Quality Account
2012/13

‘our vision is to EXCEL at patient care’
<table>
<thead>
<tr>
<th>Section/Title</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1: Statements on Quality</strong></td>
<td>1</td>
</tr>
<tr>
<td>Statement from the Chief Executive</td>
<td>1</td>
</tr>
<tr>
<td>Statement of Directors Responsibilities in Respect of the Quality Account</td>
<td>2</td>
</tr>
<tr>
<td><strong>Section 2: Looking Back on 2012/13</strong></td>
<td>3</td>
</tr>
<tr>
<td>Priority 1: Reductions in Hospital Standardised Mortality Ratio</td>
<td>3</td>
</tr>
<tr>
<td>Priority 2: Ensure High Quality Care for Older People, including those who have fallen or are at high risk of falls, or have poor bone health and those suffering from dementia</td>
<td>6</td>
</tr>
<tr>
<td>Priority 3: Ensuring Services are Fair, Personal and Diverse for all our Patients and Staff</td>
<td>8</td>
</tr>
<tr>
<td>Priority 4: Improving the Patient Experience for all our Patients</td>
<td>9</td>
</tr>
<tr>
<td>Priority 5: Making Every Contact Count (MECC)</td>
<td>14</td>
</tr>
<tr>
<td><strong>Statements of Assurance from the Trust Board</strong></td>
<td>16</td>
</tr>
<tr>
<td><strong>Section 3: Quality Improvement Priorities 2013/14</strong></td>
<td>27</td>
</tr>
<tr>
<td>Priority 1: Mortality</td>
<td>29</td>
</tr>
<tr>
<td>Priority 2: Infection Prevention</td>
<td>30</td>
</tr>
<tr>
<td>Priority 3: Patient &amp; Staff Experience</td>
<td>30</td>
</tr>
<tr>
<td>Priority 4: Culture</td>
<td>31</td>
</tr>
<tr>
<td>Priority 5: Making Every Contact Count (MECC)</td>
<td>33</td>
</tr>
<tr>
<td><strong>Annex 1: Audit Commission Limited Assurance Report</strong></td>
<td>36</td>
</tr>
<tr>
<td><strong>Appendix 1: Statements from External Stakeholders</strong></td>
<td>40</td>
</tr>
<tr>
<td><strong>Appendix 2: Amendments</strong></td>
<td>44</td>
</tr>
<tr>
<td><strong>Appendix 3: Glossary</strong></td>
<td>45</td>
</tr>
<tr>
<td><strong>Appendix 4: Quality Account Questionnaire Feedback Form</strong></td>
<td>50</td>
</tr>
<tr>
<td><strong>Acknowledgements &amp; Feedback</strong></td>
<td>51</td>
</tr>
</tbody>
</table>

Please note, as used in last year’s document the signs below are shown throughout Section 2 when ‘looking back’ against 2012/13 key priorities and are explained as:

- ✔️ = Achieved
- 🔄 = Partially met/ongoing
- ❌ = Not met
SECTION 1: Statements on Quality

Statement from the Chief Executive

Welcome to the 2012/13 Quality Account for the George Eliot Hospital NHS Trust.

The past year has once again been challenging, but has seen its fair share of successes along with several areas where we need to improve. A tough cost improvement plan and changes in the local health economy have made for an interesting but demanding environment in which all of our staff have needed to pull together to ensure we are meeting our contractual and quality obligations and delivering a high standard of care.

Whilst this document looks back at how we have performed against key quality improvement priorities in 2012/13, it also sets out our quality agenda for the 2013/14 financial year. There have been several success stories that stand out from the past year, perhaps most notably significant reductions in hospital acquired Clostridium Difficile and hospital acquired pressure sores.

Mortality rates have shown signs of improving but there is still a lot of work to do if we are to bring these in line with the national average. Perhaps the most disappointing area of performance from the past year has been in the prompt treatment of cancer patients as the Trust failed to hit its target for treating urgent cancer referrals within 62 days. However, plans are in place to urgently address this issue and we expect to get back on course in the coming months.

Looking ahead, the Trust’s Board of Directors has publicly acknowledged that the organisation is financially and clinically unsustainable in the long-term in its current format. This is why we are proactively seeking a partner organisation with whom to secure the long-term future of the hospital and ensure the local community continues to receive high quality care that meets their needs. By the time next year’s Quality Account document is produced, we expect to know who this organisation will be.

I would like to conclude by thanking each and every member of staff for their continued hard work and dedication. They are the greatest asset we have and none of our successes would be possible without their daily contribution and commitment to the hospital.

Local people should be very proud of them and all the work they do.

Kevin McGee, Chief Executive
SECTION 1: Statements on Quality

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:

[Signatures]

.............................................. ..............................................
Chairman Chief Executive
SECTION 2: Looking Back 2012/13

New Reporting Requirements 2012/13

Following notification of new reporting requirements sent out by the Department of Health, Monitor and the NHS Trust Development Agency (Gateway reference numbers 17240/18690), advice of proposed changes and the introduction of mandatory reporting against a small, core set of quality indicators were announced for inclusion in this year’s Quality Account. Where relevant, links to these quality indicators have been detailed within the Trust's existing 2012/13 key priorities below; response to all other key performance data can also be found under the headings of Domains 1, 3, 4 and 5 respectively.

It should be noted that when ‘looking back on 2012/13’ each priority and indicator set out within section 2 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 2010/11 and 2011/12.

Priority 1 – Reductions in Hospital Standardised Mortality Ratio

Target for 2012/13

1. HSMR mortality ratio and SHMI ratio have reduced by at least 5%:
   - April 2012 to March 2013 HSMR = 116, rebased HSMR for April 2011 to March 2012 was 120 (showing a 3% reduction);

HSMR Value and Banding:

- The introduction of the ‘sepsis bundle’ into the Medical Early Warning System (MEWs), an electronic scoring system, will focus our attention to respond to increasing early warning scores. Better use of this electronic trigger tool will be key in supporting the work above and contribute to reducing our mortality rates further;
- The appointment of additional clinical coding staff has improved the administrative process of coding, reducing incidence of ‘coding errors’ in Health Record Groups (HRG) coding which impacts on HSMR rates.
GEH HSMR Performance comparative to the West Midlands area:

HSMR - West Midlands Comparisons Apr 2012 - Mar 2013

Domain 1: Preventing people from dying prematurely:
Summary Hospital-Level Mortality Indicator (SHMI):
- SHMI for October 2011 to September 2012 was 1.10 representing a 0.13 point reduction on the previous figure of 1.23 for October 2010 to September 2011 (a fall of 10%);

i) SHMI value and banding:
ii) As a requirement under Domain 1, when reporting on the percentage of admitted patients whose treatment included palliative care: as the GEH do not employ doctors who work solely within the palliative care specialty the Trust can report 0%. There were however 277 patients whose treatment included palliative care, a rate of 1.1% of all patients treated at this hospital;

iii) The percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care was 14.2%.

2. Implementation and review of the action plan emanating from the Mortality review:
- The action plan arising from the Mortality Review is being monitored on a monthly basis. Monthly meetings also take place with external stakeholders ie the Primary Care Trust (PCT) or the Clinical Commissioning Groups (CCGs).
- A review of the Trust’s mortality figures by the Strategic Health Authority (SHA) took place in October 2012, with a further review into the quality of care and treatment provided at the hospital planned for May 2013 by the DoH’s Medical Director, Professor Sir Bruce Keogh. A public report will be published following the outcome of this review.
- In support of the above a greater emphasis has been placed on the completion of the World Health Organisation (WHO) checklist in theatres and the figures for this stand at 99.9%, with one ‘never event’ recorded over the last 12 months. The Board have supported this process with visits to theatres by both the Executive and Non-Executive Directors of the Trust.

3. By March 2013 a clear strategy will be in place which will improve access to key patient summary information at the point of care:
- As well as chairing the Medical Records Task and Finish Group, the Medical Director has taken chairmanship of the Trust’s Health Records Management Committee; to improve the quality and availability of patient records. A key improvement has been the appointment of additional ward clerks, resulting in the...
SECTION 2: Looking Back 2012/13

administrative service provided at ward level to cover from 8 am till 8 pm Monday to Friday.

- The improvement following this action will be measured and monitored as a Commissioning for Quality and Innovation (CQUIN) for 2013/14.

Priority 2 – Ensuring high quality care for older people, including those who have fallen, or are at high risk of falls, or have poor bone health and those suffering from dementia

Target for 2012/13

1. **Dementia Care - By March 2013 a clear strategy will be in place to improve the care of patients with dementia:**
   - A target for staff training was set at 85% for 2012/13 and the compliance level at the end of March 2013 was 94% of all staff having received basic dementia awareness training. This training has been designed to raise staff consciousness of the complexities of dementia and the needs of people who suffer from it, and how we all play a part in meeting these needs. The majority of staff can now recognise and anticipate signs of challenging behaviour and are able to take appropriate actions to remedy situations before escalation can take place.

   The Trust’s Dementia Group have worked actively on various elements of the composite approach, which is the strategy for Dementia, designed to improve the care of patients with dementia in the acute setting. A flavour of their achievements made to date is outlined below:
   - Established a “Don’t Move Me” process for patients with dementia or confusion so they don’t have multiple ward moves, unless it is for their clinical benefit;
   - Implemented a visual identifier on the status ‘at a glance’ board to highlight to all staff when a patient may need support with eating, drinking and maintaining their safety, privacy and dignity;
   - Adopted the ‘This is Me’ patient passport, published by the Alzheimer’s Society, to ask patients and their families/carers the important things about someone’s life history that will help in providing sensitive patient centred care;
   - Introduction onto our wards of a volunteer role (with a special interest in supporting patients with dementia).

2. **Adopt and implement the New Cross Hospital model for ‘delivering excellence in dementia care’ in Acute hospitals:**
   - The implementation of the Wolverhampton Composite (best evidence care) approach to improving dementia care for patients in acute general Trusts is ongoing. Two pilot wards have been identified where improvements are being implemented and, once established, will be rolled out across the Trust;
   - An important part of the work is to define the measures of good quality from the patients and carer perspective and in order to do this a number of metrics have been agreed. By utilising a ‘care bundle’ approach and adding to the existing nurse sensitive indicator process, practice is monitored on a monthly basis. From April 2013 baseline information will be collected and will be used to drive the continuous improvement process for patients requiring dementia care;
   - The above is also referenced in the achievement of CQUIN (4) 2012/13.
3. **By March 2013 implement an information and performance management system:**
   - In the UK it is estimated that there are 800,000 people with dementia and that this number is expected to rise to one million by 2021. It is also widely acknowledged that there are many people for whom a diagnosis is not made until the disease is well progressed as the early symptoms are simply put down to ‘old age’. The Trust is rising to the dementia challenge through continuing to work towards the national quality improvements standards for detecting and referring people for diagnosis. The title of the initiative is called FAIR: Find, Assess and Investigate and Refer. The scheme is designed to improve the detection and diagnosis of people over 75yrs of age who potentially may have dementia by carrying out a simple screening procedure on admission.
   - For 2012/13 the work undertaken to implement an information and performance management system has been successful to date, work will continue (as shown in 1 & 2 above) in 2013/14 and will be monitored and reported within the monthly quality report, received at Board level.

4. **Prevention of falls; a target of a 5% reduction in falls by March 2013:**
   - Improved assessment and intervention for patients assessed at high risk of falling was put in place to meet the 5% target;
   - The work undertaken for the first 11 months of the 2012/13 year showed the Trust was on track to meet the 5% reduction target. However, during March 2013 there was a sharp rise in the occurrence of patient falls which coincided with high numbers of acutely ill patients who required our care, and the target was not met;
   - Analysis shows that some falls remain with fracture (the most severe harm), and we are working towards a zero tolerance to avoidable falls in this category;
   - Further training has been undertaken by staff using the Virtual Interactive Teaching & Learning (VITAL) programme, which is a suite of on-line learning tools, (including falls) with a testing of knowledge. All qualified nursing staff are required to achieve 100% on these indicators;
   - Nurse Sensitive Indicators are monitored monthly by audit of patient documentation at the bedside to ensure appropriate assessments are being completed. The teams work closely to improve, where required, and celebrate where they have done well;
SECTION 2: Looking Back 2012/13

- A Root Cause Analysis (RCA) tool has been developed in response to improving the quality of incident investigation and is now a standard requirement of all investigations into falls within the Trust;
- Stronger links on the falls work to that of the care of dementia patients are being made as a number of these falls are due to the confusion and disorientation of being in an unfamiliar setting. The Trust has invested in falls alarms for chairs and beds for high risk groups.

Priority 3 – Ensuring services are fair, personal and diverse for all our patients and staff

Target for 2012/13
1. Evidence of service improvement through our patient and staff surveys:
   This section deals solely with the work of the Equality, Diversity and Human Rights Group, established in 2012, and links directly to service improvement for our patients, workforce and the diverse communities and groups the Trust serves. Reference to the patient and staff survey can be found in later chapters of this document.
   - The Equality, Diversity and Human Rights Group has revised its terms and conditions and membership to be more reflective of the need to embed all activities into core Trust business;
   - Using the Equality Delivery System (EDS), work has been undertaken with the nine characteristic groups (see glossary) to collect evidence and identify gaps in our service relating to all aspects of the equality agenda;
   - A workshop took place with the staff responsible for the delivery of the EDS actions and representatives from the key characteristic groups. The aim of the workshop was to train all members of the group to assess progress against the plan using a RAG (red/amber/green) rating system;
   - The Trust has developed a Public Health Strategy which was approved by the Board in July 2012. The Public Health Strategy was the outcome of a workshop including members of staff from a range of departments/services. This Strategy focuses on three key activity areas – Workplace, Improving health and Corporate citizenship. A Public Health Strategy Group has been established to ensure delivery of outcomes associated with the Strategy;
   - To increase the percentage of staff receiving updated information on equality, diversity and human rights an on-line in-house equality and diversity training programme has been developed and is now being offered. This training includes the Equality Diversity core dimension and the EXCEL Value Pledges.

2. By March 2013 to have implemented a training programme:
   - The EDS training programme for 2012/13 was fully implemented and work throughout this period to monitor the Trust’s equality and diversity performance has led to many members of the community becoming engaged in the delivery of the ongoing EDS programme which includes:
     - The development of a new George Eliot Hospital website taking into account the nine characteristic groups to ensure access and type of information offered is suitable for all individuals;
SECTION 2: Looking Back 2012/13

- A review of access through patient choice has been undertaken with the four Alternative Providers for Medical Services (APMS) GP Practices to ensure equitable access to services for all. Processes have been put in place to support some communities to make choices;
- An ethnicity questionnaire has been sent out to every formal complainant. An evaluation of the responses has informed the department of the ethnicity and age of complainants. Work is underway with Patient Advocacy Liaison Service (PALS) to ensure that all ethnic groups feel comfortable to make a complaint;
- Clinics have been held in community settings to support the fasting period of Ramadan;
- A programme of Director visits to all local community forums has been set up, this has enabled communities to be given the same messages of Trust activities and gain feedback from the diverse groups represented;
- Service reviews for all clinical specialties have taken place to inform the Trust’s Clinical Strategy;
- An equality impact assessment is now undertaken on all new business developments;

- An action plan linked to the above work has been set, with performance maintained and monitored by the EDS group reporting to the Trust’s Human Resources Group;
- Work will continue throughout 2013/14 in partnership with the community, with representation from the nine characteristic groups, to introduce and embed the initiatives and action further improvements as they are presented and agreed by the EDS group.

Priority 4 – Improving the Patient Experience for all Our Patients

Target for 2012/13
1. To improve our rating in the 2012 inpatient survey so that we are within the top 50% of Trusts in relation to overall satisfaction:

- The national cancer patient experience survey for 2011/12 consistently ranked the George Eliot Hospital in the highest scoring 20% of Trusts;
- The following gives a summary overall of the national inpatient survey for 2012 (as provided by the Clinical Quality Commission (CQC)):

<table>
<thead>
<tr>
<th>Overall Domain</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and Waiting</td>
<td>83.3</td>
<td>78.8</td>
<td>84.5</td>
</tr>
<tr>
<td>Safe, high quality coordinated care</td>
<td>60.4</td>
<td>60.4</td>
<td>59.5</td>
</tr>
<tr>
<td>Better information, more choice</td>
<td>62.6</td>
<td>62.5</td>
<td>61.1</td>
</tr>
<tr>
<td>Building closer relationships</td>
<td>80.9</td>
<td>79.9</td>
<td>81.0</td>
</tr>
<tr>
<td>Clean comfortable friendly place to be</td>
<td>76.5</td>
<td>77.1</td>
<td>77.1</td>
</tr>
<tr>
<td>Overall</td>
<td>72.7</td>
<td>71.7</td>
<td>72.7</td>
</tr>
</tbody>
</table>

- Overall there has been no significant shift from the previous years’ surveys on how our inpatients view their total experience whilst in our care, and we take this information as valuable feedback and an indicative measurement of patient experience per say. Any areas of concern raised are looked at in detail and fed back to medical staff and clinical areas to raise awareness and work towards future improvements.
SECTION 2: Looking Back 2012/13

2. **To improve the number of positive comments made in our local patient experience feedback and where a written complaint is received, improve the length of time taken to resolve a complaint:**

- In 2012 the Trust took part in the Midlands and East SHA Friends and Family test pilot. As part of this pilot smiley cards were re-designed to reflect the changes brought in regionally to newly introduced Friends & Family Test questions – see the NHS Choices web site the NHS Choices web site ([www.nhs.uk](http://www.nhs.uk)) and go to NHS England about NHS services for further information about the Friends & Family testing process.

- Comments received from service users for 2012/13:

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>%</th>
<th>2012/13</th>
<th>%</th>
<th>Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>564</td>
<td>18%</td>
<td>282</td>
<td>10%</td>
<td>✔️</td>
</tr>
<tr>
<td>Amber</td>
<td>254</td>
<td>8%</td>
<td>164</td>
<td>6%</td>
<td>✔️</td>
</tr>
<tr>
<td>Green</td>
<td>2291</td>
<td>74%</td>
<td>2319</td>
<td>84%</td>
<td>✔️</td>
</tr>
<tr>
<td>Total</td>
<td>3109</td>
<td></td>
<td>2765</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Overall positive comments received from our patients have increased from 74% in 2011/12 to 84% for the 2012/13 year;
- However it should be noted that there was a reduction of 11% in the total number of ‘smiley card’ responses (from 3109 in 2011/12 to 2765 in 2012/13) received by the Trust. This is likely to be due to the introduction of Friend and Family testing (FFT) in April 2012 where over 2012/13 the Trust surveyed 2647 patients and averaged a monthly response rate of 19% against the SHA target of 10%;
- The following is a sample of feedback received from the smiley cards over 2012/13:

  ...."The health care support workers ran the ward like a well oiled machine, they are all caring, supportive and helpful and often work over their finish time if the patients require additional care – they are a credit.”

  ...."We would like to thank all of the staff that work on **** ward and involved in the care of ****. who passed away on ****, but during his stay we are most grateful for the way that you looked after him and for making his stay as comfortable as possible. It was evident during our visits that he felt safe and secure by the kind and personable attention that you gave him; indeed we could not have asked for better. We would like to say a special thank you to ****, just for being ****, his interactions and humour definitely connected with ****, allowing him to keep cheerful. Lastly our gratitude is for the care and kindness that you showed to us and his other family and friends. It is hard to find the right words to put across what we really feel and thank you doesn’t feel quite enough, but you are a marvellous team and we will always be grateful to you all.”

  ...."The nursing staff work hard and are dedicated, resulting in patients having to wait for attention. There is also a lack of communication at times again due to pressure from staffing levels.”
..."The ticket issuing machines on the main car park are unreliable and are not registering the amount of £ accurately, hence, today I paid £2, ticket issued for 45 minutes. I then put in a further £2 to enable parking. It was then infuriating to be told inside the building that a purchase of any ticket is valid for parking, regardless of time."

- **On improving the length of time to respond to written complaints**, a target was set for 2012/13 for a 90% response rate of all written complaints received to be responded to and resolved within the Trust’s timeframe of 25 working days.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Complaints handled</td>
<td>323</td>
<td>266</td>
<td>293</td>
<td>n/a</td>
</tr>
<tr>
<td>% of responses within 25 days</td>
<td>66% (214)</td>
<td>76% (202)</td>
<td>94%</td>
<td>✓</td>
</tr>
<tr>
<td>% of responses where additional time agreed</td>
<td>34%</td>
<td>24%</td>
<td>6%</td>
<td>✓</td>
</tr>
<tr>
<td>Referrals for independent review by Parliamentary and Health Service Ombudsman (PHSO)</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>n/a</td>
</tr>
</tbody>
</table>

3. **To be in the top 50% of Trusts performance regarding the net promoter question**:
   - By March 2013 the Trust achieved a net promoter score (NPS) of 64, a good result for the Trust, and represents an improvement from 47 in April 2012. However we were not in the top 50% of Trusts performance regarding NPS;
   - The NPS was introduced as a regional initiative in April 2012 and will be adopted as a national standard from April 2013. Initially the NPS was for acute inpatients only who were to be asked the ‘question’ at the point of, or within 48 hours of, discharge;
   - In 2012/13 we were required to improve our score by 10 points and achieve a 10% response rate. The Trust has achieved both of these targets. Written comments are provided to staff that use these actions to enhance the services they provide.

**Domain 4: Ensuring that people have a positive experience of care**:
- Responsiveness to inpatients’ personal needs – in response to the first Francis Report ‘key areas of care’, a review of formal complaints received over a 6-month period in 2012 found there was a reduction in concerns raised around basic care in ward areas, and that communication was an ongoing issue;
- Work is also ongoing with the nursing and medical teams, particularly in the rolling out of the EXCEL cultural programme (see also 2013/14 quality improvement priorities below – priority Four ‘Culture’);
- The Trust’s Non-Executive Directors (NEDs) regularly review anonymised complaints and this is used as another form of ‘formal’ feedback and assurance for the Board on the quality of care provided by the hospital;
- From May 2013 NEDs will be assigned to the Divisions (x3) governance meetings where health & safety, incidents, claims, complaints etc are discussed along with actions taken, changes made and lessons learned which gives the Board further
SECTION 2: Looking Back 2012/13

reassurance of the work at directorate level to improve on patient safety and patient experience;

- The percentage of staff who would recommend the hospital to friends or family needing care – our staff survey results showed that 53% of respondents would recommend the standard of care provided by GEH to their friends, or family.

4. Other initiatives and work undertaken in 2012/13 by the Trust resulting in improvements to the overall patients experience are outlined below:

- Two Way Texting – text reminders for patients (pre-appointment) were initiated for outpatients in the middle of 2012 and for Physiotherapy at the beginning of 2013, which has led to a marked reduction in Did Not Attends (DNA’s);
- Endoscopy patients are also sent text reminders and their appointment letter requests them to confirm their appointments, which has led to increased utilisation of the theatre lists;
- Continuation of the ‘one stop’ cataract pathway (clinic) has led to a reduction of the steps in the process, along with the patient receiving their procedure and post op dates on the day of the clinic;
- A pathway has been designed for YAG laser treatment and plastic minor op procedures to be undertaken at the Trust rather than referred to another Trust for treatment. For new patients it will be a one stop appointment, which will result in reduced steps along the pathway and will enable the patient to have their treatment closer to home and reduce the number of appointments they need to attend;
- The Trust has worked effectively with partner agencies across health and social care to improve the delayed transfers of care (DTOC) of patients. For 2012/13 the DTOC target was below the required 3.5% threshold with the position at the end of March 2013 being 2.35%, representing delivery against the national target;
- The GEH and Community Health Services (managed by South Warwickshire NHS Foundation Trust) appointed a Programme Manager at the end of 2012 to embed the 5-a-day discharges on the wards and to lead on an associated project entitled ‘Discharge to Assess’ which enables patients, once medically fit, to be assessed in a community setting rather than an acute hospital bed.
- To further reduce the length of stay of patients, the Trust has a project plan to implement seven day working with the Radiology department being one of the key service areas to start working Saturdays and Sundays. This change is having a significant impact on patient care enabling diagnosis and treatment plans to be set in a more timely way and for a higher number of weekend discharges to take place. The Trust plans to implement seven day working within the Pharmacy Department from April 2013 and is working towards the same model in Physiotherapy.

Domain 3: Helping people to recover from episodes of ill health or following injury:

i) PROMS (Patient Reported Outcome Measures) Outcomes for 2012/13:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>GEH EQ-5D Index</th>
<th>National EQ-5D Index</th>
<th>GEH EQ VAS</th>
<th>National EQ VAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin</td>
<td>67.0%</td>
<td>49.8%</td>
<td>38.6%</td>
<td>38.8%</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>86.3%</td>
<td>87.4%</td>
<td>57.1%</td>
<td>63.7%</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>78.1%</td>
<td>78.4%</td>
<td>56.3%</td>
<td>53.7%</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>50.0%</td>
<td>53.2%</td>
<td>33.3%</td>
<td>42.0%</td>
</tr>
</tbody>
</table>
SECTION 2: Looking Back 2012/13

Definition: EQ-5D = A combination of 5 key criteria concerning general health improvement following an operation; EQ-VAS = Current state of general health (marked on a visual scale) improvement following an operation.

It is worth noting that in relation to the national PROMs data analysis for the same period the GEH performance compared favourably and on par with the national averages in these specialties.

ii) Emergency readmissions to hospital within 28 days of discharge: The DoH publishes national figures on the rates of readmission to hospital within 28 days of discharge for all hospitals, which are standardised to allow for different mixes of patient illnesses at different hospitals. These figures are calculated nationally and so there is a delay in their publication. The most recent readmission rate for GEH, for 2010/11, is 10.73% against a national rate of 11.42%. This was also an improvement of 1.29% on the previous year.

In 2012/13 the Trust looked carefully at readmissions to explore how they may be reduced further. It found that many readmissions are unavoidable due to underlying chronic health problems. The Trust continues to work hard to discharge patients when they are fit to leave the hospital with sufficient support in the community to minimise the likelihood of readmission during the following month.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

i) Based on a total of 97,069 bed days for the year April 2012 to March 2013, there were 16 post-72 hour C. difficile infection cases reported by the Trust (which equates to a rate of 16.48 per 100,000 bed days). This meant that the GEH was under trajectory by 11 cases against the nationally set threshold of 27 cases, for the whole year and an improved performance of a 58% reduction, compared to 2011/12;

ii) The rates of patient safety incidents and percentage resulting in severe harm or death from the NPSA (National Patient Safety Agency) are shown below, NB these figures relate to clinical incidents only ie affecting Patients.

<table>
<thead>
<tr>
<th>Period Covered</th>
<th>No’s of incidents reported</th>
<th>% resulting in severe Harm or death</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr ’10 – Mar ’11</td>
<td>2105</td>
<td>5.7%</td>
<td>Mar ’11 NPSA visited GEH and amended the mapping to ensure submission of data in line with their requirements</td>
</tr>
<tr>
<td>Apr ’11 – Mar ’12</td>
<td>2336</td>
<td>3.5%</td>
<td>From Dec 2012 Incidents were closed and uploaded to NPSA on receipt, rather than waiting for action plan closure.</td>
</tr>
<tr>
<td>Apr ’12 – Mar ’13</td>
<td>2145</td>
<td>0.93%</td>
<td>Sep ’12 – Mar ’13 data submitted to the NPSA, but not validated until Sept 2013</td>
</tr>
</tbody>
</table>

The above gives details of the number of the clinical incidents that have been reported to the NPSA (via the National Reporting & Learning System) since 2010.
SECTION 2: Looking Back 2012/13

Currently the Trust is considered to be a low reporter of such incidents when compared to other similar sized organisations. The Trust has set a target for 2013/14 to increase incident reporting by a further 10% over that reported in 2012/13. The Trust also aims to sustain and build on this increase year on year and to get within the top quartile of incident reporting organisations within our category.

Priority 5 – Making Every Contact Count (MECC)

Target for 2012-13:
1. Train the majority of staff in priority groups ie all frontline staff at induction eg: Pre-op assessment/ Day Procedures Unit, Maternity Services, Respiratory Dept, Gastric Dept, Stroke Unit, A&E/ Emergency Medical Unit, Community Division staff a target of 340 staff from these groups.

By March 2013 work undertaken to meet the above includes:
- E-learning tool available via NHS Local and the Implementation Lead now has access to reports on this. The SHA website was being used to access the e-learning as it is more reliable and accessible than NHS Local;
- Promotion of the e-learning tool to all staff started August 2012. Information has been sent to Managers of the priority areas for 2012/13 to encourage staff to complete the training. Key groups for training is shown above at 1;
- By March 2013 99 staff have completed this training. Whilst this figure is well below the target set the main reason identified for this has been the amount of statutory and mandatory training all staff are expected to complete. This only became apparent following feedback during the course of the year;
- Seven staff attended the ‘Train the Trainers’ course in October however to date most have not yet been active in training. The use of the National Learning Management System is being explored as a replacement option to the NHS Local website;
- Materials to support training, and those trained, were provided by the Arden Cluster and these will be distributed to staff as they complete training;
- MECC training has now been included in the latest version of the Trust Education and Developments Mandatory and Statutory Training Matrix, used by all staff as part of their ongoing learning and is now inbuilt into their annual appraisal process;
- MECC has been incorporated into the Trust’s Public Health Strategy and is regularly monitored by the quarterly Public Health Strategy steering group meetings.

2. Establish recording and monitoring processes for delivery of brief interventions:
- The 4 APMS Practices undertook the Patient Participation Enhanced Service to ensure that patients are involved in decisions about the range and quality of services provided by their GP Practice. The practices promoted this by establishing new Patient Reference Groups to reflect their practice populations, the use of local Patient Surveys and establishment of practice websites have also taken place;
- The 4 APMS Practices each achieved higher Quality & Outcomes Framework (QOF) scores for 2011/12 than in previous years, reflecting the hard work of clinicians and administration staff to improve and deliver quality primary care services to its registered patients. This level work has continued in 2012/13 and
we await the publication of the QOF scores at the end of June 2013 (the results will be published on the Trust’s website www.geh.nhs.uk);

- Further development of recording of brief interventions is taking place, however this will take some time due to the varying data collections processes in different departments;
- The Specialist Dentistry Service set up a systematic mechanism to deliver and record MECC and is shared as an example of good practice. Each member of the public that attends a clinic will be given a MECC sheet to complete and from information supplied staff will be able to signpost to other health care services as required.

3. Monitor referrals to Stop Smoking Services:
   - The activity for Warwickshire Stop Smoking Service (WSSS) continues to be monitored and improvements continue to be forthcoming, however the 2012/13 target (set by the SHA) is unlikely to be achieved. This is most likely to be due to the impact of the upsurge in the use of electronic cigarettes which many people are now using to quit smoking (e-cigs are not currently licensed for use for smoking cessation and are not currently being recommended/prescribed by the NHS);
   - Discussions have taken place on the introduction of e-referrals within the hospital, initially starting with referrals to the stop smoking services (in-house or community). This is a development in response to the MECC agenda and exploring all opportunities to reach those who may be planning to stop smoking.

The graph below shows the cumulative performance, comparative to 2010/11 & 2011/12 of ‘4-week Quitters’ (referred, or self referred) to the WSSS:

- Notes re 2012/13 – 3432 (8.7% down on target of 3,761). The 2012/13 performance has been affected by the upsurge in the use of electronic cigarettes.
- Due the high incidence of pregnant smokers in Warwickshire in 2012, WSSS received additional funding to further develop its specialist Stop Smoking in Pregnancy Service, and now has in post a county-wide co-ordinator and additional staff. This service generally picks up pregnant smokers after their booking appointment with the midwife when the midwife undertakes a test to see if the woman is a smoker, then refers all identified pregnant smokers to the Service (although referrals can be made from any source). Smoking and pregnancy comparative performance data is shown in the table below:
The secondary care Stop Smoking Service has been operational since 2010, helping anyone who would like to stop smoking including patients, carers, relatives, local community, staff and their families. The service has helped patients referred from a variety of sources and in 2012 over 315 people wanting to quit smoking accessed this service:

- We offer support on the wards and in clinic usually on a one-to-one basis, and to family/ friend groups which has proved very successful. We measure quit rates at 4 weeks and after 12 weeks; our success rates are shown in the table below:

<table>
<thead>
<tr>
<th>Numbers</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting a Quit Date</td>
<td>440</td>
<td>374</td>
<td>322</td>
</tr>
<tr>
<td>Quit at 4 Weeks</td>
<td>205</td>
<td>152</td>
<td>136</td>
</tr>
<tr>
<td>Pregnant Smokers</td>
<td>6012</td>
<td>5884</td>
<td>5886</td>
</tr>
</tbody>
</table>

- National Guidelines to support this service is provided by ‘the British Thoracic Society Recommendations for Hospital Smoking Cessation Services for Commissioners and Health Care Professionals.’ - George Eliot Hospital Secondary Care Stop Smoking Service is mentioned in this document.

Statement of Assurance from the Trust Board
The following statements offer assurance that the GEH 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 2012/13 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. No concerns have been identified. The income generated by the 88 NHS services reviewed in 2012/13 represents 82% of the total income generated from the provision of NHS services by the Trust in 2012/13. Where required, a service improvement plan was in place for all services, which was agreed with our commissioning partners (NHS Warwickshire, NHS Leicester City and NHS Leicestershire County and Rutland). The service reviews for 2012/13 do not cover the 4 GP practices or any of the community services such as dental and stop smoking.
The quality of services provided, or subcontracted are reviewed in a variety of ways:

<table>
<thead>
<tr>
<th>Review process</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>External reports and visits</td>
<td>Every year the Trust receives feedback on its services from a wide range of external organisations. Some reviews are initiated by the Trust, others can be unannounced, or as part of a routine inspection programme. All reviews are welcomed by the Trust as an invaluable source of feedback from our clinical and professional peers. Any recommendations made are acted upon promoting continual improvement to services provided at the hospital. Positive comments made by reviewers are always shared with staff at the forefront providing good quality care to all our patients. Examples of such reviews in 2012/13 include: CQC, Royal College of Surgeons, Royal College of Paediatrics and Child Health, Cancer Peer Reviews etc.</td>
</tr>
<tr>
<td>Integrated performance reporting (IPR)</td>
<td>The Board of Directors considers key quality indicators, performance and financial indicators at each monthly meeting. This enables a regular overview of the organisation’s performance ensuring review and monitoring takes place; and all targets and priorities are being addressed.</td>
</tr>
<tr>
<td>Complaints &amp; Compliments</td>
<td>Complaints and PALS enquiries provide a rich source of feedback on the quality of services provided to patients. Data is presented monthly to the Board of Directors via the IPR report where any trends, recommendations made and lessons learnt are discussed and agreed.</td>
</tr>
<tr>
<td>Matrons rounds</td>
<td>Matrons and senior nurses regularly conduct unannounced visits/ inspections of wards and clinical areas in the Trust.</td>
</tr>
<tr>
<td>Board rounds</td>
<td>Executives and non-executives regularly conduct ‘walkabouts’ of clinical areas in the Trust.</td>
</tr>
<tr>
<td>Simply Safer Dashboard</td>
<td>Introduced onto all ward areas in 2012, the dashboard considers compliance that patient assessments/documentation are taking place and any outcomes for the patient are recognised and followed up with the appropriate action.</td>
</tr>
<tr>
<td>Patient experience reporting</td>
<td>Smiley cards continue to be a great source of feedback for the Trust from patients, carers and relatives to gain views on real-time experience in addition to the internal surveys that take place and use of the impressions and NHS Choices websites. The Friends &amp; Family Test was introduced in April 2012 and is an essential tool in gaining real time feedback from our patients where areas of concern raised can be reviewed and action to rectify and improvements made.</td>
</tr>
<tr>
<td>Membership surveys</td>
<td>Over 2012/13 we have continued to engage with our membership using questionnaires and surveys as required. Results from such exercises are an essential form of feedback on how we are perceived as an organisation and support the forward plans we will make.</td>
</tr>
</tbody>
</table>
## 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 2012/13, the Department of Health included 46 national audits for inclusion in the Quality Accounts for 2012/13. 32 national clinical audits and 4 national confidential enquiries covered NHS services that GEH provides;
- During that period, GEH participated in 31 of the 32 (97%) of the national clinical audits and 100% of the national confidential enquiries which it was eligible to take part in;
- The national clinical audits and national confidential enquiries that GEH was eligible to participate in during 2012/13 are as set out 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:

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Did GEH participate in 2012/13?</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome/Acute Myocardial Infarction</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Cardiac surgery</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Adult critical care</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Bowel cancer</td>
<td>Yes</td>
<td>69%</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
<td>No</td>
<td>0%*</td>
</tr>
<tr>
<td>Cardiac Arrhythmia</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiothoracic transplant</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Carotid interventions</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Comparative audit of blood transfusion</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Congenital heart disease</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Chronic obstructive Pulmonary Disease</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Angioplasty</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Diabetes (Adult)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Epilepsy 12</td>
<td>Yes</td>
<td>data collection ongoing</td>
</tr>
<tr>
<td>Fever in children</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Fractured neck of femur</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Head and neck oncology</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Hip fracture database</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Yes</td>
<td>data collection ongoing</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National joint registry</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal intensive and special care</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Non-invasive ventilation</td>
<td>Yes</td>
<td>data collection ongoing</td>
</tr>
<tr>
<td>Oesophago-gastric cancer</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric Intensive care</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
</tbody>
</table>
SECTION 2: Looking Back 2012/13

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Did GEH participate in 2012/13?</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric pneumonia</td>
<td>Yes</td>
<td>data collection ongoing</td>
</tr>
<tr>
<td>Pain Database</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Potential donor</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Psychological therapies</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Pulmonary hypertension</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Renal colic</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Renal Registry</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Renal transplantation</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Stroke National Audit Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Trauma</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>National audit of Dementia</td>
<td>Yes</td>
<td>100%</td>
</tr>
</tbody>
</table>

Confidential Enquiries

<table>
<thead>
<tr>
<th>Confidential Enquiries</th>
<th>Did GEH participate in 2012/13?</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Deaths</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Child Health</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Maternal infant and perinatal</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Patient Outcome and Death</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Suicide and homicide in mental health</td>
<td>Not Relevant</td>
<td>0%</td>
</tr>
</tbody>
</table>

*The Trust did not participate in the national cardiac arrest audit during 2012/13, due to an inability to collect one piece of information for the national audit (as a partial data submission is not allowed by the national body running the audit). However, GEH has a continuous local audit being carried out in recognition of national participation.

Actions arising from clinical audits

- The reports of 23 national clinical audits, where reports have been received from the national body leading the audit, and 45 local clinical audits were reviewed in 2012/13 and GEH will take the following actions to improve the quality of healthcare provided:
  - Additional cardiac output monitoring devices have been procured
  - New acute abdomen pathway has been created
  - Re-organisation of difficult airway trolleys in line with guidelines
  - Introduction and developments of the dementia strategy including no unnecessary patient moves
  - Improve nutrition in dementia patients through use of adapted crockery and cutlery
  - Doors fitted to additional clinical rooms and additional cupboards provided to enhance medicines security
  - Provide regular feedback to consultant teams to enable targeted improvements with compliance with the antibiotic policy
  - Introduction of new nursing risk assessment documentation
  - Re-design of the Gentamicin prescribing proforma
  - Education event around end of life care and use of the Liverpool care pathway
SECTION 2: Looking Back 2012/13

- New Clinical procedure developed around the management of diabetes in surgical patients
- Development of patient information leaflets regarding diabetes and elective surgery
- Guidelines on good documentation displayed in ward areas and on drug trolleys

4. Participation in Clinical Research

- The number of patients receiving NHS services provided or sub-contracted by the Trust in 2012/13 that were recruited during that period to participate in National Institute of Health research (NIHR) portfolio research was 270. They participated in over 25 studies in the following specialties: cancer, diabetes, obstetrics, critical care, dermatology, gastroenterology, genetics, metabolic and endocrine and HIV care.

<table>
<thead>
<tr>
<th>Year</th>
<th>Studies</th>
<th>Patients recruited</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>16</td>
<td>178</td>
</tr>
<tr>
<td>2009-10</td>
<td>19</td>
<td>754</td>
</tr>
<tr>
<td>2010-11</td>
<td>32</td>
<td>534</td>
</tr>
<tr>
<td>2011-12</td>
<td>20</td>
<td>153</td>
</tr>
<tr>
<td>2012-13</td>
<td>25</td>
<td>270</td>
</tr>
</tbody>
</table>

- 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 staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes;
- There were circa 30 clinical staff participating in research approved by a research ethics committee at the Trust during 2012/13;
- As well, in the last three years, 22 publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS;
- Our engagement with clinical research also demonstrates the Trust’s commitment to testing and offering the latest medical treatments and techniques. The Trust also recruited 51 participants in NIHR Industry trials in 2012/2013;
- 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 with 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” which has recruited a large number of patients and is likely to continue the high recruitment in 2013/14;
- The NHS operating framework requires Trusts to double the number of patients recruited into NIHR portfolio trials within 5 years (i.e. from a baseline in 2008/9 to the end of 2013/14);
- There was a 52% increase in the number of patients receiving NHS services provided or sub-contracted by GEH recruited between 2008/09 and 2012/13 that were recruited to participate in research approved by a research ethics committee. This is below the national NIHR target;
However there was a 75% increase in the number of patients recruited between 2011/12 and 2012/13. This indicates that the trend to recruit patients has been improved significantly in the last year. 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. 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 2012/13 was conditional on achieving quality improvement and innovation goals agreed between GEH, NHS Coventry and NHS Warwickshire (Arden Cluster). Further details of the goals for 2012/13 and for the following 12 month period are available on request from the Trust and also available electronically at: [www.institute.nhs.uk/world_class_commissioning/pct.portal/cquin.html](http://www.institute.nhs.uk/world_class_commissioning/pct.portal/cquin.html)

During 2012/13 the total income associated with the achievement of quality improvement and innovation goals amounted to £2,257,000. The Trust had a total of 10 general CQUIN measures (5 local, and 5 national) for 2012/13. It should be noted however that the final CQUIN reconciliation is to be determined and actual income for 2012/13 will be agreed with Warwickshire North Clinical Commissioning Group.

Both national and local CQUINS for the Trust, with commentary, are listed below:

<table>
<thead>
<tr>
<th>Achieved</th>
<th>CQUIN Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 1-4 = ✓</td>
<td><strong>VTE Assessments on admission:</strong> 91.44% of adult inpatient admissions reported as having had VTE risk assessment on admission to hospital using the clinical criteria of the national tool</td>
</tr>
<tr>
<td>Q1 ✓ Q2 ✗ Q3 ✓ Q4 ✓</td>
<td><strong>VTE Appropriate chemical prophylaxis (ACP):</strong> 90% of adult inpatient admissions needing VTE risk assessments (ACP) on admission to hospital using the clinical criteria national tool. (Q2 showed a slight dip in performance by 0.42%, with one exception in prophylaxis)</td>
</tr>
<tr>
<td>Q1-4 = ✓</td>
<td><strong>Patient Experience Survey:</strong> The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme &quot;responsiveness to personal needs of patients&quot;: 1. Involvement in decisions about treatment/care, 2. Hospital staff being available to talk about worries/concerns,</td>
</tr>
</tbody>
</table>

<p>| | I | RI |</p>
<table>
<thead>
<tr>
<th>Achieved</th>
<th>CQUIN Description</th>
</tr>
</thead>
</table>
|          | 3. Privacy & Dignity when discussing condition/treatment,  
|          | 4. Informed about side effects of medication  
|          | 5. Informed who to contact if worried about condition after leaving hospital.  
|          | **NB – I = improvement, RI = reduction in improvement** |
| Q1 ✓ Q2 ✓ Q3 ✓ Q4 ✓ | Patient Revolution: (Friends & Family Test) survey where, at the point of discharge, inpatients are asked about the care they have received ie "Whether or not they would recommend the hospital to friends or family if they needed similar care or treatment" |
| Q1-4 ✓ | Dementia Screening: – Implementation of a new system for assessment of patients at admission, or referral. Q1 to Q3 system being set up (NB system in place January 2013, now achieving this CQUIN) |
| Q1-4 ✓ | Safety Thermometer: 'harm free’ care, system now fully implemented across the Trust |
| Q1-4 ✓ | Psychiatric Liaison: working in partnership with Coventry & Warwickshire Partnership Trust this new rapid response assessment process is up and running, benefiting patients requiring mental health care |
|          | Reducing Outpatient Appointments: achieving all milestones for this CQUIN |
| Q1 ✓ Q2 ✓ Q3 ✓ Q4 ✓ | Mortality: As at 11/4/13  
|          | - Bed Moves – improvements showing over same period 2011/12  
|          | - Liverpool Care Pathway – awaiting validation of Q4 (89.6 < 90%)  
|          | - Sepsis – recruitment of sepsis nurse to support this service and future improvements expected  
|          | - Mortality Case Note Review – Q2 missed by 2 case notes |
| Q1 ✓ Q2 ✓ Q3 ✓ Q4 ✓ | Primary & Secondary Care Communication: more integration of work, developing of protocols and pathways of 'shared care’ in the management of medical conditions |
| Q1 ✓ Q2 ✓ Q3 ✓ Q4 ✓ | Ambulatory Care: further implementation of pathways of care and service improvements taking place |

**NB * = awaiting end of year publication**

### 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 2012/13.

The Trust had 2 unannounced inspections during 2012/13. The first was a themed review specifically relating to termination of pregnancy. This took place at the end of March 2012 and the standard being considered was Regulation 20, Outcome 21: People's personal records, including medical records, should be accurate and kept
safe and confidential. The CQC found that the Trust met the part of the regulation which was the subject of this review in relation to the maintenance of HSA1 forms.

The second visit took place on 26th & 28th November 2012 and was a routine inspection. The assessment team looked at the personal care or treatment records of people who use the service, reviewed information sent to them by other organisations and observed how people were being cared for during the visit. They checked how people were cared for at each stage of their treatment and care, talked with people who use the service, talked with carers and / or family members and talked with staff.

The CQC were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using the service or caring for someone who uses this type of care service.

The following standards were reviewed and found to have been met by the Trust:
- Respecting and involving people who use services
- Care and welfare of people who use services
- Management of medicines
- Requirements relating to workers
- Assessing and monitoring the quality of service provision

The Assessment team commented:
- Patients and visiting relatives were positive about the staff and treatment that they had received;
- Patients said that staff were "incredibly hard working." They said staff took time to assess and meet their needs;
- Patients were confident that they knew the nature of their treatment.
- Patients spoken with told us their privacy was protected and that they felt staff were respectful during their stay at the hospital;
- We looked at patient records, which were clear, accurate and up to date. They included care and treatment plans, risk assessments and plans for safe discharge;
- To ensure ‘fluid balance’ charts are completed consistently

Some of the comments from the patients to the CQC assessors included:
"It's a marvellous hospital,"
"I don't think anyone can complain about the care here,"
"You always know if you are sent here, you are going to be looked after."

The Trust is registered as compliant with all 16 core standards.

7. Information on the Quality of Data

Good quality data underpins the effective delivery of patient care and are essential if improvements in quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data, will thus improve patient care and value for money.

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 94% for all CDS submitters and the results of the GEH was 99.9%.

**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 2012/13 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:

- APC = 99.9% - (National comparator 99.1%)
- OPD = 100% - (National Comparator 99.3%)
- AE = 99.5% - (National Comparator 94.9%)

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 99.7%)

*Source: SUS Data Quality Dashboard, Month 11 (April-February 2012/13); 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.

**Clinical Coding Error Rate:**

George Eliot Hospital NHS Trust was subject to the payment by results data assurance framework audit (covering 2 areas within Outpatients – Cardiology and Ophthalmology) during the reporting period 2012/13 by the Audit Commission (AC).

The performance of the Trust is measured against the number of attendances changing payment due to errors in attendance details (excluding the coding of procedures) which was 3.2%. This would place the trust as better than average, but not in the top 25% of trusts compared to the last time the AC undertook a national audit on outpatient data (2008-2010).

The performance of the Trust, measured against the number of attendances changing payment due to errors in attendance details (excluding the coding of procedures) would place the Trust in the best performing 25% of trusts.

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 2012/13 year. Where the Trust has failed to meet the standard an explanation is offered at the end of the following table.
<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Standard</th>
<th>2012/13</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Difficile Infections</td>
<td>27</td>
<td>16</td>
<td>✓</td>
</tr>
<tr>
<td>MRSA Bacteraemia Infections[^1]</td>
<td>0</td>
<td>2</td>
<td>✖</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 2 weeks suspected</td>
<td>93%</td>
<td>96%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 2 weeks Symptomatic Breast</td>
<td>93%</td>
<td>98%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 31 days</td>
<td>96%</td>
<td>99%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 31 days – Drug</td>
<td>98%</td>
<td>99%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 31 days – Surgery</td>
<td>94%</td>
<td>98%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 62 days[^2]</td>
<td>85%</td>
<td>82%</td>
<td>✖</td>
</tr>
<tr>
<td>Cancer 62 days from Screening Service[^3]</td>
<td>90%</td>
<td>77%</td>
<td>✖</td>
</tr>
<tr>
<td>A&amp;E 4 hrs</td>
<td>95%</td>
<td>96%</td>
<td>✓</td>
</tr>
<tr>
<td>Stroke – CT &lt;24 hours</td>
<td>100%</td>
<td>100%</td>
<td>✓</td>
</tr>
<tr>
<td>Stroke – Time on Ward</td>
<td>80%</td>
<td>81%</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Patient Experience:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to Treatment waits 95th percentile - Admitted</td>
<td>23 wks</td>
<td>18 wks</td>
<td>✓</td>
</tr>
<tr>
<td>Referral to Treatment waits 95th percentile - Non Admitted</td>
<td>18.3 wks</td>
<td>16 wks</td>
<td>✓</td>
</tr>
<tr>
<td>National Inpatient Survey</td>
<td>&gt;10/11</td>
<td>&gt;10/11</td>
<td></td>
</tr>
<tr>
<td>Mixed Sex Accommodation[^4]</td>
<td>0</td>
<td>8</td>
<td>✖</td>
</tr>
<tr>
<td><strong>Patient Safety:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Events[^5]</td>
<td>0</td>
<td>1</td>
<td>✖</td>
</tr>
<tr>
<td>VTE</td>
<td>90%</td>
<td>91%</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Falls[^7]</td>
<td>5%</td>
<td>564</td>
<td>✖</td>
</tr>
<tr>
<td>Identifying deteriorating patients (% of deteriorating patients are identified in a timely manner and action taken)</td>
<td>GEH set to improve on 2011/12 26%</td>
<td>61%</td>
<td>✓</td>
</tr>
</tbody>
</table>

Of the 20 performance indicators shown in the table above the Trust did not fully meet 6 with 1 being partially met.

The following gives a brief explanation as to why the GEH did not achieve the standard and what action has been, or is being, taken to remedy this.
1) **MRSA Bacteraemia Infections:** Root cause analysis was undertaken on the 2 cases which caused non-compliance in this standard which recommended that alternatives for complex intravenous (IV) access were developed trust wide and training has now been undertaken which allows our critical care team to put in specialist IV lines to prevent re-occurrence in the future;

2) **Cancer 62 days the target:** In quarters 2 and 3, the target was not achieved for the main waiting time standard measured from GP referral to treatment;

3) **Cancer 62 days from Screening Service:** This target was not achieved in the first quarter due to a number of patients exceeding the wait following referral from one of the national screening programmes which impacted non-achievement over the 2012/13 period;

The Trust has taken a number of actions to tackle the causes of delay and to ensure the target will be met in the future. These include setting tighter standards for stages in the diagnosis process such as for diagnostic investigations, ensuring that potential breach patients are escalated to lead clinicians and managers earlier to enable corrective action to be taken. In addition, the Trust has been working alongside colleagues from the NHS Intensive Support Team to undertake a full review of the way in which cancer services are organised and to recommend further improvements. Consistent achievement of this target is one of the Trust’s priority objectives for 2013/14. Both these targets (2&3 above) were achieved in the fourth quarter.

4) **Mixed Sex Accommodation (MSA):** The breaches that took place over the 2012/13 period were due to ITU patient to return to the ward within 6 hours and needing ITU care – nb the public can access information on MSA breaches as they are published on GEH website – [www.geh.nhs.uk](http://www.geh.nhs.uk);

5) **Never Events:** The Trust reported 1 Never Event – A root cause analysis was undertaken. Adherence to the WHO checklist is expected to prevent similar occurrences in the future.

6) **National Inpatient Survey:** It is disappointing that the survey results do not demonstrate a measurable improvement in the patient’s view of their experience. In recognition of this the Trust has set in motion a number of initiatives to focus the attention of staff on the areas of care where survey results indicate we are not meeting the needs of our patients.

7) **Patient Falls:** From April 2012 to the end of February 2013 (month 1 to 11), Patient Falls figures had been achieving the 5% reduction in falls set for the 2012/13 year; however the Trust saw a sharp rise in patient falls in March 2013. Capacity issues with high numbers of acutely ill patients also took place in Month 12 (March).
As with the previous three published Quality Accounts (2009-2012) the Trust has set out its key priorities for 2013/14 to continue to be reflective of our performance in improving the ‘quality’ of care provided to our patients alongside the results of measured outcomes from the 2012/13 priorities to ensure they are truly responsive in influencing the setting of our quality improvement priorities every year. These remain under the three main headings Clinical Effectiveness, Patient Safety and Patient Experience.

Through a structured Quality Account review process, in particular on ‘looking back’ on 2012/13’s quality performance (section 2 above), the Trust’s Quality Account Review Group work proactively with those delivering the hospital’s quality improvement agenda and key external stakeholders (who are members of the group) to enable each year’s key priorities to take shape. These have been agreed as follows.

### Clinical Effectiveness

1. Mortality:
   - Reduction in SHMI
   - External Reviews recommendations adherence (eg GEH Keogh review & response to the Francis Report)
   - End of Life Care

### Patient Safety

2. Infection Prevention:
   - MRSA rates
   - CDifficule rates
   - Sepsis Management

### Patient (& Staff) Experience

3. Patient Experience:
   - Friends & Family Test
   - Patient Survey

4. Culture:
   - Staff Survey
   - EXCEL programme
   - Incident Reporting
   - WHO checklist

5. Making Every Contact Count:
   - Training of Staff
   - Community Engagement

In striving to meet the challenges of 2013/14 (and future year’s) quality improvement priorities, the Trust will continue to focus on the health care needs of the diverse communities it serves eg heart failure, diabetes, stroke, respiratory, long term conditions, acute illness etc by proactively seeking to improve outcomes for our patients at every opportunity. It should be noted that success of the ‘Making Every Contact Count’ programme of work (5 above) will be essential in promoting more positive and healthier outcomes for those in our care, and out in the community.

Whilst some priorities that are not fully met in previous year’s QA review are not carried forward to the following year’s quality objectives, our focus continues on these priorities as part of the Trust’s routine monitoring and reporting processes eg at divisional operational meetings and highlighted within the Board’s integrated performance report where a section routinely includes an update on quality within the organisation.

Aiming to Improve Quality and Health

George Eliot Hospital NHS Trust – Quality Account 2012/13 - Page | 27
SECTION 3: Quality Improvement Priorities for 2013/14

QUALITY HEALTH ‘LIFE CYCLE’ JOURNEY (FOR OUR COMMUNITY) 2013/14 AND BEYOND

Directly linked to our 2013/14 key priorities (above at page 25) and to recognise the full circle of life’s health journey, from birth to the end of a person’s life, the Trust has made a commitment to improve the health and life style choices of all the communities it serves and will pay particular attention in 2013/14 to our communities health education through ‘innovation and collaboration with professional health and social care partners’. Results will be monitored where it is hoped that health inequalities are reduced, earlier presentation of illness is seen and a shift to improve the overall health of our communities improves.

Pre & Early Pregnancy
- SCREENING
- SMOKING CESSATION
- PREVENTION
- SEXUAL HEALTH
- VTE

Pregnancy & Child Health
- VACCINATION
- BREASTFEEDING
- POSITIVE MENTAL HEALTH
- NEW SERVICE CHANGE
- NORMAL BIRTH

Adolescence
- EDUCATION IN SCHOOLS
- ‘HEALTHY LIFE’:
  - NUTRITION
  - ALCOHOL/DRUGS
  - SEXUAL HEALTH
  - MENTAL HEALTH
  - TEENAGE PREGNANCY
  - SMOKING

Young & Middle Aged
- SCREENING:
  - TESTICULAR
  - BREAST
  - BOWEL
  - CERVICAL
  - PROSTATE
- SMOKING CESSATION

Older People
- LONG TERM CONDITIONS:
  - RESPIRATORY
  - DEMENTIA
  - STROKE
  - DIABETES
  - END OF LIFE CARE
  - FALLS
  - PRESSURE ULCERS
  - CARE WITH COMPASSION
  - VTE

Patient Survey ← PATIENT/CARER EXPERIENCE →
Friends and Family Test

C Difficile ← INFECTION PREVENTION → MRSA

Mortality ← SAFE & EFFECTIVE CARE → WHO Checklist

Incident Reporting ← STAFF WELLBEING → Staff Survey

Staff Training ← MAKING EVERY CONTACT COUNT → Community Engagement

George Eliot Hospital NHS Trust – Quality Account 2012/13 - Page | 28
SECTION 3: Quality Improvement Priorities for 2013/14

Priority 1 – Mortality

Target for 2013/14:
1. By March 2014 a target has been set by the Trust for a reduction in SHMI of 5% which equates to a figure of 104:
   - This will be achieved by a proactive response to recommendations made by the Francis report. The Board have requested the Executive Team to set out a priority list against these recommendations, many of which had been recognised and were being worked through following our own independent mortality review by Mott MacDonald in 2012;
   - Action will be taken following the review into care at the Trust by the DoH Medical Director, Professor Sir Bruce Keogh. The Trust will monitor adoption of the Francis Report recommendations and the outcome of the Keogh Review respectively;
   - Further reading on the Trust’s response to the Francis report and the publication, during the summer of 2013, of the Keogh Review can be found on the Trust’s web site – www.geh.nhs.uk and go to the link for key documents.

2. By March 2014 an End of Life Care strategy will be in place and rolled out across the Trust
   - End of life is defined as the final year or so of life. Although this can be difficult to define, prognostication tools are available to support staff in identifying when needs are changing and when a different approach is required;
   - The majority of palliative and end of life care is provided by GPs and District Nurses in the community and ward doctors and nurses within an acute environment, with support provided by specialist services. One per cent of the population die each year in the UK, most from chronic illness other than cancer with the majority spending time in hospital during their final few months and most dying within an acute environment. Around one quarter of inpatients at any time within any local district hospital are in the final year of their life. Every health and social care professional needs to be able to assess and manage these patients with palliative and end of life care needs, and this should be underpinned by appropriate training and specialist support;
   - There is an opportunity for the Trust to change this approach and bring a focus of attention to the issues by registering an interest for the second phase of the pilot of the ‘Route to Success’ transformation programme. This is supported by the DoH and will give the Trust the opportunity to learn the tools and techniques of Advanced Care Planning. This programme will focus attention on all aspects of end of life care, the principles being to identify patients who are in their final year and in particular the last few months. This process enables robust planning to take place and reduces the potential for patients to be admitted in the last few days of their life and aiming to give them a better quality of life within their final year of life;
   - Two wards have been identified as the pilot areas - Elizabeth Ward (which treats patients with respiratory disease) and Dolly Winthrop Ward (which treats patients with Heart failure which is the most common cause for an elective acute admission to the hospital). Senior Nurses from the ward will be trained in...
advanced care planning and a hospital coordinator will be appointed. In addition clinical staff will be trained in the use of the Amber Care Bundle which provides optimum care for patients in the last year of their life;

- This care includes Liverpool Care Pathway (LCP) which is a comprehensive discharge plan ensuring all aspects of the patients care is documented. Plus the provision of beds to avoid an acute admission which may prevent admission of patients to an acute ward;
- A comprehensive End of Life Care Strategy is currently being developed for submission to the Trust board in the summer of 2013.

Priority 2 – Infection Prevention

Target for 2013/14

1. **Clostridium difficile Infections (CDI)**  The 2013/14 agreed national threshold for CDI cases has been set at 21 cases. To meet this challenge over 2013/14 the Trust will aspire to sustain the following:
   - Rapid isolation of patients with suspected infectious diarrhoea into side rooms and continued enhanced bay cleaning;
   - Continued monitoring and compliance with antibiotic usage;
   - A minimum of weekly *C. difficile* ward rounds by IPCT to review the progress of all active and settled patients with *CDI*;
   - Annual deep clean programme and use of hydrogen peroxide "fogging" technology.

2. **MRSA Bacteraemia** – As for the previous year the Trust has set a zero tolerance for the incidence of MRSA and will strive to have no cases of post 48 hour MRSA bacteraemia cases apportioned to the Trust within 2013/14

3. **Sepsis management** – A sepsis Nurse will be appointed for an initial 12-month secondment period in 2013/14 to ensure the 90% compliance rate is met against the sepsis bundle by March 2014.

Priority 3 – Patient & Staff Experience

Target 2013/14:

1. **Friends & Family Test** – From 1 April 2013, all inpatients in acute hospital wards and A&E departments across the country will be asked to complete a ‘Friends and Family Test’. The test is being introduced to allow patients the opportunity to feed back their views of the care or treatment they have received at the hospital and will provide valuable information about the quality of healthcare received in our Trust. Therefore when patients leave hospital, or within 48 hours of discharge, they will be invited to give their feedback by answering one simple question: “How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?” In 2013/14 the Trust is required to reach a minimum response rate, set nationally, of 15%. This equates to around 17,120 of the 114,400 numbers of inpatient and A&E attendances dealt with by the hospital per annum. The scoring options are explained as follows:

Responses: Extremely likely, Likely, Neither likely or Unlikely, Unlikely; Extremely unlikely, Don’t know;
SECTION 3: Quality Improvement Priorities for 2013/14

Extremely likely is a promoter eg positive;
Likely is a passive ie of no benefit; and the remaining responses are classed as detractors – ie minus;

Score: The score is achieved by subtracting the promoters from the detractors and dividing them by the number of responses.

The scores will be used as a positive tool for action as we will be able to use the feedback, alongside other information, to identify and tackle concerns at an early stage and improve the quality of care we provide. The Trust has set a target of 80% as an end of year score and progress to meet this target will be monitored by the Patient Experience team.

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 us to use for engaging with and seeking out the views of our patients. This allows us to continually address any concerns raised and take forward evidence based and ‘structured’ improvements to the quality of care provided to all patients accessing services at the GEH.

Priority 4 – Culture

Target for 2013/14:
1. Staff Survey
   - Of the 28 Key Findings reported from the 2012 staff survey, the Trust has seen an improvement when compared with the average Trust. In 18 of those findings, no change in three of those findings, and worsening performance in five of those findings. Additionally, when compared over time, the 2012 results compared with the Trust’s own results in 2011 show:
     - Statistically significant improvements in nine of the Key Findings;
     - No change in nine Key Findings;
     - Worsened performance in three Key Findings;
     - The remaining seven Key Findings were measured differently from previous years and cannot be compared.
   - Pleasingly for the first time since at least 2009 there are no Key Findings where the Trust’s response is in the worst 20% of all Trusts. Additionally in 2 areas, the Trust’s performance is in the best 20% of Trust. This includes staff receiving job related training learning or development in the last 12 months and staff receiving health and safety training in the last 12 months;
   - In 2013/14 the Trust will continue to build on the improving overall survey results in respect of staff engagement and seek to improve in those areas where performance has worsened;
   - The Trust will conduct regular in-house surveys with the staff to test the temperature of the organisation and will further engage with the staff on the development of solutions against the areas identified for improvement;
   - Through the work of the Trust’s Wellbeing Group a Wellbeing Strategy is being developed which will take a holistic approach of the health and wellbeing of our staff and focus on the physical, social, financial, career, community and spiritual
SECTION 3: Quality Improvement Priorities for 2013/14

wellbeing of our workforce \((Rath\ T\ \text{and}\ Harter\ J\ 2010)\). Priorities and actions from the strategy will be taken forward by the Workforce Wellbeing Group;

- The outcome of how our staff are benefiting from the Wellbeing Strategy, the Excel programme and ongoing delivery of best HR (Human Resources) practice within the Trust will be measured through regular reporting at Board level and the outcome of the 2013 Staff Survey.

2. EXCEL Programme for Staff - “To EXCEL at Patient Care”

- Leading on from the three phase cultural development programme undertaken with our workforce in 2012/13 to establish the right cultural ‘fit’ we aspire to in order to provide excellent patient services to the people we serve. During 2013/14 we will be working hard to support 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, can have confidence in our ability to provide safe, effective services;

- Whilst continuing to inform patients of what they can expect from us, and how to challenge us if it is not received, we are providing staff with a supportive but challenging framework in the delivery of EXCEL in all that they do, from the induction of new staff into our vision and values and what we expect from them, through to ongoing training for our current workforce;

- Our vision and values are now embedded in our appraisal framework where all staff are measured against both what they do and how they do it, and leadership development programmes will support our leaders at all levels to role model our vision and values;

- Through 2013/14 we will provide support to staff through development to continually improve our communication both internally and externally.

- We will measure the success of embedding our vision and values through a variety of mechanisms including: appraisal outcomes; patient and staff survey results; Friends & Family Test results and patient and staff feedback.

3. Incident Reporting (green – low/no harm reporting)

- It is widely recognised, that organisations which have high numbers of green incidents reported, have a positive safety culture, leading to a low number of harmful and serious incidents taking place. As a result of this, the Trust has agreed that for 2013/14 they will aim for a 10% increase in the numbers of ‘all’ incidents reported in 2012/13. The levels of incident reporting is monitored on a monthly basis and reported quarterly to the Quality Assurance Committee and Trust Board. A formal report is also provided quarterly to the Commissioners at the Clinical Quality Review Group meeting.

- The Trust has reported incidents to the National Patient Safety Agency (NPSA) via the National Reporting & Learning System (NRLS) since 2003. The Trust’s reporting is compared with other Trusts in the same category - “Small acute organisations”. Twice a year the NPSA analyse the incident reporting from all reporting organisations and provides comparison reports with similar organisational groups.

- The Trust has been highlighted as being a “low” reporter of incidents via the NRLS when compared to similar sized organisations.
SECTION 3: Quality Improvement Priorities for 2013/14

- Retrospective case note review research indicates that approx 10% of patients who are admitted to hospitals will suffer an adverse event (Vincent et al 2001 BMJ Vol. 322). This research has been replicated in other countries and has indicated similar incidence levels.
- The Trust wants to ensure that there are high levels of incident reporting, but low levels of harm to patients i.e. higher numbers of low/no harm incidents (green) reported.
- A comprehensive action plan to address issues which have been identified to date has been developed to raise the profile of incident reporting within the Trust. The overall aim is to ensure that incident reporting is viewed as a positive indicator rather than a negative one.
- Incident reporting figures will be monitored on a monthly basis and feedback on reporting levels will be given to the divisions with the aim of increasing levels on a month by month incremental basis.

4. **WHO checklist – A compliance rate of 100% is the target for 2013/14.**
   - The plan for 2013/2014, as it was in 2012/13, is for all patients attending theatre for surgery to have a WHO surgical safety checklist form completed. All forms will be checked for accuracy and audited to ensure 100% compliance. Throughout 2012/13 there were a few occasions where a 100% compliance was not achieved;
   - During 2013/14 the WHO surgical safety checklist will become part of the theatres ORMIS (Operating Room Management Information System) where the form will become electronic with mandatory fields to ensure completion as part of other patient information collected. To enable an accurate audit trail, forms will be printed off and placed in the patient notes; and the electronic copy will also be stored as back up;
   - A contingency for IT or the ORMIS system failure, will be to revert back to completion of a paper copy and entry onto the ORMIS system, when the system allows;
   - Adherence to the WHO checklist and future improvements for action will continue to be monitored by the Trust’s Hospital Operational Board.

**Priority 5 – Making Every Contact Count (MECC)**

1. **Training of staff - the target for 2013-14 is for a minimum of 400 staff to complete MECC training.**
   - The Trust recognises the importance for the communities we serve to make ‘healthy’ lifestyle choices to promote better health and wellbeing throughout their life journey. It is acknowledged that we also have a responsibility in advising, educating and supporting those in our care in making healthier lifestyle choices at every opportunity;
   - ‘Health’ events are to be organised and take place within the community where ambassadors for the Trust, eg medical students, will attend and give advice on lifestyle choices, including vaccination, smoking, diet, obesity, alcohol etc. This will be monitored by the Trust’s Public Health Strategy to measure success;
SECTION 3: Quality Improvement Priorities for 2013/14

- Working in partnership with schools and colleges ‘health’ fairs/open days are being planned where the event will be run by the school children/students and the Trust will support with the input of healthy living information/advice, etc;
- The Health Trainer Service role will be developed to align more closely to the MECC approach, to raise the issue of healthy lifestyle issues within the Nuneaton and Bedworth Borough, deliver brief interventions and refer into specialist support services where appropriate.

MECC Priorities include, to:

- Continue to offer e-learning and face-to-face training
- Significantly increase the numbers of staff completing training
- Ensure that staff are aware that MECC training is now part of the Statutory and Mandatory Training Matrix
- Implement e-referral
- Develop more monitoring systems
- Develop the Health Trainer Service to align more closely to the MECC approach

The above will be achieved by:

- Additional promotion of MECC training options, linking to the Statutory and Mandatory Training Matrix;
- Delivery of more MECC training sessions with a more flexible approach, with the additional involvement of the Health Trainer Service to support this;
- Dissemination of the e-referral tool across the hospital site;
- Working with the Commissioner of the Health Trainer Service to develop a new service specification and then to implement the new specification.

2. Community Engagement:

- The Trust’s Executive Team regularly attend community forums and meetings across the locality to update on the Trust’s performance, future plans, service reviews and developments; this is a great opportunity to interact with the local population and gain feedback in a timely and proactive way;
- Currently membership numbers at the Trust total around 10,000 and represent the communities the hospital serves. Our members are recruited from the Nuneaton & Bedworth, North Warwickshire and Hinckley & Bosworth areas; patient/carers and our staff;
- The Trust is keen to ensure our membership numbers continue to reflect the strong support offered by our local population and this highlights the need for a proactive and structured engagement and involvement strategy to promote and embed an effective two-way information and communication flow between the hospital and its membership;
- Member Advocates, are selected from the Trust’s membership base and nominated governors representing key external stakeholder organisations. The Members’ Advocacy Panel (MAP) meet formally every quarter (chaired by the Trust’s Chairman), where a variety of topics are covered such as updates on the Trust’s pursuit in securing a sustainable future, the financial and operational status; quality, governance and safety issues; mortality and service developments/reviews etc. They are also informed of the current challenges
facing the organisation and any plan the Board of Directors have in trying to address these challenges;

- The work of the MAP is very important to the Trust as it champions a more responsive and closer working relationship with its public, patient/carer and staff membership. As ambassadors for the Trust, the MAPs' work is vital in sharing informed and accurate information in a timely manner, relaying positive messages and feeding back the views and opinions of the Trust’s membership, and where the opportunity arises, the wider public;

- In 2013 we are actively pursuing setting up a Young Members Forum to seek out the views of younger people and find out how we can improve our ‘youth members/young public’ engagement, give them a voice about local healthcare and become more ‘user’ friendly to young people;

- Also in 2013/14 members of the Equality, Diversity and Human Rights Group are undertaking a programme of visits to community groups representative of the nine characteristic groups within the Equality Delivery System. The purpose of these visits is to ensure that there is equal opportunity for all communities to have a say in the way services are delivered to reach their specific needs.
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 2013 ("the Quality Account") and certain
performance indicators contained therein as part of our work under section 5(1)(e)
of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the
Health Act 2008 to publish a Quality Account which must include prescribed
information set out in the National Health Service (Quality Account) Regulations
2010, the National Health Service (Quality Account) Amendment Regulations 2011
and the National Health Service (Quality Account) Amendment Regulations 2012
("the Regulations").

Scope and subject matter

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

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Rate of Clostridium difficile infections per 100,000 bed days.

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

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2008 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 2008 and the Regulations).

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria
  set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources
  specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the
  Audit Commission on 25 March 2013 ("the Guidance"); and
the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 14 June 2013;
- feedback from Local Healthwatch dated 17 June 2013;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 2012;
- the latest national staff survey dated 2012;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 14 May 2013;
- the annual governance statement dated 5 June 2013;
- Care Quality Commission quality and risk profiles dated 31 May 2013; and
- the results of the Payment by Results coding review dated December 2012.

As part of our work we are required to read the other information contained in the Quality Account and consider whether it is materially inconsistent with the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009. We have been unable to assess whether the Quality Account is consistent with the Complaints report as the Trust has not published its complaints report in accordance with requirements. We reviewed the underlying data that will be incorporated into the final complaints report which is due to be approved by the Board in August 2013 and have no issues to report in respect of that data.

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 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 1988 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 NHS Trust.
Conclusion

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

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

Mark Stocks
Senior Statutory
for and on behalf of Grant Thornton UK LLP

Colmore Plaza
20 Colmore Circus
Birmingham
B4 6AT

25 June 2013
Appendix 1: Statements from Stakeholders

As part of the Quality Account pre-publication timetable the Trust requested formal feedback and comments on the detail and content of this year’s Quality Account from the following key stakeholders:

- Adult Social Care & Heath Scrutiny Committee
- Warwickshire North Clinical Commissioning Group
- South Warwickshire Clinical Commissioning Group
- Health Watch
- NHS Trust Development Authority
- Coventry & Rugby Clinical commissioning Group
- GEH Patient Advocacy Forum

See below all statements received following this request.

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**Patients Advocacy Forum (PAF)**

**Quality Account Report – 2012/13**

Once again this year members of the PAF attended all meetings of the Quality Account Review Group. They were also very well attended by GEH staff members and the Overview and Scrutiny Task & Finish Group of Warwickshire County Council.

The meetings were very positive and agreement on the key quality improvement priorities for the coming year was reached early in the process. All input was seen as important and many valuable points were made by PAF members and others. All were noted and incorporated into the finished document where possible. The final draft was agreed by all members of the group.

It is difficult to decide on priorities as so many projects could be tackled but a good balance has been achieved and PAF members will be monitoring progress over the coming months in addition to checking that last years’ priorities have been progressed.

Maurice Charley
PAF Chair
Appendix 1: Statements from Stakeholders

Kevin McGee
Chief Executive
George Eliot Hospital NHS Trust
College Street
Nuneaton
Warwickshire
CV10 7DJ

17 June 2013

Dear Kevin

George Eliot Hospital NHS Trust – Quality Accounts 2012/13

Please take this letter as confirmation that the response prepared by the Quality Accounts Task and Finish Group set up by Warwickshire County Council’s Adult Social Care and Health Overview and Scrutiny Committee (which was chaired by me at the time), which was forwarded to you on 31 May 2013 represents the formal response of the Warwickshire County Council Adult Social Care and Health Overview and Scrutiny Committee.

This commentary, although formally presented by Warwickshire County Council, reflects the views, input and contributions of those members of Warwickshire County Council, Nuneaton and Bedworth Borough Council and Warwickshire LInk who volunteered their time and expertise to the process.

Yours sincerely

Councillor Les Caborn
Former Chair of the Adult Social Care and Health Overview and Scrutiny Committee
Dear Mr Arnold

RE: QUALITY ACCOUNT 2012/13

NHS Warwickshire North Clinical Commissioning Group welcome the opportunity to comment on the draft 2012/13 Quality Account; we do so in the capacity of lead Commissioner for hospital services as handed over by NHS Warwickshire PCT in October 2012.

In our review of the draft Quality Account we have reviewed the accuracy of the information presented against that which we have received in relation to the services commissioned, and make comment on the information that we, and our public might expect to see in the account.

Firstly, we are pleased to see that the Trust has taken some time to engage with a number of external stakeholders, patient representatives and public groups in developing the draft Quality Report this year.

The comparison of the contractual information which we receive to that stated in the draft report is consistent with one exception; it should be noted that some of the information relating to end of year targets was not yet available in the draft report, or to us as commissioners so we cannot comment on this. The one inaccuracy identified is that the Trust reported 1 never event in July 2012, which is inconsistent with the statement in Section 2, Priority 1, paragraph 2, although correctly stated later in the report. We expect this to be corrected in the final report.

In respect of the information as presented in the report and that which we would have expected to see, we make the further comments below:

In light of the significant programme of work that the Trust have had in place to improve mortality rates and, that this will be an area where the public will want to know more, we feel that the report should be improved by:

- simplifying the statements on the measures of mortality, and
- focusing more on the improvements made during the year.

The Trusts Inpatient survey results appear not to have made the progress planned and we would expect to have seen a more detailed report on action taken and work that the Trust MAPs group have completed to provide assurance on patient experience.

Chair: Dr Heather Borringe
Chief Officer: Andrea Green
Appendix 1: Statements from Stakeholders

We believe the report should contain more information on complaints, particularly some detail on trends and themes.

We believe the report would benefit from more information on serious incidents. There is some information about harm from falls but we consider that a report on types of incidents, trends and themes and what improvements have been made would be valuable.

We believe that the report on the outcome of implementing the Safety Thermometer should have been included, along with more information again on trends and themes identified.

Thank you for sharing your Quality priorities for improvement in 2013/14. We would welcome the opportunity to work with you to develop a more qualitative approach to reporting on mortality improvements and the improvements in culture as these are never easy.

Yours sincerely

ANDREA GREEN
Chief Officer

Chair: Dr Heather Gorringe
Chief Officer: Andrea Green
Appendix 2: Amendments

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

- Adult Social Care & Heath Scrutiny Committee  response received
- Warwickshire North Clinical Commissioning Group  response received
- South Warwickshire Clinical Commissioning Group  no response received
- Coventry & Rugby Clinical commissioning Group  no response received
- Health Watch (LINks)  joint response with ASC/OSC
- NHS Trust Development Authority  no response received

Overall the process the Trust has put in place to review quality performance and monitor the key quality improvement priorities in the build up to the publication of the Quality Account documents has proved a positive experience for all taking part in the process, which includes the involvement of all key stakeholders.
Appendix 3: Glossary

**Acute Care:** Medical or surgical treatment usually provided in a district general, or acute, hospital;

**Arden Cluster** – commissioners for health services in Coventry and Warwickshire for a population of around 900,000 residents until 31st March 2013. From 1st April 2014 Clinical Commissioning Groups (CCGs) officially took over this. In the main, the GEH is commissioned to provide health care services for the population within the Warwickshire North CCG;

**APMS (Alternative Providers of Medical Services):** is a contractual route where commissioners can contract with a wide range of providers to deliver health care services tailored to local needs;

**Audit Commission:** the Audit Commission are an independent watchdog driving economy, efficiency and effectiveness in local public services, including the NHS, to deliver better outcomes for all.

**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;

**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):** were formed during 2012/13 and replaced the historically commissioning role of the primary care trusts;

**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;

**CDS (Commissioning Dataset):** Commissioning Data Sets are the primary mechanism for the national reporting of secondary care activity which is either NHS funded, and/or provided by NHS organisations;

**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;

**COPD (chronic obstructive airways disease):** Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible;

**Delayed discharge:** delayed discharge is where a patient who is fit for discharge remains in an acute hospital bed because other more suitable care cannot be provided;

**DNA (did not attend):** this term is used to highlight patients who have scheduled appointments and do not turn up on the date and time allocated and who have not notified us of their non-attendance, either by cancellation or re-scheduling;

**DTOC (Delayed Transfer of Care):** is defined as a patient who is medically fit and safe to be discharged. The latter describes a situation whereby a physiotherapist assesses the patient as being able to mobilise independently or supported with specific adaptations/equipment;
Appendix 3: Glossary

**EBUS Procedure** (Endobronchial Ultrasound-guided Transbronchial Needle Aspiration): An EBUS is a procedure that allows the doctor to look into your lungs (similar to a bronchoscopy) and to take samples of the glands in the centre of your chest (mediastinum) using the aid of an ultrasound scan, these glands lie outside the normal breathing tubes (bronchi);

**EDC (Equality & Diversity Council):** The EDC was formed in 2009 with representatives from the Department of Health, NHS and other interests. It is chaired by Sir David Nicholson and reports to the NHS Management Board. The EDC supports the NHS to deliver services that are fair, personal and diverse to promote continuous improvement;

**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;

**Escherichia coli:** *E. coli* normally lives inside the intestines, where it helps the body break down and digest the food you eat. Unfortunately, certain types (called strains) of *E. coli* can get from the intestines into the blood. This is a rare illness, but it can cause a very serious infection;

**Escherichia coli (E.coli) bacteraemia** *Escherichia coli* (commonly referred to as *E. coli*) is a species of bacteria commonly found in the intestines of humans. There are many different types of *E. coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment;

**HRG (Healthcare Resource Group):** Is a group of clinically similar treatments and care that require similar levels of healthcare resource;

**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 IG 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;

**IPR (Integrated Performance Report):** The IPR is a monthly progress report to the Board which gives an overview on the Trust’s performance on Finance, Operations, Quality, Patient Experience, Mortality etc from each of the Divisions of the Trust which’ Medicine, Surgery, Corporate and Community services.

**Length of Stay:** the duration of a single episode of hospitalisation;

**Local Involvement Networks (LINks) -** are made up of individuals and community groups, such as faith groups and residents associations, working together to improve health and
Appendix 3: Glossary

social care services. From April 2014 LINks will re-emerge with new powers and responsibilities and be called Health Watch;

**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;

**Methicillin-Susceptible Staphylococcus Aureus (MSSA) & Methicillin-Resistant Staphylococcus Aureus (MRSA):** bacteria that can cause infection in a range of tissues such as wounds, ulcers, abscesses or bloodstream;

**MEWs (Medical Early Warning Score):** The MEWs is a simple physiological scoring system, suitable for bedside application and is a modified early warning score to identify medical patients at risk of catastrophic deterioration in a busy clinical area;

**MSSA Bacteremia** - Meticillin-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;

**Multidisciplinary Teams (MDT):** 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;

**NHSLA (NHS Litigation Authority):** The NHSLA handles negligence claims and works to improve risk management practices in the NHS;

**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;

**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;

**NCAAG (National Clinical Audit Advisory Group):** established by the Department of Health to drive the reinvigoration of the national clinical audit programme and provide a national focus for discussion and advice on matters relating to clinical audit;

**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;

**NHS Midlands and East (SHA) - NHS West Midlands is part of the Midlands and East SHA cluster, alongside NHS East of England and NHS West Midlands.** The cluster came into being on 3 October 2011; it is one of four across England. Our SHA Cluster has a clear purpose in the following areas: - Delivering for today, Building for the future and Supporting staff;
Appendix 3: Glossary

NIHR - National Institute for Health Research: The national centre will enable scientists to better understand and tackle diseases that are triggered by environment as well as genetic causes, and increase the potential to develop strategies for their prevention and treatment;
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.
Parliamentary Health Service Ombudsman: The Parliamentary and Health Service Ombudsman can investigate complaints about government departments and agencies in the UK and the NHS in England;
PBR (Payment by Results): Is intended to support NHS Modernisation by paying hospitals for the work they do, rewarding efficiency and quality;
PCTs (Primary Care Trusts): have the responsibility for improving the health of the community, developing primary and community health services and commissioning secondary care services. Under the new health arrangements PCTs ceased to operate on 31 March 2013;
PROMs (Patient Reported Outcome Measures): Patient Reported Outcome Measures (PROMs) 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;
Quality and Outcome Framework: Is a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement;
Quality, Innovation, Productivity & Prevention (QIPP) Programme: QIPP focuses on the NHS working in different ways to ensure that the highest quality care is delivered. It encourages efficiency and focuses on a ‘joined up’ approach to delivering healthcare;
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;
Appendix 3: Glossary

**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;

**Urgent Care Walk in centre (UCC):** A unit for patients with accidental injuries and medical emergencies that do not need intensive or specialist care. This includes cuts, broken limbs and scalds. An UCC is usually open 7 days a week;

**VITAL (virtual interactive teaching & learning):** E-learning for nurses of 14 modules fundamental care and safe practice;

**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;

**YAG laser treatment:** this type of laser is used to cut membranes in the eye that have become thickened following cataract surgery, it is also used to treat certain types of glaucoma. This treatment is very effective for these conditions.
Appendix 4 – Quality Account 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 the Quality Account 2012/13.

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 2012/13 priorities takes place which contributes immensely to the setting of key priorities for the 2013/14 year. Membership of the QARG, which is chaired by the Medical Director, includes representation from the Trust’s External Auditors, LINks, Members and Patient Advocates and the Adult Social Care and Health Overview and Scrutiny Committee.

We would like to acknowledge the helpful and useful feedback from the Warwickshire County Council Adult Social Care and Health Overview and Scrutiny committee (which encompasses feedback from Warwickshire LINks) and our local Clinical Commissioning Groups.

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.
‘our vision is to EXCEL at patient care’