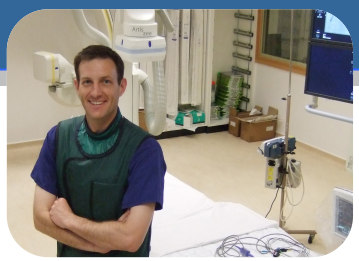
Weston Area Health NHS
NHS Trust

Quality Accounts 2012/13



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We welcome comments from readers of our Quality Accounts –

By post

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By email

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Introduction - Quality Account Requirements

Since April 2010 all providers of NHS services are required to produce an annual set of Quality Accounts, so this is the third year that we have published a mandatory Quality Account.

Quality Accounts are annual public reports from providers of NHS healthcare about the quality of services they deliver. The primary purpose of Quality Accounts is for healthcare organisations to assess quality across all of the healthcare services they offer and to demonstrate a commitment to continuous, evidence-based quality improvement..

As required by law, this report is set out as follows:

- Part 1 is our view of the quality of our services and includes a certificate from our Chief Executive;
- Part 2 starts with the list of information required by the regulations, and then goes on to explain the progress we have made with the quality priorities we set in 2012/13 and describe our priorities for improvement for 2013/14;
- Part 3 gives some extra information that will help readers understand all that we are doing. This includes a description of what we have done since the Francis Report was published and some information about many of our services that are not included in the pieces of information the regulations say we must show in Part 2.
- At the end of these Quality Accounts is an annex with copies of comments made about our Quality Accounts by three of the bodies who monitor what we do. This year we have also invited our Patients' Council to make some comments.

All this 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.

Part 1 – Statement summarising the provider's view of the quality of the Trust's services

At Weston Area Health NHS Trust we are striving to deliver the highest level of quality and safe care to our local population. The Trust Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the Single Operating Model (SOM) Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

We were ranked in the top six most clinically efficient hospitals in the country in the December 2012 Dr Foster Hospital Guide (based on data from April 2011 through to March 2012). The Guide, which is completely independent of the Trust and indeed the NHS, particularly highlighted Weston General Hospital for having the smallest percentage in England of patients readmitted to hospital within seven days.

A jewel in Weston's crown was identified by Dr Foster as its hip replacement service, which scored very highly, largely because of the very low number of patients requiring any revision to their surgery later on. We also performed well in categories relating to: high numbers of procedures performed as day cases and low lengths of stay for patients having elective procedures, such as hip and knee replacements.

Weston Area Health NHS Trust Medical Director Mr Nick Gallegos said at the time: "In an exceptionally tough financial environment for the NHS, the Trust welcomes the Dr Foster analysis of the hospital's performance, which reflects the very hard work put in by staff from all Departments within the Trust.

"Going forward into the next financial year, it is essential that the Trust continues to make the most efficient use of its valuable resources.

"The extremely good outcome for our elective hip replacement service is a tribute to the skill of our orthopaedic team and the dedication of all the staff who support the care of these patients."

We are not complacent and we know that there are areas of our service that we could and should improve. By putting information about the quality of services in our organisation into the public domain we are offering our approach to quality up for scrutiny, debate and reflection. We want our Quality Accounts to assure commissioners, patients and the public that we are regularly scrutinising each and every one of our services, concentrating on those that need the most attention."

About the Trust

Weston Area Health NHS Trust was established in April 1991 as one of the first wave of 57 NHS Trusts created following the enactment of the NHS and Community Care Act 1990. The Trust is based at Weston General Hospital, built in 1986 near Uphill in the south of Weston-super-Mare.

The Trust provides a wide range of acute and rehabilitation hospital services, as well as some community health services primarily to residents of the North Somerset area. Services are provided on a contractual basis to local health bodies that are responsible for purchasing health care for the resident population.

North Somerset has a resident population of around 202,000 people with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year. Life expectancy in North Somerset for both men (79.6 years) and women (83.8 years) in 2012 was higher than both the South West and England average – one result is that there is a much greater proportion of patients aged 65 and over than for the rest of the South West or for England.

Weston Area Health NHS Trust provides clinical services from three sites. The General Hospital is located in the main town of Weston super Mare and there are two children's centres providing community children's services located in Weston super Mare and Clevedon.

The Trust provides a wide range of acute health services to the population of North Somerset and Sedgemoor and works closely with other hospitals in Bristol as part of 'clinical networks' including, for example, cancer, pathology and cardiology.

The Trust is registered without conditions with the Care Quality Commission (CQC), the independent regulator of health and social care in England.

The majority of clinical activity was commissioned by North Somerset Primary Care Trust.

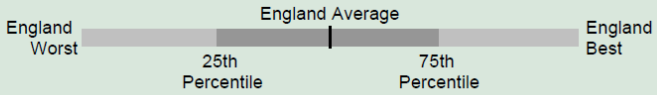
The health summary for North Somerset on the next page is from the Department of Health © Crown Copyright 2012, and gives a more detailed picture of the health of the local population:

Health summary for North Somerset

E06000024

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	19941	9.6	19.8	83.0		0.0
	2	Proportion of children in poverty ‡	5610	15.4	21.9	50.9		6.4
	3	Statutory homelessness ‡	79	0.9	2.0	10.4		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1325	57.5	58.4	40.1		79.9
	5	Violent crime	2838	13.6	14.8	35.1		4.5
	6	Long term unemployment	295	2.3	5.7	18.8		0.9
Children's and young people's health	7	Smoking in pregnancy ‡	215	9.8	13.7	32.7		3.1
	8	Breast feeding initiation ‡	1720	79.4	74.5	39.0		94.7
	9	Obese Children (Year 6) ‡	296	15.9	19.0	26.5		9.8
	10	Alcohol-specific hospital stays (under 18)	14	33.8	61.8	154.9		12.5
	11	Teenage pregnancy (under 18) ‡	118	33.3	38.1	64.9		11.1
Adults' health and lifestyle	12	Adults smoking ‡	n/a	15.9	20.7	33.5		8.9
	13	Increasing and higher risk drinking	n/a	23.6	22.3	25.1		15.7
	14	Healthy eating adults	n/a	30.0	28.7	19.3		47.8
	15	Physically active adults ‡	n/a	11.3	11.2	5.7		18.2
	16	Obese adults ‡	n/a	25.2	24.2	30.7		13.9
Disease and poor health	17	Incidence of malignant melanoma	31	14.2	13.6	26.8		2.7
	18	Hospital stays for self-harm ‡	398	212.1	212.0	509.8		49.6
	19	Hospital stays for alcohol related harm ‡	4806	1706	1895	3276		910
	20	Drug misuse	1326	10.1	8.9	30.2		1.3
	21	People diagnosed with diabetes ‡	8910	5.2	5.5	8.1		3.3
	22	New cases of tuberculosis	12	5.7	15.3	124.4		0.0
	23	Acute sexually transmitted infections	1525	719	775	2276		152
	24	Hip fracture in 65s and over ‡	261	409	452	655		324
Life expectancy and causes of death	25	Excess winter deaths ‡	150	23.0	18.7	35.0		4.4
	26	Life expectancy – male	n/a	79.7	78.6	73.6		85.1
	27	Life expectancy – female	n/a	83.9	82.6	79.1		89.8
	28	Infant deaths ‡	8	3.6	4.6	9.3		1.2
	29	Smoking related deaths	332	165	211	372		125
	30	Early deaths: heart disease and stroke ‡	128	47.7	67.3	123.2		35.5
	31	Early deaths: cancer ‡	240	91.1	110.1	159.1		77.9
	32	Road injuries and deaths ‡	51	24.6	44.3	128.8		14.1

‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2009 3 Crude rate per 1,000 households, 2010/11 4 % at Key Stage 4, 2010/11 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2010/11 6 Crude rate per 1,000 population aged16-64, 2011 7 % mothers smoking in pregnancy where status is known, 2010/11 8 % mothers initiating breast feeding where status is known, 2010/11 9 % school children in Year 6 (age 10-11), 2010/11 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2008-2010 12 % adults aged 18 and over, 2010/11 13 % aged 16+ in the resident population, 2008/2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % aged 16 and over, Oct 2009-Oct 2011 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2006-2008 18 Directly age sex standardised rate per 100,000 population, 2010/11 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2009/10 21 % people on GP registers with a recorded diagnosis of diabetes 2010/11 22 Crude rate per 100,000 population, 2008-2010 23 Crude rate per 100,000 population, 2010 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2010/11 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.07-31.07.10 26 At birth, 2008-2010 27 At birth, 2008-2010 28 Rate per 1,000 live births, 2008-2010 29 Directly age standardised rate per 100,000 population aged 35 and over, 2008-2010 30 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 31 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 32 Rate per 100,000 population, 2008-2010

To the best of my knowledge the information in this document is accurate.

Nick Wood
Chief Executive

Part 2.1 – The quality of our services during 2012/2013

This is information relevant to the quality of relevant health services provided or sub-contracted by the Trust during the reporting period. The numbers in the headings refer to the numbered paragraphs in the regulations.

Please note - the regulations require us to use data made available to the Trust by the Health and Social Care Information Centre covering the "reporting period" of 2012/13. Like other Trusts, we have used the most recent data available – for example SHMI/palliative care data is up to June 12; PROMs are up to Sep 2012 but readmissions are only to March 2011. Wherever practicable we will update the data before these accounts are published in June. ** indicates a new dataset for 2012/13 so 2011/12 data is not yet available.

1. The number of different types of our services

During 2012/13 the Weston Area Health NHS Trust provided NHS 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 during 2012/13 include:

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
- Gastroenterology
- Rehabilitation

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

1.2 The income generated by the NHS services reviewed in 2012/13 represents 100% of the income generated from the provision of NHS services by the Trust for 2012/13.

2. Participation in national clinical audits

During 2012/13, 30 national clinical audits and 3 national confidential enquiries covered NHS services that Weston Area Health NHS Trust provides.

2.1. During that period Weston Area Health NHS Trust participated in 80% national clinical audits and 100% national confidential enquiries of those which it was eligible to participate in. There were a small number of national audits that we chose not to undertake for various reasons, for example because we had prioritised other audit or research work in that area, or our patient case mix did not meet the audit criteria.

The national clinical audits and national confidential enquiries that Weston Area Health NHS Trust was eligible to participate in during 2012/13 are as follows:

2.2 Name – eligible audit and enquiry	2.3 Did the Trust participate?	2.4 % of eligible cases submitted
NCEPOD Subarachnoid Haemorrhage	✓	NA
NCEPOD Alcoholic Liver Disease	✓	NA
NCEPOD Cardiac Arrest Procedures	✓	NA
Adult Community Acquired Pneumonia	✓	100%
Adult Critical Care (ICNARC)	✓	NA
Emergency Use of Oxygen	✓	NA
National Enquiry into Patient Outcome and Death	✓	NA
National Joint Registry	✓	NA
Non-invasive Ventilation	✓	NA
Renal Colic	✓	62%
National Comparative Audit of Blood Transfusion Programme	✓	NA
Bowel Cancer	✓	NA
Head and Neck Oncology	✓	NA
Lung Cancer	✓	NA
Oesophago-gastric Cancer	✓	NA
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	NA
Cardiac Arrhythmia	✓	NA
Heart Failure	✓	NA
Inflammatory Bowel Disease	✓	NA
National Review of Asthma Deaths	✓	NA
Fractured Neck of Femur	✓	74%
Hip Fracture Database (NHFD)	✓	NA
National Audit of Dementia (NAD)	✓	90%
Sentinel Stroke National Audit Programme (SSNAP)	✓	NA
Elective Surgery (PROMs)	✓	NA
Epilepsy 12 Audit (Childhood Epilepsy)	✓	NA

2.2 Name – eligible audit and enquiry	2.3 Did the Trust participate?	2.4 % of eligible cases submitted
Paediatric Fever	✓	100%
Severe Trauma (TARN)	X	-
National Cardiac Arrest Audit (NCAA)	X	-
Adult Asthma (British Thoracic Society)	X	-
Diabetes (Adult) ND(A)	X	-
Parkinson's Disease	X	-

"NA" means the audit is ongoing and so the final number of cases submitted is still to be measured. "X" shows the Trust did not participate in those audits, generally because staff time and availability was limited.

2.5 The report of one national clinical audit published during the reporting period:

- *Emergency Use of Oxygen was reviewed by the Trust in 2012/13*.

2.6. Weston Area Health NHS Trust intends to take the following actions to improve the quality of healthcare provided

- *The audit report has been shared with the appropriate patient-facing staff at the Trust to enable them to learn from the conclusions of the audit.*

2.7. Weston Area Health NHS Trust reviewed 108 local clinical audit reports during 2012/13. Some examples of the types of audit and a summary of their results are:

Patient Satisfaction following Pelvic Floor Surgery	*Response rate 40%, feedback overall very positive (5 negative) and results confirming previous audits.*
Outcomes of hysterectomy for benign disease not including prolapse	*Met all standards for serious risk from bladder injury; slightly more complications in women with fibroid uterus and who had subtotal hysterectomy.*
Diagnosis and management of acute pancreatitis	*99% of patients correctly diagnosed within 48 hours; 62% of severe cases referred to ITU.*
Radial head replacements in elbow trauma	*Outcome depending on severity of initial injury.*
Cardiac Rehabilitation Programme Satisfaction Survey	*Overall patients found the sessions 'very' or 'quite' interesting. 'Relationships' as a topic was the least interesting.*
Speech and Language Therapy Dysphagia recommendations	*Food texture recommendations followed 100% of the time; fluid consistency 93%, additional 62.5%*

2.8. The actions the Trust intends to take to improve the quality of healthcare following the review of reports identified under entry **2.7** include:

- *Each clinical audit is reviewed by the specialist Clinical Audit Team, and the outcomes of the audits are shared with relevant staff and linked to the appropriate CQC outcome.*

The Clinical Audit Team maintain a register of all local (and national) audits, their results, and the subsequent actions by the Trust.

3. Our Participation in Clinical Research

Research and Development Team

Taking part in clinical research shows the Trust's commitment to improving the quality of care we offer and to making our contribution to the wider health economy. Active participation in research enables staff to remain up to date with the latest treatments and so contributes to achieving the best outcomes for our patients.

Last year 384 patients were recruited to participate in research approved by a research ethics committee.

As a Trust we participated in 67 clinical research studies from April 2012 to April 2013. We used the nationally recommended systems and protocols to manage these studies. In total, 26 NIHR (National Institute of Health Research) portfolio studies began in 2012/13, with an average approval time of 19 days. (The 'average' used is the median.)

During the year, 90 clinical staff across our clinical services participated in approved research.

The range of studies was:

Study Name	Covering	Number of patients recruited
ACO (NCRN 165)	Bowel cancer	4
ACTID PLUS	Diabetes	1
ADDRESS II	Diabetes	2
BADBIR	Dermatology	5
Biliary Tract Cancer QoL Validation	Gastrointestinal Cancer	5
Bowel Screening Study	Bowel Cancer	1
BSRBR	Rheumatology	6
CACHE	Cardiology	1
ChOPIN	Gastroenterology / Gastrointestinal cancer	14
CLOTS III	Stroke	1
CODIFI	Diabetes	3
CONSTRUCT	Gastroenterology	14
DARE	Diabetes	148
DELAY	Rheumatology	3
EPOC B	Bowel cancer	1
EORTC	Cancer (all sites)	6
eTHoS	Surgery	1
FAST-Forward	Breast cancer	14
IMPORT HIGH	Breast cancer	10
LaMB	Bladder cancer	1
LOPAS II	Rheumatology	2

Study Name	Covering	Number of patients recruited
New EPOC	Bowel cancer	1
NSCCG	Bowel cancer	8
NSHLG	Lymphoma	2
PATCH	Prostate cancer	2
PACIFICO	Leukaemia	1
PBC Genetics study	Gastroenterology	2
PD DNA	Parkinson's disease	33
PD Gen	Parkinson's disease	4
POETIC	Breast cancer	5
Pred 4	Gastroenterology	4
PREFER in AF	Cardiology	9
Questionnaire to assess Diabetes-Specific self care behaviour	Diabetes	2
RADICALS	Prostate cancer	4
Reach and Grasp	Stroke	1
SCOT	Bowel cancer	3
SMART	Lung cancer	1
SORCE	Kidney cancer	1
STAMPEDE	Prostate cancer	4
STARRCAT	Rectal cancer	1
STOPAH	Gastroenterology	4
Subsets	Rheumatology	4
Supremo	Breast cancer	2
T Cell studies in Type 1 Diabetes	Diabetes	2
Tran-sorce	Kidney cancer	1
TrialNet	Diabetes	6
UK Genetic Prostate Cancer Study	Prostate cancer	4
Yorkshire Heart	Cardiology	26
Holdfast - ethnographic heart failure	Cardiology	1
Revive	Emergency care	3
		384

4. Quality improvement and innovation goals (CQUIN)

Trust income in 2012/13 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because CQUIN was part of the block framework.

5. 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 the Trust's current registration status is 'registered without conditions or restrictions'. The CQC did not take any enforcement action against the Trust in the year 2012/13.

6. CQC reviews (not req'd for 12/13)

7. CQC special reviews

Weston Area Health NHS Trust has not participated in any special reviews or investigations by the CQC (under section 48 of the Health and Social care Act 2008) during the reporting period.

8. Hospital Episode Statistics

Hospital Episode Statistics (HES) is a data warehouse containing 125 million admitted patient, outpatient and accident and emergency records each year from all NHS hospitals in England. This data is collected during a patient's time at hospital and allows hospitals to be paid for the care they deliver. HES data is also used by the Secondary Uses Service (SUS) Programme, which supports the NHS and its partners by providing a single source of comprehensive data for planning, commissioning, management, research, audit, public health, and Payment by Results (a reimbursement mechanism for acute care payments).

The data below are provided by the Health and Social Care Information Centre and show the quality of records submitted by Weston Area Health NHS Trust to the Secondary Uses Service during 2012/13 for inclusion in the Hospital Episode Statistics which are included in the latest published data.

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
% of records including the patient's valid NHS number:					
Admitted patient care	99.7%	99.7%	98.7%	n/a	n/a
Outpatient care	99.8%	99.8%	99.0%	n/a	n/a
Accident and emergency care	98.6%	98.4%	93.3%	n/a	n/a
% of records including the patient's valid General Medical Practice Code:					
Admitted patient care	100.0%	100.0%	100.0%	100.0%	n/a
Outpatient care	100.0%	100.0%	99.9%	100.0%	n/a
Accident and emergency	100.0%	100.0%	99.8%	100.0%	n/a

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
care					

9. Information Governance Toolkit

Information Governance brings together all the legal rules, guidance and best practice that apply to the handling of information, keeping the information we hold about our patients and staff safe and secure. The Information Governance Toolkit is the way we demonstrate that we comply with the information governance standards set by NHS Connecting for Health, which is the part of the Department of Health Informatics Directorate that maintains and develops the NHS national IT infrastructure.

Our Information Governance Assessment Report overall score for 2012/13 was 67% and was graded green.

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

10. Payment by Results

Weston Area Health NHS Trust was subject to the Audit Commission Payment by Results clinical coding audit during 2012/13 which included a sample of 240 patients who attended the Accident & Emergency unit in Quarter 1 2012/13.

10.1 For the above period error rates for diagnoses and treatment coding (clinical coding) were 30% of attendances, leading to a change of 23.1% incorrect investigation codes and 27.3% incorrect treatment codes.

10.2 If all the errors are added together, there is a gross financial error of £3, 441. The Commissioner was potentially undercharged by £967 for the error in the sample.

11. Action we have taken to improve data quality

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

- *The Trust has a Data Quality Policy whose lead author is the Business Intelligence Manager. This policy, along with a wide range of others relevant to data quality, is regularly reviewed by the Trust's Health Informatics Committee which also monitors the work of the Information Governance Sub group.*

- *Other initiatives include, for example, the Trust having set up a Data Quality Improvement Group chaired by the Business Intelligence Manager and with a mixture of members representing end users, systems support, training, finance, and coding working in the Trust.*

- *A very wide range of data regarding quality and patient safety, operational performance, human resources and finance is discussed in depth and detail in the monthly Board public meetings. This helps to improve data quality and presentation through robust discussion, questioning and analysis by executive directors, non-executive directors, patients' representatives and members of the general public.*

- *Early in 2013 the Trust began to make more use of externally-available data such as CHKS statistics that are now being discussed at regular Divisional meetings to identify variances and learning-points. (CHKS is an independent provider of healthcare intelligence and quality improvement services.) This helps data quality by providing greater scrutiny of data collated and submitted for analysis.*

12. Summary hospital-level mortality indicator ("SHMI")

Standardised mortality rates are an important performance indicator of quality and safety. 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.

To help users of the data understand the SHMI values, trusts have been categorised into one of the following three bandings:

1 – where the trust's mortality rate is 'higher than expected'
2 – where the trust's mortality rate is 'as expected'
3 – where the trust's mortality rate is 'lower than expected'

The SHMI data below are provided by the Health and Social Care Information Centre.

(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period is:

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
(a) SHMI Value Banding	1.10 2	1.07 2	1.00 2	1.26 1	0.71 3

and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period:

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest

(b) % of deaths reported in the SHMI where the patient received palliative care	**	19.9%	18.4%	46.3%	0.3%

The Weston Area Health NHS Trust considers that this data is as described for the following reasons:

The Trust's mortality rate is within the parameters expected given the characteristics of the patients we treat.

The Weston Area Health NHS Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by:

- *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. The indicators are: Summary Hospital-level Mortality Indicator or SHMI (from the NHS Health and Social Care Information Centre); risk adjusted mortality index (CHKS – an independent hospital benchmarking company), and hospital standardized mortality ratio (Dr Foster – another independent provider of comparative information on health and social care services). Each indicator is calculated in a slightly different way, but each shows 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.*

- The Trust Board reviews mortality data every month in its Public Meeting. In February 2013, for example, the report included the statement "*The trend-line for the in hospital SHMI [is illustrated in the chart below] and demonstrates that since March 2012 mortality has been below the average experienced in the previous twelve months and comparable to or below that of our peer group. There has, however, been a month on month increase in mortality since October 2012. The Medical Director has reviewed this position and whilst at present further detailed analysis is not required it is being kept under constant review.*"

13 – 17 do not apply to acute trusts

18. Reported outcome measures scores for surgery

Patient reported outcome measures (PROMs) are short, self-completed questionnaires, which measure a patient's health status or health related quality of life at a single point in time. Patients are given the same survey both before and after their surgery. The difference between these survey responses is used to determine the outcome of the operation as perceived by the patient. The higher the outcome score, the greater the health gain. What is 'high' and what is 'low' varies greatly between surgical procedures, with, for example national scores for hip replacement ranging from 18.1 down to 2.5 while groin hernia surgery scores go from 0.16 down to -0.02. This would indicate that patients see and feel much more health benefit from hip replacement than they do from having a hernia repaired.

The data below are from the Health and Social Care Information Centre.

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
(i) groin hernia surgery	n/a	0.03	0.08	0.16	-0.02
(ii) varicose vein surgery	n/a	n/a	n/a	n/a	n/a
(iii) hip replacement surgery,	n/a	8.1	9.2	18.1	2.5
(iv) knee replacement surgery	n/a	5.4	3.1	10.1	-2.2

The Weston Area Health NHS Trust considers that the outcome scores are as described for the following reasons:

- *Patients undergoing hernia repair at the Trust are often elderly, frail, and frequently affected by other conditions which have a much greater impact on their quality of life. Hence when their hernia is repaired, often for the purpose of preventing future complications, there is likely to be relatively small gain in overall wellbeing. For hip and knee surgery the position is different. Osteoarthritis affecting the hip and knee joints has a significant impact on the quality of life which can therefore be enhanced considerably by joint replacement. Patients receiving a hip replacement achieve an improvement in their quality of life as measured by increased mobility, reduction in pain and the ability to go about their day to day activities. For those patients who undergo knee replacement surgery at Weston, the gains are even greater, well above the national average and placing the Trust amongst the top performing orthopaedic units in the country.*

The Weston Area Health NHS Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by:

- *Weston Area Health NHS Trust has a continuous focus on outcomes data from a variety of sources including PROMs and the National Joint Register and is committed to implementing change when the audit data suggests that improved outcomes will result.*

19. Readmitted to a hospital

The Trust seeks to minimise readmissions due to the impact on the patient. Whilst the ideal standard is zero, this is not always possible as patients can have multiple comorbidities or long-term conditions which require frequent medical attention.

The data below are from the Health and Social Care Information Centre and show the percentage of patients aged—
(i) 0 to 14; and
(ii) 15 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

	2011/12	2012/13			
National averages and highest/lowest peers	Weston	Weston	National average	Highest	Lowest

applicable to Weston:					
(i) 0 to 14	**	8.9%	10.2%	12.8%	6.3%
(ii) 15 or over	**	8.3%	10.9%	12.7%	7.1%

The Weston Area Health NHS Trust considers that these percentages are as described for the following reasons:

- *The population served by the Hospital has a much greater proportion of patients aged 65 and over than the rest of the South West or for England, and so patients at the Trust are often elderly, frail and frequently affected by other conditions.*

The Weston Area Health NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- *'Readmissions' are reported to the Trust Board in Public meeting every month, and all are monitored at regular Divisional Governance meetings where the Trust pays close attention to the reasons for the re-admission.*

20. Responsiveness to the personal needs of patients

An annual survey is carried out across the NHS of inpatient satisfaction and the data below is analysed and reported by the Health and Social Care Information Centre as an overall score for responsiveness to personal needs.

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100)	**	64.7	67.4	85.0	56.5

The Weston Area Health NHS Trust considers that this data is as described for the following reasons:

- *The proportion of patients who could find a staff member to discuss concerns with, and the proportion of patients who were given sufficient dignity, has improved since the previous year.*

- *The proportion of patients involved in care decisions and the proportion given appropriate information at discharge has deteriorated slightly since last year.*

The Weston Area Health NHS Trust has taken the following actions to improve this data, and so the quality of its services, by:

- *The Trust has established a Patients' Council which has a remit to challenge and hold the Trust to account on delivery of and improvement of excellent patient experience.*

- *A new Patients' Experience Strategy has been designed by the Patients Council in April 2013 to give direction to the Trust on actions to take to ensure a robust system is in place to both collect qualitative and quantitative data, respond effectively to complaints and demonstrate the lessons learned.*

21. Family and friends test

During 2012/13 the Government announced that it would be introducing the 'Friends and Family' test across the NHS. The test asks the following standardised question: "How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?". This will be assessed against a six-point response scale from 'extremely unlikely' to 'extremely likely' or 'don't know'. In line with national requirements the Trust will be publishing these results from June 2013.

The data below is published by the Health and Social Care Information Centre and is from the National NHS Staff Survey 2011. It shows the percentage of staff at the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. (The question in the survey is in two parts; part A, which is not to be reported in Quality Accounts, asks if staff would recommend the Trust as a place to work.)

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
Percentage who "agree" and "strongly agree"	**	46.9%	65.0%	89.5%	33.2%

The Weston Area Health NHS Trust considers that this percentage is as described for the following reasons:

- *Of the 750 staff who were surveyed, 53% responded, representing approximately one quarter of the total workforce. Conversely to the scores in the staff survey, the Trust was named in the list of the UK's top 40 hospitals for the eighth consecutive year compiled by CHKS (Comparative Health Knowledge Systems) and was ranked by Dr Foster as in the top 6 most clinically efficient hospitals in the country.*

The Weston Area Health NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- *TheTrust's 2013-2015 Business Plan includes these priorities under its 'People' objective:*
  - *Provide a safe and effective workforce*
  - *Develop and deliver a Health & Wellbeing plan*
  - *Develop a Communication strategy to drive two way communication and increase staff engagement*
  - *Review and develop effective organisation change and development tools.*

  These objectives will be achieved by a range of actions, for example by developing and delivering a leadership programme for all staff, by extending the 'Health and Wellbeing Days' held for staff, by surveying staff and encouraging

them to attend Board meetings, and by working with Divisional teams to encourage open, transparent improvement practices.

22 does not apply to acute trusts

23. VTE risk assessment

The data below are from the Health and Social Care Information Centre and show the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
Percentage of patients who were admitted to hospital and who were risk assessed for VTE	**	94.7%	94.3%	100.0%	84.6%

The Weston Area Health NHS Trust considers that this percentage is as described for the following reasons:

- *VTE assessment and preventative treatment was chosen as one of the Trust's Quality Priorities for 2012/13 and performance has been monitored from wards up to Trust Board monthly Public Meetings.*

The Weston Area Health NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- *Blood clots, or venous thromboembolisms (VTEs), 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. 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.*

24. C.difficile infection reported

The data below are from the Health and Social Care Information Centre and show the rate per 100,000 bed days of cases of C.difficile infection amongst patients aged 2 or over reported within the Trust during the reporting period.

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
Rate per 100,000 bed days of cases of C.difficile infection	19.5	Not yet available	Not yet available	Not yet available	Not yet available

The latest data available from the Health and Social Care Information Centre for 2012/13 and shown above is made up of the bed-days data for 2010/11 divided by the number of cases reported for 2011/12.
Weston Area Health NHS Trust considers that this rate is as described for the following reasons:

- *The two most commonly quoted risk factors for this infection are age (over 65 years) and receiving antibiotic treatment. Weston therefore has a large "risk group" since a high proportion of patients admitted to this hospital are over 65 years in age and up to a third of them are receiving antibiotic treatment at any one time.*

The Weston Area Health NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:

- *We have introduced revised guidelines which promote best practice for the prescription of antibiotics for medical patients.*
- *Early in summer 2013 we will be introducing a new drug prescription chart which has a new and separate section for antibiotics; this will help guide and inform the prescribing clinicians, dispensing pharmacists and nurses. From April 2013 any cases that develop in the hospital will be reviewed in greater detail using a new root cause analysis tool which will highlight in a clearer way any issues that may need to be addressed and communicated as necessary.*
- *We will undertake some sampling of the environment and patient care equipment in the first part of the year to identify any contamination which may require interventions such as changes in cleaning methods or frequencies. We have invested in new on site laundry equipment which will be installed at the beginning of 2013/14; this ensures that the decontamination processes comply with the latest national standards.*

The Trust's own internal data for 2012/13 shows the Rate per 100,000 bed days of cases of C.difficile infection as 18.6.

25. Patient safety incidents

The data below are from the Health and Social Care Information Centre and show the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of those patient safety incidents that resulted in severe harm or death.

	2011/12	2012/13			
National averages and highest/lowest peers applicable to Weston:	Weston	Weston	National average	Highest	Lowest
% of total Patient Safety Incidents resulting in serious harm or death	**	0.4%	0.9%	2.4%	0.1%
Number of Patient Safety incidents resulting in	**	4	16	69	2

serious harm or death.					

The Weston Area Health NHS Trust considers that this number and/or rate is as described for the following reasons:

- *The average for the South West Region is 11 patients and 0.4%. Weston Area Health Trust's result is therefore comparable to others in the region.*
- *The Trust actively encourages the reporting of incidents which affect patient safety to the National Patient Safety Agency, and is committed to learning from them to improve patient care in the future. Figures for the incidents reported in 2012/13 related to events which caused serious harm or resulted in the death of patient are in line with those reported by other small Trusts nationally.*

The Weston Area Health NHS Trust has taken the following actions to improve this number and/or rate, and so the quality of its services, by:

- *All patient safety incidents are thoroughly investigated, recommendations made and improvements put in place. In addition to local follow-up of each individual incident, the number of patient incidents month on month is reported to the Trust Board in public session along with descriptions of actions taken by the Trust.*

Part 2.2 - Our Progress Against Priorities for 2012/13

The tables on the following pages explain the priorities we chose for 2012/13 and how we performed.

How do we choose our priorities?

When we chose our Quality Priorities we used our experience from the previous two years as a start. In our Business Plan for 2013 – 2015 we defined our main strategic objective as to "Ensure that people have a positive experience of care, being treated in a safe environment that protects them from harm", and went on to select the Quality Priorities that would help us achieve that main objective. We have drawn on analysis of internal information (e.g. complaints and incidents) to identify priority areas. We have analysed information from external sources, such as the inpatient survey, to further inform our priorities.

How did we monitor our progress?

Throughout the year we reported on our progress to the Board of Directors, to our Service User Council (Patients' Council) and to our Commissioners. Every month our Trust Board looked in depth at a detailed 'Integrated Performance Report' of around 60 pages that sets out a range of performance indicators covering quality and patient safety, operational performance, human resources, and finance. Every other month our Quality and Governance Committee, which is a sub-committee of the Trust Board, reviewed all aspects of clinical effectiveness and outcomes, patient safety, and the patient and staff experience. The Committee received a detailed assurance report from each of the Trust's three operational Divisions (Emergency, Planned Care and Clinical Support). There was also a very wide range of operational committees and working-groups that work towards consistently achieving high standards in all the priority areas listed below and all the other areas that contribute to high-quality patient care.

Patient Safety

	Our **Patient Safety** Quality Priorities and why we chose them	What will success look like	How did we do?
In 2012/13 we said our No. 1 goal was:	**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.	We will 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. We will also reduce grade 2 and grade 3 pressure sores by at least 50%	*Despite an intensive programme of action being put in place we did not reduce the number of pressure sores as much as we set out to achieve in 2012/13. Five patients acquired a grade 4 pressure ulcer with a further nineteen patients acquiring a grade 3 ulcer.* *We have continued to improve on the use of the SSKIN specialist care bundle with 99% of patients at risk of pressure ulcers receiving the correct SSKIN bundle care in March 2013.* *We have invested in the most recent pressure relieving technology, procuring nearly 100 new specialist mattresses and 50 cushions.*

	Our **Patient Safety** Quality Priorities and why we chose them	What will success look like	How did we do?
In 2012/13 we said our No. 2 goal was:	**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%.	*We achieved this target.* *Although we had three months with no* C. difficile *at all, we did not achieve this target. We reported 19 cases in the year, a reduction on the 20 reported in 2011/12.* *We achieved this target. In 2011/12 there were 25 outbreaks of Norovirus necessitating wards being placed under restrictions, while in 2012 / 13 there were 11; a reduction of 56%.*

	Our **Patient Safety** Quality Priorities and why we chose them	What will success look like	How did we do?
In 2012/13 we said our No. 3 goal was:	**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.	*Overall the prevalence data for Falls Risk assessment submitted in March 2013 demonstrated that 99% of the patients had been risk assessed for their Falls Risk. If patients are assessed as high risk they would, for example, be placed in an area of the ward where they can be supervised as much as possible.* *The Matron lead for Falls Prevention is an active member of the North Somerset falls steering group which fulfils the role of the joint partnership working improvement group.*

	Our **Patient Safety** Quality Priorities and why we chose them	What will success look like	How did we do?
In 2012/13 we said our No. 4 goal was:	**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.	*By the end of January 2013 we had recorded 36 Serious Untoward Incidents against the 34 in the full year 2011/12, but this may be partly because we continue to encourage staff to report all incidents. A very large proportion of our 'serious incidents' are to do with pressure ulcers and, because of their age, our patients are particularly susceptible to those.* *However we did eradicate Never events in 2012/13.*

	Our **Patient Safety** Quality Priorities and why we chose them	What will success look like	How did we do?
In 2012/13 we said our No. 5 goal was:	**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.	*Every month medication incidents are reviewed in detail by nursing, pharmacy and governance staff enabling us to act quickly in addressing areas of concern. In 2012/13 we have focused on controlled drugs and blood thinning agents management and administration.* *We have reduced the proportion of medication errors that caused moderate or above harm from 13% in the first quarter of the year to 1% across the last quarter.* *Results of the national inpatient survey 2012 showed that 33% of patients were not fully told the purpose of medication and 70% were not fully told the side effects of their medication.*

	Our **Patient Safety** Quality Priorities and why we chose them	What will success look like	How did we do?
In 2012/13 we said our No. 6 goal was:	**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.	*We exceeded this goal, with 96% compliance year-to-date reported. Once we have assessed patients we use the "NHS Safety Thermometer", which is a template for nurses and other frontline healthcare workers to check basic levels of care and take appropriate action.*
In 2012/13 we said our No. 7 goal was:	**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	*We began to gather data on the use ODM technology in December 2012, and for the last quarter of 2012/13 this technique was used for between 80% and 95% of applicable patients.* *We have chosen this as one of our CQUIN (Commissioning for Quality and Innovation) targets for 2013/14, and will be aiming to move the percentage of eligible patients for whom Oesophageal Doppler Monitoring is used during surgery up to 90% by Quarter 4 2013/14.*

Patient Experience

	Our **Patient Experience** Quality Priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 1 goal was:	**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 one's 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 will 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%.	*We trained a nurse from each ward as 'End of Life Care Champions' embedding this into ward culture.* *Data from CHKS hospital activity data for the Trust shows that we achieved this target. Our efforts in hospital have helped to continue the increased numbers of people dying in the usual place of residence in North Somerset, now the highest in England at 51.5%. Numbers of people dying in the population are increasing but our numbers in hospital continue to decrease.* *We found that we do not have sufficient data to confirm if the change is from this initiative.* *An indication of our overall progress is that our End of Life Team was shortlisted for the BMJ Group National Awards, Clinical Leadership Team of the Year.*

	Our **Patient Experience** Quality Priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 2 goal was:	**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	*We implemented a process for screening patients in the Emergency Department for potential Dementia followed by a more detailed assessment of those in whom it was required.* *In the last 6 months of the year we screened 16% of eligible patients and carried out a more detailed assessment on 13% of patients.* *The pathway of care for an emergency patient with Dementia is to be admitted for assessment and then transferred to a recovery ward. This has been a flexible approach for 2012/13 and plans for a smoother pathway are to be discussed for 2013/14 with an established elderly care ward. A Care plan specifically for Cognitively impaired patients gives guidance and best practice for nursing staff to implement.* *63% of staff have completed the new online learning tool for Dementia care. It is designed to meet the needs of all levels of nursing and care staff.*

	Our **Patient Experience** Quality Priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 3 goal was:	**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%.	*We set up a 'Service Integration for Discharge' (SIDS) project to work with other hospitals and community services including the voluntary sector. The project has been reviewing and changing processes within the hospital (for example, 'TTO – To Take Out' prescriptions issued from the Hospital's pharmacy department) and outside the hospital (offering patients a Residential Home or Nursing Home bed whilst they await the start date of a care package).* *Our monthly Board and performance reports collect data on patients with a LOS longer than 10 days (not 14) so for consistency we worked to that figure. Although performance in the second half of the year did not meet target, we improved full year performance from 22% of patients with LOS over 10 days in 2011/12 down to 15% in 2012/13.* *We over-achieved this target. In 2011/12 46% of patients were discharged at weekends; in 2012/13 this increased to 54%.*
In 2012/13	**Improve patient**	Improve the	*Our scores in the 2012*

	Our **Patient Experience** Quality Priorities and why we chose them	What success will look like	How did we do?
we said our No. 4 goal was:	**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.	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	*national inpatient survey (published in February 2013) were mixed; significantly better than the previous year on 1 question, significantly worse on 3 questions and showing no significant difference on 54 questions. We did not significantly improve the satisfaction scores on the questions (on the left) we had intended.* *In comparison with other Trusts, we were significantly better than average on 4 questions, significantly worse than average on 40 questions, and average on the remaining 42 questions.* *In response we have increased initiatives like our 'Leadership Walkarounds' where Executive and Non-Executive Directors visit areas of the Hospital to see what they are like from the patients' perspective. We have also set up a Patients' Council and members of the Council have designed a new Patients' Experience strategy with 6 core objectives that include:* • *Effective methods of collecting patient*

	Our **Patient Experience** Quality Priorities and why we chose them	What success will look like	How did we do?
			feedback on their experience in a timely manner and in a way that patients feel free to articulate their true experience • *Engage patients and their families in influencing the way we deliver care and the services we provide.*
In 2012/13 we said our No. 5 goal was:	**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.	*We have set up a Patients' Council which now meets monthly. The Chair of the Patients' Council contributes to Trust Board meetings and members of the Patients' Council have designed a new Patient Experience strategy which is being considered by the Trust Board in May 2013.* *(The Patients' Council is what we are now calling the SUC.)*

Clinical Effectiveness

	Our **Clinical Effectiveness** quality priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 1 goal was:	**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 the 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.	*We implemented a standard Divisional Governance Report across all three of the Trust's Divisions, and strengthened the working links between Divisional Governance Leads, the Compliance Team and the Risk and Health and Safety Manager. One outcome was that we are better able to 'triangulate' our systems and processes, for example looking at individual Serious Incidents in detail with clinicians at Divisional level and then bringing together Trust-wide analysis of Serious Incidents in the Quality and Governance Committee and at Trust Board.*

	Our **Clinical Effectiveness** quality priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 2 goal was:	**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.	*With the Malnutrition Universal Screening Tool (MUST) now introduced and audited by dieticians, we have implemented an action plan – for example, we improved our documentation by separating 'food' and 'fluid' charts, and now have a training plan for volunteers who assist patients at meal-times.* *We have introduced an e-learning programme for staff and are rolling out a mandatory training plan for registered nurses and nursing assistants.*

	Our **Clinical Effectiveness** quality priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 3 goal was:	**Improve Communication between the Trust, GPs, 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	GPs 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 GPs 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.	*In 2011/12 the Trust piloted a technical solution to provide electronic inpatient discharge summaries to GP surgeries.* *The pilot was successful and enabled a final technical solution to be deployed for pilot surgeries in October 2012 and March 2013. We have been able to send over 2,000 electronic discharge summaries; the work-plan for 2013/14 will see the rollout of the technical solution to all remaining North Somerset GPs.* *Our SIDS (Service Integration for Discharge) Project is the collaborative discharge working group referred to here, and includes work-streams looking at Social Care Assessments and Community Services Assessments.*

	Our **Clinical Effectiveness** quality priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 4 goal was:	**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'.	*A team of Matrons has led this initiative with Ward Sisters leading implementation in their areas. We have installed floor signage to promote hand hygiene at all ward entrances. We have promoted patient ownership of medication on Kewstoke Ward including installation of small lockers for patients to safely store their own drugs. We continue to use safety crosses to identify in real time the number of incidents in that area including falls and pressure ulcers.* *Theatres have been working with Newton Europe to streamline theatre processes thus releasing time for direct patient contact. The World Health Organisation Surgical checklist has been fully embedded in theatres with 98% compliance recorded across 2012/13.*

	Our **Clinical Effectiveness** quality priorities and why we chose them	What success will look like	How did we do?
In 2012/13 we said our No. 5 goal was:	**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	*We have developed an Annual Audit Plan which is coordinated by our Clinical Audit Team. This includes a list of clinical audit priorities.* *Because of long-term staff sickness we were unable to coordinate this at Executive Director level for most of 2012/13. However, during 2013/14 our newly-refocused Clinical Audit and Effectiveness Committee will monitor any baseline assessments, action plans and audit plans and ensure that the outcomes of the audit are appropriately reported and disseminated throughout the organisation, and support service evaluation and improvements in the quality of care.*

Part 2.3 – How we intend to improve our quality for 2013/2014

Our Quality Priorities choices for 2013/14 have been very much based on learning and development from the significant work to choose the 2012/13 priorities and meet the needs and expectations of service users, commissioners and Trust staff. Our choices 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, as last year, are 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 Patients' Council and to our Commissioners.

On the following pages we have set out tables showing

- our chosen priorities for improvement
- the progress we have made since the last quality account
- how we will monitor and measure our progress to achieve these priorities; and
- how we will report progress to achieve these priorities.

Part 2.4 - Our Quality Priorities for 2013/2014

Patient Safety

Our **Patient Safety** Quality priorities for 2013/14 and why we chose them	What will success look like	How we will monitor, measure and report our progress
1. Further reduce the levels of healthcare associated infection, meeting national targets for reduction of MRSA and Clostridium difficile. *This has been a Quality Priority for the last three years because it has such a high impact on patient safety.*	We will have no MRSA blood stream infections We will have no more than 11 *C. difficile* infections	We will monitor progress through monthly infection prevention and control meetings. The Director Infection Prevention and Control will produce a quarterly report for the Quality and Governance Committee. Our Trust Board will also receive a full report at each monthly public meeting.
2. Reduce the levels of hospital acquired pressure ulcers. *Pressure ulcers are debilitating for patients and so have also been one of our highest-ranked Quality Priorities (along with infection control) ever since our first set of Quality Accounts We have not made the progress we would wish in this area and will continue a high focus on this area.*	We will have improved on our performance during 2012/13 when we limited levels to: Grade 1 7.48 Grade 2 32.48 Grade 3 2.27 Grade 4 0.27 (all per 1,000-bed-days)	We will report on the numbers and types of pressure ulcers, and the corrective action being taken, in our monthly Safety Thermometer and our 'Performance Assurance Framework' (which are reviewed by senior patient-facing staff). Our Trust Board will also receive a full report at each monthly public meeting.

Our **Patient Safety** Quality priorities for 2013/14 and why we chose them	What will success look like	How we will monitor, measure and report our progress
3. Improve timeliness of VTE *(venous thromboembolism)* risk assessment and prevent avoidable VTE *VTE (a blood clot) is a major contributor to severe illness or death in the UK. We have been steadily improving our performance and will continue to make this a Quality Priority.*	We will have further improved on our performance in 2012/13 – we set a target of at least 90% of patients to be assessed each month, and actually assessed a minimum of 93.5% of patients each month with a full-year total of 96% assessed.	We will report on VTE assessment and prophylaxis compliance and any corrective action necessary, in our monthly Safety Thermometer and our 'Performance Assurance Framework' (which are reviewed by senior patient-facing staff). Our Trust Board will also receive a full report at each monthly public meeting.
4. Reduce further the level of falls. *Many of our patients are very elderly, and this can put them at high risk of falls when they are moving around the wards. Whilst we have made some progress on reducing falls there is a need for us to reduce falls still further.*	We will have reduced the number of falls per 1,000 bed days – in 2012/13 we set a threshold of $\leq$4.7 falls per month, and although we achieved that as a full-year score, we missed our target in 7 out of 12 months.	We will report on the numbers and severity of falls, in our monthly Safety Thermometer and our 'Performance Assurance Framework' (which are reviewed by senior patient-facing staff). Our Trust Board will also receive a full report at each monthly public meeting.
5. Reduce the number of medication errors, focusing specifically on high risk medications and missed doses. *Medications safety is a crucial element of an overall patient safety programme. High risk medications such as blood thinning agents pose a greater risk of serious harm to patients if they are incorrectly prescribed or administered. Missed doses of medication can lead to significant harm for patients.*	We will have no medication errors leading to catastrophic harm. We will maintain the level of moderate and major harm at less than 5% across the year. We will reduce the number of reported missed doses by 20% from Q1 to Q4.	We will report on the numbers and types of medication errors, and the corrective action being taken, in our monthly 'Performance Assurance Framework' (which is reviewed by senior patient-facing staff). Our Trust Board will also receive a full report of 'serious incidents' at each monthly public meeting.

Patient Experience

Our **Patient Experience** quality priorities for 2013/14 and why we chose them	What success will look like	How we will monitor, measure and report our progress
1. Deliver dignified care that is responsive to patients' personal needs. *Patients told us in the national inpatient survey that we had only improved on two of the five indicators for how responsive we are to patients' personal needs*	We will have improved patient satisfaction scores for the following areas of the inpatient survey: • Care – wanted to be more involved in decisions • Care – could not always find a member of staff to discuss concerns with • Care – not always enough privacy when discussing condition or treatment • Discharge – not fully told of side-effects of medication • Discharge – not told who to contact if worried	We will gather and act on a wide range of qualitative data, such as • Ward observations by Patients' Council members, staff and volunteers who then discuss their findings directly with the Ward Sisters; • Real-time 'patient's stories' with volunteers trained to sit with patients and hear their experiences; • Showing an NPA (National Patients' Association) video in shopping centres and so on, and talking with the public about their experiences and impressions of the hospital. • "Ward Wednesdays", time reserved each week for Executive Directors and senior managers to leave their offices and spend time with patients and staff throughout the Hospital. We will monitor complaint themes and address any areas of concern through the performance assurance framework. We will conduct a monthly survey of inpatients.

Our **Patient Experience** quality priorities for 2013/14 and why we chose them	What success will look like	How we will monitor, measure and report our progress
2. Continue to support and strengthen the Patients Council. *We recognise that our ability to measure Patient Experience is critical to making changes and supporting staff in delivering best care. Our Patients' Council has a remit to challenge and hold us to account on the delivery and improvement of an excellent patient experience.*	An Executive Director will attend every Patients' Council meeting to hear news and views. The Patients' Council will hold a public Annual General Meeting where all members of the Council can make their views known.	The Chair of the Patients' Council (or their Deputy) will attend every Board meeting and will therefore be able to raise challenges directly with the Trust Board in public session. The Chair of the Patient's Council will report on progress within the 2013/14 Quality Account
3. Fully implement the Friends and Family test and improve the number of people who would recommend the Trust. *This is a national requirement and the measure helps us to understand the patient experience It is also one of the "learning milestones" we have set in our 'Patient Experience Strategy'.*	We will have met the national requirements for rolling out the Friends and Family programme to other areas including maternity services. We will have met the national requirement for improving the response rate in 2012/13. We will have improved on the proportion of staff who would recommend the hospital to family and friends in the national staff survey in the 2013/14 staff survey.	The results of the Friends and Family test will be reported to Trust Board within the Integrated Performance Report and discussed in public meeting.

Clinical Effectiveness

Our **Clinical Effectiveness** quality priorities for 2013/14 and why we chose them	What success will look like	How we will monitor, measure and report our progress
1. Review and reissue standards of practice and monitor compliance through the ward assurance framework. *It is essential to quality care that a consistent level of practice is applied wherever patients are cared for. This will provide a framework for staff to monitor their practice against.*	Clinical staff will have access to up to date policies, procedures and protocols to guide practice. Staff will be consistently applying standards that relate to safety and quality of care. The ward assurance framework will be used at Divisional and Corporate level to drive improvements.	Compliance to practice standards will be monitored monthly as part of the ward performance assurance framework.
2. Strengthen delivery of the CQUIN goals *CQUINs are an effective way of driving quality and effective care. The local CQUIN programme for 2013/14 has been developed with Commissioners to target areas of greatest impact across the Health community.*	We will meet the CQUIN (Commissioning for Quality and Innovation) targets as agreed with Commissioners.	Throughout 2013/14 there will be a Divisional Lead for each CQUIN, and data and performance on CQUINs will be included in our monthly reporting.
3. Implement a programme of clinical audit. *Clinical audit is an essential element of monitoring that enables the Trust to continually monitor the effectiveness of the care it provides. We did not achieve all our success factors in 2012/13 for clinical audit and we will therefore continue this focus in 2013/14.*	An audit plan will be developed for the Trust to meet local and national requirements. Implementation and outcome of audits will be monitored by the Clinical Audit and Effectiveness Committee and will ensure that lessons learned are embedded in practice across the Trust	Our Clinical Audit team hold a register of clinical audits throughout the Trust, which helps us to coordinate our work and share learning, and we have set up a new Clinical Audit and Effectiveness Committee which includes the Medical Director, the Director of Nursing, a Matron representative and a range of others who contribute to patient safety and the patient experience.

Part 2.5 - How we will monitor, measure and report on our progress

Managing effectively to ensure we have and can demonstrate we are achieving our priorities is important for both staff and service users. Governance is the term used to describe a systematic approach to planning, monitoring and improving the quality of care and services we deliver, and early in 2012 the Trust reviewed how it monitors performance through a revision of its Governance Framework. 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.

After the review, in February 2012 the Trust introduced a new Integrated Performance Report that was discussed in detail at each monthly Board Public Meeting. The report is available to any member of the public and has five sections:

- An **Executive Summary**, which includes a range of performance indicators against national targets (the "Monitor Scorecard" and the "Summary Scorecard");
- A section on **Quality and Patient Safety**, for example describing how we are working to reduce the number of patient falls and describing the compliments and complaints we receive about our services;
- A section on **Operational Performance** with a wide set of clinical indicators and statistics describing clinical pathways, waiting times in the Emergency Department, waiting times from 'referral to treatment', and the percentage of patients discharged in mornings rather than afternoons;
- A range of narratives and statistics about the Trust's **Human Resources** performance - sickness absence rates, bank and agency spend, training rates and so on;
- At the end, a section about **Finance**, describing the Trust's revenue, capital, cashflow and savings plans.

As well as the Board report, we have a range of other meetings between staff who work directly with patients, where reports such as our "Performance Assurance Framework" show operational, quality, workforce and finance metrics ward by ward.

Our performance against priorities is also subject to scrutiny and review by our commissioners, and the Strategic Health Authority (until 1 April 2013, when the SHA was replaced by the NHS Trust Development Authority) as well as the Care Quality Commission who regulate our service and conduct unannounced inspections. The CQC reports its findings to the public on their website.

As an indication of the effectiveness of these arrangements, an internal audit of "Performance Management" carried out for the Trust by Audit South West (report WAHT 08/12, published in May 2012) gave an overall assurance opinion on the design and operation of controls as "green".

Part 3 - More information about the quality of our services

The Francis Report

On 6th February 2013 The Department of Health released the 'Francis Report' resulting from the detailed inquiry into the failings of Mid Staffordshire NHS Trust. This report was a result of a culmination of failings identified at Mid Staffordshire NHS Foundation Trust, between 2005 and 2008. As was pointed out to the Inquiry, "the primary responsibility for allowing standards at an acute hospital Trust to become unacceptable must lie with its Board, and the Trust's professional staff. The system is designed for directors to lead and manage the provision of services within its allocated budget but in accordance with required standards, and for professional staff, informed by their ethical standards and commitment, to serve and protect their patients. If every board succeeded in that challenging task, and if all professional staff complied at all times with the ethics of their professions, there would have been no need for the plethora of organisations with commissioning and performance management responsibilities. It is because of the fact that not all boards are capable of maintaining acceptable standards or improving services at the required pace, or applying effective stewardship to the resources entrusted to them, that healthcare systems regulators and performance managers exist. It is because not all professionals do live up to the high standards expected of them that we have professional regulators" (Francis Report Executive Summary 2013).

The Trust Board responded by issuing a comprehensive statement.

"The Trust recognises the vital importance of the publication today of the Francis Report and will be working through those recommendations which apply to acute hospitals, and children's community services.

Chief Executive Peter Colclough said: "We know there is always potential to improve the quality of our service and we are determined to learn from all experiences, not least those identified in the findings of today's national report.

"We would, however, like to assure our local community that we have been and will continue to be, focused on the quality and safety of our services. We are working hard to ensure our patients are safe and afforded the best possible level of care. We will continue to learn from our patients, families and partners in healthcare and improve our services accordingly.

"We welcome external scrutiny by the Care Quality Commission and other regulatory partners, and are committed to responding positively to their recommendations.

"We are committed to continuing to work closely with North Somerset Community Partnership and others to ensure all patients receive the best care and experience in the right place at the right time."

Our current work programme reflects the Trust's focus on ensuring we continue to develop services to meet the needs of patients and their families. For example:

Leadership

The Trust Board has a full complement of experienced Executive and Non-Executive Directors, and a firm grasp of the strategic and operational challenges facing the organisation. Our clinical leaders, particularly, ensure that the voice of those delivering front-line care in the Trust is heard from bedside to boardroom.

Organisational Culture

The culture at Weston Area Health NHS Trust is one in which staff feel confident in raising concerns. The most recent NHS Staff Survey in 2011 showed 78 per cent of our staff reporting they would feel safe to raise a concern to their managers, compared with a national average of 73 per cent. We want all our staff to feel confident about raising concerns and will continue to work to increase the percentage. Our organisational culture is focussed on learning from incidents, sharing best practice across the Trust and working to avoid any re-occurrence.

Nursing

Director of Nursing Irene Gray said: "Nursing is a complex and challenging profession. The importance of good quality care and of preserving the dignity of their patients is at the heart of nursing practice.

"Our local population contains a higher than average number of frail elderly people and this is naturally reflected in the hospital population, where the average age of our inpatients is 76 years. Our health professionals spend the majority of their time caring for this group of patients and work collaboratively with key stakeholders to ensure we can continue to learn and improve the way we deliver care to this vulnerable group.

"Nurse leadership is critical to excellence in care and in supporting nurses at the front line. The Trust has a team of Matrons responsible for specific areas of the Trust, such as emergency care and surgical care. Each ward team is led by a Sister or Charge Nurse, whose responsibilities include ensuring all staff are up-to-date with essential training, and that their patients are satisfied by the care they are receiving from their staff."

Patient Experience

We are constantly looking to improve the ways in which patients can offer feedback about any aspect of their experience with us. The Trust has an active Patient Advice and Liaison Service, which offers assistance to patients and families before, during and after their contact with the hospital.

In June 2012 the Trust Board approved the development and appointment of the Patients' Council and its Chair attends the Trust Board. The Council will play a key role in critically analysing performance. They will conduct un-announced inspections and patient interviews.

We received 256 formal complaints during 2012 and we very much regret that anybody has cause for complaint. However, this number should be set within the context of us seeing 16,500 in-patients, 10,500 day case patients, 51,000 A&E attenders and 100,000 outpatients.

We are aware that, on occasions, patients and families do not always feel that we get everything right during their stay with us, but we will continue to be willing to listen and learn from what they say. We see every complaint as an opportunity to learn and improve.

We also work to constantly improve our patient environment and have delivered £11.7 million investment in our facilities in the last three years – most prominently of course, our state-of-the-art Urgent Care Centre which opened in spring 2011.

Performance

Medical Director Nick Gallegos said: "The Trust publishes a detailed report on performance in the monthly public board papers, which clearly demonstrates successes and challenges, along with actions taken to ensure we are actively addressing failures.

"The current performance "dashboard" demonstrates that the Trust is performing well against the national standards set by Monitor and the Department of Health, with mortality rate consistently in line with the national average for English hospitals.

The Trust's infection prevention performance is good and the Trust is proud that it has been free of hospital-acquired case of MRSA bloodstream infection for over two years and is one of the best performers in the South of England."

The Weston Board then held a Board Seminar after their March Board Meeting and another on 19 March. The Board noted that their monthly 60-page Integrated Performance Report (which was always discussed in the public part of Board meetings) gave a comprehensive set of data about the Hospital's performance and was supported by a robust analysis of the 'Patient Experience' through surveys and visits to the Wards by Executive and Non-Executive Directors.

One example of the steps we have taken to improve our service is the Nurse Staffing Review carried out towards the end of 2012/13 by the outgoing Director of Nursing and the new Director of Nursing. After they and the Trust's Matrons had conducted a very thorough review of nurse staffing, using a combination of professional judgment and nationally-recognised assessment and workforce planning tools, they concluded that to meet the expected needs of patients we should increase our in-patient ward staffing from the 271 whole-time-equivalent registered nurses and nursing assistants in 2012/13 to 301 WTEs in 2013/14. They also proposed that the Sisters on several wards should be removed from their current 50% clinical duties and become entirely supervisory. Another proposal was for the appointment of 1.65 mental health nurses to assess and plan care for individual patients with challenging behaviour.

The Trust Board accepted all these conclusions and approved an enhanced nursing establishment costing an additional £1.76 million in 2013/14.

The Patients' Council

The ability of the Trust to measure Patient Experience is critical to making changes and supporting staff in delivering best care. Over recent months there has been a significant focus on care delivery and the engagement of patients in informing how care and hospital services should and can be delivered.

The Trust has demonstrated the commitment to improving the experience of patients with the development and implementation of a Service User Council (the Patients Council) which has a remit to challenge and hold the Trust to account on delivery of and improvement of excellent patient experience.

Mr Nathan Meager, the Chair of the Council, has been appointed for three years and attends Trust Board meetings. The Council meets monthly to progress its work plan and the minutes of its meetings will be published on the Trust's website, along with the Council's Terms of Reference.

The initiative to set up the Patients' Council was led within the Trust by its then-Nursing Director, Irene Gray. She said at the time, "We chose to draw on the wealth of experience of our service users and patients through the development of a Patient Council.

"Having a Patient Council shows our community that we are serious about valuing the contributions of patients and carers to our work."

The Council's members were appointed through interviews conducted by external parties, not by the Trust.

Some particular highlights of 2012/13

The Trust was delighted to see that the achievements of many groups of staff have been recognised nationally.

In March 2013 the Trust's Palliative Care Team and the Specialist End of Life Care Nurses were shortlisted for the BMJ Group National Awards.

Also in March 2013, one of our ITU Bank Nurses was runner-up in the national Nursing Standards Awards for 2013.

Our Outpatient Development

Our "Quality OPD" development was the first national pilot site for the roll out of Productive Outpatients by NHS Elect (an NHS members' network, providing health organisations with high quality support to supplement in-house management teams and support these teams to develop new skills) and UCLH (University College London Hospitals NHS Foundation Trust, one of the largest NHS trusts in the United Kingdom). By involving all service users (patients, consultants, nurses, dieticians, community teams, specialist nurses etc) and reviewing one speciality in detail, we had an excellent insight into where general redesign improvements were required in OPD. OPD staff were fully informed at each stage of the process and freely contributed ideas and concerns - one aspect of 'Productive OPD' was the need to standardised clinical room layout, and we asked all OPD patients to take part in an 'Improving OPD' survey in preparation for the redesign.

We are confident that what is planned will vastly improve the patient pathway and therefore the patient experience in the very near future.

Special events

We also had some special events in support of achieving our Quality Priorities. For example, we took part in **Deaf Awareness Week** in May 2012 to raise awareness and understanding of the issues surrounding hearing loss and deafness. Our Audiology Service has a stand for Deaf Awareness Week in the front entrance of the hospital every year. All their staff are involved and they contact people involved with deafness in the community to join them. This year 'Action on Hearing Loss' provided an information pack and a backdrop for the stand. The Fire service, which provides smoke alarms for deaf people, and the Police Liaison Officer for the Deaf (PLOD) were also represented.

The North Somerset Equipment Officer who provides telephones, doorbells and TV aids came too with equipment to demonstrate, and Liz Watkins (Social Worker from Adult Social Care) promoted the Social Club we run jointly with the council in Weston.

Then in November 2012 we joined healthcare organisations across England raising awareness of Pressure Ulcer risks and prevention as part of European '**STOP Pressure Ulcer Day**'. We had display boards around the hospital where we distributed leaflets to the public. Our Tissue Viability Specialist Nurse also visited clinical areas distributing patient guide leaflets and staff stickers to heighten awareness of the day's events and the importance of pressure ulcer prevention.

Surveys

Cancer patients from Weston Area Health NHS Trust have given positive views of their care and treatment in the **2011 National Cancer Patient Experience Survey**, published in August 2012. Patients scored the hospital particularly highly on having confidence and trust in the care given by nurses at Weston General Hospital, and on being treated with dignity at all times, and rating their care as either excellent or very good.

Control of pain or the side effects of medication also scored exceedingly well, as did the ability of the hospital team to work well with their colleagues in the Community Health setting.

A total of 240 patients treated in the autumn of 2011 took part in the survey, which gave Weston a response rate of 74% – ahead of the national response rate of 68%.

Patients have expressed their appreciation for the **Accident and Emergency Department** of Weston Area Health NHS Trust and scored it highly in a national survey.

The survey, published in December 2012 by the Care Quality Commission, covers A&E Departments across England. A total of 850 recent users of the Weston General Hospital A&E Department were sent postal questionnaires to complete and 40 per cent of them responded. The national survey was last conducted in 2008, since when the A&E Dept at Weston has moved into newer, more spacious and modern accommodation, and this is reflected in improved results in this year's survey.

Two areas where the Trust scored particularly well were:

Privacy at reception when discussing condition; and

Dept being very clean

It also scored above average for:

Waiting less than two hours to be examined

Doctors/nurses fully discussing the patients' anxieties and fears with them; and

Patients not feeling bothered or threatened by other patients

There was one area where the Dept scored poorly, which was some patients reporting that they were not told how long they would have to wait to be examined.

Here are a selection of verbatim comments from patients who took part in the survey:

"Staff very polite and helpful - no complaints at all"

"The nurses who treated me were excellent - extremely understanding and caring"

"It made me feel safe with caring people "

The full survey results can be found on the CQC website www.cqc.org.uk

National Outpatient Survey

The National Outpatient Survey is conducted every other year. Last year's Quality Accounts contained the results of the 2011 Survey, and the next survey is expected to take place in June to October 2013.

National Inpatient Survey

The National Inpatient Survey is an annual survey and this year was commissioned by 69 Trusts. The survey was independently run by the Picker Institute Europe.

The study sample for Weston was drawn from 850 patients over the age of 16 years and who had been treated as inpatients during June and July 2012. As with the outpatient survey, the results allow the Trust to consider:

How do we compare with other Trusts – what can we learn from them?

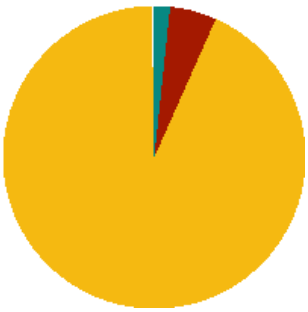
Are there areas where our patients report the most problems?

The survey results are a little unusual in that lower scores are better, because the survey is intended to highlight areas where Trusts could improve. The survey results were not published until February 2013, and many actions the Trust was taking during 2012 to improve the patient experience will not show in the survey until early 2014.

Have we improved since the 2011 Survey?

A total of 58 questions were used in both the 2011 and the 2012 surveys.

Compared to the 2011 survey Weston Area Health NHS Trust was:

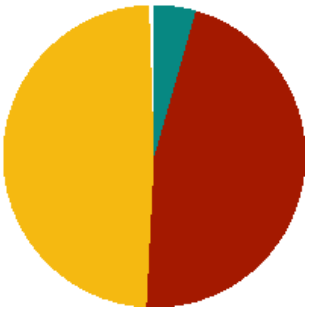


- Significantly BETTER on 1 question
- Significantly WORSE on 3 questions
- The scores show no significant difference on 54 questions

How do we compare to other Trusts?

Looking at the 86 questions asked in total this year (58 asked in both years plus 28 new for 2012), the survey showed that Weston Area Health NHS Trust is:

- Significantly BETTER than average on 4 questions
- Significantly WORSE than average on 40 questions
- The scores were average on 42 questions



The Trust improved significantly in the following areas:

Planned admissions were not offered enough choice of hospitals – down to 46% of questionnaire respondents in 2012 from 60% in 2011 (and something which had worsened significantly between 2010 and 2011).

The Trust worsened significantly in the following areas:

Hospital: shared sleeping area with the opposite sex – up to 9% in 2012 from 3% in 2011
Hospital: hand-wash gels not available or empty – up to 7% in 2012 from 2% in 2011
Discharge: did not feel involved in decisions about discharge from hospital – up to 56% in 2012 compared with 47% in 2011.

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

Planned admission: not offered a choice of hospitals
Planned admission: not given printed information about condition or treatment
Hospital: patients in more than one ward, sharing sleeping area with opposite sex
Hospital: patients using bath or shower area who shared it with opposite sex

The Trust is significantly worse than the 'Picker average' in the following areas:

Admission: had to wait long time to get to bed on ward
Care: did not always get help in getting to the bathroom when needed
Hospital: information about ward routines, noise at night, space for personal belongings and all staff introducing themselves
Doctors and nurses: communication, confidence and opportunities to talk
Care: information given, being involved in treatment
Surgery: information and time to discuss with consultants
Discharge: communication and information.

The outcomes of this survey have been shared widely with staff in the Trust and were discussed by the Trust Board at their meeting in March immediately after the results had been published. The Trust has begun some internal surveys to see if the results of the Picker Survey are still valid nearly a year after patients had been questioned. We are looking particularly closely at the questions where we are worse than average to see what we can do to improve.

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 and the National Health Service (Quality Accounts) Amendment Regulations 2012). The Department of Health guidance is mainly in the "Quality Accounts Toolkit 2010/11", which the Department has stated is still current, and in Gateway reference number 18690 "Quality Accounts: reporting arrangements for 2012/13" issued on 29 January 2013.

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;

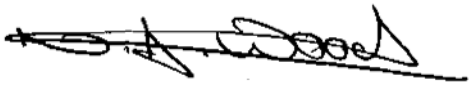
and

- 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 Trust Board

Chris Creswick, Chair *24 June 2013*



Nick Wood, Acting Chief Executive *24 June 2013*

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

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF WESTON AREA HEALTH NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Weston Area Health NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our 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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death and
- clostridium difficile infections: the rate of Clostridium difficile infections, per 100,000 bed days for patients aged two or more on the date the specimen was taken.

We refer to these two indicators collectively as "the indicators".

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 Regulations).

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.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 11th June 2013;
- feedback from Local Healthwatch dated 7th June 2013;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 1st June 2013;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated February 2013;
- the latest national staff survey dated 2012;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2013;
- the annual governance statement dated 5th June 2013;
- Care Quality Commission quality and risk profiles;
- the results of the Payment by Results coding review dated December 2012; and
- any other relevant information included in our review.

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

This report, including the conclusion, 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. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Weston Area Health NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;

- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore. The nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.]

Peter Barber
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for and on behalf of Grant Thornton UK LLP

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21 June 2013

Annex 1 – Statements by other bodies about our Quality Accounts

Statement from North Somerset CCG (including comments from Somerset CCG)

As co-ordinating commissioner, North Somerset CCG has reviewed the Weston Area Health Trust Quality Account for 2012/13 and believes this provides a fair reflection of the work of the Trust and includes the majority of the mandatory requirements.

We have reviewed the information presented in the quality account and are satisfied that it is an overall accurate account of the quality of services.

The CCG will continue to work with the Trust to ensure quality, patient safety and performance remains a priority in 2013/14.

We acknowledge the progress the Trust has made in 2012/13 in the following areas:

- The high percentage of records including the patients valid NHS number
- Maintaining performance of zero MRSA bacteraemia
- Zero 'never events'
- 96% of all patients being assessed for Venous Thromboembolism (VTE)
- Increasing the number of people who are able to die at home
- 98% compliance against the World Health Organisation Checklist in all operating theatres

The introduction of clinical commissioning on 1 April 2013 brings opportunities for much greater engagement of clinicians working across the CCG and the Trust to improve the quality of care for patients.

We will continue to work closely with the Trust and through our monthly quality review meetings to oversee progress against the NHS Outcomes Framework 2013/14, quality indicators and implement the learning from the recent Mid-Staffordshire NHS Foundation Trust Inquiry.

Throughout 2013/14, the CCG would particularly like to focus upon patient experience and the Patient Safety Thermometer to ensure we take every opportunity to learn from complaints and incidents.

Statement from Local Healthwatch

We are pleased to forward Healthwatch North Somerset comments on Weston Area Health Trust draft Quality Accounts 2012/13. We hope you will find these helpful and look forward to more involvement with the Trust as Healthwatch North Somerset develops.

Although a lengthy document, the presentation is clear and easy to read if you know something about the topic. Is there to be an Executive Summary, and/or an easy read version?

In relation to the Goals set:

Goal 2 Dementia Care
The work on dementia care is welcome, particularly the screening at various stages. However, why were only 16% of eligible people screened for a more detailed assessment and how will this be improved upon?

Goal 4 Reducing the number of Serious Untoward Incidents and Never events
We note that 'A very large proportion of 'serious incidents' are to do with pressure ulcers' and would like this given more attention.

We are pleased that Never events were eradicated in 2012/13.

Goal 5 Learning from audit
Although audit systems are in place we are disappointed that this wasn't co-ordinated at Director level during 2012/13 but note this is to be addressed in 2013/14.

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***10.1** For the above period error rates for diagnoses and treatment coding (clinical coding) were 30% of attendances, leading to a change of 23.1% incorrect investigation codes and 27.3% incorrect treatment codes.'*

Is it possible that incorrect coding will provide incorrect data which may be used to inform future services? It is unclear what action is being taken to resolve this issue and improve clinical coding. – It may not affect quality of services this year but may in future years if incorrect data leads to the wrong services being developed.

Of particular concern is 'Hospital: hand-wash gels not available or empty – up to 7% in 2012 from 2% in 2011.' How many is 7%? This is a small but important point in infection control and should be easily rectified.

Patient involvement and engagement

The importance of the role of Patient Council is noted with regard to the patient experience, it is important to monitor the effectiveness of the Council and how it is listened to.

There are improvements, 'the proportion of patients who could find a staff member to discuss concerns with, and the proportion of patients who were given sufficient dignity, has improved since the previous year' and this is clearly an important achievement.

But, we also note 'the proportion of patients involved in care decisions and the proportion given appropriate information at discharge has deteriorated slightly since last year' and this could have impacts as to the on-going well-being of patients and we would like this to be given greater priority.

We are pleased to see the Francis Report acknowledged and found the response reassuring.

We acknowledge there are pressures, particularly those of increased numbers of patients in A & E and the impact of proposals for the future of Weston Hospital.
Recent local press headline news about the future of the hospital can impact on both patients and staff morale. We have found nothing on the Trust website in relation to this and would like more public information to be available in terms of the current situation, steps being taken to address this and an indication of the timescale.

Statement from Overview and Scrutiny Committee

Thank you for inviting the Panel to comment on the draft Quality Accounts, which one Member described as:

" the most in-depth and informative Quality Account to date, highlighting several area of real improvement despite changes and uncertainties about the future of the Trust"

Members specific comments were as follows:

P.19 Family and Friends Responses

There was concern about the low percentage of staff that would recommend the hospital to a friend/relative compared with the 65% England average.

P.31 Dementia Care - How did we do?

There was concern at what Members felt was an insufficiently high number of staff (63%) reported as having completed the new online learning tool for Dementia Care.

P.32 Patient Discharge: What will Success look like; and How did we do?

There was concern both about the aim to increase the rate of weekend discharge and the actual increase from 46% to 54%. Members referred to instances where this has happened without assurance that care is in place and noted the reference to patient feedback on P.54 citing 56% of patients and carers as feeling that they were not involved in the discharge decision (up from 47% at the last survey).

P.51 Special Events

Members were please to see the reference to the joint work with North Somerset Council in respect of Deaf Awareness Week.

P.54 Hand-wash gels

Members have raised this issue on a number of occasions and are disappointed to see performance has worsened.

There were a couple of general points made about the format and content of the report.

- Members would have liked to have seen a performance breakdown for the Children's Ward and Maternity Services

- A view was expressed that there should have been section in the report on financial performance (albeit with the recognition that the format of the report is largely prescribed and focussed on "quality" elements).

Statement from the Patients' Council

As chair of the Patients' Council I was pleased to be given the opportunity to comment on this document and that the Patients' Council was invited to examine a copy whilst still in draft form. The Patients' Council is very much in its infancy but is already involved in many areas to improve the patient experience and we look forward to working with the hospital on some of the areas they have identified in this report.

There are a number of positives contained in this document: there have been no reported incidents of MRSA infections over the last 12 months, the number of never events has been eradicated as well as the hospital participating in many audits and information gathering processes. In addition it is good how the quality priorities were chosen based on previous information and complaints and incidents. As the Patients' Council develops we would look to be more involved in working with the hospital in the setting of the quality priorities. It is note worthy that the overall strategic objective is to ensure that people have a positive experience of care, being treated in a safe environment that protects them from harm, which is thoroughly endorsed by the Patients' Council.

Within this document there are obviously areas for improvement and the Patients' Council will continue to work with, as well as challenging those in charge of the hospital to make the necessary changes. To this end it is very encouraging that Weston Hospital will continue to support and strengthen the Patients' Council and I look forward to being able to comment on progress within a 2013/14 quality accounts.

Changes made to our Quality Accounts following the statements sent to us

Post-draft changes after audit comment:

Page 7 – Certification from the Chief Executive moved here to the "end" of Part 1, as required by the regulations.

Page 20 Dataset 24 – wording added to explain the data available from the Health and Social Care Information Centre for 2012/13. Table re C-diff changed as rates for 2013/14 not yet been published nationally.

Page 21 Dataset 25 – wording in table revised in agreement with auditors.

Page 33 – we have amended the narrative in the "How did we do?" column, and now include a comparison with other Trusts on the results of the 2012 national inpatient survey.

Page 53 – to help people understand why the two pie charts have different numbers of questions, we have explained that there are 58 questions used in both years (2011 and 2012) and 86 questions asked in total in 2012.

Page 54 – we have changed the wording to reflect comparisons to other Trusts in a more balanced way.