TETBURY HOSPITAL

Quality Accounts

for the year ended

31st March 2016

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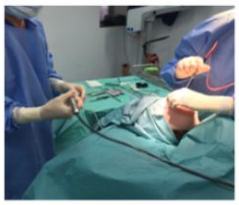


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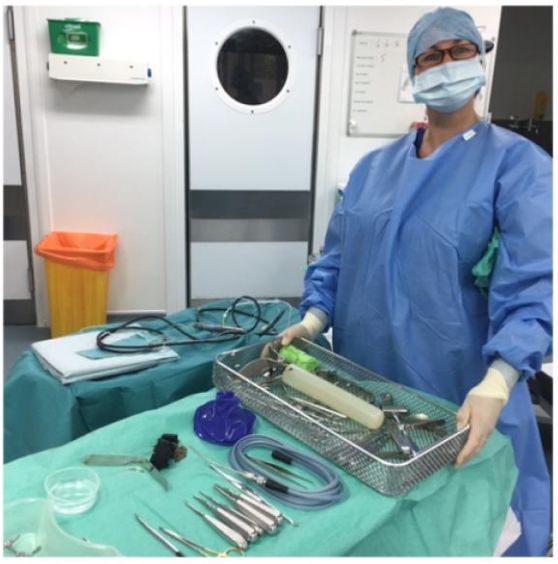
TETBURY HOSPITAL




the COVENTRY
Mar 2016
Friends of Tetbury Hospital
NINE HUNDRED
AND FIFTY POUNDS
£950.00

Contents

Part 1

1. Welcome from the Chief Executive

Welcome to Tetbury Hospital Trust's quality accounts. This report outlines the Trust's approach to quality improvement, progress made in 2015-16, a look back at 2014-15 and plans for the forthcoming year.

Our hospital is regulated by the Care Quality Commission and the Charities Commission. Tetbury Hospital Trust was faced with closure in the late 1980s. The local community pulled together and raised over £1,000,000 to purchase the hospital from the National Health Service and take over the running of the services. Tetbury Hospital Trust Ltd was established on 28 January 1992 and registered as a charity on 27 February 1992.

The Trusts focus is to deliver high quality services to our local population and surrounding areas. The hospital has 6 key values which underpin everything we do as an organisation. WE CARE about our patients, staff, visitors and stakeholders, we are:

- **W**elcoming to patients, carers, visitors, staff and stakeholders. Embracing diversity and delivering services to meet individuals needs
- **E**fficient and effective in everything we do
- **C**haritable, ensuring the organisation is well led and governed appropriately and our status as a registered charity is maintained
- **A**ccountable for our actions, acting with integrity and openness at all times. Celebrating what we do well and learning from our set backs
- **R**espectful of our patients, visitors and staff at all times, treating them with dignity and listening and supporting them
- **E**xcellence is the standard we strive to achieve

The aim of the Quality Account is to provide information to our patients, members and commissioners to assure them we are committed to making progressive improvements. We provide a safe and friendly environment where patients feel valued and respected in decisions about their care and are fully informed about their treatment at each step of their pathway.

The experience that patients have in our Trust is important to us; we are committed to delivering services where the patient is at the centre of everything we do. Our patients receive a personalised service; they are treated quickly and safely. Our service is enhanced by good communication and respecting our patient's privacy and dignity at all times.

We have excellent clinical and medical leadership. In 2015/16 we made the decision to appoint our first Clinical Lead in Anaesthesia, this post was recruited to in April 2016, and this role will drive forward clinical standards and add an additional layer of governance to our Day Surgery Unit. Dr Henry Murdoch will work closely with our Medical Director, Matrons and Day Surgery Unit Management Team, to ensure our service is delivered to the highest, safe and efficient standard.

We value patient feedback about their care. In the last year we have taken part in the NHS patient survey and received excellent feedback. We have also participated in NHS Friends and Family Survey, and have been delighted with the results and comments from patients.

In 2015/16 we completed a £243,553 investment program, an increase of 45% from the £168,461 invested in 2014/15. We have big plans for the forthcoming year, investing in our reception area to make it even more welcoming, and updating our physiotherapy department's environment and providing a new phototherapy service.

We saw our activity grow in ophthalmology and dermatology, we would like to thank the Coventry for their fundraising during the year which has enabled us to purchase additional equipment for the dermatology team to use when treating and diagnosing patients skin conditions. We would also like to thank The Hans and Julia and Rausing Trust for their generous donation.

This report is just a snap shot of all the good work our staff and volunteers do. I remain proud of their commitment in providing the best possible care and attention to patients and their families.

Zena Dalton
Chief Executive

2. Introduction to our Quality Accounts

The Health Act 2009 requires all providers of NHS services in England to produce a Quality Account to provide information about the quality of the services they deliver.

There is an exemption for organisations that have fewer than 50 full-time employees and provide under £130,000 of NHS services. Tetbury Hospital Trust Ltd holds contracts with the NHS in excess of £130,000, however, has fewer than 50 full time employees. In 2015/16 our head count was 55 and our full-time employee number increased to 26. These figures exclude medical and surgical consultants as they are not classed as employees of the Trust. 73 Consultants (physicians, surgeons and anaesthetists) hold Tetbury Hospital practising privileges and can manage patient care within our Trust.

A Quality Account is a report about the quality of services delivered by an NHS healthcare provider, this includes independent providers. Although Tetbury Hospital Trust is not mandated to publish this annual report the Board has decided that our quality information should be available to our members, our commissioners and published on the internet for the public to access.

Quality Accounts are an important way for us to report on quality and show improvements in the services we deliver to our local community and stakeholders. The quality of our service is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

This is the second published set of Quality Accounts for Tetbury Hospital Trust Ltd. The format is similar to that of a mandatory set of Quality Accounts. The report will set out the approach we are taking to continuously improve quality of care and experience at the Trust. We aim to provide high quality, safe care for all our patients, and this report will document our key achievements for this year and our future plans.

3. Description of Services

The Trust has a number of departments which deliver services on behalf of the National Health Service, these are

3.1 Minor Injuries Unit

Our Minor Injuries Unit is open from 8.30am and accepts its last patient at 4pm, it is a nurse led service delivered by an Emergency Nurse Practitioner (ENP).

3.2 Out Patient Department

Our Outpatient Department has seven clinic rooms and a range of consultants delivering services from them, we provide appointments in Cardiology, Dermatology, ENT, Gastrointestinal, General Surgery, Gynaecology, Maxilla facial, Ophthalmology, Orthopaedics, Pain Management, Respiratory Medicine and Urology.

3.3 Day Surgery Unit

Our Day Surgery Unit consisting of one theatre and ten recovery bays. The Day Surgery Unit is able to offer patients the choice of local, IV sedation and general anaesthesia for a variety of operations such as: gynaecological procedures, Knee arthroscopy, removal of cataracts, laparoscopic procedures, the removal of skin lesions, teeth extractions, facet joint injections and podiatric surgery

3.4 Imaging Department

Our Imaging Department offers GP direct access for plain film x-rays and a service to our Outpatient department and Minor injuries unit. We also have a C-arm which is used in theatre during operations. GP Care deliver ultrasound services from our hospital.

3.5 Therapies

Our physiotherapy services are provided by Gloucestershire Care Services who rent the facility so they can deliver care closer to our patient's home, we also have a private physiotherapy service provided by the Courtyard and other independent practitioners.

This year we welcomed our first foot health practitioner, who delivers services from our hospital once a week, we also welcomed a McTimoney Chiropractor who visits monthly.

3.6 The Vale Hospital

We provide dermatology out-patient clinics from the Vale Hospital.

4. User Involvement

The Trust is committed to improving services not only through the identification of local needs and gaps in service, but also by seeking user perspectives. The difficulty we face in achieving this is that many of our patients have a very limited time within our hospital environment, so capturing information from users can prove to be difficult.

The Trust uses patient feedback forms which are given to all patients on the day they attend. Patients are encouraged to complete the form on site and submit it before they leave. The feedback form contains a comment box; any comments received are reviewed monthly by the Matrons and Departmental Managers. We also perform a more formal patient experience survey annually which gives the Trust more information on patient's experiences as well as providing us information on what could be improved.

As a charity we have 58 members, and over 500 friends, we pull from this representational group to advise us on areas of the hospital that they feel can be improved, and for more formal

assessments, such as the Patient Led Assessment of the Care Environment (PLACE). Due to the unique way we are embedded into our community, many of our members and friends of Tetbury Hospital are also patients who value the services we deliver and contact us if they feel they could be delivered better.

Our Patient Led Assessment in the Care Environment (PLACE) was completed informally in the year 2014/15. A formal PLACE assessment was completed 2015/16 and submitted to HSCIC on the 27th May 2016. The timelines for submissions are set by HSCIC.

Our PLACE assessment was a valuable feedback tool, and we have received our provisional results, we are awaiting the full report. It was felt by the patient volunteers completing the documentation that many of the questions being asked seemed to be directed at larger hospitals that have patients staying overnight. We have already started to put some of the feedback into action and are scoping whether we could invest in public access Wi-Fi, and improving our signage by including gender pictures on toilet doors.

5. Outside Quality Inspections

The Chief Executive is the CQC Registered Manager for the Trust. During the period covered by this report Tetbury Hospital has not been formally inspected by the Care Quality Commission (CQC). The last formal inspection was February 2013. The next formal inspection is due to take place in September 2016.

In June 2014 we were re-evaluated by Investors in People. The Trust successfully met the 44 evidence requirements and the reviewer noted 'The overall picture of Tetbury Hospital is of quiet competence, consistently meeting external quality standards with professional, friendly and happy people all of whom are committed to continuous improvement'. The next re-evaluation is not due until June 2017.

We continue to participate in our ISO9001/14001 Surveillance visits and consistently achieve the required standards. We were formally inspected on the 13th April 2015 and the 30th September 2015

6. Safety of Medications, including Controlled Drugs

The Chief Executive is the Accountable Officer. The role of the Accountable Officer is to ensure the safe management of medicines including controlled drugs from ordering through to their disposal. The responsibility for the Accountable Officer is to make quarterly reports to NHS England on any concerns within the organisation, this is achieved by completing an occurrence report, in 2015/16 there was one incident reported, in relation to a very small quantity of schedule 5 medication which could not be accounted for.

7. Registration

The Trust welcomes the new way of inspecting, and recognises the visions to aligning NHS and independent sector reporting to support comparable ratings across the health and care sector. To support our internal monitoring processes, we continue to report to our Board using five key questions.

- ***Are we Safe?***
  - ✓ Ensuring people are protected from abuse and avoidable harm
- ***Are we Effective?***

- ✓ Promoting a good quality of life and achieving good evidenced based outcomes

- ***Are we Caring?***
  - ✓ Involving people and treating them with compassion, kindness, dignity and respect
- ***Are we Responsive?***
  - ✓ Organising products and services to provide wide access to meet people's needs
- ***Are we Well-led?***
  - ✓Promoting high quality person-centred care through strong leadership

8. Hospital Accountability Statement

To the best of my knowledge the information in the report is accurate, Mrs Zena Dalton, Chief Executive.

This report has been reviewed by the Medical Advisory Committee and approved by the Chair Mr Michael Rigby, Medical Director.

9. The Board of Trustees Statement

The Board of Trustees is fully committed to the provision of a high quality service. This report has been approved by the Board for publication.

The Hospital has a robust clinical and corporate governance structure, with members of the Board playing an active part in ensuring the trust fulfills its mission, according to its charitable intentions and insuring the organisation remains responsible and compliant in all areas of CQC registration, health and safety, employment law and other relevant legislation.

10. Please Feedback comments on our Quality Accounts

This year is the second time Tetbury Hospital Trust has published a set of Quality Accounts. We would value your feedback on whether you found them useful and easy to follow.

If you would like to feedback please email enquires@tetburyhospital.co.uk, or write to:

The Chief Executive
Tetbury Hospital Trust
Malmesbury Road
Tetbury
Glos.
GL8 8XB

Part 2

11. A review of our Quality priorities

On an annual basis, Tetbury Hospital Trust develops an operational plan to set objectives for the year ahead. The priorities are determined by the hospitals senior management team taking into account patient feedback, audit results, national guidance and recommendations from various committees and staff meetings which represent all clinical and non-clinical professions.

11.1 The plan for 2015/16 (looking back)

In last year's accounts we set out our priorities for improvement. The following section details our achievements against these priorities during the year.

11.1.1 Patient Safety

- We said we would implement an electronic discharge summary for patients as part of commissioning for quality objectives with Gloucestershire Clinical Commissioning Group. We achieved this objective, full details are in section 16.1

- We said we would update our website to include a staff only section to ensure communication cascades to staff are robust. We achieved this objective, with the introduction of a new website that provides more useful information to patients and carers, with the added benefit of a staff page

11.1.2 Clinical Effectiveness

- We said we would replace our current Patient Administration System with a state of the art Clinical Records System, we said this electronic system would improve data quality and access to outcome data that can be used to support patient choice, and that all new patient records would be held electronically. We did not achieve this ambition in 2015/16, however, the system will be implemented in September 2016

- We said that links with safeguarding, especially with children on the 'risk register', needs to be more robust, and that we were working towards this. We have signed up with the CP-IS, a national link regarding children on the risk register, and working with Gloucestershire Counties Joining Up Your Information project team, to ensure the appropriate sharing of information across the non-elective pathway

- The Matrons perform their monthly walk around to ensure standards are continually met, and that staff are working to the agreed policies and procedures

- We developed and completed the Care Quality Commission booklet which was presented to all staff and volunteers, this booklet enables staff to reflect on their practice and understand the role they undertake in the organisation and their contribution to compliance with quality standards

11.1.3 Patient Experience

- We continued to work hard to ensure that those who used our service have a positive experience. We monitored this through the annual patient survey and national 'friends

and family' test. We are extremely grateful for all the feedback we received as a result of the 2015 survey. This year's Patient Survey has demonstrated that we have consistent areas of good practice across all the hospital departments. Patient's comments complimented efficient and attentive staff, and many of them stated that they would recommend the hospital to their friends and family. Overall the results of this survey were extremely positive, which is very pleasing; however we would like to further improve on this standard of service and will continue to look at ways to improve the hospital

- We redesigned our website to include lots more patient information and information for GPs to ensure they refer to the most appropriate consultant. It details where patients are likely to be referred to should an inpatient operation or complex tests be required. We continue to develop and add more information including patient leaflets

- We have reviewed and updated all our Minor Injuries Information leaflets for patients, and we are completing our Day Surgery Unit and Outpatient leaflets. These leaflets are evidenced based, accessible and relevant

11.2 The plan for 2016/17 (looking forward)

We have used the same methodology as last year to develop the priorities for improvement they have been identified through the collation of different sources of information. These included, but were not limited to:

- Output from Clinical audits
- Government policy, to include NHS England
- Feedback from patients and carers
- Feedback from staff on service issues
- Identification of service gaps
- Review of incidents and complaints

The priorities for 2016/17 have been developed, as follows:

11.2.1 Patient Safety

- We will improve our general information to patients about who to contact if they are worried about their condition once they have left hospital

- We will adapt the current WHO check list to ensure it is fit for purpose and completed in full by all staff

- We will review and assess whether point of testing machines for blood analysis would be beneficial, and if so we will purchase them

11.2.2 Clinical Effectiveness

- The Trust will provide an external consultant who will be available for clinical supervision throughout the organisation

- We will benchmark our antibiotic prescribing practice across the hospital. This will be achieved by auditing our present prescribing to ensure that our prescribing is in line with the County wide antibiotic formulary and making adjustments if required

- We will replace our current Patient Administration System with a state of the art Clinical Records System, this electronic system will improve data quality and access to outcome data that can be used to support patient choice, all new patient records would be held electronically

11.2.3 Patient Experience

- We will continue to engage with commissioners to support the development of clinical services closer to home and facilitate the 'choice' agenda. We are currently scoping: Therapeutic Venesection for patients with Haemochromatosis, 24 hour ECG tape a diagnostic test to support our cardiology service, extending types of orthopaedic services to include upper limb, Sleep apnoea to support our respiratory service and extending our Minor Injuries Unit opening hours. If commissioned we will deliver the services within the year

- We have had approval to proceed with our phototherapy business case, the Trust will open the service in January 2017

- We will ensure waiting times are clearly written on the wipe board in the outpatient department, and strive to improve scheduling of appointments to reduce delays

- In 2015/16 there was a slight increase in the number of patients who reported that their pain was not adequately controlled, we will work with our teams to ensure adequate pain control is administered

- Patients have requested a bicycle rack, to stow their belongings when visiting. We will purchase a bicycle rack for patients, visitors and staff to use

Part 3

12. Data Quality

We have invested in a new clinical records system which will improve the level of clinical and quality data we can access, once the system is live in September 2016. The current system lacks functionality, we currently outsource our data retrieval services to a local NHS Trust, access to bespoke reports has been difficult, but this issue will be resolved with the new system as we will have access to pull our own reports.

Our SUS extracts and all external reporting is currently performed by Gloucestershire Care Services NHS Trust on our behalf. The data is audited and checked by our Trust to ensure it is robust.

Data contained within the medical records are part of our annual audit programme, this includes our medicine management audit

We complete the monthly clinical Indicator submission for the Health and Social Care Information Centre (HSCIC) and The Private and Voluntary Hospitals Performance Indicators for the CQC every quarter.

Our quality and access standards are monitored by the Wiltshire and Gloucestershire CCGs and we formally meet quarterly with Gloucestershire CCG, and twice a year with Wiltshire CCG.

We have completed the Information governance tool kit and are level 2 compliant.

13. Information Governance

Information Governance sits alongside clinical and corporate governance and the aim of Tetbury Hospital is to ensure that information is dealt with legally, securely, efficiently and effectively. In addition it is also about supporting the provision of high quality care by ensuring that the right information is available to the right people, when and where it is needed in order to deliver the best possible care. There is a range of national guidance that Tetbury Hospital complies with.

Tetbury Hospital is monitored via completion of the Information Governance Toolkit (based on the Information Security Assurance standard ISO 27001). The Information Commissioner also has the power to impose penalties, including monetary penalties.

13.1 Assurance Framework

The Chief Executive has overall responsibility for the compliance with the relevant legislation surrounding Information Governance – The Chief Executive is also the Senior Information Risk Owner. The Caldicott Guardian, is the Medical Director, he is responsible for the arrangements around the use and sharing of clinical information.

The Information Governance Lead (Head of Information, Technology & Administration) is responsible for the development, communication and monitoring of Information Governance

policies, procedures and action plans. The Information Governance committee is responsible for providing assurance to the Board that the Information Governance Framework is implemented and that information governance systems and processes are developed, coordinated and monitored.

All staff are responsible for any records or data they create and what they do with information they use, and they must adhere to all information governance policies, procedures and standards which are written into the terms and conditions of their contracts of employment.

The Trust completed the Information Governance toolkit for the first time in 2014/15 and scored 56%, the target score was 66%. This year the Trust 2015/16 scored 66%, therefore, compliant.

In 2015/16 the Trusts internal Information system was moved from a server on site to a cloud based system, thus compliant with ISO27001.

14. Environmental Objectives and Monitoring and Measurement

14.1 Reduction of overall consumption

Electricity usage down by 8% and Gas consumption down by 26%

These reductions, most notably the gas usage, are down to the continued `tweaking' of our `Buildings Maintenance Systems'. Our Estates lead has been working closely with the external systems management company to programme additional features such as `on demand' heating services for the majority of the hospital, increasing the efficient working of the boilers and promoting the `standby' functions of many electrical machines so that when the machines are not being used, the electrical supply used by the machines is greatly reduced to `standby mode'

14.2 Recycling

We now recycle more waste through the rental of dry mixed recycling bins. The waste is segregated at a couple of points in the hospital and the domestics who empty these collection points segregate in the waste bins appropriately. This staged introduction process is allowing us all to look at our recycling/waste disposal behaviour, habits and knowledge.

15. National Guidance

The Trust complies with the recommendations contained in Technical Appraisals issued by the National Institute for Health and Clinical Excellence (NICE) and Safety Alerts as issued by the Central Alerting System

We scrutinise national guidance, at the Hospital Quality Committee (monthly) and the Medical Advisory Committee (quarterly) selecting those that are applicable to our services and monitor their implementation.

16. Review of Quality Performance 2015/16

16.1 Commissioning for Quality and Innovation

The Trust achieved 100% of funding for its Commissioning for Quality and Innovation Standards for Wiltshire Clinical Commissioning Group

Our Gloucestershire CQUIN for 2015/16 was to ensure that all discharge summaries were sent electronically to GPs within 24 hours of the patients being discharged from Tetbury Hospital. There was a delay in the programme, and changes to the milestones of delivery, these were worked through and the CQUIN was delivered from December 2015 onwards.

16.2 Our Quality Account Key Performance Indicators

The Minor Injuries Unit achieved 10 out of 11 quality standards. The Time to initial assessment (95th percentile) also known as triage, was 29 minutes for the year, the standard we wish to achieve is a wait of less than 15 minutes.

All patients are seen, treated and discharged within the 4 hour standard, some patients have waited longer for their initial triage than we would like. This is because our service is delivered by a sole practitioner. If the emergency nurse practitioner is in the unit treating a patient they are not always available to perform the initial triage function should another patient then book in to be seen.

The matrons have reviewed the Minor Injuries Unit triage pathway for patients and felt that the process could be improved, all registered nurses are now trained to perform the recognised Manchester triage process, and when the unit becomes busy, nurses are called upon to assess patients to alleviate some of the pressures within the Minor Injuries Unit.

Minor Injuries Unit -Quality Requirements		2014/2015 Year End	2015/2016 Year End	Change
Schedule 4 A: Operational Standards				
Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Target	90%	90%	↔
	Actual	100%	100%	
Schedule 4 B: National Quality Reqirements				
Duty of Candour		Compliant	Compliant	↔
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Target	> 95%	> 95%	↔
	Actual	98%	98%	
Schedule 4 C: Local Quality Requirements				
Trolley waits in MIU not longer than 12 hours	Target	> 0	> 0	↔
	Actual	0	0	
All handovers between ambulance and MIU must take place within 15 minutes with none waiting more than 60 minutes	Target	> 0	> 0	↔
	Actual	0	0	
The Provider will have a process in place for assessing, implementing and monitoring all NICE publications		Compliant	Compliant	↔
MIU Patient Impact Quality indicators • Unplanned re-attendance rate	Target	> 5%	> 5%	↑
	Actual	0	4%	
MIU Patient Impact Quality indicators • Left Department without being seen (rate)	Target	> 5%	> 5%	↔
	Actual	0.50%	0.50%	
MIU Timeliness Quality indicators • Total Time spent in MIU department (95th percentile)	Target	< 4 Hours	< 4 Hours	↓
	Actual	2 hrs 33 mins	2 hrs 21 mins	
MIU Timeliness Quality indicators • Time to initial assessment (95th percentile)	Target	<15 Mins	<15 Mins	↑
	Actual	15 mins	29 mins	
MIU Timeliness Quality indicators • Time to treatment in department (median)	Target	<60 Mins	<60 Mins	↑
	Actual	33 mins	39 mins	

The Trust achieved 20 of its 22 quality requirements for the Day Surgery Unit and Outpatient department.

As in 2014/15 we missed the 99% target for service users waiting less than 6 weeks from referral to diagnostic tests again, this time by 4%. This equated to 14 patients out of 278 sent for an MRI/CT scan following their out-patient appointment, or requiring a diagnostic hysteroscopy. Patients were offered an appointment within 6 weeks but chose to wait longer than 6 weeks for personal reasons. We have no plans to invest in a CT scanner or MRI due to our small volumes, so will continue to outsource this diagnostic test. We have increased the frequency of hysteroscopy clinics to increase choice of appointment dates within the 6 week window.

We missed the 'outpatient clinic letters to be sent within 5 days of clinic' by 0.2%. This was as a result of one ad-hoc clinic being dictated on a tape rather than our electronic dictation system, and then the medical records being placed in the corner of the secretarial office and missed, this was an unfortunate mistake, rather than a workload issue.

Day Surgery and Out Patients- Quality Requirements		2014/15 Year end	2015/16 Year end	Change
Schedule 4 A: Operational Standards				
Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	Target	90%	90%	↓
	Actual	99%	97%	
Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	Target	95%	95%	↔
	Actual	100%	100%	
Percentage of Service Users on incomplete RTT pathways waiting no more than 18 weeks from Referral	Target	92%	92%	↔
	Actual	100%	100%	
Diagnostic Test Waiting Times				
Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	Target	>99%	>99%	↓
	Actual	97%	95%	
Cancer Waits - 31 days				
Percentage of Service Users waiting no more than 31 days from diagnosis to first definitive treatment for all cancers	Target	96%	96%	↑
	Actual	97%	100%	
Mixed Sex Accommodation Breaches				
Sleeping Accommodation Breach	Actual	0	0	↔
Cancelled Operations				
All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-	Target	> 0	> 0	↔
	Actual	0	0	
National Quality Requirements				
Zero tolerance MRSA	Actual	0	0	↔
Rates of Clostridium difficile	Actual	0	0	↔
Zero tolerance RTT waits over 52 weeks	Actual	0	0	↔
No urgent operation should be cancelled for a second time	Actual	0	0	↔
VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	Target	95%	95%	↑
	Actual	99%	100%	
Publication of Formulary		Compliant	Compliant	↔
Duty of Candour		Compliant	Compliant	↔
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Target	> 99%	> 99%	↔
	Actual	100%	100%	
Domain 3: Helping people to recover from episodes of ill-health or following injury				
Discharge summaries must be issued with 24 hours, following elective admission.	Target	> 95%	> 95%	↑
	Actual	98%	99%	
Outpatient clinic letters to be sent within 5 days of clinic	Target	100%	100%	↓
	Actual	100%	99.8%	
Domain 4: Ensuring that people have a positive experience of care				
Clinical triage of referral in all specialities	Target	95%	95%	↑
	Actual	93%	100%	
Report numbers and reasons by month of referral rejections from Choose & Book	Target	N/A	N/A	
	Actual	4	0	
Domain 5: Treating and caring for people in a safe environment and protecting them from				
Provider to describe and publish all relevant services in Choose and Book, through a Directory of Service.		Compliant	Compliant	↔
The Provider will have a process in place for assessing, implementing and monitoring all NICE publications		Compliant	Compliant	↔

17. Infection prevention and Control (IPC)

We have a very low rate of hospital acquired infections and have had no incidents of patients contracting MRSA or Clostridium Difficile whilst at the hospital.

We participate in the screening program for MRSA at preoperative assessment, if patients are to be admitted to the Day Surgery Unit.

Infection Prevention and Control management is very active within our Trust, we have invested in training for staff in this area and we work in partnership with a larger network to ensure we are kept abreast of best practice.

- All staff received education and training in IPC and hand-washing
- The cleanliness of the hospital is audited regularly by Departmental Managers and reported through the Hospital Quality Committee in the Matrons report
- We have an annual infection control audit completed by an external IPC lead
- All clinical staff wear a uniform and protective clothing when required
- There are hand gel dispensers throughout the hospital
- Staff take their responsibility in preventing infection very seriously

18. Safety in the workplace

Safety hazards in hospitals are diverse ranging from the risk of slips, trips or falls to incidents around sharps and needles. Our staff are very aware of safety and our external health and safety consultants visit us every month to ensure safe systems of work are in place. All incidents are reported via our manual incident reporting system. This year there were 4 needle stick injuries reported for clinical staff, there were no work related injuries or incidents for non-clinical staff or volunteers.

19. Clinical Incident Reporting

A culture of patient safety requires staff to report and learn from errors or near misses, and therefore we need a reliable system for doing this. We do not report our incidents to the national reporting and learning system, we record our incidents on a paper record and then input the data manually on to a data base. We encourage all incidents or events where things didn't quite go right to be reported. These can be clinical and non-clinical, an example of a non-clinical event reported last year was a consultant arriving late for his clinic, and this was reported due to the risk to our reputation.

This year there were 78 clinical and non-clinical near misses or incidents reported in total. 40 of these were deemed clinical.

Using the National Patient Safety Agency's Risk Matrix 52 events were ranked as Green (66.7%), 24 were ranked as Yellow (30.8%), 2 were ranked as Amber (2.5%), None were ranked as Red (0%), No Serious Untoward Incidents were reported (0%), No Never Events were reported (0%)

All incidents clinical and non-clinical are discussed at the Hospital Quality Committee and reported through to the Board on a monthly basis. The reporting system enables staff to highlight potential problems, have them investigated and actions put in place to reduce the risk to patients and improve their experience whilst in the Trust.

20. Clinical Effectiveness

Our Medical Advisory Committee and our Hospital Quality Committee meet regularly throughout the year to monitor quality and effectiveness of care. Clinical incidents, patient and staff feedback are reviewed to determine if there are any trends which require further analysis or investigation.

21. Participation in clinical audits

Tetbury Hospital Trust does not participate in NHS clinical audit programmes, however, we audit our standards against these markers to ensure parity for all patients that attend the Trust.

We undertake internal audits as part of our audit programme, and this is led by the Clinical Matrons with the support of an NHS Audit Team, through a contract. The internal audits programme for 2015/16 covered a range of areas which were:

- Discharge summaries
- Medicines Management
- MIU Record Keeping audit
- DSU record keeping audit
- Patient satisfaction survey
- Ophthalmology Audit

Action plans were produced from each of these audit reports. The audits and action plans were discussed at the Clinical Audit Meetings and Hospital Quality Committee and were reported to the Trust Board via the Medical Advisory Committee. Audits are provided to our commissioners on request.

22. Research

Tetbury Hospital Trust has not engaged in any formal research and is not commissioned to do so.

23. Risk Management

The hospitals risk register is maintained by the departmental managers and reported to the Hospital Quality Committee and reviewed by the Medical Advisory Committee (Clinical risks), the Health and Safety Committee (H&S risks) and the Risk and Audit Committee (Corperate risks)

24. Complaints and Compliments

In 2014/15 the patient contacts for the Trust were in excess of 15,000, this has increased to over 17,500 in 2015/16 of which a total of 10,974 patient contacts last year and 13,553 this year are Tetbury Hospital Trust's regulated activity.

There were 5 written complaints, 3 for Outpatients, 1 for X-Ray and 1 for the Day Surgery Unit. Our Minor Injuries Unit received no formal complaints. Physiotherapy complaints and compliments are reported through Gloucestershire Care Services NHS Trust.

When the numbers of complaints are compared to the number of patient contacts (THT regulated activity) the level of complaint as a percentage is 0.037% and 1 in 2,711 contacts,

as a ratio. This is a reduction from last year which was 0.045%, and 1 in 2,195 patient contacts.

100% of complaints were responded to within 25 working days, there was one complaint about clinical care (which was not upheld) and four complaints were about attitude/communication. One complaint resulted in the receipt of a letter detailing the complainant's further concerns. We received no requests from the ombudsman and all complaints for the year have been closed.

In total 28 written compliments were reported to the Board. This figure excludes the positive comments on the Friends and family test which was introduced in July 2014

25. Friends and Family

Comments from the friends and family forms are collated every month and discussed at the Hospital Quality Committee. This year we had a total of 1,312 responses, which is an overall response rate of 12%, which is just under the 15% response rate we aimed for.
The percentage of patients who said that they would be 'extremely likely' or 'likely' to recommend Tetbury Hospital to their friends and family for care or treatment this year was 98%, the comments received are detailed in section 26

26. What others say about us

Tetbury Hospital has not participated in any special reviews or investigations during 2015/16 by its regulators. We are regulated by the Charities Commission and the Care Quality Commission

Our Friends and Family results are very positive with comments as follows:

Day Surgery Unit
"Best visit I have had to an NHS hospital. A great example of what other NHS hospital should strive to be"
"I have been treated with dignity, respect, professionalism and efficiency"

Out Patient Department
"I courteous and professional service"
"Competent staff"
"Prompt appointment"

Minor Injuries Unit
"Efficient, quick service"
"Friendly staff"
"Nurse had a wonderful attitude"

Our Patient Participation survey was extremely positive with comments as follows:

"I have no further comments, only to say that I was treated with great respect, a wonderful hospital"

NHS choices users rate us as 5 stars

There were no new comments listed for 2015/16

Patient Participation

The Patient Participation Group at our local GP practice, Romney House Surgery are very active, in March 2016 Mrs. Skillen wrote a blog of her experiences through our service, this can be found at https://romneyhouseppg.wordpress.com/feed/ the blog demonstrates how we work closely with other NHS providers to deliver care closer to home to our local population.

27. What our staff say about us

We have completed a Friends and Family style questionnaire for all staff this year. The outcome from this is as follows:

In 2015/16 the response rate was poor, a 34% response rate equates to 19 staff members. In 2014/15 the response rate was 63%. When asked the following two questions:

How likely are you to recommend Tetbury Hospital to friends and family if they need care or treatment? 89% stated extremely likely or likely and 11% said neither likely nor unlikely.

How likely are you to recommend Tetbury Hospital to friends and family as a place to work? 94% said extremely likely or likely, 6% said neither likely nor unlikely or don't know,