicators nonetheless we are also aware that several proposed actions are dependent on partner organisations delivering on their commitments. Within the Quality Report the Trust has reported a number of achievements such as the continual reduction in the occurrence of avoidable pressure ulcers a reduction in Sepsis related deaths and a below average mortality rate. These achievements combine to help achieve an improving experience for our service users and are noted by the Governors.

The Governors have also had opportunity to undertake safety and quality visits across the hospital which enabled Governors to meet and talk directly to staff and patients in the clinical areas, gaining an insight in how the Governor role can support the business of the Trust. The visits have provided the Governors with direct oversight of patient care and improvements made throughout the year, plus added to the knowledge and understanding of Governors around patient experience and quality and staff and patient feedback. A programme of further visits has been set up for 2017/18.

The Governors have established a Patient Quality and Operational Performance Working Group where detailed presentations and reports are made and Governors have the opportunity to consider in detail specific issues and areas of improvement.

The Governors are looking forward to working with staff to build on the good work within the Quality Accounts and have identified areas for focus around Safeguarding, food hygiene, winter pressures preparation, e-rostering and management of overseas patients.



**Margaret White**

**Lead Governor on behalf of the Council of Governors**



## Statement from Swindon Clinical Commissioning Group dated 16<sup>th</sup> May 2017

Swindon Clinical Commissioning Group (CCG) has reviewed the Great Western Hospital NHS Foundation Trust (GWHFT) Quality Accounts for 2016/2017. In so far as we have been able to check the factual details, our view is that the Quality Account is materially accurate in line with information presented to the CCG via contractual monitoring and quality visits, and is presented in the format required by the NHS England 2016/2017 presentation guidance.

Swindon CCG welcomes the quality priorities outlined by GWHFT for 2017/18 which look to build on the success of the 'Sign up to Safety' quality improvement work streams established during 2016/17. The Trust quality improvement work streams have reduced the number of inpatient falls to below the national average and has sustained a reduction in the number of hospital category III and IV pressure ulcers. As identified within the quality account, problems with identification and escalation of a deteriorating patient is a key theme identified in the Trust's serious incident reporting. Swindon CCG welcomes a continued focus on this area, including the role out of e-observations aimed at improving safety, together with a review of clinical handover.

During 2016/17, The Trust has experienced increasing demand on the Emergency Department (ED) which has resulted in the Trust not achieving the 4-hour treatment target. This includes some patients spending longer than 12 hours within the department which can impact both patient experience and safety. In response to this, the commissioners requested the Trust developed an ED quality dashboard to provide assurance of safety within the department, which is also aligned to the CQC inspection recommendations. Swindon CCG is actively supporting the Trust to implement both local and national programmes of work.

Swindon CCG recognise that the Trust has experienced difficulties in achieving the 18-week referral to treatment target, resulting in some patients having to wait longer for their elective treatment. This is a national challenge across NHS organisations and is regularly monitored by the CCG who work closely with the Trust to understand the impact on both patient safety and experience resulting from increased wait time.

The Trust has made good progress in reducing hospital acquired infections over recent years, however, the Trust reported a breach in the numbers of *Clostridium difficile* infections reported (21 against a target of 20) and Methicillin Resistant Staphylococcus Aureus blood stream infections (MRSA, 1 against a target of 0) targets during 2016/17. It is recognised that The Trusts' infection prevention and control (IP&C) annual plan for 17/18 will support a continued focus on further reducing these infections within the hospital setting. Moving forward, the CCG is also committed to working with the Trust to achieve a reduction in reported gram negative bloodstream infections.

We recognise the on-going work by the Trust to monitor and improve patient experience and noted areas of improvement over the year from the results of the PICKER survey. It is also positive to note that 95%-97% of patients would recommend to the Trust to friends and family. We look forward to receiving the Trust's Patient Experience Strategy during 2017/18. Swindon CCG would encourage the Trust to report on complaint themes and trends, including associated learning in future quality accounts and look to strengthen the Friends and Family Test response rate.

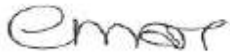
We note the national and local clinical audits that have been completed in year. Swindon CCG will seek assurance of completion of the planned actions to implement the learning from clinical audit and improve the quality of healthcare, including Ready, Steady, Go for children in transition, implementation of the recommendations from the UK Parkinson's Audit and implementation of the WHO style checklist in the ED.

Swindon CCG note the CQUIN payment framework. The 2016/17 CQUIN's have focused on key clinical pathways including Children in Transition, Frailty, Diabetes and COPD. In future Quality Accounts, Swindon CCG would request that the Trust reflect on the improved quality outcomes achieved as a result of CQUIN.

Swindon CCG is pleased to see the results of the NHS Staff Survey, which demonstrates a positive improvement in terms of staff experience and engagement despite the numerous challenges currently facing the NHS and its workforce.

The survey has identified some significant areas of improvement over the year, including the level of confidence that staff have in reporting unsafe practice, the effectiveness of communication from senior managers and job satisfaction. However, areas for further improvement have been correctly identified with a focus on bullying and harassment through the 'Never OK' campaign. The Trust has also actively engaged in a CQUIN during 2016/17 to focus on improving staff health and wellbeing.

Swindon CCG is committed to ensuring continued collaborative working with Great Western Hospitals NHS Foundation Trust to achieve identified goals going forward and support the provision of high quality care across the whole health and social care system.



**Gill May Executive Nurse, NHS Swindon CCG**

## Statement from Healthwatch, Swindon and Healthwatch Wiltshire dated 15<sup>th</sup> May 2017

This statement is provided on behalf of Healthwatch Wiltshire and Healthwatch Swindon. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment. Local Healthwatch have continued to meet regularly with the Trust over the past year and remain committed to continuing this relationship and working with the Trust over the coming year. We are happy to see the priorities for the year have been drawn from local learning and national concerns, and that patient/public Governor representatives have been involved.

We are pleased to see that the number of Never Events are decreasing over time and that full investigations are leading to changes in practice within the hospital. Likewise, we welcome the reduction in the number of serious incidents, alongside the increase in the use of the patient safety incident reporting, to ensure that incidents and near misses are used as learning opportunities.

The Trust has put in place additional developments to improve their compliance with Duty of Candour and to ensure that patients and relatives are fully supported following errors. We note that there were some dips in compliance over the winter period and will be monitoring the situation going forward to ensure that system improvements have a positive impact on compliance over the coming year.

The Trust has continued to miss its target for a maximum wait of 4 hours in the Accident and Emergency Department. Whilst we are appreciative of system wide pressures that exist, we remain concerned that current initiatives do not appear to be achieving the aim of reducing this wait time. We note that a remedial action plan is in place and we welcome this development.

However, we would like to know what measures are being taken to ensure the wellbeing of the patients, their relatives and friends who are waiting longer than 4 hours in the department. As local Healthwatch we are committed to ensuring that local people can speak out about their experiences of receiving care. We would therefore encourage local people to speak to us about their experience of using the A&E department and offer support to the Trust in their continued engagement with patients.

It is reassuring to see that of those patients who have completed the Friends and Family test, many would recommend the services of the Trust to others. We are pleased to see that the Trust is committed to increasing accessibility of services for those with English as an additional language and members of the Deaf community. We appreciate the use of the National Inpatient Survey data in setting improvement priorities for the coming year. We also welcome the work towards a patient experience and engagement strategy and would be happy to work with the Trust to support this.

We encourage the proposed incorporation of patient and public involvement into the Sepsis Working Group, and offer our assistance with this.

The staff survey has shown some positive results and it is reassuring that staff report that feel able to report concerns, are motivated and feel able to contribute to improvements at work and that the majority would recommend the Trust as a place to work or receive treatment. However, it is concerning to see that the levels of bullying and harassment remain higher than national levels.

Healthwatch Swindon congratulate the trust on winning the community health contract in Swindon and look forward to seeing joined up services and opportunities for patient and resident feedback shaping future service provision.

The Trust continues to face challenges as a result of the required actions put in place by the Care Quality Commission and NHS Improvement following the CQC's initial inspection of the Trust in September/October 2015 as well as subsequent follow-up inspections in 2016/17. We very much hope that the work being done impacts positively to reduce the pressures on staff and hence improve the experience of care for patients. We will be closely monitoring the progress of the Trust and will continue to raise concerns should we feel that the quality of care is being compromised.

Healthwatch Wiltshire and Healthwatch Swindon look forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.



**Dr. Sara Nelson**

**Head of Research and Insight**



## Statement from Wiltshire Clinical Commissioning Group dated 19<sup>th</sup> May 2017

Wiltshire Clinical Commissioning Group (CCG) has reviewed the Great Western Hospital NHS Foundation Trust (GWH) Quality Accounts for 2016-17. In doing so, the CCG reviewed the Account in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Quality Review Meetings attended by GWH and Commissioners. This evidence is triangulated with information and is further informed through Quality Assurance visits to GWH, which encompass clinician to clinician feedback and reviews. Wiltshire CCG endorses the Trusts identified quality priorities for 2017-18.

It is the view of the CCG that the Quality Account reflects the Trusts' on-going commitment to quality improvement and addressing key issues in a focused way. The Account summarises the achievements against the 2016-17 Trust quality priorities and identifies the 2017-18 priorities. The Trust priorities for 2016-17 have outlined achievement in the Sign Up To Safety Quality Improvement workstreams which has been evidenced through a reduction in the number of category III and IV pressure ulcers, and a reduction in the number of inpatient falls.

The Trust has reported twenty one (21) cases of *C.difficile* in 2016-17 which has exceeded their trajectory of twenty (20), however, following investigation, only one (1) of the cases has been identified as avoidable, with a further nine (9) cases pending investigation outcome. The CCG welcomes the continued focus on the monitoring and reducing the risk factors of *C.difficile* including the promotion of antibiotic stewardship. The CCG is committed to working with the Trust to reduce rates of Gram Negative Blood Stream Infections. Building on the 2016-17 Sepsis workstream, which was supported through CQUIN funding, the CCG anticipates that further improvement will be made through the embedding of early identification and treatment of Sepsis. This will continue as national CQUIN scheme in 2017-18.

The CCG welcomes the Trusts' continued focus on the recognition and rescue of the deteriorating patient in 2017-18, and the further embedding of the standardised National Early Warning Score (NEWS) through the roll out the e-observation system and a focus on improving clinical handover.

Wiltshire CCG acknowledges that the Trust has experienced increasing demand on the Emergency Department (ED) which has resulted in the 4 hour target not consistently being achieved and some patients spending longer than 12 hours on a trolley before a decision has been made to admit. The Commissioners have requested that the Trust develop an ED quality dashboard to provide assurance of safety within the department, which is also aligned to the CQC Inspection recommendations. The CCG will continue to work with the Trust to support improvements.

One of the Trusts' priorities in 2016-17, 'improving patient experience and reducing complaints' has shown results from the national Friends and Family Test that 95-97% of patients would recommend the Trust services.

The CCG welcome the development of the patient experience and engagement strategy in 2017-18, and look forward to receiving this in September 2017. It is positive to see that the Trust is keen to receive and respond to staff feedback. In particular, the 'Never OK' campaign will focus on addressing the findings within the national staff survey regarding bullying and harassment.

Wiltshire CCG is committed to ensuring collaborative working with Great Western Hospital NHS Foundation Trust to achieve continuous improvement for patients in both their experience of care and outcomes.

Yours sincerely



**Tracey Cox**  
**Interim Accountable Officer, NHS Wiltshire Clinical Commissioning Group**

## **Statement from Swindon Health Overview & Scrutiny Committee dated 19<sup>th</sup> May 2017**

We welcome the opportunity to comment on the quality account for Great Western Hospital. Adult and Children's services have been working closely with Great Western Hospital staff in offering care and support to patients.

There are many older people who have benefited from our joint working in improving the discharge of patients into adult social care. We welcome the actions the Trust has taken to improve the health and care of patients, particularly the reduction in serious incidents, incidents of Clostridium difficile (Cdiff) and MRSA

It is positive that nearly all patients would recommend the hospital to family and friends. In future we would welcome a section in the quality accounts that focus on how Great Western Hospital safeguards patients, both children and adults alike and the joint work with adult services as part of the Local Safeguarding Adult Board and Local Safeguarding Childrens Board.

The hospital is a member of the Local Safeguarding Children's Board. It would have been helpful if mention could be made about the work GWH have done to address the findings of local and serious case reviews. Also mention of the specific needs of children as patients.

We congratulate Great western Hospital as the new provider of some community health services in Swindon. We believe this is a unique opportunity to work together on prevention and early intervention as well as improved support to adult and children living in the community'

**Cllr Claire Ellis and Cllr Gary Sumner**

**Chair of Adults services and Chair of Children Services**



## Statement from Wiltshire Health Overview & Scrutiny Committee dated 23<sup>rd</sup> May 2017

The Health Select Committee has been given the opportunity to review the draft Quality Account for Great Western Hospital Trust 2016/17. The response below provides a record of the Committee's work relating to GWH during 2016-17:

On 27th September 2016 Health Select Committee considered:

- The CQC inspection report of the Trust, following the inspection undertaken in September 2015, the result of which was a grading of 'Requires Improvement'
- The Trust's improvement plan for addressing issues identified by the CQC.

Wiltshire CCG's Director of Quality attended to provide an overview of the report's findings.

In the course of the presentation and discussion, the issues highlighted included: that some areas require improvement; that good multi-disciplinary working had been identified; that a good culture existed for reporting serious incidents; the culture of good, caring, compassionate staff; that occupancy rates were running high and impacting on safety and effectiveness; the warning notice in relation to A&E; that some staffing levels were of concern; that some safeguarding training needed improvement; that some concerns over the way that risk registers linked together, and how can share issues be addressed properly; that Trust was re-inspected in April to address warning notice issues; that the action plan was acknowledged as being comprehensive but that improvements needed to be quicker.

The Committee resolved to ask GWH to come to its next meeting and provide further detail on its improvement programme:

On 15th November, GWH's Director of Nursing attended the Committee and provided a presentation on progress with the action plan devised following the inspection report. Specific issues discussed included how workforce issues were being addressed and which areas were progressing well and which required more focused attention.

Following a proposal from the Chair, the meeting resolved:

To note the information provided on GWH's improvement programme following their CQC inspection report published in August 2016.

**Henry Powell**  
**Senior Scrutiny Officer, Performance Risk and Scrutiny**

## 2016/17 Statement of Directors' Responsibilities in Respect on the Quality Report dated 30<sup>th</sup> May 2017

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement 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 NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance

The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period **April 2016 to 30 May 2017**.
- Papers relating to quality reported to the board over the period **April 2016 to 30 May 2017**.
- Feedback from Swindon commissioners dated: **16th May 2017**
- Feedback from Wiltshire Commissioners dated: **19th May 2017**
- Feedback from governors dated: **12th May 2017**
- Feedback from local Healthwatch organisations dated: **15th May 2017**
- Feedback from Swindon Overview and Scrutiny Committee dated: **19th May 2017**
- Feedback from Wiltshire Overview and Scrutiny Committee dated: **23rd May 2017**
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Board monthly.
- The [latest] national patient survey **26th October 2016**
- The [latest] national staff survey **10th October 2016**
- The Head of Internal Audit's annual opinion over the trust's control environment dated: **24 April 2017**.
- CQC inspection report dated **January 2016**.

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered 2016/2017.

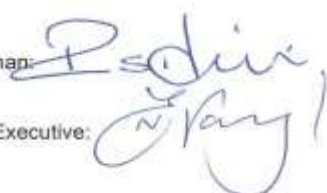
The performance information reported in the Quality Report is reliable and accurate

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

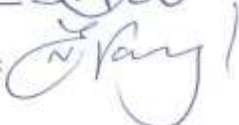
By order of the Board

Chairman:



Date 30 May 2017

Chief Executive:



Date 30 May 2017

## Independent Auditors report to the Council of Governors of Great Western Hospitals NHS Foundation Trust, on the Annual Quality Report dated 30<sup>th</sup> May 2017

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;

We refer to these national priority indicators collectively as the 'indicators'.

### Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2016/17* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17*.

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

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

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 16 May 2017;
- feedback from governors, dated 12 May 2017;
- feedback from local Healthwatch organisations, dated 15 May 2017;
- feedback from Overview and Scrutiny Committee, dated 19 May 2017;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated February 2017;
- the latest national staff survey, dated April 2017 ;
- Care Quality Commission Inspection, dated December 2015; and
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator . To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

#### Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator ;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

#### Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time.

It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

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

Basis for qualified conclusion on the percentage of incomplete pathways indicator

Our sample testing for the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways for the year ended 31 March 2017 identified nine issues within a sample of 25 pathways. These related to four cases where the pathway had been stopped incorrectly, three cases where clock start dates could not be reconciled to supporting evidence, one duplicated pathway and one patient that should not have been on an incomplete pathway.

## Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the percentage of incomplete pathways indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP  
Chartered Accountants 66 Queen  
Square Bristol  
BS1 4BE

30 May 2017

## Glossary of Terms

A&E/ED	Accident & Emergency/Emergency Department
AHSN	Academic Health Science Network
AKI	Acute Kidney Injury
C.diff	Clostridium Difficile
CAUTIs	Catheter Associated Urinary Tract Infections
CCG	Clinical Commissioning Groups
CLRN	Comprehensive Local Research Network
CQC	Care Quality Commission
CQUIN	Clinical Quality & Innovation
DOOC	Delayed Transfer of Care
DOC	Duty of candour
DVT	Deep Vein Thrombosis
E&D	Equality & Diversity
EDD	Estimated Date of Discharge
EDS	Equality Delivery System
EPMA	Electronic Prescribing and Medicine Administration
FFT	Friends and Family Test
GWH	Great Western Hospitals NHS Foundation Trust
HAT	Hospital Acquired Thrombosis
HPA	Health Protection Agency – now NHS England
HSCA	Health & Social Care Act
HSCIC	Health & Social Care Information Centre
HSMR	Hospital Standardised Mortality Rates
ICHD	Integrated Community Health Division
IP&C	Infection, Prevention & Control
KLOE	Key Lines of Enquiry
LCRN	Local Clinical Research Network
Monitor	The NHS Foundation Trusts Regulator
MRSA or	Meticillin-Resistant Staphylococcus Aureus Bacteraemia
MRSAB	
MUST	Malnutrition Universal Screening Tool
NEWS	National Early Warning System
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NRLS	National Reporting & Learning System
PbR	Payment by Results
PDSA	Plan, Do, Study, Act
PE	Pulmonary Embolism
PROMS	Patient Reported Outcome Measures
PURAT	Pressure Ulcer Risk Assessment Tool
QI	Quality improvement
RAP	Remedial Action Plan
R&D	Research & Development
RCA	Root Cause Analysis
RR	Relative Risk
RTT	Referral to Treatment
SAFE	Stratification and Avoidance of Falls
SAFER	Patient Flow Bundle
SBAR	Situation, Background, Assessment, Recommendation

SEQOL	Social Enterprise Quality of Life
SHMI	Summary Hospital Level Mortality Indicator
SHOUT	Sepsis, Hypovolemia, Obstruction, Urine Analysis, Toxins
SOPs	Standard Operating Procedures
SOS	Swindon Outreach Scoring System
SSNAP	Sentinel Stroke National Audit Programme
STEIS	Strategic Executive Information System
TEP	Treatment Escalation Plan
TV	Tissue Viability
TVNC	Tissue Viability Nurse Consultant
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WHO	World Health Organisation
WRES	Workforce Race Equality Standard



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## Children Services Performance Summary 16/17 Outturn

### Children's Health, Social Care and Education

#### Overview and Scrutiny

Date: 5<sup>th</sup> July 2017

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Author:	Peter Nathan, Head of Education Maria Young, Head of Children, Families and Community Health
Wards:	All
Locality Affected:	All
Parishes Affected:	All

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#### 1. Purpose and Reasons

- 1.1 This report provides the 16/17 annual performance report for children services. It highlights the key activity and performance measures in the service, and refers to areas of both strengths and challenges in relation to Swindon's performance during the year. Comparator data is based on the 15/16 outturn, as the national data is not published until 16/17. The detailed performance report in **Appendix 1** provides all the detail, and an overall summary of performance is included in this report to give at a glance context. For details of all the actual numbers please view **Appendix 1**. The performance included in this report will also be submitted to and published by the Department of Education and used by OFSTED in preparation for inspection.
- 1.2 A key purpose of Children's Health, Social Care and Education Overview & Scrutiny Committee is to hold Children's Community Health, Education Support, Early Help and Social Care Services to account.
- 1.3 Children services performance contributes to the Council's corporate priority in terms of protecting the vulnerable. Partnership working is key to improving outcomes for children in need and this report helps to indicate areas where stronger partnership working would be of benefit.

#### 2. Recommendations

The Committee is recommended to:

- 2.1 Note the key performance messages from the detailed performance information in **Appendix 1**.
- 2.2 Identify any areas of concern that require further investigation.

#### 3. Key performance messages

- 3.1 2016/17 performance in relation to Children's Social Care has seen some marked areas of improvement and change, as well as some areas of consistent challenge. The overall contact rate to Children Services has now steadied, and in

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Further information on the subject of this report can be obtained from Jo Ash, Direct Dial Telephone Number: 01793465849 [jash@swindon.gov.uk](mailto:jash@swindon.gov.uk).

# Children Services Performance Summary 16/17 Outturn

## Children's Health, Social Care and Education

### Overview and Scrutiny

Date: 5<sup>th</sup> July 2017

16/17 the number of contacts was broadly in line with the previous year, which is the first time in the last 4 years. As reported to the Board in March 2017, the number of referrals accepted by social care has also decreased. As a result the gap is narrowing between Swindon and the national average for this activity measure, which is positive. The Multi-agency Safeguarding Hub (MASH) arrangement continues to be a key driver in this reduction, ensuring that effective screening and signposting of contacts to the Family Contact Point/ MASH means that the majority of referrals into social care progress to a statutory assessment.

- 3.2 The re-referral rate to children's social care has seen movement in year and following an increase in the last quarter the final outturn was 26.6%. Although this is a reduction from 15/16 (27.9%), it is still higher than the national average. Reasons for this include domestic violence notifications that make up a large proportion of social care referrals. There is recognition however, that processes linked to step up and step down from social care require more development and this will be a key focus over the coming months.
- 3.3 The number of children being the subject to statutory assessment has remained at a high level despite the decrease in the social care referral rate, indicating that thresholds are effective, indeed 96.8% of social care referrals resulted in assessment. This means that overall, the demand on the social care service is still high, and this is reflected in the number of children on child protection plans and those coming into the care of the authority. The overall number of children in need (section 17), has decreased.
- 3.4 The overall number of children commencing child protection plans has increased.
- 3.5 The number of children coming into care in Swindon remained at a higher level during 16/17, with 327 children in care as at the 31<sup>st</sup> March 17. This is slightly above national and statistical neighbour average based on the 15/16 comparator data. Part of this increase is attributable to an increase in Unaccompanied Asylum Seeking children, of which there were 19 at the end of March 17, and this equals nearly 6% of the overall children in care population. Permanence planning and timeliness has improved both in relation to making a timely decision to adopt in the child's best interests and for proceeding to interim care orders, when it is clear that re-unification under a voluntary section 20 care agreement will not achieve the best outcomes for children. The overall number of adoptions and special guardianships has increased and the overall timeline of the adoption process is timely for the vast majority of cases. At the end of March 17, 34 children were on placement orders, and these will be reflected in adoption orders during 17/18.
- 3.6 Youth offending for children in care continues to be a challenge and Swindon reports a higher number of offenders compared with others. The actions outlined

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# Children Services Performance Summary 16/17 Outturn

## Children's Health, Social Care and Education

### Overview and Scrutiny

Date: 5<sup>th</sup> July 2017

in the post inspection plan for this service are being implemented to impact on performance in this area.

- 3.7 On a positive note, the number of care leavers engaged in education/employment and training has seen a positive direction of travel for 16/17 and this coupled with a very low number of children with unknown destinations gives confidence that engaging our vulnerable young people in relation to education opportunities is having a positive effect. Partnership working with post -16 providers is crucial to this area of performance.
- 3.8 The Swindon Early Help offer is extensive and covers a broad spectrum of services, including community health and education support services. The latest data in relation to early help records is not available for reporting but the local service data shows that over half of all children coming into contact with social care, have received an early help service, either before, or at the point of referral to social care. Further analysis is needed to understand if these Early Help Record and Plans have developed into actively 'worked' plans with a team around the child. The number of families identified as eligible for the troubled families programme is positive, however getting families to a point where they have a lead professional working with them to achieve sustained improvement is more of a mixed picture.
- 3.9 The activity in relation to school fixed term exclusions tells the same story as detailed in the two Board reports: The level and rate of fixed term exclusions from Swindon schools remains high in comparison with other authorities and increased when looking at the 15/16 academic year compared with 14/15. The number of permanent exclusions has increased notably and the number for the current academic year to date, exceeds the total number made in the previous year. The Education Strategy Board, chaired by the office of the Regional Schools Commissioner, is monitoring progress against the strategies that have been put in place to work with schools to reduce the level of exclusions and support pupils and families at risk of exclusion.
- 3.10 In relation to educational attainment, the Swindon Challenge initiative has been introduced to raise standards in Swindon schools, including raising attainment in key subject areas such as English. The Swindon Challenge Board includes the regional schools' commissioner, head teachers, governors, local businesses and senior council leaders, and will invest £600k in raising standards over the next three years. One aspect to be funded, for example, is having expert consultancy support for secondary Heads of English through their termly network meetings. There will also be an emphasis on phonics outcomes for Year 1 pupils to ensure they are at the national average or above and that reading, writing and mathematics standards are at least in line with national averages when children

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# Children Services Performance Summary 16/17 Outturn

## Children's Health, Social Care and Education

### Overview and Scrutiny

Date: 5<sup>th</sup> July 2017

leave primary school at the age of 11. Attainment data will be fully reported in the autumn once the Department of Education releases the statistical publications.

- 3.11 Swindon continues to have a higher percentage of pupils with a Statement of Special Educational Needs (SEN) or Education, Health and Care Plan (EHCP) compared to England and statistical neighbours. There has been definite improvement in relation to the timeliness of completing plans between 2015 and 2016 (performance is reported for the calendar year for this measure). Progress against the key actions identified by commissioners continues with the development of an SEN audit framework. A SEN performance dashboard has also been developed to help with interpretation of performance for all partners involved.
- 3.12 The overall number of young people who are NEET in Swindon has increased slightly, as a direct result of reducing the number of young people in unknown learning destinations. This means Swindon is good at tracking young people and knowing what their learning destination is. Those authorities with a higher unknown co-hort but lower NEET, may well have a proportion of unknowns that will be NEET but not reported as such. The youth employment rate in Swindon compares favourably with the national average.
- 3.13 Swindon community health professionals continue to work together to provide a strong community health service provision for children and young people. The CQC inspection of our regulated children's community health activities took place in the last week of March this year. The inspection went well and informal feedback was pleasing. The expectation is that the final report is to be published in July 17. The implementation of the Healthy Child Programme continues, and ante-natal and post-natal checks are taking place routinely to support mothers in their child's health and well-being. Robust information sharing between the hospital midwifery department and the Borough child health team has helped provide a more timely service for expectant mothers in Swindon. The new regional provider arrangements for the child health service commenced on the 1<sup>st</sup> April 17. Information sharing agreements are in place to ensure that service efficiency is not affected as a result of the service not being delivered within the Borough.

#### 4. Alternative Options

- 4.1 None.

# Children Services Performance Summary 16/17 Outturn

## Children's Health, Social Care and Education

### Overview and Scrutiny

Date: 5<sup>th</sup> July 2017

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#### 5. Implications, Diversity Impact Assessment and Risk Management

##### Financial and Procurement Implications

- 5.1 The budget in 2016/17 for Children, Families and Community Health and Education was £24.385m. The Outturn variance from the budget for 16/17 reported over-spend of £1.757m. There have been a number of pressure, the main ones being an increase in demand for placements £1.248m; the use of Agency staff to cover vacant posts, sickness and maternity cover of £800k. In addition there was a pressure of £263k on the budget funding legal counsel fees, applications and staff costs as a result of an increase in demand, particularly in relation to proceedings for children coming into care. These pressures have been partially offset by staff savings and various other net savings across the service.

##### Legal and Human Rights Implications

- 5.2 Section 21 of the Local Government Act 2000 (as amended) requires every Local Authority to establish an overview and scrutiny function to hold the Executive to account, undertake policy development and review, monitor and improve performance report.

##### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 There are no other direct implications arising as a result of this report. Any further implications will be identified when a topic is reviewed by the Overview and Scrutiny Committee and in any recommendations made by the Overview and Scrutiny Committee.

##### Diversity Impact Assessment

- 5.4 No Diversity Impact Assessment (DIA) is required at this stage as this report proposes no changes to services. Any DIA that is required during a review of topics included within the work programme, will be identified at the appropriate stage.

##### Risk Management

- 5.5 No risk management issues have been identified at this stage. Any risk management issues will be identified at the appropriate time when a topic is under review by the Scrutiny Committee and if it makes any recommendations.

#### 6. Consultees

- 6.1 The Director of Finance, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

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# **Children Services Performance Summary 16/17 Outturn**

## **Children's Health, Social Care and Education**

### **Overview and Scrutiny**

**Date: 5<sup>th</sup> July 2017**

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#### **7. Background Papers**

7.1

#### **8. Appendices**

8.1 Appendix 1: detailed performance summary

# Children's Services Performance Report

Children's Health, Social Care and  
Education Overview and Scrutiny

*16/17 Annual Outturn Report*

# Headline Messages from the data

Early Help

**Contacts**– Family Contact Point/MASH records all contacts. There were 13156 contacts from Apr 16- Mar 17, compared to 13313 for the same period in 2015/16. 3023(23.0%) contacts progressed to referral to children's social care. This is lower 3405 in the previous year. Swindon's referral rate is moving more in line with national average.

The number of contacts has stabilised, and slightly reduced compared with the previous year. The number of referrals has also reduced. The MASH implementation is key in this development.

**Early Help Record and Plan** – 684 records were completed in 16/17, compared to 822 in 15/16. 641 plans were completed in 16/17 compared to 665 in 15/16. Time lag in inputting means 16/17 figures may rise by 8-10%.

At the end of March 2017, 2249 families received extra support from the **health visiting** service in addition to the universal service offer, compared to 2573 at the end of March 2016.

Health visitors continue to provide additional support to those families in need. The Family service data is now available and shows a high level of support to vulnerable groups of children are receiving support.

**The family service data** is now available for reporting; 379 children were involved with the service at the end of March. 18.8% of these were children in need, 8.5% on child protection plans, and 4% in care. 34% had an EHCP (education, health and care plan).

**Children looked after**- At the end of March 2017, there were 327 children looked after. This is an increase from 292 at the end of March 16. 107 children.

The number of children looked after continues to remain at a higher level than in previous year.

**Adoption** – 19 children were adopted between April 2016 and March 2017. This compares with 6 for 15/16. There were 34 children on placement orders at the end of March 17.

The number of children being adopted is much higher than in previous year. The vast majority of adoptions take place within national timescale thresholds

**Post-16: In-learning rates** for 16 and 17 year olds (as at March 2017) was 91.4%, This is a 2.2% increase from the previous year, and below the national (92.2%) and regional (91.8%) averages. **NEET** rate (2.9%) increase for 16-17 year olds but the **Unknowns** for 16-17s has decreased to (2.9%), March 2016 (5.2%).

Participation in Learning has increased. Swindon is good compared with other in terms of knowing the learning destinations of young people

**Children with SEN** - At 31<sup>st</sup> Mar 2017 there were 1627 children with statutory SEN assessments maintained by the LA (527 with a Statement and 1100 with an Education, Health and Care plan). A further 4524 had a category of SEN Support as recorded by schools in the January census.

**School Absence** – Primary and Secondary school absence are at 3.9% and 5.1% for the Autumn term of 2016/17. Swindon is broadly in line with the National average, with local and National figures having risen compared to last year.

**School Exclusions** – 1,304 Fixed Term exclusions took place in the academic year to March 2017, higher than the 1,231 in the same period last year. There have been 41 permanent exclusions this year – more than the whole of 2015/16 and 2.5 times more than the same period last year.

There are 2.5 times more permanent exclusions in the academic year to March 2017 than in the same period last year.

CLA

Education

# Headline Messages from Social Care Safeguarding Data.

## REFERRALS

**Referrals** – There were 3023 referrals from Apr 2016 to Mar 2017 compared to 3405 for the previous year. Of the 2356 referrals, 26.6% were re-referrals .

Less contacts are progressing to social care referral which is partly attributable to more effective screening at the contact stage in the MASH (Multi Agency Safeguarding Hub).

## ASSESSMENTS

### Statutory Assessments

From April 2016 to March 2017, a total of 2987 statutory (social care) assessments were completed compared with 3146 for April 15– March 16. Given the lower referral rate this indicates the majority of social care referrals lead to a statutory assessment.

The demand for assessments continues at the same level, despite the decrease in contact and referrals - so the demand on the service is still high

There were 921 **child protection enquiries** (also known as **section 47 enquiries**) between April 2016 and March 2017. The percentage of enquiries going to Child Protection Conference within 15 working days has decreased from 79.6% between April 2015 and March 2016 to 65.1% between April 2016 and March 2017

Although still at a higher level, the number of children on a child protection plan in Swindon has been showing signs of stabilisation over the last 6 months. The challenges of higher numbers impacts on the capacity available to ensure constant timelines with child protection processes.

## CHILD PROTECTION

**Child Protection Plans** - 244 children were on a child protection plan at the end of March 2017. The number has increased from 238 in March 2016. The number of children on a child protection plan is above the national and statistical neighbour average. 91.7% had their child protection **reviews** completed on time as at the end of March 17 compared to 95.8% for the same period in 2015/16. This is based on those children on a plan at the end of January 17 for 3 months or more.

The rate of children starting a **child protection plan** for a second or subsequent time is consistent with 20.2% between April 16 and March 17, compared to 19% in 15/16. This is slightly higher than national average (17.9%), and Statistical neighbour average (18.8%).

The number of children on repeat plans reduced in year, but increased to be slightly above the national average by the end of year. The vast majority of children cease their child protection plan by 2 years. No children had been on a plan for more that 2 years based on those on plans on the 31<sup>st</sup> March 17.

At the end of March 2017, 3.6% (11 children) of children ceasing a protection plan had been on a **plan for 2 years or more** compared to 3.2% March in 2016.

### Performance Assessment

**Early Help Record (EHR).** During 16/17, 684 Early Help Records were completed, compared to 822 for 15/16. The inputting backlog has now been cleared. It is still expected that the 16/17 figure will rise when reports are re-run later in the year. Time lags can occur, due to late submissions by schools. In 15/16 the number of Early Help Records recorded went up by 8% between the initial report and the re-run later in the year.

**Early Help Plan (Plan) and Early Help Review (Review).** The Early Help Record will always lead to a plan being created for the child. The plan may be delivered in a number of ways depending on its complexity. The number of Early Help Plans in 16/17 was 641 compared to 665 for 15/16. As with the records, the 16/17 figure is expected to increase due to late submissions. In 15/16 the number of plans went up by 10% between the initial report and the re-run later in the year.

In addition to the number of early help records and plans, over half of social care referrals have a previous early help involvement. It is recognised that more work is required to maximise the step up/step down from social care processes, and this will be a key focus for 17/18.

The LSCB established an Early Help Working Group to support further understanding and usage of the EH R&P as tool for engaging, assessing, planning and intervening early on in child's lives; when need is identified.

### Family Service

As a relatively new service, the Family Service is building up its caseload. As at 31/03/2017, there were 379 children with an open Family Service involvement, involving 160 families. The service is supporting vulnerable groups, including children in need (18.8%), child on protection plans (8.5%), as well as children in care (4%). There is also a significant percentage of those receiving a service on EHCPs's (34%). Key performance indicators have been identified and built into the electronic child management system that will allow for reporting on outcomes for these children and families.

### Strengths

- Establishment of a cross agency Early Help Working Group (as above)
- Outcomes for children in receipt of early help services are now being routinely reported as part of quality and performance reporting arrangements, including a quarterly quality and performance board
- Family Service providing additional support for vulnerable groups

### Challenges/Risks

- We need to increase the number of Early Help Records and Plans that are created and utilised to support children early on, to record, analyse and support children and families and to prevent escalation of cases to children's social care.

### Performance Assessment

As at the end of 2016/17 there were 786 Active families on the **troubled families programme**, which exceeded our 2016/17 target of 751. There is still too heavily a reliance on families open to social care and more proactive work needs to be undertaken to ensure a more even distribution of Troubled Families across Early Help teams.

The payment by results (PBR), criteria remains stringent which brings challenges. As at the end of 2016/17 Swindon had claimed for 113 families meeting outcomes, which was 37% of our target although this is broadly in line with other LAs who are experiencing the same issues. There may need a change of direction from government re the PBR. The Troubled Families programme in Swindon would benefit from improved partnership buy-in of the TF methodology. Initial findings from the Maturity model exercise show that this is not currently the case for some key partners at this time.

#### Targeted Mental Health Service:

There continues to be high activity in TAMHS which demonstrates how the service is delivering direct treatment work to children and young people. The traded service orders remain strong - £296K for 2016/2017.

The referral to assessment within 4 weeks is a priority area for performance improvement. Actions include employing three additional members of staff (started in November 2016), changing the referral criteria in order to reduce the amount of referrals, employing a specialist business support worker to “modernise” our processes, and using a joint screening process with CaMHS.

### Strengths

- Of the families being worked with on the Troubled Families programme, 54% are in the 30% most deprived LSOAs nationally.
- A Troubled Families “Task Force” has been formed to identify families with few outstanding outcomes remaining and work intensively with lead practitioners to move families into a claim position. This has already started to generate results.
- 61% of families that have been claimed for were on the Trouble Families programme for 12 months or less

### Challenges

- Managing the conflict between the pressures on Early Help service teams to close cases whilst Troubled Families outcomes remain outstanding.
- Ensuring and evidencing that “Active” families have had an assessment incorporating the needs of the who family and the services are in place to support the family across all identified TF issues.

### Performance Assessment

**Contacts** Family Contact Point/MASH records all contacts for children's services in their wider sense (i.e. includes Early Help) as well as contacts that become referrals to Children's Social Care. There were 13156 contacts to Family Contact Point between April 2016 and March 2017, compared to 13313 for the same period in 15/16. This is a 1.2% decrease. This is the first time in the last 5 years that a steadying in the number of contacts has occurred. Improved partnership working linked to the MASH operating model helps in ensuring agencies are signposting correctly into Children, Families and Community Health.

**Referrals and Re-Referrals** 3023 referrals were received in Children's Social Care between April 16 and March 17, compared to 3405 for the same period in the previous year. Swindon's referral rate is still above the national and statistical neighbour averages based on the cumulative rate of referrals between April 16 and March 17. (Swindon 616.9 per 10,000 under 18 compared with 527.1 statistical neighbour and 532.2 national average). However, the gap between Swindon and the national and statistical neighbour averages is narrowing. Of the 2356 referrals between April 16 to March 17, 26.6% (804) are **re-referrals**. This is a decrease from 27.9% for the same period in the previous year. The national average is 22.3% (15/16).

**Statutory Assessments** Between April 16 and March 17, a total of 2987 assessments were completed, taking an average of 39 working days to complete. This compared to 3146 for the same period in the previous year. The national average for duration was lower at 28 days. The completion of timely, good quality assessments is an area of focus within the service, in order to improve the timely response to families and the clarity of planning for a child.

**Number of children in need (section 17 social care)** The number of children in need (this does not include children subject to a child protection plan or children in care) was 1184 at the end of March 2017, down from 1283 at the end of March 2016. This is still above the national average(1150) and the statistical neighbour (999) average.

### Strengths

- Improved information gathering in the MASH results in better quality referrals to social care; with a reduction in the number of referrals requiring statutory intervention in social care
- The number of contacts received has stabilised following continuous increase in the previous 4 years

### Challenges

- Re-referral rate has increased during the last quarter, and this raises questions in relation to whether a child is referred for a new reason, or if original need was not met. Routine audits are undertaken, and action taken on a case by case basis as required. The Step Down process is also promoted to ensure children are 'handed over' to support services, outside of social care, in a planned manner.



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## Child Protection Processes and Outcomes

### Performance Assessment

**Child Protection Enquires (also known as Section 47's) going to initial child protection conference:** 921 child protection enquires were completed from April 16 to March 2017. This is an increase from 766 in the same period in 2015/16. 370 out of the 921 (40.1%) of child protection enquires completed went to **child protection conference** between April and March 2017, this is compared to 334 out of 766 (43.6%) , in the same period in 2015/16. The percentage of enquires that went to initial child protection conference within 15 working days was 65.1% between April 16 and March 17. This is below the national average of 76.7%. This indicates that potentially too many enquiries are undertaken that lead to no Initial Child Protection Conference.

**Children on Child Protection Plans** 244 children were on a child protection plan at end March 17. This is higher than the national average. The average duration of a child on a plan was 179 days based on those on plans at the end of March 17, compared with 199 at the same point in the previous year.

**The number of children having second or subsequent plans** was 20.2% between April 2016 and March 2017, an increase from 19% in March 16. This is above the national average (17.9%) and the statistical neighbour (18.9%). This measure should be considered alongside duration, as a high percentage of second and subsequent plans and low duration could indicate that children's plans are being ceased prematurely, or that intervention outcomes are not sustainable. It is also important to note that a percentage of children will have subsequent plans due to family circumstances changing and for different reasons to their original plan. Regular auditing is undertaken to understand any practice changes that are required in relation to repeat plans.

**Duration of children on child protection plans:** 3.6% (11) of children ceasing a child protection plan remained on a plan for two years or more between April 16 and March 17, compared to 3.2% in the previous year. This is above the 2015/16 national average of 3.6% and the statistical neighbour average of 3.7%. AS at the end of March 17 no children had been on a plan for two years or longer.

**Timeliness of Child protection visits.** Of all children who have been on a child protection plan at any point between April 2016 and March 2017, 78.9% had their visits within 6 weeks of the previous visit. This is an improvement from 66.0% recorded for the same period in 2015/16. One late visit means the child will be late in terms of performance for the whole year. Data analysis has identified areas of excellent practice in terms of visit timeliness by social workers, and will be building on this across teams to improve the overall timeliness of visits experienced by each child for every visit throughout the year.

### Strengths

### Challenges/Risks

- To improve visit timeliness so that vast majority of children receive ALL visits on time; every time

**Performance Assessment**

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**Number of children in care.** 327 children were looked after at the end of March 2017; this compares with 292 at the end of March 2016. Swindon is above the national average (291 children in care when scaled to the Swindon population). 21.7% of children in care were placed more than 20 miles away from their home address as at the end of March 2017, up from 18.8% at the end of March 2016; this is above the national average of 13%.

**Adoption** - 19 children were adopted between April 2016 and March 2017. In the previous year there were 6 children adopted. A further 19 children also became subject to special guardianships between April 16 and March 17. Swindon was below the national average in 15/16, but performance in quarter 3 for 16/17 has shown improvement, and this will be monitored closely going forward. 34 children were on placement orders, which will reflect in further adoptions during 17/18.

**Timeliness of Adoption** – The average number of days between becoming looked after and being placed for adoption is still high, at 649 days at the end of March 17 based on the 3 year rolling average as reported in the adoption scorecard published by the Department of Education annually. This compares with 593 nationally (2012-2015). Swindon's performance has improved since end of March 16 when 905 days was recorded. We know this figure is also higher due to the legacy of poor performance in previous years as well as the complexity of the children that were found placements. The majority of children are placed well within national threshold.

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**Strengths**

- The number of special guardianships shows these are being used as a good alternative to adoption where in the child's best interests.
- Adoption timeliness has remained good for the majority of children, with a very small number of cases where needs were complex, skewing the average. The number of adoptions is higher than in previous year

**Challenges/Risks**

- Reduction in placement stability for children looked after
  - Higher number of children looked after brings resourcing impacts on placement options
  - Increase in unaccompanied asylum seeking children and their placement requirements
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## Children, Families and Community Health Quality Assurance Framework

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Children, Families & Community Health have continued to strengthen and embed its Quality Assurance Framework. The scrutiny role of the Quarterly Performance Board which oversees the audit and performance activity has continued to be more challenging with clear expectations for all managers to embrace their QA role, especially in relation to audits as well as practice improvement. The Board continues to review the Key Quality Indicators (KPIs), its Performance indicators and has now introduced the monitoring of action plans from Serious Case Reviews and their learning. It can consider qualitative as well as quantitative information, as well as its key performance indicators for improvement (known as “obsessions”).

Monthly Case File Audits have continued to take place throughout the year and in Q4 we had our highest return showing the improvement with embedding this practice. We have continued to commission 6 independent audits to measure against our internal judgements of practice. It is reassuring to note that the findings are similar. The judgements given regarding these audits across the year were that practice requires improvement with some elements of good practice.

In this year we have also evaluated the refreshed child protection conference model. As part of this we had feedback from partner agencies and parents who attended. This feedback was very positive. We also dip sample protection plans and observed conferences and can confirm that the model is working well however due to the high staff turnover of conference chairs the consistency of practice and further embedding is required.

The Independent Reviewing Officer's team has continued to increase their escalations where they see that practice requires improvement and this process is becoming more embedded.

### Strengths

- Clear evidence of the areas which need to improve.
- A proportionate approach to the audit and survey work we do so that we can concentrate on skilling the workforce with the skills and knowledge to provide “good” practice and service to the children and families in Swindon.

### Challenges/Risks

- Continued focus on consolidating the learning through audit activity and for teams to understand the journey of the child and what ‘good’ looks like.
- Staff turnover and permanent recruitment to the IRO/CP Chair teams so that consolidation and embedding of practice can continue.

### Performance Assessment

The service has commenced on a project to develop a workforce strategy and action plan for the whole of the Children's Service. Working closely with relevant teams across the authority, this project will make use of best practice – both within and outside the organisation.. Progress and achievements on this work will be reported regularly. The project will focus on four key themes:-

- **Workforce Planning &** effective workforce analysis to meet our service users' current and future needs at the most effective cost.
- **Career Progression and Staff Retention**
- **Leadership and Management, Learning and Development**
- **Horizon Scanning** - Identify and respond to the issues that have the potential to change or that present significant new or changed knowledge and skills needs for the department over the medium to long term.

#### **Social Worker Recruitment:**

Our focus on recruitment, development and retention of social workers (SW) and their managers has achieved a reduction in SW Vacancies from 42.5 at September 15 to 7.5 at 22nd May 2017. The current vacancy rate stands at 6% (well below the national average of 14%). Following a successful investment bid, an additional 12 social work posts and 1 Independent Reviewing Officer post have been agreed and these posts will be incorporated into the establishment which will increase the number of vacancies to be filled over the coming months. Further work on this area will be encompassed within the workforce development project within the service.

#### **Caseloads for social workers:**

Quarterly analysis is undertaken in relation to caseload weighting for social workers within the social work teams. In December 2016 caseloads were between 17-22 children per social worker in the long term teams. This can vary depending on the experience of the social worker and the complexity of cases.

In March 2017 this reduced to 16.4 children per social worker. The aim is to have an average of 15 children per social worker.

### Strengths

- Good progress in developing potential managers from existing workforce
- New Academy approach to developing Newly Qualified Social Workers introduced and assists in 'growing our own' social workers

### Challenges

- Continuous recruitment activity to reduce caseload for social workers

## Primary Education: Validated 2015/16 Results

### Performance Assessment

**Early Years:** Performance in the headline Early Years measures for Swindon pupils has fallen slightly below the national average. The percentage of Swindon pupils with a Good Level of Development is 68.8% (69.3% nationally), and the percentage of Swindon pupils meeting all 17 Early Learning Goals is 67.1% (67.3%) nationally. The average total points score from Swindon pupils (34.6) is still just above the national average (34.5).

**Phonics:** The percentage of Swindon Year 1 pupils achieving the required standard of Phonics decoding continued to increase, reaching 76% in 2015/16 (75% in 2014/15 and 73% in 2013/14). However, the gap between Swindon and England has grown. In 2015/16, 81% of Year 1 pupils in England achieved the required Phonics standard, up from 77% in 2014/15. The percentage of Swindon Year 2 pupils achieving the required standard of Phonics decoding remained level with the England average at 91%, having increased from 90% in 2014/15.

*The 2015/16 Key Stage 1 and 2 cohorts were the first to be assessed against the new, more challenging curriculum that was introduced in 2014. The results are now reported as scaled scores rather than levels. Because of these changes, Key Stage 1 and 2 figures for 2015/16 are not comparable to those for earlier years. A new measure of progress between Key Stage 1 and Key Stage 2 is being reported from 2015/16, replacing the previous 'expected progress'.*

**Key Stage 1:** In Swindon, 71% of pupils reached at least the expected standard in reading, with 63% reaching the expected standard in writing and 70% in maths. The comparable figures for England were 74%, 65% and 73% respectively. The percentage of Swindon pupils reaching the higher standard for reading, writing and maths were 21%, 12% and 13% compared to 24%, 13% and 18% in England.

**Key Stage 2:** The attainment of Swindon pupils in tests was broadly similar to the national average. 67% achieved at least the expected standard for reading (66% in England); 70% reached this standard for maths (70% in England) and 73% reached the standard in grammar, punctuation and spelling (73% in England). Writing is assessed by teacher assessment. Only 60% of Swindon pupils were assessed as being at the expected standard for writing compared to 74% in England. This is very different to previous years when writing achievement was similar to the national average. Nationally, 54% of pupils reached the new expected standard in all of reading, writing and maths. In Swindon, this figure was 46%, with the gap due primarily to the writing assessment results.

The new progress measure compares pupil's Key Stage 2 results to those of other pupils nationally with similar prior attainment. A score of zero means pupils on average performed as well as those with similar prior attainment nationally. A positive score means pupils did better and a negative score means pupils did worse. The Swindon average progress scores for reading, writing and maths were -0.3, -3.6 and -0.4 respectively.

### Strengths

- Attainment in the KS2 tests continues to be broadly in line with the national results in reading, mathematics and grammar, punctuation and spelling, as it had been in previous years and despite the higher expectations
- KS2 progress, from pupils' KS1 starting points, is broadly average for reading and maths

### Challenges/Risks

- Secure accurate teacher assessment in all subjects at the end of KS1
- Secure accurate teacher assessment in writing and science at KS2
- Improve the teaching and learning of phonics in Year 1

### Performance Assessment

#### Fixed term school exclusions (FTEs)

Figures for September 2016 to the end of March 2017, show that 1,304 Fixed Term exclusions were given to pupils, higher than the 1,231 given in the same period of the previous year. There is a considerable time-lag for official DfE exclusion figures (due to appeals, reviews etc.) but the 2014/15 data for the full academic year shows Swindon with a FTE rate of 5.6%, compared to 3.9% nationally and 3.8% regionally.

After last year's rise in primary exclusions, this year the number has stayed approximately the same. In the academic year to March 2017, 83% (1,078) of FT exclusions were given to secondary-aged pupils and 17% (226) were given to primary pupils; the previous year had 1,006 secondary and 221 primary exclusions. 21% (274) of pupils with an FTE in 2016/17 were Female, while 79% (1030) were Male.

Persistent Disruptive Behaviour is still the most common reason given by schools for exclusions, at 42% (545). This is followed by Physical assault against Pupil (15%, 202 pupils), Verbal Abuse against Adult (14%, 187 pupils). The average length of a FTE is 1.76 days, compared to 1.63 for the same period in 2015/16.

#### Permanent school exclusions (PEX)

41 children have been permanently excluded from Swindon schools in 2016/17 (up to end of March 2017); this is 2.5 times as many as in the same period of the previous year (16 pupils). In addition to formal permanent exclusions, parents/carers of a further 19 pupils who had reached the point of permanent exclusion, accepted their Head Teacher's offer of a 'withdrawn permanent exclusion'. This is a local agreement implemented from 2009 which is part of the Swindon Fair Access Protocol and enables pupils to move on without the stigma of a formal permanent exclusion. During the same period in 2015/16, 16 parent/carers had accepted permanent exclusion withdrawal.

33 PEXs were from secondary pupils, while 8 were primary-aged (in 2015/16 this was 12 and 4, respectively). 6 PEX were from Year 11. 36 pupils with a PEX in 2016/17 were Male while 5 were Female.

2014/15 national data show Swindon with a 'Permanent exclusions as percentage of school population' rate of 0.09%, in comparison to 0.07% nationally and 0.08% regionally.

### Strengths

- Swindon challenge initiative

### Challenges/Risks

- Fixed term exclusion rates still above the national average rate
- Over representation by vulnerable pupils receiving school exclusions
- More children permanently excluded in this academic year so far than in the whole of the previous year

## Performance Assessment

In January 2016, the percentage of pupils with a Statement of Special Educational Need (SEN) or Education, Health and Care Plan (EHCP), in Swindon was 3.8%. This is higher than the 2.8% reported for England and Statistical Neighbours. These figures are published annually in July, but for Swindon the latest census in January 2017 shows a small reduction in this figure to 3.7%.

It is worth noting that, in 2015, Swindon received more requests for assessment per 10,000 population than Statistical Neighbours and England. However, despite Swindon's figure remaining stable in 2016, England and Statistical Neighbour requests have increased notably. In Swindon in 2015 the rate was 39.0 per 10,000 population and 40.4 in 2016. Statistical Neighbours have increased from 28.6 to 43.4 and England from 34.2 to 45.0.

During 2016, 191 new EHCPs were issued; this compares to 147 for 2015. As a rate per 10,000 under 18 population in 2016 Swindon had 39.0, this is higher than England (30.9) and Statistical Neighbours (28.8).

In the calendar year 2016, Swindon issued 65.4% of EHCP plans within the required 20 weeks (excluding exceptions) a huge improvement on 37.6% for 2015. Swindon also performed better on this indicator in 2016 compared to Statistical Neighbours (59.7%) and England (58.6%).

The Special Educational Needs and Disability (SEND) reforms require authorities to convert SEN statements to EHC Plans by July 2018. Of statements and LDAs open as at January 2016, Swindon had converted 26.6% of these by January 2017, this is in line with Statistical Neighbours (26.7%) and lower than England (34.4%).

Commissioners are working closely with partners to refresh Swindon's SEND strategy and develop an action plan to drive improvement. This has included the development of a SEN performance dashboard and audit framework to track progress. A "turning the curve" exercise has been undertaken to address the high prevalence of children who have a statement/ EHC plan in Swindon. The resulting action plan being developed will focus on:

- Ongoing review of SENRAP (Special Educational Needs Resources and Assessment Panel).
- Workforce development re quality first teaching.
- A review of the SEN funding formula including the notional SEN budget to increase the funding to schools without the need for a statutory plan.

## Strengths

- Embedding the Special Educational Needs and Disability (SEND) reforms
- SEN Performance Dashboard and audit framework development completed

## Challenges/Risks

- Higher rate of children who are SEN compared with the national average
- Conversion rate for statements to EHC plans



## School Attendance, NEET, Participation in Learning and Youth Unemployment

### Performance Assessment

*The DfE introduced a more rigorous Persistent Absenteeism threshold from 2015/16. Pupils are now classified as PA if they miss 10% or more of all possible sessions – up from 15% in 2014/15.*

**Primary School Absence** has experienced a rise, bucking the previous downward trend, with a figure of 3.9% for the Autumn term of 2016/17, up from 3.4% in the previous year. This, however, reflects a similar rise to 3.9% nationally and 3.8% regionally. In terms of Persistent Absenteeism, 10.2% Primary pupils (1,715) hit the threshold in the Autumn of 2016/17, up from 8.6% in 2015/16 (1,595 pupils). Primary persistent absence in Swindon is now a little higher than national (10.0%) and comparable to regional (10.2%) averages, both of which have also risen for this period compared to last year.

**Secondary School Absence** has also increased, with a rate of 5.1% in the Autumn of 2016/17, up from 4.6% in the previous year. This is a little above the national average (5.0%) and in line with the regional average (5.1%), both of which are increases on last year. In terms of Persistent Absenteeism, 15% Secondary pupils (1,703) hit the threshold in the Autumn of 2016/17, up from 13% in 2015/16 (1,454 pupils). Persistent absence in Swindon is still above regional (14.1%) and national (13.4%) figures although both of these have also risen compared to last year.

Locally reported monthly absence data show both primary and secondary absence rates are higher than this time last year (3.8% and 5.4% respectively compared to 3.4% and 4.8% in April 2016.)

#### **Pupils attending good or outstanding schools**

As of 31<sup>st</sup> August 2016, 94% of Swindon primary pupils were attending good or outstanding schools, above both the national (90%) and regional (92% averages). However, only 48% of secondary pupils were attending good or outstanding schools, compared to 82% in England and 88% in the South West.

#### **Post-16 activities of young people: NEET, participation in Learning and Youth Unemployment**

January 2017 figures show that the proportion of 16-17 year-olds **in learning** (education or training) activities in Swindon, at 91.5%, is up on the previous year (89.3%) – a difference of 62 young people, out of a possible 4500. The learning rate is currently below the national average (92.2%) and South West average (91.8%). Looking at previous years we know that Swindon is quick to track most destinations before the October data submission. However 'In Learning' national and regional figures will start to level between November and December.

Local authorities have a statutory duty to track young people's post-16 activities, with the primary aim of identifying those not participating so that support can be provided for those to take on positive activities. The proportion of young people in '**unknown**' activities was 2.9% (145) for 16-17 year-olds in January 2017, 2.3%pts lower than the previous year, (5.2%), relating to 274 young people. This is equal to the national and regional averages. The proportion of 16-17 year-olds that were **NEET** in Swindon as at January 2017 was 2.9% (145 young people) – higher than last year's figures of 2.3% (121), and just above the national average. The increase of NEETs can be mostly explained by more young people being tracked, therefore moving from the Unknown cohort to NEET.

In terms of the wider cohort (16 to 24 year-olds), the **Youth Unemployment rate** - *those working out of all those 'available' for work* - was on average 11.6% during October 2015 to September 2016, compared to 12.6% in 2014/15 and compares favourably to a national average of 14.0% and regional average (12.8%).

### Strengths

- Primary and secondary school absence rates lower than the national average
- Reduction in the youth unemployment rate (16-24's)
- An increase in young people 'In Learning' and a drop in the Unknown rates

### Challenges/Risks

- Persistent Absenteeism & % pupils attending good or outstanding secondary schools
- Keeping our figures stable and performing in line with national average

### Performance Assessment

As well as reporting NEET for the Swindon population as a whole there are also some key measures in relation to NEET and EET that are reported to the Department of Education as part of our statutory reporting responsibilities for our care leavers.

We have a responsibility to keep in touch with our care leavers up until the age of 21 and promote, encourage participation in learning opportunities. We also have a responsibility to actively monitor whether young people are engaged in Education, Employment and Learning activity.

#### Care Leavers in NEET (Low is good)

Care leavers who are NEET decreased from 48.3% in 15/16 to 44.3% (77 out of 174 young people) in 16/17. The 14/15 National average was 39% & Statistical neighbour was 39.3%. Although a positive direction of travel since 14/15, Swindon is still above national and statistical neighbour average.

**Relevant context of NEET population:** 19 of the NEET care leavers (10.9%) were due to disability or illness as at the end of March 2017. This is higher than the 8% recorded nationally in 15/16, and is higher than the 9.1% outturn for 2015/16. 5 (2.8%), was due to parenting responsibilities; lower than 20% for 2015/16 and lower than the national average of 6%. The reason for the decrease in this group in January 17 is that a number of young parents moved out of the NEET cohort as turned 22.

#### Care Leavers in EET (High is good)

Care leavers EET increased from 48.9% in 15/16 to 55.2% in 16/17 (96 out of 174 young people) - National 14/15 comparator was 48% and the Statistical Neighbour average 46.6%. High is good for this performance measure, and we are now above national average. This is positive.

### Strengths

- EET has increased significantly from last year and is now in line with national average
- Swindon has a very low number of “unknowns”, meaning that we are in touch and actively engaged with our care leavers .
- Care leavers in NEET has reduced during 16/17

### Challenges/Risks

- Swindon has a high number of NEET with a disability compared with others, and routes to EET for this group is challenging

#### Number of Young People committing offences for the first time – First Time Entrants (FTE)

The locally set target is to maintain low numbers of first time entrants (FTEs) into the justice system. Based on previous year's outturns our local target is to have less than 30 first time entrants into the justice system per quarter. Whilst investigating the discrepancy between national and local FTE figures we have recently identified that system issues have resulted in local reporting being understated. We have therefore undertaken some significant data cleansing and reproduced the FTE figures for the whole of 2016/17. This revised reporting shows **26 FTE's in Q4, 2016/17** which is better than target and shows a decrease from its peak of **38 in Q2 2016/17**. The cumulative **full year** position for **2016/17** is **124 FTE's**. Work is continuing in terms of reconciling National and Local datasets however the Police are unable to confirm from their records which of the data sets are used by the Ministry of Justice (MoJ) to record against Swindon FTEs. For this reason, the YOT is arranging to enter into a data sharing agreement directly with the MoJ who will then be able to provide details of names, dates of birth and outcomes for checking against local data, for both pre court and post court disposals. The timetable for completion of the data agreement suggests that it will be around July/ August before the YOT has secured all the data it needs to reconcile figures on first time entrants to the satisfaction of all parties.

#### Re-offending rates

Nationally published datasets show Swindon's re-offending rate has been reducing year on year since it's peak of 43.2% in 2012/13. Latest data shows Swindon's reoffending rate at 36.6% for Apr 14 – Mar 15 which is lower than the national average of 37.7%. Whilst the decrease shown is welcome it does not reflect current data, trends or concerns. The overall re-offending rate for **2016/17** was **14.8%** which is significantly lower than previously recorded figures.

#### Strengths

- Re-offending rates continuing to show a positive direction of travel both on national and local reporting datasets

#### Challenges

- Ensuring cautions and pre-Court disposals are used appropriately and consistently.
- Reconciliation of PNC and local datasets for First Time Entrants to ensure data is accurately reported and guides strategy (including possible pre-court / charge interventions).
- Locally identified issues of offences involving possession of, or use of weapons (including knives) and ensuring a partnership response in tackling this.
- Continuing and predicted on-going reduction in core funding.

### Performance Assessment

**Healthy Child Programme – Health visiting data was only available for quarter 3 at the time of reporting. Full year data will come to the next committee meeting.**

#### Breastfeeding

Prevalence of breastfeeding at 6 weeks was 48.7% of all eligible babies (747) during Quarter 3 of 16/17 (up from 47.1% in Q2), compared with 44.1% nationally and 40.4% for Statistical Neighbours. The coverage in Q3 was 95.4% in Swindon which is in line with Q2 16/17 at 95.9%. Nationally, coverage in Q3 was 88.4% and for Statistical Neighbours it was 87.6%. Coverage is measured in terms of all eligible babies receiving a 6-8 week visit from their health visitor.

#### Health Visitor Contacts

Following the change of reporting on this data from CHIMAT to Public Health England, Q3 data for comparators was still unavailable as at 1<sup>st</sup> June.

There were 450 antenatal visits by Health Visitors at 28 weeks in Quarter 3 of 16/17, this compares to 463 in Quarter 2.

New Birth Visits were completed for 99% of eligible babies in Quarter 3 (78% before 14 days and 21% after). Nationally, this figure was 98% in Q2.

In quarter 3, 6-8 Week Reviews were completed for 86% of 747 eligible babies by the time they were 8 weeks old, which is higher than the 84% reported for Swindon in Q2 and the 82% reported nationally for Q2.

12 Month Checks were completed for 79% of 747 eligible children prior to them reaching 15 months in Q3. This has increased from the 78% reported in Quarter 2, but is lower than the Q2 national figure of 83%.

2-2.5 Year Checks were completed for 75% of 780 eligible children in Q3, increasing from 72% in Quarter 2 but lower than the national figure of 78% in Q2. In Q3, of those visited, 75% had a developmental test (known as ASQ-3 test), completed compared with 80% in Quarter 2.

### Strengths

- Coverage for the 6-8 week visit and breastfeeding advice remains high and is above national performance.
- The vast majority of new birth visits are taking place within 10 days

### Challenges

- 12 month checks have improved considerably since Q1 (7.4ppts), but still have a gap of 4.6ppts compared to national performance.
- Following an increase in Q1 of antenatal visits, in Q2 it has dropped slightly. This will need to be monitored to ensure it stabilises.

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## Work Programme 2017/18

### Children's' Health, Social Care and Education Overview & Scrutiny Committee

Date: 5<sup>th</sup> July 2017

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Author:	Director of Law & Democratic Services
Wards:	All Wards
Locality Affected:	All Localities
Parishes Affected:	All Parish Areas

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#### 1. Purpose and Reasons

- 1.1 Each Overview and Scrutiny Committee is requested to have a work programme that details the activities that it will be undertaking during the Municipal year.
- 1.2 The work programme details the various topics and issues that each Committee intends to look into during the coming year with the aim of producing evidence based recommendations intended to provide service improvements for Cabinet and external agencies/bodies to consider.
- 1.3 Under the Council's Constitution, Overview and Scrutiny Committees are required to agree a work programme at the start of the municipal year outlining their priorities and likely outcomes of considering these issues.

The work programme is developed taking into account:

- Corporate priorities and objectives, including the Cabinet Forward Plan.
  - Partnership strategic priorities and objectives.
  - The interests and concerns of Members, Council officers, members of the public and other stakeholders such as community and voluntary groups and local businesses.
- 1.4 Committees are encouraged to review the work programme on a regular basis to ensure it remains relevant and to prioritise the workload of the Committee.
  - 1.5 Members are reminded that the work programme must also take into account:
    - The workload of the Committee and of individual members.
    - The capacity of the Scrutiny Unit and other officers to support a review.
    - The resource implications of carrying out a review.
    - The timescales for a review.
    - The most appropriate method of carrying out a review e.g. Committee meeting, Task Group, Member Champion review.
  - 1.6 The Local Government and Public Involvement in Health Act 2007 have presented the Children's Health, Social Care and Education Overview and Scrutiny Committee with a role, remit and powers regarding local health matters.

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Further information on the subject of this report can be obtained from Contact Rita Glen-Gallo, 01793 463410, [rglen-gallo@swindon.gov.uk](mailto:rglen-gallo@swindon.gov.uk)

# Work Programme 2017/18

## Children's' Health, Social Care and Education Overview & Scrutiny Committee

Date: 5<sup>th</sup> July 2017

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- 1.7 The Children's Health, Social Care and Education Overview and Scrutiny Committee is encouraged to be mindful of its role and remit when considering a work programme for the 2017/18 Municipal Year.

### 2. Recommendations

The Committee is recommended to:

- Consider and discuss the Chair's proposal for the 2017/18 work programme.
- Approve the proposed Work Programme for the 2017/18 Municipal year.
- Appoint Members to any Task Groups agreed by the Committee.

### 3. Detail

- 3.1 It is important that Overview and Scrutiny adds value to the work of the Council and the Borough and produces tangible outcomes for local people that result in real service improvements. Selecting the right topics is crucial to ensure that Overview and Scrutiny will be effective.

The work programme will be reviewed at every Committee meeting or as the Committee sees fit to ensure that it remains relevant and that Members and Officers have sufficient capacity to effectively achieve its objectives.

- 3.2 The Work Programme attached at Appendix 1 includes these suggestions and the Committee is asked to approve the work programme for the 2017/18 Municipal year.
- 3.3 Members of the Children's Health, Social Care and Education Overview and Scrutiny Committee are encouraged to work with Cabinet in the best interests of the Borough and to take into account the priorities and suggestions of Cabinet as detailed in the Cabinet Work Programme and Forward Plan, attached at Appendix 2 when considering the contents for their work programme.
- 3.4 In addition, attention is drawn to the Scrutiny Process Flowchart, attached at Appendix 3, which is aimed at assisting the Committee in identifying how they could influence policy development.

Task Group Reviews

- 3.5 The Committee is required to undertake individual reviews throughout the municipal year and proposals for reviews should be proposed and discussed at the Committee meeting.

### 4. Alternative Options

- 4.1 The Committee can choose not to have a detailed work programme although it is recommended that it is best practice to do so.

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Further information on the subject of this report can be obtained from Contact Rita Glen-Gallo, 01793 463410, rglen-gallo@swindon.gov.uk



# Work Programme 2017/18

## Children's' Health, Social Care and Education Overview & Scrutiny Committee

Date: 5<sup>th</sup> July 2017

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### 5. Implications, Diversity Impact Assessment and Risk Management

#### Financial and Procurement Implications

- 5.1 There are no financial or procurement implications arising as a result of this report. Any expenditure arising as a result of an item on the Committee's work programme will be met by the Overview and Scrutiny Support budget, subject to the approval of the Committee.

#### Legal and Human Rights Implications

- 5.2 Section 21 of the Local Government Act requires every local authority to establish an overview and scrutiny function to hold the Executive to account, undertake policy development and review, monitor and improve performance.

#### All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 There are no other direct implications arising as a result of this report. Any further implications will be identified when a topic is reviewed by the Scrutiny Committee and in any recommendations made by the Scrutiny Committee.

#### Diversity Impact Assessment

- 5.4 No Diversity Impact Assessment is required at this stage, any DIA that is required during review of topics included within the work programme will be identified at the appropriate stage.

#### Risk Management

- 5.5 No risk management issues have been identified at this stage. Any risk management issues will be identified at the appropriate time when a topic is under review by the Scrutiny Committee and if it makes any recommendations.

### 6. Consultees

- 6.1 The Director of Finance (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

### 7. Background Papers

- 7.1 None.

### 8. Appendices

- 8.1 Appendix 1 – Work Programme for 2017/18.
- 8.2 Appendix 2 – Cabinet Work Programme and Forward Plan for the period 20<sup>th</sup> June 2017 to 20<sup>th</sup> June 2018.

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Further information on the subject of this report can be obtained from Contact Rita Glen-Gallo, 01793 463410, rglen-gallo@swindon.gov.uk

## **Work Programme 2017/18**

### **Children's' Health, Social Care and Education Overview & Scrutiny Committee**

**Date: 5<sup>th</sup> July 2017**

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8.3 Appendix 3 – Scrutiny Process Flowchart.

## **Children's Health, Social Care and Education** **Work Programme 2017 - 18**

### **Terms of Reference of the Committee**

To fulfil all the functions of an overview and scrutiny committee as they relate to: –

- The review, scrutiny, and development of policy recommendations.
- The management of performance.
- The monitoring of progress towards delivering relevant strategies and corporate priorities.
- The formulation of advice for the Cabinet, Council and other partners and stakeholders.

To have specific responsibility for (but not limited to) the scrutiny of:–

- The performance of services for children towards agreed local and national Performance Indicators.
- The quality of provision and effectiveness of Local Authority strategies to raise standards of education within Swindon.
- Specialist social services and integrated social services for children and young people in Swindon.
- The delivery of services to children and young people in Swindon generally.

In addition, as these relate to Children and Young People:

- The performance of services seeking to deliver healthy communities towards agreed local and national performance indicators.
- Health, health commissioning and service delivery.
- Public Health, Health promotion and the work of the Health and Wellbeing Board.
- Health Integration and collaborative working and commissioning with Health agencies and providers and General Practitioners.

In accordance with Section 7 of the Health and Social Care Act 2001 (as amended), the Children's Health, Social Care and Education Overview and Scrutiny Committee will undertake scrutiny of local health service providers jointly with the Adult's Health, Social Care and Housing Overview and Scrutiny Committee.

### **Review of the Work Programme**

The work programme will be reviewed at every meeting of the Children's Health, Social Care and Education Overview & Scrutiny Committee to ensure that it remains relevant, to ensure that Members and Officers have sufficient capacity to deliver the work programme and to include any additional items on the work programme, if appropriate.

### **Contact details**

Committee Officer: Rita Glen-Gallo  
Email: [rglen-gallo@swindon.gov.uk](mailto:rglen-gallo@swindon.gov.uk)  
Tel: 01793 463611

5 <sup>th</sup> July 2017		
Theme/Scope: Work programme and Health theme – Hospital Quality Account and CCG Children's Review		
Item	Objectives	Witnesses
Co-optees Appointment	To confirm the appointment of Co-optees to the Committee.	Chair
Annual Quality Accounts for The Great Western Hospital 2016-17	To update the Committee.	Kevin McNamara – Great Western Hospital
Clinical Commissioning Group	To update the Committee.	Gill May – Clinical Commissioning Group
Performance Report	To provide a detailed report on the Children's Services performance.	Phillipa Lamb / Peter Nathan/ Maria Young
Work Programme discussion	To set the work programme for the forthcoming municipal year.	All

20 <sup>th</sup> September 2017		
Theme/Scope: Disabilities and Special Educational Needs		
Item	Objectives	Witnesses
Education and Health Care Plans	<ul style="list-style-type: none"> <li>To update the Committee on the national model and expectations and the challenges facing services to implement E&amp;HCP</li> <li>To include exploration of the effectiveness of provision; services and Special Resource Provision in school settings:</li> <li>Guidance available to parents re pathways for Autism/ ADHD.ADD diagnoses.</li> </ul>	<p>To run as a workshop style and to involve a Head Teacher; parent; SENAT; SEND &amp; EP</p> <p>Peter Nathan to lead/ arrange</p>

29 <sup>th</sup> November 2017		
Theme/Scope:– Childrens Mental Health and Wellbeing		
Item	Objectives	Witnesses
TAMHS	<p>Update the Committee on mental health of young people</p> <ul style="list-style-type: none"> <li>Challenges and opportunities the service has encountered in the past year</li> <li>Reasons for any delay in assessments and if this is a factor in school exclusions?</li> </ul>	Maria Young
CAMHS	<p>Update the Committee on mental health of young people</p> <ul style="list-style-type: none"> <li>To include challenges, evidence of need and impact</li> <li>Update on re-commissioning of CAMHS</li> <li>CCGs overview of children's mental health pathways</li> </ul>	Thomas Kearney/ Gill May

<b>29<sup>th</sup> November 2017</b>		
Transitions to adulthood	Update the Committee to include: <ul style="list-style-type: none"> <li>Challenges and opportunities the service has encountered in the past year</li> <li>Transition to adult mental health, effectiveness, outcomes, challenges, issues, opportunities</li> </ul>	Gill May, Clinical Commissioning Group
Performance of Children's health services	<ul style="list-style-type: none"> <li>Detailed report on the Children's Services performance. Informing the Committee of the latest indicators across Children's Services.</li> <li>Detailed performance report on children's area -overview/issues</li> <li>Detailed performance report on children's area -overview/issues</li> </ul>	Phillipa Lamb / Peter Nathan/ Maria Young  Kevin McNamara, GWH Gill May, Clinical Commissioning Group
Youth Forum and Youth Parliament	To introduce new Youth Parliament members; receive details of the Youth Forum's work for the 2017/18 period and to give the Committee an opportunity to identify any issues raised that Overview and Scrutiny can assist with.	Paul Dobson/ Claire Smith

<b>24<sup>th</sup> January 2018</b>		
<b>Theme/Scope: Education and School Standards</b>		
<b>Item</b>	<b>Objectives</b>	<b>Witnesses</b>
Education Standards	To provide the Committee with an overview and highlight challenges and progress in the following areas: <ul style="list-style-type: none"> <li>Academy performance</li> <li>LA Education Plan</li> <li>Exam/ progress results</li> <li>Exclusions –progress in reducing</li> </ul>	Peter Nathan, To Invite Chairs of SAPH and SASH Committee
Youth Forum and Youth Parliament	To update the Committee.	Paul Dobson

<b>21<sup>st</sup> March 2018</b>		
<b>Theme/Scope: Childrens Safeguarding and Children's Social Work</b>		
<b>Item</b>	<b>Objectives</b>	<b>Witnesses</b>
Front Door Referrals & Threshold	To provide the Committee with the an update on: <ul style="list-style-type: none"> <li>Progress of the MASH and Thresholds work</li> <li>Brief outline of what's known about the new Childrens Ofsted framework</li> </ul>	Maria Young
Social work update	<ul style="list-style-type: none"> <li>Progress in the quality of social work, feedback from the Principal Social Worker and Social Work Health Check</li> </ul>	Maria Young and Fiona Francis

<b>21<sup>st</sup> March 2018</b>		
Safeguarding	<ul style="list-style-type: none"> <li>To receive a report on Child Sexual Exploitation, Female Genital Mutilation, Honour Based Violence and Domestic Abuse</li> </ul>	Maria Young & Gill May
Performance of Childrens health services	<ul style="list-style-type: none"> <li>Detailed report on the Children's Services performance. Informing the Committee of the latest indicators across Children's Services.</li> <li>Detailed performance report on children's area -overview/issues</li> <li>Detailed performance report on children's area -overview/issues</li> </ul>	Phillipa Lamb / Peter Nathan/ Maria Young  Kevin McNamara, GWH  Gill May, Clinical Commissioning Group

## Swindon Borough Council

### CABINET WORK PROGRAMME AND FORWARD PLAN

20 June 2017 - 20 June 2018 – Proposed AGENDA ITEMS and KEY DECISIONS (as at 22/06/17)

Key Decisions are defined as:

decisions that are likely to be significant in terms of spending or savings having had regard to the Council's budget for that particular service or function, and

decisions that are likely to have a significant impact on two or more Council wards.

If you wish to make your views known on any matter set out in this work-plan, please contact the relevant Cabinet Member or the contact officer identified.

Councillor:	Portfolio:
David Renard	Leader of the Council and Chair of Cabinet
Russell Holland	Deputy Leader of the Council, Vice Chair of Cabinet, and Cabinet Member for Finance and Commercialisation
Oliver Donachie	Cabinet Member for the Economy and Skills
Toby Elliott	Cabinet Member for Strategic Planning and Sustainability
Fionuala Foley	Cabinet Member for Children's Services and School Attainment
Brian Ford	Cabinet Member for Adults' Health and Social Care
Mary Martin	Cabinet Member for Communities and Place
Cathy Martyn	Cabinet Member for Housing and Public Safety
Garry Perkins	Cabinet Member for Regeneration
Keith Williams	Cabinet Member for Corporate Services and Digitalisation



### Cabinet Member Decisions Proposed for June/July 2017

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
NONE						

### Cabinet Meeting Date - 12th July 2017

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
Budget Management 2017-18	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A 7th June 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	
Education Transport Policy 2018-19.	No	Cabinet Member for Children's Services and School Attainment	Cabinet	N/A 13th September 2016	Director of Children's Services Head of Education	
Debt Management	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A 13th September 2016	Corporate Director Resources & Transformation Head of Revenues and Benefits	
References from the Health and Wellbeing Board - Better Care Fund 2017-2019	No	Cabinet Member for Adult's Health and Social Care	Cabinet	19th June 2017	Corporate Director Resources & Transformation Director of Law & Democratic Services	Minute for Reference - Better Care Fund Minute for

and Carers Memorandum of Understanding					(Monitoring Officer)	Reference - Carers Memorandu m of Understandi ng
Site at South East Swindon, Proposed Land Sale and Collaboration	No	Cabinet Member for Strategic Planning and Sustainability	Cabinet	N/A 6th June 2017	Corporate Director Economy, Regeneration & Skills Head of Property Assets	

### Cabinet Meeting Date - 6th September 2017

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
Budget Management 2017/18 and 2017 -2021 Efficiency Statement	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 13 <sup>th</sup> September 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	
Annual Review of Local Ombudsman Complaints	No	Leader of the Council	Cabinet	N/A Date of Notice: 13 <sup>th</sup> September 2016	Corporate Director Resources & Transformation Director of Law & Democratic Services (Monitoring Officer)	
2020 Renewables target, the achievement of "subsidy free solar projects and the reduction of Council energy costs by at least	Yes	Cabinet Member for Strategic Planning and Sustainability	Cabinet	N/A Date of Notice: 21 <sup>st</sup> March 2017	Corporate Director Economy, Regeneration & Skills	Cabinet Minute 60(9) 2016/17 refers

20%						
Skills and Employment Strategy	No	Cabinet Member for Economy and Skills	Cabinet	N/A Date of Notice: 6 <sup>th</sup> February 2017	Corporate Director Economy, Regeneration & Skills	N/A
Draft Economic Strategy	No	Cabinet Member for Economy and Skills	Cabinet	N/A Date of Notice: 16 <sup>th</sup> September 2016	Corporate Director Economy, Regeneration & Skills	Cabinet Minute 124 2016/17 refers
Kimmerfields Strategic Programme	No	Cabinet Member for Regeneration	Cabinet	N/A Date of Notice: 18 <sup>th</sup> May 2017	Corporate Director Economy, Regeneration & Skills	N/A
Swindon Borough Local Development Scheme Review 2017	Yes	Cabinet Member for Strategic Planning and Sustainability	Cabinet	N/A Date of Notice: 13 <sup>th</sup> April 2017	Corporate Director Economy, Regeneration & Skills	N/A
Lydiard House and Park - Business Transfer Agreement and	Yes	Cabinet Member for Communities and Place	Cabinet	N/A Date of Notice: 21 <sup>st</sup> March 2017	Corporate Director Communities and Place	Cabinet Minute 107 (2016/17) refers

Lease						
Wichelstowe Joint Venture	Yes	Cabinet Member for Strategic Planning and Sustainability	Cabinet	N/A 8th May 2017	Corporate Director Economy, Regeneration & Skills	

### Cabinet Meeting Date - 18th October 2017

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
2017-18 Budget Management, 2018-19 Draft Budget and Medium Term Resourcing Plan	Yes	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 21 <sup>st</sup> October 2106	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Forward Swindon Ltd - review of role and remit	No	Cabinet Member for Economy and Skills	Cabinet	N/A Date of Notice: 21 <sup>st</sup> March 2017	Corporate Director Economy, Regeneration & Skills Andy Evans, Corporate Director, Economy, Regeneration, and Skills AEvans@swindon.gov.uk	N/A
Libraries Strategy - Alternative Delivery Models	No	Cabinet Member for Communities and Place	Cabinet	N/A Date of Notice: 13 <sup>th</sup> February 2017	Corporate Director Communities and Place Head of Localities and Volunteering	Cabinet Minute 125 2016/17 refers
Swindon - A Learning Town	No	Cabinet Member for Children's Services and School	Cabinet	N/A Date of Notice: 15 <sup>th</sup> May 2017	Director of Children's Services Peter Nathan, Head of	Cabinet Minute 120(3) refers

		Attainment			Education	
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### Cabinet Meeting Date - 6th December 2017

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
2017-18 Budget Management, 2018-19 Draft Budget and Medium Term Resourcing Plan	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 24 <sup>th</sup> October 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	
Capital Programme Monitoring - Second Quarter and Treasury Management Performance 2017/18.	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Notice of Decision: 9 December 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Treasury Strategy Statement (Minimum Revenue Provision Policy)	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 26 <sup>th</sup> October 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Polling District	No	Leader of the	Cabinet	N/A	Director of Law &	N/A

and Places Review		Council		Date of Notice: 5 <sup>th</sup> October 2016	Democratic Services (Monitoring Officer) Director of Law & Democratic Services (Monitoring Officer)	
School Organisational Changes 2018/19	No	Cabinet Member for Children's Services and School Attainment	Cabinet	N/A Date of Notice: 19 <sup>th</sup> September 2016	Director of Children's Services Head of Education	N/A
Children and Adult Social Care - Emergency Duty Service	No	Cabinet Member for Children's Services and School Attainment	Cabinet	N/A Date of Notice: 19 <sup>th</sup> June 2017	Director of Children's Services Maria Young	N/A

### Cabinet Meeting Date - 7th February 2018

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
Budget 2018/19 and Beyond	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 20 <sup>th</sup> January 2017	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Capital Programme 2018/19	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 20 <sup>th</sup> January 2017	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Treasury Strategy Statement 2018/19	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 20 <sup>th</sup> January 2017	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Housing Revenue Account - Rents	No	Deputy Leader of the Council and Cabinet Member for	Cabinet	N/A Date of Notice: 20 <sup>th</sup> January 2017	Corporate Director Resources & Transformation	N/A

and Charges 2018/19		Finance and Commercialisation			Director of Finance (s151) Officer	
Swindon Pay Policy Statement 2018	No	Leader of the Council	Cabinet	N/A Date of Notice: 20 <sup>th</sup> January 2017	Head of People, Performance and Engagement	N/A
School Admission Arrangements	Yes	Cabinet Member for Children's Services and School Attainment	Cabinet	N/A Date of Notice: 20 <sup>th</sup> January 2017	Director of Children's Services Head of Education	N/A

### Cabinet Meeting Date - 14th March 2018

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
Budget Management 2017/18	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 22 <sup>nd</sup> April 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Capital Programme Monitoring 3rd Quarter 2017/18	Yes	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 22 <sup>nd</sup> April 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A

### Cabinet Meeting Date - 18th April 2018

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
Budget Management Update	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 1 <sup>st</sup> February 2016	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
School Transport	No	Cabinet Member for Children's Services and School Attainment	Cabinet	N/A Date of Notice: 22 <sup>nd</sup> December 2016	Director of Children's Services Director of Children's Services	N/A
Swindon Local Transport Plan - Implementation Plan 2017/18	Yes	Cabinet Member for Communities and Place	Cabinet	N/A Date of Notice: 6 <sup>th</sup> February 2017	Corporate Director Economy, Regeneration & Skills Jason Humm, Head of Highways & Transport	N/A

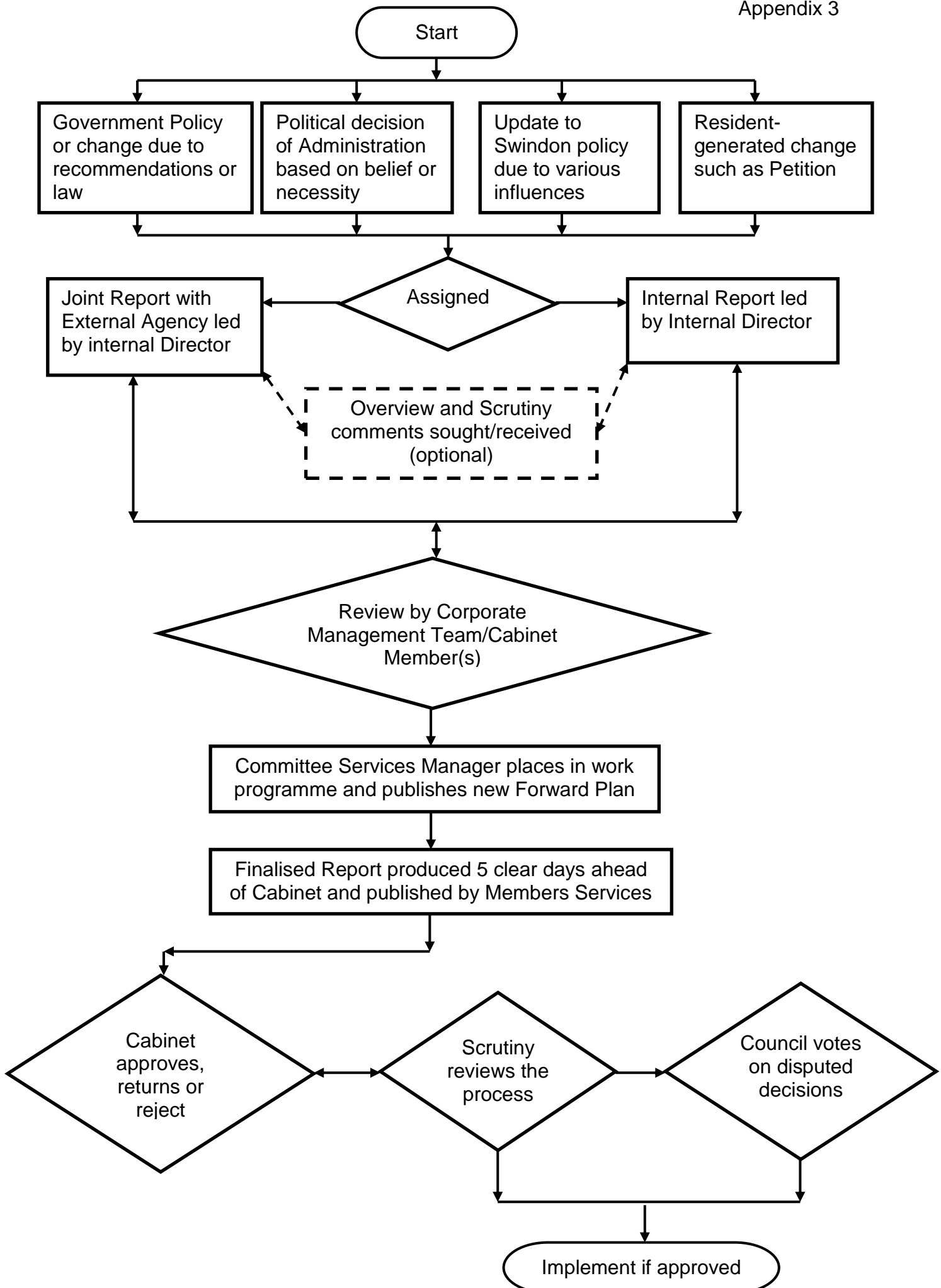
### Cabinet Meeting Date - June 2018 (TBC)

Subject	Key Decision Yes/No	Portfolio Holder / Cabinet Member	Decision Maker	Consultation Responses/Date of Notice	Contact Officer	Available Background Papers
Budget Management 2017/18.	No	Councillor Russell Holland	Cabinet	N/A Date of Notice: 27 <sup>th</sup> May 2016 20th June 2017	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Housing Revenue Account - Medium Term Financial Plan	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 27 <sup>th</sup> May 2016 20th June 2017	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Capital Programme Monitoring Out-Turn 2017/18	No	Deputy Leader of the Council and Cabinet Member for Finance and Commercialisation	Cabinet	N/A Date of Notice: 27 <sup>th</sup> May 2016 20th June 2017	Corporate Director Resources & Transformation Director of Finance (s151) Officer	N/A
Treasury Performance Management	No	Deputy Leader of the Council and Cabinet Member for	Cabinet	N/A Date of Notice: 27 <sup>th</sup> May 2016	Corporate Director Resources & Transformation	N/A

2017/18		Finance and Commercialisation		20th June 2017	Director of Finance (s151) Officer	
School Place Planning	Yes	Cabinet Member for Children's Services and School Attainment	Cabinet	N/A Date of Notice: 9 <sup>th</sup> May 2017 20th June 2017	Director of Children's Services Head of Education	N/A







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