



Quality
Accounts
2018/19



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Ⓐ This symbol identifies the mandated national priority indicators that are required for auditor review.

Introduction



Statement on Quality from the Chief Executive



I am delighted to be writing the introduction to the 2018/19 Quality Account for Weston Area Health NHS Trust. Over the last year we have continued to develop and deliver our 'Safety First' culture leading to tangible benefits for our patients and staff. We have seen six out of our seven quality priorities delivering the planned improvements, with the final priority making significant progress. I hope that when you read the detail behind each of these priorities you will see the focus and effort that has gone into each one from the Executive Lead through to the team on the ground. Delivering improvements for our patients and for staff colleagues has gained real traction across the year.

I hope you will also get a good flavour for how the PRIDE values of the Trust has influenced the improvements we have made. Key initiatives include the following:

- People:** instigating our Annual Nursing Awards to recognize the invaluable work done by our nursing and midwifery colleagues.
- Reputation:** driving significant improvements in our 'Learning from Deaths in Hospital' programme, such that our mortality rates are now lower than our peers.
- Innovation:** showcasing our quality improvement work to deliver improved sepsis recognition and care across the Trust and beyond.
- Dignity:** the Palliative Care Team has improved the quality of care, such that the Trust scores better than the national average in all domains against the National Care at End of Life Survey.
- Excellence:** the Frailty Team has developed a GEMS Service across five days. This Geriatric Emergency Medicine Service (GEMS) is delivering excellent care for our older patients.

Finally, you will see the significant progress we are making in partnership working in three areas – across our Sustainability and Transformation Partnership (Healthier Together), with local partners through Healthy Weston, and through our planned merger with University Hospitals Bristol NHS Foundation Trust. I recognise that partnership working can bring challenges but this report aims to provide assurance that our focus in developing these partnerships is to bring about improvements in the quality of services for our patients receiving them and our staff delivering them. To the best of my knowledge, the information contained in the Quality report is complete and accurate.

Thank you to all involved, in both writing this report, but also for improving our services.

A handwritten signature in black ink, appearing to read 'James Rimmer'. The signature is fluid and cursive, with a long horizontal stroke extending to the right.

James Rimmer

Chief Executive, 2nd May 2019

What we do – the services we provide

Weston Area Health NHS Trust:

- Provides acute hospital services for adults with acute health problems, including emergency care, critical care, medicine and surgery together with supporting diagnostic services.
- Additionally, the hospital provides a range of planned services including general surgery, urology, orthopaedics, endoscopy, haematology and some cancer care.
- Provides Children's and Young Peoples Community Health Services
- Delivers Child and Adolescent Mental Health Services from two children's centres located in Weston-super-Mare and Clevedon.
- The hospital is a 256 bedded district general hospital which includes 5 Maternity beds and 5 intensive care unit beds.
- Employs 1,496.26 full time equivalent staff or total headcount of 1791 staff excluding bank staff or 2297 including bank.

Activity

The Trust has an annual activity for 2018/19 of 49,442 Emergency Department attendances, 14,561 planned day case and elective admissions, 15,112 emergency admissions and 97,740 outpatient attendances.

Resident population

The effective population currently using WAHT services is estimated to be circa 200,000. In addition to the local population, Weston super Mare attracts 3 million day trippers and circa 500,000 staying visitors each year and in peak season; up to 10% of emergency department attendances are by out-of-area tourists. Included in the population figures above is the population of North Sedgemoor which has an estimated population of 152,000 (GP registered population).

Services provided within Weston Area Health NHS Trust

The effective population currently using WAHT services is estimated to be circa 200,000. In addition to the local population, Weston-super-Mare attracts 3 million day trippers and circa 500,000 staying visitors each year and in peak season; up to 10% of emergency. During 2018/19 the Weston Area Health NHS Trust (WAHT) provided 40 relevant health

services with 2 relevant health services subcontracted.

The Weston Area Health Trust has reviewed all the data available to them on the quality of care in 42 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 77% of the total income generated from the provision of relevant health services by the Weston Area Health Trust for 2018/19.

Table 1. Trust Activity

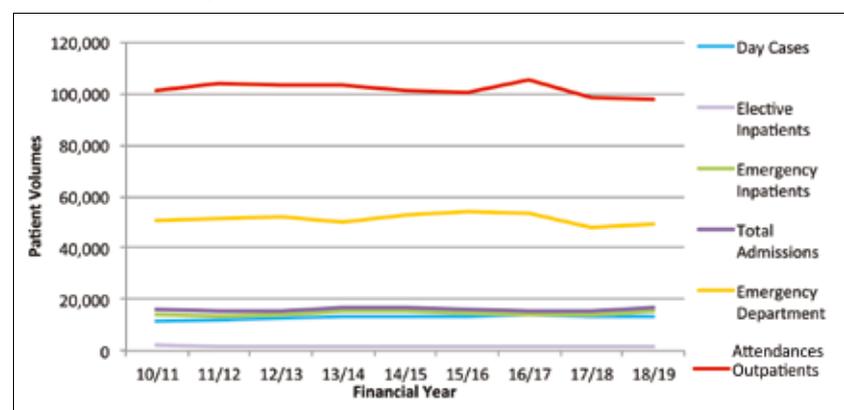


Table 2. Services provided within Weston Area Health NHS Trust

Medicine	Cardiology	Critical Care	High Dependency Unit/ Intensive Care Unit
	General Medicine	Women	Midwife Led Births
	Diabetic and Endocrinology Medicine	Paediatrics	Day Case
	Rheumatology		Outpatients
	Gastroenterology		Community Paediatrics
	Geriatric Medicine	Cancer	Acute Oncology
	Stroke Medicine		Outpatient Oncology
	Respiratory		Haematology
	Frailty		Chemotherapy
Surgery	Urology	Specialist	Stroke; Acute Stroke Unit
	Gynaecology		Sexual Health
	Trauma and Orthopaedics		Dermatology (provided by UHBristol)
	Upper Gastrointestinal Surgery		Palliative Care
	Colorectal Surgery		Child and Adolescent Mental Health
	Ophthalmology (provided by UHBristol)	Other	Private Patients Unit
	ENT (Outpatients Only)		Radiology
	Anaesthetics		Pharmacy
A&E	Major		Pathology
	Pathology		Therapies
	Major		Audiology

Partnership Working

The Trust has continued to progress the development of formal partnership arrangements with University Hospitals Bristol NHS Foundation Trust (UH Bristol) to ensure that clinical pathways for both general and specialist services are in place and to maintain peer management support for WAHT.

During 2018/19 a Strategic Outline Case was approved by UH Bristol and Weston Area Health Trust Boards to support work to commence a Full Business Case (FBC) for a ‘merger by acquisition’ of WAHT by UH Bristol. The Trust is also working in partnership with North Bristol NHS Trust relating to relevant specialist services that could be provided in a networked fashion across the Bristol and North Somerset population.

The Trust operates a number of joint clinical appointments and rotas with other NHS Trusts to ensure a sustainable delivery of local services.

Community services (excluding community-based Children’s Services, Maternity Services and Paediatrics provided by Weston Area Health NHS Trust) are provided by North Somerset Community Partnership, and Mental Health services for adults are provided by Avon and Wiltshire Mental Health Partnership NHS Trust.

Local NHS bodies and other providers

The Trust’s largest commissioner during 2018/19 was Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) with the WAHT contract being circa £68m. In addition, the Trust receives other non-patient related income including education and training monies.

We recognise that we work in collaboration with our other providers which includes the local health and social care economy including two Local Authorities, namely North Somerset Council, responsible for North Somerset and Somerset County Council, responsible for the Sedgemoor area of Somerset.

Planning for service delivery is increasingly being undertaken on a BNSSG-wide basis as part of the Sustainability and Transformation Plan, “Healthier Together”. This approach is intended to overcome inefficiencies, duplication, variation and unnecessary boundaries and interfaces for patients and staff to navigate and ensure that care is provided in appropriate care settings for all patients.

The key principles set out by the STP to underpin their planning work are:

- We will deliver care consistently and at scale as part of a fundamental change in the way we respond to demand.
- We will remain responsive to individuals and local communities and ensure appropriate care and support in the right place at the right time.
- We will ensure parity is a golden thread running through the whole of health and social care provision.

Our vision and values

The vision of Weston Area Health NHS Trust is to:

“Work in partnership to provide outstanding healthcare for every patient”

By achieving this vision we will:

- Deliver your local NHS with Pride.
- Deliver joined up care which feels integrated for patients and their families.
- Enable patients from Weston-super-Mare, North Somerset and North Sedgemoor to access a full range of services.
- Deliver services which are valued and respected by patients, carers, commissioning CCGs and referring GPs.

Our key strategic aim is to:

Deliver safe, caring and responsive services

This vision and strategic aims are supported by a series of local values which guide actions, behaviors and decision making within the organisation and which are consistent with the NHS Constitution.

These values are:



- **People and Partnership** Working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague (Care and Commitment).
- **Reputation** Actions which build and maintain the Trust's good name in the community.
- **Innovation** Demonstrating a fresh approach or finding new solutions to a problem.
- **Dignity** Contributing to the Trust's Dignity in Care priorities (Care and Commitment, Communication, Compassion, Competence).
- **Excellence and Equality** Demonstrating excellence in and equality of service provision).

Our Staff

We are proud of the awards and achievements that our staff have achieved throughout 2018/19

Awards and Achievements

- We were part of the West of England Academic Health Science Network (WEAHSN) team awarded the Health Service Journal Patient Safety Award in 2018 for the deteriorating patient and rapid response systems category.
- We showcased our quality improvement work delivering sepsis care across the Trust and worked with NHS England as part of the national nursing strategy - Leading Change and Adding Value to produce a video which has had national recognition.
- At the Comparative Health Knowledge System (CHKS) hospital awards – WAHT was awarded one of the CHKS Top Hospitals for 2018, a prestigious award made on the basis of an analysis of data from all hospital trusts in England, Wales and Northern Ireland. Over 20 indicators of performance were analysed by healthcare improvement specialists CHKS.
- For the first time there were the Director of Nursing annual awards given for 6 categories on International Nurses Day 2018.
- NHS Big7Tea tea party held to celebrate 70 years of the NHS. The event was held in the physio gym at the hospital, with display and an interesting presentation of previous hospitals in Weston with staff, patients and visitors all invited to attend.
- The CT scanner appeal is expected to reached its target by the end of March 2019 and the CT scanner is now safely installed and in use.

- We held the annual Celebration of Success awards evening which recognised staff who go above and beyond the call of duty to care for our patients.
- 12 members of our staff took part in the South West Military Challenge in September 2018 and came 4th out of 17 Trusts.
- Our teams presented work describing our quality improvements in patients Living Well with and Beyond Cancer, and the introduction of our Geriatric Emergency Medicine Service at national conferences.
- Signed Veterans Covenant Hospital Alliance to become Veteran Aware Hospital (provides integrated care and advice to veterans)
- Imaging service (radiology) reaccredited by Royal College of Radiology (Imaging Service accreditation scheme).

Support for staff raising concerns

In his review of care concerns at Mid Staffordshire Foundation Trust, Robert Frances QC found that staff can be reluctant to raise concerns and introduced the concept of a freedom to speak out guardian.

A Freedom to Speak Up (F2SU) Guardian is a senior member of staff based in NHS trusts. Their role is to work with trust leaders to create effective local processes to enable staff to raise concerns about patient safety and advice and support staff who seek to do so.

More recently, in its response to the Gosport Independent Panel Report (2018), the Government committed to legislation requiring all NHS Trusts in England to report on staff who raise concerns (including whistleblowers). Ahead of such legislation, NHS Trusts and NHS foundation Trusts have been asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

The Trust Board Secretary at WAHT was appointed as the Freedom to Speak Up Guardian (FTSU) in September 2016 and has met monthly with the Chief Executive Officer and regularly with the Non-Executive Lead for the role – as well as regularly reporting to the Trust Board. In 2018 the Trust also trained three Freedom to Speak Up Ambassadors who support the Freedom To Speak Up Guardian and sign post staff who have concerns to the right person(s). To date, all individuals who have raised concerns have been supported personally by the Guardian and have received feedback following the investigations into their concerns. Overall feedback has been positive in relation to whether individuals would speak up again. The Guardian also works to ensure that individuals who raise concerns do not suffer detriment as a result of speaking up, and, to date, no-one has identified that they have suffered detriment.

Where there are concerns relating to patient safety, these are immediately escalated to the Medical Director and Director of Nursing to investigate and take appropriate action.

The Guardian is only one mechanism through which staff can raise concerns. The Trust also has the following groups or processes which can assist staff:

- Bullying and Harassment Advisors
- Union Officers
- Occupational Health
- Employee Services
- Safeguarding Team
- Governance Team

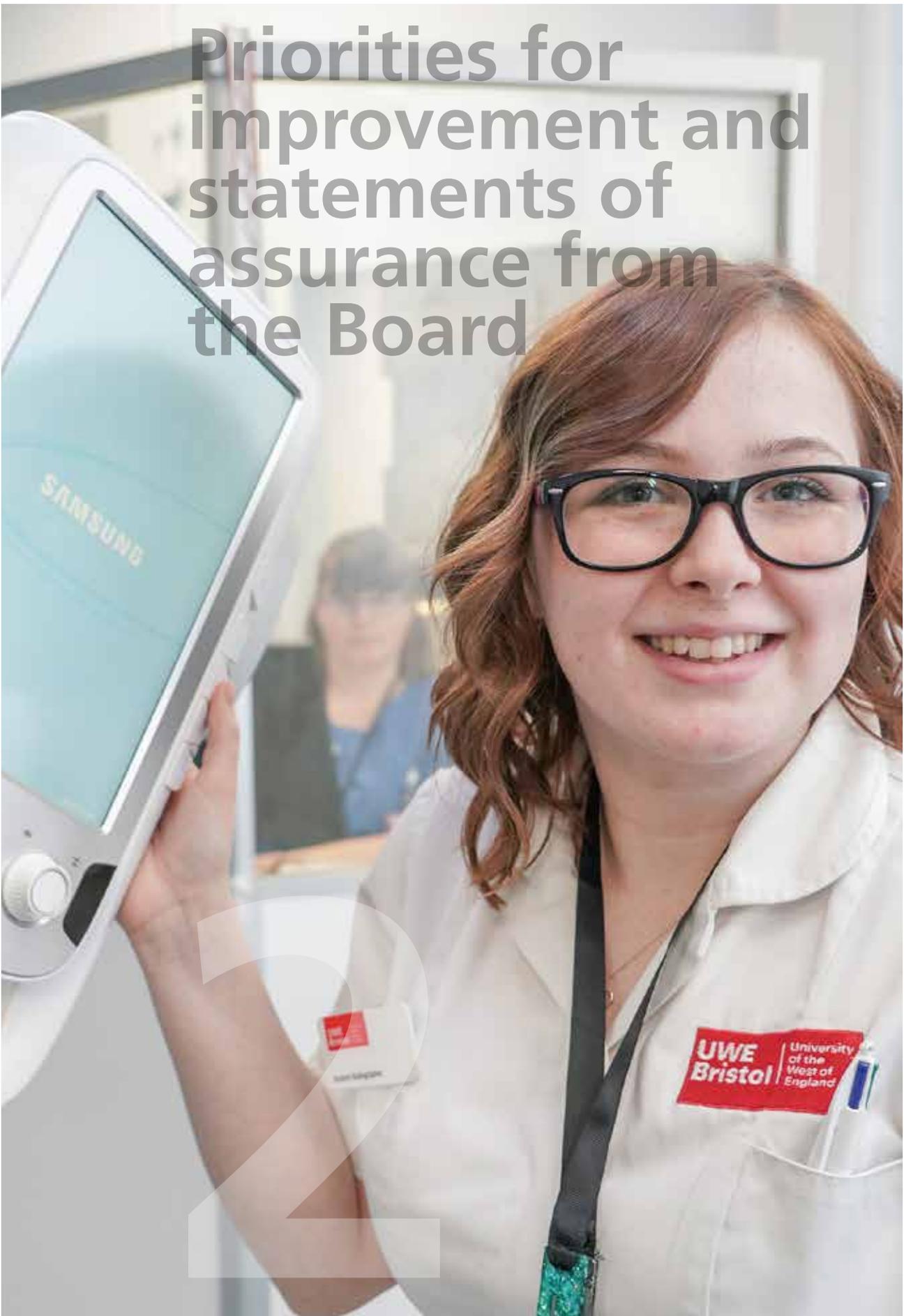
A key challenge is to ensure that staff are aware of the FTSU programme and the role of the Guardian. To support this:

- Speaking Up is included in Trust induction for all new starters.
- Speaking Up is included in mandatory training updates for all staff.
- There are posters around the Trust which describe what Speaking Up is.
- The Guardian attends meetings with staff groups to personally relay messages and ask questions about Speaking Up.

The Trust Board and its Senior Management Committee receives a quarterly update on the FTSU activity. Included in the updates are reviews to consider the learning from the National Guardian Office's case reviews of other Trusts, with learning identified where appropriate. In November 2018 the Board reviewed its performance in support of the programme using the self-review tool provided by the Office of the National Guardian – and agreed actions for improvement.



Priorities for improvement and statements of assurance from the Board



Priorities for Improvement

Twelve months ago we identified seven quality priorities to be our focus for improvement during 2018/19. These were a combination of ambitions which we had not fully achieved in 2017/18 and new objectives which included improvements to patient and staff experience. Progress on achievement is detailed below,

including why we selected each priority and each priority has been categorized by 'RAG' rating with; Red - not achieved, Amber – not fully met but improvement evident, and Green - achieved. Overall, we achieved six of the identified priorities and made significant progress on the final identified priority.

Priority One: Improving Frailty and Dementia Care within the hospital

Why we chose this priority

Frailty is a distinct clinical syndrome that generally describes the gradual loss of a person's in-built reserves. Whilst frailty is not just an issue seen in an older age group, older people living with frailty may be less able to cope with minor illnesses or injuries, leading to an unexpected or dramatic change in their physical and mental wellbeing.

We know that older people living with frailty may not show the 'classic' signs of illness, so benefit from holistic assessment and care from a team of multiple specialist healthcare professionals. We also know that older people living with frailty are at a higher risk of poorer outcomes if they are admitted to hospital. This means they may take longer to recover and need more help when they do go home, or may not return to their own home.

The patients using our Emergency Department are on average 10 years older than the national average, Weston and the surrounding areas have a higher than average number of older people living with frailty.

The frailty service was introduced with the aim to reduce mortality, reduce length of stay, reduce readmissions and improve patient outcomes.

What did we say we would do?

Implement and deliver a front door frailty service producing a model of care framework.

The frailty service at WAHT was fully launched during the last quarter of 2018/19, providing a five day service to our patients.

The multi-disciplinary "GEMS" team (Geriatric Emergency Medicine Service) are based within the Emergency Department and work very closely with the Ambulance Service, Social Care, North Somerset Community Partnership, Voluntary Organisations and GPs.

A model of care framework has been produced and a reduction in the number of frail patients admitted has been achieved with a corresponding reduction in length of stay. The number of avoidable admissions recorded by the "GEMS" team in March 2019 was 48% of the number of patients that they assessed.

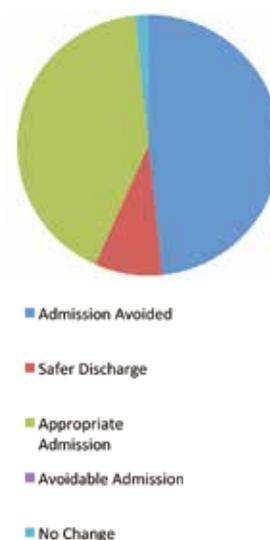
The Trust has been part of the Acute Frailty Network on a year-long programme which has included national sharing and learning.

We will develop the workforce to support frailty at the front door reducing the number of frail patients having to be admitted to hospital.

The recruitment of staff has been very successful with the following posts being filled; Advanced Physiotherapist, (Planning to progress to Advanced Clinical Practitioner), Frailty Specialist Nurse, Frailty Nurse, two Frailty Speciality Doctors, an Administrator and a Pharmacist has also been recruited which will complete the team for a five day a week service.

What difference did it make?

Table 3. Identified Patient Outcomes



Across two service trials, we were able to avoid inappropriate or unnecessary admission for around 48% of patients.

We also found that the people who had to be admitted actually stayed in hospital for less time.

Overall we saw a reduction in length of patients' average length of stay from 3.7 days to 3 days.

We also saw a significant reduction in the number of people returning within 30 days at 6.5%.

What will we do next?

We will continue to evaluate the benefits of the service including looking at options to increase the size of the team so that it can support more patients and operate over 7 days a week.

We will look at different ways that the team can be accessed, how we can work more closely with community services, and how we can broaden and deepen the skills of the team.

We will be working to make frailty everybody's business, through training and raising awareness, as well as ensuring there is a consistent approach to the care of older people living with frailty, throughout the hospital.

RAG Rating

Green - We have successfully implemented the frailty team across five days a week, demonstrating reduction in patients length of stay and avoiding admission to hospital. The service continues to grow and develop.

Improving Dementia Care within our hospital

Why we chose this priority?

There are over 850,000 people living with dementia in the UK and at Weston General hospital at least 40% of our beds are occupied by people who have a dementia diagnosis. Patients, who are living with a dementia end up staying longer in hospital, are more likely to be readmitted once they have left and are less likely to return to their own homes than someone who does not have a dementia.

We believe that we have a critical role to play in supporting people with dementia to have the best possible outcome. We are continually committed to make our hospital dementia friendly and to provide high quality care that supports both the patient and their families.

What did we say we would do?

Develop and support Dementia Care Initiatives across the Trust through delivery of the Dementia care strategy.

- We have started work on our Dementia Strategy and have recruited an Admiral Nurse, with support from Dementia UK, whose role it is to offer assessment and one to one support to people living with dementia and their family, carers, and to support best quality practice across our hospital.

- We have continued our commitment to providing a dementia friendly hospital for our patients. Our Specialist Care of the Elderly ward staff have fundraised, as has a local Secondary school, to provide the fixtures and fittings for a designated dementia friendly room on the ward. This will provide an area which is homely and calm for our staff to support our patients to feel relaxed and to engage in activities. Our estates team also ensured that when making changes to our clinical areas that the specific needs of people with dementia were taken into account.
- We have secured 21 pre-loaded MP3 players for several of our wards, with era specific music for people under and over the age of 70. This was achieved through a charitable organisation called 'Purple Angel Ambassadors' who work to increase awareness and reduce stigma for people with dementia.
- Providing a supportive environment for people with a Dementia has shown to have a positive impact on their wellbeing and reduce some of the negative effects of the condition, such as misinterpreting shapes and colours. Working with our local community helps us to reduce stigma and raise awareness of the needs of our patients.

Embed the Principles of Johns campaign, enabling flexible visiting times for carers.

We have renewed our commitment to 'John's Campaign', which offers carers of people living with dementia or learning disabilities free parking, open visiting and reduced meals in the restaurant. Raising awareness of this through our mandatory staff training. We have reviewed our ward visiting times and extended these on each ward.

We have expanded our collaborative working with North Somerset Hospital Carers Support Scheme, working with the team to share our knowledge and experience of carers needs.

What difference did it make?

Measures of improvement within this quality priority have included reducing inpatient falls per 1000 bed days which are now showing achievement consistently for four months below the trusts target.

We have increased the number of our staff who have received dementia training through making it mandatory and developing new training in our Safeguarding day which meets the Health Education England tier 2 guidelines.

We have also delivered bespoke training to our Enhanced Supervision Team. (Team of Nursing Assistants who provide care at one to one level of care for patients with cognitive impairment)

- In the last 6 months since the appointment of our Admiral Nurse, 51 families received the opportunity for one to one support from our Admiral Nurse and many more patients living with dementia had their care reviewed.
- When audited, our Enhanced Supervision team felt that they had an overall increased sense of competence in working with people with Dementia. We now plan to provide regular updates and more training in areas they identified they wanted more support in.

What will we do next?

- We will continue our work to embed a single question to identify dementia in our assessment paperwork, in acknowledgement of the fact that Dementia continues to be under diagnosed nationally.
 - We will develop a pathway to ensure that anyone who receives a diagnosis of Dementia, whilst under our care, gets access to the same support as those diagnosed in the community.
 - We will continue working with our partners in other agencies such as Alliance and the Alzheimer's Society to ensure a clear and consistent message around 'Living well with Dementia'. To reduce stigma and support our patients, staff and the public we will be hosting several events during 'Dementia Awareness week'.
 - We will start to deliver our more specialist dementia training to ward staff to ensure that there is consistency in our approaches and our style of communication.
- Research shows that music can decrease anxiety and improve mood for people with Dementia, our plan is to monitor the impact of these for our patients so that we can ensure that we are delivering care that is effective.
 - As we develop our 'Dementia Champions and Link Nurses' scheme further they will be instrumental in supporting and championing the needs of carers on their wards. Including actively promoting 'John's Campaign' and gaining feedback about carers experiences using the feedback forms.
 - We will be taking the feedback from carers to develop future quality improvement initiatives to ensure that our services continue to develop, in order to support the changing needs of carers within our trust.

RAG Rating

Green - We have continued our commitment to providing a Dementia friendly hospital for our patients and seen significant improvements in care provided for patients and their carers.

Priority Two: Reducing harm from pressure damage

Why we chose this priority?

Pressure injuries are debilitating for patients and largely avoidable injuries which cost the NHS millions of pounds every year. Whilst we had made some improvement in 2017/18 we felt we had much more to do in order to reduce the amount and level of harm to patients and prevent pressure injuries occurring.

What did we say we would do?

Reduce the number of grade 2-4 hospital acquired pressure injury.

We continue to reduce avoidable pressure injuries for our patients, particularly the

deeper injuries which are serious incidents because of the harm they cause to our patients. We therefore set ourselves an improvement target to see a 25% reduction in grade 2, 50% reduction in grade 3 and a 100% reduction grade 4 pressure injuries.

Increase staff knowledge and responsiveness to pressure injury.

We focused on developing our leadership and developing staff knowledge of promoting tissue viability through implementing education and celebration at Ward Wednesday meetings and via 'trolley dash' education for the wards. The pressure injuries steering group chaired

by the Associate Director of Nursing for Emergency includes Sisters and Matrons, who have an action plan to improve performance and meet to promote the shared learning from incidents across the Trust.

An increase in resource for the team has enabled a part time support Nurse for Tissue viability to be appointed, their focus is to work alongside staff to enhance education opportunities.

The link nurses role will be regenerated with engagement in all clinical areas.

What difference did it make?

In 2017/18 we reported 17 grade 3 and 4 pressure ulcers (which included pressure ulcers that deteriorated from grade 2). In 2018/19 we reported eight grade 3 pressure injuries and one grade 4, five of which deteriorated from grade 2. This is a 47% reduction in the past year and a considerable 74% reduction over the previous three years. Whilst not achieving our aim for a 50% reduction for grade 3 and 4 pressure injuries this is a significant reduction in harm caused to patients. All grade 2 pressure ulcers have a Directorate Level SWARM completed and for every Grade 3 or 4 there is an Executive Level SWARM. This enables any immediate learning to be shared across the Trust and will be discussed at the Pressure Ulcer Steering group. A SWARM is where a rapid response to a patient incident occurs, staff come together to discuss the incident, allowing a blame free investigation and prompt action to be taken if required.

Work continued with colleagues across the Bristol North Somerset and South Gloucestershire (BNSSG) community on working together in order to reduce the harm from pressure injuries. A project was undertaken in conjunction with the BNSSG CCG supported by Peer experts to review patients who attend hospital with a community acquired pressure ulcer. This took place in November 2018 and the report from the CCG has demonstrated that the Trust assesses Pressure ulcers well on admission and the numbers being admitted with Grade 3 or above were validated as being accurately assessed.

What will we do next?

- The Tissue Viability Nurse Specialist will continue to meet regularly with Tissue Viability Nurse colleagues in the Community for continuing improvements for patient care and to enhance patient safety and satisfaction.

- Plans are in place to work collaboratively with both the BNSSG CCG to ensure a collective strategy and the North Somerset Community Partnership for national initiatives, for example Worldwide STOP pressure ulcer day in November.
- We will implement the new guidance from NHS Improvement pressure ulcer framework for local reporting systems.
- We will continue our action plan approach for the pressure injury steering group, using lessons learnt from serious untoward incident findings.
- We will undertake a campaign to promote a "Healthy Heel" to prevent the deep heel injuries which we have seen.
- We will aim to further reduce the number of patients suffering harm from hospital acquired Grade 2 and 3 Pressure damage.

RAG Rating

Green - Progress continues with reducing pressure damage, and the Trust has achieved the 25% reduction in Grade 2 and 47% reduction in Grade 3/4 pressure injuries

This is detailed as three Grade 3 Hospital Acquired Pressure Ulcers, which deteriorated from grade 2 injuries and five Hospital Acquired Pressure Ulcers grade 3's

No Hospital Acquired Pressure Ulcers grade 4's but one existing injury deteriorated to a grade 4.

Priority Three: Continuing development of our workforce

Why we chose this priority?

The focus of Organisational Development (OD) within WAHT is to build the Trust's capacity and capability to achieve its goals through planned development of staff and improvement and reinforcement of the strategies, structures and processes that lead to organisational effectiveness. The launch of the Healthy Weston Public Consultation and the announcement of the proposed merger with University Hospitals Bristol NHS Foundation Trust is the start of a period of great change and transition for

the Trust. We recognised that to support our staff through this transition we needed to invest in our staff development and ensure that we had a clear workforce plan and a recruitment and retention strategy to support this.

What did we say we would do?

We said that we would develop and implement a recruitment and retention delivery plan as part of a Workforce strategy. We would support Directorates

to develop workforce plans that accurately reflect the Trust's objectives and changing workforce requirements over the next three years in line with planned changes as part of Healthy Weston and the proposed merger and we would improve/increase the capability of WAHT leaders and managers.

What difference did it make?

- A reduction in the staff turnover rate to 15% from 17.5%.
- Trust Operating plan 2019/20 clearly identifies planned changes to

workforce that will enable the Trust to deliver its strategy.

- Increased number of trained nurses to be recruited.
- The workforce strategy delivery plan focussed on recruitment, developing recruitment branding, open days, recruitment fairs to attract more staff to work here.
- Introduction of internal communication around Healthy Weston and monthly staff briefings to enable staff to keep up to date and for senior managers to listen to staff.
- Introduction of an electronic recruitment system to improve the speed of hiring staff.
- To ensure workforce model aligns to patients and service need, make use of new roles to ensure the provision of quality care and continuity of service.
- Directorates undertook workforce planning training with Health Education England to ensure the operating plan reflected the delivery of services to our patients.
- We introduced a 'Leadership Breakfast' for staff who have been part of a Leadership training programme to meet with the Trust Executive Team to enable further personal development and to be part of Organisational development discussions.
- 38 members of staff have attended Management and Leadership courses provided by the Leadership Academy.

What will we do next?

We will extend our management and leadership offering both within the organisations and across the system to support the implementation of the Healthy Weston Vision. Our Health and Wellbeing offering will be improved to include the launch of a health and wellbeing calendar and newsletter.

We will expand the apprenticeship programme to increase the number of apprentices and roles as well as invest further in the recruitment and retention of staff. An internal organisational communication strategy will be developed to further improve communications between managers and staff.

RAG Rating

Green: We have:

- Employed two practice development nurses for each directorate
- Reduced the trust from three to two clinical directorates
- Provided leadership development to a cohort of multi professional managers, including managing change
- Implemented Allocate for nursing staff to ensure effective rostering of staff.
- Introduced monthly staff briefings for all staff.
- Regularly updated progress of Healthy Weston and staff involvement for the consultation of the options for Weston.
- Launched new appraisal process and paperwork to enable staff to look at their achievements and development needs.

Priority Four: Learning from deaths in hospital and improving end of life care

Why we chose this priority?

We wanted to build on the learning and improvement which we had made whilst focusing on this priority in 2017/18. We felt we had more progress to be made in embedding the structured judgement review process within the Trust. We had received concerns raised about care for patients and families at their end of life and we felt we could make improvements to their experience.

End of life care provides patients with support who have an illness that cannot be cured, and the aim is to ensure that patients have the best quality of life before they die.

The people providing care should ask about the patient's wishes and preferences and take these into account as they work out the plan of care. They should also support family, carers' or other people who are important to the patient throughout the end of life process.

What did we say we would do?

We said we would continue to monitor the percentage of deaths undergoing mortality review on the mortality database and that we would establish regular directorate mortality reviews. This would be achieved through delivering teaching to the Medical Assessment Unit, Sandford Wards and the Surgical teams to support completion of 50% of reviews and regular Mortality meetings to be established.

We said we would improve our relative's experiences when a patient has died, through gathering feedback from bereaved families to understand their experience of care in the Trust and incorporate learning. We would seek to improve our staff confidence, skills and knowledge through education.

We wanted to seek improvement in care through an improvement in the outcomes from the Annual national audit of end of life care, specifically for families / carers who reported satisfaction with the care that they receive at the time of death.

What difference did it make?

We have continued to report on our learning from deaths quarterly to Trust board along with the thematic learning that we have shared with the organisation through our Clinical Effectiveness Committee, Clinical Effectiveness Showcase events and WeSMILE safety publication. Education took place in wards and departments to ensure that there were regular mortality reviews with the use of the Structured Judgement Review (SJR) process. We saw a reduction in reviews undertaken in Quarter 3 due to a vacancy in our Chief Registrar post (which had responsibility for driving the learning from deaths policy). In February 2019 one of our Consultant Physician accepted a lead role for learning from deaths with the expectation that the 50% review target will be achieved in all quarters of 2019/20.

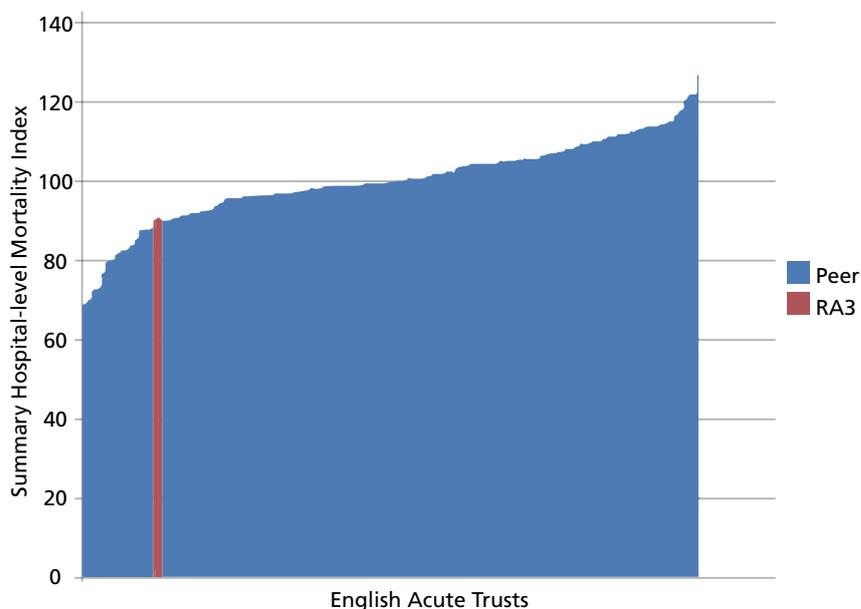
Overall in 2018/19 50% of all deaths and 100% of deaths where a specific concern about care was raised by staff or patients received a SJR. Learning from the SJR process feeds into our mortality specific clinical effectiveness group where a trust wide multi-professional team look at internal and external mortality data and use it to drive improvement and learning within the trust. This has helped to reduce all of our measured mortality indices (including the Standardised Hospital Mortality Index) to below the predicted value.

Table 4. Percentages of patient death reviewed with SJR

Quarter	Deaths reviewed with SJR
1	44%
2	43%
3	30%
4	60%

Table 5. SHMI data per reporting period

Period	SHMI
October 2015 to September 2016	1.15
January 2016 to December 2016	1.11
April 2016 to March 2017	1.06
July 2016 to June 2017	1.03
October 2016 to September 2017	1.03
January 2017 to December 2017	1.02
April 2017 to March 2018	0.99
July 2017 to June 2018	0.94
October 2017 to September 2018	0.90



The Trust has achieved a reduction in SHMI from 1.15 to 0.90 with HSMR and RAMI consistently below national and peer average

Work to progress and improve the experience of relatives and carers following the death of their relative is underway, working with the multi professional team. Feedback is obtained from a variety of sources to ensure that the family/ carers are listened to; the palliative care team provide several different methods of delivering education to staff and work alongside the bereavement and mortuary team to improve the patient / family experience. The continued efforts of the team to improve the quality of the service will be presented within the 2018 National Care at the end of life survey (NaCEL). From

the data submitted for the patient deaths within the hospital during 2018 the initial finding from the survey is very positive, with the trust scores being better than the national average in all domains.

The data was grouped into themes and will be published in its entirety later this year.

The themes identified were:

- Recognising the possibility of imminent death.
- Communication with the dying person
- Communication with families and others
- Involvement in decision making

- Needs of family and others
- Individual plan of care
- Families and others experience of care
- Governance
- Workforce/specialist palliative care

Although this is an excellent outcome we are aware we need to continue to progress with promoting and enhancing our care for patients at the end of their life. Work is being undertaken in conjunction with the South West Quality and Improvement forum and NHS Improvement to develop this work further.

RAG Rating

Green - We continued our work to embed the structured judgement review and saw improvements in all indicators of the National audit for end of life care.

Priority Five: Reducing delays in hospital to improve patient safety

Why we chose this priority?

Remaining in hospital longer than is absolutely necessary increases the risk for our patients, will increase financial cost and reduce efficiency in terms of our bed capacity and availability, therefore timely discharge is essential.

Timely discharge from hospital also means that inpatient are made available for those patients who are coming into hospital and require acute care, and helps to reduce the delays in transferring patients from the Emergency Department to a bed on a ward.

What did we say we would do?

We said we would aim to embed the SAFER (patient flow) bundle within all areas of the Trust with a specific measure of reporting each day on the attendance of Consultants on the Board round and focusing on ensuring consistent Multi-Disciplinary Team (MDT) attendance.

We recognised the importance to patients of not deconditioning whilst in hospital and had received training in the benefits of the end PJ Paralysis concept and committed to join the

Table 6. Red and Green day descriptions

A **Red** day is when a patient receives little or no value adding acute care. The following questions should be considered:

- Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
- If I saw a patient in out-patients, would their current 'physiological status' require emergency admission?

If the answers are 1. yes and 2. no, then this is a 'Red bed day'

Examples of what constitutes a **Red** bed day:

- A planned investigation, clinical assessment, procedure or therapy intervention does not occur.
- The patient is in receipt of care that does not require an acute hospital bed.
- The medical care plan lacks a consultant approved expected date of discharge.
- There are no consultant approved physiological and functional clinical criteria for discharge in the medical care plan.

A RED day is a day of no value for a patient

A **Green** day is when a patient receives value adding acute care that progresses their progress towards discharge.

A **Green** day is a day when everything planned or requested gets done.

A **Green** day is a day when the patient receives care that can only be in an acute hospital bed.

A GREEN day is day of value for the patient

Part 2: Priorities for improvement and statements of assurance from the Board

National Campaign to implement and embed best practice in order to reduce the overall length of patient stay.

We planned to utilise Red and Green days in all wards to help our staff understand their value in increasing discharge rates. "Red and Green days" are visual management systems to assist in the identification of wasted time on a patient's journey.

What difference did it make?

We reviewed the completion of the SAFER bundle via daily reporting and achieved 75% attendance by Consultants on Board rounds with consistent attendance of members of the Multi-Disciplinary team.

A reduction in the Trust overall length of stay was achieved to support the transfer of patients requiring rehabilitation into the Community by the end of September 2018 which supported the closure of an inpatient ward.

Work continued with the wards and the Clinical Site Team to improve the percentage of morning discharges, paying particular attention to preparing for patient discharges the day before and in ensuring optimal use of the discharge lounge.

Weekly reviews of patients with a length of stay of over 7 days took place, and this was an ideal opportunity to challenge plans that were in place, this would be for either clinical management plans, or discharge plans for those patients who were medically fit for discharge.

The whole of the Trust were involved in the national #endpjaralysis programme, during which time the significance of the harm that PJ paralysis can cause to patients was widely shared with staff, patients and visitors. On each Wednesday during the period of the national programme, staff came to work in their pyjamas or an #endpjaralysis t-shirt.

The Trust continue to try to encourage patients who can get up and get dressed to do so instead of remaining in bed in their pyjamas, and maintain as much mobility and independence as possible.

The use of Red and Green days is operationalised at the midday bed meeting daily, where there is a review of patients waiting for a procedure or onward care. Any internal delays are escalated, with support provided to resolve issues as quickly as possible. This has been further supported this year with the introduction of electronic whiteboards on every ward which enables real time information to be available at every board round. The information on the whiteboards show whether a patient is unwell, waiting for intervention within the hospital, medically fit with a delay or medically fit and ready for discharge.

Reduction of bed occupancy is the key to maintaining flow throughout the hospital. Work is ongoing with our health and social partners to support and improve discharge processes. On 1 October 2018 the Integrated Care Bureau was implemented. This process ensures that the referrals describe a patient's needs, rather than prescribing a pathway. The referrals are then reviewed by a triumvirate of a social worker, an acute therapist and a community in reach nurse or therapist, to ensure that the patient is directed to the right pathway first time.

The relaunch of the SAFER bundle has helped us to ensure that there is senior presence and decision making on board rounds, so that we can take any required actions early for a patient to go home as soon as they are ready, which in turn creates a bed for someone coming through our Emergency Department.

This has been, particularly beneficial over the busy winter period when we have been under pressure first thing in the morning due to the need to find appropriate beds for patients who have had to remain in the Emergency Department overnight.

Reviewing our patients with a long length of stay helps to understand what the issues and blockages are. We have been able to intervene where there have been internal delays, to provide resolution and we have also been able to see where our external delays affect our flow, bed occupancy and patient journey.

With the support of the Integrated Discharge Service and the Integrated Care Bureau, the wards were able to ensure that their patients were referred to the right services, first time and that external partners coming in to support the discharge process had access to the right information when they came in.

We have reviewed the use of our Discharge Lounge and are looking at ways in which we can use the area more productively to increase our morning discharges and as a result, our flow.

What will we do next?

We will ensure that the electronic whiteboards are used as part of the daily board round and updated live to ensure everyone who requires the most up to date patient information is able to access it via e-Flow (the application that is used via the intranet for staff who need to access whiteboard information remotely). This will also enable the site team to plan discharges for the next day and ensure that everything is ready for the patient to leave the hospital.

The success of last year's focus on ending PJ paralysis is to be built upon with a relaunch and renewed focus for multidisciplinary teams to ensure our patients get up, get dressed and be more active. This will help to maintain independence and avoid harm.

We are working more closely with our commissioners and partners across the local health economy to review our longest staying patients specifically those with a length of stay over 21 days. The majority of these patients are included on the Green to Go list (the list of patients who are medically fit but are awaiting support of some kind, such as rehabilitation, package of care or a care home). This group of patients is reviewed on a weekly basis with clear actions put in place where discharge plans are not forthcoming.

Whilst we have improved the numbers of patients being discharged we recognise through incidents raised, and patient and carer feedback that we still have some significant improvements required in optimizing safe discharges for patients and will take this forward as a quality priority for 2019/20.

RAG Rating

Green - We have embedded the process for the use of the SAFER Bundle in order to reduce the delays for patients in hospital and embraced the PJ Paralysis Campaign throughout the Trust.

Priority Six: Enhancing the way we use communication to influence care and service development

Why we chose this priority?

It is important that staff, patients and members of the local community/general public have confidence that if they need us they will receive high-quality care and they need to know they will receive the care they need, when they need it.

Additionally Staff need to understand the direction of the organisation; its values and vision for them to feel valued and acknowledged as part of the team. It is important for the success of the Trust that staff are informed of the successes and also the challenges of the organisation so they can support and contribute to making any changes. Staff need to have a voice and feel they can influence decisions within the Trust.

What did we say we would do?

We said we would develop an internal organisational communication plan that improves staff engagement and ensures staff are more aligned with the organisations values, vision, objectives and priorities.

We suggested that by doing this we would see an improvement in our staff attitude survey scores for staff reporting good communication between senior management and staff and in the ability to contribute towards improvement at work. We planned to evaluate the use of the 'Happy App' in Radiology and consider this then as operational throughout the Trust by the end of December 2018.

We developed an internal and external communication plan which included the following:

Internal

- Ensuring all staff have access to the newsletter, staff no longer need to subscribe to receive the newsletter it is now sent automatically to everyone in the Trust. Hard copies are printed and distributed to staff areas.
- Noticeboards throughout the Trust have been refreshed and are regularly updated to ensure timely communication.
- Communications team support is given to all Trust projects.
- Staff discussion groups and briefings are held monthly, allowing staff to attend and have their say in changes within the Trust and to hear what is going on organisation-wide, allowing them to understand and contribute to the Trust's vision and values.
- The communications team is working closely with the patient experience team to ensure we publish and promote patient stories, sharing experiences and learning opportunities.
- Regular communications via all available channels to encourage participation in the NHS Staff Survey.
- Monthly Executive led all staff briefings, delivered by each Executive feeding back on area of responsibility and includes time for questions.
- 'Leadership breakfast' for staff who are on leadership programmes meet with Executive team to discuss Personal and Organisational development.

We said we would assess the process for producing patient information and the quality of information for patients produced by the communications team to ensure that the process is effective and the information is of a high quality.

We said that by improving the quality of information that we provide to Patients that we would see an improvement in metrics that measure communication with patients such as complaints and patient feedback.

External

- We are refreshing all patient information leaflets, when they are due for review to ensure the information is clear and easy to understand
- We are undertaking a review of the patient's bedside book to ensure they have clear and accurate information during a stay in hospital
- We continue to review all information on the external website to make sure it is relevant, up-to-date and easy to find
- We have made significant progress with producing more press release and social media posts so the public know what services are offered by the Trust and the activities within the Trust that are occurring.
- We are developing the use of different social media platforms to engage with a variety of audiences.

What difference did it make?

We are seeing greater engagement with staff, enabling them to feel like they have a voice in the organisation and that they understand what is happening within the organisation.

Overall engagement score nationally was consistent with 2017 score.

- Staff feel more positively about their immediate managers.
- Satisfaction with pay has increased.
- Staff health and well-being has seen a decline in most measures.
- Too many staff are working whilst unwell.

Staff Engagement

Staff do want to share and promote their work, showing what they are achieving to promote patient care. In addition there is a vast amount of information being received to be included in the Trust staff newsletter, showing that more and more staff are engaging with this important communications tool.

We are seeing more positive public comments and media coverage, which is reassuring for the public so they know that high-quality care is delivered at the Trust. The Trust has received increasing amount of engagement with the public on social media with lots of positive and supportive comments, including positive patients' experiences.

Patient Complaints

The Trust has seen a reduction for the second year in a row of patient complaints, a total of 221 complaints were received and investigated during 2018/19, compared to 235 during 2017/18 and

1. Would recommend the organisation as a place to work:

2018 = 52.6%

(2017 = 46.1%)

2. Care of patients/service users is the organisations to priority:

2018 = 72.1%

(2017 = 65.6%)

3. If a friend/relative needed treatment you would be happy with the standard of care provided by the organisation:

2018 = 57.0%

(2017 = 54.6%)

251 within 16/17. It is noted that during 2018/19 the process of categorising complaints has been reviewed with complaints now being categorised as informal and formal complaints, however the total number received has reduced. The aim of the change was to support patients receiving a more timely response to their concerns and questions, enabling the Trust to achieve a 100% response time to patient complaints during March 2019

What will we do next?

An internal communications plan has been developed and implemented in April 2019 to ensure engagement with staff continues to go from strength-to-strength.

A new newsletter will be introduced, named by the staff, to help make it easier for staff and improved engagement to access important Trust information.

We will plan to complete the refresh of the intranet and external website and develop a social media strategy.

Staff communications champions are being developed to ensure that every area of the Trust has someone who ensures important information reaches all staff, this includes representing teams at staff briefings, printing and displaying posters and Trust-wide emails, monitoring and updating information on relevant pages of the intranet.

Learning will be taken from the 2018 NHS Staff Survey which we will share widely with staff to ensure an increased number of staff take part next year.

We will continue to review the patient information leaflets and bedside book.

RAG Rating

Green: We have achieved this priority; however we recognise that further work is still required.

We have:

- Introduced monthly staff briefings.
- Revamped the weekly newsletter for staff and procured a new platform to deliver this.
- Regular refresh of notice boards and provide paper copies to departments where there is limited access to computers.
- Regular review and updating of Patient information leaflets.
- Increased positive press releases and social media post to engage with staff and the public.

Priority Seven: Reducing Harm from Medicines

Why we chose this priority?

In 2017 the World Health Organisation launched a patient safety challenge called “medication without harm” which aims to reduce avoidable medication related severe harm by 50% in 5 years. In the NHS in England ‘definitely avoidable’ adverse reactions to medicines contribute to 1700 incidents, and are directly responsible for, approximately 700 deaths per year. At Weston we set an ambitious programme of improvement in order to meet this priority.

What did we say we would do?

We aimed to reduce the number of our medicines related incidents that result in any harm to our patients by focusing on:

- High risk drugs such as insulin prescribing and administration.
- Parts of the medicines administration process relating to admission and discharge which are high risk for errors occurring.
- Reducing harm from omitted medicines for patients with Parkinson’s disease
- Reducing unnecessary prescribing of medicines by not prescribing medicines identified as having limited or no value.

We said we would ensure patients received the correct medication both in hospital and when discharged and that GPs received the correct information about all discharge medications in a timely way. We listened to patient feedback and set the objective for patients to understand the medications which they are taking and where possible reduce delays to timely patient discharge due to medication issues. We aimed to reduce the inappropriate use of antibiotics by ensuring that they were prescribed only for the right patients.

What difference did it make?

We undertook safe management of diabetes training and use of insulin training on all wards. We also introduced a process which safely allows patients, who are able to, to administer their own insulin doses whilst in hospital.

We redesigned the discharge letter to include information about medicines that have been stopped and started in hospital and the reasons why to improve the quality of information provided to patients and their GP on discharge from hospital.

We checked patient’s medication on admission to make sure that the medicines they were taking prior to admission were prescribed correctly whilst they were in hospital.

We undertook a quality improvement project to identify Parkinson’s patients on all our wards and improve understanding of the need to administer their medication at the correct times and the adverse effects that can occur if there is a delay in administering.

There has been a reduction in the percentage of medication incidents with harm as reported on the metrics; however Indicators of Medicines reconciliation have not been achieved.

‘Always Events’ (an NHS England Initiative) was implemented on Kewstoke ward; this has supported the improvement work underway to ensure patients understand their medications on discharge. Whilst there has been a reduction in the inappropriate use of antibiotics this has not been to the target required.

This year 56 medication incidents were reported at Weston as causing harm to a patient compared with 64 incidents the previous year. This is a 12.5% reduction which means we are on target to reduce incidents causing harm to patients by 50% over five years.

We checked that 4,002 patient’s had their medicines prescribed accurately on admission. Although this was an increase of 4% on the previous year it was below our target of checking 80% of patients admitted between Monday and Friday. We found, on average, 1.4 differences per patient between the medicines they were taking before they came to hospital and those that were prescribed for them on admission.

The Trust submits information each month into the National Medication Safety Thermometer. This year an average of 4.7% of patients at Weston missed a dose of a critical medicine. As well as being below the national average of 6.4% for this year it is a significant improvement compared to last year when 7.6% of patients at Weston missed a dose of a critical medicine.

Further to this reducing harm from medicines is monitored through our datix system and reported through the medicines optimisation group and the harm free group and learning shared with the ward sisters and junior doctors. However, many of the key points for this quality priority on further review with the Head of Pharmacy were not able to be measured in a sufficiently robust way.

What will we do next?

Reducing harm from Medicines is a high priority for the Trust and given that this is a five year reduction programme and there has been limited improvement this year this will continue as a priority for 2019/20. This year will draw on the increased resources and education to support the reduction in the number of medication incidents which result in harm.

We will continue next year to reduce the number of medicines related incidents that result in harm to our patients by focusing on:

- Continuing education for all staff on safe use of insulin and a new focus on drugs which increase the risk of bleeding such as heparin.
- Increasing the number of staff in pharmacy so that we can achieve our target of checking over 80% of patients' medicines who are admitted to Weston from Sunday to Thursday.
- Rolling out trust wide the improvements identified in the ongoing multidisciplinary quality improvement programme focusing on missed doses of medicines on our wards and further work to identify which drugs are routinely being missed and why this is happening.

We will aim to reduce unnecessary prescribing of antibiotics by making sure they are reviewed within 2-3 days after being started so that we know they are still needed, ensuring they are not prescribed for any longer than is needed and that the correct reason for prescribing is clearly documented for each patient.

RAG Rating

Amber: Whilst we have reduced the number of medication incidents causing harm to patients and undertaken a series of medication quality improvement programmes we have not achieved the targets we set.

Quality Priorities for 2019/2020

During 2018/19 The Trust has identified five quality priorities for 2019/20. One of the priorities, reducing harm from medication errors has been included from the previous year as this was only partially achieved.

The priorities were identified through:

- Three Quality Conversation engagement events were held in May 2018, November 2018 and January 2019, supported by attendance from our staff, the Patients Council, Health watch, GPs and Bristol, North Somerset, and South Gloucestershire (BNSSG) Clinical Commissioning Group.
- National requirements included in the NHS Constitution and the NHS 10 year plan.
- The priorities of our commissioners – incorporating agreed CQUIN targets.
- Changes to the needs of our population which have occurred due to clinical pathway changes, partnership working with University Hospitals Bristol, the temporary overnight closure of the Emergency Department and the plans for 'Healthy Weston'.
- The experiences of our patients – captured by the work of our Patients' Council, Patient Experience Review Group and Health watch North Somerset.
- Performance data about the Trust – including mortality, incidents, falls, pressure ulcers, complaints/PALS contacts and audit data.

Priority	Theme
1	Improving our Governance processes and response to and learning from concerns raised
2	Promoting inclusion, involvement and engagement for Patients and Carers
3	Reducing Harm from Medicines
4	Developing and making the most of our workforce
5	Optimising Safe discharges

This year's priorities have been taken forward by the Executive Leads for quality; the Director of Nursing and Medical Director, widely discussed, reviewed and approval by the Trust's Quality and Safety Committee, Senior Management Group and finally the Trust Board.

How will we measure progress of these priorities?

Clinical leads will be allocated for each priority to monitor, track the progress and drive forward the initiative. Improvement measures will be set and the data collected and analysed to track progress.

Accountability for overall progress will be monitored and achieved through the Trust's

Quality and Safety Committee and the Senior Management Committee.

A wide range of quality measures are reported to the Board every month as part of an Integrated Board Report. This report is included in the public session of the Trust Board and is published on the Trust's external website.

In addition, quality measures are reviewed at the Quality and Patient Safety Sub Group chaired by Bristol, North Somerset and South Gloucestershire (BNSSG) CCG, NHS England who commission specialized services, NHS Improvement who are the Trust's performance regulators and the Care Quality Commission who regulate care delivery at the Trust.

Priority One: Improving our Governance processes and response to and learning from concerns raised

Executive Lead: Director of Nursing and Medical Director	
PRIORITY 1	Improving our Governance processes and response to and learning from concerns raised
Rationale and past performance	<p>Ensuring that a robust governance process is established within the Trust supports the organisation to run efficiently and effectively and ensures that we are open and honest to the staff, patients and governing bodies that we are accountable too. We would like to continue to review and strengthen our governance processes to ensure we have the correct processes and structures in place, risks are identified and managed and we continually learn and improve the ways we work.</p> <p>We have started to embed the new governance processes over the past year with a reduction in outstanding investigations but recognise that there is still more work to be done across all the wards and departments to ensure that these new processes are fully understood, robustly and consistently managed and that learning is obtained, shared widely and tested in practice.</p> <p>Additionally we would like to focus on our response to concerns raised by our patients and carers making sure that we respond in a meaningful and timely way and demonstrate our commitment to continual learning when care falls below the standard we would like.</p>
What will we do?	<ul style="list-style-type: none"> • We will ensure that complaints are responded to in a timely manner and responses are tailored to the needs of patients and their carers. • Staff will better understand the process of investigating concerns and developing meaningful action plans to drive improvement. • We will ensure that governance processes are well embedded, managed with clear reporting processes and are able to support learning from incidents at Specialty Directorate and Trust Wide levels.
Measurable target/s for 2019/20	<p>The response times for complaints will be achieved in line with the Quality Schedule at 85% Root Cause Analysis investigations for Serious Incidents will achieve the 60 day time scale in 90% of cases. We will review our patient information about investigation procedures and how they can contribute to investigations.</p> <p>We will measure the improvement in patient satisfaction with our responses to complaints by developing a process of learning from dissatisfied complaints, or where we could have provided different information or answered with a more patient centred approach.</p>
How progress will be monitored	<p>Progress will be monitored through our suite of meetings where assurance is provided on key quality indicators.</p> <ul style="list-style-type: none"> • Quality improvement Programme to Quality and Safety Committee • Patient Experience Review Group • Clinical Effectiveness Group • Executive Review Panel • Board Integrated Performance Report
Board sponsor	Director of Nursing Medical Director
Implementation lead	Deputy Director of Quality and Safety

Priority Two: Promoting inclusion, involvement and engagement for Patients and Carers

Executive Lead: Director of Nursing	
PRIORITY 2	Promoting inclusion, involvement and engagement for Patients and Carers
Rationale and past performance	<p>We have achieved the 2018/19 priority around improving care for frail patients and patients with a dementia, but recognise we need to do more for patient groups who are in danger of being overlooked or their voices are not heard.</p> <p>Our Staff/patient/user group quality conversations asked us to do more on addressing diversity, co-designing services and engagement with patients who have specific need and requirements to support them with accessing hospital care.</p>
What will we do?	<p>We will continue our education plan for staff to recognising dementia and delirium to ensure timely and effective treatment, support and education.</p> <p>We will continue our work, that was commenced this year through the “GEMS” team and the Admiral Dementia Nurse Specialist supporting the frail and elderly patients and also those with a dementia, drawing on the benefits the roles brings to patients and their carers.</p> <p>We will work to increase the involvement of the Patient Council in undertaking surveys to capture patient experience and feedback.</p> <p>We will listen to the patient and carer voice in a variety of forums in order to ensure that we communicate with some of the ‘harder to reach’ groups of patients.</p> <p>We will hold an Autism Awareness Event.</p> <p>We will work closely with our Mental Health Liaison Team and CAMHS to explore how we can involve our patients in ensuring that the services we offer are accessible and in line with what the patient needs.</p> <p>We will ensure that service users are signposted to help whilst waiting for their CAMHS assessment, ensuring that the patients are being monitored and risk assessments are completed for each patient.</p> <p>We will reinvigorate the ‘Hello my name is Campaign’ to improve our communication with patients and carers.</p>
Measurable target/s for 2019/20	<p>Improvements in both inpatient and emergency friends and family test response rates and feedback for patients within protected characteristic groups.</p> <p>Improvements in Inpatient survey results in engagement scores with patients.</p> <p>Reduction in the number of complaints received which relate to staff communication to patients through six monthly thematic reviews.</p> <p>Monthly reporting of achieving reduced length of stay and greater than 25% admission avoidance for Frailty patients attending the Emergency Department.</p>
How progress will be monitored	<p>We will monitor this at the Patient Experience Review Group and report to the Quality and Safety Committee each Quarter.</p> <p>We will monitor the reduced length of stay through the performance management reviews.</p>
Board sponsor	Director of Nursing
Implementation lead	Deputy Director of Quality and Safety

Priority Three: Reducing Harm from Medicines

Executive Lead: Medical Director		
PRIORITY 3	Reducing Harm from Medicines	
Rationale and past performance	<p>Reducing harm from Medicines is a high priority for the Trust. A five year improvement programme has been established and only limited improvement have been seen during 2018/19 will wish to continue as a priority for 2019/20.</p> <p>This year will draw on the increased resources and education to support the reduction in the number of medication incidents which result in patient harm.</p>	
What will we do?	<ul style="list-style-type: none"> • We will continue to reduce the number of medicines related incidents that result in harm to our patients by focusing on: • Continue education for all staff on safe use of insulin and a new focus on drugs which increase the risk of bleeding such as heparin. • Increase the number of staff in pharmacy so that we can achieve our target of checking over 80% of patients' medicines who are admitted to WAHT from Sunday to Thursday. • Roll out trust wide the improvements identified in the multidisciplinary quality improvement programme focusing on missed doses of medicines within our wards. • We will aim to reduce unnecessary prescribing of antibiotics by making sure they are reviewed within 2-3 days after being started so that we know they are still require. 	
Measurable target/s for 2019/20	Proportion of medicines incidents rated as causing harm	< 15%
	Proportion of medicines incidents reporting delayed or omitted medicines	< 27%
	Medicines safety thermometer - omitted medicines (excluding refusal and valid clinical reason)	< 11.8%
	Medicines safety thermometer - Omission of a critical medicine	< 6.8%
	% of Sun to Fri admissions who have their medicines reconciled	< 80%
	Medicines safety thermometer - medicines reconciliation	< 70%
	Medicines safety thermometer - allergy status documented	< 96.5%
	Compliance with antimicrobial prescribing standards	< 90%
How progress will be monitored	<p>Progress will be monitored through the Drugs and Therapeutics Committee, the Medicines Optimisation Group, and via the Medicines Safety Dashboard which is submitted to the Clinical Effectiveness Committee. On-going progress will be reported through the Quality Improvement Plan to the Quality and Safety Committee.</p>	
Board sponsor	Medical Director	
Implementation lead	Head of Pharmacy Medicine Optimisation Group Chair	

Priority Four: Developing and making the most of our workforce

Executive Lead: Director of Nursing	
PRIORITY 4	Developing and making the most of our workforce
Rationale and past performance	Workforce challenges remain one of the highest threats to quality for the whole health service. We recognise the need to ensure that we support our staff to be the best that they can be and that we invest in training and development, providing new opportunities for existing staff and those who wish to join our organisation. Our staff continue to tell us that we need to do more to raise morale and make them feel listened to and part of our vision for the future.
What will we do?	<p>We will further develop our workforce plan to enable staff to professionally develop into new roles such as trainee advanced care practitioners.</p> <p>We will listen to our staff to hear “what is important” to them through the “Happy App”, staff briefings and staff discussions/ listening events.</p> <p>We will invest in and develop our clinical and managerial leaders to help them shape and deliver our clinical services.</p> <p>We will improve the quality of our staff appraisals through further training in the use of the new achievement review document.</p> <p>We will build on the improvements in our staff survey, namely their health and wellbeing, leadership development and communicating with all staff.</p> <p>We will increase the numbers and range of Apprenticeships offered.</p>
Measurable target/s for 2019/20	<p>Increase in staff survey scores for the quality of appraisal score.</p> <p>Increase the use of the “Happy App” with full participation by December 2019.</p> <p>Sustained reduction in turnover to achieve 15%.</p> <p>Increase the number of Apprentices in post.</p> <p>Improve upon our WRES score, commencing with a board seminar, prior to developing and overarching strategy. Specifically, demonstrate to staff that there is equitable access to development and promotion.</p>
How progress will be monitored	Progress will be monitored through the Education Committee, the Health and Wellbeing group and the People and Organisational Development Committee reporting to Trust board.
Board sponsor	Director of Human Resources
Implementation lead	<p>Head of HR</p> <p>Deputy Director of Nursing- Workforce, Education and Professional Standards</p>

Priority Five: Optimising Safe discharges

Executive Lead: Director of Operations	
PRIORITY 5	Optimising Safe discharges
Rationale and past performance	<p>Whilst we delivered significant improvements during 2018/19 to facilitate timely discharge, our patients, stakeholders and staff tell us that we could do more to improve our discharge processes. Ensuring that patients are prepared for discharge with the right information for them, their carers and the healthcare professional who continue their care in the community, is key to a high quality safe discharge.</p> <p>Delays to discharge and poor communication are responsible for a significant proportion of our complaints and incident reporting.</p>
What will we do?	<p>Hold a discharge summit with community stakeholders and patient /carer representative to ensure we focus on the right aspects to make a significant improvement in the discharge pathway.</p> <p>Demonstrate improved quality of discharge summaries.</p> <p>Reducing the amount of time patients spend in hospital waiting for discharge.</p> <p>Improve the number of safe discharges from hospital at the weekend.</p>
Measurable target/s for 2019/20	<p>Reduced overall length of stay, including a reduction in the number of patients remaining in hospital over 21 days.</p> <p>Reduction in incidents and complaints relating to patient discharge.</p> <p>Improved stakeholder satisfaction with discharge information through a reduction in incidents reported.</p> <p>Improvement in inpatient survey (discharge domains).</p>
How progress will be monitored	<p>Monitoring will be via the daily green to go list (medically fit patients ready for discharge) list as well as the weekly super stranded patients (length of stay over 21 days).</p> <p>This is reported to the finance and performance committee on a monthly basis and through that, up to the Board.</p> <p>Improvement of quality progress will be monitored via the Patient Experience Review Group and the Performance Management Review meetings and via the Quarterly reports of Quality Priorities to the Quality and Safety Committee.</p>
Board sponsor	Director of Operations
Implementation lead	Operational Matron Head of Patient Flow

Participation in Clinical Audits

During 2018/19, thirty two national clinical audits and one national confidential enquiry covered relevant health services that Weston Area Health NHS Trust provides.

During that period Weston Area Health Trust participated in 87.5% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

There were a small number of national audits that we chose not to take part in. This was, for example, because our patient case mix did not meet the necessary criteria – or because of a shortage of clinical staff. Assessment and progress of the Clinical Audits is reported quarterly at the Clinical Effectiveness Committee

The national clinical audits and national confidential enquiries that Weston Area Health NHS Trust was eligible to participate in during 2018/19 as follows:

Table 7. Eligible National Clinical Audits 2018/19

National Clinical Audit Title	
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Audit of Breast Cancer in Older Patients
Diabetes (Paediatric) (NPDA)	National Emergency Laparotomy Audit (NELA)
National Chronic Obstructive Pulmonary Disease Audit	National Lung Cancer Audit (NLCA)
National Asthma Audit	Oesophago-gastric Cancer (NAOGC)
National Heart Failure Audit	Prostate Cancer
Feverish Children	National Comparative Audit of Blood Transfusion programme - Audit of O negative red cells
VTE Risk in Lower limb Immobilisation	National Comparative Audit of Blood Transfusion programme – Management of maternal anaemia
Vital Signs in Adults	Serious Hazards of Transfusion (SHOT): UK National haemovigilance
National Diabetes Audit – National Diabetes Inpatient Care	National Audit of Care at the End of Life (NACEL)
Sentinel Stroke National Audit Programme (SSNAP)	National Audit of Dementia (NAD)
Bowel Cancer (NOCAP)	Learning Disability Mortality Review Programme
National Hip Fracture Database	National Maternity and Perinatal Audit
Case Mix Programme (CMP)	National Cardiac Arrest Audit
National Joint Registry (NJR)	National Vascular Registry
Elective Surgery (National PROMS programme)	Seven Day Hospital Services
Inflammatory Bowel Disease (IBD) programme	National Audit of Inpatient Falls (NAIF)
National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	
Perioperative Diabetes	

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The national clinical audits and national confidential enquiries that Weston Area Health Trust participated in during 2018/19:

Table 8. Number of Audits Participated on during 2018/19

National Clinical Audit Title	% Participation Rate if data completed In 2018/19
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Continuous data collection
Diabetes (Paediatric) (NPDA)	Continuous data collection (Data submitted via Bristol)
National Chronic Obstructive Pulmonary Disease Audit	Continuous data collection
National Heart Failure Audit	Continuous data collection
Feverish Children	100%
VTE Risk in Lower limb Immobilisation	100%
Vital Signs in Adults	100%
Sentinel Stroke National Audit Programme (SSNAP)	Continuous data collection
Bowel Cancer (NOCAP)	Continuous data collection
National Hip Fracture Database	Continuous data collection
Case Mix Programme (CMP)	Continuous data collection
National Joint Registry (NJR)	Continuous data collection
Elective Surgery (National PROMS programme)	Continuous data collection
National Audit of Breast Cancer in Older Patients	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Continuous data collection
National Lung Cancer Audit (NLCA)	Continuous data collection
Oesophago-gastric Cancer (NAOGC)	Continuous data collection
Prostate Cancer	Continuous data collection
National Comparative Audit of Blood Transfusion programme - Audit of O negative red cells	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance	Continuous data collection
National Audit of Care at the End of Life (NACEL)	100%
National Audit of Dementia (NAD)	100% (notes audit)
Learning Disability Mortality Review Programme	Continuous data collection
National Maternity and Perinatal Audit	Continuous data collection
National Cardiac Arrest Audit	Continuous data collection
National Vascular Registry	Continuous data collection (Data submitted via Bristol)
Seven Day Hospital Services	100%
National Audit of Inpatient Falls (NAIF)	Continuous data collection
National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	Did WAHT participate?
Perioperative Diabetes	Yes

Weston Area Health Trust completed 25 local clinical audits and quality improvement projects during 2018/19. The outcomes of the audits are shared with relevant staff at specialty meetings directorate governance meetings and via the WeSMILE quality improvement magazine. The Clinical Audit Team maintains a register of all local (and national) audits, their results, and the subsequent actions by the Trust.

Examples of actions arising from these audits that the Trust has implemented or intends to implement to further improve the quality of care are provided:

Table 9 Clinical Audits completed and outcomes Identified

Clinical audit title	Outcomes
Inpatient invasive medical procedures at Weston General Hospital	Following the introduction of local invasive procedure checklists and a number of educational interventions, we saw an Increase in the use of checklists for invasive procedures from 29% to 86%.
Controlled drugs prescription	11% decrease in the error rate confirmed at 3 and 6 weeks. Increase of code 7 (2nd prescription correct) increased from 20% to 60%). Further dissemination of the results is needed.
Coeliac Disease Audit	Through analysis of a 10% sample of patients diagnosed with coeliac disease under the gastroenterology team we determined that the team had performed well in all aspects audited against NICE guidance QS134 last updated in 2016. No improvements were suggested to the team as this audit showed that they were complying with current NICE guidance.
Improving Medical Referrals	By introducing a Microsoft Access-based referral database available to clinicians on the trust intranet site and using mandatory fields for data entry, there were obvious improvements in the handover of relevant information. Handover of important details below increased from 0% to 100%: <ul style="list-style-type: none"> • date, time and source of referral • Full patient details, including current location. Following introduction of database, staff identified some improvements to the system.
A pilot of risk assessment measure within a CAMHS Learning Disability Team	Standard 1. Every learning disability initial assessment conducted after 1.1.18 should have a completed risk assessment = 90% Standard 2. Every child identified moderate or high risks should have a completed risk formulation = 25%. No improvements were suggested as this audit showed that they were complying with current NICE guidance.

NICE Quality Standards

NICE Quality Standards are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of healthcare. They are derived from the best available evidence such as NICE guidance and other sources accredited by NICE. Quality standards consider all areas of care, from public health to healthcare and social care.

A revised process for the implementation of all NICE guidance, including NICE Quality Standards, has been put in place during 2018/19. A gap analysis is undertaken by the Directorate lead and the whole process is supported and managed through the Quality Improvement Hub. The Clinical Effectiveness Group receives high level reports, with onward assurance through to the Quality and Safety Committee.

During 2018/19, 13 new Quality Standards were published, two of which were deemed not relevant to our services. The gap analyses are sent to the clinical leads/teams for completion this is then reviewed at the Clinical Effectiveness Group.

Research

We undertake many different types of research at Weston Area Health NHS Trust. This ranges from simple studies using questionnaires or sample collection right up to complex studies offering different therapies or new treatments.

Access to high quality research studies gives patients the opportunities to have therapies and treatments that may not be available yet. Participation in research enables our staff to remain up to date with the latest treatments available and contributes to achieving the best outcomes for our patients.

The numbers of patients receiving relevant health services provided or subcontracted by WAHT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee 412.

Approximately 320 patients are being followed up from previous years to see how they are progressing following treatment.

We have recruited the following number of participants into the following studies:

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Table 10. Research Study and number of Participants

Research Study	Speciality	Recruited
Add-Aspirin Trial - Investigating whether aspirin can reduce the risk of their cancer coming back.	Cancer	1
ADDRESS 2 - Incident and high risk type 1 diabetes cohort.	Diabetes	1
MUK nine a: A screening study for people with suspected myeloma	Haematology	1
PBC Genetics Study – for patients with Primary Biliary Cirrhosis	Gastroenterology	1
PLATFORM – A study looking at maintenance treatments for oesophago-gastric cancer.	Cancer	1
OPTIMA – Personalised treatment for breast cancer.	Cancer	3
PRED 4 – Predicting Side effects in gastroenterology	Gastroenterology	3
Patients views on long term follow-up of a hip replacement	Orthopaedics	4
Toxicity from biologic therapy – registry of patients with rheumatoid arthritis	Rheumatology	4
National cohort study of late effects of Hodgkin Lymphoma treatment.	Haematology	5
Vedolizumab long term safety study – for people with ulcerative colitis or Crohn’s disease.	Gastroenterology	6
STAMPEDE – comparing different treatments for men with prostate cancer	Cancer	6
TrialNet – for people with type 1 diabetes.	Diabetes	7
HORIZONS: Understanding the impact of cancer diagnosis and treatment.	Cancer	8
MAMMO-50 – a study looking at the frequency of follow-up mammograms for women who have had breast cancer.	Cancer	11
PrEP Impact Trial – for people at risk of HIV.	Sexual Health	15
Work outcome measures in arthritis and musculoskeletal conditions	Rheumatology	17
I-CARE – Inflammatory Bowel Disease Cancer and Serious Infections in Europe study.	Diabetes	23
Determinants of prognosis in stroke – a study collecting information and blood samples for people who have had a stroke.	Stroke	32
NICE FIT - A study to see if a new test called FIT can tell whether people with symptoms of bowel cancer need to have a colonoscopy.	Cancer	32
Drug Allergy Labels in the Elective surgical population	Anaesthetics	40
IBD BioResource – a registry for people with inflammatory bowel disease.	Gastroenterology	40
How people with IA perceive and understand patient activation – for patients with inflammatory arthritis.	Rheumatology	67
The second Bristol online survey of dementia attitudes	Dementia	85
Total		412

Research being undertaken includes, the PrEP Impact Trial which is looking at treatment for people who are at risk of contracting HIV. This treatment is not currently funded for NHS patients in England. Another study we provide is the Platform Study which gives people with oesophago-gastric cancer the opportunity to have maintenance treatment following their initial course of chemotherapy.

There are a number of new studies that will open to recruitment in the year 19/20. We will continue to seek high quality research studies that are of relevance to our patients and fits with the *Healthy Weston* proposals. This will be in closer partnership with our neighboring NHS Trusts and we will enable our patients to access opportunities.

National and Local Quality improvement and innovation goals (CQUIN)

A proportion of income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between WAHT and any persons or bodies they entered into a contract, agreement or arrangement with for the provision of relevant health services contract us to deliver services and the provision of relevant health services.

A proportion of WAHT income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between WAHT 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.

Weston Area Health NHS Trust has received assessment of the 2018/19 CQUIN payment, however the Trust has challenged the accuracy and final agreement has not been reached at the time of reporting.

The monetary total for the amount of income in 2018/19 conditional upon achieving quality improvements and innovation goals is £1,675,844 and a monetary total for the associated payment in the prior reporting period was £1,651,637.

Table 11. CQUIN Targets 2018/19

CQUIN	Description of indicator	Value of CQUIN	Achieved
Improving the health and wellbeing of NHS Staff	Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well. Including the Flu Vaccination.	1a 0.083% 1b 0.083% 1c 0.083%	TBC
Identification and Early Treatment of Sepsis & Antimicrobial resistance	Systematic screening for Sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. Reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours.	2a 0.063% 2b 0.063% 2c 0.063% 2d 0.063%	TBC
Advice and Guidance	To deliver a proof of concept Advice and Guidance service. To design and setup the Advice and Guidance service in two specialties and run for a 6-month period.	0.25%	TBC
Improving services for people with mental health needs who present to A&E	Acute trust review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via A&E HES data submissions is complete and accurate.	0.25%	TBC
Transitions out of CYPMHS	This CQUIN aims to incentivise improvements to the experience and outcomes for young people when they transition out of Children and Young People's Mental Health Services (CYPMHS) on the basis of their age.	0.50%	TBC
Preventing ill health by risky behaviors – alcohol and tobacco	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication. Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral.	0.50%	TBC
Sustainability and Transformation Programme	Participation in the STP work streams.	0.90%	TBC

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Care Quality Commission Inspection

Weston Area Health NHS Trust (WAHT) is required to register with the Care Quality Commission and its current registration status is 'registered without conditions or restrictions'. The Care Quality Commission has not taken any enforcement action against WAHT during 2018-2019.

WAHT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

From the CQC inspection in 2017 the Trust received a warning notice for Urgent and Emergency Care and took rapid action to address the concerns raised, following a further review in August 2018, the Section 29a safety warning notice was lifted in October 2018.

The Trust has undergone an inspection in February 2019 of four core services: Urgent and Emergency Care, Medicine, Surgery and CAMHS, with the Use of Resources and a Well Led Review in March 2019. The final Care Quality Commission report was published on the 26th June 2019.

2019 Inspection - Ratings	
Overall rating for this trust	Requires improvement 
Are services safe?	Requires improvement 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Requires improvement 

Ratings for the whole Trust					
Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← June 2019	Good ↑ June 2019	Good →← June 2019	Requires improvement ↑ June 2019	Requires improvement →← June 2019	Requires improvement →← June 2019

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Ratings for Weston General Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate →← June 2019	Requires improvement →← June 2019	Good →← June 2019	Requires improvement ↑ June 2019	Inadequate →← June 2019	Inadequate →← June 2019
Medical care (including older people's care)	Requires improvement →← June 2019	Good ↑ June 2019	Good →← June 2019	Requires improvement ↑ June 2019	Requires improvement →← June 2019	Requires improvement →← June 2019
Surgery	Good →← June 2019	Good →← June 2019	Good →← June 2019	Requires improvement →← June 2019	Good →← June 2019	Good →← June 2019
Critical care	Good June 2019	Good June 2019	Good June 2019	Requires improvement June 2019	Good June 2019	Good June 2019
Services for children and young people	Good August 2015	Good August 2015	Good August 2015	Requires improvement August 2015	Good August 2015	Good August 2015
End of life care	Good August 2015	Good August 2015	Outstanding August 2015	Requires improvement August 2015	Good August 2015	Good August 2015
Maternity and gynaecology	Good August 2015	Good August 2015	Good August 2015	Good August 2015	Good August 2015	Good August 2015
Outpatients and diagnostics	Good August 2015	N/A	Good August 2015	Requires improvement August 2015	Good August 2015	Good August 2015
Overall*	Requires improvement →← June 2019	Good ↑ June 2019	Good →← June 2019	Requires improvement ↑ June 2019	Requires improvement →← June 2019	Requires improvement →← June 2019

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Ratings for Mental Health Services						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Inadequate ↓ ↓ June 2019	Requires improvement ↓ ↓ June 2019	Good ↓ June 2019	Inadequate ↓ ↓ June 2019	Inadequate ↓ ↓ June 2019	Inadequate June 2019

Following the February/ March 2019 inspection the Trust was issued with a Warning Notice on the 5 April 2019 for the Emergency department and the CAMHS Service.

The reasons for the Warning Notice were that from the CQC's perspective the quality of health care the Trust was providing requires significant improvement in both services. The trust established an improvement plan to address these issues with immediate effect.

Throughout the year there has been robust management of the 2017 CQC improvement plan reviewed within monthly senior management team meetings, monthly Directorate Governance meetings and at the Board Quality and Safety Committee, with assurance against actions

assessed and tested by the lead Executive for each action. The CQC noted significant improvement against the 2017 improvement plan. This plan will be updated to include the recommendations from both the 2019 warning notice and the CQC report.

Engagement between the Care Quality commission and Provider

As part of the new engagement process between the provider and the CQC, we have received quarterly review meetings of core services of medicine and outpatients, which included focus groups with staff and directorate leadership teams who provided feedback to the CQC on aspects that they were most proud of, which included:

- Recruiting middle grade roles in ED
- Introduction of safety huddles

- Focusing care on dementia patients and reducing falls
- Commitment of staff and going above and beyond
- Resilience of therapy team and the wider hospital
- Teamwork and the welcoming approach from ward staff.
- New sister on stroke who is providing a holistic approach to patient care
- Support from all staff levels regardless of role
- Peoples adaptation to change
- Integration process and discussions that occur between staff
- Never hear anyone say "no" when someone asks for help
- Student evaluations from the University West of England were positive.

Hospital Episode Statistics and Secondary Users service

Weston Area Health NHS Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Weston Area Health NHS Trust self-assessment (2018.19) confirmed compliance with 35 of the 40 assertions required by the Data Security and Protection Toolkit.

WAHT was not subject to the Payment by results clinical coding audit during the reporting period by the audit commission.

Table 12. Data Quality of Secondary User Services Data

Weston Area Health NHS Trust	Weston 2017/18	2018/19 (Apr – Jan) * latest data available	
		Weston	National Average
% of records including the patient's valid NHS number:			
Admitted patient care	99.9%	99.8%	99.4%
Outpatient care	100%	99.9%	99.6%
Accident and emergency care	99.8%	99.3%	97.6%
% of records including the patient's valid General Medical Practice Code:			
Admitted patient care	100%	100%	99.9%
Outpatient care	100%	100%	99.8%
Accident and emergency care	100%	99.8%	99.3%

Clinical Coding Audit

In line with the Data Security and Protection Toolkit standards (former information Governance Toolkit Requirements 505 and 514), 200 episodes have been reviewed by external auditors D&A Clinical coding consultancy LTD in December 2018 to ensure the coded information continues to be accurate and adequate. The following results have been achieved:

Data Security Standard 1 Data Quality

The Trust has achieved the following attainment level -

Mandatory

Data Security Standard 3 Training

The Trust has achieved the following attainment level - **Advisory**

Conclusions

Weston Area Health NHS Trust has achieved the Mandatory level for Data Security Standards 1 & 3, this is to be commended.

An outstanding high level of commitment is demonstrated from all the clinical coding staff in striving to enhance the clinical coding function for the Trust.

The clinical coding validation strategy supported by the Trust clinicians has had a huge positive effect in promoting data quality; and providing assurance of the financial revenue.

Table 13. Coding accuracy

% Diagnoses Coded Correctly		% Procedures Coded Correctly	
Primary	Secondary	Primary	Secondary
91.00	88.45	93.94	92.59

Data Quality

Action we have taken to improve data quality

Weston Area Health NHS Trust will be taking the following actions to improve data quality:

- The Trust has a Data Quality Policy and an Information Improvement Team. This policy, along with a wide range of others relevant to data quality, is regularly reviewed by the Trust's Health Informatics Committee which also monitors the work of the Information Improvement Team and Health Informatics in general.
- We have set up new initiatives, including the establishment of a Data Quality Group with our commissioners which will steer the data quality improvement plan.
- The Board regularly discuss a very wide range of data regarding quality and patient safety, operational performance, human resources and finance. This helps to improve data quality and presentation through robust discussion, questioning and analysis by Executive Directors, non-executive directors, patients' representatives and members of the general public.

In order to achieve further transparency the Trust continues to benchmark its data against HES via CHKS statistics (an independent provider of healthcare intelligence and quality improvement services.).

Learning from patient deaths

Weston Area Health NHS Trust has a publicly available policy outlining our approach to learning from patient deaths including how we define the cases we would wish to look at in detail, how reviews of care are undertaken in a non-judgmental, unbiased and structured way and how any learning has been fed back into the organisation. In addition the trust is required to produce a report within each quarter to be discussed at public board outlining the number of deaths that have occurred, the number subject to a learning from death review, the number where significant failings in care have been identified and how the learning from the reviews has been shared with staff.

A mandatory structured judgment review is carried out for all patients in the following groups:

- Deaths where bereaved families/ carers, or staff, have raised a significant concern about the quality

of care provision (via a formal or informal complaint or incident report during or after the final care episode)

- Death where bereaved families and carers have requested a review
- In-hospital deaths of those with learning disabilities
- In-hospital deaths of those with mental health needs
- Infant or child death. Stillbirth or Maternal death
- Deaths where learning points have been raised from other organisations (e.g. community care, primary care or other Acute Trusts)
- Deaths in specific patient groups, service areas or diagnosis as determined by the Clinical Effectiveness Group where other data suggests a need for focus and understanding.
- Deaths where learning will inform quality improvement work (for example, if work is planned on improving sepsis care, relevant deaths should be reviewed)
- A random selection of deaths occurring in hospital

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Mortality and learning from deaths learning occurs at a trust, directorate and departmental level. Learning has been shared to a wider clinical audience using the hospital patient safety magazine, through quality improvement projects (focusing on venous thromboembolism screening, abnormal sodium, end of life care) and via the Clinical Effectiveness Showcase.

During 2018/19, 509 of Weston Area Health NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period

- 119 deaths in the first quarter
- 99 deaths in the second quarter
- 133 deaths in the third quarter
- 158 deaths in the fourth quarter

By May 2019, 232 case record reviews and 1 investigation have been carried out in relation to 507 deaths included above

- 53 in the first quarter
- 43 reviews in the second quarter
- 40 reviews in the third quarter
- 96 reviews in the fourth quarter

One case representing 0.23% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient,

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter (0% in 2017/18)
- 1 representing 2.3% for the second quarter (0% in 2017/18)
- 0 representing 0% for the third quarter (0% in 2017/18)
- 0 representing 0% for the fourth quarter (0.15% in 2017/18)

In relation to the case record reviews and investigations conducted the following learning and associated actions has been identified.

Learning identified by the teams during structured judgement reviews is discussed at their departmental meetings. Any points pertinent to a wider audience will be shared at the directorate morbidity and mortality grand round meetings, which are monthly with the teams taking it in turns to host

Relevant learning identified from independent structured judgment reviews is fed back to the relevant teams during their departmental mortality meetings or via direct contact. Where feedback is relevant to a particular individual this is fed back to their supervisor for discussion. Themes will be shared to a wider audience at the next Clinical Effectiveness Showcase – the final details of this are awaited.

In addition to this, learning is shared within the organisation via:

- Directorate Governance Meetings
- Teaching sessions
- WeSMILE Patient Safety Magazine
- Safety message of the month posters

The Trust's new Treatment Escalation Plan was successfully launched in November by our Palliative Care Team and learning from our Structured Judgement Reviews add to learning from our incident and complaint investigations through a slowly maturing Directorate governance process and departmental / team Morbidity and Mortality meetings.

The Trust's Clinical Effectiveness Group (CEG) is a multi-professional body (currently co-chaired by the Medical Director, Associate Medical Director and Deputy Director of Nursing Quality and Safety) to ensure a robust clinical effectiveness cycle where data about the care of our patients is triangulated and understood and learning themes are discussed. CEG will also commission key audits and quality improvement projects as well as directing the sharing of important learning through the organisation.

Learning that comes out of structured reviews is more often evidence of good practice rather than poor practice and it is important that good care is reinforced and celebrated at the same time as sharing areas where care could be improved.

Table 14. Mandated Quality Indicators

Mandatory Indicator	WAHT 2018/2019	National Average	WAHT 2017/18	Comments
Venous Thromboembolism risk assessment	94.52%	95.6%	79.28%	The Weston Area NHS Trust considers that this data is as described for the following reasons that it is collated and validated through a robust internal audit process). The WAHT has taken the following actions to improve this percentage, and so the quality of its services, by implementing a robust validation and assurance process throughout the organisation, monitored through the clinical effectiveness meeting.
Clostridium Difficile rate per 100,000 bed days (patients aged 2 or over)	9.35	13.84	4.39	The Weston Area NHS Trust considers that this data is as described for the following reasons as it is supplied by the official HCAI Data Tool provided by Public Health England and is validated closely on a case by case basis by the Trust's Infection Control Team. The WAHT intends to take the following actions to improve this rate, and so the quality of its services by monitoring performance monthly at the Trust Infection prevention Committee and Quality and Safety Committee and seek assurance of actions being taken to provide an improvement in performance.
Rate of patient Safety Incidents reported per 1,000 bed days	51.22	43.6	46.64	The Weston Area NHS Trust considers that this data is as described for the following reasons as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal sources. The WAHT intends to take the following actions to improve this rate, and so the quality of its services by monitoring performance monthly at the Harm Free Care Steering Group and Quality and Safety Committee to encourage open and transparent reporting and to identify improvements to practice and learning.
Percentage of patient safety incidents resulting in severe harm or death	0.39%	0.40%	0.3%	The Weston Area NHS Trust considers that this data is as described as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis. The WAHT intends to take the following actions to improve this rate, and so the quality of its services by continuing to review incident data to encourage open and transparent reporting and to identify improvements to practice and learning.
Responsiveness to inpatients' personal needs	65.7	68.6	65.8	The Weston Area NHS Trust considers that this data is as described as it is supplied by NHS digital and is consistent with internal data reviewed on a monthly basis of patient feedback of their experience. The WAHT intends to take the following actions to improve this rate, and so the quality of its services by continuing to collect feedback from patients, carers and relatives through a variety of different sources utilising the Patient Council and Patient Experience Review Group.
Percentage of staff who would recommend the Trust as a provider of care	65%	72%	55%	The Weston Area NHS Trust considers that this data is as described as it is supplied by National Survey Data. The WAHT intends to take the following actions to improve this percentage, and so the quality of its services by revitalising the approach taken when receiving staff feedback to target improvement actions rapidly and address themes.

Part 2: Priorities for improvement and statements of assurance from the Board

Mandatory Indicator	WAHT 2018/2019	National Average	WAHT 2017/18	Comments
Summary Hospital-level Mortality Indicator (SHMI) value and banding	Sept 18 - March 19 0.9	Sept18 - March 19 100	April 16 - March 17 1.05	The Weston Area NHS Trust considers that this data is as described as it is supplied by Comparative Health Knowledge System (CHKS) and analysed internally through the Clinical Effectiveness Group and Quality and Safety Committee. The WAHT intends to take the following actions to improve the score and so the quality of its services by continuing with established internal review approach and following the Learning from Deaths Framework.
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	37.50%	33.8%	34.26%	The Weston Area NHS Trust considers that this data is as described as it is supplied by Comparative Health Knowledge System (CHKS) and analysed internally through the Clinical Effectiveness Group and Quality and Safety Committee. The WAHT intends to take the following actions to improve the score and so the quality of its services by continuing with established internal review approach and following the Learning from Deaths Framework.
Emergency readmissions within 28 days of discharge: age 0-15	0.9	10%	2.91%	The Weston Area NHS Trust considers that this data is as described as it is supplied by NHS Digital The WAHT intends to take the following actions to improve this percentage and so the quality of its services by monthly reviews within clinical directorates of its own monitoring data within the Performance Assurance Framework. This will identify adverse trends and agree actions to reduce unplanned readmissions.
Emergency readmissions within 28 days of discharge: age 16 or over	8.93%	11.4%	8.11%	The Weston Area NHS Trust considers that this data is as described as it is supplied by NHS Digital The WAHT intends to take the following actions to improve this percentage and so the quality of its services by monthly reviews within clinical Directorates of its own monitoring data within the Performance Assurance Framework. This will identify adverse trends and agree actions to reduce unplanned readmissions.
Patient Reported Outcome Measures	Full details of performance are in the section below			The Weston Area NHS Trust considers that this data is as described as it is supplied by National PROMs information site. The WAHT intends to take the following actions to improve this percentage and so the quality of its services by monthly reviews within clinical directorates of its own monitoring data within the Performance Assurance Framework analysing the outcome scores and continuing to focus on participation rates for the preoperative questionnaires.

Patient Reported Outcome Measures (PROMs)

The Trust has participated in the Patient Reported Outcome Measures (PROMs) programme since April 2009 for hernias, knee and hip replacements. The programme involves patients completing a pre-operative questionnaire and then a questionnaire either three or six months after the operation (dependent on type of operation).

The national coordinating center data return includes all surveys returned to it – even when patients turn out to not be eligible – hence the percentage participation rate sometimes exceeds 100%. The data is only available a year in arrears.

The performance data shows that the trust performance is similar to the national average for hip and knee. The hernia performance is suppressed by the national database on the grounds of patient confidentiality i.e. the number of patients participating is so small that the results may enable individual patients to be identified.

Table 15. PROMS participation Rate and Performance

PROMS Participation Rate:				
	WAHT Participation Rate April 16 to March 17	NHS Participation Rate April 16 to March 17	WAHT Participation Rate April 17 to March 18	NHS Participation Rate April 17 to March 18
Hernia	29%*	80.9%		
Hip	75%*	85.9%	115%	86.1%
Knee	106%*	94.6%	123%	87.3%

PROMS Performance:				
	WAHT Health Gain Average April 16 to March 17	NHS Health Gain Average April 16 to March 17	WAHT Health Gain Average April 17 to March 18	NHS Health Gain Average April 17 to March 18
Hernia	Not measurable**	0.086		
Hip	0.395	0.437	0.475	0.468
Knee	0.334	0.324	0.368	0.337

**"Not measurable" means numbers of patients who responded were so low that the analysis was withheld by NHS Digital for confidentiality reasons. Questionnaires for Hernia activity are no longer collated.

Hospital readmission

The data made available to the trust by NHS Digital with regard to the percentage of patients aged

- (i) 0 to 15; and
- (ii) 16 or over,

Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. The readmissions rates within 28 days for 18/19 are:

Table 16. Hospital readmissions

Age Range	Site Numerator	Site Denominator	Apr 18 - Mar 19
16+ years	2604	28914	9.01%
0-15 years	25	840	2.98%

CHKS data at 8/5/2019

Table 17. Responsiveness to personal needs of patients

Mandatory indicator	Weston Area Health Most Recent	National average	National best	National worst	Weston Area Health Previous
Responsiveness to inpatients' personal needs	65.7 2017/18	68.6	85.0	60.5	65.8 2016/17

Reducing harm from infection

Clostridium Difficile infections

The table shows the rate of *Clostridium difficile* (*C. Difficile*) infections there have been at the Trust per 100,000 bed days. (Children under two are not included)

Table 18. Clostridium difficile (C. difficile) infections Data source: Public Health England

	2018/19		2017/18
	Weston	National average	Weston
Rate per 100,000 bed days of cases of <i>C. difficile</i> infection	7	13.2	4.4

In 2017/18 the Trust had the lowest rate of *Clostridium difficile* infections in the whole of the South West, reporting only four cases. In 2018/19 the Trust has reported seven cases, whilst this is a 75% increase on last year, we remain within our allocated threshold of 17 cases and our rate remains below the national average. Each case has undergone a comprehensive post infection review which has been assessed against national guidance criteria.

We have been able to demonstrate that there have been no cases of cross transmission of *Clostridium difficile* between patients on our wards. Learning has been identified in areas such as prompt isolation, sampling, consistency with documentation of duty of candour and clarity of antibiotic prescriptions. Every case is presented to the Infection Prevention and Control Committee where action plans are either signed off or it is agreed that further work is required.

At Weston Area Health NHS Trust, a high proportion of patients admitted to this hospital are over 65 years in age and up to a third of these patients are receiving antibiotic treatment at any one time. These are significant risk factors for *C. difficile* acquisition.

The strategies introduced over the last four years are now embedded and our continuing success in reporting low numbers of *Clostridium difficile* infections is testament to their success.

The strategies that have contributed to this include:

- Continued updating of our antibiotic guidance and the use of mobile technology in the form of a Smart phone App to enable our Doctors to access these guidelines at the point of care.
- Full time Antimicrobial Pharmacist in post until July 2018
- Daily auditing of antibiotic prescribing by a designated pharmacist and the Consultant Microbiologist with prompt feedback to prescribers and their teams (up to July 2018)
- Use of the Diarrhoea Assessment Tool to assist clinical staff with the prompt isolation of symptomatic patients and in determining when specimens should be sent.

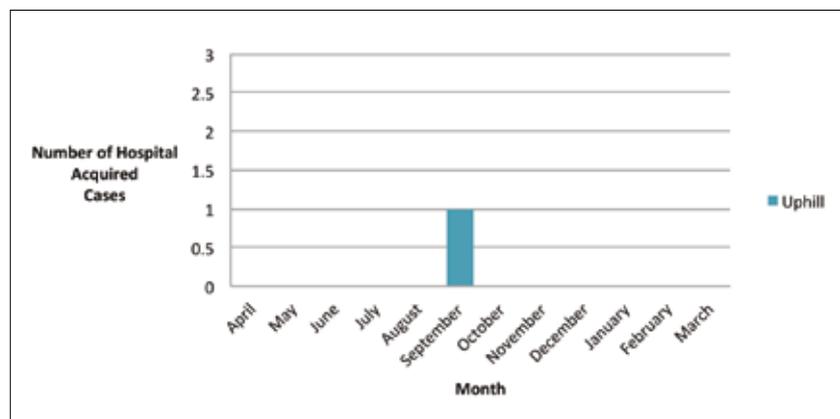
The gap in the antimicrobial pharmacist post since July 2018 has impacted on the ability to undertake daily auditing. Twice weekly auditing commenced in October 2018 and data from these audits is fed back to clinicians on a monthly basis.

The Trust will continue to support the work across the local health community and meets quarterly with the Commissioners to discuss and improve antimicrobial prescribing and to review learning from incidents across the health care economy.

MRSA (Methicillin Resistant Staphylococcus Aureus) bloodstream infections

All MRSA bloodstream infections are reported nationally and are assigned as being related to the Trust, or not related to the Trust (acquired in the community or other settings) following a post infection review. One case was reported during 2018/19 against the Trust's zero threshold. The case was fully investigated and involved a patient that was repatriated to the Trust from a neighbouring Trust. Learning was identified which included screening compliance on admission, monitoring of practice (including hand washing), awareness of previous MRSA colonization and the timely removal of invasive devices when no longer required.

Table 19. Total MRSA cases 2018/19



MSSA (Meticillin Sensitive *staphylococcus aureus*) bloodstream infections

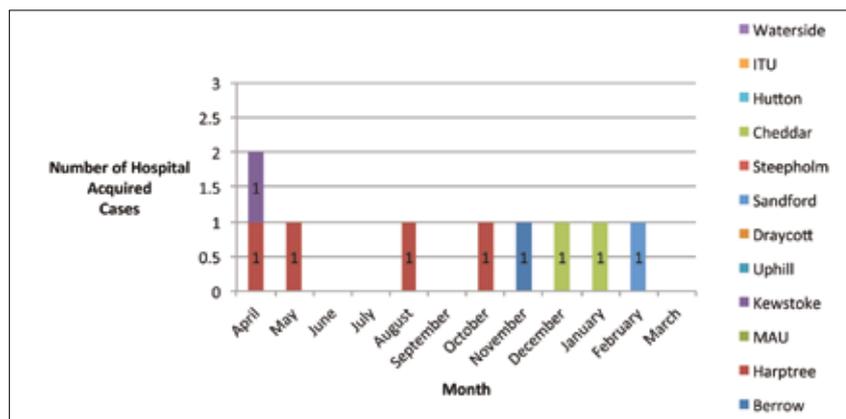
The same reporting and investigation for MSSA bloodstream infections is carried out as for MRSA infections.

The Trust has seen a threefold increase in the number of cases of MSSA reported this year, reporting nine cases compared to three in 2017/18.

Post infection reviews for each case were completed. Three of the cases were related to the care of invasive devices, particularly peripheral vascular cannula. A task and finish group is currently meeting to improve documentation of insertion and on-going care of these devices. Consistency with twice daily recording of whether the cannula is safe to remain in place is also part of the agenda in order to drive improvement and reduce bloodstream infections relating to these devices.

From these investigations it became apparent that not all staff were aware of the cannulation and blood culture collection packs that are available in the Trust to standardise and achieve best practice. This issue has been publicised Trust wide, with discussion held with both medical and nursing staff and the packs have been moved to more obvious places within the ward's clinical rooms.

Table 20. Total MSSA cases 2018/19



Escherichia coli bloodstream infections

There has been a continued focus this year on the reduction of *Escherichia coli* (*E. coli*) bloodstream infections. *E. coli* infections represent 65% of Gram-negative infections. The UK Government is targeting a 50% reduction in healthcare associated Gram-negative bloodstream infections by 2020.

Part of the Quality Premium for 2018/19 has been a requirement to achieve a further 10% reduction (or greater) in all *E. coli* bloodstream infections. This is being led by the Commissioner with input from the provider organisations.

The Trust reported 107 cases of *E. coli* bloodstream infection in 2017/18, of which 17 were deemed healthcare associated. This compares to the Trust reporting 126 cases in 2018/19 with 22 assessed as healthcare associated. The further 10% reduction ambition set has not been met.

Over 85% of these infections are present when the patient is admitted to hospital. The cases that develop in hospital (healthcare associated) are fully investigated and any learning identified is shared with both the medical and nursing teams.

Hand Hygiene Audit

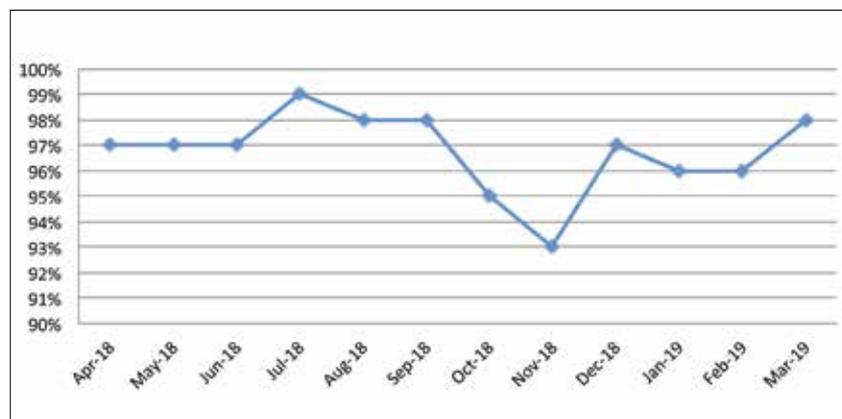
Monthly internal audits continue to be undertaken by the Ward Sisters and Infection Prevention and Control Link Practitioners. Peer audits have also been undertaken by Ward Sisters from different wards. Hand hygiene is audited in all clinical areas and departments using the Infection Prevention Society's Quality Improvement Tools. This encompasses the World Health Organisation's '5 moments of hand hygiene' to determine compliance and identify specific areas for improvement. 'Bare below the Elbow' compliance is continually monitored in the clinical areas and any concerns addressed at the time of the audit.

External validation hand hygiene audits are completed quarterly in four clinical areas. The areas chosen for these audits are not just

those with a low compliance percentage but those areas that consistently report 100%. Results from these audits are often lower

than the ward reported audits and areas for improvement are always fed back to the respective teams.

Table 21. Hand Hygiene Audits 2018/19



Mortality Outcomes - SHMI

A key indicator is the Summary Hospital-level Mortality Indicator (SHMI) which is published on a quarterly basis from NHS Digital. SHMI compares the actual number of deaths following time in hospital with the expected number of deaths. The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in England who died either while is hospital or within 30 days of being discharged.

The data made available to the Trust by NHS Digital with regard to:

- A) The value and banding of the summary hospital-level mortality indicator (SHIMI) for the trust for the reporting period; and

- B) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the trust for the reporting period.

The most recent SHMI data published during 2018/19 pertains to the period of October 2017 to September 19 and is within the “as expected” category for the trust. This represents a stabilisation and improvement over three successive quarters:

The current SHMI ratio for the Trust is 0.90 (March 2019) which has returned to within the normal distribution range of all acute trusts. The Trust Clinical effectiveness group will continue to monitor all the mortality data on a monthly basis.

Table 22. SHMI data performance

Weston Area Health NHS Trust	Jan 17 to Dec 17	April 17 to Mar 18	July 17 to June 18	Oct 17 to Sept 2018
SHMI value	1.02	0.99	0.94	0.90
National Upper Limit	1.13	1.13	1.13	1.13
National Lower Limit	0.88	0.88	0.88	0.88
Banding	As expected	As expected	As expected	As expected

Data Source: CHKS

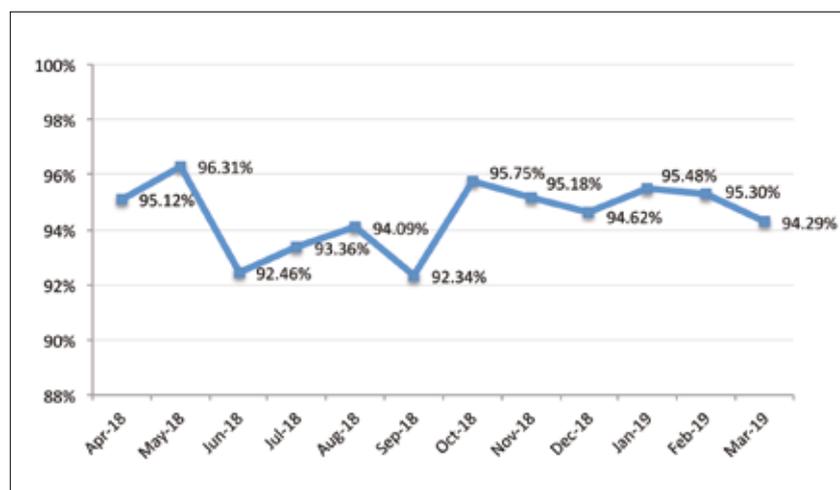
Venous Thromboembolism (VTE)

It is a national requirement that 95% of patients admitted to hospital should be assessed on their risk of developing a venous thromboembolism (blood clot) within 24 hours of admission.

The VTE risk assessment collection process became more robust during 2018/19 and the Trust’s compliance with the required standard for VTE assessment has continued to improve.

The information below shows the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Table 23. VTE Risk Assessment Compliance 2018/19



	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
% Patients VTE Assessed	≥90%	95%	96.10%	78.95	97.16	95.34	63.02%	82.02	94.52%

The data collection process has been reviewed, ensuring robustness of the data collection, efforts are being concentrated on understanding the common themes in patient records where we are unable to demonstrate completion of a risk assessment and also looking at those ward areas where completion figures is low.

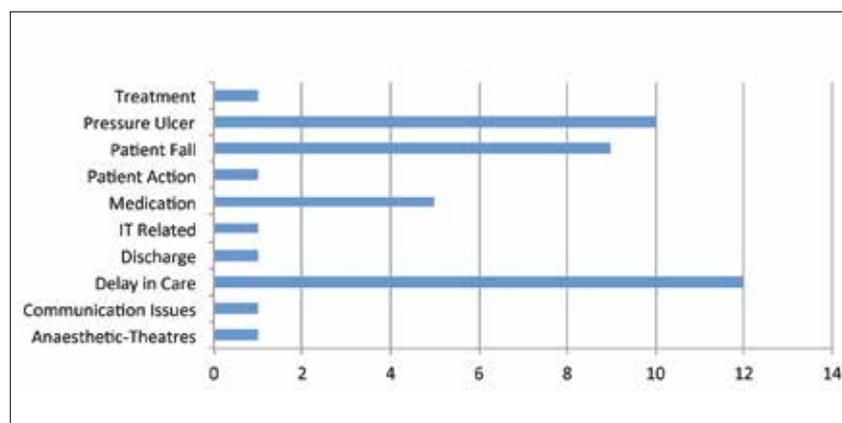
The Trust continues to see sustained improvement in the assessment of in patients at risk of venue thromboembolism. Currently performance is audited manually which can delay full validation of results. The Trust plans to move to an electronic audit tool in 2019/20 which should ensure timelier reporting.

Patient Safety Incidents 2018/2019

Serious incidents identified and reported within in an organisation help to understand what is happening, promotes learning, sharing of lessons learnt and identifies actions being taken to reduce any further incidents occurring.

The total number of serious incidents reported within WAHT for 2018/19 was 42 compared to 53 in 2017/18. The organisation has a process whereby incidents are reviewed by a member of the executive team, before being identified as a serious incident, which then requires a full investigation through a root cause analysis methodology and reporting to the national Safety database (STEIS).

Table 24. Serious incidents by category



All serious Incidents have robust action plans developed, which are implemented to reduce the risk of an incident recurring. The number of patient safety incidents reported

within WAHT during 2018/19 and the number and percentages of such patient safety incidents that resulted in severe harm or death are presented in the table below.

Table 25. Reported safety Incidents and serious Incidents

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Number of Patient Safety Incidents	1268	1313	1444	1539	5564
Incidents of Severe Harm	2	7	4	8	22
Percentage of Incidents with Severe Harm	0.2%	0.6%	0.3%	0.6%	0.4%
Number Serious Incidents	8	10	17	4	42
Percentage of Serious Incidents	0.6%	0.8%	1.2%	0.3%	0.8%
Total Number of Never Events	0	0	1	08	1

Data Source: NRLS and Internal Datix

Never Events

Never Events are a medical error that should never happen within a hospital. Never Events can be defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers.

There has been one Never Event within WAHT which was reported in December 2018, this was categorised as:

- A Medication error meeting the Never Event criteria, this was the mis-selection of high strength midazolam during conscious sedation. There was some immediate action undertaken and the incident was thoroughly investigated and the learning was identified and shared across the Trust and with the BNSSG CCG and acute Trusts at a Never Event sharing event.

Part 2: Priorities for improvement and statements of assurance from the Board

Friends and Family Test – Patients

The Friends and Family Test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The Trust introduced this survey tool in January 2013 for all acute wards and the Accident and Emergency (A&E) Department. In October 2013 the survey was extended to include Maternity services. In October 2014 the survey was extended to outpatients.

It should be noted that the Trust does not provide a service for Postnatal Care in hospital (Trust 3).

Table 26. Friends & family performance 2018/19

The tables below give further detail.

		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	
Would Recommend	Inpatient	Trust	96%	95%	96%	96%	97%	97%	97%	95%	96%	95%	94%	95%
		England	96%	96%	96%	96%	96%	96%	96%	96%	96%	95%	96%	Available 9.5.19
	A&E	Trust	96%	85%	84%	88%	94%	84%	92%	85%	95%	93%	89%	90%
		England	87%	87%	87%	87%	88%	86%	87%	87%	86%	86%	85%	
	Outpatient	Trust	99%	95%	100%	95%	88%	96%	95%	95%	95%	95%	97%	98%
		England	94%	94%	94%	94%	94%	93%	94%	94%	94%	94%	94%	
	Maternity	Trust 1	Not reported	67%	92%	100%	100%	100%	89%	100%	100%	92%	75%	91%
			England	97%	95%	96%	95%	95%	95%	95%	95%	95%	96%	95%
Trust 2		Not reported	100%	100%	100%	Not reported	100%	100%	100%	100%	100%	100%	100%	80%
		England	97%	97%	97%	97%	97%	96%	97%	97%	97%	97%	97%	
Trust 3		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		England	95%	95%	95%	95%	95%	94%	95%	95%	95%	95%	95%	
Trust 4		100%	68%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%
		England	98%	98%	98%	98%	98%	98%	98%	97%	98%	98%	98%	

Response Rate	Inpatient	Trust	47.5%	43.4%	47.9%	49.8%	50.8%	43%	46.9%	46.3%	35.3%	40.6%	44.7%	48%
		England	24.9%	25.6%	25.2%	25.3%	25%	24.7%	24.9%	24.6%	22.2%	23.7%	24.2%	
	A&E	Trust	5.8%	2.4%	2.5%	1.3%	2.8%	0.7%	6.7%	7.6%	13.3%	8.6%	19.1%	9%
		England	12.9%	12.4%	13.0%	12.8%	12.9%	12.2%	12.2%	12.1%	11.4%	11.9%	12.2%	
	Maternity (Births)	Trust 1	100%	100%	100%	Not reported	100%	100%	26.7%?	33.3%	14.3%	45.5%	66.7%	71%
		England	23.2%	N/A	21.1%	20.8%	20.3%	20.3%	21.1%	20.9%	18.4%	21.8%	22.2%	

Friends and Family Test - Staff

The staff friends and family test (SFFT) is an organisational temperature check to see how staff are feeling. It takes place every quarter except for quarter three when the staff attitude test is undertaken.

Staff are asked to answer two questions and have the opportunity to provide more detailed comments.

The two questions we ask are:

“How likely are you to recommend this organisation to friends and family if they needed care or treatment?”

“How likely are you to recommend this organisation to friends and family as a place to work?”

Table 27. Staff friends & family Results 2018/19

Staff Friends and Family Test Results 2018/19						
	Quarter 1		Quarter 2		Quarter 4	
	Question 1	Question 2	Question 1	Question 2	Question 1	Question 2
Recommended	55	67	62	46	65	54
Not Recommended	27	13	45	32	17	30

Other Information



This section provides an overview of the quality of care offered by Weston Area NHS Trust based on performance in 2018/19 against indicators selected by the board in consultation with stakeholders. These indicators have been chosen as they detail the activity undertaken within the Trust to promote the safety and experience of our patients.

Unless otherwise indicated within the text the data provided all comes from internal sources within the organisation.

Patient safety

Sign up to Safety

We remain committed to the Sign up to Safety Campaign and the five key pledges; these are evident throughout our quality priorities for 2018/2019.

The five key pledges are:

1. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
2. Make organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring the safety of services.
3. Be transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
5. Help people to understand why things go wrong and how to put them right, including giving staff the time and support to improve and celebrate the progress.

Falls

Patients who are hospitalised can be at an increased risk of patient falls due to pain, infection, nutrition, constipation, hydration, medication, and unfamiliar environment. Confusion and dementia are also contributory factors to increasing the risk of an inpatient fall.

Sometimes patient falls could be prevented, or the risk of falling reduced with timely intervention. The falls reduction and prevention programme have looked at the following elements:

- Identifying those patients likely to have a fall through risk assessment
- Helping those patients likely to fall to prevent falls through care planning
- Working effectively with people who have fallen to help reduce the likelihood that they will fall again through physiotherapy assessment and with help from the enhanced supervision team to maintain safety and build confidence.

Key improvements we have made to reduce adult inpatient falls this year are;

1. To have a clutter free ward that assesses hazards that can cause trips or falls. The Ward Sisters undertake quarterly environmental risk assessments that are reported through the harm free care group and have demonstrated that this action has improved the timeliness of repairs where required and maintained standards.
2. Effective risk assessment and care planning – A revised risk assessment has been introduced which is action based for detailed care planning. This allowed for enhanced supervision of patients at risk and supports the Ward Sister to ensure that they have the right amount of staff on shift to support those at risk of falls.
3. Patients undergoing enhanced supervision have ABC observations commenced.

- **Activity** - Prior to behaviour – Did anything provoke behaviour?
- **Behaviour** – What is the patient actually doing?
- **Consequence** – What was your reaction?
- How did the patient respond?

This has supported our staff to understand individual patient's response to stimuli and allows for meaningful interaction and safe decision making for the patient and carers especially when the patient has dementia or is suffering with delirium.

This tool is used for discharge planning for ongoing care, and also forms the basis of training for ward staff.

4. Bay "tagging" – a concept in workforce planning for the day to ensure nurse presence in a bay at all times. A significant improvement in falls reduction was noted on two medical wards after using this workforce model.

Part 3: Other Information

5. Focused education board tested on a medical ward that showed improvement in risk assessment and care planning and a reduction of falls in that area.

A detailed falls dashboard was developed for the wards to assist them with looking at the time of day and the day of the week that falls occurred. This enabled teams to assess areas of risk during daily ward activities which yielded different results for each ward and has become a unique ward identifier. An example of how this has improved falls is that one ward reviewed how ward rounds were conducted to ensure an even distribution of staff during this time.

The trend for the year showed improvement in reducing falls apart from March where a high peak was noted. Points of improvement introduced noted an improvement in falls reduction. This will be the focus of the work going forward.

What we will do next

The falls reduction team will work with the:

1. Admiral Nurse to strengthen the care, management and treatment of patients suffering with delirium in order to prevent falls.
2. Newly appointed frailty team to review the falls risk assessment and frailty assessment tool to support the joined up process and learning.

Further work will focus on:

3. Success of the education board to be replicated across all wards
4. Develop a new falls strategy to encompass the above work which is clearly understood by all levels of staff caring for patients.

Table 28. Patient Falls per 1000 bed days

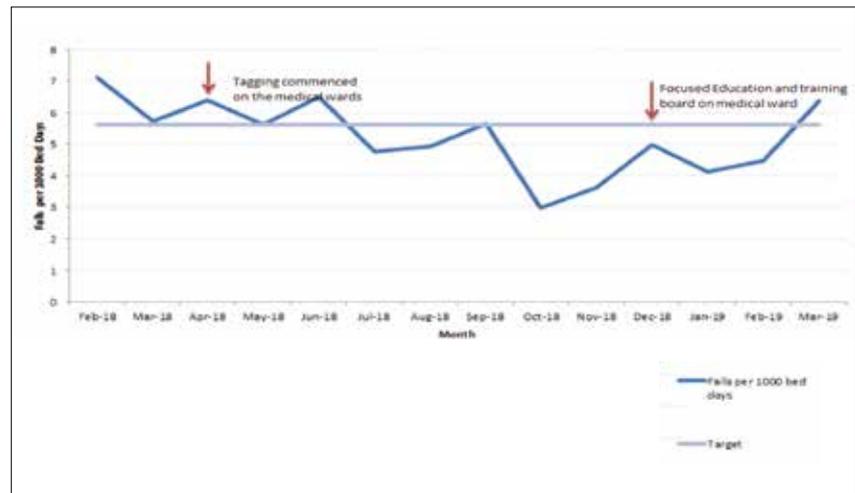


Table 29. Total number of patient falls

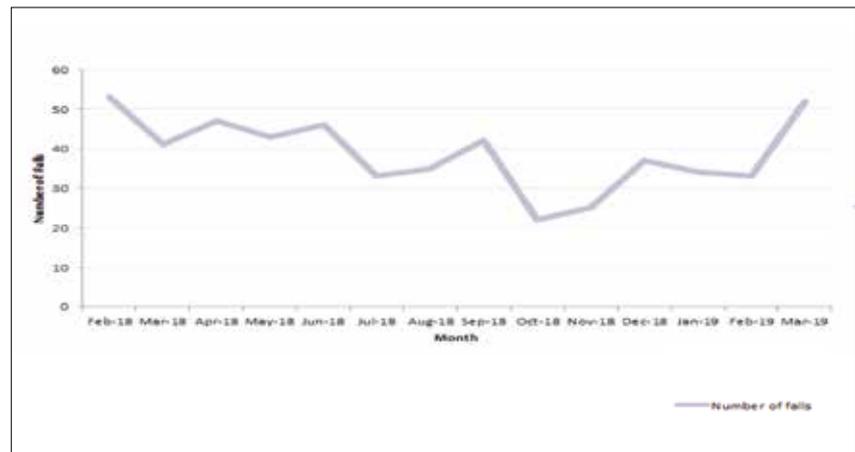
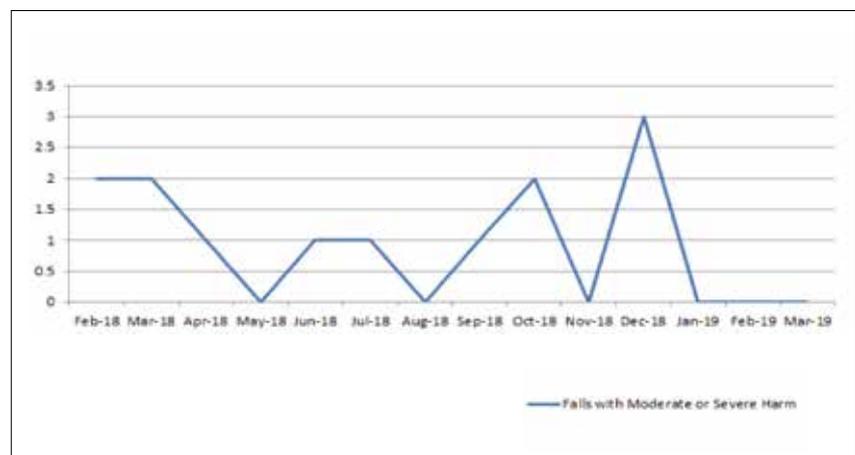


Table 30. Patient Falls in month with moderate or severe harm



Falls with moderate or severe harm have reduced from 11 in 2017-2018 to 8 in 2018-2019.

Pressure Injuries

We continue to reduce avoidable pressure injuries for our patients, particularly the deeper injuries which are serious incidents because of the harm they cause to our patients. We therefore set ourselves an improvement target to see a 25% reduction in grade 2, 50% reduction in grade 3 and a 100% reduction grade 4 pressure injuries from 2017/18.

In 2017/18 we reported 17 grade 3 and 4 pressure ulcers (which included pressure ulcers that deteriorated from grade 2). In 2018/19 we reported 8 grade 3 pressure injuries and 1 grade 4, 5 of which deteriorated from grade 2. This is a 47% reduction in the past year and a considerable 74% reduction over the previous 3 years. Whilst not achieving our aim for a 50% reduction for grade 3 and 4 pressure injuries this is a significant reduction in harm caused to patients. All grade 2 pressure ulcers have a Directorate Level SWARM completed and for every

Grade 3 or 4 there is an Executive Level SWARM. This enables any immediate learning to be shared across the Trust and will be discussed at the Pressure Ulcer Steering group. A SWARM is where a rapid response to a patient incident occurs, staff come together to discuss the incident, allowing a blame free investigation and prompt action to be taken if required.

We focused on developing our leadership and developing staff knowledge of promoting tissue viability through implementing education and celebration at Ward Wednesday meetings and via 'trolley dash' education for the wards. The pressure ulcer steering group chaired by the Associate Director of Nursing for Emergency includes Sisters and Matrons, who have an action plan and meet to promote the shared learning from incidents.

An increase in resource for the team has enabled a part time support Nurse

for Tissue viability to be appointed, their focus is to work alongside staff to enhance education opportunities.

The link Nurses role will be regenerated and utilised in all clinical areas.

The Tissue Viability Nurse Specialist will continue to meet regularly with Tissue Viability Nurse Colleagues in the Community for continuing patient care and improve/enhance patient safety/satisfaction. There are plans to work collaboratively with our North Somerset Community Partnership for national initiatives and with the BNSSG CCG for example working together on a collaborative strategy and the Worldwide STOP pressure ulcer day in November 2019.

The Tissue Viability Strategy has been reviewed in line with the new guidance from NHS Improvement pressure ulcer framework and has been incorporated in local reporting systems.

Preventing clinical deterioration of the patient

During 2018/19 we continued to work on improving the recognition, escalation and management of deteriorating patients.

The most common cause of patient deterioration includes sepsis, blood clots developing within the lungs, sudden onset of confusion, and acute kidney injury (AKI). All conditions were included within the wider deteriorating patient programme. In line with the other acute Trusts in BNSSG to monitor a patient's risk of deterioration we changed from the first National Early warning score (NEWS) to NEWS2. This means that all inpatients within the hospital have their physiological observations (respiratory rate, levels of oxygen, pulse, blood pressure, level of consciousness and temperature) measured and recorded in accordance with the Hospital Deteriorating Patient and Escalation Policy.

Cardiac arrests in hospital are rarely a sudden event, so we have tried to reduce our number of cardiac arrests by focusing

on implementing the NEWS2 scoring and escalation of unwell patients to prevent further patient deterioration and cardiac arrest occurring.

What did we do?

Over the last year we have focused on:

- Setting up two Quality Improvement (QI) projects for the deteriorating patient and one for escalation of the deteriorating patient. The aim is to improve Safety Huddles, National Early Warning Scores, (NEWS) monitoring, escalation and the use of Situation, Background, Assessment, and Recommendation (SBAR).
- Continuing to improve NEWS2 scoring and vital signs recording, we recognise this as the most effective tool for identifying at-risk and deteriorating patients.
- Improving the measurement and use of SBAR as a tool to improve timely and effective escalation and response.

- Increasing the education around deteriorating patient, monitoring of patients deteriorating and escalation to the appropriate medical teams. The table below shows how many staff have been trained on a month by month basis in the year.

What difference did it make?

- We have seen an improvement in the accurate recording of NEWS scores, aiming to achieve 100% of NEWS scores being accurately recorded. It is anticipated that by implementing electronic observations will assist with this further.
- We have seen an increase in the percentage of observations being recorded in the emergency department when a patient is admitted.
- We have increased our staff confidence in caring for a deteriorating patient by using simulation scenarios and holding deteriorating and sepsis study days.

- We have seen an increase in appropriate medical plans being put in place for patients who have become unwell, thus helping us keep those patients safe.
- There has been continued improvement in the reduction of true cardiac arrests within the hospital.
- Increased training of the deteriorating patient through practical assessment, simulation and focused debriefing for all foundation doctors and nursing staff.

What we plan to achieve for 2019/20

We will be implementing electronic observations which are proven to assist with recognising early signs of deterioration and cardiac arrests. This project is to be implemented across the Trust with an electronic Vital signs capture and messaging system called Vital Pac. This will allow staff on the wards and across the Trust to have greater visibility of their most critically unwell patients. The system also supports staff at the time of taking observations with early actions required if observations are abnormal.

Sepsis

Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure and death. Sepsis affects 250,000 people in the United Kingdom (U.K) each year and is responsible for 52,000 deaths each year across the country. Infections which can give rise to sepsis are common, and include lung infections, urine infections, and infections in wounds or the joints. It is paramount that sepsis is recognised early and treated promptly (within one hour of diagnosis) using the sepsis six, which is six simple interventions that is the most effective lifesaving treatment used in medicine.

Sepsis now claims more lives than breast, bowel and prostate cancer combined and is the second biggest cause of death in the UK after cardiovascular disease. Failure of healthcare staff to detect or act on the

Table 31. Number of staff trained to recognise the deteriorating patient

Month	Number of Staff Trained Per Month NEWS
March 2018	28
April 2018	45
May 2018	51
June 2018	47
July 2018	52
August 2018 (NEWS2)	1108
September 2018 (NEWS2)	112
October 2018 (NEWS2)	56
November 2018 (NEWS2)	28
December 2018	33
January 2019	23
February 2019	38
March 2019	40

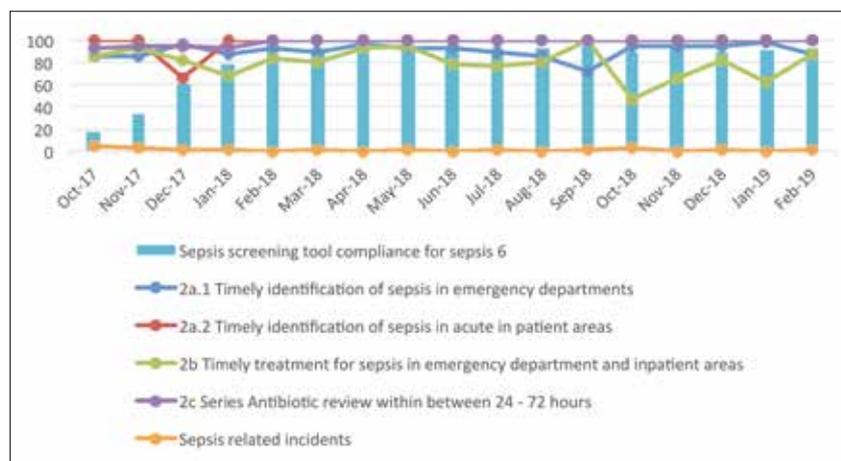
patients who have the signs and symptoms of sepsis can lead to delays in treatment that lead to further patient harm. We know that for each hour that goes by where sepsis is not treated mortality rates increase by 8% per hour.

What did we do?

- We continued undertaking sepsis education throughout the organisation, concentrating on medical, nursing and allied health care professionals.
- Our Sepsis care improvement work was recognised by NHS England and we showcased our work nationally as part of the National Nursing Strategy Leading Change Adding Value. *Leading Change Adding Value* is a collection of case studies providing quantifiable evidence of how nursing, midwifery and care staff have led change, identifying and addressing unwarranted variation in practice.

- Promoted sepsis awareness within the hospital and within the local community. We set up the first Somerset Sepsis Support Group in conjunction with other Somerset NHS hospitals.
- All clinical and non-clinical staff joining the Trust are trained in Sepsis awareness and promotion at Trust induction.
- There is a strong emphasis on sepsis care throughout the organisation where we have created a learning culture and sharing of safety lessons to learn from past harms and we look at what we can do to improve care using quality improvement methodology.
- A sepsis champion role has been introduced, where Registered Nurses and Nursing Assistants deliver further sepsis training to their teams and discuss good practice.

Table 32. Compliance with Sepsis screening



- A new Sepsis screening tool was developed and launched in the Emergency Department with criteria to use and is derived from the National Institute of Clinical Excellence (NICE) guidelines. This helps us ensure patients are being screened for sepsis and treated quickly.
- We undertook process mapping of our neutropenic sepsis pathway and redesigned these introducing neutropenic sepsis alert cards.
- We included 'Just Ask Could it be Sepsis' wraps on all staff and visitor lifts which has led to increased public and staff awareness.

What difference did it make?

- The Trust has improved care delivery to patients with sepsis by achieving better results of identification and treatment of sepsis for all our inpatients, achieving an average of 100%.
- The Trust has increased compliance with our sepsis screening tool from 17% to 95% in six months (As demonstrated in the chart below). This has also been sustained throughout 2018/19.
- A Patient Group Directive has been developed for our Emergency Department for increasing those available to deliver intravenous antibiotics.

- There has been a reduction of sepsis related incidents.
- Our sepsis crude mortality has decreased.

What will we do next?

- Achieve and maintain over 90% for Intravenous antibiotics administration to patients who have red flag sepsis in the emergency department.
- Aim to ensure: that all our patients are screened for sepsis on admission or when there are signs of deterioration whilst an inpatient and receive the sepsis six within one hour of red flag sepsis.
- Aim to implement the use of the sepsis Patient Group Directive in the Front Door Services such as the Medical Admissions Unit, Ambulatory Emergency Care and Medical Day Case.
- Aim to improve the way we document sepsis care and treatment decisions in our patient notes.
- Aim to improve the way we communicate sepsis to our patients and their relatives ensuring an open and honest relationship between staff and families.

Managing patient safety incidents and duty of candour

Duty of Candour was introduced for HealthCare providers after the publication of the Francis Inquiry in 2013 that looked into the failings of the Mid Staffordshire NHS Foundation Trust. There is also a contractual requirement to undertake duty of candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In interpreting the regulation on the duty of candour we use the definitions of openness, transparency and candour.

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about Weston Area Health NHS Trust is committed to minimising the risk of harm to patients in the course of their treatment and care. However incidents do occur and we aim to adopt a proactive approach to prevent incidents and learn lessons to improve patient safety. Occasionally people in our care are involved in a safety incident. A small number of these incidents cause harm. ▼

When things go wrong, we have a duty to inform our patients and their families what has happened. This is very much part of our culture. This year we have introduced patient and staff leaflets about the duty of candour to help our staff follow the correct process and this helps our patients and their loved ones understand what will happen.

We are committed to talking to patients and their carers at a very early stage to explain our investigation process, understand what happened and, where necessary, learn the lessons that will prevent it happening again to improve the safety of our future patients.

If something happens, we investigate the incident or complaint and:

- Ask how much the patient and their relatives or carers wish to be involved in the investigation process;
- Review the patient's medical and nursing notes;
- Talk to the staff involved in the patient's care;
- Identify the cause(s) of the incident;
- Share our findings with the patient, their family or carers;
- Share learning and improvements across the Trust;
- Let the patient and their family or carers ask any questions.

A member of the investigation team will sometimes meet with the patient and/or their loved ones to talk to them about what went wrong. This will usually be the consultant or nurse looking after them. The patient's family or a friend can attend this meeting and be part of these conversations.

Seven Day Service

The Seven Day Hospital Services ambition is for patients to be able to access hospital services which meet four priority standards every day of the week. The four standards will ensure patients:

- Don't wait longer than 14 hours to initial consultant review.
- Get access to diagnostic tests with a 24-hour turnaround time – for urgent requests, this drops to 12 hours and for critical patients, one hour.
- Get access to specialist, consultant-directed interventions.
- With high-dependence care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

During April 2018, the trust participated in the Seven Day Hospital Service Survey by looking at patients admitted as an emergency for one week to assess compliance with four standards:

- Standard 2: Time to First Consultant Review
- Standard 5: Access to diagnostic tests
- Standard 6: Access to consultant-directed interventions
- Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others

The Medical Director as lead for seven day services at WAHT describes that the trust is currently non-compliant in standard 2 and standard 8 but does achieve standards 5 and 6.

Whilst there is some internal process improvement that would demonstrate an improving position it is unlikely that the clinical standard 2 will be met without investment in (and subsequent recruitment of) further consultant workforce.

Whilst the trust has no immediate plans to increase seven day services in 2019/20 (other than in response to system support for winter pressures), we continue to explore the opportunities afforded by Healthy Weston and closer partnership with UHBristol to expand weekend services especially for pharmacy, physiotherapy and social work assessment.

The Seven Day Hospital Services Survey is changing the way it measures the improvements that trusts make. To enable trusts to monitor their progress with the four priority standards, a new self-assessment survey has been developed. This allows trust boards to provide direct oversight of progress. The trust is planning for the full implementation of this in March 2019.

The information below shows the results of the Trust's Seven Day Service Survey from April 2018:

Table 33. Time from admission to 1st consultant review

	Weekday	Weekend	Total
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	53%	39%	49%

Table 34. Provision of consultant directed diagnostic tests

Service	Weekday	Weekend
	April 2018	April 2018
CT	Yes	Yes
Echocardiograph	Yes	No
Microbiology	Yes	Yes
MRI	Yes	No
Ultrasound	Yes	No
Upper GI Endoscopy	Yes	Yes

Table 35. Access to consultant-directed interventions

Service	Weekday	Weekend
	April 2018	April 2018
Critical Care	Yes	Yes
Primary Percutaneous Coronary Intervention	Yes	Yes
Cardiac Pacing	Yes	No
Thrombolysis for stroke	Yes	Yes
Emergency General Surgery	Yes	Yes
Interventional Endoscopy	Yes	Yes
Interventional Radiology	No	Yes
Renal Replacement	No	No
Urgent Radiotherapy	Yes	Yes

Table 36. Ongoing review by consultant twice daily if high dependency patients, daily for others

	Total
Proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant	75%
Proportion of patients who required a daily consultant review and were reviewed by a consultant	69%

Patient and Staff Experience

Improving Patient Experience

We aim to provide exceptional quality services for our patients ensuring the patient experience is to a high standard and fulfils their needs and expectations. From reviewing the annual National patient survey results with staff, patient representatives and members of Healthwatch we are focusing on aspects that are important to patients and those that have higher problem scores. The agreed areas for improvement are developed with staff and patients.

The annual adult inpatient survey is carried out in all Trusts (www.cqc.org.uk) by a company called the Picker Institute. The findings from the survey are received in January each year and public report is received in February from the CQC which includes benchmarks against other NHS Trusts.

The survey asks the views of people that have stayed in hospital at least one night as an inpatient. Patients are asked what they thought about different aspects of the treatment and care they received. The purpose of the survey is to understand what patients think of the services provided by the Trust; from the patients perspective what are their priorities and concerns.

The survey was sent to discharged inpatients who attended Weston in the summer of 2018. 1179 questionnaires were sent to patients who were eligible to complete the survey. The Trust received 604 completed responses giving a response rate of 51%. This was an improvement from 2017 which was 45%.

The survey highlighted many positive aspects of the patient experience.

- Discharge: delayed by no longer than one hour 22%
- Hospital: food was very good or good 65%
- Hospital: did not share sleeping area with opposite sex 96%
- Admission: did not have to wait long time to get to bed on a ward 69%
- Discharge: was not delayed 63%

Pleasingly the report indicates improved responses regarding;

- Hospital: not bothered by noise at night from other patients 60%
- Nurses: always or nearly always enough on duty 59%
- Discharge: told of danger signals to look for 60%
- Procedure: told how to expect to feel after operation or procedure 90%.

Involvement of Patients and the Public and Involving our Board in staff and patient experience

The voice of the patient and our staff is highly valued at Weston Area Health NHS Trust. Every second month patients/carers and staff share a story at the Public Trust Board meeting, this is also shared with staff through various forums.

These have included patients attending the Board to tell their story and some telling the story to our Patient Experience Team who convert this into a presentation format. Some examples are positive and excellent experiences of care and others where the Trust recognises that we have not got it right and need to make a change. One such example which has led to a change was the cancellation of surgery procedure and ensuring that patients are

not kept nil by mouth for an extended period of time when this occurs.

The Patient Council representative also attends the Trust Board in order to share the patient experience agenda and they are also active within different committees such as Quality and Safety, Nursing and Midwifery, Patient Experience Review Group, Infection Control committee and Clinical Effectiveness Group. They are also active in a number of audit projects. Ongoing recruitment to the Patient Council is essential to continue to maintain the value of their contribution.

Supporting our Workforce - Staff Survey Questions

Improvement in Staff Attitude

Survey scores for:

Health and wellbeing

There has been a decrease in staff feeling unwell as a result of work related stress in the last 12 months (42.9% in 2017 to 40.7% in 2018) and a reduction in musculoskeletal problems (32.6% in 2017 to 29.3% in 2018). In the last three months there has been a slight decline in staff coming to work despite not feeling well enough to perform their duties (58.7% to 58.6%).

Managers

The immediate support staff gets from their managers has increased (58.3% in 2017 to 64.4% in 2018).

Staff opinions of whether their immediate manager values their work has also increased from 62.4% to 67.8%. Whether their manager asks for their opinion before making decisions that affect their work has also increased from 45.3% (2017) to 48.3% (2018).

Violence, harassment & bullying

Staff have seen a reduction in experiences of harassment, bullying or abuse at work from patients/services users/their relatives or members of the public (35.6% in 2017 to 28.7% in 2018). From at work or colleagues has also seen a reduction from 23.4% in 2017 to 20.1% in 2018.

In relation to experiencing physical violence at work from patients/service users, relatives or members of the public, staff have seen a reduction from 20.5% in 2017 to 18.1% in 2018. From colleagues, this has reduced from 2.5% in 2017 to 1.6% in 2018.

Further analysis of the results relating to the different staff groups will be undertaken when additional detailed information has been received.

Supporting Apprenticeships

The Trust recognises the important contribution that apprentices can make to the workforce and also the importance of ensuring that our valued staff have a platform that supports their professional and personal development.

Working with our procured educational providers, we have continued to recruit a number of apprentices into both administrative roles and nursing roles under the following standards:

Business and Administration – Level 2

Business and Administration – Level 3

Healthcare Support Worker – Level 2

Healthcare Support Worker – Level 3

Those apprentices that are appointed to the Healthcare Support Worker standards have been recruited into Nursing Assistant roles and we hope this will form the foundation of a learning pathway for the non-registered nursing workforce that will utilise the on-going developments in vocational training and ultimately aims to grow an internal route into professional registration by using both the trainee nurse associate apprenticeship standard and the nurse degree apprenticeship standard.

We are very proud to have increased the variety of apprenticeships that we are able to offer and that we will be offering very shortly. Historically the Trust has provided apprenticeships across approximately 5 standards, going forward, we will be offering in excess of 18 apprenticeship standards. These include Healthcare Sciences, HR Support, Health Care Support Workers, Nurse Degree Apprenticeships, Business Analysts and more.

Continuing Professional Development

Competent staff with regular access to training, who work well in teams, and are supported by effective leaders deliver safer, more effective care. Developing the skills of our workforce is vital in ensuring that our staff remain up-to-date with best practice. The organisation offers various Continuing Professional Development (CPD) opportunities from academic courses, apprenticeships, to one-off training events and attendance at regional and national conferences. During 2018/19 we were successful in securing funded places at University of the West of England (UWE), these courses ranged from enhancing specific clinical knowledge to developing leadership and innovation. Our staff's Health and Wellbeing is key priority

for us and we have offered workshops and courses in Mental Health First Aid and emotional resilience.

During 2018/19 we have employed dedicated Practice Development Nurses in both Directorates and in the Intensive Care Unit to support our staff development. These staff joins the practice development staff employed in the Theatre Unit to provide face to face support for all staff as required. The Practice Development Team also works closely with the Trust Specialist Nurses to provide weekly bespoke training for all staff on 'Teaching Thursday'. These sessions have been well attended and received by staff at all levels and will continue throughout the coming year.

Table 37. Training courses and number of Attendees

Post Registration Academic Courses undertaken	66
Clinical Skills Days	278
Conferences and Workshop	25
HR Courses	179
Management & Leadership Courses run by Leadership Academy	38
Resilience Building/ Mental Health Training	30
Sepsis	171
Teaching Thursdays	266
Total	1053

Managing Complaints

Most patients are highly appreciative of the care they receive, however we don't always get it right and meet their expectations. There is always room for improving the experience for patients and their carers.

To ensure that changes are made in the key areas identified by the patients the Trust have been working during 2018/19 to make improvements such as:

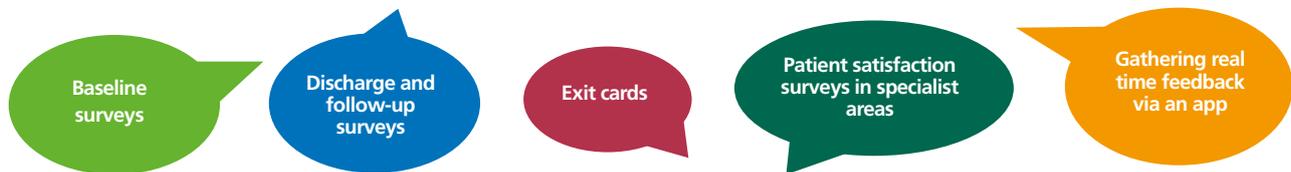
1. Committing to use the quality improvement methodology of Always Events as an opportunity to recognise what is important to patients and improve their experience of care. Always Events are defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system." The subject for the first project has the aim of always providing clear written medication advice to patients at discharge. A pilot project is underway and it is hoped that further Always Events will be started over the forthcoming year 2019/20.
2. Real time patient feedback is now being gathered from patients whilst they are still in hospital using an electronic app called Perfect Ward. The questions being asked correlate to the questions asked in the annual inpatient survey. A minimum of five patients on each ward or area complete the questionnaire monthly.

Perfect ward gives staff the opportunity to:

- Monitor the success of improvements that are being made.
 - To better understand exactly what the patients feel we need to improve through talking to them and recording their comments.
 - Take immediate action to address things that patients tell us are important to them.
 - Actions being taken include giving patients the opportunity to buy a daily newspaper, carrying out an immediate review of pain relief for a patient and offering an alternative menu to suit a patient's special diet.
3. The Trust is reviewing the patient bedside booklet which contains useful information for patients coming into hospital including how to make a complaint.
 4. To help patients and visitors knowing which nurse is in charge of care a red badge with "Nurse in charge" has been introduced and is proving highly beneficial to staff and patients.
 5. To help improve care after discharge the discharge summary is being sent electronically to the GP within 24 hours of discharge. To support this, a junior doctor is assigned each morning to review the previous day's discharges. The Trust is currently achieving 82% and is working towards achieving 100%.

Listening to what our patients say

In addition to the national surveys we also gather feedback from our patients in a number of other ways:



As a result of the patient feedback the following changes have been made:

- Improvements have been made to the Metastatic Breast Care Service to provide a more ergonomic environment, streamline consent forms and have up to date chemotherapy information to hand for patients. More timely referrals are now being made to the hospice, citizen's advice, dietician, occupational therapy, Macmillan Information Centre or to a Macmillan Support Worker. The Breast Care Nurses are seeing a greater number of patients identified as requiring their support.
- Reducing the level of noise on the wards. Staff have looked at ways to monitor noise levels; noise monitors have been introduced, doors have been fitted to individual bays to help reduce the noise at night, a decibel app is used on a mobile phone, a "ssh" poster campaign to remind staff and visitors that patients are resting is in development and will be launched during 2019.
- Another area important to patients is the standard of the bathroom facilities and general décor on the wards. Improvements to the bathroom facilities have been completed on wards where needed. The feedback from patients is also used to inform the Trust wide risk assessment in prioritising work in the areas most in need of refurbishment.
- The Endoscopy department have improved the experience for patients in the waiting room by providing more chairs, magazines and notices that are regularly updated about waiting times.
- Radiology have updated their patient information leaflets to make them more user friendly and redesigned their patient letters to include more information.
- Patient feedback has been used to develop the palliative care symbol for use when a patient is in the last days or hours of life; the symbol is on the new electronic white boards and placed on patient room doors or curtains to inform staff.
- The Palliative Care Team have extended the symptom based observation chart to include caring for a patient after death to improve the standard of care for the patient and support for any family members in the last moments of life.

Perfect Ward

Perfect Ward is the smartphone application app used for healthcare staff inspections and it provides assurance for ward leaders to monitor the quality of care that is being delivered and the app allows hospital to save 'admin' time and give more time to direct patient care. It also enables access to real time information.

What did we do?

The Perfect Ward app was implemented in 2016 at Weston Area Health NHS Trust. There are selected questions relating to the standards of care, defined by the Care Quality Commission (CQC) which helps our staff and patients ensure that their areas are meeting the CQC five domains which are:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are services well led?

Over the last year we have made significant improvements to the questions we ask,

ensuring that we capture how our staff feel and what we could be doing better. This helps teams and services provide sufficient assurance to demonstrate we are doing all we can to improve and share learning and safety lessons.

What difference did it make?

- It has enabled us to receive real time results and feedback on quality of care being delivered.
- Improved the quality of the inspection audits, working and collaborating with teams, senior nurses and the patient experience manager.
- We have developed a Standard Operating Procedure so that teams know what the Trusts expectations and standards are.
- Many areas have been able to utilise their audit results ensuring their effectiveness and efficiency is shared amongst the teams so that improvements can be made.

- We have developed a network for ongoing learning and development.
- We are currently interviewing our staff to find out about their existing processes, understand their issues and frustrations with their current process and obtain examples of their inspections that they were happy to share with other areas to help bring teams together. Matrons and Associate Directors of Nursing are also able to have an overview of their areas.

What will we do next?

- We aim to have 100% compliance with the Perfect Ward app on a monthly basis.
- Ensure that the audits are reviewed and presented at monthly Directorate Governance meetings, Ward Wednesday and Harm Free Care.
- Embed the feedback from the audits to demonstrate continuous quality improvements in the quality of care.

Improve Cancer Patient Experience (access and working with patients/carers)

We are committed to developing and promoting cancer services within Weston Area Health NHS Trust, ensuring that the services provided are suitable to meet the needs of the Somerset and North Somerset population, now and for the foreseeable future.

Cancer services within Weston Area Health NHS Trust are made up of many different areas and require the input of a range of teams and services to support day to day delivery.

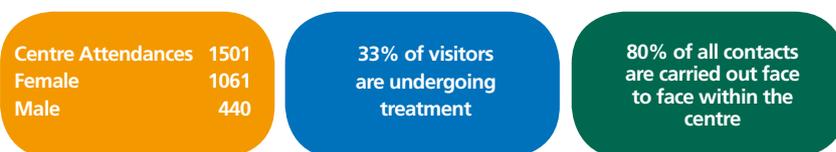
Macmillan Cancer Support Centre at Weston General Hospital serves a population with an older demographic than the England average and slightly higher than the average in the South West region. The percentage of people from ethnic minorities who reside in this area is significantly lower than the England average. There are pockets of deprivation within this community and additional factors such as transient populations to consider. The number of people being diagnosed with cancer is similar to the England average, as is the one-year survival rate which is sometimes used as a proxy measure of diagnosis of cancer at a later stage.

As well as providing support for Weston-super-Mare and the surrounding area in 2018 we have supported people from Gloucestershire, Bristol, Taunton and Cornwall.

The Trust, along with neighbouring Acute Trusts (University Hospitals Bristol NHS Foundation Trust and North Bristol Trust) aspires to provide the best possible service to the patients that are referred into the service, aiming to provide a comprehensive holistic service meeting the physical, psychological and spiritual needs of all cancer patients and their loved ones. Some of the new improvements include:

- The rebuild and delivery of the Macmillan Cancer Support centre has been very successful in reaching the Macmillan Quality Kite Mark Standards for both environment and information services.

Activity analysis of the Macmillan Centre 2018/19



- The Living Well with and Beyond Cancer initiative provide resources to deliver health and wellbeing events specifically focusing on life style, managing symptoms and empowering patients to be more involved in their access to services as required. The introduction of the first Clinical Psychological Service at Weston, funded by Macmillan is underway.
- We have seen a positive response within the organisation to the work undertaken with external organisations such as NHS Elect to support delivery of service re-design and development projects that will assist in supporting patient pathways. Through project work initiated, there have also been positive steps forward in greater collaborative working, both in terms of main cancer pathways, but also the wider work streams with our partners at University Hospitals Bristol and North Bristol Trust. Further roll out of the Living well and Beyond Cancer project will be in line with local, regional and national guidance/collaboration.

Living Well With and Beyond Cancer (LWWBC)

Following the award of transformation funding in 2016 to South West Cancer Alliances, Weston General Hospital received monies for two years to increase the roll out of the Recovery Package.

An example of achievements to date:

- LLWBC Team established
- Five Cancer Support Workers (CSW), Allied Health Professional Leads – Dietetics, Physio, Clinical Psychologist, Administrator, Project Manager
- Project structure and governance in place
- Working collaboratively across BNSSG
- Framework and structure in place to support Holistic Needs Assessments (HNA), delivery of Health & Wellbeing Events and working with patients
- Aligned CSW to specialities
- Single point of contact in place for all patients wishing to contact a CSW
- Commenced offering HNAs within 31 day of diagnosis and within 12 weeks of the end of an acute period of treatment
- Developed the Macmillan Support Centre as a HUB for CSW
- Developing Health & wellbeing events
- Establishing patient engagement

End of Life Care

End of life care provides patients with support who have an illness that cannot be cured, and the aim is to ensure that patients have the best quality of life before they die.

The people providing the care will always ask the patient and their loved ones about their wishes and preferences and take these into account as they work out a plan of care.

Individuals who are approaching the end of life are entitled to high-quality care, wherever they are being cared for.

Feedback received from the VOICES survey conducted with bereaved relatives is being used to change practice within the hospital. We now have a symbol that is placed above the patient's bed or on the side room door, so that all staff are aware that the patient is at the end of their life. This means that all staff can ensure that patients and family are supported and not unnecessary disturbed.

Treatment Escalation Plans (TEP) are now embedded in our plan of patient care, this is completed with the patient and their relatives, important to the patient, and represents what clinical decisions have been made. This includes the decision on allowing a natural and dignified death, and what level of care is appropriate, for example referral to critical care or for ward-based treatments only.

As a Trust we were involved with the National Audit for End of Life and the data was submitted in October 2018. We have so far received feedback data from the questionnaire given to bereaved carers.

The data shows:

- 75% of patients were involved in decisions about care and treatment when they were at the end of life.
- 73% agreed that staff at Weston General Hospital took into account the individuals wishes.
- 70% felt that staff communicated sensitively to the patient.
- 73% felt that the hospital was the right place for the patient to die.
- Although over 60% of patients died in a bay shared with other patients, 90% of bereaved relatives were satisfied that the location within the hospital where the person died was appropriate.
- Over 80% stated that they were definitely confident that the healthcare staff looking after their loved one had the skills and experience to care for someone at the end of their life.

- 70% felt that the patients' symptoms were controlled. The national average is 40%.
- Overall 20% rated the care and support given to the patient as outstanding, 70% as excellent and 10% as good.
- Over 90% felt that staff involved those closest to the patient in decisions about their care and treatment in the last days of life.
- 70% of those closest to the patient felt supported by hospital staff

During this year for the first time we participated in Dying Matters week and focused on Advanced Care Planning (this is where a person can write down their wishes or tell those close to them what they would wish to happen if they were dying).

We have also started an End of Life Steering Group, where we have members from the community who have experience of a close relative dying in hospital, Weston Hospice Care who we work closely with, End of Life Coordination center (Community partners), Frailty Lead, Director of Nursing, Bereavement office, discharge team and Dementia Nurse Specialist. The aim of the steering group is to work closely with our community partners and the acute trust to ensure we offer outstanding end of life care.

The palliative care team will continue to offer regular training for all staff. We now provide training to the Nursing Assistants Forum, Intravenous updates for registered nurses, new doctors induction and offer tailored training to ward areas and to our allied health care professionals.

From the National Audit for End of Life we will use this feedback to look at areas that we can improve, and our main focus will be ensuring that patients who are in the last days of life are identified more timely so that the teams can explore the patients' needs and those closest to them.

Our new frailty service and the palliative care team work very closely together. We are developing a pathway to ensure that patients who need to be admitted to an acute hospital bed are reviewed by using a Multidisciplinary team approach to ensure that we are providing the right level of care, that we explore advanced care planning, and length of stay by working closely with our community partners in frailty as part of Healthy Weston.

Dementia Care

There are over 850,000 people living with dementia in the UK and at Weston General at least 40% of our beds are occupied by people who have a Dementia diagnosis. Patients, who are living with a dementia end up staying longer in hospital, are more likely to be readmitted once they have left and are less likely to return to their own homes than someone who does not have a dementia.

We believe that we have a critical role to play in supporting people with dementia to have the best possible outcome. We are continually committed to make our hospital dementia friendly and to provide high quality care that supports both the patient and their families.

We have recruited an Admiral Nurse, with support from Dementia UK, whose role it is to offer assessment and one to one support to people living with dementia and their family carers, and to support best quality practice across our hospital.

We have continued our commitment to providing a dementia friendly hospital for our patients. Our Specialist Care of the Elderly ward staff have fundraised, as has a local Secondary school, to provide the fixtures and fittings for a designated dementia friendly room on the ward. This will provide an area which is homely and calm for our staff to support our patients to feel relaxed and to engage in activities. Our estates team also ensured that when they were making changes to our clinical areas that the specific needs of people with dementia were taken into account.

We have secured 21 pre-loaded MP3 players, with era specific music for people under and over the age of 70. This was achieved through a charitable organisation called 'Purple Angel Ambassadors' who work to increase awareness and reduce stigma for people with dementia.

In the past 6 months since the appointment of our Admiral Nurse 51 families received the opportunity for 1:1 support from our Admiral Nurse and many more patients living with dementia had their care reviewed.

When audited, our Enhanced Supervision team felt that they had an overall increased sense of competence in working with people with Dementia. We now plan to provide regular updates and more training in areas they identified they wanted more support in.

Providing a supportive environment for people with a Dementia has shown to have a positive impact on their wellbeing and reduce some of the negative effects of the condition, such as misinterpreting shapes and colours. Working with our local community helps us to reduce stigma and raise awareness of the needs of our patients.

Supporting and listening to Carers

There are 6.8 million people in the UK who provide care for disabled, seriously ill or older loved ones. This saves the UK economy £132 billion pounds a year.

Weston Area Health NHS Trust recognises and values the vital role of carers in the health and well-being of the people that they care for.

Therefore, we have a commitment to actively encouraging the involvement and opinions of carers and an assurance that carers are supported throughout their involvement with our Trust.

We recognise that carers are uniquely placed to offer us invaluable knowledge about the health, needs and wishes of those patients within our care.

We have renewed our commitment to 'John's Campaign', which offers carers of people living with dementia or learning disabilities free parking, open visiting and reduced meals in the restaurant. Raising awareness of this through our mandatory staff training.

We have expanded our collaborative working with North Somerset Hospital Carers Support Scheme, NSHCSS, working with the team to share our knowledge and experience of carers needs.

In collaboration with NSHCSS we have piloted a 'Dementia carers feedback' forms to gain an understanding of what matters to the carers of people living with dementia within our trust.

In raising awareness of 'John's Campaign' more carers have access to the benefits that accompany it. This has also allowed us to identify carers that may potentially need more support in their caring role.

North Somerset Hospital Carers Support Scheme has supported a total of 547 carers last year. Alongside the families that the Admiral Nurse has also supported we have started to gain some valuable feedback which will allow us to prioritise areas that we need to develop further as a Trust.

As we develop our 'Dementia Champions and Link Nurses' scheme further they will be instrumental in supporting and championing the needs of carers on their wards. Including actively promoting 'John's Campaign' and gaining feedback about carers experiences using the feedback forms.

We will be taking this feedback from carers to develop future quality improvement initiatives to ensure that our services continue to develop, in order to support the changing needs of carers within our trust.

Safeguarding Children

Safeguarding Children is concerned with ensuring that children are kept safe from harm. Where risks to children are identified, we have a statutory duty to take the necessary actions to minimise the risk. This involves working closely with families and other departments and agencies, sharing information appropriately and in a timely manner, to enable the correct support to be implemented.

At a strategic level it is about monitoring safeguarding practices in the Trust, promoting good practice, providing staff with training, advice and support to carry out their roles effectively, engaging in multi-agency work, and implementing best practices that are identified locally and nationally.

Over the past year we have introduced the National Child Protection-Information Sharing system (CP-IS) into all relevant areas, allowing us to check Child Protection involvement with children from across the country at the point of registration, informing our care plans and allowing us to improve, multi-agency working, information sharing and outcomes for children.

We have developed and appointed to a Children Safeguarding Practitioner role, expanding the teams skills and resources, allowing us to improve our ad-hoc and scheduled Safeguarding Supervision across all paediatric services, make progress on our audit programme for the first time in two years, and focus some much

needed resources on the promotion of valuable (but poorly utilised) safeguarding resources such as Early Help, Social Care Referral Threshold Document, and Escalation Policy.

We have participated in two Serious Case Reviews – both of which involved our CAMHS's and Paediatric services. This required a lot of dedicated time for the purpose of investigation, reflection, supporting staff, identifying learning, acting of findings, and multi-agency working.

We have made progress in all nine areas listed on the 2017-18 Quality Account as being priorities for 2018-2019

The CP-IS audits to date have been reassuring, demonstrating good uptake of the new process and an increase of children we can now identify as already being recognised as 'at risk'. Through this we have been able to share information with primary care and social care across the country for those children at high risk, where as previously this was predominantly limited to children from North Somerset.

Through the introduction of the additional role of Children Safeguarding Practitioner and the developments outlined above we are slowly but surely improving staff knowledge and skills and improving practice and therefore outcomes for children. This role was introduced in September 2018 and therefore data is still being collected to evidence any resulting improvements, as changes in cultures and practices develop over time,

but anecdotally staff awareness seems to be improving, and practice appears to be uplifted.

Current identified work streams include:

- Level 3 Children's Safeguarding training – aligning training matrix and compliance structure with the new Intercollegiate Document (RCPCH, which is currently under review)
- Continue to progress the supervision provisions in the Trust – Supervision Policy, improved compliance, audit quality
- Continue to progress the audit programme – it is in its infancy of being reinstated, in which a few key areas are being audited currently. But on a wider scale we collect a lot of data and have a fairly good overview of how things generally stand but we need to conduct the analyses to provide evidence and inform action plans.
- With the upcoming merger with UH Bristol there will be a lot of work to align the two services and further build on existing relations between our teams.
- Implementation of action plans – there are recent audit, and case review action plans outstanding as we move into 2019-20 which need to be completed.
- A Business case to be developed to evidence the need for a full time permanent Children's Safeguarding Practitioner.

Safeguarding Vulnerable Adults

All Trust staff are encouraged to report concerns for any element of suspected abuse (as detailed in the Care Act 2014). This clear message is promoted throughout statutory mandatory safeguarding training. Safeguarding awareness training for all staff at Weston General Hospital is currently 92%. Great value has been placed upon safeguarding training and a whole day approach has been incorporated within the training matrix for staff, this includes mental Capacity Act and Deprivation of Liberty Safeguards. This sets the scene for the day which covers all elements of adult and child abuse, Learning Disability, Dementia and Prevent.

The Trust saw an increase in safeguarding activity within 2018/19 raising 353 community related concerns and 95 internal concerns.

Deprivation of Liberty Safeguards

The new Supreme Court ruling on Deprivation of Liberty Safeguards (DoLS) came into force in March 2014. The Trusts position for identification of eligible inpatients and consequent submission of applications has improved. The data in the following graph reflects the improvement within this area of Safeguarding for 2018/19. Our staff accurately and rapidly assess those patients who may require an application submission and where required are supported by the Trust Safeguarding Adult Lead.

Table 37. The number of Internal Safeguarding Concerns raised 2018/19

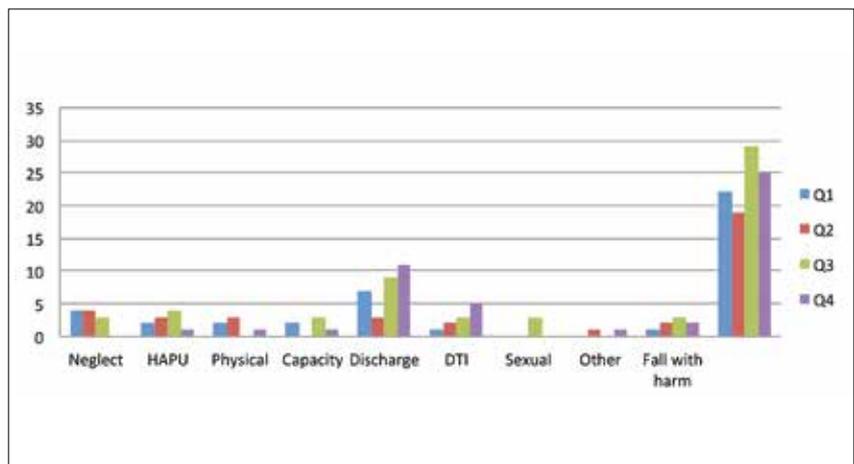


Table 38. The number of Community Safeguarding Incidents raised 2018/19

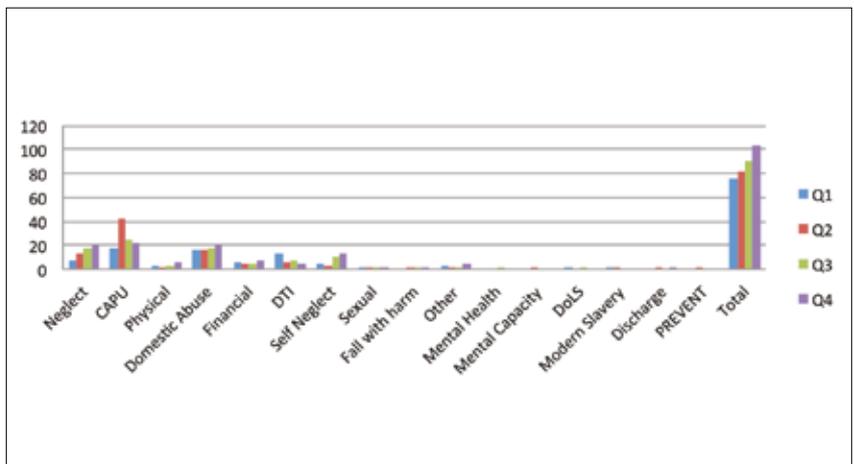
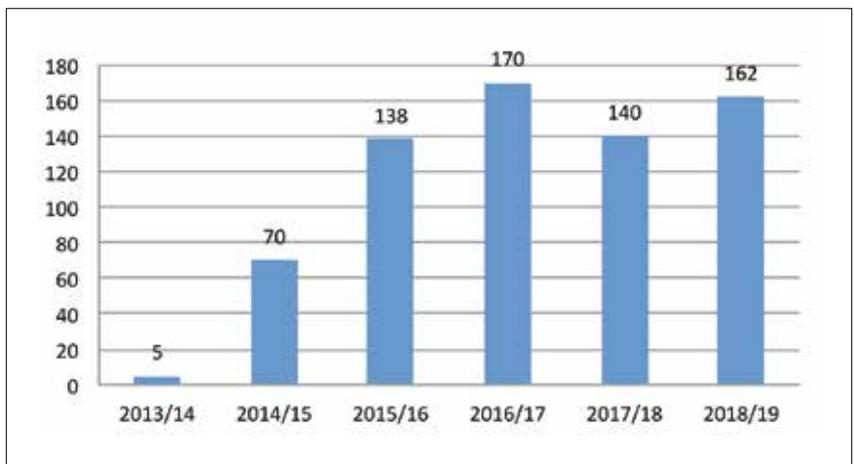


Table 39. The number of DOLS Applications made 2018/19



Learning Disabilities

The Trust provides a robust Learning Disability service for both inpatients and outpatients. The service is overseen by the Named Nurse for safeguarding adults at risk with clinical support from the Complex Needs Sister. The service accepts referrals for people with a Learning Disability that require reasonable adjustments or pre admission best interest planning.

The Learning Disability team recorded 114 contacts for people with a Learning Disability, 12 patients within the Emergency Department, 23 as an outpatient and 79 as an inpatient.

The Trust Learning Disability steering group has had an exciting work plan including making a film with North Somerset People First. This was a strong user involvement project which is now incorporated within the mandatory training for all clinical staff. A collaborative approach has been taken with Trust training, with staff from North Somerset Community Learning Disability team co-delivering the session. The North Somerset Learning Disability partnership board was disbanded by the Local Authority at the beginning of 2018, the Trust is represented at a new partnership network led by North Somerset People First.

The Trust submits quarterly commissioned standards data to the commissioners for acute learning disability care. The data is favourable and reflects the Trust delivering a safe and inclusive service.

Specialist Community Paediatrics

WAHT provides a Community Paediatric team working with Children and Young People aged 0-18 years. The team offer care for the assessment and treatment for neurodevelopmental conditions such as Attention Deficit Hyperactivity Disorder and Autism Spectrum Condition, in addition to ongoing care for children and young people with neurodisabilities. Working in partnership with our colleagues in the community; for example, school nurses, health visitors, social workers and education we ensure services are delivered jointly and delivered around the family.

Completing a service re-design initiative has seen the nursing team increase in size, which has received positive patient feedback as evidenced in our Friends and Family feedback. Our Paediatrician workforce has stabilised, meaning the team is now more robust and can provide cohesive care and better joint working.

We have taken themes and lessons learnt from complaints to implement service

changes e.g. Reviewed care pathways to ensure they are aligned to NICE Guidance

- Undertaken a comprehensions file audit to ensure that children and young people had been offered follow up appointments.
- Implemented Nurse Led initial assessment clinics.
- Redesigned the referral triage process, ensuring families are being supported at the right time by the right service.
- Streamlined the SCAMP (Social Communication Autism Multi-professional Pathway) with the view to reduce the referral to treatment time.
- Adopted a case holding/care coordinator model of care.

What difference did it make?

- The number of formal and informal complaints has greatly reduced.
- Improved patient flow on the SCAMP pathway.
- Friend and Family test showing changes are being received positively.

- Parents have a point of contact and do not have to re-tell their story.
- All children and young people have a clear care plan, with a direction of travel.
- Service and families are safer, as a result of file audit and new way of working.

What will we do next?

- Start to map where we can add value to existing work streams to further improve the quality and variety of care we deliver. For example, sleep workshops, more objective testing for ADHD, reducing referral to treatment time for some care pathways.
- Review and update the service specification.
- Continue to work in partnership with our community stakeholders.
- Develop a business plan to include service profile, caseload and risk.
- Continue to complete baseline assessment tools and quality standards for all relevant NICE Guidance.

Child and Adolescent Mental Health Services

Weston Area Health NHS Trust provides Child and Adolescent Mental Health and Learning Disability Services (CAMHS) from two sites: Drove House in Weston-super-Mare and the Barn in Clevedon; services are delivered by one multidisciplinary team across the two sites. Community Paediatric services were also based at these sites and delivered services from these locations.

The CAMHS teams provide services for children and adolescents with severe and complex mental health issues.

The multidisciplinary team provided services from the two main bases but also from clinics, schools, early years settings and in families' homes.

The team offered the following therapies/services:

- Generic and specialist mental health assessments
- Individual interventions including counselling, cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), eye movement desensitisation reprocessing (EMDR), art psychotherapy and art protocol for trauma
- Systemic psychotherapy, family work and a solution focused therapy
- Medication
- Groups for parents and young people
- The CAMHS team used set referral criteria to ensure access to assessment and treatment for children and young people who need it most.

Clinical Effectiveness

Cancelled Operations

The Trust recognises that having to cancel operations is distressing for patients and their families at a time that is already worrying. The national target is to cancel no more than 0.8% of operations for the year. Unfortunately, due to the significant pressures experienced nationally during the winter months there was a need to cancel elective operations during this period. However, cancellations during winter reduced significantly from 2016/17 following changes to bed management and increase bed capacity to manage increase in emergency admission.

Table 40. Cancelled operations

	NATIONAL TARGET	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
% Operations Cancelled	≤0.8%	0.60%	1.10%	0.18%	2.21%	1.81%	6.95%	2.77%	2.28%
% Cancelled Operations rebooked within 28 days	≥95%	100%	100%	100%	99.88%	100%	94.45%	94.44%	94.44%

Stroke

All Trusts have been set a target to ensure 80% of stroke patients spend 90% or more of their stay in a specialised stroke unit. In 2018/19 the Trust achieved 84.47% this is an increase from 2017/2018 83.54% and is above the required standards of 80%.

MRSA (Meticillin Resistant *Staphylococcus Aureus*) bloodstream Infections

All MRSA bloodstream infections are reported nationally and are assigned as being related to the Trust, or not related to the Trust (acquired in the community or other settings) following a post infection review.

One case was reported during 2018/19 against the Trust's zero threshold. The case was fully investigated and involved a patient that was repatriated to the Trust from a neighbouring Trust. Learning was identified which included screening compliance on admission, monitoring of practice (including hand washing), awareness of previous MRSA colonisation and the timely removal of invasive devices when no longer required.

Escherichia coli bloodstream infections

There has been a continued focus this year on the reduction of Escherichia coli (E. coli) bloodstream infections. E. coli infections represent 65% of Gram-negative infections. The UK Government is targeting a 50% reduction in healthcare associated Gram-negative bloodstream infections by 2020.

Part of the Quality Premium for 2018/19 has been a requirement to achieve a further 10% reduction (or greater) in all E. coli bloodstream infections. This is being led by the Commissioner with input from the provider organisations.

The Trust reported 107 cases of E. coli bloodstream infection in 2017/18, of which 17 were deemed healthcare associated. This compares to the Trust reporting 126 cases in 2018/19 with 22 assessed as healthcare associated. The further 10% reduction ambition set has not been met.

Over 85% of these infections are present when the patient is admitted to hospital. The cases that develop in hospital (healthcare associated) are fully investigated and any learning identified is shared with both the medical and nursing teams.

Performance against national priorities and access standards

Access to Clinical services

Overview

NHS improvement's Single Oversight Framework (SOF) has four performance metrics

Emergency Department (ED) Four-hour waiting standard

The Trust is required to meet the standard of 95% of patients spending four hours or less from arrival to ED to admission to a ward, transfer to another hospital or discharged home.

The four hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department within four hours.

Within the standard there are a number of timings that support how we treat patients, these are:

- Transferring patients in the Emergency Department from an ambulance within 15 minutes
- Having an initial assessment by a qualified clinician within 15 minutes of arrival
- Having a review a by a decision making clinician within 60 minutes.

The indicator is defined within the technical definitions that accompany Everyone Counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf. Detailed rules and guidance for measuring ED attendances and emergency admissions can be found at:

<https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf>

The indicator is calculated as the % of patients who have a total time in ED of four hours or less from arrival to admission, transfer or discharge, compared with the total unplanned ED attendances.

More detail on this metric is provided below.

62 day GP Cancer standard

This indicator is calculated as Patients should receive their first definitive treatment for suspected cancer within 62 days following urgent GP referral. The national standard is 85%. Weston NHS Trust achieved 65.75% at 31 March 2019.

- Referral to treatment (RTT) Incomplete pathways standard

The Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period 2018/2019 is a key quality indicator for hospitals.

The Trust performed well against this national target which sets a maximum of 18 weeks from initial point of referral to the start of any treatment necessary for planned care. This demonstrates that the Trust continues to deliver efficient and effective pathways of care to our patients. The national target is 92%.

The indicator is defined within the technical definitions that accompany Everyone Counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf.

Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at:

<http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waitingtimes/rtt-guidance/>

The indicator is calculated as the percentage of patients on an incomplete pathway at the end of the reporting period that have been waiting no more than 18 weeks, compared with the total number of patients on an incomplete pathway at the end of the reporting period.

Six-week diagnostic waiting times standard

The monthly diagnostics collection collects data on waiting times and activity for 15 key diagnostic tests and procedures, the below demonstrates where we have performed against national data, during the reporting period 2018/2019 a refurbishment of our endoscopy unit had an impact on our capacity and alternative arrangements were put in place at the time.

The national standards are:

- 95 per cent for ED four hour waits
- 85 per cent for 62 day GP Cancer
- 92 per cent RTT incomplete pathways
- 99 per cent for six week diagnostic waiting times.

Table 41. Performance Metric

Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			2017 - 18	2018 - 19
		Apr 18	May 18	June 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19		
A&E 4 Hours	Actual (A)	87.56%	92.07%	94.55%	90.15%	92.66%	84.03%	87.30%	83.22%	77.27%	82.55%	54.44%	82.98%	84.88%	86.87%
	Trajectory	88.50%	92.40%	93.40%	92.50%	90.20%	91.90%	91.30%	89.90%	88.80%	84.50%	80.10%	90.10%		
Cancer (62 days)	Actual (A)	80.00%	82.54%	70.37%	65.28%	74.63%	67.65%	73.53%	60.38%	86.00%	53.95%	52.50%	55.88%	80.95%	67.00%
	Actual Quarter		78.31%			66.82%			67.86%			53.74%			
	Trajectory	69.20%	75.00%	75.80%	81.80%	81.80%	83.30%	82.60%	82.60%	82.60%	82.10%	84.00%	84.00%		
RTT	Actual	90.11%	92.02%	91.99%	92.43%	92.02%	92.81%	92.39%	94.42%	92.87%	92.15%	92.07%	91.26%	92.94%	92.04%
	Trajectory	92.90%	92.90%	92.90%	92.40%	93.30%	93.30%	92.90%	91.10%	90.50%	90.50%	87.80%	90.50%		
6 Week Diagnostic	Actual	99.79%	99.20%	99.21%	99.25%	98.46%	99.61%	98.78%	99.45%	99.80%	99.54%	99.37%	98.93%	98.29%	99.28%
	Trajectory	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%		

Table 42. National Standards

National Standard	Target	2016/17	2017/18	2018/19
A&E Maximum wait of 4 hours	95%	76.10%	84.86%	86.87%
A&E Median Time to Initial Assessment	00:15	00:12	00:13	00:12
A&E Median Time to Treatment	01:00	00:41	00:39	00:44
A&E Unplanned re-attendance within 7 days	1-5%	6.48%	6.43%	6.28%
A&E Left Without being seen	<5%	2.08%	1.55%	1.45%
Breast Symptoms referred to a specialist who are seen within 2 weeks of referral	≥93%	89.10%	94.56%	90.47%
31 days for second or subsequent cancer treatment- surgery	≥94%	99.46%	94.66%	88.37%
31 days for second or subsequent cancer treatment- drug treatment	≥98%	96.36%	97.82%	98.89%
National screening programme who wait less than 62 days from referral to treatment	≥90%	100%	76.92%	87.03%
Cancer reform strategy 62 upgrade standard	≥90%	93.20%	80.95%	86.71%
2 week wait (urgent GP appointment to 1st outpatient appointment)	≥93%	91.55%	94.14%	91.78%
NHS cancer plan 31 day standard	≥96%	100%	98.40%	96.48%
NHS cancer plan 62 day standard	≥85%	77.00%	70.73%	65.75%
Referral to Treatment within 18 weeks incomplete pathways	≥92%	93.71%	92.94%	92.04%
Cancelled Operations on the day for non-clinical reasons	≤ 0.8%	6.95%	2.77%	2.28%
Cancelled Operations rescheduled within 28 days	95%	95.45%	94.44%	94.44%
6 Week Diagnostic Wait	99%	99.50%	98.29%	99.28%

Four Hour Emergency Access Target

Many patients initially come to the Emergency Department (ED) for care. The following graph demonstrates that over the past two years, Emergency Department attendances have increased by 3.53%.

Following a CQC inspection visit at the end of February 2017, Emergency and Urgent Care Services were rated Inadequate as there were not enough doctors to safely staff overnight rotas. Responsiveness (patient flow) was also rated Inadequate. On grounds of patient safety the Trust implemented a temporary overnight closure of ED from 10pm – 8am at Weston from 4 July 2017 including ambulances and walk-in patients.

Since this time, the local population has adapted to the opening times of the Emergency Department rather than seek healthcare elsewhere, demonstrated in the 3.5% increase of attendances.

The Trust is required to meet the standard of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. The Trust did not achieve the target with a final position of 86.87% as of 31 March 2019. A four Hour Access Recovery Plan was instigated in April 2019, with the Trust achieving against this plan for five months of the year.

The four hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department (ED) within four hours.

Within the standard there are a number of timings that support how we treat patients, these are:

- Transferring patients in the Emergency Department from an ambulance within 15 minutes
- Having an initial assessment by a qualified clinician within 15 minutes of arrival
- Having a review a by a decision making clinician within 60 minutes.

Table 43. Total number of ED Attendances

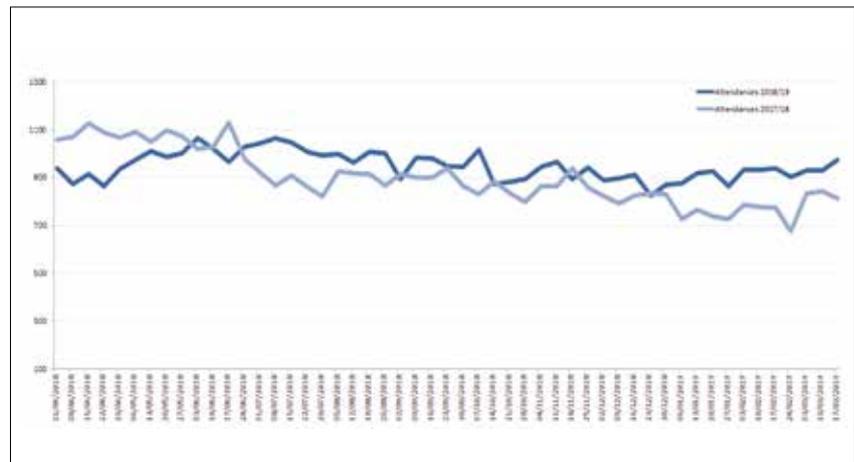


Table 44. ED Performance 2018/19

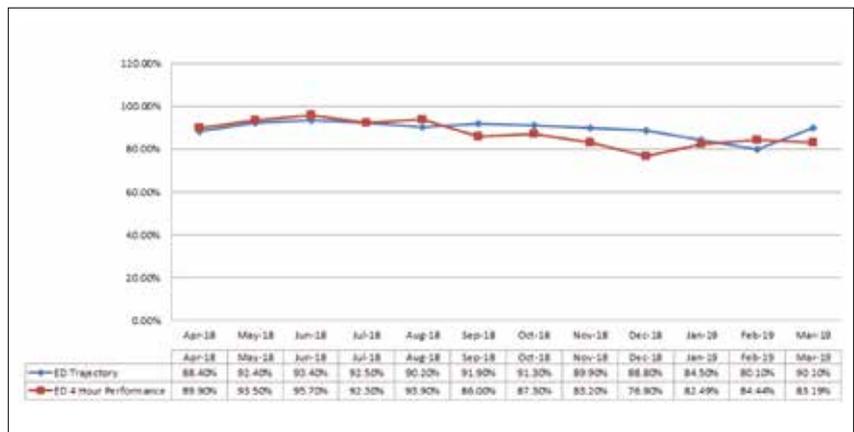
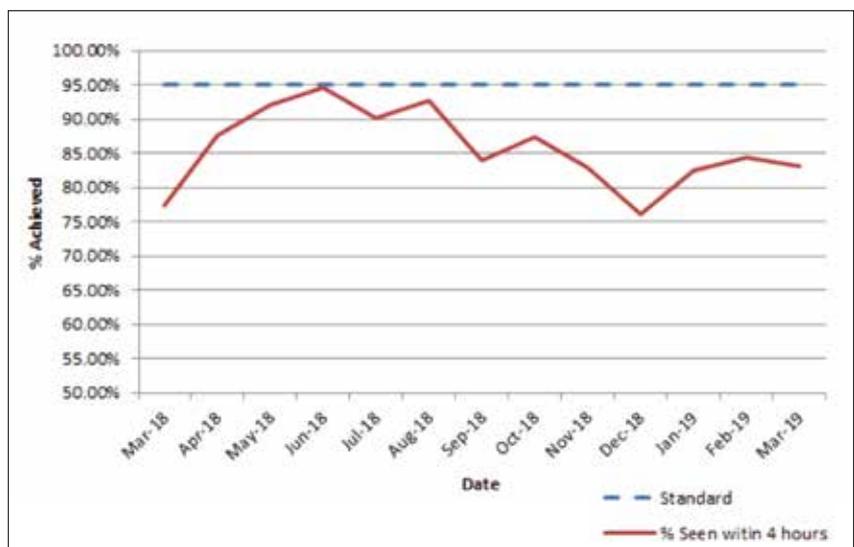


Table 45. Four Hour Emergency Access performance 2018/19



Part 3: Other Information

We also strive to ensure that all patients have a clear treatment plan within 2.5 hours from arrival into the department.

To continue to sustain our performance in relation to patient safety and effectiveness of the department we have

- Implemented a SHINE safety document in 2016 that is a quick assessment and documentation check. We audit this monthly to ensure patients are receiving appropriate and safe treatment. This is led and monitored by the Emergency Department Safety Sisters with oversight and validation carried out by the Lead Nurse for

Governance, Quality Improvement, Deteriorating Patient and Sepsis.

- A new executive led process involves a weekly meeting attended by the Medical Director and /or Director of Nursing along with senior medical and nursing staff the general manager responsible for ED and junior medical and nursing reps. It has also been supported by the ED clinical leader from UH Bristol.
- The meeting focuses on quality and examines a suite of metrics compiled on an ED quality dashboard that cover previously agreed Key Performance

Indicators for quality and performance (including workforce). The dashboard is also used to monitor responses to reported incidents, serious incident investigations and complaints and to discuss learning and actions to be taken within the department. The meeting finishes with an agreement of a departmental focus of the week and success of the week to be communicated to all team members.

- We have implemented live reporting so we can ensure we take timely action to ensure patients receive the correct and timely treatment.

62 Day Cancer Performance

The 2009 Cancer Reform Strategy sets out eight national cancer performance objectives for Trusts to deliver against. During 2018/19 the Trust met three of the national targets. The following table sets out the eight key targets and the Trust performance against each.

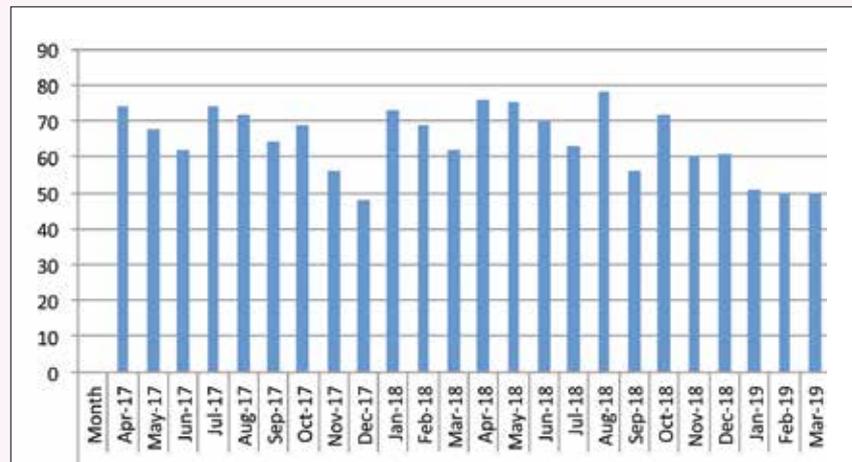
Table 46. Cancer Targets

	NATIONAL TARGET	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Breast Symptoms referred to a specialist who are seen within 2 weeks of referral	≥93%	97.20%	96.60%	93.50%	90.90%	88.68%	89.10%	94.56%	90.47%
31 days for second or subsequent cancer treatment-surgery	≥94%	100.00%	98.60%	95.30%	99.30%	98.81%	99.46%	94.66%	88.37%
31 days for second or subsequent cancer treatment-drug treatment	≥98%	100.00%	100.00%	99.10%	99.97%	99.08%	96.36%	97.82%	98.89%
National screening programme who wait less than 62 days from referral to treatment	≥90%	95.80%	98.10%	86.40%	100.00%	92.05%	100.00%	76.92%	87.03%
Cancer reform strategy 62 upgrade standard	≥90%	94.20%	93.40%	86.10%	77.96%	94.73%	93.20%	80.95%	86.71%
2 week wait (urgent GP appointment to 1st outpatient appointment)	≥93%	96.50%	96.00%	95.30%	97.26%	96.30%	91.55%	94.14%	91.78%
NHS cancer plan 31 day standard	≥96%	99.80%	100.00%	99.20%	99.65%	98.84%	100.00%	98.40%	96.48%
NHS cancer plan 62 day standard	≥85%	92.30%	88.30%	81.40%	89.08%	77.50%	77.00%	70.73%	65.75%

Long waiting specialties

The information pertained within the graph below is representative of information collected and demonstrated within our Somerset Cancer Registry and this may vary slightly from that published nationally due to the nature of data and historic data quality issues.

Table 47. Long wait specialties – compliance against 62 days performance



Venous Thromboembolism

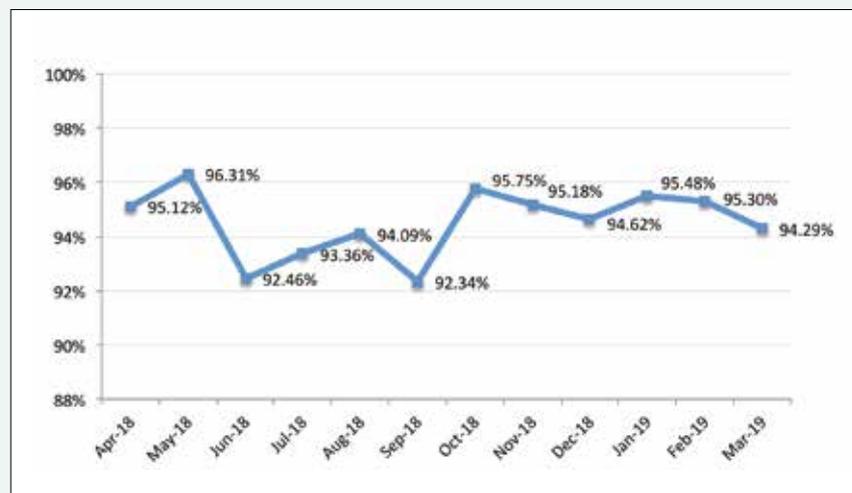
It is a national requirement that 95% of patients admitted to hospital should be assessed on their risk of developing a venous thromboembolism (blood clot) within 24 hours of admission.

The VTE risk assessment collection process became more robust during 2018/19 and the Trust's compliance with the required standard for VTE assessment has continued to improve.

The information below shows the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

The data collection process has been reviewed, ensuring robustness of the data collection, efforts are being concentrated on understanding the common themes in patient records where we are unable to demonstrate completion of a risk assessment and

Table 48. VTE Risk Assessment Compliance 2018/19



also looking at those ward areas where completion figures is low. The Trust continues to see sustained improvement in the assessment of in patients at risk of venue thromboembolism. Currently

performance is audited manually which can delay full validation of results. The trust plans to move to an electronic audit tool in 2019/20 which should ensure timelier reporting.

	NATIONAL TARGET	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
% patients VTE Assessed	≥90%	95.00%	96.10%	78.95%	97.16%	95.34%	63.02%	82.02%	94.52%

Clostridium difficile Infections

The table shows the rate of *Clostridium difficile* (C. difficile) infections there have been within the Trust per 100,000 bed days. (Children under two are not included)

Table 49. Clostridium difficile (C. difficile) infections

	2018/19		2017/18
	Weston	National average	Weston
Rate per 100,000 bed days of cases of C. difficile infection	7	13.2	4.4

Data source: Public Health England

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Target (no more than)	16	12	11	17	17	17	18	17
Cases recorded	20	19	17	20	10	10	4	7

In 2017/18 the Trust had the lowest rate of *Clostridium difficile* infections in the whole of the South West, reporting only four cases. In 2018/19 the Trust has reported seven cases, whilst this is a 75% increase on last year, we remain within our allocated threshold of 17 cases and our rate remains below the national average. Each case has undergone a comprehensive post infection review which has been assessed against national guidance criteria.

We have been able to demonstrate that there have been no cases of cross transmission of *Clostridium difficile* between patients on our wards. Learning has been identified in areas such as prompt isolation, sampling, consistency with documentation of duty of candour and clarity of antibiotic prescriptions. Every case is presented to the Infection Prevention and Control Committee where action plans are either signed off or it is agreed that further work is required.

At Weston, a high proportion of patients admitted to this hospital are over 65 years in age and up to a third of these patients are receiving antibiotic treatment at any one time. These are significant risk factors for *C. difficile* acquisition.

The strategies introduced over the last four years are now embedded and our continuing success in reporting low numbers of *Clostridium difficile* infections is testament to their success.

The strategies that have contributed to this include:

- Continued updating of our antibiotic guidance and the use of mobile technology in the form of a Smart phone App to enable our Doctors to access these guidelines at the point of care.
- Full time antimicrobial pharmacist in post until July 2018.

- Daily auditing of antibiotic prescribing by a designated pharmacist and the Consultant Microbiologist with prompt feedback to prescribers and their teams (up to July 2018).
- Use of the Diarrhoea Assessment Tool to assist clinical staff with the prompt isolation of symptomatic patients and in determining when specimens should be sent.

The gap in the antimicrobial pharmacist post since July 2018 has impacted on the ability to undertake daily auditing. Twice weekly auditing commenced in October 2018 and data from these audits is fed back to clinicians on a monthly basis.

The Trust will continue to support the work across the local health community and meets quarterly with the Commissioners to discuss and improve antimicrobial prescribing and to review learning from incidents across the health care economy.

Improving the discharge of patients from hospital

We discharge many patients each day from our Trust to a variety of care settings, and for the majority of patients this is a positive experience. However, we continue to strive to improve the process of discharge, working closely with patients and partners to reduce the length of time patients stay in hospital when they no longer need acute care services.

Part of our work around “Improving Discharge from Hospital” is to ensure patients and their relatives or carers are involved in the discussions around their discharge. We are also working towards improving the provision of the right support so that people are able to return to their living accommodation, rather than a care home placement or community hospital.

During 2018/19 we built upon the work already undertaken with the implementation of the Integrated Discharge Service. Training sessions continued with the wards to ensure that they are aware of the discharge pathways available and how to access them.

Throughout the early part of the year, across Bristol, North Somerset and South Gloucestershire a new way of working was developed in conjunction with community partners and local authorities.

This is known as the Integrated Care Bureau, and was implemented on 1 October 2018.

The Integrated Care Bureau provides a single referral process to access community and social services develop the correct

support for patients at discharge, the main focus to ensure that patients were being referred onto the right pathway for their needs.

In order to achieve this a new “Single Referral Form” was developed and implemented across the Trust. This form changed the way referrals were made as, rather than prescribing a pathway for the patient, the form would describe what the patient’s needs were (such as assistance with washing and dressing, mobility issues, help with feeding).

All single referral forms are reviewed by a team of experts (an acute hospital therapist, a social worker and a nurse or therapist from the community provider) within the Integrated Care Bureau, to ensure that the patient is referred to the most appropriate organisation to support their needs.

The Case Managers within the Integrated Discharge Service have continued to support and educate the wards around discharge processes and pathways, ensuring that wards are completing Single Referral Forms at the optimal time, with the necessary information for the Integrated Care Bureau to make their decision.

Due to the processes being established, a number of our patients are now being discharged on the day they are ready to be discharged, which means they are not added to the “Green to Go” list – this is a database of those patients for whom we are developing discharge plans (as some planning takes longer than others). The charts below give a picture of how we performed over the last 12 months.

Table 52 presents the average numbers of bed days lost (this is the number of days a patient spends in hospital after the team have agreed the patient is fit to be discharged). It must be noted that this does not refer to Delayed Transfers of Care Bed Days Lost – these are reported monthly via NHS England. The blue line was a trajectory of planned improvement based on the work we are undertaking, and the red line shows that we exceeded the trajectory and continue to improve; this was until January 2019 when there was a significant increase in the number of bed days lost.

As demonstrated within the bed days lost table we had seen a steady improvement until January 2019 when there was a significant increase in the average number of patients who were medically fit for discharge, awaiting ongoing support.

What we will do next

We will continue to work with the wards to improve the way we use the Management of Expectations Policy to ensure that interim measures for discharge that are being offered to patients are accepted and patients do not remain in hospital longer than is necessary, being at risk of infection and deconditioning.

We are working with partners in Somerset to replicate the Home First (Discharge to Assess) pathway that is currently available to other hospitals who have patients living in Somerset. This pathway will allow patients who require a short period of rehabilitation, to have this at their own home.

Table 52. Number of bed days lost 2018/19

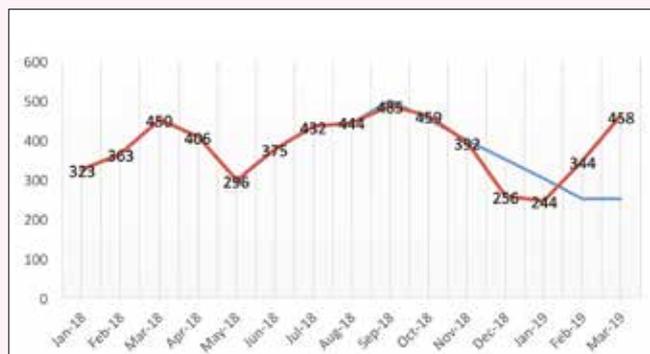
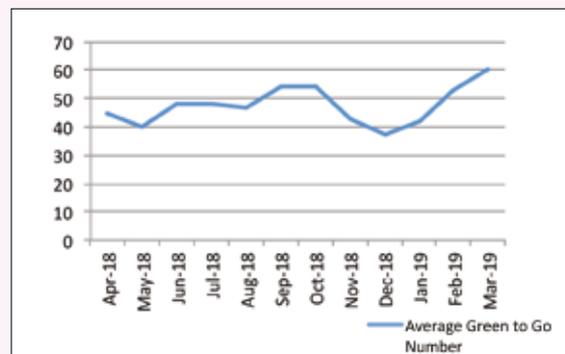


Table 53. Average number on the “Green to Go” Database





Appendices

Appendix A: Feedback about our Quality Report and Statements of Assurance

Statement from Healthwatch North Somerset

Sarah Dodds,
Director of Nursing
Weston Area Health NHS Trust

20th May 2019

Dear Sarah,

Thank you for giving us the opportunity to review the WAHT Quality Accounts for 2018-2019.

We note your 7 priorities for 2018-19:

1. Improving Frailty and Dementia Care within the hospital
2. Reducing harm from pressure damage
3. Continuing development of our workforce
4. Learning from deaths in hospital and improving end of life care
5. Reducing delays in hospital to improve patient safety
6. Enhancing the way we use communication to influence care and service development
7. Reducing Harm from Medicines

During the period covered by your accounts, we received 111 separate reviews from WAHT patients feeding back their experiences of WAHT services. 54 of these were positive, but 57 were negative experiences.

It's not possible to relate these experiences directly to your 7 priorities, but looking first at the positive experiences, 39 praised the care and support received, 8 complimented the quality of communication with the staff involved in their care and 7 noted their satisfaction with the speed at which their care was delivered.

Looking at the negative experiences, 17 were unhappy with the quality of the diagnosis or care they received. 10 mentioned long waiting times either for appointments or treatment. 7 comments related specifically to the closure of A&E overnight. 7 patients were unhappy with the communication with staff. 3 reports specifically mentioned problems on discharge from WAHT. Finally 3 patients mentioned problems with accessing services.

Looking at your identified priorities for 2019-20, we note that you have mentioned input from Healthwatch NS in deciding these. Your identified priorities are:

1. Improving our Governance processes and response to and learning from concerns raised
2. Promoting inclusion, involvement and engagement for Patients and Carers
3. Reducing Harm from Medicines
4. Developing and making the most of our workforce
5. Optimising Safe discharges

From the feedback we have received in 2018-19, your priorities 2 and 5 above take into account some of the negative experiences reported to us and we expect that improved engagement with patients and carers will lead to fewer negative reports of care quality or communication in 2019. Your commitment in priority 1 to improving response and learning from concerns raised to you through PALS is to be commended also.

We would welcome the opportunity to work with you to realise these priorities in 2019-20.

Yours sincerely,



Vicky Marriott
Operations Manager



Statement from Health Overview and Scrutiny Committee – North Somerset Council

Response to Weston Area Health NHS Trust Quality Account 2018/19

The Panel recognises the continuing improvement in performance following the CQC inspection in 2017 particularly in respect of planned care, 6-week diagnostics and the improvements in emergency patient flow. Members support the continuing focus on emergency flow and cancer waiting times as key priorities for the forthcoming year.

The Panel was also pleased to note the successful initiatives around improving frailty and dementia care and reducing harm from pressure damage (priorities 1 and 2) and delighted to see integrated discharge working well and the improving trend for hospital acquired infections.

Also welcome was the ongoing focus on improving patient experience, with Friends and Families scores exceeding the national average. Members were pleased to see that this focus continued in 2019/20 with learning from concerns raised and promoting inclusion, engagement and involvement for patients and carers identified as top priorities for the forthcoming year.

The Panel was encouraged by the work around improving staff experience as evidenced by the steady improvement in staff survey results and hope that the new Practice Development post will help deliver improvements in staff retention.

Members support the stated intention to build on this momentum by making “developing and making the most of our workforce” a key priority for 2019/20.

Other welcome notable successes include the increase in staff flu vaccine take-up and the work around the frailty hub.

Members are pleased that the merger with University Hospitals Bristol Trust still appears to be on track but concerns remain about the (nursing/consultants) staffing situation in the Emergency Department.

HOSP Quality Accounts Sub-Committee (inquorate)
North Somerset Council

15th April 2019

Statement from Patient Council

The Patient Council is a group of dedicated volunteers who work as critical friends of the hospital with the aim of supporting the best care for patients.

The Patients' Council fully recognises the significant challenges faced by Weston Area Health NHS Trust in 2018/19 - following on from several years of uncertainty about the Trust's future, sustained increased demand on services, long term recruitment difficulties and financial and operational challenges.

In this context, the Patients' Council welcomes the commitment of the Trust to develop partnership working with neighbouring Trusts and work towards a secure and safe future for the Trust and patients.

The Patients' Council has shared the experiences of patients directly with the Trust and will continue to do so to inform areas requiring service improvement.

With reference to last year's priorities for improvement, the Patients' Council particularly welcomes the development of a specialist service for the frail elderly and the investment in care of patients with dementia. The support for staff development and well-being is to be applauded – accepting that the Trust acknowledges the ongoing work required to further improve staff survey results.

For 2019/20, the intention to promote inclusion, involvement and engagement for patients and carers is welcomed as is the intention to ensure safe discharge from hospital.

Patients' Council members look forward to working with the Trust during the coming year in support of these objectives.



Annabel Plaister
Patients' Council

21st May 2019

Bristol, North Somerset, South Gloucestershire CCG Statement on Weston Area Health Trust's Quality Account 2018/19

This statement on Weston Area Health Trust's (WAHT) Quality Report 2018/19 is made by NHS Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group (BNSSG CCG).

BNSSG CCG welcomes WAHT's quality account which provides a comprehensive reflection on the quality performance during 2018/19. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality and performance contract meetings.

BNSSG CCG has undertaken assurance visits to the Trust during the year which have included the Emergency Department, Medical Admissions Unit, Intensive Care Unit and Inpatient wards. The review incorporated an environment check and discussions with staff using the metrics identified on the Weston Area Hospitals Trust staff feedback sheet. These visits not only provided assurance of the quality of care delivered, but also enabled BNSSG CCG to develop a shared understanding of the issues and challenges faced by the Trust and to facilitate close and collaborative working to improve quality.

Additionally, the CCG undertook a peer review audit of pressure injuries present on admission to the ED in November and December 2018. The completion of risk assessments and reporting of pressure injuries by the ED staff were noted to be good (>90%).

The Trust reported a Never Event in December 2018 relating to mis-selection high strength of Midazolam. A full root cause analysis process was undertaken in line with National guidance. Local recommendations/action plan have included removal of this medication in the high strength formula and a review of local policies and guidance. BNSSG CCG hosted a Never Event Summit in April 2019 with all acute providers to share learning and actions arising from Never Events in which WAHT fully participated.

Of the seven quality priorities identified by WAHT for 2018/19, the BNSSG CCG welcomes the work undertaken to achieve the quality priorities, noting that six have been achieved and significant progress has been made on the seventh. We commend the commitment to improve quality and safety noting the sustained improvement in hospital mortality rates and the "above average" scores of the end of life survey.

We also acknowledge the action that has been taken to reduce the number of Grade 2-4 hospital acquired pressure injuries and note both the reduction in the past year and considerable reduction over the previous three years.

BNSSG CCG is pleased to note that quality performance at WAHT has continued to improve during the year in a number of key patient areas.

The Trust achieved compliance with the C. difficile threshold. Although an increase on 2017/18 during 2018/19 WAHT final outcome was seven cases against a threshold of 17. MSSA cases have exceeded the 2018/19 target and show a threefold increase on 2017/18. Zero tolerance for MRSA was not achieved with one case being reported. It is also noted that the national E. coli ambition reduction target has been a challenge to achieve. The CCG would have welcomed some further narrative to confirm the actions being taken forward to address the increase in healthcare acquired infections including the introduction of the Urinary Catheter Passport during 2019/20.

In terms of the deteriorating patient the CCG acknowledges and commends the Trust on the high number of staff that have received NEWS2 training and we note the additional narrative regarding the improvement in NEWS scores and the confidence in staff in caring for acutely ill patients. This section may benefit by adding the percentage and total of total staff trained in the Trust. The introduction of E-Observations during 2019/20 will further aid this area of development.

The CCG notes that WAHT has not included any narrative regarding their progress including analysis of achievement or where

CQUINS have not been met for year one of the CQUIN programme for 2018/19.

The CCG was unable to comment on cancer standards as final year metrics were not available.

The Trust has faced challenges within the CAMHS service, particularly in terms of meeting waiting times. The CCG would have liked to have some narrative that includes the actions being taken forward to address these challenges within the document.

The CCG is supportive of the quality priorities chosen by the Trust for 2019/20

that are aimed at addressing some of the key challenges faced by the Trust this year including workforce and optimising discharges objectives although one, two, four and five may benefit from adding baseline activity and target for improvement. However, we would have liked to have seen a priority included, that specifically addressed the quality challenges being faced by CAMHS.

The Trust thanks the CCG for their helpful review and comments and as a result of this feedback have included further actions into Priority Two Promoting inclusion, involvement and engagement for Patients and Carers. These recommendations will be included within our 2019/20 quality work plan.

Appendix B

Statement of Directors' responsibilities in respect of the Quality Account

Weston Area Health NHS Trust, as an NHS Trust has opted to follow the NHS Improvement guidance as applicable to Foundation Trusts which states that:

The Directors are required under the Health Act 2009 and the NHS (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 2018/19 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 2018 to the date of this statement
- Papers relating to Quality reported to the board over the period April 2018 to the date of this statement
 - Feedback from the Commissioners received 17/05/19
 - Feedback from local Healthwatch organisations received 20/5/19
 - Feedback from Overview and Scrutiny Committee received 21/05/19
 - The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2017/2018
 - The 2018 National Patient Survey published 20/06/19
 - The 2018 National Staff Survey published 26/02/19
 - The 2019 Care Quality Commission Report published 26/06/19
 - The Head of Internal Audit's annual opinion over the trust's control environment dated 29/05/19
- The Quality Report presents a balanced picture of the NHS Trust's performance over the period covered;
 - The performance information reported in the Quality Report is reliable and accurate;
 - There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
 - The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
 - The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Trust Board



Grahame Paine, Chairman
28th June 2019



James Rimmer, Chief Executive
28th June 2019

Appendix C: External audit opinion

Independent Auditors' Limited Assurance Report to the Board of Directors of Weston Area Health NHS Trust on the Annual Quality Account

We have been engaged by the Board of Directors of Weston Area Health NHS Trust ("the Trust") to perform an independent assurance engagement in respect of Weston Area Health NHS Trust's Quality Account for the year ended 31 March 2019 (the "Quality Account") and specified performance indicators contained therein.

NHS Trusts are required under the Health Act 2009 to publish a Quality Account which must include prescribed information set out in the National Health Service (Quality Account) Regulations 2010, subsequent amendments, and the NHS Improvement ("NHSI") updates set out in their letter to Trusts dated 17 December 2018 entitled 'Quality accounts: reporting arrangements 2018/19'. These documents together will be referred to as the "regulations".

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance (the "specified indicators") marked with the symbol  in the Quality Account, consist of the following indicators:

Specified Indicators	Specified indicators criteria
Percentage of patients with a total time in A&E of four hours or less	Part 3 of the Quality Account
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Part 3 of the Quality Account

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Account each year in accordance with the regulations. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI (the "detailed guidance"), and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Account listed above.

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 Account does not incorporate the matters required to be reported on as specified in the regulations;
- The Quality Account is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the detailed guidance.

We read the Quality Account and consider whether it addresses the content requirements of the regulations; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing this limited assurance report (“the period”);
- Papers relating to quality reported to the Board over the period April 2018 to the date of signing this limited assurance report;
- Feedback from the Commissioners Bristol, North Somerset and Gloucestershire CCG dated 17 May 2019;
- Feedback from local Healthwatch organisation Healthwatch North Somerset dated 20 May 2019;
- Feedback from the Overview and Scrutiny Committee dated 21 May 2019;
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2017/18;
- The latest national patient survey dated 20 June 2019;
- The latest national and local staff survey dated 26 February 2019;
- Care Quality Commission inspection, dated 26 June 2019; and
- The Head of Internal Audit’s annual opinion over the Trust’s control environment dated May 2019.

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.

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Board of Directors of Weston Area Health NHS Trust as a body, to assist the Board of Directors in reporting the Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Board of Directors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and the Trust for our work or this report save 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 (Revised)”). Our limited assurance procedures included:

- reviewing the content of the Quality Account against the requirements included within the detailed guidance;
- reviewing the Quality Account for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
 - making enquiries of relevant management, personnel and, where relevant, third parties;
 - considering significant judgements made by the Trust in preparation of the specified indicators;
 - performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
 - reading the documents.

A limited assurance engagement is less 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 impact 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 thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the regulations and the detailed guidance.

The nature, form and content required of Quality Accounts are determined by the Department of Health and Social Care. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Account, which have been determined locally by the Trust.

Basis for Disclaimer of Conclusion — Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

Our testing of the underlying data used to calculate performance against this indicator in the year identified an unacceptable number of errors of different types where the criteria set out by NHSI in determining the clock start date and recording of cancer waiting time breaches where a patient transfers between trusts were not applied as they should have been. The errors relate to the input of data into the patient Carenotes system used to calculate the indicator performance.

Conclusion (including adverse conclusion on the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator)

In our opinion, because of the significance of the matters described in the Basis for Adverse Conclusion paragraph, the maximum wait time of 62 days from urgent GP referral to first treatment for all cancers indicator has not been prepared in all material respects in accordance with the criteria.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- The Quality Account does not incorporate the matters required to be reported on as specified in the regulations;
- The Quality Account is not consistent in all material respects with the documents specified above; and
- The percentage of patients with a total time in ED of four hours or less indicator has not been prepared in all material respects in accordance with the criteria set out in the regulations and the detailed guidance.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Bristol

29th June 2019

The maintenance and integrity of the Weston Area Health NHS Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.





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