Weston Area Health NHS Trust

Quality Account

2016/17

We are WAHT.
Our strategic aim
Work in partnership to provide outstanding healthcare for every patient.
Our values

- **People and Partnership** – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague (**C**are and **C**ommitment)
- **Reputation** –actions which build and maintain the Trust's good name in the community (**C**ommunication)
- **Innovation** – demonstrating a fresh approach or finding new solutions to problems (**C**ourage)
- **Dignity** – Contributing to the Trust's Dignity in Care priorities (**C**ompassion)
- **Excellence and equality** – demonstrating excellence in and equality of service provision (**C**ompetence)

Our vision
To work in parntership to provide outstanding healthcare for every patient

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

Our business model
The strategic plan describes a business model for the Trust with two key elements:

- moving from a sole focus on the "treatment of ill-health" service model to one which embeds proactive "ill-health prevention" and "improving health and well-being";
- moving from an "independent" service provider model to one of "formal partnership" allowing a range of service provision partnership arrangements in our PLACE:
- maximise the widest appropriate range of local services on site;
- support the delivery of care in alternative settings wherever safe;
- improve clinical sustainability;
- deliver high quality care within the Trust and across the region;
- meet targets within the Trust and support delivery across the region;
- deliver economies of scale;
- support achievement of whole system stability.

The Trust's purpose is to improve the health and wellbeing of our local community by providing excellent services to meet their healthcare needs, as close to home as possible, through innovation and collaboration with professional health and social care partners.

The Trust's strategy is founded on one overarching principle: Putting Patients First; ensuring that we give them the best experience we can, doing so safely and using the evidence of best practice to inform what we do.

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Chief Executive's Introduction

Welcome to the Weston Area Health NHS Trust's Quality Account for 2016/17

Our Quality Account is an important publication for the Trust. It sets out the steps we have taken to improve services for our patients and how we are performing against national standards and benchmarks. The Quality Account also gives the opportunity to showcase the excellent services and improvements that our staff deliver to provide care to our patients.

2016/17 has been a full and challenging year for the Trust. During the year there have been sustained periods of high demand for care through our Emergency Department. We have struggled to meet the accepted quality standards in the Department. The long term difficulties in recruitment of doctors in some specialties has proved a real test of our resilience.

We have performed well with our treatment times targets – with the exception of the 62 day target for patients with cancer. We continue to work with our partners to improve this.

Six out of twelve of our improvement priorities have either been achieved or achieved in part. In particular we have seen a reduction in falls causing harm and improvement in the way we manage complaints. We recognise that there is further work to do, particularly to reduce pressure ulcers and to introduce new guidance on learning from deaths.

Our staff survey shows that whilst the Trust has improved in some areas, other acute trusts have also improved their results which mean that our results in comparison still remain poor in many areas.

Between 28 February and 15 March 2017 the Trust underwent a CQC follow up inspection of services at the Trust. A team of twenty two inspectors were on site for the first four days with a smaller team returning the following week for the unannounced part of the inspection.

The inspection focused on the services rated as 'requires improvement' or 'inadequate' following the inspections in May and August 2015. As such, the following services were reviewed:

- Urgent and emergency care
- Medical
- Surgery
- Critical care

The report from the inspection is likely to be available during May 2017. However, initial informal feedback to the Executive Team noted improvements – particularly in the surgical directorate – but also to some degree in the medical directorate. The timeliness of the flow of patients through the Emergency Department was raised as an area of concern. The Trust subsequently received a warning notice from the CQC on the 24 March 2017 regarding the flow of patients through the hospital and crowding and senior doctor leadership to the Emergency Department.

In support of this and other opportunities, we have announced that we will work in closer partnership with University Hospitals Bristol. By so doing we will build on our existing clinical networks and establish the future services of the Trust.

In February our Commissioners sought the views of local people on a number of their ideas for the hospital. During an eight week engagement process opportunities for increasing planned surgical

operations, reducing services overnight in the Emergency Department and reducing the complexity of patients in Intensive Care were all debated. The feedback from this is expected in May.

Finally it would be remiss of me not to note the change in one of our Executive Leads for Safety and Quality. Dr Nick Lyons has recently left the Trust to work in a larger Acute Trust in Norfolk having been Medical Director for fourteen months. Nick made a significant impact supporting good governance here in Weston and I am sure he will likewise make a huge impact in Norfolk. Nick has been replaced by Dr Peter Collins who comes to us from University Hospital Bristol where he worked as a Consultant Liver Specialist. Peter and our Director of Nursing Helen Richardson are actively championing the safety and quality agenda on behalf of our patients.

I hope you find this report an enjoyable read and take assurance from the steps the Trust continues to take to improve services for our patients.

James Rimmer
Chief Executive May 2017

Addendum - 20 June 2017
On 14 June (after the draft of this Quality Account was finalised) the CQC published the result of their follow up inspection in March 2017. This showed that the Trust was assessed as;

- Overall rating for this hospital - ‘Requires Improvement’
- Urgent and emergency services – ‘Inadequate’
- Medical care (including older people’s care) – ‘Requires Improvement’
- Surgery – ‘Good’
- Critical care – ‘Good’

Please find the full report on the Trust website – or the CQC website.

Whilst it is pleasing to note that the CQC rating for both Surgery and Critical Care have improved to ‘Good’ – and that we have been assessed as ‘Good’ for Caring across all services - Urgent and Emergency Services were rated ‘Inadequate’ – particularly as there aren’t enough doctors to safely staff overnight rotas. Responsiveness (patient flow) was also rated ‘Inadequate’.

The Trust is working closely with partners on actions designed to improve patient flow throughout the hospital and on the safety of care in the Emergency Department.

Introduction to our Quality Account

Since April 2010 all providers of NHS services are required to publish an annual Quality Account. Quality Accounts are reports about the quality of services delivered. Their primary purpose is to demonstrate a commitment to continuous, evidence-based quality improvement.

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

How do we choose our priorities?

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

Our Patients' Council checked our understanding on the meaning of 'quality care' by surveying visitors to the hospital. Feedback indicated that 'good quality care' meant being treated with a sense of shared humanity and respect above all else.

Using this feedback as our frame of reference, our quality improvement goals for 2017/18 have also been informed by;

- The results of Care Quality Commission inspections of our services.
- The priorities of our staff
- National requirements included in the NHS Constitution and Five Year Forward View.
- The priorities of our commissioners – incorporating for example agreed CQUIN targets
- The needs of our population as described in the latest Joint Strategic Needs Assessment.
- The experiences of our patients – captured by the work of our Patients' Council, Patient Experience Review Group and Healthwatch North Somerset.
- Performance data about the Trust – including mortality, incidents, complaints/PALs and audit data.
- Our corporate risk register and Board Assurance Framework

Part 1 About WAHT

Trust profile

Weston General Hospital is a 234 bedded district general hospital which includes 10 maternity beds and 5 Intensive Care Unit beds. The hospital provides acute emergency services for adults including emergency, critical care, medicine and surgery together with supporting diagnostic services. In addition, the hospital provides a range of planned services including general surgery, urology, orthopaedics, and other planned treatments such as endoscopy, haematology and some cancer care.

Children's and Young Peoples Community Health Services including Child and Adolescent Mental Health Services are provided from two children's centres located in Weston-super-Mare and Clevedon.

The Trust provides 45% of acute health services to the population of North Somerset. The Trust also provides acute services to the population of the North Sedgemoor area of Somerset.

The total income for the Trust during 2016/17 was £108m.

Activity

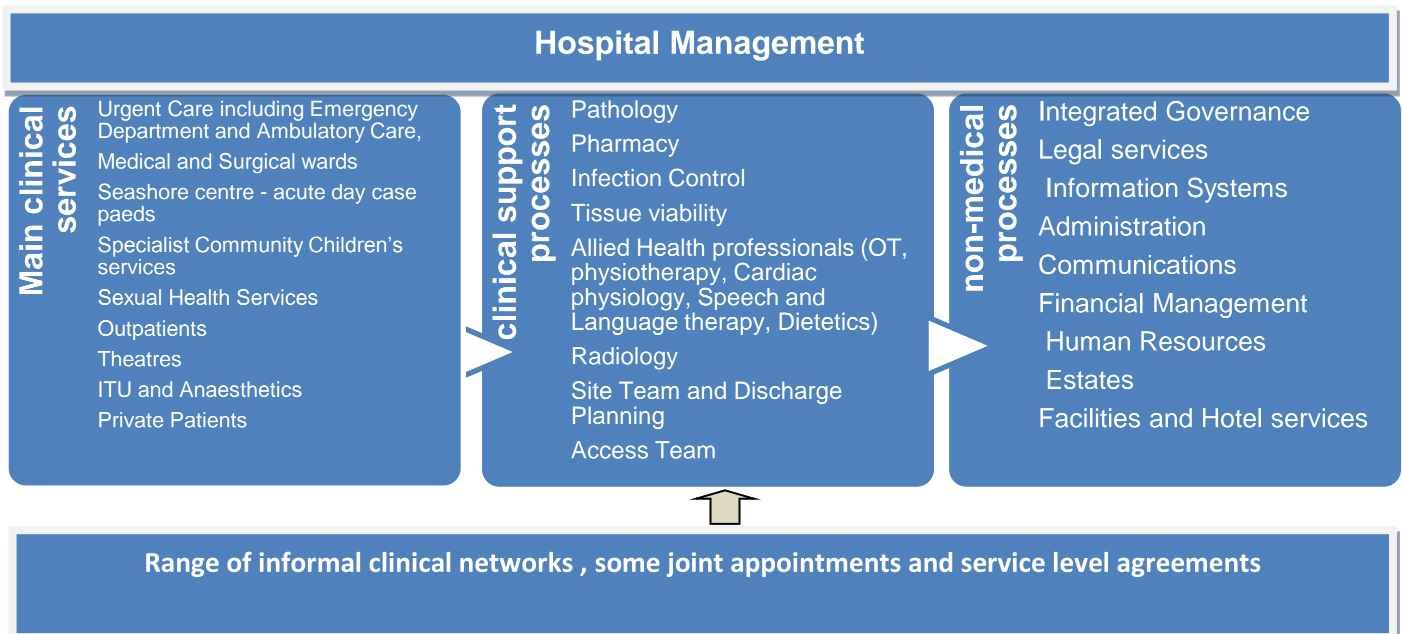
The Trust has an annual activity of circa 54,000 Emergency Department attendances, 15,700 planned day case and elective admissions, 14,700 emergency admissions and 105,500 outpatient attendances and procedures (contracted activity 2015/16). During 2016/17 the midwifery led maternity unit delivered 172 babies.

Resident population

North Somerset has a population of circa 208,154 people (source: Mid-2014 population estimate: ONS) A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

North Sedgemoor which has an estimated population of 48,400 (Mid 2014 GP registered population)

Business model and management



From April 2017, the Emergency and Surgery Directorate will be managed by a joint Associate Medical Director for medicine and surgery (Clinical), and separate Directorate Managers (General Management) supported by an Operational Head of Nursing within each Directorate. The Clinical Support Team will be managed by an Associate Medical Director, and General Manager, supported by an Associate Director for Allied Health Professionals.

All are accountable on a day-to-day basis through the Director of Operations to the Chief Executive for delivery of operational and financial performance.

Strategic challenges

Performance and service delivery

- Delivering clinical safety remains a priority with a continuing focus required on mortality, ED staffing, medical leadership and addressing CQC issues raised during their assessment.
- Current provision of healthcare across Bristol, North Somerset, Somerset and South Gloucestershire is insufficient to meet growing demand - particularly for urgent and emergency care. All four acute trusts, as well as the Community Trust and local authorities are reporting increases in demand for services, and are unable to release any spare capacity to help each other. Sustainability and Transformation Plans (STP) predict a requirement for 237 additional acute beds across the system over the next 5 years to manage predicted demand.
- In the longer term, the Plans propose that there will be strategic move of some of this activity, currently delivered at an acute hospital, into the community, primary care and to self-care. However, in the meantime the demand continues to grow.
- We have not met our 4 hour waiting time at ED since July 2015.
- We regularly have more people attending at ED than we can cope with, leading to crowded and uncomfortable waits. There is national evidence that overcrowding in ED increases mortality.
- Demand on ED services is high: We regularly have more than 160 attendances. The number of people attending our ED has increased by 7.78 per cent over the last 2 years.
- 31.86 per cent of people who go to ED in Weston leave without the need for any treatment. Of the 54,000 people who went to ED between April 2015 and April 2016, only 11,556 of those were admitted to hospital.
- The proportion of the North Somerset and North Sedgemoor population who are admitted when they attend ED is high at all four acute hospitals (30% at Weston General Hospital, 33% at University Hospitals Bristol, 62% at North Bristol Trust and 76% at Taunton & Somerset Foundation Trust) compared with the national average of 21%. This means that the hospital acute services need to handle more patients than would be expected from the number of ED attendances.
- Over 4.4 percent of planned operations a year are cancelled, often at very short notice, due to emergencies taking priority.
- Often patients have to travel to hospital several times a week for different appointments.
- At any one time we have circa 40 people in hospital beds who are medically fit but are waiting for community care to be put in place before they can be discharged.
- Delivering local District General Hospital services requires the on-site provision of a wide range of clinical specialties and functions to support a 24/7 ED. Delivering these services effectively and efficiently requires a critical mass of activity, which enables clinicians to develop and maintain their skills and provides sufficient income to meet the costs of these services.
- The Trust does not deliver a full range of clinical specialities itself. It has partnership and outsourcing arrangements in place to ensure delivery and adjusts patient flow accordingly. When activity moves, the issue will be one of partnership working to ensure continued provision of the necessary services.

Demographic challenges

- Our population of over 75s is projected to grow by between 40 – 50 percent in the next 10 years.

Already over 23 per cent of our population is over 65.

- Nationally over 70 per cent of money spent on healthcare goes on those people with one or more long term conditions, of whom 70-80 per cent are capable of self-managing. People with long term conditions are more likely to be over 65 and to live in deprived areas.
- Our local GP surgeries are stretched with some individual GPs seeing over 80 people a day;
- During the next ten years the numbers of children under the age of 14 are expected to grow by 12%.

Integrated working

- Currently we don't make good use of technology that can help resolve these issues.
- Our systems, particularly our computer systems, are not joined up so our professionals do not always have the whole picture thus are not working together.
- Older people are being admitted to hospital and staying longer than necessary because of a lack of availability of alternative community support services and poor coordination between hospital and out of hospital services. Delayed transfers of care (DTOC) for North Somerset local authority are increasing. This delay in discharging patients from hospital again means that fewer beds are available for treating both emergency and elective patients.

Recruitment

- The recruitment of medical staff in the Trust continues to be the greatest recruitment challenge faced by the Trust and some of these difficulties can be attributed to a UK wide skills shortage for certain positions, e.g. Consultants in Histopathology, Respiratory, Acute and Community Paediatrician. As a result, there are clinical sustainability issues associated with a number of services in the Trust;
- Whilst the recruitment of nurses is at times difficult, the Trust has made considerable strides in securing a substantive registered and unregistered nurse workforce and is concentrating on reducing turnover in these staff groups, particularly in the more specialist areas of nursing including ITU, Theatres and Emergency Department;
- As a small District General Hospital, establishment levels are defined to ensure they meet safe staffing requirements in line with CQC and NICE guidelines, but the small size of the teams reduces the level of resilience in rotas;
- This difficulty is compounded by the extensive reliance on locums, due to inability to recruit to substantive medical posts;
- The Trust is focusing on reducing its' over reliance on a temporary workforce and has introduced a number of measures, controls and processes to drive its annual costs down to the agency ceiling set by NHS Improvement;
- Last year we spent more than £6.6m on agency staff (all staff groups) because we were not able to fill all of our vacancies with permanent staff;
- 20 per cent of medical posts at Weston General hospital are filled by locums or agency staff to cover vacant posts;
- In recent years the Trust has been subject to uncertainty concerning the final organisational solution for the Trust, however whilst the Trust has a certain future, the reputational damage continues to have a detrimental impact on candidates' willingness to consider the Trust as a positive career move.

Financial Performance

- Over recent years we have spent more money each year than we receive nationally, leaving us with a deficit of circa £11 million annually.
- Due to increasing demands and costs over the next five years, if we do nothing this would build to a deficit in our health budget to approximately £20 million by 2021. This is against a total NHS spend in 2016/17 of £1.2 billion rising to £1.4 billion in 2020/21.
- Current tariffs do not meet the real costs of providing accident and emergency services.
- The risk of elective income being lost to competition from other NHS Trusts or the independent sector is significant - removal of any elective activity and associated diagnostic and outpatient

activity would lead to a reduction in the contribution to overheads and mean that the Trust's financial viability is further compromised.

These challenges together with those arising from demographic changes, commissioner plans and national policy developments are such that the sustainability of clinical services cannot be met by the Trust working in isolation.

Socio –economic demographic overview

- Population growth of 24% over the past 30 years, which is substantially faster than the national average growth rate of just 13%. Over the next 10 years the population is projected to increase by a further 10% compared to a national average of 7%.
- Population has a higher proportion of people over the age of 65 (23%) compared to the national average (18%). During the next ten years the elderly (75+) population is expected to grow by 45-50%, compared to a national average of 35-42%. The numbers of children under the age of 14 are expected to grow by 12% over the same timeframe. Typically these population groups are high users of health and social care services.
- The expansion plans of Weston College and the designation of the College as a University Centre will further expand the local younger population;
- Plans to develop 6,200 new houses in Weston-super-Mare, to be completed by 2026. Based on the Public Health projections this would equate to 14,260 people, many of whom would be younger families, with implications for local primary care, maternity and paediatric services.
- Household composition changing with increase in households in North Somerset occupied by one pers single parent with dependent children (faster rise than in England and Wales);
- Standardised Mortality Ratio is 94%, indicating a lower rate of mortality than the national average, but life expectancy varies significantly across the County, indicating some extremes of deprivation (and hence greater healthcare needs).
- High levels of deprivation in North Somerset with the 7th widest inequalities gap in the Country and lev relative deprivation increasing;
- Lower levels of deprivation in North Sedgemoor but 3% of the area's population live within one of the 20% most deprived areas within England, below the regional average.
- Weston-super-Mare Central Ward has the lowest life expectancy (67.5 years for males and 76 years for females). Clevedon Yeo has the highest life expectancy for both males and females, at 86.1 years and 92.5 years respectively. There is therefore a gap in male life expectancy between these wards of 18.6 years.

Health profiles

North Somerset

- Health of population generally better than the England average and life expectance is increasing;
- Early deaths from heart disease, stroke and cancer have fallen in the last 10 years and remain better tha England average. Circulatory diseases, including heart disease and stroke, and cancer are the biggest c of premature death;
- increasing age profile of the population such that the prevalence of various diseases likely to inc particularly in the older ages, specifically for Chronic Obstructive Pulmonary Disease (COPD), dial Cardiovascular Disease (CVD), which includes stroke and coronary heart disease (CHD), hypertensio dementia. A 91% increase in the number of over 65s with dementia by 2030 compared to 2009 is anticipated;
- considerably higher rate of cancer admissions (43%, in comparison to 29% for England);
- little change in premature mortality from liver and respiratory disease, and excess winter mortality;
- Single biggest cause of disability is mental health: significantly greater proportion of individuals

diagnosed with depression in comparison to the national average. Suicide rates are significantly higher than the national average;
- Hospital admissions for alcohol have risen over recent years and estimated numbers of cocaine/crack and opiate users are significantly higher than England;
- Gap in life expectancy (10.7 year for males and 7.5 for females) and disability-free life expectancy (12.2 for males and 9.3 for women) between the 10th most affluent and deprived areas is worse than England. Inequalities in disability-free life expectancy are also higher locally than the South West and England average

North Sedgemoor

- lower proportion of the population aged 0-14 than the Somerset average and a higher proportion of the population aged 75+ than the Somerset average;
- standardised rates for key health-related measures are marginally above the county average; life expectancy is slightly below average;
- Mortality rates due to respiratory disorders and COPD are some of the worst in the county;
- A lower proportion of people die at home in North Sedgemoor
- Around one in nine people aged under 65 have a limiting long-term illness, marginally above the county average;
- 2015 health statistics indicate a significantly worse than England average for recorded diabetes;
- Smoking in pregnancy remains a challenge with high rates compared to the rest of England;
- Public health priorities (relevant to the acute sector) include improving respiratory health
- Rates of adult obesity and childhood excess weight are slightly lower than Somerset average.
- Hospital admissions for drug and alcohol related reasons are lower than the Somerset average.

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Local NHS bodies and other providers

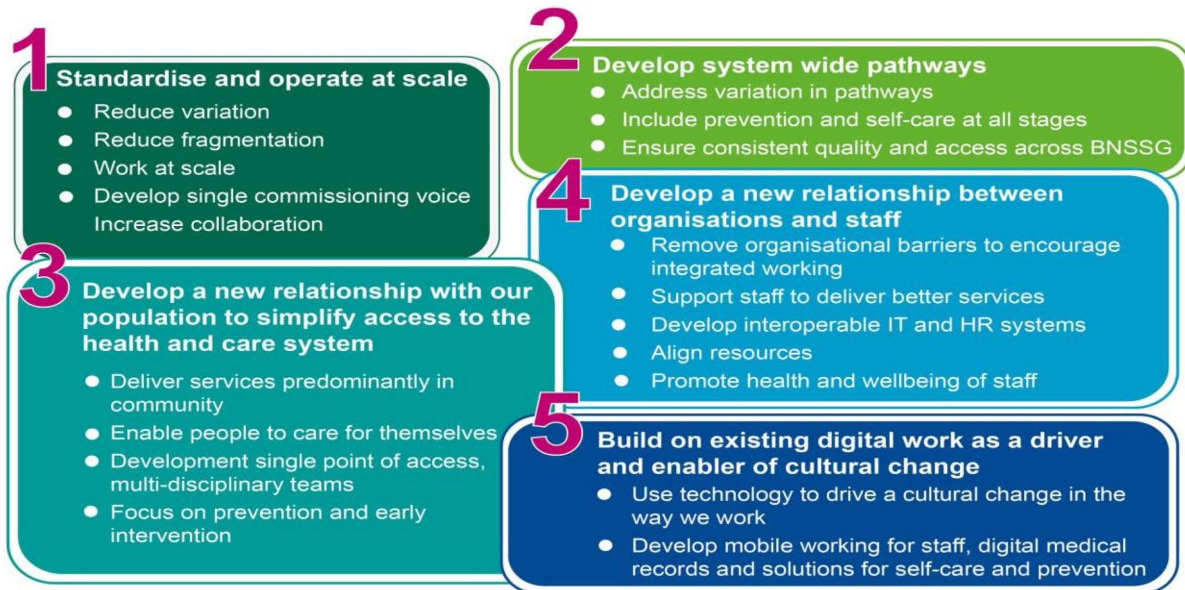
The Trust's largest commissioner is North Somerset CCG, accountable for circa £280 million of NHS spending, over 55% of which is acute spending. Most of the acute spending is with local providers with Weston accounting for circa £70 million. Increasingly, operational planning and commissioning is being conducted within a "single commissioning voice" with a single set of commissioning intentions for all BNSSG CCGs. Providers and commissioners will be required to work for a single set of activity and financial assumptions in order to avoid the risk that operational/operating plans do not add up to the whole.

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

The key principles behind the planning work currently being undertaken are:

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

Key drivers



The local health and social care economy includes two Local Authorities – North Somerset Council, responsible for North Somerset and Somerset County Council, responsible for the Sedgemoor area of Somerset.

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

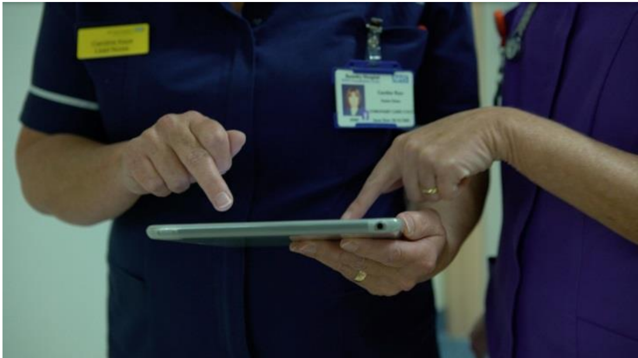
Community services (excluding community-based Children's services, maternity services and paediatrics provided by Weston Area Health NHS Trust) are provided by the North Somerset Community Partnership, a social enterprise.

Mental Health services for adults are provided by the Avon and Wiltshire Mental Health Partnership NHS Trust.

Awards and achievements

WAHT in the news

A round-up of the biggest stories to happen at Weston Area Health NHS Trust over the past 12 months, as well as our awards and achievements.



[Hospital ditches paper work in favour of app]

We teamed up with firm Perfect Ward to implement an easy-to-use app that simplifies ward assessments. The smartphone-based technology replaces our old paper-based system and sees our nurses benefiting from the apps instant feedback and the elimination of time-consuming administration. Read more here.

www.westonmercury.co.uk

[Baby friendly Weston means mums get top support]

We hosted an event at the hospital to mark our own Ashcombe Birthing Centre being honoured with 'baby friendly' status from UNICEF. This title recognises that new mums are being given the best-possible support from our hardworking midwives.

www.parenttalk.org.uk

[Teddy bear milestone for poorly children]

For more than a decade we've teamed up with Weston freemasons to supply toy bears to sick or injured children in our A&E department. This last year we passed an important milestone as we gave away our 10,000th teddy. Read more about the campaign here.

www.northsomersettimes.co.uk

Cleese backs hospital scanner appeal

Last April, the Trust and its League of Friends launched a £400,000 appeal for new scanning equipment. The campaign continues to build momentum and recently hit the £150,000 mark.

The campaign is also generating a great deal of support, including from internationally acclaimed writer, actor and comedian John Cleese. Read more.

www.westonmercury.co.uk

[Medical student creates life-saving picture book for India's poorest children]

One of our medical students developed a picture book which is now being used in some of the poorest areas of India to help children to protect themselves from life-threatening diseases. Read more here.

www.itv.com

Hospital heroes celebrated

Last summer, we hosted our third annual ‘Celebration of Success’ awards, recognising outstanding care, commitment and clinical excellence from our star performers at Weston. The evening also saw the premier of a new film, highlighting the achievements of our staff over the last year. View the full film here.

www.northsomersettimes.co.uk

[**Paramedics Vs A&E Staff In Dance-off**]

Our staff working in our emergency department challenged paramedics to a dance-off to raise money for a paramedic colleague who is trying to access life-saving cancer treatment. Watch the dance off again here.

www.westonmercury.co.uk

Nurse awarded the title of 'Queen's Nurse'

Stephanie Fricker, a nurse here at the hospital, received one of the highest accolades in her profession after being awarded the title of 'Queen's Nurse'. Read all about Stephanie's story here.

Investment will see improved endoscopy services for local patients

We recently announced a multi-million pound investment into our endoscopy unit to enhance the care that our local patients receive, including the introduction of new privacy areas for patients. Read more about the exciting project here.

Focus on wellbeing for hospital staff

Read about the launch of a new staff health and wellbeing initiative which featured a week-long programme of activities and events for staff to take part in.

www.madeinbristol.tv

Author signs books for hospital Scanner Appeal

At the end of last year, bestselling author Amanda Prowse visited the hospital to sign and donate copies of her recent novel in support of our Scanner Appeal. Read more about the book signing here.

www.northsomersettimes.co.uk

[Hospital volunteers celebrated]

Our nimble-fingered volunteers received a well-deserved spotlight after they raised more than £3,000 for the hospital by knitting and selling toy teddy bears.

www.burnhamandhighbridgeweeklynews.co.uk

[Green-fingered schoolchildren grow own food in our hospital garden]

We joined forces with a local school in the area to turn some unused land at the hospital into a plot to grow healthy food. Read more about the project here.

www.westonmercury.co.uk

Patient survey puts hospital top of the pile

In a national survey, members of the public involved in the Patient-Led Assessments of the Care Environment (PLACE), awarded us with some of the highest scores in the country for quality of food, cleanliness, dementia care and privacy.

Healthwatch North Somerset has statutory functions under the Health and Social Care Act to obtain and feedback the views of local people and to involve them in monitoring the standard of local health and social care provision.

The Trust works very successfully with Healthwatch – whilst ensuring that their independence is not compromised. The Chair of Healthwatch is a member of our Patient Experience Review Group and one of their Directors is an invited member of our Board. Healthwatch North Somerset shares feedback regularly with the Trust including monthly feedback reports – which are reviewed at the Patient Experience Review Group.

The Trusts Associate Director for Governance and Patient Experience meets regularly with the Chief Officer and ensures that all concerns raised by Healthwatch are responded to thoroughly and speedily.

Part 2

Review of 2016/17 Quality Priorities

This part of the Quality Account details how we have done in the last year. It takes a look back over our achievements and where there is more to do, against the quality priorities we identified in the last year (2016/17)

Throughout the year we reported on our progress to our Senior Management Group, to our Quality and Governance Committee and to our Commissioners. Our Trust Board looked in depth at a detailed 'Integrated Performance Report' 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 reviewed aspects of clinical effectiveness and outcomes, patient safety, and the patient and staff experience. It received assurance reports from operational Directorates.

Quality priority	Status
Quality Priority 1 Reducing avoidable mortality	Achieved in part
Quality Priority 2 Best practice in sepsis management	Not achieved
Quality Priority 3 Reducing hospital acquired pressure sores	Not achieved
Quality Priority 4 Medicines reconciliation on admission	Achieved
Quality Priority 5 SHINE checklist in the Emergency Department	Not achieved
Quality Priority 6 Learning from incidents	Not achieved
Quality Priority 7 Leadership coaching	Achieved in part
Quality Priority 8 Improving discharge from hospital	Achieved in part
Quality Priority 9 Levels of satisfaction with the complaints process	Achieved in part
Quality Priority 10 Best practice in fractured neck of femur	Not achieved
Quality Priority 11 Mental ill health – reducing reattendance in the Emergency Department	Achieved in part
Quality Priority 12 Reducing falls causing harm	Achieved

Priority one				
Reducing avoidable deaths – Executive Lead = Medical Director				
We said	**Why**	**How**	**Measure**	**Status**
We would look the embed the learning from the Keogh review of mortality – which reviewed care at ten hospitals in England.	The levels of mortality at the Trust would seem to be 'higher than expected' in some areas and we need to make sure all patients are not being put at risk of harm or death by our actions.	We would use the Global Trigger Tool to review 20 notes a month of inpatient discharges (dead or alive) to identify aspects of care delivery for improvement, learn from good practice and provide quality assurance on the safety of care We would strengthen systems to ensure reliability to clinical standards such as National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and National Audits.	20 notes a month of inpatient discharges reviewed. 1:10 of these reviews will be 'double checked' by the Medical Director. Learning from all in-hospital deaths integrated into clinical care pathways and noted in the minutes of the Mortality Review Group. Increased learning as demonstrated from governance minutes and reversal of SHMI trend. Early Warning Scores (EWS) – 70% acute medical admissions will have accurately recorded EWS which is appropriately acted upon.	**Achieved in part.** We reviewed notes as planned – reviewing 75% of deaths occurring in WGH (489 out of 656). Of the deaths marked as "a" – care optimum, five sets of notes a month have been 'double checked' by the Medical Director. We have identified the clinical pathways affected and begun to make changes to some of them. Our governance at speciality and Directorate level remain immature. Early Warning Scoring has been achieved for 70% of acute medical admissions on our Medical Assessment Unit – but we now need to achieve this across the

				whole of the Trust.

What is sepsis?
Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death if not detected early and treated promptly.
Sepsis can be caused by a huge variety of different bugs, most cases being caused by common bacteria which we all come into contact with every day without them making us ill. Sometimes, though, the body responds abnormally to these infections, and causes sepsis. We know that when recognised and treated, patients are more likely to recover.

We introduced a PGD (patient Group Directive) to enable the administration of appropriate antibiotics to be undertaken by selected nursing staff – following appropriate training – to ensure prompt administration of antibiotics in even the busiest periods in the Emergency Department.

Priority two

Best practice in sepsis management – Executive Lead = Medical Director				
We said We would work to introduce best practice in managing patients with sepsis	**Why** It has been proven that by following six best practice steps patients recover sooner.	**How** Reinvigorate Sepsis care best practice and then continue to improve by using quality improvement methodology	**Measure** By the end of March 2017 90% of patients admitted with sepsis will have the Sepsis 6 standards administered within one hour.	**Status** **Not achieved.** Our Director of Safety prioritised one of the six standards in the Emergency Department – the administration of intravenous antibiotics within an hour of admission. From a starting point of 11% in April 2016, we have increased the proportion of patients in whom the "door to needle time for the administration of antibiotics in less than one hour" to 87% in march 2017.

Priority three

Reducing the number of pressure ulcers – Executive lead = Director of Nursing

We said	Why	How	Measure	Status
We will considerably reduce avoidable pressure sores for our patients.	Pressure sores are debilitating for patients and largely avoidable injuries which can lead to long hospital stays and susceptibility to infections. They cost the NHS millions of pounds every year.	We would review and redefine our pressure ulcer reduction strategy – implementing a standardised approach to pu development to improve learning	By the end of March 2017 we will achieve a 25% reduction in Grade 3 &4 pressure ulcers acquired in hospital.	**Not achieved.** In 2015/16 we reported 25 Grade 3&4 pressure ulcers acquired in hospital (a serious incident). In 2016/17 we reported 35

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply. Typically they occur in a person confined to bed or a chair by an illness and as a result they are sometimes referred to as ‘bedsores’, or ‘pressure sores’. All patients are potentially at risk of developing a pressure ulcer, however, they are more likely to occur in people who are; seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. The use of equipment such as seating or beds which are not specifically designed to provide pressure relief, can cause pressure ulcers.
We have remained committed to reducing the incidence of pressure ulcers during 2016/17. Our Tissue Viability lead nurse attributes the deterioration in numbers to an increase in the numbers of patients being cared for that are seriously ill and the increased length of time patients are awaiting admission to a Ward from the Emergency Department.

Priority four

Medicines reconciliation on admission – Executive Lead = Medical Director

We said	Why	How	Measure	Status
We will increase the percentage of patients who have pharmacy led medicines reconciliation on admission	Getting medication prescribing and administration right for patients is essential to a speedy recovery.	We would install a robot in our pharmacy and thereby release pharmacy staff to support the wards.	By the end of March 2017, 80% of admitted patients will have pharmacy led medicines reconciliation. We will initially prioritise patients admitted via SAU and MAU.	**Achieved** 80% of patients admitted Monday to Friday have pharmacy led medicines reconciliation.

Medicines reconciliation by pharmacists

Medicines reconciliation ensures that an accurate list of current medication is compiled for each patient on admission and that the medicines prescribed in hospital are checked and confirmed with this list. Any discrepancies are quickly identified and discussed with the prescriber and all changes are documented so that the GP can be informed when the patient is discharged.

Priority five

SHINE checklist in the Emergency Department – Executive lead = Director of Nursing				
We said	**Why**	**How**	**Measure**	**Status**
We will introduce this quality of care checklist in our Emergency Department	We want to be able to demonstrate that care in our Emergency Department is of the highest standard.	We would train all ED staff in the use of the checklist and monitor it's use via a monthly audit led by the AD Nursing (Corporate)	By the end of March 2017 90% of the most unwell patients (requiring treatment in ED 'majors') will have a completed SHINE checklist.	**Not achieved** We have made good progress introducing the tool – but have not achieved the 90% target.

SHINE

The SHINE safety checklist is a time based list of tasks that is completed for every very unwell patient in the Emergency Department. The checklist can be completed by any member of clinical staff in any area. It is prescriptive and contains all basic elements of care.

Since the introduction of the checklist at other Trusts, the quality and safety of care has improved despite increasing demand and service pressure.

Our aim in using the checklist at Weston is to monitor and measure the quality and safety of patients within the ED and to improve early decision making, escalation if required and to have patients on the appropriate care pathways. There are also nurse sensitive markers on the check list that will enable care and comfort. All of which can be measured, monitored and improved.

Priority six

Learning from incidents – Executive lead = Director of Nursing				
We said	**Why**	**How**	**Measure**	**Status**
We will embed patient safety and quality of care as the primary driver of high quality and safe care at all	Whilst the Trust has achieved improvements in patient safety over the last few years, it is recognised that	Implement the National Safety Standards for Invasive Procedures (NatSSIPs)	100% compliance with safety checklists (including WHO) Zero reported 'Never Events'	**Not achieved** We have made good progress with embedding the checklist in most areas but need to carry out

levels of the organisation, reducing variation in service delivery to ensure consistent delivery of care	the most significant challenge for the Trust is to embed patient safety and quality of care as the primary driver at all levels of the organisation, embedding a culture of openness and learning.	Maintain level of incident reporting within the Trust and align themes identified via Datix and the Hazard reporting line to prevent harm to patients We would achieve all our sign up to safety pledges reducing avoidable harm to patients Implementation of Safety Measurement and Monitoring Framework for all wards/departments (implementation of local governance meetings)	Remain in the top 25% of Acute non specialist trusts for incident reporting (as per NRLS 6 monthly report) 95% (or above) of patients (via safety thermometer) will receive care without any new identified harm 100% compliance with submission of reports to the CCG (within 60 days)	further work in outpatients and on our wards. We had one never event During the year we were above average reporters of incidents – categorised by the NRLS as in the middle 50% 97.5% of patients received care without harm In March 2017 85% of our reports were submitted to CCG within 60 days.

Priority seven

Leadership coaching – Executive Leads = Director of Nursing and Director of HR				
We said	**Why**	**How**	**Measure**	**Achieved in part**
We will better equip our key staff to lead best practice - supporting them by introducing new training and techniques for improving the quality and safety of care**.**	Leadership at ward and service level is vital to the provision of high quality care.	We would train a select group of senior managers to coach others in the leadership of the safety & quality of care. Improved investigation training for staff.	Pilot of training with an initial cohort of 4-6 leaders. We will introduce 'human factors' training for key staff.	We supported key leaders in the Leadership for Improving Frontline Talent (LIFT) programme and others in ILM coaching for managers. We used our SIRI panel to coach staff in human factors and our Head of Governance

				trialled and secured formal human factors training which will occur for key staff in May 2017.

Priority eight				
Improving discharge from hospital – Executive lead = Director of Nursing				
We said	**Why**	**How**	**Measure**	**Status**
We would work closely with patients and their families to improve our discharge planning.	Being in hospital longer than is necessary increases risk for patients and is expensive and inefficient.	We would begin to plan for discharge home much earlier and improve our communications with patients and their families.	95% of inpatients will agree an expected date of discharge (EDD) within 12 hours of assessment. The responses to the national inpatients survey of 2016 will improve by 5% for question 53 – *involved in decisions around discharge* The percentage of patients readmitted within 24 hours will reduce. EDD attainment will be monitored via each ward and department clinical governance framework.	**Achieved in part** We have introduced but not yet embedded agreeing expected dates of discharge with patients. We achieved a 5% improvement in question 53 We have not consistently reduced readmissions of patients.

Priority nine				
Complaints satisfaction – Executive lead = Director of Nursing				
We said	**Why**	**How**	**Measure**	**Status**
We will work	To Improve the	We would	80% of	**Achieved in part**

towards developing a complaints resolution service that is centred around the patients and service users expectations	way we listen and respond to the concerns raised by patients and involve them in improving the patient experience and services that the Trust offer	develop a new complaints strategy that will improve the time taken to resolve complaints, increasing the numbers of face to face meetings with complainants and improve the quality of our staff training.	complaints will be closed within the time agreed with the complainant. Where a complainant provides a telephone contact we will discuss the method of resolution for100% of complainants. 100% of complainants acknowledged within 3 working days. 10% improvement in the complaints satisfaction survey response to Q17 'I felt that my complaint made a difference'	In March 2017 79% of complaints were closed within the agreed time frame. We now acknowledge formal complaints within three working days and discuss the method for resolution with complainants. In March 2016 43% of respondents 'felt that my complaint made a difference' in March 2017 this had increased to 71%

Priority ten

Best practice in managing patients with a fractured neck of femur – Executive Lead = Medical Director				
We said	**Why**	**How**	**Measure**	**Status**
We would work to introduce best practice in managing patients with a fractured neck of femur	It has been proven that by following certain best practice steps patients are more likely to return to previous levels of mobility and be able to stay in their own home	Our Quality Improvement Hub would work with junior doctors to initiate a QI project and measure the improvements made.	We will continue to achieve best practice in managing patients with fractured neck of femur. We are satisfied that we have	**Not achieved.** We struggled to recruit the medical staff required to maintain our performance and achieved 48% best practice tariff standards

	following this fracture.		maintained 60% 'best practice tariff standards' overall. However, we are keen to improve further and aim to achieve 70% overall for the coming year.	overall.

The National Hip Fracture Database and 'best practice tariff'

In England, the National Hip Fracture Database has successfully supported the first four years of the Department of Health's Best Practice Tariff (BPT) initiative, which rewards the achievement of specified standards:

- surgery within 36 hours
- shared care by surgeon and geriatrician
- care protocol agreed by geriatrician, surgeon and anaesthetist
- assessment by geriatrician within 72 hours
- pre- and post-operative abbreviated mental test score assessment
- geriatrician-led multi-disciplinary rehabilitation
- secondary prevention of falls
- bone health assessment

Priority eleven

ED reattendance rates for people with mental health issues– Executive Lead = Medical Director

We said	**Why**	**How**	**Measure**	**Status**
We would ensure that patients with mental health issues are discharged from ED with a crisis and contingency care plan and suicide prevention pack (for self-harm)	Alternatives to attendance at ED are agreed with the patient, for when they are experiencing a crisis. And they have written information on where to access alternative support if considering self-harm/suicide	We would devise a joint crisis care plan with the patient during their assessment. The patient will have a copy and a copy will be in the mental health electronic record. Any patient attending with self-harm/suicidal ideation will be given an	33.3% reduction in reattendances in our ED within 7 days for any patient attending with mental health issues or self-harm/suicidal ideation.	**Achieved in part** The Mental Health Liaison Team have developed joint crisis care plans with patients and developed an information pack for patients attending with self-harm/suicidal ideation, however collating our data systems

		information pack on where to seek further support.		has proven a challenge and we have been unable to demonstrate a reduction in reattendance rates.

Patient stories

First hand stories from patients and their carers were placed at the top of the Trust Board agenda during the year. Stories listened to included;

- *A Carer's experiences of a relative's discharge home from hospital*
- *A patient's experience of appointment setting and treatment as an inpatient*
- *The experiences of a patient with a learning disability in the Emergency Department*
- *A daughter's reflections on the care of their father who had to cared for in the corridor in the Emergency Department*

What's it like working here?

In addition, the Board invited members of staff to tell their story of working at the Trust at each Board. These stories included;

- *The experiences of a junior doctor caring for a patient with sepsis in the emergency department*
- *A nurses experience of manging an aggressive patient*
- *A junior doctors experience of the training environment and clinical supervision at the Trust.*

Work with partners

Our Patient Experience Review Group (PERG) includes membership from the Patients' Council and Healthwatch. The Group reports to the Quality and Governance Committee and ensures that the experiences of patients are regularly reviewed and that any areas requiring improvement are taken forward by the Trust.

Each quarter the Group reviews the results of the;

- *Friends and Family Test*
- *Exit survey*
- *Local inpatient survey*
- *Social media*
- *Complaints and PALS*

Dementia Action Alliance

The Trust has been a member of the Dementia Action Alliance (DAA) for a number of years and works hard to achieve its personal objectives, see http://www.dementiaaction.org.uk/account/plans *for specific actions. Mystery shoppers with a Dementia and their carers have visited the hospital and navigated the wards and departments, key findings have been discussed and action taken to further Improve the environment, this*

includes new signage and name badges black on yellow. Work with the Estates Department and the Housekeeping Manager has enabled Dementia friendly flooring to be fitted, thus reducing anxiety and promoting patient safety. The Trust led an initiative to 'sign up' many health care staff to be Dementia Friends; this was achieved with an interactive session with the Alzheimer's Society. With partners in Avon and Wiltshire NHS Partnership Trust the post of Later Life Mental Health Liaison Sister has been introduced. This has been of great benefit to the Trust and will continue to promote integrated safe dignified care for our patients with a dementia.

The Alzheimer's Society's Dementia Friends programme their biggest ever initiative to change people's perceptions of dementia.
Dementia touches the lives of millions of people across the UK. Dementia Friends was launched to tackle the stigma and lack of understanding that means many people with the condition experience loneliness and social exclusion. The aim is to create more communities and businesses that are dementia friendly so that people affected by dementia feel understood and included.

Priority twelve

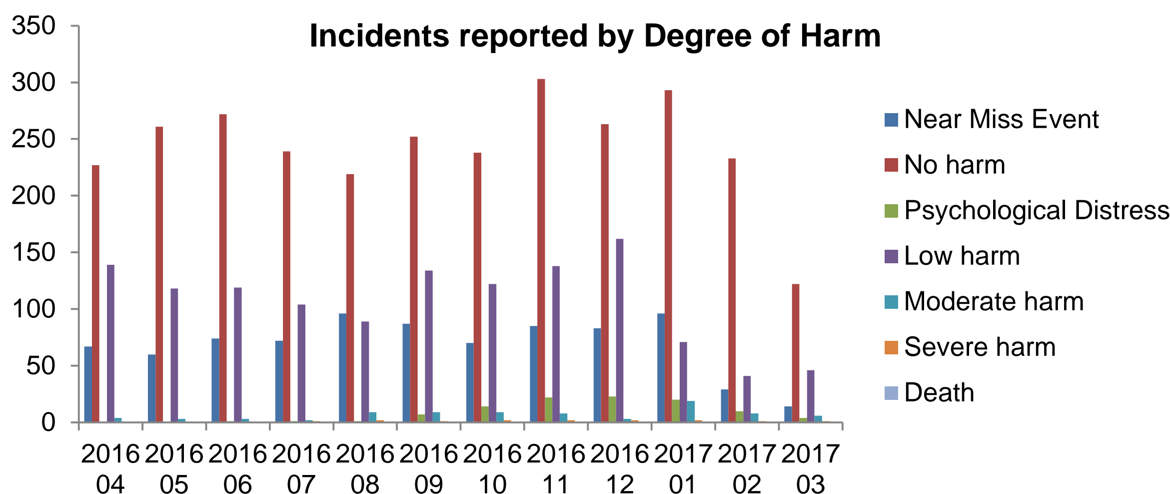
Reducing falls causing harm – Executive Lead = Director of Nursing				
We said	**Why**	**How**	**Measure**	**Status**
We would reduce falls in collaboration with community and primary care services	Falling is frightening and harmful for patients and there are means of preventing falls	We would; 1. Review our current risk assessment process 2. Improve our process for post falls review and care planning 3. Monitor and improve our learning from falls	Reduction of all falls per 1000 bed days to be in line with national performance. 40% reduction in falls causing moderate harm or worse Audit of falls documentation	**Achieved** Our risk assessments, review processes and care planning have all been revised. Falls causing moderate harm or worse have reduced by 44% and falls per 1000 bed days is now in line with national performance.

Part 3

WAHT Safety culture

Patient safety incidents

At Weston, 5707 incidents involving patients were reported by our staff in 2016/17. The chart below gives a breakdown of incidents over the past 12 months; these are categorised according to the harm that resulted, ranging from 'no harm' to 'death'. The largest numbers of incidents reported were within the 'near miss event, no obvious injury'.



The table below shows the number (and percentage) of patient safety incidents that resulted in severe harm or death from the 1st April 2016 to the 30th September 2016

Weston Area Health NHS Trust	**Acute (non-specialist) - Data for 1st April 2016 - 30th September 2016**		
	Weston	**Acute NS Highest**	**Acute NS Lowest**
% of total Patient Safety Incidents resulting in serious harm or death	0.4%	1.7%	0%
Number of patient safety incidents resulting in serious harm or death	7	98	1

The Trust has taken the following actions to improve this further;

- The daily Situation Report (SitRep) continues to be circulated by the Governance team to the Trust Executive Team and Operational Leads. The report continues to identify any daily risk trends for wards or departments so that immediate action can be taken.

- The Serious Incident Review panel with representation from the Commissioners and Patients Council is now chaired by the Director of Nursing. The purpose of the panel has grown over the last year and whilst attention is given to the quality of the investigation to make sure this effective and identifies the lessons to be learned, the panel now seek assurance from the relevant departments that the action plans have been delivered and that the learning has been embedded.

- The Trust is looking at ways it can further improve the quality of investigations and learning from incidents and has in the last year purchased the dashboard reporting function from datix (collection of information in a pictorial format) in order that teams and wards can better understand what is happening in real time. In addition to this the Trust has just commissioned an external company to provide further training around the "Human factors of error" and "Effective Investigation to improve Patient Safety".

- Redesigned the Governance team to provide stronger links with the Directorates, with the establishment of Patient Safety and Quality facilitators, working with the Directorate staff to help embed ownership and accountability for the quality and safety agenda

Improvements being taken forward in response to patient safety incidents include the following:

- Development of in house teaching for staff looking after patients that are challenged by medical ward environments. This will include skills/tools for staff to help reassure patients
- Quality improvement project established looking at separate chart for methotrexate and / or other immunosuppressant drugs.
- A new Quality improvement project led by junior doctors has commenced focusing on improving patient assessment and care planning
- E-learning package developed for staff training on pressure ulcer prevention
- A review of the Root Cause Analysis process, in relation to serious pressure ulcers, is being undertaken in partnership with the Trust's Commissioners and other regional Acute Trusts
- Dementia/delirium pathway being developed

Never events

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

In 2016/17 the Trust reported 1 never event:

- January 2017 – Retained object post-surgical intervention

This incident is subject to an ongoing investigation.

Duty of Candour

The introduction of a statutory Duty of Candour was a key recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry). The Duty of Candour places a requirement on providers of health and adult social care to be open and honest with patients when things go wrong with their care and treatment. As of the 27th November 2014 the regulation came into effect for all incidents that are reported as causing moderate/severe physical or psychological harm.

The Trust has reviewed the Duty of Candour process and implemented a Trust wide policy that details the Trust process in communicating with patients when an adverse event has occurred, causing harm. The Trust has also developed:

- Letter templates to be used when corresponding with patients, informing them that an investigation will be undertaken

- The Trust's initial reporting template, highlighting who will be the nominated lead to undertake the Duty of Candour
- The Trust's Investigation template to describe how Duty of Candour was undertaken with patients/carers (related to Serious Incidents)

Sign up to Safety Campaign

The national Sign up to Safety Campaign aims to make the NHS the safest healthcare system in the world*, halving avoidable harms over the next three years*. In September 2014 Weston Area Health Trust committed to a three year Safety Improvement Plan. This plan set out the actions we will undertake/have undertaken in response to the individual pledges we have made to the Sign up to Safety Campaign. The Plan is reviewed regularly by the Board and is available on the Trust website. The five pledges Weston Area Health Trust signed up to are as follows:

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

The Trust has achieved tangible improvements in areas of patient safety over the last few years with individuals, wards, departments and directorates having all made a contribution to improve patient safety. However there remains a long way to go. Principle achievements have been:

Pledge 1: Put safety first – Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

- The Mortality Review Group is reviewing the higher than expected conditions from the SHMI data on a monthly basis and overseeing quality improvement projects. Quality improvement projects for all areas identified are now underway. All deaths are reviewed by the clinical teams using a trust wide standardised tool.

Pledge 2: Continually learn – Make their organisations more resilient to risks by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are

- Ward governance meetings are taking place on a weekly basis based on Vincent's "Safety Measurement and Monitoring Framework"
- The hazard reporting phone line that complements our incident reporting system has had over 3000 calls since August 15. The hazards are categorised and themes are identified and a number of improvements have been made.

Pledge 3: Honest – be transparent with people about their progress to tackle patients' safety issues and support staff to be candid with patients and their families if something goes wrong.

- The Duty of Candour is continually applied to moderate and above incidents by the Governance Team (slide 7).
- The Sitrep report is emailed to key members of staff on a daily basis risk rating the clinical areas from reported Datixes.

  A weekly email is sent out to staff listing the hazards and updating the staff on any improvements that have been made

Pledge 4: Collaborative – Take a leading role in supporting local collaborative learning so that improvements are made across all of the local services that patients use.

- The Trust is actively engaged in the South West Collaborative and West of England Academic Health Science Network with involvement in the programmes on NEWS scoring (in ED), ED pathways, emergency laparotomy pathways, sepsis & insulin management.

Pledge 5: Support – Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

- The QI Hub supports all clinical staff in quality improvement methodology and patient safety science. The weekly hazard email informs staff of the hazards and unsafe conditions reported and promotes an open culture.
- The annual Quality Improvement Presentation day took place on 9th June 2016

The patient safety improvement plan is reviewed regularly.

Schwartz rounds

We will continue to introduce Schwartz rounds during 2017/18. Schwartz rounds provide a forum for staff to come together once a month (or every other month) to explore together the challenging psychosocial and emotional aspects of caring for patients.

With help from a skilled facilitator, discussion focuses on a particular case that is introduced by a mixed panel of staff, led by a doctor, who were involved in the patient's care. The panel gives a brief summary of the patient's case story and panellists take it in turns to describe their involvement in the case and, in particular, how it made them feel and what sort of challenges it may have raised for them. The discussion then opens up – participants ask questions, share experiences and reflect on the challenges of care. The Rounds are designed to be a safe and confidential environment: patient names are changed to protect confidentiality and all participants are asked to agree that no names or information shared by colleagues are mentioned outside the one-hour Round.

Mortality review

Summary Hospital-level Mortality Indicator ("SHMI")

The Trust reviews a large number of indicators on a regular basis to ensure that patients receive safe and effective care when receiving treatment in the hospital.

A key indicator is the Summary Hospital-level Mortality Indicator (SHMI) which is received on a quarterly basis from the Health and Social Care Information Centre (HSCIC), a national organisation.

This indicator compares the actual number of deaths with the expected number of deaths during (and for 30 days after) a hospital admission over a period of 12 months. These are referred to as "excess deaths", but this is NOT synonymous with avoidable deaths.

SHMI is a statistical tool that is considered by the Trust in conjunction with other clinical governance data and is NOT a direct measure of the quality of care nor should it be used to allow the comparison of mortality rates between different Trusts.

Nonetheless the indicator is taken seriously by the Trust and seen as a very important tool to understanding where we may need to improve the quality of care we provide

The most recent data was published pertains to the timeframe October 2015 until September 2016, in which the rate was in the "higher than expected" category.

However this does represent a stabilisation and slight improvement over two successive quarters from 1.17 (January 2015 – December 2015) and 1.16 (April 2015 – March 2016).

Weston Area Health NHS Trust	July 15- June 16	Oct 15 – Sept 16	Jan 16 – Dec 16	April 16 – March 17
SHMI Value	1.15	1.15	1.11	TBC
National upper limit	1.13	1.14	TBC	TBC
National lower limit	0.88	0.88	TBC	TBC
Comparative position	Higher than expected	Higher than expected	TBC	TBC

During 2016/17 25% of patients who died within 30 days of admission were being looked after by our specialist palliative care team – meaning that their death was expected and planned for.

The Mortality Review Group (MRG), chaired by the Director for Patient Safety continues to meet on a monthly basis and receives results of mortality reviews from each Department in the Trust.

This review process has recently been significantly tightened to ensure a robust process. The group has identified areas where more detailed review of clinical care should take place by reviewing 489 deaths out of 656 (75%) during 2016-7. These reviews help us try and identify areas of practice that should be improved. Using Quality Improvement (QI) strategies based on the Institute for Healthcare improvement (IHI) methodologies we are changing practice in the following areas -

- Urinary tract infections
- Community acquired pneumonia
- Hospital acquired pneumonia
- Chronic Obstructive pulmonary Disease
- Sepsis
- Fracture of the neck of the femur
- Deteriorating patient

The MRG is attended by a representative from National Health Service Improvement to provide additional support and input.

Areas for concern noted by the MRG are fed back to the relevant Directorates by formal mechanisms in the governance processes, and informally by those present to their individual departmental governance meetings (which in turn feed back into Directorate governance).

The Trust is also carrying out a comparison between the SHMI data and other mortality review statistics.

Additionally we have commenced work to ensure that there is more in depth analysis of the data to enable the Trust and providers of care in the 30 days after discharge from the hospital to focus on any areas that may require review.

In 2017/18 we will introduce the new mortality review guidance developed by the National Quality Board.

During 2016/17 25% of patients who died within 30 days of admission were being looked after by our specialist palliative care team – meaning that their death was expected and planned for.

Avoiding readmissions

An emergency readmission is defined as an unplanned readmission within an identified time of leaving the hospital. The ideal readmission rate is zero but it is recognised that this is not always possible as patients can have multiple co-morbidities or long-term conditions which require frequent medical attention. Monitoring emergency readmission rates is important to the Trust as it can help to prevent or reduce unplanned readmissions to hospital. The table below illustrates emergency readmission rates (as a percentage of all readmissions) within 30 days in 2016/17 compared to the national average.

Month	National	Trust
April 2016	7.55%	6.20%
May 2016	7.58%	6.20%
June 2016	7.55%	7.50%
July 2016	7.54%	6.20%

August 2016	7.53%	7.90%
Sept 2016	7.50%	5.40%
Oct 2016	7.49%	4.90%
Nov 2016	7.38%	5.70%
Dec 2016	7.60%	7.40%
Jan 2017	3.85%	8.30%
Feb 2017	6.64%	6.90%
Mar 2017	4.53%	4.90%

The Emergency Directorate has committed to creating a clear process of review for every medical readmission, with thematic reporting to be available monthly to the Clinical Advisory Group, to take lessons learned forward.

VTE risk assessment and prophylaxis

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

The information below, from the Health and Social Care Information Centre, show the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. The recording of VTE compliance remains challenging, with reduced capacity in the current administrative team – although our review of hospital acquired thrombosis suggests patients are not at risk of harm. The Trust has developed a VTE action plan which is currently being worked through.

Weston Area Health NHS Trust	**2015/16**		**2016/17**	
	Weston	National	Weston	National (Quarter 1-3 available only)
Percentage of patients who were admitted to hospital and who were risk assessed for VTE	95.3%	95.6%	79.93%	95.62%

Clostridium Difficile infections

The table shows the rate of C. difficile infections there have been at the Trust per 100,000 bed days. (Children under 2 are not included)

	2015/16	2016/17	
	Weston	Weston	National average
Rate per 100,000 bed days of cases of C. difficile infection	10.71	11.25	13.36

We are pleased to report that we have managed to sustain our low rate of C. difficile infections during 2016/17. This equates to 10 reportable cases which have all been assessed against national guidance. We have had one case where cross-transmission between patients was identified and actions have subsequently been put in place to ensure that this does not recur. Lapses in care were identified in 50% of the reported cases; issues related to antimicrobial prescribing, delays in both isolation and sampling and poor or no hand hygiene audit results.

The sustained reduction in cases has been due to a variety of strategies which were implemented over the last 3 years and which are now embedded in practice.

At Weston 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. These are significant risk factors for C. difficile acquisition.

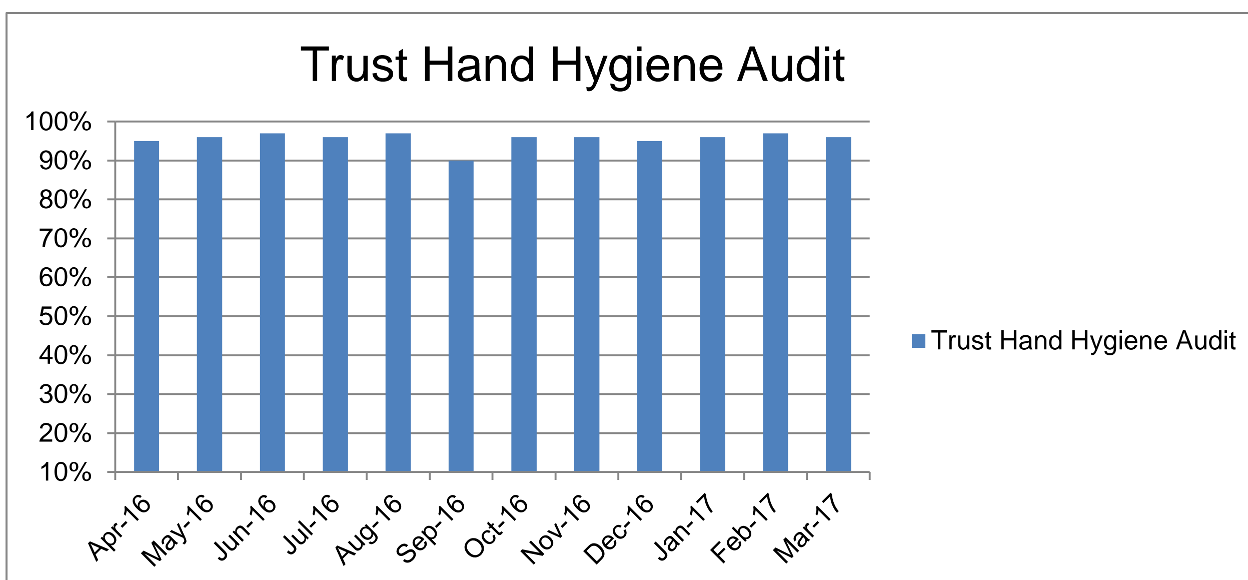
The strategies that have contributed to this success include:

- Updating our antibiotic guidance and using mobile technology in the form of a Smart phone App to enable our Doctors to access these guidelines at the point of care.
- The appointment of a permanent antimicrobial pharmacist.
- Increased auditing of antibiotic prescribing by a designated pharmacist and the Consultant Microbiologist with prompt feedback to prescribers and their teams.
- Use of probiotics for patients whilst receiving antibiotic treatment and for the 5 days following treatment completion.
- Use of the Diarrhoea Assessment Tool by clinical staff has helped with the prompt isolation of symptomatic patients and in determining when specimens should be sent.
- Installing macerators to the ward sluice areas to improve the timely disposal of waste products. This has removed the risk of non-disposable products not being cleaned effectively.
- The opening of a central waste storage area has freed up valuable space within the ward sluice areas and improved the ability to clean these areas appropriately.

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

Hand Hygiene Audit

Monthly internal audits continue to be undertaken by Infection Prevention and Control Link Practitioners with submission compliance at almost 100%. Hand hygiene is audited in all clinical areas and departments using the Infection Prevention Society's Quality Improvement Tools. This encompasses the World Health Organisation's '5 moments of hand hygiene' to determine compliance and identify specific areas for improvement. 'Bare below the Elbow' compliance is continually monitored in the clinical areas and any concerns addressed at the time of the audit.



Environment survey puts hospital among the best

In a national survey, members of the public involved in the Patient-Led Assessments of the Care Environment (PLACE), awarded us with some of the highest scores in the country for quality of food, cleanliness and privacy.

	Trust Score 2015	Trust Score 2016		National Average Score 2015	National Average Score 2016	
Cleanliness	98.55%	99.40%	↑	97.57%	98.06%	↑
Food	92.56%	91.62	↓	88.93%	88.96%	↑
Privacy, Dignity and Wellbeing	89.82%	92.59	↑	86.03%	84.16%	↓
Condition Appearance and Maintenance	94.46%	93.35%	↓	90.11%	93.37%	↑
Dementia	81.31%	85.96%	↑	74.51%	75.28%	↑

Care Quality Commission Reviews

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'.

Following a planned inspection in May and August 2015 the CQC gave an overall rating for the Trust of 'requires improvement'. The CQC report from the visit highlighted many areas of challenge but also many areas of excellence. The CQC described three areas of 'outstanding performance' – Children's Care in Hospital for Caring and Child & Adolescent Mental Health Services for Caring and Effectiveness. However three areas were highlighted as 'inadequate' – the safety of the Emergency Department, Medical Care in ED and the Trust wide leadership of medical care.

Our ratings for Weston Area Health NHS Trust

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

Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community health services for children, young people and families services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Requires improvement	Good	Good

Our ratings for Child and adolescent mental health community services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding

Our ratings for Weston Area Health NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

The two 'inadequates' in the safety domain have given the Trust an overall rating 'inadequate' for safety. The Trust sought to immediately address these issues - first, with new triage processes in the Emergency Department, and secondly, with new models of medical care, working with partners to support our medical services. Additional assistance was put in place to support our medical leadership.

The two 'outstanding' scores for Child & Adolescent Mental Health Services led to an overall rating of 'outstanding' for this service. Overall 30 of the 49 areas reviewed were rated 'good' or 'outstanding'.

The Trust developed action plans to improve all the areas 'requiring improvement' This 'must do' action plan was developed in conjunction with partners, following a Quality Summit with the Care Quality Commission in September 2015. All these action plans are due for completion by the end of April 2016.

Of the 22 'must do' actions;

- seven relate to the Emergency Department
- four to operating theatres
- two to staff attendance at mandatory training
- two to patient flow
- two to governance at Directorate and service level
- one to medical cover out of hours
- one to avoidable harm across the organisation (pressure ulcers, falls and medication incidents)
- one to acuity and staffing levels on the High Care Unit
- one to IT systems and
- one to the security of medical records.

Progress with the delivery of plans to address these actions has been monitored regularly by the Senior Management Group and updates provided to the Quality and Governance Committee, Trust Board and Care Quality Commission.

We have discussed with the Care Quality Commission deferring the target date for completion of one action – pharmacy led medicines reconciliation on admission. We intend to achieve this once a robot is installed in our pharmacy. Installation is planned during 2016.17 – therefore we have requested a revised completion date of January 2017.

The Trust has publicised the results of the inspection in line with CQC requirements and the complete reports are available on the Trust website.

The CQC undertook a follow up inspection of services at the Trust between 28 February and 2 March 2017. A team of Twenty two inspectors were on site with a smaller team returning the following week for the unannounced part of the inspection.
The inspection focused on the services rated as 'requires improvement' or 'inadequate' following the inspections in May and August 2015. As such, the following services were reviewed:

- Urgent and emergency care
- Medical
- Surgery
- Critical care

The report from the inspection is likely to be available during May 2017. However, initial informal feedback to the Executive Team noted improvements – particularly in the surgical directorate – but also to some degree in the medical directorate. The timeliness of the flow of patients through the Emergency Department and the effectiveness of the Trust's response to the national staff survey was raised as areas of concern.

The Trust subsequently received a letter from the CQC on the 24 March 2017 regarding the flow of patients through the hospital and crowding and senior doctor leadership to the Emergency Department. The Trust is required to make improvements in these areas by 15 May 2017. The Director of Operations is co-ordinating a programme of work to ensure improvements occur.

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

Addendum - 20 June 2017
On 14 June (after the draft of this Quality Account was finalised) the CQC published the result of their follow up inspection in March 2017. This showed that the Trust was assessed as;

- Overall rating for this hospital - 'requires improvement'
- Urgent and emergency services – 'inadequate'
- Medical care (including older people's care) – 'requires improvement'
- Surgery – 'good'
- Critical care – 'good'

Please find the full report on the Trust website – or the CQC website.

Readers should appreciate that this assessment was received after the stakeholder statements on the Quality Account from the CCG, Health and Overview Scrutiny Committee, Healthwatch and Patients' Council were received and it has not been possible to update these prior to the publication of this report.

Concerns raised by our staff

Freedom to Speak Up Guardian

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

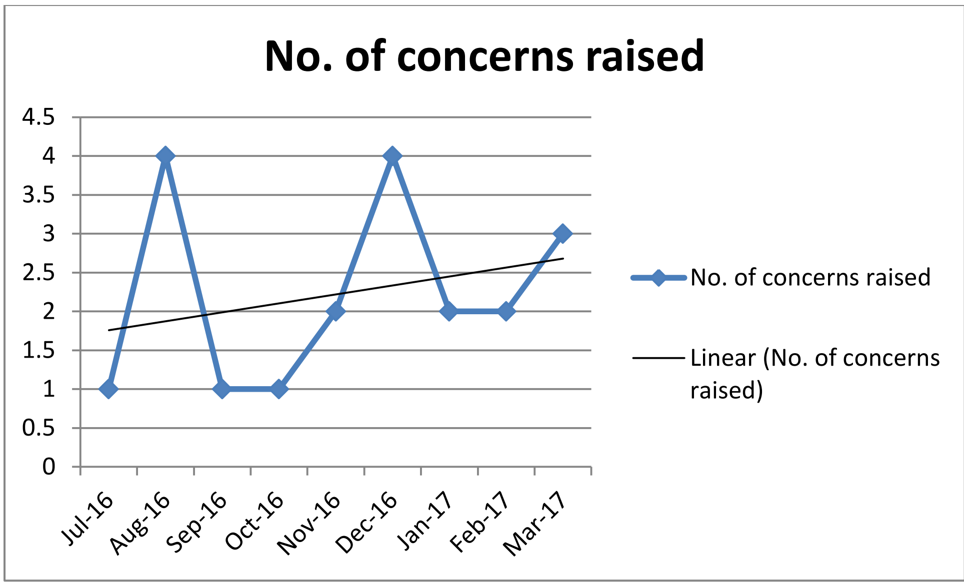
In his review of care concerns at Mid Staffordshire Foundation Trust, Robert Frances QC found that staff are reluctant to raise concerns due to;

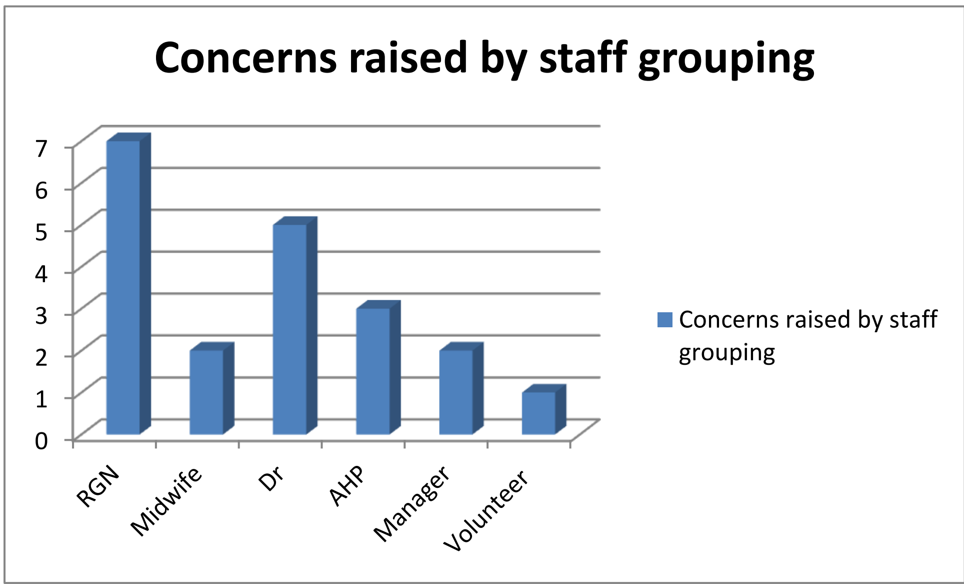
- *The potential impact on their own career*
- *The fear of being labelled a trouble maker*
- *Loyalty to colleagues – who may be implicated*
- *A lack of confidence that raising a concern will make a difference*

Frances noted that the impact on those who have raised concerns has been considerable, specifically;

- *Serious impact on mental health*
- *Reduced career chances*

The Trust's Associate Director for Governance & Patient Experience was appointed as the Freedom to Speak Up Guardian in September 2016 and has met monthly with the CEO and regularly with the Non-Executive Lead for the role – as well as reporting to the Board on two occasions.





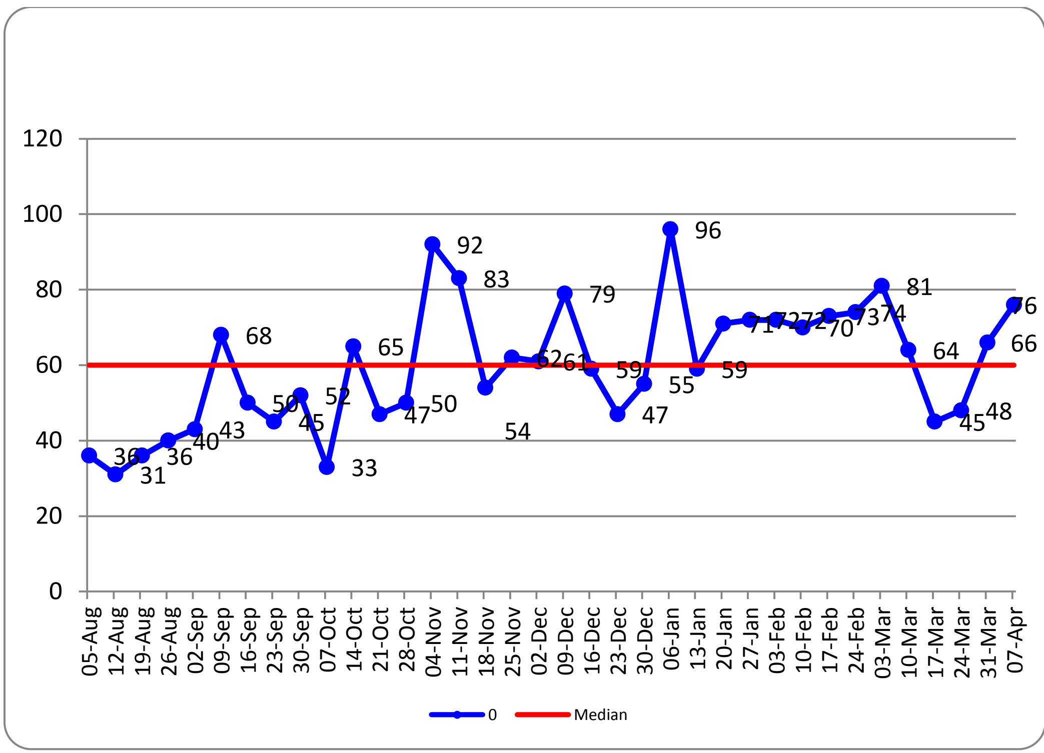
The Freedom to Speak Up Guardian agrees with the member of staff raising a concern the best way forward and supports them to the point of resolution.

Hazard Reporting

The aim of the Hazard Line is to increase the numbers of near misses, hazards and concerns reported by staff at Weston General Hospital by introducing a telephone reporting system (anonymous if preferred) alongside the current incident reporting system for actual harm.

All reported hazards are categorised and fed back to staff on a weekly basis with an update of any improvements.

Incidence of hazard reporting



It is good to see the increase in reporting as this reflects improved reporting and staff confidence in the system – rather than an increasingly hazardous environment.

The Trust has a whistle blowing policy to enable employees to raise concerns safely about malpractice so that such issues are raised at an early stage and in the right way. We know from experience that to be successful we must all try to deal with issues. The Trust welcomes any concerns raised and is committed to dealing responsibly, openly and professionally with them. Without the help of our employees, we cannot deliver a safe service and protect the interests of patients, staff and the Trust.

In the year the Trust has not received any formal concerns raised by staff under the whistle blowing policy.

Supporting our workforce

National staff survey 2016

Overall there has been a very disappointing set of staff survey results for 2016.

Staff recommendation of the organisation as a place to work or receive treatment

The scores for Q21a, Q21c and Q21d of the survey feed into Key Finding 1: *Staff recommendation of the organisation as a place to work or receive treatment*. Table 1 below illustrates how a deterioration in two of these questions which has slightly decreased the overall score for Key Finding 1. Possible scores range from 1 to 5 with 1 being the minimum score and 5 the maximum.

Table 1: Scores in Key Finding 1

	Question	2015	2016	Average for acute trusts
Q21a	Care of patients / service users is my organisation's top priority	72%	70%	76%
Q21c	I would recommend my organisation as a place to work	54%	52%	62%
Q21d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	56%	58%	70%
KF1	**Staff recommendation of the organisation as a place to work or receive treatment**	**3.62**	**3.59**	**3.77**

Overall Staff Engagement

The overall indicator of staff engagement is calculated by using the questions that make up Key Findings 1, 4 and 7.

Table 2 below illustrates that the overall staff engagement score has declined slightly from the 2015 survey results, from 3.77 to 3.73 which is not statistically significant however it means the Trust's overall rankings *'Worse than average'.* The average score for acute Trusts in 2016 is 3.81and average for acute Trust in 2015 was 3.79.

Table 2: Scores in Overall Staff Engagement

	Key Finding	2015	2016	Change since 2015 survey (benchmark change)	Ranking against all acute trusts
KF1	Staff recommendation of the trust as a place to work or receive treatment	3.59	3.58	No change (-)	Worst 20%
KF4	Staff motivation at work	3.94	3.88	No change (Average)	Worse than Average
KF7	Percentage of staff able to contribute towards improvements at work	70%	71%	No change (Average)	Better than Average
	Overall staff engagement score	3.77	3.73	Decline	Worse than average

Highest and lowest ranking scores in 2016

Tables 3 and 4 below identify the areas where the Trust has scored most and least favourably.

In the highest ranking scores table below (Table 4), key finding 24 remains one of the highest scores for a second year running as indicated by the green shaded box.

Table 3: Key Findings with the highest scores

	Key Finding	Score 2015	Score 2016	Average for acute trusts
KF 7	Percentage of staff able to contribute towards improvements at work	70%	71%	70%
KF20*	Percentage of staff experiencing discrimination at work in the last 12 months	12%	11%	11%
KF21	Percentage of staff believing the organisation provides equal opportunities for career progression / promotion	88%	86%	87%
KF27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse in the last 12 months	34%	48%	45%
KF29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	91%	90%

*The lower the score the better

In the worst ranking scores table below (Table 5), key findings 22 and 28 remain as two of the worst scores for a second year running as indicated by the red shaded box. However it is very disappointing to note that key finding 3 has moved from being one of the highest ranking scores in 2015 (as shaded green) to one of the worst ranking scores in 2016.

Table 4: Key Findings with the worst scores

	Key Finding	Score 2015	Score 2016	Average for acute Trusts
KF3	Percentage of staff agreeing that their role makes a difference to patients / service users	91%	88%	90%
KF14	Staff satisfaction with resourcing and support	3.21	3.14	3.33
KF22*	Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	19%	20%	15%
KF24	Percentage of staff / colleagues reporting most recent experience of physical violence in the last 12 months	58%	72%	67%
KF25*	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%	34%	27%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	32%	31%	25%
KF28*	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	37%	42%	31%

*The lower the score the better

In order to try and triangulate the results in the entire survey the Director of Human Resources has reviewed the worst performing 'themes' and notes the following priorities for improvement;

Errors and incidents
Staff in the Trust often report that they witness potentially harmful errors, near misses or incidents (KF28)
Staff have medium confidence that the issue reported will be dealt with fairly or effectively (KF30)- and have a medium confidence in the security of reporting unsafe clinical practice (KF31)

Health and wellbeing
More staff than in 2015 have felt work related stress in the last 12 months (KF17)
Staff continue to feel pressure to come to work (KF18)- and don't feel that the Trust or their manager takes interest in or action to support their health and wellbeing (KF19)

Managers
The level of recognition and value felt by staff by manager and the organisation has decreased (KF5)
Staff have responded that communication between them and senior management has remained the same (KF6)
Staff report that they don't feel support from their immediate manager (KF10)

Patient care & experience
Staff have reported a decline in their staff satisfaction (KF2)
They report that their role makes less difference to patients / service users than it did 12 months ago (KF3)

Violence, harassment & bullying
Staff have reported continuing experience of physical violence from non – staff in the last 12 months (KF22)- and from staff (KF23)
Staff who experience violence will report it (KF24)
More staff have experienced harassment, bullying or abuse from non-staff in the last 12 months (KF25) - and less from staff (KF26)
Staff who experience harassment, bullying or abuse from staff will report it (KF27)

Further analysis of the results relating to the different staff groups will be undertaken, together with a review of the 2015 NHS Staff Survey Action Plan.

The Trust will review the actions that were completed in response to the 2015 staff survey as they appear to have had little or no impact as many of the key findings have deteriorated.

Our initial analysis of the survey results was described in a paper to our Board in March 2017. NHS Staff Surveys - 2016 Results. A detailed action plan will be made available on the Trust's website once approved.

Supporting Apprenticeships

The Trust recognises the important contribution that apprentices can make to the workforce. Working with Weston College, we have continued to recruit a number of apprentices into administrative roles and are pleased that a high proportion are appointed to permanent positions at the end of their training. This provides a pipeline of talent into the organisation and one which we intend to grow during the year ahead.

In addition, we have continued to support our existing clinical and non-clinical staff through a number of apprenticeship programmes including Business Administration, Health and Social Care and Laboratory Technicians, with 15 staff completing their qualifications this year.

The implementation of the Apprenticeship Levy in April 2017 and the development of higher level standards including degree level apprenticeships, will undoubtedly have an impact on the way in which we train our workforce of the future. We are already planning to implement a learning pathway for the non-registered nursing workforce that will utilise the on-going developments in vocational training and ultimately aims to grow an internal route into professional registration.

Continuing Professional Development

Competent staff with regular access to training, who work well in teams, and are supported by effective leaders deliver safer, more effective care. Developing the skills of our workforce is vital in ensuring that our staff remain up-to-date with best practice. During 2016 we have been able to support staff in attending conferences in their specialist areas and investing in access to a large number of externally provided clinical and non-clinical learning programmes including leadership and management development courses.

We were also pleased to have been able to take advantage of 41 funded places on CPD modules run by the University of the West of England and commissioned by Health Education England South West. Courses included Critical Care in Practice, End of Life Care, Physical Assessment and Clinical Reasoning and Principles of Emergency Care amongst others.

Part 4
Quality improvement@WAHT

Quality improvement and innovation goals (CQUIN)

CQUINs (Commissioning for Quality and Innovation) are areas of work agreed between us and the Commissioners (North Somerset CCG) who contract us to deliver services. We agree on innovations which improve clinical quality in key areas. Some of the income generated from delivering these services is conditional on us achieving our CQUIN targets. For 2016/17 this stands at xx%. Full details of the goals set, together with how we have performed against each of them is shown below:

Commissioning for Quality and Innovation (CQUIN)

CQUIN	Description of indicator	Value of CQUIN	Achieved
Improving the health and wellbeing of NHS Staff	Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.	30%	20%
Identification and Early Treatment of Sepsis	Systematic screening for Sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review.	10%	3%
Antimicrobial resistance	Reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours.	10%	7.50%
Advice and Guidance	To deliver a proof of concept Advice and Guidance service. To design and setup the Advice and Guidance service in 2 specialities and run for a 6-month period.	8%	4%
Medicine Reconciliation	Focus on the medication reconciliation for patients admitted to all wards, including Medical Assessment Unit (MAU) and Surgical Assessment Unit (SAU) .	12%	8%
Living Beyond Cancer	Support continued implementation of the Cancer Recovery Package (for patients following cancer diagnosis and treatment).	10%	10%
End of Life TEPs	Support the implementation of agreed North Somerset Treatment Escalation Plans (TEP) at Weston General Hospital .	10%	9%
62-day Cancer	To improve timely access to first cancer treatment for patients across the region following a GP referral with suspected cancer.	10%	5%

Further detail is available via the Trust website: www.waht.nhs.uk

The income not relating to contracts for the provision of healthcare – that is, income not conditional on achieving Quality Improvement and Innovation Goals was £1,337,697 for 2016.17.

Human factors training

The Trust invited the Institute for Innovation and Improvement to train a group of its senior managers in the human factors that increase the risk of adverse incidents.

Human factors encompass all those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organisational and job factors, and individual characteristics which influence behaviour at work.

Every day in the NHS, tens of thousands of patients are treated safely by dedicated healthcare professionals who are motivated to provide high quality and safe clinical care. For the vast majority of patients, the treatment they receive alleviates or improves their symptoms and is a positive experience. However, an unacceptable number of patients are harmed as a result of their treatment or as a consequence of their admission to hospital.

In summary, some of the common human factors that can increase risk include:

- *mental workload*
- *distractions*
- *the physical environment*
- *physical demands*
- *device/product design*
- *teamwork*
- *process design.*

Awareness of human factors such as those above can help staff to:

- *understand why healthcare staff make errors and in particular, which 'systems factors' threaten patient safety*
- *improve the safety culture of teams and organisations*
- *enhance teamwork and improve communication between healthcare staff*
- *improve the design of healthcare systems and equipment*
- *identify 'what went wrong' and predict 'what could go wrong'*

• appreciate how certain tools mentioned in this guide can help to lessen the likelihood of patient harm.

Participation in national and local clinical audits

During 2016/17, there were 28 national clinical audits and 5 national confidential enquiries that covered NHS services Weston Area Health Trust provides.

During that period we took part in 93% of the national clinical audits and 100% of the national confidential enquiries relevant to us. There were a small number of national audits that we chose not to take part in. This was, for example, because our patient case mix did not meet the necessary criteria – or because of a shortage of clinical staff.

The national clinical audits and national confidential enquiries that Weston Area Health Trust was eligible to participate in during 2016/17 were as follows:

National Clinical Audit/Confidential Enquiry Title	% Participation Rate if data completed In 2016/17
Acute coronary syndrome or Acute myocardial infarction (MINAP)	20%
Adult Asthma	100%
Asthma (paediatric and adult) care in emergency departments	100%
Bowel Cancer (NBOCAP)	100%
Case Mix Programme (CMP)	100%
Child Health Clinical Outcome Review Programme	100%
Diabetes (Paediatric) (NPDA)	100%
Patient Reported Outcome Measures – Hips	78%
Patient Reported Outcome Measures – Knees	100%
Falls and Fragility Fractures Audit Programme: • Fracture Liaison Service Database • National Hip Fracture Database	 0% 100%
Heart failure	On target to be 100% by submission date
Inflammatory Bowel Disease	Nationally, participation is not ‘required’ and therefore not recorded in the audit.
Lung cancer audit (NLCA)	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	100%
Medical and Surgical Clinical Outcome Review Programme (also known as NCEPOD and Confidential Enquiries	See NCEPOD table below
National Audit of Blood Transfusion Programme: • Audit of Red Cell & Platelet transfusion in adult haematology patients • Re-audit of Patient Blood Management in adults undergoing elective, scheduled surgery	 100% 100%
National Cardiac Arrest Audit	Not participated in by the Trust.
National Audit of Dementia	100%
National Chronic Obstructive Pulmonary (COPD) Audit programme	100%
National Diabetes Audit – Adults	100%
National Emergency Laparotomy Audit	100%
National Joint Registry	100%
Oesophago-gastric cancer (NAOGC)	81% to 90%
Prostate cancer	85%

Rheumatoid and early inflammatory arthritis	100%
Renal Replacement Therapy	Nationally, participation is not 'required' and therefore not recorded in the audit.
Sentinel Stroke National Audit Programme (SSNAP)	90%
Severe Sepsis and Septic Shock – care in emergency departments	100%
National Confidential Enquiries (NCEPOD)	Percentage of required number of cases submitted
Acute Pancreatitis	60%
Mental Health	75%
Chronic Neurodisability	Not yet available*
Young People's Mental Health	Not yet available*
Cancer in Children, Teens and Young Adults	Not yet available*

*Study currently taking place; participation rate not available

There are many actions that Weston Area Health Trust is taking to improve the quality of healthcare provided following publication of several national audit reports during 2016/17 and examples are below:

National Clinical Audit/ Confidential Enquiry Title	Actions
National Adult Asthma Audit	The audit gave us an overall view of asthma care and admission demographics at Weston General hospital. It highlights the need for timely treatment and specialist care involving multidisciplinary team to care for the patients. An action plan is in place to increase the use of the asthma care bundle and to include in medical clerking proforma
National Emergency Laparotomy Audit	The action plan following the second national report includes improving CT reported before surgery, risk documented before surgery and review by Care of the Elderly Medicine when >70 years old.
Rheumatoid and Early Inflammatory Arthritis (EIA) National Audit	We have produced an action plan following the national report. The one area that we were national outliers was seeing patients within 3 weeks. We are making changes to the EIA referral pathway across the Bristol, North Somerset and South Gloucestershire networking working collaboratively across the 2 Bristol acute trusts and have had increased staffing. The outcome of the follow on audit showed the area that we were outliers on has improved significantly.

Weston Area Health Trust completed 33 local clinical audits and quality improvement projects during 2016/17. The outcomes of the audits are shared with relevant staff at specialty meetings

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

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

Local clinical audit title	Outcomes
Sepsis 6 in ED	At the start of this project 11% of patients received iv antibiotics within one hour. By February 2017 this has risen to 87%.
Audit of Neutropenic Sepsis in Weston General Hospital	Since the introduction of the Acute Oncology Service (AOS) in June 2013, intravenous antibiotic one hour door-to-needle time has been maintained at approximately 80% and neutropenic sepsis mortality is a rare event (0 – 2 % of cases). Intravenous antibiotic one hour door-to-needle time figures could be improved even more than they have been since the introduction of AOS. Actions include introduction of a Patient Specific Directive (PSD) to improve intravenous antibiotic one hour door-to-needle time and Ongoing monthly prospective audit and feedback to those involved in treating patients presenting with neutropenic sepsis.
Improved clinical management of COPD	This project is still progressing. An admission and discharge bundle has been developed together with a CO2 retainer sign.
Subarachnoid Haemorrhage	We are inappropriately discharging patients without having a lumbar puncture in suspected SAH. We have done a teaching session at our weekly grand round about SAH and CT findings and not to discharge the patients without a lumbar puncture if SAH is suspected.

Participation in clinical research

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 our staff to remain up to date with the latest treatments and contributes to achieving the best outcomes for our patients.

Last year 373 patients were recruited to participate in research approved by a research ethics committee. Nationally the median recruitment across Trusts was 11,325 (with a range of 1 – 22,649 between the highest and lowest recruiting Trusts).

As a Trust we participated in 38 clinical research studies from April 2016 to March 2017. We used the nationally recommended systems and protocols to manage these studies.

In total, 10 NIHR (National Institute for Health Research) portfolio studies began in 2016/17, with a median approval time of 24 days. Nationally the median approval time is 42 days.

During the year, 90 clinical staff across our clinical services participated in approved research. The Trust works with world renowned institutions to enable people to access high quality research studies of the type that changes practice and make a real difference to our patients.

The Trust considers that this data is as described for the following reasons:

- Size of Trust – as the smallest acute Trust in England we are unable to open the number of studies or recruit the number of participants that a large teaching trust can.
- We are reliant on "hosting" studies. We don' the resources or expertise to devise and open complex studies in our own right.

We consistently meet the 30 day target for approving studies.

The Trust works with the West of England Local Research Network to maximise the number of research studies available to patients and minimise delays in setting up these studies.

The following actions that have been implemented to improve these scores, and so the quality of services, are:

- Careful selection of suitable studies with realistic targets set for recruitment
- Concentrating resources on poor performing studies
- Paying careful attention to approval timelines with early intervention if problems arise.

Description	Speciality	Patients participating
Add-Aspirin Trial – Investigating whether aspirin can reduce the risk of cancer coming back.	Cancer	2
AFGEN: Long-term Registry of Atrial Fibrillation patients.	Cardiology	8
Airway Management in cardiac arrest patients (AIRWAYS-2).	Emergency	1
aRCC CA209-162 – collecting data about people with kidney cancer.	Cancer	26
Bridging the Age Gap in Breast Cancer.	Cancer	4
CANC – 4226 – collecting data about men with prostate cancer.	Cancer	13
CANC - 4381 PREMISE - A study for men with prostate cancer taking a drug called Enzalutamide.	Cancer	4
CANDID – For people with suspected cancer.	Cancer	95
Children of the Children of the 90's.	Maternity	2
Decision-making for intensive care unit admissions.	Critical Care	1
Incident and high risk type 1 diabetes cohort.	Diabetes	5

TrialNet - Research for people with type 1 diabetes and their siblings.	Diabetes	17
Epidemiology of Critical Care provision after Surgery (EpiCCS) - SNAP2.	Anaesthetics	54
FAIT – Hip impingement study.	Orthopaedics	1
FOCUS 4 – Personalised medicine study for people with bowel cancer.	Cancer	2
FOCUS -The effect (s) of routine administration of Fluoxetine in patients with a recent stroke.	Stroke	4
Entyvio (vedolizumab) long-term safety study: An international observational prospective cohort study comparing vedolizumab to other biologic agents in patients with ulcerative colitis or Crohn's Disease.	Gastroenterology	25
GO2 – oesophageal and stomach cancer study.	Cancer	1
Hughes Abdominal Repair Trial (HART)	Surgery	1
ICARE – Inflammatory bowel disease, Cancer and Serious Infections in Europe.	Gastroenterology	22
Intraoperative Hypotension in Elder Patients (IHypE).	Anaesthetics	6
MAMMO-50 – A study looking at the frequency of follow-up mammograms for ladies who have had breast cancer.	Cancer	6
MOCAM – Questionnaire for people with back pain.	Physiotherapy	22
Outcomes important to patients with Psoriatic Arthritis.	Rheumatology	8
PANTS – Inflammatory bowel disease.	Gastroenterology	4
PANTS E – Inflammatory bowel disease.	Gastroenterology	8
PATCH – Comparing different treatment options for men with prostate cancer.	Cancer	4
PLATFORM – for people with oesophago-gastric cancer.	Cancer	1
RADICALS (MRC PR10) - Looking at the role and timing of hormones and radiotherapy in men with prostate cancer.	Cancer	1
ReFLeCT - For people with diabetes starting a new type of insulin.	Diabetes	7
ROCS: Radiotherapy after Oesophageal Cancer Stenting Study.	Cancer	2
Screening and diagnosis in psoriasis and psoriatic arthritis.	Rheumatology	3
Select-d - Comparing different anticoagulant treatments for people with cancer who develop blood clots	Cancer	3
SPUtNIk – a study for people with lung nodules.	Radiology	1
Stampede - Comparing different treatment options for men with prostate cancer.	Cancer	3

Toxicity from biologic therapy (BSRBR).	Rheumatology	1
UNIRAD – for people who have a high risk of their breast cancer returning.	Cancer	5
Total		**373**

Making a Difference

The Patch study is a Medical Research Council study for men with prostate cancer. It has been running for a number of years and early results are encouraging. Interim analysis indicates that men receiving the patches reported better quality of life outcomes compared to men receiving the standard hormone therapy. This study continues to recruit new participants.

UNIRAD is a study for ladies with breast cancer where there is a high risk of the disease returning (relapsing). Participants are offered a drug called Everolimus to see if it will reduce the risk of relapse.

Reported outcome measures for surgery

The Trust has participated in the Patient Recorded Outcome Measures (PROMs) programme since April 2009 for hernias, knee and hip replacements. The programme involves patients completing a pre-operative questionnaire and then a questionnaire either 3 or 6 months after the operation (dependent on type of operation). The Trust is responsible for identifying relevant patients, offering them a pre-operative questionnaire and returning completed questionnaires to the national co-ordinating centre. The Trust posts the initial questionnaire to patients before they attend pre operative assessment. This allows any queries to be discussed in person at that appointment. The questions are based on quality of life measures. The national co-ordinating centre data return includes all surveys returned to it – even when patients turn out to not be eligible – hence the percentage participation rate sometimes exceeds 100%! Also the centre takes a long time to process the results – therefore the data is only available a year in arrears.

PROMS Participation Rate

PROMS participation rate	**WAHT Participation Rate April 2015 to March 2016**	**NHS Participation Rate April 2015 to March 2016**	**WAHT Participation Rate Apr 2016 to Dec 2016**	**NHS Participation Rate April 2016 to Dec 2016**
Hernia	39.50%	59.90%	32.90%	56.30%
Hip	75.50%	85.90%	90.30%	85.30%
Knee	100.00%	93.70%	125.00%	94.00%

Performance

Weston Area Health NHS Trust	**WAHT Health Gain Average April 2015 to March 2016**	**NHS Health Gain Average April 2015 to March 2016**	**WAHT Health Gain Average April 2016 to Dec 2016**	**NHS Health Gain Average April 2016 to Dec 2016**

Hernia	Not Measurable	0.084	0.249	0.087
Hip	0.405	0.427	0.496	0.449
Knee	0.318	0.313	0.379	0.330

'Not measurable' means numbers of patients who responded were so low that the analysis was withheld by the HSCIC for confidentiality reasons

Data as reported by the HSCIC Information Centre http://www.hscic.gov.uk/

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

Responsiveness to the personal needs of patients

The annual adult inpatient survey is carried out in all Trusts (www.cqc.org.uk). 83 out of the 156 Trusts use a company called Picker to manage this – and at the time of writing only the results from Picker Trusts are available. The survey is based on a sample of consecutively discharged inpatients who attended Weston in the summer of 2016. 1250 questionnaires were sent to patients of which 1158 were eligible to partake in the survey. The Trust received 538 completed responses giving a response rate of 46%, slightly higher than the previous year of 45%.

WAHT	**2015**		**2016**			
	Weston	National	Weston	National	Highest	Lowest
Survey response rate	49%	45%	46%	TBC	TBC	TBC

This data compares us with the 83 Picker Trusts – since at the time of writing this Account the nationwide comparative data was not available.

Of the 'Picker Trusts' the Trust was significantly better than average on five questions, significantly worse than average on seventeen questions and showed no significant differences on forty five questions.

The Trust has improved significantly the percentage of patients that rated care at 7+ out of 10. None of the responses have worsened significantly .

The survey has highlighted many positive aspects of the patient experience.

- Overall: rated care 7+ out of 10 - increased to 86%
- Overall: treated with respect and dignity – increased to 85%.
- Doctors: always had confidence and trust – increased to 80%.
- Hospital: room or ward was very/fairly clean – unchanged at 98%.
- Hospital: toilets and bathrooms were very/fairly clean – unchanged at 97%.
- Care: always enough privacy when being examined or treated - increased to 92%.

Most patients are highly appreciative of the care they receive. There is however also room for improving the patient experience

Pleasingly the report indicates improved responses regarding;

- The experience of discharge from hospital
- Levels of confidence and trust in doctors
- Being asked regarding the quality of care whilst an inpatient
- Receiving information on how to complain

Areas of concern and ongoing improvement include;

- Feeling threatened by other patients or visitors
- Bothered by noise at night
- Doctors talking in front of patients as if they were not there
- Knowing which nurse was in charge of care
- Finding a member of staff to discuss concerns with
- Discharge; knowing what would happen next with care
- Discharge; understanding medications
- Discharge; knowing who to contact if worried

Detailed analysis of the 2016 survey results and our response will be published on www.waht.nhs.uk once received. A detailed action plan will be developed from this feedback and will be made available on the Trust's website.

During 2016.17 we also introduced external surveys of patients' experiences in the Emergency Department and in Outpatients Departments. The action plan from Outpatients was reviewed by Patient Experience Review Group in October 2016. We are currently developing the action plan from the Emergency Department survey report – which received by the Trust in April 2017.

Our Friends and Family Test results

The Friends and Family Test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. As well as the standard six-point response for wards we have included additional questions to generate a richer data base to inform learning and change. The Trust introduced this survey tool in January 2013 for all acute wards and the Accident and Emergency Department. In October 2013 the survey was extended to include Maternity services. Each Directorate and ward receives a breakdown of the outcome of their survey results to allow them to take relevant action. In October 2014 the survey was extended to outpatients.

The Trust Friends and Family response rate and recommendation score is compared with the average scores for NHS acute services across England.

The results for 'Would Recommend' have been calculated using the formula:

$$\text{Recommend (\%)} = \frac{\text{(Extremely Likely + Likely)}}{\text{All responses x 100}}$$

The responses are divided into four categories; inpatients outpatients, maternity and A&E attendees. Our maternity, outpatients and results and A&E recommendation score has compared favourably with the national average.

The tables below give further detail.

Maternity question 1 = antenatal care
Maternity question 2 = care during birth
Maternity question 3 = care on the postnatal ward
Maternity question 4 = postnatal care in the community

			Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Would Recommend	In-Patient	Trust	94%	94%	97%	95%	95%	97%	94%	96%	95%	95%	97%	95%
		England	96%	96%	96%	96%	95%	96%	95%	96%	95%	95%	96%	96%
	A&E	Trust	88%	92%	93%	95%	81%	82%	79%	79%	90%	89%	94%	91%
		England	86%	85%	86%	85%	87%	86%	86%	86%	86%	87%	87%	87%
	Out patient	Trust	93%	89%	92%	95%	96%	95%	95%	97%	98%	95%	96%	94%
		England	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	94%
	Maternity	Trust 1	100%	96%	100%	96%	100%	96%	89%	100%	100%	93%	100%	100%
		England	96%	96%	95%	95%	95%	96%	95%	96%	96%	96%	96%	96%
		Trust 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		England	96%	97%	97%	97%	96%	96%	96%	97%	96%	97%	97%	97%
		Trust 3	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		England	94%	94%	94%	93%	93%	94%	94%	94%	94%	94%	94%	94%
		Trust 4	100%	100%	98%	100%	100%	100%	100%	97%	100%	100%	100%	98%
		England	97%	98%	98%	98%	97%	98%	98%	97%	98%	98%	98%	98%
Response Rate	In-Patient	Trust	40.4%	41.9%	42%	44%	33.4%	35.7%	31.5%	34.6%	31%	34%	38.10%	37.6%
		England	25.60%	25.90%	26.70%	27.60%	24.80%	26.70%	24.40%	24.40%	22.60%	24.3%	25.1%	26.1%
	A&E	Trust	4.9%	5.2%	4.5%	3.5%	5.2%	4.4%	2.9%	3.8%	1.6%	5.9%	5.70%	6.5%
		England	12.9%	12.9%	13.4%	12.9%	13.7%	13%	12.8%	12.7%	11%	12.3%	12.7%	12.9%
	Maternity (Births)	Trust	66.7%	73.7%	21.4%	81.3%	50%	38.1%	41.4%	100%	53.8%	40%	46.2%	23.1%
		England	23.8%	24%	35.4%	26.2%	22.9%	22.8%	21.9%	23.3%	21.5%	25.5%	23.1%	24.4%

Learning from PALs and complaints

The Trust has a well-established Patient Advice and Liaison Service (PALS) and a complaints-management system, supported and facilitated by a Senior Manager. Both services are used to ensure that patients and people using Trust services are supported in navigating the system and finding resolution to questions, concerns and complaints. The information from these questions, concerns and complaints is routinely analysed and used to inform service development and reported to the Trust Board through formal monthly reports.

The Senior Manager for complaints and PALS actively engages in supporting the development of staff to ensure they are able to respond appropriately and sensitively to complaints, whilst

handling sensitive situations and data. A complaints investigation training programme was delivered in 2016. Staff training in complaints resolution is now available a part of the Trusts annual training programme and will remain high on the training agenda for the Trust.

The Trust received a total of 251 formal complaints which represents a 16.2% increase on the last year's total of 216 for 2015/2016.

The Trust looks for trends in complaints to see if there are any recurring or growing issues that may need special attention. The main subjects of complaint are around medical treatment and communication. The proportion of complaints linked to medical treatment and nursing care has risen slightly. The most significant increase however is the number of complaints linked to communication. To improve the standards of care the Trusts continue to deliver initiatives such as ward Wednesday which involves formal weekly ward visits by the Directorate Matrons, Director and Associate Director of Nursing and other senior nurses. The purpose is to monitor how care is delivered, specifically looking at the dignity, safety and the welfare of patients.

Throughout the year the themes of all complaints are reviewed. Directorates report on the learning that has been identified from the complaints resolved during the month. The Matrons and Departmental Managers ensure that any learning identified through complaints is shared across teams within the Directorates and that all improvements identified are fully implemented.

Complainants are always invited to come into the Hospital and discuss their concerns with the relevant staff, and this helps staff to get a better understanding of how things are from a patient's or family's perspective as well as helping patients and families to hear the staff view.

The table below shows the main types of complaints received during 2016/17 and the changes from last year.

Main types of complaints received during 2016/17:

	2014/15	**2015/16**	**2016/17**
Complaints about staff attitude - %	8%	6%	6%
Complaints about medical treatment - %	24%	23%	24.7%
Complaints about nursing care - %	11%	10%	12.9%
Complaints about communication - %	23%	23%	31.5%

Deprivation of Liberty Safeguards

The new Supreme Court ruling on Deprivation of Liberty Safeguards (DoLS) came into force in March 2014. Substantial work has been implemented by the Trust introducing new processes and systems, underpinned by a robust training programme. The data in the following graph reflects the improvement within this area of Safeguarding.

The quality check by the Trust safeguarding team before all applications are submitted for assessment, has proved to be beneficial in submitting good quality applications. The following graph demonstrates a significant improvement. The DoLS training programme has included 'on the ward' teaching sessions from the Adult Safeguarding lead and is now integral to the statutory mandatory mental capacity act training delivered by the Trust Adult Safeguarding lead.

Learning Disability
The Trust provides a robust Learning Disability service for both inpatients and outpatients. The service is overseen by the adult safeguarding lead nurse with support from the complex needs sister. The service accepts referrals for people with a Learning Disability that require reasonable adjustments or pre admission best interest planning. The Trust recorded 153 emergency admissions, 9 elective admissions and 51 day cases for people with a Learning Disability in 2016/17. The safeguarding team were actively involved and made 216 contacts with patients with a learning Disability within this timeframe. Positive feedback has been received from both carers and staff re the planning and attention to detail to ensure a smooth patient journey. Best interest meetings have increased with a greater awareness from specialist nurses and Consultants re mental capacity, consent and reasonable adjustments. The complex needs sister encompasses a liaison role, building relationships with Learning Disbility teams across county borders and carers. The Trust Learning Disability steering group has been resurrected with a 2017/18 work plan. The Trust has continued representation on the North Somerset Learning Disability partnership board and actively works towards meeting north somerset strategic objectives.
The commissioner for acute learning disability care provided a comprehensive set of commissioned standards, some of the care delivered was not initially captured, as is reflected in the first quarter of the return; however the existing data base was improved allowing all data to be recorded and entered.

Hospital Episode Statistics

Keeping details of the care provided across the NHS is important for patients and the organisation. Hospital Episode Statistics (HES) is a store of data containing 125 million patient 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 to support the NHS and its partners in planning, commissioning, management, research, audit, public health, and operating the Payment by Results system (a reimbursement mechanism for acute care payments).

The data below is provided by the Health and Social Care Information Centre and shows the quality of records submitted by Weston Area Health Trust. This shows that Weston has improved the data that is submitted and continues to exceed the National Average.

Weston Area Health NHS Trust	Weston 2015/16	2016/17 (Apr – Jan)	
		Weston	National average
% of records including the patient's valid NHS number:			
Admitted patient care	99.9%	99.9%	99.3%
Outpatient care	100.0%	100%	99.5%
Accident and emergency care	99.8%	99.7%	96.7%
% of records including the patient's			

Weston Area Health NHS Trust	Weston 2015/16	2016/17 (Apr – Jan)	
		Weston	National average
valid General Medical Practice Code:			
Admitted patient care	100.0%	100%	99.9%
Outpatient care	100.0%	100%	99.8%
Accident and emergency care	100.0%	100%	99.0%

Information Governance Toolkit score

Information Governance is the term used to describe all the legal rules, guidance and best practice that apply to the handling of information. Good information governance keeps 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 the Department of Health

Our Information Governance Assessment Report overall score for 2015/16 was 74%, with a level 2 and above score across all requirements. Our performance in our 2016/17 submission resulted in a slight reduction of 1% to 73% with a level 2 and above score across all requirements.

Action we have taken to improve data quality

Weston Area Health NHS Trust has taken the following actions to improve data quality:

We keep monitoring our data quality. The Trust has a Data Quality Policy and an Information Improvement Team. This policy, along with a wide range of others relevant to data quality, is regularly reviewed by the Trust’s Health Informatics Committee which also monitors the work of the Information Improvement Team and Health Informatics in general.

We have set up new initiatives, including the establishment of a Data Quality Group with our commissioners which will steer the data quality improvement plan. This is attended by the Information Improvement Manager, finance, Information, and data warehousing.

The Board regularly discuss a very wide range of data regarding quality and patient safety, operational performance, human resources and finance. This helps to improve data quality and presentation through robust discussion, questioning and analysis by executive directors, non-executive directors, patients’ representatives and members of the general public. The Trust has also set up a Classification Group to ensure all appropriate activity is recorded and complies with national guidance.

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

'State of the art' protection

With the increase in Cyber Security incidents across the world, the trust's capital programme has invested a significant financial sum in order to reduce the risk of cyber attacks and to ensure patient and employee data is protected.

The Trust has an annual cycle of penetration testing in order to identify any weaknesses to the network, but further investment has been made to enhance the back-up and recovery of data as well as heightened cyber-attack detection and neutralisation.

There has also been a significant amount of activity regarding upgrading and enhancing some of the trust's clinical systems. This will give the trust greater functionality but also a platform to develop more clinical and administration benefit in future.

Part 5 Our future plans

Our Patients' Council checked our understanding on the meaning of 'quality care' by surveying visitors to the hospital. Feedback indicated that 'good quality care' meant being treated with a sense of shared humanity and respect above all else.

Using this feedback as our frame of reference, our quality improvement goals for 2017/18 have also been informed by;

- Feedback from Care Quality Commission inspections of the Trust.
- National requirements included in the NHS Constitution and Five Year Forward View.
- The needs of our population as described in the latest Joint Strategic Needs Assessment.
- The experiences of our patients – captured by the work of our Patients' Council, Patient Experience Review Group and Healthwatch North Somerset.
- Performance data about the Trust – including mortality, incidents, complaints/PALs and audit data.
- Our corporate risk register and Board Assurance Framework
- The views of our staff

Priority one				
Reducing avoidable deaths – Executive Lead = Medical Director				
We will	**Why**	**How**	**Measure**	**Lead**
We will implement the *National Quality Board framework on identifying, reporting, investigating and learning from deaths in care.*	In the most recent mortality data the Trust remains in the "higher than expected" category.	Our Quality Improvement Hub will lead the implementation of the National Quality Board framework on identifying, reporting,	Progress with the implementation of the NQB framework will meet the milestones set in the guidance and be monitored each quarter by	Director of Patient Safety

		investigating and learning from deaths in care.	our Senior Management Group. Learning from all in-hospital deaths integrated into clinical care pathways and noted in the minutes of the Mortality Review Group. Increased learning as demonstrated from governance minutes and reversal of SHMI trend. Early Warning Scores (EWS) – 100% acute medical admissions will have accurately recorded EWS which is appropriately acted upon. We will establish Quality Improvement Projects for our main areas of risk By the end of March 2018 90% of the most unwell patients (requiring treatment in ED 'majors') will have a completed SHINE checklist.	

Priority two

Improving discharge from hospital – Executive lead = Director of Operations				
We will	**Why**	**How**	**Measure**	**Lead**
We will work closely with patients and their families to improve our discharge planning.	Being in hospital longer than is necessary increases risk for patients and is expensive and inefficient.	We will begin to plan for discharge home much earlier and improve our communications with patients and their families. We will integrate our current discharge service. We will embed the SAFER bundle on our inpatient wards We will improve our information on medications for patients to take home	95% of inpatients will agree an expected date of discharge (EDD) within 24 hours of assessment. The responses to the national patients survey of 2016 will improve by 5% for question 51 – *involved in decisions around discharge* The percentage of patients readmitted within 24 hours will reduce. We will reduce the number of 'bed days lost' from 600 per month to 250 per month	Associate Director for Nursing (Emergency Directorate) General Manager (Emergency Directorate)

What is a safety bundle?
It's a term or concept developed by faculty at the Institute for Healthcare Improvement as a way to describe a collection of processes needed to effectively care for patients undergoing particular treatments with inherent risks. The idea is to bundle together several scientifically grounded elements essential to improving clinical outcomes. A bundle should be relatively small and straightforward − a set of three to five practices or precautionary steps is ideal.

Priority three

Organisational development – Executive Lead = Director of HR

We will	Why	How	Measure	Lead
We will focus on developing leadership capability of all managers and leaders in the Trust.	The turnover of managers is higher than expected. This has been identified as a priority for improvement by our staff. Staff survey outcomes identify that managers 'people skills' require development.	We will develop an in house leadership development programme. Introduce 'staff conversation' to improve communications between managers and staff.	Improvement in staff survey response to Theme 7; KF5 *Recognition and value of staff by managers and the organisation* KF6 *Percentage of staff reporting good communication between senior management and staff* And KF10 *Support from immediate managers*	Director of Human Resources

Priority four

Workforce development – Executive Lead = Director of HR

We will	Why	How	Measure	Lead
We will seek to stabilise our workforce by reviewing roles and increasing development opportunities.	We believe that by investing in staff we support the quality and safety of patient care	We will develop career pathways utilising the apprenticeship levy, taking into account the need to remodel existing roles. We will develop an Advanced Practice Framework for Nursing and	Our Workforce Strategy and delivery plans agreed. Increased percentage of services delivered in conjunction with partners.	Director of Human Resources Director of Nursing Medical Director Director of Operations

		Allied Health Professionals Proactively develop opportunities to work in partnership with other Providers Development of a frailty service New MD will review job plan time to provide the governance requirements of the Trust	Position scoped & business plan developed.	

Priority five				
Strengthening governance – Executive Lead = Director of Nursing				
We will	**Why**	**How**	**Measure**	**Lead**
We will further develop the oversight of care at the Trust – this includes the learning from when things go wrong.	We recognise that all staff involvement in the oversight of the quality and safety of care requires improvement.	We will Increase the organisational awareness of good governance. Improve learning from serious incidents Sharing good practice Work with partners to ensure governance processes are aligned and standardised.	100% compliance with submission of reports to the CCG (within 60 days) Regular governance meetings occur in all Departments. Monthly safety reminders (posters and newsletters) distributed to staff The Hazard and Heart line reporting consistently linked into governance	Deputy Director of Quality Assurance and Improvement Head of Governance

			processes.	

SHINE

The SHINE safety checklist is a time based list of tasks that is completed for every very unwell patient in the Emergency Department. The checklist can be completed by any member of clinical staff in any area. It is prescriptive and contains all basic elements of care.

Since the introduction of the checklist at other Trusts, the quality and safety of care has improved despite increasing demand and service pressure.

Our aim in using the checklist at Weston is to monitor and measure the quality and safety of patients within the ED and to improve early decision making, escalation if required and to have patients on the appropriate care pathways. There are also nurse sensitive markers on the check list that will enable care and comfort. All of which can be measured, monitored and improved.

Priority six				
Reducing the number of pressure ulcers – Executive lead = Director of Nursing				
We will	**Why**	**How**	**Measure**	**Lead**
We will considerably reduce avoidable pressure sores for our patients.	Pressure sores are debilitating for patients and largely avoidable injuries which cost the NHS millions of pounds every year.	We will increase our tissue viability leadership in the Trust. We will increase our work with partners in health and social care – to promote pressure ulcer prevention at home.	By the end of March 2018 we will achieve a 25% reduction in hospital acquired pressure ulcers.	Tissue Viability Lead Nurse Associate Director of Nursing (Emergency Directorate)

By choosing these measures we are intentionally focusing our efforts to improve in five key areas;

- Patient safety
- Supporting our staff
- Improved patient experience – including a speedy return home
- Partnership working

How we will monitor, measure and report on our progress

Making sure that we can demonstrate that we are achieving our priorities is important for staff, patients and carers.

Governance is the term used to describe a systematic approach to planning, monitoring and improving the quality of care and services we deliver. The type of systems we use to do this include carrying out audits of care, patient surveys, listening to staff concerns and identification of risk.

We use our Integrated Performance Report to discuss in detail at each Board Public Meeting our performance measured by such systems. 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;
- 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, cash flow and savings plans.

As well as the Board report, we have a range of other meetings between staff who work directly with patients. These consider reports such as our "Performance Assurance Framework" which shows operational, quality workforce and finance performance for each division. A local performance metrics dashboard is also produced monthly, specifically to assist departmental managers focus improvements against national priorities.

Our performance against our priorities is also subject to scrutiny and review by our commissioners and NHS Improvement. The Care Quality Commission also regulates our service and conducts unannounced and planned inspections. The CQC reports its findings to the public on their website.

Part 6
Statement of Assurance from the Directors of Weston Area Health NHS Trust

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.
- 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.

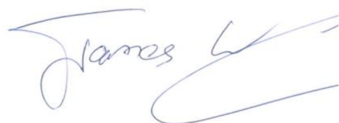
At Weston Area Health NHS Trust we are striving to deliver the highest level of good quality and safe care to our local population. The Trust Board is satisfied that, to the best of its knowledge and using its own processes and its own information on incidents, patterns of complaints, and including any 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.

To the best of our knowledge we confirm that the information in this document is accurate.

By order of the Trust Board

Date 2017

Grahame Paine, Chairman



Date 2017

James Rimmer, Chief Executive

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

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

We are required to perform an independent assurance engagement in respect of Weston Area Health NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. 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 2017 subject to limited assurance consist of the following indicators:

- percentage of patients risk-assessed for venous thromboembolism (VTE), and
- the Friends and Family Test (FFT) patient element score.

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 2014-15 issued by the Department of Health in March 2015 ("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 1 April 2016 to 28 June 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 28 June 2017;
- feedback from Commissioners, dated 12 May 2017;
- feedback from Local Healthwatch organisations, dated 10 May 2017;
- feedback from Overview and Scrutiny Committee, dated 10 May 2017;
- feedback from the Trust's Patient Council, dated 9 May 2017;

- the Trust's complaints report 2015-16, published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 5 July 2016;
- the latest national patient survey dated February 2017;
- the latest national staff survey dated March 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017;
- the annual governance statement dated 26 May 2017.
- the CQC Quality Report dated 14 June 2017.

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.

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 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;
- limited testing, on a selective basis, of the data used to calculate the indicators tested 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 limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Weston Area Health NHS Trust.

Basis for adverse conclusion

The indicator reporting the 'percentage of patients risk-assessed for venous thromboembolism (VTE)' did not meet the six dimensions of data quality in the following respects:

- Accuracy and Reliability– Our testing of a sample of 25 cases included in the indicator as not VTE risk assessed identified ten cases where a valid risk assessment had been undertaken on admission. This was due to the fact that all cases where patients' files had not been reviewed by the Trust's VTE assessor were incorrectly included as having not been VTE risk assessed in the VTE database supporting the indicator, even if a risk assessment had been carried out;
- Accuracy, Reliability and Validity - Our review of the reports underlying this performance indicator identified that patients who were admitted to hospital because they had a diagnosis or signs and symptoms

of deep vein thrombosis (DVT) or pulmonary embolism were not excluded from the numerator and denominator of the indicator, as is required by the indicator definition.

The indicator reporting the Friends and Family Test (FFT) patient element score did not meet the six dimensions of data quality in the following respects:

- Accuracy – Our testing identified that FFT scores for three of the 25 cases that we tested did not agree to patient return cards.
- Completeness, Reliability and Validity – Our testing identified that for ten of the 25 cases that we tested, no patient return cards or other appropriate supporting evidence could be provided to substantiate the FFT scores recorded.

Adverse conclusion

Based on the results of our procedures, we conclude that:

- 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.

Nothing has come to our attention that cases us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations; and
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

30 June 2017

Statement from NHS Bristol, North Somerset and South Gloucestershire and NHS Somerset CCG

1.1 BNSSG and Somerset CCGs have reviewed the Weston Area Health Trust Quality Report for 2016/17 and consider the report to be an honest account of the quality of care provided to patients.

1.2 We have reviewed the information presented in the quality report and are satisfied that it is an overall accurate account of the quality of services and can confirm that the Quality Account meets the national requirements in respect of content, provides a balanced view of the Trust's achievements and, as such, is an accurate reflection of the quality of services provided. The Quality Account should be both retrospective and forward looking, the Trust have looked back on the previous year and looked forward explaining their priorities for improvement over the coming year. The Trust has been very open explaining the challenges they have faced in 2016/17 following the Care Quality Commission visit in May and August 2015. The quality improvement priorities are linked to areas where the Trust knows performance should be improved. The importance of sustainability of services in Weston is recognised however the report does not make explicit reference to the consultation that occurred at the end of this period.

1.3 The BNSSG and Somerset CCGs regularly review the quality and safety of the services at Weston Area Health Trust, using a broad range of quality indicators; these are reported to the Quality and Performance Sub Group these include the priorities identified for 2016/17 as part of the Commissioning Quality and Innovation (CQUIN) framework agreed with the Trust along with national and local indicators. It is disappointing that only three of the twelve objectives were fully achieved however the smaller focused objectives for 2017/18 are noted together with a focus on supporting the workforce to deliver improvements and provide a sustainable basis for provision of services.

1.4 The CQC published their report from the inspection of Weston Area Health Trust undertaken in June 2016 on the 26 August 2016. Since then there has been focused activity by the Trust in partnership with commissioners and regulators to address the concerns raised. As the account recognise the outcome of the most recent visit to the Trust by the CQC is awaited.

1.5 The BNSSG and Somerset CCG are members of the Sustainability Board for Weston Area Health Trust and attend regular meetings at the Trust to support the improvement plan.

2 PATIENT SAFETY

2.1 The Trust has had a continued focus on the challenging Health Care Acquired Infection targets and achieved the zero tolerance for MRSA blood stream infections. The Trust also achieved the challenging national target that had been set for the reduction in the number of Clostridium difficile cases and lapses in care were identified in 44% of these cases, the Trust is to be congratulated on this performance.

2.2 The Trust has responded to the challenges in identifying an objective for 2016/17 to reduce the number of pressure ulcers. This was not achieved and the number of hospital acquired severe pressure ulcers (Grade 3 and 4) increased from 2015/16 to 35. It is notable that reducing pressure

ulcers remains a key objective of the Trust and that a 25% reduction is planned. We look forward to the delivery of this objective in 2017/18 in reducing harm to patients in hospital.

2.3 The Trust reported one Never Event in 2016/17 which is a reduction on the previous year. This related to a retained object post surgery. The Trust has had enhanced oversight in place from NHS Improvement who are supporting the Trust in identifying and implementing actions for individual events and incident themes.

3 CLINICAL EFFECTIVENESS

3.1 Summary Hospital-level Mortality Indicator (SHMI) remains in the ‘Higher than expected’ category and work has been ongoing in the Trust to understand why this should be the case and what actions could be taken to reduce this. This work is ongoing and will be a focus of work that the commissioner will continue to support the Trust to explore and respond to.

3.2 The 62 day cancer CQUIN will not be achieved, the Commissioners look forward to this improving in 2017/18.

3.3 The Trust has failed to meet the four hour A&E standard of treatment within four hours. Commissioners continue to work with the Trust and regulators to ensure safe provision of services within the Emergency Department and in improving access for patients.

3.4 The Trust has noted that the outcome of the staff survey for 2016 is very disappointing and deterioration in staff engagement. Improving areas are to be noted including the percentage of staff reporting violent episodes and experience of bullying and harassment.

4 PATIENT EXPERIENCE

4.1 The Quality Account is an important way of informing the users of services of how the Trust has acted on feedback to improve the quality of services.

4.2 The national inpatient survey published in 2016 for the Trust has shown some improvement, although some are showing a decrease in scores. The survey did highlight positive aspects of patient experience including level of confidence and trust in doctors; receiving information how to complain and being asked about quality of care. Areas of concern included feeling threatened by other patients and visitors, discharge processes such as understanding medications and knowing who to contact if worried. It is also noted that the number of complaints in 2016/17 amounting to a stated 16.2% increase on the previous year.

4.3 The Patient’s Council and Patient Experience Review Group are highlighted as an ongoing area of good practice in 2016/17 for providing patient feedback and patient involvement. A notable piece of work being a project to check the Trust’s understanding of the meaning of ‘quality care’ by administering a survey to visitors to the hospital.

5 DATA QUALITY

5.1 The Trust has reported on national quality standards required to be included in quality accounts and confirms with the exception of delayed transfers of care (DTOC) the data quality is sound.

Looking forward, the CCGs are supportive of the Trust's quality priorities for the year ahead and recognise its challenges. We welcome the opportunity in working together to deliver the Trust's and CCG's priorities in 2017/18.

Yours sincerely

Jacqui Chidgey- Clark
Director of Nursing and Quality,
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups

Sandra Corry
Director of Quality, Safety and Governance,
Somerset Clinical Commissioning Group
23 May 2017

Statement from the Patients' Council

The Patients' Council is pleased to be the critical friend of the Trust and to have regular updates about any changes in the hospital.

The Trust has seen an increase in activity in the Emergency Department which put large pressure on all staff. However with careful planning the patients whilst having to wait in the curtained areas in the corridor were treated with professional care and dignity.

Currently there are often problems with discharging patients but there is ongoing joint work in progress to ease this national problem.

The Trust still struggles to recruit doctors and nurses possibly due to the unknown future of the hospital which has resulted in agency staff being used.

The CCG has held an engagement process looking at the STP and the future uses of the hospital. The Patients' Council notes the building of thousands of new houses in North Somerset which will impact on all services.

The vast percentages of patients are over 70 with often extra problems. This has resulted in the hospital staff becoming dementia aware and holding dedicated dementia care.

The Patients' Council are pleased to have been involved in the PLACE inspection and expect an excellent result

We note that the Ashcombe Maternity Ward is bright and cheerful and provides an excellent service for Mum's with no known complications

The Patients' Council members attend various meetings including governance and Patient Experience Review Group. Members are regularly involved in providing information to the Trust and their Chair has a place on the Board

Members of the Patients' Council observe the quality of interactions between staff and patients on the wards and this results in improvements between staff and patients

We note that there are still areas of concern regarding pressure ulcers despite 'Edible Ed' being developed by a member of staff to improve staff awareness.

Whilst the Patients' Council note the high mortality rate we also note the age of the patients and their frailty.

Margaret R Blackmore

Date; 5 May 2017
Maggie Blackmore
Chair, Patients' Council

Statement from Healthwatch North Somerset

Healthwatch North Somerset welcomes the opportunity to provide a statement in response to the Quality Account produced by for the year 2016/17.

With reference to progress in relation to last year's priority areas, Healthwatch North Somerset acknowledges the challenges that WAHT faced during 2016/17 and recognises that these have had an impact upon Quality, Performance and Service Delivery during the year. The Quality Account reflects the challenges and is candid in its articulation of these. Of concern is the staff survey figures and the level of staff related stress and support.

Healthwatch North Somerset has shared many experiences directly with the Trust and will continue to share public feedback experiences received directly with WAHT so that this helps to inform areas of service delivery. With regards to the feedback provided, we would have liked to have seen some reference to the feedback that Healthwatch North Somerset shares with WAHT on a regular basis, such as the monthly feedback reports provided.

Healthwatch North Somerset welcomes the commitment of WAHT to develop partnerships and work towards a secure and safe future for the Trust and patients.

Date; 10 May 2017
Eileen Jacques
Chief Officer
Healthwatch North Somerset

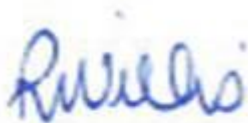
Statement from Health Overview and Scrutiny Committee

Health Overview and Scrutiny Panel – North Somerset Council
Response to Weston Area Health NHS Trust Quality Account 2016/17
QA Presented by Gillian Hoskins, Associate Director of Governance & Patient Experience

The Panel fully recognises the significant challenges faced by WAHT in 2016/17, following on from several years of uncertainty about the Trust's future, sustained periods of peak demand on services, long term recruitment difficulties and the financial and operational challenges associated with being the smallest acute trust in England.

Whilst these long term issues have clearly impacted on the quality of service, as evidenced by recent CQC inspections and annual Quality Accounts, the cause and effect is well understood. Therefore, the Panel's overriding focus in this response is forward facing: on the critical opportunity to fundamentally address these challenges as a function of the Sustainability and Transformation Partnership (STP) process, which the WAHT has recently commenced in partnership with the other health and social care providers and commissioners in Bristol, North Somerset and South Gloucestershire.

In that context, the Panel particularly welcomes the encouraging evidence within the 2016/17 Quality Account of partnership working with neighbouring Trusts, the early evidence of improvements in patient flow in the emergency department, and the Trust's ongoing commitment to engaging positively with the community and key stakeholders.



Date; Thursday 4th May 2017
Roz Willis
Chairman, Health Overview & Scrutiny Panel
North Somerset Council

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

In response to suggestions from Healthwatch North Somerset we have added the following statement to the description of their role;

Healthwatch North Somerset shares feedback regularly with the Trust including monthly feedback reports – which are reviewed at the Patient Experience Review Group.

Glossary of terms	
Adult Intensive Care Unit (AICU or ICU)	A special ward for people who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.
Atrial fibrillation (AF)	An abnormal heart rhythm in which the atria, or upper chambers of the heart, “quiver” chaotically and are out of sync with the ventricles, or lower chambers of the heart.
Cancelled operations	This is a national indicator. It measures the number of elective procedures or operations which are cancelled for administrative reasons e.g. lack of time, staffing, equipment etc.
Care Quality Commission (CQC)	The independent regulator of health and social care in England. **www.cqc.org.uk**
Chronic Obstructive Pulmonary Disease (COPD)	Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.
Clostridium difficile infection	A type of infection that can be fatal. There is a national indicator to measure the number of *C. difficile* infections which occur in hospital.
Commissioning for Quality and Innovation (CQUIN)	A payment framework enabling commissioners to reward excellence by linking a proportion of the Trust’s income to the achievement of local quality improvement goals
Department of Health	The government department that provides strategic leadership to the NHS and social care organisations in England
Emergency operation/;procedure	An unplanned operation or procedure that must occur quickly as the patient is deteriorating. Usually associated with higher risk as the patient is often acutely unwell.
EMSA	Eliminating Mixed Sex Accommodation – all providers of NHS funded care are expected to eliminate mixed sex accommodation, except where it is in the overall best interest of the patient
ENT	Clinical specialty dealing with conditions affecting the Ear, Nose and Throat
Expected death	An anticipated patient death caused by a known medical condition or illness
Health Protection Agency (HPA)	An independent organisation set up to protect the public from threats to their health from infectious diseases and environmental hazards. It provides advice and information to the government, general public and health professionals
Hospital episode statistics (HES)	The national statistical data warehouse for the NHS in England. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations
Healthwatch North Somerset	An independent organisation with statutory functions under the Health and Social Care Act to obtain and feedback the views of local people and to involve them in the monitoring the standard of local health and social care provision.
Health Overview and Scrutiny Committee (HOSC)	A committee of the local authority charged with looking at the work undertaken by primary care Trusts and NHS Trusts, acting

	as a “critical friend” by suggesting ways that health-related services might be improved. It also looks at the way the health service interacts with local social care, voluntary, independent providers and other council services.
Hospital standardised mortality ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares trusts against a national average
Indicator	A measure that determines whether the goal or an element of the goal has been achieved
Inpatient	A patient who is admitted to a ward and staying in the hospital
Inpatient survey	An annual national survey of the experience of patients who have stayed in the hospital. All NHS Trusts are required to participate
Intelligent Monitoring report	A report produced by the CQC for each NHS Trust which provides details on a number of indicators relating to quality of care. They are published on the CQC website
ITU	Intensive Treatment Unit of the hospital.
Local clinical audit	A quality improvement project involving individual healthcare professional evaluating aspects of care that they have selected as being important to them or their team
MAU	Medical Assessment Unit of the hospital.
MRG	Mortality Review Group – a committee of the Trust tasked with reviewing mortality and ensuring that any learning is shared across the Trust.
Multi-disciplinary team meeting (MDT)	A meeting involving healthcare professionals with different areas of expertise to discuss and plan the care and treatment of specific patients
Multi-resistant staphylococcus aureus (MRSA)	A type of infection that can be fatal for some patients. There is a national indicator to measure the number of MRSA infections that occurs in hospitals
National Clinical Audit	A clinical audit that engages healthcare professionals in the systematic evaluation of their clinical practice against standard and to support and encourage improvement and deliver better outcomes the quality of treatment and care. The priorities for national audits are set by the Department of Health and all NHS Trusts are expected to particulate in the national programme
National Institute for health and Clinical Excellence (NICE)	An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health
National Patient Safety Agency (NPSA)	An arms length body of the Department of health that leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
Never events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Trusts are required to report nationally if a never event occurs
NHS Number	A 12 digit number, unique to an individual and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.

OT	Occupational therapy professional.
Outpatient	A patient who goes to a hospital and is seen by a doctor, nurse or other healthcare professional in a clinic but is not admitted to a ward and is not staying in the hospital
Outpatient Survey	An annual national survey of the experiences of patients who have been an outpatient. All NHS Trusts are required to participate
Patient Administration system (PAS)	The system used across the Trust to electronically record patient information including contact details, appointments, admissions etc
Patient record	A single unique record containing accounts of all episodes of health care delivered to the patient at the Trust and any other relevant information
Pressure ulcers	Sores that develop from sustained pressure on a particular point of the body. Pressure ulcers are more common in hospital patients than in people who are fit and well as patients are often not able to move about as normal
Referral to Treatment (RTT)	A measure of the time taken from the point of referral by a doctor to treatment
Safeguarding	A term broader than "child protection" as it also includes prevention. Applies also to vulnerable adults
Schwartz rounds	A forum for staff to come together once a month (or every other month) to explore together the challenging psychosocial and emotional aspects of caring for patients.
Secondary uses service (SUSS)	A national NHS database of activity in trusts, used for performance monitoring, reconciliation and payments
Serious Incidents	An incident requiring investigation that results from one of the following: • Unexpected or avoidable death • Serious harm • Prevents an organisations ability to continue to deliver healthcare services • Allegations of abuse • Adverse media coverage or public concern • Never Events
SHINE checklist	A time based list of tasks that is completed for every very unwell patient in the Emergency Department.
SHMI	Standardised Hospital Mortality Index – an indicator of the safety of care, received on a quarterly basis from the Health and Social Care Information Centre (HSCIC), a national organisation. This indicator compares the actual number of deaths with the expected number of deaths during (and for 30 days after) a hospital admission over a period of 12 months.
Surgical Site infection	An infection that develops in a wound created by having an operation
Single Sex accommodation	A national indicator which monitors whether ward accommodation has been segregated by gender
SWARM	In response to an adverse incident or undesirable event, like bees, staff 'swarm' to the site to determine the cause of the event and how it can be corrected.
Venous thromboembolism (VTE)	A term used to describe venous thrombus – a blood clot in a vein (often leg or pelvis) and pulmonary embolism – a blood clot in the lung. There is a national indicator to monitor the number of

	patients admitted to hospital who have had an assessment made of the risk of their developing a blood clot.