Weston Area Health NHS
NHS Trust

WESTON AREA HEALTH NHS TRUST

QUALITY ACCOUNT
2011/2012

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Statement on Quality From The Chief Executive

Delivering the best care for all who use our services is the primary concern of Weston Area Health NHS Trust. Quality is at the forefront of everything we do and will remain our focus. Quality is about making sure that every day every member of staff at the Trust is equipped to provide excellent care that delivers the best possible outcomes for our patients. Whether that is around patient safety, the effectiveness of the treatments we provide, or the individual experience a patient has when using our services.

Quality will remain everyone's business and I hope that these Quality Accounts demonstrate our real commitment to ensuring quality and our drive for quality improvement, as well as explaining how we have progressed with our priorities to date, whilst demonstrating key areas where we feel we still have work to do.

As a Trust we don't just consider quality at reporting time, we aim to continuously bed it into everything we do and make every effort to make quality relevant to all our staff with leadership that ensures a focus on quality from the ward to Board. We review and will continue to review our performance through regular audit, but more importantly through listening to our patients and service users. We will continue to work hard to ensure we develop further the opportunities for patients and service users to influence service development and engage in assessing and improving the patient experience.

The engagement of service users and local people will become more evident in the year ahead. We are all committed to continually improving quality and we look forward to working with key partners and service users in the coming year to provide a quality service we can all be proud of.

This Quality Account provides a clear direction of the challenges we have set ourselves for the coming year and reviews the performance against our goals for 2011/12. It is clear that we have made significant progress against the majority of our goals, but we also recognise the opportunities for improvement. The information we provide in this report is to the best of my knowledge true and accurate and will provide a basis for future improvements in the delivery of quality of care to all our service users.

Peter Colclough,
Chief Executive

Quality Account Requirements

All providers of NHS services are required to produce an annual Quality Account as set out in the National Health Service (Quality Account) Regulations 2010. This requirement took effect in April 2010. This is therefore the second year that we have published a mandatory Quality Account.

The regulations specify the requirements for all Quality Accounts and certain elements are mandatory. We have used the Department of Health Quality Accounts toolkit as the basic template for our Quality Account.

The report provides information about our progress through last year and our priorities and ambitions for the year ahead. We believe it will be of interest and value to patients and the public as well as to those who commission our services.

Our Quality Priorities for 2012-13

The Trust is actively working with key community, primary care and social care partners towards creating a substantial Integrated Health and Social Care system to enhance the services to the local population of North Somerset. The year ahead is challenging and will aim to provide seamless services at the point of need. To support this, the Trust has determined 3 service priorities for the coming year, choosing 17 areas to focus on which span the three domains of:

- **Patient safety** – having the right systems in place to effectively report, analyse and prevent errors, ensuring that our patients receive the safest possible care.

- **Clinical effectiveness** – providing treatment and care for our patients that produces the best possible outcomes with the most effective use of financial resources.

- **Patient experience** – meeting our patients' emotional as well as physical needs. This includes being treated with dignity and respect in a comfortable and safe environment, and being given the appropriate information about their care.

The areas we have chosen are priorities for the Trust and areas where we know our performance should be improved. Throughout the year we will report on our progress to the Board of Directors, to our Service User Council and to our Commissioners.

How We Chose Our Priorities for 2012/13

In each of the 3 domains we have identified the top priorities to meet the needs and expectations of service users, commissioners and Trust staff.

Targets and goals are aligned with our identified priorities, yet remain under negotiation with commissioners.

Our Quality Priorities for 2012 -13

Patient Safety

Quality priorities and why we chose them	What will success look like	How this goal has been ranked
Pressure sore reduction: Pressure sores are debilitating for patients and largely avoidable injuries which cost the NHS millions of pounds every year. By working together with key community and Primary Care providers across North Somerset we want to considerably reduce avoidable pressure sores for our patients.	Have no avoidable grade 4 pressure sores this year, as these are the most debilitating and can lead to weeks or months of treatment and lengthen the stay in hospital needlessly. Also reduce grade 2 and grade 3 pressure sores by at least 50%	Ranked No. 1
Infection control: Whilst we have made significant strides in achieving no MRSA infections for over 12 months, we wish to see the same success in reducing the incidence of *Clostridium difficile* infection and the spread of Norovirus (Winter Vomiting) during peak periods of community infections.	Maintain the current performance of no MRSA bactereamia . Reduce the number of *Clostridium difficile* infections to less than 12 this year Reduce the number of wards closed as a result of Norovirus by 20%	Ranked No. 2
Reducing Falls: Although the Trust has done a lot of work on reducing the incidence of falls, we want to continue to improve performance in collaboration with the community and primary care services	Ensure we achieve at least 95% compliance with our 'falls policy', which sets the standard for reducing falls across the Trust Establish a joint community/acute falls improvement group	Ranked No. 3

Quality priorities and why we chose them	What will success look like	How this goal has been ranked
Reducing the number of Serious Untoward Incidents and Never events: Reporting of Untoward Incidents across the Trust is very high which demonstrates a willingness to learn from mistakes. Serious Untoward Incidents and events which should Never occur remains a high priority for the Trust to ensure improved safety and confidence of those who come into our care	We will reduce the number of Serious Untoward incidents by 25% this year and in ensuring we learn from such events, aim to eradicate Never events.	Ranked No. 4
High risk medication safety: Getting medication prescribing and administration right for patients is essential to a speedy recovery and ensuring patients understand why medication is given and what to look for as side effects is essential. Our patient surveys demonstrate that we can improve on this.	Improve on analyzing and acting on analyses of medication errors and reduce the incidence of missed medication or failure to sign for medication administered by a minimum of 15% Patients will report that they understand why medication is given and what to look for as side effects	Ranked No. 5
Venous Thromboembolism (VTE) VTE (a blood clot) is a major contributor to severe illness or death in the UK, accounting for up to 25,000 deaths a year. Whilst we have demonstrably improved patients assessment for risk of VTE we want to ensure that all patients who require preventative treatment receive treatment at the right time.	Ensure continued success in at least 90% of all patients being assessed for VTE and demonstrate that at least 90% of patients who require preventative treatment receive the correct prophylaxis.	Ranked No. 6

Quality priorities and why we chose them	What will success look like	How this goal has been ranked
Oesophageal Doppler Monitoring (ODM) is a minimally invasive technology used by anaesthetists during surgery to assess the fluid status of the patient and guide the safe administration of fluids and drugs**.**	Full adoption of this technology across the NHS is forecast by NICE to benefit over 800,000 patients and generate net financial savings of over £400m. Current information suggests that these technologies are used for less than 10% of applicable patients. The Trust is reviewing its policy on the use of this technology and will be issuing more specific guidance to ensure consistency in application	Ranked 7

Patient Experience

Our quality priorities and why we chose them	What success will look like	How this goal has been ranked
Improving End of Life Care: Over half a million people die in hospital every year. Whilst many deaths are inevitable in a hospital setting, most people would chose to die at home or in a similar home environment. Where possible being involved in planning ones own care with loved ones and care professionals at the end of life is a goal to support difficult decisions.	We will train key nurses across the Trust to work with ward staff and the local community and hospice staff to ensure all patients at the end of their lives have choices and are supported in making those choices We reduce the number of deaths occurring in our hospital by 15% over the coming year We will increase the number of patients we register as receiving End of Life Care by 50%	Ranked No. 1
Dementia Care: Dementia is a very debilitating illness for the individual and their family and is rapidly becoming the single most challenging condition in health and social care today. Having Dementia and then requiring admission to an acute trust for additional health problems can have a negative impact for both the patient and the family. It is our aim to ensure effective and appropriate care for these patients through a difficult episode of their lives and to identify those who are in the early stages of Dementia and to ensure they are directed to the appropriate care packages.	All patients over the age of 75 will be assessed on admission against an agreed criteria to determine signs of dementia All patients who have been identified as showing signs of Dementia will be assessed again following overcoming their acute episode of treatment to identify signs and symptoms of Dementia All patients who are determined to have or are in the early stages of Dementia will be put into a Dementia pathway of care All ward staff will have receive training to support the care of those with Dementia whilst in our care	Ranked No. 2

Our quality priorities and why we chose them	What success will look like	How this goal has been ranked
Improved Discharge Planning: When patients leave hospital it is essential that they and their families understand what is required to ensure continued recovery and that all services necessary are in place to support continued recovery. The results of our local and national surveys tell us that we have significant room for improvement in discharge planning.	Working with our key partners in community, primary and social care is essential to improving effective discharge. We will form a collaborative working group with key partners to ensure patients are safe on their return home and that recovery is enhanced. We will review and change processes to support effective discharge We will reduce the length of stay for patients who currently stay longer than 14 days in hospital by 50% We will increase the number of patients who are discharged at a weekend by 10%	Ranked No. 3
Improve patient experience response to the national and local surveys: Questions in the national survey are determined by the Department of Health . The results of these and local surveys inform where the Trust can improve the patient experience. The improvement areas have been determined following analyses of data provided from such surveys.	Improve the satisfaction scores on questions covering the following: Medicines information Involvement in care decisions Information about concerns Someone to talk to if worried Knowing what will happen next Having a choice of admission date Being disturbed by noise at night Reducing delays in discharge	Ranked No. 4

Our quality priorities and why we chose them	What success will look like	How this goal has been ranked
Patient and Public engagement: Whilst the Trust has actively engaged with service users through a Patient and Public engagement group, this group has not been engaged in the developments and strategy of the Trust. The Trust aims to reinvigorate this group to ensure there is a significant role in influencing the developments in the group and to provide a true service user voice to existing and new service development	The current Patient and Public engagement group will be reinvigorated and transformed into a Service User Council (SUC) The SUC will actively engage in Trust work programmes and committees, influence the revision of patients feedback approaches and provide a critical friend to service improvement and policies that impact directly on patient care	*Ranked No. 5*

Clinical Effectiveness

Our quality priorities and why we chose them	What success will look like	How this goal has been ranked
Clinical Governance: Clinical Governance is a system and process for monitoring performance and identifying where improvements can be made and then evidencing that the improvement is effective.	We will revise they way Clinical Governance is implemented across the Trust and put in place robust systems and processes to ensure we are able to demonstrate clinical effectiveness and safety	Ranked No.1
Nutrition and Hydration: We want to be confident that the essentials of nutrition and hydration are right for all our patients all of the time.	We will conduct a Trust wide audit of nutrition and hydration and develop an action plan to ensure we can demonstrate best practice when: assessing our patients assisting them with eating weighing them appropriately providing access to snacks 24 hours a day documenting and communicating care needs	Ranked No. 2

Our quality priorities and why we chose them	What success will look like	How this goal has been ranked
Improve Communication between the Trust, GP's, Social Care and Community Care: As part of the integration programme we are already in a good position to ensure effective two way communication is improved. Following feedback from commissioners and GPs we will work collaboratively to ensure timely discharge letters are sent to GP's and good communication with community and social care enables effective discharge	GP's will review timeliness and appropriateness of discharge letters and provide timely feedback to the Trust The Trust will increase the number of e discharge letters sent to GP's Community and Social care services will provide timely feedback to the Trust on effective communication The collaborative discharge working group will review effectiveness of discharge communication and make recommendations and assist with implementing new ways of working	Ranked No. 3
The Productive Series, known as 'Releasing time to care'. Whilst the Trust has already commenced work across all wards, this programme will be refreshed across all wards and the Theatre suite to provide more efficient and effective ward and theatre care	A change team will be appointed to lead ward by ward 'releasing time to care' through the 'Energising for Excellence' programme A change team will be appointed to work with the theatre complex to implement 'releasing time to care'	Ranked No. 4
Learning from audit: Whilst many audits are conducted across the Trust to meet national and local requirements, the lessons from such audits are not monitored to ensure lessons learned are rolled out and embedded into practice.	An audit plan will be developed for the Trust to meet national and local requirements Implementation and outcomes of audits will be monitored to ensure lessons learned are rolled out across the Trust and embedded in practice	Ranked No. 5

Ensuring Performance Against Our Priorities

Managing effectively to ensure we have and can demonstrate we are achieving our priorities is important for both staff and service users. The Trust has recently reviewed how it monitors performance through a revision of its Governance Framework. Governance is the term used to describe a systematic approach to planning, monitoring and improving the quality of care and services we deliver. It is a framework we use to ensure accountability for the continuing improvement of services we provide, whilst safeguarding high standards and creating an environment which provides excellence for those in our care.

Performance against our priorities is reviewed routinely at key committee meetings in the Trust, including the Trust Board and will be shared with our service users through the revised Patient and Public engagement structure we describe above.

Performance against priorities is also subject to scrutiny and review by our commissioners, and the Strategic Health Authority as well as the Care Quality Commission who regulate our service and conduct unannounced inspections, the outcome of which are reported on their web site.

Statement of Assurance from the Trust Board

A review of our services

As well as providing care to patients at Weston General Hospital, Weston Area Health NHS Trust, provides Children's Community Specialist services which include Child and Adolescent Mental Health(CAMHs), Child Health and Paediatric Therapies at the Drove Road campus and The Barn in Clevedon.

The Services provided at Weston General Hospital includes:

- A Midwifery Led Maternity unit- Ashcombe Birth Centre
- An extended day care unit for paediatrics – The Seashore Centre
- Cancer services which includes outpatient chemotherapy
- Emergency Department seeing in excess of 135 patients every day
- A sexual health clinic- Weston Integrated Sexual Health(WISH)
- General outpatient services
- In patient services for:
    - Acute general medicine
    - General Surgery including Breast, Colorectal and vascular
    - Diabetes
    - Rheumatology
    - Stroke
    - Cardiology
    - Respiratory medicine
    - ENT
    - Gynaecology
    - Haematology
    - Trauma & Orthopaedics
    - Urology
    - Oral Surgery

We continue to regularly review all the data available on the quality of care for these services. The total income for these activities in 2011-12 was £79 million and represents 100% of the income generated from the provision of NHS services by the Trust. There are no material sub contracted activities to report. Under contractual arrangements with the Trust's commissioners commissioning for quality and innovation (CQUIN) payments have been received based on progress made against quality and innovation goals. Further details of agreed goals for 2011/12 and 2012/13 are available from the Chief Executive on request.

Our participation in clinical audits and national confidential enquiries

Participation in clinical audits

During 2011/12, there were 35 national clinical audits and 1 national confidential enquiry related to NHS services provided by Weston Area Health NHS Trust.

During this period the Trust participated in 77% of all national clinical audits and 100% national confidential enquiries which we were eligible to participate in. There were a small number of national audits we chose not to undertake as we were undertaking similar audit or research in the same area, or our patient case mix did not meet the audit criteria.

The national clinical audits and national confidential enquiries that the Trust participated in during 2011/12 are as follows:

Name
NCEPOD Alcoholic Liver Disease
Paediatric Pneumonia
Paediatric Asthma
Pain Management
Childhood Epilepsy
Paediatric Diabetes
Emergency Use of Oxygen
Adult Community Acquired Pneumonia
Severe Sepsis and Septic Shock
Adult Critical Care (ICNARC)
Seizure Management
Diabetes
Heavy Menstrual Bleeding
Ulcerative Colitis & Crohn's Disease
Parkinson's
Hip, Knee and Ankle Replacements
Elective Surgery (PROMs)
Acute Myocardial Infarction & other ACS (MINAP)
Heart Failure
Cardiac arrhythmia
Lung Cancer
Bowel Cancer
Head & Neck
Oesophago-gastric Cancer
Hip Fracture (NHFD)
Bedside Transfusion
Medical Use of Blood
Care of the Dying in Hospital

The national clinical audits and national confidential enquiries the Trust participated in, and for which data collection was completed during 2011/12 are listed below, alongside the

number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name	Number of Cases Submitted
NCEPOD Alcoholic Liver Disease	100%
Pain Management	100%
Childhood Epilepsy	100%
Emergency Use of Oxygen	100%
Severe Sepsis and Septic Shock	50%
Seizure Management	100%
Diabetes	100%
Heavy Menstrual Bleeding	18.6%
Ulcerative Colitis & Crohn's Disease	100%
Parkinson's	100%
Bedside Transfusion	80%
Medical Use of Blood	100%
Care of the Dying in Hospital	90%

The reports of 8 national clinical audits were reviewed in 2011/12 and the Trust has planned the following actions to improve the quality of healthcare provided:

National Audit	Proposed Action
National Care of the Dying Audit	Team to review medical teaching around Liverpool Care Pathway, possibly through the use of e-learning. To continue this excellent level of availability of 'just in case' end of life medications. Develop a trust policy for deactivation of implantable cardiovertor defibrillators. Ongoing education of staff about the importance of completing and documenting all assessments. A review of how the GP is contacted to inform of deterioration and death. Aim to help staff understand the goal of relatives and carers expressing what is important to them; the need to explore hopes and fears and spiritual issues. Encourage senior clinicians to sign to endorse Multi Disciplinary Team decisions that the patient is dying. Review what leaflets should be given out to relatives and carers.

National Audit	Proposed Action
Emergency Use of Oxygen Audit	Development of new trust wide policy on oxygen therapy Introduction of stickers on drug charts for oxygen therapy Ongoing training for junior doctors and nurses
National Comparative Re-audit of Bedside Transfusion Practice	Ensure that all ward areas have access to electronic wristbands and handwritten wristbands as a backup. Promote the use of open ended questions when asking patient details Raise awareness of Patient Identification. Implement the post transfusion advice document across the Trust. Implement Patient Information Leaflets across the Trust.

The reports of 26 local clinical audits were reviewed in 2011/12 and the Trust will take the following actions to improve the quality of healthcare provided:

Local Clinical Audit	Proposed Actions
Audit of Acute Pancreatitis Management	Review of the existing protocol for management of acute pancreatitis Consultants to consider the utility and feasibility of creating a dedicated laparoscopic cholecystectomy list every week Re-audit following changes
Neutropenic Sepsis Re-audit	Ensure GPs are informed of the importance of monitoring the renal function and reacting to changes with dose reduction if appropriate after discussion with rheumatology Ensure that the general medical teams are aware of the need to administer folinic acid rescue when such patients are admitted. Also to inform the appropriate team of such admissions

Local Clinical Audit	Proposed Actions
Dementia Audit	Training programme to be developed for junior doctors re antipsychotic drugs and the delirium protocol. Protected mealtimes audit to be undertaken Community resources to be considered to further support the work of the volunteers, thus enhancing the patient experience A training day to be planned for all dementia champions Medical staff will be enabled to attend training for mental capacity and deprivation of liberty (DOLs) Training sessions for medical staff to be implemented re: complaints process to understand the impact of a poor patient experience
Prescribing tumor necrosis factor (TNF) Blockers in adults with ankylosing spondylitis (NICE TA143)	Feedback the results of this audit and re-educate appropriate members of the rheumatology department about the guidelines for anti-TNF therapies Produce a flowchart that shows clearly the stages involved in initiation of anti-TNF therapies to minimize confusion and assist in correct follow-up Use a continuous graph-based or tabular record of personal dated Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) and spinal visual analogue scale (VAS) scores recorded to be kept in each patient's notes to see progression, responses to treatment and to help ensure that these values are consistently recorded in a system for all healthcare professionals to reference easily with prompts to continually assess eligibility for anti-TNR treatment. Develop an anti-TNF assessment form specific to ankylosing spondylitis – addition of a clear area to record disease activity scores for rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis – addition of a follow-up box to ensure response to treatment is being assessed. Re-audit in one year to ascertain any change in practice
Spinal Cord Compression Audit (NICE)	Feedback to radiology re: need for entire spine imaging and clear reporting. Monitor use of updated guidelines and proforma to ensure best practice for patients with possible cord compression Provide ongoing slide presentation for self-directed learning

Local Clinical Audit	Proposed Actions
Audit of venous thromboembolism (VTE) risk assessment in Emergency Department patients with lower limb injuries discharged with a lower limb plaster cast	Poster in Emergency Department highlighting VTE risk assessment and treatment options Include risk assessment box as an aide memoire on acute injury of ankle proforma Rubber stamp on plaster trolley Reassessment in fracture clinic Re-audit
Acute kidney injury (AKI): how well are we assessing the risk?	Audit junior doctors on knowledge of AKI risk factors Discuss alteration of cumulative pathology chart on medical clerking form Present audit findings to wider audience
Modified Early Warning system (MEWs) Audit	Separate Millennium board for high care patients – this will help tracking the flow and usage of the beds in the high care setting Formulate an admission and discharge criteria Reassess the admission criteria for easier flow back to high care from other wards
Audit of initial health assessment for looked after children	Information from primary care GP/health visitor to be available to inform initial health assessment Specialist information to be available from hospital consultant where applicable to inform initial health assessment Information from Child and Adolescent Mental Health Services (CAMHs) when involved to be available Information from education, social care and personal health records to be available Biological parents to accompany child where possible, with current carer and social care assistant as needed Reports for initial health assessments to be made available to social services within 4 weeks of assessment.
Assessment of glycaemic control in patients with chronic kidney disease	Implementation of 24 hour ambulatory monitoring, home blood glucose (BM) monitoring and blood pressure (BP) monitoring by practice nurse

Patient Safety

Weston Area Health Trust is one of 17 acute Trusts in the Southwest participating in a wide ranging program to improve the safety and reliability of care. Since 2009 the five work streams; peri-operative, Intensive Care, Medicines Management, general ward and leadership have increased the attention to specific aspects of care known to improve the safety and quality of outcome. The overall aim for the organisation is to reduce the hospital standardised mortality index by 15% and adverse incidents by 30% by 2014. The Trust has committed resources to the implementation of safety check lists and briefings in all theatres.

The Intensive Treatment Unit (ITU) work stream has delivered a bundle of changes and ensured blood glucose is in range in over 80% of all patients at all times. This is in addition to daily goal setting and multi disciplinary care. It is now in excess of 6 months since our last ventilator acquired pneumonia as a result of changes to nursing care and physiotherapy provision.

The wide range of work in this project is challenging but is critical to the delivery of better outcomes for patients. The Safety Thermometer is an additional program we are implementing from April. This NHS wide initiative will enable us to record each month the number of patients who have not been harmed in one of four ways; had a pressure ulcer develop, suffered a fall, developed a urinary infection when a catheter is in place, developed a venous thrombo-embolism or had poor risk assessment or preventative treatment. This additional measure of the attention we pay to patient safety each day and in every clinical area will be supported by our safety improvement work streams.

Our Participation in Clinical Research

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to the wider health economy. It enables staff to remain up to date with the latest treatments. Active participation in research therefore contributes to achieving the best outcomes for our patients.
Last year 439 patients were recruited to participate in research approved by a research ethics committee.

Research and Development Team

As a Trust we participated in 46 clinical research studies from April 2010 to April 2011. We used the nationally recommended systems and protocols to manage these studies.

In total, 19 NIHR (National Institute of Health Research) portfolio studies began in 2010-11, with an average approval time of 4 days.

During the year, 70 clinical staff across our clinical services participated in approved research.

Our research studies

The following are a sample of studies we have entered into:

Study	Recruitment
Clots-3	11
Developing the UK-EDAQ for arthritis (United Kingdom Evaluation of Daily Activities)	13
Environmental interventions for falls prevention	5
Learning to live with Rheumatoid arthritis	5
PBC (Primary Billary Cirrhosis) Genetics study	1
PD Rehab (Parkinson's Disease)	2
Probiotics for prevention of AAD/CDAD (Antibiotic acquired diarrhea/*Clostridium dificile*)	52
Hip Hop Flooring study	16
UK Genetic Prostate Cancer Study	6

Our Registration with the Care Quality Commission

The Care Quality Commission (CQC) is the regulatory body which grants legal licences to practice healthcare in England. The CQC only issues licences to organisations that can rigorously prove they can offer safe high quality healthcare.

Weston Area Health NHS Trust is required to register with the CQC and our current registration status is 'registered without conditions or restrictions'. The CQC did not take any enforcement action against the Trust last year.

Weston Area Health NHS Trust had participated in 4 CQC reviews during 2011- 2012 as follows:

In January 2011the CQC undertook a review of all standards. Recommendations were made against outcome 4: 'Before people are given any examination , care, treatment or support, they should be asked if they agree to it' and outcome 21: 'People's personal records, including medical records, should be accurate and kept safe and confidential. Both standards were identified to have moderate concerns. Appropriate action was taken and a further review was undertaken in August 2011 which identified full compliance. The trusted acted swiftly and undertook a complete revision of nursing documentation. The outcome of this work was positive and met the CQC standard required.

The second review was in respect of discharge management and working with external partners in respect of CQC outcome 6. The Trust responded immediately and implemented a collaborative working group with Primary Care Trust (PCT) and community care partners to revise discharge arrangements. This work is ongoing at the time of this reporting.

The Trust also had an inspection for the registration of both the Community Childrens Specialist services campus at Drove Road and at the Barn in Clevedon, both of which achieved compliance against the 6 standards inspected.

The fourth review undertaken by the CQC took place in March 2012 and was to review the legal compliance with the Termination of Pregnancy guidelines. The Trust was found to have concerns with regard to two sets of case notes that did not comply fully with recommendations. As a result of this review, immediate action was taken to ensure clinical staff engaged in these procedures, understood their legal responsibilities and the Division responsible will conduct and report on a monthly audit of 50% of case notes for the following three months and then every six months.

Data Quality

Weston Area Health Trust is committed to driving and achieving improvements in data quality and is taking the following actions to improve data quality:

- A Data Quality Improvement Group has been set up that reports into the Health Informatics committee to ensure actions are delivered.
- Data Quality Scorecards have been developed and key indicators are included in the Trust Board Performance Report.
- Processes have been developed so that the Clinical Coding team communicate errors to clinical services staff directly responsible for data entry.
- An Admission, Transfer, and Discharge programme has been rolled out to ensure staffs follow the correct processes for data input.
- An information improvement team has been established in Health Informatics to identify areas of poor data quality and re-train those areas.
- Data correction booklets are being developed and rolled out to ensure ownership is taken at the point of input for data correction.
- A new data corrections function many be introduced into Heath Informatics.
- A new Information Governance programme has been established as a part of the new Health Informatics model to specifically target data quality.

Weston Area Health Trust submitted records during 2011/12 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99.7% for admitted patient care
99.8% for outpatient care
98.6% for accident and emergency care

The percentage of records in the published data which included the patient‟s valid General Medical Practice code:

100% for admitted patient care
100% for outpatient care
100% for accident and emergency care

The Trust was subject to a Payment by Results (PbR) Data Assurance Framework review, conducted in October 2011 by the Audit Commission, in order to look at clinical coding and the accuracy of all data items that affect the price paid by Commissioners. The performance of the Trust measured using the clinical coding healthcare resource groups (HRG) error rate is better than the national average which is encouraging. However, there were some errors that could have affected the price in the small samples taken. An action plan has been agreed which will support the continuous improvement in data quality.

Information Governance Toolkit

Information governance means keeping the information we hold about our patients and staff safe. The Information Governance Toolkit (IGTK) is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to Connecting for Health.

In 2010/11, the Toolkit against which we are measured underwent significant revisions. The more recent version is no longer assessed on a percentage basis and is now divided into two broad categories ‘satisfactory’ and ‘non satisfactory’.

In 2011/12, WAHT received a green, satisfactory (66%) compliance rating with information governance standards as assessed by the IGTK.

Safeguarding Children and Adults

The Trust takes the Safeguarding of Children and Adults very seriously and has a full time Safeguarding Lead. The trust is a member of both our local Safeguarding Boards.

In June 2011, the Trust was the subject of an external review of Safeguarding Children, undertaken by the South West SHA and the North Somerset PCT. The review made 6 recommendations and the Trust has since developed and implemented a plan to ensure it meets all safeguarding needs of children in our care. The Trust will continue to monitor compliance with this plan through its local safeguarding committee in conjunction with the North Somerset PCT.

In November 2011, a review of children's services was conducted by the North Somerset PCT and subsequently a further review was commissioned by the Trust of the Royal College of Paediatrics and Child Health (RCPH). Whilst the RCPH commended the Children's ward (Seashore Centre) along with the PCT they made 6 recommendations to enhance the service provision. The continued provision of children's services and the safety of children in our care will remain highly visible and subject to scrutiny and review through the Trust Safeguarding Committee and local Safeguarding Board. A new appointment of a midwife with protected time to work closely with the Named Nurse for Safeguarding in the Trust in October 2011 is proving to be invaluable with improved relationships and processes with Social Care children's services to safeguard newborn babies in North Somerset. We believe the integration programme will enable us to enhance the service we provide to children in North Somerset.

The Trust has a number of mechanisms in place to identify and support patients with learning disabilities, ensuring appropriate adjustments are made to meet their individual health needs. In addition, staff are regularly trained in caring for patients with learning disabilities. This includes communication, nutrition and multi-agency collaboration.

As with safeguarding, we believe that the integration programme will further improve the patient experience for people with learning disabilities. In particular, through early identification and enhanced multi-professional communication when a local resident known to community services teams needs hospital care.

Dignity, Learning Disability and Dementia Care

Weston Area Health NHS Trust has actively participated in local and regional work programmes to enhance the dignity of those in our care and to ensure continuous improvement in services for those who suffer with Dementia. The success of the Trust in enhancing treating patients and service users with dignity and respect was demonstrated through the National Outpatient survey results which said that 92 per cent of patients felt they were treated with dignity. We are not complacent with our results and will continue to strive to improve this performance.

The Trust has a full time Matron dedicated to supporting the improvements in Dignity, Dementia and Learning Disabilities, and provides a valuable service to wards and departments who may require assistance with providing appropriate care for an individual with Dementia or a Learning Disability. Training is provided to all staff on Dementia and this will continue to be a focus in the coming year.

Dementia Review

In 2010 eight quality standards for Acute Hospital Dementia Care in the south west were developed by the South West Dementia Expert Reference Group. These standards were to be imbedded into hospital care by 2013. They consisted of 2 Levels, of which level 1 was to be achieved by March 2012 and level 2 by March 2013. The South West Dementia partnership visited the Trust with members of the expert reference group to carry out a review of its dementia services on 28th November 2011; their findings were to be benchmarked by the 8 quality standards for hospital care.

Matron Deb Parsons, Practice Development Matron for Dignity

The review was planned and led by the Matron lead for inpatient dementia services and offered the review team an opportunity to view our services through a number of patient pathways. The final report of findings was published and sent to the Trust in February 2012.

Overall the review team had a very positive experience and gave praise to the work undertaken during the last year and specifically to the Trust Matron and Dementia Champions. When benchmarking their findings against the eight South West Hospital Standards in Dementia Care, the review team found many examples of good practice. It was pleasing to read that the review team noted that during their visit, they witnessed good quality care being delivered to all patients in all the clinical areas visited.

The review team identified key areas of good practice and suggested improvements in all eight standards; these suggested improvements have formed the basis for the 2012 inpatient Dementia action plan which will be monitored through the Trust Dignity in Care Steering Group and the Corporate Governance and Outcomes Committee.

End of Life Care

Over half a million people die in hospital every year. Whilst many deaths are inevitable in a hospital setting, most people would chose to die at home or in a similar home environment. Where possible being involved in planning ones own care with loved ones and care professionals at the end of life is a goal to support difficult decisions. The hospital is participating in 3 separate national pilot projects to improve end of life care in acute trusts.

We will train key nurses across the Trust to work with ward staff. Outpatients and inpatients who are in the last 6 to 12 months of life will be identified and this information is passed on the community and primary care, so that patients and families can participate in advance care planning. We will focus our efforts on both cancer and non cancer terminal diagnoses.

We will ensure that the Liverpool Care Pathway is used for all people who are identified as being in the last 2 to 3 days of life, to improve the quality of care they receive.

We will monitor our performance in identifying patients who should be entered appropriately onto the end of life pathway to ensure that we have a continuous process of improvement.

We will build on the existing good links of providers of end of life care in our community.

Patient Experience Feedback

The Trust places great value on patient feedback and Patient and Public Engagement. The Trust actively engages with Patients and the Public through its established Patient and Public Engagement Group. This group meets 6 times per year and currently focuses on view and experiences of service users. It is seen as a valuable source of information and a number of the service user representatives engage with working groups in the Trust such as the Patient Environment committee. The role of this group will be broadened during the coming year, in line with our Quality Priorities articulated in section 1 above.

Patient surveys are of fundamental value to the Trust to inform service developments and also to provide a benchmark in performance against like Trusts in England.

The Department of Health require all NHS Trusts in England to participate in national surveys each year, including an annual inpatient survey and every other year in an outpatient survey. The surveys are conducted and managed by 'Picker', an independent body on behalf of the Trust and results are fed into the national data base. The results of each of these surveys are described below:

National Outpatient Survey

The National Outpatient Survey is conducted every other year. The results below are from the fourth such survey.

The Study sample was drawn from 850 patients over the age of 16 years who attended an Outpatient Department in April or May 2011 and includes any outpatient clinic run within Emergency Departments, such as fracture clinics.

The results allow the Trust to consider:

- Are there issues of higher importance to our patients?
- Identify where there is scope to improve;
- Identify departments, specialties or sites within the Trust that are worse than others and areas of good practice that others can learn from.

The Survey covers 55 questions with subsections. 51 questions are scored. Each question is benchmarked as a score out of 10. The questionnaire is presented in sections as follows.

Section Heading	Score out of 10	How the Score Compares with Other Trusts
Before the appointment	7.98	About the same
Waiting in the Hospital	5.23	About the same
Hospital environment and facilities	8.48	About the same
Tests and treatments	8.48	About the same
Seeing a Doctor	8.89	About the same

Seeing another professional	8.67	About the same
Overall about the appointment	8.47	About the same
Leaving the Outpatient Department	7.5	About the same
Overall impression	8.77	About the same

- 93% of patients reported their overall rating of care as good, very good or excellent.
- 91% of outpatients were treated with respect and dignity all of the time at the Outpatient Department.
- 88% of respondents were definitely given enough privacy when discussing their condition or treatment.
- 81% definitely had confidence and trust in the Doctor examining and treating them.
- 75% of patients were definitely involved as much as they wanted to be in decisions about their care and treatment.

The detail of the outpatient survey results and priorities for action can be seen at **annex 1**. The actions necessary are reflected in the Trust priorities for 2012/13 (see pages 7 to 12)

National Inpatient Survey

The National Inpatient Survey is an annual survey. The study sample was drawn from 850 patients over the age of 16 years, who were treated as inpatients during June and July 2011. The results of the 2011 survey are below:

As with the outpatient survey, the results allow the Trust to consider:

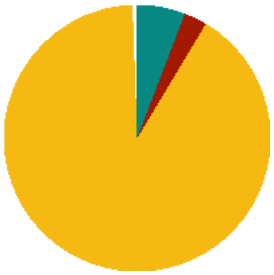
- Are there issues of higher importance to our patients?
- Identify where there is scope to improve;
- Identify departments, specialties or sites within the Trust that are worse than others and areas of good practice that others can learn from.

It is disappointing that the Trust has not seen significant improvement in performance since 2010. This demonstrates that the Trust continues to have opportunity for improvement in 10 areas, but specifically in the management of discharge, noise at night and engagement of patients in decisions about treatment. The key areas for improvement are highlighted in *Our Quality Priorities;* section 1 of this report.

Have We Improved Since the 2010 Survey?

A total of 66 questions were used in both the 2010 and 2011 surveys.

Compared to the 2010 survey Weston Area Health NHS Trust is:



- Significantly BETTER on 4 questions
- Significantly WORSE on 2 questions
- The scores show no significant difference on 60 questions

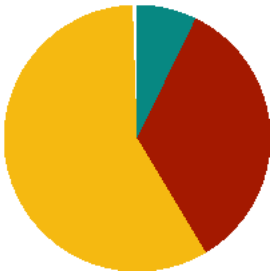
The Trust Improved Significantly in the Following Areas:

- Privacy when being examined in the Emergency Department
- Not sharing a sleeping area with members of the opposite sex
- Not using bath or shower areas with members of the opposite sex
- Nurses being seen to clean hands between touching patients

The Trust Worsened Significantly in the Following areas:

- Planned admissions were not offered enough choice of hospitals
- Not asked to give views on quality of care

How Do We Compare to Other Trusts?
The survey showed that Weston Area Health NHS Trust is:



- Significantly BETTER than average on 5 questions
- Significantly WORSE than average on 23 questions
- The scores were average on 39 questions

The Trust is significantly better than average in the following areas:

- Patients not having to share sleeping areas with members of the opposite sex
- Patients not having to use the same bathroom facilities as members of the opposite sex
- Cleanliness of toilets and bathrooms
- Hand wash gel dispensers available

The outcomes of this survey have been shared widely with staff in the Trust and with the Patient and Public Engagement Group. The actions required have been articulated in the quality priorities for 2012/13 (p7 to 12) and delivery will be monitored by the Trust Executive Team meeting, the Trust Board Governance Committee and the new Service User Council.

Local surveys

The Trust currently conducts real time inpatient surveys every month with volunteers surveying up to 100 inpatients against an agreed set of standardized questions. The data from these surveys is reported to the Trust board each month.

Currently 18 questions are asked which are based around the Care Quality Commission outcomes framework. The trust has demonstrated that it continues to perform well and patients consistently report:

- Not having to share sleeping accommodation with members of the opposite sex
- Not having to share toilets or bathrooms with members of the opposite sex
- During their stay feeling safe in our care
- An average of 84% said their medicines had been explained to them
- An average of 80% said they were aware that Drs and Nurses were washing their hands
- An average of 90% said they were getting enough to eat
- An average of 80% said their pain was controlled. With an average of 10% not answering this question as they did not experience pain.
- An average of 90% felt that the hospital responded to their needs
- An average of 42% said they rated their overall experience as 5*
- An average of 40% said it was clear what will happen next, 35% said it was very clear and 18% said it was not very clear
- An average of 89% said they would recommend the hospital to family and friends
- An average of 62% said they were disturbed by noise at night
- An average of 60% said they knew who to talk to if they had worries or fears
- An average of 60% said they were involved in decisions about their care and treatment
- An average of 95% said they were treated with respect
- An average of 26% said they were told about medication side effects and an average of 38% said they were not told about medication side effects
- An average of 25% said they were told who to contact if they were worried when they left hospital and an average of 55% said they were not told who to contact.
- An average of 90% said they were given enough privacy when discussing their treatment and condition and an average of 8% said they weren't given enough privacy.

Maternity Services

The maternity service continues to provide a high quality service that continually monitors its quality and performance. It provides maternity care for approximately 1400 women, of which on average 550 will choose to birth in Ashcombe Birth Centre with 300 circa women giving birth in the unit. The service monitors the outcomes of all women who are transferred from the service, are appropriate and have a good clinical outcome.

Ashcombe Birth Centre staff and birthing pool

The Maternity Services Dashboard is the tool which monitors both clinical and staff performance and national quality indicators which is monitored through the Maternity services Risk and Governance Group.

The service achieved an excellent pass on the Clinical Negligence Scheme assessment in January 2011 at Level 1, and will be reassessed in January 2013. Due to the changes in the standards and resource required to undertake the lead in this work the service will be assessed at level 1. However, agreement from the PCT to support part funding for this midwife post to take the lead in Patient Safety and Quality, will enhance the quality of service to drive further improvements in the standards of care with the aim to achieve Level 2 at the next assessment.

Antenatal Screening is also monitored and informs the National Screening Programme. The service provides data against key performance indicators (KPI) on the rates of women screened and the “failsafe” processes that the service has in place. The quarterly returns identify that the service is achieving the standards required and has improved in the final quarter of the year and has received positive feedback from the regional assessor.

The Maternity service works very closely with many agencies to provide care to meet the needs of the population and developments have included collaboration with agencies to meet the needs of women with complex needs assessments, including , vulnerable women, disabled women, and those who may have mental health needs and those suffering from domestic abuse. We will work very closely with the Drug Liaison Midwife, Social Care, Health Visitor and many other agencies in North Somerset.

The maternity Service is committed to providing a quality service and has many processes and networks in place; we believe that the integration programme will further improve the patient experience for women and families in North Somerset.

Cancer Services

The Trust provides cancer care for most common cancers and works closely with other NHS Trusts to ensure all patients referred are able to access the treatment of choice. To inform the development of cancer services, the Trust participates in all necessary audits and patient experience surveys.

During 2011/12 there was no national cancer patient experience survey. Following on from the success of the 2010 survey the 2012/13 survey is currently underway with publication of results anticipated later on in the year. We are pleased that the Trust is again experiencing a high level of response. Local patient satisfaction audits were also undertaken during the year, giving a strong indication of satisfaction.

Three examples of patient satisfaction surveys are as follows:

Breast 23 hour surgical pathway

Patient Responses from 14 episodes:

- Involved as much as wanted re care & treatment:
  - 12 – yes definitely
  - 2 – yes to some extent
- Information given re condition:
  - 14 – the right amount
- Involved in decisions about discharge:
  - 7 – yes definitely
  - 7 – yes to some extent
- Told who to contact re condition:
  - 14 - yes

The following letter was attached to 1 response:

> 'I would like to acknowledge the care given to me by the Macmillan Breast Care Nurses, their support was invaluable after my discharge from hospital.
>
> It is very comforting to know there was someone to express my concerns, the fact they phoned me to check all was well, made their support even more special. I was in the same situation 24 years ago after leaving hospital, was a very lonely time.
>
> This is why I had to let you know what a difference the Breast Care Nurses make'.

Chemotherapy local patient survey – 135 Patients who attended the unit in March 2010 were sent a questionnaire and the response rate was 70%. The report was published in April 2010.

The results of the survey were very positive and a quote from the survey is below:

> ‘The treatment I have received on the Oncology Unit has been exemplary. The nurses are excellent- caring, efficient, knowledgeable and supportive, as is the administration staffs. The Doctors are always clear in the information given & answer all questions clearly & explain all decisions made. The environment is comfortable and care is taken to make as pleasant as possible the treatment which could be distressing’

Gynaecological Cancer Services Patient Survey 2011 – Patients being diagnosed with a gynaecological cancer between 1st April 2010 to 31st March 2011, 20 consecutive patients were sent a questionnaire and the response rate was 60%. The results are published in the Cancer Care Annual report 2011.

The results of the survey were very positive and a quote from the survey is below:

> “I found the booklets explaining the different treatments excellent; they backed up the verbal explanations by doctors and nurses.”

> “Operation and follow up care very good – many thanks.”

It could be seen in both surveys conducted that there was however a recurrent theme regarding the general outpatient environment. The Trust is fully aware of the less than acceptable environment in which outpatient services are currently provided. This is now being addressed and a new outpatient facility is in the design stage and will be implemented during the new financial year.

National and local patient satisfaction surveys indicate a high level of satisfaction with the level of information provided by the specialist cancer teams. The Macmillan information support centre also provides additional support and information to patients, families and their carers, when required. There is also a highly successful and well received Macmillan Citizens Advice Bureau service hosted by the Trust 2 days per week.

The Trust has consistently met all waiting time targets, ensuring patients receive timely diagnosis and treatment. One of the most difficult standards to maintain is the 62 day (urgent GP referral to treatment) target. The Trust achieved 92.76% compliance during 2011/12 against a national target of 85%.

As a proactive member of Avon Somerset Wiltshire Cancer Services Network the Trust works in partnership with other cancer providers to ensure a seamless pathway of care which is compliant with national ‘Improving outcomes Guidance’. The hospital acts as a ‘Cancer Unit’ and sits within a network of cancer care providers who provide specialist complex diagnostics and treatments, including radiotherapy and complex surgery.

Weston General Hospital provides diagnostics, treatments and follow-up for the common cancers, with rarer ones being treated elsewhere. Chemotherapy treatments are offered at the Trust and there are no plans for the delivery of radiotherapy which is provided at University Hospitals Bristol.

As part of the national implementation of the National Chemotherapy Advisory Group recommendations, the Trust is aiming to develop an Acute Oncology Service, this, in conjunction with the Improving Outcomes Guidelines for metastatic cord compression and

cancer of the unknown primary. We will also continue to develop the delivery of timely treatment and care of patients who present as oncology emergencies and complex diagnostic pathways.

Cancer Care Safety

The Trust takes all safety incidents seriously and aims to ensure risks are minimised and lessons learned from incidents are translated into practice. All incidents relating to cancer and its treatment are monitored using the Trust standardised governance and assurance mechanisms.

The Trust is currently submitting data to:

1. The Lung Cancer National Audit (LUCADA). The Lucada audit focuses on measuring the care given to lung cancer patients from diagnosis to the primary treatment package, assessing against standards and bringing about necessary improvements.
2. The Bowel Cancer National Audit (NBOCAP) The main purpose of the NBOCAP audit is to measure the process of care and clinical outcomes, enabling comparisons between hospitals and bringing about improvements where necessary, and
3. The Oesphago-gastric National Audit (AUGIS). The primary objective of the AUGIS audit is to provide national information and hence facilitate and drive local quality improvement.

Cancer Care Clinical Effectiveness

Peer Review

The 2011 peer review process identified good practice and continued high attainment of the measures. Between 2010-2011 a significant number of new measures were introduced into the tumour sites standards, which subsequently lead to a reduction in percentage achieved which was largely due to the time frame available to make the necessary changes to meet the requirements before the next review. For example, where additional training or staffing was required.

Acute oncology is a newly described service for patients presenting as emergencies. An internal steering group is developing a business case for the development of the service in the Trust.

Multi Disciplinary Teams (MDTs) are scored according to the percentage of the set standards that are met and 70% compliance with standards is considered nationally to be satisfactory performance.

Peer Review Results Providing 2010 and 2011 Comparison

Tumour site/topic	2010	2011
Breast MDT	88.6%	80.7%
Lung MDT	90.3%	85.2%
Upper GI MDT	91.4%	80.7%
Urology MDT	95.6%	92.3%
Skin MDT	84.4%	82.1%
Colorectal MDT	92.7%	84.6%
Gynae Locality -Diagnostics only	90.9%	78.6%
Complementary therapies	NA	50%
Chemotherapy services	NA	70.7%
Oncology pharmacy	NA	83.3%
General oncology MDT	NA	22.2%

The Trust uses Comparative Health Knowledge System (CHKS) software to monitor clinical outcomes of all patients including those diagnosed with cancer. This provides a comparison with our nominated peer group of Trusts within England.

Weston Area Health NHS Trust Progress Against Priorities

Our progress against 2011-12 priorities

The process of consultation to select our priorities for 2011 -12 involved common traditional processes to gather intelligence, including guidance and discussion with the PCT, the review of clinical performance against local and national benchmarks, the review of complaints, patient surveys and the review of reported incidents. The following tables and text describes the goals we set ourselves and the progress made. We recognize that we have opportunity to continue to learn from our experiences and our results and lessons will be carried into the new year to ensure we can demonstrate continuous improvement.

Summary of our 2011-12 quality achievements

Patient safety

Quality Indictor	What we said we would do	How did we do?
Screen and assess all adult patients for Venous Thrombo Embolism (VTE) and achieve a minimum of 90% compliance	Implement standard documentation to monitor compliance with assessment for VTE and monitor monthly progress	We achieved this indicator and screened and assessed more than 90 per cent of inpatients at year end.
Deliver VTE prophylaxis to 90% of patients determined as requiring preventative treatment	Audit progress against this indicator to ensure compliance	Key areas of the Trust audited and monitored against this standard, including surgery and Intensive Care, are achieving full compliance. The Trust did not fulfill its expectations in auditing and monitoring all areas and this is disappointing and will remain a high ranking indicator for 2012-13

Quality Indictor	What we said we would do	How did we do?
Maintain current performance to have no MRSA blood infections and screen all emergency and elective patients for MRSA. Reduce the number of *Clostridium difficile* infections to a maximum of 16	Implemented new training and education for all staff on intravenous catheter insertion and care, and care of wounds and urinary catheters. Implemented new screening and monitoring for MRSA of all new patients entering the Trust Isolated any patient exhibiting signs and symptoms of *Clostridium difficile* and kept isolation in place until clear samples were evidenced.	The Trust maintained its excellent performance in continuing to have no MRSA blood infections during the year. By year end we achieved the 100% target for the screening of all emergency and elective patients for MRSA The Trust disappointingly exceeded the maximum number of *Clostridium difficile* infections diagnosed whilst an inpatient by 4 cases. This will remain a significant focus for the year 2012 -2013
Reduce the number of patient falls and reduce the risk of consequent injury	We will introduce an electronic recording falls assessment system Revise and strengthen and audit the Trust policy on the use of bed rails Working with the community nursing teams identify patients at risk before they come into hospital	The number of patient falls reported in 2011/12 has reduced by 20% on the previous years figures We have introduced a robust auditing system of falls management and assessment This link has been established and the Trust participates in the North Somerset Partnership Falls working group and will continue to be a focus for the future
Improve clinical documentation and meet the CQC standard 21	Demonstrate sufficient improvement has been made to meet the CQC standard Ensure all clinical documentation is documented in the correct format and in the correct space	This has been reviewed by the CQC as fully compliant An audit of compliance was undertaken in February 2012. The results of this audit were disappointing and ward sisters have been requested to provide action plans to ensure improvements are put in place. The audit will be repeated in June 2012 and outcomes reported to the Nursing and Midwifery Committee.
Introduce the use of 'Skin bundles' a process for ensuring patients at risk of developing pressure ulcers are placed on the correct care protocol	The Tissue Viability team will work with Matrons and ward sisters to support the introduction of 'Skin Bundles'	Skin Bundles have been effectively introduced into all wards and departments. The Trust will continue to make this a priority to ensure full utilization during 2012/13

Patient Experience

Quality Indicator	What we said we would do	How did we do?
Improving responsiveness to personal needs of patients	We will undertake patient surveys whilst patients are inpatients and also following discharge We will introduce new medicines leaflets for patients to refer to on discharge Introduce a 'near patient' dispensing system in the Emergency Admissions Ward Ensure more timely discharge information through the use of electronic discharge summaries to General Practitioners Reporting of incidence related to discharge	The inpatient surveys have commenced and undertaken monthly with data being fed back to staff and to the Trust Board. The National Inpatient Survey results and the National Outpatient Survey results can be found at annex 1 Work has commenced with the Community Pharmacy Services to produce guidance for patients. This work will continue through the multi agency discharge working group Near Patient dispensing on discharge is available on the emergency ward Electronic discharge summaries are in pilot phase and remains in the plan for 2012/13 Incidents relating to discharge are reported routinely by the PCT to the Trust and issues investigated. The collaborative discharge project group recently established will now review all incidents and actions taken

Quality Indicator	What we said we would do	How did we do?
Improve communication with patients on discharge	Engage with patients and families in arranging discharge Communicate more effectively with primary care and social care Provide more timely information to General Practitioners Commence the introduction of the electronic discharge information	All patients currently received a discharge summary and a transfer of care letter, if returning to care home. The Trust is developing an integrated shared transfer of care form which can be used by care homes sending patients in and the Trust discharging patients. This is a collaborative piece of work with the local community team. A discharge assessment is incorporated in the nursing admission record and prompts staff to identify needs on discharge at an early stage. A discharge checklist documents that all safety checks have taken place prior to discharge. A new Discharge process identifying discharge criteria to facilitate out of hours discharge is planned for 2012. A multiagency working group has now been established to ensure ongoing improvements throughout the coming year.

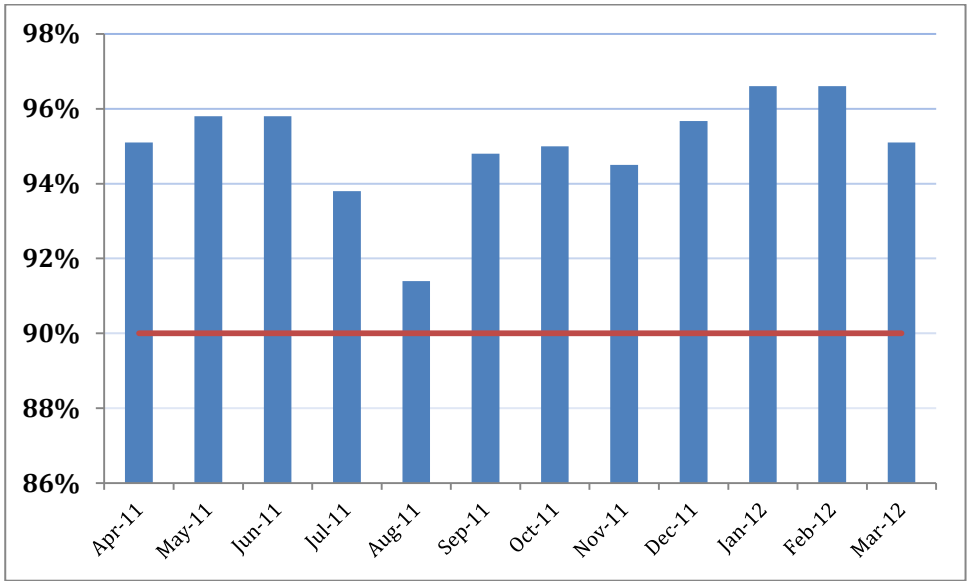
Clinical Effectiveness

Quality Indicator	What we said we would do	How did we do?
Increase the number of patients discharged over a 7 day week (increase by 12% from our base line)	The ward teams would look to ensure patients are discharged in a timely manner across all days of the week.	We haven't achieved our target of a 12% increase in weekend discharges by year-end but we are consistently achieving 8-10% and will strive to improve throughout the coming year.
Ensure all patients have a MUST assessment to determine their dietary needs	The dietetic team will work with ward staff to introduced the MUST assessment tool to all wards and undertake audits to assess effectiveness of implementation	The Must tool has been introduced across the Trust and audits have been undertaken with feedback reviewed by the Nursing and Midwifery Committee, with recommendations for a further audit and review of optional dietary assessment tools.
Improve care for people with dementia or cognitive impairment whilst in hospital	The Trust would actively work with the South West Dementia Tool and Standards and participate in undertaking peer reviews	The Trust has actively developed and delivered on going training for all staff in the management and care of those with Dementia The Trust participated in the South West Peer Review in December 2012 and received positive feedback and recommendations
Increase the number of patients and service users referred for assistance with stopping smoking, referring 300 patients or service users.	Introduce a referral system for ward and department staff to offer patients opportunity to enter into support to assist with giving up smoking	The Trust has regrettably failed to meet this expectation. Whilst considerable the number of patients and service users successfully referred to the stop smoking clinic has been significantly below expected numbers.

Venous Thrombo Embolism

Blood clots, or venous thrombo embolism (VTE's), are a major cause of death amongst hospital patients. The Trust is committed to doing everything it can to prevent blood clots forming and now undertakes to screen patients, for example those about to undergo surgery, who might be at risk of this complication so that appropriate preventative measures can be taken. Throughout the last financial year the Trust consistently screened more than 90% of patients at risk of VTE and latterly this figure has risen to more than 96%. In addition to the screening work the Trust also has a comprehensive set of guidelines which describe the best preventative measures to be prescribed for any given level of risk.

Percentage of adult patients assessed for risk of venous thrombo embolism (VTE) on admission to hospital in 2011-2012



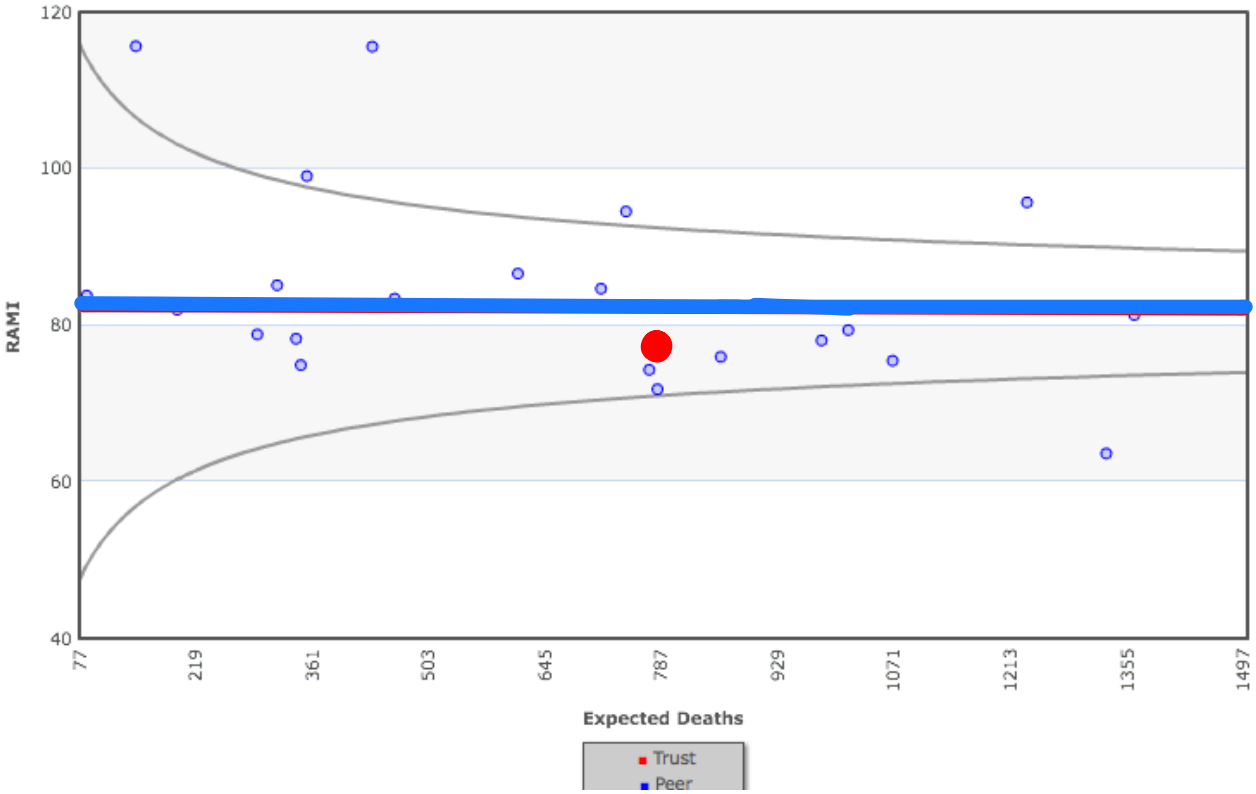
Our Standardised Mortality Ratio

Standardised mortality ratios show whether the death rate at a hospital is higher or lower than expected. It is an important marker of quality and safety. As well as internally reviewing all deaths that occur in the Trust every month, we use three external and independent benchmarking tools to monitor our mortality rates. We are pleased to report that the Trust's standardised mortality ratio continues to remain well below that expected of a Trust of our type and size.

Mortality rates are an important performance indicator. They describe whether the number of deaths within a hospital is greater or less than might be expected given the characteristics of the patients treated. Their age, how sick they were before admission and the severity of their illness all have an effect on whether a patient lives or dies. No two hospitals treat exactly the same population of patients and therefore mortality indicators make adjustments for the differences so that hospitals across the NHS can be compared with each other.

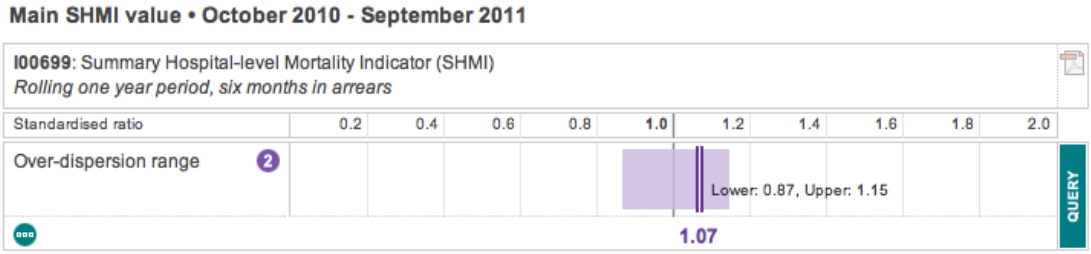
The Trust monitors its mortality rate using three different indicators calculated by independent observers. The indicators are; risk adjusted mortality index (CHKS), hospital standardized mortality ratio (Dr Foster), Summary Hospital Mortality Indicator (NHS Information Centre). Each of these indicators is calculated in a slightly different way. However, each indicator demonstrates that deaths within the Trust occur at a rate either below the National average or at the rate expected given the characteristics of the patients we treat**.**

Risk Adjusted Mortality Index (RAMI) for January 2011 to December 2011



The RAMI looks at the fate of virtually all patients admitted to the Trust. The two curved lines running horizontally across the graph indicate the limits within which the Trust's mortality rate and that of other Trusts is expected to fall. The Trust's mortality rate (red circle) is seen to lie well within these limits and is indeed slightly better than the average rate which is indicated by the horizontal blue line.

Summary Hospital- level Mortality Indicator (SHMI) for June 2010 to June 2011



The graph above demonstrates that using this method the mortality indicator for the Trust is 1.07 and lies within confidence range (0.87 – 1.15) given the characteristics of the patients whom we treat.

The SHMI treats mortality data in a different way to the RAMI. In addition to those deaths that occur in-hospital the SHMI also considers deaths, which occur within 30 days of leaving hospital. The graph above demonstrates that using this method the mortality indicator for the Trust is 1.10 and lies within the expected limits (0.9 – 1.15) given the characteristics of the patients whom we treat.

Hospital Standardised Mortality Rate (HSMR) April 2010 to March 2012

The HSMR, in contrast to the RAMI and SHMI, looks at whether patients within a specified group of 56 diagnoses were either more or less likely to survive their admission to hospital. The Trusts mortality rate by this measure is seen, in the graph above, to be below the National average. In other words patients admitted to Weston General Hospital were on average more likely to survive when compared to the performance of Trusts nationally.

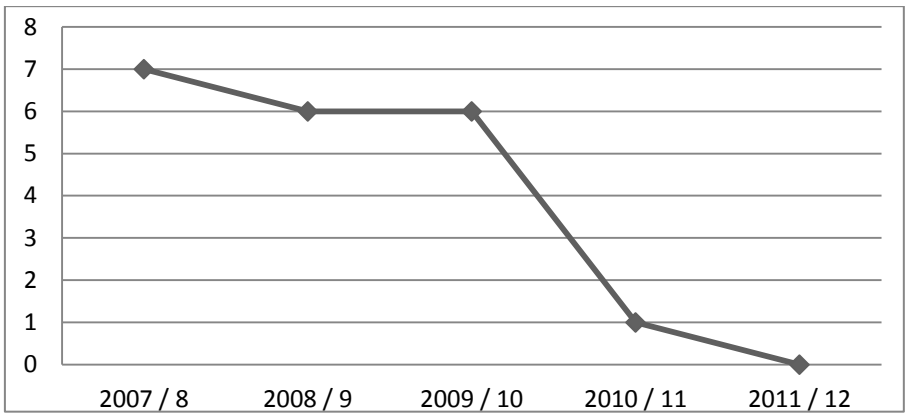
National targets

Infection prevention and control

MRSA blood infections

During the year the Trust was able to continue to demonstrate excellence in care in having no MRSA blood infections known as MRSA bacteraemias. This means that we achieved the target we were set. We have worked hard to reduce our infection rates and this year we were one of only four acute hospitals in the South West to achieve this level of performance. We aim to continue to achieve this level of performance in the future.

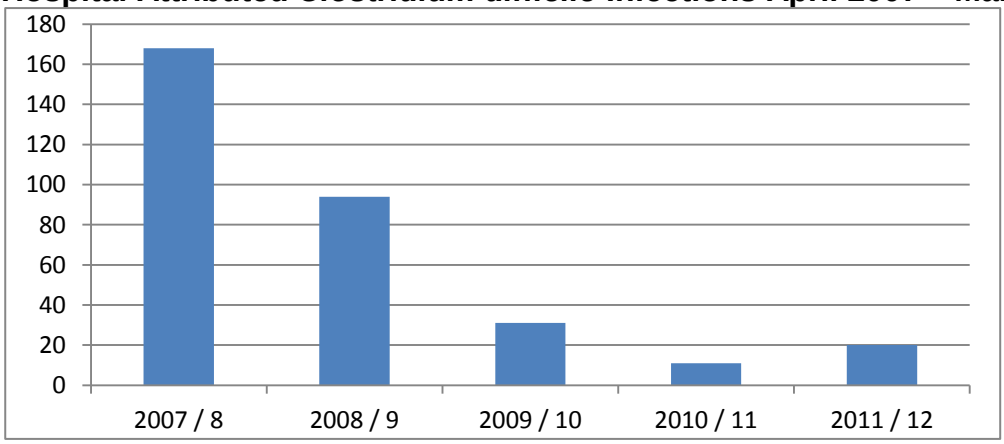
Hospital Attributed MRSA Bacteraemias April 2007 – March 2012



Clostridium difficile Infections

We were set a challenging expectation of maintaining the number of hospital attributed *Clostridium difficile* infections to no more than 16 cases. This was the result of our outstanding performance in 2010/11 year when we only recorded 11 cases against a target of 32. Whilst we are disappointed that we have exceeded the target this year with 20 cases, we remain firmly in the top half comparing out rates with all other Trusts in the Southwest. Each case is investigated using root cause analysis and from these we gain an understanding of the source and reasons for the infections occurring. It is clear that although a significant number of cases began before admission to the hospital, some of the cases could potentially have been prevented with more rigorous application of isolation precautions and antibiotic stewardship. We are now reviewing our efforts to reduce the incidence of these infections during 2012 – 13, and aim to repeat or exceed performance of last year. The nationally determined target for the Trust for 2012/13 is for a maximum of or less than 12 cases.

Hospital Attributed *Clostridium difficile* Infections April 2007 – March 2012



Emergency Department

The Trust has continued to experience significant variations in the number of patients attending our Emergency Department. On a number of days last year we saw more patients in Emergency Department than ever before resulting in an increased number of admissions. The levels of activity were 1.4% ahead of last year and this was against a planned reduction of 10% in attendances.

The local expectation of a planned reduction in the number of beds used by the Trust has not been achieved due to the volume of admissions both through A&E and directly from local GP's.

We experienced difficulties achieving the national target to diagnose, treat, discharge or admit 95 per cent of patients within four hours, the national target was achieved in Quarters 2 and 3, however for the year we have not achieved the target.

Daily A&E attendances by quarter

	2011/12 Attendances	% change on yr	Performance
Quarter 1	13246	-0.20%	92.81%
Quarter 2	13340	-1.21%	95.13%
Quarter 3	12365	0.90%	95.25%
Quarter 4	12169	2.06%	89.92%
Year 2011/12	51120	0.34%	93.32%

National standards require that after being referred to the Trust, 90% of patients should not wait longer than 18 weeks to be treated. The Trust has achieved this national target each month this year and for the year 92.5% of patients have been treated within 18 weeks.

ACCESS AND WAITING TIMES	TARGET	2011/12
REFERRAL TO TREATMENT (RTT) ADMITTED	90%	92.33%
RTT NON ADMITTED	95%	96.6%
RTT ADMITTED 95th PERCENTILE	23weeks	22.3weeks
RTT NON ADMITTED 95th PERCENTILE	18.3weeks	17.4weeks

As detailed in the above table the Trust met all national targets for both admitted and non admitted treatments within 18 weeks. Significant progress has also been made on reducing the waiting times of patients who were not treated within 18 weeks.

Cancer

We have consistently achieved the target that all patients urgently referred by their GP with suspected cancer should wait no longer than two weeks for their first appointment.

Subsequent treatment targets within 31 and 62 days have also been met consistently through the year.

All of our patients were treated within 31 days for second or subsequent treatment for cancer and both targets for NHS cancer plans within 31 and 62 days were achieved.

NB. Figures below are from April 11 to February 2012. March Figures will be available at the end of May prior to publication of the report in June

CANCER TREATMENT AND REFERRALS	TARGET	2011/12
2 Week Wait from referral to appointment	93%	96.47%
31 days for second or subsequent treatment Surgery	94%	100%
31 days for second or subsequent treatment drug	98%	100%
NHS Cancer plan standard 31 days	96%	99.78%
NHS Cancer Plan standard 62 days	85%	92.28%

Same sex accommodation

We are fully compliant with the Government's requirement to ensure that our patients do not share sleeping accommodation with members of the opposite sex, unless it is in the overall best interests of the patient, for example, in critical care.

Since October 2010, following the opening of our Acute Care Unit, patients have not had to share sleeping accommodation with members of the opposite sex. It is regrettable that in February 2012, due to intense pressures and an unprecedented increase in attendance to our Emergency department, it became clinically necessary to place males into a partially occupied female bay. Through the movement of these patients over the following 2 hours, it resulted in 9 patients experiencing sharing accommodation with a member of the opposite sex. This situation is demonstrably not the norm and will continue to be avoided unless patient care is at risk.

Feedback on our Quality Accounts

Statement from NHS North Bristol, North Somerset and South Gloucester Primary Care Trust

NHS Bristol, North Somerset and South Gloucestershire have reviewed the Weston Area Health Trust Quality Account document for 2011–2012 and believe that this provides a fair reflection of the work of the Trust and includes the majority of mandatory elements required.

We have reviewed the data presented and are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with the data supplied by Weston Area Health Trust for 2011/12 which is reviewed as part of their performance under the contract during the year.

We continue to work with the Trust to ensure that patient safety, data accuracy and information governance at all levels remains a key priority.
The account identifies significant progress in relation to:

- The sustained reduction of healthcare associated infections (HCAI) particularly MRSA bacteraemias
- High levels of compliance with Venous Thrombo Embolism (VTE) screening
- Reducing patient falls by 20%
- The introduction of 'SKINN bundles' to support patients at risk of pressure ulcers

We will continue to work closely with Weston Area Health Trust to implement a more integrated approach to caring for patients across the three domains of quality: patient safety; clinical effectiveness and patient experience. This will include continuing to raise the profile for quality improvement.

The ongoing engagement of clinicians close working with primary care will remain crucial in monitoring standards and improving services for local people.

This Quality Account follows the Quality Accounts toolkit framework.

Part 1: Statement on quality from Chief Executive:	Good clear statement, which reflects an integrated care model approach to quality and patient safety**.**
Quality Account Requirements:	Department of Health Quality Accounts toolkit was used as the basic template for the Quality Accounts 2011-12 report.
Quality Priorities for 2012-13:	Partially compliant: The quality priorities have been illustrated using the three key domains outlined in Equality and Excellence:- Liberating the NHS document. • Safety • Effectiveness • Efficiency

Part 2:	
Statement of Assurance from the Trust Board:	For 2012-13: 17 priorities for improvement defined, have set clear goals and have provided evidence of how these will be monitored and measured
Clinical Audits	Partially compliant: Data excludes participation compliance
National Audits	Compliant
Local Clinical Audits	Compliant
Clinical Research	Compliant
CQUINS	Non Compliant: Refers to a route to request data rather than presenting the data in the account.
CQC	Compliant
Data Quality	Partially Compliant: Examples of data quality improvement evident but does not refer to sharing of information with the public Clinical coding error rate not included
NHS Number and General Medical Practice Code Validity	Complaint
Information Governance	Compliant
Part 3:	
Review of Quality Performance	Compliant
Statement from Directors responsible in respect of the Account	• Compliant
Independent Auditors Assurance Report	• Non Compliant: No Statement

Roger Pedley
Acting Chief Executive BNSSG Cluster

Statement from LINKS

No statement received.

Statement of Directors' Responsibilities in Respect of the Quality Report

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:-

- The Quality Account presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with the Department of Health guidance.

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

By order of the Board

25th June 2012 ..... Date ..... Chair

25/6/12 ..... Date ..... Chief Executive

Independent Auditor's Assurance Report for Weston Area Health NHS Trust Quality Report

I am required by the Audit Commission to perform an independent assurance engagement in respect of Weston Area Health NHS Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of 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 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of Weston Area Health NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

A limited assurance engagement is narrower 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.

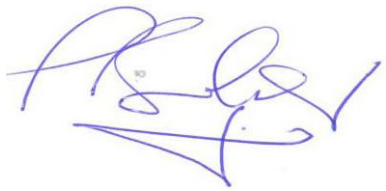
Limitations

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.



Peter Barber
Officer of the Audit Commission
Audit Commission
5th Floor, Block 3 Shire Hall
Westgate Street
Gloucester
GL1 2TG

27 June 2012

Annex 1

National Outpatient Survey 2011

Significant Differences between the Trust and the Average are indicated as Follows:

\+ scores significantly better than average
\+ scores significantly improved since 2009 survey
\- scores significantly worse than average

Trust The problem score for our Trust
Average Average score for all 'Picker' Trusts

Note that lower scores indicate better performance.

BEFORE THE APPOINTMENT

		Trust	Average	
2+	Had to wait more than 5 months for an appointment	2%	2%	
5	Not given choice of appointment time	59%	60%	+
6	Appointment changed to later date by Hospital	23%	23%	
7	Not fully aware what would happen during appointment	52%	54%	+

WAITING IN THE HOSPITAL

8	Appointment started more than 15 minutes after stated time	29%	40%	++
9	Patient waited for longer than they were told, or were not told how long the wait would be	64%	69%	

HOSPITAL ENVIRONMENT AND FACILITIES

10	Outpatient Department not clean	2%	1%	
11+	Toilets at the Outpatient Department not clean	5%	5%	

TESTS AND TREATMENT

13	Patient not clearly told why they needed tests	17%	22%	
14	Patient not told how they would find out test results	12%	16%	+
15	Staff did not clearly explain test results	25%	32%	+
17	Not fully told before treatment what would happen	21%	26%	++
18	Risks and/or benefits not fully explained before treatment	21%	26%	

SEEING A DOCTOR

20	Did not have enough time to fully discuss health or medical problem with doctor	20%	23%	
21	Doctor did not know enough about medical history	13%	15%	+
22+	Doctor did not fully explain reasons for treatment/ action	17%	21%	+
23	Doctor did not fully listen to what patient had to say	15%	18%	+
24+	Doctor did not always give clear answers to questions	22%	26%	+
25	Did not have full confidence and trust in doctor	16%	17%	

SEEING ANOTHER PROFESSIONAL

28+	Other member of staff did not always give clear answers to questions	22%	23%	
29	Did not have full confidence and trust in other member of staff	15%	16%	

OVERALL ABOUT THE APPOINTMENT

30+	Do not always see the same Doctor or member of staff	51%	59%	+
31	Not all staff introduced themselves	22%	28%	+
32	Staff talked in front of patient as if they weren't there	6%	12%	+
33	Not enough or no information given about condition or treatment	13%	16%	+
35	Staff contradicted one another	11%	12%	
36	Not fully involved in decisions about care or treatment	21%	27%	++
38	Staff did not ask patient what was important to them in managing their condition or illness	11%	11%	
39	Appointment did not help patient to better manage their condition or illness	14%	13%	

LEAVING THE OUTPATIENT DEPARTMENT

41	Patient not fully told how to take new medications	10%	15%	
42	Patient not fully told purpose of new medications	12%	17%	
43	Patient not told fully about side effects of medication	12%	17%	++
45	Reason for change to existing medication not fully explained	9%	17%	+
46+	Did not receive copies of all letters sent between Hospital Doctors and family GP	42%	41%	+
47	Not fully told about what danger signals to watch for	30%	32%	
48	Patient not given information on who to contact	28%	32%	+

OVERALL IMPRESSION

49	Reason for visit not dealt with completely to patients satisfaction	27%	25%	
50	Overall – not always treated with respect or dignity	8%	12%	++
51	Overall – care rated as fair or poor	6%	5%	

- Overall the Trust performs significantly better than other Trusts in 12 areas.
- **No** areas are significantly worse.
- The Trust has improved significantly in 13 areas since the 2009 Survey.

Written Comments Provided by Patients (Small Sample Only)

"Weston General Hospital operates a very high standard of care. Compassion and cleanliness".

"The friendliness of the staff in helping to put you at ease with the situation".
"The Doctor (lady) was very nice".

"Doctor ****** was very good at explaining everything".

"The Team are always professional, helpful and willing to offer help and advice in any way they can - a pleasure to see them all!"

"Calm, pleasant atmosphere".

"Staff very helpful and professional".

"The Doctor I saw was the one who carried out one operation to my hip, he was very efficient. Although I suffered pain after the operation this has now gone completely and I am very pleased that I had the operation done".

"My problem seemed to have been resolved on the same day; staff appeared to be professional and caring".

Valuing the survey results

Whilst the Trust has demonstrated continued improvement in the satisfaction of patients whilst using our Outpatient services, there remains room for improvement and an opportunity to become best in class. The Trust has shared the outcome of this survey widely with staff and the Patient and Public Engagement Group and has established plans to continue to improve on those areas of highest scoring areas. Progress against the plan will be reviewed by the Executive Committee and the Trust Quality and Governance Committee bi-annually, commencing in July 2012.

9	Patient waited for longer than they were told, or were not told how long the wait	64%	69%	
5	Not given choice of appointment time	52%	54%	
30+	Do not always see the same Doctor or member of staff	51%	59%	
7	Not fully aware what would happen during appointment	52%	54%	
46+	Did not receive copies of all letters sent between Hospital Doctors and family GP	42%	41%	+
47	Not fully told about what danger signals to watch for	30%	32%	
48	Patient not given information on who to contact	28%	32%	+

National Inpatient Survey 2011

The Trust has improved significantly on the following questions:

Lower scores are better

	2010	2011
A&E Department: not given enough privacy when being examined or treated	30 %	22 %
Hospital: shared sleeping area with opposite sex	8 %	3 %
Hospital: patients using bath or shower area who shared it with opposite sex	10 %	3 %
Nurses: did not always wash or clean hands between touching patients	20 %	14 %

The Trust has worsened significantly on the following questions:

Lower scores are better

	2010	2011
Planned admission: not offered a choice of hospitals	44 %	60 %
Overall: not asked to give views on quality of care	73 %	81 %

Your results were significantly better than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Hospital: shared sleeping area with opposite sex	3 %	8 %
Hospital: patients in more than one ward, sharing sleeping area with opposite sex	2 %	5 %
Hospital: patients using bath or shower area who shared it with opposite sex	3 %	13 %
Hospital: toilets not very or not at all clean	3 %	6 %
Hospital: hand-wash gels not available or empty	2 %	3 %

Questions where more than 50% of respondents reported room for improvement are listed below.
Focusing on these areas could potentially improve the patient experience for a large proportion of your patients.

N.B. Questions where less than 50 patients answered the question have been highlighted with [-]

scores significantly better than average — **Trust** — The problem score for your Trust
scores significantly worse than average — **Average** — Average score for all Picker trusts

Lower scores are better

	Trust	Average	
Discharge: delayed by 1 hour or more	88 %	84 %	
Overall: not asked to give views on quality of care	81 %	77 %	−
Planned admission: not given choice of admission date	70 %	63 %	−
Discharge: not fully told side-effects of medications	69 %	61 %	−
Hospital: nowhere to keep personal belongings safely	69 %	63 %	−
Care: could not always find staff member to discuss concerns with	65 %	58 %	−
Care: not enough opportunity for family to talk to doctor	64 %	55 %	−
Discharge: not fully told of danger signals to look for	61 %	55 %	−
Planned admission: not offered a choice of hospitals	60 %	61 %	
Hospital: patients moving ward bothered by sharing sleeping area with opposite sex	[56] %	30 %	
Discharge: family not given enough information to help	54 %	50 %	
Hospital: bothered by noise at night from other patients	53 %	38 %	−
Care: wanted to be more involved in decisions	51 %	46 %	−
Discharge: was delayed	50 %	40 %	−