George Eliot Hospital NHS
NHS Trust

Quality Account 2013/14

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'our vision is to EXCEL at patient care'

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Statement from the Chief Executive

The Quality Accounts is one of the most important documents we produce each year; it outlines what we have achieved against the quality targets we set ourselves this time last year.

Over the past year, more than any other, our focus has been on delivering substantial, sustainable improvements to quality of care. The support put in place following last year's Keogh Review enabled the Trust to deliver such improvements.

Some of our key achievements during the 2013/14 financial year have included improving mortality rates, reducing hospital acquired pressures sores and reducing hospital acquired infections.

Looking beyond the Keogh Review, in 2014/15 we will be introducing a new Quality Strategy that will ensure we continue to deliver improvements in quality of care over the next four years. This document will be vital to the long-term future of the organisation and will help us to deliver our ambition of providing consistently outstanding care to all our patients for years to come.

The Quality Strategy will become just as central to the organisation over the coming years as the Keogh Review recommendations have been over the past year. It will focus on all aspects of quality of care to ensure that we never rest on our laurels when it comes to striving to improve patient care. The strategy will support teams and individuals to deliver outstanding care by providing appropriate training, education, effective leadership and governance processes to continually drive improvements in quality of care.

The strategy will be dynamic meaning that it can be changed and adapted to meet the developing requirements of the organisation. The one thing that will remain constant is the requirement for quality to be championed by all staff who will be expected to live the standards set out in the strategy in their day-to-day job. In the same way that the Keogh Review galvanised staff to work towards the common goal of improving care, so will the new Quality Strategy.

It is important that we continue to push ourselves when it comes to quality improvement and this is why this year's Quality Accounts sets ambitious targets. While they are undoubtedly ambitious, they are also realistic and I am confident that with the support of our dedicated workforce we can deliver them.

We are committed to keeping members of the public and stakeholders informed throughout the year on how we are performing against the targets set out in this document and I look forward to reporting back this time next year on another successful year for the George Eliot.

Kevin McGee Chief Executive

Statement of Directors Responsibilities in Respect of the Quality Account

Under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, the Directors are required to prepare Quality Accounts for each financial year and are expected to take steps to satisfy themselves that:

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

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

By order of the Board:

Chairman

Chief Executive

Our year

We set ambitious targets to improve and maintain the standards of care provide by George Eliot Hospital – the table below sets out our ambition and gives some examples of the things we have done to achieve these

What we set out to do	What we did	What does this mean for people using our services
Mortality Ratios Ensure the hospital and community teams deliver the best possible care over the 7 day period	Delivered a new bigger Acute Medicine Unit which can accommodate all patients admitted with an Ambulatory care unit which allows urgent clinic type appointments where admission is not required Delivered a range of care bundles to ensure we deliver prompt evidence based care 24hrs a day Provided additional consultants to the frontline admission unit	Quicker access to the hospital and to the consultants and specialist team who specialise in your care regardless of the day of week or time of day admitted
Improve End of Life Care to our patients and those close to them	Developed a plan for end of life care for the next 5 years Trained non specialist teams to support patients with end of life care needs and respond to their needs	Better support for patients with palliative or end of life care within our ward and departments both to listen and understand and meet those needs expressed by patients
Reduce the number of Infections	Delivered a strict programme of deep cleaning for all areas Monitored, thoroughly investigated and acted on all incidences of hospital acquired infection	With no cases of MRSA bacteraemia in the hospital in 2013/14 your chance of contracting this infection is very low. Likewise Clostridium Difficile rates having fallen for another year by 38 % significantly reduces the chances of contracting this serious infection
Improved management of sepsis (blood poisoning)	Developed a clear time based plan for patients admitted with sepsis (Care Bundle) and supported delivery with a specialist nurse and group dedicated to sepsis	Patients admitted with suspected septicaemia receive assessment and treatment quickly which is proven to deliver the best possible outcomes for patients
Improve the experience of our patients	Delivered the friends and family test and wider view of experience to our areas to understand the experience of our patients Met with our team members to ensure all understand what an excellent patient experience is, how to deliver it and use the support to provide it. Delivered a carer passport which allows free access to the hospital for those caring for an individual, this helps both patients and carers enormously Delivered value based recruitment which ensures we only recruit the right team members who share our goal for excellence	Patients and carers are cared for by staff who understand the importance of good communication and steps needed to deliver the best possible experience. Where we don't get things right our teams will act quickly to correct them. Our PALS team will assist where needed.
Improve incident reporting to understand the levels of safety and risk accurately	Provided training to all staff to underline the need to report incidents as essential to understanding safety and risk	Patients are cared for by staff who treat patient safety as an absolute priority and report and act on any possible risks
Promote good health in all our encounters with patients	Trained our staff in health promotion via the Making Every Contact Count tool	Patients meeting any of our staff will receive the right care which considers all relevant factors to promote good health
Improve the experience of staff	Delivered a programme called EXCEL which supports our staff to work together to deliver excellent care Provided training opportunities across all levels of staff to meet personal development needs Surveyed our staff to understand and respond to their needs	Listening and supporting our teams means we can equip them and work together to provide the best possible patient experience and outcomes

Quality Accounts Reporting Arrangements for 2013/14

New reporting requirements were set out by NHS England, Monitor and the NHS Trust Development Agency (Gateway reference numbers 18690/00931) reminding Trusts of their mandatory reporting/ guidance requirements on the information and indicators to be included in this year's Quality Account. Throughout the Quality Account the Trust have adhered to the guidance set out by our NHS Peers and where relevant have integrated its report to correspond with existing key quality improvement priorities and other key performance data requirements.

In response to the above statement it should also be noted when 'looking back on 2013/14 - quality improvement priorities and quality indicators set out within section 2 below, each aspires to meet the following principles, that – 'The George Eliot Hospital NHS Trust has considered all the data outlined below, the rationale used when presenting it and, where relevant, actions taken or to be taken to improve percentage/scores or rates over the last two reporting periods' ie 2012/13 & 2013/14 respectively.

Priority 1 – Mortality

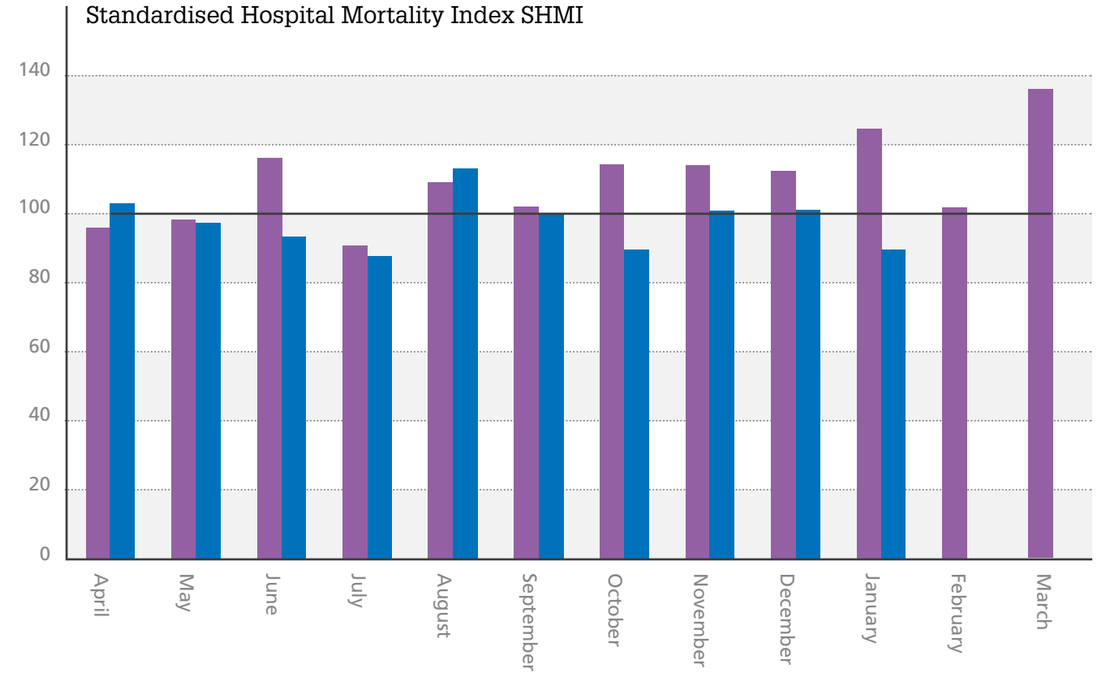
1. We set out to deliver a 5% reduction in the Standardised Hospital Mortality Ratio (SHMI) during 2013/14 as compared to financial year 2012/13 and we have achieved this reduction in both the SHMI and Hospital Standardised Mortality Rates (HSMR) measures.

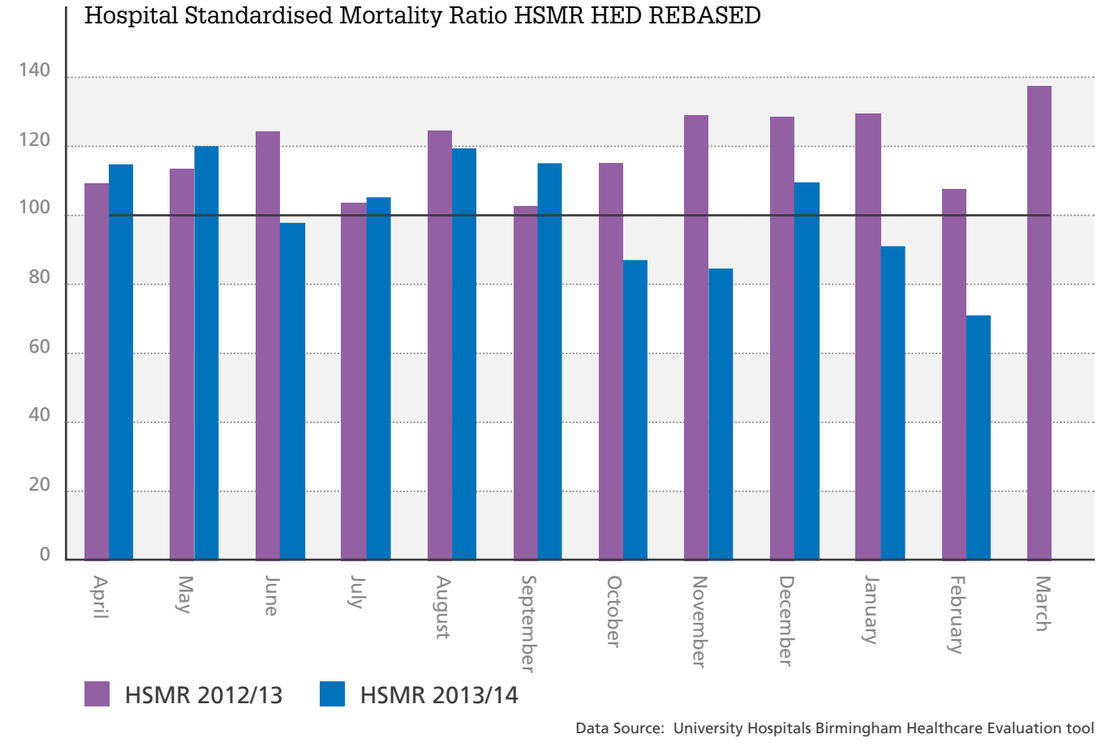
Both SHMI & HSMR are methods to understand a hospitals actual level of mortality against what might be expected based on performance across England. SHMI differs to HSMR in that it looks at deaths within 30 days of being in hospital and does not adjust for Patients supported by palliative care teams. These two important measures give an indication of the Hospital's position and are used throughout the year to point to areas for improvement. As planned we have developed our use of this important information during 2013/14 and have used it to focus our actions to improve the quality of our care. We are pleased to report that we can now see an improvement in both of these measures.

Mortality measure	April 2012 to March 2013	April 2013 to February 2014	Percentage reduction achieved
1.SHMI Healthcare Evaluation Data (HED) via University Hospital Birmingham	1.10	0.98 April 2013 – January 2014 A value below 1 represents mortality below expected levels as compared nationally	10%
2.SHMI Health & Social Care Information Centre (HSCIC)	The most recent HSCIC national publication of SHMI released on 10th April 2014 provides a value of 1.09 for George Eliot Hospital. This value is banded at level 2 which is defined as "mortality at the expected level " This information relates to the period October 2012 - September 2013 By using the most recent data shown in section 1. above we are able to understand our progress more closely and respond quickly to new themes		
3.HSMR Rebased Data Source: Healthcare Evaluation Data via University Hospital Birmingham	119.29	102.63 (April 2013 to February 2014 latest available data)	13%

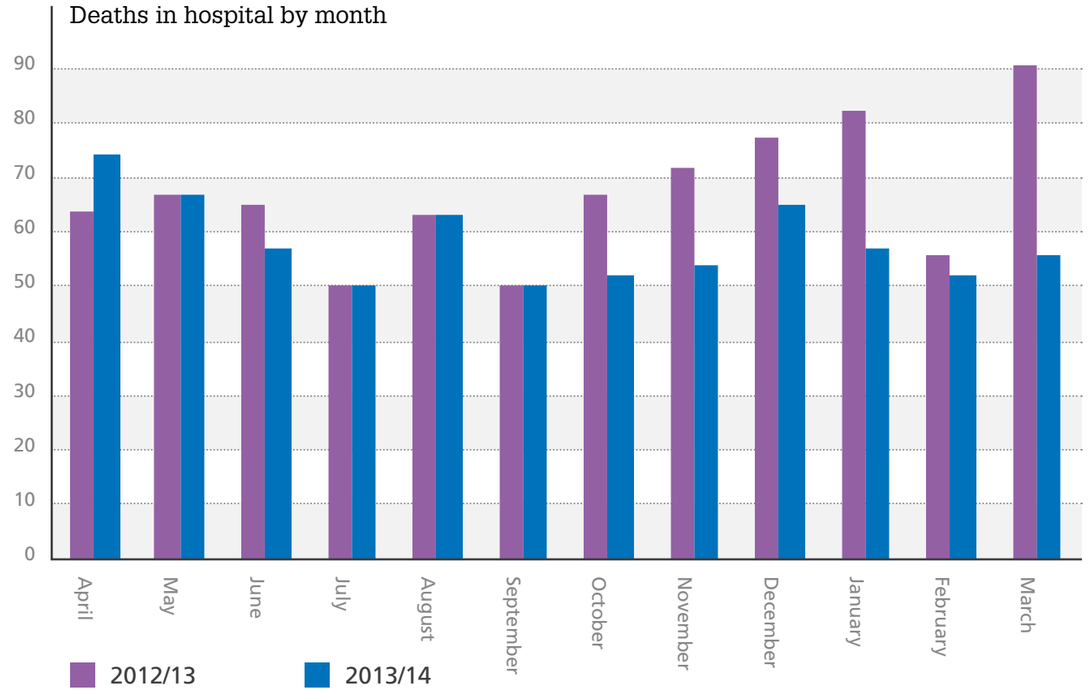
The total number of deaths within the hospital during financial year 2013/14 was 697. This is lower than the figure in 2012/13 which was 804.

The following charts show SHMI & HSMR values by month compared to the previous year and secondly hospital deaths per month 2012/13 & 2013/14





Data Source: University Hospitals Birmingham Healthcare Evaluation tool



The entire organisation from Trust Board members to ward and departmental teams, have been central to delivering this improvement. Key actions undertaken included:

- Delivering a process to review the health records of all patients that die in the hospital to understand areas for improvement and feed this information to clinical teams quickly;
- Development of a new 42 bed Acute Admissions Unit at the Trust which is able to accommodate all patients admitted over a 24 hour period in one area. This unit has a dedicated nursing team with specialist input from medical and surgical teams across all specialties in the hospital. We have increased the number of Consultant Acute Physicians that work in this area to 6 during 2013 and see a minimum of twice daily formal ward rounds and constant consultant presence within the unit from early morning and into the evening;
- In addition to existing 7 day consultant presence the Trust provided additional Consultant Physician presence at weekends. This enables senior review of patients condition and allows safe discharge to occur over the 7 days;
- Development of a Head of Patient Safety & Mortality post to drive improvement further and use information to highlight new areas requiring action. A key part of this work is to deliver a detailed monthly mortality and outcomes report which is considered and acted on across the organisation;
- Delivered a strong mortality review group and process to consider surveillance information, receive the results of patient reviews and deliver required actions. As a result of our review process we identified a need to standardise the care of key diagnosis groups over a 24 hour period. To respond to this we have delivered clear guidelines for our clinical teams to ensure the management of Pneumonia, Sepsis, Heart Failure and Obstructive Airways Disease is at the same high evidenced based standard whatever the time of day or day of week;
- These guidelines have been placed into simple checklists called “care bundles” and represent a clear set of requirements alongside a record of action. We have made good progress against delivering these standards.

2. By March 2014 the Trust aimed to have an End of Life Care strategy in place and rolled out across the Trust: The delivery of the Palliative Care service is led by Consultant in Palliative Care, Dr Julia Grant and Specialist Nurse Kristy Clayton alongside a McMillan Nurse. The team provide specialist support to over 40 patients per month who are inpatients and provide operational support to many more. In addition they provide support education and training to clinical staff across the organisation; Key highlights during 2013/14 have been:

- The Trust approved an End of Life Care Strategy in September 2013 which has all of the priorities and actions to be delivered in the coming years;
- Clinical staff have been trained in the use of the AMBER Care Bundle which identifies patients within the final stages of life (months or days) and contributes to them being treated with dignity and respect and enables them to receive consistent information from their healthcare team. This supports the need to undertake advance care planning and allows staff to act as champions in their areas to drive high quality end of life care for all in their care. By having conversations about preferences and wishes and ensuring that everyone involved is aware of care plans, people are more likely to have their needs met;
- We have been successful in achieving a Health Education England bid for £20,000. This will be used to employ a nurse part time for twelve months to support the roll out of the AMBER Care Bundle;
- Working in partnership with Myton hospices, senior Sisters from nine clinical areas have attended QELCA (Quality End of Life Care for All which holds the St Christopher's trademark) Training with action learning scheduled to take place throughout 2014;
- The Practice Development Nurse in End of Life Care has delivered training to new staff members and student nurses;
- The Consultant in Palliative Medicine has delivered training to local GPs and to Medical & Surgical Grand Rounds (Senior Doctors meetings);
- A CASTLE (Care and Support Towards Life's End) Study Day was delivered focussing on dementia care at the end of life and included workshops on complimentary therapy, bereavement, care after death, medical management of symptoms, comfort measures, mouth care and the use of end of life tools;
- The Consultant in Palliative Medicine and Practice Development Nurse have delivered sessions about Transform (Transforming EOL care in Acute Hospitals) to the Matrons, Medical and Surgical Grand Rounds and the Patient Advocacy Forum;
- The Consultant and Practice Development Nurse is working on learning resources to support Transform and end of life care delivery, including symptom control. This is a very valuable addition to ensure staff feel empowered to deliver evidence based, best practice. Palliative care is provided seven days a week within the wards and focusses on anticipation, and alleviation, of all vital distressing symptoms of patients in our care;
- A Bereavement Survey is being developed to give on-going valuable feedback on the experience of patients and their carers; this will help ensure that we learn where we are delivering good care and where we can improve;
- The End of Life Care Steering Group provides the on-going review, monitoring and action to address any constraints as required. Running alongside this, the Trust has an operational group to support actions and implement learning;
- The RIPPLE pathway (Realising Individual Patient Preferences at Life's End) supports patients and carers in end of life care and decisions. A significant factor of the programme has been helping patients to achieve their preferred place of care and support for this programme has seen an increase in uptake;
- For the period 2013/14 the number of patients receiving the right/their chosen end of life palliative care, was 314 in 2012/13 and rose by 20% to 377 for 2013/14 which highlights the positive impact the strategy has had since its introduction in September 2013;
- A bid for funding a pilot Macmillan Nurse post to be based in the Accident & Emergency and the Acute Medical Unit has been put forward. This post will provide teaching to support the implementation of 7-day delivery and recognition of palliative care needs whilst also working to support patients presenting to both departments. Before applying for funding we looked at the work of other hospitals in this area to develop the service. This support will enable us to meet the challenges of increased demand and other elements of the strategy.

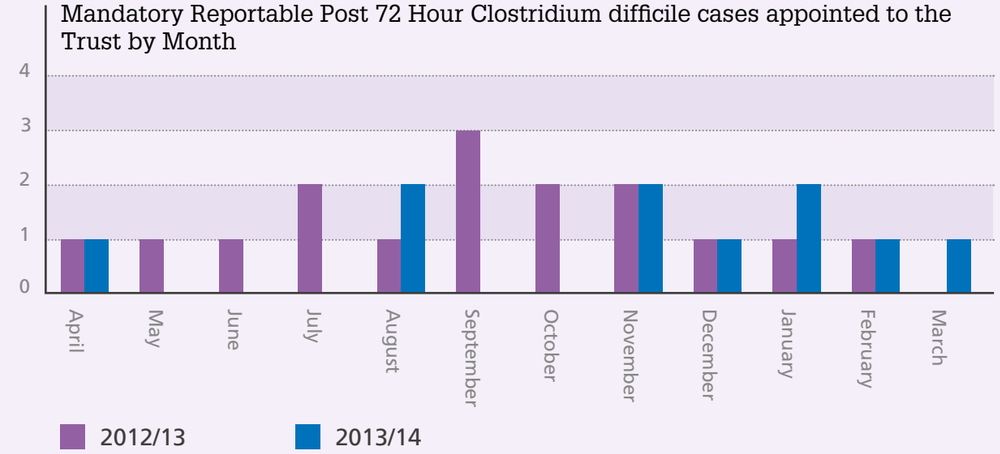
Priority 2 – Infection Prevention

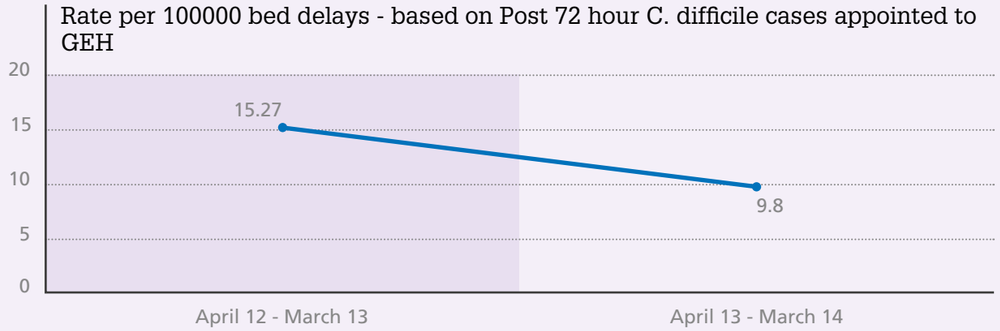
1. Clostridium Difficile (CDI) Infections: Our target for the financial year 2013/14, set nationally, was 21 cases: Since April 2013, the Trust reported 10 cases (post 72 hour) 2013/14. This is 11 cases under target and 16 less than in 2012/13.

This continued success in reducing CDI can be attributed to on-going work which includes:

- We have completed a deep clean of all ward areas, involving a mist of spray of hydrogen peroxide H202, which serves to eliminate any local contaminates which may result in Health Care Associated Infections, including CDI;
- A multifaceted approach is used to help sustain reductions in CDI for example the completion of weekly hand hygiene audits across the Trust where as part of a policy of zero tolerance to poor practice, outcomes are fed back to staff and immediate improvement is sought. Both our staff and patients are encouraged to challenge us in respect of hand hygiene and being bare below the elbow in clinical areas;
- Every Ward within the hospital has its own dashboard that is updated weekly and reported at the weekly Matrons and Sisters meeting to highlight any incidence of infection across the hospital, lessons learned and all necessary actions are shared;
- Information on infection rates is displayed on wards for patients, carers and their families to view our progress.

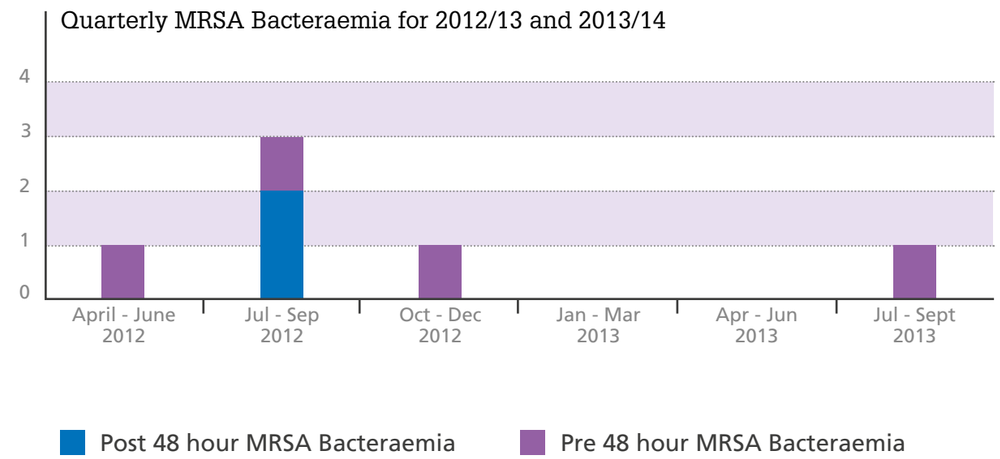
The Trust reported a further 38% reduction in the number of apportioned CDI cases from 2012/13 and the rate per 100,000 bed days reduced from 15.27 to 9.80. This is evidenced in the tables opposite.





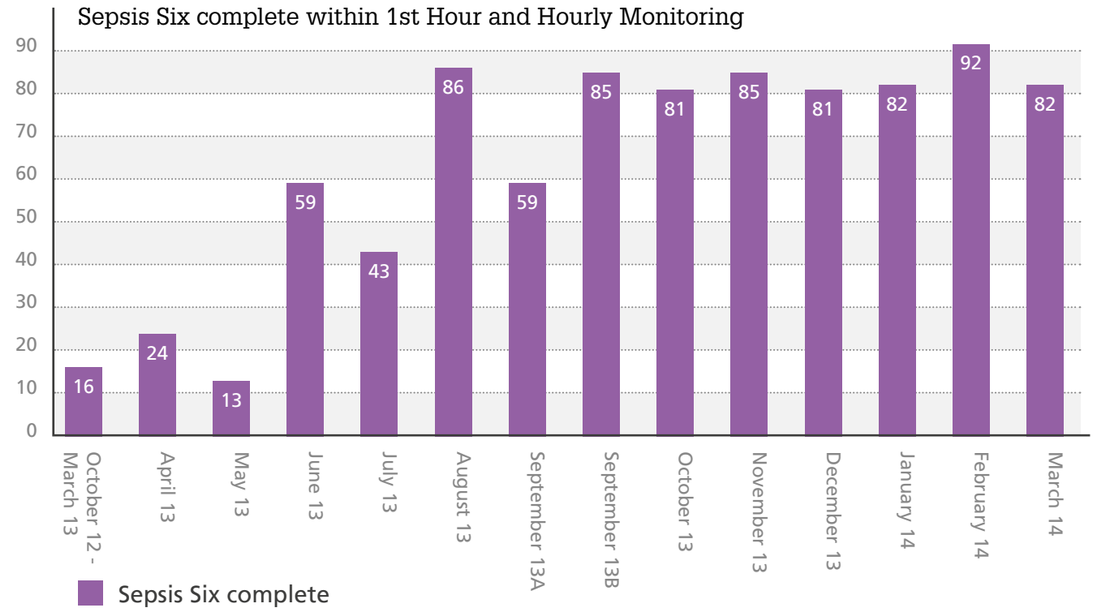
2. MRSA Bacteraemia: We set out to have no cases of MRSA Bacteraemia in 2013/14 and we are pleased to say that we have achieved this. It is actually one year and 5 months since the last reported case, which was in September 2012. This shows the considerable commitment of our clinical teams to ensure patient safety.

The table opposite shows MRSA cases detected (a) within 48-hours of admission, suggesting a pre-existing condition, and (b) after 48-hours of admission, which is often attributed to hospital care.



3. Improving sepsis management. We set out to improve sepsis management during 2013/14. Sepsis, often referred to as either blood poisoning or septicaemia, is a life- threatening illness caused by the body overreacting to an infection. To deliver this improvement in patient care we developed a care bundle (checklist) to support clinical teams. This ensures patients get the right assessment and treatment within the first hour and remainder of their stay. To support delivery of the care bundle and experiences a nurse specialist was seconded to support education and delivery of the care bundle. We aimed to achieve 90% use of the care bundle during the year and have achieved this. As a result we have seen a significant reduction in the mortality ratio.

The table below shows compliance with the care bundle 6 key actions.



The goal of 90% compliance means that 9 out of 10 patients diagnosed with 'Sepsis' will receive the 'Sepsis Six' which consists of – (1) Supplemental Oxygen, to reduce hypoxia; (2) A fluid challenge to quickly rehydrate them; (3) Intravenous antibiotics to directly fight the infection; (4) Have blood cultures taken, to help identify the micro-organism causing the infection; (5) A blood lactate level, to ensure that there is enough oxygen reaching the vital organs.

As a continuum to support the above the patient will be closely monitored to check if the treatment is improving their condition, and will have (6) hourly monitoring of their blood pressure, oxygen levels and urine output for approximately the next 6 hours. If any of these interventions were missing (even if it were only one), then for audit purposes it would be considered as non-compliance. Since September 2013 just over 8 out of 10 patients with sepsis did receive this full 'bundle' of treatments and tests, however the 2 who did not receive the complete bundle, had received 5 out of the 6 interventions.

We have delivered regular training to improve sepsis recognition, with teaching sessions for clinical staff as part of their mandatory training. Staff can attend either a one hour interactive session with the Sepsis Nurse, or complete an E-learning package via the Trust's on-line training site. A similar session is delivered to all new staff at their corporate induction.

Priority 3 – Patient & Staff Experience

1. Friends & Family Test (FFT): In 2013/14 the Trust was expected to reach the national response rate of 15% by the year end as set by NHS England. This also correlates to the CQUIN target set by Warwickshire North CCG that from 1 April 2013, all inpatients in acute hospital wards and Accident & Emergency (A&E) departments across the country were to be asked to complete a 'Friends and Family Test' (also in October the FFT question was extended to Maternity patients). This equates to around 17,120 of the 114,400 numbers of inpatient and A&E attendances dealt with by the hospital per annum. In line with guidance, we have collected data via tokens, feedback cards and telephone surveys and the Trust has fully implemented the A&E FFT.

- During 2013/14 the Trust collected feedback from all the nationally required areas across the hospital achieving an overall response rate of 27.4%
- A target was also set to measure staff responses to the FFT question. This was included in the 2013 Staff Survey with a required response to be higher than that achieved in the previous year. This was achieved and further details on this target can be found within Priority 4 'Culture' below.

2. Patient Surveys – As with our Friends & Family Test the results of the annual Patient Survey and in-house patient surveys are a useful tool for the Trust to use for engaging with, and seeking out, the views of our patients.

The organisation has a Patient Experience Group, chaired by the Director of Nursing, which seeks to understand and drive improvements in patient experience. During 2013/14 we have delivered the following actions against the results of the 2012 National Inpatient Survey:

- Patient Information - folders given to patients informing them of all pre–operative requirements when attending the hospital;
- Medicines - Pharmacy staff working to ensure patients have a greater understanding of their medication and receive it in a timely manner;
- A discharge pathway for staff to use as a checklist. This ensures that patients receive the right information and the correct help both before they leave hospital and when they leave hospital;
- All aspects of staff communications and interaction with patients is fed back and discussed at the weekly Matrons and Sisters meeting;
- Development of a new service called Impressions has also taken place which provides prompt feedback to Doctors and Nurses of the experiences of their patients;
- A 'Carer' passport was introduced in the Summer of 2013 which aims to improve the care of patients by supporting the involvement of families and carers. This enables them to come and visit the hospital over a 24-hour period, entitles them to free car parking and to receive support from the nursing teams involved in care.

The results of the 2013 inpatient surveys showed an improvement in some areas against the results of the 2012 survey, for example improved levels of satisfaction in relation to nursing care, patient information and our discharge process.

There were areas of the survey we were disappointed not to see any improvements in and we will be working in 2014 to deliver actions to ensure this improvement takes place.

Across the Trust there are many processes in place for us to gain feedback and seek the opinions from our service users. The following gives an overview of the formal, and informal, feedback opportunities we embrace as an organisation.

- Our Patient Advocacy & Liaison Service (PALs) deals with around 4,000 enquiries on average per annum. 90% of all PALs enquiries are successfully resolved in a prompt manner. PALs represents an excellent way to quickly address the enquiries of patients and carers in an effective and timely way;
- Our Customer Services Team handles complaints received by the Trust and again this formal feedback forum furnishes us with detailed analysis on patient experience and the opportunity to improve our service delivery.

Further detail on the outcome of this work can be found within the annual Complaints Report published on our website – www.geh.nhs.uk.

- National Friends & Family testing is carried out on a daily basis by hospital volunteers and is another valuable source of engaging and hearing from our patients about what they think of the services we provide. A text messaging service was introduced in March 2014 and is used by public to provide timely feedback on the care received whilst in A&E. In its first month the response rate has increased by 13.8%;
- In carrying out their annual work plan, the Trust's Patient Advocacy Forum regularly inspects the wards and feeds back to the Executive Team on their findings, making recommendations on action to be taken to address and resolve issues in Ward areas. For instance out of action call bells, overdue estates work and any areas where the patient's experience may be compromised;
- The in-house Impressions software system is accessed and used on a daily basis and proven to be an effective way to address and turnaround 'live' and ongoing concerns raised by patients whilst in our care. The following is a good example of immediate action taken on an issue, where lessons were learnt and fed back to all involved, including the patient;

A lady on a surgical ward when being discharged responded through FFT she had witnessed a member of the housekeeping team using a cloth for both clean and dirty areas. She raised this with the Ward Manager who raised with the Domestic Supervisor, and the member of staff was retrained within 48-hours of the incident taken place. No similar issue raised since.

- The hospital review section of the NHS Choices website also offers valuable feedback sharing a wealth of opinions and views from patients about their experience of services delivered and care provided whilst attending the hospital. The Patient Opinion website shares and publishes the same feedback/reviews on services with NHS Choices and is monitored on a daily basis by the Trust to enable a response in a prompt manner and early indication of any trends that may need to be addressed. The following gives some examples of such feedback.

"Early Pregnancy Assessment Unit staff were amazing….On experiencing such an upsetting time of having a miscarriage I could not have had more supportive staff on EPAU…. I can honestly say they were amazing, throughout the process….."

"Very satisfied. MRI within 2 weeks and all staff very friendly. I live in Coventry and chose George Eliot due to recommendations, very pleased so far."

"Today I was due to have day surgery at the George Eliot hospital. I waited 4 hours and was then told that my operation couldn't be done. You can go home we will send you a letter with a new date.

They then took my drips out and discharged me. I travelled one and a half hours to get there to be sent all the way home"

"Arrived at A&E with tight chest pains, and feeling shaky... within the hour I had my blood pressure taken; an ECG; an ultrasound; bloods; and a chest x-ray.

Was completely reassured that my heart was ok...and my pain was gastric, possibly an ulcer, for which I was given medication.

Can't thank the staff enough for their considered attention and care."

"My mum in law was critically ill before Christmas; I credit George Eliot Hospital and Felix Holt Ward with her amazing recovery, after a 12 week stay. The care and attention given to her during her illness, made a very difficult period of time a little easier to deal with"

The Trust responds to all feedback and shares the positive and negative comments with staff. Where the negative comments are non-specific, the patient is asked to contact PALS. This is intended to gain more detail for sharing with departments/staff and to provide an opportunity to rectify and resolve any issues and hopefully reverse any poor patient experience.

It is widely recognised within our organisation that these comments can help departments in a general way and therefore they are circulated to areas and departments for information as they arise. The reviews offer an opportunity to learn from our patents with the views being expressed providing the detail that standard surveys and other methods do not always achieve.

Priority 4 – Culture

1. **Staff Survey.** During 2013/14 the Trust set out to continue to improve the working environment at George Eliot Hospital as a preferred place to be employed. Results show that the Trust has seen an improvement in key indicators such as:

- Staff recommendation of the Trust as a place to work or receive treatment for the fourth consecutive year and for 2013 has risen to 56% (57% average across all Trusts) from 51% in 2012 (55% average across all Trusts);
- Overall staff engagement has increased for the second consecutive year and, the proportion of respondents responding positively to the question "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" has also increased such that the Trust has met its CQUIN target set for this reporting period – a 3% improvement in the Staff FFT score from the Staff Survey compared to the previous year's (2012) survey results.

During the reporting period the Trust has also continued to build on improving overall survey results in respect of staff engagement and sought to improve in those areas where performance had worsened.

The Trust has conducted table top exercises with the staff and sought feedback from the Journey to Excel project (see 2 below). The Workforce Wellbeing Group (WWG) has organised a series of 'trolley dashes' where members of the group take a trolley loaded with fruit and bottled water onto wards and departments across the Trust to hand out to staff and further engage with them on the development of solutions for identified areas of improvement.

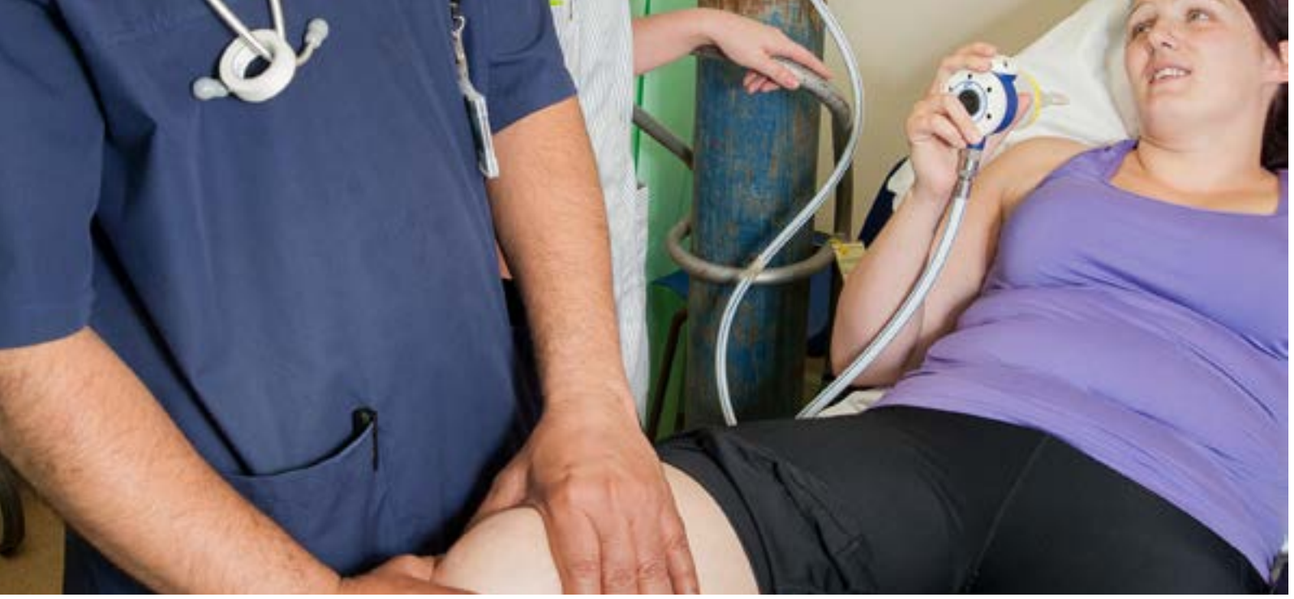
Through the work of the Trust's WWG, a Wellbeing Strategy was approved by the Trust Board and launched in September 2013. Priorities and actions from the strategy have been taken forward by the Workforce Wellbeing Group. This has seen the introduction of a number of initiatives in support of the Trust's commitment to improving the health, wellbeing and working environment for staff:

- Leadership development programme
- Staff Excel Awards
- Proposals for improvements to staff communications being developed eg the use of social media
- Electronic exit feedback from staff leavers now in place to drive service improvement
- Enhanced managers' development programme through HR six-pack programme (six modules of training across people management);
- 15-steps challenge where all disciplines of staff are invited to carry out ward audits using a multidisciplinary team approach;
- Strong links with the local Food Banks;
- Health and wellbeing initiatives aimed at staff through the MECC agenda, e.g. smoking cessation, alcohol liaison officer support, theatres wellbeing insight pilot; oasis complimentary therapies provision extended to staff, water coolers for the wards and a hospital fruit and veg market stall trading from April 2014;
- Enhanced psychological support for staff;
- Annual flu jab provision showing a 9% increase in uptake by staff for the 2013 campaign

The outcome of how our staff are benefiting from the outcomes of the Wellbeing Strategy, the EXCEL programme and ongoing delivery of best HR (Human Resources) practice within the Trust has been measured through regular discussion at the Trust's HR group, Wellbeing group meetings and also reported at Board level.

2. **EXCEL Programme for Staff** - "To EXCEL at Patient Care" During 2013/14 the Trust has been working hard with staff to embed our EXCEL vision and values in all that we do, so that our community, and our partners in the provision of services to our community, have confidence in our ability to provide safe, effective services. For example:

- Corporate Induction for new staff now includes a "How will you EXCEL" session using a quiz approach to introduce our values and asking them to consider how they will live the vision;
- Our Clinical & Non clinical update programmes for current workforce now include a "How are you EXCELling" session using a questionnaire and discussion approach asking them how they are living the values;
- All staff who have attended appraisal training are currently being invited to attend additional training on how they should assess staff performance against the values of the Trust using a behavioural framework based on those values;
- To better engage and communicate our vision and values to patients, staff and the public table top presentations of our vision and values have taken place at both the front door of the hospital and in community settings;
- A rolling programme of short presentations jointly delivered with Board members has 'toured' key regular meetings across the Trust;
- On-going review and update of promotional materials to reflect the importance of patient safety in our values has taken place and has already been embedded in the behavioural framework, appraisal documentation and included in EXCEL pledges;
- A welcome message from the Chief Executive incorporating our values and designed to pop up on computer home screens for all new starters has been created and will be implemented over the coming months;
- A COMPACT agreement which details the organisational leadership responsibilities and the responsibilities of individual members of staff in respect of acceptable behaviours based on the Trust's EXCEL core values, will become part of the recruitment process and also be embedded into the appraisal process for existing staff;
- We have made some changes to the way we recruit new staff. The process now focusses on values eg 6 'C's' …Care, Compassion, Competence, Communication, Courage, Commitment ……
- We have supported members of staff through secondments to study to become qualified health care professionals at George Eliot Hospital NHS Trust
- Over 2013/14 86% of the workforce have an 'active' appraisal and an individual PDP (personal development plan). 89% and 91% of staff received statutory and mandatory training respectively. There has also been an increase in the numbers of staff attending specialist training in Leadership and Management. This year 71 members of staff took up this opportunity;
- We have also introduced a Support Worker Development Programme and Apprenticeship Scheme.



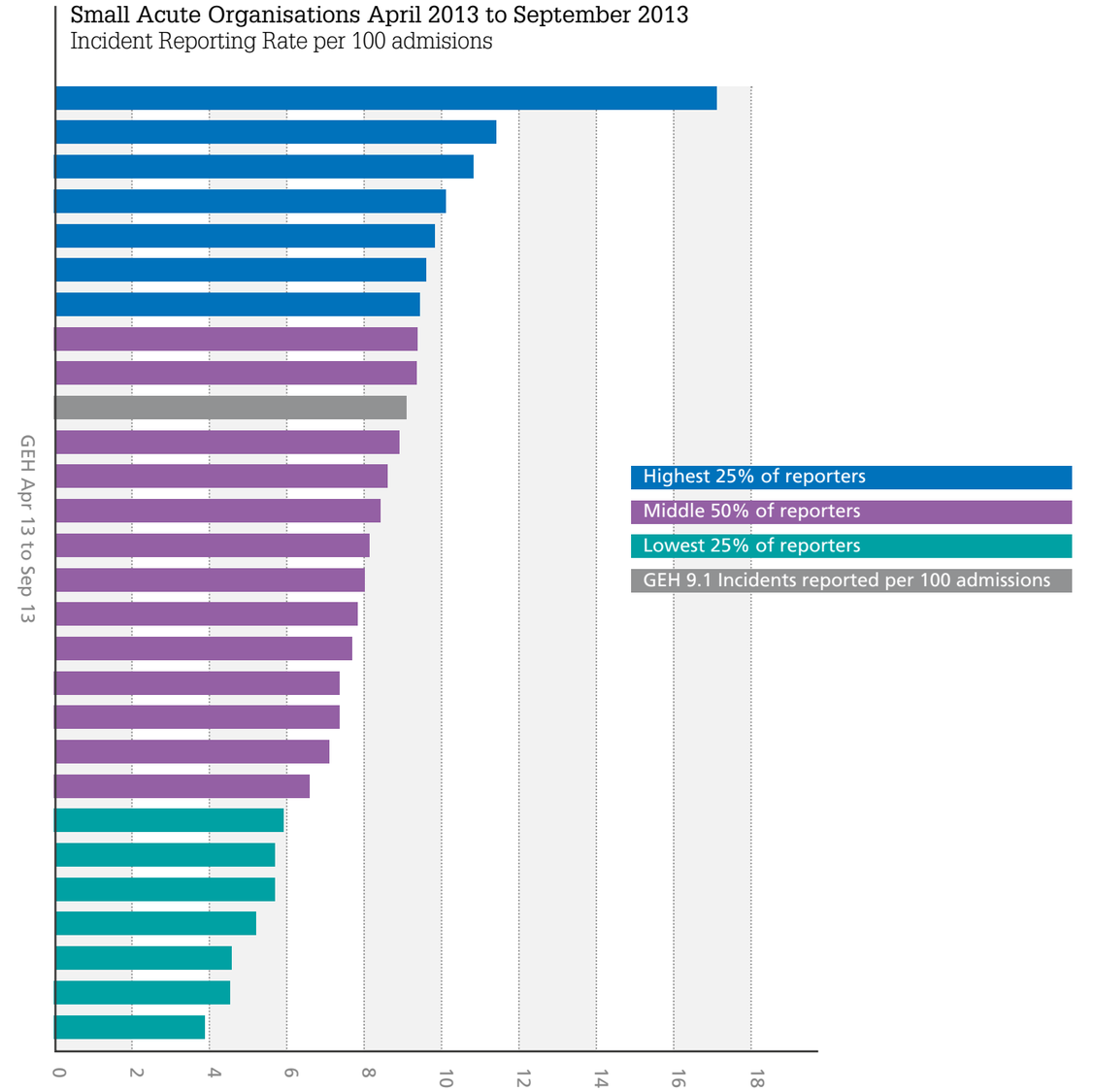
3. Incident Reporting. Following the recommendations of the Francis Report and Department of Health Directive, the Trust has introduced a duty of candour as outlined by the revised NHS Constitution 2013, the NHS Care Bill. This duty requires individuals and organisations to: "Foster a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers. NHS Constitution 2013"

The principle is actively supported across the organisation and included in the incident reporting procedure with an explicit requirement to ensure patients are informed of incidents relating to them and the immediate actions being undertaken.

For 2013/14 the Trust set out to achieve a 10% increase in the numbers of 'all' incidents reported in 2012/13. This target was fully met. Seeking to increase the numbers of incidents reported ensures we are aware of, and can act on, important issues of patient safety. This approach is supported by the National Patient Safety Agency 'Organisations that report more incidents usually have a better and more effective safety culture. "You can't learn and improve if you don't know what the problems are" (National Patient Safety Agency, NRLS website)

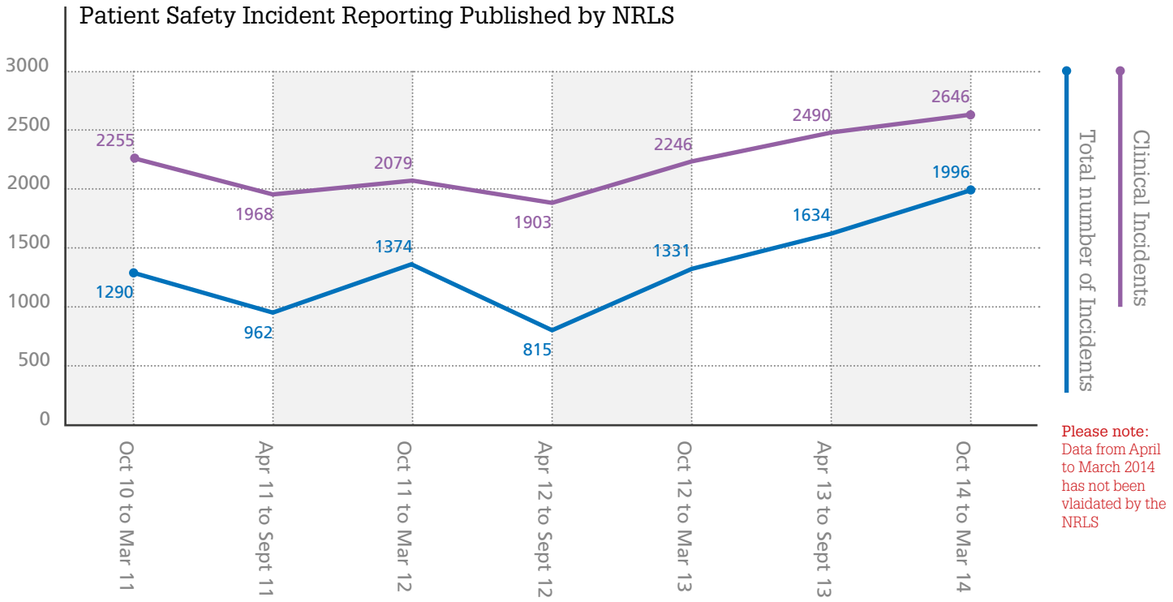
For the period April 2013 to March 2014 the Trust has shown an overall increase of 26% in the number of incidents reported. This increase is based on all incidents reported which includes both clinical & non-clinical incidents. The following section shows the actions we have taken to deliver this improvement.

- Incident reporting figures are monitored on a monthly basis and feedback on reporting levels is given to the divisions with the aim of increasing levels on a month by month incremental basis.
- Incident reporting is emphasised during mandatory updates reviewed at Divisional Governance meetings and reported and discussed at the Patient Safety Group. The SIRI (Serious Incident Reports) is formally reported to the Quality Assurance Committee and Trust Board on a monthly basis. A quarterly report is also provided on a quarterly basis to our Commissioners (Warwickshire North Clinical Commissioning Group).
- The following table shows the improvements seen from the 2013 incident reporting levels when the Trust was positioned in the lowest quartile of reporting hospitals to the latest validated data analysis showing how the Trust has now moved to average levels. This represents a significant shift in practice.

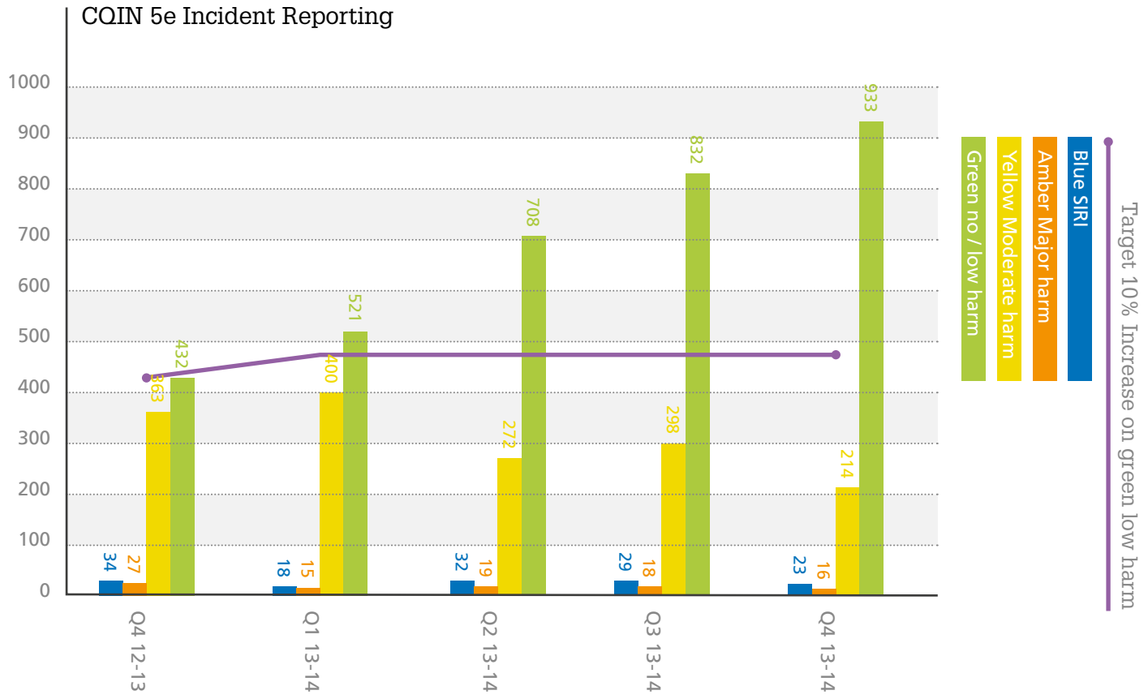


Prior to April 2013, internal analysis of incidents data was based on all incidents reported and did not differentiate between patient safety/clinical incidents and non-clinical incidents. From April 2013 incidents are now divided to allow a more timely assessment of the Trust's reporting rate to the National Reporting Learning System (NRLS) as shown below.

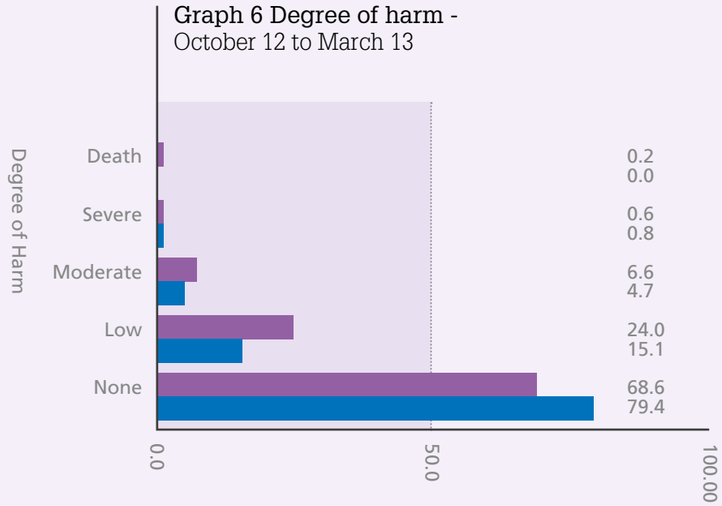
As stated above: 'Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are' (National Patient Safety Agency, NRLS website)

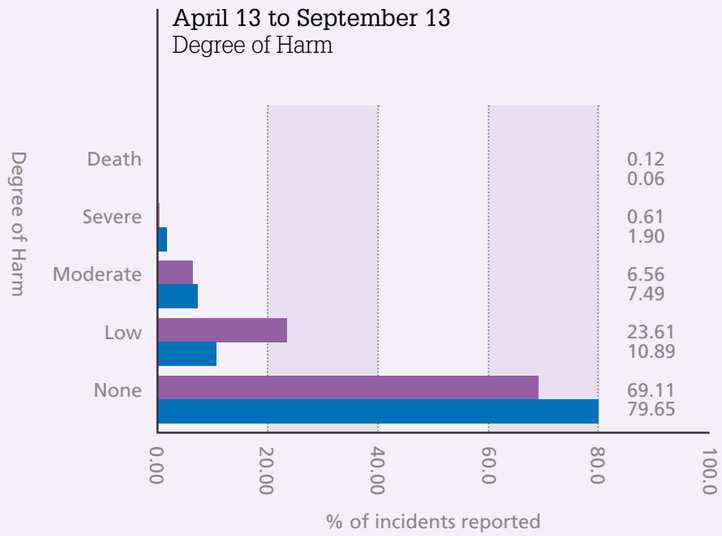


In addition to our aim to increase overall incident reporting we undertook a CQUIN target which required a 10% increase in the number of no/low harm (green) clinical incidents by April 2014. The base line would be taken from the figures reported in Quarter 4 2012/13. The graph below plots the Trust's progress, in working towards this increase, and shows for the period of April 2013 to March 2014 (Trust data) the Trust has shown an overall increase of 65% in the number of incidents reported resulting in no/low (green) harm when compared to Quarter 4 2012/13.



The graphs below (which have been generated from the most recent validation of data submitted to the NRLS and covers, in 6-month blocks, the period October 2012 to September 2013) show that in comparison with other small acute hospitals across England, George Eliot Hospital is reporting at a higher or above average number of no harm incidents.





Incidents in which harm has occurred

Our work to improve incident reporting promotes a culture of safety in which our teams are vigilant to patient safety risks and act before harm occurs. Having delivered this increase in the number of zero or low harm incidents which should relate to a safer environment we are pleased to see a reduction in both Amber incidents or incidents with Major harm by 23% (108 in 2012/13 to 83 in 2013/14) and a Yellow incidents of moderate harm reduced by 18% (1702 in 2012/13 to 1395 in 2013/14) as compared to the previous financial year of 2012/13.

Throughout 2013/14 other important work undertaken to achieve the above improvements includes:

- Reviewing the process of incident reporting across the Trust, including the investment in Datix, a new electronic incident reporting and risk management system;
- Detailed reviews of all clinical incidents takes place at the Divisional Governance meetings with feedback to staff;
- Incidents, trends and themes are published in the Trust publication "Risky Business";
- The Corporate Induction Programme for all new staff includes incident reporting as part of the governance presentation;
- The twice monthly Serious Incident Group (SIG) has meant that RCA (route cause analysis) reviews incident reports and ensures timely review and compliance with the 45-day reporting time to the Clinical Commissioning Group;
- Developing dedicated tools to understand particular types of incidents e.g. Pressure Sores and Falls (RCA) has helped to improve analysis and identification of lessons learnt. This process directly supports our aim to eliminate harm.

4. **The World Health Organisation (WHO) checklist** introduced in 2008 to improve the safety of surgical cases and to avoid critical incidents and 'never events' occurring during surgery. For 2013/14 the Trust set a compliance rate of 100% in this checklist.

Priority 5 – Making Every Contact Count (MECC)

1. The target for 2013/14 was for a minimum of 400 staff to complete MECC training which equips staff with knowledge and tools to raise healthy living issues systematically, where appropriate, with patients to encourage positive lifestyle choices and changes:

By the end March 2014, 461 staff had completed their MECC training, which, including the 99 staff trained in 2012/13.equates to around 25% of our workforce. This was achieved through a variety of E-learning and face-to-face training sessions provided to groups of staff and on an adhoc basis when requested. The target has been exceeded with a large number of staff completing their training this year

- The Health and Wellbeing Service (previously Health Trainer Service) has revised its work programme in line with new requirements from the Commissioner. The approach of the Service is more aligned to MECC, with a higher proportion of referral to specialist support services, and more of an emphasis on shorter interventions;
- A calendar of Health events has taken place in the community where the Trust's health and wellbeing advisors have given advice on lifestyle choices, including vaccination, smoking, diet, obesity, alcohol etc. to people in the locality;
- The Trust had planned to work in partnership with Schools and Colleges in supporting school children to stage health fairs and open days. However this has not yet been completed due to staff changes at the local school which was piloting the idea. We will take forward in 2014/15.

2. Community Engagement: Over the course of 2013/14 the Trust has worked across the community having regular contact with existing forums, community groups, and centres whilst also establishing new links.

- The Executive Team continues to attend community forums, including the 3 Older People's Forums, across North Warwickshire, Hinckley & Bosworth and Nuneaton & Bedworth areas and a variety of community meetings/ events as invited eg Over 50s luncheon clubs, Rotary Clubs, community transport providers, parish council meetings, carers' support groups etc;
- Since the latter part of 2013, the Chief Executive has established a weekly column in a local newspaper where he updates on current issues at the hospital and includes a topical health message;
- The opportunity to have a member of the Executive Team attend external meetings in the community is extended to the membership and the wider public via the local and county-wide press and the membership magazine BLEEP;
- Our Members Advocates are busy across the areas of the community they represent attending Patient Participation Groups and community networking events as required;
- With the current important message and information relating to Keogh Action Plan the Chairman works closely with the Members Advocacy Panel (MAP) to invigorate their role and ensure they are equipped with the right messages and information to disseminate across the community as required. The MAP also gauges the views from those they are in contact with, relays feedback and allays any uncertainty or confusion from our members and the wider public;
- The Patient Advocacy Forum (PAF) is a group of volunteers who talk to patients and their relatives gaining valuable feedback and opinions that help shape improvements from a lay perspective. Several of our Members Advocates are also involved in the work of the Patient Advocacy Forum whose annual work plan supports the work of the Executive Team and contributes as a 'Critical Friend' in finding evidence-based recommendations for change from a patient perspective;
- During 2013 we pursued setting up a Young Members Forum (YMF) to seek out the views of younger people and find out how we can improve our 'youth members/young public' engagement, giving them a voice about local healthcare, offer information on health promotion and generally become more 'user' friendly to young people. However due to a lack of sustained interest the YMF initiative has not yet been established although work has been successful in gaining input from young members into existing forums e.g. PAF and paediatric support groups etc;
- Stakeholder involvement activity regularly takes place and the populated Public Health Strategy and Equality Diversity System action plans are being undertaken proactively. Key meetings with the Black & Minority Ethnic (BME) communities and harder to reach groups are taking place where discussion on how they would like to be kept informed and offer feedback is being agreed;
- The Trust has developed a robust partnership with the Warwickshire Race Equality Partnership to review census information therefore providing a richer understanding of local communities. This has enabled targeted work programmes to be undertaken;
- A review of the existing Cultural Directory was undertaken. Using information from the Census, an updated version was developed with specific attention paid to the nine characteristic groups. Cultural Directories are now available in every ward and clinical area across acute and community services;
- An inspection of the hospital was undertaken by a disabled, wheelchair bound patient and a visually impaired patient. This identified several issues which required improvement work to be undertaken. The 2013/14 work programme includes an in-depth review of the hospital site to benchmark alongside building regulations for disabled users;
- A workshop was held with members of staff and representative community groups to train them how to review clinical services and identify opportunities for improvement;
- This was followed up through the year with members of the Equality Diversity and Human Rights Group visiting community groups to gain feedback of how they would like services to be provided to suit their individual requirements;
- Examples of visits undertaken:- Muslim Day Centre, Sikh Mission Centre, local Children's Centre, Griff Hollow Travellers Site, Gildawood Nursing Home, Diabetic Team support Muslim Day Group during Ramadan, Edward Street Day Centre to celebrate Eid,
- Challenges in sustaining a robust and effective community engagement programme are ensuring the capacity and resources are available to maintain a programme of engagement events, with the opportunity for gaining valuable feedback from all key stakeholders, and in particular from outreach communities, in an appropriate and timely way;
- Whilst there are challenges in the continuum of maintaining a truly engaged, informed and active membership base, the benefits of having an on-going meaningful exchange of views that are incorporated into the future direction of the Trust and ultimately contribute to improving the patients' experience are immeasurable and of great value to the organisation.

Statement of Assurance from the Trust Board

The following statements offer assurance that the Trust is performing to essential standards, measuring clinical processes and involved in projects aimed at improving quality. They are also common to all providers making this account comparable to other NHS Trusts Quality Accounts.

1. Review of Services:

During 2013/14 George Eliot Hospital NHS Trust provided and/or sub-contracted a variety of NHS services and for this period the Trust has reviewed all the data available to us on the quality of care. The income generated by the 88 NHS services reviewed in 2013/14 represents 89% of the total income generated from the provision of NHS services by the Trust in the reporting period.

Where required, a service improvement plan was in place for all services, which was agreed with our commissioning partners (Warwickshire North Clinical Commissioning Group, NHS West Leicestershire CCG, Coventry and Rugby CCG and other associate CCG commissioners). The service reviews for 2013/14 do not cover the 4 GP practices run by the Trust (Camp Hill GP Led Health Centre and The Chaucers Surgery, Nuneaton; Leicester Road, Bedworth and Satis House, Water Orton), or any of the community services such as Dental, Stop Smoking and the Leicester Urgent Care facility.

The quality of services provided, or sub contracted are reviewed in a variety of ways, either planned throughout the year or on an adhoc basis, (ie unannounced), where the Trust receives external reports following such visits and inspections.

Regular peer reviews, eg West Midlands Deanery, Health Education West Midlands, Joint Advisory Group etc have taken place during 2013/14 and the following table gives a flavour of the outcome of reviews that took place along with the outcomes and/or actions appertaining.

Review	Outcome / Progress
Professor Sir Bruce Keogh	The Trust was reviewed as part of the national examination of Trusts with a mortality ratio higher than national average levels. The review examined a wide range of areas and the organization supported the findings of the review and has fully completed the action plan set during 2013/14. As a result of he review the organization was placed into special measures which provided external support. As part of this arrangement the Trust has been partnered with University Hospital Birmingham and is benefiting from this relationship.
Human Tissue Authority (HTA) Inspection of GEH - Post Mortem License	Compliance confirmed and an action plan has now been completed following publication of the report.
CQC (unannounced) Visit	All Standards were met for those reviewed: • Care & welfare of People who use services • Meeting nutritional needs • Staffing
Nursing & Midwifery Council (NMC)	The NMC undertook an assurance visit associated with the delivery of courses for the Pre-registration Nursing (Adult)) and the Midwifery (Long and Short courses) have been met also evidence in support of how the Trust is preparing students to address the on-going concerns raised by the Keogh report from 2013.
Health Education West Midlands x2	Both inspections were extremely positive and both have recommended that additional trainee posts be introduced to each of the services. These additional substantive staff will benefit patients. The inspection/s identified minor issues but these have been promptly addressed.

2. Participation in Clinical Audits and National Confidential Enquiries

- The Trust is committed to delivering clinical audit in order to develop and maintain high quality patient-centred services.
- During 2013/14, the Department of Health detailed 43 national audits for inclusion in Quality Accounts 2013/14, 38 national clinical audits and 5 national confidential enquiries, all but 9 (highlighted as 'not relevant' in the table below) are NHS services that George Eliot Hospital NHS Trust provides.
- During that period, George Eliot Hospital NHS Trust participated in 24 of the 29 (83%) of the national clinical audits and 100% of the national confidential enquiries (5) which it was eligible to take part in.
- The national clinical audits and national confidential enquiries that George Eliot Hospital NHS Trust was eligible to participate in during 2013/14 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Did GEH participate in 2013/14	% of cases submitted
Acute coronary syndrome or Acute myocardial infarction	Yes	98 %
Adult critical care (Case Mix Programme)	Yes	100%
Bowel cancer	Yes	100%
Bronchiectasis[1]	No	0%
Cardiac arrhythmia	Yes	100%
Chronic Obstructive Pulmonary Disease	Yes	Awaiting publication of report
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	100%
Diabetes (Paediatric)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	100%
General Surgery - Hernia Repair, Orthopaedics	Yes	69%
Emergency Use of Oxygen	Yes	Awaiting publication of report
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Falls and Fragility Fractures Audit Programme, includes National Hip Fracture Database	Yes	100%
Heart failure	Yes	91,2%
Inflammatory bowel disease	Yes	100%
Lung cancer	Yes	96%
Moderate or severe asthma in children (care provided in emergency departments)	No	0%
National Audit of Seizure Management (NASH)	Yes	100%
National Cardiac Arrest Audit[2]	Yes	50%
National Dementia Audit	Yes	100%
National emergency laparotomy audit	Yes	on-going
National Joint Registry	Yes	100%
National Vascular Registry, including CIA and elements of NVD	Yes	Awaiting publication of report
Neonatal intensive and special care	Yes	100%
Oesophago-gastric cancer	Yes	100%
Paediatric asthma	Yes	100%
Paracetamol Overdose (care provided in emergency departments)	Yes	84%
Sentinel Stroke National Audit Programme (SSNAP), includes SINAP	Yes	95%
Severe sepsis & septic shock	No	0%
Head and neck oncology	Not Relevant	Not Relevant
National audit of schizophrenia	Not Relevant	Not Relevant
Adult cardiac surgery audit	Not Relevant	Not Relevant
Paediatric intensive care	Not Relevant	Not Relevant
Renal replacement therapy (Renal Registry)	Not Relevant	Not Relevant
Prescribing Observatory for Mental Health (POMH-UK) (Prescribing in mental health services)	Not Relevant	Not Relevant
Congenital heart disease (Paediatric cardiac surgery)	Not Relevant	Not Relevant
Coronary angioplasty	Not Relevant	Not Relevant
Severe trauma (Trauma Audit & Research Network)	Not Relevant	Not Relevant

Audit Title	Did GEH participate in 2013/14	% of cases submitted
CONFIDENTIAL ENQUIRIES		
National review of asthma deaths	Yes	No Patients
Child health programme	Yes	100%
Maternal, infant and newborn clinical outcome review programme	Yes	100%
Medical and Surgical Programme National Confidential Enquiry into Patient Outcome and Death	Yes	100%
Mental Health Programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness	Not Relevant	Not Relevant

- [1]The Bronchiectasis audit was not completed as there were insufficient numbers of patients (2 patients) to enter the audit
- [2]The Trust did not participate in the national cardiac arrest audit during 2013/2014. The organisation has a detailed data collection and review tool in place for this area.

3. Actions arising from clinical audits (local and national)

- There is a rolling Clinical Audit Programme where clinicians meet on a quarterly basis to hear presentations. These meetings require multispecialty input.
- Clinical audit meetings are held in the individual specialties on a regular basis ranging from monthly to quarterly. Completed audits and their outcomes are discussed at these meetings.
- The Trust wide Clinical Audit Group meets 8 times per year. Standing agenda items include an update on the annual plan, national/local audits and external audit reports coming into the Trust;
- Quarterly reports on all clinical audit activity, outcomes and actions are received by the Quality Assurance Committee with an end of year report submitted at Board level on an annual basis

4. Participation in Clinical Research

- The number of patients receiving NHS services provided or sub-contracted by the Trust in 2013/14 that were recruited during that period to participate in National Institute of Health research (NIHR) portfolio research was 455 by end of February 2014. Another 17 patients were recruited for commercial studies for the same period. In total there were 472 patients recruited for studies by the end of February 2014 (over 11 months). This demonstrates that there is already 75% increase in recruitments compared with the previous year.

Year	Studies	Patients recruited
2008/09	16	178
2009/10	19	754
2010/11	32	534
2011/12	20	153
2012/13	25	270
2013/14	21	472

Topic/Speciality	Studies	Recruits
Age and Ageing	1	23
Cancer	10	56
Cardiovascular	2	6
Dermatology	2	9
Diabetes	4	370
Primary care	1	4
Surgery	1	4
Total	21	472

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. This ensures our clinical teams stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes;

- During the last three years there have been approximately 72 clinical members of staff participating in research approved by a research ethics committee at the Trust;
- As well, in 2013-2014 there were 29 publications which have resulted from our involvement in research. This demonstrates our commitment to transparency and desire to improve patient outcomes and experience across the NHS;
- Our engagement with clinical research also shows the Trust's commitment to testing and offering the latest medical treatments and techniques. The Trust also recruited 17 participants for NIHR Industry trials in 2013/14;
- The Trust has a long-standing and effective partnership with the University of Warwick for research. Each year a number of collaborative research studies are undertaken, demonstrating the value that the Trust places on research. In 2012 the Trust was sponsored by the Warwick Medical School in partnership with the University of Southampton and King Edward Memorial Hospital in Pune India to undertake an MRC study; "The Pride Study". The overall aim of this study is to look at various risk factors for the development of GDM, gestational diabetes mellitus, where there is a 1 in 6 chance of a pregnant mother developing, which has recruited a large number of patients and is likely to continue the high recruitment in 2014/15;
- The NHS operating framework requires Trusts to double the number of patients recruited across into NIHR portfolio trials within 5 years (i.e. from a baseline in 2008/9 to the end of 2013/14. The Trust has already increased recruitment by 1.65 fold February 2014. The Trust is expected to triple the number of patients recruited for studies by the end of 2013/14 compared to 2008/09;
- There was a 75% increase in the number of patients recruited between 2012/13 and 2013/14. This indicates that the trend to recruit patients has been improved significantly in the last year. Thirteen studies have been approved recently or are awaiting approval, which will significantly increase the number of recruits required in 2014/15. This increase in recruitment has resulted from a number of factors; the appointment of a new and active Research & Development Director, recruitment of two Research Champions and a part-time Research and Development Manager from the West Midlands Comprehensive Local Research Network. More research nurses provided by the West Midlands Comprehensive Local Research Network and employed by the Trust funded by money generated from research. There were several meetings run during the year to promote research and to build up a culture of research in the Trust and several courses organised by the West Midlands Comprehensive Local Research Network on introducing research to staff, research governance and ethics. These resulted in a significant increase in the number of studies running at the GEH and in the number of patients recruited to these studies.

5. Use of CQUIN Framework:

The Commissioning for Quality & Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS Services and is a pivotal part of ensuring that local, and national, quality improvement priority setting is kept at the fore of the Trust Board's agenda. By encouraging commissioner and provider discussion and agreement at Board level within, and between organisations, this important document is enhanced and gains added value when collating the detail of the Quality Account.

- A proportion of GEH's income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between GEH and Warwickshire North Clinical Commissioning Group.
- During 2013/14 the total income associated with the achievement of quality improvement and innovation goals amounted to £2,234,062. The Trust had a total of 8 general CQUIN measures (4 local, and 4 national) for 2013/14. It should be noted however that the final CQUIN reconciliation is to be determined and actual income for 2013/14 will be agreed with Warwickshire North Clinical Commissioning Group.

Ref	Indicator	Q1 Milestones achieved	Q2 Milestones achieved	Q3* Milestones achieved	Q4* Milestones achieved	Comments
1a	Friends and Family: Delivery of Friends and Family roll-out for maternity services.	N/A	N/A	Yes	Yes	Achieved
1b	Friends and Family: Increased Response Rate	No	No	No	Yes	Whilst the response rates were good for inpatient wards and maternity unit throughout Q1-3 We found it difficult to ensure sufficient patient participation for patients presenting to the Accident & Emergency Department. The introduction of text message responses helped greatly to improve this position as can be seen in Q4
1c	Improved performance or remaining in the top quartile on the staff F&F Test	Yes	Yes	Yes	Yes	Achieved
2	NHS Safety Thermometer: Reduction in the prevalence of pressure ulcers	No	No	No	No	Not Achieved The organisation as a whole has reduced the number of pressure ulcers that develop in inpatients however this CQUIN measure includes pre-existing pressure ulcers in patients admitted to hospital i.e. not hospital acquired.
3a	The no. of patients aged 75 and over: • screened following emergency admission • identified as potentially having dementia and having diagnostic assessment / investigations • referred on to specialist services.	Yes	Yes	Yes	Yes	Achieved
3b	Named lead clinician for dementia and appropriate training for staff	Yes	Yes	Yes	Yes	Achieved
3c	Ensuring carers feel supported	Yes	Yes	Yes	Yes	Achieved
4a	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool.	Yes	Yes	Yes	Yes	Achieved
4b	The number of root cause analyses carried out on cases of hospital associated thrombosis	Yes	Yes	Yes	Yes	Achieved
5a	Mortality 7 day hospital IT support to clinical decision making Improved Nursing Home liaison Hydration & Nutrition Case Note Review	Yes	Yes	Yes	Yes	Achieved
5b	Percentage compliance with the care bundle for pneumonia, sepsis and heart failure	Yes	Yes	Yes	Partial	Partial The action plan related to this area was fully achieved however the increased percentage compliance for care bundles was not met in Jan 14 although was achieved in Feb Mar 2014
5c	95% compliance with the Royal College of Clinicians Standards for record keeping- 5 elements	Yes	Yes	Yes	Partial	Partial Audit undertaken throughout the year with improvement actions however full compliance with records standards was not seen in all records as required by the CQUIN scheme in Q4
5d	Transform programme for End of Life Care	Yes	Yes	Partial	No	Partial An IT system related to this CQUIN was not delivered in year as planned
5e	Percentage rise increase in incident reporting	Yes	Yes	Yes	Yes	Achieved
6	High level plan to implement recommendations of the Francis Report	Not Applicable	Yes	Yes	Yes	Achieved
7a	Reduction of Outpatient Follow Ups: T&O (Carpal tunnel and shoulder with U/S), Diabetes and Rheumatology / Yag laser / CFS	Yes	Yes	Partial	Partial	Partial All elements of the CQUIN scheme were not met
7b	Conversion to outpatient procedures: Increase number of Day Cases to outpatient procedures	Yes	Yes	Yes	Yes	Achieved
7c	Improving Theatre efficiency	Yes	Yes	Yes	Yes	Achieved
8	Specialist Palliative Care	Yes	Partial	Partial	Partial	Partial All elements of the CQUIN scheme were not met

Please note that Q3&4 are subject to confirmation with our Commissioners
For guidance on the details of CQUINS for 2014/15 please contact the Directors Office, Trust Headquarters, Lewes House, George Eliot Hospital.

6. Registration with Care Quality Commission

The Trust is currently registered with the Care Quality Commission (CQC) without any compliance conditions and is licensed to provide services. The CQC has not taken any enforcement action or issued any notices against the Trust during 2013/14.

These are the most recent results from the CQC following checks during an inspection carried out in February 2014 on whether the care service (GEH) provides is meeting each of the standards that the government says our patients have a right to expect.

Review	Outcome	Overall
1: Treating people with respect and involving them in their care	People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run (outcome 1)	✓
	Before people are given any examination, care, treatment or support, they should be asked if they agree to it (outcome 2)	✓
2: Providing care, treatment and support that meets people's needs	People should get safe and appropriate care that meets their needs and supports their rights (outcome 4)	✓
	Food and drink should meet people's individual dietary needs (outcome 5)	✓
	People should get safe and coordinated care when they move between different services (outcome 6)	✓
3: Caring for people safely and protecting them from harm	People should be protected from abuse and staff should respect their human rights (outcome 7)	✓
	People should be cared for in a clean environment and protected from the risk of infection (outcome 8)	✓
	People should be given the medicines they need when they need them, and in a safe way (outcome 9)	✓
	People should be cared for in safe and accessible surroundings that support their health and welfare (outcome 10)	✓
	People should be safe from harm from unsafe or unsuitable equipment (outcome 11)	✓
4: Staffing	People should be cared for by staff who are properly qualified and able to do their job (outcome 12)	✓
	There should be enough members of staff to keep people safe and meet their health and welfare needs (outcome 13)	✓
	Staff should be properly trained and supervised, and have the chance to develop and improve their skills (outcome 14)	✓
5: Quality and suitability of management		✓

CQC Monitoring

The CQC also routinely check the quality of services against a core set of quality indicators and produce a quarterly Intelligence Monitoring Report with the latest results reported at Board level. This forms part of a 'Surveillance Framework' where a process using an intelligence tool which was introduced and made accessible to individual Trusts and the public in March 2014. The current indicators for the hospital show that for the period there are two elevated risks and three risks as laid out in the table below:

Risk	Indicator	Review Period
Elevated Risk	Dr Foster: Composite of Hospital Standardised Mortality Ratio Indicators	1st July 2012 to 30th August 2013
Elevated Risk	TDA (Trust Development Agency) – Escalation Score	1st July 2012 to 30th August 2013
Risk	TDA (Trust Development Agency) – Escalation Score	1st July 2012 to 30th August 2013
Risk	Composite Indicator – In hospital mortality – Cardiological conditions and procedures	1st October 2012 to 20th September 2013
Risk	GMC National Training Survey – trainee's overall satisfaction	26th March 2013 to 8th May 2013

COMMENTS...

This relates to hospitals in special measures.

This above table shows an improvement on the figures published earlier in 2013 where the Trust had four elevated risks and three risks.

The Trust has been graded at Band 1, and it should be noted that all trusts in special measures are automatically graded at Band 1.

7. Information on the Quality of Data

The National Data Quality Dashboard is available to help monitor and drive improvement in the quality and completeness of data. The GEH benchmarks well against other Trusts as the average results of the overall commissioning dataset (CDS) data validity is 96.1% for all CDS submitters and the results of the GEH was 99.6%. Good quality data underpins the effective delivery of patient care and these results are essential if improvements in quality of care are to be made, which includes the quality of ethnicity and other equality data, thus contributing to improvements patient care and value for money.

NHS Number and General Medical Practice Code Validity:

The patient NHS number is the key identifier for patient records and the quality of NHS number data has a direct impact on improving clinical safety.

The Trust submitted records during 2013/14 to the secondary user service (SUS) for inclusion in the hospital episodes statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

1. APC = 99.9% - (National comparator 99.1%)
2. OPD = 100% - (National Comparator 99.3%)
3. AE = 99.5% - (National Comparator 95.8%)

Records which included the patient's valid General Medical Practice Code was:

- APC = 100% - (National Comparator 99.9%)
- OPD = 100% - (National Comparator 99.9%)
- AE = 100% - (National Comparator 99.1%)

Source : SUS Data Quality Dashboard, Month 9 December 2013); NB: APC = Admitted Patients Care (This includes Inpatients and Day Cases); OPD = Outpatients/ Ward Attenders and Tele-Medicine activity; AE = Accident & Emergency

Information Governance Toolkit Attainment Levels:

The Trust recognises the importance of preserving the integrity of the Information Governance toolkit and the contribution that this makes in placing the necessary safeguards for, and appropriate use of, patient and personal information. The Trust has completed both the initial and baseline audit at level two and is colour coded at green (satisfactory).

Clinical Coding Error Rate:

George Eliot Hospital NHS Trust was subject to the Information governance audit (covering 4 specialties, general medicine, trauma and orthopaedics, maternity and surgery) in January 2014.

The performance of the Trust was measured by assessing the percentage accuracy of diagnoses and procedures. The trust performed well with primary diagnosis being 95% correct, secondary diagnosis 88% correct, primary procedure 92% correct and Secondary procedure 92% correct.

The Trust was also subject to a Payment by Results audit during the reporting period 2013/14, (November 2013), and the following gives a brief summary of the outcome to the Audit.

In admitted patient care we audited 200 episodes at the Trust, which equated to 186 spells (100 of these were to look at the capture of co-morbidities and 100 were chosen locally by the commissioners). I n the sample audited, the Trust had an overall error rate of 10.2 per cent. This means that 10.2 per cent of spells had either a clinical coding error affecting the HRG, or a data entry error (or both). This performance would place the Trust in the worst 25 per cent of Trusts compared to last year's national performance.

Following the payment by results audit we commissioned external trainers to carry out orthopaedic and pain coding workshops for the coders to resolve some of the errors found at audit. Further to this internal training and feedback has been delivered on all coder errors found on audit. We have also increased clinical engagement which allows us to educate both coders and clinicians to improve the quality of information.

8. External Assurance and Performance Indicators:

Within this section the Trust has reviewed its performance against a core set of national and local performance indicators where a set standard is aimed to be met, or bettered, over the 2013/14 year.

Performance Indicator	Standard	2013/14	Achieved
Safety:			
C Difficile Infections	21	10	✓
MRSA Bacteraemia Infections	0	0	✓
Quality:			
Cancer 2 weeks suspected	93%	97.2%	✓
Cancer 2 weeks Symptomatic Breast	93%	94.8%	✓
Cancer 31 days	96%	98.7%	✓
Cancer 31 days – Drug	98%	100%	✓
Cancer 31 days – Surgery	94%	98.8%	✓
Cancer 62 days	85%	85.2%	✓
Cancer 62 days from Screening Service	90%	95.3%	✓
Patients seen in A&E <4 hours	95%	96.02%	✓
Patients who leave A&E without being seen	5%	0.7%	✓
Time to initial assessment in A&E in minutes (95th percentile)	<15	<11	✓
Time to Treatment in A&E in minutes (median time)	<60	<31	✓
Readmission within 28 days following discharge	14%	13.7%	✓
Stroke – Time on Ward	80%	81.74%	✓
Patient Experience:			
Referral to Treatment (RTT) waits 95th percentile - Admitted	23 wks	20 wks	✓
RTT waits 95th percentile - Non Admitted	18.3 wks	17 wks	✓
RTT incomplete non-emergency pathway (92nd centile)	28 wks	14 wks	✓
Patients offered an appointment to Genito-Urinary Medicine (GUM) Clinic within 48 hours	95%	100%	✓
Patients seen in GUM Clinic – access within 48 hours	95%	100%	✓
Percentage of patients whose operations were cancelled for non-clinical reasons on the day of admission	0.8%	0.61%	✓
Mixed Sex Accommodation	0	0	✓
Patient Safety:			
Never Events[1]	0	3	✗
VTE	95%	95.13%	✓

Stroke – CT <24 hours – The hospital does not provide hyper-acute stroke services which are provided by another organisation and as such imaging within 24hours does not apply to the George Eliot Hospital

Of the 23 performance indicators shown in the table above the Trust did not fully meet 2 and the following gives a brief explanation as to why the standard was not fully met and what action has been, or is being, taken to remedy this.

1. Never Events – Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Regrettably three Incidents occurred during 2013/14 which were classified as Never events. Each related to the category of wrong site surgery, none of which related to serious physical harm to patients however these are serious events which occurred in different areas of the Trust. Detailed investigations were undertaken for each area with identified key learning points being acted upon. During the year we have implemented a procedure checklist in all areas of the Trust wherever procedures take place to prevent recurrence of this event.

Patient Reported Outcome Measures (PROMs): measure quality from the patient perspective. The PROMs programme cover four clinical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein surgery. Nationally PROMs scores calculate the health gain (as reported by the patient) after surgical treatment using pre and post-operative surveys.

Participation: The most recent regular quarterly release by HSIC reflects April to September 2013 (published 13th February 2014) In this 6 month data period 211 of a possible 390 pre-op questionnaires were returned by patients (55% participation compared to 77% England) 31 Postoperative questionnaires have been returned to date (28% compared to 36% nationally).

Health Gain Scoring Summary: Within this latest data period ….

- 53% of groin hernia patients reported an improvement in EQ-5D Index (a combination of five key criteria concerning general health) compared to 50% England;
- 12.5% of groin hernia respondents recorded an increase in their EQ VAS (general health marked on a visual analogue scale) score following their operation (37.9% in England);
- 88.9% of knee replacement respondents recorded an increase in their EQ-5D Index score following their operation (82.9% in England);
- 37.5% of knee replacement respondents recorded an increase in their EQ VAS score following their operation (56.5% in England);
- 100.0% of Oxford Knee Score respondents recorded joint related improvements following their operation (94.3% in England);
- A limited number of records for hip surgery limits reporting however of 11 records returned 10 reported an improvement in the oxford hip score;

Through a structured Quality Account review process, the Trust's Quality Account Review Group (includes members of the public, patients, commissioners and other key stakeholders) worked proactively with those delivering the hospital's quality improvement agenda. This group works to inform the development of annual objectives and formally review progress at quarterly intervals to enable each year's key quality improvement priorities to take shape and ensure they are delivered.

The Trust's key priorities for 2014/15 continue to reflect our commitment to improve the quality and safety of care delivered to our patients, and are based on information taken from incident reports, detailing themes such as patient falls and medication safety. In addition patient feedback has been considered to identify key areas of action alongside the results of measured outcomes from the previous year's Quality Account. We also incorporate external reviews on our quality delivery and include national audits (NCEPOD, clinical specialty reviews ie National Joint Registry) and the Intelligent Monitoring Report (IMR) provided by the Care Quality Commission (CQC). The CQC IMR, released on a quarterly basis, provides valuable insight and is based around the domains of safety, effectiveness, how caring, responsive and how well led the organisation is.

The organisation's revised Quality Strategy follows the themes of the 2014/15 Quality Account priorities and this will ensure they are delivered across all levels of the organisation. For example divisional team objectives set for 2014/15 directly reference and provide an operational plan for delivery.

What will success look like?

Delivery of the following objectives will ensure that we continue to deliver safe, high quality care whilst affording the opportunity to deliver further improvements throughout our service, key to which will also be continued involvement of the patients and carers' from across the community the hospital serves.

Priority 1 – Clinical Effectiveness - High Quality Care

(Executive Lead – Dr Gordon Wood, Medical Director)

During 2014/15 we will deliver a revised series of clinical guidelines including the provision of a range of care bundles in order to standardise the delivery of evidenced based care over the 24 hour 7 day period.

In 2014 we will deliver an Acute Renal Failure bundle to build on the success of the Sepsis, Pneumonia (delivered in 2012/13) and Heart Failure bundles delivered during the following reporting period.

To improve inpatient documentation and communication with GPs and Patients, we will revise the inpatient documentation to make this clearer, more centered to rapid access of the right information. This will ensure patients and GPs receive accurate copies of discharge and transfer information within 48 hours of hospital discharge and 5 days of outpatient appointment

We will adopt the NHS England commitment to deliver 7 Day services and in year 1 of a 3 year programme understand the changes needed to begin to deliver this service, alongside a series of clinical standards which require inpatient review by a consultant within a minimum period of 14 hours over the 7 day period.

We will develop the ownership and management of quality at Divisional and team level by supporting teams with the right information, tailored to their needs and ensure teams have both the time and skills to plan and act to effect improvement. Complaints, incident information and patient feedback will be central to this improvement and will feature in all divisional governance meetings alongside the learning that is needed.

To support this we will deliver a quality champion scheme which will be open to all staff to receive training and be encouraged and supported to engage in quality improvement. This model has worked extremely well in other organisations and we will learn to adopt this approach for these Centres of Excellence.

To be assured of the standards being delivered throughout the year, we will build in existing mechanisms to deliver a Ward Accreditation Programme which sets high standards across a range of areas from cleanliness and infection control to staff training. We will employ a regular programme of review and support to ward areas to both meet and maintain these standards. Progress and status on meeting these standards will be displayed in each ward area.

Encompassing and guiding these improvements will be a revised Quality Strategy which builds on the achievements of 2012/13 and takes us into a process of continual improvement through the regular and detailed consideration of a range of information from Board to ward level and

the rapid action to identify and act on necessary improvements.

In 2014/15 we will continue to develop Palliative Care Services to meet the growing needs across the north Warwickshire area. Having established a service to support patients in 2012/13 we will seek to expand this service and in particular reach Patients with chronic disease conditions such as heart failure and bronchitis. We will also seek to work with our nursing and residential home colleagues and General Practitioners to deliver improved standards of discharge arrangements making a seamless transfer of care a priority. In addition we will seek to support patients and colleagues in the process of producing anticipatory care plans which ensures patients receive the most appropriate care possible via a planned approach. Our end of life care strategy, established in 2013 will continue to guide our work and the Strategy Group, formed from across patient, carer and health professional groups will continue to meet monthly to assess and guide progress.

Priority 2 – Patient Safety - Harm Free Care

(Executive Lead – Dr Gordon Wood, Medical Director)

We will aim to ensure no Never Events occur within the organisation by adherence to clinical guidelines, delivering appropriate checking processes and by a process of regular testing to ensure our preventative methods are in place that are effective, acting rapidly and where necessary bring about improvement.

Following the recommendations of the Francis report and Department of Health Directive the Trust has introduced a duty of candour as outlined within the revised NHS Constitution 2013, NHS Care Bill and originated from the Francis enquiry. This duty requires individuals and organisations to "Foster a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers. NHS Constitution 2013 "

This principle is actively supported across the organisation and included in the incident reporting procedure with an explicit requirement to ensure patients are informed of incidents relating to them and the immediate actions being undertaken.

We will aim to deliver a 10% reduction in harm caused through clinical incidents eg Falls, Pressure Ulcers, Medication Errors etc.

Specific targets will be attached to the following areas:

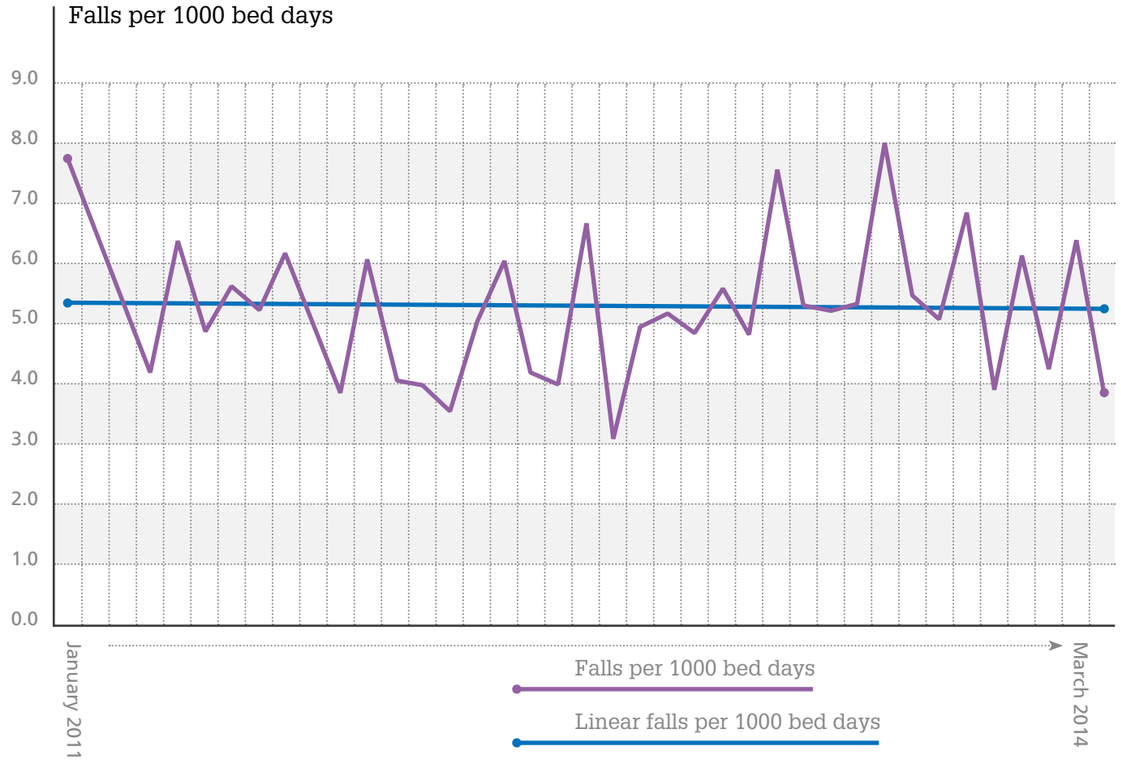
1. Hospital Acquired Thrombosis

Whilst striving for a 100%, we will aim to continue to assess a minimum of 95% of patients for risk of thrombosis on admission and will review where a thrombosis occurs whilst an inpatient. We will undertake a review of the causes of this event (route cause analysis) and ensure we share findings with clinical teams to prevent recurrence. Themes from these reviews will be collated and managed by the thrombosis committee with our performance on both the number of thrombosis occurring, whilst an inpatient, and the findings of reviews, will be shared with clinical teams and reported within our monthly quality report.

2. Patient Falls:

Falling as an inpatient is a serious event and we aim to eradicate inpatient falls by a series of actions to both identify the risk of falls and preventative action. During 2014/15 we aim to achieve a minimum 20% reduction in the number of patient falls and as a result see a reduction in the number of falls which result in severe harm that can be classified as head Injury or fracture.

A 20% reduction in falls equates to a figure of 3.7 falls per 1000 bed days aiming to come down from 4.7 being the average falls per bed day during 2013/14.



We have worked on falls prevention in 2012/13 and during 2014/15 we will strengthen our actions to ensure further improvement. A falls care bundle will be central to this work and make clear to all, the key actions to be taken to understand risk and prevent a fall.

Monitoring and reporting of Falls remains part of the monthly Quality Assurance Committee and Board level reporting. Falls where patients suffer injury are treated as a serious clinical incident and investigated using a route cause analysis process which is then shared across the organisation.

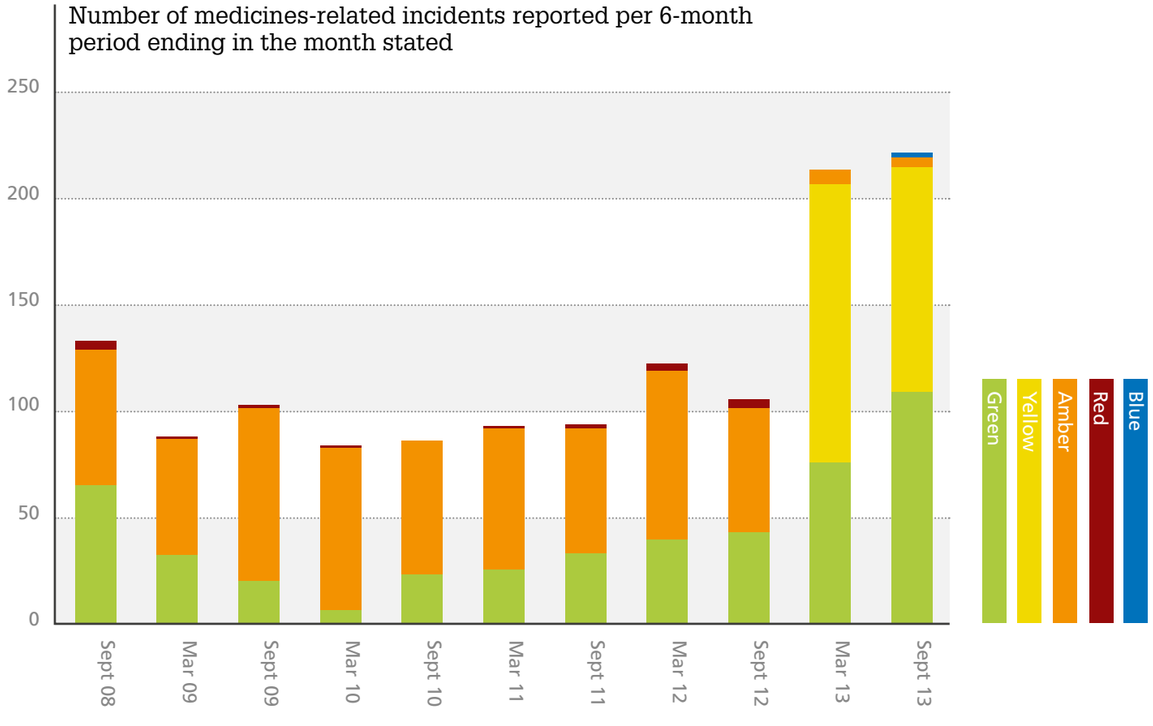
3. Medication errors

The Trust has historically been a low reporter of clinical incidents, including medication-related incidents. The classification of incidents was revised in October 2012 to introduce a "low harm" category (yellow). Prior to this, such incidents were included in the "amber" classification.
Medicines-related incidents are reviewed bi-monthly by the Trust's multi-disciplinary Medicines Management Group, managed by the Chief Pharmacist and chaired by a Consultant. Key issues and themes are identified by the Group and publicised widely in the hospital via publication of the monthly Risk Reminders bulletin by the pharmacy team. Copies of all Risk Reminders bulletins are available on the Trust Intranet. Risk Reminders is distributed monthly alongside the corporate Team Brief document by the communications team.

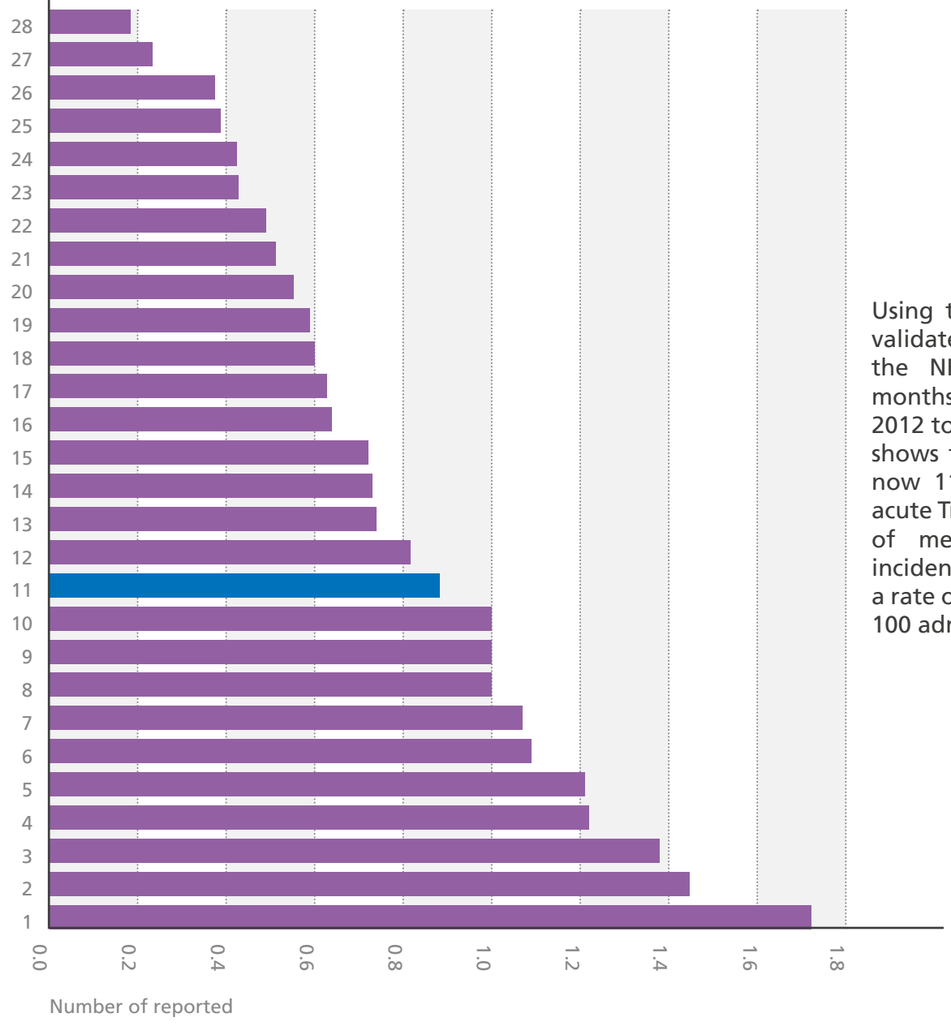
From March 2013, members of the multi-disciplinary Medicines Management Group have actively promoted the importance of reporting no-harm and low-harm events, including near misses, in their clinical areas to enable learning to be derived with a view to preventing more serious incidents in future.

The table below shows that this initiative has increased the number of incidents reported from 100-120 per 6-months to over 200 per 6-months, the increase being in no-harm (green) and low-harm (yellow) incidents.

Number of medicines-related incidents reported per 6-month period ending in the month stated



Comparison of medication-related incident reporting rate per 100 admissions for small acute Trusts (GEH Trust 11)



Using the most recent validated data from the NRLS for the 6 months from 1 October 2012 to 31 March 2013, shows that the Trust is now 11th of 28 small acute Trusts for the rate of medicines related incident reporting, with a rate of 0.9 reports per 100 admissions.

Given the significant improvement in incident reporting already achieved, a target of a further 10% increase in reporting of (no-harm and low harm) incidents has been agreed for 2014/15, and we will aim to have no serious harm-related to medication errors.

It is anticipated that this will be achieved as part of the Trust's response to the MHRA Patient Safety Alert NHS/PSA/D/2014/005, which aims to improve medication error incident reporting and subsequent learning. The Trust's response to this alert, for completion by September 2014, will include the identification of Board-level leadership, supported by the Chief Pharmacist and identification of a Medication Safety Officer who will be part of a National Medication Safety Network. It is anticipated that the new Network will identify and share initiaves to further improve the reporting and management of medicines-related incidents.

The impact of these changes will be monitored monthly by the Chief Pharmacist, as part of the Medicines-related Incident Report and the medicines management section of the monthly Quality Report. The Medicines Management Group will review progress bi-monthly, whilst the Patient Safety & Experience Group will monitor quarterly via the Chief Pharmacist's Medicines Management report.

4. Healthcare Associate Infection (HAIs)

HAIs will continue to be a focus and we will aim to see no more than 7 'avoidable' cases of Clostridium Difficile (CDI) developed as an inpatient during 2014/15. This represents a significant reduction on successive years and will require strong attention to antibiotic use and infection control principles in relation to hand hygiene and environmental cleaning.

Similarly we will aim to have no hospital acquired MRSA Bacteraemia and as with our focus on CDI, a concerted effort to sustain continued best practice and innovative approaches to HAIs.

5. Mortality

This will remain a clear focus and we will aim to deliver both an end of year 2014/15 HSMR & SHMI at or below national average by accelerating our programme of improvement to deliver timely effective care over a 24 hour period. We will also have a responsive approach to learn lessons and deliver continual improvement to our services.

Priority 3 – Patient & Staff Experience

(Executive Leads – Dawn Wardell, Director of Nursing & Quality & Dorothy Hogg, Director of Human Resources)

The Experience our Patients receive remains central to our work during 2014/15. In addition to featuring within our annual quality account our revised Quality Strategy has Experience as one of the three key priorities. We will work to deliver further improvements to communication between our patients and staff by adopting new techniques and emphasis on the fundamental principles of delivering an excellent Patient experience.

Our inpatient survey results show us where specific focus is needed; during 2014/15 we will target these areas working to enhance communication between our Doctors and Patients with enhancements also to the communications sent to GP's. We will also be delivering improvements to the information about discharge from hospital and the medications required after Patients leave hospital

We will understand our progress by use of the friends and family score and through continuing use of detailed patient surveys to understand experience across all services. We will also provide daily feedback to teams via friends and family score results and detailed comments made, this will enable us to act quickly where needed and recognise excellence when seen.

Some of the key areas of action during 2014/15 include:

- Review of all patient information available ensuring relevance in order that each area follows the latest evidence. Within this work there will be a specific focus around medication and discharge information;
- Team discussions on patient experience results which will include Schwarz rounds (a multi professional group to review and act on the challenges of delivering high quality care);
- Provision of written diagnosis and treatment plans for Patients and carers whilst an inpatient to improve understanding and involvement in treatment;
- Recruiting new staff members based on values of care, compassion and high standards of clinical care;
- A healthcare support worker training programme which includes key factors for delivering an excellent patient experience;
- Delivering a ward accreditation programme which sets high standards for clinical care and experience with regular review and publically available results;
- Twice weekly feedback to staff of "impressions" Patient feedback (Patient feedback collation method);
- A "Night Noise Charter" setting out the standards to prevent noise at night and promoting patient rest; this standard will be assessed by regular spot checks on progress;
- Daily staffing level boards to provide information on the numbers and skills of those working within each area – this work is linked with the constant consideration of staffing levels across the trust which is formally reviewed at the three times daily operations meetings ;
- Delivering a new scheme within our children's services to understand children's experience of their care called PREMS (Paediatrics reporting experience measures) which is a tool to measure the experience of paediatric patients (0-16) years in all urgent and emergency care

settings and use this information to drive improvement;
- Promoting the "six steps to a great patient experience" across our teams and ensuring these principles are observed in all patient contact.

In delivering these and other actions, which are formally recorded with our Patient Experience Improvement Plan led by the Patient Experience Group, we will firstly aim to see an improvement in the 2014 results based on the previous year's performance with a clear ambition to be at or above national average levels in all categories.

Our paediatric team will take up a new scheme to understand children's experience of their care called PREMS

Staff Experience: A summary of the 2013 Staff Survey tells us that there have been some improvements to key indicators such as:

- Staff Recommendation of the Trust as a place to work or receive treatment has increased for the fourth consecutive year;
- Overall staff engagement has increased for the second consecutive year and
- The proportion of respondents responding positively to the question "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" has also increased.

However, the Trust recognises that whilst there have been improvements in the areas outlined above, a number of areas remain where we would wish to see further improvements building on achievements of previous years. The survey results are subject to detailed review by the Trust's Workforce Wellbeing Group and wider management team. Focus groups have been set up with staff and are being used to further understand the detailed responses. This will inform our actions in 2014/15 to ensure that George Eliot remains a great place to work and that we are able to retain and attract high quality, competent staff who will continue to provide excellent care for our patients.

Specific task and finish groups have also been assigned to address issues in relation to:

- Management relationships
- Pressure and emotional wellbeing
- Learning and development
- Hygiene
- Incidents
- Harassment, bullying and equality issues

The Trust will work with Staff Side colleagues to increase the engagement of our staff throughout the year through wellbeing initiatives and recognising excellence in individuals and teams and through the further embedding of our EXCEL vision and core values. For 2014/15 our Staff Educational and Development programme will aim to sustain the achievements acquired throughout 2013/14 and actively work towards increasing staff numbers accessing the education and development curriculum based on the targets attached to the annual funding allocation from HEE (Health Education England), academic funding and local education and training boards allocated funding priorities. A particular area of focus will be to continue to maintain our excellent performance in the numbers of staff receiving statutory and mandatory training.

The above will be monitored throughout the year via the Quarterly and Annual reports to the learning board and the Trust's bi-monthly HR group

Annex 1 – Auditor's Limited Assurance Report

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF GEORGE ELIOT HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of George Eliot Hospital NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Percentage of patient safety incidents resulting in severe harm or death

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 24 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated 06/06/2014
- feedback from Local Healthwatch 04/06/2014
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey
- the latest national staff survey
- the Head of Internal Audit's annual opinion over the trust's control environment
- the annual governance statement dated 05/06/2014;
- Care Quality Commission quality and risk profiles dated 13/03/2014
- the results of the Payment by Results coding review.

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

This report, including the conclusion, is made solely to the Board of Directors of George Eliot Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and George Eliot Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

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

Grant Thornton UK LLP

Grant Thornton UK LLP
Colmore Paza
20 Colmore Circus
Birmingham
B4 6AT

16 June 2014

Appendix 1 – Statement from Stakeholders

In the build up to the production of the Trust's annual Quality Account document there is an opportunity to gain feedback and comments on the detail and content Quality Account from all our key stakeholders, in 2013/14 these included:

- Adult Social Care & Heath Scrutiny Committee
- Warwickshire North Clinical Commissioning Group
- South Warwickshire Clinical Commissioning Group
- Coventry & Rugby Clinical commissioning Group
- Health Watch, Warwickshire
- NHS Trust Development Authority
- North Warwickshire Borough Council
- Nuneaton & Bedworth Borough Council
- Hinckley & Bosworth Borough Council
- GEH Patient Advocacy Forum

See below all statements received following this request:

Response on behalf of the Quality Accounts Task and Finish Group (TFG) set up by Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee with North Warwickshire Borough Council, Nuneaton and Bedworth Borough Council and Warwickshire Healthwatch. This commentary is formally presented on behalf of these organisations, who volunteered their time and expertise to the process.

The new approach developed in 2012 towards developing a more meaningful outcome focussed process for Quality Accounts has been strengthened this year, using the successful work done with GEH in 2012 as an example of good practice. The TFG has welcomed the opportunity to continue to work with GEH over the past six months to consider the implementation of the Priorities on Improvement identified in the previous QA, to work with the Trust on identifying their priorities for the next year and to comment on the 2013/14 Quality Account (QA). To this end, the TFG are supporting GEH to use their QA as an on-going tool for improvement and developing this approach for scrutiny to continue to use the QA as a tool for identifying areas for the overview and scrutiny committee to consider in more depth. Over the past year, the Adult Social Care and Health OSC has scrutinised in some depth some of the priorities selected by the Trust for improvement, such as the work done to reduce pressure ulcers both internally and in the wider community. An important role for overview and scrutiny in the future is to ensure the integration of health and social care services and this approach is highlighted by this work.

The Group have challenged GEH, over the year, to make the experience of patients and staff central to their priorities for QA, and to ensure that QA priorities are locally driven and focussed on outcomes rather than national or CQUIN targets, which the Trust are already performance-monitored against. It is therefore disappointing that the QA this year has taken on a stronger "corporate" image that is more statistical in addressing the Keogh Review and less focussed on the patient experience. The Group feels that there needs to be some consideration given by the Department of Health to establishing the role of Quality Accounts as an improvement tool from a patient and staff perspective and to ensure that Trusts are allowed to structure these documents for a public audience.

The TFG welcomes the improvements that have been made in reducing mortality, infection prevention and improving sepsis management.

There has been a lot of discussion with the Trust to ensure that the work done by the Trust as a result of patient and staff surveys demonstrate how the patient voice is listened to and what is done as a result, rather than focussing on processes. Where the QA identifies recurring areas that have been identified for improvement by patients, it should be made clear what these are and what is going to be done to make improvements. The Group are pleased to endorse the additional document produced by the Trust – Our Year – to highlight the work the TFG knows is being done by staff to make the patient experience a better one.

There is clearly a lot of work being done to improve staff health and wellbeing, but again the QA focusses on processes and there needs to be more evidence of the outcomes of those processes.

The graphical information within the section on Incidents is clearly focussed at clinicians and should follow the narrative, which does provide some context for non-clinician readers.
The Group welcomes the priority to improve documentation and communication with GPs and patients, as well as the priority to continue to develop palliative care across the north Warwickshire area. This reflects the change in culture that needs to happen across health and social care to an integrated service where everyone is responsible for improving health and wellbeing together.

It is disappointing that the priority selected for Patient Safety is around Never Events, as this should (and the Group believes already is) embedded in the work of the Trust. The priority to introduce a duty of candour is however welcomed, as is the on-going focus on falls and medicine management.

The section on patient and staff experience is again process-driven and does not set out how GEH uses what they hear to improve services, although the Group believes this is happening. The Group has been clear that there needs to be work done with the Warwickshire North CCG around how the patient experience and patient journey is measured, and how patient safety is measured. The Group does not, in any way, want to undermine the successes and improvements that have been achieved over what has been a very challenging year, but this QA does not tell the patient and staff story along that journey, or their role in making the improvements, and the Our Year document again goes some way to doing that.

The TFG would like to record their thanks to the staff who have worked with the Group over the year, and to highlight the clear commitment and loyalty the staff have, which has been instrumental in turning the Trust around. The Group look forward to working with GEH over the next year to monitor progress against the priorities that have been identified, the improvement plan and the patient experience more generally.

Adult Social Care and Health Overview and Scrutiny Committee, Warwickshire County Council - 9th June 2014

NHS Warwickshire North Clinical Commissioning Group (WNCCG) welcomes the opportunity to comment on the draft 2013/14 Quality Account. We do so in the capacity of lead commissioner for George Eliot NHS Trust hospital services and our response adheres to the requirements set out by the Department of Health. This is our draft response as the CCG received the report on 20 May 2014, a final version will be produced after discussion at the CCG Clinical Quality, Safety and Governance committee on the 19 June.
Our review of the draft Quality Account has included checking the accuracy of the information presented against that which we have received in relation to the services commissioned, and commenting on the information that we, and our public might expect to see in the account.

An overall comment about the account this year, is that the CCG is pleased to see a clear description of the improvement action taken throughout the year to address the findings from the review led by Sir Bruce Keogh, namely issues and concerns regarding the quality of care provided and clinical outcomes. The design, implementation and monitoring of Care bundles for Sepsis, Pneumonia, Heart Failure and Obstructive Airways disease has underpinned this improvement. Substantial progress has also been made in addressing shortfalls in clinical staffing and moves towards 7 day senior clinical cover are amongst other elements of a recovery action plan which has been implemented. Not all of the actions have been in place for the whole year, however the CCG and, we expect the public, welcome the Trust achievement in lowering mortality rates to expected levels, and look forward to the Trust sustaining the improved performance.

Additional to the report on progress against the priorities identified following the Keogh Review, the CCG acknowledges the progress made supported and facilitated by CQUIN (Commissioning for Quality and Innovation), Quality Improvement and other contractual monitoring measures. It is noted that the Trust report the findings of the unannounced CQC visit early in February 2014, and that a full CQC review was undertaken in April 2014 the formal outcome of which is awaited.

In respect of the information presented in the report and that which the CCG would have expected to see, we make the following comments;

- It is evident from data provided that there has been an increase in incident reporting at the Trust, this was one element of the CQUIN program for 2013/14. This is welcomed, as a demonstration of a demonstration of improved organisational culture which is open to learn from adverse patient events. The Quality Account however makes little mention of the number of 'Serious Incidents' and 'Never Events' reported, and would benefit from additional narrative in respect of themes, trends and actions taken following Root Cause Analysis investigations, which would evidence organisational learning;
- The CCG welcomes the very positive report concerning the Patient Advice and Liaison Service; both the number of enquiries signifying accessibility to the service, and the promptness of response. No mention is made however of the number of formal complaints, trends and themes nor challenges faced by the Trust in responding to these in a timely manner;
- It is satisfying to see that the Trust has demonstrated its willingness to engage with the community which it serves, demonstrating an openness which is also reflected in its adherence to 'duty of candour' guidance. Clearly public and patient feedback is important to any Acute Trust and the Friends and Family Test is designed to facilitate patients providing such feedback in a form which is clear and which enables the organisation to benchmark itself against other acute healthcare providers;
- Progress is noted with regard to the overall response rate and scores of the Friends and Family Test which as reported includes in-patient, A&E and Maternity services, though challenges have been experienced in achieving the A&E response targets in particular. Noted is the introduction of a text messaging service for A&E respondents with a subsequent improvement in response rates; it is hoped that the improvement will be sustainable going forward;
- The inpatient survey, as last year, appears not to have made the progress planned although as reported describes an improvement is some areas. The Quality Account describes that 'the Trust were disappointed to see no improvement in other areas', however no narrative is provided with regard to the specific areas that were not improved, nor and detail of actions proposed to improve the patient experience in these area's;

- It is the CCG's view that the Quality Accounts should have more comprehensively reported on the outcomes achieved in respect of the Safety Thermometer, specifically in regard to Pressure Ulcer prevalence as this was a significant concern for the Warwickshire Health Overview and Scrutiny Committee and members of the public.

The CCG welcomes the proposed development and future implementation of a four year Quality Strategy and notes that the Quality Improvement Priorities for 2014/15 seek to establish priorities for the first year. The CCG fully supports these quality goals which reflect the requirements of the Francis Inquiry and more locally Keogh review though as yet cannot reflect any findings of the CQC inspection.

The CCG thank you for sharing the Quality Account report with us and we welcome the opportunity to continue to work with George Eliot Hospital NHS trust in achieving the goals for the year 2014/15.

Andrea J Green, Chief Officer, NHS Warwickshire North Clinical Commissioning Group

Email from Alan Franks, Managing Director, Nuneaton & Bedworth Borough Council:

I can endorse that your focus as a NHS Trust has been on delivering sustainable improvements to quality of care. It is certainly pleasing and reassuring to see the positive steps that are being taken in a number of key areas, for eg mortality, incident reporting and infection control and I would clearly endorse the actions you have taken to bring about this level of substantial improvement.

I recognise that you are at the beginning of a journey and while there is a long way to go, the improvements in priority areas are certainly encouraging and you have focused your actions to improve the quality of care. It is also pleasing to note, the ambitious targets that have been set, ones that have been embraced by all the staff at the Hospital.

I would urge you to keep members of the public informed, including Stake Holders in relation to performance as against targets, and I would suggest six months into the new Quality Strategy that you liaise with ourselves in order to present a progress report to the relevant Overview and Scrutiny Panel.

To conclude, this is a very encouraging report, the emphasis must now be on sustainability and communication to include the public, stakeholders, staff and patients.

Patient Advocacy Forum Statement on Quality Accounts:

PAF members attended all meetings of the Quality Accounts Review Group. This group is well attended by GEH staff members and the Overview and Scrutiny Group of Warwickshire County Council.

These meetings were positive and agreement on the priorities for the Quality Account 2014/15 were reached early in the process.

All input is regarded as important and a true balance of 2013/14 targets with graphs and explanations made for easy reading, valuable input was made by PAF members and others.

All suggestions and feedback has been noted and incorporated into the finished document.

The final draft was received and agreed by all members of the Patient Advocacy Forum.

The priorities covered the Keogh Review recommendations and how priorities are being achieved will continue to be monitored by PAF members over the coming year.

Appendix 2 – Amendments

Following receipt of the many constructive comments and meaningful and useful feedback from our stakeholders, see Appendix 1 above, the Trust has considered all the comments received and the Quality Account document has been amended to reflect all comments accordingly.

Overall the process the Trust has put in place to review quality performance and monitor the key quality improvement priorities in the buildup to the publication of the Quality Account documents has proved a positive experience for all taking part in the process, which included the involvement and working closely of all key stakeholders.

Appendix 3 – Glossary

Acute Care:

Medical or surgical treatment usually provided in a district general, or acute, hospital;

Amber Care Bundle:

The AMBER care bundle provides a systematic approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months. It is an intervention that can fit within any care pathway or diagnostic group for patients whose recovery is unclear;

Care Pathway:

The process of diagnosis, treatment and care negotiated with the involvement of the patient and his/her carer or family;

Care Bundle:

A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. Multidisciplinary teams work to deliver the best possible care supported by evidence-based research and practices, with the ultimate outcome of improving patient care;

CASTLE

Care and Support towards life's end – The CASTLE clinical implementation group is the C&W forum for providers of EOL care, the CASTLE website www.c-a-s-t-l-e.org.uk is the Coventry wide resources for providers and users of EOL care services;

CQC – (Care Quality Commission):

Is the independent regulator of Health and Social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations;

CCGs (Clinical Commissioning Groups):

Commission most of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed, and ensuring that they are provided. CCGs are overseen by NHS England, which retains responsibility for commissioning primary care services such as GP and dental services, as well as some specialised hospital services. All GP practices now belong to a CCG, but groups also include other health professionals, such as nurses;

Clinical Audit:

A continuous process of assessment, evaluation and adjustment of practice by doctors, nurses and other health professionals;

Clostridium Difficile:

An intestinal infection commonly associated with healthcare;

CQUIN (Commissioning for Quality & Innovation):

The CQUIN payment framework is a national framework for locally agreed quality improvement schemes. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and Provider, with active clinical engagement. The CQUIN framework is intended to reward genuine ambition and stretch, encouraging a culture of continuous quality improvement in all providers;

EDS (Equality Delivery System):

9 Characteristic Groups = Age, Disability, Gender re-assignment, Marriage and civil partnership (but only in respect of eliminating unlawful discrimination), Pregnancy and Maternity, Race (this includes ethnic or national origins, colour or nationality), Religion or belief (this includes lack of belief), Sex, Sexual orientation;

HSMR (Hospital Standardised Mortality Ratio):

HSMR is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect;

IG Toolkit

The Information Governance Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments;

Incident

An event or circumstances which could have resulted, or did result in unnecessary damage, loss or harm to a patient, member of staff, visitor or member of the public:

- Moderate - an incident resulting in moderate medical attention e.g. sutures, staff injury sustained at work resulting in more than 3 lost days from work or disruption to services, actual damage to property: Examples: - Recurrent slips, trips and falls, injuries needing treatment such as sprains, strains and burns, damage to property, with obvious cost implications to the Trust, verbal aggression, physical violence, or intimidation, incident resulting in fire brigade attendance, clinic treatment or surgical cancellations.
- Severe - any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. For example these could be incidents that occur within the Trust or on one of the Primary care services managed by the Trust that result in serious injury, long bone / skull fractures, loss of multiple services in an area, loss of sight or a fatality;

Length of Stay

The duration of a single episode of hospitalisation;

MECC (Making Every Contact Count)

Encouraging people to make healthier choices to achieve positive behaviour for better health.

- Systematically promoting the benefits of healthy living across the organisation
- Asking individuals about their lifestyle and if they want to make a change
- Responding appropriately to the lifestyle issue/s once raised
- Taking the appropriate action to either give information, signpost or refer service users to the support they need;

Members Advocacy Panel (MAP)

A group of volunteers who became advocates to represent the Hospital within the community and are selected from the Trust's membership base which is drawn from across the hospital catchment population ie Nuneaton & Bedworth, North Warwickshire and Hinckley & Bosworth areas;

Methicillin-Susceptible Staphylococcus Aureus (MSSA) & Methicillin-Resistant Staphylococcus Aureus (MRSA)

Acteria that can cause infection in a range of tissues such as wounds, ulcers, abscesses or bloodstream;

MSSA Bacteremia - Methicillin-Sensitive Staphylococcus Aureus (MSSA)

Is a strain of the bacteria (germ) staphylococcus aureus. It is commonly found on human skin and mucosa (lining of mouth, nose etc). The bacteria live completely harmlessly on the skin and in the nose of about one third of normal health people;

MDT Multi-disciplinary Teams: a team of medical and nursing professionals who meet to discuss a patient who has more than one medical problem to ensure that treatment administered works together within a set care plan;

National Patient Survey

The NHS national patient survey programme was established as a result of the Government's commitment to ensuring that patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services. All NHS Trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. One main purpose of these surveys is to provide organisations with detailed patient feedback on standards of service and care in order to help set priorities for delivering a better service for patients. There are inpatient and outpatient surveys;

NPSA (National Patient Safety Agency)

The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector;

NICE (National Institute for Clinical Excellence)

An independent organisation responsible for providing national guidance on promoting good health and treating ill health;

Never Events

Are inexcusable actions in a health care setting, the "kind of mistake that should never happen;

ORMIS theatre system

Operating Room Management Information System - The ORMIS system is a simple tracking the system which allows users to manage appointments, theatre schedules, patient records, care planning and performance reports aiming enhance the patients' journey, and safety, from waiting list to recovery;

Overview and Scrutiny Committees

Since 2003, every local authority with social services responsibilities have had the power to scrutinise local health services. OSCs take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into health care decisions and make the NHS more publicly accountable and responsive to local communities;

PALS (Patient Advice & Liaison Service)

This service provides support to patients, carers and relatives, representing their views and resolving local difficulties speedily.

Patients Advocacy Forum (PAF)

A group of volunteers who talk to the patients and their relatives carry out approved projects within a work plan makes recommendations to the hospital for improvements.

Perceptorship

A period (of preceptorship) is a time to guide and support all newly qualified practitioners to make the transition from student to develop their practice further;

PREMs (Paediatric Reporting Experience Measures)

A survey developed 'by the children, for the children' which is a tool to measure the experience of paediatric patients 0-16 years in all urgent and emergency care settings ensuring that their views are captured and evidenced based feedback is given to those providing their care;

PROMs (Patient Reported Outcome Measures)

PROM assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys;

RCA (Root Cause Analysis)

Root cause analysis is a problem solving process for conducting an investigation into an identified incident, problem, concern or non-conformity. Root cause analysis is a completely separate process to incident management and immediate corrective action, although they are often completed in close proximity. Root cause analysis (RCA) requires the investigator(s) to look beyond the solution to the immediate problem and understand the fundamental or underlying cause(s) of the situation and put them right, thereby preventing re-occurrence of the same issue. This may involve the identification and management of processes, procedures, activities, inactivity, behaviours or conditions;

REC (Research Ethics Committee)

Research Ethics Committees are independent committees that review the ethical issues within research projects that involve people as participants or their data or tissues;

Sepsis Bundle

Sepsis Six (bundle) and other interventions are designed to treat patients with sepsis and to prevent them from deteriorating. The Sepsis Six consists of a variety of clinical interventions for use on such patients in a proactive and timely manner;

SHMI (Summary Hospital Mortality Indicator)

A trust's SHMI value is the ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die, on the basis of average England figures given the characteristics of the patients treated there. The baseline SHMI value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment there was exactly the same as the number expected using the SHMI methodology;

Transform

The Transform Programme aims to improve the quality of end of life care within acute hospitals across England, enabling more people to be supported to live and die well in their preferred place.

VTE (Venous Thromboembolism)

A condition in which a blood clot (thrombus) forms in a vein;

WHO (World Health Organisation) Checklist

The WHO surgical safety checklist (world health organisation check list) was established in 2008 to improve the safety of surgical cases and to avoid critical incidents and never events occurring. The process surrounding it has improved compliance with standards and decreased complications from surgery;

Appendix 4 – Feedback Form

We hope you have found this Quality Account informative, interesting and helpful

To save costs the report is available on our website and hard copies are available in waiting rooms or on request.

We would be grateful if you would take the time to complete this feedback form and return it to:

Patient Feedback
George Eliot Hospital NHS Trust
FREEPOST (CV3262)
College Street
Nuneaton CV10 7BR
Email: pals@geh.nhs.uk

How useful did you find this report?

[ ] Very Useful
[ ] Quite useful
[ ] Not very useful
[ ] Not useful at all

Did you find the contents?

[ ] Too simplistic
[ ] About right
[ ] Too complicated

Is the presentation of data clearly labelled?

[ ] Yes, completely
[ ] Yes, to some extent
[ ] No

If no, what would have helped?

Is there anything in this guide you found particularly interesting and helpful/not interesting/helpful?

Comments

Acknowledgements

The George Eliot Hospital NHS Trust would like to thank the corporate and divisional teams for their contribution to the production of this year's Quality Account.

The Trust would like to acknowledge the invaluable contribution of the Quality Account Review Group (QARG) which meets regularly to ensure the process to support the review of the 2013/14 priorities takes place which contributes immensely to the setting of key priorities for the 2014/15 year. Membership of the QARG, which is chaired by the Medical Director, includes representation from the Warwickshire North Clinical Commissioning Group, Health watch, Members and Patient Advocates and the Adult Social Care and Health Overview and Scrutiny Committee.

Readers can provide feedback on the quality account and make suggestions for the content of future reports by completing the feedback form at Appendix 4 above.

The Trust has access to interpreting and translation services. If you need this information in another language or format please contact 024 7686 5550 and we will do our best to meet your needs.