Quality Account
2016/17

‘Our vision is to EXCEL at patient care’
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About our Quality Account

Welcome to George Eliot Hospital NHS Trust’s Quality Account for 2016/17.

The Quality Account is important because it summarises the Trust’s annual quality journey and reports publicly on our performance in delivering safe, high-quality, and effective care to all our patients.

The purpose of a Quality Account

The Quality Account provides an overview of the quality of care provided to our patients. Specifically, this account highlights how we have improved, why we have chosen different courses of action, and what we still have to do to continue improving the quality of care being delivered at our organisation.

What is included in a Quality Account?

During the year, we routinely review and evaluate the quality of our services against a set of three quality improvement criteria:

- Clinical effectiveness – high-quality care
- Patient safety – harm-free care
- Patient and staff experience.

Throughout our Quality Account, you will find consideration of how we have performed against these priorities along with further reporting against a set of national standards and quality improvement goals.

How to get involved

At the end of this document (appendix 4), you will find details of how to provide feedback and tell us what you think of our Quality Account and the improvements we have achieved.

Accessibility

We have access to interpretation 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.

Further supporting information

While this report focuses on specific areas of quality improvement, further information about our annual quality agenda can be found within our public Board papers at http://www.geh.nhs.uk/about-us/trust-board-of-directors/public-board-papers/.

Quality Accounts 2017/18

We have a statutory duty to publish a Quality Account, and Annual Report and Accounts, which review quality improvement achievements and business and finance outlay respectively. From 2017/18, we will combine these documents into one report on the quality, business, and financial outcomes for each reporting period.
Section 1: Statements on quality

Statement from the Chief Executive

Over the past year, we have experienced a highly pressurised local NHS system. In response, we have set our sights on transformation and reform to enable our clinical and financial model to better match the challenges of future service provision.

We are partnering with other providers, across health and social care, to develop a Sustainability and Transformation Plan (STP). This plan looks at how services in Coventry and Warwickshire will need to change to continue to deliver high-quality care.

Coventry and Warwickshire’s STP Board is made up of nine organisations, including hospitals, mental health and community services, local authorities, and clinical commissioning groups. Healthwatch also attend the STP Board meetings.

The STP focuses on using current resources to deliver sustainable prevention of physical and mental ill health. Our vision is that joint working, across health and social care, will deliver higher quality care, and support our communities to live well, stay independent, and enjoy life. Throughout 2017/18, this plan will be developed in partnership with our staff and the local community.

The publication and interpretation of the first draft STP caused a great deal of external scrutiny and speculation about the future of services on our site. In response, our Trust Board reassured the public that there are no plans for any service closures. Furthermore, our Board will not commit to any plan that compromises the quality of service provision or patient safety.

Over the past year, we have invested in services so that we can continue to provide high-quality care and exceptional experience for our patients, visitors, and staff. We have built an Endoscopy Unit to deal with the increasing demand for diagnostic testing procedures, an Energy Centre to reduce our carbon footprint, and refurbished our maternity ward’s labour and delivery suite, special care baby unit, and post-natal ward.

We continue to receive accolades for the quality of care across a wide range of services. For example, we were first in the NHS Employers Flu Fighter Award, and won two patient safety awards, a CIPR Pride Award (for communications excellence in the #jointeameliot recruitment campaign). We also received a highly commended from the Parkinson’s Excellence Network, and, in partnership with our union colleagues, we received a Health and Safety Award from Unison, in the category of improving staff and patient care for our innovative work on Freedom to Speak Up.

We are always wanting to hear from patients, with regard to their experience, and we are pleased to see the excellent patient feedback, both in writing and through social media.

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We are always wanting to hear from patients, with regard to their experience, and we are pleased to see the excellent patient feedback, both in writing and through social media.

I am extremely proud of our ‘Team Eliot’ and remain in awe of how they continue to show professionalism, care, and dedication when delivering high-quality, safe care to patients each and every day of the year.

I hope you enjoy reading the Quality Account.

Katherine Kelly
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:

[Signatures]

Chairman

Chief Executive
## Section 2: Looking back on 2016/17

<table>
<thead>
<tr>
<th>What we set out to do</th>
<th>What we did</th>
<th>What this means for people using our services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustain and further improve our mortality ratios</td>
<td>Applied greater emphasis on the identification, management and treatment of the deteriorating patient, enabling a proactive and timely response, which has led to better outcomes</td>
<td>Ongoing improvement in our mortality ratios promotes a positive outcome for all our patients</td>
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<tr>
<td>Improve the discharge planning process for all inpatients in our care</td>
<td>We launched the ‘SAFER’ patient flow care bundle which offers 5 key elements of best practice to improving patient flow and prevent unnecessary waiting for our patients</td>
<td>Discharge planning from the point of admission now takes place, which follows the patient at every stage of their journey with us until they are medically fit to go home</td>
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<td>Improve the outcomes of Acute Kidney Injury (AKI) patients and aim for a reduction in harm and death from AKI</td>
<td>Following an in-depth review of the processes for management of our AKI patients, a revised policy and updated AKI care bundle was launched</td>
<td>An overall downward trend of the total number of AKI alerts (less incidence of AKI) has been realised for all stages of AKI which is a truly remarkable achievement, improving the care of our most poorly patients</td>
</tr>
<tr>
<td>Expedition discharge summaries within 24 hours and transfer of Outpatient Department (OPD) discharge summary information to within 5-working days to our GPs and health care partners in the community</td>
<td>We integrated the capability of our medical discharge management functionally to improve our electronic discharge output, which has impacted positively on the flow of information both internally and externally</td>
<td>By providing accurate and timely discharge information and OPD summaries to our GPs, ongoing treatment and care of our patients can extend seamlessly into the community, following an episode of care</td>
</tr>
<tr>
<td>Increase the number of substantively appointed clinical staff</td>
<td>We staged open days for different clinical /non clinical careers and launched a successful award-winning recruitment campaign #jointeameliot</td>
<td>With more substantive staff working within our hospital, an established, dedicated and loyal workforce becomes a reality</td>
</tr>
<tr>
<td>Show an overall harm reduction and achieve better results within our Patient Safety Thermometer</td>
<td>We reduced the numbers of pressure ulcers, falls, infections, urinary tract infections in catheterised patients, and Blood Clots (VTEs) and aimed for no incidence of never events</td>
<td>By supporting patients, particularly very poorly patients, through early recognition of deterioration we ensure the right treatment plan is in place promptly to support better inpatient care</td>
</tr>
</tbody>
</table>
Looking back on our quality improvement priorities 2016/17

During 2016/17, our key priorities have remained focused on improving the quality and safety of care being delivered to our patients. In aspiring to meet measurable quality goals, we have coordinated with our clinical, quality, operational, estates and governance strategies. Alignment to departmental strategies and our Commissioning for Quality and Innovation (CQUIN) targets has been pivotal to our success.

From Board to ward-level, we are using real-time data to identify and act on necessary improvements. Guiding these improvements will be the biennially revised Quality Improvement Strategy, which builds on the Trust’s achievements and promotes continual improvement.

<table>
<thead>
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<th>What we set out to do</th>
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<tbody>
<tr>
<td>Reduce the number of hospital acquired infections</td>
<td>We promoted best practice in prevention and adherence to strict infection control (IC) guidance, held hand hygiene events (staff and public) to raise awareness of best IC practice</td>
<td>Having very low rates of infections (e.g., Clostridium Difficile), with no reporting instance of MRSA, leads to a reduction of the incidence of patients acquiring an infection whilst in our care</td>
</tr>
<tr>
<td>Maintain and further improve medicines safety management</td>
<td>Further embedment of safe practice in the dispensing of all medicines prescribed for our patients</td>
<td>Working with our pharmacy team and the medicines management group on measures to improve patient safety in this area, we have reduced the risks of medications misuse</td>
</tr>
<tr>
<td>Improve and sustain the delivery of safe qualitative maternity services</td>
<td>We have implemented the harm free birth tool and launched the saving babies lives campaign</td>
<td>Positive results have been achieved across all areas of maternity care, empowering confidence for parents choosing to have their babies with us</td>
</tr>
<tr>
<td>Promote awareness and support staff who want to raise a concern, enabling them to speak out safely</td>
<td>We continued to work in partnership with our Union colleagues to introduce and establish a Freedom to Speak Up ethos across the Trust</td>
<td>By advocating an open, honest and transparent culture, across the Trust, we have promoted positive learning and a safer environment for our patients</td>
</tr>
<tr>
<td>Improve staff wellbeing and safety at work in response to national staff survey results and local staff friends and family testing</td>
<td>We aligned our Wellbeing Strategy’s action plan to the national CQUIN for staff physical health and wellbeing reporting arrangements, where outcomes continue to be monitored</td>
<td>Engaging with staff proactively, to raise awareness of wellbeing initiatives, and in-house support services helps to alleviate stress and improve the general wellbeing of our workforce.</td>
</tr>
</tbody>
</table>
Priority One: clinical effectiveness - high quality care

Mortality reduction

During 2016/17, we set out to maintain the Trust’s Hospital Standardised Mortality Ratio (HSMR) and further improve our Summary Hospital Mortality Indicator (SHMI) to a level below the national average (100). We focussed on reducing avoidable mortality and improving the overall clinical care received by our patients.

The HSMR is a ratio of observed number of deaths to expected deaths from a basket of 56 diagnosis groups, which represent approximately 80% of in-hospital deaths. SHMI is like HSMR, a ratio of observed number of deaths to the deaths. However, it only applies to non-specialist acute providers. The SHMI calculation is the total number of patient admissions to the hospital, which resulted in a death either in-hospital or within 30 days of discharge.

The latest HSMR, for the period February 2016 to January 2017, was 91. Not only is this figure below the national benchmark of 100, it is also one of the best in England (see figure 1 below).

Following the success of the work undertaken during this year, we will continue to focus on reducing avoidable mortality and improving the learning from deaths through the mortality review process.

In aiming to improve patient care and outcomes we have also established a deteriorating patients steering group, which focusses on the identification, management, and treatment of the deteriorating patient.

HSMR Statistical Process Chart

Our SHMI for the latest time period, October 2015 to September 2016, is 114, remaining a national outlier. However, while the position has remained the same as last year, we have strengthened our collaborative working with Warwickshire Public Health, Myton Hospice, and Warwickshire North CCG (WNCCG). WNCCG have also established a mortality oversight group to further investigate and understand the SHMI outliers. This oversight group commenced an audit to look at the pathway
of all patients who have been discharged from hospital and who die within 30 days. Although some of these patients will be at the end of their life already, it is important to understand where improvements can be made to enhance patient care, at every stage. This work has involved our local GPs and nursing/care/residential homes.

**SHMI Statistical Process Chart**

![SHMI Statistical Process Chart](image)

Statistical process control charts are used to identify unexpected variations in clinical outcomes. The funnel plots above shows the Trusts HSMR and SHMI for a 12 month period. A Poisson distribution model was used to calculate 95% (dotted line) and 99.8% (solid line) control lines. Trusts that fall within the dotted line are ‘within the expected range’ nationally. Trusts that fall outside of the control lines are considered to be an outlier. We are not an outlier for HSMR.

It is important to remember that the HSMR and SHMI risk models use different methodologies and should never be directly compared, however, a certain level of insight can be gained from understanding the characteristics of what is driving them. They should be used as a ‘smoke alarm’ to prompt further investigation by the Trust, when the need arises.

**Moving forward**

The number of preventable deaths in the NHS remains uncertain and estimating preventable deaths is complex when reviewing patients with complex conditions and comorbidities. In 2018, we aim to sustain our HSMR and further improve our SHMI through continued collaborative working with our commissioning, public health, community, and primary service colleagues. We will also review the whole patient-pathway to identify the specific interventions that will improve outcomes and overall patient experience.

In March 2017, the National Quality Board published guidance on learning from deaths. Within this, a framework for NHS Trusts was outlined for identifying, reporting, investigating, and learning from deaths. We will use this guidance to continue improving learning from deaths, data collection and reporting, as well as linking with our partnership trusts to improve clinical governance capabilities. Above all, we will attempt to involve bereaved families and carers in all stages of the review process.

‘Our vision is to EXCEL at patient care’
Deliver safe high quality, co-ordinated discharge

As in previous years, we are continuing to introduce more care bundles across the hospital, which will complement patient care and experience.

It has been important to meet targets, set at the start of the quality reporting period, which were established following a review from the ECIP (Emergency Care Improvement Programme) in 2015. This review recommended the Trust should introduce the SAFER patient flow bundle, which blends 5 elements of bestpractice to improve patient flow and prevent unnecessary waiting for patients, including:

- **Senior review**: requires all patients to have a senior review before midday. This should be taking place routinely during the daily Board and Ward rounds by a multidisciplinary team. This is a crucial part of the reviewing and planning of patient care. It also enables senior staff the opportunity to inform and involve patients in their care. In some areas of the hospital, such as the Acute Medical Unit, they have introduced three daily senior board/ward reviews. The results of the seven-day service self-assessment tool, submitted to NHS England, showed that 86% of our patients received a daily review, which is above the regional and national average.

- **All patients** will have an expected date of discharge within 24-hours of admission. This is based on our inpatient treatment plans having an expected date of discharge recorded within the 24-hour timeline.

- **Flow of patients** from assessment to inpatient wards in a timely manner. The Trust monitors patient flow by admission, transfer, and discharge, within every 15-minutes, to maximise overall patient flow throughout the organisation. Our Care Co-ordination Centre ensures focus remains on a seamless operational pathway for all our patients. To further support this, we have introduced [1] Red and Green bed days (R2G), which enable our team to better identify obstacles that may prevent progression in patient care and treatment. To date, we have improved overall admission, transfer, and discharge within 15-minutes by 22% from the original baseline.

- **Early discharge**: *33% of all patients to be discharged by lunchtime (*prescriptions for planned discharges will be sent to pharmacy by 3pm the day before the expected date of discharge). Overall, in Quarter 4, 25% of patients are being discharged by 1pm. While we have not achieved the target, further improvements are being progressed using our R2G initiative, alongside the SAFER patient flow bundle from April 2017. To facilitate TTOs (i.e. patients discharge prescriptions) before 3pm the day before discharge, clinical teams are working together to monitor progress and report on a monthly basis.

- **Review**: a clinically-led weekly review of all patients with an extended length of stay of over seven-days. Following the daily ward round, patients who have had an extended length of stay are escalated to our senior management team, who work collaboratively with external stakeholders to address delayed transfers of care.

While we have seen improvements from our SAFER patient flow bundle, we have further plans to re-energise, re-educate, and support wards with a key focus on discharge within 15-minutes, and prescriptions being received by 3pm on the day prior to discharge. We will remain focused on real-time monitoring systems and engaging staff to ensure the SAFER patient flow bundle and the Red to Green bed day initiatives are firmly embedded into clinical areas, as part of the daily ward routine.

[1] Red to Green is a simple initiative that helps turn patients’ ‘red days’ into value-adding ‘green days’, which help to facilitate a safe discharge from hospital. A red day is when a patient does not receive an intervention to support their pathway of care e.g. a planned diagnostic is not undertaken. A green day is when a patient has received an intervention that supports their journey e.g. a review of a diagnostic intervention, or a senior review by a consultant to plan and progress a patient’s episode of care. We aim to make every day a green day and involve both our staff and patients in making this happen.
Discharge summaries/transfer of information (to GPs within 24 hours)

Our aim to improve communication with our GPs has been strewn with many challenges throughout the year. Although some headway has been made with providing copies of accurate discharge summaries/transfer information within 24 hours and outpatient summaries within 14 days, there is still a long way to go before this target is met.

All inpatient discharge letters are being sent to GP Practices (81 Practices configured, including ‘in area’ and beyond) electronically, via the document management electronic discharge transfer (DocMan EDT) hub:

- where prescribed, TTOs are contained within the electronic discharge letter
- the discharge letters and TTOs are produced using an in-house developed solution
- the baseline rate of electronic discharge letters sent to GPs is 95%
- the baseline rate of discharge letters that contain TTO’s is 96%.

For 2016/17, our achievements also include:

- validating the capability of medical discharge management (MDM) functionality within Lorenzo and integrating the existing in-house electronic discharge solution with MDM
- developing the in-house portal to accept discharge summaries and TTO’s from the existing in-house electronic discharge solution.

Our 2017/18 Ambitions:

| 17/18 Q1 | Gather requirements for new in-house electronic discharge solution |
| 17/18 Q2 | Develop new in-house electronic discharge solution |
| 17/18 Q3 | Test and refine new in-house electronic discharge solution |
| 17/18 Q4 | Implement new in-house electronic discharge solution |

Provision of outpatient summaries (to GPs within five working days)

We have invested in the replacement of analogue dictation and transcription hardware with a digital hardware, and software solution. The new solution helps to identify workload volumes, enabling work to be distributed amongst many medical secretaries. With the visibility allowing workload sharing, it is anticipated that the amount of backlogged letters will be reduced. Therefore, letter turnaround times, to GPs within five working days, are more likely to be achieved. The project is currently live in the following areas:

- Gastroenterology
- Rheumatology
- Stroke
- Orthopaedics
- Cardiology
- Respiratory
- Palliative Care
- Neurology
- A&E (including Acute Medical Unit, Ambulatory Care Unit, and CDU).

Acute kidney injury (AKI) is the sudden damage to the kidneys, which causes them to not function properly. AKI can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness, it’s not the result of a physical blow to the kidneys, as the name might suggest. In the UK, up to 100,000 deaths each year in hospital are due to AKI. However, it is thought up to 30% of these deaths could be preventable with the right care and treatment.

AKI is associated with extremely high mortality rates. In 2016, we aimed to build on previous AKI initiatives to reduce the number of incidences of avoidable harm and death from AKI, and improve patient care.

Last year, we launched an organisation-wide strategy to assist in the prompt recognition and management of affected patients.

A steering group was established to review the current process and identify areas for improvements. AKI guidance and NICE best practise were reviewed, which enabled us to produce a local policy and update our AKI care bundle.

We integrated the NHS algorithm for AKI.
detection into the hospital’s laboratory results system. Now, the system generates a test result, by analysing a specific result known as creatinine, for patients’ blood results that are consistent with AKI. This is in line with the national campaign by NHS Improvement and Think Kidney campaign to improve awareness and management of affected patients.

In October 2016, we launched the new AKI strategy. As part of this, we wanted to ensure that patients with more severe stages of AKI (stage 2 and 3) were recognised in a timely manner, prompting a review and management plan. Now, we have a team available 24/7 and integrated clinical systems with an alert mechanism. These will trigger the critical care outreach team, advising them of the patient, with stage 2 or stage 3 AKI, and their location, to allow for a prompt review. This is also supported by:

- an AKI care bundle, which staff complete for their AKI patients
- a Local AKI policy, which staff can refer to
- a Patient information leaflet
- an AKI promotional video, which is now available on YouTube, at https://www.youtube.com/watch?v=YQfCHyy8uRc, and educational sessions for staff members.

Figure 1.1. AKI summary for hospital inpatients

From October 2016 to February 2017, there was a downward trend in the total number of inpatients affected by AKI and the total number of AKI alerts generated by inpatients. Specifically:

- 15.95% reduction in total number of AKI alerts generated by inpatients (351 → 295)
- 9.09% reduction in total number of inpatients affected by AKI (121 → 110)
From October 2016 to February 2017, there was a downward trend in the number of inpatients affected by all stages of AKI.

Specifically:
- **8.49% reduction in number of patients affected by AKI stage 1** (106 → 97)
- **18.75% reduction in number of patients affected by AKI stage 2** (32 → 26)
- **23.81% reduction in number of patients affected by AKI stage 3** (21 → 16)

With fewer patients generating AKI alerts and a clear reduction across all stages of AKI since the launch of the strategy, including the most severe AKI stage 3, the improvement is truly remarkable.

At present, we regularly review AKI data, both at the Trust mortality meeting and the deteriorating patient group (DPG), to ensure there is organisational oversight. It should be noted there was a small spike in total AKI alerts and affected patients during March 2017. A specific review is being led by the Trust’s new AKI lead on this, who will report to the DPG their findings and any identified key themes, trends, and actions will be discussed in order that we can facilitate, learn and improve further.

In 2016, Chris Meally, Ali Bakewell, and Claire Hayward worked together to launch the AKI strategy, and we have now appointed an AKI lead to manage this.
Developing the numbers and skills of our clinical workforce

As part of our aim to increase the number of substantively appointed clinical staff during 2016/17, we launched a recruitment campaign in Spring 2016. We used a variety of methods to attract new staff to join our Trust. In particular, we co-ordinated a recruitment campaign on social media called #jointeameliot, which involved:

- The use of Facebook, Twitter, and YouTube to share the experiences of individual hospital workers who lived and worked in and around Nuneaton. Front-line staff embraced taking over the Trust’s Twitter account to share experiences of their working day, and a series of short video interviews with different staff, from a variety of service areas, were produced.

- Careers events were held locally to advertise the campaign and engage with those who may be thinking about pursuing a career in health, particularly working in a hospital.

- An informative ‘Welcome to our Nursing Team’ recruitment brochure was produced and used throughout the campaign to attract healthcare job hunters to consider joining Team Eliot.

- A specific social media campaign around a theatre ‘open day’, which saw the hospital open one of its operating theatres to potential recruits and showcasing the patient ‘surgical’ pathway, resulted in seven new theatre staff joining their team.

Our Communications and Engagement Team were innovative, in creating and managing the #jointeameliot recruitment campaign, and were recognised nationally, when they were awarded the prestigious Chartered Institute of Public Relations Gold award. This was a great accolade for the Trust.

Later in the year, an overseas recruitment event took place in Manilla in the Philippines. Four of our senior nurses attended and interviewed many prospective candidates, several of whom will be joining us in the coming months.

All this work, which continues to take place, has resulted in an overall in-year increase of 43 substantive WTEs (whole time equivalents), as shown in the graph below.
The increase in our substantive workforce has had a positive impact on our aims to reduce clinical agency usage and ‘spend’. We predominately spend on agency staff to cover existing medical and nursing vacancies within the Trust, such as A&E and Acute Medicine, as these areas continue to be difficult to recruit into.

The introduction of capped agency rates in April led to a reduction of agency costs in nursing and medical staffing for the Trust. We have therefore, seen an overall reduction in agency spending of £4.6 million (see chart below), from 2015/16 to 2016/17, respectively. In real terms when offset against the increase in our substantive workforce costs of around £3.2 million a saving of approximately £1.4 million has been achieved in year.

![Total Agency Spend by Month](chart.png)

NHS Improvement (NHSI) set our Trust a ceiling for agency spend, and, even though we have maintained spending below this, it remains high in relation to other Trusts in the Midlands and East region.

We monitor an overarching action plan on the use of agency staff at the weekly medical productivity meeting, and nursing agency meeting. We also discuss the plan at the monthly meeting with NHSI and the Workforce Development Committee.

As highlighted above, during the latter part of 2016, the Trust undertook an international recruitment campaign where we appointed two doctors for general surgery, and three nurses, all from the Philippines. We will continue to focus on recruitment and retention of a fully substantive workforce in all service areas to continue to reduce spending on agency staff.
In June 2016, we launched a new E-rostering system (ERS), which will help to achieve safe staff deployment. Currently, the ERS is live on 18 wards and the rest of our hospital wards are preparing to go live in early 2017.

The ERS is a huge cultural change for nursing staff, when managing staffs’ rota, and was met with mixed feelings during the initial launch and roll-out period. The Trust’s E-rostering team worked hard to support individual areas to become familiar with the benefits of the system, and embed knowledge and familiarity.

In March 2016, the interface between NHS Professionals (NHSP) and ERS went live. Now, all ward areas that use E-rostering will send their shifts from ERS to the NHSP system to allow for a more streamlined and controlled process.

To support the ongoing development of our clinical workforce, a complete review of all consultant job plans has taken place throughout 2016/17. The Medical Director met with all consultant groups to set the parameters and expectations of these reviews, detailing how job plans would be undertaken. The medical appraisal system database, ‘PReP’, has been populated with all relevant data that was reflective of the objectives set. It is expected that we will have all consultant job plans on the system by Spring 2017, and, from this, we can identify future training requirements. In support of this, as part of the Trust’s Job Planning Policy ‘oversight’ process, each CBU meets regularly to check individual and departmental compliance with the policy.

Revalidation is the process that all registered nurses and midwives (N&M) in the United Kingdom must follow to maintain their registration with the Nursing and Midwifery Council (NMC).

In April 2016, following a consultation period, we introduced a new process for registered N&M, to support them in demonstrating their safe and effective practice, and satisfy the NMC Code requirements. Revalidation of N&Ms takes place every three-years and we have introduced a variety of enabling methods to ensure that our N&Ms are supported to meet this requirement.

To launch and embed the revalidation process over the course of 2016/17, in particular the submission of timely revalidation evidence, our Clinical Education Team implemented the following for N&M staff:

- twice a month awareness sessions
- a dedicated intranet page
- a step-by-step guide
- two events, showcasing revalidation, which were run jointly with Coventry and Warwickshire Partnership NHS Trust
- routinely held, reflective practice sessions to help N&M staff fully embrace the revalidation principles into day-to-day practice
- bespoke one-to-one sessions on completion of the associated NMC documentation
- 45 personal support sessions, where our Practice Education team acted as confirmers/discussion partners

Since the national launch, 230 of our registered nurses and midwives have been subject to the process. The quality of their portfolios has been judged as very good and all have been successfully revalidated.

A customer care programme for bookings, admissions, and outpatients’ staff is being developed and implemented for all our front of house reception, telephonist, and outpatient teams. We have placed an emphasis on ensuring all staff embrace customer care initiatives at every opportunity. With the ‘Hello my name is’ campaign, we have worked to embed this within our workforce, when meeting and dealing with our patients, their carers, and visitors.

Our training and development initiatives have placed us in a good position as we rollout the next stage of our three to five-year clinical strategy plan. We want to ensure it is responsive, patient focused, and able to deal with all our local health care needs.
Priority 2: patient safety – a commitment to deliver harm free care

As with previous years, we have taken our responsibilities in meeting our statutory obligations of Duty of Candour (DoC), by empowering staff to communicate clearly and openly with patients, relatives, and carers. This communication relates to all occurrences of clinical incidents, whether it is the actual event, the immediate actions taken, or the future outcomes from subsequent investigations. This has helped further develop and ‘fostered a culture of humility, openness, and honesty’.

Throughout 2016/17, we have:

- trained clinical and non-clinical staff on their duties, and the incident reporting process, in respect of meeting the DoC requirements
- developed and implemented a ward template on the Datix system for the completion and inclusion in patient medical notes of any clinical incidents, which will detail and record the process and outcomes of such events
- developed and launched an on-line DoC training tool for staff to access DoC training and future mandatory updates.

To support the DoC further, we feel it is important that staff are able to communicate any concerns. Not only is it an essential part of helping us to keep improving our services for all patients, but also improving the working environment for our staff. Therefore, during 2016, we implemented the Freedom to Speak Up (FTSU) Policy across the organisation, which supersedes the Speak out Safely Policy. In order to raise awareness and encourage an open, honest, and transparent culture, we have identified FTSU ambassadors and collaborated with Unison and other union colleagues.
Since the beginning of 2016, we rolled out a training programme across the organisation on key competences for the Mental Capacity Act and consent. We have coordinated this training alongside a specific policy, which addresses best practice and improving the management of safeguarding issues at our hospital. Since the latter part of 2016, we have included dementia and Mental Capacity Act guidance as part of the safeguarding adults training for staff.

We are currently developing a policy called ‘Enhanced Care for Vulnerable Patients’ and we aim to provide a framework for all observation and care delivery for all patients who are suffering with dementia. This policy advocates heightened levels of observation for patients who may be considered ‘at risk’ of harm to themselves and/or others, and/or are considered to have an unstable mental condition that may deteriorate. From this, we will continue to implement the action plan to deliver the Dementia Friendly Hospital Charter (DFHC) promises.

As part of working towards the Dementia Action Alliance’s – DFHC, the following work is ongoing:

- our Dementia Steering Group has been re-energised
- there continues to be a senior dementia lead working across the organisation
- we have signed up to the John’s Campaign, which aims to give the same rights to carers of people with dementia, as those of parents of children, when their relative is in hospital
- we have successfully recruited to the enhanced care team, to support and provide activities for vulnerable people when they are inpatients.

We are also participating in the Royal College of Psychiatrists National Audit of Dementia, with the results expected 2017/18.
During the quality reporting period, we aimed for an overall reduction in inpatient falls compared to 2015/16. Inpatient falls are the most commonly reported patient safety incident in acute hospitals in England. In 2016, we strengthened our fall prevention and management strategies, which has led to an overall reduction in the total number of falls, and falls with harm. In 2015/16, there were 540 falls within the Trust compared to 510 falls reported in 2016/17. Within 2016/17, 98.4% (502) of falls were of ‘no harm’ or ‘low harm’ compared to 96.2% (520) in 2015/16. The Trust has also reduced falls that are classed as ‘moderate’, ‘severe’, or ‘death’ as a result of the incident, from 3.8% (20) in 2015/16 to 1.6% (8) in 2016/17.

As shown above, the total volume of falls has been declining over the period, however the metric does not take into consideration the bed capacity of the hospitals. The nationally recognised way of monitoring falls is by the number of falls per 1000 occupied bed days (OBD). Our trend in falls, per 1000 OBDs, is relatively static - with only a slight improvement. However, the quarterly data shows that we are below the national average of 6.3 (FFFAP 2015), and the average falls per 1000 bed days for the Trust for 2016/17 is 4.9, compared to 5.2 in 2015/16.

In December 2016, we were selected to participate in the Falls 90-Day Improvement Collaborative by NHS Improvement. This initiative helped kick-start the falls prevention and management improvement plan and we have re-energised the falls groups and identified ‘falls champions’ in all ward areas.

Falls are a major patient safety concern and a marker of care quality. As such, the prevention and management of falls remains a priority for us in 2017/18.

During 2016/17, we have also reviewed avoidable deaths and, from this, implemented a plan to achieve National Safety Standards in Invasive procedures (NatSSiPs). We are now fully compliant with the required NHS England CAS Alert for NatSSiPs.

Our clinical business units continue to develop LocSSiPs (local standardised surgical invasive procedures) for all invasive procedures. We have developed and approved a standardised procedural template and policy for LocSSiPs. Since October 2016, this template and policy has been available to all clinical staff, via a dedicated intranet page.
In relation to the above, we have also developed and launched a Human Factor Training Plan (HFTP), which centres on how humans behave physically and psychologically in relation to specific environments, products, or services. Two combined root cause analysis and human factor training sessions were delivered to 40 senior clinicians and managers in 2016/17. A key aim of the training plan focuses on improving patient safety, as well as investigating and analysing incidents.

In 2017, as part of the Trust’s learning needs analysis programme, we are rolling out the HFTP to all identified staff. Other staff will be chosen to undergo a 5-day intensive ‘train the trainer’ course in October.

As part of the Trust’s annual training programme for 2017/18, clinical staff will receive an introductory education session on human factors.

Healthcare associated infections

Clostridium difficile (c-diff) – In aiming to reduce c-diff incidence during 2016/17, we have reported two mandatory, post-72 hour, cases registered against a Government threshold of 13 cases for the year. One case was deemed as avoidable, as the specimen was sent unnecessarily; the other case is still in the process of being investigated. An action plan linked to both cases has been initiated by the Trust’s Infection Prevention Team.

Methicillin-resistant Staphylococcus aureus (MRSA) – We have had no incidence of hospital acquired MRSA during 2016/17, which is in line with the Government’s target of a zero tolerance for MRSA Bacteraemia for all NHS trusts in England.
Medicines safety

During 2016/17, we achieved our aim for a reduction in medication errors resulting in harm. Here is a summary of our work:

- since March 2016, the newly appointed substantive medication safety officer pharmacist (MSOP) has reviewed all medicines-related incidents to confirm that the level of harm assigned is in accordance with NRLS guidance, and to provide advice and support to investigating managers
- the MSOP now presents a summary of prescribing errors to the medical grand round three times per year, to highlight key learning points
- the multidisciplinary Medicines Management Group continues to review the key themes from medicines-related incidents, highlighting opportunities to share learning.

We have further reduced the number of incidents associated with moderate (or more severe harm) in the last 6 months (September 2016 to March 2017).

From an average of 4.5 incidents per month in 2015/16, the rate fell to 2.2 incidents per month in the first 6 months of 2016/17, and further to 0.8 incidents per month from October 2016 - March 2017 (Figure 1 below).

Figure 1

Incidents associated with moderate or more serious harm Apr-15 to Mar-17

The incidents associated with low harm have slightly increased, from 5.5 in the previous two-and-a-half years, to 6.5 per month in the period October 2016 to March 2017. We are clear that further work is needed to reduce the frequency of low-harm incidents.

Performance against the Medication Safety Thermometer (MST) indicators is published on the MST dashboard website. The latest published data is for November 2016. Allergy documentation remained variable from April-November 2016, though the average rate of completion, 96.9%, was in line with the national average of 96.8%. Emphasis continues to be placed on documenting allergy status during induction and on grand round presentations.

‘Our vision is to EXCEL at patient care’
Omitted doses remain higher than average within our Trust, but there has been significant improvements in for “all reasons” and “reasons excluding patient refusal”, since data collection started in October 2013 (Figure 2 overleaf).

**Figure 2:**

The following charts (Figures 3 and 4 below) show our Trust’s improvement performance over time, compared with the national average data for “all omissions” and “omissions excluding patient refusal” respectively.

**Figure 3:**

The charts above illustrate the proportion of patients who have had an omitted dose in the past 24 hours. The green line represents omitted doses excluding valid clinical reasons, while the red line represents omitted doses excluding valid clinical reason and patient refused.
The omission rate for critical medicines was lower than average - 6.4% for GEH, compared with 8.2% nationally.

All this data confirms that the Trust is improving its performance but further progress is still required.

The ‘five steps’ process is being widely publicised within the Trust, to emphasise the key checks that need to be completed when administering medicines. Ward managers are being encouraged to be more involved in data collection for the MST, to foster ownership and take responsibility for the process. Our reliance on agency nursing staff may be adversely affecting this measure. Further work to tackle this is ongoing.

The introduction of medicines reconciliation by the pharmacy team, within 24 hours of admission, was better than the UK average from April 2016 to November 2016 (81.6% compared to 79.8%), despite the service only being provided Monday to Friday. The provision of medicines reconciliation to AMU at weekends is included in the draft Hospital Pharmacy Transformation Plan for the Trust, prepared in response to the Carter Report. When implemented, it is anticipated that this will improve performance to at least 90%.

Maternity – safety and quality of services

Over the course of 2016/17, the Trust’s maternity services implemented a harm-free birth tool, using the maternity safety thermometer (MaST). This is a nationally agreed tool to monitor our maternity services, measuring certain types of harm that women and babies may have experienced whilst in our care. The MaST tool takes sample information available and acts as a ‘temperature check’ of safety, experience, and improvement. During 2016/17, a score of around 90% was reported, as part of our integrated performance report at Board level. This was further monitored, as part of the maternity service performance management agenda. The level of detailed information taken from these reports shows continuous improvement in our maternity services regarding issues that may not otherwise have appeared.

During 2016/17, the maternity team also fully implemented the saving babies lives care bundle, which has the following four elements:

1. Monitoring of carbon monoxide levels in pregnancy and referral to Stop Smoking Warwickshire
2. Improved fetal growth surveillance and audit to establish lessons learned
3. Improved reporting and management of reduced fetal movements
4. Improved interpretation of fetal monitoring in labour, and appropriate action where required.

The final year-end results for 2016/17 include:
- 70% reduction in the number of stillbirths
- 50% reduction in the number of babies transferred for therapeutic hypothermia treatment for hypoxia.

Maternity services are reviewed in a variety of ways, through the FFT, Facebook reviews, and the maternity impressions feedback software.

All the FFT results continue to be analysed and fed back to the maternity ward teams and are seen - similar to the MaST - as a measure of the quality of care being provided. The year-end FFT score for maternity was 94%, which tells us that the majority of this patient group would recommend using our maternity unit and the services we offer. This highlights our staff’s positive attitude, their professionalism, knowledge base and, most importantly, the safe care given at all times.

Whilst these results are positive, we are not complacent. We continue to evaluate, through our quality monitoring processes, where further improvements in care can be made.

The maternity team will continue to focus on increased engagement with their patients at every opportunity and plan open day type events where they can give feedback to staff in a less formal setting. This gives patients the opportunity to share their experiences face-to-face. It will be an invaluable learning process and further enhance the patient safety agenda, alongside feedback from the Friends and Family Test (FFT) and impressions surveys.

<table>
<thead>
<tr>
<th>Total responses</th>
<th>Patients eligible</th>
<th>Response rate</th>
<th>% who would recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016 - March 2017</td>
<td>3828</td>
<td>8380</td>
<td>45.7%</td>
</tr>
<tr>
<td>April 2015 - March 2016</td>
<td>1618</td>
<td>8136</td>
<td>19.9%</td>
</tr>
</tbody>
</table>

The maternity team also receive service reviews on patients’ experiences via their Facebook page (Facebook.com/GEHMaternity launched in April 2016) and, of the 70 reviews given to date, 89% were five-star. See below a ‘snapshot’ of comments via our impressions feedback and Facebook review pages:

"Our midwife was amazing, very informative, always busy looking after everyone’s babies, such a hero. so lovely and easy to talk to. thanks for looking after us so well"

"They really were excellent, kind and helpful supporting me and my husband through a new and scary experience"
All of the above outcomes and actions lead to improving overall patient safety at our Trust and are key elements that can lead to continual improvement in the delivery of hospital harm-free care, and, for 2016/17, we can report a patient safety thermometer (PST) score of 97.13%. We have seen an overall reduction in the number of patients harmed during this year (see chart below), with an overall improvement, compared to the same period last year (96.27%).

<table>
<thead>
<tr>
<th>Period</th>
<th>Total surveyed</th>
<th>Patients with harm-free care</th>
<th>Patients with one harm</th>
<th>Patients with two harms</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16 - March 17</td>
<td>3035</td>
<td>97.13% (3210)</td>
<td>2.81% (95)</td>
<td>0.06% (2)</td>
</tr>
<tr>
<td>April 15 - March 16</td>
<td>3351</td>
<td>96.27% (3226)</td>
<td>3.61% (121)</td>
<td>0.12% (4)</td>
</tr>
</tbody>
</table>

The end of year PST score is taken from local and national key performance indicators (KPIs) and quality standards, which we monitor at Board level every month.

As in previous years, we once again aimed to have no ‘never events’ occurring within the Trust. Unfortunately, four were reported over the course of the year. Two involved theatre practice, where reviews and processes have been thoroughly revised to ensure that these types of errors don’t happen again. The other two never events involved passing naso-gastric tubes incorrectly. We have undertaken a robust review of the clinical management of naso-gastric tubes in line with national guidance and have developed new policies and procedures in line with our findings and NHS best practice.

The above actions also correspond to the routine testing of all preventative methods and our aim to act rapidly and make necessary improvements.

When a never event occurs, it is presented to our Serious Incident Group, where the root cause analyses are scrutinised and discussed in detail. Themes identified and lessons learned are shared with all teams across the organisation.

All staff fantastic (caring a compassionate); very knowledgeable and helpful. The mum plus one scheme is invaluable

Great midwives and beautiful water birthing room and labour suite shower etc

Amazing level of care, great hospital

Everyone I have come into contact with that work at the hospital have been extremely helpful and kind I would recommend the unit to any friends or family who are planning to have a baby

‘Our vision is to EXCEL at patient care’
Priority 3: patient and staff experience

For 2016/17, we aimed to further improve communications between our patients, carers and staff by developing a suite of accessible patient information, such as new communications materials. NHS England also introduced the Accessible Information Standard, which aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read, or understand with support, so that they can communicate effectively with services.

In response to this, we have continued to review and strive to improve patient information.

During the review process, we seek out the views of patients and make reasonable adjustments in line with suggestions and comments received.

Complaints 2016/17

We continue to value the patient and public feedback we receive. Our complaints policy was revised this year and recognised ‘My Expectations’, a collaboration of Local Government Ombudsman, Healthwatch and the Parliamentary and Health Service Ombudsman for raising concerns and complaints.

We have invested in our Datix Reporting System, which has allowed us to continue to capture and improve our reporting processes, and we now have two years of complaints data we can compare. We also continue to work closely with our Risk Management Team as some complaints may need to be investigated under our serious untoward incident arrangements.

During 2016/17, we responded to 98% of complaints within our locally set target of 25 working days. Several complaints meetings were also held within the year to resolve concerns.

The table below details formal complaints received over the last three years. We saw a further decrease in the number registered this year, as we recognised a number required direct action and sought to achieve this.

<table>
<thead>
<tr>
<th>Period</th>
<th>No. of formal complaints received</th>
<th>Patient episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
<td>355</td>
<td>474,009</td>
</tr>
<tr>
<td>2015-16</td>
<td>197</td>
<td>394,063</td>
</tr>
<tr>
<td>2016-17</td>
<td>167</td>
<td>474,977</td>
</tr>
</tbody>
</table>

Of the 167 registered in 2016/17, 62% were upheld or partly upheld.

Complaints by subject 2016/17

- Accident & Emergency: 17%
- Surgical Group: 17%
- Values & Behaviours: 16%
- General Medicine Group: 10%
- Obstetrics & Gynaecology: 9%
- Admissions, Discharges and Transfers: 8%
- Patient Care: 7%
- Appointments: 6%
- Radiology Group: 5%
- Communications: 4%
- Other (Aggregated Subjects): 2%
Learning from complaints

<table>
<thead>
<tr>
<th>Your concern</th>
<th>Our action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient discharged from clinic with prescription that contained errors and</td>
<td>The concern was correctly reported as an incident and raised with both the service prescribing and the pharmacy to ensure that instructions are clear and all checks are performed before dispensing. The case was also selected for a patient story, presented at Board.</td>
</tr>
<tr>
<td>should have been checked before being dispensed.</td>
<td></td>
</tr>
<tr>
<td>Patient was concerned that they were not recalled for their procedure</td>
<td>Apology given that, due to an administrative error, the patient’s recall had been overlooked. Patient was offered an appointment to see the consultant to discuss their care and to reassure them that they are listed for their next recall.</td>
</tr>
<tr>
<td>in accordance with our surveillance guidelines.</td>
<td></td>
</tr>
<tr>
<td>Concern raised that the specialist hoist was not located in time for use in</td>
<td>Hoist is stored in A&amp;E. A whiteboard was installed above the hoist so that staff can detail its location when taking it to another area.</td>
</tr>
<tr>
<td>Radiology. A patient’s appointment had to be cancelled and rebooked as a result.</td>
<td></td>
</tr>
</tbody>
</table>

Referrals to the Parliamentary Health Service Ombudsman (PHSO)

Under the second and final stage of the complaints process, the PHSO requested six files between April 2016 and March 2017. Four cases were concluded, three were partly upheld and one was not upheld. As of 31 March 2017, two cases were awaiting a decision. All cases are reported to our Quality Assurance Committee.

Moving forward in 2017/18

- The complaints service will work more closely with staff around actions and learning from complaints that are upheld to ensure continuous improvement.
- Complaints will be represented at People Experience Group, which is responsible for improving the overall staff experience and ensuring that patients are at the centre of all we do.
- Complaints will continue to be presented to Quality Assurance Committee on a quarterly basis.

The Friends and Family Test (FFT) is also an invaluable resource for engaging and gathering views by hearing first-hand what our patients think about the services we are providing.

During 2016/17, participation in the FFT continued to increase, with the addition of the Endoscopy Unit and Day Procedures Unit. The use of the SMS text messaging service has been extended to include Maternity. This method of feedback has proved particularly popular in the Emergency Department, with the Trust achieving one of the best response rates in the country.

The feedback system is now in use in the 12 integrated health clinics which are managed by the Trust.

FFT feedback is provided to all wards and departments on a monthly basis in line with the reporting of results to NHS England. Verbatim comments are automatically forwarded by the system to ward managers and matrons, and senior staff on a daily basis, as they arise. This ensures any issues and trends can be identified, action plans put in place, and compliments and thanks shared with staff in real time.

The number of responses received in 2016/17, together with the percentage of patients who would recommend our services, is detailed below. Response rates have increased in the year, from 23,554 to 24,224.
The aim of our ‘Well to Excel’ Wellbeing Strategy continues to focus on improving the overall health and wellbeing of our workforce. Within this, we are taking forward initiatives to support our staff’s physical, financial, emotional, career, social, and spiritual wellbeing within the Workforce Health and Wellbeing Group’s (WHWG) annual work programme.

The WHWG have carried out a myriad of wellbeing initiatives, promotions and events during the year for staff. As a result, staff have had the opportunity to access a variety of the wellbeing benefits that are on offer, such as taster sessions for relaxation, goody bags full of freebies, mocktails, Christmas treats, subsidised boxercise classes and staff gym membership, health and wellbeing information, and advice signposting to support services, like the foodbank, smoking cessation services, and alcohol awareness. The work of the WHWG continues to be a successful staff engagement tool, borne from our Well to Excel Strategy’s action plan, which is now linked to the 2017-2019 Health and Wellbeing CQUIN requirements.

The WHWG will continue to roll out the workforce health and wellbeing action plan, and aspire to meet the 2017-19 health and wellbeing CQUIN requirements. The aim of improving the health and wellbeing of our staff will remain central to this work.

Our feedback report from the 2016 national NHS Staff Survey results, shows that, of the 32 key findings, we have performed positively against comparator Trusts. Overall, the results demonstrate some improvement in performance on 2015, with two indicators moving from below average to average:

- Five key findings – better than average
- 19 key findings – average
- Nine key findings – below average.

National comparison with acute and community trusts shows that we have an above average performance overall and a positive trend, making it in the top quadrant of performance.

Within NHS England’s Quality Accounts Reporting Arrangements for 2016/17, there are two key outcomes from the national Staff Survey to report:

- KF21: The proportion of staff that considers that the Trust provides equal opportunities for career progression or promotion, which remained average at 85%. When this is broken down by ethnicity the proposition is supported by 88% of white respondents and 82% of BME respondents, an improvement of 11% for BME staff and better than average.

- KF26: The results are mixed in relation to staff experience of harassment, bullying, and abuse. The number of respondents experiencing harassment, bullying, and abuse from patients fell by 3% over the last 12 months, to 23%, and is considered better than the average of 26% reported by comparable Trusts. Unfortunately the number of respondents experiencing harassment, bullying, and abuse from other staff in the last 12 months remained the same as 2015 at 3%, which is higher than at comparator trusts. This theme show areas for significant improvement and highlights the need for further work by the Trust’s Workforce Development Committee and our union colleagues to continue developing a set of actions to raise awareness of this issue to improve the experience of our staff and protect their wellbeing.

During 2016/17, further staff wellbeing focus has included:

- Increasing access to counselling support for all our staff, enabling emotional support when the need arises. Currently, support for Trust and community staff includes a one-day per week service. However, demand for counselling support is on the increase and plans to submit a business case to expand this service are ongoing.
Offering access to **musculoskeletal** services for staff suffering from back/limb injury or strain through priority response and treatment. A rapid referral service is in place, where staff access priority referral to physiotherapy treatment through our Occupational Health Department.

Improving access to **healthier food choices** for staff, which includes their feedback, comments about staff catering and sharing various ideas. In response to a staff questionnaire on improving catering services, the following have been introduced:

- a new range of drinks with more choice and some with less sugar content, also healthy sparkling drinks and improved the variety of flavoured water on offer
- improved choice of our snacks range, such as baked crisps, having removed full fat/salt crisps
- low saturated fat meat wraps served with salad, and greater choice of healthy dishes on the restaurant menu for staff
- Soup is served with either white or brown bread, and brown rice is now available.

**Plans for 2016/17:**

- A new contract for vending machines across the Trust will commence in April 2017. The new supplier will be required to meet the 2017/18 to 2018/19 national CQUIN requirements on the provision of healthier food and drinks choices for staff, patients, and visitors
- Once the vending are in place, during May/June 2017, sugary drinks machines will be removed from the site completely
- Raveloe’s Restaurant will be having a small makeover to improve its appearance. The fresh new look for the serving area will include a salad bar, a juice bar, and a wider range of food and vegetarian options on offer for staff, with plans to introduce a porridge bar for early morning workers

- New menus will be developed and introduced in the summer, following staff feedback

Over the course of 2016/17, we have worked to further embed **a positive and inclusive culture across our multi-disciplinary workforce.** Work continues to progress and we have added two initiatives as follows:

A ‘listen and learn’ approach to staff engagement, introducing a series of facilitated focus groups across all areas of the Trust, called ‘ExCEling through Engagement’ (ETE), led by senior teams where staff have been encouraged to discuss:

- What makes a good day at work?
- What makes a bad day at work?
- What can we do to make more good, than bad days?

These workshops gave staff an opportunity to air concerns, discuss common issues, and feedback their ideas for improvements. Evaluation feedback has also been useful in gauging staff views on the ETE exercise. Overall, the feedback was very positive, with specific comments including:

- ‘It’s good to have the chance to be listened to’
- ‘I hope the bosses listen to what we have to say’
- ‘It’s good to hear others have the same concerns as me’

‘Our vision is to EXCEL at patient care’
A ‘COMPACT’ staff charter, which includes compliance in individual objectives, emulating a code of conduct, was launched during March 2017 for all staff to sign up to. It will help to further embed the Trust’s vision and values.

The aims of COMPACT are:

- To improve staff’s understanding of the Trust’s expectations, in terms of behaviour, and outline our commitment as their employer
- To act as a tool for providing feedback to staff on their attitudes and behaviours
- To enhance the patient and staff experience.

It is expected that the staff charter will be integrated into all appraisal discussions about individuals’ behaviour, which will be measured through our behavioral framework.

All staff will be expected to have signed up to the COMPACT agreement by the end of April 2017.

Our Executive Team are very supportive of new developments and initiatives, as they led by example, as the first group of staff to sign up to the COMPACT agreement.

Monthly Board development sessions take place involving our Trust Board. The agenda centres on the importance of leadership to retaining the Trust’s ‘good’ rating from the CQC. Following the recent appointment of two new non-executive directors in the past twelve months, the Board is planning further development to ensure the effectiveness of the team.
Section 2:
Looking back on 2016/17

Section 3:
Quality improvement priorities 2017/18

Annex 1:
Auditors Limited Assurance Report
Appendix 1-4

Acknowledgements
and feedback

Section 1:
Statements on quality

“Our vision is to EXCEL at patient care”
Statement of assurance from the Trust Board

The following statements offer assurance that we are performing to essential standards, measuring clinical processes, and are involved in projects aimed at improving quality. Furthermore, this statement of assurance also shows how this document is comparable to the content of all providers of NHS Trusts’ Quality Accounts.

Review of services

Over the 2016/17 review period, we provided/sub-contracted a variety of NHS services where each was reviewed against all the data available to us on the quality of care. Collectively, for this reporting period, income generated by those NHS services reviewed represents 85% of the total income generated from the provision of NHS services by the Trust.

Every year, a service development improvement plan is put in place and agreed with all associated commissioning partners; in particular, Warwickshire North Clinical Commissioning Group. Key milestones are set and regularly monitored and reviewed, where areas of concern are noted, and resolved, as they arise.

Service reviews are carried out in a variety of ways, either planned or unannounced. Outcomes from 15 steps, mock CQC inspections, and the patient forum ward audits and reports are being reported and monitored at Board level.

Any areas of immediate or ongoing concern are targeted by the Trust’s Governance Team, as required.

Participation in clinical audits and national confidential enquiries

We are committed to delivering an active and focused clinical audit programme, in order to develop and maintain high-quality, patient-centred services. During 2016/17, the Department of Health included 51 national audits for inclusion in Quality Accounts, of which, 35 were relevant to services that we provide.

During that time, 32 national clinical audits, and three national confidential enquiries, covered NHS services that we provide.

Over the last year, we participated in 97% (31/32) of national clinical audits and 100% of national confidential enquiries that we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2016/17 are listed below, alongside the number of cases submitted to each audit or enquiry, as a percentage of the number of registered cases required:
### National clinical audit and clinical outcome review programmes

<table>
<thead>
<tr>
<th>Programme</th>
<th>Participated in 2016/2017</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome and acute myocardial infarction (MINAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Adult asthma</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Asthma (paediatric and adult) care in emergency departments</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac rhythm management (CRM)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Case mix programme (CMP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Child health clinical outcome review programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes (paediatric) (NPDA)</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>Endocrine and thyroid national audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and fragility fractures audit programme (FFFAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Inflammatory bowel disease (IBD) programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Maternal, new-born and infant clinical outcome review programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Medical and surgical clinical outcome review programme</td>
<td>Yes</td>
<td>80%</td>
</tr>
<tr>
<td>National audit of dementia</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National audit of pulmonary hypertension</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National cardiac arrest audit (NCAA)¹</td>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td>National chronic obstructive pulmonary disease (COPD) audit programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National comparative audit of blood transfusion</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National diabetes audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National emergency laparotomy audit (NELA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National heart failure audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National joint registry (NJR)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National lung cancer audit (NLCA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National ophthalmology audit²</td>
<td>Yes</td>
<td>Data collection ongoing</td>
</tr>
<tr>
<td>National prostate cancer audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Nephrectomy audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric pneumonia</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Percutaneous nephrolithotomy (PCNL)</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>Severe sepsis and septic shock – care in emergency departments</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Stress urinary incontinence audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Adult cardiac surgery</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Chronic kidney disease in primary care</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Congenital heart disease (CHD)</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Coronary angioplasty/national audit of percutaneous coronary interventions</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Head and neck cancer</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Learning disability mortality review programme</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Major trauma audit</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Mental health clinical outcome review</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>National neurosurgery audit programme</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>National vascular registry</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Paediatric intensive care (PICANet)</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Prescribing observatory for mental health (POMH-UK)</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Radical prostatectomy audit</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Renal replacement therapy (renal registry)</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>Specialist rehabilitation for patients with complex needs</td>
<td>Not relevant</td>
<td></td>
</tr>
<tr>
<td>UK cystic fibrosis registry</td>
<td>Not relevant</td>
<td></td>
</tr>
</tbody>
</table>

¹ The Trust did not participate in the national cardiac arrest audit during 2016/17, as it has its own detailed data collection and review tool in place for this area. Data collection for the national ophthalmology audit is still ongoing and will be completed in August 2017.
² ‘Our vision is to EXCEL at patient care’
Examples of actions arising from clinical audit activity 2016/17:

- Recommendations made by the national inflammatory bowel disease (IBD) audit an IBD care bundle has been introduced to enable timely decision-making.
- A local audit into knowledge and attitudes to insulin therapy, extended sessions on insulin prescribing and diabetes management for junior doctors during induction.
- A local audit of diabetic ketoacidosis management (DKA), the DKA management pathway and pro forma has been revised and more training offered.
- A local audit of antenatal steroids, a new insulin sliding scale, specifically for administration of antenatal steroids has been created.

Participation in clinical research

Research improves knowledge of healthcare, to influence practice for the benefit of patients. It can also give patients and staff the chance to access treatment and techniques earlier than they would be available commercially. It is well-documented that departments participating in clinical research perform better and this directly impacts on patient outcomes. Research increases staff job satisfaction and patient confidence in the services provided to them. It can also generate funding to improve services.

In 2016/17, 671 patients receiving NHS services provided or sub-contracted by the Trust were recruited to participate in research approved by a research ethics committee. Patients were offered the chance to take part in 25 large-scale National Institute of Health Research portfolio research studies, seven of which were new studies opened during 2016/17. There was a 30% increase in the number of patients recruited for research studies, compared to 2015/16.

This table demonstrates the number of patients recruited in different specialities:

<table>
<thead>
<tr>
<th>Topic/speciality</th>
<th>Patients recruited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia, perioperative medicine and pain management</td>
<td>13</td>
</tr>
<tr>
<td>Cancer</td>
<td>74</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>442</td>
</tr>
<tr>
<td>Health services and delivery</td>
<td>77</td>
</tr>
<tr>
<td>Infectious diseases and microbiology</td>
<td>5</td>
</tr>
<tr>
<td>Injuries and emergencies</td>
<td>1</td>
</tr>
<tr>
<td>Primary care</td>
<td>4</td>
</tr>
<tr>
<td>Reproductive health and childbirth</td>
<td>44</td>
</tr>
<tr>
<td>Respiratory disorders</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>671</strong></td>
</tr>
</tbody>
</table>

These studies are greatly beneficial to NHS patients and enhance our reputation in the national clinical research field, especially for the 14 members of our staff who acted as Principal Investigator on one of these studies. Staff engagement in clinical research also ensures clinical teams stay abreast of the latest treatment options and active participation in research leads to successful patient outcomes.

In line with our commitment to increasing access to the latest medical treatments and techniques, six industry trials took place. This offered 90 patients and three departments access to research that is of the highest quality, due to its extensive resources for monitoring data quality.

We are amongst 18 partner trusts supporting the West Midlands NHS Genomics Medicine Centre’s 100,000 Genomes Project. The project will sequence 100,000 genomes from around 70,000 people. Participants are NHS patients with a rare disease, plus their families, and patients with cancer. The aim is to create a new genomic medicine service for the NHS, transforming the way people are cared for. We acknowledge participation in this project as a great accolade and further evidence of our standing within the NHS network.
Use of the CQUIN framework

The use of the Commissioning for Quality and Innovation (CQUIN) payment framework embeds quality as a key driver for ensuring that local and national quality improvements remain at the fore. The majority of CQUINs are set from a national perspective, although local targets are also put in place where commissioner and provider agreement is required. This corresponding local target ensures the best improvement outcomes are reached, as detailed throughout this Quality Account.

The total potential income associated with achieving quality improvement and innovation goals amounted to £2.5 million for the 2016/17 reporting period. This potential income is a proportion of our total income and conditional on achieving the agreed CQUIN targets. In total, we had six general CQUIN measures (three local, and three national) for 2016/17.

We once again made significant improvements with all our CQUINs and strengthened our collaborative working, which leads to improvements in the delivery of safe and high quality care for local people.

During 2017/18, we will once again aim to meet the requirements set within the CQUIN framework, with information on our progress regularly reported at Trust Board level. Papers for these meetings can be found on our website www.geh.nhs.uk.

Registration with the Care Quality Commission

We are currently registered with the Care Quality Commission (CQC), without any compliance conditions, and are licensed to provide services. The CQC has not taken any enforcement action, or issued any notices against the Trust during 2016/17 and our CQC ratings remain the same as for the previous reporting period (see below). All required improvement actions from the outcome of that formal CQC review in 2014 are now complete.

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Requires improvement</td>
<td>*Not rated</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Medical care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Surgery</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Critical care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity and family planning</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Children and young people</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End-of-life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>*Outstanding</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Good</td>
<td>*Not rated</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Overall</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Overall Trust</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

Please note ‘not rated’ simply means not reviewed at this time
Internal assurance visits

To continually monitor and review the quality of services being delivered at the Trust, we routinely undertake internal assurance visits across all wards and departments. These visits aim to promote a proactive approach to the ongoing improvement of the quality and safety of the services we provide to our patients. They are carried out to emulate CQC inspections, with outcomes on any concerns raised, and recognition of good practice being fed back, within hours of the reviews taking place. Reports from these visits are then delivered to the relevant clinical business unit for their review and for the development of action plans to address any areas for improvement. Progress on actions is monitored. These reports are also shared across the Trust to act on lessons learned and to share good practice. During 2016/17, we undertook two Trust-wide mock CQC inspections, as per the outlined CQC format, where subsequent improvements have been delivered from the action plans we developed. Progress, as with all improvement plans, is monitored via the CBU governance meetings, our Quality Assurance Committee, and our integrated performance reports at Board level.

The quality review programme enables us to be proactively reflective and provides confidence that we are embracing and sustaining areas of good practice. It also allows us to promote a continual learning environment across the Trust and meet our aspirations to remain a safe, responsive, effective, and well-led organisation.

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. We perform well in comparison to other trusts, as the average results of the overall commissioning dataset (CDS) data validity is 96.5% (month 1-11) for all CDS submitters, and our result was 95.8%.

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.

We submitted records during 2016/17 to the secondary user service (SUS), for inclusion in the hospital episodes statistics, which are part of the latest published data (Source: SUS Data Quality Dashboard, February 2016.)

<table>
<thead>
<tr>
<th></th>
<th>% of records in the published data that included the patient’s valid NHS number</th>
<th>% of records that included the patient’s valid General Medical Practice Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>George Eliot Hospital</td>
<td>National comparator</td>
</tr>
<tr>
<td>APC</td>
<td>99.9</td>
<td>99.3</td>
</tr>
<tr>
<td>OPD</td>
<td>100.0</td>
<td>99.5</td>
</tr>
<tr>
<td>AE</td>
<td>99.3</td>
<td>96.8</td>
</tr>
</tbody>
</table>

APC = Admitted Patients Care (Inpatients and day cases)
OPD = Outpatients/ward attenders & tele-medicine activity
AE = Accident and emergency
Information governance toolkit attainment levels

The information governance toolkit is critical to the day-to-day management of our data quality output. It makes a significant contribution to ensuring the necessary safeguards for, and appropriate use of, patient and personal information always takes place. We have completed both the initial and baseline audit at level two. Like last year, we were colour coded green (satisfactory).

Clinical coding error rate

As part of the information governance toolkit, a clinical coding audit took place in February 2017. Results show 97.6% of primary diagnoses were correct, 91.3% of secondary diagnoses were correct, 90.1% of primary procedures were correct, and 93.9% of secondary procedures were correct.

External assurance and performance indicators

Over the year, we monitor our performance against a core set of national and local performance indicators, where we aim to meet the standard set, with some standards being bettered (or not met) over the last year.

The following table shows our results for 2016/17.

<table>
<thead>
<tr>
<th>Performance indicator</th>
<th>Standard</th>
<th>Year end</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C difficile infections</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>MRSA bacteraemia infections(^1)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Quality:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer – two weeks suspected</td>
<td>93%</td>
<td>96.74%</td>
</tr>
<tr>
<td>Cancer – two weeks symptomatic breast</td>
<td>93%</td>
<td>95.21%</td>
</tr>
<tr>
<td>Cancer – 31 days</td>
<td>96%</td>
<td>99.85%</td>
</tr>
<tr>
<td>Cancer – 31 days – drug</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Cancer – 31 days – surgery</td>
<td>94%</td>
<td>98.48%</td>
</tr>
<tr>
<td>Cancer – 62 days(^2)</td>
<td>85%</td>
<td>79.27%</td>
</tr>
<tr>
<td>Cancer – 62 days from screening service(^3)</td>
<td>90%</td>
<td>97.26%</td>
</tr>
<tr>
<td>Patient experience:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients seen in A&amp;E &lt;4 hours(^4)</td>
<td>95%</td>
<td>87.71%</td>
</tr>
<tr>
<td>Patients who leave A&amp;E without being seen</td>
<td>5%</td>
<td>1.53%</td>
</tr>
<tr>
<td>Time to initial assessment in A&amp;E in minutes (95th percentile)(^5)</td>
<td>&lt;15</td>
<td>&lt;18</td>
</tr>
<tr>
<td>Time to treatment in A&amp;E in minutes (median time)</td>
<td>&lt;60</td>
<td>&lt;28</td>
</tr>
<tr>
<td>Readmission within 28 days following discharge</td>
<td>14%</td>
<td>6.20%</td>
</tr>
<tr>
<td>Stroke – time on ward(^6)</td>
<td>90%</td>
<td>74.11%</td>
</tr>
<tr>
<td>RTT incomplete non-emergency pathway (92nd centile)</td>
<td>92%</td>
<td>91.46%</td>
</tr>
<tr>
<td>Patients offered an appointment to Genitor-Urinary Medicine (GUM) Clinic within 48 hours</td>
<td>95%</td>
<td>99.37%</td>
</tr>
<tr>
<td>Patients seen in GUM Clinic – access within 48 hours</td>
<td>95%</td>
<td>99.37%</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>1.10%</td>
</tr>
<tr>
<td>Mixed sex accommodation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patient safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never events</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>VTE risk assessment where all inpatient service users undergo a risk assessment for VTE</td>
<td>95%</td>
<td>95.54%</td>
</tr>
</tbody>
</table>
Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROM) is a national tool to measure quality from the patient’s perspective, measuring the level of recovery, improvement and wellbeing - otherwise known as health gain - after surgery. The process involves patients completing a survey before and after surgery and this allows comparisons to the national average to be made. There are four clinical procedures covered by the PROMs programme (groin hernia repair; hip replacement (first procedure); knee replacement, and varicose vein surgery (which is not undertaken at this Trust). Results for George Eliot Hospital NHS Trust are below and relate to a number of measures.

April 2016 to December 2016 - (provisional data published 11 May 2017)

<table>
<thead>
<tr>
<th>Org level</th>
<th>Org name</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>GH</td>
<td>England</td>
<td>EQ VAS</td>
<td>10,568</td>
<td>80.218</td>
<td>80.039</td>
</tr>
<tr>
<td>GH</td>
<td>GEH NHS TRUST</td>
<td>EQ VAS</td>
<td>40</td>
<td>86.55</td>
<td>86.25</td>
</tr>
<tr>
<td>GH</td>
<td>England</td>
<td>EQ-5D Index</td>
<td>10,329</td>
<td>0.79</td>
<td>0.877</td>
</tr>
<tr>
<td>GH</td>
<td>GEH NHS TRUST</td>
<td>EQ-5D Index</td>
<td>41</td>
<td>0.805</td>
<td>0.916</td>
</tr>
<tr>
<td>HRP</td>
<td>England</td>
<td>EQ VAS</td>
<td>16,243</td>
<td>64.264</td>
<td>77.726</td>
</tr>
<tr>
<td>HRP</td>
<td>GEH NHS TRUST</td>
<td>EQ VAS</td>
<td>32</td>
<td>65.188</td>
<td>78.25</td>
</tr>
<tr>
<td>HRP</td>
<td>England</td>
<td>EQ-5D Index</td>
<td>16,926</td>
<td>0.355</td>
<td>0.804</td>
</tr>
<tr>
<td>HRP</td>
<td>GEH NHS TRUST</td>
<td>EQ-5D Index</td>
<td>35</td>
<td>0.258</td>
<td>0.822</td>
</tr>
<tr>
<td>HRP</td>
<td>GEH NHS TRUST</td>
<td>Oxford Hip Score</td>
<td>40</td>
<td>15.475</td>
<td>40.525</td>
</tr>
<tr>
<td>KPP</td>
<td>England</td>
<td>EQ VAS</td>
<td>10,568</td>
<td>80.2183</td>
<td>80.0389</td>
</tr>
<tr>
<td>KPP</td>
<td>GEH NHS TRUST</td>
<td>EQ VAS</td>
<td>40</td>
<td>86.55</td>
<td>86.25</td>
</tr>
<tr>
<td>KPP</td>
<td>England</td>
<td>EQ-5D Index</td>
<td>17,590</td>
<td>0.417</td>
<td>0.747</td>
</tr>
<tr>
<td>KPP</td>
<td>GEH NHS TRUST</td>
<td>EQ-5D Index</td>
<td>67</td>
<td>0.342</td>
<td>0.728</td>
</tr>
<tr>
<td>KPP</td>
<td>England</td>
<td>Oxford Knee Score</td>
<td>19,020</td>
<td>19.143</td>
<td>35.879</td>
</tr>
<tr>
<td>KPP</td>
<td>GEH NHS TRUST</td>
<td>Oxford Knee Score</td>
<td>77</td>
<td>16.364</td>
<td>34.675</td>
</tr>
</tbody>
</table>

GH = Groin hernia / HRP – Hip replacement primary / KPP = Knee replacement primary

EQ5D Scoring

This series of questions asks for patients views on five areas, which include pain, mobility, the ability to care for oneself, anxiety and depression levels, and usual activities.

EQVAS

This measure relates to a visual analogue score from 1-100, in which patients are asked to rank themselves with respect to levels of general health. These scores are not specific to the procedure undertaken and may relate to other areas of physical, social and psychological wellbeing.

Oxford Hip / Knee Score

This measure relates to pain and mobility and also includes hip or knee specific questions, such as: “How would you describe the pain you previously felt in your hip?” “Have you been able to put on a pair of stocking or tights?”.
Our quality improvement priorities 2017/18

Our aim is to create a culture of continuous improvement that is patient-centred and safety-focused, closing the gap on health and wellbeing, care and quality, funding and efficiency. We want to improve the experience that our patients and staff receive – keeping them at the forefront and centre of everything we do.
Our Quality Improvement Strategy for 2017/18 sets out a clear description of our quality improvement priorities and how these will be measured and monitored. The quality priorities have been developed into ‘quality goals’, which are supported by a range of more detailed measures and targets based on local and national quality priorities, CQUIN requirements, key improvement areas identified within the Trust and feedback from patients and other key stakeholders.

The quality priorities and goals are cascaded through our Divisions and Directorates and are reviewed through the integrated performance monitoring process. The Board tracks a range of key quality metrics, which are reviewed and scrutinised by our quality priorities and goals. The quality priorities and goals are summarised below.

**Priority 1: patient safety and effectiveness**

**Quality goal 1 - reduce avoidable harm and deliver safe effective care**

We have identified and will achieve deliverable improvements in key measures to support the national and local safety improvement programmes with the aim of reducing harm to patients within our care. We will focus on falls prevention and management, reducing pressure ulcers and reducing incidents with associated harm.

**Quality goal 2 - reduce avoidable mortality and improving outcomes**

During 2017/18, we will aim to sustain our HSMR and further improve our SHMI through collaborative working with our commissioning, Public Health, community, and primary care colleagues. We will review the whole patient pathway and identify the specific interventions that will improve outcomes and patient experience.

We will implement the guidance set out by the National Quality Board on learning from deaths, with a focus on strengthening our governance and capability, data collection and public reporting, and improving our engagement with families and carers. We will roll out the Structured Judgement Review case note methodology, as required by the Royal College of Physicians.

**Quality goal 3 - advanced planning and end-of-life care**

We will improve the care of patients identified as being at the end of life to ensure that they are identified early, appropriate care plans are put in place, they and their carers are involved in decision-making, and that patients are able to die in their preferred place.
Quality goal 4 - ensure that safe staffing levels are in place across the Trust

We will put in place measures to ensure that there are sufficiently trained and competent staff available to achieve safe staffing levels across all services, and we will monitor this using our ward dashboard system on a daily basis.

Quality goal 5 - freedom to speak up

We will continue to promote an open and transparent culture across the organisation to ensure all members of staff feel safe, confident, and able to speak out and raise any concerns they may have.

Priority 2: productivity and efficiency

Quality goal 6 - seven day service

We will continue to make appropriate healthcare services accessible seven days per week to avoid compromising patient care, safety and patient experience. There are a number of key goals associated with this programme and we will work to comply with the four priority standards set by NHS England.

Quality goal 7 - proactive and safe discharge

Having implemented the SAFER discharge bundle and developed the clinical co-ordination centre in 2016/17, we will work with our local community services and GPs to increase safe and efficient discharge from hospital.

Quality goal 8 - improve shared care with primary and community healthcare providers

We will work collaboratively with commissioners, GPs and community service providers to widen direct access to diagnostic testing, consultant advice and guidance; and to identify and put in place appropriate care plans for patients attending our A&E, for whom mental health interventions would have the greatest impact.

Quality goal 9 - improve clinical technology and communication

We will ensure our clinical teams are using both technology and the very highest standards of communication to aid early recognition of patient deterioration. We will ensure safe and robust handovers, aid early recognition of patient deterioration, and ensure safe discharges and transfers from our care.

Priority 3: people’s experience

Quality goal 10 - people’s experience

All staff will communicate effectively with patients, and their carers, to ensure that they feel engaged in, and informed about, their care.

Quality goal 11 - people’s experience improve public engagement

We will build on existing public engagement events and design our services around our patients’ needs, both functional and emotional, to ensure we provide an exceptional standard of care and experience to all our patients.

Quality goal 12 - improve staff experience

We will improve staff wellbeing and safety at work through the ‘well to EXCEL’ strategy, with a focus on mental health, physical activity, and rapid access to musculoskeletal services.
Section 1: Statements on quality

Section 2: Looking back on 2016/17

Section 3: Quality improvement priorities 2017/18

Annex 1: Auditors Limited Assurance Report

Appendix 1-4

Acknowledgements and feedback
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 2017 (“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 2017 subject to limited assurance consist of the following indicators:

- percentage of patients risk-assessed for venous thromboembolism (VTE); selected from the subset of mandated indicators based on risk and agreed with the Trust.
- rate of Clostridium Difficile Infections; selected from the subset of mandated indicators based on risk and agreed with the Trust.

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 the Department of Health 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 2016 to 29 June 2016;
- papers relating to quality reported to the Board over the period April 2016 to 29 June 2016;
- feedback from Commissioners dated 21/06/2017;
- feedback from the Quality Accounts Task and Finish Group (T&FG) set up by Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee, with North Warwickshire Borough Council and Warwickshire Healthwatch dated 05/06/2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 18/05/2017;
- the latest national patient survey dated 31/05/2017;
- the latest national staff survey dated 07/03/2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 29/03/2017; and
- the annual governance statement dated 25/05/2017.

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

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

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the 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;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

**Limitations**

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

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

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

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by George Eliot Hospital NHS Trust.
Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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
The Colmore Building
20 Colmore Circus
Birmingham
B4 6AT

29 June 2017
Appendix 1: statements from external stakeholders

Kath Kelly  
Chief Executive  
George Eliot Hospital  
College Street  
Nuneaton  
CV10 7DJ

5th June 2017

Dear Ms Kelly,

George Eliot Hospital – Quality Account 2016/17

This is the response on behalf of the Quality Accounts (QA) Task and Finish Group (TFG) established by Warwickshire County Council’s Adult Social Care and Health Overview and Scrutiny Committee, with North Warwickshire Borough Council and Healthwatch Warwickshire. This commentary is formally presented on behalf of these organisations.

The TFG welcomes the opportunity to comment on the Quality Account for 2016/17, which is again well presented for its target public audience and patients. It is easy to read, with graphics to assist the reader’s understanding. The document avoids the overuse of clinical language, which is welcomed. A final check to ensure all acronyms are referenced in the glossary and explained clearly on first use will improve this further.

There are a number of specific areas that the TFG wishes to comment on in more detail:

1. The TFG welcomes the recognition that the Trust has received, with continued success in awards, including patient safety awards and the CIPR Gold Award.

2. Looking back at the priorities for 2016/17, additional clarification regarding the two mortality indicators (HSMR and SHMI) would help the public to understand the differences between them and progress made. It is noted that additional work with the local clinical commissioning group and others is planned as the SHMI indicator is above the expected national level at 114.
3. The TFG was provided with the first draft of the QA document. Some data and appendices were missing and the TFG has requested sight of these. The auditor's report was referenced particularly.

4. There are some areas where the data could be clearer to include both percentage and actual data; percentage data alone is less easy to interpret and the QA is a public facing document. There is a need to provide clearer information about VTE, a condition in which a blood clot (thrombus) forms in a vein. A consistent approach is suggested to the graphics used to assist the reader's understanding of the QA and its important messages. The colour coded bar charts used in the previous QA were advocated.

5. It is noted that the quality of some graphics such as that for HSMR would be improved for the final version. Similarly recommendations were made for additional explanation in some areas of the document to assist the public, such as the red and green bed days and VTE.

6. The TFG acknowledges the significant improvements made in the early detection and treatment of acute kidney injury, also the continued excellent position with no cases of MRSA and the reduction in agency costs.

7. The TFG welcomes the continued focus on prevention of falls and on end of life care. Additional context would be helpful to clarify the section of the QA on the reduction in the number of stillbirths at the Trust.

8. There is concern at the number of 'never' events with four in this period. The QA explains these as clearly as is possible for a public facing document.

9. There has been a reduction in the number of complaint cases received, whilst patient episode numbers have increased. The Trust's approach to complaints is open, showing the opportunity for lessons to be learnt, giving patients the confidence to complain and the potential for better patient outcomes.

10. The TFG notes that a substantial proportion of the Trust's clinical research is focussed on diabetes. Locally, there are a high number of patients with diabetes, linked to lifestyle choices. The work that GEH is doing to promote healthy eating is welcomed.

11. The Care Quality Commission (CQC) summary provides a positive reflection of the Trust, but this relates to the last formal review in 2014. It is noted that the Trust undertakes six monthly inspections, which may be an area for future engagement with elected members, at least in the form of briefings.

12. The importance of secure IT systems was raised, given the recent national NHS cyber-crime incidents.
13. The TFG will recommend areas for additional monitoring by the County Health OSC. Examples are discharge summaries/transfers of information to GPs, end of life care and Hospital mortality / aspects relating to case studies of those dying in the 30 days after discharge.

14. The TFG is supportive of the ten quality goals proposed for the next two year period and particularly those related to end of life care and mental health provision, working with the Coventry and Warwickshire Partnership Trust to identify those in need of support.

Overall, this is an excellent Quality Account that demonstrates the Trust is performing well. The Chair and members of the TFG wish to place on record their thanks to the staff that have assisted for their attendance at meetings, for the information provided and for responding to members’ questions.

Yours sincerely,

[Signature]

Councillor Bill Oliver,
Chair of the Quality Accounts TFG
Dear Dr Wood,

Warwickshire North Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the Trust’s Quality Account 2016/17. We do so in the capacity of lead commissioner for the George Eliot Hospital NHS Trust and our response meets the requirements set out by the Department of Health.

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, comments have been provided to the authors of the report in advance of its publication; this feedback has been included in the final Quality Account.

The Quality Account clearly demonstrates the actions taken to improve the quality of care within the trust and the CCG recognises the achievements in relation to priorities set in the 2016/17 Quality Account particularly in relation to the reduction of health care acquired infections (HCAI), pressure ulcers, sepsis and implementation of the acute kidney injury (AKI) strategy.

The CCG would also like to acknowledge the additional scrutiny and ongoing actions taken by the Trust in addressing the Hospital Standardised Mortality Ratio (HSMR), continued action on bringing the Standardised Hospital Mortality Ratio Indicator (SHMI) back within the expected range.

While improvements have been made, it is very disappointing that staffing recruitment remains a significant challenge and there are a few areas where the Trust has not achieved their targets,

- Never Event- Reporting of 4 never events in year
- Cancer 62 day waits
- Safeguarding training

We recognise your continued progress against the action plan following the Care Quality Commission (CQC) reviews.

Yours sincerely

[Signature]

Dr Deryth Stevens
Chair

21st June 2017

Dr Gordon Wood
George Elliot Hospital
College Street
Nuneaton
CV10 7DJ
Appendix 2: amendments

Each year, we invite our local and county stakeholders to be involved in the review of the content of our Quality Account report. During this crucial stakeholder engagement phase, we benefited from useful and constructive feedback from all involved. Healthy discussion and feedback offered has been considered and responded to in a positive way. This is reflected throughout the report.

This work is pivotal to the final outcome of the Quality Account and, in particular, the review of our 2016/17 quality improvement priorities and the formation and setting of our key quality improvement goals for 2017/18. Such valuable input is very much appreciated and will continue to be a key driver in supporting the completion of the final document within the required time-frame.

We would once again like to thank all who took part in the review and scrutiny process of this key document. We look forward to continuing this work as part of our ongoing quality improvement journey, and will do so by working closely with our patients and stakeholders at every opportunity.
## Appendix 3: Glossary

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>medical or surgical treatment usually provided in a district general, or acute, hospital.</td>
</tr>
<tr>
<td>Care bundle</td>
<td>a set of interventions that, when used together, significantly improve on patient treatment and 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.</td>
</tr>
<tr>
<td>Care pathway</td>
<td>the process of diagnosis, treatment and care negotiated with the involvement of the patient and his/her carer or family;</td>
</tr>
<tr>
<td>CQC – (Care Quality Commission)</td>
<td>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.</td>
</tr>
<tr>
<td>CCGs (Clinical Commissioning Groups)</td>
<td>groups of GPs that 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.</td>
</tr>
<tr>
<td>Clinical audit</td>
<td>a continuous process of assessment, evaluation and adjustment of practice by doctors, nurses, and other health professionals.</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>an intestinal infection commonly associated with healthcare settings</td>
</tr>
<tr>
<td>CQUIN (Commissioning for quality and innovation)</td>
<td>a national payment framework for locally agreed quality improvement schemes. It makes a proportion of provider income conditional on achieving ambitious quality improvement goals and innovations agreed between commissioner and provider, with active clinical engagement. The CQUIN framework is intended to reward genuine ambition, encouraging a culture of continuous quality improvement in all providers.</td>
</tr>
<tr>
<td>Friends and Family Test (maternity)</td>
<td>a questionnaire is offered to all women, at 36 weeks (ante natal), after the birth and on discharge from the midwife (post-natal at hospital or home), who are asked: ‘How likely are you to recommend the maternity service to friends and family?’ Feedback results are used to improve services.</td>
</tr>
<tr>
<td>HSMR (Hospital Standardised Mortality Ratio)</td>
<td>an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. Mortality ratios are a good source of information that help us understand the care provided in hospitals and allow us to target areas for improvement, review, and investigation.</td>
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<td>Name</td>
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<tr>
<td>Hypothermia (in babies)</td>
<td>a condition characterised by moderate body temperature (28-32°C), which can include symptoms such as violent, uncontrollable shivering, although this can stop completely at lower temperatures as the body is unable to generate heat.</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>occurs when a baby receives inadequate oxygen to its brain before, during, or after delivery. The condition can lead to brain injury and, if improperly treated, may progress into a permanent disorder.</td>
</tr>
<tr>
<td>Information Governance Toolkit</td>
<td>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.</td>
</tr>
<tr>
<td>Incident</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>No harm:</strong> 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.</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Impact not prevented:</strong> any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Low:</strong> any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. For example, the patient required first aid, minor treatment, extra observation or medication</td>
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<td></td>
<td>▪ <strong>Moderate:</strong> 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. For example, likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Severe:</strong> any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. For example, permanent harm, such as brain damage or disability, was likely to result</td>
</tr>
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<td></td>
<td>▪ <strong>Death:</strong> any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.</td>
</tr>
<tr>
<td>Medication Safety Officer</td>
<td>a role all NHS trusts are required to fill in order to target safer prescribing practice, such as reducing medication and prescribing errors.</td>
</tr>
<tr>
<td>My Expectations</td>
<td>The ‘my expectations for raising concerns and complaints’ is a report from the Parliamentary and Health Service Ombudsman in collaboration with Healthwatch and The Local Government Ombudsman. It is a user led vision fundamental to good complaints handling. see also: <a href="https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf">https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf</a></td>
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<td>Name</td>
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<tr>
<td>National Safety Standard in Invasive</td>
<td>a high-level framework of national standards of operating department practice which has been created for local providers to use to develop and maintain their own more detailed and standardised local operating procedures. These standards are intended to sit alongside and complement existing safeguards, including the WHO Checklist, and aim to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur.</td>
</tr>
<tr>
<td>Procedures (NatSIPPs)</td>
<td></td>
</tr>
<tr>
<td>Never events</td>
<td>inexcusable actions in a healthcare setting. The kind of mistake that should never happen, they are, by definition, preventable.</td>
</tr>
<tr>
<td>Overview and Scrutiny Committees (OSCs)</td>
<td>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 healthcare decisions and make the NHS more publicly accountable and responsive to local communities.</td>
</tr>
<tr>
<td>PALS (Patient Advice and Liaison Service)</td>
<td>provides support to patients, carers and relatives, representing their views and resolving local difficulties speedily.</td>
</tr>
<tr>
<td>Parliamentary and Health Service</td>
<td>where local resolution of a complaint has been exhausted, the PHSO will look into complaints where an individual believes there has been injustice or hardship, where they feel an organisation has not acted properly, or fairly, or has given a poor service and not put things right. Outcomes from a PHSO investigation can be to either uphold the hospital's review and efforts to resolve the complaint, or to make a recommendation in favour of the complainant.</td>
</tr>
<tr>
<td>Ombudsman (PHSO)</td>
<td></td>
</tr>
<tr>
<td>Patients Forum</td>
<td>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.</td>
</tr>
<tr>
<td>PROMs (Patient Reported Outcome Measures)</td>
<td>PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.</td>
</tr>
<tr>
<td>SHMI (Summary Hospital Mortality</td>
<td>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 one. A trust would only get a SHMI value of one if the number of patients who die following treatment there was exactly the same as the number expected using the SHMI methodology.</td>
</tr>
<tr>
<td>Indicator)</td>
<td></td>
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<tr>
<td>VTE</td>
<td>a condition in which a blood clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE.</td>
</tr>
<tr>
<td>WHO (World Health Organisation)</td>
<td>– the WHO surgical safety checklist 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 reduced the number of complications arising from surgery.</td>
</tr>
</tbody>
</table>
Appendix 4: feedback form

We hope you have found this Quality Account informative, interesting and helpful. To save costs, the report is available on our website and hard copies are available in waiting rooms or on request.

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

Patient Feedback
George Eliot Hospital NHS Trust
FREEPOST (CV3262),
College Street
Nuneaton
CV10 7BR

Alternatively, please email: pals@geh.nhs.uk

How useful did you find this report?

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

Did you find the contents?

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

Is the presentation of data clearly labelled?

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

If no, what would have helped?

Comments:
Acknowledgements

The George Eliot Hospital NHS Trust would like to thank the following staff, organisations, groups and individuals for their invaluable contribution through ongoing feedback and support in the production of this year’s Quality Account.

- Warwickshire North Clinical Commissioning Group
- Healthwatch Warwickshire
- Adult Social Care and Health Overview and Scrutiny Committee
- GEH Patient Forum
- GEH Clinical Business Unit quality leads, PALs team, Maternity, Governance, Pharmacy, Quality, Finance, Infection Prevention.

‘Our vision is to EXCEL at patient care’
For more information

Main switchboard: 024 7635 1351
Main e-mail address: enquiries@geh.nhs.uk

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