Annual Report
2010/11

... our future is in our hands...
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Welcome to our Annual Report for 2010/11. Over the last year we have faced some growing challenges, achieved some real successes and experienced some significant changes here at George Eliot Hospital NHS Trust.

The growing challenges we face include the need for the Trust to address a sizeable financial challenge by finding efficiencies within what we do, whilst ensuring we are able to provide the quality of care that local people rightly expect and deserve.

Change is expected and needed across the NHS. We recognise this and we are committed to working with our staff, our members and local people to define what those changes might look like over future months and years. In many ways, the George Eliot is already one step ahead having taken clear steps to providing care out in the community, closer to people’s homes, and in some cases in our patients’ homes.

Particular successes during the past year have included the measures taken to improve the experience our patients have when they access care from our teams both on and off the hospital site, including much reduced infection rates, increasing the number of people treated as ‘day cases’ to allow them to go home as soon as possible and increasing the services we provide through GP surgeries, such as physiotherapy.

It has also been a year of change at the George Eliot Hospital with several new faces on our senior management team bringing a significant injection of new ideas and energy to drive forward the changes and developments we need to make. During the year we were delighted to welcome our new Director of Operations, Kath Kelly, new Medical Director Andrew Arnold, our Associate Director of Human Resources, Dorothy Hogg, Deputy Director of Nursing Rebecca Bartholomew and last, but by no means least, our new Chief Executive, Kevin McGee. Between them, they bring a wealth of experience from their respective careers and I have absolute confidence that we have the right skills and experience to take our hospital, and the care we provide to people, into the future.

I would like to thank Sharon Beamish, former Chief Executive for the significant contribution she made to improving the safety of patient care at the hospital over the last four and a half years and I also extend my thanks to all of our staff who remain so committed to making the lives of local people better through their own area of expertise.

It is a new era for the Trust and on behalf of the Board, I am delighted to introduce Kevin, who will be instrumental to the way the George Eliot goes forwards into that new era.
Welcome to 2010/11 Annual Report, a comprehensive review of the financial year just gone; what we’ve done well and where we need to improve.

I have recently taken up my position as Chief Executive and as such can only bring you my early impressions of the hospital, the service it provides and the challenges it faces.

My first impression is of an organisation that has an extremely dedicated and skilled workforce with a strong focus on patient care working alongside a local community that has a great deal of pride in their hospital.

I would also like to assure you that I am fully committed to working with our staff and the community to ensure the George Eliot continues to provide a range of high-quality, safe care that meets the needs of local people, whilst recognising that we face some big challenges and will need to implement changes in order to move forwards.

As Stuart has already outlined, the overriding challenge we face in the coming years is the need to make significant efficiency improvements whilst ensuring we maintain and build on levels of patient safety and quality of care.

By working together as a team, listening to the views of our staff, our partners and our patients, I am sure we will succeed in achieving our key aims of delivering safe, efficient and effective care.

Kevin McGee
Chief Executive
A year in the life of George Eliot Hospital

April
Chair of the League of Friends, Linda O’Raw, retired after 22 years as a loyal volunteer during which time she helped raise over £1 million to buy new equipment for the hospital to benefit its patients and staff. The Trust would like to thank Linda for all her hard work over many years.

May
Mayor of Nuneaton and Bedworth, Councillor Don Navarro, launches his Mayor’s Appeal with money raised being donated to the hospital’s Special Care Baby Unit. He selected the unit following the lifesaving care his now 15-year-old son received there when he was born. At the end of March 2011, the appeal had raised over £10,000.

June
Following the award of a Certificate of Commitment by the Baby Friendly Initiative, a worldwide programme that forms part of the World Health Organisation and UNICEF, Trust midwives celebrate Breastfeeding Awareness Week. This includes staging a series of events to raise awareness of the benefits of breastfeeding.

July
The Trust begins the search for four new A&E consultants, three of which are newly created posts. This move is intended to help the hospital deal with historical shortages of senior staff. The recruitment process was successful and all consultants have now taken up their posts.

August
£30,000 of funding is secured to build a new cancer information centre on the hospital site which will include the appointment of staff to support the specific needs of cancer patients. Work will shortly begin on building the centre which will be staffed by a full-time specialist cancer nurse and a team of volunteers.

September
Hospital security staff introduce state of the art surveillance technology in a bid to make the hospital a safer place. The body worn cameras are used to record footage when security staff are called out to an incident. Any footage recorded can be submitted as evidence in court should it ever be required.
October
Trust staff are able to benefit from an exciting new ‘Passport to Health’ programme aimed at improving their health and wellbeing. The scheme offers all employees a comprehensive health check that will identify those who are at risk from some of the country’s biggest killers such as heart disease, stroke and diabetes and offer them advice.

November
The Trust’s breast and urological cancer services receive an exemplary report as part of an annual peer review process. Both services are highlighted as performing at a consistently high standard and as such are granted ‘earned autonomy’, meaning they now only have to be externally assessed every two years rather than annually.

December
The Trust celebrates 44 days without a case of the hospital acquired C diff infection, the longest run since records began and a vast improvement on a few years ago when it was not unusual to be reporting a new case every day. The success is partly thanks to improvements in hand hygiene and more intensive cleaning methods.

January
Chief Executive Sharon Beamish leaves the Trust to take up a position at the East Midlands Specialised Commissioning Group. During her four years at the Trust Sharon played an instrumental role in reducing health care associated infections and mortality rates.

February
The Board of Directors pledges to increase qualified nurse staffing ratios on its wards. The decision reflects the improvements that can be made to quality of care by increasing qualified nurse ratios. As well as improving patient safety, it is expected that the Trust will make financial savings in the long run by reducing the amount of time patients spend in hospital.

March
The Trust welcomes new Chief Executive Kevin McGee. Kevin joins the Trust from Heart of Birmingham Teaching Primary Care Trust where he was also Chief Executive. With 24 years experience working in the NHS, he has also had experience of working as a Finance Director and Chief Operating Officer in an acute trust setting.
“The staff on Melly Ward were excellent and a credit to the nursing profession, well done ten-out-of-ten. Thank you.”
Melly Ward patient

Trust overview
George Eliot Hospital NHS Trust is a small district general hospital based in Nuneaton, serving over 300,000 people in North Warwickshire, South West Leicestershire and North Coventry.

The Trust's main hub is the George Eliot Hospital, a 32-acre site on the outskirts of Nuneaton. The hospital provides a range of acute surgical, medical and children's services, including orthopaedics, accident and emergency and maternity care.

Named after the Nuneaton born author whose works include The Mill on the Floss and Middlemarch, the hospital opened in 1948, although a hospital has existed on the site since 1893.

In addition to providing many traditional acute health services, the George Eliot became the first acute trust in the country to have a primary care directorate. Initially this division was responsible for running the GP-led health centre in Camp Hill, Nuneaton. However, with the Department of Health led transfer of community services from primary care trusts to other providers, from 1 April 2011 the primary care directorate will have responsibility for a further three GP surgeries in North Warwickshire as well as specialised community dentistry, TB control and smoking cessation services across Warwickshire.

The Trust is part of several 'clinical networks' including cancer, pathology, coronary heart disease and women’s and children’s services. These partnerships enable Trusts to share resources and expertise, strengthening services for local people.

One of the Trust’s key goals is to provide care closer to home. Over recent years the Trust has developed ways of working to provide more services in community settings such as GP practices and people’s homes. These include physiotherapy, occupational therapy, respiratory care and stroke care.

The Trust’s main commissioner is NHS Warwickshire (Primary Care Trust), accounting for 71% of healthcare income, with Leicestershire County and Rutland PCT adding 12.8% and NHS Coventry 6.6%.

The Trust has four directorates providing health care services. Each directorate is responsible for providing a range of services as outlined below. The medical, surgical, and women’s, children’s and clinical support directorates each have their own management structure that includes a general manager and clinical director. The primary care directorate is run by an associate director.

Medical directorate
Accident and emergency, cardiology, cardio respiratory unit, emergency medical unit, general medicine, cancer services and chemotherapy, genito-urinary medicine, physiotherapy, occupational therapy, dietetics.

Surgical directorate
General surgery, orthopaedics, anaesthetics, pain management, operating theatres, intensive therapy unit, day procedures, urology, breast care, intensive therapy unit (ITU).

Women’s, children’s and clinical support services
Maternity, obstetrics, gynaecology, paediatrics, special care baby unit, diagnostics, imaging (radiology), outpatients department, pharmacy, health records, audiology.

Primary care directorate
GP services, smoking cessation, community dentistry, TB services.
Emergency preparedness

The Civil Contingencies Act 2004 provides a framework for emergency preparedness within the UK and places a statutory duty on NHS organisations to make necessary preparations in the event of an emergency or disaster.

The Trust is classed as category 1 responder, meaning the hospital would be in the first wave of a response to a major incident.

The Trust is an active member of the Warwickshire Local Health Resilience Forum along with other local NHS organisations as well as the Warwickshire Local Resilience Forum, which also includes representatives from local councils, Warwickshire Police and West Midlands Ambulance Service.

During the past year, staff from the Trust have taken part in a range of tabletop and live exercises alongside their colleagues in both forums. These exercises are aimed to test the readiness and robustness of multi-agency plans in responding to a major incident. The Trust received positive feedback for its participation in these exercises. More exercises are planned for the coming year.

The Trust has a Major Incident Plan. This document is reviewed and updated on a regular basis to reflect changes in national guidance and best practice.
The Trust is committed to cutting its carbon footprint and ensuring it plays its part in the whole country moving towards a low-carbon economy. It will take part in the Department of the Environment’s Carbon Reduction Commitment (CRC), a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

Participants in the CRC will need to measure and report their carbon emissions annually, following the introduction of a specific set of measurement rules. The first annual report of emissions is due in July 2011.

The Trust initially planned to purchase an emissions allowance under this scheme for 2011/12; however, following the government’s comprehensive spending review in October 2010, this has been delayed by a year and allowances will not need to be purchased until 2012/13.

Starting in 2012, participants will buy allowances from the government each year to cover their emissions in the previous year. This means organisations that decrease their emissions can lower their costs under the CRC.

The price of allowances has not yet been determined following the changes announced in October 2010, but the intent prior to that announcement was to sell allowances at a fixed price of £12 per tonne of CO2 through fiscal year 2012/13, with a floating market price after that.

In March 2010 when the Trust was planning for the initial scheme, it estimated the cost of allowances would total £113,664; however, it is confident that with the work that has taken place to reduce emissions since then, this will reduce substantially by the time it is required to purchase allowances for 2012/13.

The Trust has been working with the Carbon Trust, an organisation set up to provide assistance to private and public sector organisations in cutting carbon emissions. They have conducted a no-cost energy survey to identify opportunities for emission reductions.

Over the past year, amongst other things, work has taken place to reduce unnecessary areas of air conditioning, reduce lighting power requirements within the hospital general areas by replacing old inefficient lighting and introducing voltage reduction technology.

The Trust has developed a strategy that aims to deliver an annual reduction of 5% in energy consumption based on 2009/10’s consumption. Achieving this will mean that the organisation will achieve the national target of a reduction of 15% in carbon emissions by 2013 based on figures from 2000. Not only will this mean the Trust is providing a more environmentally friendly and sustainable service, but will also provide financial savings that will benefit patient care.
“We have been so impressed today with the care that has been taken of our daughter and granddaughters. We have met lovely people who have done everything they can at this stressful time.”

Relative of maternity patients
**Summary**

Despite the financial challenges faced, the Trust has maintained delivery of key performance and quality objectives. The Trust has maintained a governance risk rating (based on Monitor’s compliance framework) of ‘amber-green’ for each quarter. The Trust has:

- Met waiting time targets for both admitted and non-admitted care (maximum 18 week from referral to treatment).
- Met the cancer waiting time standards overall for the year.
- Had no cases of hospital acquired MRSA bloodstream bacteraemia.
- Halved cases of hospital acquired *Clostridium difficile* (*C. diff*); down from 79 to 40.
- Met the revised Accident and Emergency (A&E) waiting time target.

However, performance in some of these areas was not consistent across the whole year and as such the Trust must continue to drive improvement. This includes:

- A&E four-hour waiting time dropping below target to 94.7% from January-March.
- Failing to achieve the 18-week referral to treatment target for several specialties - Oral Surgery, Neurosurgery and Orthopaedics.
- Failing to screen all elective patients and emergency patients (from January 2011) for MRSA.

Please see the following page for more information

**Activity levels**

Overall, admitted patient care spells reduced in 2010/11 by 1.8%. The most significant impact on this was the introduction of a prior approvals policy for elective care in the middle of the year by NHS Warwickshire, the Trust’s main commissioner. This contributed towards an overall reduction in inpatient elective care of over 15%.

Day case activity fell by less than 1%; however, this was due to the full year effect of ophthalmology care. Without this, the reduction would have been over 5%.

A&E attendances increased by 1.9%; however, non-elective general and acute activity reduced by 1.9%, largely due to a reduction in activity from the Hinckley and Bosworth area.

Outpatient attendances fell by 0.3%. This was due to a reduction in GP referrals from mid-year and reduced outpatient procedures.

The number of births increased by 7.5%, reversing the trend from previous years.

**Operational performance**

The Trust continues to monitor its performance throughout the year against the Compliance Framework targets published by Monitor (the organisation that regulates Foundation Trust’s).

There are two key areas that Monitor uses; the governance risk rating and the financial risk rating. The table on the following page summarises the governance risk rating targets and performance throughout the year.

Hospital acquired *C. diff* infection rates reduced significantly in the last three quarters of the year with an average of only two cases per month. There were no cases of hospital acquired MRSA bloodstream bacteraemia in 2010/11.

The winter period saw significant pressures placed on hospitals across the region and the Trust failed to hit the A&E target for December and January. Bed capacity was increased during this period, partly as a measure to address increase in demand but also because of delays in discharges. Overall, the rate of admissions from A&E has remained fairly stable and it is anticipated that with the recent appointment of new A&E consultants this will continue to be the case.
## Performance Indicators 2010/11

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<th>Threshold 2010/11</th>
<th>Trust performance 2010/11</th>
<th>Performance 2009/10</th>
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<tr>
<td>Cases of Clostridium difficile (more than 48 hours after admission to the hospital)</td>
<td>56</td>
<td>40</td>
<td>79</td>
</tr>
<tr>
<td>Cases of MRSA bloodstream bacteraemia (more than 48 hours after admission to the hospital)</td>
<td>2</td>
<td>0</td>
<td>5</td>
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<tr>
<td>A&amp;E waits less than 4 hours</td>
<td>95%</td>
<td>96.8%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Cancer - 2 weeks from referral to first outpatient appointment</td>
<td>93%</td>
<td>96.2%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Cancer - 2 weeks from referral to first appointment for patients with breast symptoms</td>
<td>93%</td>
<td>96.5%</td>
<td>62.6% (recorded from 1 January 2010)</td>
</tr>
<tr>
<td>Cancer - 31 days from diagnosis to treatment</td>
<td>96%</td>
<td>98.5%</td>
<td>99%</td>
</tr>
<tr>
<td>Cancer - 31 days from diagnosis to treatment (drugs)</td>
<td>98%</td>
<td>100%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Cancer - 31 days from diagnosis to treatment (surgery)</td>
<td>94%</td>
<td>97.6%</td>
<td>100%</td>
</tr>
<tr>
<td>Cancer - 62 days urgent referral to treatment</td>
<td>85%</td>
<td>93.8%</td>
<td>85.7%</td>
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<tr>
<td>MRSA - compliance with elective screening</td>
<td>100%</td>
<td>96.5%</td>
<td>No data</td>
</tr>
<tr>
<td>MRSA - compliance with emergency screening</td>
<td>100%</td>
<td>88%</td>
<td>No data</td>
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Improving quality and the patient experience

“May I say, that all the personnel who attended to me did so in a courteous and caring manner and I cannot praise them all enough. Had I paid £10,000 for my treatment privately I could not have had a better service.”

Day procedure patient
Healthcare associated infections

The prevention of healthcare associated infection continues to be a key factor in ensuring the hospital provides safe, high quality care to its patients. The Trust has made excellent progress in recent years and remains fully committed to maintaining a zero tolerance stance towards infections.

The Trust has a dedicated infection prevention team whose role it is to support and advise staff on techniques and practices that have been proven to reduce infection rates.

The 2010/11 financial year saw the Trust reach two milestones in its ongoing mission to reduce infection rates. In January 2011, the Trust achieved an entire year without a single case of hospital acquired MRSA bloodstream bacteraemia, the first time this has happened since records began. The Trust finished the 2010/11 financial year without reporting a single incident.

In addition, in October 2010, the Trust went an entire calendar month without reporting a single case of hospital acquired Clostridium difficile (C diff), again the first time this has happened since records began. C diff rates for the year fell to a total of 40 (an average of less than four a month), a vast improvement from a few years ago when it was not unusual for the Trust to be reporting a new case every day.

MRSA testing

The Trust was ahead of the game in the fight to eliminate hospital acquired MRSA bloodstream bacteraemias when in October it started to screen all emergency patients for the bug, over three months ahead of the Department of Health’s deadline of 31 December. This screening of emergency patients was in addition to the screening of patients coming into hospital for planned treatment, something that has been happening since April 2009 for day cases and June 2007 for elective patients.

MRSA is carried harmlessly on the skin in as many as one in three people without them suffering any ill effects or even being aware of its presence. It is only when the bacteria enters the bloodstream that patients can become seriously ill with what is known as an MRSA bacteraemia (bloodstream infection). By identifying emergency patients who may be carrying the bacteria on their skin and promptly prescribing appropriated treatment, it is hoped that cases of the infection will be further reduced.

Norovirus

During the winter of 2009/10, the George Eliot, along with other hospitals across the region, was severely impacted by outbreaks of the winter vomiting bug, Norovirus. This led to a number of ward closures, suspension of visiting and the need to open additional capacity.

A lot of lessons were learnt from this experience and as such, despite isolated outbreaks of the bug over the winter just gone, the disruption to services was minimal.

Norovirus is predominantly community acquired and is often inadvertently brought into the hospital by patients, visitors and possibly staff. This winter, the infection prevention team focussed on ensuring outbreak areas were isolated quickly to ensure the chances of the virus spreading were limited.

“Every patients who unnecessarily catches a healthcare associated infection is one patient too many, this is why the battle to reduce such incidents will remain a key focus.”  
Pat Hutchinson, Lead Infection Prevention Nurse
Nursing investment
In January 2011, the Trust’s Board of Directors pledged to strengthen qualified nurse ratios to enhance frontline patient care. This will see qualified to unqualified nursing ratios rise from 50:50 to 60:40. The decision recognised the improvements that can be made to the quality of patient care by increasing qualified nursing ratios.

Evidence suggests that increasing qualified nursing ratios reduces occurrences of pressure sores, falls, drug errors and other events that can have a negative impact on a patient’s treatment and recovery.

Pressure ulcer prevention
In February 2011, staff at the hospital were asked to make a pledge to cut incidents of pressure ulcers amongst patients.

A pressure ulcer, sometimes referred to as a pressure or bed sore, is an area of skin that breaks down leading to an open sore. The hospital’s ‘PUP’ (Pressure Ulcer Prevention) initiative aims to raise awareness of the pain and harm pressure ulcers can cause to patients and the billions of pounds it costs the NHS each year to treat. In the majority of cases, they can be prevented if simple measures are taken.

Staff from across the hospital were invited to a launch event where they were asked to make a personal commitment to reduce incidences of pressure ulcers.

This new initiative follows a recent public commitment by the Trust’s Board of Directors to adopt a zero tolerance approach to pressure ulcers and introduce a new way of tackling and recording such incidents. In future, incidents of pressure ulcers will be reported as ‘harm events’ in a similar way that serious healthcare associated infections such as C diff and MRSA are. The hospital has seen a significant drop in cases of such infections over recent years and it hopes that by introducing the same level of prominence for pressure ulcers, a similar reduction will be seen.

Improving the Patient experience
In September 2010, the Trust’s Board of Directors approved a new strategy aimed at ensuring the experience it provides to its patients is amongst the best in the country. The ‘Best Care, Best Outcome’ patient experience strategy aims to pull together a range of methods already in place to measure patient satisfaction into one streamlined initiative. It will focus specifically on areas of concern raised by patients in relation to the services provided by the hospital and aim to build on areas of best practice locally and nationally, building a culture of continuous improvement.

Priority areas include:
• First impressions of the hospital and the service
• Ease of access and ease of use
• Improving communication regarding treatment options, allowing patients to make informed decisions
• Ensuring care is provided with compassion and is responsive to individual needs.

Feedback on patient experience is now reported monthly to the Board of Directors alongside performance data.
Customer care training
The Trust has been working in partnership with North Warwickshire and Hinckley College to run an innovative training programme aimed at improving the ‘patient experience’.

The ‘Enhancing the Patient Experience’ programme is underpinned by national customer care occupational standards that have been adapted for use in an NHS environment and specifically looks at improving the way staff communicate with patients and improve the information they provide them with. The course has been developed specifically for George Eliot Hospital, but it is hoped that if successful, it can be rolled out to the wider NHS.

New satisfaction survey
In January 2011, the Trust launched a new initiative aimed at providing instant feedback on patient satisfaction. The survey is carried out by a team of volunteers who visit patients on the ward to quiz them on aspects of their care. This feedback can be promptly fed back to ward managers who can make changes as appropriate. This initiative is in its early stages so no data is currently available; however, this data will be made available in public board papers in 2011/12.

Complaints
The Trust welcomes all aspects of feedback provided by patients, carers, visitors and staff. The formal complaints procedure plays an instrumental role in ensuring any areas of care that have fallen below the standard expected by patients and the Trust are highlighted and investigated. This allows the Trust to identify and implement changes to ensure standards of care are improved or procedures altered where necessary to prevent any repeat incidents.

In response to recent feedback through the complaints procedure and the national patient surveys, the Trust is undertaking customer service skills training with key staff groups to improve communication skills. Similarly, feedback from complaints and surveys has prompted the Trust to reintroduce dedicated smoking areas for patients that will remove the problem of people smoking by the main entrances, which has been causing discomfort to others entering and exiting the hospital site.

The Trust received 330 complaints in 2010/11 about the level of care and service it provides. This is up from 294 in 2009/10. 214 (66%) of these complaints were responded to within the Trust’s 25 day time limit, up from 115 (40%) in 2009/10.

Six complaints were referred to the Ombudsman’s Office. Following their initial assessment, the ombudsman decided not to investigate five of them. The remaining case is currently under investigation.

The Trust adheres to the Parliamentary and Health Ombudsman’s Six Principles for Remedy. These outline how the ombudsmen believes public bodies should put things right when they have gone wrong and their approach to recommending remedies. The principles can be found in full at www.ombudsman.org.uk

Quality accounts
A more detailed review of the Trust’s quality objectives can be found in its Quality Accounts document which is available at www.geh.nhs.uk or by contacting 02476 865383.
“Staff were very friendly and helpful. They have treated my husband with all the care and attention I could have wished for. Many thanks to everyone.”

Relative of patient on Adam Bede Ward

Division of medicine
Cancer services

Over the past year a significant amount of funding has been identified to improve the service the Trust provides to cancer patients.

In August, £30k of funding was agreed to build a new cancer information centre on the hospital site. The centre will be located next to the main entrance to the hospital and will offer cancer patients, their family and friends and members of staff the latest advice, support and information regarding the illness. A full-time Cancer Support Specialist Nurse, a newly created post, will staff the centre. A network of volunteers will provide additional support.

The cancer service was further enhanced thanks to £30k of funding from the Kay Kendall Leukaemia Fund. The funding will be used to develop a complementary therapy service for patients; paying for a part-time qualified complementary therapist and for the development of a dedicated complementary therapy room. The therapist will be able to offer a range of therapies including aromatherapy, massage and reflexology, all of which have been shown to help patients relax and promote a feeling of well being. The service received an additional boost with the appointment of Karen Pedley to the newly created post of Matron and Lead Cancer Nurse, a position jointly funded by Macmillan Cancer Support. Karen’s role involves translating national cancer policy into effective delivery at local level, while providing an expert nursing perspective in the planning and delivery of cancer services.

Accident and emergency

In July the Trust’s Board of Directors gave the go-ahead to recruit four new substantive A&E consultants, three of which were newly created posts. This recruitment process was successful and the consultants are now in post, meaning the Trust now has a full establishment of five A&E consultants and the reliance on costly locum cover is expected to decrease.

Respiratory care

In the past year, the Trust’s respiratory team has launched a twice monthly ‘breathlessness clinic’ to help an increasing number of patients who are suffering from this condition. The programme utilises a range of strategies such as breathing exercises, energy conservation and relaxation to help patients cope with breathlessness.

Physiotherapy

From June 2010, an additional 20 hours of physiotherapy has been provided to orthopaedic patients to enhance the care they receive over the weekend. This has been largely self funding due to the resultant reductions in length of stay.

At the beginning of September, the team carried out a satisfaction survey amongst musculo-skeletal outpatients. 98% of patients said they were satisfied with the service they received.

“We are delighted that despite the Trust and the NHS facing cost pressures, we have been able to expand many of our services in the medical division, ensuring local people have access to an increasing range of high quality healthcare on their doorstep.”

Kay Farmer, General Manager for Medicine
“Everyone was brilliant - receptionists, healthcare support workers, nurses, doctor, anaesthetists. They couldn’t have done any more to put my mind at ease.”

Day procedure patient
The focus of the surgery division over the past 12 months has been on delivering projects that improve the patient experience, enhance patient safety and reduce length of stay. It has been a challenging year but we’ve worked hard to ensure patient care remains our primary focus.”

Sasha Moran, General Manager for Surgery

Cancer services
The Trust performed exceptionally in a peer review of breast and urological cancer services during 2010. Both services at the hospital have been performing consistently at such a high standard, that they have been granted ‘earned autonomy’, meaning they only need to be externally assessed once every two years instead of annually.

The George Eliot joined other hospitals in the local area in expanding the age range for its breast-screening service on a permanent basis following a successful pilot scheme. The expansion of the service means that local women between the ages of 47-73 will now be offered this potentially lifesaving service every three years. Previously, in line with the national programme, breast screening had been offered to women between the ages of 50-70. This means that compared to the old programme, women will receive two additional screens in their lifetimes, taking them to nine in total.

The Coventry and Warwickshire Breast Screening Service (of which George Eliot Hospital, University Hospital Coventry and Warwickshire and Warwick Hospital are a part) was one of three areas across the country to take part in the pilot scheme run by the NHS Breast Screening Programme (NHSBSP). The pilot aimed to improve the detection of breast cancer at an early stage and increase the recovery rates for women diagnosed with the condition. Following the success of this scheme, the programme expansion will now be rolled out across the country.

Ophthalmology
The ophthalmology service was enhanced this year when the Trust brought preoperative assessment for patients undergoing cataract surgery in-house; this service was previously provided at University Hospital Coventry and Warwickshire. This has formed part of a new ‘one-stop’ cataract assessment clinic that takes place every week where patients can receive their assessment and be given a surgery date. This has helped to reduce waiting times.

Colourectal care
The colourectal team has significantly increased the number of operations being carried out laparoscopically (keyhole). Three of the four colorectal surgeons can now perform operations this way and this has led to a reduced risk of infection and a quicker recovery time.

Intensive Therapy Unit (ITU)
ITU received an excellent peer review in May 2010 with staff demonstrating the unit met virtually all required quality standards.

The unit has also been working to improve communication between staff and patients’ families by introducing a new process by which relatives/carers can contact ward staff directly if they have any concerns about any aspect of the patient’s care or treatment.

Day surgery
In 2010/11, day surgery accounted for 80% of all the surgery carried out by the Trust, higher than the recommended 75% and higher than many hospitals in the area. A higher rate of day case procedures means patients are able to return home more quickly thereby increasing efficiency and easing pressure on beds.

Surgical site infections
The division has started to provide data for the National Surgical Site Surveillance for patients being treated for hip fractures. The current rate of infection for such patients is well below the national average and this included no cases being recorded between April-September 2010. From April 2011, data will also be collected for knee surgery. Data for fractured neck of femur is already recorded.
Women’s and children’s services

“During their time at the hospital they received the best care that a very concerned patient could ask for. The doctors have been extremely thorough and the standard of nursing care that they have received has been outstanding.”

Parent of Special Care Baby Unit patients
Management of paediatric services

For some time, it has been agreed that an integrated paediatric service would be developed between University Hospitals Coventry and Warwickshire (UHCW) and George Eliot Hospital NHS Trust.

On 1 November 2010, clinical leadership responsibilities for doctors and nurses within paediatric services at George Eliot. This means that UHCW staff are currently responsible for providing support and leadership around professional standards.

It is anticipated that the overall transfer of management of paediatric services will take place later in 2011/12.

A more collaborative approach to working would ensure Trust staff and trainees are able maximise their skills and range of experience to benefit patient care by treating a wider range of patients, their conditions and illnesses.

In the longer term, a Coventry and Warwickshire-wide network for Women’s and Children’s services has been developing an options appraisal over several years to consider future models to ensure the long term sustainability of women’s and children’s services across the area. This process is underway and following involvement of relevant stakeholders and NHS partners, NHS Warwickshire will begin a public consultation. Further information regarding this will be available in the coming months.

Breastfeeding certificate

Trust midwives recently received recognition for the work they do to encourage local mothers to breastfeed their babies and promote the health benefits breastfeeding brings to babies and mothers.

The Certificate of Commitment recognises that the Trust is dedicated to implementing recognised best practice and is the first step towards gaining international recognition from the UNICEF (United Nations Children’s Fund) Baby Friendly Initiative, a global programme set up in conjunction with the World Health Organisation which aims to improve the care provided to all mothers and babies.

To receive the certificate, the Trust had to demonstrate that all midwives have received breastfeeding training and stay up to date with modern breastfeeding techniques. To further support the Trust’s commitment the maternity service has been recruiting a team of women to train as ‘peer supporters’ who can offer help and advice to women breastfeeding in the hospital and the community. The breastfeeding rate amongst new mothers at the Trust currently stands at 59%; the Trust is committed to increasing this by 2% a year over the next few years.

Promoting ‘normal birth’

The Trust is committed to increasing the ‘normal’ birth rate; the avoidance of instrumental delivery and caesarean sections. Increased rates of ‘normal’ births are shown to decrease length of stay, reduce adverse incidents and admissions to neonatal units, improve health outcomes for mothers and improve rates of successful breastfeeding.

Trust midwives have been receiving normal birth training to help them provide skilled support and information to first time mothers and women who have had one previous caesarean section.

The Trust’s caesarean rate for the 2010/11 financial year was 20.3%. This has been consistently below the national average of 24.6% and on two months has dropped as low as 17%.

“"The way we deliver women’s and children’s services will change over the next few years. Our role is to ensure that local people continue to have access to a safe, high quality services.”
Tina Kane, General Manager for Women’s and Children’s Services
“All aspects of the practice were superb... The nursing team and health care staff made sure my needs were met which helped my comfort considerably. We cannot praise the practice enough.”
Camp Hill Health Centre
Patient
Camp Hill GP Led Health Centre
In October 2009, the George Eliot Hospital NHS Trust became the first acute trust in the country to run a GP led health centre. Since then, the centre in Camp Hill has gone from strength to strength, now boasting over 2,500 registered patients.

Opened by then Health Minister Mike O'Brien, the health centre offers a range of services including GP appointments from 8am-8pm 365 days a year as well as a range of other services including diabetes clinics, family planning clinics, stop smoking services and weight management clinics.

The service has proved popular with local people. A patient satisfaction survey carried out by the health centre last year showed that 79% of patients rated the care they received ‘good’ or ‘excellent’.

Anyone interested in registering with the surgery or requiring more information can call 02476 390008.

Health trainers
Specialist health trainers have been working with residents from less affluent areas of the region to offer advice and support in improving health and wellbeing. This includes advice on healthy eating, weight management and exercising. They also offer support to help residents attend medical appointments.

Transforming community services
From 1 April 2011, George Eliot Hospital NHS Trust became responsible for providing community dental surgery, smoking cessation services and specialist TB nursing across the whole of Warwickshire, an urgent care, out of hours service based at Leicester Royal Infirmary and health trainers in Nuneaton and Bedworth. In addition, it will also be responsible for running three more GP practices; in Water Orton, Attleborough and Bedworth. 100 members of staff currently providing these services have become employees of George Eliot Hospital NHS Trust.

This is all part of a government led initiative to Transform Community Services (TCS), the proposals for which were set out in a 2009 White Paper. The paper stated that all primary care trusts should separate the commissioning of community services from their provision. The aim of this initiative is to provide more personalised care closer to home.

Smoking cessation
In 2010, the Trust was awarded contracts to provide smoking cessation services to people in Coventry and Warwickshire. This service is now well established, receiving 160 referrals since it began in September 2010. The service supports people attempting to quit smoking using a 12-week programme of behavioural support and medication, both at the hospital and through outreach clinics. The current success rate (patient still not smoking after four weeks) is 40%. This figure rises to 75% for patients participating in group sessions.

The service has been targeting smokers both in the community, in places such as colleges and factories, and in the hospital, with routine carbon monoxide screening being introduced for all patients undergoing elective surgery. Staff are being encouraged to refer patients who smoke to the service.

Anyone in Coventry or Warwickshire can access the Stop Smoking Service. For more information call 024 76 153071. Alternatively, contact the Coventry Stop Smoking Service (tel. 0800 051 1310) or the Warwickshire Stop Smoking Service (tel. 0800 085 2917).

“Providing care in people’s homes and community settings is going to become central to the way the NHS works over the coming years. As one of the first acute trusts in the country to have a primary care division we have a head start in ensuring we develop high quality services appropriate to the needs of the people we serve.”

Julie Whittaker, Associate Director of Primary Care
“The treatment my mother received was second to none... She was able to build good relationships with other patients and all the staff. Whenever she requested help, it was given promptly and efficiently.”

Dolly Winthrop Ward patient
Foundation Trust application

In January 2011, the Trust underwent an external review to establish its suitability to progress towards becoming a Foundation Trust (FT). The review focused on the Trust’s clinical and financial capabilities.

The review concluded that the key concern for the Trust is the scale of the financial challenge it currently faces. A programme of action has been established to tackle this challenge and the Trust’s Board of Directors remains firmly committed to pursuing FT status.

Earlier in the year, Chairman Stuart Annan wrote to Andrew Lansley, Secretary of State for Health, stating the Trust’s commitment to pursuing FT status. The Trust is working on a proposed timeline for achieving FT status subject to approval by the Department of Health.

The Trust’s Board of Directors firmly believes that pursuing FT status is in the best interests of patients, staff and the wider community, allowing the hospital to continue to deliver and develop services that best meet the needs of the people it serves.

Membership and the Members Advocacy Panel (MAP)

The Trust’s membership currently stands at over 10,300, a small increase from the same time last year, which reflects a reduction in proactive member recruitment in 2010/11.

The reduction in recruitment activities has not stopped the hospital proactively engaging with its members. In April 2010, the Trust established a Members Advocacy Panel (MAP) a group set up to mirror some of the roles of a future Board of Governors, something that will be implemented when the hospital becomes a Foundation Trust.

Members of the panel were selected from those people who had shown an interest in sitting on the Board of Governors. The group was set up by Trust Chairman Stuart Annan who was keen to harness this support to drive positive change at the hospital.

The group consists of 6 members of staff, 15 public members and 11 representatives from local partner organisations.

The MAP is seen as a key way of building robust relationships and two-way communication channels between the members they represent and Trust staff. As ambassadors for the Trust, their work will be vital in relaying positive messages, feeding back views and opinions from the Trust’s membership and sharing informed and accurate information in a timely manner.

The role of the MAP will grow further with the development of a work plan for 2011/12. This sets out key ways in which the MAP and the wider membership base can play an active part in developing the Trust’s Quality Accounts, Integrated Business Plan and membership strategy as well as becoming more involved in consultations, reviews and focus groups.

“The Trust’s Board of Directors firmly believes that gaining Foundation Trust status is in the best interest of the local community, the hospital and it’s staff. We remain fully committed to achieving this goal.”

Stuart Annan, Trust Chairman
Supporting patient care

“The staff are lovely and friendly and are willing to help. Nothing is too much trouble. They are always happy with a lovely smile.”
User of the Patient Advice and Liaison Service (PALS)
Medical records
In the 2009/10 financial year, the Trust undertook a major project to digitise the medical records library. Following a move to new premises in Bedworth, the medical records team began the process of scanning over 350,000 sets of records in September 2010 to enable them to be stored electronically.

The digitisation process is expected to take several years. Once completed it is expected to significantly improve the experience of patients, as clinicians will have instant access to an electronic copy of a patient’s medical history alongside up-to-date information from additional supporting systems.

In addition to this, the team has continued to provide a high quality service, dispatching an average of 25,000 sets of case notes per month to the main hospital site, ensuring their colleagues can provide high standards of care.

Security
In August, the Trust’s security team started using the latest surveillance technology in a bid to make the hospital a safer place for patients, visitors and staff.

Security staff worked closely with Warwickshire Police to introduce Robotronic Cameras (body worn devices) that can be used to record footage when security staff are called out to an incident. Any footage recorded can be submitted as evidence in court should it ever be required.

It is anticipated that the cameras will deter people from committing crime on the premises and assaulting or abusing staff.

Chaplaincy service
The Trust’s chaplaincy team includes 25 volunteer lay visitors, each undergoing an eight-week foundation-training course to prepare them to visit wards on a weekly basis. Six new volunteers have been recruited in the past year; four from the Christian community and two from the Hindu community.

The chaplaincy team works very closely with all the major faith group communities of North Warwickshire, helping them to meet the spiritual needs of the people they serve as patients. They also play an active part in the Trust’s Equality and Diversity Group, which works to increase awareness of the rich diversity of the local area.

Patient Advice and Liaison Service (PALS)
The PALS service is the first point of contact for patients and their family members who have queries or concerns regarding the care they have received.

In 2010/11, the service responded to over 3,713 queries, most of which related to appointments. 97% of these queries were responded to on the same day. Any other queries were dealt with as quickly as possible.

The PALS team are keen to see if extended opening hours would be of benefit to patients, carers and visitors. They plan to trial this in the coming year.

Estates
The estates team were involved in the upgrade of the hospital’s additional theatre capacity over the summer of 2010. This will provide the additional capacity to allow them to undertake a major upgrade of the hospital’s main theatres in the summer of 2011.

The department has also played a lead role in ensuring the hospital has the infrastructure in place to meet its requirements under Same Sex Accommodation Guidelines.
Information systems
There have been lots of IT developments in the past year that will benefit patient services. A new site wireless network along with a remote access solution was implemented. The new network will enable the Trust to be far more flexible in the way it works. One of the main advantages will be the ability to electronically tag and track key equipment and resources, meaning increased service efficient.

The Trust is in the process of piloting a new clinical system called Vital Pack, which will further support the provision of safe, high quality care within the Trust. This is a system that uses hand held devices to record patient observations and tests and keep an up to date track of the patient’s condition, speeding up the identification and provision of appropriate treatment. It is expected that this system will be rolled out across more wards in 2011/12.

In 2011/12, the Trust reported no serious incidents requiring investigation in relation to the loss of personal information.

Pharmacy service
The Trust’s pharmacy service was commended by NHS West Midlands during a visit in December 2010. They were impressed with the processes in place to ensure patients receive their medication in a prompt and timely manner and receive all the information they require regarding their medication.

The Trust’s Drugs and Therapeutics Committee (DTC) continues to assess new products for their appropriateness for use within the Trust and to approve medicines-related policies and other documents. The Medicines Policy was reviewed and extensively updated in 2010 to ensure the Trust’s compliance with national guidance. 15 new product requests, from hospital clinicians, were considered by the DTC in 2010-11.

Work experience
Over the past 18 months, the Trust has been working with local schools to give young people an insight into a career in the NHS.

The work experience programme has seen 170 students from 12 local schools and colleges receive work placements at the hospital and another 100 students invited to take part in clinical skills days, in the last academic year. Students have been given the opportunity to experience a range of jobs across many departments including maternity, physiotherapy, HR and communications.
Over the past year, the Trust sadly said a fond farewell to three individuals who each in their own way have made a very special contribution to the hospital and its patients.

In October, one of the Trust’s best known voices, Anker Radio’s Alan Green (pictured top left) died suddenly. Alan, who was better known as ‘Big Al’, was a regular volunteer on Anker Radio for nine years and was instrumental in raising funds to keep the station on the air. He was best known for his lunchtime radio show, ‘Big Al’s Lunchbox’, which was broadcast live from the studio on the top floor of the maternity block three times a week.

In August, the Trust also mourned the death of Kath Turner (pictured top right), the driving force behind the Bermuda and Stockingford Intensive Care Support (BASICS) charity. The charity, which has raised almost £250k for the Trust over the past 30 years, was founded by Kath and her husband Pete as a way of saying thank you for the care she received from staff on the coronary care unit following an emergency heart valve operation.

October also saw the sad death of sculptor, John Letts (pictured bottom). John was best known at the hospital as the creator of the bust of the queen in the hospital’s main reception area along with several other sculptures around the site, some of which he kindly donated. John was perhaps best known locally as the creator of the bronze statue of George Eliot in Nuneaton’s Newdegate Square, a replica of which sits at the main road into the hospital.

Trust Chairman Stuart Annan paid tribute to Al, Kath and John, saying: “It’s so sad to lose three people in such quick succession who have made such an impact on our staff, patients and the wider community. Our thoughts are very much with their families. They can be very proud of what they each achieved and the happiness they brought to others.”
"I found all the staff to be kind and attentive at all times. They could answer any questions I asked of them with good knowledge."

Patient on Nason Ward

Community Support
Charitable funds
In 2010/11, donations have come from many different sources including members of the local community, staff, past patients and carers, and local organisations.

Donations in 2010/11 exceeded £95k. The range of donations received varied from a few pounds to several thousands and a wide variety of fundraising activities have benefited the Charity. The Trust is extremely grateful for donations of any size. Events throughout the year have included, but are not limited to:

- A group climbing the three peaks in 23 hours raising £3,928 for the Special Care Baby Unit.
- A member of staff, while receiving treatment himself, raised £2,000 from a fundraising evening to purchase fans and televisions for the Oncology Department.
- A sponsored bike ride from Newcastle to Nuneaton raised funds for Caterina Ward in memory of a loved one.

In addition, the Coronary Care Unit received a legacy of over £8,000, which has been used to purchase specialist chairs to benefit patients.

Money raised has been used to purchase a variety of equipment including, but not limited to:

- Vital signs monitor for Melly Ward and the Diabetes Unit
- Patient monitors for Caterina ward

Mayor’s appeal
The Trust was delighted when Councillor Don Navarro, Mayor of Nuneaton and Bedworth, announced that he had chosen the Trust’s Special Care Baby Unit as the beneficiary of his civic appeal for the year. The Trust has worked closely with the fundraising appeal committee to support some of the many fundraising events they have been involved in. It is expected that the appeal will raise over £10,000, which will be used to purchase a monitor to work with the resuscitare equipment purchased thanks to a previous civic appeal.

League of Friends
League of Friends volunteers continue to work tirelessly to raise funds to purchase equipment for the hospital.

The teabars continue to provide the bedrock for the league’s fundraising. The income from this is supplemented by other events, tombolas and sales in the hospital entrance area.

During 2010/11, the league raised £120,000 and purchased £62,000 of equipment. As always, the Trust is extremely grateful for the league’s ongoing support.

Volunteers
The Trust has made a commitment to support those wishing to volunteer in the hospital. The Trust currently has over 150 assisting in areas such as meeting and greeting, supporting the patient satisfaction survey programme, administration and patient care.

The Trust is always looking to recruit more volunteers. Anyone interested in volunteering should contact Christine Longstaff on 02476 865576.

Corporate support
Many local organisations have shown their support for the Trust over the past year.

Tesco’s at the Ricoh Arena shopping park has been a major supporter of the hospital, making regular donations of funds and other items as well as sponsoring the Trust’s annual health fair.

Making a donation
The easiest way to make a donation is via one of two fundraising websites the Trust subscribes to; www.justgiving.com or www.virginmoneygiving.com.

Community art project
In 2010, the Trust launched a community art initiative aimed at involving local people in creating artwork for the hospital. There is evidence that suggests pleasant surroundings can influence the way people feel and bring significant benefits to a healthcare environment. This is something the hospital has been aiming to achieve through this initiative.

Over 100 pieces of artwork and photography have been donated or lent to the hospital by over 20 local artists, art groups and colleges.

“We are very fortunate that we have a community who are so passionate about their hospital. This is demonstrated by their ongoing fundraising, donations and support, all of which benefits our patients. As ever, we are immensely grateful for the ongoing support.”
Malcolm Dade, Chair of the Charitable Funds Committee
“Marvellous. You lot deserve a medal. Thank you for your kindness. Couldn’t wish for nicer people.”
Patient on Elizabeth Ward

Our people
Workforce key performance indicators

Agency expenditure
The Trust continues to experience high levels of expenditure on temporary staff whether bank, agency or locum. Much of this expenditure is as a result of additional capacity that has been opened within the hospital and ensuring Trust medical rosters meet the requirements of the European Working Time Directive (EWTD) for doctors in training. Reducing this cost in the coming year will be crucial in ensuring the Trust achieves its financial goals. The move to 60% of ward staff being qualified nurses should help to reduce dependency on agency staff.

Attendance at work
Staff continue to show their commitment to patients by achieving high levels of attendance. In 2010/11 4.3% of working days lost to sickness absence compared to 4.5% in 2009/10.

The Trust continues to work towards a benchmark of 4%. To help it achieve this goal, a Workplace Wellbeing Group has been established under the leadership of the Associate Director of HR. The group takes the view that a healthy workforce is a happy workforce and the benefits of a happy, healthy workforce will be improved levels of service to patients.

In 2010, the Trust joined forces with Nuneaton and Bedworth Borough Council to offer staff the chance to benefit from a new ‘Passport to Health’ programme.

Learning and development
The Trust is committed to being a learning organisation, where staff engage in the learning process in order to improve the quality of service provided. The Trust has a dedicated Learning and Development Team whose role it is to support staff to access appropriate learning and development opportunities.

One of the team’s key commitments is to ensure staff are compliant with statutory and mandatory training. This includes training in infection prevention, manual handling and fire safety, and ensures the hospital is a safe and secure environment for staff, patients and visitors. The Trust is aiming to have all of its staff compliant with statutory and mandatory training requirements.

The Trust works closely with a range of organisations to offer educational opportunities to staff. In the past year, this has included a management development course with NHS Elect, dementia awareness courses with Staffordshire University and a range of NVQs with North Warwickshire and Hinckley College. The Trust remains an accredited centre for the delivery and assessment of NVQs.

The future for the workforce
In the coming years, the Trust’s workforce will be required to adapt to meet the changing nature of the NHS. This will involve making significant cost improvements while ensuring patient safety isn’t compromised.

Over 70% of staff responded to the 2010/11 staff satisfaction survey, its highest response rate ever. The Trust received its highest Staff Satisfaction Survey Response in 2010/11. This was followed up by a series of ‘Call to Action’ focus groups which looked to involve staff in developing a vision for the organisation moving forward.

The Trust’s Cultural Programme and Wellbeing Group has been central to ensuring lessons are learnt from this and other feedback and positive changes are made.

Equal opportunities
The Trust has adopted a Single Equality Scheme to help stop discrimination and lessen equality between groups of staff and service users.

The Trust Board of Directors believes that it is crucial that the organisation links the issue of diversity to the core of its business, at the centre of its aims and objectives. An Equality and Diversity group meets on a quarterly basis to ensure the Trust is meeting its goals in relation to ensuring all service users can expect the same level of high quality care.

“Without doubt our staff are our greatest asset and over the coming years they will be instrumental in shaping the long-term future of the hospital. Our role is to ensure they get all the training and support they need to carry out their role to the best of their ability.”
Dorothy Hogg, Associate Director of Human Resources
Meet the Board of Directors

Stuart Annan  
Trust Chairman

Kevin McGee  
Chief Executive  
from March 2011

Sharon Beamish  
Chief Executive  
until January 2011

Chris Bradshaw  
Director of Finance and Performance

Andrew Arnold  
Medical Director  
from March 2011

Ray Steingold  
Medical Director  
until December 2010

Dawn Wardell  
Director of Nursing and Quality

Kath Kelly  
Director of Operations  
from July 2010

Heather Norgrove  
Commercial Director

Malcolm Dade  
Non-executive Director

Chris Bain  
Non-executive Director

Rupert Herd  
Non-executive Director

John Acornley  
Non-executive Director

Shabir Ismail  
Non-executive Director  
until September 2010

Don Navarro  
Non-executive Director

Kevin McGee  
Chief Executive  
from March 2011

Sharon Beamish  
Chief Executive  
until January 2011

Malcolm Dade  
Non-executive Director

Chris Bain  
Non-executive Director

Shabir Ismail  
Non-executive Director  
until September 2010

Don Navarro  
Non-executive Director
# Directors’ register of interests

<table>
<thead>
<tr>
<th>Name of director</th>
<th>Nature of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuart Annan, Chairman</td>
<td>• Director of “Terrain” Ltd. Management Consultancy</td>
</tr>
<tr>
<td></td>
<td>• Daughter - Occupational Therapist</td>
</tr>
<tr>
<td>Kevin McGee, Chief Executive from March 2011</td>
<td>• Nil return</td>
</tr>
<tr>
<td>Sharon Beamish, Chief Executive until January 2011</td>
<td>• Nil return</td>
</tr>
<tr>
<td>Chris Bradshaw, Director of Finance and Performance</td>
<td>• Governor/Director of Queen Alexandra College and subsidiaries</td>
</tr>
<tr>
<td></td>
<td>• Member of the Healthcare Financial Management Association</td>
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<tr>
<td></td>
<td>• Membership of Autism West Midlands</td>
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<tr>
<td></td>
<td>• Membership of National Autistic Society</td>
</tr>
<tr>
<td>Andrew Arnold, Medical Director since March 2011</td>
<td>• Nil return</td>
</tr>
<tr>
<td>Ray Steingold, Medical Director until December 2010</td>
<td>• Nil return</td>
</tr>
<tr>
<td>Dawn Wardell, Director of Nursing and Quality</td>
<td>• Company Secretary, Securex Ltd</td>
</tr>
<tr>
<td>Kath Kelly, Director of Operations since July 2010</td>
<td>• Nil return</td>
</tr>
<tr>
<td>Heather Norgrove, Commercial Director</td>
<td>• Nil return</td>
</tr>
<tr>
<td>Malcolm Dade, Non-executive Director</td>
<td>• Director of MMD Associates</td>
</tr>
<tr>
<td>Chris Bain, Non-executive Director</td>
<td>• Member of the Labour Party</td>
</tr>
<tr>
<td></td>
<td>• Associate Mental Health Act Manager with Coventry and Warwickshire NHS Partnership Trust</td>
</tr>
<tr>
<td>Rupert Herd, Non-executive Director</td>
<td>• Member of the Labour Party</td>
</tr>
<tr>
<td>John Acornley, Non-executive Director</td>
<td>• Director (Chairman) and shareholder of Rainford EMC Limited which which may look to do business with the NHS on the sale of MRI rooms</td>
</tr>
<tr>
<td>Shabir Ismail, Non-executive Director until September 2010</td>
<td>• Employed at North Warwickshire and Hinckley College as Director of Finance</td>
</tr>
<tr>
<td>Don Navarro, Non-executive Director</td>
<td>• Nil return</td>
</tr>
</tbody>
</table>

Directors have taken all reasonable steps to ensure that information relevant to the external auditors is available and has been made available to the auditors.
## Salary and pension entitlements of senior managers

### A) Remuneration

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary (bands of £5k)</th>
<th>Other remuneration (bands of £5k)</th>
<th>Bonus payments (bands of £5k)</th>
<th>Benefits in kind rounded to the nearest £100</th>
<th>Salary (bands of £5k)</th>
<th>Other remuneration (bands of £5k)</th>
<th>Bonus payments (bands of £5k)</th>
<th>Benefits in kind rounded to the nearest £100</th>
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</thead>
<tbody>
<tr>
<td><strong>2010/11</strong></td>
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</tr>
<tr>
<td>Stuart Annan, Chairman</td>
<td>£20k-£25k</td>
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<td>0</td>
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<td>£20k-£25k</td>
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<td>Sharon Beamish, Chief Executive until 4/1/11</td>
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<td>Kevin McGee, Chief Executive from 28/3/11</td>
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<td>N/A</td>
</tr>
<tr>
<td>Chris Bradshaw, Deputy Chief Executive and Director of Finance and Performance¹</td>
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<td>£95k-£100</td>
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</tr>
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<td>Raymond Steingold, Medical Director until 31/12/10</td>
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<td>£65k-£70k</td>
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</tr>
<tr>
<td>Gary Lawrence, Acting Medical Director from 1/1/11-28/2/11²</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gordon Wood, Acting Medical Director from 1/1/11-28/2/11²</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Andrew Arnold, Medical Director from 1/2/11</td>
<td>£5k-£10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Heather Norgrove, Commercial Director</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£75k-£80k</td>
<td>0</td>
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</tr>
<tr>
<td>Nigel Kee, Chief Operating and Nursing Officer</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£105k-£110k</td>
<td>0</td>
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</tr>
<tr>
<td>Amanda Robson, Acting Director of Operations until 31/7/10</td>
<td>£25k-£30k</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£25k-£30k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Katherine Kelly, Director of Operations until 1/8/10</td>
<td>£55k-£60k</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dawn Wardell, Director of Nursing</td>
<td>£80k-£85k</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>£25k-£30k</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Rupert Herd, Non-executive Director</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Shabir Ismail, Non-executive Director until 30/9/10</td>
<td>£0-£5k</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chris Bain, Non-executive Director from 1/4/10</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Malcolm Dade, Non-executive Director</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>John Acornley, Non-executive Director</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
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<td>£5k-£10k</td>
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### Salary and pension entitlements of senior managers

#### 2009/10

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary (bands of £5k)</th>
<th>Other remuneration (bands of £5k)</th>
<th>Bonus payments (bands of £5k)</th>
<th>Benefits in kind rounded to the nearest £100</th>
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<tr>
<td><strong>2009/10</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Stuart Annan, Chairman</td>
<td>£20k-£25k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sharon Beamish, Chief Executive until 4/1/11</td>
<td>£95k-£100k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kevin McGee, Chief Executive from 28/3/11</td>
<td>£0-£5k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chris Bradshaw, Deputy Chief Executive and Director of Finance and Performance¹</td>
<td>£100k-£105k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Raymond Steingold, Medical Director until 31/12/10</td>
<td>£45k-£50k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gary Lawrence, Acting Medical Director from 1/1/11-28/2/11²</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gordon Wood, Acting Medical Director from 1/1/11-28/2/11²</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Andrew Arnold, Medical Director from 1/2/11</td>
<td>£5k-£10</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Heather Norgrove, Commercial Director</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nigel Kee, Chief Operating and Nursing Officer</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amanda Robson, Acting Director of Operations until 31/7/10</td>
<td>£25k-£30k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Katherine Kelly, Director of Operations until 1/8/10</td>
<td>£55k-£60k</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dawn Wardell, Director of Nursing</td>
<td>£80k-£85k</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Rupert Herd, Non-executive Director</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shabir Ismail, Non-executive Director until 30/9/10</td>
<td>£0-£5k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chris Bain, Non-executive Director from 1/4/10</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Malcolm Dade, Non-executive Director</td>
<td>£5k-£10k</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>John Acornley, Non-executive Director</td>
<td>£5k-£10k</td>
<td>0</td>
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</tr>
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</table>
### B) Pension benefit

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60 (bands of £2,500)</th>
<th>Real increase in pension lump sum at age 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31/3/2011 (bands of £5k)</th>
<th>Lump sum at age 60 related to accrued pension at 31/3/2011 (bands of £5k)</th>
<th>Cash equivalent transfer value at 31/3/2011</th>
<th>Cash equivalent transfer value at 31/3/2010</th>
<th>Real increase (decrease) in cash equivalent value</th>
<th>Employer’s contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuart Annan, Chairman</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sharon Beamish, Chief Executive until 4/1/11</td>
<td>£0-£2.5k</td>
<td>£2.5k-£5k</td>
<td>N/A</td>
<td>N/A</td>
<td>£711k</td>
<td>£750k</td>
<td>(£30k)</td>
<td>N/A</td>
</tr>
<tr>
<td>Kevin McGee, Chief Executive from 28/3/11</td>
<td>£0-£2.5k</td>
<td>£0-£2.5k</td>
<td>£40k-£45k</td>
<td>£120k-£125k</td>
<td>£669k</td>
<td>£603k</td>
<td>£1k</td>
<td>N/A</td>
</tr>
<tr>
<td>Chris Bradshaw, Deputy Chief Executive and Director of Finance and Performance</td>
<td>£0-£2.5k</td>
<td>£2.5k-£5k</td>
<td>£20k-£25k</td>
<td>£60k-£65k</td>
<td>£477k</td>
<td>£481k</td>
<td>(£4k)</td>
<td>N/A</td>
</tr>
<tr>
<td>Raymond Steingold, Medical Director until 31/12/10</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Gary Lawrence, Acting Medical Director from 1/1-28/2/11</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Gordon Wood, Acting Medical Director from 1/1-28/2/11</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Andrew Arnold, Medical Director from 1/2/11</td>
<td>(£0-£2.5k)</td>
<td>(£0-£2.5k)</td>
<td>£45k-£50k</td>
<td>£145k-£150k</td>
<td>£1.031m</td>
<td>£1.219m</td>
<td>(£16k)</td>
<td>N/A</td>
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<tr>
<td>Amanda Robson, Acting Director of Operations until 31/7/10</td>
<td>£0-£2.5k</td>
<td>£0-£2.5k</td>
<td>N/A</td>
<td>N/A</td>
<td>£335k</td>
<td>£325k</td>
<td>£4k</td>
<td>N/A</td>
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<tr>
<td>Katherine Kelly, Director of Operations until 1/8/10</td>
<td>(£0-£2.5k)</td>
<td>(£0-£2.5k)</td>
<td>£30k-£35k</td>
<td>£90k-£95k</td>
<td>£455k</td>
<td>£530k</td>
<td>(£50k)</td>
<td>N/A</td>
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<tr>
<td>Dawn Wardell, Director of Nursing</td>
<td>£7.5k-£10k</td>
<td>£22.5k-£25k</td>
<td>£30k-£35k</td>
<td>£90k-£95k</td>
<td>£463k</td>
<td>£404k</td>
<td>£59k</td>
<td>N/A</td>
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<tr>
<td>Rupert Herd, Non-executive Director</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Shabir Ismail, Non-executive Director until 30/9/10</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chris Bain, Non-executive Director from 1/4/10</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Malcolm Dade, Non-executive Director</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
</tr>
<tr>
<td>John Acornley, Non-executive Director</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

1. Mr Bradshaw acted as chief executive from 5 January 2011-27 March 2011
2. Messrs. Gary Lawrence and Gordon Wood jointly covered the post of Medical Director from 1 January 2011-28 February 2011. They received no remuneration for this.

**Remuneration Committee**: All the Trust’s Non-executive Directors sit on the Remuneration Committee. The role of this committee is to set the remuneration for very senior managers at the Trust.

The accounting treatment for pensions and pension liabilities for staff employed by the trust are explained in Note 11 to the Annual Accounts.
“The service, help, treatment and assistance I have received during my hospitalisation has been first class and I cannot speak highly enough of all the staff.”
Patient on Alexandra Ward
Summary
The year has been challenging for the Trust largely due to the significant reduction in referrals and approvals for treatment of elective patients implemented by commissioners half way through the year, together with cost pressures we faced ourselves. As a result, the surplus achieved by the Trust in the first half of the year was turned into a significant deficit in the second half.

Because of the scale and timing of these events, the Trust received financial support from NHS West Midlands Strategic Health Authority. This has allowed the Trust to report a break-even position for 2010/11.

Moving forward, reductions in demand for acute services will continue. The Trust is working closely with its commissioners to ensure these reductions are managed in a way that allows for clinical and financial sustainability.

The financial pressures meant that the Trust failed to achieve two of its key objectives:

- To reduce the historic deficit. In previous years this had been achieved through making between a £1m-£1.4m surplus.
- To ensure repayment of the working capital loan made to the Trust in 2005 by NHS West Midlands are made from surpluses rather than reducing cash balances.

Financial performance
The trust had a deficit of £7.2M in 2005/06 and received a working capital loan of £6.8M in 2006/07. It achieved surpluses of £1.0M-£1.4M in the period from 2006/07 to 2009/10. In 2010/11 it was set to maintain this performance. However, reduced elective activity in the second half of the year led to elective income being reduced by £0.8M per month. This caused a monthly deficit of £0.7M.

Because reducing activity is part of the commissioners long-term plans, NHS West Midlands allocated additional resources to the Trust. This has allowed the Trust to achieve its breakeven duty for the year. However, it has fallen behind its planned recovery profile and the repayment of the working capital loan was made from cash reserves rather than cash generated from operations.

Income from both NHS Warwickshire and NHS Leicester County & Rutland were below plan (please see graph on following page). In the first half year, the lower income from the latter was offset by higher activity from Warwickshire. However, the reductions implemented by Warwickshire meant that the offsetting income was lost. The funding allocated by NHS West Midlands offset the impact of these changes in the second half year.

The higher activity in the first half year was met in part through additional capacity to ensure that waiting time targets were achieved. When activity reduced only marginal costs were avoided. Additional costs were incurred during the winter period as length of stay remained high and additional capacity had to be put in place. Agency and locum staff costs were high throughout the year, especially in A&E and Paediatrics. The trust also incurred a one-off charge due to the payment of injury benefit for a former employee.
Cash flow
The Trust’s cash position increased from £2.9M at the start of the year to £6.0M at the end. The profile was consistently above plan. In spite of the deteriorating operational performance, the main commissioners paid contracted income levels throughout the year. Capital expenditure reduced because of the reduced cash generated from operations. Financial support from the SHA increased cash inflow in the final quarter.

In September and March each year, the Trust pays pay down our working capital loan and make dividend payments to the Department of Health (see graph on following page).

The cash position will reduce in the first quarter of 2011/12 as some of the payments on account are returned.

Staff numbers and employment costs
A key challenge the Trust has faced throughout the year has been the high level of agency and locum staff use. This resulted partly from the need to increase capacity to address winter pressures and throughout the year due to vacancies for medical staff especially in A&E and Paediatrics.

Capital investment
The main capital expenditure incurred during the year was £0.5m for the delivery of same sex accommodation and £0.4m for the project to digitise medical records as part of our move towards improved hospital information systems.

The key challenges for 2011/12
2011/12 will be the most challenging year the Trust has faced for some time. It needs to get back on track in delivering annual surpluses so that the historic deficit and working capital are paid down.

All providers in the local health economy are facing requirements to reduce acute expenditure and focus on prevention and admissions avoidance. The Trust has agreed an acute contract with NHS Warwickshire for 2011/12 with income of £72.2m. This is around £1m greater than the contract outturn value for 2010/11 and is £1m lower than the plan for 2010/11.

The aggregate impact of tariff efficiency, reduced activity, cost pressures and financial recovery to achieve a recurrent surplus requires significant cost reductions of around £11M (10% of income) in 2011/12.

The trust will make final repayment of its working capital loan in 2011/12 and will achieve its cumulative breakeven duty the following year.

Delivery of the cost reductions is a significant risk. The Trust has now self-declared as being in turnaround in order to emphasise the urgency and scale of financial challenge it faces. It has set up a project management office and appointed a turnaround team to drive forward the changes required over the next 18 months. Reductions in resources will not be at the expense of quality and patient safety.

The trust will acquire approximately £5m of business under the Transforming Community Services programme including three APMS primary care practices, the county-wide community dental service and an urgent care centre for NHS Leicester City. Its total community business will be in excess of £6M including the existing APMS and services already delivered within the acute contract.

Better payment code of practice
During the year, the Trust became a signatory to the Prompt Payment Code. Performance improved for the year to 96% by value (compared to 88% in 2009/10) and 94.5% by number (compared to 88% the previous year). For trade creditors the Trust met the national target of 95%, the first time this level of performance has been achieved.

The trust will make final repayment of its working capital loan in 2011/12 and will achieve its cumulative breakeven duty the following year.

Delivery of the cost reductions is a significant risk. The Trust has now self-declared as being in turnaround in order to emphasise the urgency and scale of financial challenge it faces. It has set up a project management office and appointed a turnaround team to drive forward the changes required over the next 18 months. Reductions in resources will not be at the expense of quality and patient safety.

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The financial picture

Annual surplus/deficit

Cumulative deficit/surplus
Outstanding working capital loan

Income by commissioner £m

Income and expenditure
<table>
<thead>
<tr>
<th>Financial risk rating</th>
<th>2009/10</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA* margin</td>
<td>7.9%</td>
<td>7.9%</td>
</tr>
<tr>
<td>EBITDA* achieved</td>
<td>80.5%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Return on assets</td>
<td>4.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Liquidity ratio (days)</td>
<td>16.3%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Weighted financial risk rating</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Overall financial risk rating</td>
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<td>3</td>
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*EBITDA: Earnings before interest, tax, depreciation and amortisation

<table>
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<tr>
<th>Public sector prompt payment</th>
<th>Last year no.</th>
<th>Last year value</th>
<th>Actual Q1</th>
<th>Actual Q2</th>
<th>Actual Q3</th>
<th>Actual Q4</th>
<th>This year no.</th>
<th>This year value</th>
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<tbody>
<tr>
<td>Non-NHS</td>
<td>89%</td>
<td>87%</td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
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<td>95%</td>
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<tr>
<td>NHS</td>
<td>76%</td>
<td>91%</td>
<td>91%</td>
<td>79%</td>
<td>84%</td>
<td>95%</td>
<td>84%</td>
<td>96%</td>
</tr>
<tr>
<td>Local trade within 10 days</td>
<td>48%</td>
<td>46%</td>
<td>80%</td>
<td>81%</td>
<td>76%</td>
<td>77%</td>
<td>77%</td>
<td>79%</td>
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</table>

<table>
<thead>
<tr>
<th>Staff numbers (average number of people employed)</th>
<th>2009/10</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>254</td>
<td>263</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>354</td>
<td>354</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>150</td>
<td>161</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>751</td>
<td>755</td>
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<tr>
<td>Scientific, therapeutic and technical</td>
<td>251</td>
<td>249</td>
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<tr>
<td>Other</td>
<td>43</td>
<td>44</td>
</tr>
<tr>
<td>Total</td>
<td>1803</td>
<td>1826</td>
</tr>
</tbody>
</table>
Statement of internal control

1. Scope of responsibility
The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation’s policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation’s assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

I am accountable to the Board of Directors for ensuring that plans and objectives are implemented and that progress towards implementation is regularly reported to the Board using accurate systems of measurement and data management. The Trust’s corporate governance policies and other advice on expected standards of behaviour of staff apply to me as Chief Executive and to other members of staff. I subscribe to the code of conduct for NHS Managers.

Staff throughout the organisation are made aware of their responsibility to maintain high standards of conduct and accountability. In support of good governance, and to ensure the safekeeping and appropriate use of public funds, the Trust also maintains a proactive programme of counter-fraud and a “whistle blowing” policy.

The Trust has a range of mechanisms in place to facilitate effective working with key partners, in particular the West Midlands Strategic Health Authority, NHS Warwickshire, Coventry (Teaching) Primary Care Trust, and University Hospital Coventry and Warwickshire NHS Trust. I meet regularly with the Chief Executives of each of these organisations, individually, jointly and collectively.

Governance and risk issues are regularly discussed at a variety of health economy wide forums, including formal review meetings with the Strategic Health Authority and monthly meetings of Chief Executives.

2. The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation’s policies, aims and objectives; and
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the George Eliot Hospital for the year ended 31 March 2011 and up to the date of approval of the Annual Report and Accounts.

3. Capacity to handle risk
The Trust has adopted a robust approach to risk management with the structures and processes in place to successfully deliver the risk management objectives. Leadership arrangements are defined within the Trust and are supported by job descriptions and objectives.

Leadership is further embedded at the directorate level where managers have responsibility for risk identification assessment and analysis. Staff are trained or equipped to manage risk, both clinical and non clinical in a manner appropriate to their authority and duties. All new members of staff are required to attend a mandatory induction (supplemented by local induction) which covers all key elements of risk management.

All staff are required to complete mandatory and essential update training, which covers risk management, risk assessments and health and safety training. Due to the changes in the standards since the last NHS Litigation Authority assessment the Trust made the decision in respect of acute services to be assessed for level 1 compliance. The Maternity unit was assessed in December 2010 and scored a total of 49/50 across the standards at level 1 and was successful in obtaining level 1.

Learning from incidents and good practice is discussed in a number of arenas which includes Back to Basic meetings Patient Experience Group, Patient Safety Group, individual divisions governance meetings and also at Board level.

Responsibility and accountability for risk management is clearly defined in the risk management strategy which sets out the trust’s approach to risk, the accountability arrangements including responsibilities of the Board and its sub committees, directors, governance team, specialist leads and employees.

The Board of Directors and Chief Executive ensure that the risk management arrangements are implemented monitored and reviewed and meet all legal and regulatory requirements. The Board receives reports from both the Audit and Quality & Risk committees on the status of the Trust’s control risk measures.
During 2010/11 the Board decided the role of the Risk Committee should be widened to encompass quality as well as risk; it became the Quality & Risk committee and remains a subcommittee of the Board of Directors. Its remit of managing, mitigating and monitoring risk management arrangements (clinical and non clinical) on behalf of the Board has been expanded to ensure risks to quality are also identified and managed. This Committee is chaired by a Non Executive Director, supported by the Board Secretary.

4. The risk and control framework
The Risk Management Strategy is the framework for the management and control of risk throughout the Trust. The Strategy is based on the following risk statements:

• The Trust is committed to providing a safe environment for patients, staff and visitors, by creating an open, transparent and just culture that encourages proactive identification of risks, implementation of risk reduction measures and when adverse incidents occur, learning and sharing lessons to prevent where possible or reduce the likelihood of reoccurrence.

• The Trust wishes to put safety and patient safety in particular, at the very core of policy development and service delivery by developing a positive safety culture within the trust. The trust is committed to implementation, embedding and ongoing development of the Seven Steps to Patient Safety (2004) and Building a Safer NHS for Patients: implementing an organisation with a memory (2001) to support the trust vision. This strategy also ensures that the Trusts commitment to best practice and legal requirements / guidance notes to include HSG 65 Successful Health and Safety management, which places a duty on organisations to have robust Policies, Organisational Control, Monitoring/Audit review in place and the Management of Health and Safety at Work Regulations (1999).

• The Trust has a legal requirement to give assurance that risks in the organisation are identified and appropriately managed.

The Risk Management Strategy is approved by the Board. The strategy is published widely and includes:

• The aims and objectives for risk management in the Trust.
• The relationship and responsibilities of the relevant committees.
• The role of key individuals with responsibility for advising on and co-ordinating risk management activities.
• A description of the processes that the organisation employs in reviewing risk management arrangements and in gaining assurance on risk management.
• Guidance on what is acceptable risk to the organisation.

The strategy defines the risk management process including risk identification, analysis and evaluation. The strategy was independently reviewed as part of the NHS Litigation Authority acute risk management assessment visit undertaken in September 2009 where the Trust retained Level 1 compliance. The strategy is reviewed annually by the Board of Directors with the last review taking place in March 2011

The strategy includes a description of the overall risk management process and requires that all hazards are assessed and risks recorded, when identified, in a standard format risk register and prioritised using a standard scoring methodology. Divisions are required to maintain systems and processes that enable them to operate within the Risk Management Strategy.

The strategy clearly states that it is the responsibility of all staff to identify risk and communicate those risks, through the line management structure and, ultimately to the appropriate committee. This responsibility is reinforced through annual statutory update training.

Divisions have their own divisional risk register which should contain all of the risks identified within their Division. Risks that can be managed locally will remain on the risk register.

The corporate risk register is maintained by the Governance Department and all significant risks identified by the trust risk assessment process populate this register in addition to risks that cannot be managed locally. This register is reviewed by the Executive team and is a standing agenda item on the Quality & Risk Committee.

During 2010/11 the Trust recognised the flow of risks from board to ward and vice versa could be made clearer and in March 2011 set up the Healthcare Risk Group. This group will review and challenge the risks placed on the divisional risk registers, have an oversight of the plans put in place to mitigate risks to ensure actions are being taken, and also act as the conduit between the board and ward in disseminating risk both ways. The group will escalate significant risks which cannot be managed locally to the corporate risk register and disseminate risks to divisions where appropriate. The corporate risk register is reviewed by the Executive Team and is a standing agenda item for the Quality & Risk Committee.

In addition to the assurance framework at the 31st March 2011
the corporate risk register contained 12 risks, 4 Red, 5 Amber and 3 Green. The red risks were
• pipe work providing hot and cold water and drainage to/ from the Maternity building is corroding, resulting in significant plumbing issues for the unit.
• corrosion of waste pipe drainage system in the maternity building.
• diabetic service being non compliant with NICE guidelines Action is being taken to address these risks. The progress against all actions to address risks is presented regularly to the Quality & Risk Committee.

During the past 12 months the Trust has reported in excess of 3500 incidents. Of these 101 were categorised as Significant Incidents Requiring Investigation (SIRI). The largest single trend (category) reported has been related to pressure damage. Each incident has been investigated using Root Cause Analysis (RCA) and actions put in place to reduce the likelihood of re-occurrence. The Trust has also launched a Pressure Ulcer Prevention (PUP) campaign to raise awareness across the Trust.

The Quality & Risk Committee is charged by the Board of Directors with reviewing the risk management practice of the Trust ensuring that it operates within the Risk Management Framework. The Risk Committee has reviewed the risk management structures and processes within the Trust, recommending improvements where necessary, and has reviewed entries to the corporate risk register, both in terms of completeness and the consistency of risk scoring.

The Quality & Risk Committee have recognised the data base developed in house a number of years ago used for recording risks needs to be replaced and are supportive of the Trust seeking to replace with software designed specifically for risk management.

The Trust has an established Information Governance Group with responsibility for overseeing day to day information governance issues; developing and maintaining policies, standards, procedures and guidance and reviewing related issues and risks, reporting to the Risk Committee. The Trust Caldicott Guardian, supported by the Information Governance team, is responsible for the establishment of policies for the control and appropriate sharing of patient information with other agencies. The Director of Finance & Performance is the appointed Senior Information Risk Owner.

The Trust completed the Information Governance Toolkit in line with prescribed timescale with a satisfactory score of 75% against the enhanced IG requirements which reflects a realistic view of the challenges faced by the Trust around areas such as the new requirements for IG training. All relevant IT security related policies, including the Information security policy, have been reviewed, distributed, and added to the share-point catalogue. The links to all policies are published on a regular basis. A number of measures remain in place to prevent the loss of data including the encryption of laptops, the use of encrypted memory sticks, and the introduction of email encryption software, all of which have been implemented along with lockdown laptops. Smartcard access rights are regularly reviewed. Security incidents are reported and investigated fully, and operational checks include intrusion detection tests. An internal audit of information governance compliance was performed February 2011.

The Trust policy on the development of policies ensures all trust policies must be equality impact assessed before seeking approval by the Board.

The Trust has a well developed Assurance Framework, now firmly embedded in the regular performance reporting and management arrangements, both to the Board and throughout the Trust. The Assurance Framework provides a comprehensive framework for the management of principal risks. The principal risks are mapped to the trust’s strategic objectives and the framework also demonstrates the links with the Care Quality Commissions outcomes. The Framework examines the system of internal control and records the actions to be taken to address gaps in control or assurance.

The Assurance Framework has identified areas where the control framework needs improvement. The Framework also identifies a number of “red” risks where action plans are in place to mitigate the risks which are routinely being reported to the Quality and Risk committee; these include:-

• Patient experiences highlighted by the patients survey- action is being implemented through the Patient Experience Group including doctor sensitivity indicators.
• Delayed discharge of patients- the trust is working with partner organisations in local health and social care services to ensure patient stays in hospital are not longer than necessary.
• Commissioner purchasing intentions and health strategy- the trust is working with commissioners to implement the strategy to reduce expenditure on acute hospital services, managing public and patient expectations and maintain reputation for services provided to the public. The impact of public expenditure reductions is being addressed through an update of the integrated business plan and long term financial model.
• Dependency on agency staff and issues of low staff morale arising from the staff satisfaction survey. An established agency working group has been able to reduce the level of agency expenditure which was closely related to additional capacity open in the hospital during the year. In 2010-11 the overall response rate from the staff survey improved to 67%; the trust is implementing a “call to action” programme to address issues raised.

The action plans are owned by Executive directors and they are held to account for progress at the monthly formal executive meeting. I am assured by this process that there are no significant deficiencies within the system of control.

There is a fully established Internal Audit programme approved by the Audit Committee in the Strategic Internal Audit Plan of Work and the Audit Committee receives reports, which provide assurance of the Trust’s key internal control objectives. The Internal Auditor presents an Annual Audit opinion to inform those charged with Governance on the overall level of assurance on the system of internal control.

All risks identified which involve public stakeholders, including Primary Care Trusts and the Strategic Health Authority, are dealt with in an open and transparent way using the appropriate recording mechanisms and include appropriate communication strategies with the public.

Internal Audit’s review of the organisation’s overall arrangements for gaining assurance has concluded that:

‘Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.”

This view is based on Internal Audit reports prepared in 2010-11 where positive opinions were given following the audits.

Weaknesses were identified in capacity planning and financial forecasting, reporting and budgetary control.

Weaknesses in capacity planning included the lack of a robust discharge policy and guidelines and the need to improve the administrative process. An action plan is being implemented and Internal Audit has reported in March 2011 that good progress has been made in implementing the recommendations included in the initial report.

Weaknesses in financial forecasting, reporting and budgetary control which principally relate to setting more realistic budgets and improved forecasting, given the trust was not able to achieve the planned revenue surplus, have been addressed as part of the budget setting process for 2011-12 and in training given to budget managers.

A draft report on Planned Preventative Maintenance which is to be agreed with management identifies a number of weaknesses in the process which would give the final report a rating of red.

The Trust has an established counter fraud and corruption service provided by a Local Counter Fraud Specialist. During 2010-11 there were a number of referrals to the Local Counter Fraud Specialist which resulted in 8 investigations. Two investigations were concluded with no fraud proven, two investigations were referred for disciplinary action and there are four on-going cases. The Trust was given a satisfactory qualitative assessment rating by NHS Protect.

During 2010-11 the Trust continued to maintain the controls governing the transfer of patient identifiable data as part of the information governance assurance process. No incidents of patient identifiable data being released into the public domain occurred directly by the trust.

The Trust’s External Auditors conduct an annual review of the Trust’s control environment and present an annual report to those charged with governance in the form of an Annual Audit Letter.

The Trust involves stakeholders by informing and consulting on the management of any significant risks. Stakeholder involvement is sought through:

• monthly open board meetings and information provided on the trust’s web site;

• the wide range of communication and consultation mechanisms, which already exist with relevant stakeholders, both internal and external; and

• consultation on appropriate policy documents; stakeholders have the opportunity to comment on the risk elements.

• the Trust has introduced a member advocacy panel (MAP) which mirrors to some extent the Board of Governors in a foundation trust. The panel members have no statutory or legal powers, but play an important link to the hospital membership and the wider community.

Control measures are in place to ensure that all the organisations obligations under equality, diversity and human rights legislation are
complied with. The Trust has an Equality and Diversity Group, chaired by the Deputy Chief Executive. Its purpose is to promote equality of opportunity, treatment, dignity and respect for all patients, staff and members of the communities we serve. The group advises and makes recommendations to the board of directors, committees and other groups on equality and diversity matters, compliance with statutory and other requirements and on areas for improvement.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments in to the Scheme are in accordance with the Scheme’s rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust is fully compliant with CQC essential standards of quality and safety.

The Trust has completed a self assessment of performance against the 16 Care Quality Outcomes and in January 2011 assessed itself as being compliant with all 16 outcomes. There is an established process to assess performance against the outcomes and control measures are in place to ensure that all the organisations obligations under equality, diversity and human rights legislation are complied with.

5. Review of effectiveness
As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- the opinion of both Internal Audit and External Audit, given in reports to the Audit Committee; and
- reports presented to the Risk Committee, Executive Group and supporting groups Finance and Performance Group, Hospital Management Group, Human Resources Group and Patient Safety Group.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, Audit Committee and Risk Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board is assured that there are robust mechanisms in place to ensure that the evidence to support compliance is in place and available, and is routinely monitored and reported upon within the Trust’s governance and performance management framework.

The Trust has continued to monitor data quality issues and regular reports have been made to Board of Directors and sub committees providing assurances on the quality of data.

The process that has been applied to maintain and review the effectiveness of the system of internal control is as follows:

- The Trust’s Audit Committee approves an annual internal audit programme and receives all internal audit reports. The Committee, with the support of the Risk Committee, reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole organisations activities (both clinical and non clinical), that supports the achievement of the organisation’s objectives. In 2010-11 the Committee submitted an annual report to Board of Directors and completed a self assessment of its own performance to ensure compliance with the NHS Audit Committee Handbook.

- The Trust’s Quality & Risk Committee on behalf of the Board of Directors and Chief Executive reviews the establishment and maintenance of an effective system of risk management across the whole Trust’s activities (both clinical and non clinical) that supports the achievement of the Trust’s objectives.

The Board receives a monthly Compliance, Performance & Finance Report (based on Monitor’s Compliance Framework for foundation trusts) which includes exception reports on operations, human resources and
finance and an Integrated Performance pack. The Board receives a monthly Quality Report which includes hospital acquired infection rates, performance in meeting quality and innovation targets and patient experience.

In 2010-11 the Trust achieved break-even with the support of £4m from NHS West Midlands which offset the impact of significant and unplanned demand management reductions implemented by commissioners in the second half year and an exceptional injury benefit claim for a former employee settled by NHS Pensions. The support recognises the strategic objective to plan reduced expenditure in acute hospital services within the local economy. The trust plan was to achieve a surplus of £1.2m as part of a financial recovery plan to address a £7.3m deficit incurred in 2005-06.

In April 2006 a Public Interest Report was issued under Section 8 of the Audit Commission Act 1998 in relation to the financial standing of the Trust. The Trust developed a 5 year Financial Recovery Plan (FRP) which was agreed with the Strategic Health Authority and the Department of Health and secured Department of Health Working Capital loan to provide cash support in the short/medium term. Since then the Trust has achieved revenue surplus of £4.8m and repaid all but £1.0m of the working capital loan. External Auditors have issued a Section 19 letter to the Department of Health because the Trust has not met its statutory duty to break-even within a 3 year period. The letter sets out the current financial position of the trust, the action being taken to address the deficit and that Audit will continue to monitor the position but that there is no requirement at this stage to issue a further report in the public interest to the Department of Health.

The Trust has recently prepared a Tripartite Formal Agreement (TFA) with NHS West Midlands and the Department of Health. The TFA contains a milestone plan to foundation trust status. The Board of Directors will determine whether to proceed on this course by the end of June 2011.

In 2010-11 the Trust has worked with organisation in the local health economy and NHS West Midlands develop a Long Term Sustainability Model and plans to achieve surpluses 2011-12 and 2013-14 in line with the recovery plan and to repay the working capital loan by March 2012 in line with Department of Health requirements. The plan recognises the significant challenges facing the Trust to meet the NHS change agenda and to deliver significant savings and cost improvements; at the same time there are opportunities to manage and develop integrated primary and community services.

The Trust has adhered to the terms and conditions of its acute healthcare contract and had no outstanding performance notices at the end of the year. The Trust self declared non-compliance with delivering same sex accommodation from April 2010 but became compliant from July 2010.

The Trust has continued to focus on initiatives to improve patient safety and quality of care and was recognised for providing a high standard of care in a Risk Summit completed in December 2010. The Trust has continue with a very low number of hospital acquired infections with no cases of MRSA in the year and 40 cases of Clostridium Difficile compared with 62 in the previous year. A zero tolerance approach is taken to infection prevention and control.

The Trust met the revised target for waiting times in Accident and Emergency achieving overall performance of 96.82%. Plans are in place to ensure compliance with the revised targets.

With the exception of the internal control issues that I have outlined in this statement my review confirms that George Eliot Hospital NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Signed on behalf of the Board of Directors:

Kevin McGee
Chief Executive
Summary financial accounts

In this section you will find a summary of the Trust's financial accounts for the financial year 2010/11. A more detailed set of accounts can be obtained at www.geh.nhs.uk/about-us/annual-report or by contacting the Trust on 02476 865383.

Statement of comprehensive income for the year ended 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>2010/11 £000</th>
<th>2009/10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from patient care activities</td>
<td>98,805</td>
<td>95,091</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>9,519</td>
<td>10,239</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(106,210)</td>
<td>(101,951)</td>
</tr>
<tr>
<td><strong>Operating surplus</strong></td>
<td>2,114</td>
<td>3,739</td>
</tr>
<tr>
<td><strong>Finance costs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment revenue</td>
<td>35</td>
<td>23</td>
</tr>
<tr>
<td>Finance costs</td>
<td>(95)</td>
<td>(152)</td>
</tr>
<tr>
<td><strong>Surplus for the financial year</strong></td>
<td>2,054</td>
<td>3,250</td>
</tr>
<tr>
<td>Public dividend capital dividends payable</td>
<td>(2,007)</td>
<td>(2,242)</td>
</tr>
<tr>
<td><strong>Retained surplus for the year</strong></td>
<td>47</td>
<td>1,008</td>
</tr>
<tr>
<td><strong>Other comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals (Note 1)</td>
<td>(136)</td>
<td>(13,710)</td>
</tr>
<tr>
<td>Gains on revaluations</td>
<td>2,069</td>
<td>0</td>
</tr>
<tr>
<td>Receipt of donated assets</td>
<td>171</td>
<td>202</td>
</tr>
<tr>
<td>- Transfers from donated and government grant reserves</td>
<td>(156)</td>
<td>(159)</td>
</tr>
<tr>
<td>- On disposal of available for sale financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total other comprehensive income for the year</strong></td>
<td>(1,948)</td>
<td>(13,667)</td>
</tr>
<tr>
<td><strong>Total comprehensive income for the year</strong></td>
<td>(1,995)</td>
<td>(12,659)</td>
</tr>
</tbody>
</table>
### Statement of financial position as at 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>31/3/2011 £000</th>
<th>31/3/2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>62,841</td>
<td>62,639</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>1,938</td>
<td>1,885</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>262</td>
<td>235</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>65,041</td>
<td>64,759</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>1,737</td>
<td>1,730</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>2,437</td>
<td>3,698</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>6,032</td>
<td>2,905</td>
</tr>
<tr>
<td></td>
<td>10,206</td>
<td>8,333</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>10,206</td>
<td>8,333</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>75,247</td>
<td>79,092</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(9,604)</td>
<td>(8,611)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(1,033)</td>
<td>(1,032)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(462)</td>
<td>(596)</td>
</tr>
<tr>
<td><strong>Net current assets/(liabilities)</strong></td>
<td>(893)</td>
<td>(1,906)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>64,148</td>
<td>62,853</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrowings</td>
<td>(7)</td>
<td>(1,038)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(480)</td>
<td>(149)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>63,661</td>
<td>61,666</td>
</tr>
<tr>
<td><strong>Financed by taxpayers’ equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>41,396</td>
<td>41,396</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>1,877</td>
<td>1,149</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>19,149</td>
<td>17,910</td>
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<tr>
<td>Donated asset reserve</td>
<td>1,239</td>
<td>1,211</td>
</tr>
<tr>
<td><strong>Total taxpayers equity</strong></td>
<td>63,661</td>
<td>61,666</td>
</tr>
<tr>
<td>Balance at 31 March 2011</td>
<td>Balance at 1 April 2010</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>£000</strong></td>
<td><strong>£000</strong></td>
<td></td>
</tr>
<tr>
<td>Other reserves</td>
<td>Other reserves</td>
<td></td>
</tr>
<tr>
<td>63,661</td>
<td>61,666</td>
<td></td>
</tr>
<tr>
<td>- Transfers from donated government grant</td>
<td>- Transfers from donated government grant</td>
<td></td>
</tr>
<tr>
<td>Reserve</td>
<td>Reserve</td>
<td></td>
</tr>
<tr>
<td>(136)</td>
<td>(136)</td>
<td></td>
</tr>
<tr>
<td>Government grant reserve</td>
<td>Government grant reserve</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>- Transfers of received donated or government-authorized assets</td>
<td>- Transfers of received donated or government-authorized assets</td>
<td></td>
</tr>
<tr>
<td>171</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant, and equipment</td>
<td>Net gain on revaluation of property, plant, and equipment</td>
<td></td>
</tr>
<tr>
<td>2,069</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>- Impairments and reversals</td>
<td>- Impairments and reversals</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>- Transfers between reserves</td>
<td>- Transfers between reserves</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>Retained surplus/(deficit) for the year</td>
<td></td>
</tr>
<tr>
<td>19,149</td>
<td>19,149</td>
<td></td>
</tr>
<tr>
<td>Total comprehensive income for the year</td>
<td>Total comprehensive income for the year</td>
<td></td>
</tr>
<tr>
<td>63,661</td>
<td>63,661</td>
<td></td>
</tr>
</tbody>
</table>

**Statement of changes in taxpayers' equity for the year ended 31 March 2011**
<table>
<thead>
<tr>
<th></th>
<th>31/3/2011 £000</th>
<th>31/3/2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>62,841</td>
<td>62,639</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>1,938</td>
<td>1,885</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>262</td>
<td>235</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>65,041</td>
<td>64,759</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>1,737</td>
<td>1,730</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>2,437</td>
<td>3,698</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>6,032</td>
<td>2,905</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>10,206</td>
<td>8,333</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>75,247</td>
<td>79,092</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(9,604)</td>
<td>(8,611)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(1,033)</td>
<td>(1,032)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(462)</td>
<td>(596)</td>
</tr>
<tr>
<td><strong>Net current assets/(liabilities)</strong></td>
<td>(893)</td>
<td>(1,906)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>64,148</td>
<td>62,853</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrowings</td>
<td>(7)</td>
<td>(1,038)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(480)</td>
<td>(149)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>63,661</td>
<td>61,666</td>
</tr>
<tr>
<td><strong>Financed by taxpayers’ equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>41,396</td>
<td>41,396</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>1,877</td>
<td>1,149</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>19,149</td>
<td>17,910</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>1,239</td>
<td>1,211</td>
</tr>
<tr>
<td><strong>Total taxpayers equity</strong></td>
<td>63,661</td>
<td>61,666</td>
</tr>
</tbody>
</table>
Annual accounts. The annual accounts of an NHS body provide the financial position for a financial year i.e. 1 April-31 March. The format of the NHS trust annual accounts is set out in a manual of accounts.

Better Payments Practice Code. The target of the better payments practice code is to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. From October 2008 the Department of Health set a target to make payments to local suppliers within 10 days.

Break Even. NHS bodies have a statutory duty to break even, which is to balance income and expenditure reported in their accounts. If a body makes a deficit (where expenditure is more than income) it is required to recover the deficit in future years; where the deficit is significant this is achieved through the implementation of a financial recovery plan (FRP). Any carrying surplus or deficit is carried forward to future periods as a cumulative surplus or deficit.

Capital expenditure. Expenditure on fixed assets e.g. buildings and equipment used in the provision of services.

Capital Cost Absorption Duty (CCA). This is an annual measure that NHS trusts are required to achieve. A trust has a duty to absorb the cost of capital at the rate of 3.5% of its average relevant net assets.

Capital Resource Limit (CRL). This is a target set by the Department of Health to control the amount of capital expenditure that a trust may incur in the financial year. Overspends against CRL are not permitted. Under-spends can normally be carried forward to the next financial year.

Cost Improvement Programme (CIP). (Previously Cash Releasing Efficiency Saving (CRES)). These are cost savings arising from improvements in Trust efficiencies that are readily convertible into real cash savings.

External Financing Limit (EFL). This is a target set by the Department of Health to control cash spent by NHS Trusts. Trusts are not permitted to overshoot the cash target. A positive EFL arises where Trusts draw on government funding or spend cash resources while a negative EFL arises where trusts repay Public Dividend Capital or save cash.

Financial Risk Rating and Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITA). This measure is one of the main financial criteria that Monitor (the NHS Independent Regulator for Foundation Trusts) looks at in assessing underlying Trust financial performance. Besides measuring earnings before interest, taxes and depreciation and amortisation it also includes cash flow before debt financing, taxes and depreciation charges. It is a significant factor in Monitor’s assessment of the Trust’s financial risk rating. The George Eliot Hospital NHS Trust monitors its own performance using the risk ratings in preparation for becoming a foundation trust.

Financial statements. The annual accounts include a statement of comprehensive income, a statement of financial position, a statement of changes in taxpayer’s equity and a statement of cash flow.

Impairment. A decrease in the value of an asset.
International Financial Reporting Standards (IFRS). Since April 2009, the NHS is required to prepare accounts in accordance with international reporting standards (replacing UK Generally Accepted Accounting Practice). The presentation of the accounts has therefore been changed this year to comply with the new reporting requirements and the comparative information relating to 2008/09 has been restated. The financial impact of the change is detailed in note 44 to the accounts in 2009/10.

Monitor. The NHS independent regulator for Foundation Trusts.

NHS Operating Framework. The operating framework sets out a brief overview of the priorities for the NHS in the forthcoming year. It is accompanied by annexes (some part of the document, some web-based only) which provide more detail on the priorities, how they are measured and how the new arrangements for managing the system will work.

Payments by Results (PBR). This is the system introduced by the Department of Health by which commissioners (chiefly Primary Care Trusts) are required to contract and pay providers of NHS Services (chiefly NHS and Foundation Trusts). The system includes a set tariff for work completed. The system first implemented in 2004/05 has been updated every year and now includes most patient activity.

Public dividend capital (PDC). PDC is a form of long-term government finance which was initially provided to NHS Trusts when they were first formed to enable them to purchase the Trust’s assets from the Secretary of State. Additional capital expenditure can be funded as PDC or as borrowing. A dividend is payable by Trusts to the Exchequer to cover the expected return on the Secretary of State’s investment.

Retained surplus. When income earned during the year is more than expenditure the trust achieves a surplus.

Revenue income and expenditure. Income and expenditure associated with operating activities of the NHS body e.g. income from Primary Care Trusts who are the commissioners of NHS services and expenditure in providing the services e.g. salaries of NHS staff and payments to suppliers.

Valuation - land and buildings. NHS organisations are required to report land and buildings at fair value and during 2009/10 were required to complete a full valuation of the estate to be reported in the annual accounts.

Working Capital Loan. This is a loan arranged to provide cash, usually in the short term, to meet operational cash requirements e.g. payments to staff and suppliers. Loans are repayable from future cash flows.
The Audit Commission was the Trust’s appointed external auditors in 2010/11. The fee for completing the statutory audit of accounts was £107,000 plus VAT.

The Trust’s Audit Committee consists of all Non-executive Directors excluding the Chairman.

Independent auditors report
I have audited the financial statements of George Eliot Hospital NHS Trust for the year ended 31 March 2011 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies. I have also audited the information in the Remuneration Report that is subject to audit, being:

• the table of salaries and allowances of senior managers on page 40 and
• the table of pension benefits of senior managers on page 41

This report 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.

Respective responsibilities of Directors and auditor
As explained more fully in the Statement of Directors’ Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice’s Board’s Ethical Standards for Auditors.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

whether the accounting policies are appropriate to the Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements
In my opinion the financial statements:

• give a true and fair view of the state of George Eliot Hospital’s affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
• have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on financial statements
I have a duty under the Audit Commission Act 1998 to refer the matter to the Secretary of State if they have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On June 2011 I referred a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 in relation the Trust’s failure to achieve break-even taking one year with another over a 5 year period ending 31 March 2010. This, I have reason to believe, exceeds the Trust’s statutory powers as the Board is accountable for financial control and for ensuring that the Trust meets its statutory duty to break-even under paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

Conclusion on the Trust’s arrangements for securing economy, efficiency and effectiveness in the use of resources

Trust’s responsibilities
The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor’s responsibilities
I am required under Section 5 of
the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In considering the Trust arrangements for securing financial resilience, I identified the following:

- the implementation of revised controls over elective referrals by its lead commissioner part way through the financial year, and other unanticipated changes in activity and costs placed the Trust under financial pressure in 2010/11. In response the Trust reduced additional capacity and took action to redeploy staff and reduce costs. Despite its actions the Trust was not able to deliver its 2010/11 cost improvement plan in full, and required £4m non-recurrent support to achieve breakeven in 2010/11
- the Trust has agreed contracts with its commissioners for 2011/12, however, the aggregate impact of efficiency savings, reduced activity, and cost pressures included in the contracts requires the Trust to make significant cost reductions (£11.2M) in 2011/12. The cost improvement plan, at 10 per cent of income, presents a significant challenge to the Trust
- the Trust Board is currently reviewing its strategic plan, and its long term clinical and financial viability. This includes a full review of the options available including becoming a Foundation Trust. This review and the Trust’s financial performance in 2010/11 have impacted on the Trust’s preparations for its foundation trust application and as a result, at the end of the financial year 2010/11 the Trust did not have an up-to-date Integrated Business Plan or Medium-Term Financial Strategy.

Adverse Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, the matters reported in the basis for adverse conclusion paragraph above prevent me from being satisfied that in all significant respects George Elliot Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2011.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide assurance over the Trust’s annual quality accounts. I am satisfied that this work does not have a material effect on the financial statements.

Mark Stocks
Officer of the Audit Commission

No 1 Friarsgate, 1011 Stratford Road, Solihull, B90 4EB

June 2011