Contents

Section 1: Statements on Quality
Statement from the Chief Executive 4
Statement of Directors Responsibilities in Respect of the Quality Account 5

Section 2: Looking Back on 2014/15
Priority 1: Clinical Effectiveness – High Quality Care 7
Priority 2: Patient Safety - Harm Free Care 14
Priority 3: Patient & Staff Experience 28
Statements of Assurance from the Trust Board 38

Section 3: Quality Improvement Priorities 2015/16
Priority 1: Clinical Effectiveness - High Quality Care 55
Priority 2: Patient Safety - Harm Free Care 56
Priority 3: Patient & Staff Experience 57

Annex 1: Auditors Limited Assurance Report 60
Appendix 1: Statements from External Stakeholders 64
Appendix 2: Amendments 71
Appendix 3: Glossary 68
Appendix 4: Quality Account Questionnaire Feedback Form 72

Acknowledgements & Feedback 75

Quality Accounts Reporting Arrangements
Throughout the Quality Account the Trust have adhered to the guidance set out by our NHS Peers and where relevant have integrated its report to correspond with existing key quality improvement priorities and other key performance data requirements to enable our continued journey to improve our patients care pathways and uphold our vision to ‘Excel at Patient Care’.
Welcome to the 2014/15 Quality Account for George Eliot Hospital NHS Trust. The Trust has faced a year of many challenges as we built on the service delivery changes implemented after the Keogh review; worked within challenging financial pressures; waved goodbye to our former Chief Executive, Kevin McGee and consolidated a new Executive Team with myself as Acting Chief Executive.

I am privileged to have had the opportunity to lead the Trust forward over the past year in building on the solid foundation that Kevin left, and supported by the wider Trust Board, I remain passionate and driven to provide leadership and support to an enthusiastic and hard working team of staff.

The year started with a major inspection by the Care Quality Commission which recognised the hard work we had all implemented following the Keogh review, and which summarised our care as ‘Good’. This was a major achievement for the Trust and has left us in a good position on which to build our future. Our financial position continued to be extremely challenging however, I am pleased that we have achieved all that we set out to achieve, meeting the targets that were set for the Trust.

I am also pleased to present this year’s Account that once again shows an overall improvement in the quality of care and services provided to local people at our hospital and out the community.

In essence, with a continued strong focus on patient care the highlights of improvement are many and include:

- increased use of ‘care bundles’ that ensure a better outcome for our patients at the crucial early stages of their stay with us;
- improved the speed of communication with our GPs to enable more seamless care following discharge;
- achieved the first of a three year programme to provide services over 7 days as standard;
- further embedded and developed our end of life care strategy to enable the right care and support to patients who are nearing the end of their life, or require palliative care;
- continued to reduce our mortality ratio for the second year running;
- maintained incident rates reporting to ensure focus on continued learning from incidents and a heightened safety culture throughout our organisation.

The NHS ‘Five Year Forward’ View which sets out the vision for the NHS over the next 5-years is our basis for the future and supports our vision for high quality services for the people of Nuneaton and Bedworth and beyond, both within the Trust and out in the community. All of the these achievements demonstrate the Trust’s commitment to the Five Year Forward View; where improving quality of care would not be possible without the dedication of our skilled workforce who will be aiming to sustain these improvements and, I am confident, will also aspire to meet the challenges of next year’s quality improvement targets.

Katherine Kelly
Acting Chief Executive
Statement of Directors Responsibilities in Respect of the Quality Account

Under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, the Directors are required to prepare Quality Accounts for each financial year and are expected to take steps to satisfy themselves that:
- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board:

Chairman

Acting Chief Executive
Looking Back Our Year 2014/15

The following summarizes our ambitions derived from the quality improvement priorities (QIPs) set for the year 2014/15. Our year shows an overview giving some examples of the things we have done to achieve these QIPs and, most importantly, the impact on patient experience for all who use our services.

<table>
<thead>
<tr>
<th>What we set out to do</th>
<th>What we did</th>
<th>What does this mean for people using our services</th>
</tr>
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<tbody>
<tr>
<td><strong>Introduction of a range of ‘Care Bundles’ or checklist similar to Pre-Flight Checklists</strong></td>
<td>We delivered care bundles or checklists into our services for patients with pneumonia, sepsis, heart failure, kidney failure and those at risk of falling. These checklists ensure we deliver all of the most important actions at the right time</td>
<td>Our support to patients with these serious conditions is even more consistent over the 7 day 24hr period and outcomes are better for patients. The opening of our acute medical admissions unit (AMU) and improved A&amp;E department has been key to this achievement</td>
</tr>
<tr>
<td><strong>Improved our inpatient documentation</strong></td>
<td>We reviewed, streamlined and used best practice to revise all paperwork in use for patients admitted to hospital</td>
<td>Patient documentation is clearer, more valuable to our teams and, most importantly, accessible to patients and provides clear explanations of treatment plans</td>
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<tr>
<td><strong>Improve our written communication with GPs and Patients</strong></td>
<td>Provided regular reports to all of our teams on the content and timeliness of discharge information and outpatient letters sent. We then supported teams to make necessary improvements</td>
<td>Patients and GP’s receive copies of discharge summaries and outpatient letters more promptly and these contain a greater level of detail. Patients in hospital in a number of wards receive written information from their consultant about their diagnosis, progress and treatment plans. We plan to continue this work into 2015/16.</td>
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<tr>
<td><strong>Improve the availability of services over 7 days</strong></td>
<td>Delivered year 1 actions of a 3-year national programme for delivery of the 7 day service standards</td>
<td>Patients attending the hospital as an emergency admission will be seen and treated by a senior doctor at the beginning of their stay whatever the day of the week</td>
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<td><strong>Develop End of Life Care services</strong></td>
<td>Delivered an individualised end of life care plan process which supports staff to meet patients’ needs. Provided education to clinical teams and secured funding for a Macmillan nurse within our AMU</td>
<td>Patients admitted with end of life care needs will receive the care and support they require and, in particular, at the start of their admission</td>
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<td><strong>Delivered the ‘duty of candour’</strong></td>
<td>We included the ‘duty of candour’ which has been mandated nationally, which is a national requirement for all NHS care providers, into our incident reporting process</td>
<td>All patients involved in clinical incidents will be informed of the incident, its type and potential harm alongside what actions have been taken to prevent recurrence.</td>
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<tr>
<td><strong>Continue to reduce Mortality Ratios</strong></td>
<td>Delivered a detailed mortality surveillance and review process alongside undertaking improvement actions for key areas</td>
<td>Our improvements in this area show that outcomes for patients are either at, or better than, the national average</td>
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<td><strong>Reduce the number of Infections</strong></td>
<td>Continued to deliver strict infection control and prevention actions</td>
<td>Our rates of infections (Clostridium Difficile &amp; MRSA) are extremely low and this minimises the chance for cross infection for our patients</td>
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<tr>
<td><strong>Maintain rates of incident reporting</strong></td>
<td>Delivered a new incident reporting process which is simpler and more focussed to specific types of incidents and assists in learning lessons</td>
<td>Our reporting rate of incidents shows that we have a vigilant, safety conscious service; as a result of learning from incidents we have demonstrated a further reduction from all clinical incidents in 2014/15</td>
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We set out to deliver even better care in 2014/15 to be sure our services offer safe high quality care whenever our community needs us, 24 hours a day, 7 days a week. In striving to meet these ambitions and with the aim of improving clinical services we have developed the following processes.

- **Acute Kidney Injury Care Bundle**: Building on the success of the Sepsis, pneumonia and heart failure care bundles we have developed an acute kidney injury care bundle, shown below, which is based on national best practice and evidence. This bundle can be used for patients admitted with kidney damage and ensures we deliver the right care at the right time. Having delivered the bundle to all areas we will continue to work on this in 2015/16 through provision of further training to our clinical teams and frequent audits to understand how effective this work is.

- **Improved Inpatient Documentation**: A review of all inpatient documentation has taken place focussing on rapid access of the right information being available for use to promote clarity and a more streamlined process at the point of use. To achieve this, a multi-disciplinary documentation group was established which reviewed all forms of inpatient documentation to ensure it was fit for purpose and function. A cataloguing process was created to make certain all future documentation was being controlled centrally. In addition to this nursing documentation has been completely redesigned to improve the quality of information being recorded. Folders have been developed and piloted with segregation dividers for differing aspects of ‘care’ being introduced, which also act as a prompt to indicate what information must be recorded. This has led to standardisation of which information is recorded and stored.

- **Communication with GPs and Patients**: We set out to improve both the quality and timeliness of our communication with GPs in 2014/15 and agreed a Commissioning for Quality and Innovation (CQUIN) scheme with our Commissioners (Warwickshire North CCG) which incentivises improvement in this area.

(Executive Lead – Dr Gordon Wood, Medical Director)
Information provided to GP's and patients after discharge from hospital admission was our first area of focus and we aimed to improve the percentage of summary letters sent to GP's within 48 hours of discharge throughout the year.

In April 2014 73% of summaries reached GP's within 24 hours. During the year we have delivered actions to improve both the content and timeliness of sending this important information to GP's. As a result we are pleased to report that there has been a month on month improvement and we completed the 2014/15 year delivering 87% of summaries within 24 hours. A total of 1,802 admissions occurred in March 2015, of which 1,609 Patients summaries were delivered to GP's during the month achieving 90% of summaries being sent within the 24 hour timeframe. This demonstrates an excellent improvement in this area of work. In addition to timeliness, the content of discharge summary letters has also improved. Achieving this ensures GP's receive accurate and timely information about patients’ stays in hospital making certain important treatment changes are communicated and care continues seamlessly.

We also aimed to improve the timeliness of summary letters sent to GP's following outpatient appointments. These letters relay findings and treatment decisions on care and management of diagnosed conditions. Having started 2014/15 delivering 36% of outpatient summaries being sent to GP's within the 5 working days, we complete the year having achieved 42%.

There is room for further improvement in this area and we will continue this work into 2015/16 agreeing with our Commissioners a further year of the ‘discharge summary and outpatient letter’ CQUIN.
7 day services: We set out to deliver year 1 of a 3-year programme of developing **7 day services** as defined by NHS England’s challenge on 7 day services. Developing services to work over 7 days provides better care for patients and responds to the national evidence that better availability of services provides better outcomes for patients.

Our progress against these 10 key standards is outlined in the following table and we will continue to develop our services as part of this 3-year plan alongside our Commissioners.

<table>
<thead>
<tr>
<th>Seven Day Standard</th>
<th>Position Statement</th>
<th>Achievement</th>
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| **1. Patient Experience:**  
- Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times  
- The format of information provided must be appropriate to the patient’s needs and include acute conditions  
- With the increasing collection of real-time feedback, it is expected that hospitals are able to compare feedback from weekday and weekend admissions and display publically in ward areas | - The Friends and Family test was expanded to all areas  
- Weekly Impression feedback collects verbatim comments from patients and feeds this back to clinical leads and teams promptly  
- Training for Do Not Attempt Resuscitation includes elements related to patient and family involvement in care decisions and an audit process tracks progress and standards | ✓ |
| **2. Time to First Consultant Review:**  
- Early Warning score & Medicines reconciliation | - A continuous achievement of more than 90% of patients having a consultant review within 14 hours of admission was established in 2014 and sustained throughout the year with planned improvement for 2015/16  
- Delivery of this standard is measured weekly and reported within the Acute Medical Unit team dashboard  
- An Early Warning Score is in place and held within our electronic track and trigger system  
- Medicines Reconciliation is in place and reported quarterly to the Clinical Quality Review Meeting with the Clinical Commissioning Group | ✓ |
| **3. Multi-disciplinary Team review 14 -24 hours** | - There is a 90% achievement of the 14 hour consultant standard established  
- The Trust is also working towards increased therapist availability at weekends and currently the service is available via a reduced weekend service to enable mobility assessment  
- Pharmacy service is similar to the above; a senior pharmacist is available 24/7 and is on site 12 hours a day over the 7 day period | (Plan to expand during 2015/16) |
| **4. Shift Handovers:**  
- This must be led by a competent senior decision maker and take place at a designated time and place | - A formal handover room was established in 2014 with a set agenda and led by senior clinician and this is predominantly consultant led twice daily over 7 days  
- An electronic handover system is in final development stage and due for deployment early in 2015 | ✓ |
<table>
<thead>
<tr>
<th>Seven Day Standard</th>
<th>Position Statement</th>
<th>Achievement</th>
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<tbody>
<tr>
<td>5. Diagnostics:</td>
<td>- 24/7 access to diagnostics in place</td>
<td>(Plan to expand during 2015/16)</td>
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<td>- Reporting available for urgent cases within 1 hour for critical cases and working towards and largely achieving 12 hour urgent and 24 hour non urgent inpatient reporting over weekend and bank holiday periods</td>
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<td>- Hospital inpatients must have scheduled seven-day access to diagnostic services</td>
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<td>- Reporting will be available seven days a week</td>
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<td>6. Intervention/Key Services take our 24 hour access, seven days a week, to:</td>
<td>- 24/7 access to critical care in place with network arrangements in place to support capacity and demand issues</td>
<td>✓</td>
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<tr>
<td></td>
<td>- Critical care</td>
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<td></td>
<td>- Interventional radiology</td>
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<td></td>
<td>- Interventional endoscopy</td>
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<td></td>
<td>- Emergency general surgery</td>
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<td></td>
<td>- Interventional radiology available onsite and as part of Service Level Agreement with UHWC</td>
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<td></td>
<td>- Consultant delivered interventional endoscopy and emergency surgery available</td>
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<td>7. Mental Health:</td>
<td>- Psychiatric liaison and crisis team available within A&amp;E 24/7 and 12 hours daily onsite on call outside these hours via Coventry Partnership Trust</td>
<td>Plan to expand during 2015/16 for which Commissioner input required to achieve this standard</td>
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<td>- Response times</td>
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<td>- This requires improvement and extension to onsite presence</td>
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<td>8. On-going Review:</td>
<td>- Daily consultant led review in place within acute admission areas (Acute Medical Unit, Acute Surgical Admissions, Maternity, ITU, CCU &amp; CDU)</td>
<td>(Plan to expand during 2015/16 for which commissioner support is required to deliver this level of service)</td>
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<td>- Ward based reviews by lead consultants over 5 days</td>
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<td></td>
<td>- Weekend and bank holiday review established for patients in specialty wards requiring review of condition or to review prior to potential discharge</td>
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<td>9. Transfer to Community, Primary and Social Care:</td>
<td>- Primary and community care services are able to access the appropriate senior clinical expertise via phone call for all specialties</td>
<td>(Plan to expand during 2015/16)</td>
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<td></td>
<td>- Community Services: pharmacy, physiotherapy, occupational therapy, social services, equipment provision, district nursing available Monday – Friday however not at weekends to accept new referrals or to adjust packages of care for instance</td>
<td>Commissioner input required</td>
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<td></td>
<td>- Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led review, can be taken</td>
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<td>10. Quality Improvement:</td>
<td>- Clinical teams are involved in service and quality review by involvement in audit, divisional governance and teaching opportunities</td>
<td>Plan to expand during 2015/16</td>
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<td></td>
<td>- The establishment of clinically led business units in 2015 will support quality improvement at specialty level</td>
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<td>- IHI Improvement chapter established</td>
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We will continue our journey to achieving year 2 of these standards in 2015/16 ensuring further improvements to 7 day provision of care and endeavouring to meet the needs of our patients and the communities we serve.
- **Ownership and management of quality at Divisional and team level** has been achieved by the establishment of Clinical Business Units (CBU’s) on 1st April 2015. This change makes services more responsive and effective by grouping clinical services together and by putting doctors, nurses and other health professionals in control of their areas.

- **A Ward Accreditation Programme** has been introduced and includes nurse sensitive indicators which show the quality of service being delivered within each ward. In addition to ward level incident information we have provided specific trends in respect of falls which relates to ‘time of day’ and ‘type of incident’. This process has allowed the delivery of the falls reduction programs at ward level.

- A revised **Quality Strategy** was delivered during 2014. This document set out our approach to delivering high quality care and the methods we used to continue to improve our services. In focussing on a streamlined approach throughout the organisation to quality priorities, the strategy is based around the following and encompass:
  - Clinical effectiveness – Delivering safe high quality care
  - Patient Safety – A commitment to harm free care
  - Patient and staff experience

This four year strategy will develop annually to reflect changing needs, and as mentioned above in 2015 we are improving the hospital structure with the introduction of CBUs. Each of these 6 ‘CBU’ teams will be led by senior doctors, nurses, allied health professionals and a manager who will lead the services within their service area. These teams will be best placed to both lead their services and develop them further. Revising the Quality Strategy and governance functions in 2015 will support teams to do this in the most efficient way. It will also establish a framework that allows them to receive the correct level of information relevant to their CBU at all times.

**Specialist Palliative Care Team (SPCT)** have again developed this year to improve the care offered to patients and carers and have delivered on the following actions:

- The Trust was successful in gaining funding (a 3-year pilot post) for a senior Acute Medical Unit (AMU) MacMillan Nurse, who is based in our AMU, with on-call duties in A&E to enable quicker referrals, full assessment and treatment and the right discharge pathway. Evaluation of this role has already demonstrated there is a need for this type of senior nursing input as part of our SPCT at all times.

- **Individual Plan of Care for the Dying Person - Coventry and Warwickshire wide approach** to anticipatory planning of care in the final days or hours of life whether the patient is in hospital, hospice, or own home. To support the Trust wide phasing out of the LCP (Liverpool Care Pathway) we have delivered education to over 300 members of acute and community staff. This has heightened awareness and has resulted in an increased referral rate to the SPCT. This means our patients and families are receiving an individualised end of life care experience and regular holistic assessment of needs with multi-professional working across all healthcare boundaries.

- **AMBER Care Bundle (ACB)** – Better use of the ACB trust-wide this year and the SPCT offering increased levels of education for staff (classroom and ward based) has raised awareness the benefits for patients of using the ACB which has resulted in a month on month increase in the use of ACB. An ACB information leaflet has also been developed to provide better information and support to patients and their relatives.

- **Increased numbers of staff taken part in the Coventry & Warwickshire wide training for Advance Care Planning with more planned to attend during 2015.**

- **Discussions regarding the implementation of a treatment escalation plan proforma**

- **A review of Patient Information has taken place in particular difficult DNACPR decision making, involvement of the SPCT, with their families when their loved one is in the last days/hours of life.**

- **Care after Death Policy - developed collaboratively with SPCT, Bereavement Services and the Mortuary and updated in 2014 using evidence-based guidance on caring for deceased patients. This is available to all staff and promotes integrated relationships across palliative and end of life care, mortuary and bereavement services.**
Continual Learning and Education which embeds confidence and competence amongst the staff who care for our patients. During this year more has been achieved via our monthly clinical nursing induction, regular Individual Plan of Care for the dying person EOL care plan training, bite-size training on Transforming EOL in Acute Hospital enablers, Tissue Viability training on Skin Changes at Life's End, RIPPLE education for discharge liaison and link nurses, wider engagement events for community staff etc.

- Gaining real time feedback from patients and their families is imperative to enabling an informed view to support service development, service delivery, learning and improvements to the SPCT. Sources used to gain such feedback are in-house surveys and Customer services where any complaints concerning SPCT are reviewed and fed back to the Team by the Clinical Nurse Specialist for EOL care.

- Throughout the year we have worked with the following teams which enable us to integrate health and social care boundaries within the Coventry and Warwickshire area ie Warwickshire Health and Well Being Board, Macmillan service review team, Warwickshire Social Services, Psychology services, Tissue Viability, Public Health England, NHS Improving Quality, Mary Ann Evans/Myton Hospices, CASTLE Clinical Implementation Group, East Midlands End of Life Care Facilitators, East Midlands Strategic Clinical Network Senate, Health Watch, Health Overview and Scrutiny Committee, Older Persons Forum, Patient Advocacy Forum etc. This provides improved links and successful integration promoting good working relationships within the organisation and the wider health and social care providers encouraging more seamless patient care pathways.

- In line with the national awareness campaign ‘Dying Matters 2015’ the Trust is planning to run A Good Death Cafe which is open to healthcare professionals and the public which essentially raises awareness of end of life care and services available, both nationally and locally, for those in the last 12 months of their life

- In support of delivery of the end of life care, the Trust’s End of Life Strategy Group, whose membership includes patients, carers and health professionals have met monthly to review progress and decide new areas of work.

Following the outcomes of the National Care of the Dying Audit (Hospitals Round 4) received in May 2014 which outlined our progress, areas for improvement and a national action plan. Key actions taken since have included:

- Implementation executive member support on Trust Board
- Presented findings to Mortality Group and End of Life Care Strategy Group
- Patient experience measured and feedback used to ensure that patients & families receive effective, safe and timely care in a dignified environment via a Bereavement Survey

Recognition for the improvements and progress made by the SPCT during 2014/15 include

- ‘Outstanding’ awarded by CQC for ‘leadership’ in end of life care
- Winner of 2 GEH EXCEL Awards:
  - Core Service
  - Chief Executive award
- Finalist of national NHS England Compassion in Practice Award:
  - A Leader Who Puts Compassion into Practice
- Nominated for the Kate Granger Compassionate Care awards
Priority 2: Patient Safety
- Harm Free Care

(Executive Lead – Dr Gordon Wood, Medical Director)

1.0 During 2014 we developed our responsibilities under the statutory obligation of Duty of Candour which requires individuals and organisations to “foster a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers” (NHS Constitution 2013). We have taken this commitment very seriously and inform all patients involved in clinical incidents of the actual event, our immediate action and the outcome of investigations. We include this information in all incident reports.

2.0 We aimed in 2014/15 to ensure that no ‘Never Events’ occurred within the organisation. Regrettably one such event occurred and this related to the dispensing of a drug called methotrexate which must only be taken weekly; however this was dispensed with guidance to take daily. The consequence of this error can be serious harm if not detected. Detection of this incident occurred promptly and the dispensing error was corrected immediately. Importantly, the patient received medical assessment and care and suffered no long term effects. Our review of this incident was comprehensive and led to changes in the information provided to patients and General Practitioners alongside a series of actions within the hospital and community pharmacy teams to ensure incorrect labelling is prevented and that the electronic dispensing system does not allow recurrence.

3.0 During 2014/15 96% of our patients received harm free care* Keeping our patients safe whilst they are under our care is very important to us. We use a tool called the Safety Thermometer every month to audit our patients’ care to help us understand how well we are doing and to highlight areas for further improvement. The Safety Thermometer records how many of our patients suffer from four types of harm which are defined as:

- Pressure Ulcers
- Falls
- Urinary tract infections in patients who are catheterised (CA-UTI)
- Blood clots (VTE)

*The following graph incorporates all of the above definitions as a collective.

% of our patients that were NOT harmed while under our care

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<tr>
<td>%</td>
<td>97.13</td>
<td>96.77</td>
<td>95.68</td>
<td>96.03</td>
<td>95.95</td>
<td>96.17</td>
<td>96.61</td>
<td>94.61</td>
<td>95.51</td>
<td>94.50</td>
<td>97.36</td>
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*Data source: NHS Safety Thermometer
We also aimed to deliver a reduction in harm caused by clinical incidents in 2014/15 and set ourselves a goal of a 10% reduction. Due to the introduction of a new and significantly improved incident reporting process we are able to compare 2013/14/ to 2014/15 national data. This information, supplied by the national reporting and learning service shows that there has been a fall of 7.7% in actual harm incidents at George Eliot Hospital. This decrease is associated with a continued high level of overall reporting of incidents which signifies a positive safety culture.

We continue to focus on reducing harm in 2015/16 seeking to make our services safer and able to respond to new issues as they are reported. Our Clinical Business Unit system, which ensures nurses, doctors and other health professionals are leading services is a key part of this improvement. The ‘looking forward’ section of this account sets out how we will continue to improve in 2015/16.

### 4.0 Incident Reporting
The National Reporting and Learning Service (NRLS) is clear that high incident reporting is a mark of a ‘high reliability’ organisation; this is endorsed by both the Care Quality Commission (CQC) and NHS Litigation Authority (NHSLA) who consider Trusts with high incident reporting rates are more likely to demonstrate other features of a strong safety culture. The importance of incident reporting is emphasised during mandatory updates and Divisional Governance meetings.

The NRLS make it possible to compare hospitals level of incident reporting and the following tables set out how we compare nationally.

Table 1 below covers the period **October 2013 to March 2014** and shows that the organisation reported 10.06 incidents (1,918) per 100 admissions. With a national comparison, this shows George Eliot to be in the **highest 25%** of reporting hospitals which is a good and sustained position.

The NRLS commend this level of reporting as a marker of a positive safety culture.
“Organisations that report more incidents usually have a better and more effective safety culture. You can’t learn and improve if you don’t know what the problems are”


The Latest information available compares all England Hospitals between 1st April 2014 to 30th September 2014. This shows that George Eliot Hospital NHS Trust is within the middle 50% of all reporting organisations and actually very close to the top 25%.

The National Reporting Learning System (NRLS) have revised the format of reporting incident reporting data in for acute non-specialist hospital Trusts. Previously the Trust was grouped in the Small Acute Hospitals Trusts section of the report, following the review the graph above shows where the Trust is now placed with the other 138 non-specialist Trusts in England.
For the most recently available period with national comparison April 2014 to September 2014, 86.9% of incidents reported (1,827) involved no patient harm. This compares to 84.5% in the previous period 1st October 2013 to 31st March 2014.

The percentage of patient safety incidents resulting in severe harm or death at George Eliot Hospital (reporting period 01 April 2014 to 30 September 2014) is 0%. Source: National Reporting and Learning Service – Organisational Patient Safety Incident Report.

These events highlight potential risk and harm which we can act on to prevent further incidents happening (nationally 73.7% of incidents reported do not involve harm).

The most common form of incident reported related to patient accidents which includes falls (19%) followed by medication (11%).

The delivery of the Datix system in 2014 has significantly improved both the ease and timeliness of reporting incidents. Incidents are reported with clear and specific questions and the process of investigation and action is made clearer with handy dashboards, trends and alerts. Having introduced the Datix system we now categorise all incidents according to the following criteria:

No Harm, Low Harm, Moderate Harm, Severe Harm and Death (full details of each group can be found in the glossary towards the end of this document)

5.0 Hospital Acquired Thrombosis

In striving to reach a 100%, we have continued to assess a minimum of 95% of patients for risk of thrombosis on admission.

Where a thrombosis has occurred, whilst an inpatient at GEH, a review has taken place and themes from the outcomes of these reviews are collated and managed by the thrombosis committee. Performance analysis numbers and findings of reviews (from inpatient data) are shared with our clinical teams and reported within our monthly quality report.

6.0 Patient Falls

During 2014/15 we aimed to achieve a minimum of a 20% reduction in the number of patient falls. We have worked hard in 2014/15 to reduce inpatient falls however have not seen the level of reduction we hoped to achieve.
Falls in 2013/14 averaged 5.5 per 1000 bed day and in 2014/15 this figure was 5.2. The increased admissions and increasing frailty of patients admitted to hospital this year has undoubtedly been a factor in failing to achieve this aim. Similar to the national trend in December 2014 we saw a 25% increase in patients over the age of 85 admitted to hospital as compared to the previous year and many of these patients had complex needs and were at risk of falling.

Understanding patients’ risk of falling is at the heart of preventing falls as this both identifies and initiates prompt action. A falls care bundle which lists the key actions on admission has been central to this work and implementation during 2014 has progressed well. Monitoring and reporting of Falls remains part of the monthly Quality Assurance Committee and Board level reporting. Falls, where patients suffer injury, are treated as a serious clinical incident and investigated using a root cause analysis process which is then shared across the organisation.

Other actions that have been followed in 2014/15 to prevent and reduce inpatient falls include:
- Establishment of a falls group which reviews all patient falls and actions taken
- Establishment of 1:1 sitter or supervisory nurse for patients at high risk of falls
- Falls risk assessment process revised by the falls group
- Best practice review to understand actions to adopt
- Dedicated falls incident report via Datix which includes route cause analysis (RCA)
- Fall Prevention Care bundle
- Ward based falls prevention training
- Ward dashboards and improvement plans
- Falls escalation process
- Post falls checklist which prompts detailed medical assessment and imaging (yellow sticker).
7.0 Medication errors

In accordance with the requirements of NHS/PSA/D/2014/005 in September 2014, the Trust appointed the Chief Pharmacist as its Medication Safety Officer (MSO) nominating the Medicines Management Group (MMG) to take on the additional role of Medication Safety Group with the Director of Nursing being identified as the Executive Lead for Medication Safety. The MMG discusses reported incidents, trends, national alerts and other issues around medicines safety and security at length. Members off MMG are proactive in promoting the importance of reporting no-harm and low-harm events, including near misses, in their clinical areas. This enables learning with a view to preventing more serious incidents in the future. Key issues and themes identified by the MMG are publicised widely across the hospital and discussed at multi-disciplinary forums, Drugs and Therapeutics Committee and the senior nurses “Back to Basics” meeting.

During 2014/15 the Trust has significantly exceeded its agreed target of achieving a 10% increase in reporting of no-harm and low-harm incidents and the following table shows a comparison of the number of reported incidents over the last two reporting periods (ie 2013/14 to 2014/15).
Number and designation (‘colour’) of medicines-related incidents reported April 2013–March 2015

Table above shows that the average number of medicines-related incidents reported increasing to over 73 per month in the first 6 months of 2014/15, compared to 39 per month for 2013/14. This increase was due to an increase in ‘no harm’ (green) or ‘low harm’ (yellow) incidents. The high rate of reporting during the following 3-months was in part as a result of a pharmacy-led audit programme, aimed at addressing issues raised by the CQC. One report involving significant harm (a ‘blue incident’) was reported in year, compared to three such incidents in 2013/14. The apparent increase in the incidence of moderate harm (‘amber’) incidents resulted from changes in incident classification following the implementation of the new Datix incident management system in September 2014.

Nationally, the most recent validated data from the NRLS is for the 6 months from 1 April 2014 to 30 September 2014, which shows that the Trust increased its rate of reporting from 1.03 per 100 admissions (Table 2) to 6.53 incidents per 1000 bed days (Table 3). This improved level of reporting resulted in the Trust moving from 15th to 4th out of 28 in the Trust’s group of “Small acute Trusts”.

As highlighted above (p17) the NRLS commend this level of reporting within health care organisations as a marker of a positive safety culture.
### Table 2: Trust’s medicines incident reporting rate and ranking for year to March 2013

Comparison of medication-related incident reporting rate per 100 admissions for small acute Trusts (GEH is Trust 15): Data to March 2014

<table>
<thead>
<tr>
<th>Trust</th>
<th>Reporting Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>2</td>
<td>0.2</td>
</tr>
<tr>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>4</td>
<td>0.6</td>
</tr>
<tr>
<td>5</td>
<td>0.8</td>
</tr>
<tr>
<td>6</td>
<td>1.0</td>
</tr>
<tr>
<td>7</td>
<td>1.2</td>
</tr>
<tr>
<td>8</td>
<td>1.4</td>
</tr>
<tr>
<td>9</td>
<td>1.6</td>
</tr>
<tr>
<td>10</td>
<td>1.8</td>
</tr>
<tr>
<td>11</td>
<td>2.0</td>
</tr>
</tbody>
</table>

#### Highest 25% of Reporters
- Trust 1
- Trust 2
- Trust 3
- Trust 4
- Trust 5

#### Middle 50% of Reporters
- Trust 6
- Trust 7
- Trust 8
- Trust 9
- Trust 10
- Trust 11
- Trust 12
- Trust 13
- Trust 14
- Trust 15

#### Lowest 25% of Reporters
- Trust 16
- Trust 17
- Trust 18
- Trust 19
- Trust 20
- Trust 21
- Trust 22
- Trust 23
- Trust 24
- Trust 25
- Trust 26
- Trust 27

### Table 3: Trust’s medicines incident reporting rate and ranking for year to March 2014

Comparison of medication-related incident reporting rate per 1000 bed days for small acute Trusts (GEH is Trust 4): Data to September 2014

<table>
<thead>
<tr>
<th>Trust</th>
<th>Reporting Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>2</td>
<td>0.2</td>
</tr>
<tr>
<td>3</td>
<td>0.4</td>
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<tr>
<td>4</td>
<td>0.6</td>
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<td>5</td>
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<td>7</td>
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<td>8</td>
<td>1.4</td>
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<td>1.6</td>
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<td>10</td>
<td>1.8</td>
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<tr>
<td>11</td>
<td>2.0</td>
</tr>
</tbody>
</table>

#### Highest 25% of Reporters
- Trust 1
- Trust 2
- Trust 3
- Trust 4
- Trust 5

#### Middle 50% of Reporters
- Trust 6
- Trust 7
- Trust 8
- Trust 9
- Trust 10
- Trust 11
- Trust 12
- Trust 13
- Trust 14
- Trust 15

#### Lowest 25% of Reporters
- Trust 16
- Trust 17
- Trust 18
- Trust 19
- Trust 20
- Trust 21
- Trust 22
- Trust 23
- Trust 24
- Trust 25
- Trust 26
- Trust 27
Medicines Reconciliation:
A medicines reconciliation service (9-5.30 pm Monday to Friday) has been established and is provided to all adult medical and surgical wards within the Trust.

The pharmacy technician team maintain a log of all patients on whom medicines reconciliation is completed. Numbers of usage are collated monthly by ward and Figure 1 below shows the proportion of adult medical and surgical patients who received medicines reconciliation since April 2012.

Figure 1: Medicines reconciliation performance to March 2015

The level of performance has been consistently above 70% for the last two years and the need for additional bed capacity opened from December 2014 modestly reduced performance.

The Trust continues to pilot the national Medication Safety Thermometer tool (MSST), now on ten adult wards, which amongst other elements, assesses the proportion of patients on whom medicines reconciliation has started within 24 hours of admission. Data for the latest MSST (December 2014) with all patients on the pilot wards showed that 55% of patients had medicines reconciliation started within this timeframe, whilst a further 8% had been admitted within the last 24 hours and so it could not be determined whether medicines reconciliation would be achieved within the 24 hour timeframe. The data did suggest that medicines reconciliation is generally being completed in a timely manner.

Access to patients’ summary care record, via Lorenzo, provides a further opportunity to refine the medicines reconciliation process, by reducing the need to contact GP practices for details of patients’ medication histories. The impact of this change will be monitored during 2015/16.
Healthcare Associated Infections (HAIs)

We set out in 2014/15 to have no more than 7 cases of Clostridium Difficile (CDI) developed in patients in hospital and deemed not to be ‘avoidable’ due to all possible preventative measures being delivered. This represents another year of excellent achievement in limiting this serious infection.

In April 2014, NHS England introduced a new methodology for identifying which cases of CDI would count against individual hospitals’ target objective. It was reported that the level of CDIs in some organisations may be approaching their irreducible minimum level in which CDI’s will occur regardless of the quality of care provided, due to the fact that some people carry C. difficile in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take.

The proposed change was for each organisation to assess all CDI cases to determine whether the case was linked with a “lapse in the quality of care” provided and highlight any areas where care could be improved. It is the most effective approach for delivering continuous improvement of patient safety.

During 2014/15, 11 Clostridium difficile (CDI) infection cases were identified in patients after admission (post 72 hour CDI case) against a threshold of 7. However in light of this new methodology, the Hospitals team and local Clinical Commissioning Group (CCG) reviewed all 11 cases to establish if they were any lapses in the quality of care provided. The outcomes to the reviews were:

- 4 cases were deemed to be “avoidable”
- 6 cases were deemed unavoidable; which means that all aspects of care had been delivered in line with best practice and local guidance
- *1 further case in March 2015 is under review in respect to the level of avoidability; the outcome of this review is due in early May 2015 following a CCG & Local team meeting

Where there has been no lapse of care, then that case is not counted towards the total number of actual C. difficile cases on which any sanction will be based. At year ending 2014/15, GEH had 4 avoidable cases against threshold of 7 therefore no contractual sanction will be applied.

Multidisciplinary Post Infection Reviews (PIR) during 2014/15 identified the significant good practice whilst also identifying areas for further action. In 2015/16 Antibiotic stewardship will be a continued area of focus and specifically relate to the prescribing and review of antibiotics in hospital and prior to admission.

All outcomes are shared at the weekly senior nurses forum, monthly Infection Prevention & Control Committee (IPACC) and the Serious Incident Group (SIG) meetings chaired by the Medical Director. This process ensures that infection prevention and control actions are rapidly disseminated.

The minimisation of Clostridium difficile and other Healthcare associated infection (HCAI’s) is due to strict observance of infection prevention and control principles by healthcare staff. In addition the Infection Prevention and Control Team (IPCT) provide support and advice to staff dependant on the particular (HCAI) that the patient may have.

Key actions of the team include:
- Rapid isolation of patients with suspected infectious diarrhoea into side rooms and continued enhanced bay cleaning.
- Strict monitoring and compliance with antibiotic usage.
- Weekly C. difficile ward rounds by the infection prevention & control team to review the progress of all patients with C. difficile infection.
- Annual deep clean programme and use of hydrogen peroxide “fogging” technology.
- Robust norovirus information alerts to raise awareness particularly to visitors to avoid introducing norovirus into the hospital.

- Clear processes in place to manage any potential cases of norovirus, which include strict quarantine.

### Quarterly MRSA Bacteraemia for 2013/14 and 2014/15

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr–Jun 12</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Oct–Dec 12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr–Jun 13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oct–Dec 13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr–Jun 14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oct–Dec 14</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- **Post 48 hour MRSA Bacteraemia**

- **Pre 48 hour MRSA Bacteraemia**

8.1 Observing a zero tolerance approach for 2014/15 we were successful in having **no cases of hospital acquired MRSA Bacteraemia**. It is an accolade for the Trust that it has been almost two and a half years since the last reported case of MRSA Bacteraemia at our hospital.

### Quarterly MRSA Bacteraemia for 2013/14 and 2014/15

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr–Jun 12</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Oct–Dec 12</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Apr–Jun 13</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Oct–Dec 13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr–Jun 14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oct–Dec 14</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- **Post 48 hour MRSA Bacteraemia**

- **Pre 48 hour MRSA Bacteraemia**

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Mandatory Reportable Post 72 hour CDI Cases Apportioned to the Trust by Month

<table>
<thead>
<tr>
<th>Month</th>
<th>2013/14</th>
<th>2014/15 Avoidable</th>
<th>2014/15 Unavoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jun</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Jul</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Aug</td>
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<tr>
<td>Sep</td>
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<tr>
<td>Oct</td>
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<td>0</td>
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<tr>
<td>Nov</td>
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<td>0</td>
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<td>Dec</td>
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<tr>
<td>Jan</td>
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<tr>
<td>Feb</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mar</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- **2013/14**
- **2014/15 Avoidable**
- **2014/15 Unavoidable**

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- **Pre 48 Hour MRSA Bacteraemia cases:**
  - In 2014/15 there was 1 pre 48 hour MRSA Bacteraemia reported which also was a contaminant but was allocated to a third party. This is because the PIR process was amended in April 2014 and there is now an arbitration process that may be convened in exceptional cases, where the acute Trust or the CCG is unable to determine which organisation should be assigned a case of MRSA bloodstream infection may be allocated to a “third party” (see glossary).
9.0 Mortality

We set out to continue to deliver improvements across hospital services which would support reductions in mortality ratios. Mortality ratios are a means to understand the care provided in hospitals and mark both progress and areas for further investigation. George Eliot Hospital NHS Trust uses both the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI) linked with reviews of patient care to monitor our progress and signal areas for improvement.

Key actions to reduce mortality ratios and improve outcomes centre upon consistently delivered high quality care over the 7 day period 24 hours a day.

The building and development of the acute medical unit, improving handover between teams and limiting patient moves are examples of improvements delivered during 2014. Our delivery of “care bundles”, similar to aircraft pre-flight checks have also helped us to ensure we deliver consistently the most important actions at the right time.

Care Bundles to support patients with pneumonia, sepsicaemia, kidney failure, heart failure and falls prevention have been instigated in 2014 and as a result we have seen significant improvement in the outcomes for patients both in mortality ratio length of stay reduction and timeliness of care.

Our hospital Mortality committee, chaired by the Medical Director Gordon Wood, reviews our progress in this area and uses both the information from Mortality Ratios and importantly the results of Patient Case note reviews to understand our progress and any necessary actions.

Mortality ratios are a valuable means to track our progress and we are pleased to report that we have seen a continued improvement in both the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI) in 2014/15.

<table>
<thead>
<tr>
<th>National SHMI Trend</th>
<th>SHMI Value</th>
<th>Band</th>
</tr>
</thead>
<tbody>
<tr>
<td>Via Health and Social Care Information Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>October 2012 - September 2013</td>
<td>1.09</td>
<td>2</td>
</tr>
<tr>
<td>January 2013 – December 2013</td>
<td>1.08</td>
<td>2</td>
</tr>
<tr>
<td>April 2013 – March 2014</td>
<td>1.05</td>
<td>2</td>
</tr>
<tr>
<td>July 2013 – June 2014</td>
<td>1.03</td>
<td>2</td>
</tr>
<tr>
<td>October 2013 – September 2014 (MOST RECENT RELEASE)</td>
<td>1.00</td>
<td>2</td>
</tr>
</tbody>
</table>
Most recent data 2014/15 (via HED)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHMI April 2014 – December 2014</td>
<td>0.98 (below national average mortality)</td>
</tr>
<tr>
<td>HSMR April 2014 - Jan 2015</td>
<td>93.05 (below national average mortality)</td>
</tr>
</tbody>
</table>

Funnel Plot HSMR 12 Months February 2014 January 2015 English Acute Trusts George Eliot Hospital NHS Trust

Please note that the funnel plot is only valid when the overall HSMR score is around 100.
Priority 3: Patient & Staff Experience
(Executive Leads – Dawn Wardell, Director of Nursing & Dorothy Hogg, Director of Human Resources)

1.0 Patient Experience: The experience our patients receive remains central to our improvement work and the Trust uses a variety of feedback forums to inform on specific areas of focus.

The results of the latest national Inpatient Survey, undertaken in 2014, indicates that for George Eliot Hospital, 25 areas demonstrate improvement, 23 remain unchanged and 14 show a reduction in performance.

Areas where the Trust had reached, or been above the national average are;
- Choice of Hospital
- Admission date not changed by the hospital
- Medicines explained more fully (not all indicators on medicines were above)
- Hospital food quality and choice
- Handwash gel availability
- Lack of noise at night from staff

- Privacy on examination and treatment
- Same Sex Accommodation compliance
- Explanations and information on treatment, procedures and care especially A&E
- Delay on discharge due to waiting for Doctor or Ambulance

Local Results
When we compare the results from 2014 to those of 2013 Inpatient survey there are a number of areas that have improved, some maintained but a number have reduced. Below in table 2 are the overview results of all of the indicators.
Areas where the Trust had improved or stayed the same are:
- Medicines explained more fully and side effects in a way you could understand
- Pain control
- Trust and Confidence in Nurses and Doctors
- Enough Nurses on duty
- Notice of, and information on, discharge
- Cleanliness of the hospital
- Risks and Benefits of operations, procedures or treatment explained
- Treated with respect and dignity
- Overall experience in care Good = 8-10 score

Areas where the Trust had deteriorated from the previous year are:
- Noise over Night
- Communication
- Discharge Communication
- Medicines explanations

These areas are also detailed in full with our actions to improve within the 2015/16 quality improvement priorities later in this document.

The national Inpatient survey results show us where specific focus is required and informs where improvement is needed.

We have used a daily “patient impressions” survey tool and the friends and family recommendation score to gain detailed real time feedback during 2014/15. This information is passed to teams weekly to both mark excellent practice and areas for action.

The Director of Nursing chairs the Patient Experience Group (PEG) which has taken forward improvement work in 2014. Key actions include:
- Developed patient information booklets for those undergoing surgery, anaesthesia, and information on discharge from hospital
- Established communication standards for all staff
- Formed a discharge improvement group to support both an improvement in the experience and safety of discharge
PEG also carried out the following actions in 2014

<table>
<thead>
<tr>
<th>Area of Work</th>
<th>Action Taken</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of all patient information available to ensure relevance and that each area follows the latest evidence</td>
<td>A review was undertaken by the Head of Nursing for Surgery of all patient information leaflets used in day surgery and elective services. Improvements implemented include the use of ‘plain English’ and a uniform approach.</td>
<td>✓</td>
</tr>
<tr>
<td>Provision of written diagnosis and treatment plans for patients and carers whilst an inpatient to improve understanding and involvement in treatment</td>
<td>Established pilots with lead Consultants in two areas of the Trust and intend roll out of this plan during 2015/16.</td>
<td>On-going</td>
</tr>
</tbody>
</table>
| Recruiting new staff members to the organisation based on values of care, compassion and high standards of clinical care | - All nursing post appointments are now using the ‘recruiting for values approach’, where staff are assessed not only for competence but also for their suitability and fit to the Trust’s Excel values.  
- New starters now attend an additional clinical induction day which is based on the 6Cs.  
- Newly qualified nurses and nurses new to the Trust are supported by our Practice Development Team to ensure that they are able to offer care of high quality and adhere to Trust standards.  
- All the above to ensure that staff retention and development is central to our recruitment practice. | ✓        |
| Establish a healthcare support worker training programme which includes key factors for delivering an excellent patient experience | - A Healthcare support workers development programme is on-going.  
- HCAs attend 6 core sessions across the year addressing all areas of basic healthcare and changes in practice; this includes a focus in all sessions on patient experience.  
- HCAs are now being recruited with a view to undertaking the National Care Certificate and existing HCAs will also be offered this opportunity. | ✓        |

Some Reported patient experiences (All taken from NHS Choices)......

“Arrived at 18.45 on a Wednesday in January expecting to be there for a couple of hours. Seen and treated and on my way home by 19.50. Very impressed with the staff and how quickly I was seen to. Reason for going to A & E eye injury”
<table>
<thead>
<tr>
<th>Area of Work</th>
<th>Action Taken</th>
<th>Achieved</th>
</tr>
</thead>
</table>
| Twice weekly “impressions” Patient feedback to staff                        | - Impressions feedback is shared with ward managers, matrons and senior nurses who receive impressions feedback on a daily basis. This enables teams to respond quickly to any concerns raised by patients  
- Issues regarding ward temperature, food quality, hygiene and access to pain relief have been acted on immediately with the ward teams                                                                                                                                                                                                                     | On-going  |
| A “Night Noise Charter” setting out the standards to prevent noise at night and promoting patient rest; this standard will be assessed by regular spot checks on progress | The Night Nurse Practitioners continue to undertake quarterly audits against the Night Charter. These audits look at whether lights are still on after 11pm, whether there is excessive noise from both staff and patients. The feedback is given to the matron for each area so that areas of concern can be addressed immediately                                                                                     | On-going  |
| Daily staffing level boards to provide information on the numbers and skills of staff working within each area – this work is linked with the constant consideration of staffing levels across the Trust and formally reviewed at the three times daily operational meetings | - Outside each ward there is public information regarding safer staffing levels which is updated daily by the nurse in charge and audited by the matrons to ensure accuracy  
- Data is also collected electronically and a monthly report is submitted to the Board and our peers nationally  
- Daily management of safer staffing is achieved through the bed meetings thus ensuring that all wards are safe and staffing is used effectively                                                                                                                                                                                                                             | On-going  |
| Responding to the NHS England requirement that all services use patient feedback to drive improvements, the delivery of a new scheme called PREMS (Paediatrics reporting experience measures) within our children’s services to understand children’s experience of their care. Children make up 26% of patients in emergency settings. PREMS are the first measure of its type for children | We incorporated collection of PREMS into our department, first in paper format and then electronically. We have listened to what children and parents had to say and learnt that overall they were very well cared for and the department is working effectively and delivering compassionate care  
For those areas needing improvement we have acted eg:  
- providing ready access to fruit and drink to parents and children in the department  
- ensuring a twice daily clean  
- improving the signage to and from the X-Ray department                                                                                                                                                                                                                                             | On-going  |

“I was taken into George Eliot A&E following an accident. Firstly I would like to thank all of the ambulance staff who attended & the controller who stayed on line reassuring my daughter until the ambulance arrived. When they said they were taking me to George Elliott I was not too sure as I had only ever heard bad things. Well I would just like to say I had nothing to worry about the treatment I received was second to none. I was seen straight away by a nurse in under 10 minutes I had been seen by a Doctor, I was immediately sent for an X-ray fortunately nothing was broken. I am however black & blue all over & in a lot of pain. I can honestly say I was treated with respect & dignity at all times, treated promptly & with the utmost of care. I would have no hesitation in going to or recommending this hospital & its staff to anybody. Please keep up the good work, these standards are some of the best I have experienced from the NHS. Complaints and Patient Feedback 2014/15”
1.1 Complaints and Patient Feedback 2014/15

The Trust values and uses the patient and public feedback it receives to continue to improve the quality of service and care it provides to its patients. The Trust recognises that complaints in particular are an effective measure of the services it delivers and whether it needs to use these to support improvement.

This information helps the Trust to:
- Understand the patient experience, expectations and perspective
- Ensure we met our standards of service delivery and the quality of care and continue to use complaints to make improvements for our patients
- Address any areas where our care standards are not being met
- Identify actions to address areas of concern

During 2014/15 the Trust undertook a number of actions to improve its complaints process, these included:
- Improved and sustained response rate performance in Q3 and Q4
- More face to face complaints meetings
- Delivery of a Patient Experience episode at every Trust Board meeting
- Improved complaints reporting that includes the Trust's Patient Experience Group and Divisional Governance Groups. The reports include the speciality areas concerned, nature of complaint, outcomes and actions.

During 2014/15 the Trust registered 355 formal complaints, compared to 326 the previous year. This was against 474,009 patient episodes compared with 425,185 for 2013/14.

Ratio of Complaints to Activity:

<table>
<thead>
<tr>
<th></th>
<th>Total complaints received</th>
<th>Inpatient, outpatient &amp; maternity activity</th>
<th>Leicester Urgent Care</th>
<th>Accident &amp; Emergency (GEH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints 2014/15</td>
<td>355</td>
<td>275</td>
<td>43</td>
<td>37</td>
</tr>
<tr>
<td>Activity level</td>
<td>473938</td>
<td>308214</td>
<td>99471</td>
<td>66253</td>
</tr>
<tr>
<td>Ratio of complaints to activity level</td>
<td>0.07%</td>
<td>0.09%</td>
<td>0.04%</td>
<td>0.06%</td>
</tr>
</tbody>
</table>
Complaints by Primary Subject as reported in the KO41a return
(NHS written complaints data collection)

Examples of Complaints and Actions taken

<table>
<thead>
<tr>
<th>Concern raised</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication incorrectly labelled which resulted in a patient taking a significant increase in drugs requiring admission to hospital</td>
<td>Patient was advised during admission of the drug labelling error and knowledge of this led to a root cause analysis being undertaken prior to the complaint being received. Full explanation and apology given and patient advised via the Complaints Process that this detailed investigation/complaint had resulted in the dosage codes being changed on the pharmacy computer system for this particular drug</td>
</tr>
<tr>
<td>Concerns re listening to a parent and their experience of asthma when their child was unwell</td>
<td>Meeting held with parent who was advised as part of that discussion that as a result of the complaint a teaching session regarding the Asthma Pathway had taken place. Audit for children with asthma also undertaken with results shared</td>
</tr>
<tr>
<td>Concern raised regarding review of patients in the Clinical Decisions Unit (CDU)</td>
<td>Agreed that as there is no resident doctor attached to CDU and responsibility can vary between A&amp;E, Medical and Surgical clinicians the morning bed meeting would include covering patients in CDU to ensure ownership</td>
</tr>
</tbody>
</table>

Referrals to the Parliamentary Health Service Ombudsman (PHSO)
Under the second and final stage of the complaint process the Parliamentary and Health Service Ombudsman requested or concluded 8 cases during April 2014 to March 2015 some of which pre-dated April 2014. Of the 5 cases concluded, 1 was upheld, 3 were partly upheld and 1 was not upheld. As at 31 March 2015, 3 cases were awaiting a decision.
Moving Forward in 2015/16
The new corporate structure has addressed the need for smaller, more specialised, Clinical Business Units (CBUs) which will work more closely with the Complaints Service.

Investment has taken place into the Datix Reporting System which has been tailored to ensure direct ownership of the complaint within the CBUs. This aims to capture more than the primary issue, and try to identify secondary themes or trends and more importantly to ensure learning. It will also have a valuable link to PALS contacts and incidents.

The Complaints Service, through meeting with staff, has identified a training deficit and commencing with key staff, a comprehensive complaints training plan is to be devised and rolled out this forthcoming year.

2.0 Staff Experience: A report of the 2014 National NHS Staff Survey summarises key results for George Eliot Hospital NHS Trust from Listening to Staff 2014, noting the Trust has seen an improvement in key indicators such as:

- Staff Recommendation of the Trust as a place to work or receive treatment for the fifth consecutive year; and
- Overall staff engagement has increased for the third consecutive year.

This report also deals with other measures of staff engagement undertaken throughout the year, specifically Staff Impressions – the vehicle used for capturing Staff Friends and Family Test (FFT) data, which was introduced by NHS England in April 2014, and requires staff to undertake formal Staff FFT surveys. At this time the Trust took the opportunity to introduce Staff Impressions mini surveys and these are run three times per year (over one month at a time) each quarter with the exception of the quarter when the National Staff Survey takes place.

The Staff Impression survey provides additional data on staff experience themed around key areas that are considered appropriate at the time. During the first year the following themes have been explored:

Q1 Additional Hours Working, Stressors and Staff feeling of being valued
Q2 Communication
Q4 Values and the extent to which they are embedded

2.1 Friends and Family Test – National Staff Survey. The staff survey asks two ‘Friends and Family’ type questions. Firstly, the survey asks staff whether they agree with the statement “I would recommend my organisation as a place to work” and secondly whether they agree with the statement: “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”.

In respect of the first question, the Trust’s score improved to 61% in 2014 (compared with 55% in the average Trust). In respect of the second question, 65% of respondents stated that they would be happy with the standard of care provided by the Trust should a friend or relative require it (compared with 63% in the average Trust), again an improvement on 2013. Performance in both of these responses using Quality Health data is shown in the charts below:
Proportion of respondents indicating they would recommend GEH as a place to work

Proportion of respondents indicating they would be happy with the standard of care if a friend or relative needed treatment
Over the past year we have continued to introduce ways to engage with staff and offer support aiming to improve their health and wellbeing at work. The roll out of the ‘Well to Excel’ Wellbeing Strategy was the main objective driving the Trust’s Workforce Wellbeing Group (WWG). The WWG members champion elements of the annual health and wellbeing at work programme to engage with staff using a myriad of innovative initiatives to promote their overall health, physical, emotional, social, financial and career wellbeing. The following ‘wordle’ gives a flavour of the initiatives carried out by the WWG.

2.2  For 2014/15 our staff Educational and Development programme sustained the achievements acquired from the previous year by increasing staff numbers accessing the education and development curriculum. Our progress for this reporting period includes:

- 86% of Trust Staff compliant with Statutory Training requirements
- 88% of Trust staff compliant with Mandatory Training requirements
- 78% of Trust staff have an active appraisal.
- Increased e-learning opportunities and site specific training
- Partnership working with West Midlands Leadership Academy
- Funding secured for leadership & management development for bands 1-4 and for junior doctors and physicians associates
- Embarked on the national ‘Talent for Care’ programme supporting development of bands 1-4
- Increased commissioning of learning opportunities leading to wider access for Trust Staff
- Increased Apprenticeships across more services including introducing Care apprenticeships
- Educational pathway for support workers, including the introduction of the Care Certificate Programme from April 2015
- A 4-day workshop introduced in October 2014 for newly qualified nurses as part of the educational support package for the increasing numbers of preceptors
our vision is to EXCEL at patient care

- Transformational & Transactional development programmes to be delivered in partnership with WM Leadership Academy

- Increased technology based learning opportunities within clinical education:
  - Access for clinical teams to Simulation Education within the newly developed Simulation Suite
  - Introduction of clinical skills videos and e learning resources for staff and students undertaking procedural skill training or updates
  - Introduction and development of an e induction for Doctors and medical students new to the Trust.

Challenges encountered which are monitored via the Quarterly and Annual reports to the learning board and the Trust’s bi-monthly HR group include:

- Monthly monitoring and reporting along with the capacity to support moving to full ESR (Electronic Staff Record) self service
- Performance management of staff and managers non-compliant with Statutory training
- Withholding of incremental pay increases for non-compliant staff
- Session based delivery to support staff release for Statutory & mandatory training to meet increasing national and regional educational and training targets.
Statement of Assurance from the Trust Board

The following statements offer assurance that the GEH is performing to essential standards, measuring clinical processes and is involved in projects aimed at improving quality and are in common and comparable to the content of all providers of NHS Trusts Quality Accounts.

1.0 Review of Services:
During the 2014/15 review period George Eliot Hospital NHS Trust provided and/or sub-contracted a variety of NHS services which the Trust has reviewed against all the data available to us on the quality of care. The income generated by the 88 NHS services reviewed in 2014/15 represents 89% of the total income generated from the provision of NHS services by the Trust in the reporting period.

A service development improvement plan was in place for services and was agreed with the commissioning partners (Warwickshire North Clinical Commissioning Group, West Leicestershire CCG, Coventry and Rugby CCG and other associate CCG Commissioners). The service development improvement plan is regularly monitored and consists of key milestones of when the review and implementation of any changes to the service has taken place.

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

Regular peer reviews, eg West Midlands Deanery, Health Education West Midlands, Joint Advisory Group etc have taken place during 2014/15 and the table on the next page gives a flavour of the outcome of the reviews that took place along with the actions appertaining.
### Review

<table>
<thead>
<tr>
<th>Event</th>
<th>Outcome/Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Quality Commission</td>
<td>A complete review of the organisation took place by the CQC review team between 30th April and 1st May 2014. The overall score for the Trust was ‘Good’ with an action plan linked to some areas requiring improvement</td>
</tr>
<tr>
<td>West Midlands Quality Review Service (WMQRS)</td>
<td>Following the visit in June 2014, where the overall outcome of ‘excellent’ was awarded, there were 2 areas requiring action: 1) Junior Doctors: Ensure recruitment to the junior doctor tier is progressed, with an identified induction and training package – 8 posts required now filled; 2) Anaesthetics: Develop and implement a training and skills update for anaesthetists, at a children’s hospital, to support the skills required in emergency intubations – Ongoing training has taken place since from January 2015</td>
</tr>
<tr>
<td>QIDs (Quality in Dental Services) Assessment: Special Care Dental</td>
<td>Association for membership to the QIDs scheme – a huge achievement for the service</td>
</tr>
<tr>
<td>Joint Advisory Group (JAG) on GI (Gastro-Intestinal) Endoscopy</td>
<td>During October 2014 JAG carried out an inspection of GI Endoscopy at the Trust and they were pleased to confirm that the endoscopy unit at George Eliot Hospital met all of the required JAG Accreditation standards</td>
</tr>
<tr>
<td>TDA IPC (Trust Development Authority), Infection Prevention Committee visit</td>
<td>The visit identified areas for improvement in relation to the Hygiene Code. A repeat visit identified significant improvements made and full compliance with the Hygiene Code</td>
</tr>
<tr>
<td>New-Born Screening</td>
<td>A quality assurance visit looking at antenatal and new-born screening programmes took place in March 2015. Initial feedback was positive and final report published 29th May 2015 which will be presented to the Trust board alongside any necessary improvement action</td>
</tr>
</tbody>
</table>

### 1.1 Participation in Clinical Audits and National Confidential Enquiries

The Trust is committed to delivering clinical audit in order to develop and maintain high quality patient centred services and during 2014/2015, the Department of Health included 44 national audits for inclusion in Quality Accounts. 29 national clinical audits and 2 national confidential enquiries covered services that George Eliot Hospital NHS Trust provides. During that period, George Eliot Hospital NHS Trust participated in 28 of the 29 (97%) national clinical audits and 100% of the national confidential enquiries which it was eligible to take part in. The national clinical audits and national confidential enquiries that George Eliot Hospital NHS Trust was eligible to participate in during 2014/2015 are shown below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit, or enquiry.
## Audit Title

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Did GEH participate in 2014/2015?</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome or Acute myocardial infarction (MINAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Community Acquired pneumonia</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Bowel cancer</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Case Mix Programme (ICNARC)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme, includes National Hip Fracture Database</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Yes</td>
<td>95%</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Health (care in emergency departments)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit</td>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td>National comparative audit of blood transfusion</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Dementia Audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National emergency laparotomy audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Joint Registry</td>
<td>Yes</td>
<td>97%</td>
</tr>
<tr>
<td>Neonatal intensive and special care</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Non-invasive ventilation – adults</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Oesophago-gastric cancer</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Older people (care in emergency departments)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Pleural procedure</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Pulmonary hypertension</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Adult cardiac surgery audit</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>British society for clinical neurophysiology and association of neurophysiological scientists standards for ulnar neuropathy at elbow testing</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Chronic Kidney Disease in Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital heart disease (Paediatric cardiac surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary angioplasty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fitting Child (care in emergency departments)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head and neck oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National audit of intermediate care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Vascular Registry, including CIA and elements of NVD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric intensive care audit network (PICANet)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Prescribing in mental health services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Trauma: Trauma Audit &amp; Research Network (TARN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidential Enquiries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal, infant and new-born clinical outcome review programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

NB The Trust did not participate in the national cardiac arrest audit during 2014/15 as it has a detailed data collection and review tool in place for this area.
1.2 **Examples of actions arising from clinical audit activity 2014/15**

- An audit of the continence and midwifery initiative showed that 53% of patients referred to physiotherapy did not attend (DNA) the appointment. The introduction of ward contact by a physiotherapist to those at risk of experiencing incontinence increased patient contact with the service by 25% and decreased the DNA rate by 50%. This shows that a physiotherapy presence on the ward is effective in improving the number of patients that are accessing physiotherapy intervention during the postnatal period.

- The Trust's emergency department took part in the pilot of the college of emergency medicine national audit of mental health care. Participation in the pilot audit identified some areas of performance that could be improved; as a result of this the department implemented a mental health risk assessment matrix. This has significantly improved the results seen in the national audit of mental health care e.g. 94% of patients had a risk assessment, compared to 70% in the initial audit; previous mental health issues were recorded in 96% of patients, compared to 26% initially and 90% had a mental state examination, compared to 20% in the pilot audit. This shows a marked improvement in the quality of care provided in A&E.

- An audit looking at the documentation of risks and benefits of total knee replacements as part of the consent process identified some areas for improvement. The audit also looked at whether patients were able to recall the risks and benefits of the procedure. After the initial audit a printed sticker label was implemented to act as a prompt when taking consent of the common risks of the procedure. This significantly improved the documentation of risks, for example risk of bleeding being documented improved from 70% to 100%; documentation of joint stiffness increased from 63% to 98%; documentation of pain as a risk of surgery improved from 50% to 98%. Patients also showed an improved recall of the risks and benefits of the surgery after the implementation of the sticker.

<table>
<thead>
<tr>
<th>Year</th>
<th>Studies</th>
<th>Patients recruited</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>19</td>
<td>754</td>
</tr>
<tr>
<td>2010/11</td>
<td>32</td>
<td>534</td>
</tr>
<tr>
<td>2011/12</td>
<td>20</td>
<td>153</td>
</tr>
<tr>
<td>2012/13</td>
<td>25</td>
<td>270</td>
</tr>
<tr>
<td>2013/14</td>
<td>25</td>
<td>525</td>
</tr>
<tr>
<td>2014/15</td>
<td>31</td>
<td>641</td>
</tr>
</tbody>
</table>

1.3 **Participation in Clinical Research**

Research directly impacts on patient outcomes and it is well documented that departments participating in clinical research perform better. Therefore participation in clinical research demonstrates the Trust’s commitment to improving the quality of care we offer and contributing to wider health improvements.

Studies on the National Institute for Health Research Portfolio are deemed high quality and of benefit to the NHS. As of end of April 2015, 641 patients volunteered to participate in these studies, going above and beyond our target of 524 patients. This represents a 22% increase from 2013/14.
Six new clinical areas have recruited into trials this year. There is a continued drive to increase research led by the Research and Development Director, Research Champions and Research and Development Management service, who actively work together to increase the research culture of the Trust. Participating in research ensures clinical teams stay abreast of the latest treatment options, and attracts high quality staff. Over 80 members of staff have participated in clinical research.

The Trust is committed to increasing access to the latest medical treatments and techniques. Industry trials offer the chance to access these earlier than available commercially. The Trust has increased its industry trial activity, opening 7 commercial trials and recruiting a combined 57 patients.

Commercial research offers access to novel treatments that could be lifesaving or life changing; the chance for staff to have early access to treatments which results in better trained and engaged staff; and the opportunity for staff and patients to access research that is of the highest quality due to its extensive resources for monitoring data quality.

In 2014 the Trust was recognised for outstanding recruitment performance (including commercial studies) by the Clinical Research Network and the hard work done to re-build the research within George Eliot Hospital Trust. The Medical Director on behalf of the Executive of the Comprehensive Research Network wrote “you are an example to small Trusts everywhere, and by far the Most Improved Trust in our network this year”.

In 2014, Dr Venkataraman, Consultant Cardiologist was awarded a Principle Investigator Recognition Award from the Clinical Research Network for going above and beyond what is expected to get selected for commercial trials, and for recruiting to time and working to target.

Staff engagement in clinical research ensures clinical teams stay abreast of the latest possible treatment options and active participation in research leads to successful patient outcomes. During the last four years, over 75 clinical members of staff have participated in research approved by the Trust.

<table>
<thead>
<tr>
<th>Topic/Speciality</th>
<th>Studies</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics</td>
<td>1</td>
<td>48</td>
</tr>
<tr>
<td>Cancer</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>5</td>
<td>46</td>
</tr>
<tr>
<td>Children</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6</td>
<td>433</td>
</tr>
<tr>
<td>Haematology</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Infectious Diseases &amp; Microbiology</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Primary Care</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Stroke</td>
<td>1</td>
<td>58</td>
</tr>
<tr>
<td>Surgery</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
In 2014/15 there were 29 publications which have resulted from our involvement in research. This demonstrates our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

The Trust has a long-standing and effective partnership with the University of Warwick for research. Each year a number of collaborative research studies are undertaken. The Trust continues to sponsor and recruit significant numbers of patients to an International MRC funded study “Pride” with Warwick Medical School, and in partnership with the University of Southampton and King Edward Memorial Hospital in Pune India. The overall aim of this study is to look at various risk factors for the development of GDM, gestational diabetes mellitus, where there is a 1 in 6 chance of a pregnant mother developing.

Other achievements in 2014 include; refurbishment of a Research Hub to be used by research staff funded from the research fund and strengthening the research governance at George Eliot hospital and adopting a high standard Research policy for the Trust. More research nurses have been appointed, funded by the research fund and succeeding in a bid for extra funds for research from the strategic fund of the Regional Comprehensive Research Network.

In 2015/16 the Trust aims to:
- Strengthen and embed research activity within oncology, haematology, dermatology, GUM and geriatric medicine
- Maintain its strong performance in Diabetes and Cardiovascular research
- Meet the national targets of recruiting the first patient into every trial within 70 days of R&D application, and recruiting all patients within the agreed timeframe
- Increase patients recruitment to both Portfolio and Commercial studies for next year and to further the importance of participation in research to the staff and patients.

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

A proportion of GEH’s income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between GEH and Warwickshire North Clinical Commissioning Group. During 2014/15 the total income associated with the achievement of quality improvement and innovation goals amounted to a potential income of £1,803,002. The Trust had a total of 8 general CQUIN measures (5 local, and 3 national) for 2014/15. It should be noted however that the final CQUIN reconciliation is to be determined and actual income for 2014/15 will be agreed with Warwickshire North Clinical Commissioning Group.
Both national and local CQUINS for the Trust, with commentary, are listed below:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3*</th>
<th>Q4*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1a</td>
<td>Friends and Family Test – Implementation of staff FFT - NHS Trusts Only</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>CQUIN scheme</td>
</tr>
<tr>
<td>1.1b</td>
<td>Friends and Family Test - Early Implementation</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>CQUIN scheme achieved</td>
</tr>
<tr>
<td>1.2</td>
<td>Friends and Family Test - Increased or maintained Response Rate</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>CQUIN scheme achieved</td>
</tr>
<tr>
<td>1.3</td>
<td>Friends and Family Test - Increased Response Rate in acute inpatient services</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>CQUIN scheme achieved</td>
</tr>
<tr>
<td>2.1</td>
<td>NHS Safety Thermometer - Improvement Goal Specification</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>The Trust has made significant improvements with New Pressure Ulcers. However this CQUIN measures new and old pressure ulcers and the Trust has very little influence over patients who come into the Trust with an existing pressure ulcer.</td>
</tr>
<tr>
<td>3.1</td>
<td>Dementia - Find, Assess, Investigate and Refer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>CQUIN scheme achieved</td>
</tr>
<tr>
<td>3.2</td>
<td>Dementia - Clinical Leadership</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>CQUIN scheme achieved</td>
</tr>
<tr>
<td>3.3</td>
<td>Dementia - Supporting Carers of People with Dementia</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>x</td>
<td>Q4: Carers Audit not completed within the required timeframe</td>
</tr>
<tr>
<td>4.1</td>
<td>Admitted Patient Discharge Summaries within 24 hours</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>The Trust is continuing to make good progress with sending patient discharge summaries within 24 hours; however the Trust did not meet the planned target</td>
</tr>
<tr>
<td>4.2</td>
<td>Quality of Admitted Patient Discharge Summaries</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>*</td>
<td>* The Q4 requirement to meet with GPs to discuss communication between primary and secondary care will be undertaken in Q2 2015/16 as this scheme continues into a second year</td>
</tr>
<tr>
<td>4.3</td>
<td>Outpatient Appointment Summaries within 5 Working Days</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>The Trust is continuing to make good progress with sending outpatient appointment summaries within 5 days; however the Trust continues to miss the target.</td>
</tr>
<tr>
<td>4.4</td>
<td>Quality Communication with GPs - quality of outpatient appointment summaries sent to GP following the patient’s attendance.</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>Q3/4: Audit not completed within the required timeframe</td>
</tr>
<tr>
<td>4.5</td>
<td>Quality of Deceased Patient Summaries sent to GPs within 5 Working Days</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Q2/3/4: Summaries did not meet required percentage delivery</td>
</tr>
<tr>
<td>5.1</td>
<td>Seven Day Services - Time to First Consultant Review</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>CQUIN scheme achieved</td>
</tr>
<tr>
<td>6.1a</td>
<td>Care Bundles Roll Out - Sepsis</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>The Trust has significantly reduced mortality for these conditions as a result of improvement work which includes care bundle delivery. We did not however achieve the required &gt;95% delivery percentage for each bundle</td>
</tr>
<tr>
<td>6.1b</td>
<td>Care Bundles Roll Out – Heart Failure</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>6.1c</td>
<td>Care Bundles Roll Out – Pneumonia</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>7.1</td>
<td>Zero Tolerance - New Pressure Ulcer Incidence</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>We achieved Q1-Q3 delivery. However in Q4 identified 1 pressure ulcer against the target of zero.</td>
</tr>
<tr>
<td>8.1</td>
<td>Paediatrics Patient Reported Experience Measures (PREMs) for urgent and emergency care</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>Q3/4: Audit not completed within the required timeframe</td>
</tr>
</tbody>
</table>
3.0 Registration with Care Quality Commission

The Trust is currently registered with the Care Quality Commission (CQC) without any compliance conditions and is licensed to provide services. The CQC has not taken any enforcement action or issued any notices against the Trust during 2014/15.

The Trust was last inspected by the CQC in April/May 2014, where the inspection focussed on the care provided at the hospital looking at eight core service areas: A&E; acute medical pathways including the frail and the elderly; surgery and theatres; critical care; paediatrics; end of life care and outpatients.

The findings from the inspection rated the overall leadership of the Trust as good, with the leadership in some services, such as A&E, surgery, maternity and radiology requiring improvement. However the CQC did recognise the progress made by the leadership team where it had demonstrated effective action on all areas of concern, resulting in many examples of outstanding practice, including:

- The positive impact of the ambulatory care unit, opened in December 2013, on preventing admissions by meeting people’s needs in the community.
- Initiatives to help people with dementia to eat, including warmed plates and adapted cutlery.
- The use of individual booklets in all medical wards by members of the multidisciplinary team (including social services) to try and ensure safe discharge.
- Multidisciplinary networks in children’s and young people’s services, developed to deliver care closer to their homes.
- A special service developed to offer information and positive parenting support to teenage mothers and those identified as vulnerable.
- A team of volunteer therapists, who had a professional qualification in relaxation, would identify and support patients who may be anxious about surgery at their pre-operative assessment.

There were two areas where Inspectors felt the Trust must improve, alongside a number of other areas where it should make improvements, to ensure that:

- Medicines are managed in accordance with codes of practice at all times.
- Leadership and governance arrangements are effective in A&E, surgery, maternity and radiology.

An action plan was prepared in response to the CQC report. Headlines and full updated versions of the document have been presented on a quarterly basis to the Trust Development Agency (TDA), to the Trust Board and to the WNCCG respectively.

The detail within the CQC reports at clinical area level is monitored via the Trusts peer visit programme, with progress reported to CQC Leads meetings. The CQC action plan provides an overall view and update on progress against the high level specific areas for improvement.
3.1 CQC Monitoring

The CQC also routinely check the quality of services against a core set of quality indicators and produce an Intelligence Monitoring Report. This forms part of a ‘Surveillance Framework’ where a process using an intelligence tool which was introduced and made accessible to individual Trusts and the public in March 2014. The current indicators (published in April 2015) by the CQC for the hospital show that for the period there are three elevated risks and three risks as laid out in the table below:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevated Risk</td>
<td>Never Event Incidence (01/02/2014 to 31/01/2015)</td>
</tr>
<tr>
<td>Elevated Risk</td>
<td>SSNAP Domain 2: Overall team centred rating score for key stroke unit indicator (01/07/2014 to 30/09/2014)</td>
</tr>
<tr>
<td>Elevated Risk</td>
<td>Snapshot of whistleblowing alerts (case status as a 04/03/2015)</td>
</tr>
<tr>
<td>Risk</td>
<td>Composite Indicator – Emergency re admissions with an overnight stay following an emergency admission (01/10/13 – 30/09/2014)</td>
</tr>
<tr>
<td>Risk</td>
<td>Composite of hip related PROMs indicators (01/04/2013 – 31/03/2014)</td>
</tr>
<tr>
<td>Risk</td>
<td>TDA – Escalation score (01/11/14 – 30/11/14)</td>
</tr>
</tbody>
</table>

The TDA Escalation Score is allocated to all Trust in Special Measures. The Trust has been removed from Special Measures and this elevated risk will not be included in the next set of figures due to be published in July 2015 (supplied for final QA). Trusts that have recently been inspected are not awarded a banding. This is to reflect that the new CQC inspections provide definitive judgements for each organisation.

Detail relating to Risks identified in the CQC monitoring:

Never Event Incidence (01/02/2014 to 31/01/2015):

The Never Event Incidence has been discussed in detail in the Trust’s Quality Account on page 14.

SSNAP Domain 2: Overall team centred rating score for key stroke unit indicator (01/07/2014 to 30/09/2014). This refers to Domain 2 as a composite score, graded on a five point scale (A-E), based on an assessment of the following three individual key Stroke Unit indicators:

- Proportion of patients directly admitted to a stroke unit within 4 hours of clock start (clock start is defined as the time of arrival at hospital. Where stroke occurred in hospital it refers to the time of onset of symptoms)
- Median time between clock start and arrival on a stroke unit
- Proportion of patients who spent at least 90% of their stay on a stroke unit
As a result of these findings, and the overall “Good” rating, the Chief Inspector of Hospitals recommended that George Eliot Hospital NHS Trust was brought out of special measures.

<table>
<thead>
<tr>
<th>Responsive</th>
<th>Well - Led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
</tr>
<tr>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
</tr>
<tr>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

As with many other Acute Hospital Trusts in England during this reporting period the George Eliot Hospital NHS Trust was under a period of increased pressure from emergency admissions and this had an adverse impact on waiting times for elective patients. This is why the Trust was assessed as being at risk over delivery issues.
4.0 Information on the Quality of Data

The National Data Quality Dashboard is available to help monitor and drive improvement in the quality and completeness of data. The GEH benchmarks well against other Trusts as the average results of the overall commissioning dataset (CDS) data validity is 96.2%* for all CDS submitters and the results of the GEH was 96.9%*. Good quality data underpins the effective delivery of patient care and these results are essential if improvements in quality of care are to be made, which includes the quality of ethnicity and other equality data, thus contributing to improvements in patient care and value for money.

NHS Number and General Medical Practice Code Validity:

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

The Trust submitted records during 2014/15 to the secondary user service (SUS) for inclusion in the hospital episodes statistics which are included in the latest published data. The percentage of records in the published data which included the patient’s valid NHS number was:

- APC = 99.9% - (National comparator 99.2%)
- OPD = 99.9% - (National Comparator 99.3%)
- AE = 99.9% - (National Comparator 99.2%)

Source: SUS Data Quality Dashboard, (March 2015);
APC = Admitted Patients Care (This includes Inpatients and Day Cases);
OPD = Outpatients/Ward Attenders and Tele-Medicine activity;
AE = Accident & Emergency

Information Governance Toolkit Attainment Levels:

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

An Information governance audit took place in February 2015, results showing:
- Primary Diagnosis 91%
- Secondary Diagnosis 92%
- Primary Procedure 93%
- Secondary Procedure 96%

This achieved IG level 2. Recommendations made are to review the oncology coding process and to ensure coders read full operation notes.

A Payment by Results audit has also taken place with key findings showing:

The Trust currently has 3 contractors, 2 coders on maternity leave, 2 trainee coders and a system change which are all likely to have contributed to the results. The data audited was June/July/August 2014 and Lorenzo was implemented in June 2014.
- 200 episodes were audited which equated to 153 Spells
- HRG changes - 11 changes 7.5 %
- Primary Diagnosis incorrect 9.5%
- Secondary Diagnosis incorrect 7.8% (those caused by Lorenzo 0.6%)
- Primary Procedure incorrect 16.7% (those caused by Lorenzo 3.3%)
- Secondary Procedure 34.8% (those caused by Lorenzo 7.2%)

Although national figures are not currently available to enable a comparator our auditors advise that these figures should put us in line with the national average.

Following the audits last year the coders have undertaken training in areas highlighted (orthopaedics and pain) and clinical engagement has continued to be a priority. The department has a high number of contract coders and this is impacting on consistency but measures are in place to address this. The implementation of Lorenzo has proved challenging with increased data quality issues impacting on the team.
8. **External Assurance and Performance Indicators**

The Trust reviews its performance against a core set of national (& local) performance indicators where a set standard should be met, or bettered throughout 2014/15.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Standard</th>
<th>2014/15</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Difficile Infections</td>
<td>7</td>
<td>6 (11)*</td>
<td>✓</td>
</tr>
<tr>
<td>MRSA Bacteraemia Infections</td>
<td>0</td>
<td>0</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 2 weeks suspected</td>
<td>93%</td>
<td>94.90%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 2 weeks Symptomatic Breast [1]</td>
<td>93%</td>
<td>92.93%</td>
<td>-</td>
</tr>
<tr>
<td>Cancer 31 days</td>
<td>96%</td>
<td>98.21%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 31 days – Drug</td>
<td>98%</td>
<td>99.54%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 31 days – Surgery</td>
<td>94%</td>
<td>94.44%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer 62 days [2]</td>
<td>85%</td>
<td>81.09%</td>
<td>-</td>
</tr>
<tr>
<td>Cancer 62 days from Screening Service</td>
<td>90%</td>
<td>96.43%</td>
<td>✓</td>
</tr>
<tr>
<td>Patients seen in A&amp;E &lt;4 hours [3]</td>
<td>95%</td>
<td>93.34%</td>
<td>-</td>
</tr>
<tr>
<td>Patients who leave A&amp;E without being seen</td>
<td>5%</td>
<td>0.96%</td>
<td>✓</td>
</tr>
<tr>
<td>Time to initial assessment in A&amp;E in minutes (95th percentile) [4]</td>
<td>&lt;15</td>
<td>&lt;55</td>
<td>-</td>
</tr>
<tr>
<td>Time to Treatment in A&amp;E in minutes (median time)</td>
<td>&lt;60</td>
<td>&lt;32</td>
<td>✓</td>
</tr>
<tr>
<td>Readmission within 28 days following discharge</td>
<td>14%</td>
<td>7.69%</td>
<td>✓</td>
</tr>
<tr>
<td>Stroke – Time on Ward [5]</td>
<td>80%</td>
<td>70.20%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Patient Experience:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to Treatment (RTT) waits 95th percentile – Admitted</td>
<td>23 wks</td>
<td>96.9%</td>
<td>✓</td>
</tr>
<tr>
<td>RTT waits 95th percentile - Non Admitted</td>
<td>18.3 wks</td>
<td>97.1%</td>
<td>✓</td>
</tr>
<tr>
<td>RTT incomplete non-emergency pathway (92nd centile)</td>
<td>28 wks</td>
<td>99.4%</td>
<td>✓</td>
</tr>
<tr>
<td>Patients offered an appointment to Genito-Urinary Medicine (GUM) Clinic within 48 hours</td>
<td>95%</td>
<td>99.57%</td>
<td>✓</td>
</tr>
<tr>
<td>Patients seen in GUM Clinic – access within 48 hours</td>
<td>95%</td>
<td>99.51%</td>
<td>✓</td>
</tr>
<tr>
<td>Percentage of patients whose operations were cancelled for non-clinical reasons on the day of admission</td>
<td>0.80%</td>
<td>0.88%</td>
<td>✓</td>
</tr>
<tr>
<td>Mixed Sex Accommodation [6]</td>
<td>0</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>Patient Safety:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Events [7]</td>
<td>0</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>VTE</td>
<td>95%</td>
<td>95.1%</td>
<td>✓</td>
</tr>
</tbody>
</table>

*C-Difficile infections. A joint investigation by the Trust and North Warwickshire CCG, using DoH guidelines, found that of the 11 reported 4 were ruled as avoidable, 6 were classed as unavoidable and 1 was still under investigation.*
Of the performance indicators shown in the table on previous page the Trust did not fully meet 7, and the following gives a brief explanation as to why the standard was not fully met and what action has been, or is being taken, to remedy this.

[1] **Cancer 2 weeks Symptomatic Breast** – Patients choice for two week wait breast referrals has impacted on our ability to achieve this target. 89% of the breaches were due to patient choice or other issues. To counteract this and reduce the number of breaches a Patient leaflet is now distributed with all appointment letters and via GP’s to remind patients of their responsibilities to make themselves available for further tests and clinic appointments.

[2] **Cancer 62 day Target** - The 62 day standard target has not been achieved due to a number of factors including:
- A 12% increase in demand for 2 week wait referrals compared to the same period last year (from 4845 in 2013/14 to 5420 in 2014/15)
- Delays in some histopathology results from our pathology network provider
- Patients choice to delay treatment or diagnostics
- Co-morbidities (pre-existing medical conditions of patients)
- Multiple diagnostics testing requirements
- Delays from partner organisations

Going forward actions taken to meet and sustain this target in the future are:
- Ongoing senior reviews of all patients are now in place to ensure early escalation and tracking of timelines on pathways
- Partnership working with University Hospitals Coventry & Warwickshire (UHCW) on shared pathways and monthly meetings are on-going with all partner agencies
- All delays are identified and communicated with partners agencies at an early stage in the pathway
- On-going monitoring against stretched targets and issues identified early for action
- Continual review of capacity and additional sessions being undertaken to meet demand
- Reaffirmed patients responsibility for being available for diagnostics and treatment throughout their pathway
- Improved anaesthetic pathway to avoid delays

[3] Patients seen in A&E <4 hours – A combination of factors throughout the autumn and winter resulted in the Trust’s failure to achieve this target. Significant increases in attendances, ambulance conveyances and the proportion of patients which were frail elderly with complex needs contributed to the Trust’s performance difficulties. These issues were compounded by poor patient flow through the organisation which was in turn exacerbated by a severe lack of capacity held by Intermediate Care and Social Care colleagues.

A number of measures were put in place over the winter in order to reduce the impact of these factors including the provision of a ‘transfer team’ to move patients to hospital wards rapidly and as well as the presence of Intermediate and Social Care employees in A&E and AMU. Winter pressures funding was released to allow for the provision of additional senior consultant cover in A&E and an Urgent Care Centre model was piloted from 1st October 2014. All of these measures contributed to incremental monthly improvements in performance from December onwards and some (transfer team, UCC) will be continued throughout the year in order to safeguard improving performance.
[4] **Time to initial assessment in A&E in minutes (95th percentile):** A significant increase in A&E activity made it difficult for the Trust to achieve the highest possible standards in relation to the timeliness of initial assessment in the department. Performance against this has been improving steadily in line with the continuous development of the Urgent Care Centre which aims to quickly assess and turn around patients who are unlikely to be admitted to a hospital bed. Further developments are planned to include Rapid Assessment and Treatment of major’s patients in line with the National Emergency Care Intensive Support Team (ECIST) recommendations.

[5] **Stroke:** Time on Ward: due to extenuating capacity issues across the Trust linked to an unusually high volume of activity (see 3 above); some stroke patients were not admitted within the 4-hour time frame impacting on the failure to meet the 90% target. Once admitted onto the Stroke Ward the standard of patient care has met all other expected levels of qualitative care. In striving to meet this target in the future the Stroke team is working more closely with the capacity (bed management) team to ensure patient assessment and prompt admission to the Stroke ward takes place and the target is met.

[6] **Mixed Sex Accommodation:** There is a zero tolerance to mixed sex accommodation breaches. During 2014/15 there were two occasions where patients in Intensive Therapy Unit (ITU) were ready for ward transfer, but this was not achieved within the 6-hour window. A plan was put in place to prevent recurrence and this was shared with our commissioners. As per national reporting, the Trust’s website was updated with this information. Since this event there have been no further single sex breaches.

[7] **Never Events:** During 2014/15 there was one incidence classified as a Never Event relating to methotrexate (please see page 14 item 2 above showing detail regarding this incident).

**Patient Reported Outcome Measures (PROMs):**
This is a national tool to measure quality from the Patients perspective. This measure looks to the level of recovery, improvement and general wellbeing otherwise known as health gain after surgery.

Four clinical procedures are covered by the PROMs programme these are:
- Groin Hernia repair
- Hip replacement (first procedure)
- Knee replacement ("")
- Varicose Vein surgery (Procedure not undertaken at this Trust)

PROMs scores are reported nationally and this allows comparisons to the national average to be made. The process involves patients’ completing a survey before and after surgery. Key to the success of the programme and measure is the level of patient participation in the programme.
Results for George Eliot Hospital NHS Trust are as follows and relate to a number of measures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Organisation Name</th>
<th>Measure *</th>
<th>Modelled Records</th>
<th>Average Pre-Op Q Score</th>
<th>Average Post-Op Q Score</th>
<th>Adjusted Average Health Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin Hernia</td>
<td>England</td>
<td>EQ VAS</td>
<td>21696</td>
<td>80.401</td>
<td>79.348</td>
<td>-1.053</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>EQ VAS</td>
<td>61</td>
<td>80.197</td>
<td>77.656</td>
<td>-3.279</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>England</td>
<td>EQ-5D Index</td>
<td>20856</td>
<td>0.788</td>
<td>0.873</td>
<td>0.085</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>EQ-5D Index</td>
<td>60</td>
<td>0.766</td>
<td>0.849</td>
<td>0.065</td>
</tr>
<tr>
<td>Hip Replacement Primary</td>
<td>England</td>
<td>EQ VAS</td>
<td>33349</td>
<td>65.441</td>
<td>76.929</td>
<td>11.487</td>
</tr>
<tr>
<td>Hip Replacement Primary</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>EQ VAS</td>
<td>65</td>
<td>63.785</td>
<td>69.431</td>
<td>7.005</td>
</tr>
<tr>
<td>Hip Replacement Primary</td>
<td>England</td>
<td>EQ-5D Index</td>
<td>34828</td>
<td>0.357</td>
<td>0.793</td>
<td>0.436</td>
</tr>
<tr>
<td>Hip Replacement Primary</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>EQ-5D Index</td>
<td>73</td>
<td>0.288</td>
<td>0.7</td>
<td>0.389</td>
</tr>
<tr>
<td>Hip Replacement Primary</td>
<td>England</td>
<td>Oxford Hip Score</td>
<td>37275</td>
<td>17.986</td>
<td>39.326</td>
<td>21.34</td>
</tr>
<tr>
<td>Hip Replacement Primary</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>Oxford Hip Score</td>
<td>83</td>
<td>15.843</td>
<td>35.747</td>
<td>19.33</td>
</tr>
<tr>
<td>Knee Replacement Primary</td>
<td>England</td>
<td>EQ VAS</td>
<td>34430</td>
<td>68.157</td>
<td>73.797</td>
<td>5.64</td>
</tr>
<tr>
<td>Knee Replacement Primary</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>EQ VAS</td>
<td>95</td>
<td>67.621</td>
<td>73.789</td>
<td>5.602</td>
</tr>
<tr>
<td>Knee Replacement Primary</td>
<td>England</td>
<td>EQ-5D Index</td>
<td>36503</td>
<td>0.41</td>
<td>0.733</td>
<td>0.323</td>
</tr>
<tr>
<td>Knee Replacement Primary</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>EQ-5D Index</td>
<td>105</td>
<td>0.33</td>
<td>0.699</td>
<td>0.308</td>
</tr>
<tr>
<td>Knee Replacement Primary</td>
<td>England</td>
<td>Oxford Knee Score</td>
<td>39284</td>
<td>18.891</td>
<td>35.139</td>
<td>16.248</td>
</tr>
<tr>
<td>Knee Replacement Primary</td>
<td>GEORGE ELIOT HOSPITAL NHS TRUST</td>
<td>Oxford Knee Score</td>
<td>114</td>
<td>16.289</td>
<td>33.009</td>
<td>15.215</td>
</tr>
</tbody>
</table>
**PROMS Results**

Patients reported improvement in all areas both national and local with the exception of groin hernia in the visual analogue score of wellbeing 1-100. The EQ5D scoring shows improvement in hernia both nationally and locally.

Remaining areas similarly show improvement post operatively. It is notable that overall participation in the PROMS programme is below expected levels and during 2015/16 teams have been challenged to improve overall uptake.
Quality Improvement Priorities 2015/16

Key Quality Improvement Priorities for George Eliot Hospital NHS Trust 2015/16

The Trust’s key priorities for 2015/16 are based on information taken from incident reports, detailing themes such as patient falls and medication safety and continue to reflect our commitment to improve the quality and safety of care delivered to our patients. These priorities continue to be centered on the CQC domains of safety, effectiveness, how caring and responsive the organisation and teams are, and how well led the organisation is.

Priority 1: Clinical Effectiveness
- High Quality Care

(Executive Lead – Dr Gordon Wood, Medical Director)

1) **Mortality Reduction**: During 2015/16 we will build on the improvements of 2014/15 which saw the achievement of mortality ratios at the national average. For this we will work with patients, GPs and community colleagues to improve the management of chronic conditions such as heart failure and asthma.

2) Having been part of a process to develop a national quality of care review process we will adapt our current process to this scheme. Doing this will help us to better understand the care provided and areas for potential improvement.

3) **Incident reporting** will continue to be a focus and we aim yet again to see the organisation in the top 25% of incident reporting organisations. Doing so will ensure we maintain a positive learning culture. We will also aim to see a reduction in harm from clinical incidents within the year.

4) **Discharge**: We will continue to improve on the discharge planning process from admission to transfer of care. This work will include working with local authority providers to ensure seamless processes for patients and include the ‘safer’ discharge care bundle. Our measures for success in this area will relate to the feedback from our patients in the form of complaints and compliments and the actions undertaken.

5) **Building leadership capability**: Success in meeting our patient’s needs is achieved by individuals and teams; during 2015/16 we will deliver support in the form of an organisational development programme. This will support our newly developed clinical business units and the teams within them to be equipped with the right skills and support for the challenges ahead. Key skills sessions will be delivered alongside master class sessions. This work will be supported by the establishment of an Institute of Healthcare Improvement Chapter (IHI). The IHI is internationally recognised for excellence in healthcare improvement and we will use this to support our teams to lead improvement. Additionally our new consultants’ development program will support new consultants to fulfill both the clinical and leadership aspects of their role.
Priority 2: Patient Safety
- Harm Free Care

(Executive Lead – Dr Gordon Wood, Medical Director)

We have again set out to reduce harm from clinical incidents in 2015/16 as compared to the previous year.

Having achieved 96% of hospital patient care as harm free in 2014/15, as defined by the NHS Safety thermometer, we aim to further improve and see achievement of 97% in 2015/16. To do this we will deliver actions to reduce harm and overall incidence of:

- Pressure Ulcers
- Falls
- Urinary tract infections in patients who are catheterised (CA-UTI)
- Blood clots (VTE)

1) **Pressure Ulcers** – during 2015/16 we will aim to further reduce the incidence of avoidable hospital acquired pressure ulcers, show learning from incidents, outline necessary changes to practice and share our data with our commissioners and local community service providers (eg nursing and residential care homes) to achieve a reduction of community acquired pressure sores. To assist in the reduction of pressure ulcers in the local community and support our aim for overall harm reduction as can be seen in the `Patient Safety Thermometer`, we will invite our care and nursing homes to join in education, learning and best practice in this area.

2) **Medicines Safety** – There has been a significant improvement in incident reporting related to medication in 2014-15. During 2015/16 we aim to continue this improvement for no-harm and low harm incidents. We will also aim to have no serious harm-related to medication errors.

3) The **Medication Safety Thermometer**, which builds on the standard safety thermometer, reviews in detail medication standards. We have begun use of this tool in 2014/15 and we will continue to use it to identify and progress areas for further improvement.

4) **Effective fluid management and Acute Kidney Injury (AKI) support**: During 2015/16 we will deliver a programme of improvement centred on effective fluid replacement and infusions alongside optimising our detection and management of acute kidney injury.

5) Preventing **Never Events** remains a clear priority. To achieve this we will test every action we have in place to prevent these events occurring and make necessary changes. The National Sign Up to Safety Campaign supports this commitment and will help us to build governance within teams and develop vigilant safety focussed teams.
Priority 3: Patient and Staff Experience

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

1.0 Patient Experience

Over the course of 2015/16 we will continue our efforts to improve on the overall experience of our patients. A review of the patient experience strategy will take place at the start of the year which will identify key areas of work and awareness campaigns to address not only those areas to be improved but should lead overall to improving the whole of the national Inpatient survey results. Patient Experience needs to be everyone’s business and fits in with our EXCEL values and our aim to EXCEL at Patient Care.

Core pledges for communication with initiatives such as the “You said we did” and the “Hello my name is” campaign are being pulled together in a clear plan leading up to the next survey due to take place in July 2015.

Looking at specific issues raised by our patients from the outcomes of the 2014 national Inpatient Survey the following table outlines areas we will be focussing on during 2015/16.

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Improve the standards of communication to patients and relatives but also between staff, verbal and written targeting:</td>
</tr>
<tr>
<td></td>
<td>- Nurses talking as if you ‘the patient’ weren’t there</td>
</tr>
<tr>
<td></td>
<td>- Information given by nurses but not understood</td>
</tr>
<tr>
<td></td>
<td>- Information given by doctors but not understood</td>
</tr>
<tr>
<td></td>
<td>- Privacy when discussing treatment, or condition with patient</td>
</tr>
<tr>
<td>Improve the discharge</td>
<td>Involving patients to ensure a more planned and a positive experience of discharge without unnecessary delays. This work is to include:</td>
</tr>
<tr>
<td>communication process</td>
<td>- working with and beyond health and social care services (Local authority, voluntary sector) to meet patients’ needs</td>
</tr>
<tr>
<td></td>
<td>- Revision of the Patient Experience Strategy</td>
</tr>
<tr>
<td></td>
<td>- “Hello my name is ” campaign launch</td>
</tr>
<tr>
<td></td>
<td>- Re-launch of the “you said, we did” boards in clinical areas</td>
</tr>
<tr>
<td></td>
<td>- Improve written information on what to look for, or what to expect</td>
</tr>
<tr>
<td></td>
<td>- Enough notice given</td>
</tr>
<tr>
<td></td>
<td>- Involvement of patients’ and families, particularly when delays on day of discharge with Drs, To Take Out (TTOs), ambulance etc</td>
</tr>
<tr>
<td></td>
<td>- Launch of a ‘discharge bundle’</td>
</tr>
<tr>
<td>Clinical responsiveness</td>
<td>Care elements to be targeted:</td>
</tr>
<tr>
<td></td>
<td>- Admission timeliness</td>
</tr>
<tr>
<td></td>
<td>- Call bells response timing</td>
</tr>
<tr>
<td></td>
<td>- Noise reduction at night</td>
</tr>
<tr>
<td></td>
<td>- Pain relief addressing concerns</td>
</tr>
<tr>
<td></td>
<td>- Eliminating unnecessary ward moves.</td>
</tr>
<tr>
<td></td>
<td>- Help to eat</td>
</tr>
<tr>
<td></td>
<td>- Respect and dignity</td>
</tr>
<tr>
<td></td>
<td>- Support when anxious</td>
</tr>
<tr>
<td>Food</td>
<td>Ensuring Nutrition support, Food quality assurance programme</td>
</tr>
<tr>
<td>Medicines</td>
<td>Improved explanation of medication whilst in hospital and on discharge</td>
</tr>
</tbody>
</table>

Monitoring of the progress and completion of these actions will be monitored by the Trust’s Patient Experience Group and reported at Board level via the monthly patient experience report.
To further support this work, and make the best use of our community engagement programme, the Trust will continue to work closely with the GEH Patient Advocacy Forum (PAF). Their support is invaluable as they carry out regular ward audits, inspections, take on projects and surveys, attend meetings with Clinicians and Management to put forward the patients’ view and air concerns when any decisions are being made to ensure patient quality, dignity, compassion and safety are always taken into account. The patient experience being paramount to the outcome of the PAFs work to improve quality of care for all attending the hospital.

- During 2015 we will also be undertaking a research project with Coventry University which will measure the delivery of ‘Compassion in Care’ and provide regular feedback to staff and ward areas. The research will look specifically at Compassion in Education Practice. Three clinical areas have been chosen to undertake group feedback from patients, staff and visitors regarding the areas relating to delivery of compassionate care. This data compliments the Friends and Family data whilst giving more in depth feedback from all people who come in contact with the area. This has been described as a 360 degree appraisal of a clinical area. The ward manager and matron are then able to share the report with the team and will publish it in the clinical area for all to see. The team can then develop any actions that are required from the feedback. It is useful to use all types of feedback to inform wards and departments of the experience of their patients and their families.
2.1 **Staff Education & Development for 2015/16**

For 2015/16 our staff Educational and Development programme will aim to sustain the achievements acquired throughout 2014/15 and actively work towards increasing staff numbers accessing the education and development curriculum based on the targets attached to the annual funding allocation from HEE (Health Education England), academic funding and local education and training boards allocated funding priorities. A particular area of focus will be to continue to offer leadership development to CBU leads and newly appointed consultants as well as supporting managers to further develop management and leadership skills. The Trust will continue to work with staff side colleagues to increase the engagement of our staff throughout the year through wellbeing initiatives and recognising excellence in individuals and teams and through the further embedding of our EXCEL vision and core values.

2.0 **Staff Experience**

The 2014 Staff Survey highlighted improvements and importantly pointed to areas for continued action. During 2015/16 we will:

- Aim to improve the percentage of staff who agree their role makes a difference to patients based on 2014 delivery;
- Improving reporting rates of health and safety incidents and near misses;
- Continue to proactively manage issues where staff experiences violence and aggressions from patients relatives and the public.

For 2015/16 we will aspire to emulate the good work of this year and the following is an example of the verbatim comments taken from our staff impressions survey during the course of 2014.
ANNEX 1: Auditors’ Limited Assurance Report

Independent Auditor’s Limited Assurance Report to the Directors of George Eliot Hospital NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of George Eliot Hospital NHS Trust’s Quality Account for the year ended 31 March 2015 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:
- Percentage of patient safety incidents resulting in severe harm or death
- Percentage of patients risk-assessed for venous thromboembolism (VTE).

We refer to these two indicators collectively as “the indicators”.

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated 17/06/2015;
- feedback from the Local Healthwatch dated 27/05/2015;
- feedback from other named stakeholders (the Overview and Scrutiny Committee) involved in the sign off of the Quality Account, dated 27/05/2015;
- the latest national patient survey dated 20/04/2015;
- the latest national staff survey dated 11/02/2015;
- the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 20/05/2015;
- the annual governance statement dated 03/06/2015; and

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

This report, including the conclusion, is made solely to the Board of Directors of George Elliot Hospital NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and George Elliot Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.
Assurance work performed

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

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

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

Limitations

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

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

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

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

Basis for qualified conclusion

The indicator reporting the percentage of patients risk assessed for VTE did not meet the six dimensions of data quality in the following respects:

- Accuracy and Validity - of the sample of 45 admissions we reviewed, 19 of these were not correctly recorded. The errors identified fell into two categories: either there was no evidence on the patient’s file that a risk assessment had been carried out when the admission had been categorised as risk assessed; or there was evidence on the patient’s file of a completed risk assessment and the admission had been categorised as not risk assessed. Consequently we cannot conclude that the indicator is sufficiently accurate for the intended purpose or compliant with the relevant requirements.
Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

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

Grant Thornton UK LLP
Colmore Plaza
20 Colmore Circus
Birmingham
B4 6AY

20 June 2015
Dear Kath

George Elliot Hospital NHS Trust – Quality Account 2014/15

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

The TFG have continued to build upon the good working relationship with George Elliot Hospital by continuing to monitor the progress of the Quality Improvement Priorities for 2013/14 and the process for feeding into the Quality Account (QA) has been strengthened with the opportunity to have suggestions reflected in the QA. The TFG has welcomed this approach and continues to value the partnership work with GEH.

The QA is a document that is intended to give members of the public easy access to information on the performance of the hospital and the priorities that have been identified for their service users. With this in mind, the QA is considered to be well written and the Group welcomes the ‘Looking Back’ section, which gives a clear snapshot of what the hospital has been doing and the impact it has had on the service provided. We commend this approach, which we consider to be a good example of providing information clearly to the wide range of audiences that will read the QA.

We believe that there should be more explanation given where data is provided in a graph to add more context and to stop any misunderstanding about performance and national benchmarking.
Consideration has been given to the onsite Patient advice and liaison service (PALs) and the complaints procedure. Both were considered to be good and robust with the patient’s voice feeding into and influencing the improvement of services.

GEH has faced some considerable challenges over recent years, and we feel that the open and frank approach to the QA is an example of the commitment by the Trust to ongoing improvement. We would like to thank the Trust representatives who have worked with the TFG to produce this QA.

Please take this letter as confirmation that the attached response prepared by the Quality Accounts Task and Finish Group set up by Warwickshire County Council’s Adult Social Care and Health Overview and Scrutiny Committee (which was chaired by Councillor Derek Pickard, North Warwickshire Borough Council), represents the formal response of the Warwickshire County Council Adult Social Care and Health Overview and Scrutiny Committee.

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

Yours sincerely

[Signature]

Councillor Maggie O’Rourke, Chair of the Adult Social Care and Health Overview and Scrutiny Committee
GEH Patient Advocacy Forum (PAF)

Following a request from the Trust’s Medical Director for the PAF to review this year’s Quality Account, the PAF Chair would like to submit the following statement:

I can confirm on behalf of the PAF that the presentation of information and content detailing the Trust’s quality performance and improvements realised over the 2014/15 year are reflective of our understanding of the achievements reported and made during this time.

The PAF have once again worked closely, and successfully, with the Trust during the roll out of its annual work plan where we carry out ward audits and inspections, patient surveys and feedback any issues raised, gathering views and making recommendations for improvement to the overall patient experience at the hospital. The PAF also regularly attend key meetings and working groups of the Trust representing the patients’ voice and taking part in discussions when monitoring and review takes place.

Representation and involvement from the PAF at the internal Quality Account Review Group meetings has once again taken place in the build-up of the narrative within the looking back section, but more importantly in the involvement of the looking forward section when setting the 2015/16 quality improvement priorities.

The PAF look forward to building on their close working relationship during 2015/16 in support of the new quality improvement priorities alongside the Trust’s teams and involvement of monitoring the quality improvement priorities as the year progresses.

Maurice Charley
PAF Chair
17th June 2015

Dr G Wood
Medical Director
George Eliot Hospital NHS Trust

Dear Dr Wood,

NHS Warwickshire North Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the Quality Account for 2014/15. We do so in the capacity of lead commissioner for the George Eliot Hospital NHS Trust (GEH), and our response meets the requirements set out by the Department of Health.

Before commencing our review, the CCG would wish to acknowledge the positive report received following the CCG’s inspection in April/May 2014, which resulted in the Trust achieving an overall rating of ‘Good’ published in July 2014. The Trust leaders and staff have demonstrated a significant improvement since the ‘Kogan’ review in 2013, and continue to work to improve the areas identified as ‘requiring improvement’, the progress of which is reviewed regularly by the CCG.

Our review of the draft Quality Account has included checking the accuracy of the information presented against that previously received in relation to the services commissioned, and commenting on the information that we, and the public, might expect to see in the Account. Following our review, feedback has been provided to the authors of the report in advance of its publication, and the suggestions we made have been included in the final version of the Quality Account.

Overall it is evident that in the financial year 2014/15, the Trust has set out to deliver against the priorities set out in the ‘Looking Forwards’ chapter of the 2013/14 Quality Account. The 2014/15 Quality Account provides the detail of achievements against these priorities, and evidences improvements in patient experience and staff satisfaction using the outcomes of the National Inpatient Survey and the National staff survey Friends and Family test as sources of external validation.

The Trust has made good progress this year however, it is disappointing that there are a small number of the priorities which have not been met for example:

- in respect of complaints, the Trust consistently struggled to achieve the prescribed 25 working days for their formal response rate during the first half of the year;

Chair: Dr Deryn Stevens
Chief Officer: Andrea Green
• in January 2015, an inspection of Infection Prevention and Control by the NHS Trust Development Agency (NTDA), identified areas requiring improvement,
• insufficient progress was made on the Commissioning for Quality and Innovation (CQUIN) indicators in respect of pressure ulcers, and discharge summaries to GPs,
• the aim to reduce patient falls by 20% was not met.

During 2014/15 the Trust made the required improvements in response time to complaints after the first half of the year, and the solution put in place to address the issue, is expected to ensure the required response times are sustained. It is worth noting that very few complaints during the year have been referred to the Parliamentary Health Service Ombudsmen, an indicator that overall the quality of responses is satisfactory. Also, a repeat inspection of Infection Prevention and Control by the NTDA conducted in March 2015, recognised improvement in the areas required.

It is welcome to see that where sufficient improvement has not be achieved, the Trust have included additional focus and planned improvements in 15/16, specifically

• continuing focus on reducing the incidence of avoidable hospital acquired pressure ulcers
• and working with other community and care home providers to reduce the incidence of community acquired pressure ulcers,
• working with the CCG and GPs to improve the discharge summary and outpatient letters,

Having worked with the Trust over the last 2 years tackling what have been some significant quality challenges, we have welcomed the transparency of your approach to reporting, improving and monitoring quality of care. We would welcome the opportunity to continue to work together in this way, so that we can achieve the priorities set out for this year.

Yours sincerely

Andrea J Green
Chief Officer

NHS Warwickshire North Clinical Commissioning Group

CC James Avery

Chair: Dr Heather Gorringe
Chief Officer: Andrea Green
Our vision is to EXCEL in patient care.
Appendix 2: Amendments

During 2014/15 and in all previous years we have engaged and regularly met with our stakeholders. This input has been a valuable source of guidance and we have incorporated their opinions as part of the of the Trust’s annual Quality Account formation. In addition to periodic review we have also sought feedback on this final report and invited comments on its content and progress illustrated. Stakeholders, in 2014/15 include:

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

We value enormously and would like to express sincere thanks to those individuals and groups who have met with us throughout the year to review progress and provide valuable challenge and scrutiny to our progress in improving the quality of services.

The input of stakeholders has been instrumental in informing the development of the 2015/16 priorities and can be seen within the completed document.

We look forward to continuing this relationship to support the delivery of high quality care through close working with our patients and stakeholders.
Appendix 3: Glossary

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

**Care pathway**: the process of diagnosis, treatment and care negotiated with the involvement of the patient and his/her carer or family;

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

**CQC – (Care Quality Commission)**: is the independent regulator of Health and Social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations;

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

**Clinical Audit**: a continuous process of assessment, evaluation and adjustment of practice by doctors, nurses and other health professionals;

**Clostridium difficile**: an intestinal infection commonly associated with healthcare;

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

**HSMR (Hospital Standardised Mortality Ratio)**: HSMR is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect;

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

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

National Incident reporting categories:

- **No harm**: Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.

- **Low**: Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Example - patient required first aid, minor treatment, extra observation or medication.

- **Moderate**: Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Example - likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital

- **Severe**: Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. Example - permanent harm, such as brain damage or disability, was likely to result.

- **Death**: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care
National Patient Survey: The NHS national patient survey programme was established as a result of the Government’s commitment to ensuring that patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services. All NHS Trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. One main purpose of these surveys is to provide organisations with detailed patient feedback on standards of service and care in order to help set priorities for delivering a better service for patients. There are inpatient and outpatient surveys; 

NICE (National Institute for Healthcare Excellence): an independent organisation responsible for providing national guidance on promoting good health and treating ill health; 

Never Events: are inexcusable actions in a health care setting, the “kind of mistake that should never happen; they are, by definition, preventable 

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

PALS (Patient Advice & Liaison Service): This service provides support to patients, carers and relatives, representing their views and resolving local difficulties speedily. 

Patients Advocacy Forum (PAF): a group of volunteers who talk to the patients and their relatives carry out approved projects within a work plan makes recommendations to the hospital for improvements. 

PREMs (Paediatric Reporting Experience Measures): A survey developed ‘by the children, for the children’ which is a tool to measure the experience of paediatric patients 0-16 years in all urgent and emergency care settings ensuring that their views are captured and evidenced based feedback is given to those providing their care; 

PROMs (Patient Reported Outcome Measures): PROM assesses the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys; 

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

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

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

WHO (World Health Organisation) Checklist: The WHO surgical safety checklist (WHO check list) was established in 2008 to improve the safety of surgical procedures and to avoid critical incidents and never events occurring. The process surrounding it has improved compliance with standards and decreased complications from surgery.
Appendix 4: Feedback Form

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

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

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

Patient Feedback

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How useful did you find this report?
[ ] Very Useful
[ ] Quite useful
[ ] Not very useful
[ ] Not useful at all

Did you find the contents?
[ ] Too simplistic
[ ] About right
[ ] Too complicated

Is the presentation of data clearly labelled?
[ ] Yes, completely
[ ] Yes, to some extent
[ ] No
If no, what would have helped?

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

Comments
Acknowledgements

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

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

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

The Trust has access to interpreting and translation services. If you need this information in another language or format please contact 024 7686 5550 and we will do our best to meet your needs.
Quality Account
2014/15

‘our vision is to EXCEL at patient care’

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