Weston Area Health NHS Trust

# Weston Area Health NHS Trust Quality Account 2019/2020

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# Part 1 Introduction

## Statement on Quality from the Chief Executive

Welcome to our Quality Account for 2019/20.

Our merger with University Hospitals Bristol on 1 April 2020 means this will be the final annual quality account for Weston Area Health NHS Trust.

The merger brings an exciting opportunity to create a new organisation with a greater shared purpose, which is seen as a beacon for outstanding education, research and innovation alongside the highest standards of patient care. In preparation for merger, from 1 September 2019, I took up a dual role as Chief Executive across both Weston and University Hospitals Bristol. Following regulatory approval, our two organisations merged to become University Hospitals Bristol and Weston NHS Foundation Trust on 1 April 2020.

I have been hugely impressed with the energy, enthusiasm and mutual support of staff in both trusts as they have embraced the changes the merger has to offer, notwithstanding the disruption inevitably caused by the coronavirus pandemic.

The pandemic was declared as the year 2019/20 was drawing to a close, heralding the greatest challenge faced by the NHS in its history. I am humbled every day by what I see from teams across our hospitals – both in Weston and Bristol – and the lengths they go to, to provide compassionate high-quality care. My wholehearted thanks and admiration go out to all our staff for their commitment, bravery and professionalism in these most challenging of times.

Whilst the impact of the pandemic has overshadowed much of what went before, it is important to register Weston's achievements in the course of 2019/20 in the pages of this Quality Account. I should note as well that, prior to merger, our aim at Weston was to support staff to deliver high quality, safe services specifically for the people of North Somerset. That aim remains in place but now forms part of the wider goals of the merged Trust.

A chapter has now closed on the history of Weston Area Health NHS Trust but Weston General Hospital lives on inside the bigger Trust, with a bright and certain future as a dynamic hospital at the heart of the local community. I commend WAHT's final Quality Account to you. As ever, my thanks go to those who have prepared and contributed to this report. I am pleased to confirm that the Board of Directors of University Hospitals Bristol and Weston NHS Foundation Trust has reviewed this 2019/20 Quality Account and I confirm that it is an accurate and fair reflection of WAHT's performance in that year.

Robert Woolley
Chief Executive

# Weston Area Health NHS Trust Profile

Until 31st March 2020, Weston Area Health NHS Trust provided:

- Acute hospital services for adults with acute health problems, including emergency care, critical care, medicine and surgery together with supporting diagnostic services.
- A range of planned services including general surgery, urology, orthopaedics, endoscopy, haematology and some cancer care.
- Children's and Young Peoples Community Health Services.
- Child and Adolescent Mental Health Services from two children's centres located in Weston-Super-Mare and Clevedon.

## Activity

The Trust had an annual activity for 2019/20 of 50198 Emergency Department attendances, 16686 planned day case and elective admissions, 14450 emergency admissions and 124250 outpatient attendances.

## Resident population

The population using WAHT services in 2019/20 is estimated to be circa 200,000, In addition to the local population, Weston super Mare attracts 3 million day trippers and circa 500,000 staying visitors each year and in peak season; up to 10% of Emergency Department attendances are by out-of-area tourists. Included in the population figures above is the population of North Sedgemoor which has an estimated population of 152,000 (GP registered population).

## Services provided within Weston Area Health NHS Trust

During 2019/20 the Weston Area Health NHS Trust (WAHT) provided 40 relevant health services with 3 relevant health services subcontracted.
The Weston Area Health Trust has reviewed all the data available to them on the quality of care in 42 of these relevant health services.
The total BNSSG contract equates to 74.3 million.

**Services provided within Weston Area Health NHS Trust**

| | | | |
|---|---|---|---|
| Medicine | Cardiology | Critical Care | High Dependency Unit/ Intensive Care Unit |
| | General Medicine | Women | Midwife Led Births provided by UHBristol |
| | Diabetic and Endocrinology Medicine | Paediatrics | Day Case |
| | Rheumatology | | Outpatients |
| | Gastroenterology | | Community Paediatrics |
| | Geriatric Medicine | Cancer | Acute Oncology |
| | Stroke Medicine | | Outpatient Oncology |
| | Respiratory | | Haematology |
| | Frailty | | Chemotherapy |
| Surgery | Urology | | |
| | General Surgery | Specialist | |
| | Gynaecology | | Stroke; Acute Stroke Unit |
| | Trauma and Orthopaedics | | Sexual Health |
| | Upper Gastrointestinal Surgery | | Dermatology (by UH Bristol) |
| | Colorectal Surgery | | Palliative Care |
| | Breast | | Child and Adolescent Mental Health |
| | Ophthalmology (provided by UH Bristol) | Other | Private Patients Unit |
| | ENT (Out Patients Only) | | Radiology |
| | Anaesthetics | | Pharmacy |
| A&E | Major | | Pathology ( microbiology and blood sciences.<br>Pathology (cellular pathology provided by North Bristol NHS trust) |
| | Minor | | Therapies<br>Audiology |
| | Primary Care | | |

## Partnership Working

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

In November 2019, UH Bristol formally approved the Full Business Case (FBC) for the merger by acquisition of WAHT, and the FBC was supported by the WAHT Trust Board on the same day. Formal consultation with staff to TUPE transfer to UH Bristol commenced at the beginning of December 2019, and closed at the end of January 2020. It has been agreed that the newly merged organisation will be called University Hospitals Bristol and Weston NHS Foundation Trust

UHBW. In April we became a merged organisation and are now a division of UHBW.

Staff from three services will transfer to alternate specialist providers on 1 April 2020, with services continuing to be provided from the same premises. These services are Specialist Community Children's Services (child and adolescent mental health services (CAMHS) and community paediatrics).

During 2019/20, two services were transferred to other providers. Maternity services were transferred to UH Bristol, with the maintaining of a midwife led birthing unit on the Weston General Hospital site, and strengthened community midwifery service provision. Cellular pathology services transferred to NBT, which included the move of the service to the purpose built Pathology Services Building on the Southmead site, a move in line with the Carter Review and the West of England Pathology Network vision.

Community services (excluding community-based Children's services and paediatrics provided by Weston Area Health NHS Trust, and community-based maternity services provided by UH Bristol) are provided by North Somerset Community Partnership, and Mental Health services for adults are provided by Avon and Wiltshire Mental Health Partnership NHS Trust.

## Local NHS bodies and other providers

The Trust's largest commissioner during 2019/20 was Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) with the WAHT contract being circa £74.3m In addition, the Trust receives other non-patient related income including education and training monies.

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

During 2019/20, the BNSSG CCG undertook the extensive 'Healthy Weston' consultation, culminating in the approval of the Decision Making Business Case (DMBC) in October 2019, which set out a number of commissioning changes for WAHT and improvements in services within the community. Senior doctors and clinicians from WAHT and across the system were involved in the design and evaluation of the proposals, and the Trust is in the process of implementing the changes in line with the timeframes as set out in the DMBC.

Planning for service delivery is increasingly being undertaken on a BNSSG-wide basis as part of the Sustainability and Transformation Plan (STP), "Healthier Together". This approach is intended to overcome inefficiencies, duplication, variation and unnecessary boundaries and interfaces for patients and staff to navigate and ensure that care is provided in appropriate care settings for all patients. During 2019/20, planning assumptions from the Trust formed part of the system Long Term Plan.

This five year plan has a clear ambition: to build one health and care system, so that community becomes the preferred place for care, high quality hospital services are used only when needed and people can maximise their health, independence and be active in their own well-being.

There are eight steering groups within the STP, and the Trust has been actively engaged in the relevant areas: children and families; integrated care; acute care collaboration; urgent care; mental health; workforce; digital; and estates.

## Our vision and values

The vision of Weston Area Health NHS Trust is to:

***"Work in partnership to provide outstanding healthcare for every patient"***

By achieving this vision we will:

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

Our key strategic aim is to:

***Deliver safe, caring and responsive services***

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

These values are:


**People and Partnership** – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague.

**Reputation** – actions which help to build and maintain the Trust's good name in the community.

**Innovation** – demonstrating a fresh approach or finding a new solution to a problem.

**Dignity** – contributing to the Trust's Dignity in Care priorities (Care and Commitment, Communication, Compassion, Competence).

**Excellence and equality** – demonstrating excellence in and equality of service provision.

We will adopt the vision and values of University Hospitals Bristol NHS Foundation Trust when we become one organisation.

# Our staff

We are proud of the awards and achievements that our staff have achieved throughout 2019/20 with the following awards and achievements.

## Awards and Achievements

- At the Comparative Health Knowledge System (CHKS) hospital awards – WAHT was again awarded one of the CHKS Top Hospitals for 2019, a prestigious award made on the basis of an analysis of data from all hospital trusts in England, Wales and Northern Ireland. Over 20 indicators of performance were analysed by healthcare improvement specialists CHKS.
- The Director of Nursing annual awards were presented for six categories on International Nurses Day 2019, celebrating the contribution of our nurses and midwives.
- We held the annual Celebration of Success awards evening which recognised staff that go above and beyond the call of duty to care for our patients.
- 11 members of our staff took part in the South West Military Challenge in September 2019 and came 10th out of 20 trusts.
- Our Geriatric Emergency Medicine Service (GEMS) in A&E (Accident and Emergency) became the south west regional winners for Urgent and Emergency Care in the NHS Parliamentary Awards – beating A&Es to win the accolade in larger hospitals from Bristol and Taunton down to Cornwall.
- More than 84% of staff were vaccinated against influenza in 2019. This was an improvement from last year by nearly 4%.
- The Trust signed up to the Dying to Work Charter, a charter aimed at helping employees who become terminally ill at work.
- We successfully achieved a bid for investment from the national NHS winter funds to refurbish our medical day case unit and discharge lounge.
- We completed a successful TUPE of maternity staff to University Hospital Bristol NHS Foundation Trust to ensure the best possible care for all patients and ongoing support and development for staff.

## Support for staff raising concerns

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

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

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

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

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

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

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

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

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

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

# 2 Priorities for improvement and statements of assurance from the Board

## Priorities for Improvement

We identified five quality priorities to be our focus for improvement during 2019/20. These were a combination of quality priorities that we had not fully achieved in 2018/19 and new objectives which included improvements to patient and staff experience and improving our governance processes. We engaged with and obtained views from patients, staff and the wider public. Progress on achievement is detailed below, including why we selected each priority and each priority has been categorized by 'RAG' rating with; Red - not achieved, Amber – not fully met but improvement evident, and Green - achieved. We have partially achieved all of the identified priorities and made significant progress on each of them however as they have not been fully achieved they will be continued as Quality Priorities during 2020/21 as Quality objectives for the Division of Weston.

### Priority One:

### Improving our governance processes and response to and learning from concerns raised.

## Why we chose this priority

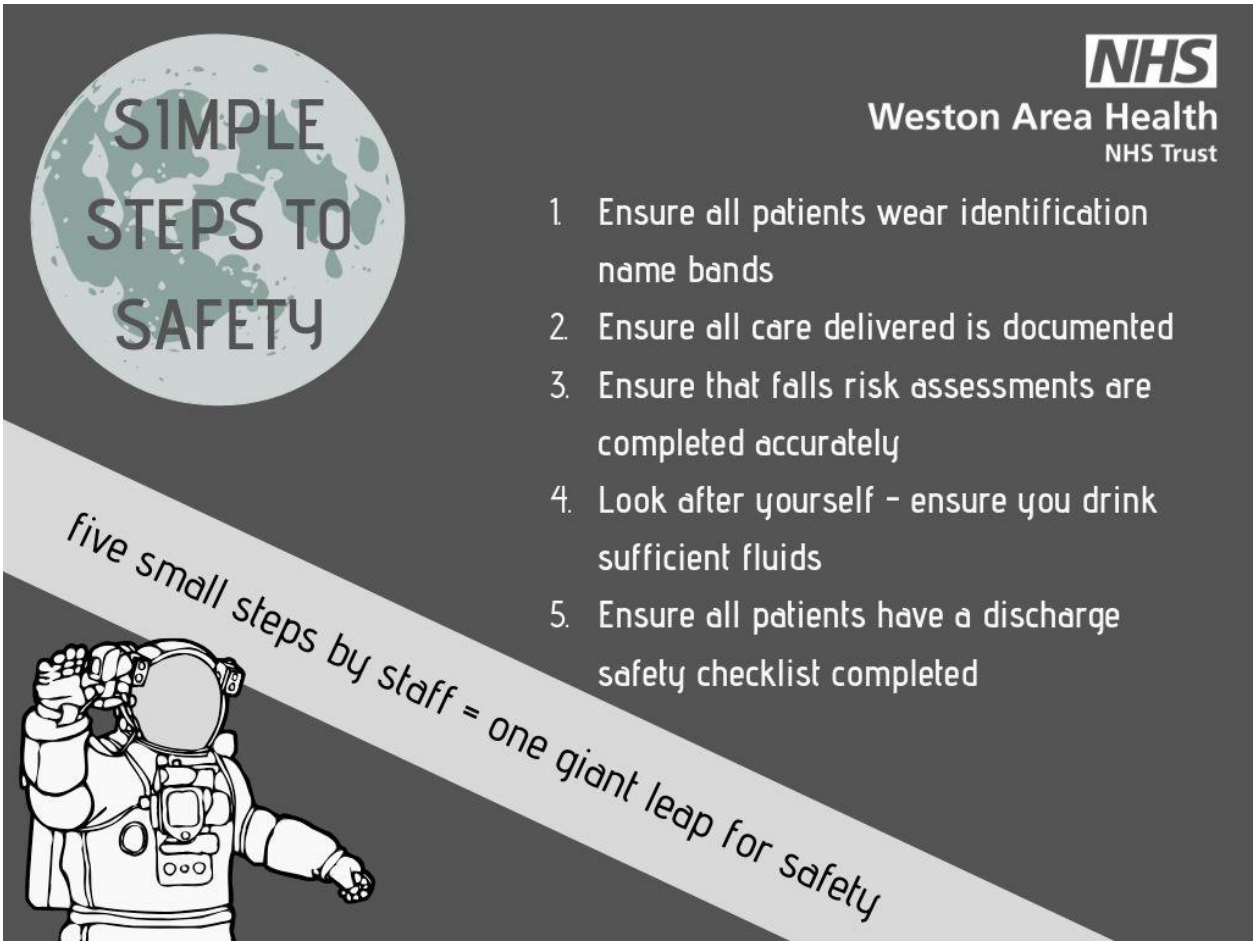
Ensuring that a robust governance process is established within the Trust supports the organisation to run efficiently and effectively and ensures that we are open and honest to our staff, patients and governing bodies that we are accountable too. We continued to review and strengthen our governance processes to ensure we have the correct processes and structures in place, risks are identified and managed and we continually learn and improve on the way we work.

## What did we say we would do?

- We wished to ensure that complaints are responded to in a timely manner and responses are tailored to the needs of patients and their carers. We have not achieved the 35 day response target for responding to patient complaints. The focus has been on ensuring a high quality response to all the complainants concerns. Teaching & education has been provided. Within the directorates the Associate directors of nursing have been tasked to ensure there is a clear sign off process and that the responses are completed on time for each stage of the sign off process. In addition the process of who writes the complaint has changed to enable less clinical staff to write them and the speciality managers to provide the responses where appropriate. SOPs in place for escalation, extensions and processes

- Staff will have a better understanding of the process of investigating concerns and developing meaningful action plans to drive improvement. Staff have been invited to the executive panel meetings to ensure that there is a greater knowledge and understanding of the investigation process with shared learning across the trust. Training is provided to all staff groups to develop their understanding of governance.

- We will ensure that governance processes are well embedded and managed with a clear reporting process and that we are able to support learning from incidents at specialty directorate and trust wide levels. We have undertaken patient safety trolley dashes around the organisation to ensure that learning gets out to the staff on the wards and departments, also a number of patient safety posters have been developed.




## What difference did it make?

We now hold an Executive weekly review panel, this is an open forum with attendance from the Medical Director and Director of Nursing which reviews incidents and complaints across the Trust and decisions are made as to whether an incident requires further investigation and recommendations for learning are made. This was evidenced by an observational visit by NHS England and Improvement.

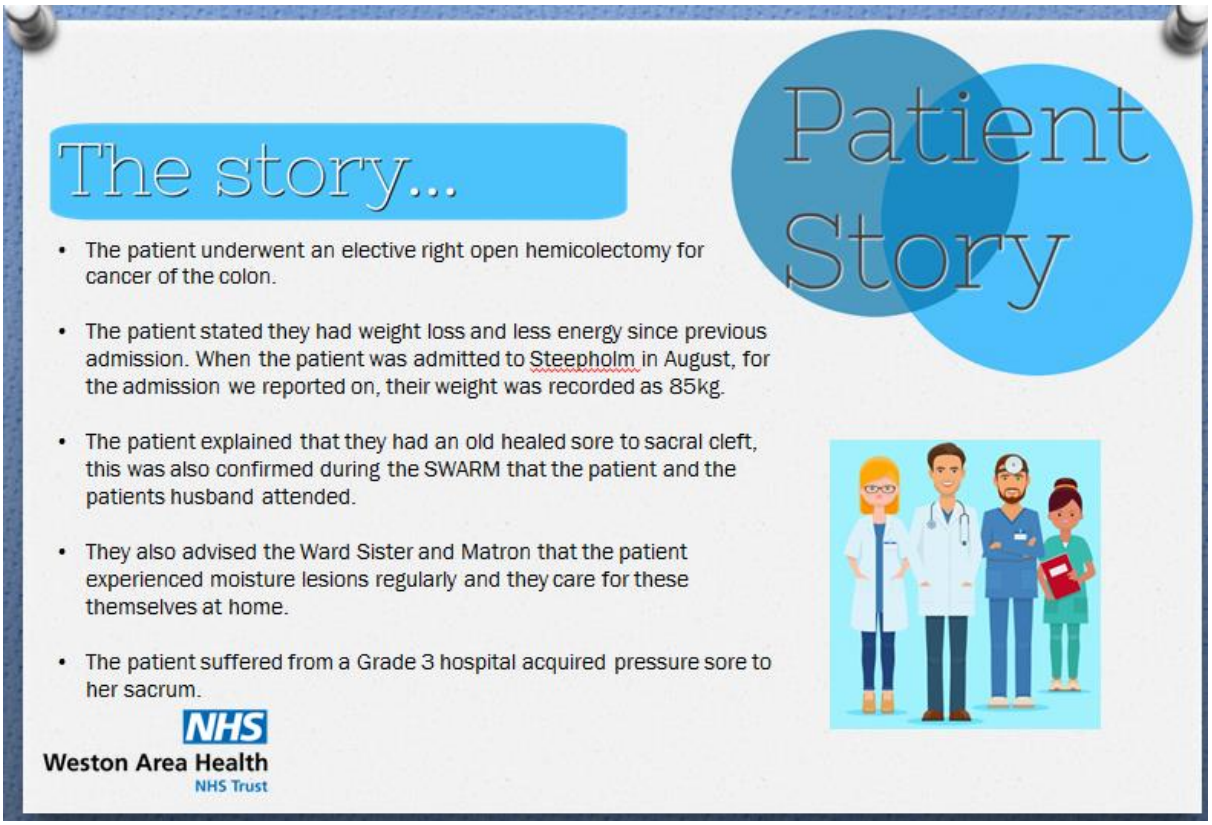
''At the Executive Panel weekly meeting, the team witnessed a tight grip by the clinical executives on the operational issues..... The Executive Panel felt at ease with each other and members were not afraid to challenge''( *NHS England and NHS Improvement February 2020)*

We have started to embed the new governance processes over the past year with a noted reduction in the number of outstanding investigations but we recognise that there is still more work to be done across all the wards and departments to ensure that these new processes are fully understood, robustly and consistently managed and that learning is obtained, shared widely and tested in practice**.**

In August the Trust held a patient safety week to launch the CQC improvement plan for the Trust. With significant engagement from the clinical teams within the hospital at the launch event.

The WAHT Governance team facilitated in the learning and education of a number of patient safety areas across the Trust. This included reduction of high harm patient falls, promoting staff wellbeing, increasing use of the discharge checklist, improving documentation and increasing awareness of the importance of completing patient ID bands.

Patient stories have been developed to provide learning across the trust from serious incidents. There is a statutory duty to provide a report to the Clinical Commissioning group (CCG) when a serious incident has occurred. This report is very clinical so the governance team have taken the report and made it more tangible to a multi-disciplinary audience.




A Governance intranet page has been developed to provide staff with advice and toolkits for learning relating to Governance.

### What will we do next?

We would now like to focus our efforts in the timely completion of our responses now that the quality has improved. We are developing a 72 hour workshop to look at the quality, timeliness and ensuring that understanding of the process is embedded, working from ward to board level, enabling staff to create their own projects with the data that is available to them. We endeavour to ensure that governance is truly embedded at the local level.

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| **RAG rating** | Amber: Whilst we have made significant improvements in the governance processes and the learning from incidents, we needed to embed the learning trust wide to fully achieve this priority. |

## Priority Two:

## Promoting inclusion, involvement and engagement for patients and carers

### Why we chose this priority

Our Staff/patient/user group quality conversations asked us to do more on addressing diversity, co-designing services and engagement with patients who have specific needs and requirements to support them with accessing hospital care.

We recognised that in 2018/19 we achieved our priority with improving care for frail patients with dementia but felt that we needed to do more for certain other patient groups who were in danger of being over looked or their voices not being heard.


### What did we say we would do?

We will continue our education plan for staff to recognising dementia and delirium to ensure timely and effective treatment, support and education.

We will continue our work, that was commenced last year through the “GEMS” team and the Admiral Dementia Nurse Specialist supporting the frail and elderly patients and also those with a dementia, drawing on the benefits the roles bring to patients and their carers.

We will work to increase the involvement of the Patient Council in undertaking surveys to capture patient experience and feedback.

We will listen to the patient and carer voice in a variety of forums in order to ensure that we communicate with some of the 'harder to reach' groups of patients. We have done this by using patient stories and complaints to ensure that we are learning.

We will hold an Autism Awareness Event.

As part of the NHSI Improvement Standards, service users with a Learning Disability who have used our organisation over the last 12 months have been encouraged to feedback on their patient experience.

We will work closely with our Mental Health Liaison Team and CAMHS to explore how we can involve our patients in ensuring that the services we offer are accessible and in line with what the patient needs.

We will ensure that service users are signposted to help whilst waiting for their CAMHS assessment, ensuring that the patients are being monitored and risk assessments are completed for each patient.

We will reinvigorate the 'Hello my name is Campaign' to improve our communication with patients and carers.

### What difference did it make?

We have continued to work alongside Dementia UK to develop the Admiral Nursing service, as one of less than twenty Trusts in the UK who have this designated specialist role.

We have continued our commitment to providing a Dementia friendly hospital for our patients.

- This year we started work on a 'quiet bay' in ED, where patients can be supported in a calmer environment which we hope will help reduce the understandable anxiety and stress that can be part of being in a busy hospital environment. We worked to ensure that this not only met recognised guidelines for best practice but we consulted people living with dementia and acted on their suggestions.
- Following on from this we now have representation from a person who lives with dementia and a carer on our dementia steering group.
- Building on our refurbishment work last year with our care of the elderly ward, we have started a 'Bus Stop' project. Secured a bus stop and personalised timetable from 'First' and the support of a local graphic designer who is creating a decal to mirror Weston Seafront. This has also demonstrates our strong partnership working with our mental health colleagues, as this is a joint initiative with Avon and Wiltshire Mental Health Partnership.

In 2019 our Admiral Nurse accepted a total of 142 referrals for families who have a loved one living with a dementia. Undertaking a total of 1805 contacts with families, patients and colleagues, working in a 'triangle of care' to ensure better outcomes. For example a reduction in repeated admissions to hospital for some of our patients

Providing a calm and supportive environment for people who live with a dementia has shown to have a positive impact on their wellbeing and reduce some of the negative effects of the condition, such as misinterpreting shapes and colours. Ensuring that the voices of people who experience the condition are heard helps us know that we are moving in the right direction with our decisions. It also demonstrates that having a dementia diagnosis does not mean that your opinions and contribution are diminished.

Other areas in the country that have trialled a 'Bus Stop' project have found it has reduced agitation in patients living with dementia as it helps them focus on something familiar when they

become anxious or worried.

We have built on our commitment to people living with dementia and their families by launching 'Lillian's Memory Café', a monthly space for people living with dementia, their carers and anyone who is worried about their memory to come and meet people, have a cup of tea and get some advice and support.

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

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

The patient's council have undertaken a number of surveys that capture patient experience and feedback these included a survey regarding the overnight closure of the Emergency Department (ED) and the type of presentations that patients come to ED with and their views on the closure of ED overnight. They have also undertaken a survey regarding noise at night and what measures can be put in place to minimise the noise that patient's experience this was as a result of numerous complaints.

Our CAMHS service acknowledge referrals and then provide families with a letter which signposts them to websites and services that are available to them whist on the waiting list to be seen by a specialist this has resulted in a reduction in complaints which was the primary reason for most complaints.

### What will we do next?

We will be involving the patient's council in a number of patient experience projects one of which is how patients felt their discharge from hospital went? This will be important in seeing the areas that we need to focus on to ensure that patients are getting the best care and advice on discharge from hospital.

We will complete our 'Bus Stop' project and then take steps to evaluate what impact it may have on our patient's wellbeing.

Work on recommendations from our last Royal College of Psychiatry Dementia Audit, looking at areas such as patient moves and discharge discussions. Complete the next round of Dementia Audit.

We will review the new national guidelines for adult carers, (NICE). To ensure that we are supporting carers in line with their recommendations.

We will review the first round of dementia carers questionnaires to in order to look at the best ways to improve on the support we currently give.

Moving into 2020 we have an Autism awareness day planned in May with external speakers; raising the awareness Autism following the LeDeR review of Oliver McGowan, at this point we will be launching our new reasonable adjustments cards for patients and carers to use, along with a revised Hospital passport developed with North Somerset People First. The Learning Disability team are aiming to make a short film 'The Pledge' raising the awareness of communication/Makaton with non-verbal patients. NHS Futures shared a Condolence Card for

Learning Disability, which our local service user group and Learning Disability team at Weston General Hospital will be taking forward as a new initiative. Collaborative working will continue with North Somerset Community Team in identifying our top 3 reasons for hospital admission and potential admission avoidance. We will be working with University hospitals Bristol as of April 2020 and will align services and national objectives, however our focus will remain on our local service users.

| RAG rating | Amber: We made significant improvements but there is still work to be done. |
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## Priority Three:

## Reducing harm from medicines.

**Why we chose this priority;**

Medicines safety is ensuring that wherever possible patients do not suffer avoidable harm from medicines.

In 2018 the World Health Organisation launched an initiative to decrease avoidable harm from medicines by 50% across the globe by 2023. In response to this initiative BNSSG CCG launched in 2019 a medicines optimisation quality and safety group with the aim of improving medicines safety in all areas of healthcare in the local area. Two working groups have been set up focusing on using high risk drugs such as insulin and anti-coagulants (blood thinning drugs) safely.

## What did we say we would do?

We identified four specific areas to target to reduce avoidable harm to patients from medicines:-

- Insulin – we have reinstated a programme of regular training by the diabetes specialist nurses of ward staff on the safe use and administration of insulin. As well we ran a week long campaign for all staff on how to recognise and act on the signs that a patient has low blood sugars which can indicate the patient has had too much insulin. We have arranged in March 2020 for Queens University Belfast to train our doctors in a programme to make insulin treatment safe.

- Anticoagulants – we have reviewed the drug charts used to prescribe heparin infusions to make sure it is clear and to avoid any confusion on the amount given to patients and the speed at which it is given. We said that we would implement a single use Heparin chart this hasn't happened due to capacity of staff however will be focus moving forward.

- Medicines reconciliation – we agreed extra investment into the pharmacy team to allow them to make sure that, for 80% or more patients, the medicines they have been prescribed on admission to hospital are the same as those they were taking beforehand.

- Missed doses – we have implemented the learning from the Parkinson's QI project on Kewstoke across the Trust to make sure that patients receive these critical medicines at the right time and they are not missed or delayed. All Parkinson's patients are highlighted by a yellow sticker on the front of their drug charts alerting nursing staff for the need to administer medicines on time all the time to prevent patients symptoms worsening. Wards are also highlighting other time critical medicines for other conditions such as epilepsy on their drug charts.

## What difference did it make?

Overall the proportion of medicines related incidents this year that have been reported as causing harm was 21% which has exceeded the target we set of 14%. However there were only 3 incidents rated as causing moderate harm (compared with 13 the previous year) and none as causing severe harm or death.

During the year we noticed an increasing number of patients suffering from adverse effects following administration of a contrast media in our radiology department. As we monitor the incidents reported in the Trust to cause harm we were one of the first Trusts in the country to notice these incidents, to report them nationally and to switch to an alternative product.

1. Insulin – we will continue with our programme of training for staff on the safe use of insulin and keep monitoring the incidents that cause harm to see how many are due to treatment with insulin. In 19/20 there were 7 incidents involving insulin which were reported as causing harm. This accounted for 7% of all incidents reported as causing harm compared with 9.3% in the previous year.
2. I.V Anticoagulants – following the update of our drug chart we will continue to monitor the incidents that cause harm to our patients to see how many are due to treatment with IV anticoagulants. There have been no incidents for 19/20.
3. Medicines reconciliation – although the extra staffing was agreed for pharmacy earlier in the year we struggled to recruit people into these posts and had to wait until January 2020 before we have been fully established with all the staff in place.

Once the new staff have completed their training we would expect the number of patients to have

their medicines checked and confirmed on admission to rise from 75% in January to over 80% by the end of the year. All staff have been recruited into post and are awaiting start dates. Rates fell in March to 62% due to the effect of Covid on the department. They have risen in April and May to 90%.

Although it has been slow progress it is pleasing that we expect our target number of patients to have the medicines they are prescribed on admission to hospital confirmed as correct to be reached by the end of the year? Whether it's been achieved at the beginning of 20/21.

4. Missed doses –The proportion of medication incidents reported involving patients missing a dose of their medication or there being a delay in the administration of their medicines remains high at 26% however it is below the target set of 30% of all incidents.

The proportion of patients who miss being given their medicine is 9.69% which is below our local target and the national average of 10%. The proportion of patients who miss a dose of a critical medicine that may lead to harm is 3.88% which is well below our target and the national average of 6.34%.

This shows that the work that we have been doing over a number of years has led to a reduction in the number of patients missing doses of a critical medicine with the possibility of this leading to harm.

### What will we do next?

- Insulin, anticoagulants and other high risk drugs- we will continue to work with partners from all healthcare sectors in the local area to help reduce avoidable harm to patients from these drugs. Next year the group is looking at ways to avoid problems with high risk drugs when patients move from one area of healthcare to another.

- Medicines reconciliation – we will continue to work over the next year to increase the number of patients who have their medicines confirmed on admission and as our service expands to cover weekends to increase the speed at which that occurs so that for the majority of patients this happens within the first 24 hours of their admission.

- Missed doses – we will continue our work with wards to make them more accountable for the doses that are missed and delayed on their ward and for developing local quality improvement plans to address their particular issues. Missed doses will also be reported from the medication safety thermometer on the ward to board dashboard.

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

## Priority Four:

## Developing and making the most of our workforce

### Why we chose this priority

Workforce challenges remain one of the highest threats to quality for the whole health service. We recognise the need to ensure that we support our staff to be the best that they can be and that we invest in training and development, providing new opportunities for existing staff and those who wish to join our organisation.

Our staff continue to tell us that we need to do more to raise morale and make them feel listened to and this is part of our vision for the future.


### What did we say we would do?

We will further develop our workforce plan to enable staff to professionally develop into new roles such as trainee advanced care practitioners.

We will listen to our staff to hear “what is important” to them through the “happy app”, staff briefings and staff discussions/ listening events.

We will invest in and develop our clinical and managerial leaders to help them shape and deliver our clinical services.

We will improve the quality of our staff appraisals through further training in the use of the new

achievement review document.

We will build on the improvements in our staff survey, namely their health and wellbeing, leadership development and communicating with all staff.

We will increase the numbers and range of Apprenticeships offered.

### What difference did it make?

The development of the trainee Advanced Care practitioner program has not taken place based on the availability of staff and capacity to facilitate this change. However, the merger of Weston Area Health Trust and UH Bristol will see significant work taking place to adopt processes and pathways from the centralised training and education function within the merged Trust, and the new facilitation roles will be implemented to support staff development. Please see ' what we will do next' for more information.

The Happy App has been rolled out Trust wide and is successfully utilized in a number of departments which has improved localized communication. Monthly briefings held by the Executive Team have given staff continual opportunities to hear about what is happening in the Trust and how we are performing, which has been well received. A number of listening events called ' Hopes & Fears' have been held with an external facilitator prior to the merger between WHAT and UHB, which has given staff the opportunity to have their voice heard and raise concerns, suggestions and feedback specifically relating to the merger.

We have invested in our clinical and managerial leaders by implementing a specific two-date development program for band 6s and 7s ('Leadership for Managers') to help develop best practice managerial skills. Sixty Three managers have attended to date and the feedback has been positive.

We have continued to offer regular training sessions for managers in how to conduct effective Achievement Reviews as well as effectively complete the review process. This has been beneficial for managers to have targeted development in supporting their teams in this way, and they are able to attend regularly to refresh their skills if they would like to.

In addition to the leadership development and communication improvements outlined above, significant work has been done to build on the improvements reported from our Staff Survey; in terms of health & wellbeing, we have implemented a new Employee Assistance Programme (EAP), trained a number of Mental Health First Aiders to support staff, and held events to promote positive behaviours as well as continually evolving the health & wellbeing resources our staff can access via the intranet and signposting them to external sources of support. We hope to see a further improvement in the responses to the questions around health & wellbeing in the next staff survey.

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

Working with our procured educational providers, and the regional Sustainability and Transformation Partnership (STP), we have continued to procure a wider range of apprenticeships to meet the various demands of the workforce. We have continued to recruit a number of apprentices into both administrative roles and nursing roles.

With the proposed merger with UH Bristol, as a trust we look forward to the joint relationships we can build on to develop a sustainable workforce which will focus on the apprentice, this will include

nursing apprenticeships.

## What will we do next?

- **Professional development of staff;** the Advanced Care Practitioner qualification is now available as an apprenticeship for staff to apply for. Via a number of dedicated facilitation roles that will be recruited into the Trust post-merger between WAHT and UHB, we will be able to develop multiple new professional development pathways for staff.
- **Listening to our staff;** a new Staff Forum, 'The Voice', will be launched to understand what is most important to staff. The main focuses of the forum will be hearing ideas and suggestions, as well as 'myth busting' and asking for their views on potential site improvements, such as increasing rest area capacity. We will ask for advocates from each department to bring forward the views, ideas, suggestions and concerns from their teams for direct discussion with the Senior Management Team. Feedback from the forum will then be relayed back to staff.
- **Investing in our managers;** A number of clinical and managerial leads have been nominated to be part of the Peloton development programme to support them in developing their skills, relationships, networks, and facilitating change across the BNSSG region. Managers will continue to be nominated in ongoing waves of the programme. We will also share details of other potential external development opportunities with managers, such as those available via the South West Leadership Academy, as well as developing our internal offering on developing capability around HR policies and staff development.
- **Improving the quality of appraisals;** the format we use for appraisals will change following the merger between WAHT and UH Bristol, so that it is aligned across both sites and all conversations around development are structured in a similar way; this format will eventually be moved online for accessibility. Line managers will be developed in how to use the new system and continue to have effective conversations with staff.
- **Building on improvements in the staff survey;** to further improve the flow of communication to all staff, a weekly Manager Bulletin will be developed to share key workforce messages with managers, for them to share with their team. The results of the next Staff Survey will be reviewed and a priority plan put together to determine our next areas of focus based on staff feedback.
- **Apprenticeships;** through the introduction of x 2 dedicated Apprenticeship facilitation roles at Weston, we will continue to expand our apprenticeship offering to both support development of existing staff and also expand our ability to recruit & retain new staff for example by offering Healthcare Assistant/Nursing Assistant apprenticeships.
- **Cultural and People development;** In order to make the most of our workforce, staff need to feel safe, valued, recognised, developed and work in a respectful environment free from harassment or bullying. To incorporate and build on our workforce priorities outlined above, a Culture & People plan will be developed on the basis of the following priority areas, with dedicated initiatives linked to each priority to improve the working lives of our staff.

| RAG rating | Amber: A number of elements of the plan have been achieved and further achievements will be enabled by the organisational merger between WAHT and UH Bristol. |
|---|---|

## Priority Five:

## Optimising safe discharges.

### Why we chose this priority

The optimising of safe discharges as a quality priority matters to us as ultimately the safe discharge of a patient improves the patient experience, anxiety and improvement in the overall health of the patient.

Reputation of the Trust is reliant on the safe flow of a patient's journey through the hospital and seamless transition into the community. This also allows for the patients, families and carers to have confidence that the aspect of discharge has equal bearing and importance in the whole patient journey.

Reducing the length of stay of patients and readmissions will affect the ability to effectively use the resources at Weston and limit the increasing financial burden of delays in hospital.


### What did we say we would do?

The trust has re- invigorated the 'safer bundle' and 'model ward rounding tool' , engaging all of the clinical teams to ensure discharge is a focus from admission, with an emphasis on reducing delays whilst in hospital and providing timely responses to required actions to deliver care

effectively.

The use of the e- flow electronic boards has been reviewed, with an idea to improve the multi-disciplinary communication, and the social plan from the Integrated Discharge Team has been designed to link information from the Green to Go database directly to the e-flow electronic boards.

As part of the wider BNSSG collaborative work to improve the discharges at weekends, an initiative to use the discharge checklist designed as an individual envelope, a safety process pre discharge, has been introduced. The checklist allows for a final check to be carried out ensuring that all relevant documentation and referrals including contacting the patient's next of kin has been undertaken to ensure the patients safe discharge.

The collaborative BNSSG out of hospital delivery group have produced a 'managing expectations policy', this ensures patients understand the process of timely discharges and how this will be achieved.

Current work with the medical teams is underway to improve the information, timeliness and quality of the discharge summaries produced, with specific emphasis on those patients with Chronic Obstructive Pulmonary Disease (COPD). This will include the COPD discharge bundle; if successful the aim will be to increase the number of conditions, allowing for an improved communication to the patient and community. This will optimise self-care of the patient's specific conditions.

### What difference did it make?

The current initiatives will continue to be monitored and improvements identified, by the reduction of incidents, complaints and a reduction in the patients length of stay. The hope being that the numbers of medically fit patients awaiting social input will be reduced. This will also be monitored by the effective use of community services. The improved communication will assist patients with identifying community services that could be used prior to a hospital admission. There has also been a community discharge event which looked at the main route causes of incidents reported into Weston. The outcome of the meeting was improved communication and better understanding of pathways, between Weston and partners.

### What will we do next?

The focus on discharge as a quality priority will be a constant focus for the Division of Weston as part of the merged organisation with UHBristol. There are many supporting actions that need to be fulfilled to address the challenge of discharging a community of patients with varying and complex needs. We will be undertaking an audit of discharge in collaboration with the patients council to look at areas of improvement. We will have a newly refurbished discharge lounge for staff to be able to relax in prior to discharge which will support discharges from the ward environment.

| | |
|---|---|
| **RAG rating** | Amber<br>We have made a number of discharge improvements however we feel that there is still a considerable amount of work to be done. |

### Quality Priorities for 2020/2021

From April 2020 WAHT will become a new merged organisation with University Hospitals Bristol

NHS Foundation Trust and we will adopt the quality priorities identified in the Quality Account of the new organisation of University Hospitals Bristol and Weston NHS Foundation Trust. The newly established Division of Weston will continue with the quality priorities identified within the WAHT 2019/20 Quality Account to sustain and embed the learning that we have achieved against these quality priorities.

## How will we measure progress of these priorities?

The Quality priorities that were identified in 2019-20 will roll into 2020/21. A number of the actions have been achieved and identified actions will become the division of Weston's focus in the merged organisation, patient and staff will report into the Division of Weston's lead governance group and divisional board.

## Participation in Clinical Audits

During 2019/20, there were 42 national clinical audits and two confidential enquiries covered relevant health services that Weston Area Health Trust provides.

During that period Weston Area Health Trust participated in 88% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. There were a small number of national audits that we chose not to take part in. This was, for example, because our patient case mix did not meet the necessary criteria – or because of a shortage of clinical staff to dedicate the time required..

The national clinical audits and national confidential enquiries that Weston Area Health NHS Trust was eligible to participate in during 2019/20 were as follows:

## Eligible National Clinical Audits 2019/20

| National Clinical Audit Title | % Participation Rate if data completed In 2019/20 |
|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Continuous data collection |
| Diabetes (Paediatric) (NPDA) | Continuous data collection (Data submitted via Bristol) |
| National Chronic Obstructive Pulmonary Disease Audit | Continuous data collection |
| National Asthma Audit | Started data collection in July 2019 |
| National Heart Failure Audit | Continuous data collection |
| Mental Health (self-harm) | 100% |
| Assessing for cognitive impairment in older people | 100% |
| Care of children in ED | 100% |
| National Audit of Seizures in Hospital (NASH3) | 0% |
| National Diabetes Audit – National Diabetes Inpatient Care | 0% |
| National Diabetes Audit – continuous harm database | Continuous data collection |
| National Diabetes Audit – Type 1 diabetes | Continuous data collection |
| Sentinel Stroke National Audit Programme (SSNAP) | Continuous data collection |
| Bowel Cancer (NOCAP) | Continuous data collection |
| Maternal, newborn and infant clinical outcome review programme | Continuous data collection |
| National Hip Fracture Database | Continuous data collection |
| Case Mix Programme (CMP) | Continuous data collection |

| | |
|---|---|
| National Joint Registry (NJR) | Continuous data collection |
| National clinical audit rheumatoid and early inflammatory arthritis | Continuous data collection |
| Elective Surgery (National PROMS programme) | Continuous data collection |
| Inflammatory Bowel Disease (IBD) programme | 0% |
| National Audit of Breast Cancer in Older Patients | Continuous data collection |
| National Emergency Laparotomy Audit (NELA) | Continuous data collection |
| National Lung Cancer Audit (NLCA) | Continuous data collection |
| National gastro-intestinal cancer programme | Continuous data collection |
| Perioperative quality improvement programme (PQIP) | 0% |
| Prostate Cancer | Continuous data collection |
| National Comparative Audit of Blood Transfusion programme – Re-audit of the medical use of blood | 100% |
| Society for Acute Medicine's Benchmarking Audit (SAMBA) | 0% |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance | Continuous data collection |
| National Audit of Care at the End of Life (NACEL) | 100% |
| Mandatory surveillance of blood stream infections and clostridium difficile infection | Continuous data collection |
| Surgical site infection surveillance | Continuous data collection |
| Reducing the impact of serious infections (antimicrobial resistance and sepsis) | Continuous data collection |
| National Maternity and Perinatal Audit | Continuous data collection |
| National Cardiac Arrest Audit | Continuous data collection |
| National Smoking Cessation Audit | 0% |
| Falls and fragility fractures audit programme: fracture liaison service database | Continuous data collection |
| National Vascular Registry | Continuous data collection (Data submitted via Bristol) |
| UK Parkinson's Audit | 100% |
| Seven Day Hospital Services | 100% |
| National Audit of Inpatient Falls (NAIF) | Continuous data collection |
| **National Confidential Enquiry into Patient Outcome & Death (NCEPOD)** | **Did WAHT participate?** |
| | |

## Number of Audits participated in during 2019/20

| **National Clinical Audit Title** | **% Participation Rate if data completed In 2019/20** |
|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Continuous data collection |
| Diabetes (Paediatric) (NPDA) | Continuous data collection (Data submitted via Bristol) |
| National Chronic Obstructive Pulmonary Disease Audit | Continuous data collection |
| National Asthma Audit | Started data collection in July 2019 |
| National Heart Failure Audit | Continuous data |

| | |
|---|---|
| | collection |
| Mental Health (self harm) | 100% |
| Assessing for cognitive impairment in older people | 100% |
| Care of children in ED | 100% |
| National Diabetes Audit – continuous harm database | Continuous data collection |
| National Diabetes Audit – Type 1 diabetes | Continuous data collection |
| Sentinel Stroke National Audit Programme (SSNAP) | Continuous data collection |
| Bowel Cancer (NOCAP) | Continuous data collection |
| Maternal, newborn and infant clinical outcome review programme | Continuous data collection |
| National Hip Fracture Database | Continuous data collection |
| Case Mix Programme (CMP) | Continuous data collection |
| National Joint Registry (NJR) | Continuous data collection |
| National clinical audit rheumatoid and early inflammatory arthritis | Continuous data collection |
| Elective Surgery (National PROMS programme) | Continuous data collection |
| National Audit of Breast Cancer in Older Patients | Continuous data collection |
| National Emergency Laparotomy Audit (NELA) | Continuous data collection |
| National Lung Cancer Audit (NLCA) | Continuous data collection |
| National gastro-intestinal cancer programme | Continuous data collection |
| Prostate Cancer | Continuous data collection |
| National Comparative Audit of Blood Transfusion programme – Re-audit of the medical use of blood | 100% |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance | Continuous data collection |
| National Audit of Care at the End of Life (NACEL) | 100% |
| Mandatory surveillance of blood stream infections and clostridium difficile infection | Continuous data collection |
| Surgical site infection surveillance | Continuous data collection |
| Reducing the impact of serious infections (antimicrobial resistance and sepsis) | Continuous data collection |
| National Maternity and Perinatal Audit | Continuous data collection |
| National Cardiac Arrest Audit | Continuous data collection |

| | |
|---|---|
| Falls and fragility fractures audit programme: fracture liaison service database | Continuous data collection |
| National Vascular Registry | Continuous data collection (Data submitted via Bristol) |
| UK Parkinson's Audit | 100% |
| Seven Day Hospital Services | 100% |
| National Audit of Inpatient Falls (NAIF) | Continuous data collection |
| **National Confidential Enquiry into Patient Outcome & Death (NCEPOD)** | **Did WAHT participate?** |
| | |

Weston Area Health NHS Trust completed 33 local clinical audits and quality improvement projects during 2019/20. 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 audits that the Trust has implemented or intends to implement to further improve the quality of care are provided:

## Clinical Audits completed and outcomes identified

| Clinical audit title | Outcomes |
|---|---|
| **Holistic Needs Assessment (HNA) Patient Questionnaire** | Patients strongly agreed to being able to raise concerns, felt listened to, had the opportunity to ask questions, talk about fears/worries. 78% of patients questioned would recommend a HNA. The HNA documentation has been changed following the questionnaire to be more explicit as to what the patient is having. |
| **Coeliac disease audit to ensure we are meeting NICE guidance** | The results reflect good practice in compliance with NICE guidance for the management of coeliac disease. No improvements were suggested to the team as this audit showed that they were complying with current NICE guidance. |
| **Appropriateness of CT head requests re-audit** | All the head injury scans are as per in hospital/trust protocols and NICE guidelines. Continued adherence to current ongoing strategy of creating awareness amongst all hospital doctors about the importance of NICE guidelines and to follow them |
| **Assessing the impact of changing lung biopsy technique on patient safety and diagnostic accuracy** | We are meeting the British Thoracic Society guidelines on complication rates and diagnostic accuracy following CT guided lung biopsy. |
| **Oncology and Haematology Day Unit Patient Satisfaction Survey** | There were an exceptional number of excellent and positive comments detailed in the report that reflect the continued high standards of patient centred care delivered by the Oncology and Haematology Day Unit team. The nurses, doctors, reception staff and volunteers are dedicated to delivering care and treatment while supporting patients through a very |

| | |
|---|---|
| | difficult time. The team are all continually committed to learning, developing skills and adapting to change of work processes in this diverse and complex speciality and should feel very proud of their achievements. |
| **Pabrinex Dose for prevention of Wernicke's Encephalopathy in patients with history of excessive alcohol intake** | All patients were managed according to trust guideline. However, the trust guideline does need to be updated in view of updated data and national guidelines. A re-audit is planned in 2020 to ensure patients are being managed according to updated guidelines. |

## NICE Quality Standards

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

A revised process for the implementation of all NICE guidance, including NICE Quality Standards, has been put in place during 2019/20. All newly released NICE guidance (including NICE Quality Standards) are identified and collated by the Clinical Audit Manager. The list is then sent to a consultant Microbiologist and the Lead Pharmacist to identify the appropriate member of staff to review the guidance. This is supported by the Consultant Rheumatologist and Associate Medical Director for Surgery and Emergency as required.

The guidance is then sent to that member of staff, asking them to review and complete the assessment form, which is then collated by the Clinical Audit Manager. If no responses are received, reminders are sent and the responses are tracked and reviewed by the Clinical Effectiveness Committee.

## Overview of NICE implementation in 2019/20

| Type of Guidance | Total published April 19 to December 19 | Reviewed and NOT relevant to Weston | Gap analysis undertaken and current practice consistent with guidance | Gap analysis undertaken and current practice NOT consistent with guidance | Awaiting response |
|---|---|---|---|---|---|
| Quality Standards (QS) | 7 | 0 | 5 | 0 | 2 |
| Diagnostics Guidance (DG) | 4 | 4 | 0 | 0 | 0 |
| NICE Guidelines (NG) | 26 | 7 | 4 | 4 | 11 |
| Interventional Procedures Guidance (IPG) | 20 | 18 | 0 | 0 | 2 |
| Medical Technology Guidance (MTG) | 4 | 3 | 0 | 0 | 1 |
| **Total** | **61** | **32** | **9** | **4** | **16** |

Overview of technology appraisals in table below:

| Total number of TAs published April 19 to December 19 | Not relevant to Weston | Technology appraisal terminated | Reviewed and no further action required | Awaiting response |
|---|---|---|---|---|
| 44 | 17 | 8 | 16 | **3** |

The overall report has been reviewed at the Development Clinical Effectiveness meeting, to review risks around non-compliance and highlight lack of responses, with onward assurance through to the Quality and Safety Committee.

## Research

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

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

The number of patients receiving health services provided or sub contracted by Weston Area Health NHS Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee were 281 patients and staff.

This year Weston participated in 16 recruiting studies with approximately 300 patients being followed up from previous years to see how they are progressing following treatment.

We have recruited people into the following studies:

| Project | Speciality | Recruited |
|---|---|---|
| Add-Aspirin Trial - Investigating whether aspirin can reduce the risk of their cancer coming back. | Cancer | 5 |
| ADDRESS 2 - Incident and high risk type 1 diabetes cohort. | Diabetes | 1 |
| ELAN: Early versus late initiation of direct oral anticoagulants in post-ischaemic stroke patients with atrial fibrillation. For people who have had a stroke. | Stroke | 1 |
| FLO-ELA: Fluid optimisation in emergency laparotomy. For people undergoing emergency abdominal surgery. | Anaesthetics | 1 |
| Fatigue - Reducing its Effects through individualised support Episodes in Inflammatory Arthritis (FREE IA). For people with certain types of arthritis who are experiencing fatigue. | Rheumatology | 6 |
| Healthcare professional's perspectives on the dietary advice they provide to people with an ileostomy. | Staff | 3 |
| IBD Bioresource – a registry for people with inflammatory bowel disease. | Gastroenterology | 41 |
| OPTIMA – Personalised treatment for breast cancer. | Cancer | 3 |
| PREDICT: Prostate Patient Study – a tool to predict risk for men with prostate cancer. | Cancer | 6 |
| PrEP Impact Trial – for people at risk of HIV. | Sexual Health | 35 |
| SATiRe: Staff attitudes towards clinical research in the NHS | Staff | 134 |
| STAMPEDE – comparing different treatments for men with prostate cancer | Cancer | 2 |
| STAMINA: supported exercise training for men on ADT – for men with prostate cancer receiving hormone treatment. | Cancer | 24 |
| Sunflower Study – for people who have their gallbladder removed. | Surgery | 11 |
| TrialNet – for people with type 1 diabetes. | Diabetes | 5 |
| Vedolizumab long term safety study – for people with ulcerative colitis or Crohn's disease. | Gastroenterology | 3 |
| **Total** | | **281** |

## What difference did it make?

Offering studies to patients locally increases access for our patients. Otherwise either they would miss out on the opportunity or they would have to travel to a larger hospital.

For example the STAMINA study provides a personal trainer and access to a network of gyms to men with prostate cancer who are receiving hormone treatment. NICE guidelines recommend resistance and other exercises for these men however in practice this is something that is often not available to them.

The FREE IA study follows on from a previous study for people with inflammatory arthritis. This study evaluates the effectiveness of a programme, which aims to reduce the effects of fatigue, delivered during routine clinic visits.

## What will we do next?

We have a number of new studies that will open to recruitment in the next year. We will continue to seek high quality research studies that are of relevance to our patients and fits with the *Healthy Weston* initiative.

Merging with University Hospitals Bristol NHS Foundation Trust will increase the number and

types of research opportunities we can offer to our patients at their local hospital.

## National and Local Quality improvement and innovation goals (CQUIN)

CQUIN stands for Commissioning for Quality and Innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care**.**

A proportion of Weston Area Health trusts income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between WAHT and any persons or bodies they entered into a contract, agreement or arrangement with for the provision of relevant health services through the commissioning for Quality and Innovation payment framework.

**CQUIN Targets 2019/20**

| CQUIN Indictors | Aim |
|---|---|
| **Antimicrobial Resistance – Lower Urinary Tract Infections in Older People** | To achieve 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment. |
| **Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery** | To achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines. |
| **Improving the uptake of flu vaccinations for frontline clinical staff** | To achieve an 80% uptake of flu vaccinations by frontline clinical staff. |
| **Alcohol and Tobacco - Screening** | To achieve 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use. |
| **Alcohol and Tobacco – Tobacco Brief Advice** | To achieve 90% of identified smokers given brief advice. |
| **Alcohol and Tobacco – Alcohol Brief Advice** | To achieve 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral. |
| **Three high impact actions to prevent Hospital falls** | To achieve 80% of older inpatients receiving key falls prevention actions |
| **Same Day Emergency Care – Pulmonary Embolus** | To achieve 75% of patients with confirmed pulmonary embolus (PE) being managed in a same day setting where clinically appropriate. |

| | | |
|---|---|---|
| **Same Day Emergency Care – Tachycardia with Atrial Fibrillation** | To achieve 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate. | |
| **Same Day Emergency Care – Community Acquired Pneumonia** | To encourage patients with confirmed Community Acquired Pneumonia (CAP) to be managed in a same day setting where clinically appropriate. | |

**Due to the pandemic a majority of the indicators were not able to be audited due to staff being reassigned to clinical duties.**

**CQUIN Targets 2019/20**

| CQUIN Indictors | Aim | Achieved |
|---|---|---|
| **Antimicrobial Resistance – Lower Urinary Tract Infections in Older People** | To achieve 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment. | 42.8% |
| **Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery** | To achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines. | 80.4% |
| **Improving the uptake of flu vaccinations for frontline clinical staff** | To achieve an 80% uptake of flu vaccinations by frontline clinical staff. | 84% |
| **Alcohol and Tobacco - Screening** | To achieve 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use. | 95.9% |
| **Alcohol and Tobacco – Tobacco Brief Advice** | To achieve 90% of identified smokers given brief advice. | 46.2% |
| **Alcohol and Tobacco – Alcohol Brief Advice** | To achieve 90% of patients identified as drinking above low | 53.4% |

| | | |
|---|---|---|
| | risk levels, given brief advice or offered a specialist referral. | |
| **Three high impact actions to prevent Hospital falls** | To achieve 80% of older inpatients receiving key falls prevention actions | 51.6% |
| **Same Day Emergency Care – Pulmonary Embolus** | To achieve 75% of patients with confirmed pulmonary embolus (PE) being managed in a same day setting where clinically appropriate. | 56.3% |
| **Same Day Emergency Care – Tachycardia with Atrial Fibrillation** | To achieve 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate. | 67.6% |
| **Same Day Emergency Care – Community Acquired Pneumonia** | To encourage patients with confirmed Community Acquired Pneumonia (CAP) to be managed in a same day setting where clinically appropriate. | 78% |

## Care Quality Commission Inspection

Weston Area Health NHS Trust (WAHT) is required to register with the Care Quality Commission (CQC). As of 31st March 2020, WAHT had the following condition on its registration: CQC issued a warning notice for the Emergency Department on 7th October 2019.

In February and March 2019 the CQC undertook a full inspection of four core services of the Trust; Urgent and Emergency Care, Medicine, Surgery and Child and Adolescent Mental Health Services (CAMHS) along with a Well Led review and a review of Use of Resources. A Section 29a warning notice was received in April 2019 for both CAMHS and the Emergency Department where it was identified that the quality of health care provided in these areas required significant improvement.

The Trust received a further unannounced visit by the CQC on 17 September 2019 in order to assess improvements in line with the warning notice. The initial feedback at this time noted improvements and meeting of the warning notice requirements within the CAMHS service with some work still to be embedded, and whilst some changes had been seen within the Emergency Department there remained concerns with regards to governance processes, risk and adequate training, and supervision and support for staff to carry out their roles and responsibilities safely. A further warning notice was issued for the Emergency Department on 7 October 2019 and the CQC improvement plan was enhanced to include the additional requirements.

Following the core services inspection in March 2019 the CQC inspection report was published on the 26 June 2019 which rated the Trust as overall 'Requires Improvement', with some areas showing improvement since the previous March 2017 inspection. The 2019 report identified 27

‘Must do’ requirements for action and 48 ‘Should do’ recommendations.

## 2019 Inspection

### Ratings

| Overall rating for this trust | Requires improvement |
|---|---|
| Are services safe? | **Requires improvement** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive? | **Requires improvement** |
| Are services well-led? | **Requires improvement** |

**Ratings for the whole trust**

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires improvement → ← Jun 2019 | Good ↑ Jun 2019 | Good → ← Jun 2019 | Requires improvement ↑ Jun 2019 | Requires improvement → ← Jun 2019 | Requires improvement → ← Jun 2019 |

### Ratings for Weston General Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate →← Jun 2019 | Requires improvement →← Jun 2019 | Good →← Jun 2019 | Requires improvement ↑ Jun 2019 | Inadequate →← Jun 2019 | Inadequate →← Jun 2019 |
| Medical care (including older people's care) | Requires improvement →← Jun 2019 | Good ↑ Jun 2019 | Good →← Jun 2019 | Requires improvement ↑ Jun 2019 | Requires improvement →← Jun 2019 | Requires improvement →← Jun 2019 |
| Surgery | Good →← Jun 2019 | Good →← Jun 2019 | Good →← Jun 2019 | Requires improvement →← Jun 2019 | Good →← Jun 2019 | Good →← Jun 2019 |
| Critical care | Good Jun 2017 | Good Jun 2017 | Good Jun 2017 | Requires improvement Jun 2017 | Good Jun 2017 | Good Jun 2017 |
| Services for children and young people | Good Aug 2015 | Good Aug 2015 | Good Aug 2015 | Requires improvement Aug 2015 | Good Aug 2015 | Good Aug 2015 |
| End of life care | Good Aug 2015 | Good Aug 2015 | Outstanding Aug 2015 | Requires improvement Aug 2015 | Good Aug 2015 | Good Aug 2015 |
| Maternity and gynaecology | Good Aug 2015 | Good Aug 2015 | Good Aug 2015 | Good Aug 2015 | Good Aug 2015 | Good Aug 2015 |
| Outpatients and diagnostics | Good Aug 2015 | N/A | Good Aug 2015 | Requires improvement Aug 2015 | Good Aug 2015 | Good Aug 2015 |
| **Overall*** | Requires improvement →← Jun 2019 | Good ↑ Jun 2019 | Good →← Jun 2019 | Requires improvement ↑ Jun 2019 | Requires improvement →← Jun 2019 | Requires improvement →← Jun 2019 |

### Ratings for mental health services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Specialist community mental health services for children and young people | Inadequate ↓↓ Jun 2019 | Requires improvement ↓↓ Jun 2019 | Good ↓ Jun 2019 | Inadequate ↓↓ Jun 2019 | Inadequate ↓↓ Jun 2019 | Inadequate Jun 2019 |

By 31st March 2020, Weston Area Health NHS Trust had completed actins arising from the two warning notices.Throughout the year there has been continuous monitoring and robust management of the improvement plan, via monthly senior management team meetings, monthly directorate governance meetings and the trust's quality and safety committee, with assurance against actions assessed and validated by the lead executive for each recommendation.

## Engagement between the Care Quality commission and Provider

As part of a new engagement process between the provider and the CQC, quarterly review meetings have focussed on the core services of medicine, outpatients and end of life care.

## Hospital Episode Statistics and Secondary Users service

Weston Area Health NHS Trust submitted records during 2019/20 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Data Quality of Secondary User Services Data

| Weston Area Health NHS Trust | Weston 2018/19 | 2019/20 (Apr – Dec) * latest data available | |
|---|---|---|---|
| | | Weston | National average |
| **% of records including the patient's valid NHS number:** | | | |
| Admitted patient care | 99.9% | 99.8% | 99.4% |
| Outpatient care | 100% | 99.9% | 99.7% |
| Accident and emergency care | 99.8% | 99.3% | 97.7% |
| **% of records including the patient's valid General Medical Practice Code:** | | | |
| Admitted patient care | 100% | 100% | 99.7% |
| Outpatient care | 100% | 100% | 99.6% |
| Accident and emergency care | 100% | 100% | 99.7% |

## Clinical Coding Audit

In line with the Data Security and Protection Toolkit standards (former information Governance Toolkit Requirements 505 and 514), 200 episodes have been reviewed by external auditors D&A Clinical coding consultancy LTD in December 2019 to ensure the coded information continues to be accurate and adequate. The following results have been achieved:

**Data Security Standard 1 Data Quality**

The Trust has achieved the following attainment level – **Standards Met**

**Data Security Standard 3 Training**

The Trust has achieved the following attainment level – **Standards Met**

## Conclusions

Weston Area Health NHS Trust has satisfied the requirements for Data Security Standards 1 and 3, this is to be commended.

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

A robust clinical validation programme with regular peer coder discussions are in place and this is proving successful in increasing the quality of data.

HRG changes have been greatly reduced from 16.5 %(2019) to 7%: and this financial deficit reported should potentially be recouped by the trust during the data reconciliation process

**Coding accuracy**

| % Diagnoses Coded Correctly | | % Procedures Coded Correctly | |
|---|---|---|---|
| **Primary** | **Secondary** | **Primary** | **Secondary** |
| **91.50** | **94.31** | **94.17** | **89.14** |

## Data Quality

### Action we have taken to improve data quality

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

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

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

### Learning from patient deaths

All NHS Trusts are required to have in place a process to look at the care of patients who die in hospital. Many patients choose to die in hospital and a standardised review of these expected deaths is designed to find examples of both excellent care and areas where care could be improved.

The Trust committed to performing a standardised review of care for >50% of deaths occurring in hospital and ensuring that learning from these reviews was shared widely within the organisation.

The Trust's chief registrar has continued to lead the learning from deaths process. In the first 9 months of the 2019/20 financial year there were 440 deaths in the Trust. The trust achieved its target of 50% of deaths receiving a structured review. Three reviews were judged to demonstrate possible avoidable harm and these cases were subject to more detailed investigation.

Examples how lessons learned from reviews have been shared this year include:

- Junior doctor teaching session on specific cases using patient story approach.
- Quality improvement project started by Respiratory Specialist Nurse team on the correct use of non-invasive ventilation in patients following issues identified during learning from deaths review.

- WESMILE patient safety magazine; updated with mortality data and learning.
- Learning from deaths focus of medical grand round to all medical staff.
- Peer to peer learning from deaths reviews set up between pairs of medical wards.
- Learning from Deaths Workshop attended in Exeter in November by Chief Registrar; Weston Area Health Trust on track currently. Medical Examiner Officer recruitment is beginning and Weston services are being mapped into the Regional plan for the South West.

Learning from deaths reviews have improved the care given to patients that die in hospital especially those whose deaths are expected. Sharing good practice and focusing on specific areas of improvement has contributed to the recognition of our excellent end of life care by the Care Quality Commission and the National Audit of Care at the End of Life

The Trust will continue to focus on learning lessons from reviewing the care given to patients that die in hospital and look to widen our learning with our primary care and community partners to those patients who die soon after leaving hospital.

In 2020/21 the new University Hospitals Bristol and Weston NHS Foundation trust will work with partners in BNSSG to implement the new national Medical Examiners process. This process looks to standardise the process of completing death certificates and will ensure that all patients that die in hospital will receive a consistent review of care by a senior doctor. Pilot schemes of this process have demonstrated that medical examiners are able to provide information and explanation about care to the families of patients who have died which in turn leads to reduced levels of distress and worry at what can be a very difficult time.

### Patient Reported Outcome Measures (PROMs)

The Trust has participated in the Patient Reported Outcome Measures (PROMs) programme since April 2009 for hernias, knee and hip replacements. The programme involves patients completing a pre-operative questionnaire and then a questionnaire either 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 coordinating centre. The Trust posts the initial questionnaire to patients before they attend pre-operative assessment, this enables any queries to be discussed in person at that appointment. The questions asked are based on quality of life measures.

The national coordinating center data return includes all surveys returned to it, even when patients turn out to not be eligible; hence the percentage participation rate sometimes exceeds 100%. Also the center takes a long time to process the results, which therefore means that the data is only available a year in arrears.

**PROMS Participation Rate: (*cannot update these as NHS digital haven't published yet)***

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

**PROMS Performance:**

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

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

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

## Hospital readmission

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

(i) 0 to 15; and

(ii) 16 or over

Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. The readmissions rates within 28 days for 19/20 are:

## Hospital Readmissions

| Age Range | Site Numerator | Site Denominator | Apr 19 – Jan 20 |
|---|---|---|---|
| 16+ years | 1995 | 24530 | 8.13% |
| 0-15 years | 21 | 803 | 2.62% |

**Data taken from CHKS 02/03/2020**

## Reducing harm from infection

## *Clostridium difficile* infections

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

*Clostridium difficile* (*C. difficile*) infections

| | 2019/20 | | 2018/19 |
|---|---|---|---|
| | Weston | National average | Weston |
| Rate per 100,000 bed days of cases of *C. difficile* infection | 8.39 | 15.42 | 8.13 |
| Data source: Public Health England | | | |

In 2018/19 the Trust maintained its low rates of *Clostridium difficile* infections, reporting seven cases. In 2019/20 the criteria for reporting of *Clostridium difficile* infections changed. Cases are split between hospital onset, healthcare associated (HOHA) and community onset, healthcare associated (COHA). COHA cases occur in the community or within two days of admission when the patient has been an inpatient in our care in the previous four weeks. The Trust has reported eight cases of HOHA and seven cases of COHA against a threshold of 14 cases; our rate remains well below the national average. Each case has undergone a comprehensive post infection review which has been assessed against national guidance criteria.

In all but two cases, we have been able to demonstrate that there have been no cases of cross transmission of *Clostridium difficile* between patients on our wards. The reason we could not categorically exclude cross-transmission was due to not being able to sub-type the *Clostridium difficile* to prove this. Learning has been identified in areas such as prompt isolation, sampling and review of antibiotic prescriptions. Every case is presented to the Infection Prevention and Control Committee where action plans are either signed off or it is agreed that further work is required.

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

The strategies introduced over the last 5 years are now embedded and our continuing success in reporting low numbers of *Clostridium difficile* infections is testament to their success.

The strategies that have contributed to this include:

- Continued updating of our antibiotic guidance and the use of mobile technology in the form of a Smart phone App to enable our Doctors to access these guidelines at the point of care.
- Recruitment of antimicrobial pharmacist in June 2019.
- Daily auditing of antibiotic prescribing by a designated pharmacist and the Consultant Microbiologist with prompt feedback to prescribers and their teams from July 2019.
- Use of the Diarrhoea Assessment Tool to assist clinical staff with the prompt isolation of symptomatic patients and in determining when specimens should be sent.

The gap in the antimicrobial pharmacist post from July 2018 until June 2019 impacted on the ability to undertake daily auditing during this period.

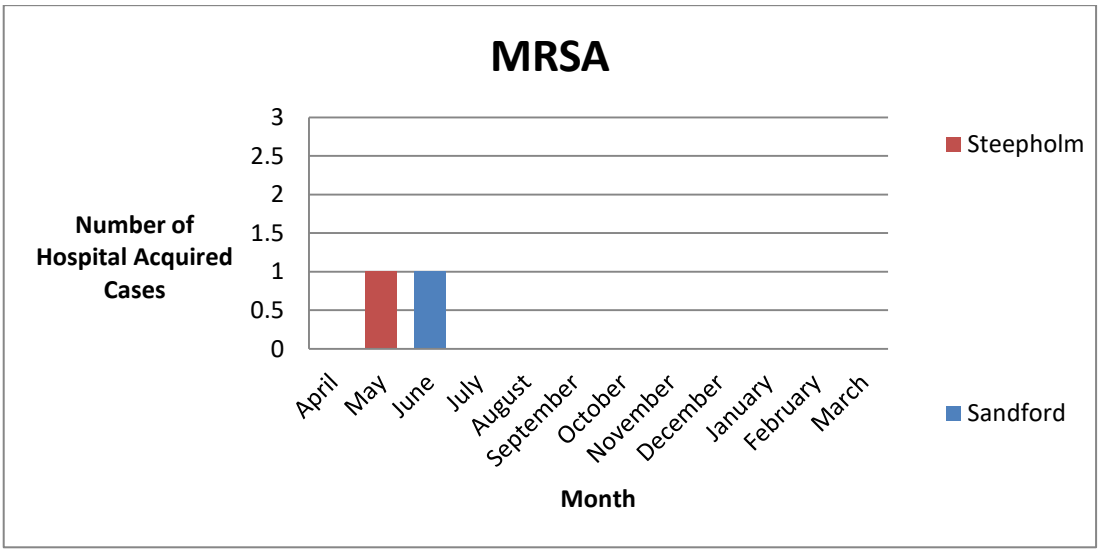
The Trust will continue to support the work across the local health community and meets quarterly with the Commissioners to discuss and improve antimicrobial prescribing and to review learning from incidents across the health care economy.

## MRSA (Methicillin Resistant *Staphylococcus Aureus*) bloodstream infections

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

Two cases were reported during 2019/20 against the Trust's zero threshold. The cases were both fully investigated and involved patients that had previously been colonised with MRSA. No lapses in care were able to be identified that directly contributed to these cases. Learning was identified, however, in relation to peripheral vascular cannula documentation in one of the cases. Work is ongoing to improve compliance with this.

**Total MRSA cases 2019/20**




## MSSA (Methicillin Sensitive *Staphylococcus Aureus*) bloodstream infections

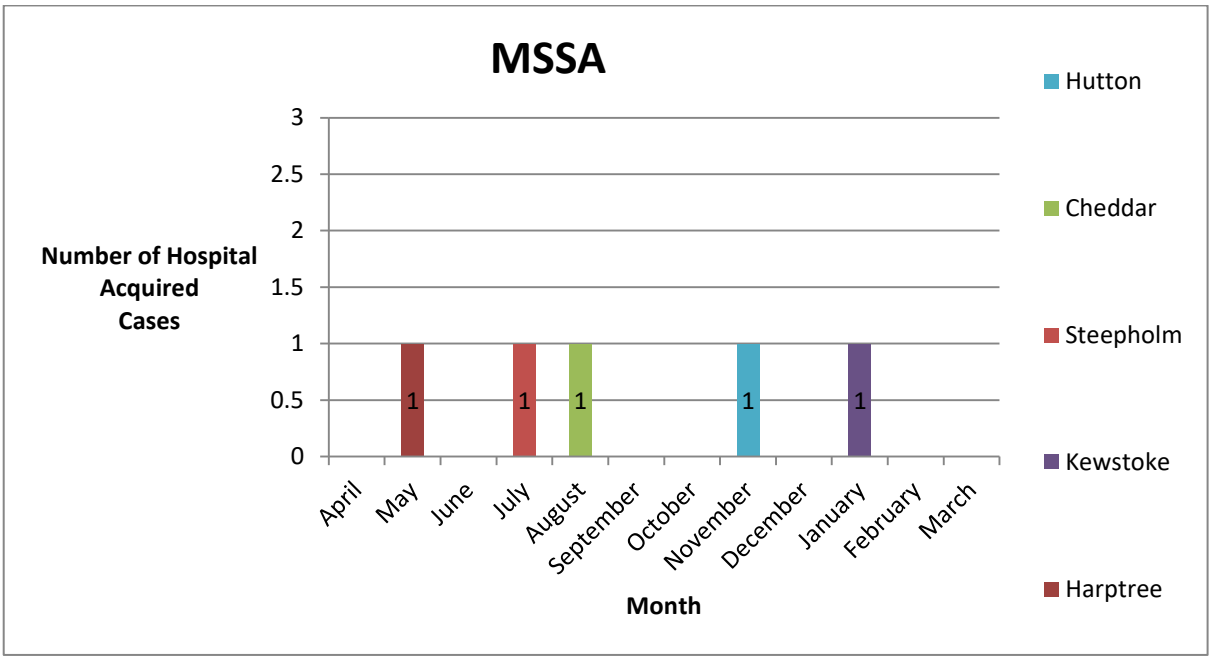
The same reporting and investigation for MSSA bloodstream infections is carried out as for MRSA infections.

The Trust has seen a 45% decrease in the number of cases of MSSA reported this year, reporting five cases compared to nine in 2018/19.

Post infection reviews for each case were completed. One of the cases was related to the care of invasive devices, particularly a peripheral vascular cannula (PVC). A piece of work to improve compliance with invasive device care is ongoing and is being led by our practice development nurses.

Other sources of MSSA infection were the urinary tract and soft tissue.

**Total MSSA cases 2019/20**

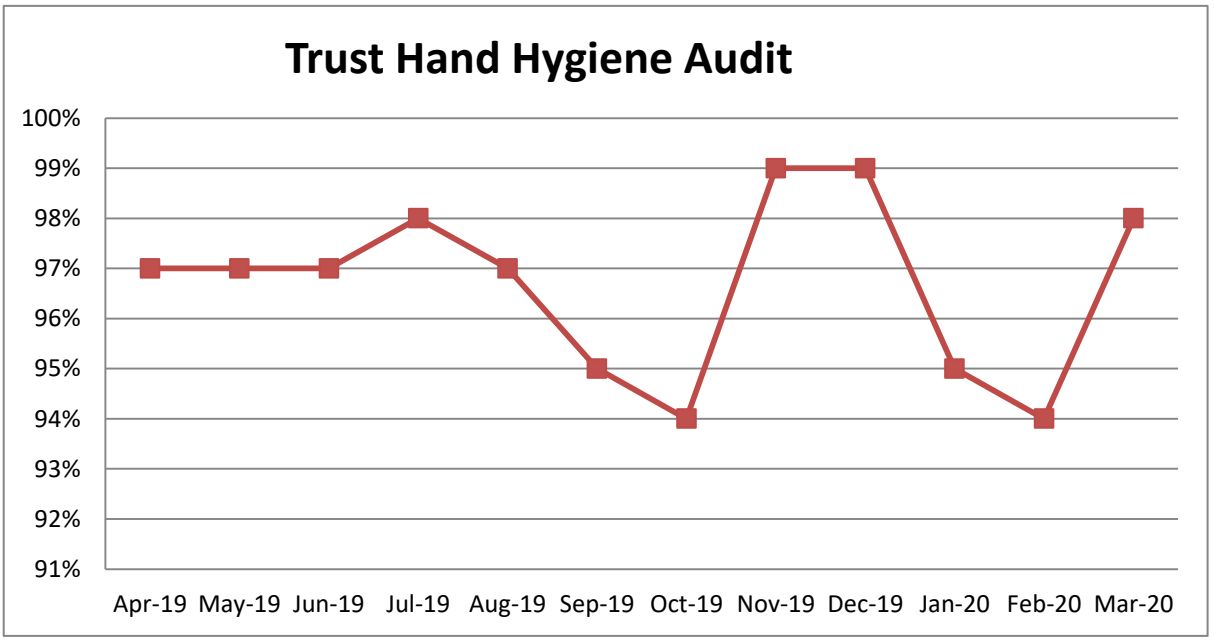



## Hand Hygiene Audit

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

External validation hand hygiene audits are completed quarterly in four different clinical areas. The areas chosen for these audits are not just those with a low compliance percentage but those areas that consistently report 100%. Results from these audits are often lower than the ward reported audits and areas for improvement are always fed back to the respective teams.

**Hand Hygiene Audits 2019/20**



## Escherichia coli bloodstream infections

There has been a continued focus this year on the reduction of *Escherichia coli (E. coli)* bloodstream infections. *E. coli* infections represent 65% of Gram-negative infections and there is a UK government ambition to significantly reduce them. The Clinical Commissioning Group set the Trust a 10% reduction ambition of healthcare associated cases against our 2018/19 data.

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

The Trust reported 129 cases of *E. coli* bloodstream infection in 2019/20, of which 19 were deemed healthcare associated. This compares to the Trust reporting 127 cases in 2018/19 with 22 assessed as healthcare associated. The further 10% reduction ambition set by the Clinical Commissioning Group has therefore been met.

## Mortality Outcomes – SHMI Data

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 published on a quarterly basis from NHS Digital. SHMI compares the actual number of deaths following time in hospital with the expected number of deaths. The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in England who died either while is hospital or within 30 days of being discharged. A higher number of deaths than predicted can be an early indication of unrecognised problems with aspects of patient care.

The trust's Clinical Effectiveness Group monitors several different mortality measures on a monthly basis and has looked at specific patient groups or disease types to ensure that there are no patterns of care that might have contributed to a higher than predicted number of deaths. The group also ensures that learning from reported incidents of harm or poor care are shared widely within clinical teams and (where appropriate) lead to focused quality improvement.

The Trust's SHMI has remained within the expected range since December 2017 and has been consistently below the average for all acute Trusts in England since March 2018

| Weston Area Health NHS Trust | April 18 to March 19 | July 18 to June 19 | Oct 18 to Sept 19 |
|---|---|---|---|
| SHMI value | 0.88 | 0.92 | 0.98 |
| National Upper Limit | 1.18 | 1.14 | 1.14 |
| National Lower Limit | 0.88 | 0.88 | 0.87 |
| Banding | As expected | As expected | As expected |

From 1st April 2020 the newly merged University Hospitals Bristol and Weston NHS Foundation Trust will continue to publish its SHMI and monitor the quality and effectiveness of its care.

## Venous Thromboembolism (VTE)

Venous thromboembolism (a blood clot in the veins) is considered one of the commonest causes of serious avoidable harm for patients in hospital. Ensuring that all patients admitted for care are assessed for their risk of blood clots and given appropriate treatment to prevent them is a vital part of keeping our patients safe.

We have continued to educate all clinical staff about the importance of risk assessment in the prevention of harm from venous thromboembolism. The topic is covered at junior doctor induction and has been the subject of a safety poster campaign.

The trust has achieved the national standard of greater than 95% of eligible inpatients for each quarter of the 2019/20 financial year. Each case of hospital acquired thrombosis (where a patient has developed a blood clot in hospital or soon after discharge is subject to an independent review from a senior clinician to look for any failures in our assessment or treatment processes and lessons learned are reported through the trusts harm free care group to the Quality and Safety Board sub-committee.

We will continue to ensure we exceed the national requirement to risk assess patients for VTE. Following the merger with University Hospitals Bristol, and implementation of the Trusts digital transformation programme, the audit of VTE risk assessment will be automated, increasing the capacity of the quality improvement team. The oversight of the prevention and treatment of VTE will pass to a Venous thromboembolism group within the corporate governance structure of the new organisation.

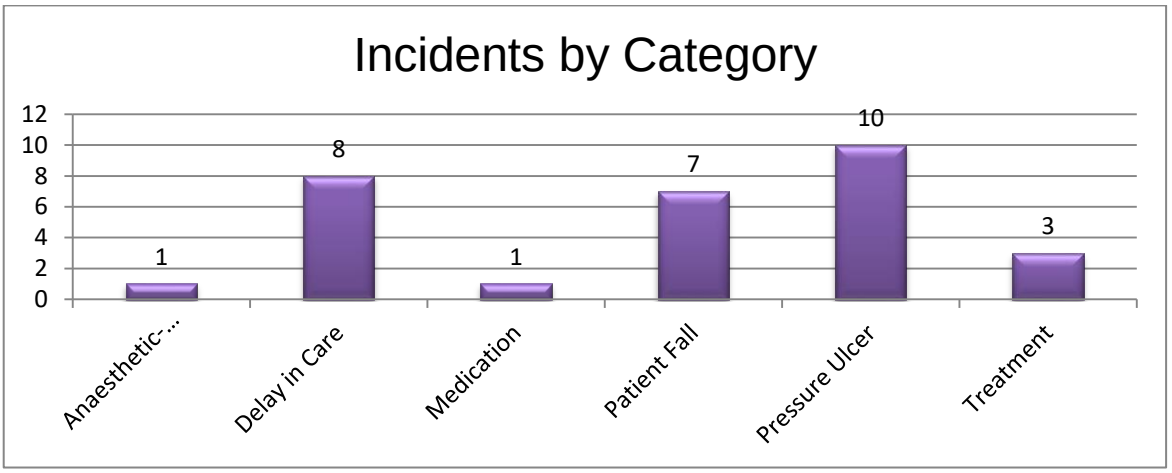
## Patient Safety Incidents 2019/20

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

The total number of serious incidents reported within WAHT for 2019/20 was 30 compared to 42 in 2018/19 and 53 in 2017/18 This shows a 57% decrease in serious incidents over the last 2 years. The organisation has a robust process whereby incidents are reviewed by the Executive Review panel, before being identified as a serious incident, which then requires a full investigation through a root cause analysis methodology and reporting to the national Safety database (STEIS).

There has been a Trust wide focus and training on improving the reporting of incidents and the closure of them to ensure that learning is extracted and shared.

## Serious incidents by category




All serious Incidents have robust action plans developed, which are implemented to reduce the risk of an incident recurring.

The number of patient safety incidents reported within WAHT during 2019/20 and the number and percentages of such patient safety incidents that resulted in severe harm or death are presented in the table below.

**Reported safety incidents and serious Incidents**

| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
|---|---|---|---|---|---|
| Number of Patient Safety Incidents | 1587 | 1752 | 1635 | 884 | 5858 |
| Incidents of Severe Harm | 13 | 18 | 11 | 9 | 22 |
| Percentage of Incidents with Severe Harm | 0.8% | 1 % | 0.3% | 0.6% | 0.4% |
| Number Serious Incidents | 9 | 12 | 6 | 3 | 30 |
| Percentage of Serious Incidents | 0.6% | 0.7% | 0.4% | 1 % | 0.5% |
| Total Number of Never Events | 0 | 0 | 1 | 0 | 1 |
| Data Source: NRLS and Internal Datix | | | | | |

## Never Events

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

There has been one Never Event within WAHT which was reported in December 2019, this was reviewed by the Executive panel and declared a Never Event and has been identified as wrong site surgery and reported externally.

## Friends and Family Test – Patients

The Friends and Family Test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. 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 (A&E) 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. It should be noted that the Trust does not provide a service for Postnatal Care in hospital (Trust 3).
The tables below give further detail.

| | | | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Would Recommend | In-Patient | Trust | 98% | 96% | 96% | 97% | 97% | 98% | 96% | 97.% | 98% | 98% | 98% | NR |
| | | England | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | NR |
| | A&E | Trust | 93% | 93% | 98% | 95% | 92% | 92% | 95% | 94% | 92% | 93% | 92% | NR |
| | | England | 85% | 86% | 85% | 85% | 86% | 85% | 85% | 84% | 84% | 85% | 85% | NR |
| | Out patient | Trust | 93% | 97% | 96% | 97% | 95% | 98% | 98% | 97% | 99% | 97% | 99% | NR |
| | | England | 94% | 94% | 94% | 94% | 98% | 98% | 94% | 94% | 94% | 94% | 94% | NR |
| | Maternity | Trust 1 | 100% | 100 % | 100 % | NR | NR | 100 % | NR | NR | NR | NR | NR | NR |
| | | England | 95% | 95% | 95% | 95% | 94% | 95% | 95% | 95% | 95% | 95% | 95% | NR |
| | | Trust 2 | 100% | 100 % | 100 % | 100 % | 100 % | 100 % | NR | NR | NR | NR | NR | NR |
| | | England | 96% | 97% | 95% | 95% | 96% | 97% | 97% | 96% | 97% | 97% | 97% | NR |
| | | Trust 3 | NR | NR | NR | NR | NR | NR | 100 % | NR | NR | NR | NR | NR |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | England | 95% | 95% | 97% | 97% | 96% | 95% | 96% | 94% | 95% | 95% | 95% | NR |
| | | Trust 4 | 100% | 94% | 100 % | NR | 100 % | 100 % | 100 % | 100 % | NR | NR | NR | NR |
| | | England | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | NR |
| | | | | | | | | | | | | | | |
| Response Rate | In-Patient | Trust | 44.89 % | 46.31% | 46% | 44.26% | 42.92% | 37.85% | 42.73% | 40.18% | 39% | 39% | 39% | NR |
| | | England | 24.8% | 24% | 25.1 % | 26.1 % | 25.6 % | 25% | 25% | 24.8 % | 22.6 % | 24.4 % | 24% | NR |
| | A&E | Trust | 5.53% | 3.56 % | 3.68 % | 5.24 % | 4.68 % | 2.93 % | 11.29% | 10.85% | 9.04 % | 10% | 9% | NR |
| | | England | 11.5% | 12.1 % | 12.1 % | 12.4 % | 13.3 % | 12.2 % | 12.6 % | 12% | 11.6 % | 12.1 % | 11.7 % | NR |
| | Maternity (Births) | Trust | 18% | 11% | 9% | 3% | 9% | 8% | NR | NR | NR | NR | NR | NR |
| | | England | 20.5% | 19.7 % | 20.5 % | 21.3 % | 21.1 % | 20% | 19.8 % | 20.9 % | 18.2 % | 19.9 % | 18.6 % | NR |

## Friends and Family Test –Staff

The staff friends and family test (SFFT) is an organisational temperature check to see how staff are feeling. It takes place every quarter except for quarter 3 when the National staff survey is undertaken.

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

The two questions we ask are:

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

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

### Staff friends & family results 2019/20

| Staff Friends and Family Test Results 2019/20 | | | | | | |
|---|---|---|---|---|---|---|
| | Quarter 1 | | Quarter 2 | | Quarter 4 | |
| | Question 1 | Question 2 | Question 1 | Question 2 | Question 1 | Question 2 |
| **Recommended** | 69% | 56% | 63% | 49% | 61% | 50% |
| **Not Recommended** | 13% | 23% | 12% | 29% | 14% | 25% |

# Part 3: Other Information

This section provides an overview of the quality of care offered by Weston Area Health NHS Trust based on performance in 2019/20 against indicators selected by the board in consultation with stakeholders. These indicators have been chosen as they detail the activity undertaken within the Trust to promote the safety and experience of our patients.

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

## Patient Safety

The safety of our patients is central to everything that we want to achieve as a provider of healthcare. We are committed to continuously improve the safety of our services, and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will also continue to conduct thorough investigations and analyse when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident, and will strive to eliminate avoidable harm as a consequence of care we have provided.

## Sign up to Safety

We remain committed to the Sign up to Safety Campaign and the five key pledges; these are evident throughout our quality priorities for 2019/20.

The five key pledges are:

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

## Falls

Every year patients in Weston Area Health NHS Trust fall and injure themselves.

Sometimes severely and often the fall results in the person needing to stay in hospital and can permanently reduce their physical and mental health and wellbeing. Sometimes these falls could have been prevented, or the repercussions of the fall reduced.

The overarching falls reduction programme has been to focus on timely interventions to prevent falls by identifying those;

1. Likely to have a fall, through risk assessment.
2. Helping those likely to fall, through care planning.
3. Working effectively with patients who have fallen to help reduce the likelihood that they will fall again, through physiotherapy assessment and with enhanced nurse supervision to maintain safety and build confidence.

The key elements that the teams have focused on in 2019 – 2020 were;

1. To have a clutter free ward that assesses hazards that can cause trips or falls → twice a year environmental audits were introduced which have been used to effect improvements in the clinical areas.
2. Effective risk assessment and care planning → continued to imbed the multidisciplinary risk assessment for falls prevention.
3. Patients undergoing enhanced supervision → ABC observations
    - **Activity** prior to behaviour – Did anything provoke behaviour?
    - **Behaviour** – What is the patient actually doing?
    - **Consequence** – What was your reaction?
    - How did the patient respond?

This has helped us to understand patients who are experiencing delirium and how they respond to stimuli. This has allowed for meaningful interaction and care planning along with inclusive decision making for both the patient and the carer.

4. Bay "tagging" → a concept in workforce planning for the shift to ensure that a nurse is present in a bay at all times. This has been helped with the introduction of Allocate an electronic on duty rota for nurses which allows for three times a day assessment of acuity and dependency on the wards.
5. Ward to board reporting aided by a detailed falls dashboard → this allowed teams to assess areas of risk during high activity on their wards which allows staff to be deployed effectively.

Together this has resulted in a 15% reduction in falls when compared to same time period in 2018 – 2019

### What did we do?

The team has continued to build on the work of 2018 – 2019 as mentioned and during 2019-2020 focused on the following key actions that also have direct links to the CQUIN CCG7: Three high impact actions to prevent hospital falls in practice:

1. Delirium pathway – This has been led by the frailty team. A new pathway has been tested and supported by the medical team which has resulted in staff being now aware of the signs of delirium and together with the ABC observations have helped to identify triggers and risky behaviour that may lead to a fall especially in the care of the elderly and orthopaedic and trauma wards. When the pathway is applied the use of hypnotics or antipsychotics or anxiolytics is now clearly documented with rationale.
2. Get up, keep moving – Prevent muscle wasting and therefore preventing falls from fatigue. The concept of walk with me, not sit with me has been encouraged with the aid of the physiotherapy team and encourages patients to mobilise and walk with staff. When the falls risk assessment and mobility risk assessment are managed appropriately it allows for the correct use of mobility aids to be made available and build individual confidence to maintain a level of independence
3. Trust-wide Safety Week – The practice development nurses spent time with teams asking

"Why do we undertake a falls Risk assessment?" and "What is the importance of a lying and standing blood pressure?" - Simple conversations and active learning at the bedside was received well in the clinical areas from staff, patients and families. This was extended to the Emergency Department who now actively participate in the falls reduction programme especially for patients who are admitted following a fall as if appropriate they will assess lying and standing blood pressure on admission.

## What difference did it make?

Data from April 2019 to January 2020 demonstrated:

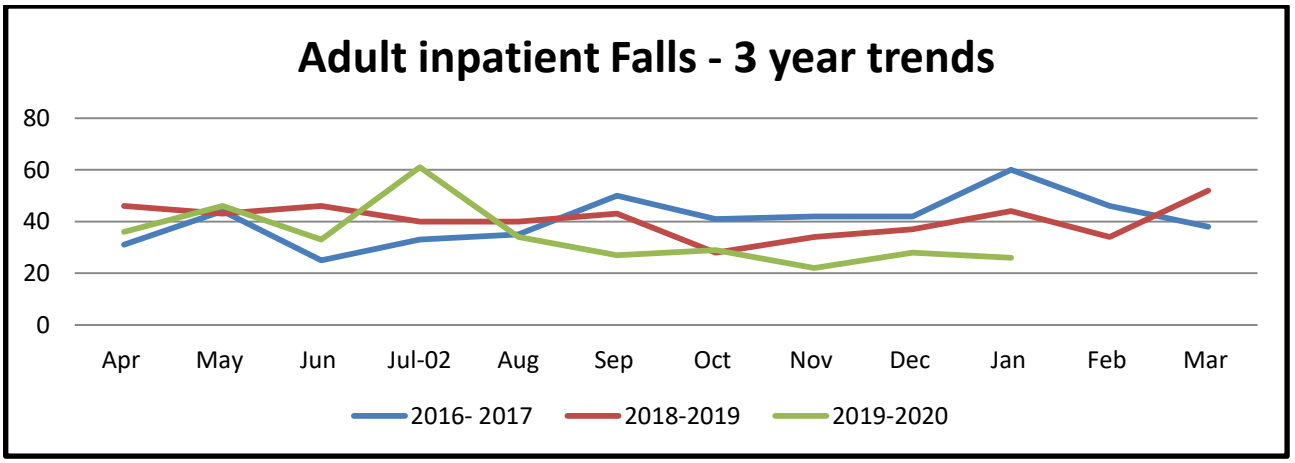
1. Reduction in total falls by 59 (15%) in year.
2. No reduction in falls with harm with 7 incidents that required further investigation and went on to become Serious Incidents for further investigation.

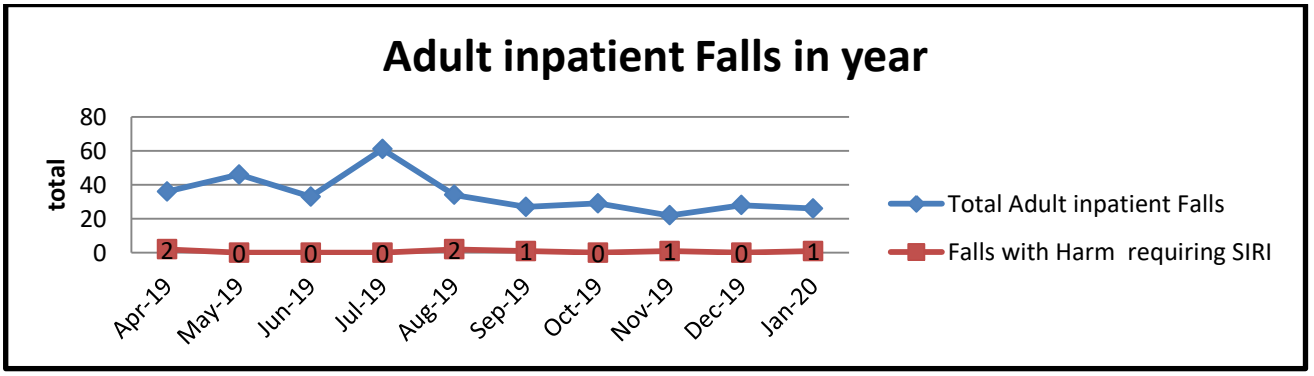
Safe levels of care are maintained. Following the introduction of a new electronic nurse staffing system (Allocate) Matrons have been able to monitor acuity and dependency levels on the wards in real time. This has demonstrated that safe levels of care were maintained and those patients at risk have been supervised.

CQUIN data and improvements in care have been met.

On average (for the 10 months) this means that there has been.

1. 1.1 falls per day = reduction of 0.21
2. 34.2 falls per month = reduction of 5.9



## What will we do next?

A Thematic review of the 7 falls with harm requiring a serious incident review has shown that learning and improvement needs to be focused in the following areas

1. Risk assessment in regards to bed rails – when to use, and when it is best to leave down.
2. Strengthening the mobility programme- Continue to work with the physiotherapy team.
3. Education and training leading to improve care planning and management of those patients who are suffering with delirium especially it they are experiencing terror, resulting in aggressive behaviour.
4. Care planning with families for those patients who have been admitted following falls. This needs to include realistic care planning and future care needs.

## Pressure Injuries

We continue our attempts to reduce avoidable pressure injuries for our patients, particularly the deeper injuries which are serious incidents because of the harm they cause to our patients.
In 2018/19 we had 8 grade 3 pressure injuries and 1 grade 4. In 2019/20 we have reported the same number of deep pressure injuries; therefore we did not achieve our target of 50% reduction grade 3's and 100% reduction of grade 4's. However the number of Grade 2 pressure injuries have reduced by 18%. Grades 2's have a Directorate Level SWARM completed and for every Grade 3 or 4 there is an Executive Level SWARM. This enables any immediate learning to be shared across the Trust and will be discussed at the Pressure Ulcer Steering group. A SWARM is where a rapid response to a patient incident occurs, staff come together to discuss the incident, allowing a quick investigation and prompt action to be taken if required.

We focused on developing our leadership and developing staff knowledge of promoting tissue viability through implementing education at Thursday teaching sessions.

A decrease in resource for the team this year has reduced the education and learning opportunities. Wound care representatives have been utilised as a teaching resource to assist the tissue viability nurse.

We are working collaboratively with our North Somerset Community Partnership now Sirona, for national initiatives and with the BNSSG CCG for example working together, and will continue to improve patient care and enhance patient safety and satisfaction.

With the merger with University Hospitals Bristol NHS Foundation Trust there will be changes within the tissue viability team which will support the workload capacity of the tissue viability nurse.

## Preventing clinical deterioration of the patient and Sepsis

During 2019/20 we continued to work on improving the recognition, escalation and management of deteriorating patients. The most common cause of patient deterioration includes sepsis, blood clots developing within the lungs, sudden onset of confusion, and acute kidney injury (AKI). All conditions were included within the wider deteriorating patient programme. In line with the neighboring Trusts in BNSSG to monitor a patient's risk of deterioration we changed from the first National Early warning score (NEWS) to NEWS2. This means that all inpatients within the hospital have their physiological observations (respiratory rate, levels of oxygen, pulse, blood pressure, level of consciousness and temperature) measured and recorded in accordance with the Hospital Deteriorating Patient and Escalation Policy.

Cardiac arrests in hospital are rarely a sudden event, so we have tried to reduce our number of cardiac arrests by focusing on implementing the NEWS2 scoring and escalation of unwell patients to prevent further patient deterioration and cardiac arrest occurring.

## What did we do?

We continued to develop the two Quality Improvement (QI) projects for the deteriorating patient and one for escalation of the deteriorating patient. The aim is to improve the number and quality of the Safety Huddles, and ensure an accurate National Early Warning Score (NEWS2) monitoring through the following interventions:

- Escalation and use of Situation, Background, Assessment, and Recommendation (SBAR).
- Increasing the education around deteriorating patient, monitoring of patients deteriorating and escalation to the appropriate medical teams.
- A quality improvement week titled ‘Good NEWS2 week’ took place in January 2020, where all inpatient NEWS2 charts were reviewed and audited against the Trust policy.
- The ‘Deteriorating Patients’ audit questions on Perfect Ward were reviewed and improved, to ensure the monitoring of NEWS2 and fluid balance charts were sufficient.
- Continued to improve NEWS2 scoring and vital signs recording, as we recognise this is the most effective tool for identifying at-risk and deteriorating patients.
- All clinical and non-clinical staff joining the Trust are trained in Sepsis awareness and promotion at Trust induction.
- There is a strong emphasis on sepsis care throughout the organisation where we have created a learning culture and sharing of safety lessons to learn from past harms and we look at what we can do to improve care using quality improvement methodology.
- A sepsis champion role has been maintained, where Registered Nurses and Nursing Assistants deliver further sepsis training to their teams and discuss good practice.
- The Sepsis screening tool derived from the National Institute of Clinical Excellence (NICE) guidelines has continued to be proactively used in the Emergency Department. This helps us to ensure patients are being screened for sepsis and treated quickly.

## What difference did it make?

- ‘Good NEWS2 Week’ highlighted areas of potential improvement needed to see an improvement in the accurate recording of NEWS2 scores.
- We have seen an increase in the percentage of observations being recorded in the Emergency Department when a patient is admitted.
- We have increased our staff confidence in caring for a deteriorating patient by using simulation scenarios and holding deteriorating patient study days provided by the Trust Resuscitation officer.
- We have seen an increase in appropriate medical plans being put in place for patients who have become unwell, thus helping us keep those patients safe.

- There has been continued improvement in the reduction of true cardiac arrests within the hospital.
- We have increased the training of staff of the deteriorating patient through practical assessment, simulation and focused debriefing for all foundation doctors and nursing staff.

## What we plan to achieve for 2020/21

We will be implementing electronic observations which are proven to assist with recognising early signs of deteriorating patients and cardiac arrests. This project is to be implemented across the Trust with an electronic vital signs capture and messaging system called Careflow Vitals.

This will allow staff on the wards and across the Trust to have greater visibility of their most critically unwell patients. The system also supports staff at the time of taking observations with early actions required if observations are abnormal.

Careflow Connect will also be rolled out Trust-wide to link to Careflow Vitals. “CareFlow Connect” is a secure and mobile clinical communications and collaboration solution designed to facilitate faster and safer care co-ordination for teams within Weston Area Health NHS Trust. Initially it is hoped this system will be used to inform the Critical Care Outreach Team of patients requiring urgent assessment at the immediate time of their electronic observations being completed on Careflow Vitals.

## Managing patient safety incidents and duty of candour

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

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question is asked about.

Weston Area Health NHS Trust is committed to minimising the risk of harm to patients in the course of their treatment and care. However incidents do occur and we aim to adopt a proactive approach to prevent incidents and learn lessons to improve patient safety. Occasionally people in our care are involved in a safety incident. A small number of these incidents cause harm.

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

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

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

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

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

We have also introduced an audit of compliance for completion of the Duty of Candour process.

## Seven Day Service

10 clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

Standard 2 – Time to first consultant review

Standard 5 – Access to diagnostic tests

Standard 6 – Access to consultant-directed interventions

Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.

We recognise that as a small Trust we have significant challenges in meeting all of the requirements of the 7 Day Standards. Our workforce challenges mean that increasing staff cover to ensure clinical services are identical across 7 days is not practical.

We have focused on key areas of improvement, including ensuring accurate documentation of the timeliness of consultant review, and working with other hospitals in the area to ensure formalised pathways to allow patients to access diagnostic tests at weekends.

The results of the Trust's Seven Day Service Audit in November 2019 demonstrated a significant improvement in response to concerted quality improvement work around documentation The proportion of patients reviewed by a consultant within 14 hours of admission at hospital - weekday = 83%; weekend = 77%; total 81%. Whilst this does not achieve the 90% standard it represents a 65% improvement on the 2018 data.

The Trust reported achieving standard 5 and 6 and partial achievement of standard 8 (100% of patients requiring twice daily senior review received this although the daily review of all stable

patients remains challenging at weekends when numbers of senior staff are reduced.

Further analysis of the weekday data suggests that the trust is able to achieve 100% on some weekdays but performance dips during time of operational pressure. This is likely to be due to a backlog of patients waiting for assessment by the medical team in the afternoon and evening that therefore miss an opportunity for evening review by the medical consultant in the evening. The trust has expanded the established numbers of medical registrars to allow an extra medical registrar to assess patients in the evening when we recognise admissions increase, however slow recruitment means that this is likely to come into effect in 2020. Weekend reviews have also improved and it is recognised that the current operating model for surgical review at weekends does not support compliance. From April 2020 the trust will seek to implement new surgical care models following the Healthy Weston service review and consultation. A move to focus on an ambulatory surgical model provided 7days per week across 12 hours will mean that a reduced number of patients will be admitted and there will be an increase opportunity for consultant review at the weekends.

It is anticipated that the forthcoming merger with University Hospitals Bristol NHS FT will allow further scope for improvement in all of the 7 day service standards as new models of care are implemented and clinical integration further improves weekend staff cover.

## Patient Experience

### Improving Patient Experience

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

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

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

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

The survey highlighted many positive aspects of the patient experience.

- Discharge: delayed by no longer than 1 hour 22%.
- Hospital: food was very good or good 65%.
- Hospital: did not share sleeping area with opposite sex 96%.
- Admission: did not have to wait long time to get to bed on a ward 69%.
- Discharge: was not delayed 63%.

Pleasingly the report indicates improved responses regarding;

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

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

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

These have included patients attending the Board to tell their story and some telling the story to our Patient experience team who convert this into a presentation format. Some examples are positive and excellent experiences of care and others where the Trust recognises that we have not got it right and need to make a change. One such example which has led to a change was the cancellation of surgery procedure and ensuring that patients are not kept nil by mouth for an extended period of time when this occurs.

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

## Supporting our Workforce - Staff Survey Questions

### Improvement in Staff Attitude Survey scores for:

### Health and wellbeing

There has been an increase in staff reporting that the trust takes positive action on health and wellbeing, improving from 20.6% in 2018 to 22.1% in 2019.

There has also been a slight decline in staff felling unwell as a result of work related stress, from 40.8% in 2018 to 40.5% in 2019.

### Managers and colleagues

The encouragement staff get from their managers has stayed relatively static (64.8% in 2018 to 64.5% in 2019).

Staff report being increasingly involved in choices about how they do their jobs (54.4% in 2018 to 54.4% in 2019).

Respect between colleagues has increased, with 71.5% of staff reporting in 2019 that they receive the respect they deserve at work, compared with 67.2% in 2018. This is mirrored in a reported improvement in relationships between colleagues, with a reduction in people reporting that

working relationships are strained from 42.7% in 2018 to 40.8% in 2019.

## Staff engagement

There has been a slight increase in staff looking forward to coming to work (up to 54.8% in 2019 from 54.4% in 2018) and feeling enthusiastic about their job (up to 75.1% in 2019 from 72.3% in 2018.

## Supporting Apprenticeships

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

Working with our procured educational providers, and the regional Sustainability and Transformation Partnership (STP), we have continued to procure a wider range of apprenticeships to meet the various demands of the workforce. We have continued to recruit a number of apprentices into both administrative roles and nursing roles.

With the proposed merger with UHBristol, as a trust we look forward to the joint relationships we can build on to develop a sustainable workforce which will focus on the apprentice, this will include nursing apprenticeships.

## Continuing Professional Development

Competent staff with regular access to training, who work well in teams, and are supported by effective leaders deliver safer, more effective care. Developing the skills of our workforce is vital in ensuring that our staff remain up-to-date with best practice. The organisation offers various Continuing Professional Development (CPD) opportunities from academic courses, apprenticeships, to one-off training events and attendance at regional and national conferences. During 2019/20 we were successful in securing funded places at University of the West of England (UWE), these courses ranged from enhancing specific clinical knowledge to developing leadership and innovation.

| Course | Number of Staff Attended |
|---|---|
| Post Registration Academic Courses undertaken | 49 |
| Clinical Skills Days | 433 |
| Conferences and Workshops | 24 |
| HR Courses | 166 |
| Management & Leadership Courses | 74 |
| E-Learning courses for CPD | 231 |
| Teaching Thursdays | 788 |
| Total | 1,765 |

During 2019/20 we have employed a dedicated Practice Development Nurse (PDN) in the Emergency Department who works alongside the other PDNs to support our staff development. These staff join the practice development staff employed in the Theatre Unit to provide face to face support for all staff as required. The Practice Development Team also work closely with the Trust Specialist Nurses to provide weekly bespoke training for all staff on 'Teaching Thursday'. These sessions have been well attended and received by staff at all levels and will continue throughout the coming year.

During 2019/20 we have collaborated with the Management Trainer at University Hospitals Bristol NHS Foundation Trust, to deliver a 2 day Leadership for Managers course specifically aimed at Band 6 and 7 managers.

## 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. Staff training in complaints resolution is available a part of the Trusts annual corporate training programme and remains high on the training agenda for the Trust.

The Trust received a total of 213 formal complaints during 2019/20 which represents an increase from the 2018/19 total of 181.

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 communication and medical treatment: with communication the most significant theme. Discharge is one of the top three of the complaint themes.

To improve the standards of care the Trust has delivered a number of initiatives related to main themes:

## Communication

- Care Rounds have been introduced on the medical wards to improve communication with patients and relatives by both clinical and nursing staff.
- To ensure the patient is fully aware of where they are on their care pathway and know when all their appointments are the pathways specific in relation to communication have been strengthened between the administration staff and the patient.

- The Nurse in charge of the shift wears a red badge so that they are clearly identifiable to patients and visitors.
- To refocus staff on dignity and respect in care the Trust has reintroduced “my name is”; running focused training sessions for staff and promoting through trust wide communication.
- Visiting hours were extended to allow family to communicate with doctors for effectively and in a timelier manner.
- Training on effective communication skills for all clinical staff in the Emergency Department was delivered in August and November by the Emergency Medicine Consultants and Senior Nursing Team which has resulted in an improvement in the feedback from patients related to communication.

## Medical treatment from doctors

The Emergency Department have developed a specific pathway on managing and investigating falls, hip fractures and ongoing limb pain, to be followed for patients with or without a history of a fall to improve patient safety through effective risk assessment.

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 2019/20 and the changes from last year.

**Main types of complaints received during 2019/20:**

| | **2017/18** | **2018/19** | **2019/20** |
|---|---|---|---|
| Complaints about staff attitude - % | 12% (50) | 10% (33) | 9% (19) |
| Complaints about discharge arrangements -% | 8%(35) | 10% (34) | 13% (27) |
| Complaints about medical treatment - % | 29% (118) | 22%(75) | 37% (78) |
| Complaints about nursing care - % | 9% (38) | 11% (38) | 12% (25) |
| Complaints about communication - % | 25% (104) | 30% (103) | 22% (47) |

## Parliamentary and Health Service Ombudsman

The Parliamentary Ombudsman can investigate complaints when individuals feel they have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. The Ombudsman can decide not to investigate, to agree with how the original complaint was dealt with, or to uphold a complaint and insist that the public organisation puts things right.

During 2019/20 there was one complaint referred and accepted for investigation by the Ombudsman. This case was not upheld by the Ombudsman.

## Perfect Ward

Perfect Ward is the smartphone application (app) used for healthcare inspections, led by ward sisters and matrons. The app releases time for senior clinical staff to provide direct patient care, it also enables access to real time information. Perfect Ward reporting provides assurance for leaders that the quality of care that is being delivered, is at a consistent high standard.

## What did we do?

The Perfect Ward app was implemented in 2016 at Weston Area Health NHS Trust. Throughout this time it has been refined and adapted to the required need, there are selected questions relating to the standards of care, defined by the Care Quality Commission (CQC) which helps our staff and patients ensure that their areas are meeting the CQC five domains which are:

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

In 2019, all questions were reviewed and significant improvements were made to the inspection questions. The vast majority of questions originated from recurrent themes highlighted in patient safety incidents, many were also improved to reflect updated current practice.

Patient experience and staff wellbeing questions were added to capture how our staff and patients feel and what we could be doing better. This helps teams and services provide sufficient assurance to demonstrate we are doing all we can to improve and share learning and safety lessons.

## What difference did it make?

- With all inspection questions being service specific, there has been an uptake in clinical inspections being completed on time and in more areas, such as Oncology and Haematology Day Unit and the Intensive Care Unit.
- It has enabled us to receive real time results and feedback on the quality of care being delivered.
- It has enhanced the quality of the inspection audits, working and collaborating with teams, senior nurses and the patient experience manager.
- Many areas have been able to utilise their audit results ensuring their effectiveness and efficiency is shared amongst the teams so that improvements can be made.
- We have developed a network for ongoing learning and development.
- It has allowed us to better understand exactly what the patients feel we need to improve through talking to them and recording their comments.
- It also enables us to take immediate action to address things (where possible) when patients tell us what is important to them.

## What will we do next?

- We aim to improve monthly completion compliance to 100% by August 2020, across all inpatient wards, Oncology and Haematology, Endoscopy, Outpatients, Ambulatory Care Unit, Medical Day Case Unit and the Emergency Department.
- We will produce high level reports to be presented to monthly Directorate Governance meetings, Ward Wednesday and Harm Free Care. This will ensure that results from audits are reviewed.
- We will develop new approaches to embed the feedback from the audits to demonstrate continuous improvements in the quality of care provided.

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

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

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

During the past year the Macmillan support centre has become well established as the central point of contact for all cancer patients. It continues to serve a diverse but mainly elderly population.

The number of people being diagnosed with cancer in North Somerset is similar to the England average, as is the one-year survival rate which is sometimes used as a proxy measure of diagnosis of cancer at a later stage.

As well as providing support for Weston Super Mare and the surrounding area in 2019 we have supported people from Gloucestershire, Bristol, Taunton, Cornwall, France and Australia.

The Trust, along with neighbouring Acute Trusts (University Hospitals Bristol NHS Foundation Trust and North Bristol Trust) aspires to provide the best possible service to the patients that are referred into the service, aiming to provide a comprehensive holistic service meeting the physical, psychological and spiritual needs of all cancer patients and their loved ones. Some of the new improvements include online information library for all cancer services enables accurate and up to date information for our patients and families. A smaller version of this document is also available for patients on the Trusts website.

### Activity analysis of the Macmillan Centre 2019/20

Centre Attendances - 1330
Female - 903
Male - 426

44% of visitors have a cancer diagnosis
76% of all contacts are carried out in the centre.

## Personalised care and support in cancer

Personalised care and support in cancer has aligned cancer support workers to all specialties

supporting patients practical, emotional and spiritual needs through a Holistic Needs Assessment (HNA) and has enabled Weston hospital to deliver health and wellbeing events specifically focusing on what help and support is available, life style, managing symptoms and empowering patients to be more involved in their access to services as required. The first Clinical Psychological Service at Weston, funded by Macmillan is embedded and being well received by our patients.

Following the award of transformation funding in Somerset, Wiltshire, Avon and Gloucestershire (SWAG) West Cancer Alliances, Weston General Hospital received monies for 2 years to increase the roll out of the recovery package, the focus being on 3 metric sites, colorectal, breast and urology-prostate.

## End of Life Care

The hospital palliative care team provides holistic support for patients and those close to them who have a life limiting illness.

During the last year we have contributed to the National Audit for Care at the End of Life (NACEL). This was the second year of a three year data collection cycle.

Results from the 2018/19 audit have been analysed, The key findings are:

It appears we are good at recognising patients who are likely to die within the next few days. However 46.2% died soon after it had been recognised that they were dying. We ideally need to be identifying dying patients as early as possible and continue with ongoing education to try to improve this.

We are doing well at devising and documenting an individualised plan of care for the last days of life. This was completed in 77.4% of patients compared to 61.5% nationally. This is probably partly due to the work which was undertaken to develop the Individualised Care for the Last Days of Life booklet. It is encouraging to see that this education initiative has improved practice.

The audit also showed that the plan for end of life is generally discussed with the nominated person. We are very aware that we don't have designated quiet spaces for relatives and carers on all the wards. This needs to be considered on a ward by ward basis.

Holistic assessments are being undertaken for the majority of patients. The evidence shows that our assessments and documentation is generally good, however

In 22.6% there was no documentation regarding who was present at the time of death. This might be something which we could consider how to improve e.g. through different prompts on the care after death.

Overall, carers reported that the care provided to the patient in the last few days of life in Weston General hospital was outstanding or excellent in 90% (NACEL- 60%).

These global assessments of the care provided to our dying patients and their family/carers is extremely encouraging.

We have continued to work to promote appropriate use of the Hospital treatment Escalation Plans (TEP) these have also been key to the introduction of the respect community Treatment Escalation plan which are used for patients who are discharged with a TEP. Audit has shown that the number of TEP forms being completed is increasing and the number of patients who have

complex medical problems and no TEP in place is decreasing. The emphasis is not on withholding any treatments, but having a discussion about what would be appropriate and likely to be of benefit as well as acceptable to the patient.

The number of patients being referred for non-cancer diagnosis continues to appropriately increase. Figures were over 40% for last year.
We have developed a policy for Moving Patients at the end of life to try to ensure that patients are not moved around the hospital in their last hours to day of life, unless on balance this is in their best interest.

We have shown appropriate use of the hospital TEP forms, both for clarifying treatments that would not be appropriate as well as documenting what treatments would be suitable.
The documentation for individualised care at the end of Life is being well used.

Ongoing education for all staff groups to ensure that dying patients are recognised as early as possible, is a high priority for us.

We are looking at working with medical teams regarding the use of High Flow oxygen in the Trust.

## Dementia Care

There are over 850,000 people living with dementia in the UK and in North Somerset alone the number of people in the over 65 age group is estimated to be **3,354.** People who are living with a dementia and are admitted to hospital end up staying longer, they are also more likely to be readmitted once they have left and are less likely to return to their own homes than someone who does not have a dementia.

As a Trust we are committed to supporting people with dementia to have the best possible outcomes and we support this by continually looking at ways to make our hospital more dementia friendly and listening to and acting on the feedback we receive from both our patients and carers.

- We have continued to work alongside Dementia UK to develop the Admiral Nursing service, as one of less than twenty Trusts in the UK who have this designated specialist role.
- We have continued our commitment to providing a Dementia friendly hospital for our patients.
- This year we started work on a ‘quiet bay’ in ED, where patients can be supported in a calmer environment which we hope will help reduce the understandable anxiety and stress that can be part of being in a busy hospital environment. We worked to ensure that this not only met recognised guidelines for best practice but we consulted people living with dementia and acted on their suggestions.
- Following on from this we now have representation from a person who lives with dementia and a carer on our dementia steering group.
- Building on our refurbishment work last year with our care of the elderly ward, we have started a ‘Bus Stop’ project. Secured a bus stop and personalised timetable from ‘First’ and the support of a local graphic designer who is creating a picture on special paper which is then transferred to glass or porcelain to mirror Weston Seafront. This has also demonstrates our strong partnership working with our mental health colleagues, as this is a joint initiative with Avon and Wiltshire Mental Health Partnership.
- In 2019 our Admiral Nurse accepted a total of 142 referrals for families who have a loved one living with a dementia. Undertaking a total of 1805 contacts with families, patients and colleagues, working in a ‘triangle of care’ to ensure better outcomes. For example a reduction in repeated admissions to hospital for some of our patients
- Providing a calm and supportive environment for people who live with a dementia has shown to have a positive impact on their wellbeing and reduce some of the negative effects of the

condition, such as misinterpreting shapes and colours. Ensuring that the voices of people who experience the condition are heard helps us know that we are moving in the right direction with our decisions. It also demonstrates that having a dementia diagnosis does not mean that your opinions and contribution are diminished.

- Other areas in the country that have trialed a 'Bus Stop' project have found it has reduced agitation in patients living with dementia as it helps them focus on something familiar when they become anxious or worried.

## Supporting and listening to Carers

There are 7 million people in the UK who provide care for disabled, seriously ill or older loved ones, that's 1 in 10. Their commitment and support saves the UK economy £132 billion pounds a year.

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

Therefore, we have a commitment to actively encourage the involvement and opinions of carers and an assurance that carers are supported throughout their involvement with our trust.
We recognise that carers are uniquely placed to offer us invaluable knowledge about the health, needs and wishes of those patients within our care.

- We have built on our commitment to people living with dementia and their families by launching 'Lillian's Memory Café', a monthly space for people living with dementia, their carer's and anyone who is worried about their memory to come and meet people, have a cup of tea and get some advice and support.
- We have expanded our collaborative working with North Somerset Hospital Carers Support Scheme, NSHCSS, working with the team to share our knowledge and experience of carers needs.
- In collaboration with NSHCSS we have been completing 'Dementia carers feedback' forms to gain an understanding of what really matters to the carers of people living with dementia within our trust.
- Loneliness and isolation are particular problems if you live with dementia or care for someone that does, (Alzheimer's society 2018). Having a designated space where you can meet people in similar situations and gain advice and support from local services can go a little way to alleviate that.
- North Somerset Hospital Carers Support Scheme has supported a total of 546 carers last year. Alongside the 146 families that the Admiral Nurse has also supported we have started to gain some valuable feedback which will allow us to prioritise areas that we need to develop further as a trust.
- One such area is around carer involvement in the decisions we make about the care we deliver. We are honoured to now have the family carer of former patient who lives with dementia as an active member of our steering group.

## Safeguarding Children

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

At a strategic level it is about monitoring safeguarding practices in the Trust, promoting good

practice, providing staff with training, advice and support to carry out their roles effectively, engaging in multi-agency work, and implementing best practices that are identified locally and nationally.

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

We have developed and appointed to a Children Safeguarding Practitioner role, expanding the teams skills and resources, allowing us to improve our ad-hoc and scheduled Safeguarding Supervision across all paediatric services, make progress on our audit programme for the first time in 2 years, and focus some much needed resources on the promotion of valuable (but poorly utilised) safeguarding resources such as Early Help, Social Care Referral Threshold Document, and Escalation Policy.

We have completed 2 Serious Case Reviews – both of which involved our CAMHS's and paediatric services. This required a lot of dedicated time for the purpose of investigation, reflection, supporting staff, identifying learning, acting of findings, and multi-agency working.

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

Through the introduction of the additional role of Children Safeguarding Practitioner and the developments outlined above we are slowly but surely improving staff knowledge and skills and improving practice and therefore outcomes for children. This role was introduced permanently in June 2019 and therefore data is still being collected to evidence any resulting improvements, as changes in cultures and practices develop over time, but anecdotally staff awareness seems to be improving, and practice appears to be uplifted.

Current identified work streams include:

- Level 3 Children's Safeguarding training – efforts to improve attendance and notify relevant managers of future dates to aid compliance.
- Continue to progress the supervision provisions in the Trust – Supervision Policy, improved compliance, audit quality and actioned.
- Continue to progress the audit programme which was reinstated in November 2019, in which a few key areas are being audited. But on a wider scale we collect a lot of data and have a fairly good overview of how things generally stand but we need to conduct the analyses to provide evidence and inform action plans
- With the upcoming merger with UH Bristol there has been a lot of work to align the 2 services and regular monthly meetings held to assist the merger and work alongside the UH Bristol safeguarding Team.

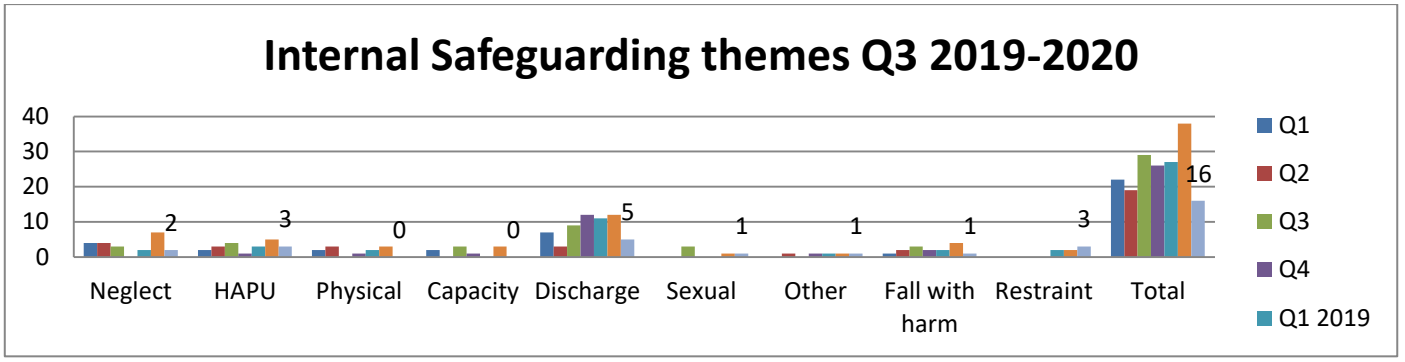
## Safeguarding Vulnerable Adults

All Trust staff are encouraged to raise concerns for any element of suspected abuse (as detailed in the Care Act 2014). This clear message is promoted throughout statutory mandatory safeguarding training. Safeguarding awareness training for all staff at Weston General Hospital is currently 90%. Great value has been placed upon safeguarding training and a whole day approach has

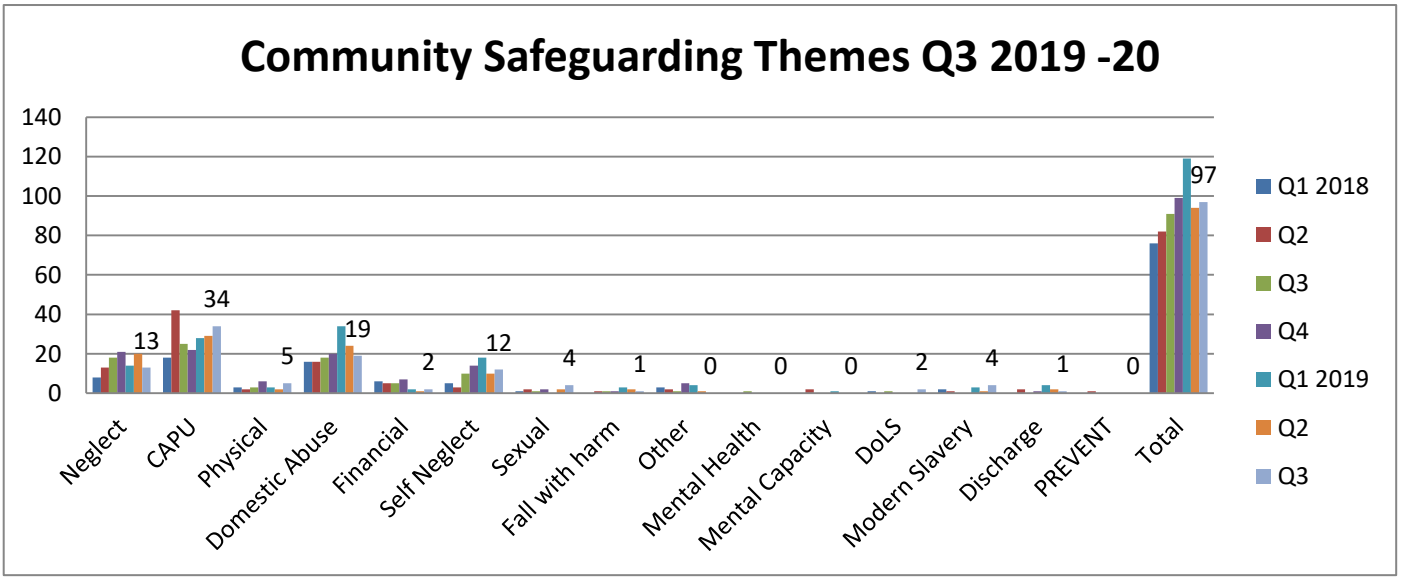
been incorporated within the training matrix for staff. The day enables staff to deliver safe care to various groups of vulnerable adults and children and includes the Mental Capacity Act and Deprivation of liberty Safeguards, Safeguarding Adults and Children , Learning Disability, Autism, Dementia and Prevent (Governments de-radicalisation programme).

The Trust saw an increase in safeguarding activity within 2019/2020 raising 388 community related concerns and 97 internal concerns.

**The number of Internal Safeguarding Concerns raised 2019/2020**



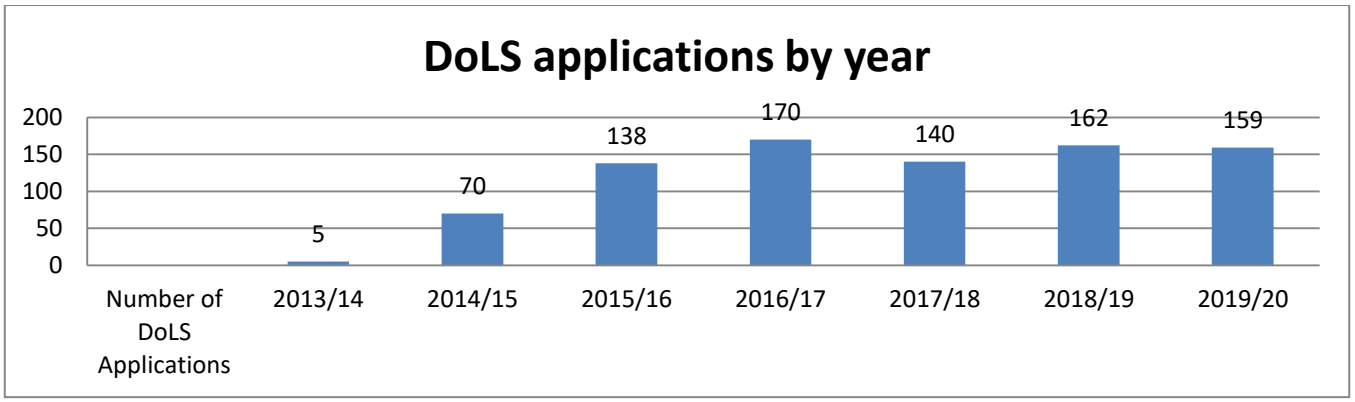

**The number of community safeguarding incidents raised 2019/20**




## Deprivation of Liberty Safeguards

The Supreme Court ruling on Deprivation of Liberty Safeguards (DoLS) came into force in March 2014. The Trusts position for identification of eligible inpatients and consequent submission of applications has improved. The data in the following graph reflects the improvement within this area of Safeguarding for 2019/20. Our staff assess those patients who may require an application submission and where required are supported by the Trust Safeguarding Adults team. The ward based DoLS process is monitored closely by the Safeguarding Adults team via spot audits.

**The number of DOLS applications made 2019/20**




**Learning Disability**

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

The Learning Disability team recorded 105 contacts for people with a Learning Disability, 14 patients within the Emergency Department, 18 as an outpatient and 73 as an inpatient.

The Trust Learning Disability steering group has had an exciting year, with key professionals attending sharing expert knowledge on a range of topics including health and nutrition, sleep deprivation and medicine management.

The Trust has engaged with the NHSI improvement standards and supporting LeDeR with structured judgment reviews on all patients deceased in Weston General Hospital with a learning Disability. Autism has been introduced into statutory mandatory training, reflecting learning from the death of Oliver McGowan.

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

The Complex needs sister who is a Registered Learning Disability Nurse also supports inpatient and outpatient areas with complex patients; advising on Mental Capacity decisions.

## Specialist Community Paediatrics

The Community Paediatric Team works with Children and Young People aged 0-18 years.
We offer assessment and treatment for neurodevelopmental conditions such as Attention Deficit Hyperactivity Disorder and Autism Spectrum Condition. We also provide ongoing care for children and young people with neurodisabilities.

We are a team of Paediatricians and Nurses, who are committed and passionate about providing the best possible care to our patient group. Additionally, we work in partnership with our colleagues in the community; for example, school nurses, health visitors, social workers and education to ensure care we deliver is integrated, holistic and collaborative.

This year has seen a period of stability for the Community Paediatric Team, enabling the team to galvanise the quality improvements highlighted in the 2018/19 Quality Account.

Over the last financial year, we have:

- Funded training to allow a nursing team member to undertake the Non-Medical Prescribing course enabling a more responsive service for patients. A second member of the team is now completing the course.

Community Paediatric and Community Paediatric Therapies teams have utilised CCG non-recurrent funding to address Autistic Spectrum Disorder diagnosis long waits in South Gloucestershire and North Somerset, to appoint a Locum Psychologist to further improve patient flow on Social Communication Autism Multi-Professional Pathway (SCAMP)

- Nurse Led clinics are fully embedded into the service delivery model.
- Utilised clinic space at Quantock Outpatients to provide more clinics which in turn improves Referral to Treatment Time (RTT) facilitating access to the service in a more timely way.
- Continuation of jointly held clinics in Specialist Education Provisions and with Community Paediatric Therapies Colleagues ensures the delivery of joined up bespoke care.

We have continued to represent WAHT Specialist Community Children's Services at external meetings and events (e.g SEND Board, Social Communication Fayre, Transitions Steering Group, Transitions Fayre, North Somerset SEND Patient Participation Engagement Group.

- The number of formal and informal complaints continues to decline.
- Patient experience data remains positive.
- Locally collected data from Nurse Led clinics indicates that 89.8% of families felt listened to.
- RTT time reduced from Red to Amber in the first month of delivering clinics at Quantock.
- Positively representing the organisation at external meetings has improved organisational reputation and has supported the development of a positive narrative.

As a service, we are looking forward to the opportunities that joining with Sirona Health and Care will bring as we merger as a service from 1st April 2020.

As the direction of travel around pathways across Sirona Community Children's Services becomes clearer, we will welcome the opportunity to work collaboratively and align with existing pathways across the geographical location.

It is our aim to have substantive clinicians in post and not to be reliant on locum cover.
Business cases (Qb, Neurodisability Nurse, SCAMP Clinical Psychology Lead) will be taken forward.

We will continue to deliver business as usual to the same high standard, during this period of organisational change and development.

### Child and Adolescent Mental Health Services

Weston Area Health NHS Trust provides child and adolescent mental health and learning disability services (CAMHS) from two sites: Drove House in Weston-Super-Mare and the Barn in Clevedon; services are delivered by one multidisciplinary team across the two sites. Community paediatric services were also based at these sites and delivered services from these locations.

The CAMHS teams provide services for children and adolescents with severe and complex mental health issues. The multidisciplinary team provided services from the two main bases but also from clinics, schools, early years settings and in families' homes. The team offered the

following therapies/services:

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

## Clinical Effectiveness

## Cancelled operations

The Trust recognises that having to cancel operations is distressing for patients and their families at a time that is already worrying. The national target is to cancel no more than 0.8% of operations for the year. Unfortunately, due to the significant pressures experienced nationally during the winter months there was a need to cancel elective operations during this period.

**Cancelled operations**

| | National Target | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|---|---|---|---|---|
| % Operations Cancelled | ≤0.8% | 0.60% | 1.10% | 0.18% | 2.21% | 1.81% | 6.95% | 2.77% | 2.28% | 3.50% |
| % Cancelled Operations Rebooked Within 28 Days | ≥95% | 100% | 100% | 100% | 99.88% | 100% | 95.45% | 94.44% | 94.44% | 94.06% |

## Stroke

All Trusts have been set a target to ensure 80% of stroke patients spend 90% or more of their stay in a specialised stroke unit. As at the end of January 2020 the Trust have achieved 76.60% during 2019/20, which has decreased from 84.47% during 2018/19. We have a specialist Stroke team and we thrombolyse patients with a confirmed stroke Monday to Friday 9-5 and outside of these hours patients attend North Bristol for treatment.

Work is being done within the Trust to ensure that wherever possible we keep a “hot” bed available on the stroke ward to ensure that when a patient requires admission to a Stroke Ward, there is a bed available and the patient does not have to start their admission on a different ward.

## MRSA (Methicillin Resistant *Staphylococcus Aureus*) bloodstream infections

All MRSA bloodstream infections are reported nationally and are assigned as being related to the Trust, or not related to the Trust (acquired in the community or other settings) following a post infection review.
Two cases were reported during 2019/20 against the Trust’s zero threshold. The cases were both fully investigated and involved patients that had previously been colonised with MRSA. No lapses in care were able to be identified that directly contributed to these cases. Learning was identified, however, in relation to peripheral vascular cannula documentation in one of the cases. Work is ongoing to improve compliance with this.

## Escherichia coli bloodstream infections

There has been a continued focus this year on the reduction of *Escherichia coli (E. coli)* bloodstream infections. *E. coli* infections represent 65% of Gram-negative infections and there is a UK government ambition to significantly reduce them. The Clinical Commissioning Group set the Trust a 10% reduction ambition of healthcare associated cases against our 2018/19 data.

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

The Trust reported 110 cases of *E. coli* bloodstream infection in 2019/20, of which 16 were deemed healthcare associated. This compares to the Trust reporting 127 cases in 2018/19 with 22 assessed as healthcare associated. The further 10% reduction ambition set by the Clinical Commissioning Group has therefore been met.

## Performance against national priorities and access standards

### Access to Clinical services

### Overview

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

The national standards are:

- 95 per cent for A&E 4 hour waits
- 85 per cent for 62 day GP Cancer
- 92 per cent RTT incomplete pathways
- 99 per cent for 6 week diagnostic waiting times
- Accident and Emergency (A&E) 4 –hour waiting standard

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

The 4 hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department within 4 hours.

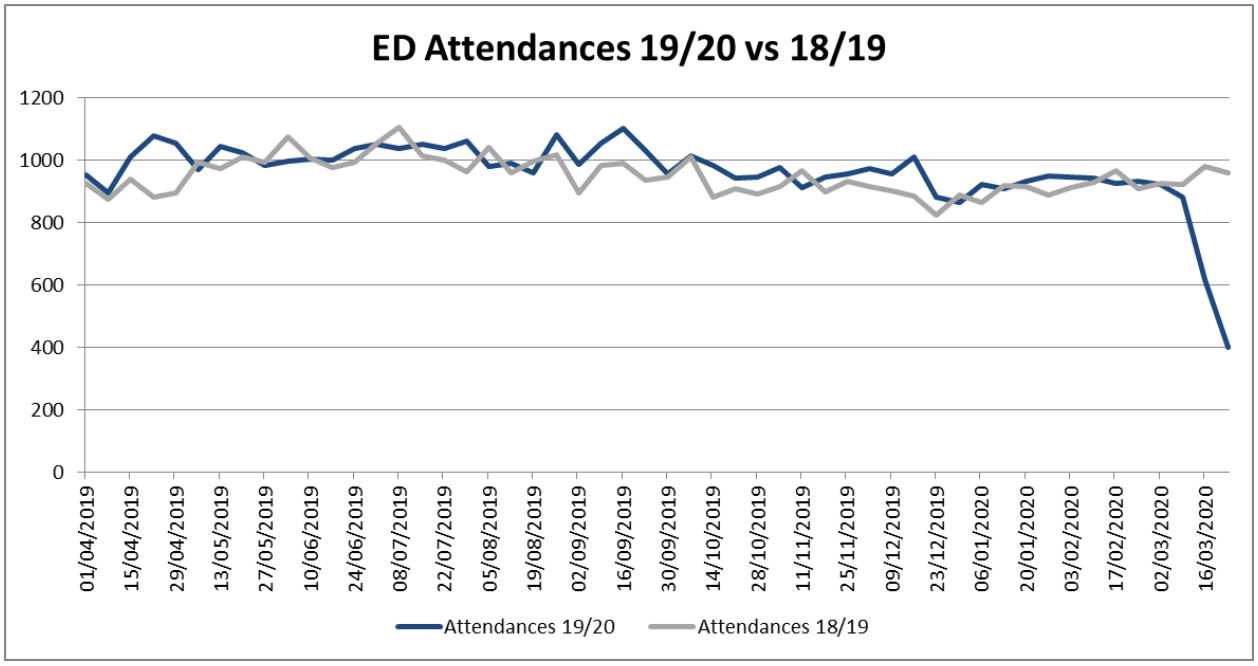
Within the standard there are a number of timings that support how we treat patients, these are:

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

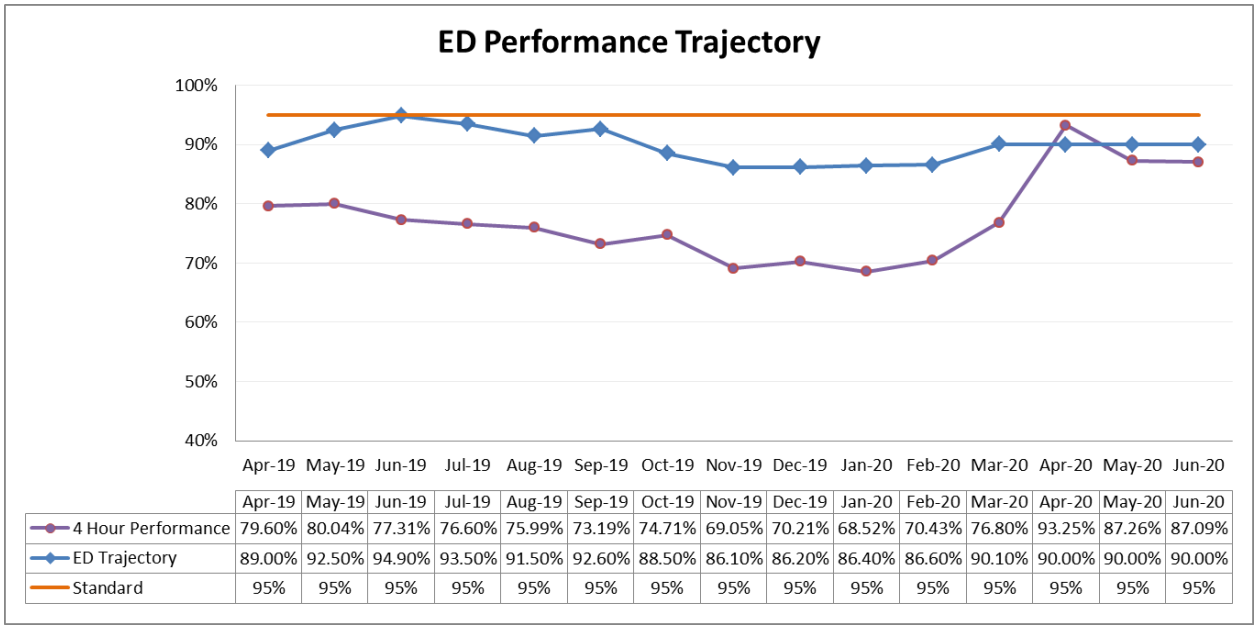
The indicator is calculated as the % of patients who have a total time in ED of four hours or less from arrival to admission, transfer or discharge, compared with the total unplanned ED attendances.

The trust did not meet the national 95 percent standard for the number of patients discharged, admitted or transferred within four hours of arrival in our Emergency Department.

## Total number of ED Attendances




## Four Hour Emergency Access performance 2019/20




| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 Hour Performance | 79.60% | 80.04% | 77.31% | 76.60% | 75.99% | 73.19% | 74.71% | 69.05% | 70.21% | 68.52% | 70.43% | 76.80% | 93.25% | 87.26% | 87.09% |
| ED Trajectory | 89.00% | 92.50% | 94.90% | 93.50% | 91.50% | 92.60% | 88.50% | 86.10% | 86.20% | 86.40% | 86.60% | 90.10% | 90.00% | 90.00% | 90.00% |
| Standard | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

## Four Hour Emergency access

The 4 hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department (ED) within 4 hours.

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

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

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

- There is an Emergency Department Recovery Plan in place to improve the performance against the four-hour key performance indicators. Actions we have undertaken to date include:

    - We have made change to our Consultant Rota to ensure safety and support for junior staff.
    - Capacity and Demand work has been undertaken to help us understand how we need to staff our rotas and what future developments we need to consider.
    - We are now informing patients on arrival what the waiting time should be after triage.
    - We have developed an Induction pack for locum staff.
    - When staffing allows, we undertake a rapid assessment to determine what investigations and immediate treatment is needed, this is known as RAT (Rapid Assessment and Treatment).
    - We have created a new Fit-to-Sit area for minors patients.
    - Following a staffing review we have implemented a Minors Area Nurse Co-ordinator
    - The Safety Sister role is now embedded within the department
    - We have relocated the Patient Flow office to be alongside the ED department for ease of communication
    - ED Patient Tracker role has been developed further and is in place in majors and minors areas of the Department.
    - We have introduced an Information Board at the front door for navigation for patients to alternative services, with their waiting times which is updated hourly.

The Trust is required to meet the standard of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. The Trust will not achieve the target by 31st March 2020, with the current position being 74.41%, as shown in the table below. There is an Emergency Department Recovery Plan in place to improve the performance against the four-hour key performance indicators.

The 4 hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department (ED) within 4 hours.

Whilst our four-hour access target is not currently being achieved, this is not an accurate reflection of how well patients are treated in our Emergency Department. What the current position is showing us is that we have an issue with flow across the hospital, rather than suboptimal care within the Emergency Department:

During 2019/20 our average time to an initial assessment by a qualified clinician has been 17 minutes (slightly over the target of 15 minutes)

During 2019/20 our average time to a review a by a decision-making clinician has been 71 minutes (slightly above the target of 60 minutes)

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

We are aware that there is much work to be done to bring us back in line with our recovery plan. The following work is either underway or due to start within the next 6 weeks.

- Implement recruitment and retention strategy, to support safer staffing for both nursing and medical staff.
- We are introducing a service called 'Push Doctor', where patients who would be better placed seeing a GP, can have a virtual consultation instead of being seen in the Emergency Department
- Plans to increase the footprint, medical model and pathways of Ambulatory Emergency Care and Same Day Emergency Care.
- We are working with Alamac to refresh the SAFER flow bundle across the Trust.
- We are in the process of refurbishing and relaunching the Discharge Lounge to increase early flow from the wards.

In addition to the above, a small working group has been established to identify the key issues that are preventing us from achieving our four-hour target. Once the issues have been identified, a series of actions will be agreed, along with time frames for achievement and expected outcome in terms of effect on the four-hour target. From this work we will be able to develop a trajectory for improvement and a plan for how we will move towards achieving 95%.

- **62 day GP Cancer standard**

  This indicator is calculated as Patients should receive their first definitive treatment for suspected cancer within 62 days following urgent GP referral. The national standard is 85%. Weston NHS Trust achieved 60.85% at the 31st March 2019.

- **Referral to treatment (RTT) Incomplete pathways standard**

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

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

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

  In accordance with the national Referral to Treatment (RTT) target, we try to ensure that at least 92% of our patients have their required treatment within 18 weeks of referral by their GP. A challenging area for meeting the RTT target is Child and Adolescent Mental Health Services – there are difficulties nationally in meeting this particular target.

  Whilst the Trust are taking action to reduce the waiting list, there remains a risk to children and young people who are waiting to be seen, and as such it is essential that risks of these children and young people waiting to be seen are clearly and accurately documented and actively monitored.

  The current process was reviewed by a senior team of managers and clinicians to identify how children and young people waiting for treatment could be reviewed to ensure they did not

decline or require more urgent treatment whilst on the waiting list.

A process of risk assessment of every child and young person on the waiting list was put in place. This involved contacting every person (or their parent/carer as appropriate) to undertake a risk screen to assess whether their risk had increased, decreased or stayed the same and whether any urgent action was required, or indeed whether the symptoms had resolved and the person no longer required to be on the waiting list.

These risk screens are undertaken by trained CAMHS practitioners to ensure that patient safety was paramount at all times.

By following the Standard Operating Procedure (SOP) and developing a risk screen for all patients who have been referred into CAMHS, to ensure that they are monitored whilst waiting for treatment, we can be assured that they are safe whilst waiting for treatment.

In addition, we have also developed a SOP to ensure that every child or young person on the case load has a comprehensive risk assessment and that this is kept in the front of their case notes to ensure it can be reviewed and updated at each appointment.

We also put in place a monthly case note audit, which is undertaken by clinical staff on a random sample of ten sets of note each month, to ensure that the risk screen and risk assessments are accurate and documented.

All of the above actions ensure that children and young people are safe whilst awaiting treatment.

The initial risk assessment of the complete waiting list was complete.

If there is any evidence of a change in risk (increased or decreased) during the risk screen, the risk screen will be updated and will be undertaken every 12 weeks for low risk, every 4 weeks for medium risk and where an urgent assessment is deemed necessary, the child or young person will be expedited into an urgent assessment.

- **6 week diagnostic waiting times standard**

This covers the top 15 high volume diagnostic tests. The standard is that at each month-end 99 percent of patients waiting for one of those tests should have been waiting under six weeks.

The monthly diagnostics collection collects data on waiting times and activity for 15 key diagnostic tests and procedures, the below demonstrates where we have performed against national data, during the reporting period 2019/2020 a refurbishment of our endoscopy unit had an impact on our capacity and alternative arrangements were put in place at the time.

## Performance Metric

| Key Performance Indicator | | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
| A&E 4 Hours | Actual | 79.60% | 80.04% | 77.31% | 76.60% | 75.99% | 73.19% | 74.71% | 69.05% | 70.21% | 68.52% | 70.43% | 76.80% |
| | Trajectory | 89.05% | 92.51% | 94.90% | 93.50% | 91.50% | 92.62% | 88.52% | 86.24% | 86.24% | 86.41% | 86.60% | 90.10% |
| Cancer (62 Days) | Actual | 85.11% * | 53.33% | 61.43% | 73.17% | 50.00% | 57.38% | 53.62% | 78.57% | 60.00% | 45.28% | 58.82% | 64.52% |
| | Actual Quarter | 65.00% | | | 58.75% | | | 62.00% | | | 57.87% | | |
| | Trajectory | 73.10% | 75.00% | 75.80% | 77.30% | 81.80% | 83.30% | 81.50% | 78.30% | 82.60% | 85.70% | 80.00% | 80.00% |
| RTT | Actual | 91.02% | 89.23% | 87.14% | 86.61% | 84.69% | 85.63% | 83.43% | 83.63% | 84.07% | 84.72% | 84.60% | 83.19% |
| | Trajectory | 93.12% | 93.12% | 93.12% | 92.65% | 93.55% | 93.55% | 93.12% | 92.32% | 92.58% | 92.57% | 92.60% | 92.00% |
| 6 Week Diagnostic | Actual | 97.99% | 92.37% | 93.37% | 94.51% | 97.88% | 98.67% | 98.91% | 97.51% | 95.57% | 94.75% | 98.83% | 97.62% |
| | Trajectory | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% | 99.04% |

*Nationall

## National Standards

| National Standard | Target | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| A&E Maximum wait of 4 hours | 95% | 76.10% | 84.86% | 86.87% | 74.63% Ⓐ |
| A&E Median Time to Initial Assessment | 00:15 | 00:12 | 00:13 | 00:12 | 00:17 |
| A&E Median Time to Treatment | 01:00 | 00:41 | 00:39 | 00:44 | 01:12 |
| A&E Unplanned re-attendance within 7 days | 1-5% | 6.48% | 6.43% | 6.28% | 6.25% |
| A&E Left Without being seen | <5% | 2.08% | 1.55% | 1.45% | 2.29% |
| Breast Symptoms referred to a specialist who are seen within 2 weeks of referral | ≥93% | 89.10% | 94.56% | 90.47% | 96.39% |
| 31 days for second or subsequent cancer treatment- surgery | ≥94% | 99.46% | 94.66% | 88.37% | 83.72% |
| 31 days for second or subsequent cancer treatment- drug treatment | ≥98% | 96.36% | 97.82% | 98.89% | 96.77% |
| National screening programme who wait less than 62 days from referral to treatment | ≥90% | 100% | 76.92% | 87.03% | Ⓐ *** |
| Cancer reform strategy 62 upgrade standard | ≥90% | 93.20% | 80.95% | 86.71% | 77.83% |
| 2 week wait (urgent GP appointment to 1st outpatient appointment) | ≥93% | 91.55% | 94.14% | 91.78% | 90.30% |
| NHS cancer plan 31 day standard | ≥96% | 100% | 98.40% | 96.48% | 98.31% |
| NHS cancer plan 62 day standard | ≥85% | 77.00% | 70.73% | 65.75% | 62.01% |
| Referral to Treatment within 18 weeks incomplete pathways | ≥92% | 93.71% | 92.94% | 92.04% | 84.72% |
| Cancelled Operations on the day for non-clinical | ≤ 0.8% | 6.95% | 2.77% | 2.28% | 3.60% |

| | | | | | |
|---|---|---|---|---|---|
| reasons | | | | | |
| Cancelled Operations rescheduled within 28 days | 95% | 95.45% | 94.44% | 94.44% | 93.33% |
| 6 Week Diagnostic Wait | 99% | 99.50% | 98.29% | 99.28% | 95.84% |

## 62 Day Cancer Performance

The 2009 Cancer Reform Strategy sets out eight national cancer performance objectives for Trusts to deliver against. During 2019/20 the Trust met one of the national targets.
The following table sets out the eight key targets and the Trust performance against each.

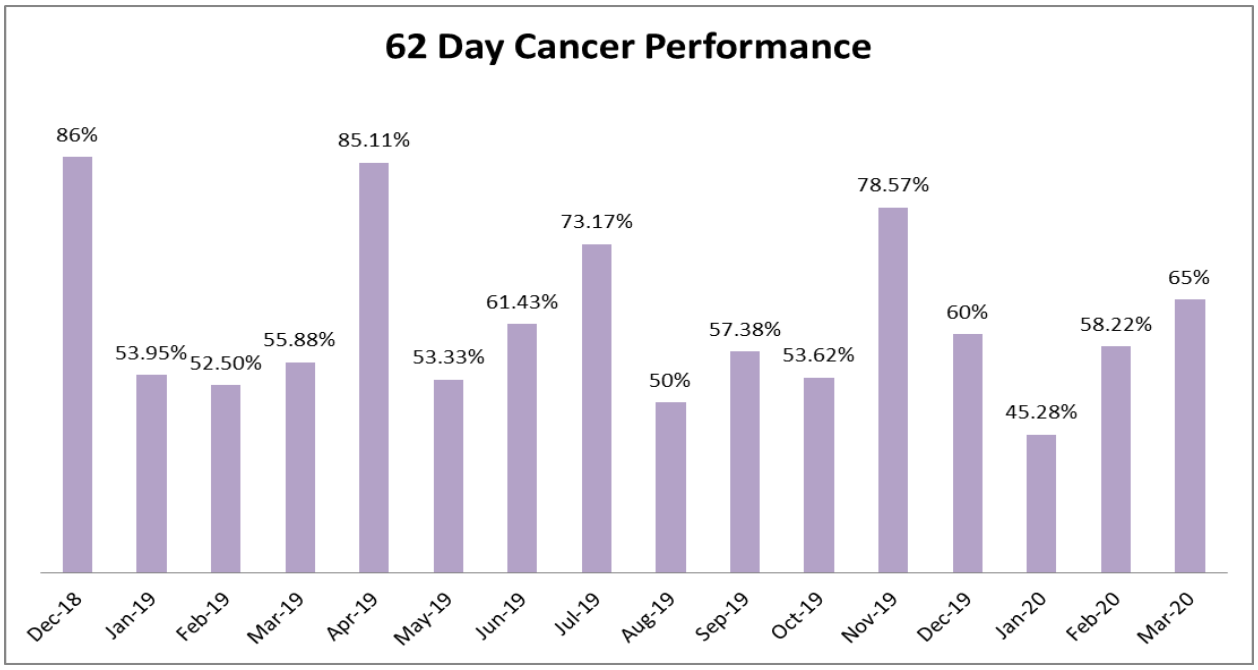
### Cancer Targets

| | National Target | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|---|---|---|---|---|
| Breast Symptoms referred to a specialist who are seen within 2 weeks of referral | ≥93% | 97.20% | 96.60% | 93.50% | 90.90% | 88.68% | 89.10% | 94.56% | 90.47% | 94.17% |
| 31 days for second or subsequent cancer treatment-surgery | ≥94% | 100% | 98.60% | 95.30% | 99.30% | 98.81% | 99.46% | 94.66% | 88.37% | 88.52% |
| 31 days for second or subsequent cancer treatment-drug treatment | ≥98% | 100% | 100% | 99.10% | 99.97% | 99.08% | 96.36% | 97.82% | 98.89% | 97.87% |
| National screening programme who wait less than 62 days from referral to treatment | ≥90% | 95.80% | 98.10% | 86.40% | 100% | 92.05% | 100% | 76.92% | 87.03% | n/a |
| Cancer reform strategy 62 upgrade standard | ≥90% | 94.20% | 93.40% | 86.10% | 77.96% | 94.73% | 93.20% | 80.95% | 86.71% | 78.47% |
| 2 week wait (urgent GP appointment to 1st outpatient appointment) | ≥93% | 96.50% | 96.00% | 95.30% | 97.26% | 96.30% | 91.55% | 94.14% | 91.78% | 91.72% |
| NHS cancer plan 31 day standard | ≥96% | 99.80% | 100% | 99.20% | 99.65% | 98.84% | 100% | 98.40% | 96.48% | 98.23% |
| NHS cancer plan 62 day standard | ≥85% | 92.30% | 88.30% | 81.40% | 89.08% | 77.50% | 77.00% | 70.73% | 65.75% | 60.85% |

## Long waiting specialties

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

**Long wait specialities – compliance against 62 days performance**

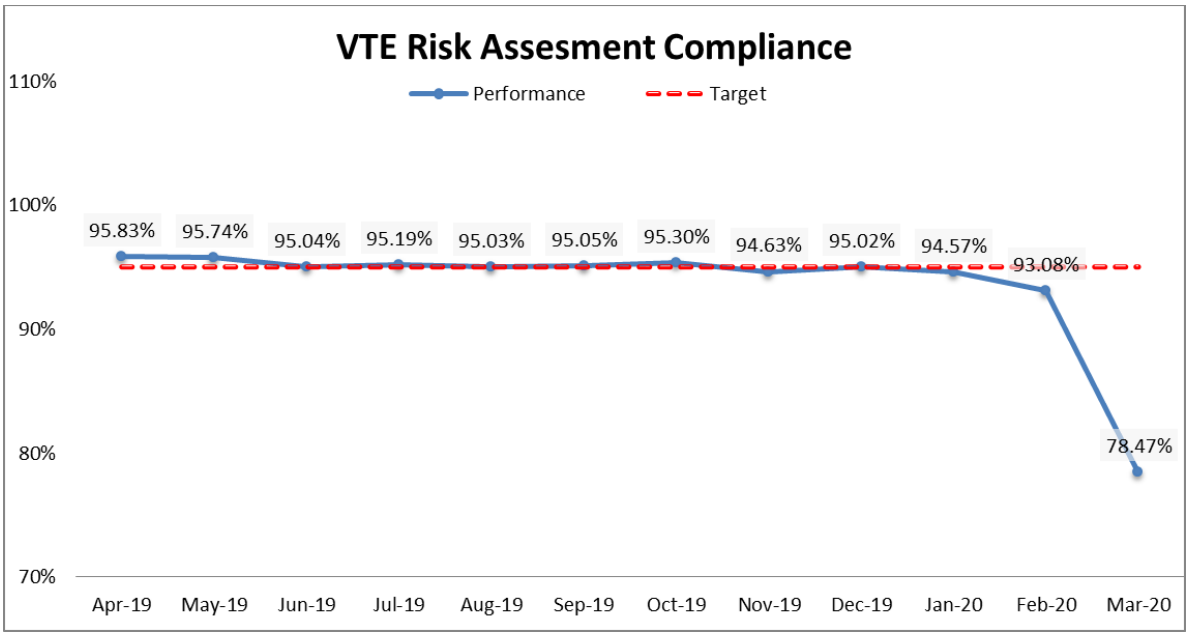



## Venous Thromboembolism (VTE)

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

The trust has achieved the national standard of greater than 95% of eligible inpatients for each quarter of the 2019/20 of the financial year.

**VTE Risk Assessment Compliance 2019/20**



| | National Target | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|---|---|---|---|---|
| % Patients VTE Assessed | ≥90% | 95.00% | 96.10% | 78.95% | 97.16% | 95.34% | 63.02% | 82.02% | 94.52% | 93.84% |

VTE assessment for Q4 has not been validated due to returns being suspended due to Covid-19

The data collection process has been reviewed, ensuring robustness of the data collection, efforts are being concentrated on understanding the common themes in patient records where we are unable to demonstrate completion of a risk assessment and also looking at those ward areas where completion figures is low. The Trust continues to see sustained improvement in the assessment of in patients at risk of venue thromboembolism. Currently performance is audited manually which can delay full validation of results. The trust plans to move to an electronic audit tool in 2019/20 which should ensure timelier reporting

## *Clostridium Difficile* infections

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

### *Clostridium difficile* (*C. difficile*) infections

| | 2019/20 | | 2018/19 |
|---|---|---|---|
| | Weston | National average | Weston |
| Rate per 100,000 bed days of cases of *C. difficile* infection | 8.18 | 15.6 | 8.13 |
| Data source: Public Health England | | | |

In 2018/19 the Trust maintained its low rates of *Clostridium difficile* infections, reporting seven cases. In 2019/20 the criteria for reporting of *Clostridium difficile* infections changed. Cases are split between hospital onset, healthcare associated (HOHA) and community onset, healthcare associated (COHA). COHA cases occur in the community or within two days of admission when the patient has been an inpatient in our care in the previous four weeks. The Trust has reported seven cases of HOHA and seven cases of COHA against a threshold of 14 cases; our rate remains well below the national average. Each case has undergone a comprehensive post infection review which has been assessed against national guidance criteria.

In all but two cases, we have been able to demonstrate that there have been no cases of cross transmission of *Clostridium difficile* between patients on our wards. The reason we could not categorically exclude cross-transmission was due to not being able to sub-type the *Clostridium difficile* to prove this. Learning has been identified in areas such as prompt isolation, sampling and review of antibiotic prescriptions. Every case is presented to the Infection Prevention and Control Committee where action plans are either signed off or it is agreed that further work is required.

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

The strategies introduced over the last 5 years are now embedded and our continuing success in reporting low numbers of *Clostridium difficile* infections is testament to their success.

The strategies that have contributed to this include:

- Continued updating of our antibiotic guidance and the use of mobile technology in the form of a Smart phone App to enable our Doctors to access these guidelines at the point of care.
- Recruitment of antimicrobial pharmacist in June 2019.
- Daily auditing of antibiotic prescribing by a designated pharmacist and the Consultant Microbiologist with prompt feedback to prescribers and their teams from July 2019.
- Use of the Diarrhoea Assessment Tool to assist clinical staff with the prompt isolation of symptomatic patients and in determining when specimens should be sent.

The gap in the antimicrobial pharmacist post from July 2018 until June 2019 impacted on the ability to undertake daily auditing during this period.

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

### Improving the discharge of patients from hospital

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

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

During 2019/20 we built upon the work already undertaken with the implementation of the Integrated Discharge Service. Training sessions continued with the wards to ensure that they are aware of the discharge pathways available and how to access them. And also the continued development of the integrated care bureau, this is in conjunction with Bristol, North Somerset and South Gloucester community partners.

The Integrated Care Bureau provides a single referral process to access community and social services develop the correct support for patients at discharge, the main focus to ensure that patients were being referred onto the right pathway for their needs.

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

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

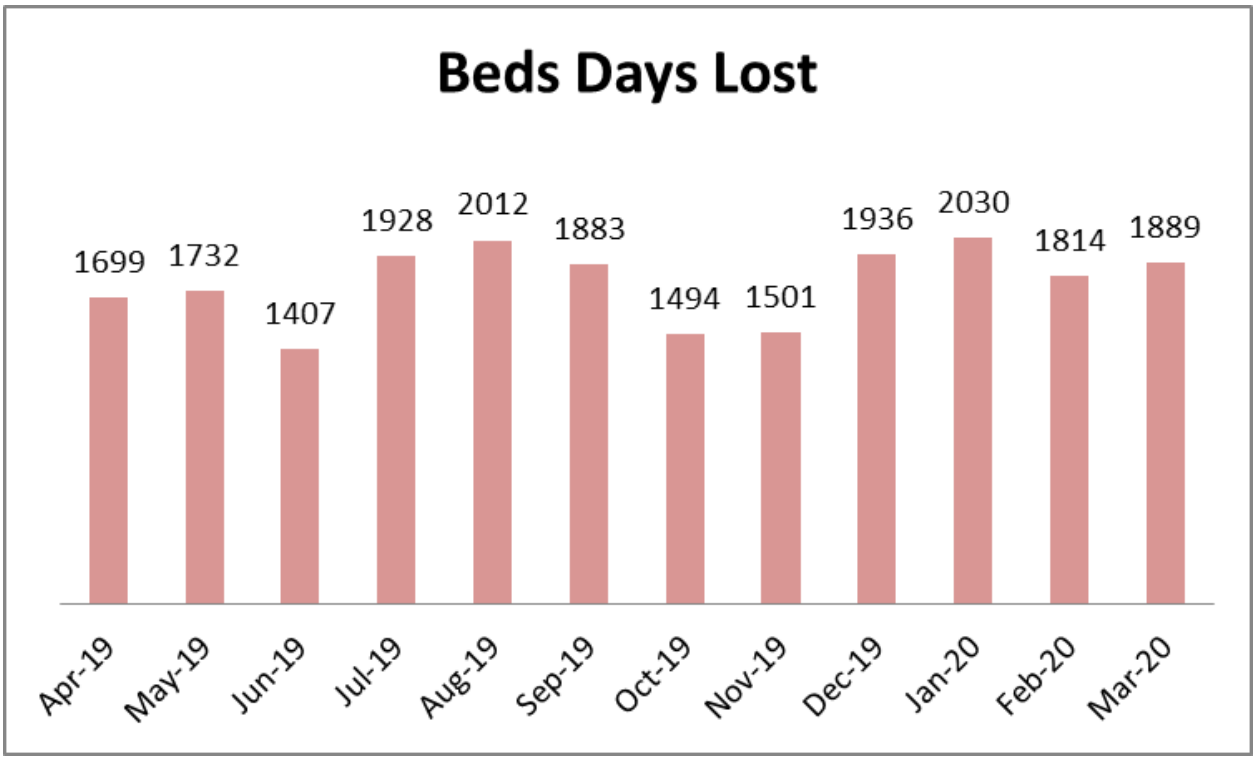
The Case Managers within the Integrated Discharge Service have continued to support and educate the wards around discharge processes and pathways, ensuring that wards are

completing Single Referral Forms at the optimal time, with the necessary information for the Integrated Care Bureau to make their decision; this process is embedded well within the ward areas.

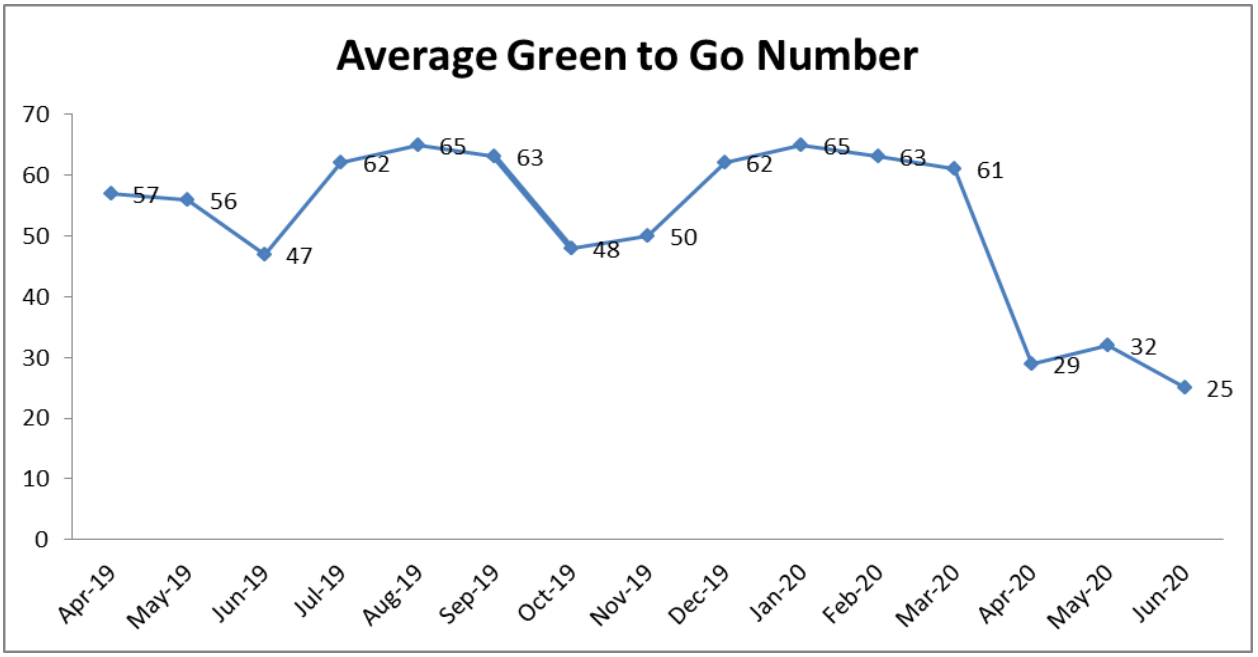
Due to the processes being established, a number of our patients are now being discharged on the day they are ready to be discharged, which means they are not added to the “Green to Go” list – this is a database of those patients for whom we are developing discharge plans (as some planning takes longer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

### Bed Days Lost to MFFD Patients

The chart below presents the average numbers of bed days lost (this is the number of days a patient spends in hospital after the team have agreed the patient is fit to be discharged). It must be noted that this does not refer to Delayed Transfers of Care Bed Days Lost – these are reported monthly via NHS England.



**Average number on the "Green to Go" Database**




As demonstrated within the bed days lost table we have seen a steady improvement since October 2019 in the average number of patients who were medically fit for discharge, awaiting ongoing support.

### What we will do next

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

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

**Appendix A**
**Feedback about our Quality Report**

## Statements of assurance

### a) Joint statement from Healthwatch Bristol, South Gloucestershire and North Somerset

Thank you for the opportunity for respond to your draft Quality Account.

Weston Area Hospital Trust's final Quality Account shows the wide range of services Weston General Hospital provides for North Somerset residents and the efforts they take to supply a safe, effective, and caring service. Efforts to address the CQC concerns and priorities in 2019/20 are clearly described but are hamstrung by unclear criteria for measuring success and this may have led to their 'not achieved' award they scored themselves on.

WAHT had been closely watched by the Care Quality Commission and others, due to serious shortcomings in A&E services in the year before the merger with University Hospitals Bristol NHS Foundation Trust (UHBW). However, it should be noted that WAHT was rated well for its caring and effective staff.

There are many improvements that the Weston leadership list for the 2020/21 year in this Quality Account, although these may change as a result of merger. Healthwatch will be monitoring the progress Weston General Hospital makes and we look forward to the benefits that will come to Weston patients from the merger.

### b) Please note that the following will receive this year's Quality Account, but are not formally commenting:

- Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
- North Somerset Health Overview and Scrutiny Panel (QA Sub Committee)