Adult Social Care and Health Overview and Scrutiny Committee

7 June 2011

Agenda

A special meeting of the Adult Social Care and Health Overview and Scrutiny Committee will be held at the **SHIRE HALL, WARWICK on TUESDAY, 7 JUNE 2011 at 9.00 a.m.**

The agenda will be: -

1. General (From 9.00 – 9.15)

(1) Election of Chair and Vice Chair of Committee

(2) Apologies

(3) Members' Disclosures of Personal and Prejudicial Interests.

Members are reminded that they should disclose the existence and nature of their personal interests at the commencement of the relevant item (or as soon as the interest becomes apparent). If that interest is a prejudicial interest the Member must withdraw from the room unless one of the exceptions applies.

'Membership of a district or borough council is classed as a personal interest under the Code of Conduct. A Member does not need to declare this interest unless the Member chooses to speak on a matter relating to their membership. If the Member does not wish to speak on the matter, the Member may still vote on the matter without making a declaration'.

2. 2011 Quality Accounts

9.15 – 9.30	Introduction to Quality Accounts – NHS Warwickshire
9.30 – 10.05	University Hospitals Coventry and Warwickshire NHS Trust (Draft Quality Account circulated with agenda)
10.05 – 10.40	South Warwickshire NHS Foundation Trust (Draft Quality Account circulated with agenda)
10.40 – 11.15	NHS Warwickshire Community Health (Draft Quality Account circulated with agenda)
11.15 -11.20	Break
11.20 – 11.55	West Midlands Ambulance Service NHS Trust (Draft Quality Account to follow)
11.55 – 12.30	Coventry and Warwickshire Partnership NHS Trust (Draft Quality Account to follow)
12.30 – 13.05	George Eliot Hospital NHS Trust (Draft Quality Account circulated with agenda)
13.05 – 13.10	Closing remarks

3. Any Urgent Items

Agreed by the Chair.

JIM GRAHAM
Chief Executive

Adult Social Care and Health Overview and Scrutiny Committee Membership

Councillors Martyn Ashford, Penny Bould, Les Caborn (Chair), Jose Compton, Richard Dodd, Kate Rolfe (S), Dave Shilton (Vice Chair), Sid Tooth (S), Angela Warner and Claire Watson.

District and Borough Councillors (5-voting on health matters) One Member from each district/borough in Warwickshire. Each must be a member of an Overview and Scrutiny Committee of their authority:

North Warwickshire Borough Council:	Councillor Derek Pickard
Nuneaton and Bedworth Borough Council:	Councillor John Haynes
Rugby Borough Council	Councillor Sally Bragg
Stratford-on-Avon District Council	Councillor Helen Haytor
Warwick District Council:	Councillor Michael Kinson OBE

Portfolio Holders:- Councillor Izzi Seccombe (Adult Social Care)
Councillor Bob Stevens (Health)

The reports referred to are available in large print if requested

General Enquiries: Please contact Paul Williams on 01926 418196
E-mail: paulwilliamscl@warwickshire.gov.uk

QUALITY ACCOUNT 2010/2011

University Hospitals Coventry and Warwickshire NHS Trust

CONTENTS

Chief Executive Officer's Statement on Quality	
Introduction to the Account and overview of last year's Priorities	
Overview of Organisational Quality	
Review of Quality Performance 2010/2011	
Priorities for Improvement	
Quality Improvement Priority 1 Patient Safety - Management of Sepsis	
Quality Improvement Priority 2 Clinical Effectiveness - Nutrition	
Quality Improvement Priority 3 Patient and Staff Experience - Managing Patients with Dementia	
Statements from the Trust Board	
Statements from 3rd Parties	
How to Provide feedback	
Appendix - Glossary of Terms	

Chief Executive Officer's Statement on Quality

The overall vision set out in Equity and Excellence: Liberating the NHS is about putting patients at the heart of the NHS: transforming the relationship between citizen and service through the principle of no decision about me without me; focusing on improving outcomes: orientating the NHS towards focusing on what matters most to patients – high quality care.
Equity & Excellence: Liberating the NHS (2010)

Welcome to our second Annual Quality Account. I hope you find it useful in showing how we performed in 2010/11 and what our priorities are for the next 12 months. Our mission is to Care, Achieve and Innovate by:

- delivering safe, high quality and evidence based patient care
- developing excellence in research and education
- enhancing efficiency and promoting our high quality service successes both locally and nationally.

Last year we committed to focus on infection prevention and control, the discharge process and improving information for patients. I am pleased to report that we made many improvements in these areas including a new bedside folder of information for patients, upgraded website with additional accessibility features and reduced C Diff and MRSA rates for the fifth year in a row. We have also had other success in these 12 months with staff being nominated for various awards:

- Research staff Natasha Wileman and Margaret Goodman were shortlisted and won a West Midlands NHS Innovation Awards 2010 for their Teggy Mouthcare device which allows patients to brush their teeth without a sink.
- Consultant surgeon Richard King was shortlisted for a Patient Safety Award 2011 in the 'Technology and IT to Improve Patient Safety' category for his KingMark invention which accurately measures the size of hip replacement needed in operations in a way which promotes patient dignity.

- Practice Facilitator Maggie Denton was shortlisted for a West Midlands NHS Innovation Award 2010 for her 'privacy and dignity sign' for clinical areas.
- The Trust team who managed and implemented the Venous Thromboembolism assessment programme and tool across the Trust, meeting the Government's target three months ahead of time, was shortlisted for the 2010 E-Government National Awards. The tool assessed patients to determine their individual level of risk they of developing potentially fatal venous Thromboembolism.

While we will continue our work in all these areas, this year we have picked another three issues to prioritise: sepsis, nutrition and caring for patients with dementia. We know these core areas of care can make a big difference to our patients' experience. Looking at sepsis will help us spot early warning signs to stop patients becoming more ill and we know studies show that patients receiving nutritionally balanced meals recover quicker.

With an increasingly ageing population we sadly know that we will start to see more patients with dementia using our services. They can have specific needs for us to meet to ensure they are treated with the dignity and respect they deserve. We have already made some moves in this area including producing a film for staff training and receiving funding from the Kings Fund to provide areas specifically for those with dementia, their family and carers. In this report you will find more details about the work we are doing in these areas as well as how we are performing compared to national and local targets which I hope you will find informative.

I am aware that this is a time of great uncertainty within the NHS with national changes on a scale that are unprecedented for many of us. It is understandable that people may worry at such a time but we are confident that we can face these changes so our staff can continue to provide high quality and safe care for our patients. It may not be easy but everyone is clear on one point – patient care is, and will continue to be, our highest priority and we will not lose sight of that.

I hereby state that to the best of my knowledge the information contained within the Quality Account is accurate.

Andy Hardy
Chief Executive Officer
UHCW NHS Trust

Introduction to University Hospitals Coventry and Warwickshire NHS Trust's Quality Account

Current view of the Trust's position and status for quality

This Account covers the financial year of 2010/2011 across University Hospitals Coventry and the Hospital of St. Cross Rugby. The first part of our Account details how we performed against last year's Quality Account, followed by an overview of organisational quality and patient safety and our performance against national and local metrics in 2010/2011. The second section of the account specifies our top three quality priority areas for the coming year and where we believe further improvements are required to enhance patient care.

Overview of Meeting Last Year's Quality Account Priorities

Our 2009/2010 Account detailed 3 quality improvement priorities.

- Reducing healthcare acquired Infections,
- Improving discharge from hospital and;
- Improving information for patients.

The table below highlights our key achievements against these priorities.

Progress - Priority 1- SAFETY

Infection Prevention and Control: Kate Prevc, Infection Control Nurse

Identified areas for improvement	Key Achievements
To continue to reduce rates of infection	UHCW has for the 3rd year in a row continued to reduce its infection rates. The data is displayed on page (X)
Improve practice through targeting education at junior medical staff.	In conjunction with the IV team and the blood transfusion team an education package has been delivered to Junior Medical Staff.
Continue to ensure timely data is collected and disseminated to wards and departments, to observe trends and identification of potential outbreaks	An infection prevention and control bulletin is produced monthly with data for each ward and division.
Infection Control Team will continue to work with public forums on issues	Infection Prevention and Control have been involved with local schools

Identified areas for improvement	Key Achievements
relating to infection control	teaching children about hand hygiene. UHCW also organised a day in the centre of Coventry to educate the public about hand hygiene and how to help us prevent the spread of infection especially norovirus.
Tuberculosis Strategy .	There is a bi monthly meeting chaired by Dr Ravi Gowda, Infectious diseases consultant at UHCW. There are networking meetings chaired by the Health Protection Agency which occur regularly & are usually held at UHCW.

Progress - Priority 2 - CLINICAL EFFECTIVENESS

Effective Discharge from Hospital: Michelle Linnane, Deputy Divisional Nurse Director

Identified areas for improvement	Key Achievements
Completion of a discharge checklist for every patient who is admitted.	The checklist has been implemented across the Medical specialty wards
Patients will be provided with an information leaflet about what to expect on discharge.	An updated version of a discharge leaflet has been introduced.
Working collaboratively with Coventry LINks	Discharge team met with Coventry LiNK on 17th November 2010. The group were satisfied that the Trust had taken on board the issues raised and were happy with progress to date.
Fully embed the use of QFI JONAH in everyday clinical practice to manage the patient's journey from admission to discharge.	Divisional Management Teams support wards to ensure QFI JONAH is utilised and updated daily. Twice weekly meetings take place at UHCW to enable both internal and external stakeholders to work in partnership to resolve issues resulting in delayed patient discharge
Increase training to ensure all staff are aware of their roles and responsibilities with regards to discharge.	Integrated Discharge Team provide regular training sessions for Junior Doctors and nurses.
Increase the use of 'Impressions' locally to listen to patient's comments to drive further improvements.	Individual Matrons monitor 'Impressions' at a local level, enabling feedback to be given directly to individual wards.
Develop a business case for approval to provide additional resource to enable the current integrated discharge team model to be implemented across all wards within the Trust.	Work is ongoing to further develop the Integrated Discharge Team. (IDT). Additional resource has been provided to enable all medical wards to have a dedicated member of IDT to support ward

Identified areas for improvement	Key Achievements
	staff with discharge planning processes. A pilot project is being undertaken on Ward 22 (Vascular) to ascertain the effectiveness of a dedicated discharge facilitator.

Progress - Priority 3 - PATIENT EXPERIENCE

Improving Information to Patients: Julia Flay, Patient Involvement Facilitator and Kerry Beadling, Communications Manager

Identified areas for improvement	Key Achievements
Bedside Folders on every ward	A bedside folder is now available next to each bed on wards for every inpatient in the Trust (both Coventry and Rugby). It has been produced on plasticized paper so that it is wipe-clean for infection control purposes.
Website Upgrade	The new Trust website was launched in June 2010 – it features many more accessibility features including browse aloud, auto-translate and videos featuring sign language.
General Information Leaflet	Two general information leaflets (one for University Hospital in Coventry and one for the Hospital of St Cross in Rugby) are now available which contains general information including a map, ward contact details, visiting hours. These are available in the Health Information Centre and have been sent out to Coventry and Rugby GPs to display in their surgeries.
Increasing Dementia Awareness	A DVD outlining the experience of two carers of patients [at the Trust] with dementia has been produced and has been sent out to 4,000 front line staff to raise their awareness of the issues facing patients with dementia. Please refer to Quality Priority 3 for further information on Dementia

Overview of Organisational Quality

Patient Safety

Continuous improvement in patient safety and quality is one of UHCW's principal values; you deserve to receive high quality and safe healthcare. Last year we

reported how each clinical speciality has a Quality, Improvement and Patient Safety (QIPS) meeting so the multi-disciplinary team can discuss issues like; clinical incidents, complaints and audit.

Ensuring patients' safety whilst in Hospital is of paramount importance. Information provided by the National Patient Safety Agency (NPSA) demonstrates that the Trust has a good incident reporting culture (Figure 1) where staff feel able to report incidents and near misses demonstrating an open culture that supports improvement and learning. The data also clearly shows in Figure 2 that the vast majority of those incidents that are reported are 'no harm' events.

Figure 1 overleaf shows rates of reported patient safety incidents per 100 patient admissions during the period 1 April 2010 to 30 September 2010 across Teaching Trusts nationally. The black bar represents the data from UHCW and highlights we are in the upper range for reporting patient safety incidents. The NPSA found that Trusts with higher rates of reporting incidents are safer Trusts. This means we are recognised as being one of the safest Teaching Trusts in England.

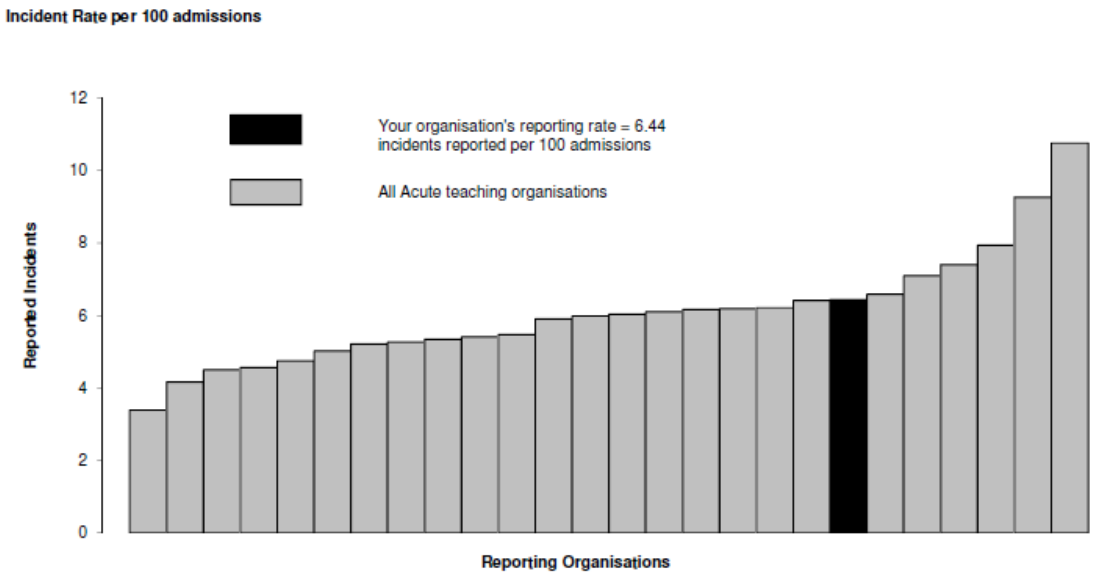


Figure 1: Reporting Patient Safety Incidents. Rate per 100 Admissions

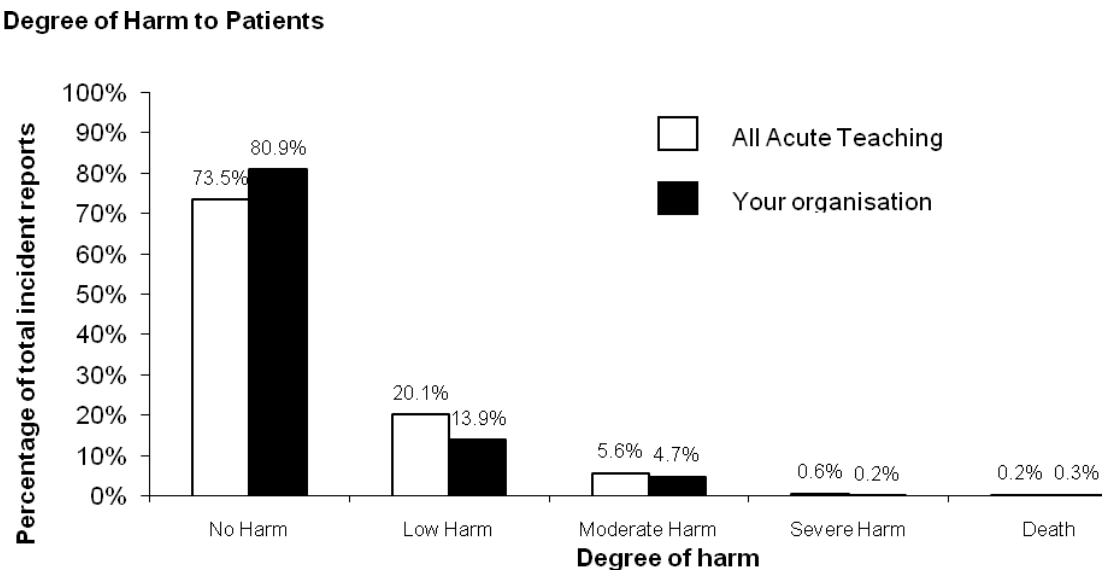


Figure 2: Degree of Harm

Clinical Risk Management

UHCW were involved in an announced themed quality review for risk management which took place on the 1st December 2010. The purpose of the visit was to ensure the services commissioned by NHS Warwickshire and Coventry at UHCW are safe and comply with national and local governance legislation. The review concluded that the organization had excellent processes for monitoring and investigating incidents and performed aggregated reporting at local and executive levels.

The review team held discussions with ward staff who confirmed that there was a strong understanding of the incident reporting process and that a cascade system for learning from SI's was in place. Staff interviewed also confirmed the use of written feedback via team meetings and/or feedback books.

The final report from our Commissioners stated;

> *"Findings of the review did not reveal any areas of risk to patients and confirmed that the organisation has excellent systems and processes in place for the fundamental management of incidents and complaints. University Hospitals Coventry and Warwickshire NHS Trust demonstrated that they are continually trying to improve their processes and several examples of best practice have been introduced."*

UHCW records all incidents, clinical and non clinical on an electronic system called Datix. Last year we reported the Trusts top 5 reported clinical incidents, the table below shows 2010/2011's top 5 reported clinical incidents.

Category	2009/2010	2010/2011
Falls	1621	1558
Admitted with pressure sore / ulcer	340	590
Hospital acquired pressure sores/ulcers	Not reported as incidents	532
Missing equipment / device	317	321
Delay	-	194

Table (x)

Complaints

The Complaints Process underwent new statutory changes in April 2009 when the Parliamentary and Health Service Ombudsman (PHSO) became the second tier in the NHS Complaints process. Trusts were encouraged to adopt a more flexible approach to complaints and to improve their communication with complainants. It is important that the learning from complaints is shared, not just with those directly involved in the care but with the managers who have responsibility for the services being complained about. As such, we aim to share all complaints in as wide a forum as possible to ensure there is appropriate learning from the issues raised.

Between 2008 and 2010 we have seen a slight increase in the number of complaints received which is commensurate with our increase in activity. There has been a slight increase in the number of complaints being assessed at the PHSO, but in most instances these have either been closed or we have been afforded the opportunity to again try and resolve the complaint locally. Three complaints were investigated by the PHSO, two of which are awaiting a decision at this time. For the third, we are now working to meet the recommendations made. The Trust reports to the Trust Board and the Clinical Governance Committee details of our complaints, both dealt with locally and any that are considered by the PHSO. In addition we have introduced a Patient Storyboard so that real experiences can be shared.

Total Number of Complaints	2008/09	2009/10	2010/11
Total Number of Complaints - University Hospital	**419**	**443**	**443**
Total Number of Complaints – Rugby St. Cross	**33**	**34**	**60**
Total Number of Complaints - Other	**4**	**7**	**9**
TOTALS	**456**	**484**	**512**
Total number of complaints referred for independent review	**13**	**20**	**24**
Top 5 Complaint Categories 2010/2011			
All aspects of clinical treatment (298)			
Attitude of staff (71)			
Communication/information to patients (written and oral) (66)			
Failure to follow agreed procedure (18)			
Appointments, delay/cancellation (in-patient) (16)			
Ratio of Complaints to Activity			
	828'389	888'428	May 11
	0.05%	**0.05%**	**May 11**

Figure x: Complaints Data

Patient Satisfaction

The Trust has developed innovative ways of capturing and acting upon real-time feedback on its' services. Our own online feedback survey 'Impressions' is a continuous tool which allows us to see in real time what our patients, carers and visitors are saying at University Hospital and Rugby St Cross. In 2010/2011 the results were as follows:

Category	No of respondents	Overall 'Impression'
Safeguarding your wellbeing	1404	98
Cleanliness	1570	97
Care and Treatment	1605	96
Our Staff	1678	96

Category	No of respondents	Overall 'Impression'
Premises and Facilities	1409	96
Privacy and Dignity	1541	96
Written and Spoken Information	1549	91
Discharging you from hospital	764	84
Food and Drink	1389	84
Getting to/from our hospital	1466	84
Timeliness	1504	84
Parking	1241	43

Impressions information is fed back on a monthly basis to all Specialties in the Trust via the QIPS meetings and reports, it is also reported to the Trust Board alongside real patient stories. Actions are delivered locally and are feedback to ensure the whole clinical team are made aware.

Reducing Mortality

UHCW routinely monitors its mortality rate to identify any adverse trends. Hospital Standardised Mortality rates or HSMR, is the rate at which an expected outcome for a patient is assessed. A score of 100 or below means that the expected outcome of death for a patient is reduced. Last year UHCW reported an HSMR of 98 meaning 2% less people are dying at our hospital. Below is a table which demonstrates where UHCW currently is in comparison with our peers.

HSMR	Score
UHCW HSMR	To be included after rebasing
Peer Group of 12 other Hospitals* ***please refer to Glossary**	To be included after rebasing

Figure 4: Hospital Standardised Mortality Rate

Commissioning Quality and Innovation (CQUIN) Performance in 2010/2011

The CQUIN schemes are an agreement between the Trust and our local Primary Care Trusts, NHS Warwickshire and NHS Coventry. The aim of CQUIN Schemes is to agree priorities for improvement and agree stretching goals to achieve that have a financial incentive attached to them. UHCW's final position is listed below:

Goal No	CQUIN Description	Target	Achievement (Trust Data)
1a	Within 6 hours of admission all patients should be assessed by a registered nurse for their risk of developing a pressure ulceration using recognised evidence based tool.	99%	
1b	Patients assessed to be at risk of ulceration, or who have an ulcer, will have appropriate preventative / treatment actions documented in their care plan.	100%	
1c	a) % Decrease on numbers of UHCW acquired grade 2 ulcerations demonstrated by Q4 against baseline level established in Q1 & Q2 b) % Decrease on numbers of UHCW acquired grade 3 and 4 ulcerations demonstrated by Q4 against baseline level established in Q1	a) 40% reduction of Grade 2 sores b) 75% reduction for grades 3 and 4 (combined values)	

Goal No	CQUIN Description	Target	Achievement (Trust Data)
1d	All service acquired ulcerations of grade 3 or 4 pressure ulcers will be recorded as a serious incident on the Appropriate system (STEIS) and investigated using root cause analysis.	100%	
2	The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching theme: "responsiveness to personal needs : • Involved in decisions about treatment/care • Hospital staff available to talk about worries/concerns • Privacy when discussing condition/treatment • Informed about medication side effects • Informed who to contact if worried about condition after leaving hospital	An improvement in the composite score	
3	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the national tool	90%	
4	Undertake and report root cause analysis of all confirmed cases of hospital acquired pulmonary embolus (PE) or deep vein thrombosis (DVT).	100%	
5	3% Increase in of mothers breastfeeding at time of Guthrie Test	Baseline + 3%	
6	Prescribing the correct dose of warfarin on an outpatient basis. Planned improvement of 1.5% above baseline.	Baseline + 1.5%	
7a	50% of all patient facing clinical staff	100%	

Goal No	CQUIN Description	Target	Achievement (Trust Data)
	receive dementia training.		
7b	Evidence through audit, of compliance in the prescription of antipsychotic medication as per NICE Guidance to patients with a recognised diagnosis of dementia. This description excludes the continued prescription, by provider staff, of anti-psychotic medication that patients are already prescribed at the point of admission.	100%	
8a	All over 65's presenting for emergency medical attention with fragility fracture (excluding hip fracture) to be assessed for risk of falling using a defined screening tool.	100%	
8b	All over 65's presenting for emergency medical attention with a fragility fracture to receive information on about what measures they can take to prevent further falls.	100%	
8c	All over 65's presenting who are identified as being of high risk of falls and admitted for more than 48 hours should receive a multifactorial falls risk assessment prior to discharge	100%	
8d	All over 65's who present for emergency medical attention because of a fall, or report recurrent falls, demonstrate abnormalities of gait and/or balance or are identified as being of high risk should receive either a multifactorial falls risk assessment or a falls clinic when available.	100%	

Nurse Led Discharge

Nurse Led/Delegated/Facilitated discharge (NDD) is a key driver in supporting the smooth transition of patient pathways within any organisation, and has been highlighted as a key component of the High Impact Actions program by the

Department of Health. This was also an area which we identified as an action in last year's Quality Account.

The initial NDD program concentrated upon a small number of pathways as a 'proof of concept' through developing protocols with clinicians, patient information, clinical education and supporting the training of nursing staff. A number of challenges were noted including training sufficient staff and agreeing protocol triggers to be clinically effective in practice. This learning has been used within the project to assist other areas in NDD development. It has also been noted that planned surgical pathways are ideal for NDD work, due in part to their often clear clinical triggers for discharge. This is less clear in other specialities, such as Medicine and requires more work and training with the staff to be effective.

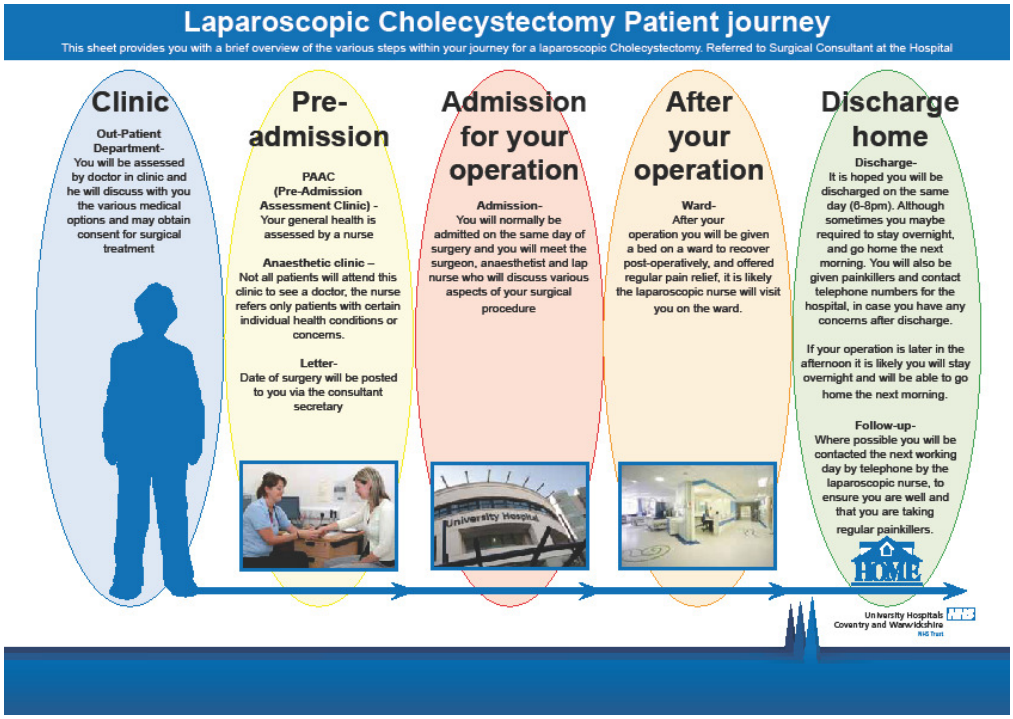


Figure 5: Patient pathway Information poster

Mandatory Training for Staff

TO BE ADDED once approved by T board

Staff Survey 2010

RESPONSE TO BE ADDED once approved by T Board

Foundation Trust Membership

As part of UHCWs Foundation Trust Application we have been actively recruiting members from the surrounding areas, we currently have 6502 public members in addition to 8405 staff members. Newsletters are being distributed on a quarterly basis with opportunities for members to get involved in redesigning patient information leaflets and discussing health issues with our award winning clinical teams. For more information about becoming a member and getting involved with UHCW please go to the Foundation Trust pages of our Website.

Patient Environment Action Team (PEAT)

PEAT is an annual assessment of inpatient healthcare sites in England with more than 10 beds. PEAT is self assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas).

NHS organisations are each given scores from 1 (unacceptable) to 5 (excellent) for standards of privacy and dignity, environment and food within their buildings. These scores are then turned into an overall assessment against each of the areas. The National Patient Safety Agency (NPSA) publishes these results every year to all NHS organisations, as well as stakeholders, the media and the general public.

Year	Overall Score			
2011		**Environment**	**Food**	**Privacy & Dignity**
	HOSPITAL OF ST CROSS	GOOD	EXCELLENT	GOOD
	UNIVERSITY HOSPITAL	GOOD	EXCELLENT	GOOD
2010		**Environment**	**Food**	**Privacy & Dignity**
	HOSPITAL OF ST CROSS	GOOD	GOOD	GOOD
	UNIVERSITY	GOOD	GOOD	GOOD

	HOSPITAL			
2009		**Environment**	**Food**	**Privacy & Dignity**
	HOSPITAL OF ST CROSS	GOOD	EXCELLENT	GOOD
	UNIVERSITY HOSPITAL	ACCEPTABLE	EXCELLENT	GOOD

Elimination of Same Sex Accommodation

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. UHCW is committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

We are proud to confirm that mixed sex accommodation has been virtually eliminated in our Trust. Patients who are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen by exception based on clinical need (for example where patients need specialist equipment such as in General Critical Care, Cardiothoracic Critical Care, Coronary Care Unit, Step Down Unit, or when patients choose to share for instance the renal unit or the Arden Cancer Centre.

Account of 2010/2011 Performance

Safety Measures	2008/2009	2009/2010	2010/2011	Trend
Pressure Ulcer Point Prevalence Audit Prevalence audit records the number of patients with a hospital acquired pressure ulcer on the day of the audit over the total number of inpatients on the day of the audit. This is expressed as a percentage. The lower the rate the better the Trust performs.	January 09 4% 48 patients	January 10 3.7% 41 patients	January 11 2.9% 32 patients	
Incidence of 'serious' Patient Falls graded as % of total number of reported falls.	0%	0.05%	Not available until May	
Total number of Serious Incidents(including infections) reported to the Primary Care Trust and Strategic Health Authority	83	57	273 (Increase due to all pressure ulcers being reported as serious incidents)	
Incidents of Wrong site Surgery ∞ NPSA Never Events	0	1 	1 	

Clinical Outcomes	2008/2009	2009/2010	2010/2011	Trend
Hospital Standardised Mortality Ratio* ***(100 or less indicates a good outcome)***	111.8	98	Available after rebase	
Participation in the National Clinical Audit and Patient Outcomes Programme	100%	100%	100%	
Delayed Transfers of care ***(Target 3.5%)*** *Definition:* Delayed Transfer of care occurs when a patient is ready for transfer from acute care, but is still occupying an acute bed.	3.6%	3.4%	Not available until May	
Breastfeeding Initiation ***(Target 73%)***	77%	76%	Not available until May	
% Patients spending more than 90% of their stay in hospital on a stroke unit ***(National Target 60%)***	57%	62.%		

Patient Experience Measures	2008/09	2009/10	2010/11	Trend
Overall Satisfaction as reported in National Patient Survey		66%	AWAITING	
Patient Only Satisfaction rating using UHCW online 'Impressions' survey tool		76%	93%	

Staff Experience Measures (National Staff Survey)	2008	2009	2010	Trend
% of staff feeling satisfied with the quality of work and patient care they can deliver	60	70	73	

National Priorities 2010/2011	2008/09	2009/10	2010/11	Trend
NHS Healthcare Standards	GOOD	Licensed without Conditions	Licensed without Conditions	
CQC Hygiene Code Compliance	Compliant	Compliant	Compliant	
Incidents of Clostridium Difficile (***Target 110)***	147	116	104	
Incidents of MRSA Bacteraemias ***(Target 7)***	23	11	4	

National Priorities 2010/2011	2008/09	2009/10	2010/11	Trend
All cancers: one month diagnosis to treatment ***(Target 96%)***			Not available until May	
All cancers: two week wait from urgent GP referral to first outpatient appointment ***(Target 93%)***	97%	94.%	Not available until May	
18 week Wait referral to treatment times: **Admitted referral to treatment *(Target 90%)*** **Non-admitted referral to treatment *(Target 95%)***	91% 96%	94% 97%	Not available until May	
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge ***(Target 98%)***	97%	97%	Not available until May	
Cancelled operations not admitted within 28 day ***(Target 5%)***	4.57%	3%	Not available until May	
The percentage of eligible patients with acute myocardial infarction who received primary percutaneous coronary intervention (PPCI) within 150 minutes of calling for professional help *(National target 75%)*	N/A	89%	Not available until May	

National Priorities 2010/2011	2008/09	2009/10	2010/11	Trend
Maximum 2 week wait for Rapid Access Chest Pain Clinic ***(Target 98%)***	100%	100%	100%	

For more information on Performance please contact Simon Reed, Head of Performance Management

Quality Improvement Priorities 2011/2012

How we prioritised our quality improvement priorities

In order to identify the three highest priorities for quality improvement in 2010/2011, the Trust's Executive Management Group, chaired by the Chief Executive Officer, considered performance on patient safety, patient experience and effectiveness of care based upon information gathered from our internal complaints system, patient surveys both local and national, performance information, such as the CQUIN outcomes and the views of the Patients Council and the Local Coventry LINKs.

The Trust has agreed three priorities under which there are a number of current and planned initiatives, only a small selection of which are included in this report. This section of the report will cover the Trusts performance in these three areas and detail the planned actions and initiatives to improve Quality for our patients, carers and families. The Trust Board have agreed that the three selected priorities are:

Priority 1- SAFETY

Management of Sepsis

Sepsis is the body's response to infection. Normally, the body's own defence system fights infection, but in severe sepsis, the body's normal reaction goes into overdrive, setting off a cascade of events that can lead to widespread inflammation and blood clotting in tiny vessels throughout the body. The forms of sepsis include severe sepsis, which occurs when acute organ dysfunction or failure results; septic shock, which occurs in severe sepsis when the cardiovascular system begins to fail so that blood pressure drops, depriving vital organs of an adequate oxygenated blood supply; and septicaemia, which is sepsis that has an infection in the bloodstream itself.

Priority 2 - CLINICAL EFFECTIVENESS

Looking after Patients' Nutritional needs

Nationally around 30% of admissions to acute hospitals are at risk of malnutrition. The benefits of improving nutritional care and providing adequate hydration are immense, and the evidence shows clearly that if nutritional needs are ignored health

outcomes are worse. The detrimental effects of malnutrition are well documented. It has implications for recovery from disease, trauma and surgery and is generally associated with increased morbidity and mortality both in acute and chronic diseases.

Priority 3 – PATIENT &STAFF EXPERIENCE

Improving Care for Dementia patients

Dementia is a term which describes a syndrome, which may be caused by a number of illnesses, which results in progressive decline in multiple areas of function, including memory function, communication and the ability to carry out daily activities. Up to 70% of acute hospital beds are currently occupied by older people and up to a half of these may be people with cognitive impairment including those with dementia and delirium (DOH 2009). It is vital that staff who come into contact with people who have dementia are aware of how to care for this group of people to ensure they have a positive hospital experience

Quality Priority 1

SAFETY: Management of Sepsis

1.1 Why is it a priority for UHCW?

By analysing and investigating the Trust's clinical incidents and specifically following a serious incident that went to the Coroner's Court in 2010, the Trust undertook a major review of its processes for the management of sepsis. Whilst there is an established, appropriate Trust clinical guideline it was clear from the evidence that a campaign was required to really embed the principles into the organisation. Because sepsis can have such a devastating outcome for patients and their families and carers, it is vital that we heighten awareness of the signs and symptoms of sepsis and continue to aid the clinical staff in recognising and managing the septic patient. This will be through the use of emerging technologies as well as through continuous education and training.

1.2 What did we do?

We reviewed the incidents that had occurred and brought together a short-term working group to develop and oversee an extensive action plan to address the issues identified. The main priorities for action centred on the staff's knowledge and experience of the process for managing septic patients and to this end the following actions were immediately implemented:

- A direct communication reinforcing the Sepsis Pathway was sent out from the Chief Medical Officer to all consultants and their teams
- In October 2010 a week-long front page advert on sepsis was placed on the Trust intranet site with hyperlinks to further information.

1.3 Identified areas for improvement

The following areas were identified for improvement:

Training

- Sepsis awareness is now included in induction for all new medical staff
- Targeted teaching has taken place in the Emergency Department (ED) and in acute medicine

Communication

- We have reiterated to staff the process for requesting and transporting "urgent" specimens to the laboratory, with the default for ED to be "urgent".
- Introduction of skills drills and simulation training
- Electronic processes are being introduced into ED to aid recognition of and to prioritise the most unwell patients within the ED environment
- Trust wide, staff have been trained to use the SBAR (Situation, Background, Assessment, Recommendation) communication tool to provide clear communications when escalating or handing over a patient to another team. SBAR is included at Trust induction and staff are given a credit-card style aide-memoir to carry with them
- Antibiotic protocols were standardised

1.4 New initiatives for 2011/2012

- We recognise that these actions need to be strengthened with further, more ambitious actions to ensure continuous learning and improved patient care. We have therefore identified the following areas for improvement during 2011/2012:
- Make the sepsis pathway documentation more readily available and easier to file within the health records, e.g. by the use of stickers or pre-punched sheets.
- Develop the process for timely communication of results from Pathology to clinicians.
- Develop medical trauma documentation, similar to that currently used for major trauma.
- Develop clearer lines of responsibility for patients who are released from the resuscitation area.

Clinical Lead: Andy Phillips, Divisional Medical Director, Diagnostics and Service

Quality Priority 2 - CLINICAL EFFECTIVENESS

Meeting Nutritional Needs

2.1 Why is it a priority for UHCW?

In 2010 UHCW undertook a clinical audit to show compliance with national guidance on nutrition screening. This highlighted weaknesses with screening across the Trust. The Trust was also peer reviewed by the Royal College of Physicians whose findings intimated that improvements needed to be made in both policy and clinical practice. Based on this information the Trust Board felt very strongly that improvements and action needed to occur as a result and it should be a Trust Quality Priority.

Nationally around 30% of admissions to acute hospitals are at risk of malnutrition. Malnutrition is defined as 'a state of nutrition in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition) and function, and clinical outcome' (Elia, 2000). Malnutrition, in terms of undernourishment, is both a cause and consequence of disease in adults and children. The benefits of improving nutritional care and providing adequate hydration are immense, and the evidence shows clearly that if nutritional needs are ignored health outcomes are worse.

The detrimental effects of malnutrition are well documented. It has serious implications for recovery from disease, trauma and surgery and is generally associated with increased morbidity and mortality both in acute and chronic diseases. Length of hospital stay is significantly longer in malnourished patients and higher treatment costs are reported for those who are malnourished. The length of stay for malnourished patients is on average 1.4 days longer than better nourished patients (NICE, 2006b).

NICE guidance on Nutrition Support in Adults sets out clear recommendations for nutritional screening in hospital. Screening for malnutrition is a rapid and simple process which should be carried out on admission to hospital and identifies patients who are in need of more detailed assessment in order to plan for their nutritional

needs to be met utilising a "food first" approach, but may require nutritional supplementation or artificial nutritional support.

Provision of nutritional supplements to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%. Better nutritional care for individuals at risk, can result in substantial cost savings to the NHS. (BAPEN 2010)

2.2 What did we do?

The Clinical team carried out a clinical audit to consider whether patients were being assessed in line with NICE clinical guideline 32 - Nutrition Support in Adults. A review of 63 patient's health records was undertaken, and the results were as follows.

Standard being assessed against	Compliance
A Nutrition Screening Tool should be present within the patient's health record	71%
The Nutrition Screening Tool should be fully completed	23%
A nutritional risk score should be documented within 24 hours of admission	38%
A nutritional risk score should be documented on a weekly basis	19%
The patient's % weight loss should be documented	52%
The patient's BMI should be documented	46%
If a nutritional problem is identified there should be evidence of the action taken within the health record	49%

Following this audit an action plan was compiled and implemented and a reaudit is currently being undertaken. Interim results look encouraging with a marked improvement in most areas.

Essence of Care Clinical Practice Benchmarking is also undertaken within the Trust across clinical areas and includes the nutrition benchmark. The process is facilitated by the Practice Facilitators; these are senior nurses who visit the clinical areas and meet with the Ward or dept managers and Modern Matrons who provide evidence of best practice. In each clinical area a random selection of 5 health care records are reviewed and 5 patients interviewed.

Elements of Benchmark reviewed	Compliance with Evidence best practice April 2010	Compliance with Evidence best Practice Audit March 2011	Trend
Nutritional Needs Assessed	69.4%	84.3%	
Patient prepared meal times	91.8%	98.8%	
Patient observed receive assistance	92.9%	92.8%	
Patients dietary intake monitored	92.9%	90.4%	
Protected Meal times observed	90.6%	94%	

Other actions the Trust has taken are:

- An additional 27 sets of hoist scales were procured to improve facilities for weighing and weighing scales were provided in outpatient areas to start weighing patients in clinics where this had previously not been undertaken. Training was provided to staff.

- A survey was undertaken on the availability of weight scales and height measures and additional equipment provided where gaps have been identified.

- The nutrition screening tool was incorporated into the new Nursing Risk Assessment booklet to ensure that all screening tools were available in one pack aiming to improve compliance with nutrition risk screening of in-patients.

- An audit of completion of the new risk assessment booklet has been undertaken following its implementation in June 2010. A total of 175 records were reviewed (a random sample of 5 from 35 clinical areas). The results identified that 62.3% patients had a completed nutritional risk assessment.

- The nutrition risk screening tool was modified for use with outpatients.

- Increased training was provided for registered nurses on how to complete the nutrition risk screening tool

- Education and training in relation to nutrition and hydration is included in the student nurse induction programme, preceptorship programme for newly qualified staff, pressure ulcer prevention and wound management study days

- The Effective Care Practices programme for Healthcare Support workers has been reviewed and increased time has been allocated to practical sessions relating to nutrition and hydration.

- An information leaflet has been developed for staff entitled 'Keeping Nourished getting better'. This provides an overview of the importance of nutrition, responsibilities and actions to be taken to prevent malnutrition and dehydration.

- Nutritional Awareness week has been held which utilised a roving board that was taken to all ward areas highlighting the importance of nutrition, screening, and preparation of the environment and patients for mealtimes.

- A benchmark of best practice for hydration as been developed

- A patient information leaflet was developed for patients found to be at moderate to high risk.

- In patient meal provision was reviewed and improved, taking patient and staff views into account and snacks for patients with swallowing difficulties who require a pureed diet were introduced.

- A visit was made to another hospital to look at a different style of patient meal service being considered for UHCW, followed by a local presentation to Modern Matrons and Dieticians to gain staff views.

- A radiologically inserted gastrostomy (RIG) service commenced in order to provide this locally rather than transfer to another hospital.

- Additional training sessions for nurses on insertion and management of nasogastric feeding tubes have been delivered.

2.3 Identified areas for improvement

Leadership

The Nutrition Steering Group was reconvened, chaired by the Medical Director and attended by senior staff, including all Divisional Nurse Directors. A further Consultant Gastroenterologist is being appointed to lead the nutrition service.

Nutritional Assessment

Training for nursing staff in nutrition screening has increased, and a plan to introduce outpatient nutrition risk screening at a first outpatient appointment has commenced.

Parenteral Nutrition Practice

Out of hours initiation of parenteral nutrition and overnight bag changes were discontinued. Parenteral nutrition is only to be used in designated wards and bag changes/site dressings to be carried out by appropriately trained nurses.

2.4 New Initiatives for 2011/2012

- To introduce weekly Nutrition Team Multi Disciplinary meetings to discuss difficult cases relating to enteral or parenteral nutrition in hospital or the community.
- To improve compliance with inpatient nutrition screening.
- To complete the rollout plans for the implementation of nutrition screening for outpatients.
- To introduce a dedicated central line insertion service.
- To audit central line infection rates (feeding lines).
- To implement and monitor nutrition and hydration in line with requirements for High Impact Actions.
- To implement NPSA guidance on nasogastric tube insertion by September 2011.
- To implement “Eatwell” menu.
- To consider changing from the locally developed Nutrition Screening Tool to Malnutrition Universal Screening Tool (MUST) in 2012.

Clinical Lead: Beryl Reed, Dietetics Manager

Quality Priority 3 - PATIENT & STAFF EXPERIENCE

Improving care for dementia patients

3.1 Why is it a priority for UHCW?

One quarter of people accessing acute hospitals are likely to have dementia and the number with the condition is expected to double over the next 30 years (National Audit office 2010). Dementia is a term which describes a syndrome which may be caused by a number of illnesses. It results in progressive decline in multiple areas of function, including memory function, communication and the ability to carry out daily activities (Department of Health (DOH) 2009). The two most common forms of dementia are Alzheimer's disease and vascular dementia.

Over 700,000 people are affected by dementia in the UK (Centre for Ageing and Mental Health 2009) and dementia care costs approximately £17 billion per year.

The National Dementia Strategy was published in 2009 with the aim of ensuring that all people with dementia and their carers should live well with dementia. Early diagnosis and interventions are key priorities for health and social care providers. Several other objectives of the strategy include improving the quality of care for people with dementia in general hospitals; of particular importance are the objectives for defining care pathways and ensuring the workforce has necessary skills to offer the best quality of care by providing training.

At UHCW NHS Trust we recognise the vulnerability of patients with dementia, delirium and physical frailty and are taking action to improve the hospital experience for these groups of patients. This led to the development of two new positions in April 2010; a lead nurse for dementia and lead nurse for older people

3.2 What did we do?

The lead nurses for dementia and older people have initiated new ways of working, developed training for staff and increased their profile within the Trust, whilst networking externally to showcase good practice from UHCW. Below highlights some of the progress made in the care of patients with dementia.

- Reinforced links that had already been made with external agencies, including meetings with our colleagues from Mental Health services (Coventry and Warwickshire Partnership Trust) to enhance the service we provide to people who have dementia.
- Dementia Awareness Training for all front line staff has been developed. 2000 staff have undertaken the training so far, and the number attending grows weekly.
- Development and delivery of bespoke training sessions for different staff groups, including support worker induction, therapy staff awareness and junior doctor lunch time teaching.
- Delivered a session dealing with how to manage difficult behaviour at the September 2010 Support Workers Conference.
- Initiated a link nurse group; this is held monthly. This has members from many areas throughout the Trust and is a forum for sharing best practice.

- Activity packs have been distributed to the link nurses to work with patients with dementia and delirium.
- The environment has been reviewed following comments by patients and signage has been improved including toilet and bathroom signs in many wards.
- Links have also been developed with the Alzheimer's society, with the Coventry Dementia Service manager visiting the hospital weekly to attend link meetings and to sign post services and facilities for patients, carer's and staff.
- Participated in the National Dementia audit. This looked at many factors such as environmental issues, drug usage and record keeping.
- A number of events have been based in the main hospital entrance with the purpose of raising awareness as part of an Alzheimer's society campaign.
- Introduction of a 'Getting to know me' form that enables staff to understand the preferences of a person who has dementia, delirium or communication problems. The Trust is liaising with community care to encourage the use of the form, which can then be sent into hospital with any patient.

.

3.3 Identified areas for improvement

Area of Improvement	Timescale
Completion of National Dementia Audit Action Plan	July 2011
Completion of Forget me not Lounge and Memory Lane	August 2011
Development of observational policy for vulnerable patients.	May 2011
Pathway for older patients with Dementia/delirium/physical frailty.	Complete
Rolling programme of Dementia and Delirium awareness for all front line staff. Over 2000 staff trained.	Complete April 2011
Developing on-going programme of training, addressing issues of care for older people.	First session for newly qualified staff April 6th 2011
Development of joint nursing and medical protocols	June 2011

Area of Improvement	Timescale
regarding the management of challenging behaviour.	
Multi-professional working group to work on various issues- firstly to look at reducing use of anti-psychotic medication.	Review May 2011

3.4 New initiatives for 2011/2012

- The provision of a Memory Lane will start from May 2011 through to September 2011. Commemorative Art Work and a Lounge for the exclusive use of patients with dementia, their relatives and carers and any accompanying staff. The Trust is very pleased to have successfully appointed two professional artists, Matilda Moreton to design their Memory Lane and Jo Chapman their 'Forget Me Not Commemorative Shrub' respectively.

- Members of the Project Team set up especially to oversee this exciting work, have attended training courses run by the King's Fund, have chosen to design the Lounge themselves.

- The Forget Me Not Commemorative Shrub will hang within the Hub area of the designated ward, near to the planned Forget Me Lounge. Designed by Jo Chapman, and taking inspiration from the Forget Me Not shrub, the design will have the ability to record memories from the local community, by way of engravings on some of the leaves.

- The Memory Lane will be situated along the corridor leading to the Forget Me Not Lounge and Shrub. Matilda Moreton will design sets of ceramic tiles incorporating photographs and images of Coventry and Warwickshire, significant life events, world events and figures all designed to trigger memory in patients with dementia. The Lane will comprise of images from 1911 onwards of Coventry, Warwickshire, Ireland, the Asian Sub Continent, the Carribean, Poland, household items and images of people carrying out various occupations.

- The Forget Me Not lounge will have a peaceful and relaxing ambience and will include sofas and easy chairs and various games available such as packs of cards, dominoes, flash cards for reminiscence, painting and drawing equipment.

- The Trust and artists will be working closely with the Alzheimer's Society in Coventry and Warwickshire to ensure that all aspects of their designs e.g. colour schemes, images, and furniture, are easily accessible to people with dementia and follow best practice in the field.

- UHCW will host a conference on 'Improving the experience of older people with dementia in the acute setting' in December 2011.

- Develop intermediate level of training and possibly link it to an NVQ

Clinical Leads: Rose O' Malley, Clinical Nurse Specialist- Dementia

Liz Kiernan, Clinical Nurse Specialist for Older People.

Example of artwork by Matilda Moreton

4.0 Statements from the Trust Board

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

4.1 Review of Services

During 2010/2011 UHCW provided and/or sub contracted (x number) NHS services. UHCW has reviewed all the data available to them on the Quality of Care in (x number) of these NHS services.

The income generated by the NHS services reviewed in 2010/2011 represents (x%) per cent of the total income generated from the provision of NHS services by UHCW for 2010/2011.

*this number represents the number of services as detailed in the Trust's 2009/2010 annual report.

4.2 Participation in Clinical Audits

During 2010/2011 64 national clinical audits and 3 national confidential enquiries covered NHS services that UHCW provides. During that period UHCW participated in 79% of national clinical audits and 100% of national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHCW was eligible to participate in during 2010/2011 are listed in the table below. The national clinical audits and national confidential enquiries that UHCW participated in, and for which data collection was completed during 2010/2011 are listed below indicated with a green tick, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of cases required by the terms of that audit or enquiry in column three

Eligible audits applicable to UHCW	Did UHCW participate (submit data) in 2010/2011	% participation 2010/2011
Women & Children		
Perinatal Mortality (CEMACH)	✓	95
Neonatal intensive and Special Care (NNAP)	✓	100
Paediatric Fever	✓	100
Paediatric Diabetes Audit	✓	94
National maternal and perinatal mortality surveillance (CMACE)	✓	100
Maternal death enquiry (CMACE)	✓	100
Acute Care		
Vital Signs in Majors	✓	100
Adult Critical Care (Case Mix Programme)	✓	100
Potential Donor Audit	✓	100
CAPD Peritonitis Audit	✓	Awaiting response from Natalie Millidge
NCEPOD Peri-operative Care Study	✓	No qualifying cases
Long Term Conditions		
National Adult Diabetes Audit	✓	100
Heavy Menstrual Bleeding	✓	Awaiting response from RCOG
National IBD Audit	✓	100
National Inpatient Diabetes Audit (NaDIA)	✓	100

Eligible audits applicable to UHCW	Did UHCW participate (submit data) in 2010/2011	% participation 2010/2011
National Audit of Services for People with Multiple Sclerosis 2011	✓	Organisational questionnaire
National audit for bisphosphonate jaw necrosis (Royal College of Surgeons)	✓	awaiting
Elective Procedures		
National Joint Registry	✓	95
National PROMs Programme: April 2009 - October 2010 *(Groin Hernia, Hip Replacement Knee Replacement, Varicose Veins)*	✓	79
NICOR Adult Cardiac Interventions		Awaiting response from Ann Nugent
VSGBI Vascular Surgery Database	✓	39 (Apr–Sep 2010)
Carotid Intervention Audit	✓	79 (Apr-Sep 2010)
CABG Adult Cardiac Surgery Audit	✓	100
Cardiovascular Disease		
Management of Familial hypercholesterolemia	✓	32
Acute Myocardial Infarction (MINAP)	✓	Awaiting response from Ann Nugent
Heart Failure	✓	48
Pulmonary Hypertension Audit		**Awaiting response from Ann Nugent**
National Sentinel Stroke Audit	✓	**100**
NCEPOD Cardiac Arrest Study	✓	100
HQIP National Cardiac Rhythm Management	✓	Awaiting response from Ann Nugent

Eligible audits applicable to UHCW	Did UHCW participate (submit data) in 2010/2011	% participation 2010/2011
Safe Implementation of Thrombolysis in Stroke (SITS)	✓	? 50% due to national database failure
Renal Disease		
Renal Registry	✓	100
Renal transplantation	✓	100
National Kidney Care Audit	✓	100
Renal Colic	✓	100
Cancer		
National Lung Cancer Audit	✓	100
National bowel cancer audit programme	✓	100
Head and Neck Cancer (DAHNO)	✓	100
SLOANE Project	✓	100
National audit of screen detected DCIS	✓	100
National audit of invasive cervical cancers (NHS Cancer Screening Programme)	✓	100
National Audit of Head and Neck Cancer Treatment Pathway 2010	✓	awaiting
NHSBSP Breast Screening Audit	✓	awaiting
Trauma		
National Hip Fracture Database	✓	100

Eligible audits applicable to UHCW	Did UHCW participate (submit data) in 2010/2011	% participation 2010/2011
Severe Trauma (TARN)	✓	100
National Falls and Bone Health	✓	98
Psychological Conditions		
National Audit of Dementia	✓	100
Blood Transfusion		
National comparative audit of blood transfusion - O Neg blood use	✓	100
National Comparative audit of blood transfusion – Platelet use	✓	88
Compliance with BBT3	✓	Organisational questionnaire
NHSBT Neonatal Exchange Units	✓	100
Audits in which UHCW did not participate		
Paediatric Pneumonia	✗	-
Paediatric Asthma	✗	-
Emergency Use of Oxygen	✗	-
Adult Community Acquired Pneumonia	✗	-
Non-invasive ventilation	✗	-
Pleural Procedures	✗	-
National Cardiac Arrest Audit	✗	Participated in NCEPOD National Cardiac Arrest Study
Chronic Pain (National Pain Audit)	✗	Not a pilot site in 2010/11. Participating 2011/12.
National Parkinson's Audit	✗	UHCW chose not to participate as continuing to implement actions from 2009 audit
COPD	✗	
Adult Asthma	✗	
Bronchiectasis	✗	

Eligible audits applicable to UHCW	Did UHCW participate (submit data) in 2010/2011	% participation 2010/2011
Acute Stroke (SINAP)		Participate in National Safe Implementation of Thrombolysis in Stroke (SITS) instead

The reports of 17 National clinical audits were reviewed by UHCW in 2010/2011. Below is a table of actions for 3 of the largest audits that UHCW participated in and the action we have taken to improve the quality of healthcare:

National audit title	Description of Actions following National Audit
National Care of the Dying	• Revised the End of Life (EOL) Care Pathway (Version 12) with accompanying training sessions and local audit to ensure compliance with the goals as dictated in the national audit; • Training sessions provided to all medical staff including medical students & junior doctors.; • Information is now input onto the Dendrite system for performance monitoring purposes via monthly reports since January 2011.
National Audit of Dementia	• An integrated care pathway for patients with dementia has been implemented across the Trust. • 'Getting to Know me Form' has been implemented which is a record of the patients personal preferences. • A DVD for staff to raise awareness of how to deal with patients with dementia has been created and rolled out. • Staff training has increased with over 2000 members of staff now trained. • Planned introduction of a mental state assessment.
National Sentinel Stroke Audit	• Training has been provided to nurses with regards to swallow screen assessments. • Introduced weekend physiotherapy assessments. • A business case has been put forward for additional therapists. • Ongoing business case with regards to Developmental Apraxia of Speech (DAS) and Speech & Language Therapy. • Currently reviewing the role of the Stroke Specialist Nurses with the aim of providing nurse-led clinics to cover 6 week patient follow-up. • Business case has been put forward to have a nurse based in the Emergency Department overnight who has competences in both Stroke and Cardiac;

National audit title	Description of Actions following National Audit
	• In December 2010 the Hyper-acute unit on Ward 43 was moved to Ward 41 so that all Stroke patients get treated on the one ward which assists in adherence to the Stroke Pathway.

The reports of 25 Local (not national) clinical audits were reviewed by UHCW in 2010/2011. Below is a brief summary of some of the key actions we have taken to improve the quality of healthcare provided. All audits include patients at both Coventry and Rugby sites unless otherwise stated.

Local audit title	Description of actions following Local audit
Peri-operative antibiotic management	A peri-operative antibiotic guideline has been developed
Is blood culture antibiotic susceptibility authorisation for clinical usage in keeping with the local Standard Operating Procedure?	The Standard Operating Procedure for E.coli blood culture isolates has been revised
Audit of Endoscopic Retrograde Cholangiopancreatography (ERCP)	The antibiotic regime for ERCP has been revised to prevent antibiotics from being prescribed unnecessarily.
NICE CG 36 - Atrial Fibrillation	Guideline on the 'Management of Patients Admitted with Recent Onset Atrial Fibrillation' developed

For more information on National or Local Clinical Audit please contact the Quality and Effectiveness Department on 02476 968282

4.3 Participation in Clinical Research

The number of patients receiving NHS services provided or subcontracted by UHCW in 2010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 4,939.

The NHS Operating Framework requires Trusts to double the number of patients recruited across into National Institute of Health Research (NIHR) portfolio trials within 5 years (i.e. from a baseline in 2008/9 to end of 2013-14). We are exceeding this target with 5,941 of our patients taking part in National Institute of Health Research during 2010.

Research is an integral component of providing world-leading excellence in clinical care. It enables UHCW NHS Trust to lead innovation and development which enables us to provide the highest quality patient care. It ensures that we are a leader rather than a follower in healthcare provision and allows us to attract and maintain highly skilled and motivated staff. We are committed to establishing our Trust as an internationally recognised centre of excellence through supporting our staff, working in world class facilities and conducting leading edge research focused on the needs of our patients.

Our current major research themes are metabolic medicine, reproductive health, musculoskeletal and orthopaedics and cancer (includes ENT). These are complemented by additional areas of clinical research activity (for example cardiovascular, renal and respiratory medicine). Research activity continues to increase. There are currently 154 Principal Investigators within the Trust, with 394 active research projects. There are over 50 research nurses, midwives and allied health professionals assisting with research projects and increasing numbers of staff are undertaking research, higher degrees and PhDs. The Trust provides free research training for all staff. This increasing level of participation in clinical research demonstrates UHCW NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

In the last three years, 535 publications have resulted from our involvement in research, helping to improve patient outcomes and experience across the NHS.

The Trust's mission, Care – Achieve – Innovate, is explicit in that we will deliver the best care for our patients, achieve excellence in education and teaching and innovate through research and learning. As such, we have a clear strategy to develop research and innovation. The key areas for delivery are to 'instil and embed a culture of research and innovation' and 'grow investment in, and revenue from, research and innovation'. By delivering on our research and innovation strategy, we also contribute to the delivery of the other Trust strategic priorities.

For a list of all the publication Titles please contact the Research and Development Department on 02476 966196

4.4 Goals Agreed with Commissioners

A proportion of UHCW's income in 2010/2011 was conditional on achieving quality improvement and innovation goals agreed between UHCW, NHS Coventry and NHS Warwickshire. Further details of the goals for 2010/2011 and for the following 12 month period are available on request from, The Quality and Patient Safety Department, University Hospitals Coventry and Warwickshire, 02476 968282.

The agreed goals for 2011/2012 are as below:

CQUIN Goals 2011/2012	
Indicator 1a	National - VTE
Indicator 1b	Chemical Prophylaxis is prescribed
Indicator 2	National - Patient Experience
Indicator 3	Preferred prescribing list
Indicator 4a	Emergency ambulatory care pathways
Indicator 4b	Development of implementation plans for ambulatory care pathways
Indicator 5a	Reducing Harm, Use of Alert Trigger Tool
Indicator 5b	Reducing Harm, Mortality Review
Indicator 6	right bed right time

4.5 Care Quality Commission

UHCW is required to register with the Care Quality Commission and its current registration status is registered without any compliance conditions and licensed to

provide services. The Care Quality Commission has not taken enforcement action against UHCW during 2010/2011.

The CQC completed an unannounced inspection at UHCW on 16th March 2011 around dignity and nutrition for older people. The team of inspectors completed observational reviews on two wards, along with staff and patient interviews. Further supporting documentary evidence to demonstrate assurance was also provided. The CQC were complimentary about the Trust's patient centred care and did not place any actions on the Trust.

UHCW also participated in a further CQC review during March 2011. This was part of an Ofsted Inspection of Coventry City Council's Safeguarding and Looked After Children's Services across Coventry. As part of this Ofsted inspection, CQC inspectors completed a review of UHCW's services, as one of the partner organisations and healthcare providers in the wider Coventry Health Economy.

In January 2011, the Imperial College, London informed the CQC regarding a mortality outlier for "diabetes mellitus without complication". UHCW completed an internal review the results of which were notified to the CQC. The CQC responded to UHCW on 17th February 2011 stating that did not need to undertake any further enquiries at that time.

4.6 Data Quality

Data quality is encompassed within many requirements of the Information Governance Toolkit of which the Trust is meeting the required attainment levels. The data quality team provide regular training to users who collect and record patient data which supports patient care and data submissions.

External data quality reports are reviewed and appropriate actions are taken to address areas of concern. In addition, internal data quality reports and performance dashboards are in place to provide the Trust with an overall view of the quality of data also highlighting areas for improvement.

UHCW submitted records from April 2010 to December 2010 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data: which included the patient's valid NHS number was:

98.8% for admitted patient care;

99.4% for outpatient care; and

96.8% for accident and emergency care

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

100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

4.7 Information Governance Toolkit

UHCW score for 2010/2011 for Information Quality and Records Management assessed using the Information Governance Toolkit was *68%** .

*Version 8 of the Connecting for Health Information Governance Toolkit was released at the end of June 2010 with the consolidation of 62 requirements to 45 more complex requirements, for which evidence must be uploaded onto the toolkit before submission on 31st March 2011. The changes link directly to the NHS Operating Framework (Informatics Planning 2010/2011), which requires that all NHS organisations achieve level 2 in 22 'key' requirements. The Trust has met level 2 in all 22 'key' requirements.

4.8 Clinical Coding Error Rate

UHCW was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission but did commission an external clinical

coding audit of 200 case records and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

NOTE: We have not received the final version of our audit report. We have disputed some elements of it and the incorrect primary diagnosis rate may fall to 10% as a result.

- Primary Diagnoses incorrect 11%
- Secondary Diagnosis incorrect 5%
- Primary Procedures incorrect 4%
- Secondary procedures incorrect 5%

Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees

Coventry Local Involvement Network (LINk)

Warwickshire LINk

Warwickshire Overview and Scrutiny Committee

NHS Coventry and NHS Warwickshire Primary Care Trusts Combined Statement

Providing Feedback on this report

Your Views, Your Involvement

Thank you for taking the time to read UHCW's first Quality Account. We hope you have found it an interesting and enjoyable read. If you would like to comment on any aspect of this Account and give us feedback, please write to:

Communications Office (Quality Accounts)
University Hospitals Coventry and Warwickshire NHS Trust
Clifford Bridge Road
Coventry
CV2 2DX

Please email: communications@uhcw.nhs.uk

Visit www.uhcw.nhs.uk, or www.nhs.co.uk

We look forward to hearing your comments and suggestions.

APPENDIX - Glossary of terms

Acute Trust

A Trust is an NHS organisation responsible for providing a group of healthcare services. An acute Trust provides hospital services (but not mental health hospital services, which are provided by a mental health Trust).

Audit Commission

The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS Trusts, primary care Trusts and strategic health authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service, and, working with the Care Quality Commission, undertakes national value-for-money studies. Visit: www.audit-commission.gov.uk/Pages/default.aspx

Board (of Trust)

The role of the Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.

Care Quality Commission

The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

Clinical Audit

Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clinical Coding

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of coding is an indicator of the accuracy of the patient's health record.

Commissioners

Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary care Trusts are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Commissioning for Quality and Innovation (CQUIN)

High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Discharge

i) Complex

Concerns patients' who have continuing healthcare needs and may have a level of social care need requiring specialist equipment to support them in a community environment

ii) Simple

Concerns patients' discharge into the community or home utilising access to intermediate care services, restarting short term packages of care and accessing rehabilitation facilitates in the community.

Health Act

An Act of Parliament is a law, enforced in all areas of the UK where it is applicable. The Health Act 2009 received Royal Assent on 12 November 2009.

Healthcare

Healthcare includes all forms of healthcare provided for individuals, whether relating to physical or mental health, and includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, for example cosmetic surgery. .

High Quality Care for All

High Quality Care for All, published in June 2008, was the final report of the NHS Next Stage Review, a year-long process led by Lord Darzi, a respected and renowned surgeon, and around 2000 frontline staff, which involved 60,000 NHS staff, patients, stakeholders and members of the public.

Local Involvement Networks (LINks)

Local Involvement Networks (LINks) are made up of individuals and community groups which work together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. LINks also have powers to help with the tasks and to make sure changes happen.

National Patient Safety Agency (NPSA)

The National Patient Safety Agency is an arm's-length body of the Department of Health, responsible for promoting patient safety wherever the NHS provides care.

National Patient Surveys

The National Patient Survey Programme, coordinated by the Care Quality Commission, gathers feedback from patients on different aspects of their experience of recently received care, across a variety of services/settings. Visit: www.cqc.org.uk/usingcareservices/ healthcare/patientsurveys.cfm

National research Ethics Service

The National Research Ethics Service is part of the National Patient Safety Agency. It provides a robust ethical review of clinical trials to protect the safety, dignity and well-being of research participants as well as ensure through the delivery of a professional service that it is also able to promote and facilitate ethical research within the NHS.

NHS Choices

A website for the public for all information on the NHS.

NHS Next Stage Review

A review led by Lord Darzi. This was primarily a locally led process, with clinical visions published by each region of the NHS in May 2008 and a national enabling report, *High Quality Care for All*, published in June 2008.

Overview and Scrutiny Committees

Since January 2003, every local authority with responsibilities for social services (150 in all) have had the power to scrutinise local health services. Overview and scrutiny committees 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. .

Periodic reviews

Periodic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term 'review' refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/10.cfm

Primary Care Trust

A primary care Trust is an NHS organisation responsible for improving the health of local people, developing services provided by local GPs and their teams (called primary care) and making sure that other appropriate health services are in place to meet local people's needs.

Registration

From April 2009, every NHS Trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC). In 2009/10, the CQC is registering Trusts on the basis of their performance in infection control.

Research

Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Secondary Uses Service

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

Special Review

A special review is a review carried out by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social

care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national-level findings based on the CQC's research.

Strategic Health Authorities

Strategic Health Authorities (SHAs) were created by the Government in 2002 to manage the local NHS on behalf of the Secretary of State. SHAs manage the NHS locally and are a key link between the Department of Health and the NHS

SHAs (there are ten in total) are responsible for:

- developing plans for improving health services in their local area;
- making sure that local health services are of a high quality and are performing well;
- increasing the capacity of local health services – so they can provide more services; and
- Making sure those national priorities – for example, programmes for improving cancer services – are integrated into local health service plans.

Glossary courtesy of Department of Health, Quality Accounts toolkit, advisory guidance for providers of NHS Services producing Quality Accounts for the year 2009/2010

South Warwickshire NHS
NHS Foundation Trust

South Warwickshire NHS Foundation Trust

Annual Report 2010/11

Contents

About the Trust
Chairman's Statement
Chief Executive's Statement

SECTION 1 - PAGES 6 - 31:
Directors' Report (Incorporating the Operating Financial Review)

- Corporate Strategy
- Trust Service Profile
- Review of Trust's 2010/11 Objectives
- 2011/12 Objectives
- Operational Performance Review
- Key Relationships
- Financial Performance Review
- Patient Safety and Risk Management
- Key Developments in 2010/11
- Listening and Learning
- Valuing and Developing Staff
- Environment and Sustainability

SECTION 2 - PAGES 32 - 41:
Council of Governors and Membership

- Council of Governors Structure
- Governor Profiles and Register of Interests
- Meetings of the Council of Governors
- Sub-Committees of the Council of Governors
- Trust Membership
- Membership and Engagement Strategy
- Changes to Governance Arrangements

SECTION 3 - PAGES 42 - 55:
Board of Directors

- Appointments and Roles
- Board Profiles and Register of Interests
- Executive Structure
- Board Statements
- Board Committees
- Board and Committee Membership
- Directors' Remuneration and Pension Benefits

SECTION 4 - PAGES 56 - 91:
Quality Report

Part 1: Statement on Quality
Part 2: Priorities for Improvement and Assurance Statements
Part 3: Review of Quality Performance

SECTION 5 - PAGES 92 - 97:
Statement of Accounting Officer's Responsibilities and Statement on Internal Control

SECTION 6 - PAGES 98 - 103:
Summary Financial Statements & Auditor's Statement

About the Trust

This annual report covers a twelve month period ending 31 March 2011, the first full year as a Foundation Trust. The Trust was authorised as a Foundation Trust on 1 March 2010 by Monitor, Independent Regulator for Foundation Trusts.

On 1 April 2011, Warwickshire Community Health transferred to South Warwickshire NHS Foundation Trust from NHS Warwickshire (from the 1 April 2011 they are now referred to as Warwickshire Community Services, a division of the Trust) therefore in next year's annual report the Trust will be reporting on community services across Warwickshire as well as the services below.

The services provided during the period 1 April 2010 – 31 March 2011 were from two hospital sites, Warwick and Stratford-upon-Avon.

Warwick Hospital houses the majority of the Trust's Acute Services including; Accident and Emergency services, Medical and Surgical admissions wards, Diagnostic and Pathology departments, Maternity and SCBU (Special Care Baby Unit), Main and Day Surgery Theatres together with an Intensive Care Unit and Coronary Care Unit.

Stratford-upon-Avon Hospital is a community hospital and services are provided from a Minor Injuries Unit, Outpatients department, Radiology department and an immediate care ward. Therapy services are also available at this hospital.

Vision

"Our vision is to provide high quality, clinically and cost effective NHS healthcare services that meet the needs of our patients and the population that we serve."

Values

This is supported by the Trust's values which are:

1. The care and safety of patients is our first priority and we will focus on patients' needs and preferences in every aspect of service delivery.
2. We will provide care in comfortable, clean surroundings using effective techniques and technology delivered by experienced and capable staff.
3. We are committed to the highest standards of probity and accountability in the conduct of our public duties.
4. We want our staff to feel pride in and satisfaction from their work and to work as part of an effective team in a safe environment.
5. We aspire to excellence through an open and supportive culture that enables people to perform at their best, and that promotes innovation and individual and collective learning.
6. We will engage constructively with Governors, Members, partner organisations and stakeholders to develop seamless, cost-effective services that respond to public priorities.

Chairman's Message

This Annual Report looks back over our first full year as South Warwickshire NHS Foundation Trust, and it provides a comprehensive record of the Trust's achievements and developments in the year. I am proud to present this report, and I commend it to all who take an interest in our services.

The past year has seen emerging structural change and growing financial pressure across the NHS, and the exceptionally severe winter presented additional challenges. Against this background the Trust maintained its full range of services, delivered notable improvements in several areas and continued to invest in the future. This performance reflects the outstanding work of our executive team, led by Glen Burley, and the skills and dedication of our staff across the organisation. I thank all our staff for their hard work and loyalty, and congratulate them on another very successful year.

Our non-executive directors bring independence and a range of special expertise to the governance of the Trust, and I would like to thank them for their support and for their distinctive contribution to the work of the Board.

The essence of foundation trust status is that the organisation is accountable to the community it serves, rather than to the regional and national hierarchy of the NHS. The Trust has made progress in translating this principle into a reality, through the operation of its new constitutional structure. At the heart of this structure is the Council of Governors, comprising representatives of Staff and Public Members as well as of key local bodies. I would like to congratulate the Governors on the conscientious and enthusiastic way they have entered into their role – scrutinising the performance of the Trust and holding the Board of Directors to account.

The Trust has communicated regularly with its Members and welcomed feedback from them on its progress and plans. A highlight early in the year was the first Annual Meeting of the foundation trust, held in Stratford, attended by around two hundred Members and others. Subsequently the Governors have been instrumental in arranging public meetings in various locations around the area, with presentations on clinical or organisational topics and opportunities to take questions and first-hand comments from Members.

The engagement of the Trust with Governors and Members is both stimulating and challenging, but we are still learning how best to exercise these relationships to promote the success of the Trust for the benefit of the community. I am encouraged that our experience to date shows all parties are committed to the same ends.

With the acquisition of Warwickshire Community Services at the end of the year we welcome its 1,500 staff to the Trust, and we look forward to engaging with new Members and Governors of the foundation trust from the additional districts we now serve.

The Hospital Patients Forum has continued its work of reviewing and inspecting aspects of the Trust's services, as an independent group of 'expert patients'. The Trust places great value on their feedback and suggestions.

The Trust and its patients continue to benefit from the efforts of local fund-raisers and the generosity of donors. At the beginning of the year we opened the Helen Clark Breast Unit, and the superb quality of this new facility owes much to the contributions of our supporters. I would like to pay particular tribute to the splendid work of the respective Leagues of Friends of Warwick and Stratford Hospitals, who raise funds year-in year-out and fund a great variety of large and small items for the benefit of patients.

The generosity of members of our community is also marked by the many volunteers who give their time in our hospitals, assisting and supporting patients and visitors. Their work makes a real difference to people's experience of our hospitals, and it is greatly appreciated.

The immediate outlook for the NHS holds uncertainty, radical change and severe financial constraint, but the Trust faces these challenges with determination and confidence.

Graham Murrell
Chairman

Chief Executive's Message

It is very pleasing to report on another very successful year for the Trust. Whilst this was our first year as a foundation trust, importantly we did not rest on our laurels and have continued to press ahead with developing and improving services and, equally importantly at this time, taking steps to improve our productivity.

If I was to reflect on some of the positive things during the year, I would certainly point to the very strong performance to further reduce healthcare acquired infections, the delivery of the A&E waiting times target and finally the excellent performance of the Trust in the staff, inpatient and national cancer surveys.

Our approach to improving productivity has been spearheaded by our quality assurance strategy which is to delivery the right care at the right time in the right place. As a consequence we have speeded up assessment and diagnostics and in this latter area, it was incredibly encouraging for the Trust to gain a highly commended award in the National Health Service Journal Patient Safety Awards. Our Acute Flows project is now attracting national attention and whilst there is still further work to be done, we have certainly proved with some of the projects so far that improvements can be made without increasing our cost base. We have also delivered on one of the most significant investments in recent years in the hospital through the upgrading of the main components of our Radiology Department. Our new MRI and CT scanners are the envy of other hospitals and I am sure will help us to deliver faster care and more accurate diagnostics for years to come.

Finally as we move into the next few years of financial challenge for the NHS, it is extremely gratifying that we have yet again delivered against our financial targets and have been able to make further repayments against our working capital loan. We now owe less than £3m of the original £18.5m borrowing which puts us in a strong position to continue to flourish over the next few years.

As I mentioned at the start, we have not rested on our laurels in anyway in this first year as foundation trust and perhaps the best example of this has been the successful completion of the acquisition of Warwickshire Community Services. This has added significantly to our viability and provides a great opportunity for us to improve care and patient experience as we will closely join up hospital, community and primary care services. The Senior Team in the Trust put considerable effort into this acquisition and I would like to thank them for completing this so professionally whilst continuing to deliver high quality care to our patients.

Over recent weeks we have held a number of Membership events which have helped to reinforce the value of being a member based organisation. The feedback, support and encouragement from our members provides great impetuous for the Trust to continue to go from strength to strength.

Glen Burley
Chief Executive

/ / 2011

SECTION 1:

Directors' Report

(Incorporating the Operating Financial Review)

Directors' Statements

The Directors have confirmed that so far as they are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware, and all Directors have taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditors is aware of that information.

This review is to present the Board of Directors' analysis of the Trust's business, for the year ending 31 March 2011. This analysis reviews the key events and performance of the year. It also looks forward to key developments and progress planned for the coming year. Included in this Report is the Trust's Quality Report (Section 4, starting on page 56) which will provide a more in-depth look at the Trust's quality objectives this year and next.

Full details of the individuals who were Directors of the Trust during 2010/11 are:

Glen Burley – Chief Executive	**Graham Murrell** – Chairman
David Moon – Director of Finance	**Tony Boorman** - Non-Executive Director
Jayne Blacklay – Director of Development	**Alan Harrison** – Non-Executive Director
Dr Steve Mather – Medical Director	**Veronica Cotterill** – Non-Executive Director
Jane Ives – Director of Operations and Nursing (until 31 Dec 2010), Director of Operations (from 1 January 2011)	**Diane Colley** - Non-Executive Director
Helen Walton - Director of Nursing (from 1 January 2011)	**Dr David Derbyshire** - Non-Executive Director

Please note there will be a new Medical Director from 1 April 2011, Professor Ian Philp.
Full information on terms served, profiles and roles can be found in section 3, pages 44-46.

Corporate Strategy

Following the transfer of Warwickshire Community Health on 1 April 2011 the Trust will now move forward with the integration of acute and community services. The Trust's strategy is to continue to develop specialist services to meet the needs of our population in a range of settings. The Trust will focus in on patient safety and patient experience to fully maximise the opportunities available through patient choice.

Corporate Priorities – More detail about actions to achieve the following priorities can be found on page 11.

Maintaining and Improving Productivity – The Trust aims to maintain high levels of elective productivity in the future, through consultant delivered care. We will also continue to work to redesigned emergency care pathways to maximise productivity and quality.

Focus on quality – The Trust continues to place quality as the top priority moving into 2011/12 and more information on this can be found in our key objectives on page 11.

Use of technology – The Trust has committed to using technology to improve quality and speed up the care process. Projects to be implemented next year include e-rostering, which will enable the trust to plan workforce resources in a more efficient way. A technology project that was implemented during 2010/11 was 'Hospital Heartbeat'. This uses mobile devices to support the redesigned emergency care pathway. More information on this can be found in the development section on pages 18-19.

Developing an integrated service – The acquisition of Warwickshire Community Health on 1 April 2011 provides the perfect vehicle to realise the Trust's vision to provide the right care, in the right place at the right time. The provision of community services in the north of the county brings a new dimension to this challenge and creates a greater need to collaborate with other local acute providers to realise the strategic aim of vertical integration across Warwickshire.

Developing our workforce – The Trust aims for staff to feel supported, encouraged and valued, which will be demonstrated by their commitment to the Trust. More information on plans for the future can be found in our developing and valuing staff section, on pages 22-26.

The Trust believes that the Foundation Trust model provides a real opportunity for the organisation to continue to develop and deliver our strategic goals and to provide services that meet the needs of our population. The Trust will need to continue to make efficiency savings without compromising on the quality of our services and will do this in partnership with clinical staff and local GPs

Commissioning for Quality and Innovation (CQUIN)

Similar to last year the Trust will agree a number of CQUIN schemes with NHS Warwickshire (PCT) in 2011/12 more information is outlined in our Quality Report (page 62).

Trust Service Profile

During this period South Warwickshire NHS Foundation Trust was a major supplier of acute services in South Warwickshire serving a population of approximately 270,000. In the future the Trust will not only continue to be a major supplier of acute services in South Warwickshire but will also provide the majority of community services across the whole of Warwickshire to a population of approximately 535,000.

During the period 1 April 2010 – 31 March 2011, the Trust provided services from two hospitals as shown below:

Warwick Hospital	Stratford Hospital
A&E, Emergency medicine, Emergency surgery, Trauma, Paediatrics, Haematology.	Minor Injuries Unit operated by the Trust from 1 February 2010. It was managed by NHS Warwickshire for the other part of the accounting year.
Clinical specialities: General surgery, Urology, Breast surgery, Colorectal surgery, Orthopaedic surgery, ENT surgery, Ophthalmology, Gynaecology, Endoscopy	**Clinical specialities:** (local anaesthetic surgery unit), General surgery, Dermatology, Plastic surgery, Orthopaedics Intermediate care delivered through the Nicol Unit.
Outpatient services: General surgery, Urology, Breast Surgery, Colorectal, Trauma and Orthopaedics, ENT, Ophthalmology, Oral surgery, Orthodontics, Plastics surgery, Anaesthetics and Pain, General Medicine, Gastroenterology, Endocrinology, Clinical Haematology, Diabetic Medicine, Cardiology, Dermatology, Thoracic Medicine, Rheumatology, Paediatrics, Geriatric Medicine, Gynaecology, Clinical Oncology, Neurosurgery (visiting from UHCW), Renal Medicine (visiting from UHCW), Neurology (visiting from UHCW)	**Outpatient services:** General surgery, Colorectal, Dermatology, Orthopaedics, Plastics surgery, Diabetic Medicine, ENT, Gynaecology, Paediatrics, Urology, Clinical Haematology, Oral Surgery, Orthodontics, Ophthalmology, Rheumatology **Ellen Badger Hospital (Shipston on Stour) outreach clinics** Orthopaedics, ENT, Paediatrics, Urology
Obstetrics and Neonatal, Anaesthetics	Genito-Urinary Medicine, Radiology
Genito-Urinary Medicine. Radiology	Therapy Services
Pathology	
Therapy Services	

From 1 April 2011 the Trust will continue to provide the services above together with community services across Warwickshire including:

- **Acute Care Closer to Home -** Community Wards, District Nursing, Intermediate Care, Muscat and Virtual Ward.
- **Long term care –** Podiatry, Community Matrons, Continence Services, Dietetics, District Nursing, Occupational Therapy Physiotherapy and Tissue Viability.
- **Rehabilitation -** Community Wards, District Nursing, Occupational Therapy, Physiotherapy, Rehabilitation, Speech and Language Therapy, Wheelchair Service and Neuro. Rehabilitation.
- **End of life care -** Palliative Care (Macmillan)
- **Children's services -** Health Visiting, Child Development Services, Safeguarding Children, Child Health Services, Child Immunisation Services, Children's Community Nursing Services, School Nursing Services, Community contraceptive service and sexual health, Family Nurse Partnership, Community Paediatrician and Birth to Three Portage Service.

The Trust will provide these services from a range of clinics across Warwickshire and will also operate from two additional hospitals, Royal Leamington Spa Rehabilitation Hospital and Ellen Badger Hospital.

Review of Trust's 2010/11 Objectives

Each year the Trust sets a number of key objectives based on local and national priorities. The table below shows what these were for 2010/11 and demonstrates the progress that the Trust made against them. Many of the areas identified will continue to be priorities for the future years consistent with the Trust's overall vision and strategy. The objectives set by Trust Board for the following year (2011/12) can be found on page 11. In addition to the following objectives the Board, through consultation with key stakeholders, have set a number of quality objectives and more information on these can be found in the Quality Report starting on page 56.

Objective	Progress
Deliver Safer Care **Achieved**	• Infection Prevention Board monitored the delivery of improvements which also included the implementation of MRSA screening for all admissions before the national deadline of 31/12/10. • The Trust met both the contractual MRSA target and the Monitor target. • The Trust also comfortably achieved the contractual stretch target for C Diff reduction and the Monitor Compliance Framework target. • Executive Director patient safety walk-rounds took place throughout the year and were a very effective tool in delivering continuous quality improvement. • The monthly performance scorecard demonstrated improvements against nurse care indicators. • Arrangements are now in place for Venous Thromboembolism (VTE) assessments and associated evidence gathering but these were only able to demonstrate adequate assurance later in the year. • Falls and pressure sore reductions remain a priority but our plans to significantly reduce these were not met. A number of these areas were tracked through CQUIN target measurement. • Mortality rates fell during the year on both a risk adjusted and absolute measure.
Deliver care at the right time in the right place **Achieved**	• A&E delivery plan approved and monitored by the Board. Target reduction ensured ongoing compliance. Target met in all 4 quarters with 96.44% being met overall for the year. • The Health Foundation project is now part of a wider bed reduction plan. Improvements to turn-around times in Blood Sciences were most notable with the Trust team being "highly commended" in the National Patient Safety Awards. • Work is still ongoing regarding improvements in radiology turnaround times but the departmental upgrade has now been completed. • Many process changes have been implemented in A&E and the Medical Assessment Unit with the latter using new technology to speed-up processes. • Further work required to adjust medical staffing profiles in A&E
Improve patient's privacy and dignity **Achieved**	• Met Trust deadline of compliance with single-sex directive by 1 August 2010. Compliance since that date has been satisfactory. Most significant non-compliance linked to Medical Assessment Unit occupancy. • Capital schemes delivered on time with excellent results. • Staff awareness much improved and reporting and monitoring mechanisms in place. • The Trust have declared compliance against new standard from 1 April 2011. • Significant improvements noted in national inpatient survey.

Review of Trust's 2010/11 Objectives [continued]

Listen and respond to Patients and Members **Partly Achieved**	• Some reductions in rescheduled appointments reported but not sufficient to meet internal stretch improvement target. • Concentration now on multiple cancellations as these are the main cause of patient dissatisfaction. • National inpatient survey results were good as were the results in the national cancer survey. • National maternity survey also produced encouraging results for the Trust.
Create the capacity required to deliver our services **Partly Achieved**	• Occupancy still remains higher than target mainly as a result of increases in admissions – inparticular admissions in the final quater were high. • Business plans regarding maternity expansion plan and changes to A&E layout. • Productive Ward roll-out plan experienced some slippage.
Develop our workforce **Achieved**	• Positive progress on recruitment of nursing staff in identified areas. • Review of nurse staffing levels completed and implemented. • Improvements in bank fill rates. • Middle management development programme effective. • Transforming Community Services staff engagement work replaced internal plan. • Excellent results in national staff survey, particularly regarding standards of care delivered, staffing levels and quality of appraisal.
Assure the Trust is well governed **Achieved**	• The Trust was 'Green' on the compliance Framework measures throughout the year. • 2009/10 Quality Accounts produced and plans formulated for 2010/11. • Performance dashboard showing signs of improvement against local standards. • Council of Governors are working effectively including positive engagement in the Trust's strategy refresh. • Progress slow on Service Line reporting, tariff changes and TCS had a major impact on cost and income structures. • Organisational structure now under review to maximise integration benefits.
Improve the integration of patient care across hospital and community settings **Achieved**	• Transaction completed to plan. Project plan ensured smooth process through due diligence, Competition & Co-operation Panel approval, PCT approval, Strategic Health Authority approval and Monitor assessment. • TUPE process managed effectively in collaboration with PCT with effective resultant transfer of 1,670 staff. Welcome pack distributed to all new staff on 31st March following Board approval.

2011/12 Objectives

Objective	Actions
Continue to improve the quality of our services	• Reduce the number of outpatient appointments rescheduled at the request of the hospital to 9% • Increase the capacity and improve the quality of the accommodation in the Special Care Baby Unit to support the development of Maternity Services • Reduce the number of falls within hospital by 10% as part of the continued implementation of the Patient Safety Programme • Monitor organisational quality improvement through the development of new Board-level measures
Improve efficiency to maintain financial performance and sustainability	• Reduce emergency occupied bed days to enable 20 beds to be closed by October 2011 • Monitor organisational productivity through the development of new Board-level measures • Integrate corporate functions of the acute and community services to deliver recurrent savings • By the end of the financial year agree an estate strategy that efficiently supports acute and community services and their development for the next three years
Equip ourselves for the future	• Provide a modern and effective Theatre complex which is able to support the provision and future development of surgical services • Implement alternative technology based solutions to achieve the efficiency gain as described in the business cases in the 3 key areas of; document management, workforce management and risk management • Develop and implement a solution for improving work flow and data capture within community services
Develop an integrated Hospital and Community Service to ensure that patients are treated in the right place at the right time	• Develop and implement a comprehensive change programme to deliver cost effective patient pathways across hospital and community services • Develop and implement the 'Cutting the Cost of Frailty' programme to reduce admissions to the acute hospital
Develop our workforce to be fit for the future	• To develop and deliver a staff engagement programme to support the transformation and integration of acute and community services • Review and harmonise key policies and procedures across acute and community services • Review and implement a new clinical leadership structure that will increase management accountability for clinical leaders

Operational Performance Review

Care Quality Commission

South Warwickshire NHS Foundation Trust is required to register with the Care Quality Commission. The Trust declared full compliance on 10 January 2010 against the Health and Social Care Act 2008 Regulations, which came into effect 1 April 2010. The CQC analysed our submission the current registration status is 'registered without conditions'. The Care Quality Commission has not taken enforcement action against South Warwickshire NHS Foundation Trust during 2010-11.

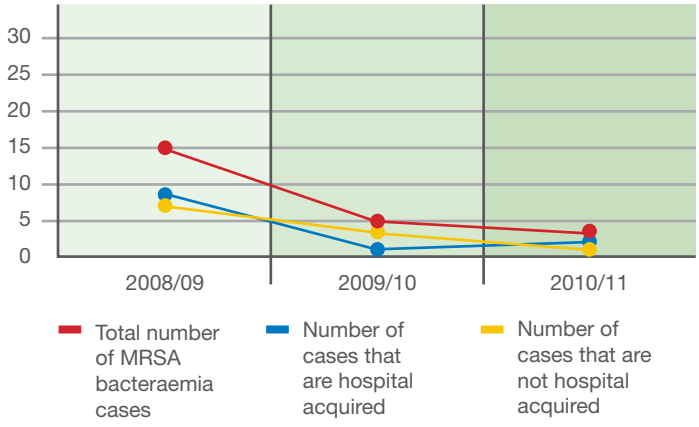
South Warwickshire NHS Foundation Trust has participated in one special review by the Care Quality Commission during 2010-11 which related to 'Dignity and Nutrition for Older People'. The report for this review had not been issued by the end of the reporting period therefore any actions taken to address the conclusions or requirements reported will be included in next year's quality account.

Trust Performance against National Targets

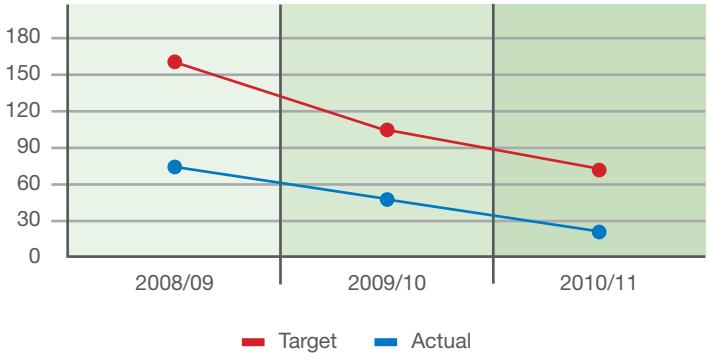
18 Weeks target	**Achieved** – Admitted: 89.6% (target 90%) Non-Admitted: 96% (target 95%)
A&E target	**Achieved** – The Trust achieved the target of treating, admitting or discharging 95% of A&E patients within four hours of arriving at the hospital. The Trust actually achieved 96.4% against the national A&E target.
31-Day 'Diagnosis to treatment' target for patients with diagnosed cancer	**Achieved** – 99.3% of patients started treatment for cancer within 31 days of diagnosis (target 96%)
62-Day 'Referral to treatment' target for patients with suspected cancer	**Achieved** – 86.3% of patients started treatment for cancer within 62 days of referral from GP (target 85%)
Reduction in C.Difficile cases	**Achieved** – The Trust had 27 C.difficile cases this year against a national target of 75 and an internal target of 40.
Reduction in hospital acquired MRSA cases	**Achieved** – The Trust had 3 MRSA bacteraemia cases reported in this period.

Infection Prevention and Control

Hospital acquired MRSA cases



Number of C.difficile cases



Please note: *The target for 2007/08 was locally set, however for subsequent years it was set nationally.*

More information on the Trusts performance in reducing Health Care Acquired Infections (HCAI) can be found in the Quality Report (Section 4 – Pages 56).

Activity for the Trust over the last three years

Activity	2010/11	2009/10	2008/09
A&E Attendance	57,463	52,415	51,596
First Outpatient Attendances	66,617	63,305	56,494
Follow-up Outpatients Attendances	139,562	134,012	119,636
Non-elective (Emergency) Admissions	30,639	26,108	24,376
Elective (Planned) Inpatient Admissions	4,622	4,778	4,790
Elective (Planned) Day Cases	22,351	22,119	19,209
Births	2,898	2,732	2,699

The Outpatient numbers above don't include Physiotherapy, Occupational therapy and Dietetics, however these numbers are shown below:

Activity	2010/11
Therapy – First Outpatient Attendance	13,231
Therapy - Follow-up Outpatient Attendances	35,565

Monitor's risk rating for the Trust

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	3	4	4	3	3
Governance Risk Rating	Green	Green	Green	Green	Green

*** [Level 5 would demonstrate the lowest risk]**

Trends and Factors affecting the Trust

The Trust has seen an increase in the number of people choosing to give birth at Warwick Hospital, particularly from immediate surrounding areas, including Solihull. The Trust has put plans in place to speed up care and reduce the number of hospital beds by 20 in 2011/12 and to reallocate this space to expand the Special Care Baby Unit and Maternity Department.

In October 2010, NHS Warwickshire (PCT) implemented a scheme called 'Fast, slow, stop' aimed at reducing their costs and improving their financial position. This meant that a number of orthopaedic cases were put on hold (slow) by the PCT until 1 April 2011. This reduced activity levels for elective orthopaedic cases, however this work will be undertaken in the new financial year 2011/12 and therefore the anticipation is that activity levels in elective orthopaedics in particular will rise. The Trust will continue to work closely with NHS Warwickshire to ensure that patients are still treated within 18weeks of their referral to the hospital.

The population of Warwickshire is 535,000 (mid year estimates 2009) and the County has a rapidly ageing population. The over 65 population level is currently 17.3% compared to 16.2% nationally. The rate of growth increases with age, with the eldest group (aged 85 and over) projected to increase by 194% by 2033. This trend is reflected across all the districts and boroughs in Warwickshire. To limit the affects of this trend Professor Ian Philp, Medical Director from 1 April 2011, will be implementing a 'cutting the cost of frailty' programme. This is aimed at preventing acute admissions by providing more preventative care in the community and to speed up discharge. It also aims to allow people to live as independently as possible at home through to end of life.

As we will be providing services to the North of Warwickshire the Trust must be aware that not only is there a rapidly ageing population but that this is compounded by high levels of deprivation. These factors mean that many people need support with long term conditions.

Serious Untoward Incidents (SUIs)

The Trust reported 67 SUIs in 2010/11 which is double the level reported the previous year. However, the increase relates to our requirement to report a wider range of incidents than previously. The Trust does however encourage staff to report incidents and have used these as opportunities to learn and make improvements.

Information Governance

The Information Governance Toolkit sets out 45 standards for information governance within all NHS organisations. For the 2010/11 submission the Trust achieved a score of 69% compliance with the toolkit, which is inline with scores reported nationally.

Monitor has stated that Foundation Trusts should be working towards achieving level 2 against 22 key standards within the toolkit and the Trust met or exceeded level 2 in 20 out of the 22.

Of the 2 standards currently below level 2 work is already underway to ensure that these will be at level 2 by the March 2012 submission.

Information Governance Successes

Freedom of Information - The Trust received 195 Freedom of Information requests during the year and to date the Trust has met and responded to all 195 within the statutory 20 working day deadline. The Trust has not received any complaints regarding its handling of FOI's during the same period.

Training – The Trust is pleased that it has had its own local IG training course approved by Connecting for Health, something which very few Trust around the country have achieved.

Port shutdown - The Trust successfully implemented Sophos port shutdown software, which ensures that only encrypted or approved devices are able to connect to PC's within the Trust.

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2010/11

Category	Nature of Incident	Total
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	0

Department of Health guidance states that incidents relating to an actual or potential breach of confidentiality involving person identifiable data, including data loss should be considered as a serious incident (SI) and graded 0-5. Level 0 incidents are not required to be reported externally. Level 1 and 2 incidents are reported as statistics and the following table details 3 low level incidents the Trust reported in 2010/11. The Trust is pleased to report that it has had no level 3 – 5 SI's during 2010/11 and is maintaining a very low level of IG incidents overall.

Key Relationships

West Midlands Strategic Health Authority were one of the first areas to implement cluster arrangements across primary care trusts in preparation for the changes being made to the NHS, ensuring resilience through the transition period. The Arden Cluster (Warwickshire and Coventry) was formed last year and the Trust has worked closely with the leadership teams in all of the local health and social care bodies and will continue to strengthen these relationship moving into the future.

There are a number of examples of effective partnership working across the health economy including the now well established Pathology Network.

The Trust has strong relationships with local GPs in South Warwickshire and meet regulary with them to discuss future partnership working in 2011/12. The Trust will work to strengthen these relationships with GPs in North Warwickshire and Rugby to ensure that the Trust continues to improve community services across Warwickshire.

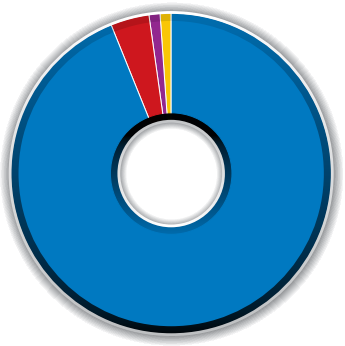
The Trust recognises that financial constraints will present a challenge next year, however feel that this will also present opportunities to further the aim of vertical integration by treating patients in the most appropriate setting at the optimal cost in partnership with key stakeholders.

Financial Performance Review

The Trust earned £137m income in 2010/11. Of this, £124m relates to income from activities from Primary Care Trust's. The Trust has again performed well financially delivering a £2.167m surplus (adding back impairments as per national guidance). The surplus was broadly in line with the Trust's original financial plan and while there was some over-performance in the year, this was partly offset by some additional expenditure.

94% of the Trust's direct patient income from activities was earned from NHS Warwickshire, see below:

% Income by Source 2010/11:

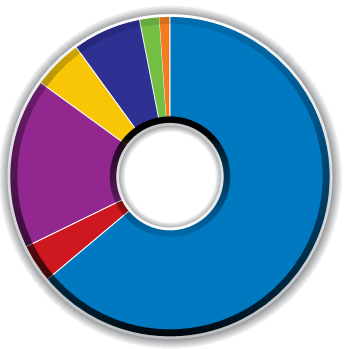


Note The analysis includes Market Forces Factor – linked to the appropriate Primary Care Trust

Operating Expenditure

The Trust has again largely delivered its cost improvement target for the year of £4.5 m. Operating expenditure amounted to £133m and is analysed across the Trust's operational groups shown below:

Operating Expenses 2010/11:



Capital Expenditure

During 2010/11 the Trust had a total allocation of £7.696m for capital expenditure and the total spend during this period was £6.234 with £1.233m carried forward to 2011/12. More information on the schemes completed during this period can be found on pages 18 and 19.

In 2011/12 the Trust is planning to spend £6.833m on capital schemes. This figure includes £1.233m carried forward from the previous year. The majority of this funding is allocated to the refurbishment of the main operating theatres due to start in June 2011.

Loan Repayment and Cash Management

In March 2007 the Trust Board approved a working capital loan of £18.5m. The loan enabled the Trust to re-finance itself after three years of significant deficits, enabling sufficient working capital for the Trust to move forward. The terms of the loan were that the Trust had to repay the principle in eight years out of surpluses. The outstanding balance on the loan also attracts an interest charge of 5.35%.

For the third consecutive year, the Trust has been able to make additional in year loan repayments following approval by the Board. In 2010/11 the total loan repayment equates to £2.106m which was £1.145m more than planned in line with the remaining terms of the loan as at 31 March 2010. The Trust has now repaid a total of £15.8m off the loan in the last four years significantly ahead of profile.

As an NHS Foundation Trust there is more flexibility in investing short-term to increase returns and to this end the Trust has an investment policy which is aimed at ensuring that any investment is done so at minimum risk. While the cash balances remains healthy, due to the significant reductions in interest rates over the last 12 months interest receivable has fallen from a high in 2007/08 (£1m) to only £114k in 2010/11. However, this has increased from £51k in 2009/10.

Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost of the NHS body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

Financial Viability

The Tariff uplift for 2011/12 is -1.5% with an assumed level of Pay and Price Inflation of 2.5% offset by an assumed level of efficiency of -4.0%. The economic environment is becoming much harder and the Operating Framework seems to have passed even more of the challenge onto Acute Trusts by the Payment by Results and contracting rules put in place for 2011/12. The contracting rules now mean that the Trust can be fined for a variety of issues. It will not be possible for any Trust to "grow" itself into financial balance and cost savings have to be real moving forward. The Trust embarked on a three year project funded by the Health Foundation which is looking at the links between improving quality and reducing cost. We have started to implement some of the work streams during 2010/11 which should lead to longer term cost improvements. It will be imperative that these cost improvements are achieved if the Trust is to retain its financial health.

Prompt Payment Code and the Better Payment Practice Code

The Department of Health requires that Trusts pay their non-NHS trade creditors in accordance with the CBI Prompt Payment Code and Government Accounting Rules. The Trust's payment policy is consistent with the CBI Prompt Payment Code and Government Accounting Rules and its measure of compliance is:

	2010/11		2009/10	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	29,704	41,919	29,711	40,831
Total Non-NHS trade invoices paid within target	21,993	32,267	24,570	34,255
Percentage of Non-NHS trade invoices paid within target	74%	77%	83%	84%
Total NHS trade invoices paid within target	594	10,895	551	11,525
Total NHS trade invoices paid within target	459	9,772	426	9,350
Percentage of NHS trade invoices paid within target	77%	90%	77%	81%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of the receipt of goods or valid invoice, whichever is later. In March 2010 the Trust signed up to the Prompt Payment Code where the Trust will try and ensure that all suppliers are paid within agreed terms.

The Directors can confirm that they have a reasonable expectation that SWFT has adequate resources to continue in operational existence for the foreseeable future, therefore the Board of Directors continue to adopt the 'going concern' basis in preparing the accounts.

Patient Safety & Risk Management

The Patient Safety Group has continued through 2010/11 and this group co-ordinates, supports and monitors the implementation of the work-streams associated with the Leading Improvement in Patient Safety Programme (LIPPS). The group also monitors the implementation of patient safety alerts and provides assurance to the Clinical Governance Committee.

The Executive Walkrounds continue to form one of the key mechanisms to encourage an open and honest communication channel with staff. The Board of Directors have regular presentations that are delivered by staff about patient stories. The Trust has seen a 100% increase in the number of serious untoward incidents reported which is important for a learning organisation that is always striving to continuously improve.

The Trust continues to use the World Health Organisation (WHO) Safer surgery checklist to improve patient safety. More information on Patient Safety can be found in our Quality Report on pages 66-71.

An example of good practice is the bloods team work that the Trust was highly commended in the National Patient Safety Award. This award recognised the work undertaken by the Trust to improve patient diagnostics by speeding up blood test results.

The Trust has been part of a national Health Foundation funded project and as part of this work an issue was identified with turnaround times for blood results. It was found that results were not returned to the ward in time for doctors that day to include them in consideration of best care. A 'bloods team' was established and included staff from across the Trust. Key members of the team included porters, phlebotomists, nurses and members of the pathology lab. Together this team made a number of changes to the process which had a dramatic effect on performance. Previously approximately 15% of blood results were available to support ward rounds on the same day and since these changes this is now over 80%, resulting in safer patient care.

Emergency Planning

The prime focus of Emergency Planning during the past year has continued to be the management of a pandemic flu outbreak. The winter saw a rise in cases but this year, a pandemic was not declared. Locally, there were more cases and a higher number of hospital admissions. The Pandemic Flu Plan was tested, with business continuity plans and proved fit for purpose.

An annual review of the Major Incident Plan took place in July 2010. The Business Continuity Policy and Pandemic Flu Plan are currently being updated from this exercise. There have also been a number of other training exercises this year including a communications test and a table-top exercise held in April 2011. There has also been training for on-call managers and Executives during 2010/11.

NHS Litigation Authority Risk Management Standards

The Trust achieved level 2 with the NHS Litigation Authority Risk Management Standards in November 2008 and is aiming to raise this to level 3 at its next assessment in November 2011.

Clinical Negligence Schemes for Trusts (CNST)

The Trust also gained level 2 for the CNST Maternity Risk Management standards, (the first in the West Midlands to achieve this level) and plans to go forward for level 3 in 2012.

Key Developments in 2010/11

Acute Flow Project

Over the past 12 months, the Trust has been working in partnership with the Health Foundation on an Acute Flow Programme to improve emergency patient flow through the Trust and thereby raise the quality of our patients' outcomes and experiences.

On 1 November 2010 we launched a new emergency assessment process designed to deliver safer, more timely patient care by reducing how long it takes to complete emergency patients' assessments and diagnostics and by providing senior consultant review and decision making within 2 hours of the patient arriving. By removing the unnecessary delays that patients have experienced we are initiating treatment earlier, ensuring patients are admitted to the right team and ward and consequently reducing the length of time patients need to spend in hospital. The new process has delivered a number of benefits for example getting blood results and x-ray results back to the doctor within 2hours when previously it could take up to 1 day.

New Coronary Care Unit and refurbished Malins Ward

The new Coronary Care Unit and refurbished Malins Ward opened in June 2010. These areas are now one unit enabling better quality of care for patients. The bays in the new ward area are closed, supporting the Trust's commitment to single sex accommodation and privacy and dignity standards.

As part of the design an additional 10 telemetry devices (mobile cardiac monitors) were installed. This means that patients can be monitored whilst being mobile aiding a speedy recovery. This enables the patient to participate in gentle exercise can also help the medical team diagnose any other issues before the patient is discharged home.

Expansion to Medical Records Developments

A second storey has been added to the existing medical records facilities at Warwick Hospital to ensure that the Trust has enough storage to cope with the ever expanding medical records library.

New Radiology Department

The Trust has invested £3.6million in the refurbishment of the Radiology department and the replacement of key diagnostic equipment including a new MRI scanner, new CT scanner and a new fluoroscopy machine.

At Warwick Hospital there is now a Titan MRI scanner that is the first of its kind in the UK. Often patients can feel claustrophobic when undergoing an MRI scan, however the new scanner at Warwick Hospital offers more space for patients inside the machine and limits acoustic noise using Toshiba's patented PianissimoTM technology. This means that patients at Warwick Hospital will now have a better imaging experience, especially those with claustrophobia.

The new technology offers many benefits to patients at Warwick Hospital, for example faster imaging for stroke patients and the ability to perform scans to look at blood vessels with or without contrast injection which is useful in patients with renal impairment.

The Medical Team at Warwick Hospital are now able to perform the latest scans in detection and follow up of cancer imaging together with functional scans to look at response to cancer treatments. The scanner is also used to scan bone, cartilage and joints with greater accuracy.

Previously patients who required such an in-depth scan would have had to travel much further, for example to Birmingham, therefore the new technology supports the Trust's vision to provide more care closer to home.

The Trust has also purchased a new 128 slice CT scanner and fluoroscopy machine. To support this new equipment there have also been some positive changes to the environment. The improvements made to the environment support the hospital's dignity promises to patients by offering small sub-areas for waiting with separate bathroom facilities.

Developments for the future

Main Theatre Refurbishment – The Trust has approved a business case for £4million to refurbish our main theatres at Warwick Hospital. The refurbishment work will start in June 2011 and the theatres will be closed for 20 weeks.

This work is essential to ensure that the hospital has modern and update facilities for the future. The plans involve extending the theatres footprint to provide storage and changing facilities on two levels together with a patient holding bay and an integrated operating theatre.

Maternity and Special Care Baby Unit development – The Board of Directors have agreed a proposal to expand and develop existing maternity services to meet quality standards and projected demand, providing capacity to deliver up to 3,500 births per annum over the next 5 years. The Trust will need to provide both capital and resource for this project as well as the release and redevelopment of an existing ward to provide a large enough footprint for capacity to meet demand.

Nicol Unit – Freedom Project – Stratford upon Avon Hospital was awarded £50,000 from the Healing Environment Project from the King's Fund, to improve facilities for patients, staff and visitors.

Listening and Learning

The Trust continues to have a strong track record or working closely with patients to improve services. One of the main ways that the Trust does this is through the support received from the Patients Forum. The forum continues to carry out regular audits of services, making suggestions on improvements as well as reporting into our Council of Governors their findings. The Trust has also established a sounding board with Foundation Trust Members. Everyone that has signed up to the sounding board has chosen their areas of interest for consultation, this is helping with engaging Members in topics that are relevant to them or that they are interested in. One example of this was that a small group of Members recently were involved in focus groups to help design and deliver the Trust's new website. The Trust will continue to involve patients and members with decisions to ensure that the most appropriate services are delivered to the local population.

Survey Results

The Trust participates in a number of surveys throughout the year including the National Inpatients Survey, National Cancer Survey and the Trust's own internal CARE (Communication, Attitude, Responsiveness and Environment) survey.

The National Inpatient Survey results show that patients rate the hospital in the top 20% for providing good communication. The survey is designed to listen to patient opinion on their overall experience of their hospital visit and at Warwick hospital, 94% of patients surveyed said that overall their experience was excellent, very good or good. Patients were asked questions including whether they believed hospital staff did everything they could to control their pain and whether they were offered enough privacy throughout their time at the hospital. The hospital has seen some real improvements with the scores in both these areas. The Trust also received positive responses when patients were asked about their operations and procedures. Patients were asked whether staff explained procedures clearly and answered patient questions in an understandable way. These results were again an improvement for the Trust and were well above the national average.

Disappointingly, patients rated the hospital food lower than expected. This service is provided by our hotel services provider G4S using food which is prepared freshly in our on-site kitchens. Our aim is to ensure that we speed-up the delivery times from kitchen to bedside and work to provide more choice nearer to mealtimes.

The National Cancer Survey Results were also very positive for the Trust. On issues relating to dignity and care the Trust scored in the top 20%. Other areas where the Trust rated in the top 20% of Trusts were; waiting time no longer than 30 minutes for outpatients appointments, community staff and hospital staff always worked well together and patients did not feel that they were treated as a set of cancer symptoms.

More information on the CARE survey results can be found in the Quality Report on page 72.

Work Experience

The Trust recognises the importance of work experience, not only to provide individuals with an insight into potential NHS careers, but also as a means of initial contact with potential future employees, service users or Members. As such, the Trust is committed to supporting local, schools, colleges, adult training organisations and any other individuals, requiring work experience with the Trust's service areas. The Trust takes very seriously its responsibilities, as a local employer, in supporting local students to explore a career in the NHS.

The work experience project has so far seen over 175 students pass through the doors of South Warwickshire Foundation Trust in clinical and non clinical placements throughout various locations. The Trust has also held 3 successful Taster days for school and college students so that they can get a chance to meet staff in a variety of health service professions. The Trust has also visited local schools and colleges in order to raise the profile of the Trust and the NHS within the local community.

Complaints

The Trust recognises that patient feedback, comments and complaints are effective measures of services delivered and necessary learning. The information gained assists the Trust in:

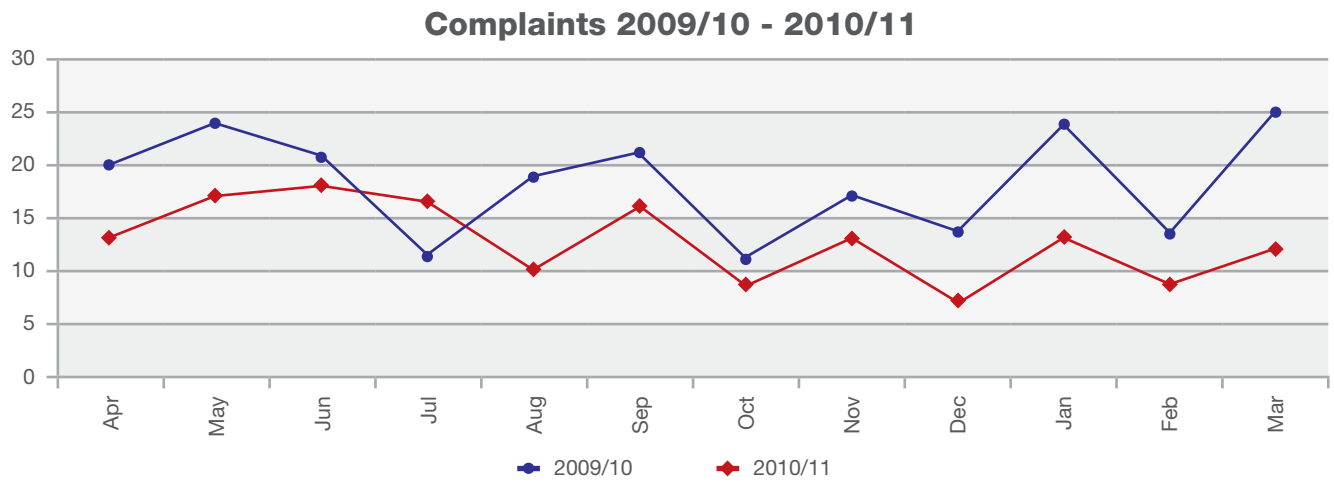
- Recognising standards of service delivery and continuing to improve those services
- Being aware of patient experience, perspective and expectations
- dentifying problematic areas
- Identifying actions needed
- Monitoring service delivery requirements

The Trust's complaints policy was revised and issued on 31 March 2010. This revised policy complies with the NHS (Complaints) Regulations 2004 and the Trust's policy incorporates the NHS (Complaints) amendments 2006 and, most recently, the NHS Complaints (England) Regulations 2009. These regulations came into force on 1 April 2009.

The number of complaints for 2010/11 are significantly lower than the previous year. It is felt that this is due to early resolution of issues at ward and department level to prevent escalation into a formal complaint. The development of the patient experience team with PALs and complaints working closely together has also had an impact. The matron team also spend a lot of time on the wards to ensure that patients and their families have direct access to a senior nurse.

A summary of our performance against complaints can be seen below

Year	Number of formal complaints	Number of complaints not responded to within 25 days
2010/11	153	16
2009/10	219	21
2008/09	223	25



Patient Advice Liaison Service (PALS)

PALS is an independent and confidential advice and support service for patients and their relatives/friends. It offers patients the opportunity to raise any concerns they might have at a very early stage, enabling them to be dealt with promptly. The service works in partnership with patients and staff to identify where the Trust can improve services.

Year	Number of contacts
2010/11	1711
2009/10	1974

This year's contacts fall into the same five top categories as the previous year; clinical care/decision, outpatient appointment issues, communication, discharge and transfer arrangements and patient property – including lost items.

Bereavement Service

The Bereavement Service started at the end of 2009 with the appointment of the Bereavement Co-ordinator in October 2009. The aim for this service has been to provide a co-ordinated bereavement service, based on best practice, which handles all aspects of work following the death of a patient through to the funeral directors taking over the care. The number of contacts dealt with through this service was 893 for the period April 2010 to March 2011.

Valuing and Developing Staff

During the period 1 April 2010 to 31 March 2011, South Warwickshire NHS Foundation Trust employed over 2000 members of staff. There are a number of policies and procedures in place to support and develop this workforce, ensuring a work-life balance. The positive work the Trust does for this was recently highlighted in the national staff survey results, which demonstrated our staff's utilisation of a range of flexible working options.

The Trust continues to enjoy a positive working relationship with trade unions and staff representatives and implements partnership working with these organisations. Both the Joint Negotiating and Consultative Committee and the Local Negotiating Committee meet on a regular basis, chaired by the Chief Executive, to provide a forum for formal negotiation, consultation and communication. In 2011/12 there is likely to be a greater need for joint policy formulation as the Trust looks to integrate the current trust policies with those currently used by Warwickshire Community Health.

Staff Group	Total Headcount as at 31 March 2011
Consultants	107
Other medical Staff	159
Qualified Nursing and Midwifery	777
Unqualified Nursing Staff	326
Qualified Scientific,Therapeutic & Technical Staff	242
Support Staff - Non Nursing	133
Managers and Senior Managers	44
Admin & Estates	462
All Other Staff	26
Total	**2,276**

Please note that on 1 April 2011, 1670 members of staff transferred from NHS Warwickshire to South Warwickshire NHS Foundation Trust. This group of staff now forms a division called Warwickshire Community Services. The total headcount from 1 April 2011 is 3,946.

Learning and Development

Widening Participation

The Trust in collaboration with the Coventry and Warwickshire Workforce Board is piloting a Theatre Apprenticeship Programme. Following a successful bid for £40,000 the Trust has employed 4 apprentices together with some senior Operating Department Practitioner support to underpin the programme. In addition to developing our workforce in a skills escalator type approach, the Trust will also compile an 'apprentice manual' with guidance on how to recruit and support an Apprentice in the workplace. It is hoped to establish more apprenticeship programmes in both clinical and non clinical areas of the Trust, and the Trust will continue to work closely with local educational providers in order to achieve this.

Life Support Training

This year the Resuscitation service has trained 1,842 Trust staff either basic or "in Hospital support" which includes training in automated external defibrillation.

The Resuscitation department has also trained 80 staff in Acute Life Threatening Events Recognition course (a course designed to teach healthcare staff how to anticipate, recognise and prevent critical illness at an early stage). The aim of the course is to train staff on the aspects of acute illness with the aim of reducing hospital mortality and admission into the Intensive Care Department.

The Resuscitation Department has trained a further 54 staff in Immediate Life Support course, equipping staff to be effective members of the Cardiac Arrest Team.

Undergraduate Nursing and Newly Qualified Nursing Support

The Trust now provides 32 placements for Student Nurses, Midwives and Allied Health Professionals. The placements are supported by qualified mentors from across all disciplines. To assure the quality of the learning environment, an audit tool "the Nursing, Midwifery and Operating Department Practitioner's Learning Environment Profile Educational Audit (LEP)" is used. The tool has been reviewed to incorporate the revised Skills for Health Enhancing Quality in Partnership standards. Feedback regarding the quality of nurse placements continues to be excellent.

For the period September 2010 to March 2011 the Trust supported 31 new Band 5 nurses through the Preceptorship Programme. Attendance has been excellent with many nursing staff having completed or nearly completed the programme. Specific frameworks have been adapted especially in paediatrics and orthopaedics to support the Trusts' newly qualified nursing workforce.

The Trust is also supporting nurses returning to practice. There are currently 6 undergoing this programme.

Supporting Equality and Diversity

The Trust's Equality and Diversity Steering Group supports the Trust in overseeing its processes to eliminate discrimination and promote diversity and the Trust's lead in this area is the Director of Human Resources.

The Trust promotes a Single Equality Scheme which brings together our gender, disability and race equality schemes. The Trust also incorporated equality and diversity training into the mandatory training for all staff.

The Trust's progress and monitoring in this area is not only through the Equality and Diversity steering group but also with reports to Trust Board. Data is collected to support monitoring of recruitment, access to training, disciplinary procedures and grievances raised, in relation to ethnicity, gender, age and disability.

As a "Positive about Disability" employer, all applicants who declare a disability, who meet the minimum criteria for a vacancy, are interviewed.

The Trust is committed to supporting all staff and has been developing networks with other public sector organisations in Coventry and Warwickshire with a view to ensuring that our staff have access to Black and Minority Ethnic networks and Gay, Lesbian, Bisexual and Trans-gender networks.

As a "Positive about Disability" employer, all applicants who declare a disability, who meet the minimum criteria for a vacancy, are interviewed.

Update on progress against objectives set for 2010/11:

- Improve the usability of the Trust's website – The Communications Manager worked with the Equality and Diversity Steering Group and Foundation Trust Members to redesign the website. Additional features were added to the site for example the ability to translate into numerous languages through google translate. There is continuing work to enhance the website to increase accessibility.
- Review and expand the current equality and diversity training – Following the 2009 national staff survey feedback the Trust reviewed the Equality and Diversity training to make further improvements. This training is also now part of the mandatory training programme for all staff. Since these changes we have seen improvements in the 2010 survey.
- Target equality impact assessments towards patient areas- There have been number of training sessions during 2010/11 on how to complete an assessment. There has also been one to one support for managers in areas that have had a large number of assessments to complete.

Summary of the Trust's equality and diversity data can be seen below:

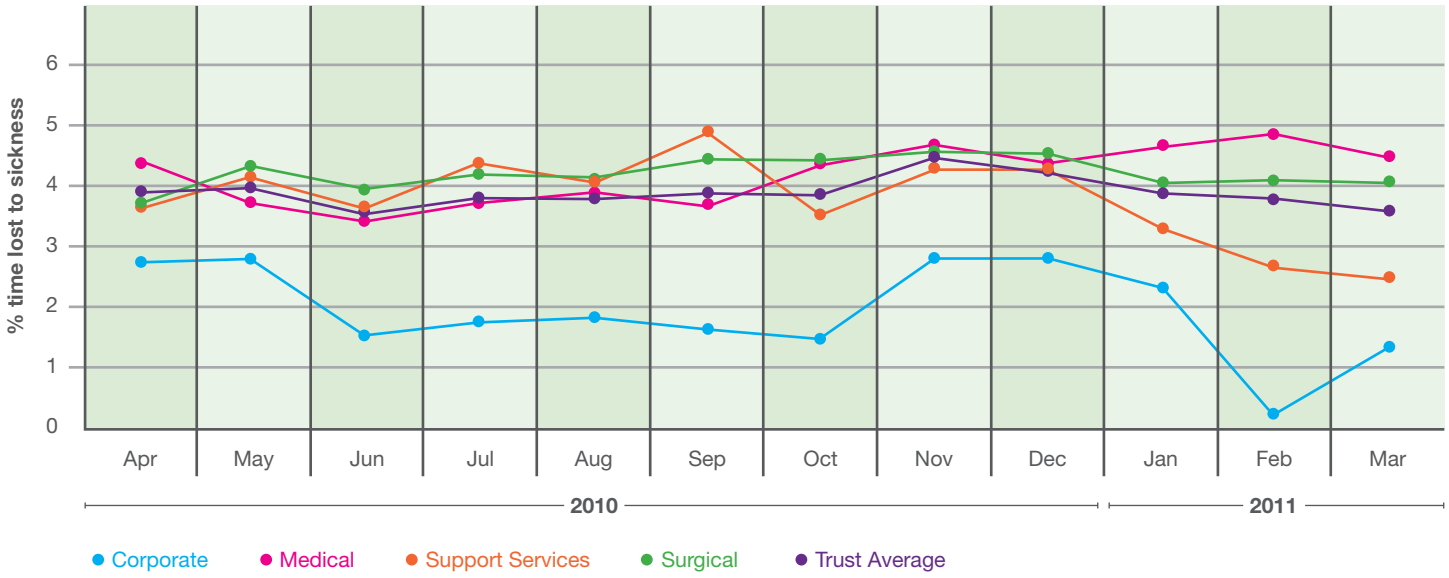
Age	2009/ 2010	%	2010/ 2011	%
16-24	129	5.88	130	5.71
25-44	1065	48.54	1096	48.15
45-64	972	44.30	1019	44.77
65+	28	1.28	31	1.36
Ethnicity	**2009/ 2010**	**%**	**2010/ 2011**	**%**
White	1804	82.22	1822	82.69
Mixed	27	1.23	32	1.41
Asian or Asian British	201	9.16	213	9.36
Black or Black British	49	2.23	51	2.24
Chinese or other ethnic group	28	1.27	26	1.14
Not disclosed	85	3.87	72	3.16
Gender	**2009/ 2010**	**%**	**2010/ 2011**	**%**
Male	400	18.23	423	18.59
Female	1794	81.77	1853	81.41
Trans-gender	0	0.00	0	0.00
Recorded Disability	**27**	**1.24**	**30**	**1.32**
Total staff (as at 31 March)	**2194**		**2276**	

Emotional Health and Wellbeing

The Trust understands that engaging fully and effectively with staff has been shown to increase staff motivation, job satisfaction and commitment and to reduce work related stress. Our Leadership Charter supports our aim of providing an open and supportive culture that enables people to perform at their best, promoting innovation and individual and collective learning.

The Trust's Occupational Health Department provide support to staff who suffer accidents at work or who experience work related health issues. The Trust makes every effort to retain employees who become disabled and the Occupational Health Team provides advice to staff and their managers in relation to this. All staff, both individuals and teams, are able to access support via the staff support service provided by our Psychology Team.

Sickness rates by Division, Financial year April 2010 to March 2011:



The Trust average sickness rate has improved from 2009/10 and compares favourably with acute trusts within the NHS West Midlands area, where the average sickness rate is approximatley 4.4%. For more detailed analysis of last years sickness data please see our annual report 2009/10.

Early retirement on ill health grounds

During 2010/11 there were four retirements from the Trust on the grounds of ill health at an additional cost of £191,815 and these ill health retirements will be borne by the NHS Business Services Authority (Pensions Division). These retirements represented 1.2 per 1000 active scheme members.

NHS Staff Survey

The Care Quality Commission (CQC) published the results of the 2010 National NHS Staff survey in March 2011. There were 750 members of staff chosen at random to receive a questionnaire and the response rate was similar to the previous year (see table to the right). The profile of the random sample was similar to last year, with a similar ethnic and occupational profile. In general terms responses to the 2010 survey showed an improvement on the 2009 results with only a small number of areas of concern highlighted. The top and bottom ranked scores can be found on page 25 with some actions identified for the future.

	Response Rate
Trust 2009/10	56%
National Average 2009/10	53%
Trust 2010/11	53%
National Average 2010/11	53%
Trust Improvement/Deterioration	-3%

The following tables illustrate the Trust's top and bottom ranked scores in the staff survey

Number	Top four rankings 2010	2009/10		2010/11		Trust Improvement/ Deterioration
		Trust	National Average	Trust	National Average	
K37 This was KF39 in 2009 survey	Percentage of staff believing that the trust promotes equal opportunities for career progression or promotion	90%	90%	96%	90%	+6%
KF29 This was KF30 in 2009 survey	Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	22%	26%	19%	26%	-3% (lower score is better)
KF9 This was KF10 in 2009 survey	Percentage of staff using flexible working options	75%	70%	69%	63%	-12%
KF24 This was KF25 in 2009 survey	Percentage of staff experiencing physical violence from staff in last 12 months	1%	2%	0%	1%	-1% (lower score is better)

Number	Bottom four rankings 2010	2009/10		2010/11		Trust Improvement/ Deterioration
		Trust	National Average	Trust	National Average	
KF8 This is KF9 in 2009 survey	Percentage of staff working extra hours	69%	65%	70%	66%	+1%
KF2	Percentage of staff agreeing that their role makes a difference to patients	89%	90%	89%	90%	0%
KF14 This is KF13 in 2009 survey	Percentage of staff appraised with personal development plans in last 12 months	77%	70%	61%	66%	-16%
KF21 This is KF22 in 2009 survey	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	94%	95%	94%	95%	0%

Key Actions

The Trust is implementing an e-rostering system across the whole organisation from April 2010, to support consistent and fair management of our employee resources. This will enable managers to see when staff are working too many hours and support a worklife balance.

The Trust has reviewed and further simplified the appraisal paper work and will continue to support managers and staff with this process. Appraisal performance is also monitored in our monthly Finance and Performance Committee.

Internal Communications

There are a number of formal channels that are used to communicate with staff across the Trust including weekly bulletins, screensavers, monthly team briefs (delivered by the Chief Executive) and a quarterly magazine (Pulse). There continues to be an open door policy to the Chief Executive.

The Trust shares organisational objectives and encourages involvement with these. Objective posters are displayed throughout the organisation and this material is also presented in more details with managers, enabling individual and team objectives to be aligned.

Recognition Group

The recognition group was formed from staff across the organisation after a series of staff engagement sessions. This group of individuals meet on a regular basis to implement a number of projects that promote recognition of staff within the Trust.

The group organised a long service recognition event and this year also provided recognition to those staff who had worked 30+ years in the NHS, previously it was just 20 and 25 years that was recognised.

The group also judged a number of star award entries and out of 53 nominations, 26 were awarded a STAR award.

The Woods Nurse of the Year award was awarded to Selina Doughlin-Bugg and the Woods Nursing Team of the Year award went to the Colposcopy team.

Fraud and Corruption

Every health body has an NHS Local Counter Fraud Specialist (LCFS) working with them, specifically tasked with preventing, detecting and investigating any issues of fraud and corruption either within or against the health body they work with. The LCFS is specially trained to undertake this work; and is required to ensure that all work is conducted to the highest standards and fully complies with legislation such as the Police & Criminal Evidence Act and the Criminal Procedure & Investigation Act.

During 2010 -11, the LCFS has continued to participate in the Trust's staff induction programme, ensuring that all new staff are aware of how fraud and corruption can occur, and how any concerns they may have can be reported confidentially. In addition, the LCFS has met with staff at all levels to make them aware of the Trust's work in preventing and detecting fraud, and the role of the LCFS. Regular liaison also takes place with the Trust's Finance and Human Resources departments, to ensure that any matters of concern are addressed in the most appropriate way. Other work has included reviewing internal operating processes to ensure that controls are in place to prevent fraud happening and identify any possible fraud if it occurs; and also investigating any concerns that may be highlighted. The Trust has also participated in national exercises such as the Audit Commission's bi-annual National Fraud Initiative, which seeks to identify fraud and overpayment across the public sector.

All staff also have access to the NHS's confidential Fraud & Corruption Reporting Line (0800 028 40 60), should they wish to raise any concerns via that route.

Environment and Sustainability

Why we undertake sustainability reporting:

Sustainability reporting allows us to engage with a wide range of stakeholders inside and outside of the Trust, and continues to develop confidence that we have a structured and achievable plan for improving our sustainability without compromising the quality of the service we provide. More importantly, it allows us to clearly demonstrate that we are making tangible progress towards our sustainability targets.

Overall strategy:

The Trust Carbon Management Plan sets targets and a strategy for reductions in carbon emissions under the following areas:

- Waste minimisation and recycling
- Energy use and generation
- Water efficiency
- Sustainable transport and active travel
- Sustainable/ low carbon buildings
- Procurement activities

We are committed to achieving a 5% reduction in energy related carbon emissions year on year for the next five years to deliver a total saving of 25% (1,977 tonnes of carbon dioxide emitted (tCO2e)) by 2015 and then 35% by 2020. Across all the above areas, we recognise that we need to reduce our total emissions by around 85% by 2050, and are developing transition plans to enable this.

In 2010/11 we saved in excess of 530 tonnes of CO2e through energy efficiency improvements funded through the Salix SEELS programme. This year we anticipate increasing this saving to over 1,000 tCO2e, representing 15.7% of our target emission reduction. These projects included new combined Heat and Power (CHP) boiler plant, roof and cavity wall insulation, fitting inverter drives to fans and motors and lagging hot water and heating pipes across both hospitals. The look and feel of circulation corridors at Warwick Hospital have also been refreshed with more efficient lights that are designed to dim or switch off when not required.

We haven't stopped at spending money on more efficient equipment – there has been a strong focus throughout the year on engaging staff, raising awareness and changing behaviour too. We recognise that this holds the key to transforming the Trust into a provider of low carbon, sustainable healthcare services. We have run events, workshops and provided role-specific training to encourage and enable our staff to act in more sustainable ways; in addition to developing a network of 'carbon champions' who will be empowered in the future to champion 'grass roots' and local action to reduce carbon emission.

We've revolutionised the way we manage waste and, for the first time, now recycle a significant proportion of our waste through our Trust-wide 'co-mingled scheme'. Staff have really engaged with the new and simple system and since introduction we recycle approximately 20% of the waste that would otherwise would have been sent to landfill. We will shortly also become the first NHS Trust to install an aerobic digestion unit on site to deal with food waste. This innovative system converts food waste destined for waste disposal or landfill into 'grey water' which can then be recycled or reused.

CARBON FOOTPRINT REPORT (Non-financial report)

The absolute footprint is the total quantifiable amount of carbon emission known and recordable for the footprint period stated and is used to monitor progress against our annual reduction targets.

Energy	1 April 2008 - 31 March 2009	1 April 2009 - 31 March 2010	1 April 2010 - 31 March 2011
Electricity (grid)	3,805.5	3,885.3	3,771.2
Natural gas	2,392.4	2,449.8	2,827.4
Oil	790	691.2	25.3
Absolute energy footprint (tCO_2e)	6,987.90	7,026.30	6,623.90

Waste	1 April 2008 - 31 March 2009	1 April 2009 - 31 March 2010	1 April 2010 - 31 March 2011
Waste to landfill	145.79	145.73**	148.81*
Waste to incineration	86.83	91.86	90.15
Recycling (diverted from landfill)	0	(8.03)***	(18.00)
Absolute waste footprint (tCO_2e)	232.62	229.56	220.96

** Includes recorded weights from Stratford, not included in previous years. ** Total domestic waste generated, including recycled/ diverted wastes. *** Recycling weights estimated from volumes.*

Water	1 April 2008 - 31 March 2009	1 April 2009 - 31 March 2010	1 April 2010 - 31 March 2011
Absolute water footprint (tCO_2e)	70.7	74.3	74.3

	1 April 2008 - 31 March 2009	1 April 2009 - 31 March 2010	1 April 2010 - 31 March 2011
Scope 1 emissions	3,182.40	3,141.00	2,852.70
Scope 2 emissions	3,805.5	3,885.3	3,771.2
Scope 3 emissions	1,170.82	1,175.86	1,069.26
Scope 3 - Energy	867.5	872	774.9
Scope 3 - Transport		NOT REPORTED	
Scope 3 - Waste	232.62	229.56	220.96
Scope 3 - Water	70.7	74.3	73.4
Total recorded gross emissions	8,158.72	8,202.16	7,693.16
Growth metric	n/a	6.0	11.5
Absolute metric	n/a	-0.53	5.95

In addition to continuing to meet the efficiency and sustainability targets under each section of the Carbon Management Plan, the Trust will focus on consolidating its improved environmental performance through greater engagement with the workforce and community. In particular we plan to introduce new models for third and community sector involvement into our Plan.

We will also develop the following key sustainability themes in detail and integrate with the Carbon Management Plan to form a complete Sustainable Development Management Plan (SDMP) framework:

- Pollution reduction
- Biodiversity

A trust wide survey of work related travel habits will be conducted, which will inform the Trust Sustainable Travel Plan, due for completion this Summer. We aim to reduce transport related emissions by 40% over the next decade and develop a transport infrastructure that is reliable, resilient and equitable.

FINANCIAL INFORMATION

Area	Energy consumed kWh	Energy consumed kWh	Energy spend £	Energy spend £
	2009/10	2010/11	2009/10	2010/11
Electricity*	7,126,175	6,916,895	564,729	491,238
Gas	12,159,890	13,753,696	298,762	347,033
Oil	2,443,625	89,500	104,455	8,508
Renewables	0	0	-	-
TOTAL	**21,729,690**	**20,760,091**	**£967,946**	**£846,779**

**25% of grid supplied electricity is sourced from renewable supplies.*

Area	Water consumed m3	Water consumed m3	Water and sewage spend £	Water and sewage spend £
	2009/10	2010/11	2009/10	2010/11
Water	70,878	69,910	131,500	131,181

Area	Volume	Volume	Cost £	Cost £
	2009/10	2010/11	2009/10	2010/11
Total waste produced by the Trust	749.73	793.08	154,090.67	150,712.24
Total volume of waste sent for landfill	315.6	354.8	27,315.74	31,269.24
Total volume of waste sent for incineration	372.0	372.5	119,224.07	108,176
Total volume of waste sent for recycling	57.3	101.29	3,411.32	11,267
Total volume of waste sent for treatment (tonnes)	4.83	0	4,139.54	0

The Carbon Management Team role will be expanded to oversee the development and implementation of the SDMP and include representation from Community Services. The group will be chaired by the executive Director and supported by an operational lead.

The Trust will continue to utilise the NHS 'Good corporate citizen model' to review and improve our contribution to sustainable development every six months and use the assessment to provide an action plan for improving sustainability.

We will assess our procurement carbon impact and calculate our footprint for this area. To reduce future procurement related emissions, the sustainability of all new capital projects and significant capital expenditure will be appraised through the use of a 'Sustainability Impact Assessment' which will be considered in conjunction with the existing financial appraisal included in the Trust Business Case template.

Future priorities and targets:

Our strategy will focus on four key areas of sustainable development and actions below:

1. Sustainable consumption and growth – reducing the amount of waste we produce and reusing and recycling where possible, as well as using other finite resources like fossil fuels in a responsible and ethical way.

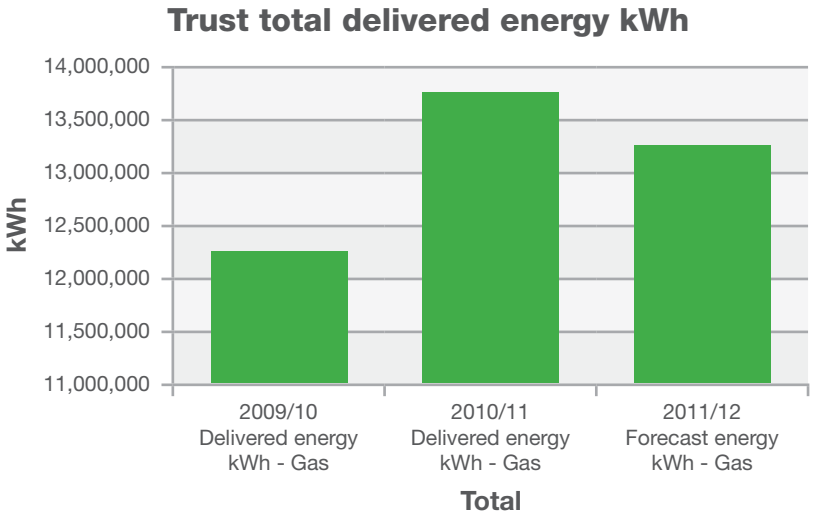
2. Climate change and energy – reducing the carbon intensity of the energy we use and investing in alternative forms of renewable energy to provide low carbon, resilient healthcare and ensuring that our services and facilities are equipped to deal with changing climates and healthcare demands.

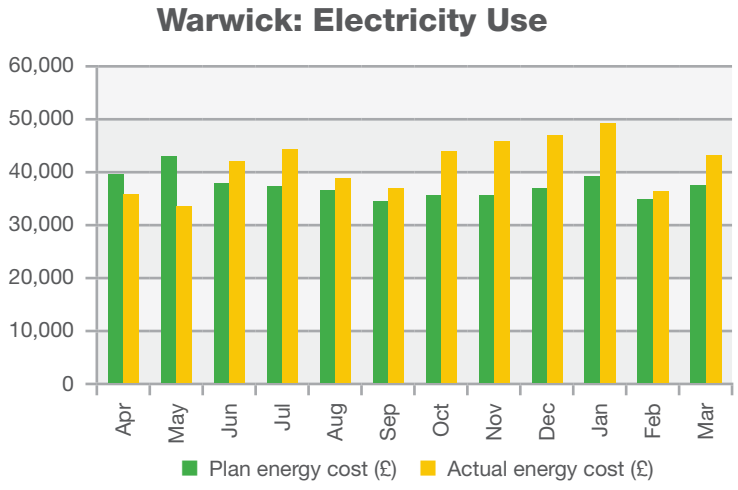
3. Natural resource protection – developing new opportunities for biodiversity on the Trust estate and ensuring that...

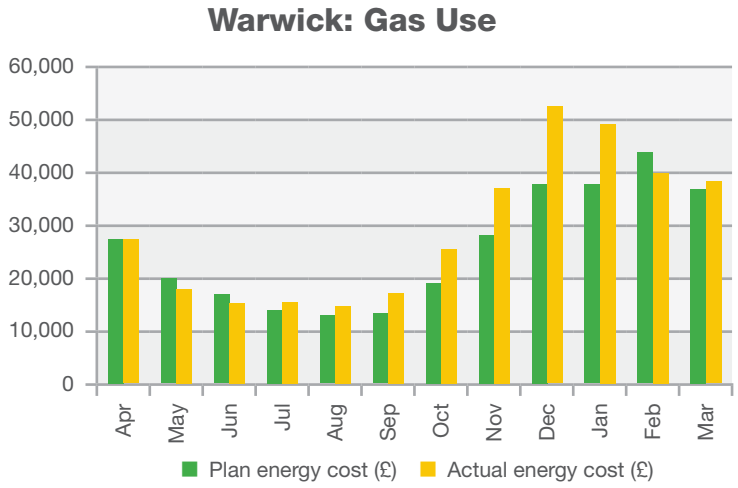
4. Sustainable communities – reducing health and other inequalities and supporting social and community engagement for our patients, staff and visitors. Engaging the community to become an active stakeholder in the healthcare service we provide and working with our community to promote low carbon living and sustainable travel habits.

Significant progress has already been made towards our sustainability agenda through the implementation of a Board approved Carbon Management Plan which sets targets and identifies measurable actions for delivering carbon reduction in energy, procurement, transport, waste, water use and the built environment. We anticipate achieving a 5% reduction in energy related carbon emissions year on year for the next five years to deliver a total saving of 25% (1,977 tCO2e) by 2015 and then 35% by 2020.

In 2010/11 we saved in excess of 530 tonnes of CO2e through energy efficiency improvements funded through the Salix SEELS programme. In 2011/12 we anticipate increasing this saving to over 1,000 tCO2e, representing 15.7% of our target emission reduction.







SECTION 2:

Council of Governors and Membership

Council of Governors Structure

Structure and Members

The Council of Governors currently comprises a total of 26 members. From 1 April 2011 this number will increase, please see page 40 for more information. Fourteen of these Members are duly elected to represent public constituencies, 5 who are elected as staff representatives, and 7 members appointed from key local stakeholders and partners.

During the year there has been one change to the membership of the Council of Governors. Marilyn Taylor (Elected Governor: West Stratford and Borders) stood down and was replaced by Clive Thomas. Under the terms of the Constitution, the Council of Governors chose to offer the seat to Clive Thomas who had been the candidate for that seat at the most recent election, who had received the highest number of first preference votes of those not elected. Clive Thomas will fill the seat until the next ordinary elections.

The members of the Council of Governors who served during the year are as follows:

Public Governors	No	Name	Number of Attendances at 5 CoG meetings between 1 April 2010 – 31 March 2011
Warwick and Leamington Towns	4	Mrs Ruth Cowan Mrs Carol Gough Prof Eric Ives Mr Matthew Statham	5 2 4 3
Warwick District and Borders	4	Mr Bob Ashby Mr Michael Coker Dr Richard Grimes Ms Pat Jagger	4 4 5 4
West Stratford and Borders	3	Mr Douglas Badger Mrs Sarah Cossey Mrs Marilyn Taylor (up until 14 August 2010 therefore only eligble to attend 3 meetings) Mr Clive Thomas (from 2 September 2010, therefore only eligble to attend 1 meeting)	5 3 1 1
East Stratford and Borders	3	Mr Brian Fletcher Mr David Gee Mrs Yvonne Hunter	4 4 4
Staff Governors	**No**	**Name**	**Number of Attendances at 5 CoG meetings between 1 April 2010 – 31 March 2011**
Nursing and Midwifery Non-Clinical Support Clinical Support Medical and Dental	5	Mr Brendan Duffy Mrs Julie Smith Mrs Eilidh Lees Mrs Karen Sharpe Dr Jeremy Shearman	2 4 3 4 4
Appointed Governors	**No**	**Name**	**Number of Attendances at 5 CoG meetings between 1 April 2010 – 31 March 2011**
Stratford District Council Warwick District Council University of Warwick NHS Warwickshire GP Consortium CAVA Warwickshire / VASA Warwickshire County Council	7	Cllr Susan Adams Cllr Felicity Bunker Prof Neil Johnson Mrs Lucy Noon Dr David Spraggett Dr Liz Willetts Cllr David Wright	4 4 3 2 0 3 1
Total No of Seats	**26**		

Elected Governors

Elections for public and staff Governors took place on 17 March 2009. Although the Trust's application was later deferred by Monitor – the independent regulator of NHS Foundation Trusts – the results of the election stood. The Trust was authorised as an NHS Foundation Trust on 1 March 2010. Public and Staff Governors are elected for a period of three years from the date of authorisation. No elections have been held since the date of authorisation.

Public: Warwick and Leamington Towns

Ruth Cowan - Ruth is a Chartered Physiotherapist and has worked not only in the NHS but also in Education and the private sector. Her motivation as a Governor is to help reflect the voice of the public. Ruth feels that having a Foundation Trust is a great opportunity for South Warwickshire to have a first class health service both for patients and providers.

Carol Gough - Carol is a Registered Nurse and is currently working for the independent sector in a management role. She has lived in Warwick all her life and has a strong sense of community. She became a Governor so that, through her, the local community can influence the way the Trust delivers its services.

Eric Ives - Having lived in Warwick for 40 years, Eric became a Governor so that he could give something back to the hospital that has served him and his family well. He is watchful of efficiency and of the quality of patient care - particularly senior patients (he is himself retired).

Matthew Statham - At 42 years of age, Matthew has lived in the Leamington/Warwick area for most of his life. He is married with two children and likes to take an active role in the community. As a Governor he will bring a fresh perspective, with 20 years industry experience from outside the healthcare profession.

Public: Warwick District and Borders

Bob Ashby - Bob believes that local people can influence the way our hospital is run for the better and promises to make sure that the views of his constituency members are heard. He is active in the local community both socially and in several clubs and societies.

Michael Coker - Michael has a close association with the Warwick area, having worked in the area for many years. Through his previous roles as Councillor for Kenilworth Town Council and Warwick District Council, he has had close contact with the general public and is aware of the difficulties and benefits of the local NHS. He feels that his close association with the local community, both personally and professionally, gives him the experience to fill the role as a Governor of the Trust.

Richard Grimes - As an outpatient and day surgery patient over a number of years, Richard has seen many improvements at Warwick Hospital. He became a Governor because he wants to see the Trust to continue to build upon these improvements. He is passionate about maintaining the principles upon which the NHS was founded and, as a Governor, will ensure that the Trust is held to those principles and that the Trust's actions are always to the benefit of the community.

Pat Jagger - Pat worked in the NHS for over 40 years in clinical and managerial posts. She became a Governor on account of her deep interest and concern in the progress of the NHS. She is especially committed to maintaining high standards and to the eradication of MRSA, and would seek to comment and influence future plans, and to defend and support them in the community.

Public: West Stratford and Borders

Douglas Badger - Douglas became a Governor because of his experience of the NHS both as a patient and carer. He believes that Foundation Trust status is improving local accountability in the NHS. His mother was a nurse at Stratford Hospital in the 1960's and 1970's and he also worked there as a nursing auxiliary. He is 62 years of age and retired, and lives with his wife in Stratford. Douglas supports plans to increase the number of services offered at Stratford Hospital.

Sarah Cossey - Sarah is 40 years old and married with four children between the ages of four and sixteen. She works as an Antenatal Educator, working alongside new parents and has attended maternity committees at Warwick Hospital for several years on a voluntary basis. In her spare time she is an Explorers leader in the Scouting Association. Sarah enjoys the diversity of her work which keeps her in contact with families of all ages.

Clive Thomas (Governor from 2 September 2010) - Clive served 39 years with the ambulance service (21 based at Stratford). He is an officer brother of the Order of St John with over 50 years service. Along with his wife he owned and ran a guest house in Stratford for 25 years. He has served on both Stratford-upon-Avon Town Council and Stratford-on-Avon District Council being a Mayor of Stratford-upon-Avon in 2003-2004. He was involved in the management of Stratford-upon-Avon Ambulance Station and was in charge of the St John divisions in Stratford for 25 years.

Marilyn Taylor (Governor until 14 August 2010) – Marilyn believes passionately in the future of the NHS and has acquired an understanding of the healthcare needs of the local community both as a user of the facilities at Stratford Hospital, and in her previous position working for a Primary Care Trust.

Public: East Stratford and Borders

Brian Fletcher has had regular contact with hospitals in Warwickshire and other areas, both through his work with the North Cotswolds Voluntary Help Centre and also on a personal note. He became a Governor because he has always believed in the NHS and sees Foundation Trust status as vital in enabling South Warwickshire Hospitals to provide an even better service.

David Gee was actively involved in representing the interests of patients throughout South Warwickshire for a number of years and is now a member of the Warwickshire LINks (Local Involvement Networks). He will use this experience to ensure that the Trust continues to deliver an improving healthcare service.

Yvonne Hunter lives in a small rural community and recognises the important role which the health service plays in the community. Her career with the NHS Confederation brought her into close contact with the health service for several years.

Staff: Medical and Dental

Jeremy Shearman has been a consultant in the Trust for ten years. His clinical specialty of gastroenterology is one that is anchored in traditional general hospital medicine, and he has worked hard with colleagues to ensure the very best care for local patients. As a Governor he will strive to ensure that teamwork and integration become fundamental parts of the new Foundation Trust and that local patient needs are understood by all.

Staff: Nursing and Midwifery

Brendan Duffy wants to contribute to the effective development and future direction of the Trust. He has worked within the NHS, progressing through a variety of nursing roles. He is now Manager of the Surgical Unit and oversees the Pre-Operative Assessment Unit and the implementation of MRSA screening for all elective surgical patients.

Julie Smith joined the health service in 1976 and, after a short career break to bring up her two sons, she joined Warwick Hospital in 1992 as a Bank Nurse and has stayed ever since. She is now one of the Medical Ward Managers. Julie became a Governor in order to inject the challenges and issues from the 'shop floor' and also to support the Trust in moving forward to meet the needs of the local community.

Staff: Clinical Support (including Scientific, Technical and Therapeutic Groups)

Karen Sharpe is the Pharmacy Operational Manager at Warwick Hospital. She became a Staff Governor so that she can be involved in influencing strategy, and wants the best for her clinical support staff colleagues. She believes that becoming a Foundation Trust will provide the crucial balance of views from patients, local people, staff, stakeholders and the Board, in the Trust's future development.

Staff: Non-Clinical Support (including Managerial and Administrative Staff)

Eilidh Lees has worked at Warwick Hospital since1973, initially in the visitors' canteen but mainly in the telephone exchange. She has become used to being the first point of contact for patients and/or their relatives and has sometimes been on the receiving end of their frustrations when unable to speak directly with the appropriate department. Eilidh believes that her experience of seeing both sides of the picture, in a non-medical capacity, will be put to beneficial use as a Governor.

Appointed Governors

Susan Adams – Representing Stratford District Council

Felicity Bunker – Warwick District Council

Neil Johnson – University of Warwick

Lucy Noon – NHS Warwickshire

David Spraggett – GP Consortium

David Wright – Warwickshire County Council

Liz Willetts – (Resigned 1 March 2011) Warwickshire Community and Voluntary Action (CAVA)/Voluntary Action Stratford-on-Avon District (VASA)

Jayne Longfield – (Appointed 1 April 2011) Warwickshire Community and Voluntary Action (CAVA)/Voluntary Action Stratford-on-Avon District (VASA)

Govenors can be contacted in the following ways:

Call: **0800 085 2471**
Post: **Freepost RRUR-BBAH-CAJA**
Email: **membership@swft.nhs.uk**

To access the Governors' Register of Interests please visit www.swft.nhs.uk or alternatively contact the Trust Secretary at Warwick Hospital.

Meetings of the Council of Governors

During the period 1 April 2010 to 31 March 2011 the Council of Governors has met on five occasions including the Annual Meeting. A record of the number of attendances by each Governor at these meetings is included in the table on page 33.

20 May 2010

At this meeting, the Council considered the first set of Quality Accounts 2009/10 to be produced by the Trust, which demonstrated the Trust's performance against national and local targets and standards, as well as against its own key objectives.

The Council was also consulted on the forward planning elements of the Trust's Annual Plan 2010/11 which was required prior to Board approval.

This meeting was also attended by the Chairman, Chief Executive, Trust Secretary and Director of Finance.

3 June 2010

At this meeting, the Council received a presentation on the Work of the Stratford and Warwick Hospitals Patient Forum, and approved a proposal on the representation of patients in the Trust's governance structure. The Council also considered a number of standing items of business.

This meeting was also attended by the Chairman, Chief Executive, Trust Secretary, Director of Finance and Non-Executive Director (David Derbyshire).

27 July 2010 (including the Annual Meeting)

The Council of Governors met for the 2010 Annual Meeting in Stratford, which was attended by members of the public. The meeting received presentations on the Annual Report and the Summary Accounts 2009/10, the Auditor's statement, report on the proceedings of the council and the Trust's future plans. Following the conclusion of the formal meeting Mr Dayalan Clarke, Consultant Breast Surgeon gave a presentation on the development of breast cancer treatment and its diagnosis and the Trust Chairman presented the Woods' Nursing Awards.

2 September 2010

The Council approved recommendations made by the Nominations and Remuneration Committee (N&RC) about the levels of remuneration for the Trust's Chairman and Non-Executive Directors, as well as the rules on expenses.

As the term of office of the Trust Chairman would end in February 2011, the Council also agreed that the N&RC should pursue a process for the re-appointment of the Trust Chairman.

At this meeting, the Council also received the resignation of Marilyn Taylor (Public Governor: West Stratford and Borders) and agreed the process for her replacement, which was to offer the seat to the candidate who had received the highest number of first preference votes of those not elected for that seat, at the inaugural elections on 17 March 2009.

This meeting was also attended by the Chairman, Chief Executive, Trust Secretary, Director of Development and Non-Executive Director (Veronica Cotterill).

2 December 2010

At this meeting the Council approved the recommendation to re-appoint Graham Murrell as Chairman of the Trust. The salaries of the Trust Chairman and Non-Executive Directors were also reviewed and, while increases were approved in some cases, it was agreed that those changes would not be implemented at the present time due to the current economic climate but would be reviewed again in September 2011.

The Council also supported the proposals to create one new public constituency area and one new class of staff membership as part of the Trust's plans for the acquisition of Warwickshire Community Services from NHS Warwickshire on 1 April 2011.

The Council also received a progress report on the Trust's Annual Objectives 2010/11 as well as an update on the Trust Strategy.

This meeting was also attended by the Chairman, Chief Executive, Trust Secretary, Director of Finance and Non-Executive Directors (Veronica Cotterill and David Derbyshire).

Sub-Committees of the Council of Governors

At the inaugural meeting on 4 March 2010, the Council of Governors appointed three sub-committees to help the Council discharge its functions. Details of these commitees are as follows:

Nominations and Remuneration Committee

The Nominations and Remuneration Committee makes recommendations to the Council of Governors on the appointment or re-appointment of the Chairman and Non-Executive Directors, and on the terms of appointment and remunerations for these positions.

This Committee has met on two occasions and made recommendations to the Council of Governors on the re-appointment of the Trust Chairman, as well as the remuneration and rules on expenses for the Chairman and Non-Executive Directors.

The Committee Chair is Michael Coker
(Public Governor: Warwick District and Borders).

Other members of the Committee include:

Felicity Bunker
(Appointed Governor: Warwick District Council)
Yvonne Hunter
(Public Governor: East Stratford and Borders)
Neil Johnson
(Appointed Governor: University of Warwick)
Karen Sharpe
(Staff Governor: Clinical Support)

The Committee is advised by the Director of Human Resources and Trust Secretary who attend the meetings but are not members of the Committee.

Membership Development Committee

The Membership Development Committee is responsible for overseeing the recruitment and engagement of both public and staff Members. In recognition of both the Trust's and the Council's responsibilities regarding membership, this Committee has been convened as a joint Committee, with a combined Trust/Governor membership.

This Committee has met five times during the period 2010/11 and has reviewed and developed the Trust's Membership and Engagement Strategy, which now incorporates a vision statement and Membership Action Plan. The Committee has also been responsible for co-ordinating a series of public events aimed at engaging with Members of the Trust and raising awareness of the work of the Trust with members of the public.

The Chair of this Committee is Brian Fletcher
(Public Governor: East Stratford and Borders).

Other members of the Committee include:

Susan Adams
(Appointed Governor: Stratford District Council)
Douglas Badger
(Public Governor: West Stratford and Borders)
Sue Bunn (Membership Officer)
Veronica Cotterill (Non-Executive Director)
Sophie Gilkes (Communications Manager)
Carol Gough
(Public Governor: Warwick and Leamington Towns)
Richard Grimes
(Public Governor: Warwick District and Borders)
Eilidh Lees (Staff Governor: Non-Clinical Support)
Meg Mold (Trust Secretary)
Ann Pope (Director of Human Resources)

General Purposes Committee

The purpose of this Committee is to oversee the arrangements for the conduct of business for the Council of Governors.

The Committee meets approximately three weeks after each Council of Governors meeting to review the business conducted at the last Council meeting and to consider and agree the agenda items for the next Council meeting. The Committee also considers the format and content of reports received by the Council.

The Chair of this Committee is the Lead Governor Matthew Statham (Public Governor: Warwick and Leamington Towns).

Other members of this Committee include:

Douglas Badger
(Public Governor: West Stratford and Borders)
David Gee
(Public Governor: East Stratford and Borders)
Yvonne Hunter
(Public Governor: East Stratford and Borders)
Eric Ives
(Public Governor: Warwick and Leamington Towns)
Pat Jagger
(Public Governor: Warwick District and Borders)
Lucy Noon
(Appointed Governor: NHS Warwickshire)
Julie Smith
(Staff Governor: Nursing and Midwifery)

The Chairman and Trust Secretary also attend these meetings but are not members of the Committee.

Trust Membership

The Trust membership is defined into two categories – staff membership and public membership. Membership is open to anyone over the age of 16 who lives within the public constituency areas (see map below) or is an employee of the Trust, providing none of the exclusions in the Constitution or Annex 8 to the Constitution (Miscellaneous Provisions) apply.

Staff Membership

In the case of staff membership, the following staff are eligible to become Members:

- Staff on a permanent contract
- Staff on a fixed-term contract of 12 months or more
- Staff who have been employed continuously for 12 months, and
- Staff employed by an independent contractor working on the Trust's behalf who have done so for 12 months or more

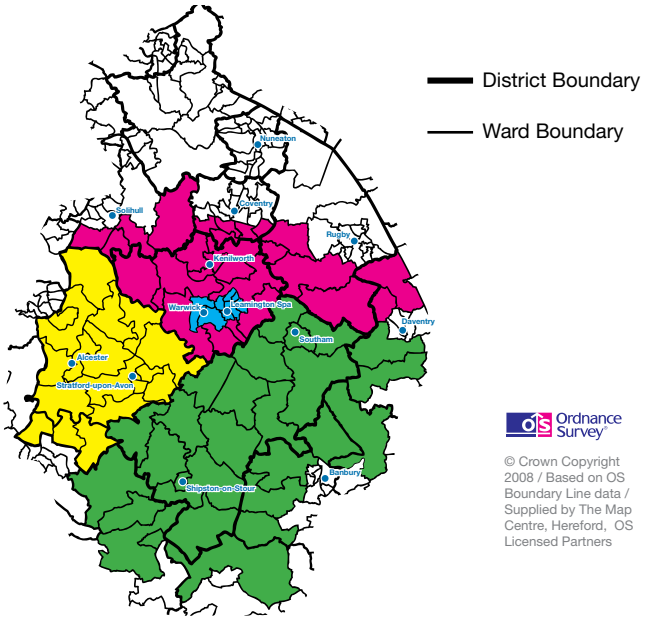
All eligible Trust staff automatically become Members unless they actively decide to opt out. For those staff acting on the Trust's behalf but who are not employees of the Trust, including contractors' staff and registered volunteers, they are invited to become Members through an 'opt-in' arrangement.

At 31 March 2011, only two members of eligible staff had chosen to opt out of membership. From 1 April 2011 all staff that transferred to the Trust from NHS Warwickshire were asked in their welcome letter to inform the Membership Office if they would like to opt out and no requests have been received.

Public Membership and Constituencies

In the case of public membership, this reflects the local population of South Warwickshire and outer areas as contained in Annex 1 of the Constitution (The Public Constituency). The constituent areas are shown on the map to the right:

Public membership has increased from 5,783 at the beginning of April 2010 to 5,814 at 31 March 2011.



Constituency	31 March 2011
Warwick and Leamington Towns	2,009
Warwick District and Borders	1,451
West Stratford and Borders	1,421
East Stratford and Borders	933
Sub-Total	**5,814**
Staff (incl. opt-in Staff)	2,305
Total	**8,119**

Public membership analysis as at 31 March 2011 is as follows

Age Group	Total Membership
16-24	323
24-44	990
45-64	1,685
65+	2,816
Total	**5,814**

Ethnicity	Total Membership
White	5,213
Mixed	27
Asian or Asian British	288
Black or Black British	26
Chinese or Other Ethnic Group	26
Not supplied	234
Total	**5,814**

Gender	Total Membership
Male	2,485
Female	3,329
Total	**5,814**

Membership and Engagement Strategy

The Trust first developed a Membership Strategy as part of its Integrated Business Plan (IBP) submitted to Monitor during the Foundation Trust application process. The strategy has since been reviewed and developed, through the Membership Development Committee, and is now known as the Membership and Engagement Strategy.

The overall objectives of the strategy are to:

- Build and maintain an engaged public membership base that takes an active interest in the affairs of the Trust, and that is broadly representative of the population served by the Trust in terms of numbers, geographical distribution, demographic profile and ethnic diversity.
- Develop staff membership as a meaningful opportunity for participation in the governance and future direction of the Trust and not merely as the default status for employees.
- Educate and inform Members so that they are equipped to act as critical friends of the Trust, to provide feedback on the Trust's activities and to help evaluate development proposals.
- Encourage Members to act as ambassadors for the Trust and the NHS within the community, to help promote the Trust's reputation and the loyalty of patients, and to promote fund-raising and volunteering.
- Embed the Trust firmly in the community through Members' connections with the diverse and overlapping networks of local people and organisations.
- Enhance the governance of the Trust, for the benefit of the communities it serves, through effective oversight by a well-balanced and suitably-equipped Council of Governors.

These objectives are in alignment with the values and vision for the Trust set out in the IBP and the Trust's overall strategy.

The Membership Engagement strategy has been considered and discussed by the Governors. The revised strategy has been considered by the Membership Developement Committee who are particularly keen next year to focus on developing a more engaged membership. This new strategy will be ratified at one of the first Council of Govenors meeting in 2011.

Membership Recruitment

Since authorisation the Trust has focused attention on developing an engaged Membership base, rather than recruiting more Members. There have been a number of projects where Members have been heavily involved, such as the Trust's new website, where a number of Members attended focus groups to help design the layout and content of the site.

The Trust has also continued the initiative to include a membership application form with each Outpatients appointment letter sent out (approximately 2,500 per week) to generate new Members. A membership information booklet has also been produced which is sent out in response to all membership enquiries.

In 2011/12 the Trust will need to actively recruit Members in North Warwickshire and Rugby to ensure that the Membership base is representative now that the Trust provides services across these areas, following the transfer of community services on 1 April 2011. More information on the new constituency can be found on page 40.

Future Membership for the Trust

As part of the acquisition of community services a number of developments to the Foundation Trust Governance arrangements have been identified, which will ensure the Trust continues to seek a representative membership from all the areas it serves, including both the local population and staff.

Events

In pursuit of an engaged Membership base the Governors have supported a number of events for Members and potential new Members. These have included a series of medical presentations, such as 'Learning more about Arthritis' together with other presentations such as 'Developments at Stratford Hospital'. Feedback from these events has been excellent with Members saying they have enjoyed the presentations. The events have also provided the opportunity to sign up new members. During 2011/12 the Governors plan to continue these events offering more opportunities for them to engage with the Membership.

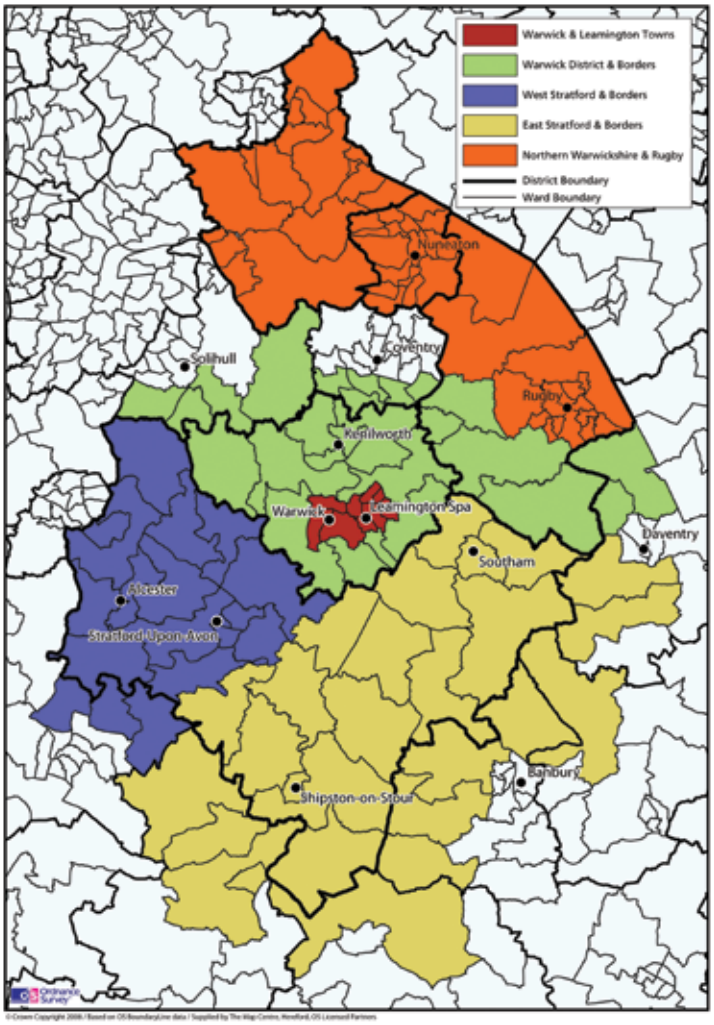
Changes to Governance Arrangements

Public Constituency

A new public constituency area covering the north of Warwickshire, excluding Coventry and those wards already part of the Warwick District and Borders Constituency area has been created. This new area is called Northern Warwickshire and Rugby.

Membership from the eligible population in this area will be sought on an opt-in basis, and will be represented by two additional public Governors.

Given the geography of the county and the proximity of other acute providers, it is very likely the population of the Northern Warwickshire and Rugby constituency area will access a smaller range of services provided by the Trust, largely focused around community services. The allocation of two Governors is to reflect this difference. Their initial term of office will end in 2012 to bring the timing of subsequent elections into line with the existing public Governors.



Staff Constituency

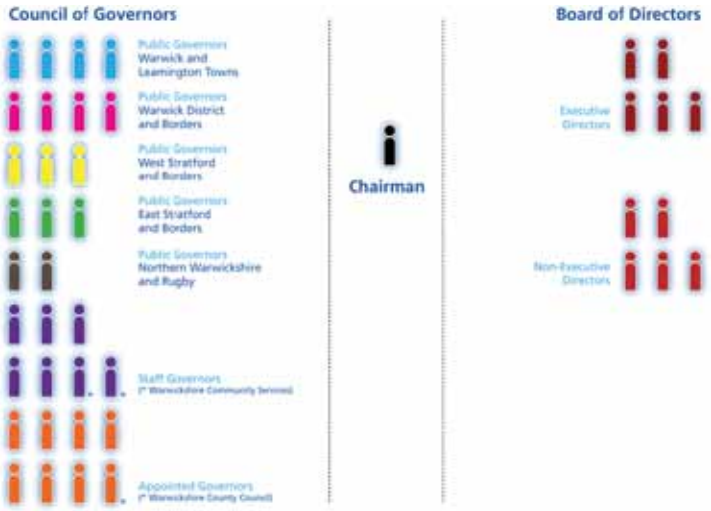
An additional class of staff member covering those staff that will work in the Warwickshire Community Services Division has been created. This new class is called Warwickshire Community Services. Membership is on an opt-out basis, represented by two Staff Governors.

Warwickshire Community Services division will form approximately 43% of the Trust's staff base. The creation of a separate class for community health staff is in recognition of this 'day-one' organisational structure.

As the transformation of services progresses the Trust intends to review the classes within the staff constituency to ensure they are appropriate for the organisation and may propose a new arrangement of classes for the term of office commencing 1 March 2013. The initial term of office ending in 2013 will bring the timing of subsequent elections in line with the existing staff Governors.

Appointed Governors

Given the forthcoming changes to the organisations involved in the commissioning of NHS services, the creation of an additional public constituency, coupled with the regular elections held in the County and District Councils, it was agreed to add an additional appointed Governor, ensuring that Public Governors still formed the majority of the council. Therefore one additional Governor has been appointed from Warwickshire County Council. The diagram below illustrates the structure for the Council of Governors from 1 April 2011.



Contact with Governors

Any comments or questions for public Governors can be sent by email to governors@swft.nhs.uk or by post via the Membership Office, South Warwickshire NHS Foundation Trust, Freepost RRUR-BBAH-CAJA, Warwick Hospital, Lakin Road, Warwick CV34 5BW. Staff members can contact their appropriate Staff Governor using their work email address or extension number.

SECTION 3:

Board of Directors

Board Composition

The Board of Directors comprises a Non-Executive Chairman, five other Non-Executive Directors and five Executive Directors with voting rights, one of whom is the Chief Executive.

During the period 1 April 2010 – 31 December 2010, the Director of Operations and Nursing was a voting member of the Board of Directors. This post was then separated into a Director of Nursing Post and a Director of Operations post and during the period 1 January 2011 – 31 March 2011, the Director of Nursing was a voting member of the Board and the Director of Operations was in attendance. Also in attendance during 1 April 2010 – 31 March 2011, without voting rights, was the Director of Human Resources and Trust Secretary.

Appointments and Roles

The key Non-Executive roles within the Board are as follows:

- Chairman – Graham Murrell (until 28 February 2014)
- Vice-Chairman – Alan Harrison (until 30 November 2011)
- Senior Independent Director – Veronica Cotterill (until 30 November 2012)

In accordance with the Constitution, the Nominations and Remuneration Committee considered the re-appointment of Graham Murrell as Trust Chairman, prior to the end of his term of office on 28 February 2011. The committee agreed to recommend to the Council of Governors, the reappointment of Mr Murrell for a three year term and the council accepted this recommendation at its meeting on 2 December 2010.

Board Member Profiles and Register

Graham Murrell
Chairman

Graham worked in scientific research for several years before moving to Boots the Chemists for 15 years. He then worked for 12 years with Halfords and gained a wide range of management experience in operational, commercial and technical roles developing special expertise in supply chain management, business systems and project management. After leaving Halfords Graham launched his own consultancy practice and has been the Trust's Chair since July 2006.

Term of Appointment: **From 1 March 2010 to 28 February 2014**

Declared Interests: **Director and Vice-Chair of Trustees at Castel Froma Ltd and Non-Executive Director of Acorns Children's Hospice Trading Ltd**

Veronica Cotterill
Non-Executive Director

Veronica started her career at the Horton General Hospital in Banbury and has previously held Chief Executive posts in Lambeth Healthcare Trust, Richmond, Twickenham and Roehampton Trust and Battersea PCG. Veronica's last NHS role was that of Deputy Chief Executive and Director of Primary Care for Wandsworth PCT.

Term of Appointment: **until 30 November 2012**

Declared Interests: **None**

David Derbyshire
Non-Executive Director

Dr Derbyshire graduated as a doctor from the University of Birmingham and is a retired Consultant Anaesthetist. Appointed Lecturer in Anaesthesia at University of Leicester in 1982 he later took up post as Consultant in Anaesthesia at Warwick Hospital. After seven years as a Clinical Director he became Chairman of the Anaesthetic Department, and Associate Medical Director with responsibility for Clinical Governance.

Term of Appointment: **until 31 October 2013**

Declared Interests: **Trustee Parish of Alveston, St James' with St Peter's Manor Road, Governor, King Edward VI School, Stratford and Spouse is Medical Director of Medco Health Solutions**

Glen Burley
Chief Executive

Glen started his career as a Finance Trainee in 1983 and has held a number of posts within the NHS including; Director of Finance, Director of Operations for the Surgery Division of University Hospitals Coventry and Warwickshire, and Deputy Chief Executive of Worcestershire Acute Hospitals. Glen has been Chief Executive at this Trust since 2007.

Declared Interests: **No personal interests, Spouse is a Governor of Myton School**

Tony Boorman
Non-Executive Director

Tony is currently the Principal Ombudsman at the Financial Ombudsman Service, appearing regularly on TV and radio programmes dealing with consumer and financial issues. Prior to joining the Ombudsman Service in 2000 Tony was Managing Director of Ofgem. Tony is also a commissioner for judicial appointments overseeing the process used to appoint judges across England and Wales. Tony joined the Trust as a Non-Executive Director in 2007.

Term of Appointment: **until 31 May 2014** *(re-appointed for 3 year term at the Council of Govenors Meeting on 13 April 2011)*

Declared Interests: **Director of SWFT Clinical Services Ltd, a wholly owned subsidiary of South Warwickshire NHS Foundation Trust**

Diane Colley
Non-Executive Director

Diane is a qualified Accountant and began her career in local government at Dudley Metropolitan Borough Council. Diane has worked at Councils in Dudley, Wolverhampton and Redditch, as well as at the former West Midlands Regional Health Authority. She joined Rugby Borough Council in 1993 as Borough Treasurer and from 1996 to 2006 was Chief Executive and Chief Financial Officer.

Term of Appointment: **until 31 October 2013**

Declared Interests: **None**

# of Interests

Alan Harrison
Non-Executive Director

Dr Alan Harrison was appointed as a Non-Executive Director in December 2007 and Vice-Chair of the Trust in 2010.

He is currently Chairman of the Staffordshire and West Midlands Probation Trust having overseen the merger of the two probation areas and their successful bid for Trust status.

Alan became the first chief executive for England Athletics, and was responsible for setting up the new governing body for the sport. He has also worked closely with disabled people and a range of charitable organisations.

He spent his early career with Courtaulds plc as a research scientist and following a succession of senior management roles, set up Courtaulds Specialty Fibres with its focus on the medical sector. He has managed a number of business turnarounds and led a worldwide business improvement programme for Courtaulds Fibres.

Term of Appointment: **until 30 November 2011**

Declared Interests: **Chair of the Staffordshire and West Midlands Probation Trust, Director of the Probation Association, Director of Fry Housing Trust and Justice of the Peace.**

Jayne Blacklay
Director of Development

Jayne trained as a pharmacist and worked at Warwick Hospital for a number of years before moving to the post of Performance Manager in 2000. She took over as Acting Director of Modernisation and Performance Management in 2002 and then moved on to be Director of Service Development and Performance Management in 2003. Jayne also took twelve months sabbatical leave in 2004 to undertake voluntary work in Ghana.

Declared Interests: **Director of SWFT Clinical Services Ltd, a wholly owned subsidiary of South Warwickshire NHS Foundation Trust and spouse is a partner of Warwick Surgical Partners.**

Jane Ives
Director of Operations and Nursing *(up until 31 December 2010 then Director of Operations from 1 January 2011)*

Jane trained as a registered general nurse and gained clinical experience on a renal unit as well as general medicine and intensive care. Jane has held director roles at City hospital in Birmingham and at the Royal Orthopaedic Hospital in Birmingham and has been Director of Nursing at this Trust since 2003 taking responsibility for the operations portfolio from 2005.

Declared Interests: **None**

Helen Walton
Director of Nursing
(from 1 January 2011)

Helen Walton was appointed as the new Director of Nursing for South Warwickshire NHS Foundation Trust on 1 January 2011. Helen has worked in the Trust for just under 7 years. Previously the Associate Director of Nursing, Helen also recently worked at the Department of Health as the development lead for 'patient and service user experience'.

Helen started in the NHS as a student nurse and later trained as a midwife at University Hospitals of Leicester. She has held a number of Board level positions across the Midlands. Helen will be the Trust's lead for a number of areas including single sex accommodation, safeguarding children and adults, privacy and dignity, quality of care, infection prevention and control and patient experience.

Declared Interests: **No personal interests and Spouse was a Director of Lighting Plus (previous contractor to the Trust). Spouse is now Lighting Consultant for Siteco.**

David Moon
Director of Finance and Deputy Chief Executive

David started his career within the NHS as a Finance Trainee for South Warwickshire Health Authority. After qualifying, David held a number of Director Roles and gained an MBA from the University of Birmingham in 1998. David returned to the NHS in 1999 after spending some time working in the Private Sector as a Commercial Manager. In 2002, he became Director of Finance and Commissioning (Deputy Chief Executive) of South Worcestershire PCT and moved to become Director of Finance of Worcestershire Acute Hospitals NHS Trust in 2003. David has also worked briefly at Solihull PCT helping them achieve financial balance in 2005/06.

Declared Interests: **Associate Governor (Finance) Brookhurst Primary School, Trustee at the Myton Hospices, Chairman of the Coventry and Warwickshire Internal Audit Consortium Board, Member of the HFMA West Midlands Branch Executive and Director of SWFT Clinical Services Ltd (a wholly owned subsidiary of South Warwickshire NHS FT).**

Steve Mather
Medical Director
(until 31 March 2011)

Dr Mather graduated as a doctor in 1977 and spent 18 months as a principal in general practice. In 1980, he joined the anaesthetic rotation at Leicester and gained his FFARCS in 1982. In 1986, he was appointed to Warwick as consultant anaesthetist. In 1999, he joined the Local Negotiating Committee, becoming the chairman within months, a post which he held for 7 years, until being appointed as Medical Director in December 2005. Dr Mather is also the Deputy Assistant Coroner for Warwick.

Declared Interests: **private anaesthetic practice at Warwickshire Nuffield Hospital, Coroner, spouse is local treasurer of the Royal Medical Benevolent Fund.**

Ian Philp
Medical Director
(from 1 April 2011)

Professor Ian Philp joins South Warwickshire NHS Foundation Trust on 1 April 2011 from NHS Warwickshire (PCT) where he has led the PCT's work for Clinical Leadership in healthcare across Warwickshire.

For the last 15 years Professor Ian Philp, CBE, has been the Marjorie Coote Professor of Health Care for Older People at the University of Sheffield and an Honorary Consultant Physician at the Northern General Hospital, Sheffield. Prof Philp was awarded the CBE for services to health care and older people in the Queen's Birthday Honours list last year.

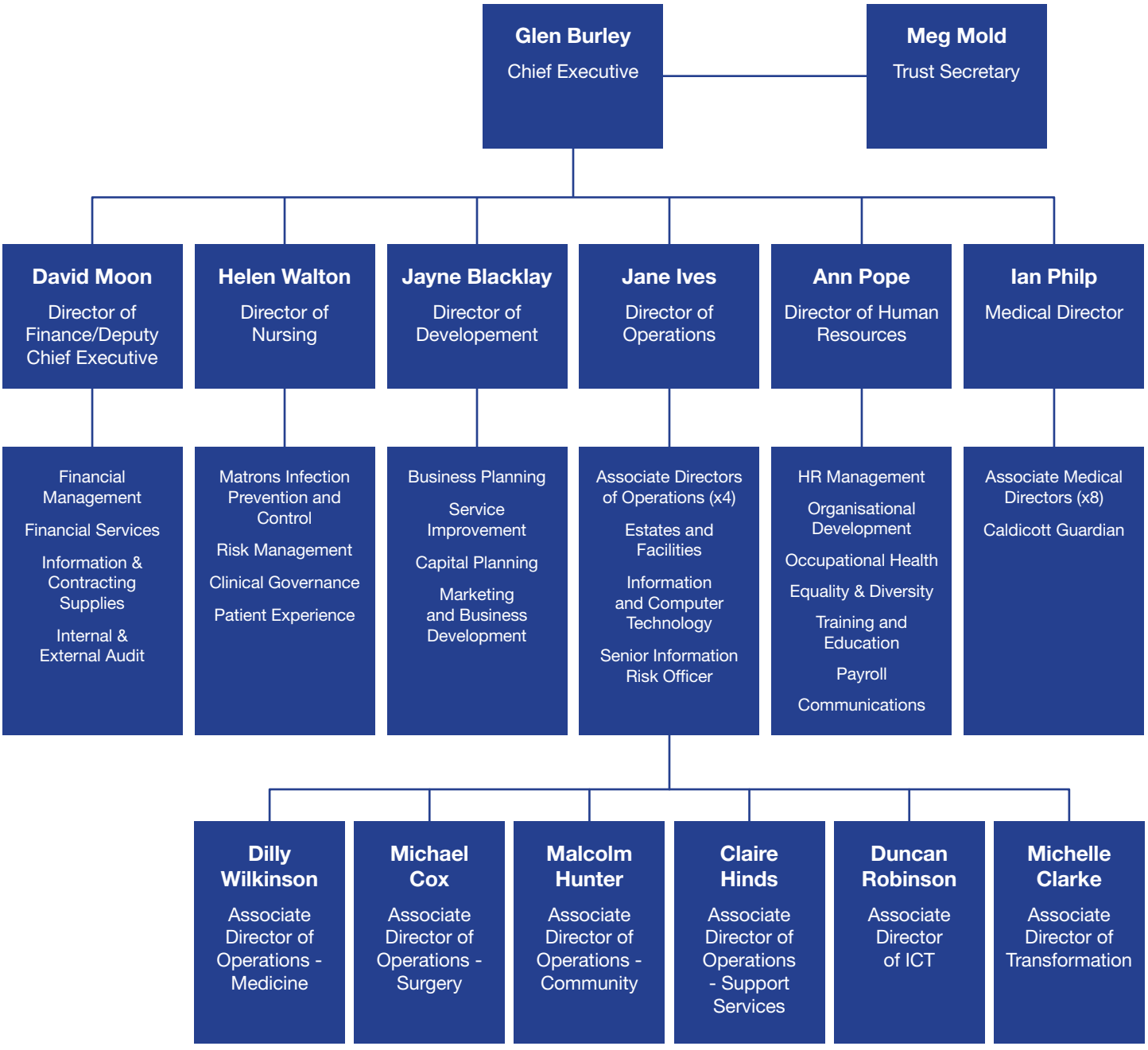
Prof Philp was also the National Clinical Director - or "Tsar" – for Older People in the Department of Health from 2000 to 2008, leading the development and implementation of the National Service Framework for Older People. He is also currently the Parliamentary spokesperson for the British Geriatrics Society.

Prof Philp is an adviser to the World Health Organisation, and he has also passed on his expertise to governments in many countries on the care of elderly people.

Declared Interests: **Director of EASY-Care Foundation (spouse also a Director), Member of Global Stroke Advisory Networks for Allergan PLC (honoraria paid for work undertaken), Member of Medical Directors Advisory Group for McKinsey (Honorarium received for advisory role with options to participate in projects on a privately contracted basis). Director of DILL Investments Ltd (spouse also a Director). In receipt of unrestricted grants paid to the University of Warwick from Pfizer PLC, to support research and development of the EASY-Care Programme.**

Please note that Professor Ian Phil has joined the Trust from 1 April 2011 as Medical Director.

Executive Structure 2011/12



Board Statements

Balance, Completeness and Appropriateness of the Board of Directors

As previously stated the Board of Directors comprises both Non-Executive and Executive Directors. The Executive Directors comprise the Chief Executive, Director of Finance/Deputy Chief Executive, Medical Director, Director of Development and Director of Operations and Nursing (up to 31 December 2010) and Director of Nursing (from 1 January 2011).

The Non-Executive Directors comprise two appointments with financial expertise: one of whom is a qualified Accountant, one with business expertise, and two with previous NHS experience: one with a medical background and one previous NHS Chief Executive. The Chairman has a private sector management background.

Taking the wide range of experience of the Board of Directors as a whole, the balance and completeness of the Board is felt to be appropriate.

Statement of Operation of the Board of Directors

The primary role of the Board of Directors is to lead the Trust within the context of its strategic direction, whilst ensuring successful financial stewardship of the organisation. In order to achieve this, the Board receives regular reports on all aspects of its business to enable appropriate decisions to be taken. In addition the Board has a schedule of reserved decisions, which lists out those decisions which only the Board can make and a scheme of delegation which details those areas of responsibility delegated to committees and individual Directors/Managers.

Independence of the Non-Executive Directors

The Board reviewed the relevant edition of the NHS Foundation Trust Code of Governance and took the view that all Non-Executive Directors could be deemed independent. As for all Board Members, Non-Executive Directors declare their interests in the Register of Directors' Interests, which is available on the Trust's website and in paper form via the Trust Secretary. Should their interests conflict with those of the Trust, the Non-Executive Director would be excluded from any discussion and decision relating to the matter in question.

Meetings of the Board and Attendance

From 1 April 2010 to 31 March 2011, the Board of Directors met on a monthly basis (except in August and December) in both public and private sessions. A small number of ad hoc Board meetings have been held during 2010/11 to transact business in relation to the acquisition of Community Services from NHS Warwickshire. An attendance record of the Board meetings can be found on page 52.

Meetings of the Non-Executive Directors

In accordance with the NHS Foundation Trust Code of Governance, the Chair and Non-Executive Directors have continued to meet outside of the normal Board meetings during 2010/11, with the Chief Executive in attendance as requested.

Appointment and Removal of Non-Executive Directors

In accordance with the Trust's Constitution, the Council of Governors has the power to appoint and remove the Chair and Non-Executive Directors of the Trust. Although authority for the final decision can not be delegated, much of the business of appointment or removal is carried out by the Nominations and Remuneration Committee.

Trust Secretary

Meg Mold was appointed as Trust Secretary in August 2007 and is also Secretary to the Council of Governors.
Meg is a chartered secretary, holds a Masters in Public Administrations (MPA) and is an associate member of the Institute of Chartered Secretaries and Administrators.

Significant Commitments of the Trust Chairman

Mr Graham Murrell, Trust Chairman, had no significant commitments other than to the Foundation Trust.

Directors' Remuneration

The Appointments and Remuneration Committee of the Board of Directors is responsible for setting the remuneration of the Executive Directors. Full details of the Directors' remuneration is set out on page 53 of the accounts.

The Nominations and Remuneration Committee of the Council of Governors is responsible for setting the remuneration of the Chairman and Non-Executive Directors.

Board Performance Evaluation

The Chairman is responsible for the appraisal of the Non-Executive Directors and the Senior Independent Director is responsible for the appraisal of the Chairman in association with the Council of Governors.

The Chief Executive is responsible for the appraisal of the Executive Directors, with the Chairman appraising the Chief Executive, and these appraisals are reported to the Appointments and Remuneration Committee.

As part of the annual planning process, the Board considered its capacity and capability, and self certified that it was able to discharge its functions effectively by signing the Board Statement.

Board Effectiveness

In March 2011 the Directors undertook a review of the Board's effectiveness, by each independently rating the Board's 'maturity' on ten key elements of fitness for effective governance. A similar self-assessment had been undertaken by the Board in 2008, early in its preparations for FT status, and it was possible to compare the two set of results.

The overall profile of maturity ratings from the 2011 review was of generally 'firm progress' with 'maturity' achieved on some elements, compared with 2008 ratings that showed generally 'basic' development with 'firm progress' on some elements. This indicated the Board has achieved significant overall improvement in fitness for effective governance over the last two to three years.

The review also indicated some areas where the Board could further improve its effectiveness, and a Board Development Workshop is being planned to decide upon follow-up actions.

Separately, over the last year the Trust has participated in the Burdett Board Development Programme conducted under the auspices of The King's Fund. This programme is designed to support boards of directors in developing their behaviours and approaches to the leadership and management of high quality patient care. The work is focused mainly on the roles of Chairman and Director of Nursing, but is reviewed by the whole Board. Several initiatives have been pursued on the recommendation of the independent programme consultant, reinforcing the Board's approach to promoting a quality focus across the organisation.

Board Communication with Govenors

During the year the Board, and in particular the Non-Executive Directors, have ensured that they are aware of the views of the Governors and Members through a number of activities, including:-

- Annual Round Table meeting between the Board of Directors and the Council of Governors
- Attendance by the Non-Executive Directors and Executive Directors at Council meetings
- Attendance by Board members at the Members' events, held throughout South Warwickshire
- Consideration of the responses from the members' questionnaire on strategic priorities
- Attendance by Governors at the Board of Directors meetings, including an opportunity to ask questions
- Consideration of reports from Council meetings at Board meetings
- Establishment of a joint Board/Council committee to consider membership development

Board Committees

The Board has three Committees: the Audit Committee, Clinical Governance Committee and the Appointments and Remuneration Committee.

Audit Committee

Remit - The Audit Committee provides the Board with assurance on the establishment and maintenance of an effective system of integrated governance, risk management and internal control. It is advised and supported by representatives from the Audit Commission, representatives from CW Audit Services, a representative from CW Counter Fraud Services (the Trust's Local Counter Fraud Specialist) and the Director of Finance and Trust Secretary.

The accounts for the accounting period 1 April 2010 to 31 March 2011 have been prepared by South Warwickshire NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Services Act 2006 in the form which the Independent Regulator of NHS Foundation Trusts (Monitor) has, with the approval of the treasury, directed.

Annual Report - In accordance with Monitor's Audit Code, the Committee prepared an annual report of its activities undertaken during the year, which was received by the Board in March 2011.

Committee Membership - Membership and attendance at the Audit Committee during 2010/11 is indicated in table below.

Member	No. of Meetings	No. of Attendances
Diane Colley (Chair)	6	6
Tony Boorman	6	4
Veronica Cotterill	6	5
David Derbyshire	6	5

External Audit - The Trust's external auditors for the year were the Audit Commission. The Commission's fee for the period 1 April 2010 – 31 March 2011 was £56,525 + VAT.

Internal Audit - The Trust's internal auditors are CW Audit Services.

Clinical Governance Committee

The Clinical Governance Committee provides the Board with assurance on clinical governance and compliance with related national standards and local objectives. Membership and attendance during 2010/11 of the Committee is indicated in table below.

Member	No. of Meetings	No. of Attendances
Veronica Cotterill (Chair)	11	11
David Derbyshire	11	8
Alan Harrison	11	10
Tony Boorman	11	7

Appointments and Remuneration Committee

This committee advises the Board on the remuneration and terms of service of the Chief Executive and Executive Directors and monitors and evaluates their performance. It is also responsible for the appointment of the Chief Executive in conjunction with the Council of Governors. Membership and attendance of the Committee is indicated in the table below.

The Trust Secretary provides advice in relation to governance and administration support to the committee. The Director of HR provides professional HR support and advice, and the Chief Executive also attends this committee.

Information to support discussion and decisions around Senior Managers (i.e. Exec) pay is taken from benchmarking exercises undertaken by the Foundation Trust Network (FTN). This data looked at roles in relation to headcount and turnover of FTs. The committee used data from Trusts of a similar size as a benchmark for these discussions. The remuneration for the most senior managers within the organisation, all of whom are on 'Agenda For Change' salary scales, is also considered. There is no performance related pay and all Executive Directors are on substantive contracts with a 3 month notice period. There have been no termination payments but contracts do allow for notice to be paid in lieu. During 2010/11 there have been no significant awards made to past senior managers.

Member	No. of Meetings	No. of Attendances
Graham Murrell (Chair)	4	4
Veronica Cotterill	4	4
David Derbyshire	4	3
Alan Harrison	4	4
Tony Boorman	4	4
Diane Colley	4	3

Terms of Reference

The Board of Directors has approved all Committee terms of reference, and these are reviewed on a regular basis, and amended as and when required.

Statement of Compliance with the Foundation Trust Code of Governance

The Board of Directors has stated that it supports and agrees with the principles set out in the NHS Foundation Trust Code of Governance, published by Monitor (March 2010).

The Board has also reviewed the provisions of the Code and has confirmed its compliance, with the following exceptions, for which it is declaring partial compliance:

Provision A.1.3 – Appraisal of the Chairman and meeting between the Senior Independent Directors (SID) and the Non-Executive Directors, and

Provision D2 – Performance evaluation

During the year Veronica Cotterill, Non-Executive Director was appointed as the Senior Independent Director (SID) and is scheduled to discuss the process for the Chairman's appraisal with the Nominations and Remuneration Committee at their next meeting in June 2011. Once this process has been agreed she will be meeting with the other Non-Executive Directors. On completion of these actions the Trust will be fully compliant with the above provisions of the Code.

Board and Committee Membership

Members	Audit Committee	Clinical Governance	Appointments and remuneration committee	Number of Board of Directors Meetings	Number of Board of Directors Meetings attended
Glen Burley Chief Executive			✓	10	10
Graham Murrell Chairman			✓ Chair	10	10
David Moon Director of Finance and Deputy Chief Executive				10	9
Jayne Blacklay Director of Development				10	9
Dr Steve Mather Medical Director		✓		10	9
Jane Ives Director of Operations and Nursing (until 31 December 2010) Director of Operations (from 1 January 2011)				7	6
Veronica Cotterill Non-Executive Director and Senior Independent Director (until 30 November 2012)	✓	✓ Chair	✓	10	10
Alan Harrison Non-Executive Director and Vice-Chair (until 30 November 2011)		✓	✓	10	10
Tony Boorman Non-Executive Director (until 31 May 2014)	✓	✓	✓	10	9
Dr David Derbyshire Associate Non-Executive Director (until October 2013)		✓	✓	10	9
Diane Colley Associate Non-Executive Director (until October 2013)	✓ Chair		✓	10	9
Helen Walton Director of Nursing (From 1 January 2011)				3	3

Please note: Also in attendance at the Board meetings during 2010/11 were, Ann Pope, Director of Human Resources and Meg Mold, Trust Secretary.

Directors' Remuneration

Name and Title	2010/11 Salary (bands of £5000) £'000	2010/11 Other Remuneration (bands of £5000) £'000	2010/11 Benefits in kind Rounded to the nearest £100	2009/10 Restated Salary (bands of £5000) £'000	2009/10 Other Remuneration (bands of £5000) £'000	2009/10 Benefits in kind Rounded to the nearest £100
Mr G Burley Chief Executive	130-135			130-135		
Mr D Moon Director of Finance	105-110			110-115		
Mrs J Blacklay Director of Development	85-90			85-90		
Dr S Mather Medical Director	80-85	135-140		65-70	135-140	
Mrs J Ives Director of Operations	90-95			90-95		
Mrs A Pope Director of Human Resources	75-80			75-80		
Mrs H Walton Director of Nursing	20-25	70-75		0		
Mr G Murrell Chairman	20-25			20-25		
Ms V Cotterill Non Executive Director	5-10			5-10		
Mrs D Colley Non Executive Director	5-10			0-5		
Mr A Harrison Non Executive Director	5-10			5-10		
Mr T Boorman Non Executive Director	5-10			5-10		
Dr D Derbyshire Non Executive Director	5-10			0-5		

The Trust's Appointments and Remuneration Committee which consists of the Chairman and all the Non-Executive Directors, considers all annual adjustments to Executive Directors' salaries and travel reimbursement costs based on NHS guidance and national surveys of earnings for directors in the Health Service.

The Chief Executive and Executive Directors have standard NHS managerial contracts with the Chief Executive on 6 months notice and the Executive Directors on 3 months notice. The Chief Executive and the Executive Directors have no provision for performance related pay in their contracts.

Please note the remuneration and pension information is subject to audit.

The Register of Interests is available on the Trust's website or by writing to the Trust Secretary.

SIGNED:

Chief Executive

DATE: / /

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2011 £'000	Cash Equivalent Transfer Value at 31 March 2010 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension £'000
Mrs J Blacklay Director of Development	0-2.5	2.5-5.0	20-25	70-75	355	397	-42	-
Mrs J Ives Director of Operations	0-2.5	2.5-5.0	25-30	85-90	439	481	-42	-
Mr D Moon Director of Finance	0-2.5	2.5-5.0	30-35	90-95	382	436	-54	-
Dr S Mather Medical Director	0-2.5	65-67.25	90-95	275-280	0	2,167	-2,167	-
Mrs A Pope Director of Human Resources	0-2.5	2.5-5.0	15-20	50-55	270	286	-16	-
Mrs H Walton Director of Nursing	22.5-25	67.5-70	20-25	65-70	321	0	321	-
Mr G Burley Chief Executive	0-2.5	2.5-5.0	40-45	130-135	625	703	-78	-

The accounting policies for pensions and other retirement benefits are set out in note 1.4 and 10.4 to the accounts and details of senior employees' remuneration can be found in page 47 of the remuneration report.

Please note the remuneration and pension information is subject to audit.

SECTION 4:

Quality Report

Part 1: Statement on Quality

Our core purpose is to provide high quality, clinically and cost effective NHS healthcare services that meet the needs of our patients and the population that we serve.

I am very pleased to introduce our second Quality Report which reflect on the financial year which ended March 2010. The Department of Health mandated the production of a Quality Report from all healthcare organisations last year, and this year we have been able to refine them and focus on things that matter more to the organisation and our Members. To help us to do this we have undertaken an engagement exercise involving our Foundation Trust Members and staff

Our overall approach to quality has been to put this in the forefront of all of our work and through this not only improve the care to patients but also deliver necessary productivity gains by getting things right first time. For a while now our Board and Council of Governors have been able to regularly review a balance scorecard of quality measures including patient safety, experience and outcomes. These have also helped us to track our improvements in hospital flow through our Health Foundation Project and are also now helping us to focus on some system-wide improvements as we take over the running of Warwickshire Community Services.

There are some encouraging signs in our Quality Report including the impressive improvements in reducing healthcare acquired infection and general improvements in our care standards at ward level. These have also been reflected through results of the key national surveys. It is also encouraging that throughout the year we have managed to maintain delivery against the requirements of the Monitor Compliance Framework including this year meeting the A&E waiting times target. It has also been encouraging to see improvements in same sex accommodation compliance, reductions in complaints and the increased engagement levels of clinical staff in audit and research and development. All of which ensure that we have a learning culture within the organisation which embraces the key pillars of good clinical governance and help to deliver continuous improvement and quality.

It is important however that we continue to focus our efforts on improving things that matter to us. In particular in the coming year we need to improve our performance on patient falls and deliver sustainable improvements in patient experience of our booking systems. This latter indicator is not measured widely in the NHS but has been something that we have focused on this year and which we intend to track closely to demonstrate that our patients experience has improved.

As well as the concentration of our Board and Council of Governors on continuous quality improvement, it is important that this is owned by every single member of staff. We were therefore very pleased to see some positive indicators in the National Staff Survey, particularly in those areas where staff were asked about the standards of care to patients. It is encouraging to see such strong results from our staff on questions regarding the quality of service to patients where we have seen scores well above the national average. It is important that we take this approach forward with us and continue to put quality at the forefront of everything that we do as an organisation.

I hereby state that to the best of my knowledge the information contained within the Quality Report is accurate.

/ / 2011

Glen Burley
Chief Executive

Part 2: Priorities for improvement

The Trust has 5 key objectives for the forthcoming year covering all aspects of the Trust:

1. To continue to improve the quality of our services
2. To improve efficiency to maintain financial performance and sustainability
3. Equip ourselves for the future
4. Develop an integrated hospital and community service to ensure that patients are treated in the right place at the right time
5. Develop our workforce to be fit for the future

From 1 April 2011 Warwickshire Community Health (WCH) transferred to South Warwickshire Foundation Trust therefore next years quality accounts will be inclusive of both acute and community services. To view WCH quality accounts for 2010-2011 please visit www.swft.nhs.uk

Within objective 1 we have agreed 6 priorities for quality improvement next year and these are:

a. Improve systems and processes to further reduce mortality rates
b. Improve the process for emergency medical admissions leading to faster safer care
c. Implement a pathway for frail elderly patients
d. Improve the discharge pathway both in the Trust and with partner agencies to reduce the number of patients delayed in hospital when their need for a hospital environment is complete
e. Improve the patient experience of food service
f. Improve patient safety by reducing the number of falls and pressure sores

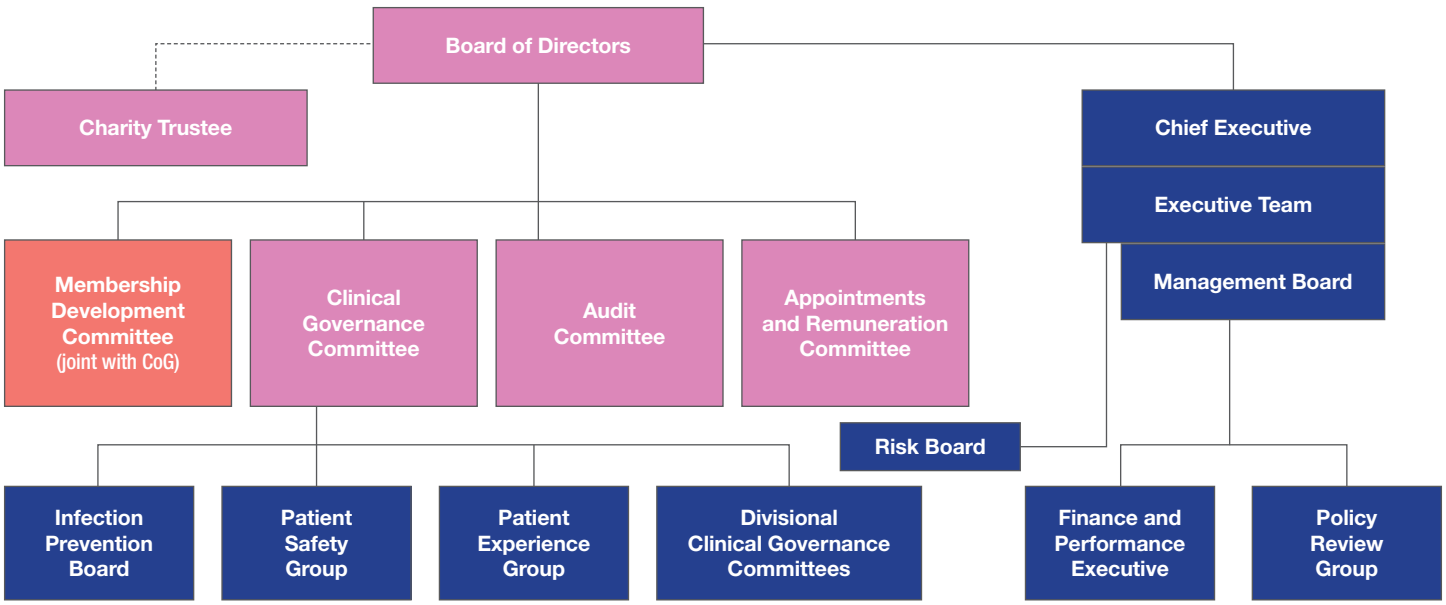
How our priorities were decided and why they are our priorities

The Chief Executive and the Executive Team agreed a long list of priorities for quality improvement based on what staff and patients have said. This list was developed into a questionnaire and was sent to 5854 stakeholders of the Trust who were asked to vote on their top 5 priorities. The stakeholders included the Trusts Board of Directors, Council of Governors, Management Board, Patient Forum, all staff and Members of the Trust. A number of the initiatives identified are ongoing from the previous year as they remain high priorities for the Trust.

How we will achieve our priorities; measure, monitor and report them

Our Board of Directors receive a monthly report of standards and targets that contains a broad range of performance measures. The Board Assurance Framework provides assurance to the Board for delivery of all key objectives including our quality improvement priorities. Each objective has a Lead Director that is accountable for the delivery of that objective. Our Management and Governance Structure provide a mechanism for reporting progress against the priorities, for implementing change and assurance on risk.

Management and Governance Structure:



We will report progress on our priorities for quality improvement in our 2011/12 Quality Report.

[Figure 1]

Statements of Assurance from the Trust

Review of Services

During 2010-11 South Warwickshire NHS Foundation Trust provided and/or sub-contracted 47 NHS services.

South Warwickshire NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100 per cent of these NHS services.

The income generated by the NHS services reviewed in 2010-11 represents 91 per cent of the total income generated from the provision of NHS services by South Warwickshire NHS Foundation Trust for 2010-11.

Participation in Clinical Audits

During 2010-11, 37 national clinical audits and 3 national confidential enquiries covered services that South Warwickshire NHS Foundation Trust provides.

During that period South Warwickshire NHS Foundation Trust participated in 62.1% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that South Warwickshire NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Clinical Audit Information :

COLUMN A **National audits the Trust was eligible for in 2010/11**	COLUMN B **National audits that the Trust participated in during 2010/11**	COLUMN C **% of National audits completed**
Perinatal mortality (CEMACH)	Yes	100
Paediatric Pneumonia (British Thoracic Society)	No	-
Paediatric Asthma (British Thoracic Society)	No	-
Paediatric Fever (College of Emergency Medicine)	Yes	100
Diabetes (RCPH National Paediatric Diabetes Audit)	No	-
Emergency use of oxygen (British Thoracic Society)	No	-
Adult community acquired pneumonia (British Thoracic Society)	No	-
Non Invasive Ventilation (NIV) – adults (British Thoracic Society)	No	-
Pleural Procedures (British Thoracic Society)	No	-
Cardiac Arrest (National Cardiac Arrest Audit)	No	100
Vital signs in majors (College of Emergency Medicine)	Yes	100
Adult critical care (Case mix programme)	Yes	100
Diabetes (National Adult Diabetes Audit)	Yes	100
Heavy Menstrual Bleeding (RCOG National Audit of HMB)	Yes	ongoing
Chronic Pain (National Pain Audit)	Yes	ongoing
Ulcerative colitis and Crohn's disease (National IBD Audit)	Yes	ongoing
Parkinson's disease (National Parkinson's Audit)	No	-
COPD (British Thoracic Society/ European Audit)	Yes	ongoing
Adult Asthma (British Thoracic Society)	No	100
Bronchiectasis (British Thoracic Society)	No	100

[Table A]

National audits the Trust was eligible for in 2010/11	National audits that the Trust participated in during 2010/11	% of National audits completed
Hip, knee and ankle replacements (National Joint Registry)	Yes	67
Elective Surgery (National PROM's Programme)	Yes	100
Familial hypercholesterolaemia (National Audit of Mgt of FH)	Yes	100
Acute Myocardial Infarction and other ACS (MINAP)	Yes	100
Heart Failure (Heart Failure Audit)	Yes	100
Pulmonary Hypertension (Pulmonary Hypertension Audit)	No	100
Acute Stroke (SINAP)	No	95
Stroke Care (National Sentinel Audit)	Yes	100
Renal colic (College of Emergency Medicine)	Yes	100
Lung cancer (National Lung cancer Audit)	Yes	100
Bowel cancer (National Bowel Cancer Audit)	Yes	100
Head and Neck cancer (DAHNO)	Yes	100
Hip fracture (National hip fracture database)	Yes	100
Falls and non-hip fractures (National Falls and Bone Health Audit)	Yes	95 - hip fractures 0 - Non hip fractures
O negative blood use (National Comparative Audit of Blood Transfusion)	Yes	100
Platelet use (Comparative Audit of Blood transfusion)	No	-
National Confidential Enquiry into Patient Outcome and Death (NCEPOD).	Yes	100
Confidential Enquiry into Maternal and Child Health (CMACH)	Yes	100
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	Yes	100

[Table A continued]

The reports of 3 national clinical audits were reviewed by the provider in 2010-11 and South Warwickshire NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Sentinel Stroke Organisational Audit Report 2010

Main actions:

- Purchase of continuous physiological monitoring equipment and provision of staff training on the new equipment.
- Set up 7 day carotid scanning with the capability to scan within 24 hours.
- Increase of psychology input in to stroke team.

National Dementia Audit (Interim Report 2010)

Main action:

- Provide mandatory training in dementia awareness for all staff whose work is likely to bring them into contact with patients with dementia.

Acute Myocardial Infarction and other ACS (MINAP)

The 9th annual public report for the Myocardial Ischemia National Audit Project (MINAP) 'How the NHS cares for patients with heart attack' was received by the Trust in September 2010. Since September 2009 patients with chest pain and ECG findings suggestive of myocardial infarction have been admitted directly to University Hospitals Coventry and Warwickshire (999 calls) or transferred there from A&E (presentations on foot). This has resulted in a reduced submission of data of eligible patients from this Trust.

Data from the three College of Emergency Medicine Audits has been submitted in February 2011 and reports are expected later in 2011.

Data has also been submitted for the Diabetes (National Adult Diabetes Audit) and National Falls and Bone Health Audit and reports are awaited.

Data collection is on going for the Ulcerative Colitis and Crohn's Disease (National IBD Audit) the COPD (British Thoracic Society/European Audit) and the Heavy Menstrual Bleeding (RCOG National audit of HMB)

The reports of 44 local clinical audits were reviewed by the provider in 2010-11 and South Warwickshire NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit actions from local audits reported to the Trust Board during 2010-11 have been précised and grouped together where possible:

- Re-designing peripheral intravenous access (PIVA) forms to increase compliance of completion and improve documentation.
- Continuing education of the Trust's Do Not Attempt Resuscitation policy with particular emphasis on correct completion of forms and filing of the (DNAR) forms. Reinforcing that a new DNAR form is required for every admission.
- Amendment of green operation record to improve recording of GMC number and printed name.
- Developing a new leaflet for staff providing clearer guidance on VTE risk assessments making it easier to differentiate between major and minor risk factors.
- Completion of VTE assessment form made mandatory before transfer to theatre to increase completion rates.
- Implementation of a new fluid balance booklet together with clear instructions on how the booklets are to be used and charts completed. New booklet is to include a positive/negative balance box to improve documentation and fluid balance management.
- Improving design of anticoagulation charts to ensure safe anticoagulation prescribing. This includes practice sessions on anticoagulation chart completion for junior doctors.
- Consideration of electronic prescribing for inpatients to reduce the number of prescribing errors.
- Continuing to provide training on how to use the antibiotic guidelines and prescribe an antibiotic using the new prescription chart at Trust induction. Reinforcing that if guidelines are not adhered to motives must be documented.
- Improve recording of GMC numbers, printed name and bleep number by providing more portable rubber stamps, especially for middle and senior grades.
- New on-line consent form to be developed and piloted to improve the procedure for taking consent.
- Continuing to educate junior medical staff on diagnosing and managing community acquired pneumonia via pneumonia guidelines, prescribing guidelines and consultant teaching with particular emphasis on using CURB score plus clinical judgement and documenting reasons for escalating therapy.
- Hip and Knee booklets to be updated and a CD to be provided for patient information following South Warwickshire Accelerated Transfer Team (SWATT) Patient Questionnaire.
- Ensuring practitioners do prescribing course to speed up TTO process.
- Increasing focus on the Time Out and Sign Out elements of the World Health Organisation (WHO) checklist by ensuring staff complete team Time Out before knife to skin.
- Establishing and designing a symptom calendar to assist with the management of genital herpes in genito-urinary medicine.

Research

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by South Warwickshire NHS Foundation Trust in 2010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 1009. This is a vast increase on the previous year (2009/2010 - 179 patients) primarily due to a high recruiting observational study being undertaken in Maternity Services. Recruitment outside of this study was up on last year at 188.

At the end of year there were 96 studies open and actively recruiting at South Warwickshire NHS Foundation Trust with a further 6 studies undergoing final research governance checks prior to being approved. Of these studies 69 were supported by the National Institute for Health Research (NIHR) through its research networks.

During the year 32 studies have closed and are now in follow up and 26 new studies have been approved and are open to recruitment.

100% were given permission by an authorised person within 5 days from receipt of a valid complete.

Breakdown of NIHR portfolio Studies

Oncology	35
ENT, Eyes and Child Health	7
Rheumatology and Orthopaedics	6
Cardiology	5
Stroke	5
Dermatology	4
Reproductive Health	3
Diabetes	2
Gastroenterology	2

51% of NIHR studies are being undertaken in the Oncology department supported by the Arden Cancer Network.

Breakdown of non portfolio Studies

Educational (PhD etc.)	20
Commercial	6
Trust	1

In the last four years, over 50 publications have resulted from our involvement in research, helping to improve patient outcomes and experience across the NHS.

The Trust continues to partake in multi-centred studies supporting high quality research for the benefit of our patients.

Goals Agreed With Commissioners

A proportion of South Warwickshire NHS Foundation Trust's income in 2010-11 was conditional on achieving quality improvement and innovation goals agreed between South Warwickshire NHS Foundation Trust and NHS Warwickshire, through the Commissioning for Quality and Innovation payment framework.

The CQUIN payment framework enables commissioners to reward for excellence, by linking a proportion of income to the achievement of local quality improvement goals. This part of the contract carried a financial value equal to 1.5% of the contract and the final monetary payment is still to be confirmed. There were 7 CQUIN schemes agreed with NHS Warwickshire for 2010-11. The Trust achieved 5 out of 7 schemes, of the remaining 2, one is in negotiation and the other was not achieved. The one that wasn't achieved was tissue viability and is subject to a CQUIN for 2011/12. This year and previous year's schemes can be accessed www.institute.nhs.uk/world_commissioning/pct_portal/cquin.html.

What Others Say About the Provider

South Warwickshire NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'. The Care Quality Commission has not taken enforcement action against South Warwickshire NHS Foundation Trust during 2010-11.

South Warwickshire NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2010-11: Dignity and Nutrition for Older People. The report following this review undertaken had not been issued by the end of the reporting period therefore any actions taken to address the conclusions or requirements reported will be included in next year's quality account.

Information Governance Toolkit Attainment Levels

South Warwickshire NHS Foundation Trust Information Governance Assessment Report overall score for 2010-11 was 69% and was graded Red from IGT (information governance toolkit) Grading Scheme. The new toolkits RAG status has been altered to only give a red or green outcome with no amber rating. A red in previous years would have been for a score of 39% or less. This year, to be graded as satisfactory, the Trust would require a score of 70% or above and all 45 requirements at level 2 or above.

Clinical Coding Error Rate

South Warwickshire NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010-11 by the Audit Commission

All data items are monitored through the SUS Data Quality Dashboard and CHKS. The Data Quality Benchmarking Report below shows the improvements that are taking place year on year.

Quality Objectives and Performance

At the beginning of 2010 the Trust identified and published 8 key objectives for 2010/11. These included quality improvement initiatives and plans which are discussed in further detail in this report including the Trusts performance against them.

Review of priorities for 2009-2010

- To improve systems and processes to reduce mortality rates (pages 79 to 80)
- To improve the discharge pathway both in the Trust and with partner agencies to reduce the number of patients delayed in hospital when their need for a hospital environment is complete (pages 83 to 84)
- To redesign the process for emergency medical admissions leading to faster safer care (page 81)
- To implement a pathway for the care of patients with dementia in hospital (page 74)
- To improve the experience of patients booking appointments with the hospita (page 78)

As part of the process to determine the Trust key objectives a SWOT (strengths, weaknesses, opportunities and strengths) analysis was carried out. This was to obtain a wide organisational perspective from staff and Members of the Trust.

This part of the quality accounts includes our progress against the priorities identified and a review of quality objectives under the headings of patient safety, patient experience and clinical effectiveness.

Data Quality

Statement on Relevance of Data Quality and Actions to Improve Data Quality

South Warwickshire NHS Foundation Trust will be taking the following actions to improve data quality. It recognises that good quality data is vital to the performance and management of the activities of the Trust. Data quality is crucial and the availability of complete, accurate and timely data is important in supporting patient care, clinical governance, and service agreements for healthcare planning. It also supports internal and external reporting of the Trust's performance targets and income.

Timeliness of data inputted to PAS is high on the agenda and therefore monitored. Data can be found on the Trust's intranet showing all admissions admitted on PAS within 6 hrs and discharges completed on PAS within 25hrs. This data is available so that the wards can also monitor themselves.

Accuracy and completeness is of course expected but to ensure this, internal reports are run on a daily/weekly basis to gain maximum coverage.

Internal audits have taken place for Inpatients and Outpatients and from these it has been acknowledged that further work is required to ensure all data is of a high standard.

Further Data Quality workshops will take place to help and advise all areas where improvements need to be made.

South Warwickshire NHS Foundation Trust achieved level 3 for the Data Validity Check (IG 507) 2010/11 assessed using the information Governance Toolkit.

	% of records that include the patient's valid NHS Number	% of records that included the patient's valid General Medical Practice Code
Admitted Patient Care	99.80%	100%
Outpatient Attendances	99.90%	100%
A&E Attendances	98.60%	100%

[Table C]

The Data Quality Measures Report is provided to the Trust Board on a monthly basis. The table below shows the data that was submitted in March 2011, showing a comparison over the last 3 months and current YTD.

	Last Month				Latest 3 Months			Current YTD		
Measure	Target	Actual	Month	RAG	Target	Actual	RAG	Target	Actual	Rag
Investigation or Treatment Recorded Within 24 Hours	95%	85.0%	Feb	A	95%	85.0%	A	95%	87.0%	A
NHS Number Coverage	98%	99.6%	Jan	G	98%	98.1%	G	98%	96.9%	A
Valid Discharge Code	100%	100%	Feb	G	100%	100%	G	100%	100%	G
Valid GP Practice Code (Valid GP Code)	98%	98.1%	Jan	G	98%	97.9%	A	98%	99.7%	G
Inpatient Diagnoses Per Episode	3	3.2	Feb	G	3	3.5	G	3	3.2	G
Inpatient Maternity Data Item Completion (CQC)								85.0%	96.8%	G
Inpatient NHS Number Coverage	99%	99.9%	Jan	G	99%	99.8%	G	99%	99.3%	G
Inpatient NHS Number Coverage - Births	100%	100%	Jan	G	100%	99.5%	A	100%	98.6%	A
Inpatient Treated Within A Day But Not Intended Day case	10%	14.6%	Feb	A	10%	14.6%	A	10%	14.1%	A
Inpatient Valid GP Practice Code	99%	99.4%	Jan	G	99%	99.2%	G			
Inpatient Waiting List: Outstanding TCIs	5	16	Feb	R	15	57	R	55	176	R
Outpatient Appointments Without Future Management	n/a	642	Dec	n/a	n/a	1,645	n/a	n/a	3,906	n/a
Outpatient Attendances NHS Number Coverage	99%	99.9%	Jan	G	99%	99.9%	G	99%	99.5%	G
Outpatient Attendances Valid GP Practice Code	99%	99.8%	Jan	G	99%	99.8%	G	99%	100%	G
Outpatient Attendances Procedure Coded (%)	20%	12.7%	Feb	A	20%	13.6%	A	20%	14.4%	A
Outpatient Attendances Without Outcome	1%	0.2%	Feb	G	1%	0.4%	G	1%	1.2%	A
Outpatient Appointments Without Attendance or Outcome	1%	0.5%	Feb	G	1%	1.3%	A	1%	0.9%	G

[Table D]

South Warwickshire NHS Foundation Trust submitted records during April 2010 to January 2011 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data, see Table E.

SWFT Data Quality Benchmarking Report - Finance & Performance Executive December 2010

		2008/09		2009/10			Q1 - Q3 2010/11	
Measure	Source	SWFT	National	SWFT Vol	SWFT	National	SWFT	National
CHKS Overall DQ Index*	CHKS	92	90.5	57,987	92	90	93.4	92.3
Blank primary diagnosis	CHKS	0.00%	1.39%	2	0.00%	0.47%	0.00%	0.96%
Average Diagnosis per coded episode	CHKS	2.7	3.2		3.1	3.4	3.5	4.2
Sign and symptom as a primary diagnosis	CHKS	10.72%	12.09%	6,561	11.31%	11.66%	10.77%	14.67%
HRG U Groups (HRGv4)	CHKS	0.15%	0.50%	1	0.00%	0.30%	0.00%	0.15%
Diagnosis non-specific	CHKS	19.45%	17.08%	11,962	20.63%	16.42%	18.08%	16.47%
Procedure non-specific	CHKS	3.64%	3.59%	1,472	2.54%	3.09%	2.53%	2.46%
Admitting diagnosis emergency for elective admission	CHKS	1.80%	1.35%	382	1.46%	1.35%	1.55%	1.62%
Volume of coded FCEs with Palliative care code	CHKS	0.07%	0.34%	300	0.52%	0.49%	0.57%	0.63%
Volume of deaths with Palliative care code	CHKS	1.22%	7.59%	135	16.21%	12.08%	27.48%	15.58%
Date Conflicts	CHKS	0.37	0.28	206	0.35	0.19	0.21	0.09

*Scale: Score out of 100, High=good

[Table E]

Part 3: Review of Quality Performance

Patient Safety

Incidents within the healthcare environment do occur. Serious Incidents are relatively uncommon. The Trust has a responsibility to make every effort to reduce the likelihood of repeat occurrences of incidents by investigating events, understanding their root causes and taking appropriate preventative action. The Trust is committed to proactive incident management processes rather than reactive, encouraging and supporting the reporting of incidents and near misses. This helps the Trust to build a strong safety culture, by reducing error which is a key priority for the Trust.

The Trust has two groups who lead on patient safety and monitor progress, these are the Infection Prevention Board and the Patient Safety group. The infection Prevention Board ensures that that there is Zero Tolerance to Healthcare Associated Infections within the Trust. The Patient Safety Group oversees the work required to reduce incidents occurring and develop a learning culture.

Infection Prevention

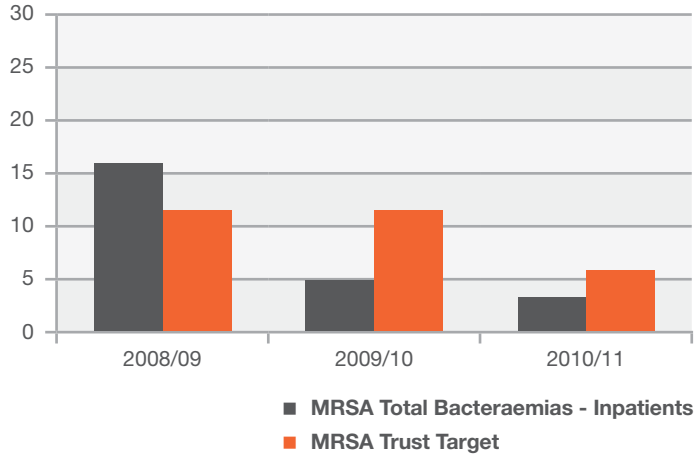
During the last year the Trust has continued to focus on the importance of improving patient safety and reducing healthcare associated infections by maintaining an emphasis on infection control as one of the Trust's Key Objectives 2010/11. The number of MRSA bacteraemia and Clostridium Difficile Associated Disease (CDAD) cases have reduced significantly over the last 3 years. Of particular note, the Trust has achieved approximately an 84% reduction in hospital attributed cases of CDAD since March 2008.

The Root Cause Analysis (RCA) process has continued to be rigorously applied by the Infection Prevention Team for the investigation of cases of MRSA bacteraemia, CDAD and deaths where CDAD has been certified as a leading cause of death. This has enabled the Trust to understand how these infections have occurred and if we could have prevented them. This leads us to understand what measures must be implemented to prevent further patients developing these infections or being seriously affected by the complications of such infections. The benefit of RCA can never be underestimated as it has meant a targeted approach to reducing infections can be implemented within the Trust. These RCA findings are shared with the Trust as a whole and form specific elements of our action plans to reduce infections.

The Infection Prevention Board, chaired by the Chief Executive, continues to meet monthly. Departmental managers and clinicians are required to attend this board and present their Infection Prevention audit results, rates of infection and findings of RCA associated with their areas. This has helped ensure managerial responsibility for infection acquisition and these managers and clinicians have assisted greatly in the RCA process.

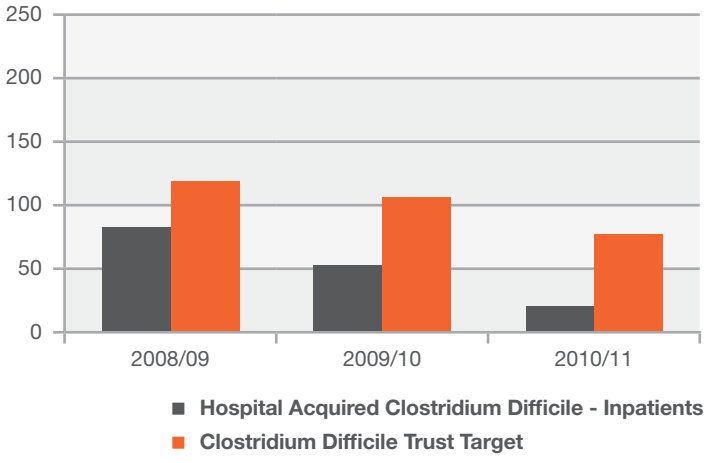
The Trust achieved its MRSA bacteraemia target in 2010/11 reporting only 3 cases of hospital attributed MRSA bacteraemia. A focus on reducing infections associated with invasive devices, which are a key cause of MRSA bacteraemias has been emphasised and the Trust has developed an improved central line monitoring form to ensure that any minor infection is identified early to prevent more significant infections occurring.

Infection Prevention MRSA Bacteraemias



[Figure 2]

Infection Prevention Clostridium Difficile



[Figure 3]

Another key activity in preventing MRSA bacteraemias has been the daily identification, isolation and decolonisation of known MRSA carriers, which has been embedded in the organisation over the last 3 years. This has been instrumental in not only reducing the risk of severe infection to those already known to carry MRSA on their skin but by isolating and treating these patients, this has helped reduce any risk of transmission to other patients.

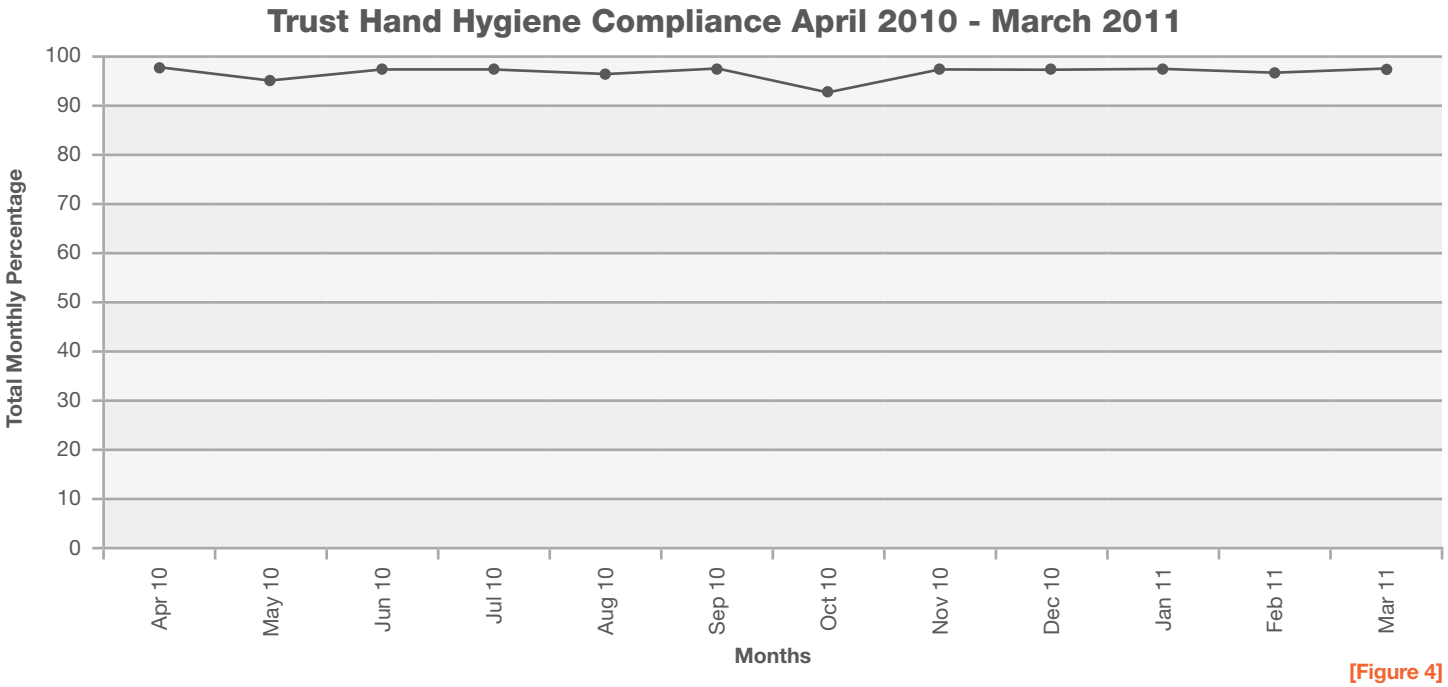
In respect of CDAD reduction the Trust is delighted but not complacent about our performance this year. 27 hospital attributed cases were identified, which is significantly below the target set for us by the Department of Health. Strict and prompt isolation of patients with diarrhoea, adherence with the Trust's antibiotic policy, strict hand hygiene and a robust cleaning service have had a combined effect on reducing the incidence of CDAD. In addition, a weekly ward round comprising of key experts in the management of patients with CDAD has been conducted resulting in improved outcomes for those patients suffering from CDAD.

*MRSA screening for elective patients

During the year the trust has aspired to be 100% compliant in all areas including minimal risk patient groups and those patients requiring urgent elective procedures. At the year end the Trust achieved 96.99% compliance. In the forthcoming year a national point prevalence study will be undertaken as commissioned by the Department of Health (DOH). This study will review all aspects of screening with a formal response from the DOH in the Autumn.

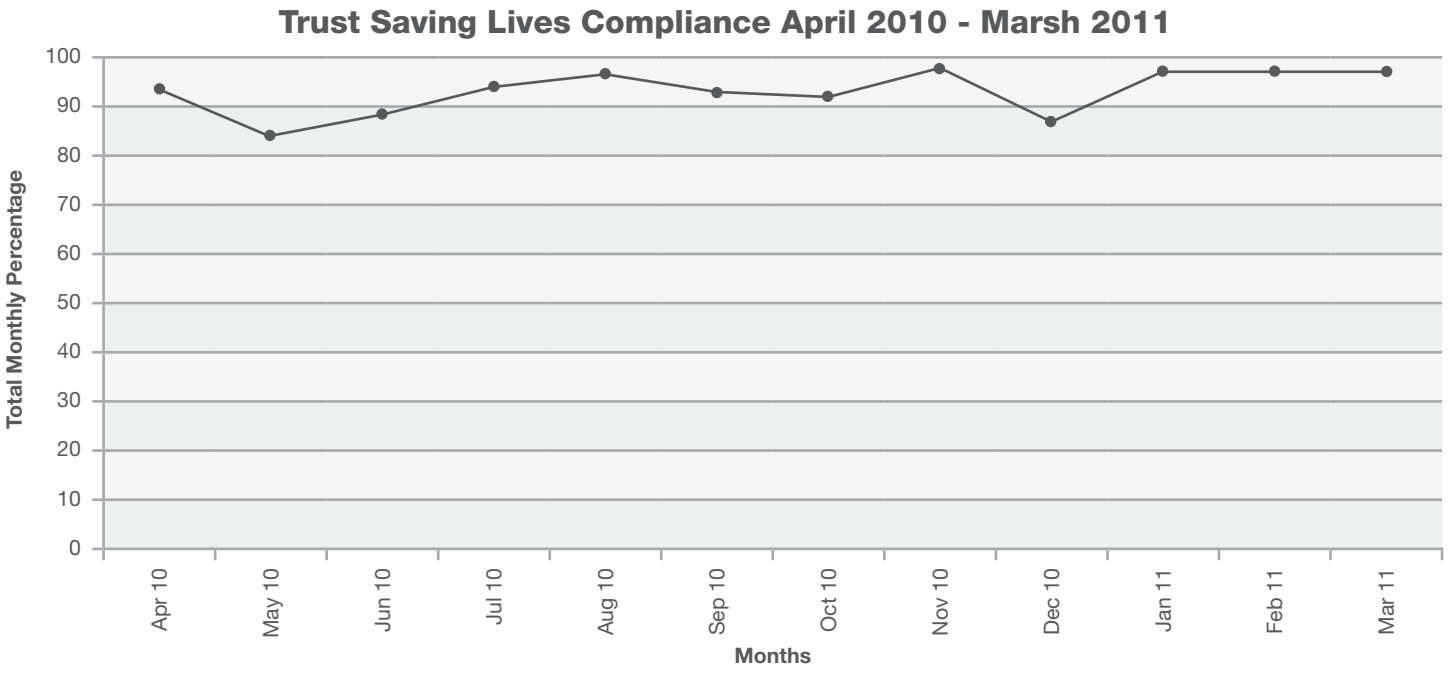
Infection Prevention (continued)

In March 2008, the Department of Health's 'Bare below the elbows' directive was introduced Trust-wide. This explains the behaviour expected of all staff involved in hands on care in clinical settings within the Trust and compliance with this is monitored monthly in the form of ward and departmental Hand Hygiene audits. Results of these audits are fed back to all ward and departmental managers, Infection Prevention Board and the Trust's Governance groups on a monthly basis. Hand Hygiene compliance has increased with an average compliance figure of 97.8% achieved trust-wide during the year.



[Figure 4]

The Department of Health's 'Saving Lives' initiative is now a fully-embedded audit process within the Trust. Wards and departments audit a series of 'high impact interventions' specific to procedures performed in their area. These interventions relate to those key clinical procedures which can increase the risk of infection if not performed appropriately.



[Figure 5]

Improving Medication Safety

The Trust was given the challenge of reducing by half the number of inpatients who did not have a prescribed medicine administered for more than 24 hours because it was not available on the ward.

Background Information

When a dose of a prescribed medicine is administered to a patient, the nurse/midwife who administers the dose initials the appropriate administration box on the treatment chart. If the dose is not given as prescribed the nurse/ midwife enters a numerical code indicating the reason why the medicine was not administered. One of the codes used is for 'Drug not found'.

It is possible for drugs not to be available on a ward for a variety of reasons. It may be that the drug in question is not stocked on that ward and the patient may not have brought in their own drugs from home; it might be a newly prescribed item for the patient and has to be specially dispensed by the Pharmacy but the Pharmacy is not open at that time; it may be that the drug was on the ward and the nurse was unable to locate it.

When the Pharmacy is closed a pharmacist is available to undertake an 'emergency duty commitment' and, when necessary, they will come in to dispense an urgently needed medicine. Whilst we aim to give every patient all their prescribed medicines at the correct time, there are some medicines where missing a dose or two is not going to have any significant impact on their treatment e.g. iron medicines and vitamins. However, there are many other medicines where missing a dose, or even a dose being delayed, can have a critical effect upon a patient's care e.g. antibiotics, drugs for diabetes, epilepsy, Parkinson's disease etc.

What We Did Initially and What Was Found

In May 2010 a baseline audit was undertaken to find out to what extent medicines were not being given for more than 24 hours because the drug was not found on the ward. This was done by reviewing the inpatient prescription sheets of 244 patients who had been prescribed medicines intended to be taken regularly.

It was found that 16 patients (6.6%) had not had a prescribed medicine given for more than 24 hours where the reason stated was 'Drug not found'.

What We Did Next

To meet the challenge we had been given to reduce this figure to no more than 3.3%, an action plan for improvement was implemented. This included:

- A flowchart for nurses/midwives to use to indicate how to deal with not having a drug available on the ward when the Pharmacy was closed.
- Information on how to check and access the Out-of-Hours Emergency Drugs Cupboard and the stock drugs kept on other wards so that doses could be obtained.
- Production and circulation of a 'Critical Medicines List' which detailed those drugs which must not be delayed or missed.
- Nurses/ midwives and pharmacy staff being reminded to be more vigilant and proactive in preventing the occurrence of missed doses.
- Reminders of the importance of giving prescribed doses which were issued by the Medical Director, Associate Directors of Nursing and Midwifery and the Clinical Director of Pharmacy.

The results of the audit work and the action plan were discussed and monitored by the Patient Safety Medication Working Group.

Did The Improvement Plan Work?

Yes it did!

When the audit was repeated in September 2010, 233 inpatient prescription sheets were checked and the number of patients who had not had a regular prescribed medicine for more than 24 hours had reduced to 3, representing just 1.3% of patients.

The new challenge then was could we sustain that improvement or improve on the results.

A further re-audit in January 2011 when 240 inpatient prescription sheets were checked unfortunately delivered a disappointing setback in that 7 patients (2.9%) had not had a prescribed medicine given for more than 24 hours where the reason stated was that the drug was not found.

We had still achieved the original challenge to reduce the figure to less than 3.3%, but it showed that we could not relent in our efforts to ensure that the drugs that our patients require are available on the wards when needed.

Implementation of Nurse Care Indicators

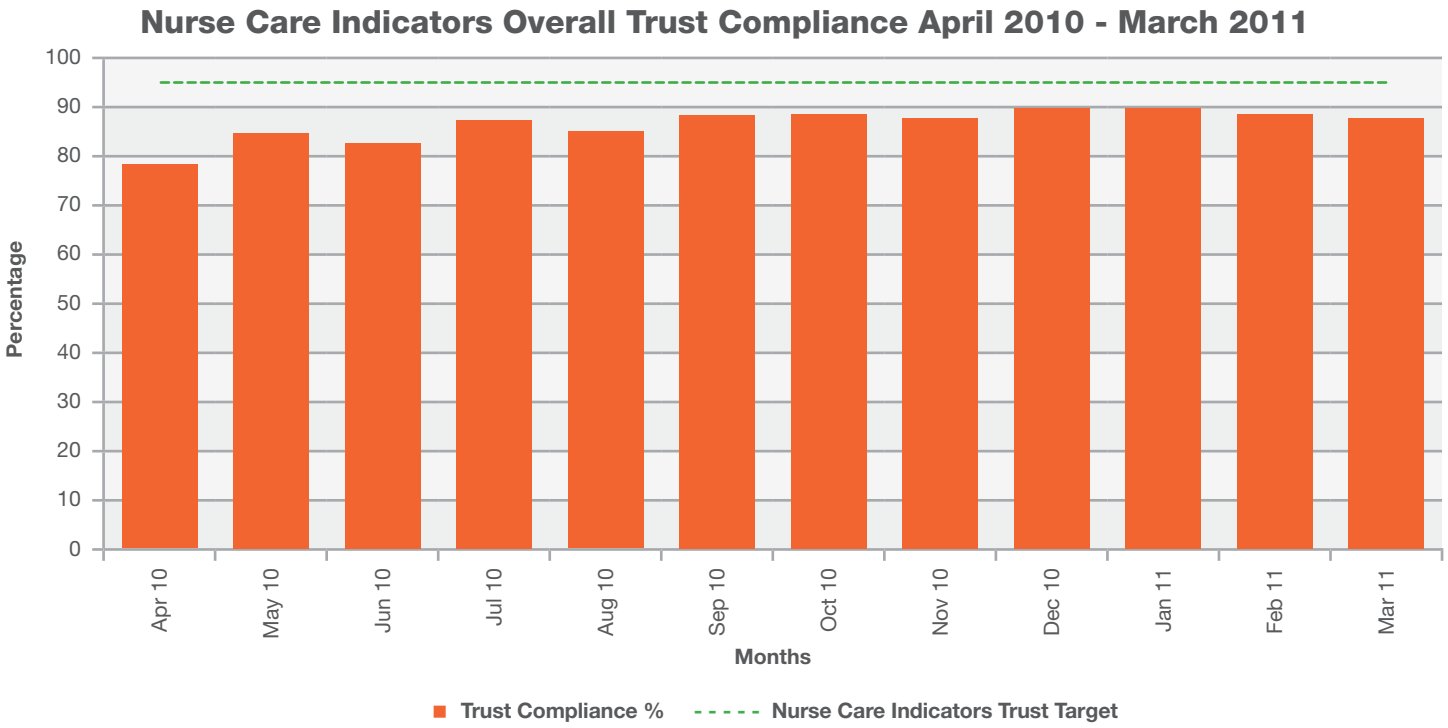
The corporate nursing team led by the Director of Nursing implemented a set of nurse care indicators in June 2010 to demonstrate the quality of care at ward level. The indicators are developed from evidence based practice and recommendations from NICE, NPSA and the RCN. The consistent application of the interventions demonstrates improvement in the quality and outcomes of nursing care.

What We Have Done

Standards were agreed with the ward managers who then implemented them on their wards. Each month, 50% of current inpatient records are audited by an audit clerk to eliminate bias for evidence of comprehensive assessment, care planning and evaluation of care for the following areas:

- Patients observations
- Pain management
- Risk of falls
- Risk of pressure damage
- Nutrition
- Medication
- Infection prevention
- Medical management

Our target is to attain and maintain 95% consistency in care in these key areas. Matrons continually work with ward and department managers that are failing to achieve the requirement, by sharing best practice and successes. They will continue to support the areas that have seen improvement and achieved good compliance concentrating on sustainability. Quality rounds with the Director of Nursing have been introduced to review individual areas outlining successes and agreeing action plans for areas that do not reach the agreed level.



[Figure 6]

Reducing patient falls in hospital

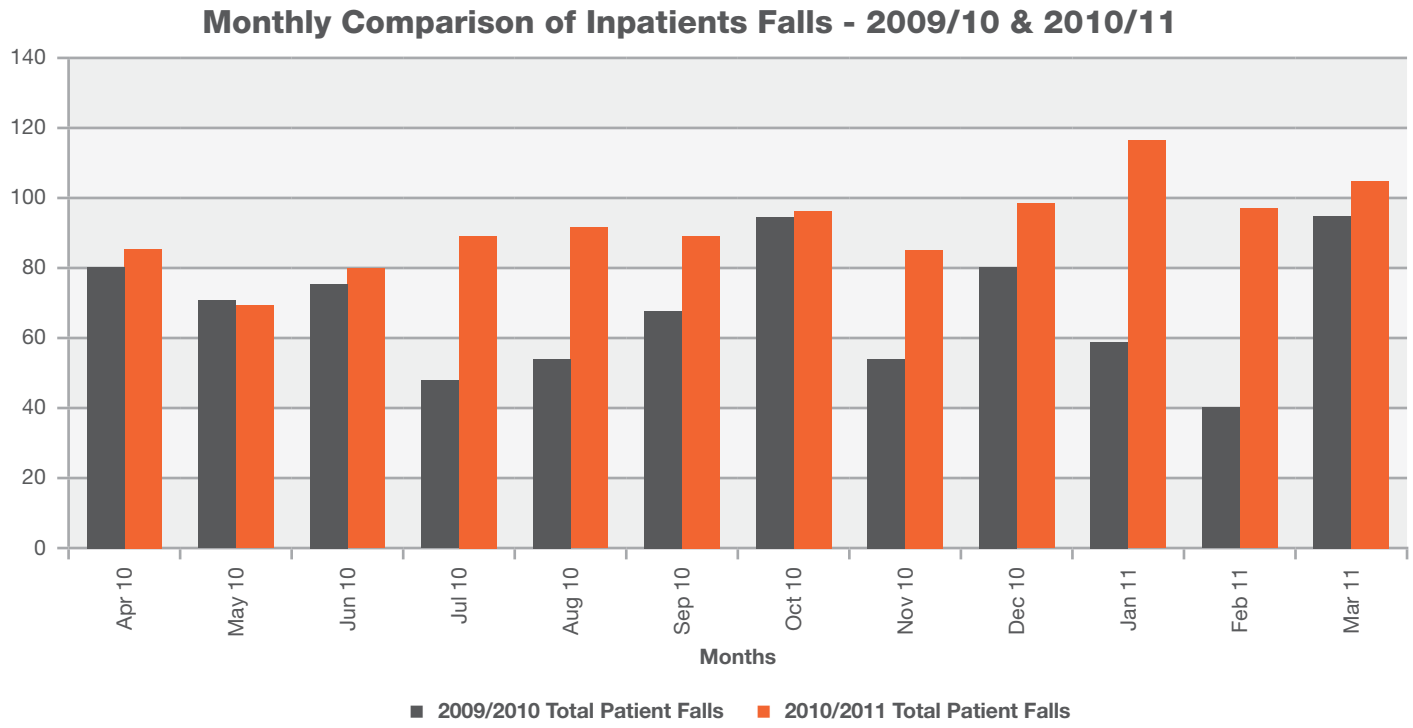
Our Patient Falls Group chaired by the Director of Nursing implemented the 'Falls Challenge' in April 2009 which has similarities to the Nursing High Impact Interventions for falls. Data suggests that although there has been an increase in the number of falls reported within the Trust during the year. This may have been due to the high profile given to falls across the Trust. All near misses and slips are also reported and the number of falls with harm has reduced.

What We Have Done

As part of the Reducing Falls Group, led by the Director of Nursing the team previously had identified the main reasons for patients falling and had identified these as:

- Needing a drink
- Needing to go to the toilet
- Inappropriate footwear
- Tripping over an object
- Call bell not to hand
- Walking aids not to hand
- Levels of confusion

A Matron has been identified to lead on Preventing Falls in the hospital and awareness of the issues has been raised across the Trust. Amendments have been made to the original 'Falls Challenge' documentation and the new format has been trialled in 4 wards. The focus has been moved to recording interactions with the patients who are deemed to be at risk of falling, rather than routinely assessing patients every two hours. The document is to be completed by any member of staff, either nursing or allied health professional, when they have interacted with the patient as part of their care. This is audited through our nurse care indicator programme. Additional high/low beds have been purchased and distributed to the wards where there is a higher prevalence of falls.



[Figure 7]

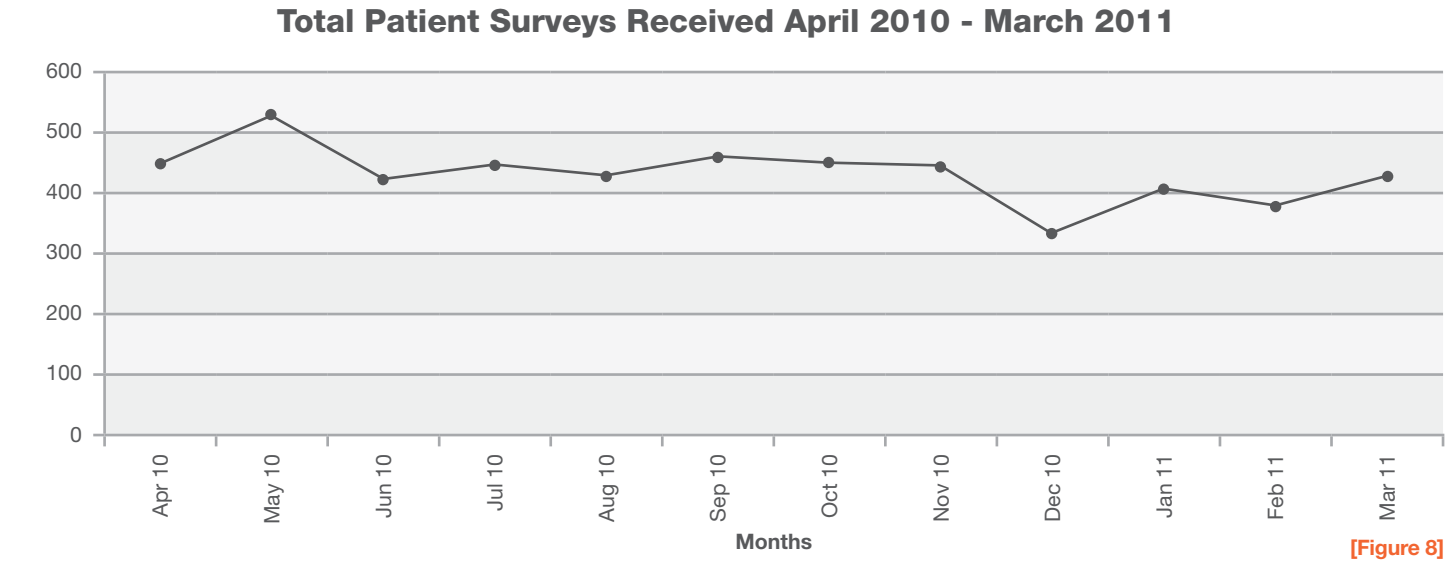
Patient Experience

Our aim is to continually improve the patient experience within the Trust. Through the Patient Experience Group (PEG), chaired by the Director of Nursing, a range of work is overseen, in all departments across the Trust. The PEG holds clinicians and mangers to account for the patient experience in their area through direct reporting to the group. Each manager/ clinician is expected to provide actions plans for improvement.

Care Survey

The bedside TV survey CARE (Communication, Attitude, Responsiveness and Environment) continues to be used to provide a forum for patients to rate aspects of the care and hospital stay. Ward managers can access their ward's results on a daily basis enabling real time feedback and responsiveness.

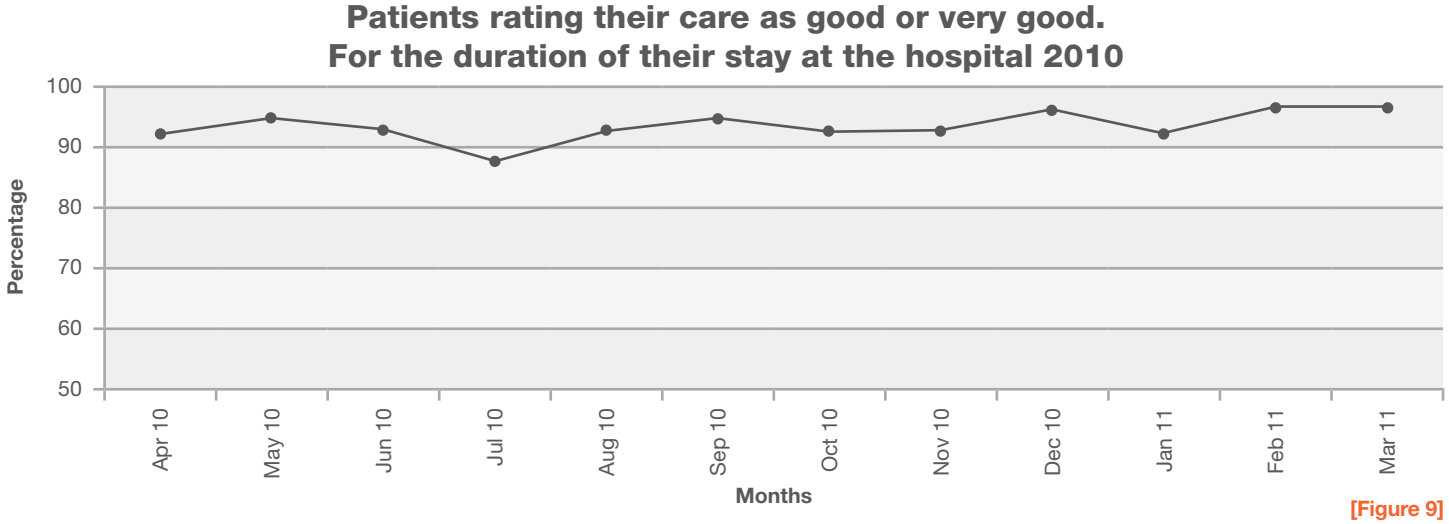
The trust set a target of 300 completed surveys per month which provides a good sample size for analysis. This target has been exceeded month on month since October 2009 when wards were individually set a target of facilitating one completed survey per day.



[Figure 8]

The survey results form a key component of the Productive Ward Module Knowing How We Are Doing which aims to keep staff up to date with ward performance and targets, celebrate successes and action plan for areas of concern.

Patients are asked how they would rate their overall care whilst in the hospital, over the last year there has been an increase in patients rating their care as good or very good, with on average over the year, 93% of patients positively rating the care they received.



[Figure 9]

More information on the National Inpatient Survey results can be found at http://caredirectory.cqc.org.uk//caredirectory/searchthecaredirectory.cfm?FaArea1=customWidgets.content_view_1&cit_id=RJC&element=SURVEY

Privacy and Dignity

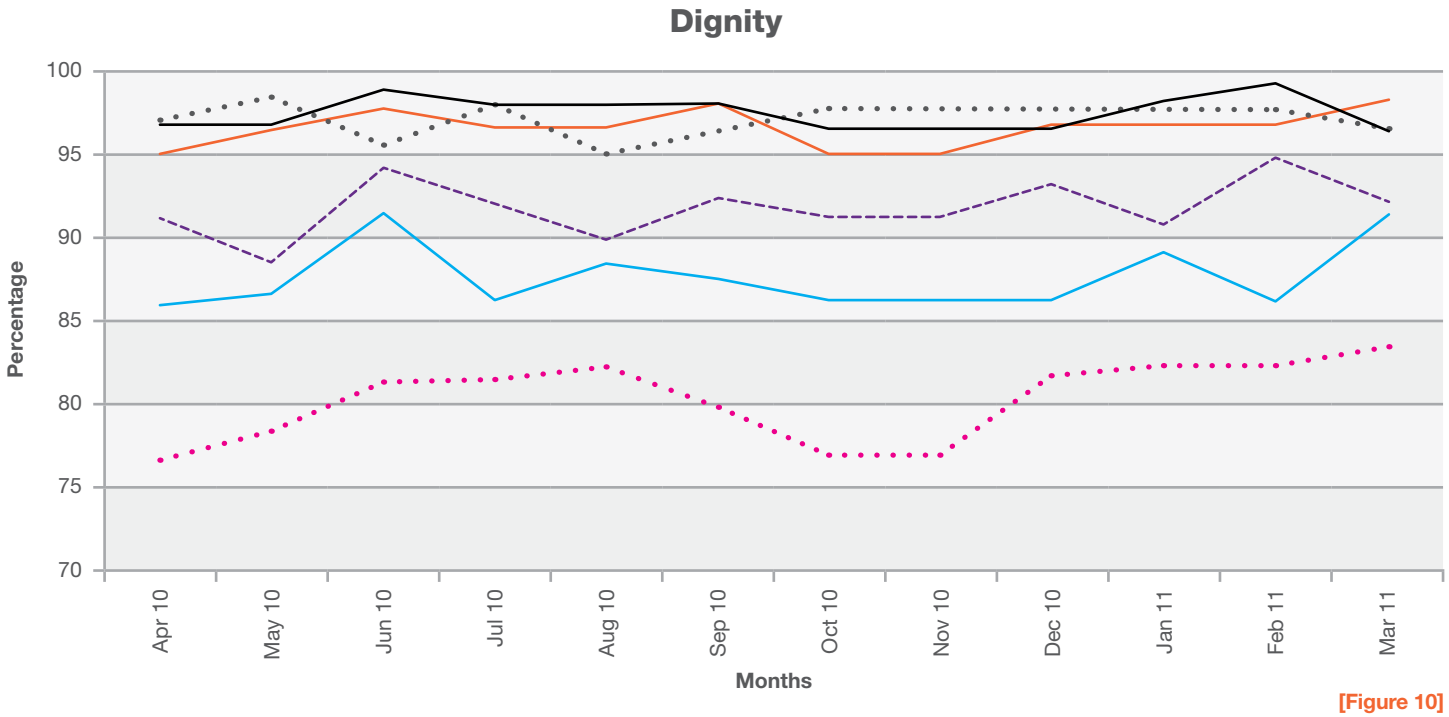
Maintaining patient privacy and dignity continues to be an essential component in care delivery throughout the hospital. The dignity promises as set out below are deeply embedded within the organisation and are displayed in all ward and departments. They are also published on the website as a commitment to patients and relatives. They form an integral element of customer service and are utilised as part of corporate induction and this will be carried through to the induction of the Community Staff as part of the transfer of Community Services. They will also be disseminated and shared with our community hospitals.

We promise that:

- You will be introduced to the staff who are caring for you
- You will be called by a name of your choosing
- We will respond to your questions promptly, or find someone who can
- Your privacy and modesty will be maintained at all times
- You will be treated in a courteous manner that respects you, taking into account your religious and cultural beliefs
- You will be cared for in a clean and safe environment
- If you require any physical assistance from a member of staff, it will be given in a safe and gentle manner.

In return we ask that you treat our staff with the dignity and respect they deserve. The 'Dignity Promises' are monitored through the CARE survey with 6 specific related questions. There has been a sustained improvement in responses regarding privacy and dignity against 2009 figures.

Results from the CARE survey are fed back to PEG on a quarterly basis and monthly at the Senior Nurses Meeting with highlighted areas which need improvement. Particular attention has been paid to asking patients which name they would like to be called by and ensuring more privacy for patients when discussing treatment or their condition.



[Figure 10]

Care of Patients with Dementia

During the last year a large emphasis has been placed upon dignity in care for patients with a dementia and a programme with four levels of training has been developed and delivered. An integral component of the level 3 training involves relatives of a patient who had been cared for in our Trust, sharing their experience about their mother who has a dementia, directly with staff.

All of our substantive staff has received at least level 1 basic dementia awareness training, information about caring for patients with a dementia in our wards and departments. This will be rolled out for community staff and non substantive staff during the coming year.

We are also developing a team of dedicated key workers in dignity in dementia care at ward and departmental level.

We have worked closely with the Alzheimer's Society this year who have provided volunteers and an information stand with details of the support networks and assistance available to people with a dementia and their families within South Warwickshire, during January 2011 and again in June 2011. We are also promoting Dementia Awareness Week with the Alzheimer's Society during July. This collaborative partnership has enabled us to develop resources folders for all of the wards and departments to empower staff to assist patients and relatives with services and support available within the community.

Following a competition searching for innovations to promote dignity in care, the winning entry supported the use of the 'This is Me' document, a tool to help support patients with a dementia in an unfamiliar environment. This is being implemented within the Accident & Emergency Department as the first point of contact for many patients. This tool allows families and carers to record essential information about the person with a dementia, to allow staff to plan and deliver appropriate care.

A multidisciplinary focus group for implementing the National Dementia Strategy has been developed and is focussing on the design and implementation of a pathway of care for people with a dementia within the acute hospital setting in partnership with the integrated community services.

The Nicol Unit, Stratford Hospital, has launched, 'The Freedom Project', in conjunction with the King's Fund, London, enhancing the environment and employing assistive technology, to provide a more conducive, caring environment and atmosphere to care for patients with a dementia, in the rehabilitation setting.

Single-Sex Accommodation

During 2010/11 the Trust made a significant improvement in the number of patients experiencing mixed sex accommodation (MSA). At the beginning of the year over 200 patients a month were experiencing MSA. This was reduced to 11 patients in September, the lowest month to date for breaches.

The feedback from patients about their experience of MSA has improved over the year, with 95% of patients surveyed at their bedsides reporting that they did not share sleeping accommodation with the opposite sex (approximately 350 patients are surveyed every month). This is also reflected in the 2010 Care Quality Commission annual in patient survey, where there was a dramatic improvement in the percentage of patients reporting MSA. 91% of patients, the same as the national average, reported that they did not experience MSA, compared to 78% in the previous year.

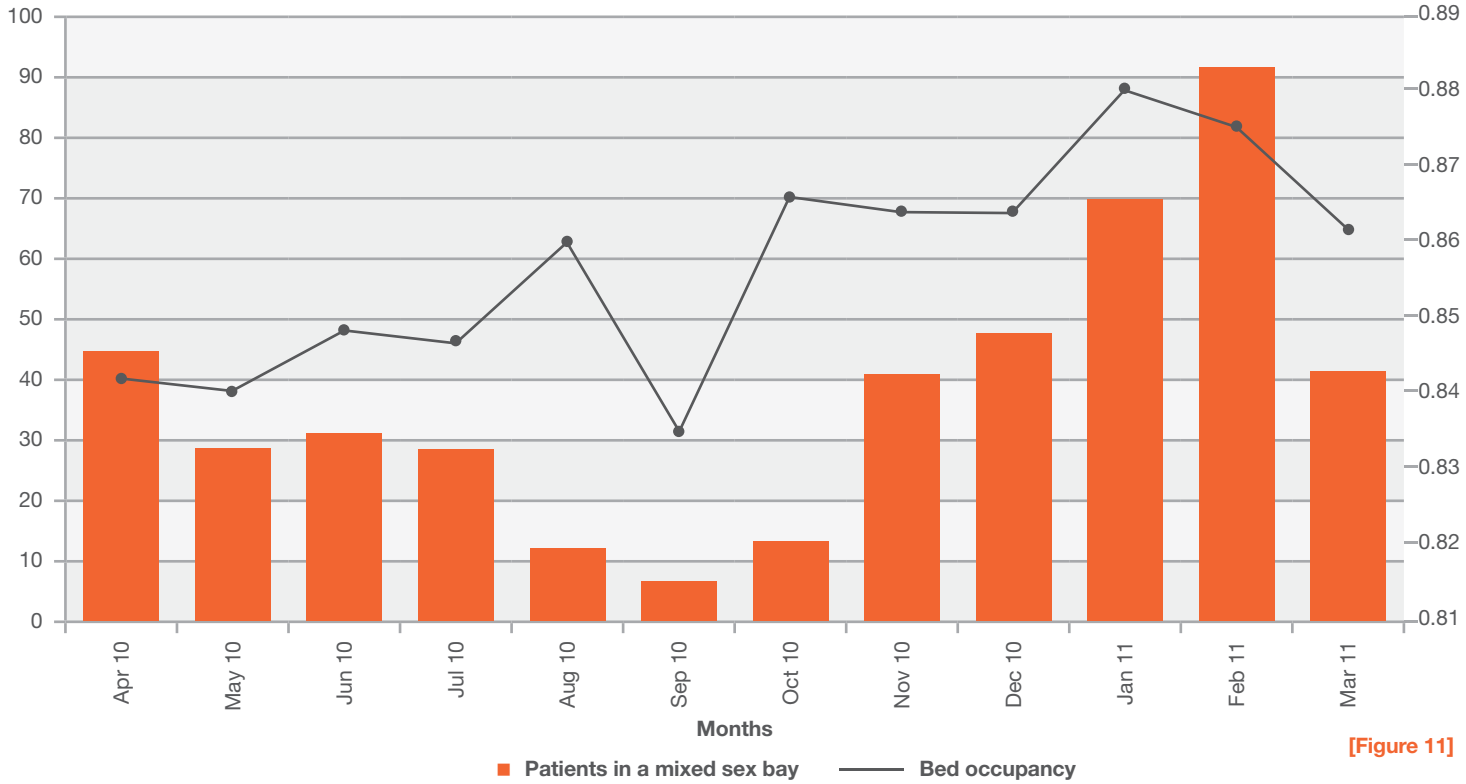
What We Have Done

To achieve the improvement in same sex accommodation (SSA), the Trust has been delivering on its Same Sex Accommodation Delivery Plan, which is monitored by the Board of Directors. The actions that have been achieved in 2010/11 include increasing the culture of SSA through increasing information and reporting of SSA to staff and patients; monitoring and route cause analysis of breaches through the SSA Group, and completion of estates projects on Malins Ward, CCU, Day Surgery Unit, 23 Hour Ward and Endoscopy.

Next Steps

The Trust's commitment is to achieving 100% compliance with SSA. While the Trust almost achieved this in September, it became increasingly difficult to achieve this during the winter months. The main reason for not achieving compliance has been difficulties with the flow of patients through and out of the Hospital. The Trust is currently engaged in and are planning many work streams to address patient flow, as part of the Trust's 'Right Size Action Plan'. These include ambulatory care pathways, the acute flow programme, 7 day services, productive ward rounds and discharges, Cutting the Cost of Frailty, improved flow to community hospitals, community intravenous services and reduced surgical length of stays. The Trust is also considering moving towards same sex wards.

Mixed Sex Accommodation
Number of patients spending more than 4 hours in a mixed sex bay



[Figure 11]

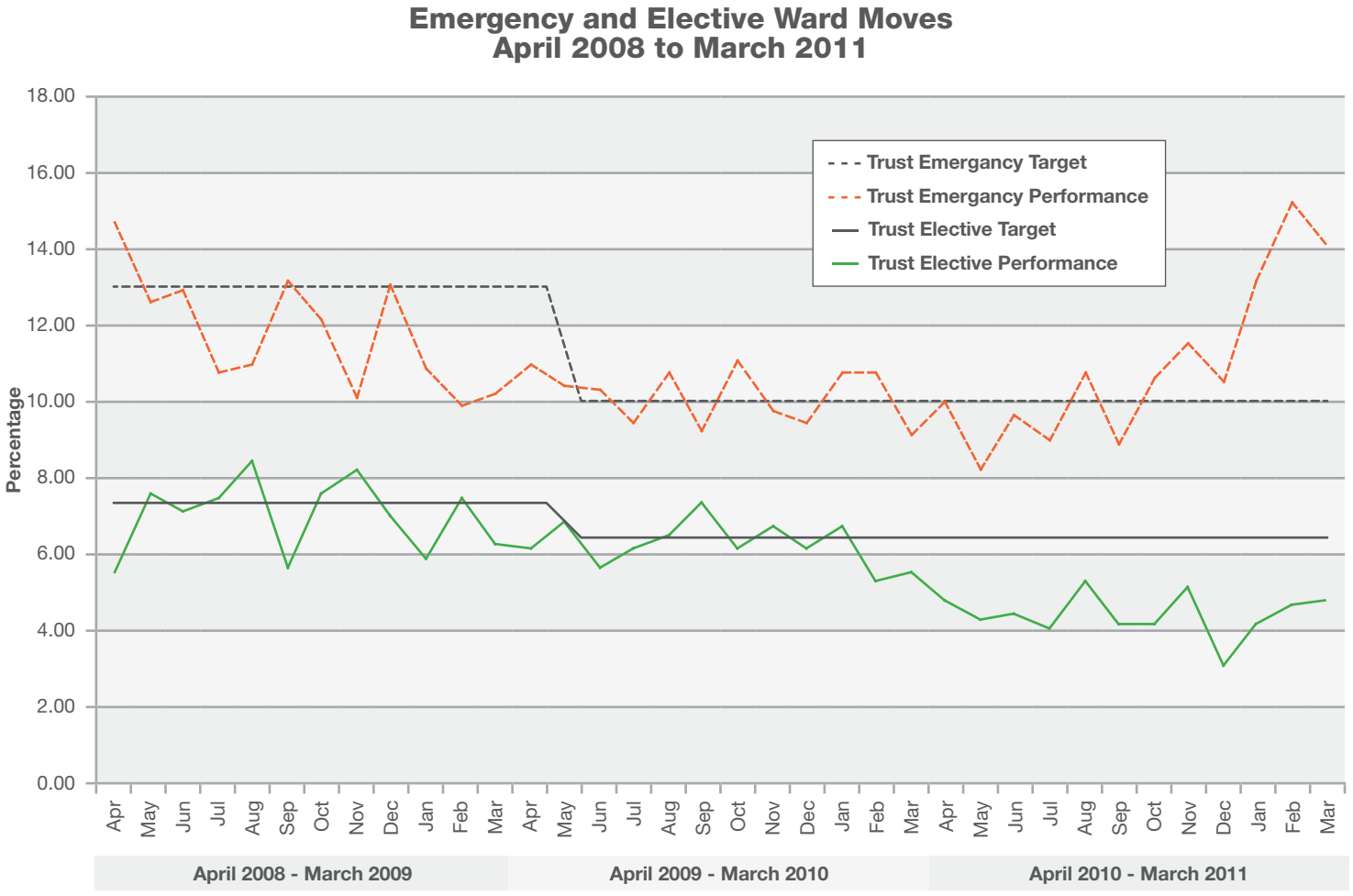
The number of breaches equates to the number of patients in a bay on a ward.
For example one male on a 6 bedded female bay would equate to 6 breaches.

Non-clinical ward moves

The monitoring and analysis of non-clinical ward moves for patients continue with monthly data being reported to the Patient Experience Group. The matron team has continued to work with ward mangers and their teams in an attempt to minimise the number of moves a patient experiences, which can result in disruption to communication and continuity of care. The concept of outlying patients with the Trust still exists within the organisation due to the pressures on beds and the number of patient's who's discharges are delayed due to complexity and lack of availability of community placements and services.

It is anticipated and expected that patients will move from wards and departments to receive specialist care, treatment or diagnostics which is clinically indicated. The Trust has set a standard whereby patients should not expect to be moved more than 3 times during one hospital stay. This concurs with the Trust's acute admission process of admission to an assessment unit, a move to a specialist ward and one move following medical fitness for discharge being declared. The increased awareness amongst nursing, medical staff and access co-ordinating staff, about minimising the disruption to a patients' journey has assisted in reducing the same patients being moved multiple times with a specific emphasis being placed on not moving patients with cognitive impairment unless clinically indicated. The majority of patients experiencing higher levels of moves are usually within the medical division or trauma orthopaedics.

The chart below demonstrates the improvements made in elective admissions but highlights the challenges within the emergency admission process especially at times when there is high demand on capacity due to emergency admissions.



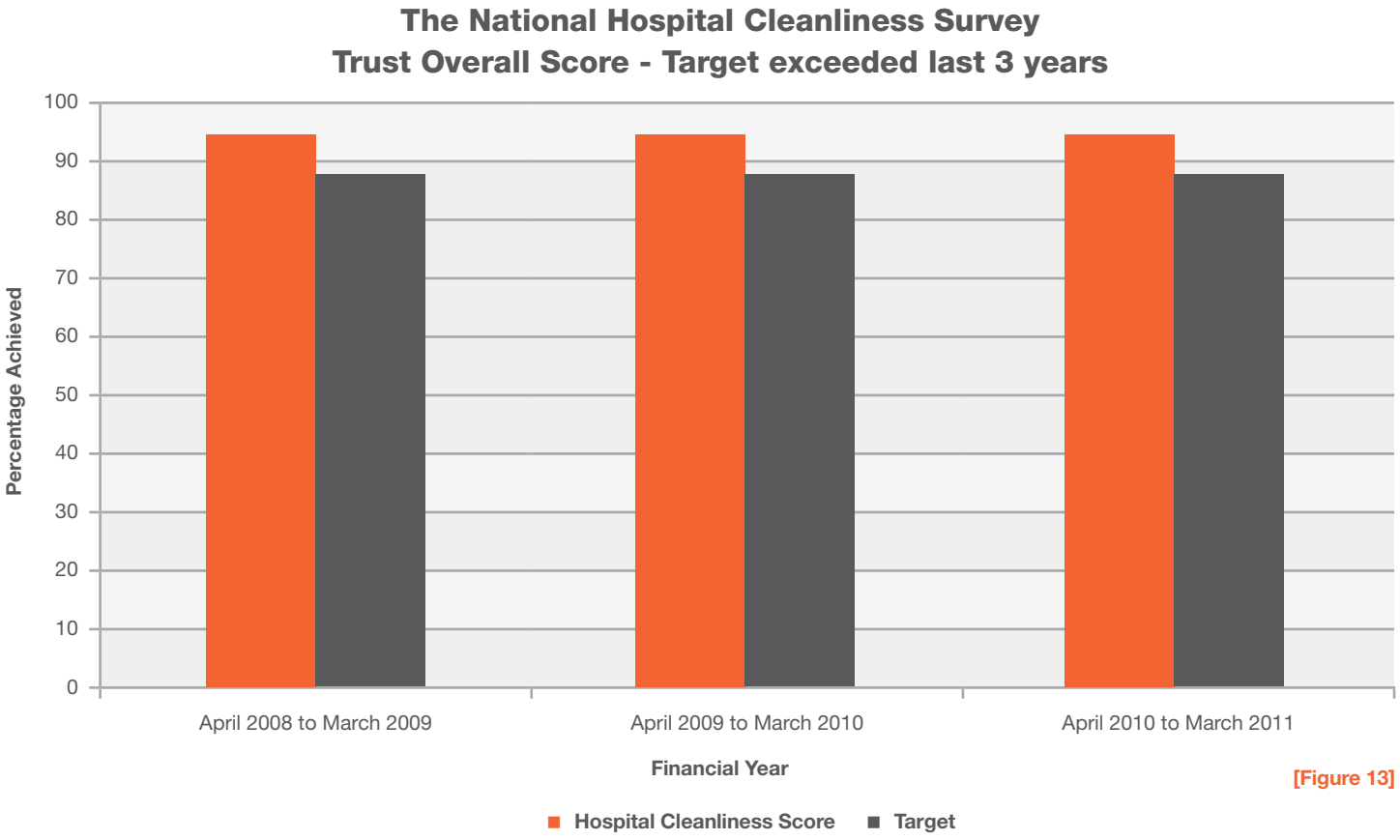
[Figure 12]

Despite the work undertaken to reduce unnecessary ward moves, the concept remains a feature of the Trust's operational system especially at times of high occupancy. In view of this the matron team in consultation with the ward managers, and following the audit of compliance with the Trust's patient transfer procedure have developed and implemented a 'transfer in' form supplemented by a transferring ward checklist to ensure the correct documentation, information and equipment has been facilitated for the patient transfer. This is hoped to make the transfer procedure of patients much more standardised and safer for all patients throughout the organisation. Success and compliance will be re-audited in April 2011.

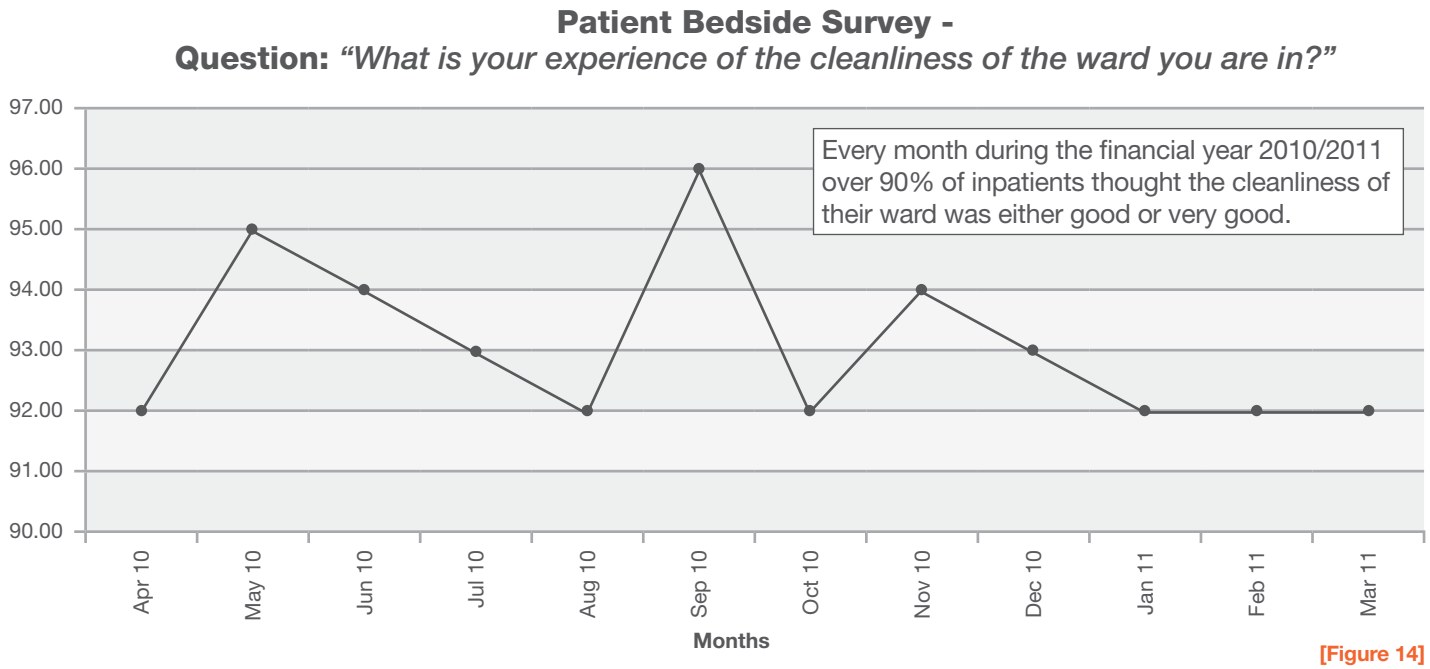
Cleanliness

National Hospital Cleanliness Key Performance Indicators have been met at Warwick and Stratford Hospitals on a continuing basis over the last year for all categories, Very High Risk – 98%, High Risk – 95%, Significant Risk 85%. The Trust has a robust monitoring process and the positive performance is reflected in the patient surveys carried out in house.

The Trust has invested in new flooring and replaced ward furniture in a number of wards and departments.



[Figure 13]



[Figure 14]

Complaints

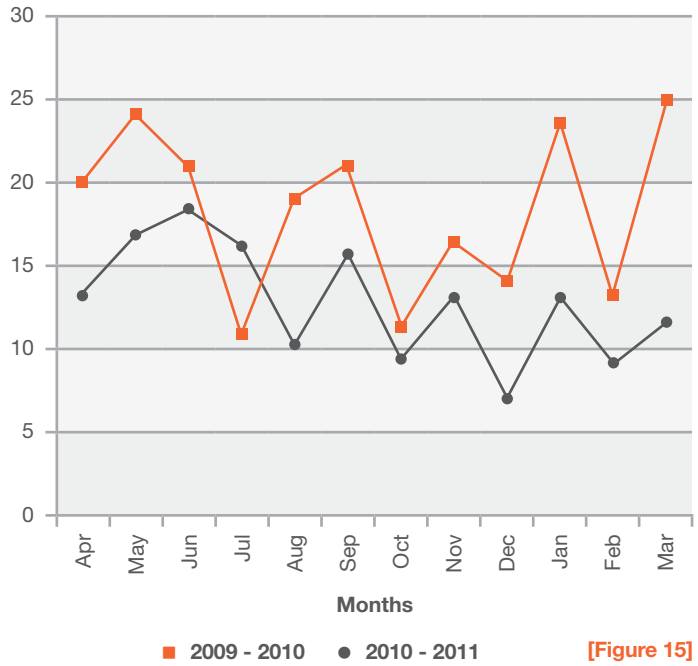
The Trust recognises that patient feedback, comments and complaints are effective measures of services delivered and necessary learning. The information gained assists the Trust in:

- Recognising standards of service delivery and continuing to improve those services
- Being aware of patient experience, perspective and expectations
- Identifying problematic areas
- Identifying actions needed
- Monitoring service delivery requirements

The Trust has seen a significant fall in the number of complaints over the year; this is due to the high profile role of the Matrons and the Patient Experience Team who resolve issues at a local level before they become a complaint.

In 2010/11 the Trust received 153 compared to 219 in 2009/10.

No. of Complaints by Monthly Comparisons



[Figure 15]

Patient Advice Liaison Service (PALS)

PALS is an independent and confidential advice and support service for patients and their relatives/friends. It offers patients the opportunity to raise any concerns they might have at a very early stage, enabling them to be dealt with promptly. The service works in partnership with patients and staff to identify where the Trust can improve services.

This year's contacts fall into the same five top categories as the previous year; clinical care/decision, outpatient appointment issues, communication, discharge and transfer arrangements and patient property – including lost items.

Outpatient Booking Service Improvement

Outpatient Booking Services have continued to implement measures to improve the patient experience when booking an appointment. It has been clear that patients are frustrated when they cannot get through to the Call Centre easily to book, change or cancel an appointment, particularly when the hospital has rescheduled their appointment.

One of the key objectives was to provide a number of options for patients to contact and communicate with the Booking Call Centre. The first of the initiatives was to provide one number for all patients to contact, that was covered for longer hours of the day and this was put in place operating from 8.30am until 7.00pm. We are currently analysing the data to see if these hours need to be extended further. Secondly an e-mail address is now in place and increasing numbers of patients are now using this method to cancel and change appointments, and negotiating a date and time for an appointment. These changes are communicated via all appointment letters.

A further improvement is in the Call Centre response times which have achieved between 85% and 90% of all calls being answered.

Rescheduled appointments cause frustration and annoyance to patients and the Trust has been tackling this problem over the last year with Clinical Specialties and Booking Services. The Trust has been monitoring and reporting on the number of patients rescheduled in Consultant led clinics. Performance during 2010-11 has seen, despite some in year peaks and troughs in number, a 25% reduction in the number of patients rescheduled by the hospital from the start of the year with 2841 reported in April to 2111 in March. Analysis of the reasons for the reschedules has been carried out to better inform which are avoidable and which are not. As a consequence of this analysis Action Plans have been implemented to reduce those reschedules that are avoidable and to improve planning and communication between the Clinical Teams and Booking Staff.

Clinical Effectiveness

Hospital mortality rates

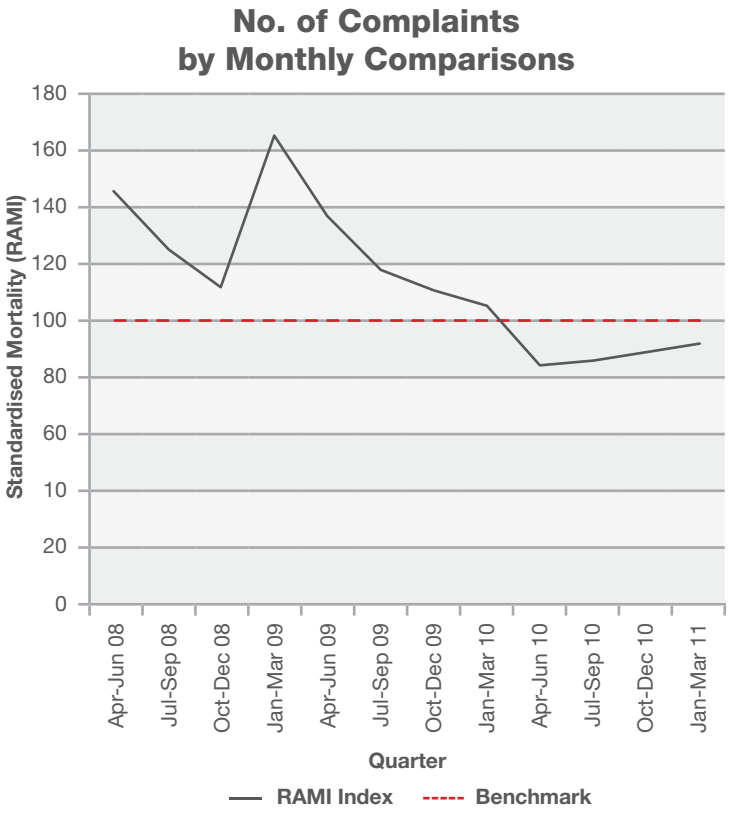
The Trust had a high Hospital Standardised Mortality Rate (HSMR) for a number of years. During 2009 the Trust changed the provider of the analytical tool used. The Risk Adjusted Mortality Index (RAMI) is an index that compares mortality rates across the country risk adjusted for age and co-morbidity. This is an alternative measure to HSMR. The average is 100, an index above that would demonstrate a higher level of deaths in the hospital than would be expected.

The chart below shows the RAMI over the last five years. As can be seen there has been a continuing reduction in the mortality index.

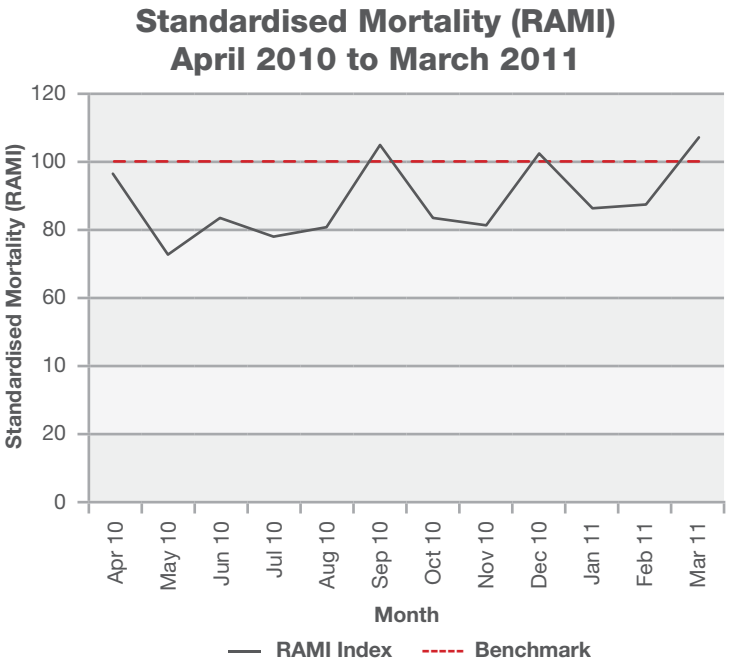
The reduction that was seen in 2009 has continued in 2010. The RAMI will be subject to rebasing and so may increase a little when the year is complete and all the data is available.

Our RAMI and actual mortality rates (actual deaths) have both been seen to fall during the year compared to previous years. A number of quality improvements have led to this reduction, many mentioned elsewhere in the report.

Mortality is subject to seasonality with more deaths occurring in the winter months. The chart below shows that there has been less seasonality over the last two years than in previous years.

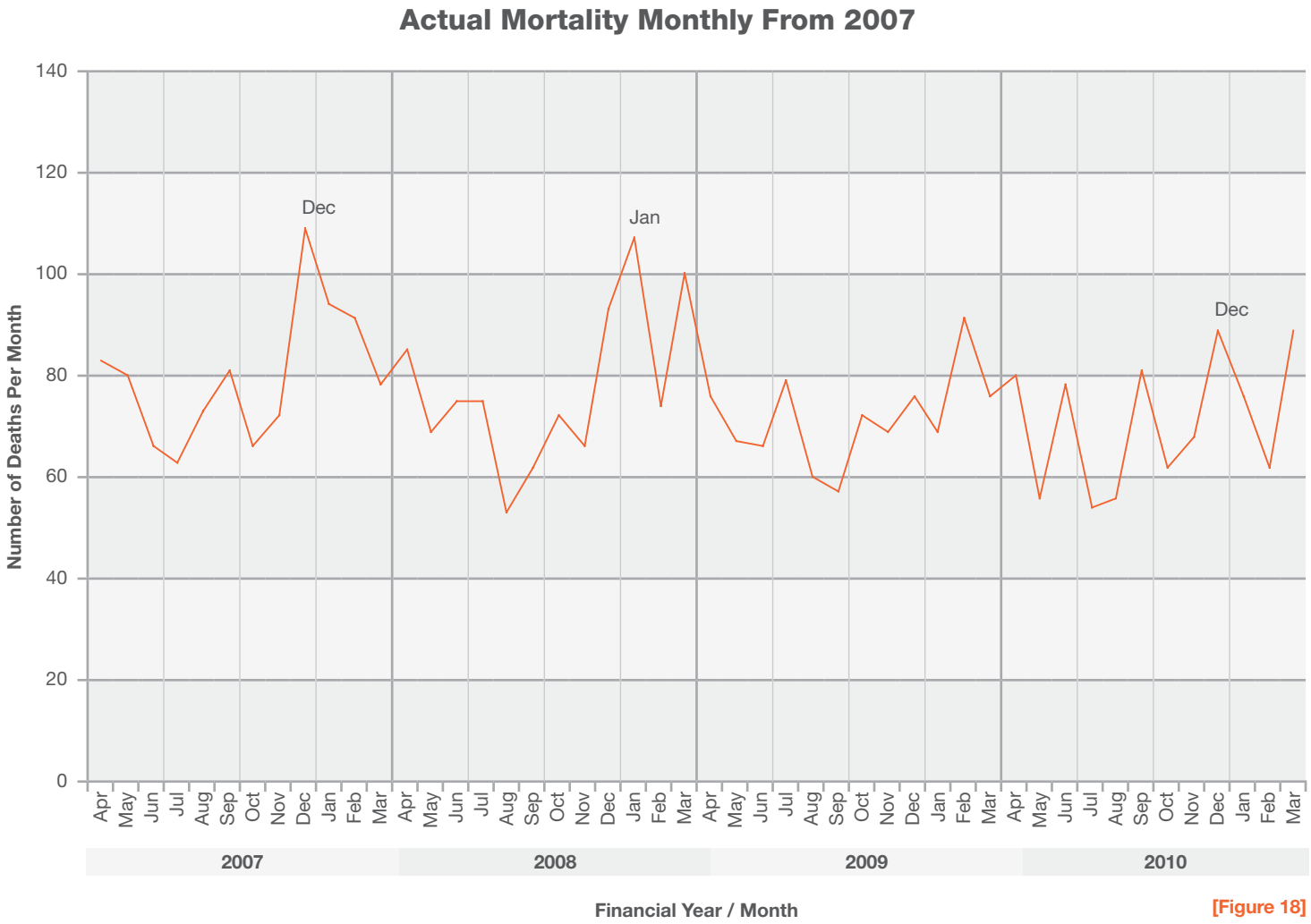


[Figure 16]



[Figure 17]

Hospital mortality rates (Cont)



[Figure 18]

What We Have Done

This Trust as part of its focus on safety and quality introduced a mortality group in 2009 that continues to work on improving mortality rates across the Trust by ensuring all deaths are subject to scrutiny.

The Mortality Group continues to review mortality on a number of indicators; age, gender, cause of death.

The group is also taking forward the following:

- The introduction of a mortality dashboard to track mortality across different specialities e.g. Stroke, Fractured Neck of Femur
- Investigation of a Pleural Effusion Mortality Alert received from Imperial College.
- Understanding how coding of Palliative Care impacts on mortality ratios

A major element in improving the mortality has been improved flow of patients through the hospital, getting more of the patients to the right place first time. A major redesign of the pathways for emergency medical admissions has been implemented as part of our work with the Health Foundation.

Process to Improve Emergency Medical Admissions

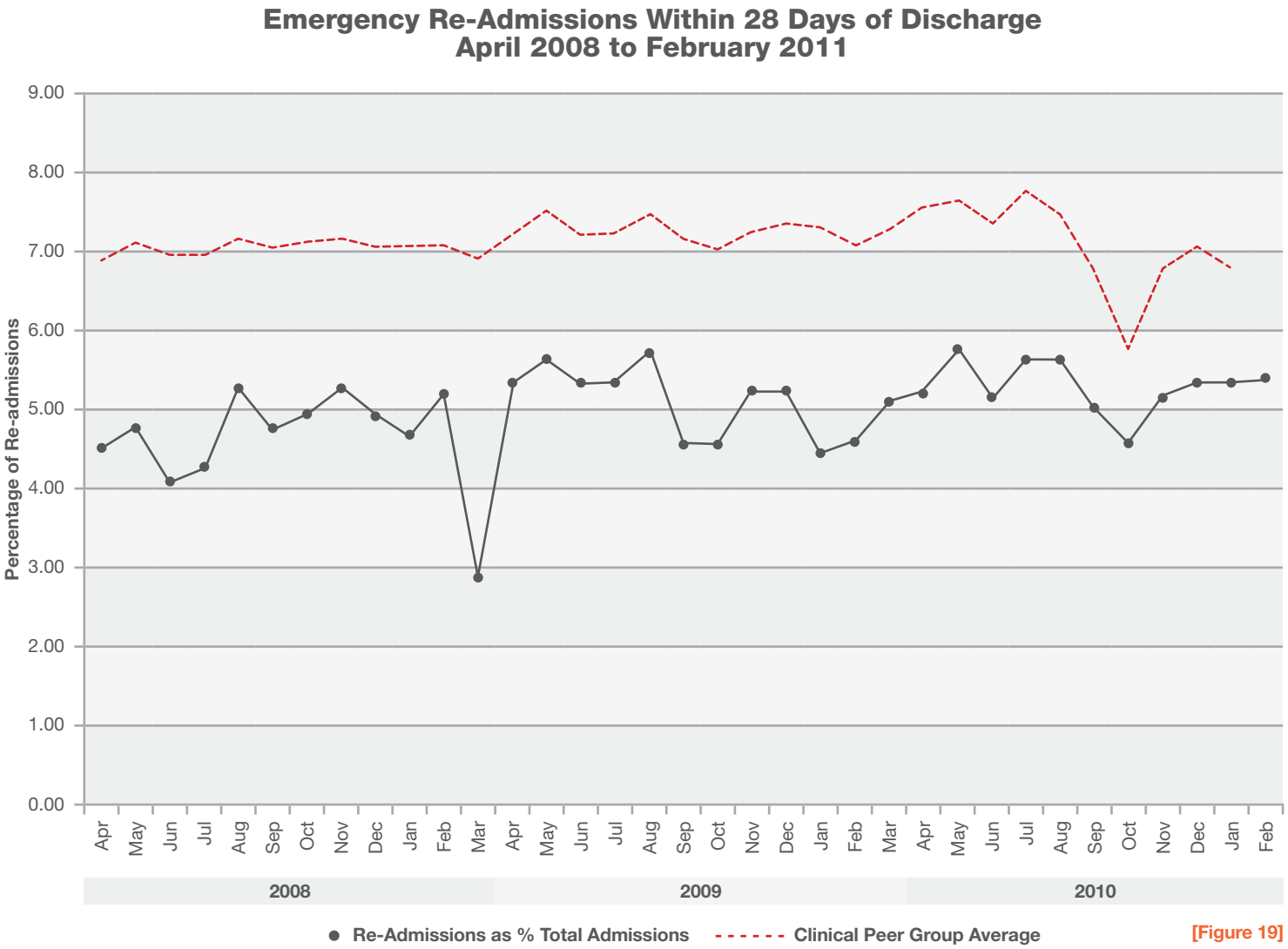
Over the past 2 years the Trust has been working in partnership with the Health Foundation on our Acute Flow Programme to improve emergency patient flow through the Trust and thereby raise the quality of our patients' outcomes and experiences.

On 1 November 2010, we launched a new emergency assessment process designed to deliver safer, timelier patient care by reducing how long it takes to complete emergency patients' assessments and diagnostics and by providing senior consultant review and decision making within 2 hours of the patient arriving. By removing the unnecessary delays that patients have experienced we hoped to initiate treatment earlier, get patients admitted to the right team and ward and consequently reduce the length of time patients need to spend in hospital.

The new process has already delivered some benefits - reduced turnaround times for blood results and x-rays, and potentially more patients being discharged from both A&E and EAU after consultant review without an overnight stay. We have also been able to provide assurance that all patients are receiving their early review due to assessments taking place in both A&E and EAU by implementing the Hospital Heartbeat system, supporting us to further eliminate delays, particularly due to shortfalls in on-time communication processes and non-visibility of individual patient hold ups.

Readmission Rates

Readmissions are an indicator of the effectiveness of clinical care and the discharge process. Readmissions are monitored for patients who are readmitted as an emergency to the hospital within 28 days of discharge form our care. A high readmission rate could be an indictor of either poor quality care or poor quality discharge necessitating readmission to hospital. The Trusts admission rate has traditionally been low as compared with trusts of a similar size and case mix.



[Figure 19]

What We Have Done

The dedicated Discharge co-ordinators provide support to families and patients during the discharge process and ensure the process is of high quality and that there is appropriate and timely communication between the Trust and external agencies. Alongside the dedicated discharge co-ordinators considerable work has been done in improving the discharge pathways as detailed earlier in the report.

Improving the Discharge Pathway

A discharge improvement team led by the Director of Operations with partner agencies has worked on 6 key areas through the year:

- Implementation of a complex discharge database
- Parallel processing of Continuing Health Care (CHC) and adult health and social care (AHSC) assessments.
- Introduction of an electronic TTO prescribing and discharge letter system.
- Improved partnership working with adult health and social care services.
- Improve patient flow through the Nicol unit.
- Training of ward staff in discharge planning.

What We Have Done

The discharge coordinator team has implemented a complex discharge database that monitors where patients are in their discharge process and flags up delays by internal or external processes. The database is used by both hospital and AHSC staff.

Introduction of parallel processing of patients who require ongoing care but the decision about whether the patient requires continuing healthcare (CHC) funding, local authority funding or will be responsible for funding their own care has not yet been made. Previously this process was sequential with the local authority only starting their assessments after CHC funding had been ruled out. The change to the discharge process to run the two assessment processes in parallel has reduced the time complex discharge patients spend in hospital.

The introduction of an electronic TTO prescribing and discharge letter system was planned to reduce the time that patients spend in hospital after their discharge decision has been made until they actually leave. The electronic system has been implemented on all wards and a change management project to ensure that the time from decision to actual discharge is less than 4 hours is underway

A number of changes have been made to the way that hospital and local authority staff work together. Notably; the social care team has been co-located on the Warwick hospital site, an agreement has been reached so that patients who have previously been in receipt of a package of care prior to admission do not have to be reassessed by a social worker prior to their discharge if they are discharged within 7 days of their admission. Delays to discharge caused by a delay to the AHSC scrutiny panel decision for funding have been eradicated and a pilot of ward allocated social workers has started to improve multi-disciplinary working.

The Nicol Unit was transferred to SWFT in March 2010. The team have received support and training to improve the discharge processes. The latest audit has shown a 20% increase in throughput, meaning that patients are delayed less for accessing rehabilitation beds.

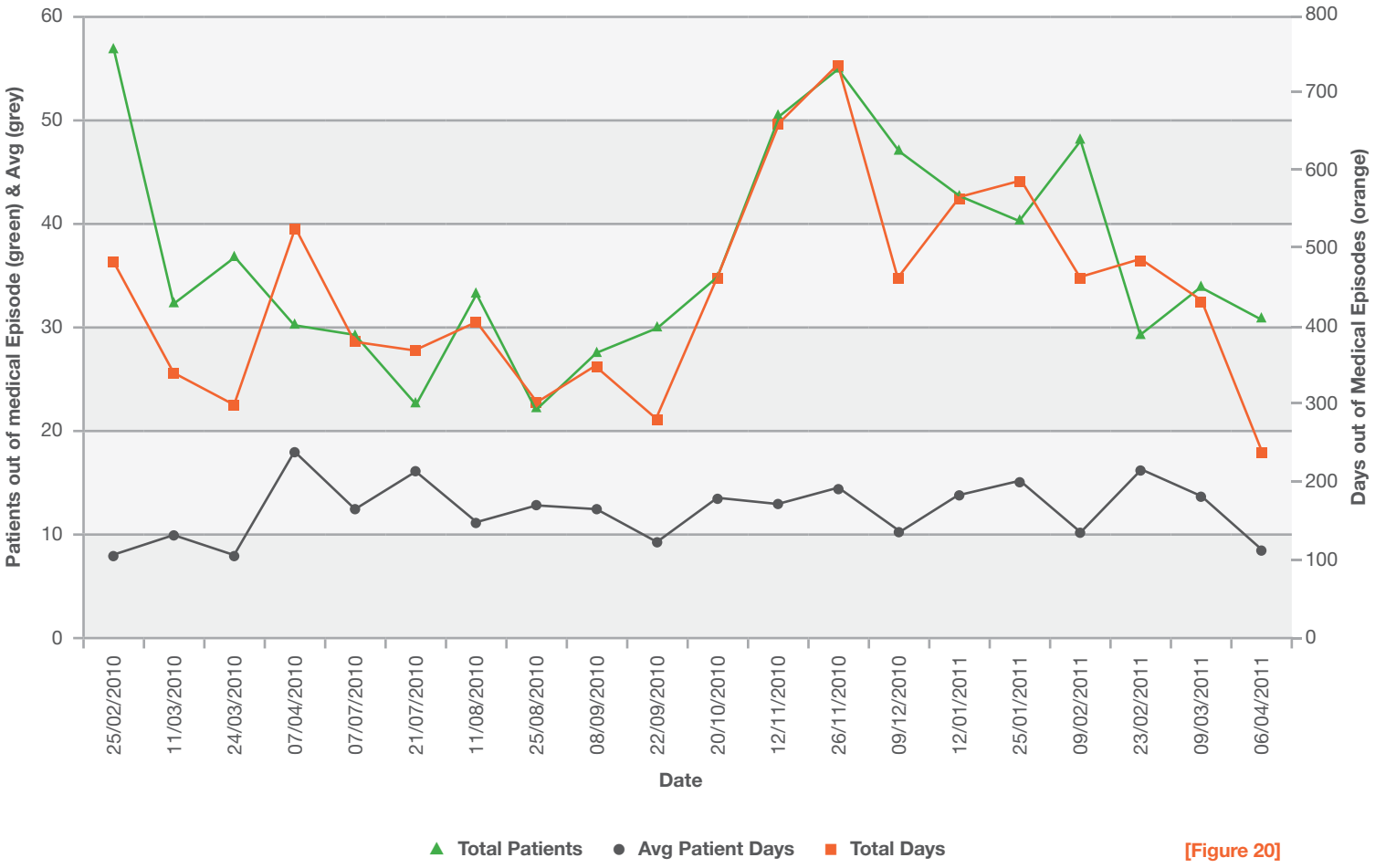
The discharge co-ordinator team have developed resource packs for wards and have trained staff in discharge planning. Audits have shown that the level of inappropriate expected dates of discharge notified to the AHSC team has reduced from 19% to 7%.

The data in the chart on page 84 is taken from the discharge database and shows the number of patients who have completed their acute medical care and are clinically ready to be discharged. (This is a hospital measure and is not the same as the nationally monitored delayed discharges – reported through the delayed transfers of care act).

Delays are subject to seasonal trends – with more patients requiring complex care to facilitate their discharge in the winter months.

With all of the changes in place the numbers of days delayed in the hospital are the lowest recorded and the average number of delays per patient reduced to 8 days. The test of whether this is a sustainable improvement will be next Winter when it is expected that the seasonal increase will be reduced.

Delayed Discharges



[Figure 20]

Next Steps

Improving discharge for patients will continue to be a focus for the Trust in both acute and community services.

There are 4 key elements to next years plan to continue to improve the discharge process.

- The implementation of the 'Cutting the Cost of Frailty' project across Warwickshire
- Full implementation of ward processes to reduce decision to discharge to actual discharge to under 4 hours
- Work with the Partnership Trust to improve access to assessment services for patients with dementia
- Work with commissioners to improve processes for patients funded through continuing health care.

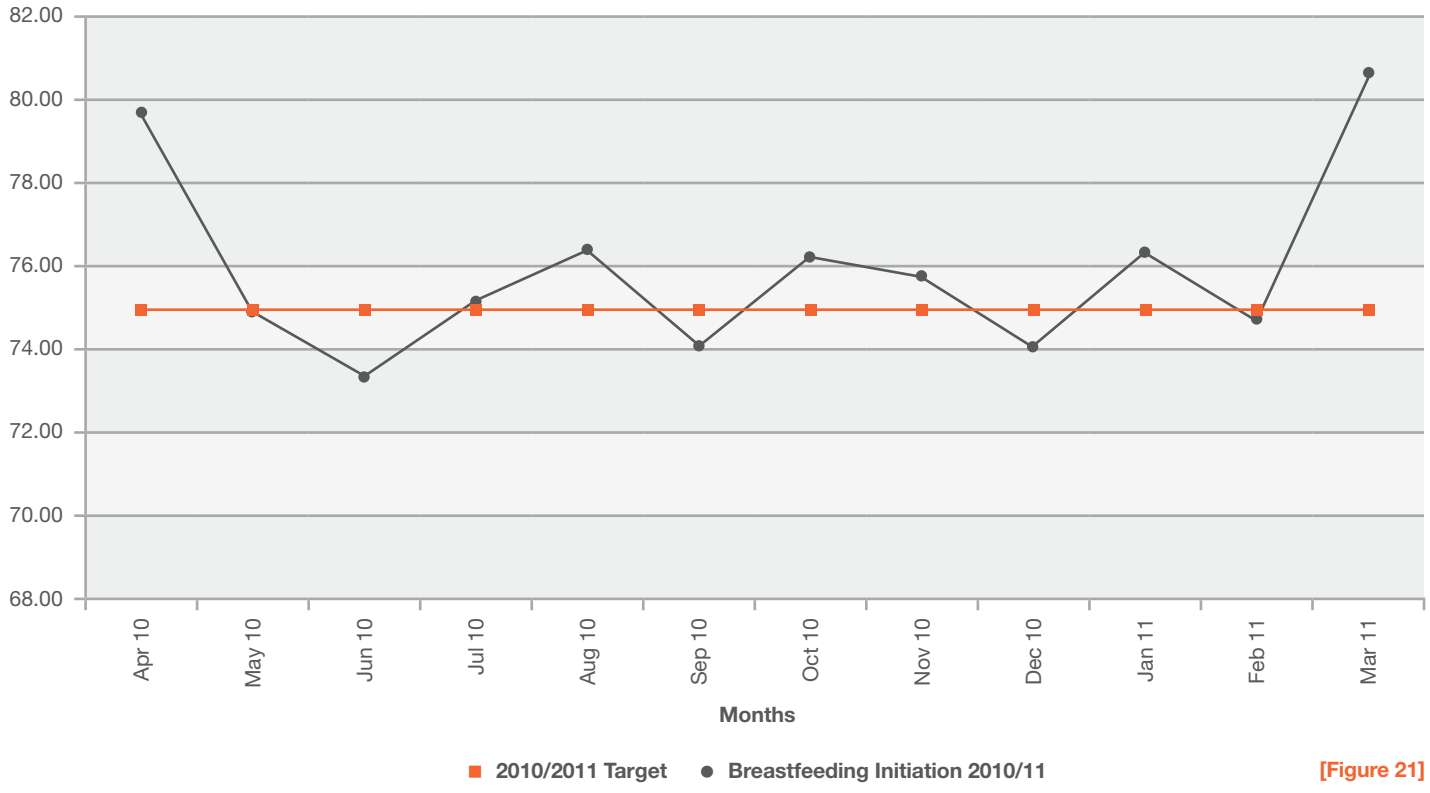
Increasing Breast Feeding Rates

The Trust recognises the importance of breast feeding, registered our commitment to the Baby Friendly Initiative (BFI) and received our certificate of commitment during 2010.

What We Have Done

A BFI co-ordinator was appointed and the Trust will under go a level 1 assessment in May 2011. Training has been widespread across the professional groups to include midwives, nursing staff and doctors. Standardised advice and information has been developed to be given out to women at the earliest opportunity ideally at the first antenatal booking appointment. Further developments included the health visitor being notified early in pregnancy so that an appointment can be made to discuss feeding before 28 weeks of pregnancy. Parent craft classes have been reviewed and the content is now uniform across all classes. A data quality exercise was carried out to ensure that the numbers reflect the BFI definition of initiation of breast feeding. The chart below demonstrates the increase in numbers of mothers initiating breastfeeding. Further developments will include feeding status being collected on transfer to the community and to the health visitor.

Trust Performance - April 2010 to March 2011 on the Percentage of Mothers Intiating Breasfeeding within 48 hours of Birth



[Figure 21]

Quality Overview

This section of our Quality Report provides information on our compliance with national standards and targets, locally derived quality targets (not covered elsewhere) and CQUIN schemes. At the time of writing the national thresholds for some of the targets were unavailable and therefore local targets have been used.

	Current YTD				Latest 3 Months			Last Month		
Target	Target	Actual	(Date)	Penalty Points	Target	Actual	Penalty Points	Target	Actual	Penalty Points
Cdiff (In-Hospital)	75	27	March	0	18.8	5	0	6	1	0
MRSA (Post 48hr)	6	3	March	0	1.5	0	0	1	0	0
Cancer 31-Day (all subsequent cancer treatments):										
surgery	94%	97.6%	March	0	94%	95.6%	0	94%	100%	0
anti-cancer drug treatments	98%	99.5%	March	0	98%	100%	0	98%	100%	0
Cancer 62-Days National Screening Programme	90%	97.6%	March	0	90%	95.3%	0	90%	100%	0
Cancer 62-Day (2WW Ref to treat, all cancers)	85%	86.5%	March	0	85%	87.0%	0	85%	89.74%	0
A&E 4-hour	95%	96.4%	March	0	95%	95.4%	0	95%	97.05%	0
Cancer 2WW all cancers (Urgent GP Referral)	93%	95.4%	March	0	93%	96.8%	0	93%	97.8%	0
Cancer 2WW (Symptomatic Breast)	93%	94.8%	March	0	93%	95.7%	0	93%	97.0%	0
Cancer 31-Day (Diagnosis to treat, all new cancers)	96%	99.3%	March	0	96%	98.5%	0	96%	100%	0
Screening Elective Patients for MRSA	100%	96.99%	March	0.5* See page 67	100%	100%	0	100%	100%	0
Compliance with requirements regarding access to healthcare for people with a learning difficulty	Compliant	Compliant	March	0	Compliant	Compliant	0	Compliant	Compliant	0
Overall Compliance				**0.5**			**0**			**0**

[Table B]

Primary Care Trust Statement

Text to follow due to meeting to discuss the Quality Report being scheduled for 7 June 2011.

Health Overview and Scrutiny Committee Statement

Text to follow due to meeting to discuss the Quality Report being scheduled for 7 June 2011.

Local Involvement Network Statement

Text to follow due to meeting to discuss the Quality Report being scheduled for 7 June 2011.

Trust Statement

Text to follow due to meeting to discuss the Quality Report being scheduled for 7 June 2011.

Glen Burley
Chief Executive

SECTION 5:

Statement of Accounting Officer's Responsibilities and Statement on Internal Control

Statement of the Chief Executive's responsibilities as the Accounting Officer of South Warwickshire NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed South Warwickshire NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South Warwickshire NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust

Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and

- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

SIGNED:

Chief Executive

DATE: / /

Statement on Internal Control - 1 April 2010 to 31 March 2011

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South Warwickshire NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in South Warwickshire NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Accounting Officer I have overall responsibility for risk management and am accountable for the effective implementation of risk management and the internal control processes.

The capacity of the Trust to handle risk is achieved through the delegated responsibilities in place as defined in the Trust's Risk Management Strategy. The Strategy sets out the Trust's approach to risk, the accountability arrangements including responsibilities of the Board and its sub-committees, directors, specialist leads, auditors and individual employees. It defines the risk management process including risk identification, analysis and evaluation, which will be undertaken to ensure delivery of the Strategy and the capacity to handle risk across the Trust. With effect from January 2011, the Board of Directors revised the executive director structure to take account of organisational need including the planned transfer of community services. This involved the separation of the Director of Operations and Director of Nursing role. Along-side this, the responsibility for clinical governance, quality and risk management has been transferred from the Medical Director to the Director of Nursing.

Relevant risk management training, information and support is given to all staff (including the Board of Directors) to enable them to undertake their work safely. Additional training has been provided in specific areas as required for example: risk assessment, root cause analysis, moving and handling, resuscitation and first aid. All staff received information on risk management and their responsibilities during the induction process.

4. The risk and control framework

The Trust's Risk Management Strategy identifies how risks are identified, evaluated, scored and monitored within the organisation. The Trust has in place a risk matrix, which is used for all risks, both clinical and non-clinical, incidents and complaints within the organisation. All extreme risks were included in the Trust's Risk Register, which during last year was monitored by the Risk Management Board (which is an executive committee) and the Board. Lower level risks were included on local risk registers and monitored appropriately.

Risks to data security were managed and controlled as part of this process. The Trust has an Information Security Policy which supports the Information Governance Strategy. The Trust identified no significant breaches of data security during the year.

Extreme risks were identified in the Trust's Risk Register. The Trust's major risks identified during 2010/11 are listed below along-side a summary of mitigation action:

- "Agency use not controlled" – controls have been put in place and progress is reported to the Finance and Performance Executive.
- "The level of unscheduled admissions to hospital is higher than the agreed planned level impacting on planned budgets, patient safety and experience" – the Trust managed this through regular contract monitoring meetings with the PCT and continuing the work on the Health Foundation work of acute flows.
- "The Trust does not improve booking procedures and waiting times sufficiently to significantly reduce rescheduled appointments which will affect the patient experience and the Trust's reputation" – the Trust has developed policies for complaints, booking of annual leave and access. Management focus has also been applied in the monitoring of performance on a monthly basis to help Directorates and departments identify where they can improve.
- "The medical workforce does not align working patterns and practices to workload leading to financial risk" – annual objectives were set to match job planning to workload requirements.
- "Focus of transforming community services stretches management capacity" – project management and operational management were separated.
- "There is an inability to fill medical vacancies to the

required level" – the Trust have worked with the Deanery to fill posts from abroad and taken steps to adjust establishments.

The Board of Directors have identified the following high-level future risks, which will be evaluated as part of this year's Board Assurance Framework:

- Risks to meeting all the requirements of the Compliance Framework
- Risks to maintaining the Trust's financial position and financial risk rating of 3, and
- Risks to the effective functioning of the organisation as a result of the acquisition of community services.

The Board Assurance Framework has been updated and reviewed throughout 2010/11. The Audit Committee was responsible for providing independent assurance on the robustness of governance and risk management in the Trust. The Assurance Framework was the key process used by the Board to ensure that all principal risks were controlled, that the effectiveness of those key controls was assured and that there was sufficient evidence to support the Statement on Internal Control.

During the year this included a focus on the need to control occupancy and demand levels due to the potential detrimental affect on waiting times and HCAI performance. As a result the Board continues to develop the measures which will help to provide greater insight into the quality of patient care which will be produced as part of our Quality Accounts in the future. The Risk Register and the Board Assurance Framework were subject to regular review by the Board to consider any gaps in either the assurance or controls. Where required further action was taken by managers to mitigate the risk.

Risk management is embedded into the Trust, for example, Equality Impact Assessments must be carried out before a policy can be approved. Completed Equality Impact Assessments are published on our website.

The Trust has an independent Patient Forum which during 2011/12 the Trust is seeking to include within the Council of Governors' reporting structure. Where possible the Trust proactively works with all stakeholders.

The Foundation Trust is fully compliant with the requirements of registration with the Care Quality Commission.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

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

5. Review of economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Risk Management Board, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust employs a number of processes to deliver economy, efficiency and effectiveness of the use of its resources. The Board of Directors sets the standards and has specified within the Standing Financial Instructions and Scheme of Delegation the appropriate delegated authority levels throughout the Trust. Executive Directors and managers therefore have responsibility for the effective management and deployment of their staff and other resources to optimise the efficiency of their division.

The Board of Directors receives both performance and financial reports at each of its meetings and receives reports from the chairs of its committees to which it has delegated powers and responsibilities. In addition from time to time the Board receives further assurance on these matters including an external financial benchmarking study reported during 2009/10.

A Non-Executive Director of the Board chairs the Audit Committee with regular attendance by representatives from both the Trust's internal and external auditors. The Committee has reviewed and agreed audit plans for both the internal and external auditors during the year (which has informed this accounting period), against which progress is regularly reviewed by the Audit Committee.

6. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts/Report for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

We have presented our Quality Report as part of our Annual Report and Accounts based on a range of indicators, many of which are regularly reported internally and externally through our Standards and Targets Report and Patient Experience and Patient Safety Reports. The Board of Directors is satisfied that the messages within the report reflect the regular information received throughout the year. The Council of Governors has reviewed the quality report and felt that it was representative of the main quality issues that they were aware of. The report has been shared with the Health Overview and Scrutiny Committee of Warwickshire County Council, LINkS and NHS Warwickshire, all of whom have been given the opportunity to provide formal comment for publication within the report.

The Board has taken assurance on quality of data included in the report from the following sources:

- Internal audit reports.
- The Audit Commission Reports on Payment by Results – where data quality and governance were assessed.

Data has also been subjected to scrutiny by commissioners and the Healthcare Commissioning Services on their behalf. The Quality reporting process is now led by the Director of Nursing.

7. Review of effectiveness

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board and Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board regularly reviewed progress against a number of action plans including the Assurance Framework to ensure that identified actions were implemented in a timely manner. The Audit Committee received regular reports on assessments undertaken by the Trust's Internal and External Auditors and the Trust's Finance and Performance Executive monitored the Trust's system of financial control. The annual report produced by the Trust's Internal Auditors identified that significant assurance could be given and that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. A separate report provided assurance regarding the work of the internal audit function regarding Counter Fraud Activities.

The Trust has reported that it met the revised performance target for Accident and Emergency four hour wait. Where weaknesses have been identified through audit reviews, the Trust has been proactive in monitoring progress to ensure that timely remedial action is taken and the Audit Committee actively monitors this progress. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust reported level one compliance with the new requirements of the Information Governance Toolkit, a position which was reviewed both by the Board and Audit Committee. The Trust's Information Governance Steering Group is taking action to address areas of weakness to ensure continual improvement in information governance.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control is summarised below:

- The Board oversees risk and governance assessments regularly;
- The Audit Committee ensures that systems and processes are in place;
- The Risk Management Board and assuring committees review and manage risk on a routine basis;
- Directors/Managers lead on defined areas of risk
- Internal Audit provides an opinion on the system of internal control and the Board Assurance Framework

Regular reports regarding clinical and non-clinical incidents, complaints, legal claims and other risks identified were submitted to the Clinical Governance Committee and the Health and Safety Committee (which reports to the Risk Management Board), which monitored progress and suggest action to be taken as appropriate. Directors and senior managers of the Trust have specific responsibilities for reviewing the risks and controls for which they are responsible and for maintaining internal control systems.

The Trust will continue to monitor its governance processes, particularly in light of the community services acquisition and make any appropriate changes to strengthen process and control.

7. Conclusion

There are no significant internal control issues which have been identified.

SIGNED:

Chief Executive

DATE: / /

SECTION 6:

Summary Financial Statements & Auditor’s Statement

Statement of Comprehensive Income

This statement provides a summary of the income we have received for providing healthcare, education and research services and expenditure we have incurred in delivering these services.

	Total 2010/11	Restated 2009/10
	£000	£000
Income from activities	**124,527**	117,442
Other operating revenue	**12,745**	12,834
Operating expenses	**(133,077)**	(123,362)
OPERATING SURPLUS	**4,195**	6,914
Profit on disposal of fixed assets	**0**	0
SURPLUS BEFORE INTEREST	**4,195**	6,914
Finance income - interest receivable	**239**	52
Finance costs - Interest payable	**(250)**	(559)
Other finance costs - unwinding discount	**(58)**	(3)
SURPLUS FOR THE FINANCIAL YEAR	**4,126**	6,404
Public dividend capital dividends payable	**(1,957)**	(1,901)
RETAINED SURPLUS	**2,169**	4,503
Other comprehensive income		
Impairments and reversals	**-**	(5,500)
Gains / (losses) on revaluations	**(1,865)**	466
Receipt of donated / government granted assets	**173**	12
Reduction in the donated asset reserve	**(26)**	(14)
Reclassification adjustments:		
Transfers from donated and government grant reserves	**-**	(204)
On disposal of available for sale financial assets	**-**	0
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**451**	(737)

Statement of Financial Position

This statement provides a summary view of the net worth of the Trust represented by its assets and liabilities and how this worth is represented in terms of taxpayers equity.

	March 2011	Restated March 2010
	£000	£000
NON-CURRENT ASSETS		
Property, plant and equipment	**73,710**	73,774
Intangible assets	**690**	403
Trade and other receivables	**569**	585
TOTAL NON-CURRENT ASSETS	**74,969**	74,762
CURRENT ASSETS		
Inventories	**2,134**	1,790
Trade and other receivables	**3,754**	3,460
Cash and cash equivalents	**11,258**	8,527
TOTAL CURRENT ASSETS	**17,146**	13,777
TOTAL ASSETS	**92,115**	88,539
Creditors falling due within one year	**(18,115)**	(15,926)
NET CURRENT ASSETS/(LIABILITIES)	**(969)**	(2,149)
Creditors falling due > one year	**(2,764)**	(3,945)
Provisions for liabilities and charges	**(1,889)**	(2,204)
TOTAL ASSETS EMPLOYED	**69,347**	66,464
FINANCED BY TAXPAYERS' EQUITY:		
Public dividend capital	**63,612**	60,962
Revaluation reserve	**9,598**	11,948
Donated asset reserve	**2,165**	2,162
Retained earnings	**(6,028)**	(8,608)
TOTAL TAXPAYERS' EQUITY	**69,347**	66,464

SIGNED:

DATE: / /

Chief Executive

South Warwickshire NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector guidance.

Statement of Cash Flows

This statement provides a summary view of how the Trust has made use of the cash it has received and how it has sought additional and repaid existing capital.

	March 2011	March 2010
	£000	£000
CASH FLOWS FROM OPERATING ACTIVITIES	**4,195**	592
Depreciation and amortisation	**4,094**	327
Impairments and reversals	**0**	0
Transfer from donated asset reserve	**(245)**	(14)
Tax paid	**0**	0
Dividends paid	**0**	0
(Increase)/decrease in inventories	**(344)**	(55)
(Increase)/decrease in trade and other receivables	**(278)**	(150)
Increase/(decrease) in trade and other payables	**2,677**	(201)
Increase/(decrease) in other current liabilities	**0**	0
Increase/(decrease) in provisions	**(262)**	0
Other movements in operating cash flow	**424**	(18)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**10,261**	481
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	**114**	4
(Payments) for property, plant and equipment	**(6,118)**	(592)
Proceeds from disposal of property, plant and equipment	**155**	0
(Payments) for intangible assets	**(385)**	0
(Payments) for other investments	**0**	0
Proceeds from disposal of other financial assets	**0**	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(6,234)**	(588)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**4,027**	(107)
CASH FLOWS FROM FINANCING ACTIVITIES		
Public dividend capital received	**2,650**	0
Public dividend capital dividend paid	**(1,948)**	(970)
Interest paid	**(249)**	(227)
Loans received	**753**	0
Loans repaid to the DH	**(2,203)**	(3,667)
Capital element of finance leases and PFI	**(106)**	(44)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(1,103)**	(4,908)
Net increase/(decrease) in cash and cash equivalents	**2,924**	(5,015)
Cash (and) cash equivalents at the beginning of the financial year	**8,332**	13,347
CASH (AND) CASH EQUIVALENTS AT THE END OF THE FINANCIAL YEAR	**11,256**	8,332

The Audit Committee and Trust Board have reviewed in full the financial statements and Annual Report for 2010/11 and the Board formally approved them at the 1 June 2011 meeting.

Auditor's Statement

Mark Stocks
Officer of the Audit Commission

Audit Commission
2nd Floor, No.1 Friars Gate
1011, Stratford Road
Solihull
B09 4EB

DATE: / /

South Warwickshire NHS
NHS Foundation Trust

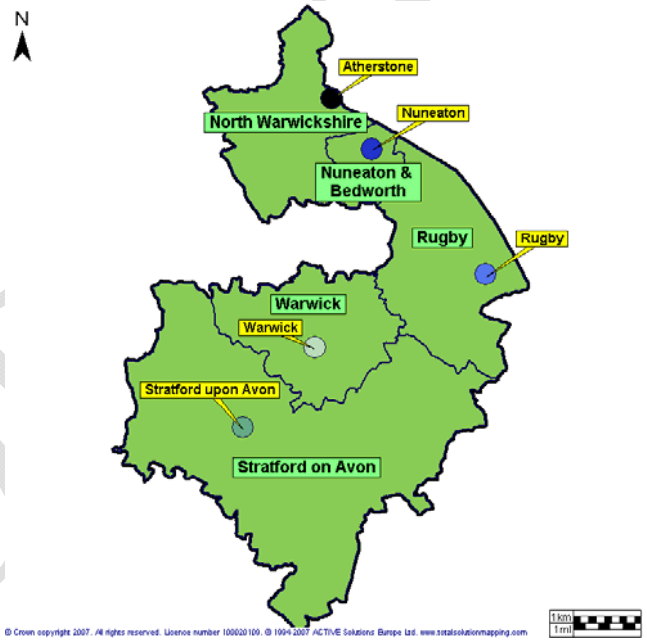
South Warwickshire NHS Foundation Trust
Warwick Hospital
Lakin Road
Warwick
CV34 5BW

Phone : **01926 495321**
Fax : **01926 482603**
www.swft.nhs.uk

NHS WARWICKSHIRE COMMUNITY HEALTH

QUALITY ACCOUNT

APRIL 2010 – MARCH 2011



Contents **Page Number**

PART ONE

Our Commitment **Page 4**
Executive Summary **Page 4**
Introduction **Page 5**
Provider Profile **Page 5**

PART TWO

Priorities for Quality Improvement **Page 6**
Integrated Governance Framework **Page 8**

Patient Safety **Page 9**
- **Incidents** **Page 9**
- **Serious Incidents** **Page 10**
- **Infection Prevention and Control** **Page 11**
- **Tissue Viability** **Page 12**
- **Falls** **Page 13**
- **Safeguarding** **Page 14**
- **Patient Safety First Campaign** **Page 15**

Clinical Effectiveness **Page 17**
- **Audit** **Page 17**
- **National Guidance** **Page 18**
- **NICE Quality Standards** **Page 19**
- **Essences of Care** **Page 20**
- **Commissioning for Quality and Innovation** **Page 22**
- **Quality Schedule** **Page 23**
- **Care Quality Commission** **Page 23**
- **NHS Litigation Authority** **Page 24**
- **Themed Reviews** **Page 24**
- **Workforce** **Page 27**

Service Specific Improvements **Page 27**
- **Adult Services** **Page 27**
- **Children's and Young Peoples Service** **Page 30**
- **Therapies Services** **Page 32**

Patient Experience **Page 33**
- **Patient Survey** **Page 33**
- **Delivery Same Sex Accommodation** **Page 35**
- **Complaints** **Page 36**
- **Claims** **Page 37**
- **Compliments** **Page 37**

PART THREE

Review of Quality Performance **Page 38**

- **WCH CQUIN Targets 2010/11** **Page 38**
- **Pressure Ulcer Quality Performance** **Page 39**
- **Falls Quality Performance** **Page 40**
- **Nutrition Quality Performance** **Page 40**
- **Dementia Training Quality Performance** **Page 41**
- **Patient Survey Quality Performance** **Page 41**
- **Risk Stratification Tool Quality Performance** **Page 41**
- **Specific Achievements Service Improvement Programme** **Page 41**

New CQUIN Priorities for 2011 **Page 43**

- **Quality Performance Measures 2011/12** **Page 44**

Part One
Our Commitment

Since the inception of Warwickshire Community Health (WCH) services in 2006, we have as a Provider organisation, strived to ensure we are a committed and successful organisation as well as being effective to the patient population we serve.

Much has been done to improve the quality of care we provide to our patients and enhance their experience, whether as an inpatient or in the patients own home.

We have established Patient Safety walkrounds which have been a huge success allowing the Executive team to hear first hand from patients and staff. Although this initiative was originally intended for inpatient settings, Warwickshire Community Health has adopted this approach to other community settings across Allied Health Professionals, Adult Nursing and Children's Services.

WCH successfully registered with the Care Quality Commission (CQC) in April 2010 and achieved level one assessment with the NHS Litigation Authority in March 2010. Since 2008 WCH has made an 85% reduction in health care acquired infections in the Community Hospital setting.

WCH has taken part in two national audits (Royal College of Physicians National Falls and Osteoporosis Audit and National audit of Continence Care) as well as undertaken 107 local audits across WCH.

An unannounced visit from the CQC took place to ascertain compliance with the Infection Prevention and Control Code of Practice. Immediate feedback from the CQC confirmed the areas visited had met all the required standards.

As we merge with South Warwickshire Foundation Trust, it is imperative all of the excellent developments on quality continue. We will ensure quality remains at the heart of our care, keeping the trust of our community and never allowing our vision and values to be affected by purely financial decisions.

Michelle Clarke
Managing Director
February 2011

Executive Summary

WCH has a total workforce of approximately 1,600 staff and operates across a catchment population serving approximately 549,257 people within Warwickshire.

WCH vision is to "Provide Care Closer to Home" and as a health provider we have developed and implemented innovative ways of working to ensure our services are easily accessible, are responsive to patient needs and are of a

consistently high standard. The three key quality goals identified for the year 2010/2011 were:-

- Deliver improved patient experience, clinical effectiveness and safety.
- Treat more long-term complex cases closer to home
- Achieve sustainable financial balance.

The WCH quality agenda has been delivered in conjunction with the Transforming Community Services agenda (DoH 2008). The workforce of Warwickshire Community Health is committed to delivering the transformation agenda with good leadership, engagement and communication with the public, staff and stakeholders has been at the heart of this transformation.

This quality account will outline:

- Quality improvement priorities for 2010/11 and how the priorities were monitored and performance managed
- Specific achievements
- Learning and action implementation for identified under achievement of the quality improvement priorities
- The new priorities for 2011/12

Introduction

Warwickshire Community Health is currently the 'Arms length Provider' of NHS Warwickshire and provides a comprehensive range of Community based and Community Hospital services across all age ranges. Its focus is on the provision of services for Older People with physical healthcare needs, the provision of services for Children, Young People and Families with physical, health protection and health improvement needs, and the provision of Specialist Nursing and Therapy services (preventative & treatment) to all age ranges.
WCH operates from 22 clinics and health centres and 29 office, store and ancillary premises and 3 community hospitals, however in February 2011, the NHS Warwickshire Board took the decision to de – commission inpatient provision at the Bramcote Hospital located in North Warwickshire. There are also 2 units within one of our community hospitals that specialise in stroke services, and neurological conditions or an acquired brain injury respectively and 7 Special Care Dentistry Clinics and 3 PCT Medical Services,

Provider Profile

Currently the county of Warwickshire has an approximate population of 549,257of this 116,264 are children aged 0-16 with 74,000 of those being school age. The population in Warwickshire is estimated to grow to 554,700 in 2013 with the biggest increase expected in the over 65 year age group. Newborns are expected to increase by approximately 5% over the next five years. Currently one in ten (6,600) of the older population in Warwickshire are estimated to suffer from Dementia. This is projected to increase in the year 2020 by a further third to around 10,200 cases. The ageing population will

have implications on the future demand profile for our services, specifically care of the elderly and associated health conditions. The increase in the elderly population in Warwickshire suggests that this should be an area of delivery that we focus on delivering and marketing our services.

The 2007 Index of Multiple Deprivation highlights a polarised picture of Warwickshire. Nuneaton and Bedworth have the highest levels of deprivation in the county, whilst Stratford-upon-Avon has the lowest levels. The most deprived area in Warwickshire is in the northern Bar Pool ward located within Nuneaton and Bedworth. This is followed by an area within Camp Hill ward, also within Nuneaton and Bedworth. These two areas feature in the worst 10% of the 32,482 identified areas in England. North Warwickshire; Nuneaton and Bedworth and Rugby have lower than average life expectancies for both men and women. Stratford-upon-Avon and Warwick have higher than national life expectancy for both men and women.

Part Two
Priorities for Quality Improvement

WCH Board ensure the organisation operates to a clear Accountability Agreement linked to the approved Scheme of Delegation and reporting requirements.

WCH successfully registered with the Care Quality Commission's Essential Standards of Quality and Safety in April 2010. WCH is, and will continue to be, compliant with the Care Quality Commission requirements, responding to new guidance and legislation as it comes in to force. WCH was also assessed against the NHS Litigation Authorities Risk Management Standards in March 2010, successfully achieving level one. Indicating WCH works within a structured framework which focuses on effective risk management that delivers quality improvements in organisational governance, patient care and the safety of patients, staff and visitors to the organisation.

WCH is committed to capturing the views and experiences of patients and using this feedback to improve local services and inform local decision making is key to driving service improvements and being responsive to the preferences and priorities of the local population.

WCH manages equality, diversity and human rights by encompassing organisational processes, systems, culture and the skills of staff.

The quality priorities for 2010/11 were decided upon using national, regional and local guidance. Data was collected from the following agencies:-

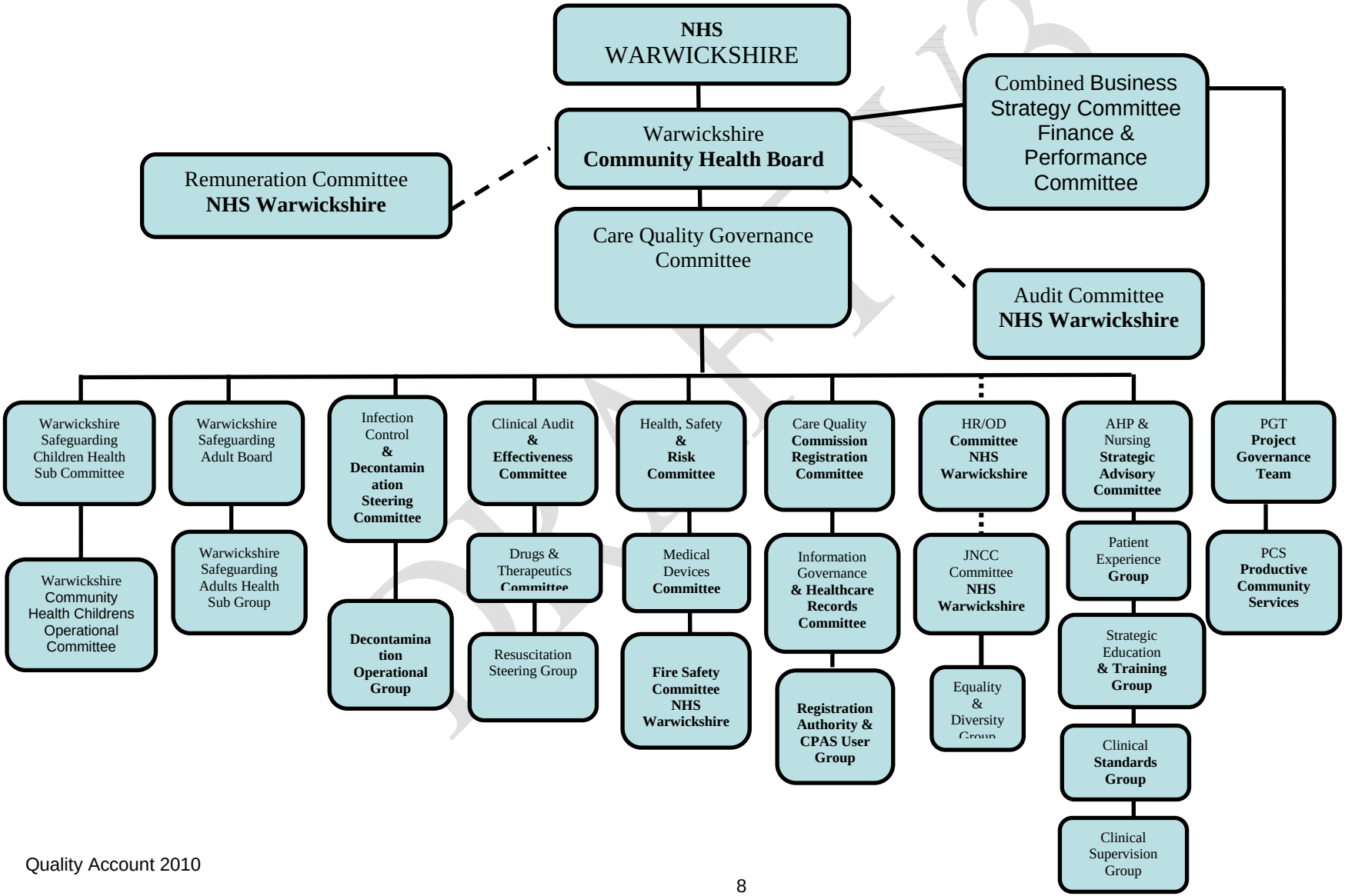
- Department of Health
- Care Quality Commission
- The NHS Litigation Authority
- Institute for Innovation High Impact Actions
- Commissioning for Quality and Innovation (CQUIN) Payment Framework.

- Commissioning Quality Contract
- Learning from Incidents, Complaints and Claims
- Patient Experience Feedback
- Staff survey feedback
- Stakeholder feedback
- Local Involvement Network
- Community Patient Forums

The national, Regional and local guidance was debated by the WCH Board and the quality priorities agreed. In agreeing the priorities the Board considered information collected from patient and staff feedback, learning from incidents, complaints and claims, and compliments.

Achievement against the agreed priorities was measured and monitored through the Integrated Governance Structure (table below). Whereby any deviation from the highest standard of achievement was actioned and monitored to maintain the level of achievement desired.

Integrated Governance Framework



Patient Safety

High Impact Actions

The High Impact Actions are eight actions developed through the NHS Institute for Innovation and Improvement
WCH recognises that cost effectiveness and high quality care has the greatest impact on patient care.
The high impact actions are a fantastic opportunity for WCH to make a difference to our patients. Clinicians base the care we give, using the following actions

- Your skin matters: preventing avoidable pressure ulcers in NHS provided care
- Staying safe- preventing falls: achieving year-on-year reductions in falls among older people in NHS-provided care
- Keeping nourished - getting better: stopping inappropriate weight loss and dehydration in NHS provided care
- Important choices - where to die when the time comes: avoiding inappropriate hospital admission and giving more people the choice of where they die
- Fit and well to care: reducing sickness absence among nurses and midwives - aiming for no more than three percent
- Ready to go - no delays: letting nurses and midwives manage and lead patient discharges where appropriate
  Protection from - infection: reducing urinary tract infections for patients in NHS. provided care.

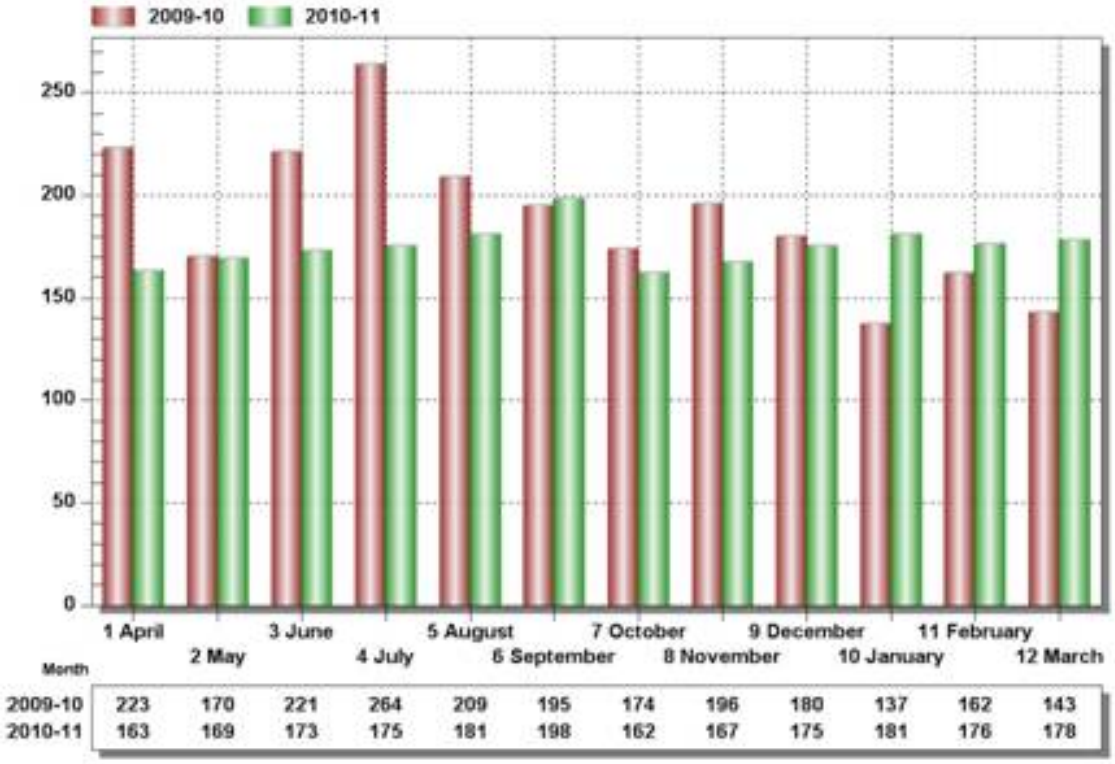
Incidents

A key component of an effective Risk Management System is the reporting of incidents both clinical and non-clinical. All staff are required to report all incidents, clinical and non-clinical, in line with WCH Incident Reporting Policy. Incident reporting has continued to have a high priority across the organisation with the emphasis on encouraging all groups of staff to report incidents and near misses.

The implementation of electronic incident reporting has enabled staff to have an improved route through which they can report incidents and near misses in an efficient and timely manner. We have seen positive change in the culture of reporting incidents and near misses. Being able to analyse the number of incidents and near misses reported, we can carry out trend analysis and thereby improve on patient safety by disseminating and sharing lessons learnt from the reported incidents.

WCH systematically review all incidents at the Health, Safety and Risk Committee whereby common trends and themes are highlighted and appropriate actions/ recommendations are implemented across service areas.

The total number of incidents reported between 1 April 2010 and 31 March 2011 were two thousand and eighty two (2082), compared to two thousand, two hundred and seventy four (2274) between 1.April 2009 and 31 March 2010.



Month	1 April	2 May	3 June	4 July	5 August	6 September	7 October	8 November	9 December	10 January	11 February	12 March
2009-10	223	170	221	264	209	195	174	196	180	137	162	143
2010-11	163	169	173	175	181	198	162	167	175	181	176	178

The decreased incident reporting is reflected in the NPSA feedback report, published in March 2011. The NPSA publish a bi - annual comparative report of 90 Primary Care Trusts with inpatient facilities. WCH is in the lowest 25% for reporting incidents per 1,000 bed days. The NPSA report for the previous year stated WCH has well-established systems for incident reporting and the local risk management or clinical governance team should be congratulated.

During this year of transforming community services WCH has experienced a decrease in the number of patient contacts and services and a substantial amount of work has been progressed in reducing the number of patient falls, medication errors and reducing the number of internally acquired pressure ulcers. The consequence to improving patient safety has resulted in a reduction in the number of incidents reported by 230/year.

Serious Incidents (SI)

There were twenty one (21) SI's reported to the Strategic Health Authority (SHA) between 1 April 2010 – 31 March 2011. All SI are fully investigated by a trained members of staff using Root Cause Analysis (RCA). All investigation reports are in line with the National Patient Safety Agency (NPSA) reporting template, which has provided consistency and structure when writing up reports.

Type of Serious Incident	Themed Lessons Learnt
Unexpected deaths – inpatient provision GP cover is not provided on a 24 hour basis. All deaths are reported as unexpected and reported to the coroners officer. All deaths are reviewed by the joint mortality group for acute and community services. The healthcare records are reviewed using the NPSA Global Trigger tool. No evidence of suboptimal care identified.	• Introduction of MEWS Modified Early Warning Score within community hospitals. This is a tool which assists staff in recognising the deteriorating patient • Training for staff to update their knowledge related to venous thromboembolism risk assessments and treatment plans following ratification of the venous thromboembolism policy.
Grade 3 & 4pressure ulcers Root Cause Analysis investigations completed	Best practice guidance communicated to Staff. • Staff to be able to recognise and treat different causes of pressure ulcers and appropriate treatment and accurate assessment and stepping up/down of pressure relieving equipment • Wound Care Formulary Implemented • Malnutrition Screening Tool implemented • Nursing Assessment documentation implemented. • To maintain regular visits to support vulnerable patients.
Clostriduim.Difficille and other healthcare acquired infections	• Mandatory education for all clinical staff implemented. • Best guidance documentation implemented. • Environmental guidance provided
Security incident	• Conflict Management for all staff • Security review by NHS Counter Fraud Security Management Service and best practice guidance provided.

Central Alert System (CAS)

The Central Alert System (CAS) is the national system for disseminating alerts relating to medical devices, estates and medications from the Medicines

Healthcare Regulatory Authority (MHRA). WCH is responsible for ensuring all alert notices are brought to the attention of WCH staff and appropriate action is taken. The procedures cover the following alerts:

1. Medical Devices Alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA)
2. Drug Alerts issued by MHRA
3. Public Health Link issued by Department of Health
4. Estates and Equipment Alerts issued by the Estates and Facilities Division
5. National Patient Safety Alerts (NPSA)

Table 3 outlines the different types of alerts received. All alerts are sent to Service Managers to cascade to their teams, to develop action plans where applicable.

Alerts disseminated during 1 April 2010 – 31 March 2011

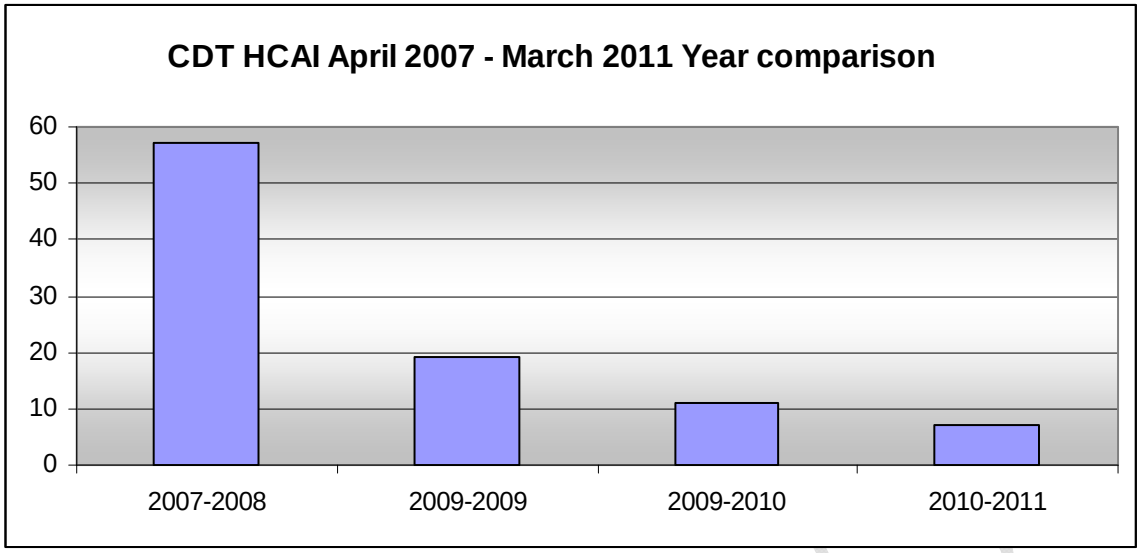
Type of Alert	**Total Number**
Medical Devices Alerts	107
National Patient Safety Alerts	12
Public Health Alert - DH	4
Estates and Facilities Division Alert	11
Drug Alerts	35
Total	**169**

The total number of relevant Safety Alerts received by WCH was nineteen (19). Action plans have been developed by the Services to show how they will be compliant with the alerts and any equipment identified has been removed from practice.

Infection Prevention and Control

The reduction of Healthcare associated infections (HCAI) has remained an absolute priority for the Trust and the Infection Prevention and Control Team.

WCH have continued to reduce levels of Clostridium difficile (CDT) associated infection year on year as illustrated below. Since targets to reduce CDT were made by the Department of Health (DH) in 2008, WCH has made an 85% reduction in the number of healthcare associated CDT infections in inpatients in community hospitals. This sustained reduction in CDT within inpatient areas is clearly a reflection of both improved practices and a clean environment.



WCH have continued to undertake MRSA screening on admission and have recorded 100% compliance.

WCH have dealt with just one outbreak of infection with Norovirus over the 2010 Christmas period, where the ward was closed for almost two weeks to admissions and discharges

WCH has invested in staff, products and systems to further reduce the risk of HCAI for all who use the services we provide. The allocation of funding to support infection prevention and control initiatives has enabled the team to introduce new systems and replace products resulting in an improvement in the standards of cleanliness and care. These initiatives include; continued funding of; disposable curtains, annual deep cleaning, off site decontamination and service of dynamic pressure relieving mattresses and new initiatives that include; the provision of scrubs and single use instruments for minor operative procedures, single use grazeby pump holsters, fogging of isolation areas, wipe able computer keyboard and mouse sets in specific areas, hand hygiene packs for community nursing services and MRSA decolonisation packs amongst other services.

During the last financial year one of the team has had regular allocation of shifts onto the inpatient areas in order to guide and support the staff and to assist in undertaking the infection prevention audit requirements. This move has had a huge impact on the integration of infection prevention practices at ward level and in the production of accurate timely audits.

All staff are required to undertake infection prevention on both induction to the organisation and annual mandatory updates. In addition we have developed a link staff for infection prevention group, for which we provide bi-annual sponsored education days.

Tissue Viability

A total of five hundred and eighty eight (588) pressure ulcers were reported within this period. Of these, three hundred and ninety eight (398) patients who were transferred into WCH from other care providers with an existing pressure ulcer and one hundred and ninety (190) patients developed a pressure ulcer while receiving care services from WCH.

Pressure ulcer development is a recognised key quality indicator. WCH is compliant with the assessment and reporting of all pressure ulcers as clinical incidents (National Institute of Clinical Excellence (NICE) guidelines 2005). The total number of internally acquired pressure ulcers represents 0.17% of the active patient caseload.

NICE guideline (29) suggests early detection and effective monitoring and management, can reduce the risk of pressure ulcer development. Patients accessing WCH's services are assessed for actual or potential development of pressure ulcers. A risk assessment tool, namely The Waterlow 1985 (reviewed 2005) scoring system, is used in conjunction with the clinicians clinical judgement to assess the potential and actual pre-disposing factors to developing pressure ulcers.

WCH aim to undertake assessments within 6 hours of becoming an inpatient or at first assessment in the community. A skin inspection is completed on all patients. All patients identified as being at risk are put on pressure relieving equipment. New documentation was launched in community teams December 2010 these included revised tissue viability care plans, decision pathways and repositioning charts. All patients are given information on how to prevent or improve pressure ulcers.

Guidelines for the prevention and treatment of pressure ulcers and an equipment flow chart have been developed and are available to inform and guide staff and new criteria for the supply of preventative equipment have been developed and will cover the provision of equipment to children, young people, adults and bariatric clients.

Falls

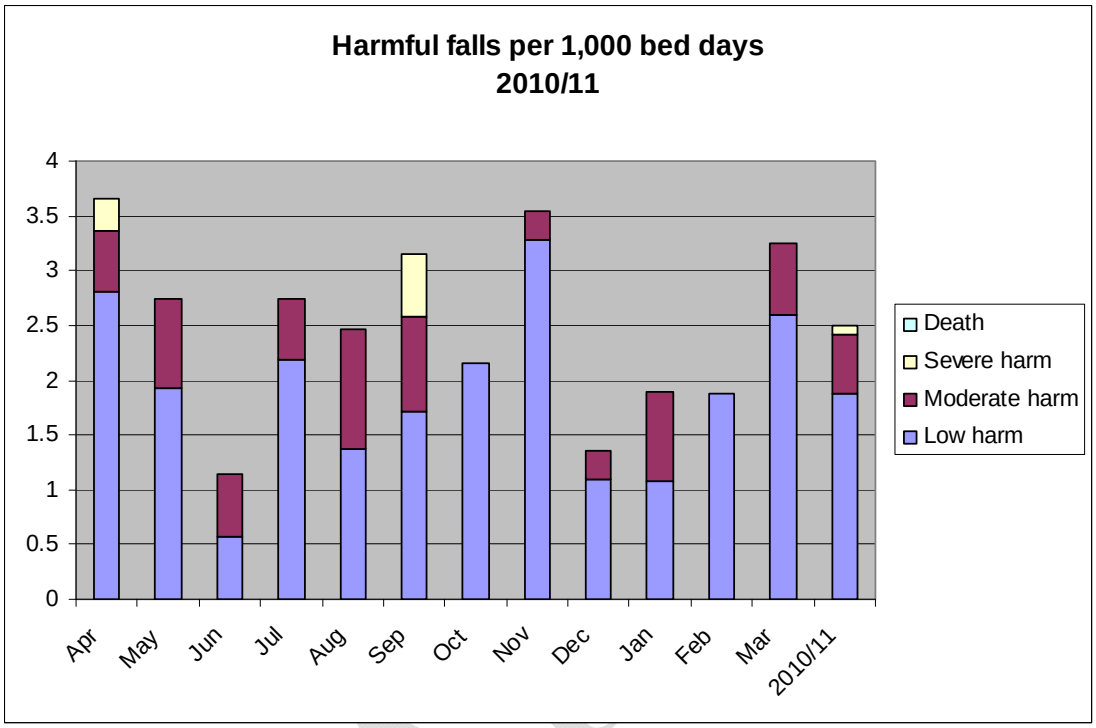
The Falls Prevention Framework implements national guidance by National Patient Safety Agency (NPSA), Patient Safety First and High Impact Actions. This includes analyses and monitoring of falls incidents by the Health, Safety and Risk Committee and reporting to individual wards.

In 2010, WCH developed and implemented a Falls Prevention Framework, to assist in the prevention and management of patients who receive healthcare from WCH services either with a history of falls, following a fall or who are at risk of falling whether as an inpatient or in their own home.

The framework endeavours to ensure all patients at risk of falling receive a falls and bone health risk assessment when admitted to community hospitals or on first contact by community teams. Patients can be referred on for

specialist assessment by the Specialist Falls Service, a multidisciplinary team providing multifactorial risk assessment and evidence based interventions.

The graph shows the average ratio of falls rates per 1.000 bed days has significantly dropped since April 2010 compared to the average ratio of falls in 2009/10, from 8.3 to 6.6 falls per 1.000 bed days.



A Post Fall Protocol has been developed to ensure patients receive essential care following a fall and to improve incident reporting for analysis and learning opportunities. The protocol complies with all recommendations in the subsequent released NPSA Rapid Response Report– Essential care after an inpatient fall (NPSA/2011/RRR001).

Safeguarding

Safeguarding Children Team

The Safeguarding Children Team audit programme has reviewed the attendance of health professionals from Warwickshire Community Health at Initial Child Protection Case Conferences. A commendable rate of 80% was compliant with the standard set by Warwickshire Safeguarding Children Board (WSCB) which stipulates that health professionals attend Initial Case Conferences. Out of the remaining 20%, 83% of those that could not attend either sent a representative or gave apologies.

The Named Nurses Child Protection provide supervision to all health staff involved in Child Protection cases, 97% of supervision sessions which were booked were completed as planned across WCH.

The Named Nurses Child Protection continue to support Health Visitors and School Nurses with the production of court statements requested by the Local Authority. Figures for 2010/11 demonstrate a 100% increase in Warwickshire of completed requests on the previous year.

There is an ongoing robust programme of in house safeguarding children training for staff in WCH.

Safeguarding the Vulnerable Adult

WCH is committed to delivering, implementing and monitoring the organisation's structures, systems and processes to safeguard adults.

WCH recognises some patients may be unable to uphold their rights and protect themselves from harm or abuse. They may have greatest dependency and yet be unable to hold service to account for the quality of care they receive. WCH has particular responsibilities to ensure these patients receive high quality care and their rights are upheld, including their right to be safe.

WCH has representation at the Warwickshire Safeguarding Adult Board and has developed a operational group to:

- Prevent safeguarding incidents arising through the provision of high quality care.
- Ensure effective responses where harm or abuse occurs through implementing multi agency safeguarding adults procedures and polices.

Patient Safety First Campaign

The campaign was developed and supported by the National Patient Safety Agency (NPSA), The Health Foundation and the NHS Institute for Innovation and Improvement. The aim of the campaign is to provide ongoing vision and strategic leadership to reduce harm to patients by changing practise based on existing evidence. Patient Safety First is about actively looking for examples of harm, examining the causes and learning from them to avoid future incidences.
Sign-up to the campaign is voluntary however. WCH committed to the following areas to improve patient safety and quality:

- Leadership for Safety
- Reducing harm from deterioration

<u>Leadership for Safety</u>

The Patient Safety First Campaign suggested NHS leaders needed to interact with staff by visiting their work place, creating a shared insight into the organisation's safety issues.
WCH Patient Safety Walkrounds have shown to be very effective within the organisation providing an opportunity to develop action plans and changes to practice. Key themes and significant information from Walkrounds are fed

back to the workplace, through follow up Walkrounds. Every Walkround results in the formation of an action plan from discussions with staff.

To summarise, Walkrounds have:

- Demonstrated top level commitment to patient safety
- Established lines of communication about patient safety among employees, directors and managers
- Provided opportunities for senior directors to learn about patient safety concerns
- Identified opportunities for improving safety
- Encouraged reporting of issues, errors and near misses
- Promoted a culture for change pertaining to patient safety
- Established local solutions to minimise risk.

These have been expanded to include not only the inpatient setting but also community based settings.

Recognising the Deteriorating Patient

WCH is committed to embedding the timely recognition of patients with established or impending critical illness; and has empowered clinical staff to secure experienced help through the operation of a trigger threshold. WCH has adopted a trigger system, known as the Modified Early Warning Score (MEWS). The score aids recognition of a deteriorating patient. The baseline for using MEWS is that daily observations are performed on all inpatients. The MEWs score determines frequency of observation and subsequent transfer to an acute hospital when the patient triggers the highest MEWs score.

To summarise the implementation of the MEWS system has ensured:

- The recognition of patients whose condition is deteriorating.
- Staff are aware of their responsibilities regarding the use of MEWS
- A training and competency package for staff is in place.
- The process is monitored.

Progress made:-

- Clinical Procedure for the implementation of a Modified Early Warning System (MEWS) has been approved and implemented
- An annual audit of the process has been incorporated in the audit forward programme.
- The audit will be monitored through the Clinical Audit and Effectiveness Committee and the Resuscitation Committee.
- The Resuscitation Committee will review any incidents reported involving the MEWs process.

- A training programme and competency package has been incorporated in the organisational training.

Clinical Supervision

WCH is committed to ensuring that all staff involved in delivering clinical care and treatment receives appropriate supervision, taking into account national guidance from relevant professional bodies.

Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection. The concept of clinical supervision underpins a number of professional and national issues including codes of practice, autonomy, clinical governance, life long learning, risk management, continuing professional development, and reflective practice. To enable this the following is set out in the Clinical Supervision Policy:

- All Clinical Staff will participate in clinical supervision for a minimum of one hour per 8 weeks. Non-Clinical Staff do not have to fulfil this requirement , however support should be offered to facilitate this if the need arises.
- Supervisors and supervisees will keep a written record of each supervision session – on Trust approved documentation.
- Training needs of both supervisors and supervisees will be addressed.
- Each clinical job description will include the statement “will participate in clinical supervision” thereby forming part of the Key Stage Framework (linking to the core values).
- A core part of senior practitioners job descriptions should be an expectation that they will offer clinical supervision to colleagues and other practitioners within the trust and this will be included in job descriptions.
- All line managers should review the adoption of clinical supervision at the point of annual personal development reviews (PDR).
- Each directorate has developed a mechanism for supporting and reviewing the implementation of this policy.
- The uptake of supervision is subject to an annual audit

Face to face Clinical Supervision for Supervisors is provided in centres across the county every 8 weeks, with face to face Clinical Supervision Up-Date sessions being provided 4 times per year, however this will now be provided as an e-learning session in Spring 2011.

Clinical Effectiveness

Audit and Effectiveness Position Statement

Clinical audit and effectiveness are elements of healthcare governance concerned with the identification and monitoring the standards of health care delivery. The publication of Care Quality Commission - Essential Standards and Quality and Safety (2009) created a common set of standards for quality and safety in all NHS organisations and created a framework for the continuous improvement in the quality of care within them.

In addition to the requirements outlined by the Care Quality Commission, WCH must also be able to provide evidence to support the requirements set by the NHS Litigation Authority (NHSLA) in order to achieve accreditation

Audits

During 2010 /2011, two national clinical audits covered NHS services that WCH provides and which they were eligible to participate in. These were:

- Royal College of Physicians National Falls & Osteoporosis audit
- National Audit of Continence Care (NACC) 2010

National confidential enquiries are regularly reviewed but within this period were not relevant to services within WCH.

National clinical audits are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP).
Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

Audit is critical to the improvement of services and WCH has a team, dedicated to supporting a fully comprehensive audit program to demonstrate effectiveness and safety for patient care. The nominated Board lead is the Director of Quality and Clinical Leadership who ensures clinical effectiveness remains a key priority for the Board and has overall responsibility for audits within the Organisation. In clinical areas some audits are carried out on a daily/weekly/monthly or even six monthly basis. Last year the Audit Team worked on a number of audits across WCH in priority areas including pressure ulceration care and clinical records. The results were extremely helpful and have formed the focus of their action plans this year to improve a wide number of services prior to them carrying out a re-audit to measure what improvements we have made.

Table one show the breakdown of areas audited within WCH during 2010/11.

Organisational Audit Total 2010/11	107
Audit Breakdown	**Audit Numbers**
Audit Policy/procedure	59
Nice Guidelines	12
Multiple Standards/guidance	9
National Service Framework	1

Essence of Care	13
Infection prevention and Control	8
Other Audits- Local drivers specific to individual needs	7

Learning from audit
By definition clinical audit is all about measuring the quality of care and services we provide against agreed standards and making improvements where necessary.

As an example:-

Audits around three of our key concerns – **Falls, Pressure Ulcers and Nutrition** have highlighted areas for further development.

- New patient documentation has now been implemented to prompt and thus ensure
    - Risk assessments are completed by staff, thus identifying concerns before problems arise.
    - Any risk identified is followed up with a patient care plan.
    - A new / updated risk assessment and care plan is completed after a fall or pressure point occurs.
- Staff training around the documentation will raise awareness of the importance's

Finally a re-audit of these areas will occur later in the year to monitor our improvement and ensure best practice continues to be paramount.

Infection Control audits regularly occur throughout WCH which have shown

- A sustained reduction in Clostridium Difficile Toxin positive (CDT) within inpatient areas, a good reflection of both improved practices and a clean environment
- WCH can demonstrate that the community hospitals are 100% compliant with the Department of Health requirement for all admissions to be screened for MRSA from 31st December 2010 this initiative ensuring that all patients found to be positive for MRSA are offered appropriate treatment. Interventions are then implemented that will minimise the risk of infection and cross infection

National Guidance

There are many pieces of national guidance currently available which are relevant to services provided by WCH and throughout each year new national guidance is published. This includes guidance from National Institute of Clinical Excellence (NICE), National Confidential Enquiries into Patient Death (NCEPOD's), National Services Frameworks (NSF's), High Level Enquiries and other national guidance.

All relevant guidance is reviewed and incorporated within patient care ensuring that the care provided is both clinically and cost effective.

Table two shows a breakdown of published national guidance and the number relevant to WCH

Published Guidance 2010/11	**97**
Relevant to WCH	18
WCH implemented 11which includes the following:	11
• **Chronic obstructive pulmonary disease** • **Hypertension in pregnancy** • **Delirium** • **Lower urinary tract symptoms** • **Bacterial meningitis and meningococcal septicaemia** • **Alcohol-use disorders - preventing harmful drinking** • **Prevention of cardiovascular disease** • **Constipation in children and young people** • **Quitting smoking in pregnancy and following childbirth** • **Strategies to prevent unintentional injuries among under-15s** • **Preventing unintentional injuries among under-15s in the home**	
The following guidelines are currently in the process of being implemented	7
• **Neonatal jaundice** • **Chronic heart failure** • **Nocturnal enuresis - the management of bedwetting in children and young people** • **Looked-after children and young people** • **Diabetes (type 2) – liraglutide** • **Osteoporotic fractures – denosumab** • **Pregnancy and complex social factors**	

NICE Quality Standards

NICE quality standards are a set of specific, concise statements that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

Derived from the best available evidence such as NICE guidance and other evidence sources accredited by the NHS, they are developed independently by NICE and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

NICE quality standards enable:

- **Health and social care professionals** to make decisions about care based on the latest evidence and best practice.
- **Patients** to understand what service they can expect from their health and social care providers.

- **NHS Trusts** to quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide
- **Commissioners** to be confident that the services they are providing are high quality and cost effective

For 2009/10 the NICE quality standards were:

- Stoke
- Venous thromboembolism prevention (VTE)
- Dementia

WCH has action plans in place to ensure that the NICE standards are implemented.

Essence of Care

The Essence of Care, launched in February 2001, provides a toolkit to help organisations to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.

WCH has worked with patients and professionals to agree best practice in the quality of care patients' experience.

The Integrated Essence of Care groups looked at following topics;

- Falls – Community Hospitals and Community Teams
- Food and Drink (Nutrition) – Community Hospitals and Community Teams
- Safety (Orientation to ward) – Community Hospitals
- Communication – Community Teams
- Respect – Community Teams

The following recommendations developed from the audits have been implemented:

- New Documentation including Falls risk assessments and care plans to be implemented county wide, re-audit in 6 months time.
- Additional national screening tool and care plan training. National screening tool to be rolled out across the community setting.
- Staff to introduce themselves and identify named nurse on admission, staff to ensure patients are aware of which ward they are admitted to, staff to remind patient's at all opportunities of bed controls and call bell, where they are and how to safely use them.
- Best practice guidance sheets produced and displayed. Staff to follow guidance, particularly where clients are unable to leave a message outside normal working hours.
- Staff to ensure all patients are offered the opportunity to be seen on their own where appropriate and that they are satisfied with their visit.

Commissioning for Quality and Innovation/Quality Schedule

The Commissioning for Quality and Innovation (CQUIN) payment framework is a national framework for locally agreed quality improvement schemes. It makes a proportion of provider income conditional on the achievement of quality improvement goals and innovations agreed between the Commissioning Primary Care Trust and the Provider Organisation. Achievement of the agreed goals enables WCH to earn the full CQUIN payment. The CQUIN targets for 2010/11 addressed the three domains of quality: safety, effectiveness and patient experience.

Description of goal	Indicator number[1]	Indicator name
Tissue Viability Reduction	1a	Pressure ulcer risk assessment within 6 hours
	1b	Patients assessed to be at risk of ulceration or who currently have a pressure ulcer will have preventative actions taken and documented in their care plan.
	1c	Decrease in numbers of service acquired grade 2, 3 and 4 ulcerations
	1d	Recording and root cause analysis of all service acquired ulcerations of grade 3 or 4. The Director of Nursing will be accountable for the RCA, action, patient care to improve and safeguard the patient and reporting to the Board . The RCA and subsequent action taken will be reported to the PCT contemporaneously
Falls Risk Assessment	2	Falls Risk Assessment
Nutritional Risk Assessment	3	Nutritional Risk Assessment
Improving Dementia Care	4	Dementia Care Training
Patient Experience	5	Patient Experience
Risk	6	Risk Stratification

Stratification		

Quality Schedule

Quality, effectiveness and the patient experience are integrated into every element of service delivery agreed within the following Quality Schedule

There has been extensive work undertaken by WCH, in conjunction with the commissioning Primary Care Trust, to support a system that is transparent and accountable to local people which focuses on outcomes of high quality care and empowers patients through choice and information. Patient experience has been a key priority for WCH and the organisation has used a variety of approaches to capture views and experiences of patients, services users and carers.

WCH reviewed service delivery to enable alignment, where possible, to the quality schedule. The efficiency and effectiveness of the quality schedule are monitored through the monthly Clinical Quality Review Committee.

Care Quality Commission Essential Standards of Quality and Safety Health and Social Care Act 2008

WCH is successfully registered with the Care Quality Commission (CQC), which is a legal requirement under the Health and Social Care Act 2008 and as such have demonstrated that the Essential Standards of Quality and Safety are met.

A WCH Care Quality Commission Registration Standards Committee has been established and is responsible for monitoring the self assessment tools and action plans to ensure the CQC Essential Standards of Quality and Safety continue to be met.

CQC Infection Prevention & Control visit

The CQC made an unannounced visit to on 28th July 2010 with teams visiting two inpatient facilities - Bramcote Community Hospital in Nuneaton and Royal Leamington Spa Hospital in Leamington. The inspection was to ascertain compliance with the code of practice criterion 1, 2, 3, 7 and 9. The visit required the CQC to review the patient environment, policies and processes; in addition to interviewing staff and patients in order to ascertain compliance with the code. Immediately following the review the visiting CQC teams gave verbal feedback to both staff and managers – they confirmed that the environment and the care delivered by WCH in the areas visited had met all of the required standards. The visiting team congratulated clinical staff on the high standards of care observed during the visit and the cleanliness of the patient environment; in addition they informed managers that this had been the first occasion that had not necessitated their use of a camera to obtain photographic evidence of poor practices or a poor environment.
The formal report of the visit is available on the CQC website it noted ***'no cause for concern regarding the providers compliance with the***

regulation on cleanliness and infection control and we had no concern about the 14 measures we inspected'

NHS Litigation Authority Risk Management Standards

The NHS Litigation Authority (NHSLA) is a Special Health Authority who assess organisations against the 50 risk standards. Membership of the scheme is voluntary, however by participating in the scheme WCH can demonstrate:

- A structured framework which focuses on an effective risk management framework which delivers quality improvements in patient care and the safety of patients, staff, contractors, volunteers and visitors;
- Increase awareness and implementation of the national agenda for the NHS;
- A proactive approach to quality and safety improvement;
- A robust risk management culture within the organisation
- A commitment to minimise the number and cost of claims by reducing the number and severity of adverse incidents and the likelihood of recurrence;
- Assurance of the provision of a quality service provision to the Directors, other inspecting bodies and stakeholders, including patients.

In March 2010 the NHSLA conducted an assessment and WCH successfully achieved compliance with the first level of the standard criteria and continues to maintain compliance and progress towards the next level of compliance.

Themed Reviews

NHS Warwickshire monitors the quality of the care it commissions from WCH through the Clinical Quality Review meetings. However, in order to ensure these processes were reflected in care and service delivery, a series of announced and unannounced inspections, covering key themes is conducted throughout the year.

Safeguarding Children

In April 2010 NHS Warwickshire carried out a themed quality review of our Safeguarding Children and Young People.

The purpose of the visit was to:

- Support providers to review and improve Safeguarding Children and Young People systems, processes and practices
- Promote communication, partnership and integration with multi agencies across health and social care

- Improve services and outcomes through measurement of quality, safety and provision of feedback
- Obtain information to assist with the formulation of the review
- Seek opinion on the future direction of Safeguarding Children and Young People
- Understand and observe staff support, attitudes, and behaviour to Safeguarding Children and Young People.
- Future directions

Recommendations

The following recommendations were suggested to progress the existing Safeguarding Children and Young People arrangements, and areas of good practice within WCH.

WCH was required to develop a Safeguarding Children and Young People Action Plan to improve practices, systems, processes, relationships, multi agency, and inter agency working together across health and social care; incorporating the requirements of 'Working Together to Safeguard Children and Young People 2010'.

The action plan focused on:

Communication, understanding and involvement between safeguarding children and young people leads and staff in adult services in WCH.

Reviewing the time named doctors and nurses for safeguarding children and young people have to undertake their roles and responsibilities.

Ensuring staff are aware of agreed policies for Safeguarding Children and Young People Policies. Ensure that systems and processes are monitored so staff act responsibly to safeguard and promote the welfare of children and young people underpin these.

Refreshing the Safeguarding Children and Young People training plan

Completing enhanced CRB checks for all long term employees working with children by 31st March 2010.

Ensuring all staff have safeguarding children built into job descriptions.

Reviewing safeguarding children and young people data set to inform and improve performance/practice/training. In particular with regards to the impact and outcomes of single agency, inter agency and e learning training.

Providing quarterly reports to the WCH Board on progress against safeguarding children and young people board approved single agency and inter agency audit / actions plans.

All areas for improvement have been achieved and the action plan is under continuous review by the Safeguarding Children Operational Committee.

Infection Prevention and Control

In June 2010, WCH received a themed quality review of our Infection Prevention and Control Service. The purpose of the visit was to ensure the services commissioned by NHS Warwickshire and NHS Coventry were safe and complied with Health Care Acquired Infection (HCAI) Code of Practice.

WCH is registered with the Care Quality Commission and meet a range of government regulations, including one on cleanliness and infection control. To meet legal requirements, WCH must ensure that patients, workers and others are protected against the identifiable risks of acquiring HCAI. The Department of Health provided guidance on what is required under the code of practice regarding HCAI s on the 1st April 2010, under The Health and Social Care Act 2008.

Overall, the panel found the clinical review demonstrated WCH is operating to the HCAI code of practice and sharing their infection control data openly with the public on ward display boards and had introduced several examples of best practice.

Risk Management

In November 2010, WCH received a themed quality review of our risk management process. The purpose of the visit was to ensure the services commissioned by NHS Warwickshire and NHS Coventry were safe and complied with national and local governance legislation. The focus of the Risk Management themed review was to establish how WCH's integrated risk management processes were put into practice and how lessons learnt were embedded throughout the organisation and shared with staff and patients.

The findings of the review did not reveal areas of concern or risk and confirmed WCH has robust systems and processes in place for the management of incidents and complaints. WCH demonstrated they are continually trying to improve their processes to share best practice across the organisation and there are several examples of best practice that have been introduced.

Overall, the panel were delighted with the exemplar progress made. The openness and transparency of WCH and its Governance is to be applauded.

The quality of the evidence provided was of an exceptionally high standard.

The emphasis will be to continue to engage with staff through education, training, supervision; audit and feedback, with support from Director level to ensure service users are protected.

Workforce

Following the 2009 staff survey there were 4 goals set during 2010/11,

GOAL 1: To improve communications between senior management and staff.

GOAL 2: To increase clarity of job role and where job fits.

GOAl 3: Staff to feel more satisfied with the quality of work and patient care they are able to deliver.

GOAL 4: To improve the physical, emotional and mental health a wellbeing of staff.

The 2010 Staff Survey response rate has remained high at 67% and the responses received demonstrate that the action plan associated with the goals has been successful.

- Increased senior management visibility, with workplace visits, attendance at team meetings and staff briefing events making a huge impact as staff have rated highly senior management commitment and communications.
- We redesigned the Personal Development Review (PDR) paperwork and have had excellent feedback on the improvements.
- Staff who have had their PDR, feel their work is valued by the organisation and managers, and this is an area which is rated higher than average compared with other PCTs.
- Further work is being undertaken to increase the number of staff undertaking a PDR.
- Reduction in the use of temporary staff, particularly agency staff.
- A commitment to make substantive appointments where vacancies exist to ensure there is better continuity and commitment.

There has been a significant improvement in the survey responses about staffing levels, the ability to do job to a good standard, the time for staff to carry out their work, which reflects improved staffing levels

Staff want to work here, this is a very clear message in the survey and they also believe we are committed to their work life balance. We have had good responses to the Health and Well Being questions with a big improvement in managers taking an interested in staff's well being.

Areas which need attention in the coming months are uptake of statutory and mandatory training and feedback on incidents.

Service Specific Improvements Adults Services

Neighbourhood Teams

As part of the transformation of Community Services the reorganisation of teams throughout Warwickshire commenced in March 2010.

The Integrated Health Teams (Neighbourhood Teams) have been able to demonstrate efficiency improvements through the development of integration in conjunction with the effects of rapid improvement events.

Through scheduling and lean office events, the teams have increased nursing hours by 594 per week to date which has enabled the implementation of extended hours within the teams. Taking the principles of scheduling into the daily management of the team caseloads has reduced the travelling costs of £60,000 across the teams.

The final implementation of the roll out plans should be completed by April 2011 relocating 27 teams into 12 larger locality based teams enabling more staff to undertake long term condition modules and degrees *(see figure 1)*

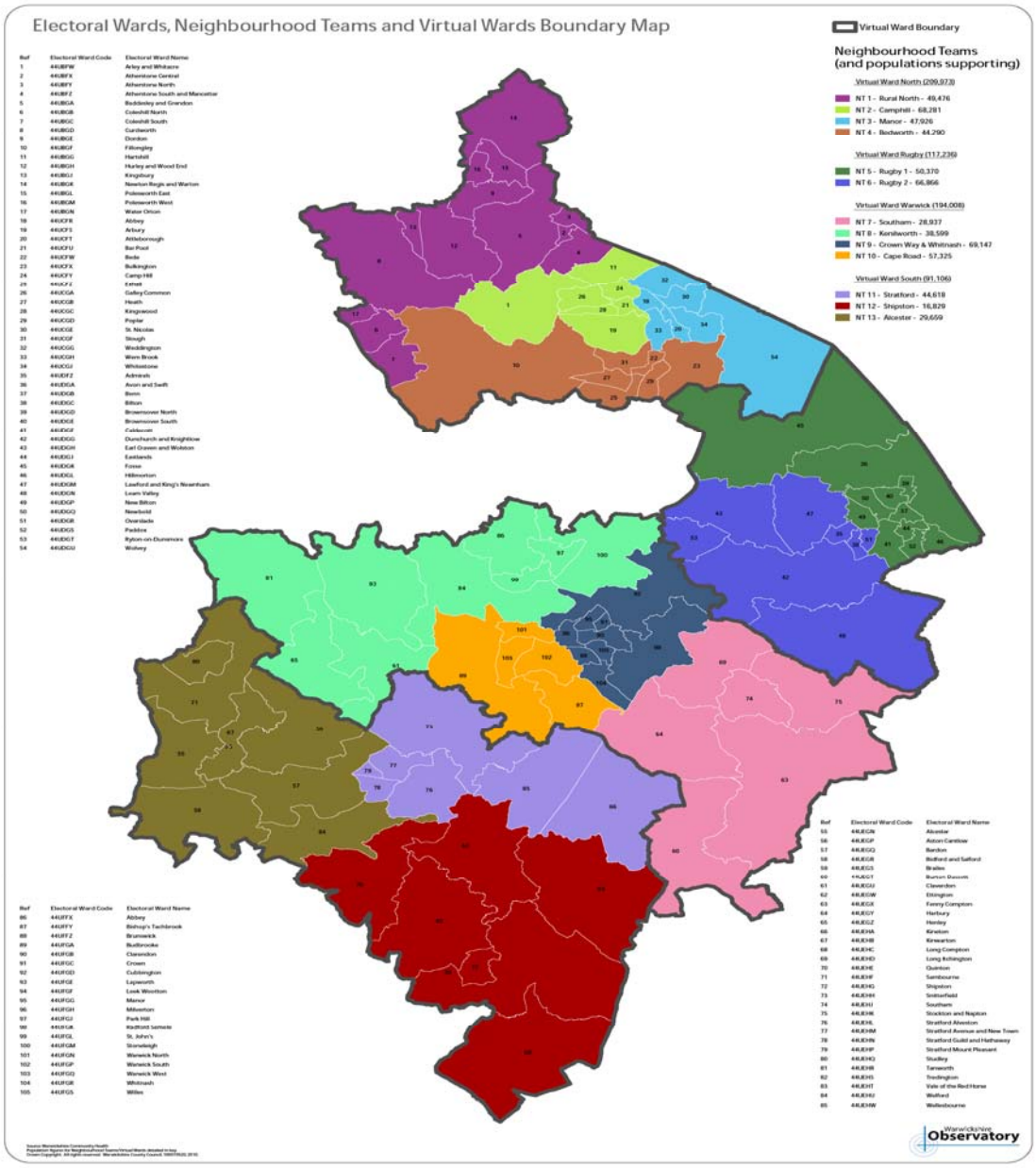
Virtual Wards

The Virtual Ward pilots in North Leamington and Bedworth are now part of core business and on 1 October 2010 the launch of the third Virtual Ward in Rugby proceeded on time. The fourth Virtual Ward in Alcester is due to go live in April 2011.

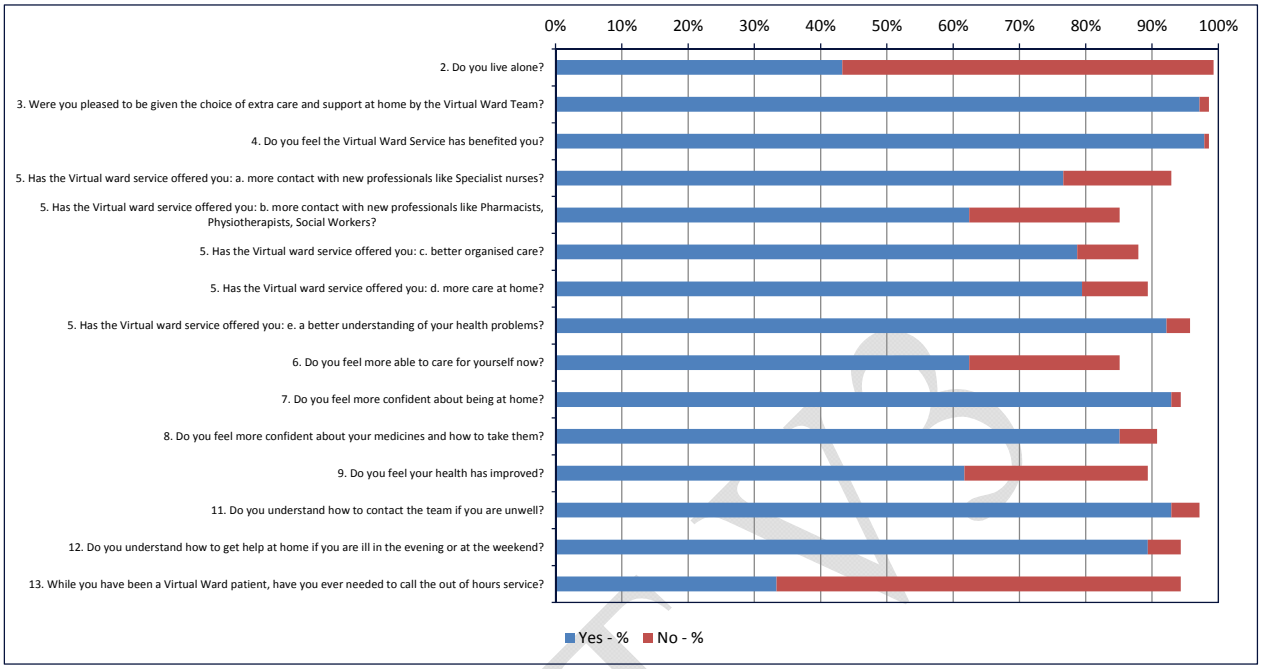
A 12 week discharge pathway has been implemented to ensure flows of patients from the Virtual Ward to the Integrated Health Team and vice versa. The Virtual Ward have continued their work to proactively recruit patients with long term conditions and at high risk of acute medical interventions.

The key performance indicators (KPIs) for the Virtual Ward have been agreed and routinely monitored through a dashboard. Patients discharged from the Virtual Ward are ask to fill out a patient experience questionnaire giving feedback on the experience and impressions of the Virtual Ward service. Detailed below in *figure 2* is a summary of completed questionnaires. This summary information is based on 141 patient questionnaires collected to October 2010.

Integrated Health Team (Neighbourhood Team) and Virtual Ward Boundary map *(Figure 1)*


Electoral Wards, Neighbourhood Teams and Virtual Wards Boundary Map
Virtual Ward Boundary
Neighbourhood Teams
(and populations supporting)
Virtual Ward North (299,973)
NT 1 - Rural North - 49,476
NT 2 - Camphill - 68,281
NT 3 - Manor - 47,926
NT 4 - Bedworth - 44,290
Virtual Ward Rugby (117,236)
NT 5 - Rugby 1 - 50,370
NT 6 - Rugby 2 - 66,866
Virtual Ward Warwick (194,008)
NT 7 - Southam - 28,937
NT 8 - Kenilworth - 38,599
NT 9 - Crown Way & Whitnash - 69,147
NT 10 - Cape Road - 57,325
Virtual Ward South (91,106)
NT 11 - Stratford - 44,618
NT 12 - Shipston - 16,829
NT 13 - Alcester - 29,659
Observatory

Patient Experience Questionnaire responses – Yes / No questions *(Figure 2)*



Children's and Young Peoples Services

Health Visiting

The priority of the Health Visiting Service in Warwickshire has been to implement the Healthy Child Programme. It has been a challenging task with the rise in child protection cases and the extra workload that this brings. All the health visitors attended a two day course last year on promotional interviewing at Warwick University. Where possible the health visitors are seeing pregnant women at around 28 weeks in their pregnancy to identify any issues that will impact on the future relationship and attachment to their baby after the birth.

More than 50% of the health visiting teams are based in children's centres and the health visitors are working geographically around the children centres with a named health visitor for each centre. A Service Level Agreement has been developed between the health visitors and children's centres to set out the shared responsibilities of the children's centres and health visiting teams in order to deliver a quality service to all the families who access the children's centres. The whole health economy has signed up to the Baby Friendly Initiative and this includes children's centres. There has already been an increase in mothers continuing to breast feed up to six weeks after the birth of the baby particularly in the most deprived areas of the County.

Last year the Child Death Review Process highlighted that there had been eight Sudden Infant Deaths (SUDI or Cot Deaths) across the County and a similar number in Coventry. This led to a Coventry and Warwickshire "Sleep Safe" campaign to reduce the numbers led by the health visitors. A "goody

bag" containing appropriate Sleep Safe messages and a number of items such as a room thermometer have been given out at the First Baby Review visit. The evaluation of the campaign carried out in July showed a greater knowledge of the sleep safe messages.

School Nursing

The School Nursing Teams like the health visitors are focussing on developing the Healthy Child Programme 5-19. A Year 6 health assessment will be starting in September 2011 and the teams are considering ways to support young people in the 17-19 age bracket that are currently not being commissioned but are considered to be a very important group. A Service Level Agreement has been developed in partnership with the Healthy Schools Team in the Local Authority and has been signed off in all schools across the County. The Agreement sets out the roles and responsibilities of the school and the school nurses and includes for example, the provision of appropriate rooms for advisory drop in sessions and agreement as to the support the nurses can provide with the school's health priority. The Team has expanded this year to include Change for Life Advisers who are working with the families and individual children and young people who have been identified with a weight problem in reception and Year 6 following the height and weight programme. The school nurses offer families a number of different opportunities to explore healthy lifestyle changes. Warwickshire has the lowest incidence in obesity in the West Midlands.

All the School Nursing Team has received training in the Solihull Approach and many have had training in the Triple P parenting programme.

The Family Nurse Partnership

The Family Nurse Partnership was launched in Warwickshire in July 2010 and went live in October 2010. The four Family Nurses are based in Children's Centres and provide the programme to young people across Warwickshire.

There have been a total of 101 referrals to the service and so far have recruited 40 clients, 24 from the North, and 16 from the South and Rugby (Mean figure for wave 4 sites is 32 so Warwickshire is within target). In June, July and August the team has received more referrals than it can take, which means that the programme cannot be offered to some clients as the nurses can only take a maximum of four clients per month. Where there are more referrals than the team are able to take the clients are assessed according to the most need and tend to be the younger ones.

90% of clients have additional needs such as mental health problems, leaving care, unstable living arrangements and learning difficulties. For the first month of the programme 87.5% of eligible clients were recruited (fidelity goal is 75%). So far 0 clients have left the programme. All the Family Nurses have all the resources they require and have completed the pregnancy and infancy training, motivational interviewing techniques and post natal depression training.

Therapies Service

Bringing down waiting times for therapy

Allied Health Professions (AHPs) have traditionally had long waiting times for their services. The Department of Health has announced that from April 2011 AHP services will now have to collect and report on waiting times for their services. In 2010 WCH was chosen to be a pilot site for the collecting and reporting of Referral to Treatment times (RTT). As a pilot site we have been involved in defining and agreeing what information will be collected nationally and how it will be reported.

Alongside the RTT pilot we instigated our own waiting list management project. The aims were to reduce waiting times for all AHP services and in particular to eliminate if possible waits over 18 weeks; to develop reports that managers could use to monitor waiting times and to understand capacity and demand for the services. The AHP managers worked with the Information and Service Improvement teams and have successfully developed a number of new reports.

As a result of having better information managers have been able to bring down waiting times significantly, even though the number of patients referred to their services has gone up. At the start of the project there were 2832 patients waiting for therapy, there are now 2538 patients waiting, but the numbers waiting over 18 weeks has fallen from 279 (9.8%) to 75 (2.95%).

Chart to show total numbers waiting for AHP services:

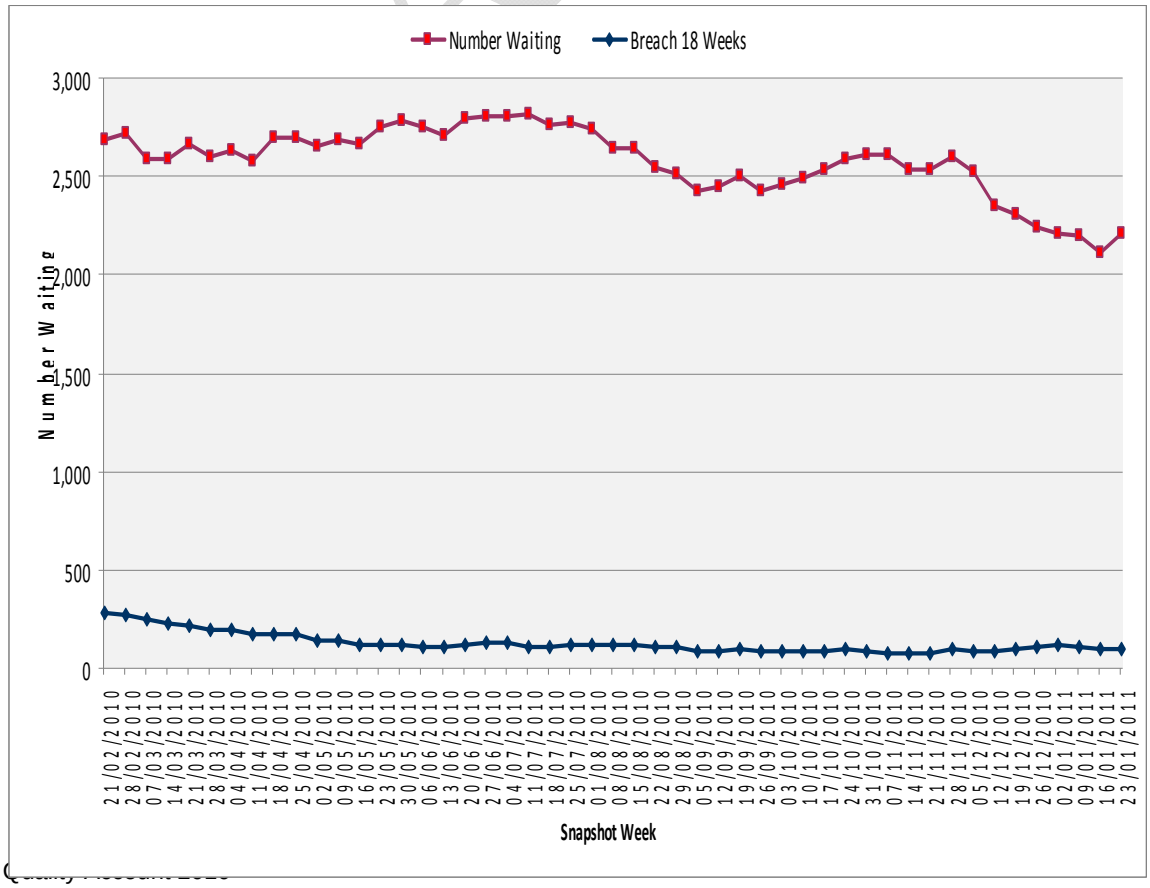
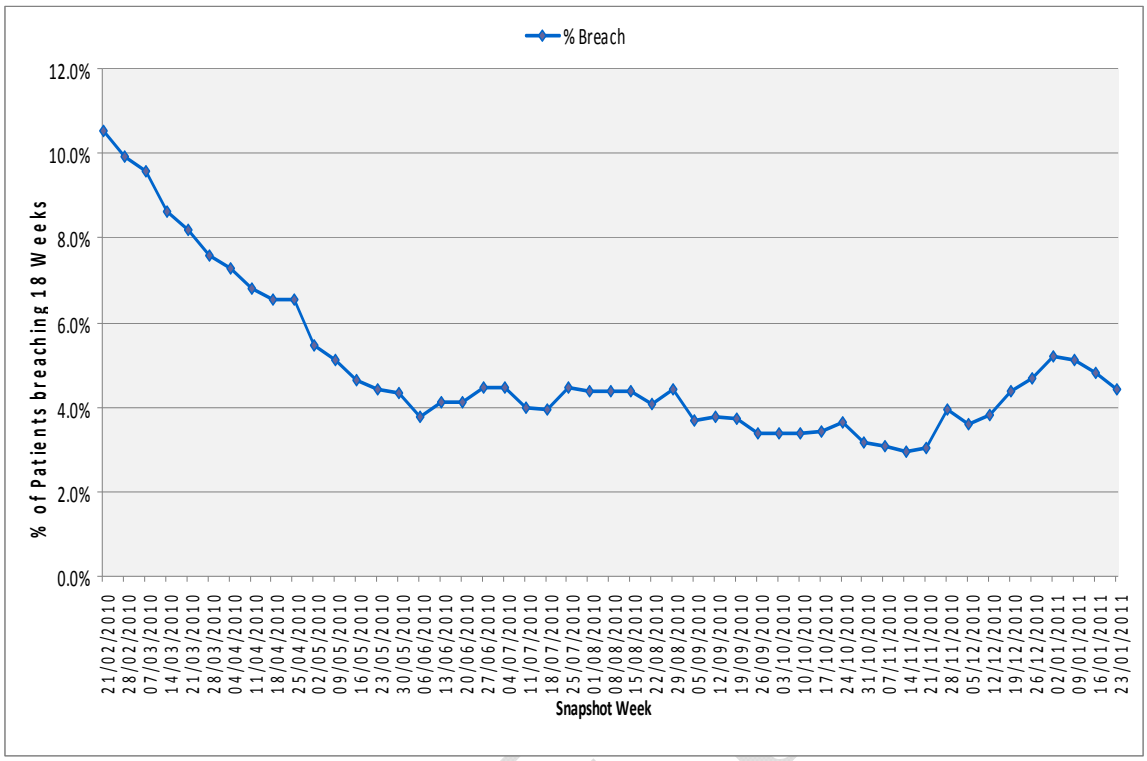


Chart to show percentage of patients waiting over 18 weeks:



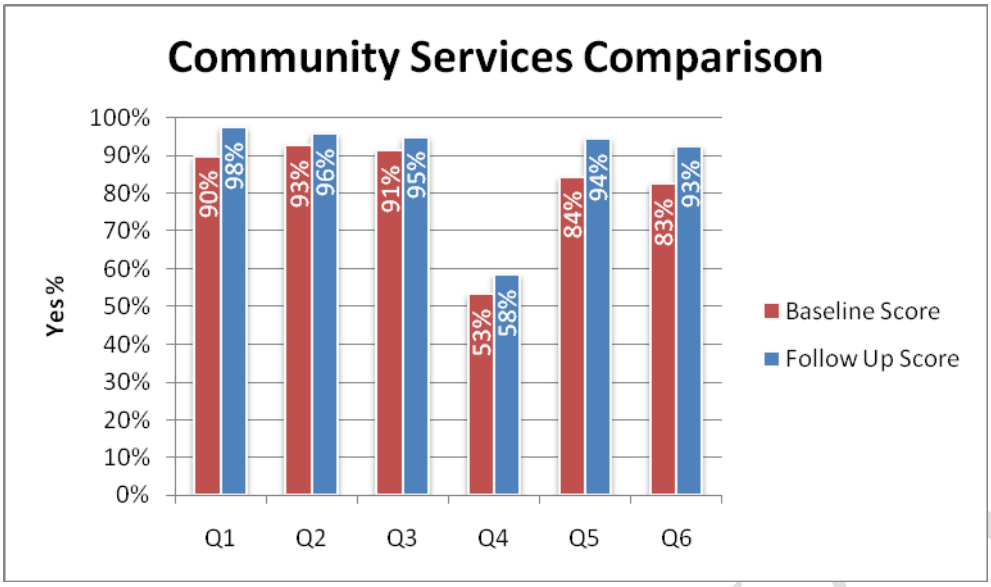
The project was presented as a poster at the recent Coventry and Warwickshire Quality Conference and was awarded second prize. The Department of Health visited WCH as a pilot site. They were very impressed with the results we have achieved and have asked us to present the project at a national Transforming Community Services conference in March.

Patient Experience

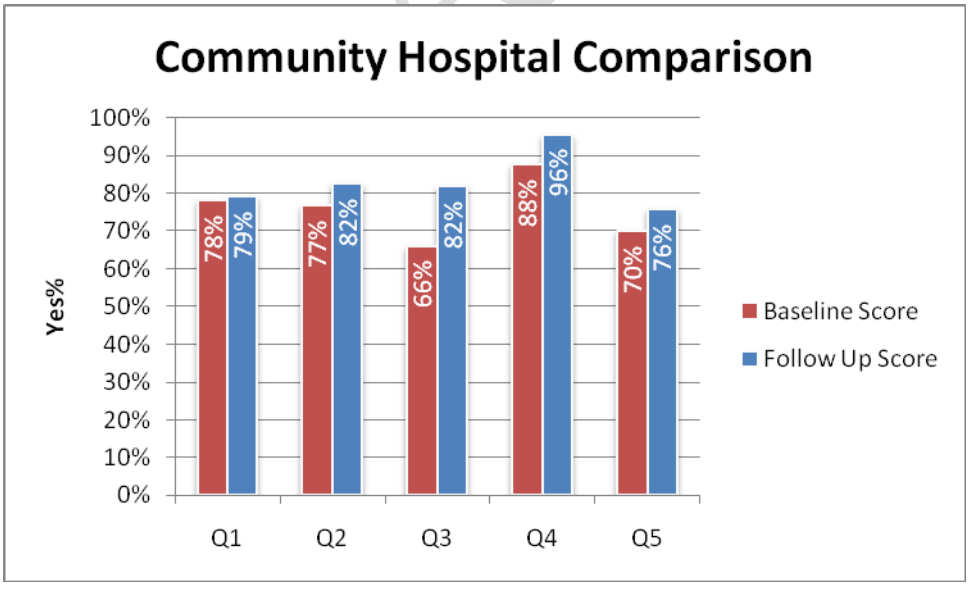
Patient Surveys

The results from both the regional Inpatient and community surveys were positive with overall improvements on patients' views of their stay in hospital and community care provided by WCH. A baseline survey was carried out in May with a follow up in December

Results from surveys



Q1 - Have you been involved as much as you wanted in decisions about your care and treatment?
Q2 - Were you given enough time to discuss your condition with healthcare professionals?
Q3 - Did staff clearly explain the purpose of any medication and side effects in a way that you could understand?
Q4 - Do you know what number/who to contact if you need support out of hours (after 5pm)?
Q5 - Overall, have staff treated you with dignity and respect?
Q6 - Overall, are you satisfied with the personal care and treatment you have received from community services?



Q1 – On your arrival were you welcomed, introduced to people on the ward and given information about your stay?
Q2 – Were you given enough time to discuss your condition, worries and fears with healthcare professionals?

Q3 – Did staff clearly explain the purpose of any medication and side effects in a way that you could understand?
Q4 – As far as you know, did hospital staff take your family or home situation into account when planning discharge from hospital?
Q5 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- The results overall within the Community Services pathway was positive with all questions receiving over 90% satisfaction, except for Q4 relating to an out of hours contact number only scoring 58%. **All questions showing an improvement on the baseline figures**.

- The results overall within hospital based services were also positive with all questions receiving over 75% satisfaction, with a great improvement around Q3 relating to patients feeling informed about their medication now scoring over 81% an increase of 15%. **All questions showing an improvement on the baseline figures**

Recommendations from the patient survey

All patients accessing services who do provide an out of hour's service are supplied with the contact number and arrangements. For non emergency services all patients should be provided with advice on the alternative arrangements. All patients have access to a welcome/orientation package to the community hospitals ward, containing the name of the named nurse, meal times etc. All discharge packages from community hospitals contain contact numbers and information for who and when to call after they are discharged from the hospitals.

The Audit and Effectiveness team continue to work with clinical staff to assure our services are safe, effective and up to date for the patients we care for.

Delivering Same-Sex Accommodation

The revised Operating Framework for the NHS in England, 2010/11(Department of Health) states that:

- "mixed-sex accommodation needs to be eliminated, except where it is clearly in the overall best interests of the patient"

WCH has eliminated mixed sex accommodation in all Community Hospitals. WCH consistently reports a nil return, for beaches of the single sex accommodation, to the Strategic Health Authority on a monthly basis. A statement outlining WCH's commitment to the provision of single sex accommodation is on NHS Warwickshire's web site. In addition guidelines to maintain single sex accommodation are also on the web site.

Patient Environment Action Team (PEAT)

PEAT is an annual assessment of inpatient healthcare sites in England that have more than 10 beds.

It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

An interim inspection was carried out in July 2010 to progress actions from the PEAT in February 2010. Most actions from issues have been completed and some new requests have been raised. All day to day maintenance is completed; any new furniture required has been purchased.

The programme of planned PEAT inspections has provided an excellent reporting mechanism to help facilitate change and make improvements. WCH endeavours to plot the progress of improvements between each inspection, to ensure that any recommendations have been actioned in a timely way.

Complaints

WCH Complaints Team has adopted the essence of the Ombudsman's Six Principles of Remedy, October 2007 which are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

WCH believe patients, relatives and carers voicing their concerns, provides invaluable feedback and an opportunity to review and question the quality of services they are delivering. During 2010/11 emphasis has been to ensure quality within the process, the investigations, the report, the response and the implementation of any actions required.

This has been achieved by introducing a new complaints process with control measures in place to ensure the internal standard of responding to formal complaints within 25 working days is met. In addition a pool of staff has undergone in-house Specialist Root Cause Analysis Training, based on the National Patient Safety Agency's model, to ensure consistency for all formal complaints and Serious Incidents investigations.

The focus for 2011/12 is to continue to provide an efficient and effective support to our service users and support to the organisation in identifying potential improvements.

The total number of formal complaints received in WCH for the period 1 April 2010 – 31 March 2011 was thirty four (34). Recommendations were made in relation to staff training, communication both internal and external and with outside bodies, record keeping and the review of policies and procedures. WCH has not been informed of any complaints being referred to the Parliamentary & Health Service Ombudsman.

The total population of Warwickshire at 1 April 2011 was 549,257. As of 1 April 2011 WCH employed 1,600 staff and made 600,440 community patient contacts with 767 patients admitted to hospital between April 2010 and March 2011. 0.01% of the population formally complained.

During 2010 there were a number of complaints in Community Hospitals that demonstrated common themes. The themes related to poor communication both written and verbal, knowledge and skills in relation to Dementia and Care planning. Fundamentally there was a need to strengthen leadership at ward level. An action plan to learn from complaints was implemented and has been updated to demonstrate progress

Key Points

- Leadership development for Ward Managers, Ward Sisters and Charge Nurses commenced in September 2010.
- Roles and responsibilities of this group were reaffirmed and job descriptions were reviewed.
- Training programmes were introduced to address knowledge and skills deficits.
- Standardised care plans are currently being introduced and care plan training is in place.

Improvements implemented include Dementia and care plan training. This has been enhanced by the introduction of the National Assessment tool, red jug and tray scheme to improve nutrition. Leadership has been strengthened with Job descriptions reviewed and a leadership programme in place. This has also been enhanced by the Leadership Development Programme to increase leadership skills.
In addition a customer service programme has been developed to improve therapeutic relationships and is aimed at all clinical staff.

Claims

No claims were received during 2010/11. However 3 Clinical Negligence claims and 3 staff claims relating to patient manual handling remain open. All 6 claims predated 1 April 2010.

Compliments

The total number of compliments received within WCH was eighty five (85). The following table shows the compliments by service area. All staff members who receive a compliment are acknowledged in Exchange and also receive a

congratulatory letter from the Managing Director of WCH. An acknowledgment letter is also sent to the person making the compliment.

Service Area	Total number of compliments
Bramcote Hospital	3
Child Development Service	6
Community Neuro Rehab Team	2
Continence Service	2
Dietetic	1
District Nursing	17
Ellen Badger Hospital	12
Health Visiting	2
Intermediate Care Team	18
Physiotherapy	6
Podiatry	5
RLSRH	5
School Nursing	5
Wheelchair Services	1
Total	**85**

Samples of comments received

Pleasure to be dealt with such charm and efficiency.
Superb support.
Excellent care and attention.
Wonderful job, helpful, polite and efficient.
Praise the standard of care.
All experts in field.
Positive step to avoiding hospital admission.
Good worker and being extremely knowledgeable.
Utmost gratitude for providing a wheelchair.

PART 3

Review of Quality Performance

Warwickshire Community Health CQUIN Targets 2010/2011

Goal Number	Performance Indicator	Agreed Target	WCH Achievement
1a	Patients assessed for pressure ulcers within 6 hours of admission or on first contact in the community.	95% of all patients	79.9%
1b	Patients assesses to be at risk of ulceration or who currently have a pressure ulcer will have preventative actions	98% of all patients	86.5%

	taken and documented in their care plan		
1c	Decrease in numbers of service acquired grade 2,3 and 4 ulcerations	40% reduction in grade 2 75% reduction in grade 3&4	Grade 2 –numbers remained the same at 39 Grade 3 & 4 – numbers have increased by 50%
1d	Recording and root cause analysis of all service acquired ulcerations of grade 3 & 4	100% of all grade 3&4	100%
2	All patients over 65 years will have a falls risk assessment within 24 hours of admission or initial contact in the community. For those identified at risk, an individualised falls care plan will be implemented	99% of patients over 65 years	63.8%
3	Patients will have a nutrition assessment completed on admission, using a nationally recognised tool. For those identified at risk, an individualised nutrition care plan will be implemented	99% of inpatients	85% had risk assessments 94% had a documented care plan
4	Patient facing clinical staff to have received dementia appropriate to their job role and grade	50%	60%
5	One baseline survey and one follow up survey to be carried out on patients who have been an in patient and patients who are in delivery of care in the community.	At least 4 of the 5 scores for the questions for hospital based services to show an improvement on baseline. At least 5 of the 6 scores for the questions for hospital based services to show an improvement on baseline.	All 5 scores showed an improvement All 6 scores showed an improvement
6	Appropriate staff to have received risk stratification tool training appropriate to their job role and grade.	90 clinical staff at bands 7&6 and Macmillan nurses to have received the training	Risk Stratification tool to be further developed and this will completed by the NHS Commissioners. WCH was not measured against this CQUIN

The table above demonstrates the quality agenda driving WCH service provision. The targets were agreed with the commissioning PCT to stretch and challenge the systems and processes ensuring that safety, effectiveness and efficiency are at the heart of our core business. The heart of WCH's business is to guarantee the patient experience and clinical outcome are of the highest achievable standard

Pressure Ulcer Quality Performance

- To continue to monitor the incidence and prevalence through Pressure ulcer and prevalence audit cycle.
- To investigate pressure ulcers grade 3 and above through root cause analysis and disseminate results back to managers and clinical teams, for learning and action plan implementation
- On going training in pressure ulcer prevention and treatment continues to be available to all staff.
- WCH wound care formulary available to staff to ensure clinical and cost effective treatment of pressure ulcers. Formulary to be reviewed April 2011.
- The tissue viability team are attending the operational group and health and safety meetings with integrated adult services monthly to regularly update and advise the management team on actions taken.
- To consider whether there are vulnerable adult issues in relation to pressure ulcers and report them through the Warwickshire Vulnerable Adult Safeguarding Health Sub Group.
- Good practice bi – annual audit. Findings reported to the Heath, Safety and Risk Committee and cascaded to team leads and managers for learning and action plan implementation
- New criteria for supply of preventative equipment to be developed for children, young people, adults and bariatric clients.
- New documentation to be embedded throughout the whole organisation by April 2011 which includes revised tissue viability paperwork including prevention of pressure ulcer care plan and decision tree, Waterlow risk assessment, and repositioning chart for all at risk patients and pressure ulcer wound assessment forms.

Falls Quality Performance

- 25% reduction in patient falls achieved
- Approved Falls prevention and Management of Falls Policy
- Warwickshire Community Health sign up to the Warwickshire Falls and Bone Health Implementation Plan 2010-2013
- Annual national audit of Falls and Bone Health
- Bi – annual audit of completion of falls risk assessments and care plan implementation.
- Risk Management Data base adapted to include 'post fall data, allowing better analysis and learning from every incident reported.

- Analysis and Learning from Incidents reported and monitored monthly

All staff to review the process for notifying patients of contacts details.
To raise awareness of NHS direct in all patient areas
through the Health, Safety and Risk Committee and bi – monthly through the Falls Committee.

- Training programme embedded within the Training Needs Analysis. Training sessions are arranged throughout the community setting and the Community Hospitals.

Nutrition Quality Performance

- Malnutrition Standardised Tool introduction to all Community Hospitals
- Standardisation of Care Plans and associated care plan training in place will enhance completion of nutritional assessment.
- Training and re-audit of nutritional assessment and care planning to improve compliance.
- An action plan implementation to be monitored by the Modern Matron
- Red Tray/Red Tray system introduced to identify those at risk of malnutrition and/or dehydration
- Volunteer or relatives visit during protected mealtimes to support those patients who require assistance

Dementia Training Quality Performance

- Additional Dementia training has been developed
- Dementia awareness included in the Vulnerable Adult training
- Coventry University has been commissioned to deliver dementia training linking it with the NHS West Midlands Module.
- Learning and Development Department monitor attendance and ensure a compliance report is monitored through line management and the Education, Learning and Development Committee.
- WCH has benchmarked against the National Dementia Strategy.

Patient Survey Quality Performance

Overall an improvement was shown on the level of patient satisfaction within WCH. The results overall within the Community Services pathway was positive with all questions receiving over 90% satisfaction, except for Q4 relating to an out of hours contact number only scoring 58%.

- All Patients contacting via phone will be know emergency details
- Patient Information Leaflets to be designed resourced and distributed
- Report disseminated to all services for action implementation
- report and action plan implementation monitored through Patient Experience Committee and the Care Quality Governance Committee

Risk Stratification Tool Quality performance

The two Virtual Ward pilot sites in the North and South of the county are now part of WCH core business. On 1 October 2010 a further Virtual Ward was launched in Rugby with a total of 120 beds. The Risk Stratification Tool training has still not been validated, however, due to the roll out programme, informal training for Band 8, 7 and 6s has commenced. The roll out programme will continue to ensure that all Adult Community Services have knowledge in and ability to use the Risk Stratification Tool to identify patients who are at risk of frequent acute admissions, Outpatient visits and GP visits.

Grade of Staff	Numbers Trained
5	5
6	7
7	15
8	6

Specific Achievements

Service Improvement programme

WCH Service Improvement programme delivers improved quality of services for Warwickshire residents

WCH placed service improvement high on its agenda during 2010\11, to support the delivery of its organisational GOAL's:

- Deliver improved patient experience, clinical effectiveness and safety
- Treat more long-term complex cases closer to home
- Achieve sustainable financial balance

Whilst addressing these goals, service improvement projects have been able to deliver improved quality of care, productivity and cost effectiveness. For example:

- District Nursing documentation has been standardised for all patients
- The Early Supported Discharge Team have enabled patients to leave hospital earlier to be supported in their own homes
- Neighbourhood Teams and Virtual Wards have been established and provide multidisciplinary support to patients in their own homes, thus preventing hospital admission
- Patients suffering with leg ulcers are now able to receive state of the art "VAC therapy" in the community to improve the rate of healing
- Waiting times and waiting lists for therapy services such as Physiotherapy, Speech and Language Therapy and Occupational Therapy have been reduced

In January 2010 the Project Governance Team (PGT) were established to support project leads in the successful delivery of their service improvement

projects and to enable the identification and celebration of the quality Improvements being achieved.

To support the ongoing focus on delivering quality and productivity improvement, WCH have initiated the roll out of Productive Community Services (PCS) (November 2010), which will be mainstreamed throughout the organisation. PCS forms part of the "Productives Series" of tools designed by the NHS Institute for Innovation and Improvement to support clinical teams in delivering better quality care. WCH believes that PCS will:

"Empower staff to make improvements within their own workspace to increase quality and safety: Creating a culture of continuous improvement to benefit both patients and staff"

During 2010\11 WCH have continued to deliver the "Productive Series" Productive Community Hospital (PCH) initiative which has been able to:

- Increase direct patient care time
- Reduce infection risk
- Improve patient engagement via patient forums
- Introduce Ward welcome packs

WCH recognise an essential element to redesigning services is the involvement of patients, carers and staff. During 2010\11 WCH Service Improvement team completed a pilot study looking at the effectiveness of the "Experience Based Design" tool (EBD). EBD involves patients and staff describing the emotional journey they experience when coming into contact with a care pathway or service. Staff worked together with patients and carers from a number of services to understand their experiences and how to improve them.

The Clinical Lead for WCH Nursing Team said "This has been an amazing experience for both families and staff. Just having the opportunity to be open and honest about how they feel has meant that we know that any changes we have made have improved the families' experience of our service"

Quotes extracted from interviews with patients, talking about their experience of the Community Children's Nursing service, provided invaluable insights into the service delivered by the Team:

"Felt like a lifeline".
"Made me feel confident and relaxed"
"I feel like I'm their priority"
"Brilliant, no stress for me"

Based on the success of the Experience Based Design pilot the service improvement team will now be using this tool support improvement in service quality throughout 2011\12.

Must be able to demonstrate achievement against local/regional/national Targets. This section to be linked to part 2

Overview statement on quality objectives and performance and how we monitored achievement/ celebrated good practice/ performance managed failure.

Statement on who and how the staff/patients/stakeholders/public were involved in the making of this report.

New CQUIN priorities for 2011

Description of goal	Indicator number[2]	Indicator name
Patient Experience	1a	Community Patients
	1b	Community Hospital Patients
Improved Assessment in Health Prevention	2a	Improved Falls Risk Assessment
	2b	Improved Nutritional Risk Assessment
	2c	Smoking Status and Brief Intervention
	2d	Alcohol Intake Status and Brief Intervention
Supportive Care Planning	3	Patients on the virtual ward have supportive, personalised care plans in place with defined health outcomes
Pressure Ulcers	4	Reduction in grade 2 pressure ulcers
Continuing Health Care fast track	5a	Fast Track monitoring and review
	5b	Multi – Disciplinary Team Assessment
Reduction in Catheter Acquired Infection	6	Reduction of Catheter associated Urinary Tract Infection for Patients in the NHS and Commissioned Care

Quality Performance Measures for 2011/12

Patient Safety

Ensure patients and relatives know how to complain and compliment
Implementation of the High Impact Actions for Nursing and Midwifery

Implementation of the Dementia Strategy
Develop a nutritional care pathway between hospital and community

Patient Experience

Improved Patient Information, particularly consent, smoking, alcohol, discharge,
Elimination of mixed sex accommodation
Implementation of a local pathway supporting patients at the end of their lives.
Improving patient transfer and discharge communication
Demonstrate patient and public engagement
Capture Patient Stories
Patient surveys

Clinical Effectiveness

Increase the number of staff receiving Personal Development Plans
Develop an action plan to address the comments from the staff survey 2010/11
Deliver the audit forward programme incorporating all local, regional and national requirements
Monitor and measure virtual wards and neighbourhood teams.

West Midlands Ambulance Service NHS
NHS Trust

QUALITY ACCOUNT 2010-11

Contents

Part 1. ..... - 3 -
1.1. Foreword from the Chair ..... - 3 -
1.2. Statement on quality from the Chief Executive of West Midlands Ambulance Service ..... - 4 -
Part 2 ..... - 5 -
2.1 Priorities for Improvement; Projects for 2011/12 ..... - 5 -
2.6 Review of Services ..... - 9 -
2.11 What Others Say about West Midlands Ambulance Service ..... - 12 -
Part3
3.3 WMAS Year End Key Performance Indicators 2010/11 .....
Who we have involved in the preparation of this account ..... - 30 -
Appendix 5 Glossary of Terms ..... - 33 -

The Vision for West Midlands Ambulance Service NHS Trust's is:

"Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies"

Part 1.

1.1. Foreword from the Chair

To be included once full account update is in place

Sir Graham Meldrum
Chairman

1.2. Statement on quality from the Chief Executive of West Midlands Ambulance Service

Last year (2010/11) overview and foreword for 2011/12

Statement summarising the providers view of the quality of NHS services provided or sub-contracted by WMAS during reporting period

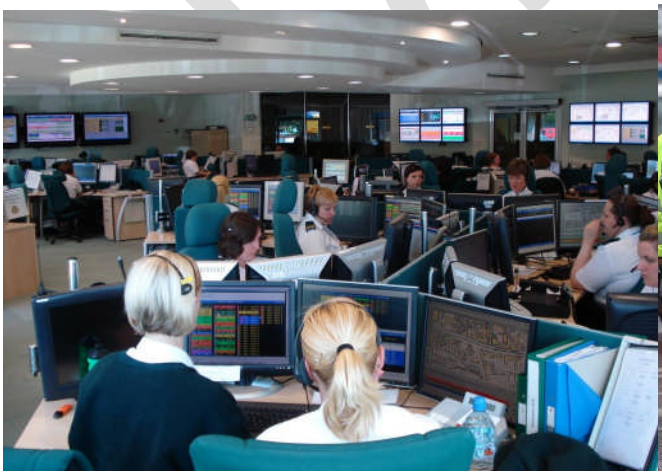
And

Statement required that to the best of the CEO`s knowledge the information in the document is accurate

Signature required

To be completed once full account of 2010/11 is included

Anthony C Marsh
CEO



Part 2

2.1 Priorities for Improvement; Projects for 2011/12

To help us select our Trust priorities for patients for improvement in care delivery, we suggested some key areas to our public and commissioners as `no decision without me about me` is important to this Trust. The priorities are to be monitored through regular processes. The Trust board has agreed the following priorities for improvement over 2011/12 based on risk, quality of care, a need to and continue to improve care from the three quality domains, patient safety, patient experience and clinical effectiveness.

2.2 Patient Safety

Priority 1; Slips Trips and Falls in our care

Rationale	We know that falls have a major impact on quality of life. Building on the work that was achieved last year around reducing patient falls in our care, it appeared that particularly with Patient Transport Services was where this work needed to be concentrated and in line with the national Patient Safety Express initiative hence this as one of our priorities carried forward to 2011/12..
Measure	The number of patients that slips, trip or falls in our care
Target	For a 25% reduction in the number of 'harm' incidents and an increase in near miss reporting
By When?	31 March 2012
Lead	Regional Head of Risk and Governance
Baseline	To be confirmed once final data verified.

Priority 2; Prescription Only Medicines

Rational	Due to the success of our management of controlled drugs as last year's priority, we want to approach the same method and concentrate on increasing compliance of management of Prescription Only Medicines (POMS). The Trust wants to do this as it presents a patient and public safety issue and efficiency challenge with regards to risk, ensuring availability of drugs; and regarding costs of investigations, replacements etc.
Measure	Compliance with storage in line with the Controlled Drugs management
Target	by 25% of the baseline figure of March 2011
By When?	31 March 2012
Lead	Regional Head of Clinical Practice (Medicines Management
Baseline	Our incidences are 166 for 2010-11

Priority 3; Infection Control

Rational	Patients still worry about getting an infection and the cleanliness of equipment and premises. Healthcare Associated Infection (HCAI) costs the NHS an estimated one billion pounds annually. It is estimated that 5,000 deaths each year are attributed to HCAI. So we aim to continue with improve compliance in hand hygiene that staff are adhering to procedures at point of care, our premises are clean , and our vehicles are clean and safe. The aim is to increased public, patient and staff confidence, continued registration and increased partnership working with other health providers
Measure	This will be measured by - Operational Premises Audit: to ensure premises are clean and safe for staff and patients - Vehicle Cleanliness Audit : to ensure vehicles are clean and safe for staff and patients - Staff Competencies : to ensure compliance to hand hygiene standards
Target	Premises Cleanliness Audit: Target for the Trust is to achieve 90%. If quarter 2 data shows the trust is below 90% the Trust will improve 10% on each quarter to achieve the target. Vehicle Cleanliness Audit : Target for the Trust is to achieve 90%. If quarter 2 data shows the trust is below 90% the Trust will improve 10% on each quarter to achieve the target. Staff Competencies : 100% of Emergency staff have a planned assessment date for IP&C competencies as part of their clinical supervision
By When?	31st March 2012
Lead	Infection Prevention and Control Lead
Baseline	Baseline data to be identified from Quarter 2 data

2.3 Patient Experience

Priority 4; Patient Survey offered to all service users proactively

Rational	The Trust is committed to enhance patients experience by increasing the quality of feedback we receive in order to learn from patients experiences which will help us improve patient care thus the overall patient experience.
Measure	Through quarterly patient surveys, as well as an online survey and engagement with LINKs & PPEG
Target	% of quarterly activity to be surveyed. The % will be determined by the activity for that period. For example at least 384 patients of an activity of 230268 calls
By When?	31 March 2012
Lead	Regional Head of Patient and Public Experience
Baseline	To be retrospectively obtained

Priority 5 (CQUIN 3); People with anticipated care needs are supported to meet their advanced care plan

Rational	The Trust is aware that some people have healthcare needs that can be planned ahead which would give patients reassurance that their care needs are pre - planned. Some people with long-term conditions will on occasion have exacerbation of that condition. The Trust feels that this it is important that when the urgent needs for these group of patients arises, that is a pre-agreed plan of care in-acted appropriately so that the patients receives the most appropriate care first time.
Measure	Calls received by the EOC where a person has an advanced plan of care that is enacted by the call resulting in the agreed plan of care being delivered appropriately.
Target	WMAS has evidence that at least 70 patients in each Cluster have had anticipatory care plans in use (except where GP choose not to use the anticipatory care plans), and a patient story annual report is produced to demonstrate how patient care has improved during the year.
By When?	31 March 2012
Lead	Regional Head of Long Term Conditions
Baseline	To be established

Priority 6; Patient involvement when things go wrong (Being Open policy)

Rational	The Trust strives to have Open and honest communication with patients. some research indicates that being open when things go wrong can help patients and staff to cope better with the after effects of a patient safety incident (NPSA 2010) This is in order to improved patient experience which it would be in hope to reduce complaints and improve learning and maintain the Trusts reputation.
Measure	Number of patients are contacted following each patient safety incident that has resulted in harm
How much?	100% of patient safety incidents will comply with the Trusts Being Open policy
By When?	31 March 2012
Lead	Regional Head of Risk and Governance
Baseline	34% as of March 2011 (YTD figure requires confirmation in April 2011)

2.4 Clinical Effectiveness

Priority 7; Patients Pain assessment.

Why?	We want to improve our documentation for taking patients pain scoring for patients experiencing a heart attack. If patients state they have no pain the documentation appears to be neglected and appears as if no pain score has been taken. The Trust wants to ensure that pain assessment is taken and documented as pain management for our patients is taken very seriously and we endeavor to document this accordingly before and after treatment.
Measure	Patients will have a pain score documented even if they have stated they have no pain
Target	90 % of patients will have a pain score documented.
By When?	31 March 2012
Outcome	Patients will have pain assessed appropriately.
Lead	Regional Head of Cardiac and Stroke Management
Baseline	78%

Priority 8 (CQUIN 1); Development of a Regional Directory of service

Rational	The Trust wants to ensure that when patients call the emergency and urgent ambulance that the Trust is well placed for triaging their calls and directing them to the most suitable service as the first point of contact, and in a timely way. In order to direct patients to the appropriate services a Regional Directory of Service has to be developed.
Measure	Total number of calls relating to a patient whose call is received in our Emergency Operations Centres
Target	Where a patient is able to be treated via alternative pathways, and there is capacity within the alternative service, 75% of people are routed to that service in the first instance.
By When?	31 March 2012
Outcome	Increasing effectiveness of care by ensuring patients having their calls directed to the most suitable service as the first point of contact, and in a timely way.
Lead	Regional Head of CMS DoS
Baseline	0

Priority 9 *CQUIN 2;* Effective use of Alternative Pathways- right 1st time

Rational	Implementation of an enhanced triage tool to ensure patients get to the right service first time. This will improve patient care by referring to the appropriate health care facility at source or on scene. This will improve patients being treated at the appropriate facility at the appropriate time. This will allow more trust resources available for emergencies and equate to NHS savings.
Measure	Conveyance reports and commissioning dashboard from NHS Pathways
Target	100% of patients calling 999 for an ambulance are triaged via the NHS Pathways triage tool
By When?	31 March 2012
Lead	Regional Clinical Support Desk & Regional Alternative Pathways Manager

2.5 Statements relating to the quality of NHS Service Providers

2.6 Review of Services

During 2010/11 West Midlands Ambulance Service provided and/ or sub-contracted (The Number) NHS services.

The West Midlands Ambulance Service has reviewed all the data available to us on the quality of care in (Number) of these services.

The income generated by the NHS services reviewed in 2010/11 represents (Number) % of the total income generated from the provision of NHS services by the West Midlands Ambulance Service for 2010/11

The Trust plays a central role in providing out of hospital care for patients.

- 999 emergency responses
  - Assessing the patient's needs quickly and accurately to determine the most suitable response for the patient
  - Following assessment and where required, we will send clinically qualified staff to assess further the patient on scene.
  - Clinicians will then provide initial treatment to stabilise the patient's condition and will then decide what further treatment the patient require.

  This could include:
  - transport for further treatment to an acute hospital
  - treatment at the scene with the patient left at home perhaps with follow up from primary care
  - a referral to an alternative location for further treatment such as their GP or a minor injuries unit

  The clinicians who attend patients range in skills from volunteers trained in basic life support to help patients until a clinician arrives, through to doctors trained in anaesthetics to deal with major trauma and other very serious conditions

- Providing urgent transport for patients where a doctor or other clinician has determined that they need to be admitted to hospital
- Sending urgent transport for patients who need to be transferred between different health providers
- Providing other related patient transport services to the NHS with staff that are trained in basic life support and have life saving automated defibrillator machines on board.
- Providing primary care, assessment and single point of access, to patients to allow them to be treated outside hospital settings.
- Supporting emergency preparedness for large scale civil emergencies working in conjunction with the other emergency services and relevant authorities

2.7 Participation in Clinical Audits

The Trust has a comprehensive Clinical Audit Programme which includes both national and local audits:

The Trust want to continue improving and submit's data for the National Clinical Performance Indicators which provide us with a benchmark against all ambulance trusts in England. In order to monitor our performance and improve care, we also undertake a monthly audit of all the clinical performance indicators, looking at a trust wide view but also looking at the performance within the localities i.e. Coventry & Warwick, Black Country etc. This provides useful information for clinical and operational managers and staff to review, identify and share good practice and develop local action plans to address any areas of concern.

The Trust has taken a lead and has been working with the Department of Health as a pilot site to develop a system of data collection and reporting for the new Clinical Quality Indicators. These indications include both clinical and operational indicators and the Trust will be submitting data nationally from April 2011.

Local audits include areas such as infection control related to staff practices such as hand hygiene, our vehicles and premises, as well as controlled drugs, mental health care, feverish illness and also asthma in children. We also carry out several audits related to stroke care and management of heart attacks, which provides staff with more detailed information about the care of these patients than the above indicators.

2.8 National Confidential Enquires

During 2010/11 West Midlands Ambulance Service were not invited to participate in national clinical audits and one national confidential enquiry covered NHS services that West Midlands Ambulance Service provides.

The national confidential enquiry that West Midlands Ambulance Service was eligible to participate in during 2010/11 was the CMACE Head Injury in Children

2.9 Participation in clinical Research 2011/12

The number of patients receiving NHS services provided or sub-contracted by West Midlands Ambulance Service in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 182

a Paramedic in this Trust is currently working with the National Innovation Centre to develop an improved Carry Chair to transport patients and also a Pelvic Splint which will help to reduce pain and further trauma to patients with this injury.

In April 2008, the Comprehensive Local Research Network (CLRN) for West Midlands (South) was commissioned to undertake Research and Development (R&D) management for the Trust.

The trust is taking part in the following projects:

- A National Institute for Health Research (NIHR) portfolio study into the use of mechanical Cardio Pulmonary Resuscitation (CPR) device in partnership with Warwick University Clinical Trials Unit. (This machine undertakes chest compressions on patients whose heart has stopped)
- A National Institute for Health Research (NIHR) portfolio study into Optimisation of the management of stroke and TIA (Transient Ischemic Attacks – a “mini stroke”)
- A National Institute for Health Research (NIHR) portfolio study into Engaging Ambulance Clinicians in Quality Improvement. Specifically looking at patients with Heart Attacks and Stroke

A study from Warwick University into `Exploring the experiences of Ambulance Personnel in managing patients at the end of life.

2.10 Goals Agrees with Commissioners

Use of the Commissioning Quality Innovation Schemes (CQUIN) for 2011/12

A proportion of West Midlands Ambulance Service and commissioners prompted income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between West Midlands Ambulance Service and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework as key objectives in 2010/11 to improve quality.

Further details of the agreed goals for 2010/11 and for the following 12 months period is available on request see contact details at the back of this document.

This year 2011/12 the goals agreed with the commissioners are schemes regarding improvements in:

- Development of a capacity managed Regional Directory of Health Services
- Implementation of an enhanced triage process to ensure patients get to the right service first time

  Patients supported in their wishes at the end of their life, to die at a place of their choosing (where practicable)

2.11 What Others Say about West Midlands Ambulance Service

2.12 Care Quality Commission

West Midlands Ambulance Service was registered with the Care Quality Commission and its current registration status is compliant without conditions

2.13 Data Quality

West Midlands Ambulance Service will be taking the following actions to improve data quality

For the clinical indicators, the clinical audit completes them, using specific reports to identify the patient group. The Patient Report Forms/Electronic Care Summary records are then audited manually by the Clinical Audit team. A process for the completion of the indicators is held within the clinical audit department on the central network drive

Initial checking:

- The results of the indicators are checked by a second person within the relevant department, checking for any anomalies in the data.
- The results are checked against previous month's data checking for trends and consistency.
- Once completed and checked, the indicators are sent to the Director of Nursing and Primary Care for approval.

2.14 NHS Number and General Medical Practice Code Validity

West Midlands Ambulance Service did not submit records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

2.15 Information Governance Toolkit attainment levels

Information Governance Assessment Report score overall score for 2010/11 was 68% and was graded satisfactory

2.16 Clinical coding error rate

West Midlands Ambulance Service was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission

Part 3

3.1 Review of Quality Performance

West Midlands Ambulance Service was one of only two in the country to achieve all three of its national performance standards. After an extremely tough winter, only a massive effort by staff ensured that the Trust achieved the result.

3.2 End of year performance:

National Target	75%	95%	95%	95%
Birmingham	78.1 %	99.1 %	94.3 %	97.5 %
Black Country	78.8 %	99.4 %	95.6 %	98.1 %
Coventry & Warwickshire	74.0 %	97.0 %	94.6 %	99.0 %
Staffordshire	76.8 %	98.2 %	96.6 %	98.9 %
West Mercia	75.6 %	95.8 %	94.6 %	99.0 %

	Cat A 8 Mins	Cat A 19 Mins	Cat B 19 Mins	Cat C Combined
National Target	75%	95%	95%	95%
WMAS	**76.8%**	**98.0%**	**95.0%**	**96.8%**

3.3 WMAS Year End Key Performance Indicators 2010/11

To ensure patients of the West midlands receive quality care from their ambulance service a set of key performance indicators have been set nationally. These help set our policies and guidelines and develop and continue to develop an organisation and a culture that places quality at the top of this Trusts agenda. We have made significant progress in many areas in the last year and those highlighted show our performance regionally against the national targets.

The charts below show the percentages achieved at both the beginning and end of the year for our key performance indicators.

Stroke / Mini Stroke:

- Blood pressure – as raised blood pressure may be a contributing factor for stroke
- Blood glucose level - as patients with an altered level may present with the same symptoms as a stroke
- FAST test – this is an assessment of the following:
  - **F**acial weakness - can the person smile? Has their mouth or eye drooped?
  - **A**rm weakness - can the person raise both arms?
  - **S**peech problems - can the person speak clearly and understand what you say?
  - **T**ime to call **999**

This test can be used by anyone (not just ambulance or hospital staff). If you suspect a stroke think FAST and provide valuable information when you call for an ambulance.

Stroke Indicators

FAST Test		**Blood Glucose**		**Blood Pressure**	
	April to March 11		April to March 11		April to March 11
Birmingham	98%	Birmingham	95%	Birmingham	100%
Black Country	96%	Black Country	98%	Black Country	100%
C&W	96%	C&W	94%	C&W	100%
HSW	97%	HSW	94%	HSW	100%
Staffs	100%	Staffs	96%	Staffs	100%
WMAS	**98%**	**WMAS**	**95%**	**WMAS**	**100%**
National Mean	**95.6%**	**National Mean**	**92.5%**	**National Mean**	**98.6%**

STEMI: (ST-elevation myocardial infarction)

This is a type of heart attack. It is important that these patients receive the following:

- Aspirin - this is important as it can help reduce blood clot formation
- GTN – this is a drug that increases blood flow through the blood vessels within the heart (improving the oxygen supply to the heart muscle and also reducing pain)
- 2 pain scores – so that we can assess whether the pain killers given have reduced the pain.
- Morphine – a strong pain killer which would usually be the drug of choice for heart attack patients
- Analgesia – Sometimes if morphine cannot be given entonox, a type of gas, often given in childbirth, can be used.

Aspirin		**GTN**		**Two Pain Scores**	
April 2010 to March 2011		April 2010 to March 2011		April 2010 to March 2011	
Birmingham	97%	Birmingham	98%	Birmingham	77%
Black Country	98%	Black Country	95%	Black Country	74%
C&W	97%	C&W	93%	C&W	86%
HSW	96%	HSW	96%	HSW	82%
Staffs	92%	Staffs	95%	Staffs	67%
WMAS	**97%**	**WMAS**	**96%**	**WMAS**	**78%**
National Mean	**96.9%**	**National Mean**	**92.2%**	**National Mean**	**79.9%**

Morphine		**Analgesia**	
April 2010 to March 2011		April 2010 to March 2011	
Birmingham	63%	Birmingham	59%
Black Country	71%	Black Country	69%
C&W	80%	C&W	76%
HSW	84%	HSW	82%
Staffs	64%	Staffs	64%
WMAS	**73%**	**WMAS**	**70%**
National Mean	**72.1%**	**National Mean**	**73.3%**

Asthma: A common respiratory condition where the tubes going into the lungs are inflamed and thus narrowed, making it difficult for the patient to breath. Measurements of quality include;

- **Respiratory rate** – how frequently the patient takes a breath, usually measured as number of times per minute.
- **PEFR** prior to treatment – **PEFR** is a device used to determine and measures the flow on breathing out and indicates the amount of narrowing of the tubes. Measuring this before treatment allows doctors in the hospital to assess how bad the asthma attack was, and thus what further treatment is required.
- **PERF** after to treatment – this shows how effective the treatment given has been.
- **SpO2** before treatment - this shows the amount of oxygen present in the blood
- **Oxygen** – whether we gave oxygen as a treatment

Asthma indicators

Respiratory Rate		**PERF before treatment**		**SpO2 before treatment**		**Oxygen**	
April 2010 to March 2011		April 2010 to March 2011		April 2010 to March 2011		April 2010 to March 2011	
Birmingham	100%	Birmingham	51%	Birmingham	100%	Birmingham	96%
Black Country	100%	Black Country	40%	Black Country	100%	Black Country	97%
C&W	99%	C&W	50%	C&W	99%	C&W	97%
HSW	99%	HSW	66%	HSW	100%	HSW	98%
Staffs	100%	Staffs	66%	Staffs	99%	Staffs	96%
WMAS	**99%**	**WMAS**	**55%**	**WMAS**	**100%**	**WMAS**	**97%**
National Mean	**97.4%**	**National Mean**	**50.0%**	**National Mean**	**92.8%**	**National Mean**	**93.6%**

Beta-2 agonist recorded		**Oxygen**	
April 2010 to March 2011		April 2010 to March 2011	
Birmingham	93%	Birmingham	96%
Black Country	95%	Black Country	97%
C&W	96%	C&W	97%
HSW	96%	HSW	98%
Staffs	94%	Staffs	96%
WMAS	**95%**	**WMAS**	**97%**
National Mean	**96.0%**	**National Mean**	**93.6%**

Hypoglycaemia:

This is when the amount of glucose (sugar) in the blood is lower than the normal range. This is usually related to diabetes but can be caused by other conditions.

Blood Glucose before treatment		Blood Glucose after treatment		Treatment given recorded	
April 2010 to March 2011		April 2010 to March 2011		April 2010 to March 2011	
Birmingham	100%	Birmingham	98%	Birmingham	99%
Black Country	99%	Black Country	98%	Black Country	99%
C&W	99%	C&W	99%	C&W	99%
HSW	98%	HSW	97%	HSW	99%
Staffs	100%	Staffs	97%	Staffs	98%
WMAS	**99%**	**WMAS**	**98%**	**WMAS**	**99%**
National Mean	**98.8%**	**National Mean**	**93.3%**	**National Mean**	**95.3%**

Successful resuscitation of people (Return of Spontaneous Circulation/normal heartbeat) whose heart has stopped (Cardiac Arrest): The data submitted for the last three years is:

	2007/08	2008/09	2009/10	2010/11
Number of patients with return of spontaneous circulation upon arrival at hospital	156	146	148	394
Total number of patients in cardiac arrest with resuscitation attempted	1993	1373	1360	1819
Percentage	7.83%	10.63%	10.88%	21.66%

For 2010/11 our total % of patients is 21.66% which is the best performing Ambulance Trust nationally.

The definition for cardiac arrest is when resuscitation is started by a healthcare professional and not those patients where death has been confirmed and/or patients who have said that they did not wish to be resuscitated with a written instruction (advanced directive). Return of Spontaneous Circulation is agreed as only those patients where spontaneous circulation returned and is confirmed by the presence of a regular pulse which could be felt and which did not include odd heartbeats.

3.4 Review of Patient Safety

Patient safety is the Boards top priority. This section provides some details of the projects we undertook to improve on for 2010/11

Project 1; Slips Trips and Falls in Our Care

It is nationally recognised that slips, trips and falls remain a high cause of injury. Analysis of WMAS 2009-10 adverse incidents identified 33 patient slip trips and falls resulting in harm. These were mainly in the non emergency transport area of our service. Although no serious injuries occurred the Trust recognises the potential for serious harm and the trauma that a fall can have on an individual. There were also 37 near miss incidents reported during 2009/10.

Full analysis of 2010-11 data is in the verifying stage and is expected to be complete by the end of April 2011. Draft data suggests a 27% decrease in harm and a rise of 75% in near miss reporting has been achieved. Encouragingly we have surpassed the 25% set target and achieved in reducing harm to our patients and raising awareness by 25%.

PROJECT 2 Controlled Drugs Management

There were 415 controlled drug incidents in 2009-10. This presents a patient and public safety and efficiency challenge for the Trust; a patient and public risk regarding availability; and a Trust efficiency challenge regarding costs of investigations, replacements. These ranged from breakages to documentation. Our target was to reduce incidences by 25%. By the 31 March 2011 the Trust has achieved a reduction in controlled drug incidents by 60% exceeding our original target.

PROJECT 3 Reducing the risk of infection

Surveys show that the public and patients still worry about getting an infection and the cleanliness of equipment and premises. Healthcare Associated Infection (HCAI) costs the NHS an estimated one billion pounds annually. It is estimated that 5,000 deaths each year are attributed to HCAI. Statistics suggest that 1 in 9 patients acquire an infection during their hospital stay. The Code of Practice, January 2009, assists NHS organisations to plan and implement how they can prevent and control Healthcare Acquired Infections.
Our target was 90% compliance of hand washing audits. Hand hygiene audit reports have been received from acute trusts staff that conducted the audits looking at ambulance crews hand hygiene. Unfortunately compliance only reached 67%. However during further investigation it has been found that the results were inaccurate as non-ambulance staff had been included in the audit resulting in inaccuracy.

Our actions are to;
Ensure all aspects of hand hygiene and staff practices at hospital are now added to the Mandatory training for the year 2011/12.

Clinical Team Mentors will be working with staff regarding competency at point of care with hand hygiene, and then observing their compliance.

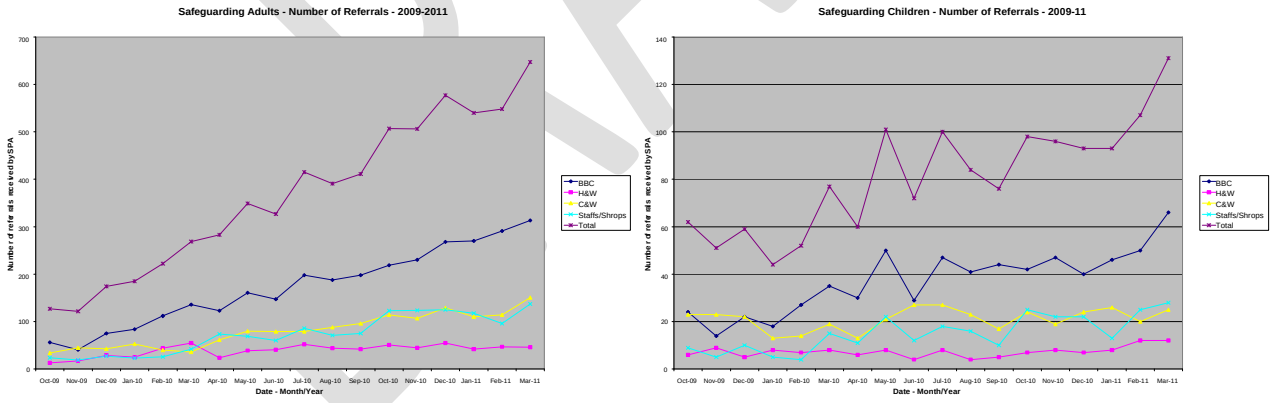
To continue with this as a project for the 2011-12 and to include the hand hygiene, use of Personal Protective Equipment, Cleaning of equipment and disposal of waste.

Project 12; Safeguarding Children and Vulnerable Adults

Children & Vulnerable Adults within our society are at highest risk of all types of abuse. It is a moral and legal requirement that we do as much as we can to safeguard these individuals against such abuse. Ambulance staff are in the unique position of seeing family and what is happening around the child or adult in their own homes that others do not. Are target was to increase the number of safeguarding referrals by 10% from the baseline measured against rates as of 31 March 2010. This aim was to increased awareness of crews regarding safeguarding, increased number and quality of referrals in order to improve the safeguarding of patients, improve quality of referral. Provide evidence for crews for ongoing learning and evidence of practice and to highlight gaps in health and social care

Safeguarding has been a majorly successful quality improvement in the past year. Lord Laming's report following the tragic death of Baby Peter called on services to improve their training, referrals and communication with other agencies and feedback to be given to referrers. WMAS introduced a 'Single Point of Access' to make it simple for crews to refer, provide consistency and accuracy of information to Social Services, performance reports and a system of recognition of best practice. This, linked with additional work regarding Consent and Mental Capacity policies and procedures, has provided a best practice and cost effective model of managing safeguarding for the most vulnerable of our patients. The Trust during 2010/11 sought to improvement in the referral numbers and quality hence being included as a priority in this Quality Account.

The graphs below show the significant increase in the referrals made over 2010/11 by our crews. They show by division the increasing amount of referrals made by the crews to the safeguarding team from April 2010-March 2011 thus showing a 412% increase for adult referrals increase and a 110% children referrals increase, achieving well above that target of 10%



3.5 Patient Experience

PROJECT 4; Improving complaints response times
Evidence shows that complaints from the public to healthcare are a valuable way of learning and improving the services. It is important to do this in as short a time as possible to assist the patient and improve the service. There are national requirements within the Department of Health policies. Our target was to reduce the delays in complaint resolution caused by Trust actions by 5 days. Average response times when reviewing closed complaints between 1 April –28 February 2010 to 23 days.

YTD Complaints will be closed by May 2011

PROJECT 5; Reducing delays in resolving claims

This project was about reducing delays in resolving patient claims which can cause anxiety for the patient / claimant and increased costs to the Trust in legal fees. Our target was to ensure claim resolution within 28 days for 95% of claims. For 2010/11 the Trust has provided the NHSLA with information on new patient and staff claims within an average of 14 working days, therefore the Trust has achieved well above target.

PROJECT 6 *CQUIN (1);* Service users are taken to appropriate care facilities rather than A&E

The emergency and urgent ambulance service deals with increasing numbers of requests for assistance. Many of those requests can be more suitable dealt with outside of a traditional acute A&E environment. So the aim was to ensure that our service users were to be taken to appropriate care facilities rather than to A&E. The target was maximum of 67% of patients conveyed to A&E departments**.** The outcome was for more patients seen, were to be treated and left at home by crews; more patients seen at local services such as Walk In Centres; and more patients being seen and treated in their own homes by community services. The aim being for higher patient satisfaction and less demand on A&E services

This was achieved and 63.1% of emergency patients were conveyed to hospital during the year ending March 2011 compared to 64.9% in 2009/10

PROJECT 7- *CQUIN (2);* Pro-active Management of Frequent Callers

Where the same people are using the service frequently this could indicate that they do not have sufficiently robust care plans that allow them to pro-actively manage their condition. WMAS have a responsibility to work with other primary care providers to pro-actively manage the care needs of these people. Our rationale is, people who have a need to use the service frequently are helped to get and agree to use alternative care options with formal care plans in place. This will include people who have called the service five or more times in a rolling 12 week period. Our aim was for the number of frequent callers to have clinical management plan agreed between WMAS and Primary Care to be above 60%. The outcome for this would mean that the number of patients frequently calling the service is reduced and those patients have their needs appropriately met by other services, reduced risk of inappropriate admission to hospital.

In the full 50 **weeks (duration of the project)** there were 635 individual frequent callers identified by WMAS.

- 78.4% of all frequent callers were successfully managed and have only triggered the system once (one week) during the entire year.
- Over 91% of all frequent callers were managed within 4 trigger weeks (not consecutive) and only two service users still present a concern with trigger points for half of the entire period – (2 out of 635 patients)
- 67% of all frequent callers who have triggered > 1 week have had a coincidental safeguarding referral made by a WMAS clinician. This clearly demonstrates the link between vulnerable individuals and frequent callers, and additionally highlights the excellence of WMAS clinicians identifying appropriate safeguarding concerns and reporting them via WMAS Single Point of Contact. This continues to evidence the previous trends.

PROJECT 8 *CQUIN (3)*; Service User Feedback

The feedback of service users is an important part of making sure we have a safe and effective service. Service users in other parts of the healthcare system are offered the opportunity to provide formal feedback via patient surveys and it is equally important that we get patient satisfaction feedback on the service. Our aim was that100% of the patients will have been offered the opportunity with the minimum of 2.5% (c.20,000 per annum) giving feedback with the intention of increased patient satisfaction.

161,649 people viewed our Patient Survey via our web page. It is disappointing that the Trust only received 151 completed surveys during this period. However, overall the results of this survey are favourable in all areas. The free text opinion field within the survey indicates praise for the service and the attending ambulance crews.

Below are some of the negative points raised: -

- Staff need to be trained in lifting and handling
- The Paramedic didn't really talk to me
- The cleanliness of the ambulance
- Numerous comments with regard to delay.

This feedback has been used as part of the Trusts analysis and learning which takes place within the Trusts Learning Review Group. The group uses information from a variety of sources such as incident reporting, complaints surveys, etc, to ensure the Trust learns from them and is constantly improving the service it provides.

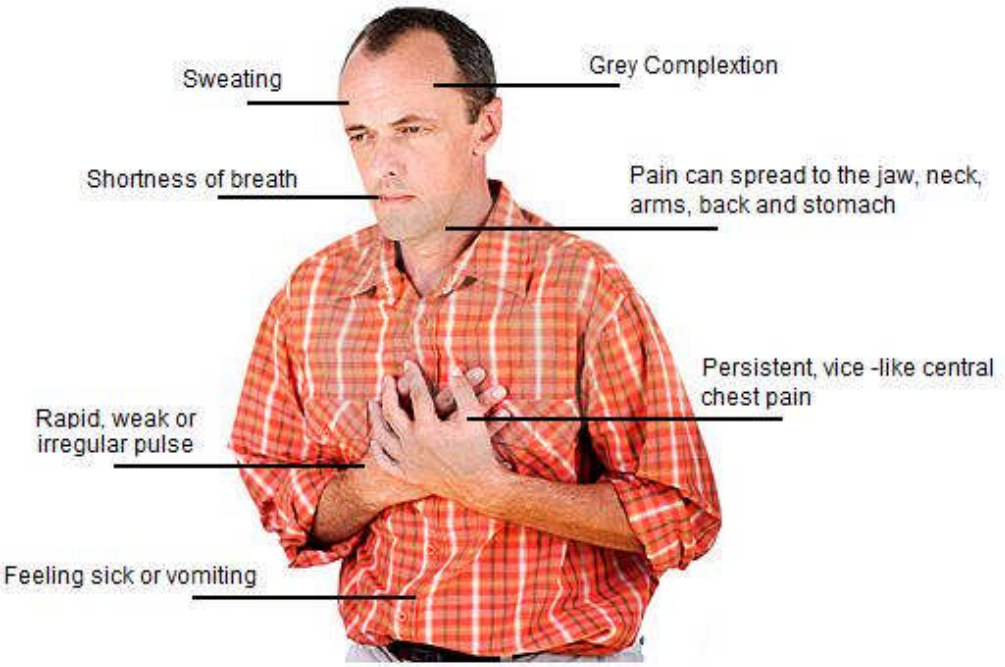
The Trust will continue to learn from Patient Experience through: -
Engagement with all stakeholders including Local Involvement Networks (LINks)
Complaints, PALS contacts and compliments
Patient Surveys and real time feedback

The Trust is currently investigating new ways to improve patient surveys and feedback in order to see an improvement during 2011/12

PROJECT 9 *CQUIN (4);* Appropriate care for people with Stroke, mini stroke and Heart Attack

Patients with suspected stroke, mini stroke or heart attack will have rapid assessment, diagnosis and rapid transfer to appropriate care setting by our staff. This is because for people with heart attack, stroke or mini stroke there is evidence that early diagnosis and rapid specialist treatment improves the outcome for the patient. The trust audited monthly a sample of patient notes to determine whether the correct observations were undertaken and documented in accordance with current Joint Royal Colleges Ambulance Liaison Committee guidance and those people suspected of having a stroke or mini stroke had a FAST (as described earlier in this account) test undertaken and documented. Also audited was that the diagnosis has been recorded on the patient notes. These audits were to ensure patients quality of care. The target was to achieve this at least 90% of the time by March 2011. The results for March 2011 were that performance all of the audits never dropped below 90% from the introduction of the quality markers.

.



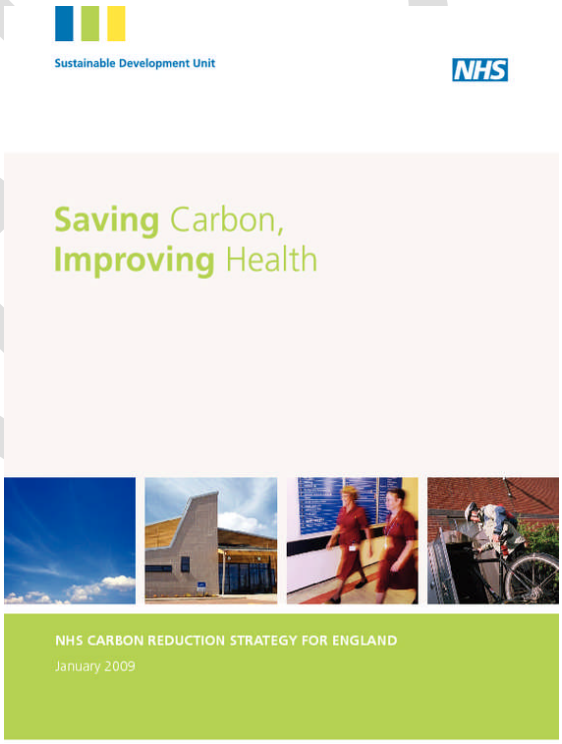
PROJECT 10 *CQUIN (5);* Mortality Reviews

High quality clinical care requires that a mortality review is undertaken when people die whilst in the care of the service. By reviewing mortality, lessons can be learned that allow improvements to be made in the service. This has been a requirement of the Care Quality Commission in hospitals for some time and evidence from the Bristol Report and recently the enquiry into Mid Staffordshire Hospital showed that if they had reviewed the deaths of patients in their care, improvements could have been made and further deaths avoided. This Trust looked at a review of care delivery whilst in the care of the Trust. This is when a person was breathing on their own when a 999 call is received, but were dead on arrival to A&E or Recognised as life Extinct which is abbreviated as ROLE whilst in our care. This excluded patients with an Advanced Decision order or a Do Not Resuscitate Order. The aim was to clinically review 100% of all patients who die in the care of the Trust by this definition. The aim was to ensure lessons learnt for all staff and for reductions in deaths where appropriate to improved outcomes for patients.

The Trust achieved 100% of mortality clinical reviews in WMAS care reviewed to date

PROJECT 11; Patient Safety and Effectiveness- Sustainability and Carbon Reduction

Climate change is now recognised as one of the most significant challenges facing the world. As one of the largest organisation in Europe, the NHS can make a substantial contribution to the UK's efforts to reduce greenhouse gas emissions and prepare for the major impact that climate change will have realising that many of these affects will be on the health of the population. It is a priority within the NHS operating Framework. The aim was for the trust was the implementation 2010-11 targets within WMAS 5 year plan (2010-2015) Sustainability Action Plan for WMAS 2010/11 and to achieve 95% of 2010-11 actions. This is in order to increase confidence of public and other stakeholders and increased resources available to Trust by reducing energy costs. To date 83% of the action have been implemented or are in progress. Realistically some of the actions target dates are under review as targets were optimistically set but would be reached within the 5 year plan.



3.7 Training

Mandatory Update Training 2010 - 2011
Mandatory Update training for all West Midlands Ambulance Service NHS Trust staff for 2010 -2011 commenced early June 2010.

The mandatory update training programme had been scheduled for the whole year, with sufficient capacity available to ensure all staff has a guaranteed training place arranged through to the end of March 2011.

Staff were required to attend two days for operational staff (Clinical Update) and ½ day for Patient Transport Services (PTS Update) and Admin & Support staff (Non Operational Update).

The importance of ensuring staff receive regular updates to their training is one of the key principles enshrined in the Trust's Strategic Direction document. A huge amount of work has been put into developing the programme that was rolled out during the current year (2010-11). The Trust received external backing from Commissioners who stated the underpinning evidence and rationale were extremely impressive; the quality of the training packs and the interactive material demonstrated was very high. The material produced was of a 'world class' standard and could be shared more widely as best practice.

Blended Learning
All staff are required to complete Year 2 of the Mandatory Training Workbook covering areas including: Health & Safety, Fire Safety, Manual Handling, Equality & Diversity, Corporate Services, Information Governance, Risk Management, Conflict Resolution, Protecting the Public, Emergency Preparedness, Infection Control, Countering Fraud within the NHS, Positive Mental Attitude.

Emergency Care Assistant (ECA) - Technician Programme
The Trust agreed and made a commitment to train 240 ECAs to Technician level throughout 2010-11 & 2011-12. All trainee technicians are required to perform a minimum of 750 hours observed clinical practice and satisfactory completion of a competency portfolio before their qualification is achieved. To date we have converted and trained 181 of the 240 commitments made.

Student Paramedic
A new student paramedic programme was developed, the first cohort commenced on 15 February 2010. This provided a two year training contract where students commenced an in house IHCD Technician programme, IHCD Driver Training programme & their observed clinical practice in year 1, followed by a full time Technician to Paramedic Science conversion programme at university in year 2. The financial year 2010-11 achieved 94 successful students through the first year of the route.

Full Time Paramedic Education.
A further 72 full time Paramedic training places were secured by the Trust, which were fully funded by the West Midlands Strategic Health Authority. Three universities are delivering this programme on our behalf this year; Coventry, Worcester & Staffordshire Universities. Completion dates throughout 2011.

Advanced Paramedic Programme
2010-11 saw the first Advanced Paramedic programme successfully complete, providing the Trust with good clinical and quality feedback as well as enhanced patient assessment skills and pathway referrals. A further 9 courses have been planned throughout 2011-12 to reach our 120 target for this financial year. This programme includes an online learning programme followed by a 2 week clinical face to face contact programme, then further followed by a 2 week clinical placement period. Further courses in 2011/12 will be planned accordingly.

Health Care Referral Team (HCRT)
A request to develop 50 HCRT staff was received, 3 courses delivered during August, September and October 2010 assisted the Trust in delivering its mission statement and a world class service to its community, service users, commissioners and stakeholders.

Clinical Supervision Programme
The Education & Training team have been liaising closely with the clinical team to agree and arrange the development for staff that are to be selected for the planned introduction. Courses ran late 2010 and will continue into 2011/12, enabling the Trust to embed its clinical supervision model.

Driving Assessors Programme
A two-week driving assessor's programme is now designed. The programme meets the learning outcomes for the soon to be introduced Department for Transport (DfT) assessor's course. An advert will shortly be expressed for 10 staff that can regionally assess driving standards, both at recruitment and emergency driving standards, these staff will require selection from all the areas. The process for utilising these staff in the 5 yearly assessment processes has still to be completed and ratified with Operational colleagues.

Clinical Development Officers (CDO's)
The Clinical Development Officers deliver the above programmes. The requirements of the CDO role necessitate the inclusion of several training courses to ensure a robust and wide ranging workforce and to develop them into clinically competent roles. With this in mind the current development plans include Instructional Methods, Instructor Qualifying, National Educational Qualifications such as, Driving Instructor Qualifying and Potential Driving Instructor, and also Conflict Resolution Training Train the Trainer and Moving People Train the Trainer programmes.

Continuing Professional Development (CPD) has this year included the following:

End of Life Education Consortium
Various lectures and events arranged by the End of Life Education Consortium.

Maternity Placements
New dates have now been arranged to continue with the present arrangement for 1 day placements to run from early September to the end of March 2011. Attendance and feedback from students has been positive.

Acute Coronary Syndrome Updates at New Cross Hospital
Following on from the success of the first study day on 1st July, arrangements were made for a second event on 16th Nov 2010 specifically for WMAS clinical staff.

Local CPD Lectures
Recent meeting with Rebecca Tinsley Manager Air Operations Cosford and Dr Nick Crombie proved positive. Dr Crombie has agreed to be involved and make enquiries amongst his colleagues with regard to facilitating local trauma related lectures. Topics covered were those recommended by the clinical department.

ENAV (are learning packages via our intranet) Clinical CPD Input

Recent input onto Enav includes:-
link to e-learning package by Dept of Health titled Spotting the Sick Child
BASICS Conference 15th - 16th October at Coventry
National Fire and Rescue Trauma Conference 12th – 13th November 2010.
Life Connections Conference in Paramedic Practice 7th April 2011.
Birmingham Medical Student Pre-hospital Trauma Course
Faculty of Pre-hospital Care Lectures at Royal Orthopaedic Hospital
Birmingham Emergency Medicine Society Lectures
National End of Life Care Newsletters

Pre-hospital Obstetric Emergency Training and Pre-hospital Paediatric Life Support e-learning Packages.

A proposal was submitted to Head of Education and Training and Head of Organisational Development recommending the purchase of annual licences to access e-learning packages Produced by the Advanced Life Support Group (ALSG) titled Pre-hospital Obstetric Emergency Training (POET) and Pre-hospital Paediatric Life Support (PHPLS). We have now purchased the licences and have to date 239 registrations.

3.8 Organisational Development

The Organisational Development (OD) Team has made vital contributions to support the Trust's delivery of its strategic objectives.

The Trust is committed to, and has signed the NHS Skills Pledge, thereby undertaking to support all staff to achieve a minimum of a level 2 qualification. To this end, we supported 222 people to achieve National Vocation Qualifications (NVQ) and Apprenticeships in a variety of areas, giving them the necessary skills, knowledge and confidence to carry out their roles.

A virtual learning environment (E-Nav) went live in August (and in February for our volunteers) giving staff the opportunity to learn on-line from work or from home, to access key e-learning programmes, documents and information, and to form communities of practice.

Our leaders and managers have been a focus of development. September saw the launch of the "Engaging Leaders' Programme" for 50 middle and senior managers, giving them the opportunity to achieve a Diploma In Professional Development from Coventry University. This is now also being offered to junior managers identified as potential leaders, as a Certificate in Leadership Capability. Also, managers have been supported in carrying out appraisals with their teams, and this year we are delighted that 93% of staff received an appraisal and development plan.

Much work has gone into working collaboratively with our Higher Education Institutions to ensure that there is partnership working, consistency of quality and standards, and innovative development of the programmes on offer, supported by a skilled, dedicated pool of mentors.

3.9 Equality and Diversity at WMAS

Our aim is to bring Equality and Diversity to the heart of the organisation, through our staff, patients and volunteers. Equality and Diversity is built into everything that we do from our policies, practices and strategies, which are always impact assessed, to public engagement and consultation events where we ask our local communities how we can improve our services and practices to provide a positive working environment to work within.

Employees of WMAS are encouraged to participate in various activities to help promote the Diversity agenda. Ongoing courses such as the Theatre Style based training and the Equality and Diversity Mandatory Training book will equip individuals and provide them with an opportunity to keep up-to date with the organisational commitment to Equality and Diversity.

We take Equality and Diversity training as an integral part of the organisation's commitment into developing a fair and inclusive culture. Supporting this commitment we have a dedicated Regional Equality and Diversity (RED) Officer who co-ordinates workshops, training, develops the work stream and provides creative solutions in delivering the WMAS Equality and Diversity Agenda.

The Trust has just recently been accepted as a pilot for implementing the National Equality Delivery System, which is a new framework produced to help NHS organisations deliver the Equality Act 2010. WMAS will be implementing the 18 different cross organisational objectives, which is stated within the EDS

3.10 Statements from Local Involvement networks, Overview and Scrutiny Committees and Primary Care Trusts

Who we have involved in the preparation of this account

This Account has been prepared with the involvement of our own Patient and Public Engagement Group and the Commissioner Quality Review Group. A stakeholder meeting was held with the Trust's Patient & Public Engagement Group and LINks members in March 2011. The following LINks groups were also contacted:

Birmingham, Coventry, Dudley, Herefordshire, Sandwell, Shropshire, Solihull, Staffordshire, Stoke-on-Trent, Telford and Wrekin, Walsall, Walsall, Warwickshire, Wolverhampton and Worcestershire.

Our internal governance processes were also involved including sign off by relevant working groups, which include, Local Intelligence Networks, Regional Partnership Forum and the Clinical Governance Group.

Feedback from Local Intelligence Networks, Strategic Health Authority and Health Overview and Scrutiny Committees from which constructive feedback from the draft WMAS Quality Account. All comments and feedback have been considered in the re-writing of this account.

Our Regional Partnership Forum which represents Staff side were consulted about the Quality Account at their May 2011 meeting.

3.12 Specialist Commissioners Statement Commissioner Statement

During the financial year of 2010/11the West Midlands Specialised Commissioning Team worked on behalf of the 17 Primary Care Trusts in the West Midlands to commission urgent and emergency ambulance services.

Commissioning an ambulance service is an enormous responsibility, not only in terms of the resource committed, but also public expectations of the service. During 2010/11 we increased the funding of the service to just under £155 million, and this enabled the West Midlands Ambulance Service to deliver target performance that is amongst the best in the country, indeed, West Midlands was one of only two ambulance trusts in mainland England to meet all national targets, despite a particularly bad period of winter weather.

During 2010/11 we have continued to see an improvement in the quality of care delivered by the West Midlands Ambulance Service, and, for the first time, during this year, Commissioners have funded specific quality initiatives. Using targeted resources (£2.27million), we have seen dramatic improvements in a number of areas of care, for example:

By focusing on patient need, we have seen a reduction in the number of people taken to Accident & Emergency Departments, and more people treated at home or via less acute settings. Only two thirds of people that ring 999 for an ambulance are taken to a hospital.
Where people are frequent users of the service, the ambulance service have been working pro-actively to agree appropriate plans of care that may avoid the need for the person to ring 999.
By up-skilling the workforce, the ambulance service has been able to accurately assess patients for early signs of stroke and heart attack, and to take patients to specialist centres for treatment; by doing this, more people survive these conditions and return to normal living.

Commissioners are learning the wider lessons of the Independent Inquiry into Care Provided by Mid-Staffordshire NHS Foundation Trust. During 2010/11 we continued to strengthen the governance arrangements for the contract, and as a result, monthly meetings between the ambulance service takes place to review the contract, and review the quality of care delivered. In addition, a comprehensive range of announced and unannounced inspections of the service are undertaken by commissioners to assure the quality of the service. The lead ambulance commissioner is given open access to all areas of the west midlands ambulance service at any time. This gives additional assurance of the quality of the service being delivered, ensuring that services do not improve only for the time of their inspection.

We recognise that measuring response targets and improving quality measures are only part of the overall patient experience. We are pleased that during 2011/12 the West Midlands Ambulance Service will be implementing the monitoring required for the 2011/12 clinical quality indicators for ambulance services. This will ensure that we continue to develop the quality metrics by measuring patient outcomes following care from the ambulance service.

We can confirm that the information within the Quality Account is an accurate reflection of the financial year 2010/11 and has been fairly interpreted and presented in a way that meets the needs of the target audience.

As the lead commissioner of services from West Midlands Ambulance Service, we believe that the report reflects the quality and safety priorities that have been jointly agreed with Commissioners. We also believe that the report presents a balanced view of the quality of the services that West Midlands Ambulance Service deliver for the local population.

Dr Ken Deacon
Medical Director

Mark Docherty
Lead Ambulance Commissioner

Further information

Further information and action plans on all projects can be obtained by contacting the lead clinician named on the project

Further information on performance for local areas is available as an Information Request from Lynsey Bull, Freedom of Information Officer or from the leads for the individual projects.

Progress reports will be available within the Trust Board papers every three months with the end of year progress being given in the Quality Report to be published in June 2012.

If you require a copy in another language, or in a format such as large print, Braille or audio tape, please call West Midlands Ambulance Service on 01384 215 555 or write to:

West Midlands Ambulance Service
Regional Headquarters
Millennium Point
Waterfront Business Park
Brierley Hill
West Midlands
DY5 1LX

You can also find out more information by visiting our website: **www.wmas.nhs.uk**

Patient Advice and Liaison Service

If you have any comments, feedback or complaints about the service you have received from the Trust, please contact the Patient Advice and Liaison Service in the first instance. You can write to the address above or call one of the 24 hour helpline numbers: 01384 246 370 or 01926 883 160.

Appendix 1 Glossary of Terms

DRAFT v9

Coventry and Warwickshire NHS Partnership Trust

Quality Account 2010/11

Albert Oppon

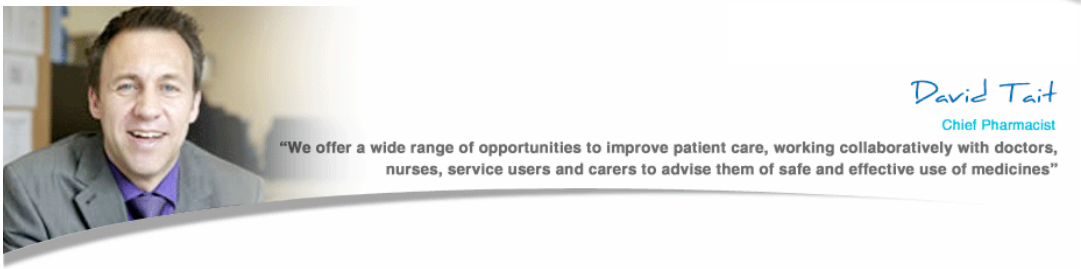
Unit Manager

"I'm really proud of the way we care for our residents, some come from out of County and we try to resettle them into the community"

Kam Madar

Secretary

"I'm proud to work within mental health and am sensitive people's needs. It's rewarding and fulfilling to work together in a team helping our service users."



David Tait

Chief Pharmacist

"We offer a wide range of opportunities to improve patient care, working collaboratively with doctors, nurses, service users and carers to advise them of safe and effective use of medicines"

Janice Leedle

Healthcare Assistance

"As a team we communicate and work well together, I really enjoy the interaction with clients"

Part 1: Statement from Rachel Newson, Chief Executive

Welcome to Coventry and Warwickshire Partnership NHS Trust second Quality Account. Our Quality Account reflects upon the many successes that the Trust has achieved over the past year; it also reflects upon the challenges for the coming year that we have agreed with key stakeholders and partners. We aim to involve as many service users and their carers, staff and those with an interest in our organisation in determining regular quality improvement initiatives.

In 2011/12 Coventry and Warwickshire Partnership NHS Trust was responsible for providing Mental Health, Learning Disability and Substance Misuse Services for the population of Coventry and Warwickshire.

Some of the initiatives that have had the most significant impact on improving quality over the past year have included:

- Supporting people to leave hospital earlier and making sure that they were all followed up within 48 hours;
- Ensuring that people are assessed by the Crisis Resolution Home Treatment Teams to ensure that admission to hospital is appropriate and necessary;
- Undertaking patients surveys and acting on the results to improve the delivery of care and treatment that service users receive;
- Ensuring that service users care plans are regularly reviewed;
- Exceeding our commitment to serve new psychosis cases;
- Being seen as having safe risk management systems and processes by those that commission services from us;
- Learning and sharing lessons from our most serious incidents;
- Being externally assessed as providing safe services for people with Learning Disabilities;
- Being assessed as having Good or Excellent Cleanliness, Food provision and privacy and dignity arrangements within our inpatient areas.

One of our most significant challenges in 2010/11 was to prepare the way for the transfer to the Trust of Community Health Services from NHS Coventry as well as Community Learning Disability and Psychological Therapy Services previously provided by Solihull Care Trust to the

Partnership Trust. The transfer of these services complements our existing portfolio of services. Our priorities for 2011/12 reflect the important work that these services provide for the local community and we have reflected these initiatives within our Quality Account.

Map of where our services are provided, and some of our key locations.

During the reporting period the Trust Board has overseen the development of a Vision and Values Statement that underpins the work that is undertaken in the Trust. The development of these principles has involved the whole Trust, with every single staff member being offered the opportunity to provide input into the process.

The vision statement consists of a set of values and behaviours expected of our staff, together with a set of strategic objectives. The vision statement describes what we set out to do and achieve as an organisation. Our values can be defined as core beliefs about what matters to us as individuals.

Our Vision Statement: Our vision is to work for the well being of the people we serve and to be recognised as the best at what we do.

Values	What this means to the Trust
Respect for everyone	• Users and carers are at the heart of the services we provide. • We aim to exceed people's expectations, and actively encourage everyone who comes into contact with us to let us know if we fail to do this. • We provide person-centred care and treat everyone with dignity at all times. • We are proud to be part of the NHS. • Our staff are key to the quality of all our services, and we offer appropriate support and development to them all. • We respect the contribution everyone makes.
Seeking excellence	• We aim to achieve the best possible outcomes for people. • We provide evidence-based care, offering good value at all times. • We are resourceful, and do everything we can to encourage initiative and reward innovation. • We welcome feedback, learn from our experience and build on success. • We continually seek opportunities to improve our Trust and our services. • We work with others in a way that is flexible and adaptable.
Giving hope	• We help people to build their own routes to recovery and wellbeing. • We give hope through the care we provide, and the compassion with which we provide it. • We always show empathy for others. We keep the future in mind, and see life from their point of view. • We always take time to hear and understand the needs of users and carers.
Breaking down barriers	• We break down barriers which prevent people from achieving the quality of life they want, and the support, advice, care or treatment they need.

The Trust treats the safety of quality of care delivered to our service users very seriously and over the past year the trust has developed its reporting systems for quality in relation to safety, clinical effectiveness and user experience which have reinforced the focus of our clinical governance arrangements.

Overall the quality of care experienced by our service users particularly reflects the professionalism and commitment from all of our staff and this report is a testimony to the work of everyone within our trust.

The Trust Board is confident that this account presents an accurate reflection of quality across Coventry and Warwickshire Partnership NHS Trust. As Chief Executive and to the best of my knowledge the information in this Quality Account is accurate.

SIGNATURE TO BE ADDED

Rachel Newson,
Chief Executive
Coventry and Warwickshire Partnership NHS Trust

DATE TO BE ADDED

Our Priorities for Improvement in 2011/12

The Trust has undertaken a series of workshops with our Commissioners to develop, in line with the NHS Operating Framework 2011/12, a number of Commissioning for Quality and Innovation (CQUIN) indicators. These indicators will be implemented over the course of the year and progress will be monitored, on a quarterly basis, through the Trust's clinical quality and contractual meetings held between the Trust and the Commissioning PCTs.

The objectives of the CQUIN indicators on which the Trust will concentrate on in 2011/12 are as follows:

Patient Safety Objectives

	Description	Rationale	Intended Outcome
To support the national initiative to reduce the number of Suicides.	Demonstrate full compliance with the National Patient Safety Agency (NPSA) 'Preventing Suicide Toolkit' in inpatient mental health settings that provide services to working age adults.	The safety of inpatients on mental health wards is a priority for all staff and service users. To maintain safety, regular audits should take place to monitor and reduce any dangers in the design, equipment and organisation of the ward, care interventions, and the service user's experience.	The Trust has agreed to works towards achieving 70% compliance in all within the toolkit at year end.
Promoting Safe, Rational, and Cost Effective Prescribing within Mental Health: A co-ordinated approach between primary and secondary care.	This indicator has five individual, but inter-linked components, that will be managed via appropriate networks and supported by appropriate governing arrangements. The development of these indicators ensures that the important features of patient choice, side effects, individualising therapy in line with NICE guidance, and previous patient response to therapy is not lost. The indicators respond to the Department of Health National guidance on Medicines Use & Procurement.	An agreed approach to prescribing across mental health and primary care supports safe, rational and cost effective prescribing in both sectors.	Development, implementation and monitoring of the Preferred Prescribing List. The development and implementation of joint prescribing guidance. Development of Prescribing Cost Charts to aid clinical decision making. Provision of comparative prescribing information. Development of a monitoring mechanism to support appropriate use of escitalopram and pregabalin.

Clinical Effectiveness Objectives

	Description	Rationale	Intended Outcome
To improve the transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) for service users.	Improved Transitions - All Coventry and Warwickshire 16 and 17 year olds who require mental health services have access to services appropriate to their age and level of maturity. When these services transfer from CAMHS to AMHS services it is important to ensure	Promoting an explicit connection between CAMHS (child and adolescent mental health) and AMHS (adult mental health services) and mark the formal handover of responsibility for young people with mental illness for care co-ordination and planning to adult	Development and implementation of a successful structured face to face handover meeting initiated and facilitated by CAMHS with AMHS in a minimum of 75% of transition cases.

	that a Robust Care Plan is in place.	services.	
To develop a health economy wide Eating Disorder Pathway.	The Trust will support the development and implementation of a health economy Eating Disorder Pathway.	Eating Disorder patients across the health economy do not currently have a seamless pathway of care and individuals presenting at early stages do not routinely receive early intervention to support them with their condition.	Improved support for service users with eating disorders, prompt access to improved community based interventions and reduced inpatient care requirements. All service users requiring a review of care will have a care coordinator allocated.
Implementation of Case Management for out of area placements	The development of clear assessment, review criteria and case management for all out of area clients with clearly established review periods.	To ensure and enhance assurance to the commissioners of the quality and governance arrangements of the services commissioned for their clients whether this be provided by CWPT or other providers.	All service users on the Out of Area Client list will be allocated a Care Coordinator and will be reviewed to bring service users into local services or where this is not possible review the provision of care currently being provided.
Development and delivery of a clinical supervision programme	Development of a clinical supervision programme for the health visiting service (Healthy Child Programme).	To ensure safe, competent practitioners and supporting workforce and to support the delivery of the Healthy Child Programme and ' A Call to Action' The Health Visiting Implementation Plan (Department of Heath 2011).	All staff within the health visiting service will participate in structured supervision programmes.
The delivery of Healthy Child Programme using an agreed Family Assessment Tool	To develop and pilot the use of a family assessment tool within the Health Visiting Service.	To support the use of an evidenced based tool for providing a standardised approach to assessment.	Development of a 'good practice' assessment tool in conjunction with commissioners and partners and incorporated into the 6-8 weeks checks.
The delivery of the Healthy Child Programme with Children's Centre's	Health Visitors will lead on the development and delivery of the Healthy Child Programme. This will be targeted at 3 Children's Centres (Hillfields, Woodend, Willenhall).	To support the delivery of the Health Visiting Implementation Plan (Department of Health 2011).	Development and delivery of an agreed health action plan for the targeted centres.
Long Term Conditions – Case Management	Roll out of a root cause analysis process (RCA) for all the case managed patients of the community nurses, community matrons and specialist nurses who attend hospital or are admitted to hospital due to an exacerbation of their Long Term Condition.	Reducing admissions to hospital is a key priority for the Trust and it is recognised that learning the causes of how attendances and admissions may be avoided is key.	Root Cause Analysis undertaken in 80% of attendances/admissions where an exacerbation of a patients Long Term Condition has occurred.

Long Term Conditions - Co-ordination/integration of all clinical care interventions to support avoidance of admissions	All LTC patients known to Community Services have an integrated care plan for all nursing and therapy services. Patient plans are to be contained in the same file and updates contemporaneously written in continuation notes.		95% of patients with a long term condition will have an integrated clinical care plan in place.
Long Term Conditions - Improving integrated work with primary care	Establish multi-disciplinary meetings between Community Matrons/Care Co-ordinator and GP/Primary Care Clinicians for patients with Long Term Conditions to support review of case load and ongoing patient management.		Development and implementation of an agreed approach and communication plan.

Patient Experience Objectives

	Description	**Rationale**	**Intended Outcome**
Improvement in patient feedback to support the development of the delivery of care and treatment	The Trust will develop its arrangements for the routine collection of patient feedback through use of a survey. The survey will focus on both community and inpatient services and will provide information that will enable the Trust to take action to improve services.	This indicator helps ensure that all service activities and improvements are oriented towards improving the experience of service users. The survey questions are based upon the service user experience questions set by the Care Quality Commission and have been extended to add additional questions to focus on local issues.	It is intended that the survey be conducted at least twice during the year, with actions taken as a result of the first survey leading to a demonstrable improvement in service users experiences.
Delivery of an enhanced 6-8 week development review service	Pilot of an enhanced 6-8 week assessment, through the home visiting programme.	To increase access and positive family satisfaction with the service by reducing non attendance rates, maximising continuity of care and increasing opportunities for Health Visitors.	Develop, implement and evaluate a pilot 6-8 week assessment review service and commence roll-out across all appropriate services.
Development and delivery of the maternal mental health pathway	Pilot of a maternal mental health pathway	To increase access and positive family satisfaction with the service by reducing DNA rates, maximising continuity of care and increasing opportunities for Health Visitors.	Develop, implement and evaluate a pilot maternal mental health pathway and commence roll-out across all appropriate services.

Part 3 Review of Quality Performance

Understanding Quality at Board Level

The Trust has developed comprehensive reporting dashboards for safety and quality performance indicators which underpin the Board Performance Report. A dedicated safety and quality performance report has been developed which is reported to the Safety and Quality Committee bi-monthly, and which forms part of the overall performance report to Trust Board on a monthly basis.

The reporting framework, facilitates local service and sub-committee reporting of safety and quality performance data and additional ”ward to board” reports and professional reports, such as the monthly Matrons’ reports.

The Board of Coventry and Warwickshire Partnership Trust has implemented Director Service Visits, whereby Non-Executive and Executive Directors are assigned particular areas of the Trust to visit and inspect. The focus of the visit is to offer the Board an opportunity to talk to frontline staff, service users, carers and relatives and complement the data and information received and debated at Trust Board level.

“My wife and I would like to thank the crisis team for their prompt action when our daughter was taken ill over a year ago. Jo was brilliant, keeping us informed.’’

A Carer

In addition Non-Executive Directors lead ‘Deep Dive’ reviews of risks highlighted on the Trust Risk Register or recently completed investigations and responses to complaints. The Deep Dives have added to the Board assurance that key controls are in place and actions implemented.

Use of the CQUIN payment framework

A proportion of the Trust’s income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.”

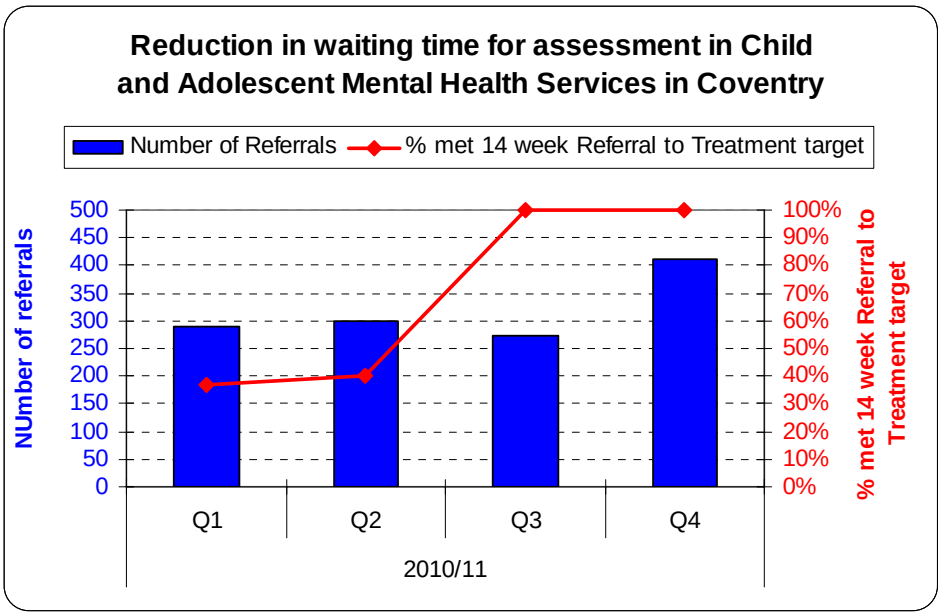
Further details of the agreed goals for 2010/11 and for the following 12-month period are available electronically at (http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html)

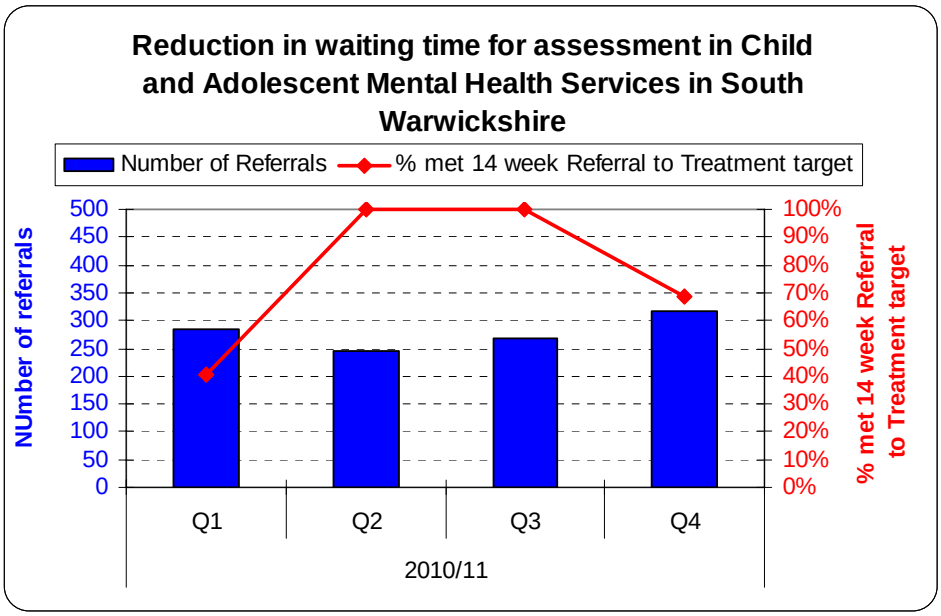
Many of the supporting data have been presented in Quarters. Quarters relate to periods of time within the financial year as follows:

	Period from	Period to
Quarter 1:	1 April 2010	30 June 2010
Quarter 2:	1 July 2010	30 September 2010
Quarter 3:	1 October 2010	31 December 2010
Quarter 4:	1 January 2011	31 March 2011

Indicator 1: Reduction in waiting time for assessment in Child and Adolescent Mental Health Services

Intended Outcome	Maximum waiting time of 14 weeks from referral to commencing treatment by March 2011 which will lead to improved outcomes for young people through earlier intervention. Please note: data only reflect services in Coventry and South Warwickshire.
Actual Outcome	The Child and Adolescent Mental Health Service has undertaken a significant amount of work and redesign of referral pathways in order to reduce the waits across both Coventry and Warwickshire. In order to achieve the exceptionally challenging targets the service has implemented the Choice and Partnership Approach (CAPA) which involves a comprehensive triage system and an 'Opt in' approach for referrals. • **100%** of patients referred to Coventry services were seen with treatment commencing within 14 weeks in Quarter 2 and 3. • **100%** of patients referred to South Warwickshire in Quarter 2 and 3 were seen with treatment commencing within 14 weeks. As a consequence of a significant increase in the rate of referrals received in Quarter 4 the percentage of patients seen within the 14 weeks fell.





We are currently working with our commissioners to sustain delivery of this important target. The Trust continues to meet the legal requirement to meet the 18 week Referral to Treatment target.

The Trust has met the CAMHS target

Indicator 2: Reducing the duration of untreated psychosis (DUP)

Intended Outcome	All Early Intervention Services (EIS) should have undertaken an audit and have an action plan in place to reduce DUP. The median duration of untreated psychosis should be no more than 3 months
Actual Outcome	In line with the CQUIN indicators the Trust has: • Undertaken a DUP audit and produced a summary report of findings and developed an action plan to implement improvements. • A follow up audit has been undertaken to check on the findings and identify additional improvements.

Duration of Untreated Psychosis. ***A Comparison of Quarter 1 to Quarter 4***

Area	April to June 2010	January to March 2011
South Warks (9 cases)	52 days (>2 months)	63 days (2 months)
North Warks (15 cases)	53 days (>2 months)	288 days (9.5 month)
Coventry (50 cases)	59 days (2 months)	21 days (>1 month)
Overall (74 cases)		31 days (1 Month)

Although North Warwickshire's median DUP has increased and no longer falls within the 3 months target, there are several reasons which are likely to explain this:

- The team had an increase in referrals after undertaking positive promotional activity, potentially identifying clients who would not have normally been referred to EI but who have been 'in the system' for some considerable time. Although their DUP is long, this represents a positive shift as such clients are now getting the help that they need.

"Being a long term in-patient it is very important to have kind, helpful staff to help you settle in, and they have achieved this in my eyes.''

A Service User

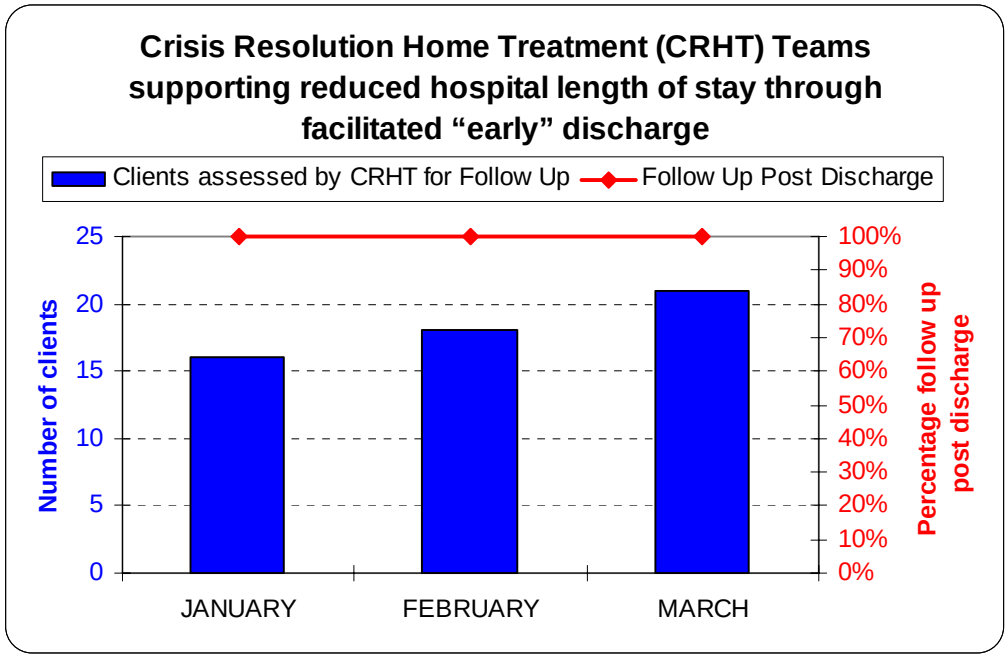
- Due to the small numbers in the audit (15 cases), just a few outliers can strongly influence the data.

The median DUP for the EI Service is within the CQUIN target of a median DUP of less than 3 months. The EI service has been able to collect and audit DUP and Pathways to Care information. The latest audit has highlighted some disparity between the 3 EI teams in their current capacity to conduct and record DUP and Pathways to Care information. The main difference is the amount of psychological resource currently allocated to the teams. The psychologists in South and North Warwickshire have the expertise to lead on this type of service evaluation. The Trust has recently appointed a new Clinical Psychologist in Coventry to ensure this disparity can be resolved.

The Trust has met the Duration of Untreated Psychosis target

Indicator 3: Crisis Resolution Home Treatment (CRHT) Teams supporting reduced hospital length of stay through facilitated "early" discharge

Intended Outcome	It was expected that, by March 2011, every client will be assessed by the Crisis Team and those users that would benefit from crisis involvement would be followed up within 48 hours of discharge.
Actual Outcome	In line with the CQUIN indicators the Trust has: • Reported quarterly achievement against the target - Quarter 4 indicates that 100% of clients identified as appropriate for early discharge were followed up within 48 hours

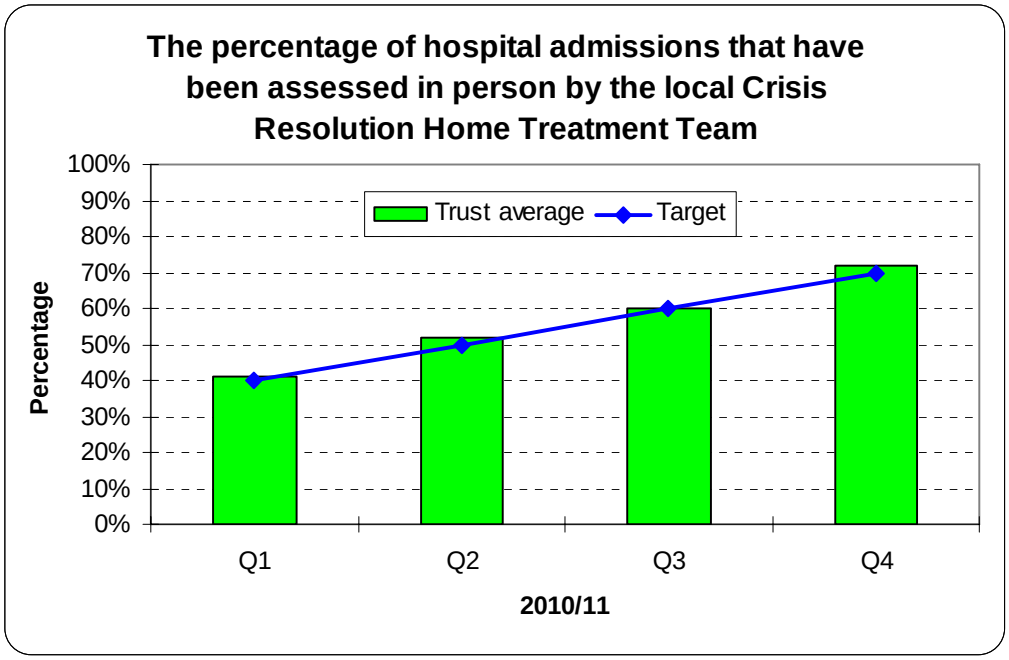


In addition all Crisis Resolution Home Treatment Teams formally visit respective wards on a weekly basis to review and discuss patients who may be considered for early discharge with Crisis Team support.

The Trust has met the Early Discharge target

Indicator 4: The percentage of hospital admissions that have been assessed in person by the local Crisis Resolution Home Treatment Team.

Intended Outcome	By March 2011 it was expected that 70% of all admissions will have been assessed 'face to face' by Crisis Teams.
Actual Outcome	In line with the CQUIN indicators the Trust has: • Reported quarterly achievement against the target - Quarter 4 indicates that 72% of clients were face to face gate-kept by the Crisis Team



The Trust considers the Face to Face Gate-keeping target to have been met

The Trust has met the Face to Face Gate-Keeping Target

Indicator 5: Productivity and Pathways Improvement Programme (PIP)

Intended Outcome	The Trust had a number of initiatives to meet on an incremental basis throughout the year including: ▪ Checks on application of pathways; ▪ Development of a quality framework and subsequent collection of data; ▪ Allocation of current caseloads to appropriate pathways.
Actual Outcome	The Trust has routinely submitted the Strategic Health Authority reports that indicate the CQUIN targets have been met.

The Trust has met the Productivity and Pathways Improvement Programme target

Indicator 6: Patient survey

Intended Outcome	The Trust developed a survey to focus on both community and inpatient services and undertook to collect data to enable it to improve services. It was intended that the survey be conducted at least twice during the year, with actions taken as a result of the first survey leading to a demonstrable improvement in service users' experiences.
Actual Outcome	In line with the targets the Trust has • Administered the Quarter 1 Patient Surveys and produced a summary report of findings; • Produced an action plan; • Administered the Quarter 4 Patient Surveys and produced a summary report of findings.

<u>Inpatient Services – Questionnaire undertaken in Quarter 4</u>

In total, forty Inpatient Services questionnaires were distributed and twenty-nine were returned (73% return rate).

The results are as follows:

Standards	**Yes / Partially**	**Improved from Quarter 1**
1. On arrival on the ward or soon afterwards, a member of staff should tell you about the daily routine of the ward such as times of meals and visitors.	24 (83%)	Yes
2. You should be given enough time to discuss your condition with healthcare professionals.	20 (69%)	Yes
3. The purpose and side effects of medications should be explained to you.	15 (52%)	Yes
4. Hospital staff should take your family or home situation into account when planning your discharge from hospital.	25 (86%)	Yes
5. Sufficient activities should be available for you to do during your stay.	21 (72%)	Yes

Community Services - Questionnaire undertaken in Quarter 4

In total, sixty questionnaires were distributed and forty-six were returned (77% return rate).

The results are as follows:

Standards	**Yes / Partially**	**Improved from Quarter 1**
1. Your views should be taken into account when deciding was what was in your care plan.	41 (90%)	Yes
2. You should be given enough time to discuss your condition with healthcare professionals.	36 (78%)	Yes
3. The purpose and side effects of medications should be explained to you. (note: 13% stated this did not apply therefore n=	39 (85%)	Yes
4. You should be given the number of someone from your local NHS mental health service that you can phone out of office hours.	44 (96%)	Yes
5. You should be given a written or printed copy of your care plan.	28 (61%)	Yes

The Quarter 4 Summary Report shows an overall improvement in the levels of satisfaction however the Trust is working to address the key issues arising from both surveys which include:

"Thanks for helping me to stay sober. 17 years, it's a miracle.''

A Service User

1) Not having a copy of the care plan
2) Time to discuss condition in a community setting
3) Not having enough activities on the inpatient wards
4) The purposes and side effects of medication being explained in inpatient settings

These issues will be included on an action plan that was first developed during 2010 that encompasses actions from all service user feedback and surveys.

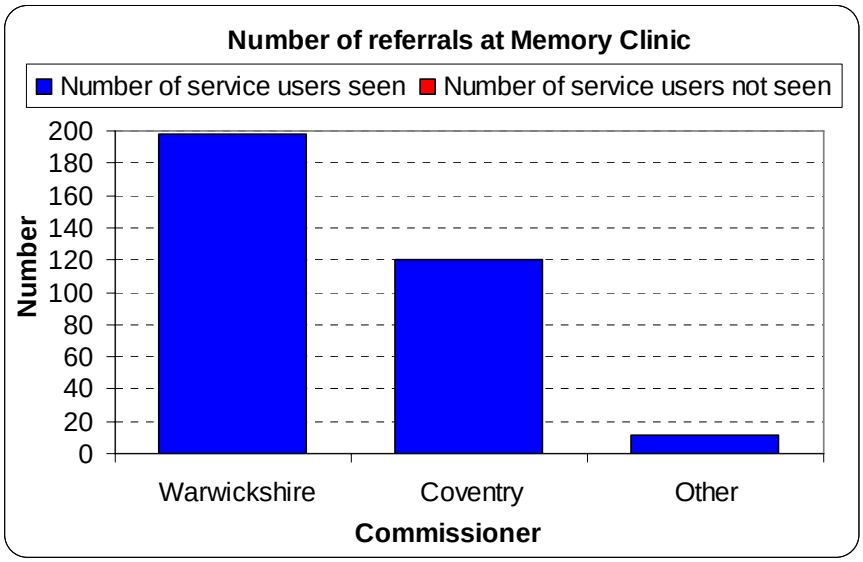
The Trust has met the Patient Experience target

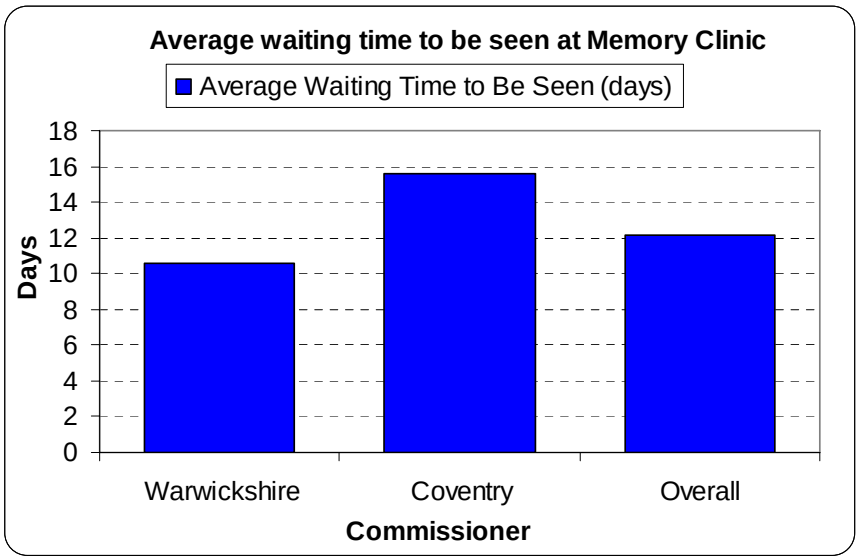
Indicator 7 – Dementia Waiting Times, Medication Reviews and Awareness and Increase in number of patients diagnosed with dementia

Intended Outcome	7a) By March 2011 it was expected that patients will be seen within 4 weeks from referral from GP. 7b) It was expected that a 40% reduction in use of anti-psychotic medication, for users receiving medication for 12 or more weeks, would be achieved by March 2011. 7c) It was expected the Trust would work with other health services in the local health economy to revise the referral pathway with GP colleagues and other healthcare professionals leading to increased numbers of people treated for dementia.
Actual Outcome	As at March 2011 the Average Waiting Times for Memory Assessment Clinic referrals is 1.7 weeks (equivalent to just over 12 days)

The Older Adults service has undertaken a significant amount of redesign of Memory Assessment Services across the Trust. In line with the target the Trust has provided:

- waiting list reports for all quarters this demonstrated that the average waiting times for memory assessment clinic referrals is 1.7 weeks





In addition

- The Trust developed and implemented an action plan for the implementation of the revised patient pathway;
- The work programme to raise awareness and launch the revised patient pathway has been extensive and the reviews of medication have commenced. The data (to February 2011) demonstrates continued and sustained reductions in antipsychotic use.
- The Trust recognises that there has not been a significant increase in referrals to the service despite the programme outlined and continues to work with commissioners to address this.

The Trust has met the Dementia targets

The Garden at the Caludon Centre.

Important Patient Safety, Clinical Effectiveness and Patient Experience Indicators

In addition to reporting on activity that we introduced in our last Quality Account we also want to take the opportunity to reflect on a number of other patient safety, clinical effectiveness and patient experience indicators and these are presented below:

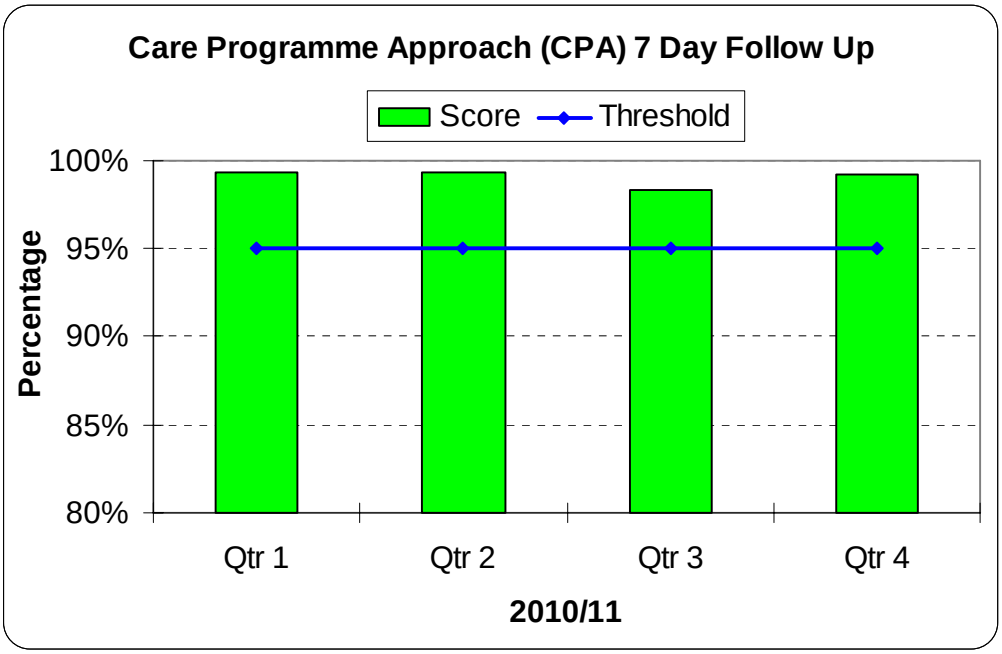
Care Quality Commission and Monitor Compliance Targets and Indicators

The Care Quality Commission (CQC) has, in the past, monitored Trusts through a number of different indicators and although the CQC is not currently performance monitoring performance on an annual basis, the Trust has continued to self monitor progress and performance

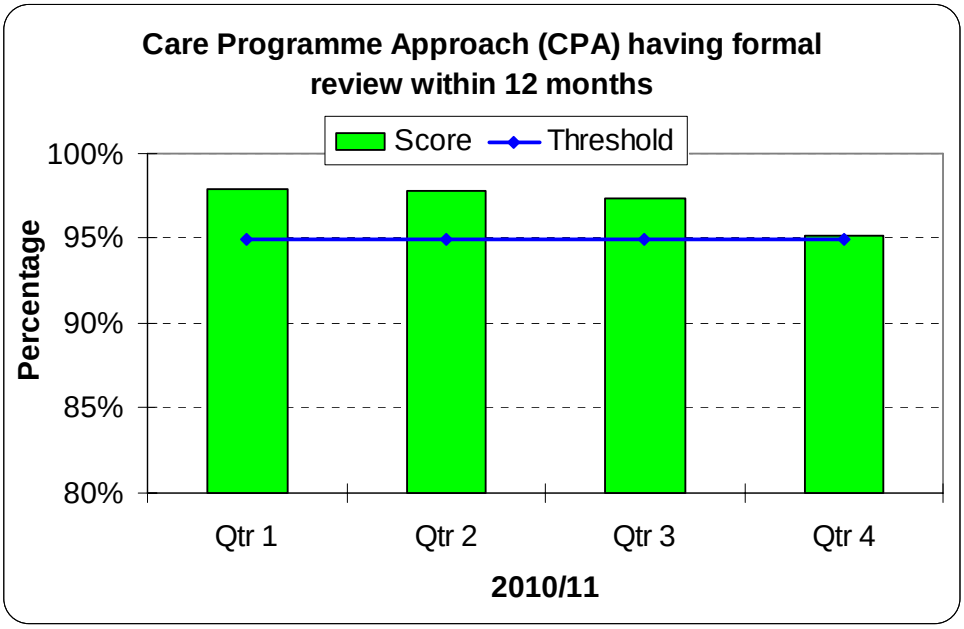
The Trust aspires to become a Foundation Trust in 2012. Monitor is the organisation that assesses whether NHS Trusts can become Foundation Trusts and then regulates them to make sure they are well run on behalf of patients and taxpayers.

Monitor has published a number of important patient experience and performance related indicators and these, along with our actual performance are reported below.

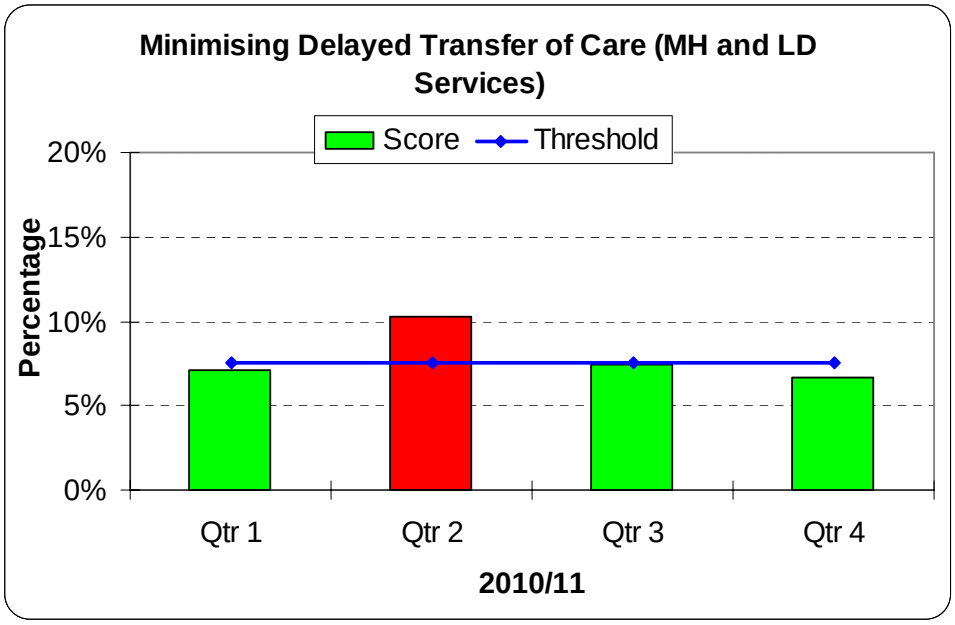
Care Programme Approach (CPA) 7-Day Follow Up
Follow-up of patients on the Care Programme Approach (CPA) after a spell of inpatient care is one of a range of actions that can be taken to achieve a reduced risk of suicide for those with mental ill health. Department of Health guidance states that all patients discharged to their place of residence, care home, residential accommodation or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. The Trust has exceeded the target threshold in 2010/11.



Care Programme Approach (CPA) having formal review within 12 month
Reviewing the Care Plan as part of CPA review meetings helps confirm which aspects of care are effective and which elements may need to change because they are not working or are no longer required. The frequency of CPA meetings will need to be determined in relation to the service user's level of need. However reviews should take place at least once every year. The Trust has exceeded the target threshold in 2010/11.



Minimising Delayed Transfer of Care (MH and LD Services)
The indicator is a measure of the mechanisms in place within the Trust to facilitate timely discharge from hospital settings once a clinical or multi-disciplinary decision has been made that a patient is ready for transfer and it is safe to do so. Mental health trusts must ensure, with primary care organisations and social services that people move on from the hospital environment once discharge criteria are met. Delayed transfers of care must be maintained at a minimum level. The Trust has exceeded the target threshold in 2010/11 except in Quarter 2.



Meeting Commitment to serve new psychosis cases by early Intervention Teams

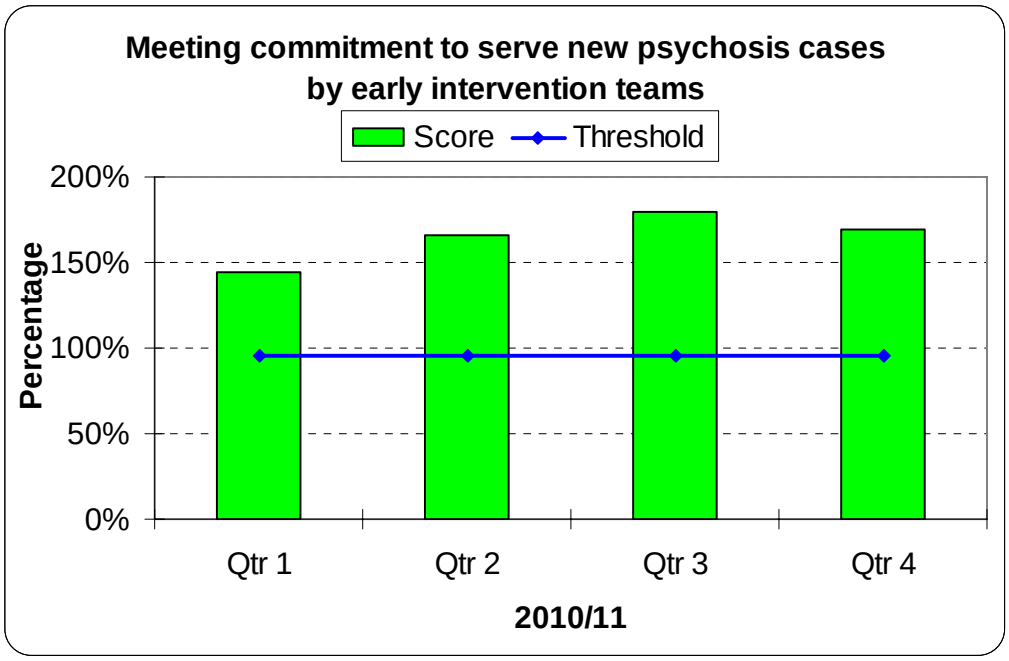
Early intervention involves detection and treatment of the first onset of a psychotic disorder during the critical early phase of illness. Delays cause unnecessary distress, increase the risk of relapse and give rise to other negative impacts on the individual such as unemployment, depression, substance abuse, breaking the law and self-harm. Delays in treatment may also lead to a slower and less complete recovery.

Early treatment has been shown to improve the long-term course of psychosis.

The 2011/12 Operating Framework highlights that early intervention and prevention should be used further to reduce the likelihood of mental illness developing, including within groups at high risk such as offenders. It is expected that access to evidence based early intervention services in the community should continue to be available to all young people who need these services. The Trust has exceeded the target threshold in 2010/11.

"I'm probably never going to come across a more dedicated and caring team, I can't list all the things they will do for you it's endless.''

A Service User

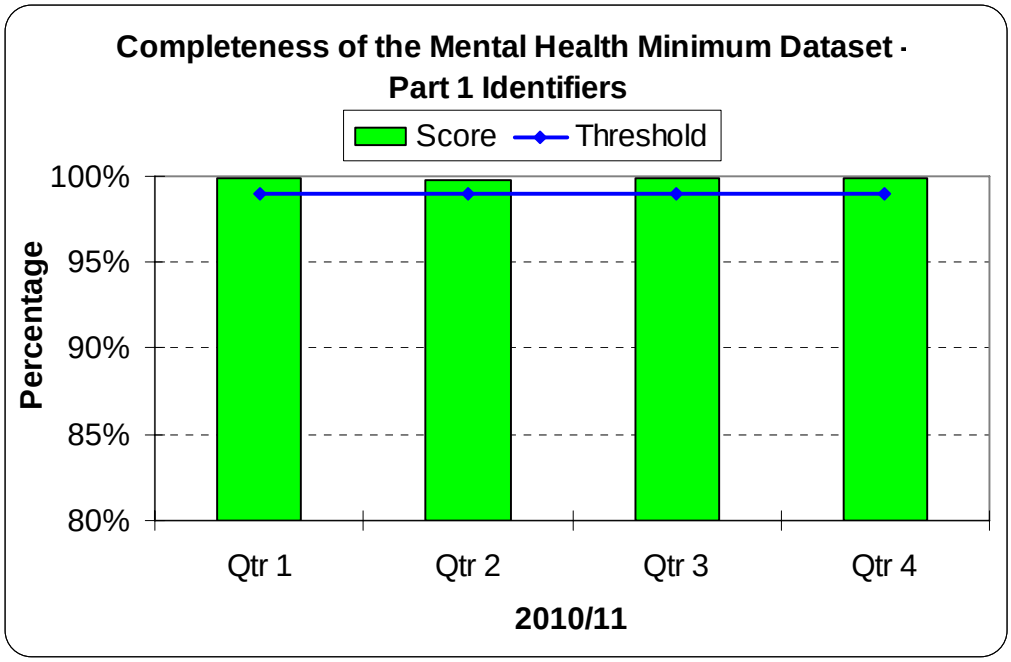


Completeness of Mental Health Minimum Dataset Part 1- Identifiers
The purpose of the Mental Health Minimum Dataset (MHMDS) is to facilitate the collection of person-focused clinical data and the sharing of those data to underpin the delivery of mental health care. The MHMDS comprises a number of data tables which need to contain enough demographic and other information (e.g. name, date of birth, postcode) to reliably to match or distinguish patients and clients. The information within the MHMDS is key to clinical and resource management: for example, benchmarking and for the assessment of patient outcomes after intervention.

This indicator applies only to the following fields in the dataset:

- NHS number
- Date of birth
- Postcode (normal residence)
- Current gender
- Marital status
- Registered General Medical Practice organisation code
- Commissioner organisation code

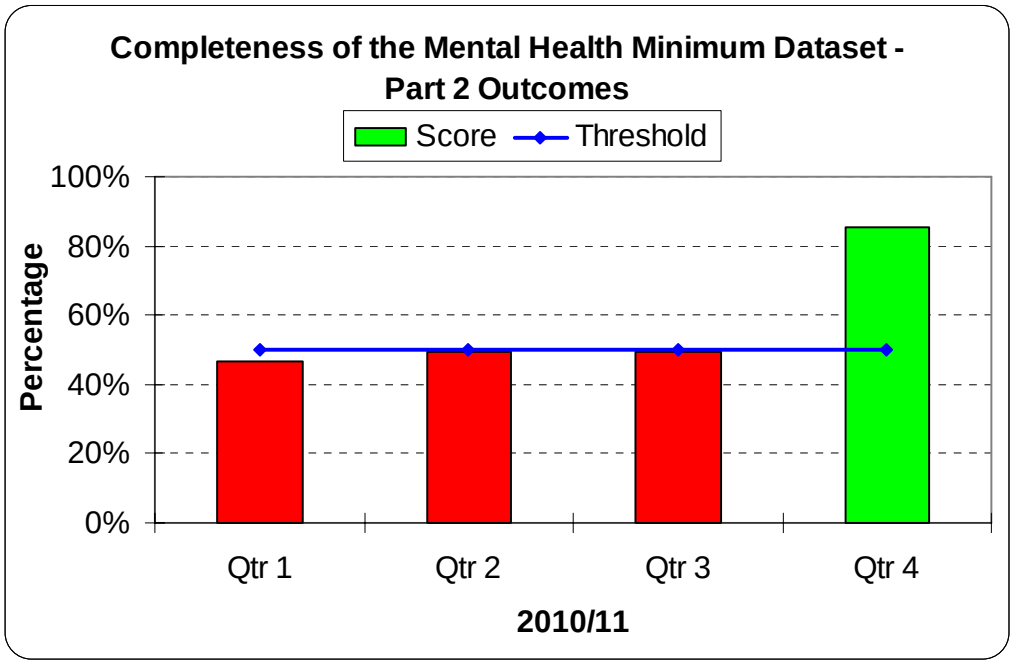
The Trust has exceeded the target threshold in 2010/11.



Completeness of Mental Health Minimum Dataset Part 2- Outcomes

The indicator for Part 2 - Outcome applies to the following fields in the dataset:

- Employment status - most recent entered for in the last 12 months
- Settled accommodation status - most recent entered in the last 12 months
- Health Of the Nation Outcome Scale (HONOS) rating - most recent in Mental Health Care Spell



Access to Healthcare for People with a Learning Disability

The Independent Inquiry into Access to Healthcare for People with Learning Disabilities (2008) identified actions needed to ensure adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England. Central to the actions is the need to ensure equality of access and equity for all people with learning disabilities. This indicator is a response to the recommendations made in the Inquiry report. It centres on the collection of data and information necessary to allow people with a learning disability to be identified and to ensure that their views and interests are taken into consideration in the planning and development of services. The Trust has self-assessed itself as compliant with this indicator.

"Thanks for looking after me. ''

A Service User

Drug Mis-Users Sustained in Treatment

A major strand of the National Drug Strategy is the provision of effective and high quality drug treatment. Evidence suggests that drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more. Providing effective treatment for drug users reduces rates of individual harm but also contributes significantly to reducing wider social harms such as rates of acquisitive crime.

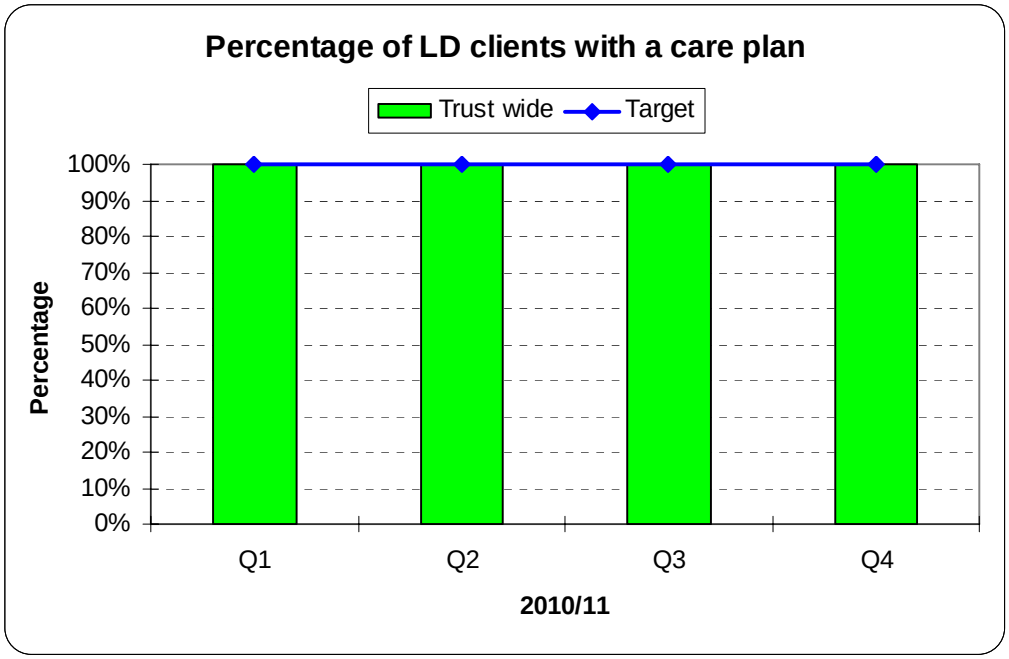
Indicator	Target	Score
Number of drug users sustained in treatment (Dec'09 - Nov'10)[1]	93%	COVENTRY 83.63%
	85%	WARWICKSHIRE 85.46%
	No target	TRUST WIDE 84.54%

Twelve-month rolling data up to November 2010 indicate that performance has been maintained in Warwickshire, but there has been a decrease in Coventry in the proportion of clients retained in treatment. The Trust is constantly revising its plans to address underlying contributory factors.

Percentage of Learning Disability Services Users with a Care Plan

Poor care planning was highlighted as one of the recurrent themes within the Healthcare Commission's (now CQC) national learning disability audit in 2007 and in the follow up audit in 2009. Integral to the CQC's position statement and action plan for learning disability 2010-2015 is ensuring that the care of people with learning disabilities becomes more person-centred, including a greater focus on person-centred care plans. Issues to be addressed include the accessibility of care plans to people with learning disabilities, how frequently they are reviewed and kept up-to-date, and for detained and specialist inpatients, alignment with the Care Programme Approach (CPA). The Trust has met the target threshold in 2010/11.

[1] Year to date data was not available a the time of publication



NHS Litigation Authority (NHSLA) summary

On 30 March 2011 the Trust underwent an intensive two-day assessment process by NHSLA. Following the assessment the Trust achieved Level 1 status. The assessment for NHSLA consists of five standards covering 50 criteria.

The five standards were:

Standard 1 Governance The Trust scored 8/10 for this standard.	The Trust needed to show effective functioning of the board, managerial leadership and accountability, and the organisation's systems and working practices ensure that quality assurance, quality improvement and patient safety are central to the activities of the organisation.
Standard 2 Competent and Capable Workforce The Trust scored 8/10 for this standard.	The Trust needed to show that it delivers a safe service to patients by ensuring appropriately qualified and skilled professionals are equipped to deliver high quality care by receiving support and training, on appointment and as an ongoing process.
Standard 3 Safe Environment The Trust scored 10/10 for this standard.	A safe environment is essential to the provision of healthcare to ensure that staff, patients and their visitors are protected from accidents, injury and disease, and to provide a safe place in which high quality care can be provided.

Standard 4 Clinical Care The Trust scored 10/10 for this standard.	The Trust must ensure the highest quality care is delivered. Robust policies and procedures should be in place for all clinical care deemed to be high risk, for example resuscitation and infection control processes.
Standard 5 Learning from Experience The Trust scored 10/10 for this standard.	This standard covers reporting, investigating of incidents including near misses, complaints and claims when examined in conjunction with incident reports, trends etc. Sharing lessons from other areas of the organisation and wider, to enable learning to occur.

The overall score achieved by the Trust was 46/50.

Commissioner-Led Themed Review of Risk Management

NHS Coventry and NHS Warwickshire completed an announced themed quality review for risk management which took place in November 2010. The purpose of the review was to ensure the services commissioned by NHS Warwickshire and NHS Coventry at CWPT are safe and comply with national and local governance legislation. The Conclusion from the report was as follows:

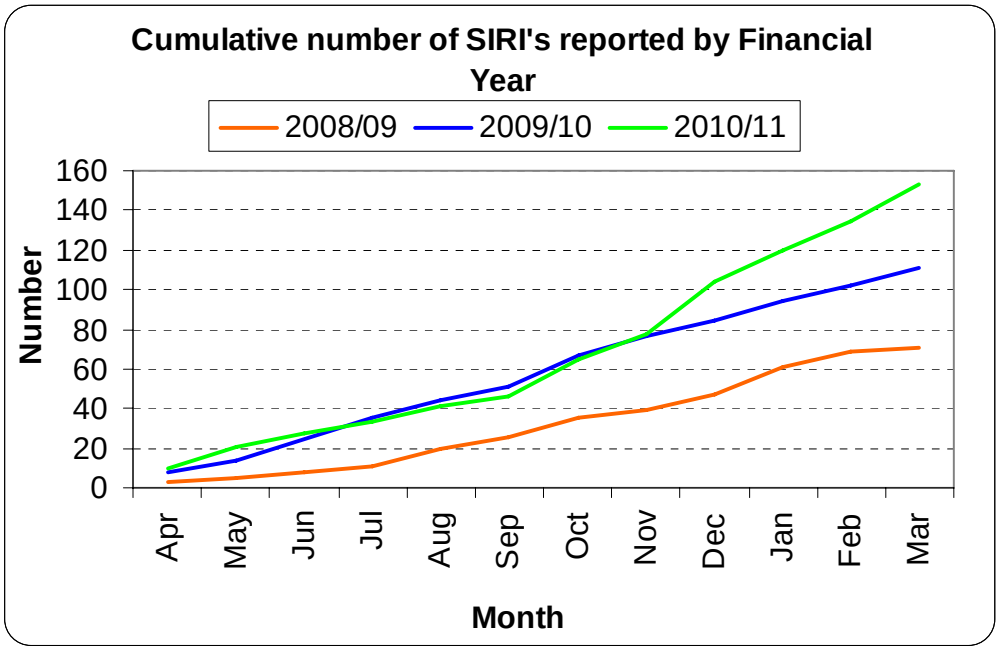
> "The fundamental principle of this risk management quality review was to evaluate the underpinning processes to ensure that care delivery is safe, effective and ultimately improves patient experience. This can only be achieved with true collaboration and feedback from staff and stakeholders.
>
> The findings of the review did not reveal areas of concern or risk and confirmed that the organisation has robust systems and processes in place for the management of incidents and complaints. Coventry & Warwickshire Partnership Trust demonstrated that it is continually trying to improve its processes to share best practice across the organisation with several examples of best practice introduced.
>
> Overall the panel was impressed by the dedicated team and advancing system the organisation has in place.
>
> The panel thanks Coventry & Warwickshire Partnership Trust for its hospitality and for facilitating a collaborative approach to the themed review of Risk Management" (NHS Coventry and NHS Warwickshire, January 2011).

Management of Serious Incidents Requiring Investigation (SIRI)

The Trust adopts the definition of serious incidents as set out by the National Patient Safety Agency (NPSA) in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and as adopted by NHS West Midlands.

A serious incident requiring investigation is defined as an **incident** that occurred in relation to our services resulting in one of the following: -

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm;
- A scenario that prevents or threatens to prevent the Trust's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of 'Never Events' as updated on an annual basis by the Department of Health



The number of SIRI investigations that the Trust has undertaken has increased year on year. This is due to a number of factors:

- The definition of what constitutes a SIRI has developed over the years in line with national guidance and commissioner intentions;
- The Trust has reported all absconsions in line with Strategic Health Authority guidance, that exceeds the requirements of other NHS Trusts;
- The Trust is cautious in its approach to identification and management of SIRI and this approach has been welcomed by the Strategic Health Authority and Commissioners;
- The Trust is very active in promoting the need to identify and investigate SIRI concerns.

The Trust is continuously learning lessons from SIRI investigations and is reviewing its mechanisms to disseminate learning, one outcome of which culminated in two Practice Development Days which enabled the Trust to share lessons learned across a broad staff group. The broad lessons and the agreed action to be taken are reflected in the table below.

Issue	**Action**
Falls risk assessments not being completed and updated correctly	Programme of training for use of falls risk assessments to be put in place
Lack of co-ordination of discharges between wards and care co-ordinators	Develop arrangements to improve communication lines
Patient with ongoing anxiety not considered for IAPT	Clarification of pathway for IAPT referral
Detained patient allowed off ward when there was no Section 17 leave granted	Review use of intercom systems to ensure staff can see who is leaving site
Breach of confidentiality when a work diary was stolen off site.	All user email to warn staff and policy to be clarified on taking papers off site
Staff could not reach a patient who had collapsed against a door	Review doors to ensure they can open outwards as well as inwards
Patient had hidden tablets under his/her own mattress	Ensure mattresses are lifted as part of environmental search

Patient Experience Indicators

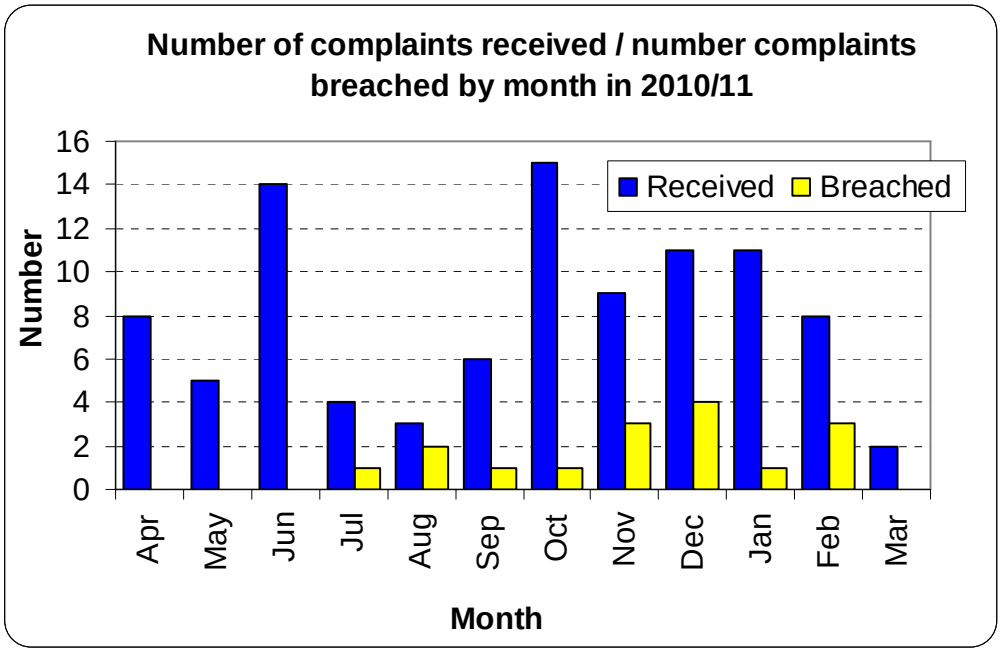
Learning through Complaints

The Trust is committed to learning from the information we receive on our services and aim to provide service users, relatives, carers and members of the public with lots of different ways to provide feedback to the Trust about their experiences.

When patients and carers contact us with concerns about our services, we aim to resolve these as soon as they occur. If it not possible for staff to resolve the issue immediately, further support and advice is available from the Customer Service Department which incorporates the Patient Advice and Liaison Service (PALS) and Complaints.

PALS provides advice, information and support to patients and carers to resolve issues. This may be sign posting to other services, providing information about how to access services or supporting someone in a ward round, outpatient appointment or case conference to help them get their views across. For some people PALS can be an alternative to making a complaint when they want to resolve an issue or concern and in most cases provides a more speedy resolution.

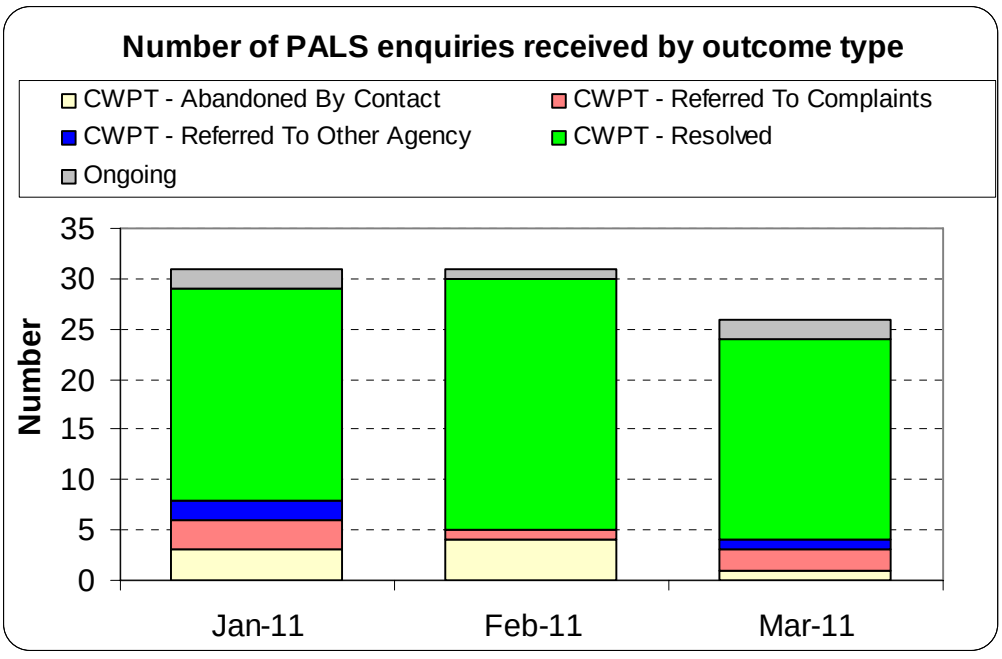
Our complaints arrangement seeks to address complaints in a fair, open and transparent manner and where fault is found, to put this right and ensure that lessons are learnt across the whole organisation.



The table below shows a break down of complaints by type:

Theme	Number of Complaints
Admission/Discharge	8
Attitude of Staff	5
Cancellation of Appointments	2
Client Rights	27
Communication	14
Confidentiality	4
Medical Care	18
Nursing Care	9
Other Direct Care	8
Waiting Times	1
TOTAL	**96**

The graph below demonstrates the number of PALS contacts during the period 1st January 2011 to 31st March 2011.



The table below shows the number of compliments received for the period 1st April 2010 to 31st March 2011 and highlights a significant increase.

Compliments 2009-2010	Compliments 2010-2011
73	151

The Trust's complaints arrangements incorporate the Ombudsman's key principles and set out our approach to handling complaints, from ensuring that complainants are informed about how their complaint will be dealt with to the identification of where we need to improve our services as a result of the complaints we receive. We also ensure that at the end of each complaint, the complainant is invited to feed back on the handling of their complaint.

In addition to responding to complaints, any recommendations that are identified during the course of the investigation are actioned by the service involved and this is reported to General Managers to ensure that actions are completed and lessons are learnt as a result.

Patient Environment Action Team (PEAT) Assessments

PEAT assessments are conducted across the NHS each year, to check on standards regarding food, privacy and dignity. We have now received the results of this year's assessments and the results reflect really well on our services and our staff.

The following locations in our Trust have been assessed this year as part of this process:

Site Name	Environment	Food	Privacy & Dignity
The Manor Hospital	Good	Excellent	Good
Hawkesbury Lodge	Good	Self Catering	Excellent
The Caludon Centre	Good	Excellent	Excellent
Harry Salt House	Good	Self Catering	Excellent
St Michael's Hospital	Good	Good	Good
Woodloes House	Excellent	Excellent	Excellent
Loxley/Stratford	Good	Excellent	Excellent
Woodleigh Beeches Centre	Good	Excellent	Excellent
Brooklands Hospital	Good	Excellent	Excellent

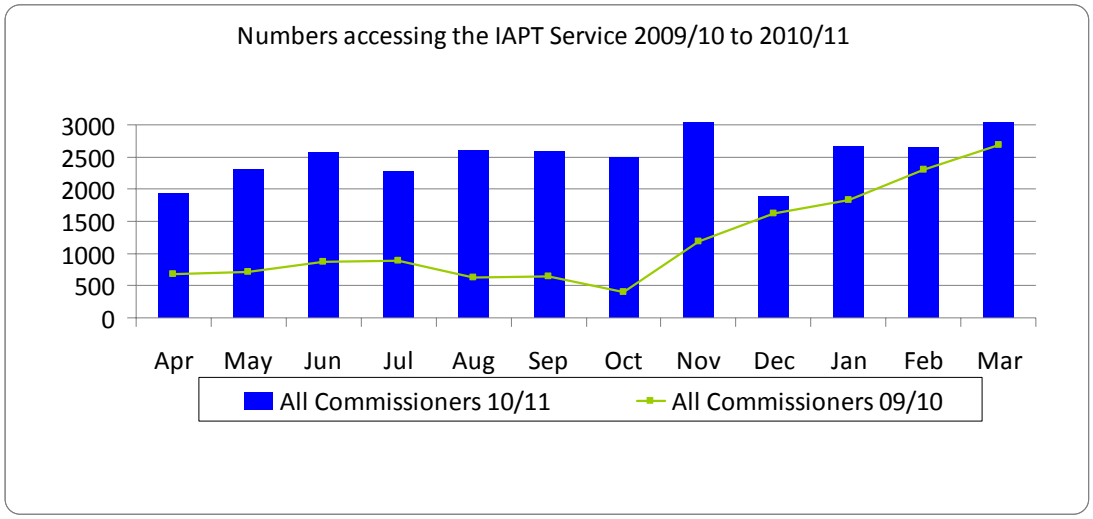
The quality of food has been rated Excellent in most Inpatient areas

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies is a NHS programme rolling out across England between 2008 and 2015 aimed at improving services within local communities. The IAPT programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. The programme was first targeted at people of working age but in 2010 was opened to adults of all ages.

The Trust is committed to the delivery of a successful IAPT service and has doubled the number of people who have accessed this service from 2009/10 to 2010/11 as indicated in the graph below



Improving Access to Psychological Therapies Staff

Eliminating Mixed Sex Accommodation
In January 2009, the Secretary of State announced an intensive drive to eliminate mixed sex accommodation and a number of measures were put in place to support local delivery of this commitment.

The Department of Health also established an external Taskforce to guide the work and an internal programme team to drive delivery. The Taskforce issued a report, Delivering Same-Sex Accommodation; The Story So Far, in December 2009 outlining national progress. The Trust made its most recent declaration of full compliance in March 2011and this can be accessed via the following website:

http://www.covwarkpt.nhs.uk/AboutUs/AboutUsDocuments/EMSA%20declartion%20page%202011v3.pdf

High Impact Actions and the Older Adults Mental Health Service
High Impact Actions is nationally devised tool to empower Nurses to make significant changes to patient care. By making these changes it improves quality, outcomes and the overall patient experience are improved, whilst the cost the local health economy is reduced.

Our Older Adult Mental Health Service has had a particular focus on reducing the number and severity of falls within one particular ward identified which had routinely reported a greater number of falls than comparable wards.

The changes the team have introduced are split between leadership actions and front line actions all aimed at preventing the occurrence of falls. This approach can be summarised as follows:

Leadership Actions
Improve analysis & learning from falls incidents;
Training all staff in falls prevention;
Using Physical Health Mapping tools to understand a patient's needs;
Skills mix review of the staff providing care on the ward.
Front Line Actions
Increased use of the activity co-ordinator's role;
Increased activity scheduled for patients at key times;
Twilight shift work pattern to improve monitoring of patients;
Undertake routine audit of all falls incidents.

The data collection to support this work is currently ongoing but early results suggest a positive impact.

Peer Review of Learning Disability Services at Brooklands
Our Learning Disability Services have been subject of continuous benchmarking and peer review by a number of agencies including:

- Quality Network for Inpatient CAMHS (note: this peer review has evolved to include Learning Disability services over time)
- Accreditation for Inpatient Mental Health Services
- Quality Network for Forensic Mental Health Services

The Learning Disability units that have been subject to peer review are:

- Janet Shaw Clinic - a medium secure service providing assessment, treatment and rehabilitation for 15 adult males with a learning disability who require this care provision in conditions of medium security;
- Adolescent Service – a service providing assessment and treatment for 12 children ranging between the ages of 12 to 19 years;
- Acute Assessment and Treatment Service - a service providing low secure, short-term assessment and treatment services and, where appropriate, rehabilitation services, for people with a learning disability.

The review of Janet Shaw Clinical service identified the following achievements and challenges:

Achievements	- Praised the work that had been done to further the service since it was re-developed; - Acknowledged high levels of commitment by staff; - Highlighted as good practice the provision of meaningful activities for service users; - Reviewed the implementation of Occupational Therapy programme and the involvement of speech and language therapists on the ward; - Reviewed the implementation of improvement to the environment and amenities, including a gym, and en-suite bathrooms.
Challenges	- Further work to ensure physical security is ongoing; - Re-design of the layout of the kitchen and improvements to service user access; - More service user involvement in the Care Programme Approach process; - Increase in the number and type of activities at the weekend.

The review of the Adolescent Service identified the following achievements and challenges:

Achievements	- Complimentary of the engagement between front line staff and the children; - Staff described as proud, passionate, a good team who worked well together; - Impressed with the feel of the unit - very child focused; - Good use of visual clues, pictorial timetabled structure of the day and user friendly documentation; - Good range and uptake of training by staff.
Challenges	- Lack of appropriate space for children in distress, need for low arousal or ‘safe space’ areas; - Expansion of the multi-disciplinary team to include occupational therapy and a social worker; - Quicker response to maintenance issues; - Improve the frontage of the unit and signage; - Better management/co-ordination of children who have been in the service for extended periods.

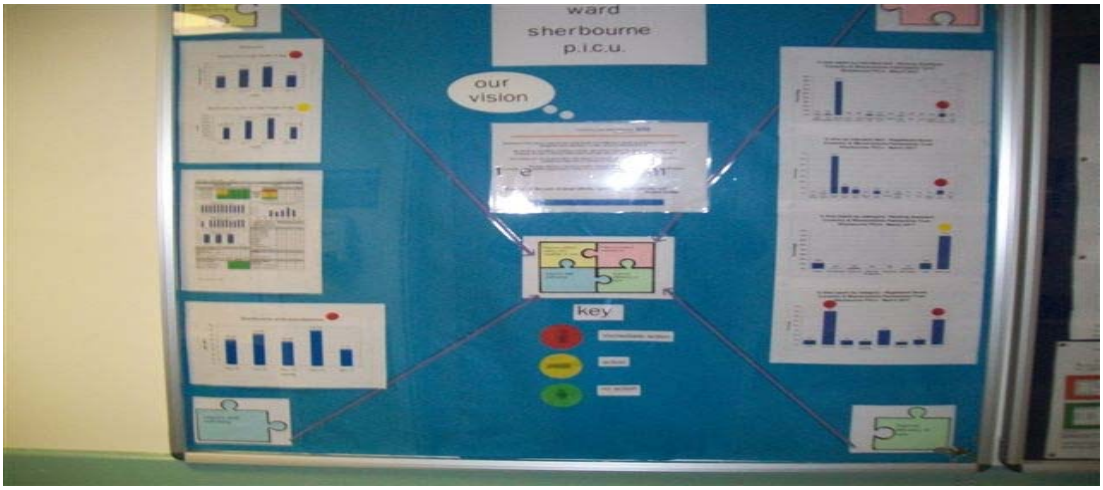
The review of the Acute Assessment and Treatment Service identified the following achievements and challenges:

Achievements	- Good user accessible information for patients during their stay;

	- Good interaction and engagement between patients and staff; - Reviewers noted the information recorded pre to post discharge was 'the best they had seen'.
Challenges	- Provide an environment that is fit for purpose - Develop stronger links with community teams to support planning for discharge at the point of admission. - Development of user accessible information in relation to their diagnosis/condition and treatment - Expansion of the multi-disciplinary team to include occupational therapy and a social worker;

Productive Ward

Productive Ward is a national initiative that enables clinical staff to increase their time spent on direct patient care. It empowers staff to make challenging changes to the way they work to help them deliver safe, effective, high quality care to all patients. Key improvements from the national programme include improved quality through increasing direct patient care time and staff satisfaction and improved productivity through reduced staff absence.



Example of a Productive Ward Board

Productive ward is being rolled out in several areas across the Trust and below are examples of how this has been done.

Rowans Psychiatric Intensive Care Unit (PICU) - St Michaels Hospital

Since November 2010 staff on Rowan Ward have been actively involved in completing work for Module 1: Knowing how we are doing and Module 2: Well organised ward.

Module 1: Knowing how we are doing

Aim	To create a vision statement for the ward listing measures that will allow staff to evaluate their progress and achievement of the vision.
How this was done	Staff completed a questionnaire to highlight their concerns as well as activity flows (time spent on key ward activities).
Findings	Vision statement and key measures identified.
Outcome	11% increase in 1:1 time with patients. 89% reduction in errors and omissions on medication kardexs.

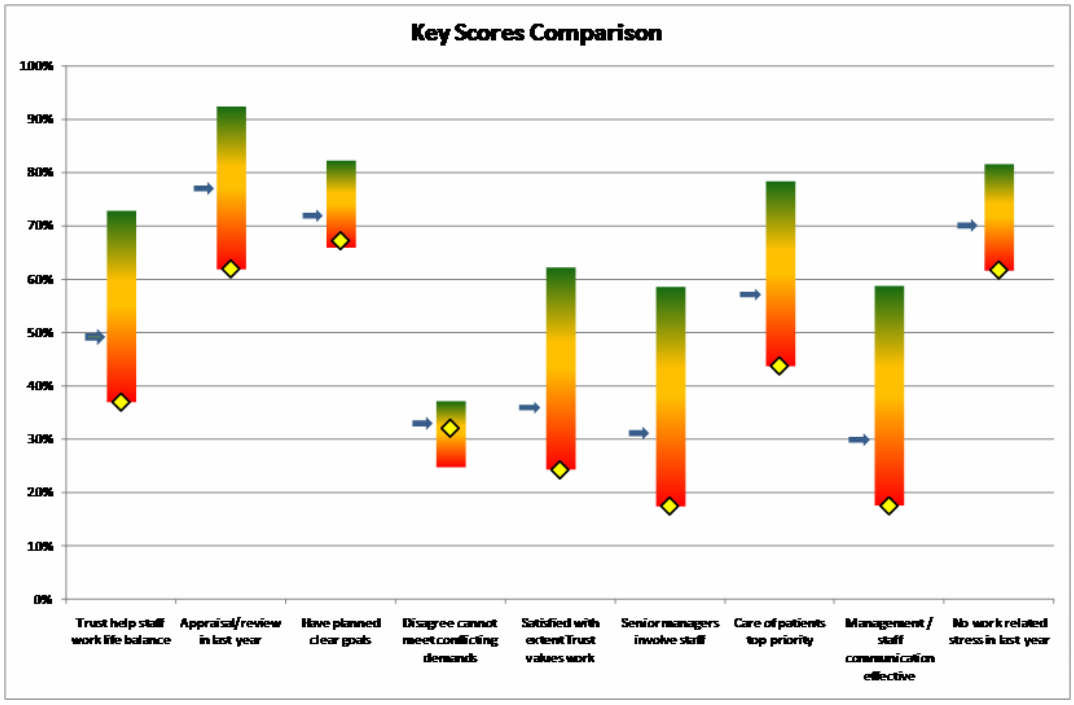
Module 2: Well organised ward

Aim	To simplify the ward area to reduce waste by having everything in the right place, at the right time and ready to go.
How this was done	Staff were asked to identify areas of concern
Findings	Patients using the office telephone. ▪ Average 36 minutes daily = 20 eleven hour shifts per year Time spent letting staff on and off ward. ▪ Average 14.5 minutes daily = 8 eleven hour shifts per year Time spent searching for paperwork. ▪ Same 5 forms found 66% more quickly in drawer files versus suspension files Overstock in clinic room and medication cabinet. ▪ Audit of stock showed surplus of around £800 worth of items.
Plan / Outcomes	• To provide all doctors and regular staff with key pass fobs to reduce time spent escorting them in and out of the ward. • To provide a phone for patients to minimise interruptions and non productive time in office. • Use money saved on medication surplus to scope and purchase a different filing system and for purchasing a phone for patients. • Utilise time freed up by all of the above initiatives to increase direct contact time to for service users.

Staff Satisfaction Survey

The Trust participates in annual staff satisfaction survey and has spent considerable time analysing the results and planning things that we can do to improve satisfaction.

The results are summarised below:



The Trust has recently established a 'Social Partnership Forum', which brings together some of the Staff Side Representatives, some members of staff with an interest in organisational culture, staff engagement and involvement and some of the Executive Directors. This forum provides an important place to reflect on and consider both what the issues are that the organisation faces in terms of the culture and those things that we may all be able to contribute to in order to make sure we learn from the best in the Trust and elsewhere; and think about how we ensure that all staff have a positive experience when working in the Trust.

The overall picture would suggest that most indicators show an overall improvement, compared to last year and we continue to ensure that staff are encouraged to participate in developing ideas to improve the Trust for example through 'Lets Talk' sessions whereby front line staff can meet with senior members of the Trust to ensure that their views and thoughts are captured.

Staff at Oakwood Day Treatment Service

Mandatory Statement

During 2010/11 the Trust provided five NHS services which covered the following areas:

- Adults of Working Age Mental Health
- Older Adult Mental Health
- Substance Misuse
- Learning Disability
- Child and Adolescent Mental Health (CAMHS)

The Trust has reviewed all the data available to it on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2010/11.

Participation in Clinical Audit

During 2010/11, five national clinical audits and one national confidential enquiry covered NHS services that Coventry & Warwickshire NHS Partnership Trust provides.

During that period the Trust participated in 80% of clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate.

The national clinical audits and national confidential enquiries in which the Trust was eligible to participate during 2010/11 are as follows:

National Clinical Audit / Inquiry	Eligible	Participated	% of the registered cases submitted by terms of the audit
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	✓	✓	To be confirmed
Depression & Anxiety – National Audit of Psychological Therapies (NAPT)	✓	✓	83%
National Audit of the Organisation of Services for Falls and Bone Health	✓	✓	Only organisational data required

National Clinical Audit	Eligible	Participated	Minimum cases required	Number of registered cases submitted by terms of the audit
Prescribing in mental health services (POMH):				
Monitoring of Patients Prescribed Lithium	✓	✓		10
Medicines Reconciliation[2]	✓	✗	NA	0
Use of Antipsychotic in People with Learning Disability	✓	✓	12	26
Use of Antipsychotic Medication in CAMHS	✓	✓	10	42

The reports of three national clinical audit were reviewed by the provider in 2010-11 and the Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audit	Description of actions taken following publication of report.
National Audit of Continence Care	A Continence Care Policy has been developed covering: training for staff, evidence based assessment, use of continence care products, and means for regular clinical audit. To support this three standardised assessment tools have also been developed. Patient information leaflets are currently being developed.
Monitoring of Patients Prescribed Lithium	Following this audit, (and in conjunction with actions following the National Patient Safety Agency Alert (NPSA/2009/PSA 005), the Trust has developed Prescribing Guidelines and an Essential Shared Care Agreement to help ensure appropriate prescribing and monitoring of lithium.
Use of Antipsychotic Medication in CAMHS	In response to the findings the Trust intends to take the following action: 1.Teams to review pre-treatment measurements / screening to determine appropriateness; 2.Teams to continue to review and document the need for antipsychotic medication; 3.Teams to assess for and document extrapyramidal symptoms; 4.Teams to review physical measurements to determine; appropriateness of current monitoring / screening.

[2] A procedure for medicines reconciliation is currently being implemented Trust-wide. Once fully embedded participation in the above national clinical audit will commence.

The reports of 23 local clinical audits were reviewed by the provider in 2010-11 and the Trust intends to take a number of actions to improve the quality of healthcare provided. Examples of actions the Trust has taken or intends to take are reflected in the four examples below.

Physical Monitoring of Patients on Antipsychotics in Learning Disabilities

This clinical audit was undertaken to evaluate our current practice in terms of physical health monitoring of patients on antipsychotic compared to local guidance.

Following this clinical audit all outpatient clinic rooms have been supplied with the appropriate equipment to undertake all physical health checks. Blood monitoring tables have been updated to incorporate all of the appropriate blood tests that are required. Patient information leaflets are also being developed.

A system has also been introduced which highlights to staff those patients who are on antipsychotic medications.

Audit Investigating the Effectiveness of Service Provision for Service Users with Attention Deficit Hyperactivity Disorder (ADHD)

A significant sub-section of our general adult psychiatry patients are diagnosed with ADHD. These patients require a specific type of service to meet their needs as outlined by the NICE guidance.

The aim of the clinical audit was to assess adherence to the NICE guidance.

In response to the findings the Trust intends to take the following action:

- Joint handovers between children and adolescent mental health services and general adult services
- A standardised proforma is to be developed to include for example medication; physical examination, annual review and information given to patients
- Explore with Commissioners the possibility of establishing a specialist ADHD team to manage patients and to educate other healthcare professionals.

Audit of Absconding Persons

In 2006 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness reported that 27% of in-patient suicides occurred after the patient had left the ward without permission. Of those in-patients who died in the first week after admission, 32% had absconded from the ward.

The aim of the clinical audit was to ensure that the local multi-agency policy for absent patients was adhered to when patients were reported absent.

In response to the findings the Trust intends to take the following action:

- A review of the current reporting process for managing and monitoring incidents of absconding will be undertaken;
- A process for undertaking a continuous clinical audit will be developed and implemented.

Audit of Naltrexone for the Management of Opioid Dependence

Biological, psychological, social and economic factors influence when and why a person starts taking illicit opioids. Use of opioids can quickly escalate to misuse (repeated use despite adverse consequences) and then dependence (opioid tolerance, withdrawal symptoms, compulsive drug-taking). In 2007 NICE published the following guidance: Naltrexone for the Management of Opioid Dependence.

The aim of this clinical audit was to assess adherence to the NICE guidance.

As a result of this clinical audit an action plan proforma has been developed and is completed upon the first prescription. This plan outlines what should happen if the patient re-starts using opioids and the subsequent discontinuation of Naltrexone. This action plan is filed in the patient's case notes.

Research

The number of patients receiving NHS services provided or sub-contracted by Coventry and Warwickshire Partnership NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 1,038 of which 872 where recruited into NIHR portfolio studies. There were 54 studies approved by a research ethics committee opened in the Trust during this period and have successfully recruited patients or staff.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. This active participation is further reflected in the increased number of grant applications submitted and hosted in the Trust.

There were 74 clinical staff participating in research approved by a research ethics committee at the Trust during 2010/11. These staff participated in research covering a number of medical specialties.

Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques.

Care Quality Commission

The Trust is required to register with the Care Quality Commission and its

current registration status is Registered without Safety and Quality Compliance Conditions.

The Care Quality Commission has not taken enforcement action against The Trust during 2010/11.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC has inspected services provided at two locations within the Trust (Brooklands and the Caludon Centre) as part of the CQC's routine scheduled activity monitoring compliance with the 16 Essential Standards of Safety and Quality. The Trust has received reports which indicate that the CQC has identified that the Trust is compliant with the Essential Standards of Safety and Quality but that the CQC identified minor concerns in three aspects of care as indicated below.[3]

Outcome	Improvements
Safety and suitability of premises (Brooklands)	Improvements to the outdoor space of the medium secure unit would enable full use to be made of the facilities available.
Safety and suitability of premises (Caludon Centre)	Improvements to the outdoor spaces for PICU and Westwood wards would have a positive impact on improving on peoples' mental health and wellbeing.
Assessing and monitoring the quality of service provision (Brooklands and Caludon Centre)	Clearer evidence that the views of all people using the service have been sought

The Trust is currently developing actions plans to reflect the CQC minor concerns.

Statement on relevance of Data Quality and our actions to improve our Data Quality

High quality information and data are critical to the Trust being able to provide high quality clinical and care services to its service users, to enable the effective monitoring of the services and for the continuous improvement of services. High quality information is also required for clinical and research governance processes, for research projects, for business and performance management, for national requirements such as the Mental Health Minimum data set, the Hospital Episode Survey data sets (HES), the Commissioning Data sets, quarterly monitoring returns, Local development plans, data accreditation and external inspections such as those by the Care Quality Commission.

[3] A **minor concern** means that people who use services are safe but there are improvements that should be made to ensure that the outcomes and individual experiences are as expected.

The Trust recognises that data are not just statistics but cover all recording both statistical data and text information such as those recorded in service user records or other corporate documents. Thus data quality is essential for both clinical and non-clinical record keeping.

The Trust also recognises the importance of reliable information in the day-to-day delivery and management of front line services and their management. Poor information quality leads to poor decision-making both operationally and strategically and poor understanding of performance across the Trust.

Data quality is the responsibility of everyone in the Trust whether at the clinical/care level, support functions or higher management level. Thus from initial data collection to the analysis and application of data/information within the Partnership Trust the approach must be consistent and meet the essential criteria for data quality.

NHS Number and General Medical Practice Code Validity[4]

The Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.7% for admitted patient care;
- 100% for out patient care; and

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for out patient care

Information Governance Toolkit attainment levels

The Trust Information Governance Assessment Report overall score for 2010/11 was attainment at a minimum of Level 2 for each of the 45 standards included in the Toolkit. This is equivalent to achieving 65%, which is the minimum requirement for passing the Information Governance Toolkit.

Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

[4] Figures will be subject to refresh in line with national requirements in April/May 2011

Whom we have involved in the development of the Quality Account
The following groups were consulted to be involved in the development of the Quality Account:

- All Trust Staff were invited to participate in a series of 'Lets Talk' events which focused on the delivery and promotion of quality;
- The Trust Leadership Team reviewed and debated the content of the Quality Account;
- The Trust Safety and Quality Committee and Trust Board monitored the development and publication of the Quality Account;
- NHS Coventry and NHS Warwickshire have led the Clinical Quality and Contractual meetings throughout the year and have been invited to comment on the Quality Account;
- Local Involvement Networks (LINks) have contributed as part of a wider programme of user and carer engagement. The Trust has jointly organised a 'LINk up for Quality' event at which the development of the Quality Account was debated;
- The Trust was invited to attend a formal session hosted by Warwickshire Health Overview and Scrutiny Committee (joint session with Warwickshire LINk) to present its Quality Account.
- The Quality Account was submitted to Coventry Health Overview and Scrutiny Committee but the Trust was not required to attend a formal session (to be confirmed).

Rachel Newson, Chief Executive, Tracey Wrench, Director of Quality and Service User Experience and Sue Eato, Associate Director of User Involvement, with Jerry Roodhouse, Chair of Warwickshire LINk, and David Spurgeon, Chair of Coventry LINk at the 'LINk up for Quality' event, held in May 2011.

Statements provided from commissioning PCT, LINks or OSCs (in regulations) including an explanation of any changes you made to the final version of your Quality Account after receiving these statements.

The 'LINk Up for Quality' event. May 2011.

George Eliot Hospital NHS
NHS Trust

Quality Accounts

2010/11

Contents

Chairman's Introduction 4

Section One- Statements on Quality 7

1.1 Statement from the Chief Executive

Section Two-
Priorities for Improvement and Statements of Assurance
From the Board 11

2.1. Key Priorities for improvement and Action 2011/12

2.2 Statements of Assurance from the Board 14

2.2.1 Review of Services

2.2.2 Participation in Clinical Audits and National Confidential Enquiries

2.2.3 Actions arising from Clinical Audits and National Confidential Enquiries

2.2.4 Participation in Clinical Research

2.2.5 Use of CQUIN Framework

2.2.6 Registration with Care Quality Commission

2.2.7 Information on the Quality of Data

Section Three - Review of 2010/11 Quality Performance (Looking Back) 25

3. Progress against key priorities for Action 2010/11

3.1 Do not Harm

3.2 Create a Positive memorable Experience

3.3 Apply Best Practice

3.4 Analysis of Performance 28

Priority One- Patient Safety

Priority two –Patient Experience

Priority Three- Effectiveness of Care

Appendix A –What others say about the GEH 38

Risk Summit

Commentaries received

Links,

PCT Overview & Scrutiny Committee

Appendix B - Glossary 39

If you require the Quality account in any other format please contact the Patient Advice and Liaison Service (PALS) on 024 7686550

Chairman's Introduction - Welcome to the George Eliot Hospital's Quality Account 2010/11

2010/11 has been an interesting and challenging year in many ways and I wish to start by giving our thanks to the staff at the Trust for the service they have given over the last 12 months. Their dedication is appreciated by the Board particularly in the latter part of the year when the Trust experienced some significant changes.

The Trust is ever mindful of patient quality and services and this has been reflected in successes during the past year. This includes the measures taken to improve the patient experience, reductions in infection rates, increased numbers of people treated as 'day' cases allowing them to go home as soon as possible and an increase in the services we provide through GP surgeries, such as physiotherapy.

The Trust Board recognises its role on placing quality and safety at the centre stage of everything it does. The Board adopted its quality strategy in July 2010.

"How will we know our strategy is successful?".

Our measures of success include :-

- Top ten performer in patient satisfaction
- Top ten performing organisation in staff satisfaction
- High performing clinical outcome assessment by commissioners and peer reviews
- No harmful events
- No waste in the system
- Financial efficiency plans achieved
- Market share reflects plan
- National reputation for high quality innovative provision of service

The Trust is committed to focusing on quality, and in particular looking at the stories and experiences of our service users, their carers, relatives and the public at large. These stories are used as a way of supporting the development of the priorities for 2011/12 Quality Account.

We recognise we must all engage more effectively with our patients if we are to improve our services. Over the last year we have worked with both patients and staff to develop and revise care pathways and in particular have introduced a Customer Care Programme which is mandatory for staff to attend.

This Account describes some of our many achievements in 2010/11, and the positive impact this has had on our patients' outcomes and experience. We are determined to build on the foundations now in place to deliver ever improving services in both secondary and primary care.

Engagement and involvement with Service Users

As the hospital's membership numbers continue to reflect strong support from the local population a proactive and structured engagement and involvement strategy to promote and embed an effective two-way information flow between the hospital and its membership community, and the wider public, continues to be taken forward.

In April 2010, the Trust established a Members' Advocacy Panel (MAP) which has been a great success to date. The MAP is chaired by myself and has 37 members, with selected representation from staff, public and patient/carer groups along with nominated governors representing key stakeholder organisations. The MAP meet on a quarterly basis, where a variety of topics are covered such as updates on the Trust's financial and operational status; quality, governance and safety issues; service developments and service reviews along with the current challenges facing the organisation and any plan the Board of Directors have in trying to address them.

The remit of the MAP is seen as key to building up a robust two-way communication flow with the members they represent and, where the opportunity arises, the wider public.

As ambassadors for the Trust their work is vital in relaying positive messages, feeding back views and opinions from the Trust's membership and sharing informed and accurate information in a timely manner.

Throughout the year members' advocates have been involved in supporting key priorities of the 2010/11 Quality Account and reviewing and commenting on the 2011/12 document and these can be cross referenced with their participation in Clinical Services reviews, taking part in consultations and focus groups as required.

The work of the MAP is very important to the Trust as it champions a more responsive and closer working relationship with its public, patient/carer and staff membership at every opportunity. Within the MAP Work Plan for 2011/12 the expectation of support for the Quality Account agenda is set out below:

Member Advocacy Panel Work Plan

Priority	How	Executive Lead
1. Patient Safety 2. Patient Experience Key priorities for MAP: • Communication of priorities internally and externally with a strong focus on public engagement • Staff engagement	• Reviewing Patient Safety/Quality & PEAT reports and feedback analysis • Ward based surveys/walkabouts, Visits to OPD etc • Links established with Community Forums, Community media network, Patient Interest Groups • Staff MAP communications/drop in sessions and links to regular directorate/departmental meetings	Director of Nursing, Quality & workforce/ Medical Director

Stuart Annan, Chairman

Section one Statements on Quality - Chief Executive's Summary and Statement

Welcome to our second quality account which covers the financial year 2010/11(1 April 2010 to 31 March 2011). This document focuses on the quality of services we deliver to patients. The Quality Account for this year covers all services provided by the Trust and is structured to examine:

- What our organisation is doing well
- Where improvements in quality are required
- What the Trust priorities for improvements are for 2011/12
- How we have engaged our stakeholders in the determination of priorities for improvement

Having recently taken up the post as Chief Executive of the GEH, my first impression is of an organisation that has an extremely dedicated and skilled workforce with a strong focus on patient care alongside a local community that has a great deal of pride in their hospital and the services we provide. By working together as a team, listening to the views of our staff, our partners and our patients, I am sure we will succeed in achieving our key aims of delivering safe, efficient and effective care.

Our quality account is an annual report to the public about the quality of services we deliver. The document allows the Trust to demonstrate its commitment to continuous, evidence based quality improvement.
The quality account was developed following consultation with our Members Advocacy Panel (MAP), staff, Board Members and LINks representatives.

The Trust has four directorates providing health care services. Each directorate is responsible for providing a range of services as outlined below. The Medical Directorate; Surgical; Women's; Children's and Clinical Support Services and Primary Care Directorate.

Medical Directorate
Accident and emergency, emergency medical unit, general medicine, cancer services and chemotherapy, genito-urinary medicine, physiotherapy, occupational therapy, dietetics

Surgical Directorate
General Surgery, orthopaedics, anaesthetics, pain management, operating theatres, intensive therapy unit, day procedures.

Women's, Children's and Clinical Support Services
Maternity, obstetrics, gynaecology, paediatrics, special care baby unit, diagnostics, imaging (radiology), outpatients department, pharmacy, health records, audiology.

Primary Care Directorate
GP services, smoking cessation, community dentistry, TB services

In 2010/11 we achieved improvements in the quality of our services. Patients and visitors tell us that one of their main concerns about coming into hospital is getting an infection. In 2010/11 we built on our previous progress to reduce healthcare associated infections. Fewer patients acquired Clostridium *difficile* infections at GEH than in previous years and indeed fewer than in most similar hospitals. We have had no cases of hospital acquired MRSA bloodstream bacteriamia for 15 months.

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

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

From 1 April 2011 George Eliot Hospital NHS Trust became responsible for providing community dental surgery, smoking cessation services and specialist TB nursing across the whole of Warwickshire and an urgent care and out of hours service based at Leicester Royal Infirmary. In addition, it will also be responsible for running three more GP practices; Water Orton, Attleborough and Bedworth. The Trust has incorporated three-performance measures specific to primary care in its priorities for 2011/12.

Mortality rates
The Trust's HSMR rate for 2009/10 was 98.6 which is below the national benchmark of 100. The Trust's current HSMR rate by Dr Foster is 104. The Trust will be rebased by Dr Foster shortly and is awaiting final confirmation of data.

Customer Care Training
In partnership with North Warwickshire & Hinckley College fifteen staff have been trained to provide Training Skills Practitioners Level 3/Customer Care. Subsequently we developed an internal training programme specifically for GEH. The programme has been included in the Trust's Training Needs Assessment as a mandatory requirement for all staff.

The first course was delivered in January 2011.

To date 114 staff have attended with a further 205 booked to attend to date.

Call to Action
The 'Call to Action' project was implemented as part of the cultural framework development for GEH aimed at supporting the implementation of the Trust's Integrated Business Plan, in particular the aim:

Ensure staff have pride and confidence, feel valued and rewarded for what they do and have zero tolerance for poor practice and/or behaviours. Clinical leaders and managers support and lead their teams to achieve excellence and poor performance is dealt with fairly and consistently.

The aims of the Call to Action sessions were to:

- Develop cultural value pledges for GEH
- To reflect those values in all our communications
- To embed the cultural value pledges into our appraisal process

Workshops took place beginning in May 2010, facilitated by the Head of Organisational Development and each workshop was supported by a member of the Executive team. Using a variety of activities and methodologies the groups were asked to consider how they perceived the values, culture, behaviours and attitudes of the Trust at that time. They were then asked to determine what they thought the values, culture, behaviours and attitudes should be to move the Trust forward and achieve our organisational objectives. Analysis of the findings took place with support from an Strategic Health Authority (SHA) Educational lead. A formal report was produced with a series of recommendations for endorsement by the Board.

Our quality account is presented in two main sections:

In the following Section Two, we describe our priorities for improvement in 2011/12, why we have chosen these priorities, and how we will deliver and measure the ways in which we are making our services better for patients. This section contains some specific measures of GEH quality (as required by law and enabling comparison with other NHS trusts, and hence patient choice).

Section Three includes detailed information on the safety and experience of patients in a range of services we provided through 2010/11. It sets out who has helped us to determine the priorities and content of our quality account (in line with equality legislation and the Health Act 2009).

The statements about our Account by commissioning Primary Care Trusts,

Local involvement Networks (LINks) and
Overview and Scrutiny Committee
are included in Appendix A.

I can confirm that to the best of my knowledge the information presented in our Quality Accounts for 2010/11 is a true and accurate reflection of the Trust's performance.

Kevin McGee
Chief Executive

Section Two - Priorities for Improvement, Statement of Assurance from the Board

2.1 Key Priorities for Improvement and Action 2011/12

The improvement priorities for 2011/12 were initially selected by the Medical Director who presented them to the Board, following consideration of performance in relation to patient safety, experience and effectiveness of care. These were then shared with a focus group made up of representatives from the Trust's Members Advocacy Panel, Staff and the Patient Forum to capture the wishes of all our community, and to reflect in particular the views of those in our community who may be most in need of our services, but least able to influence them by traditional, established routes. By addressing these patient needs we will make our services better and safer for all.

The Trust's overarching three priorities for 2011/12 remain the same as 2010/11, namely; Do no Harm, Ensure a Memorable Positive Experience and Apply Best Practice. Details are below:

Priority One

Aim: To reduce unavoidable harm (Patient Safety & Effectiveness of Care)

Measured by: Five performance indicators

- Reducing our HSMR to 95
- Reduce the percentage of moderate or severe clinical incidents by 20% by 2012.
- To reduce the number of patients falls by 30% by 2012.
- Achieving the national CQUIN target for VTE risk assessment
- In line with CQUIN targets, reducing incidents of hospital acquired grade 2 pressure ulcers by 30% and grade 3 and 4 pressure ulcers by 50%, compared to 2010/11 figures.

Monitored by: The DNQW (DIPC)

Reported to:

- Trust Board monthly via Director of Nursing & Quality (DNQW) Quality report
- Quarterly to Board via Quality account report

Priority Two

Aim: Infection Prevention & Control (Patient Safety)

Measured by: Two performance indicators

- Reducing incidence of bacteraemia (MSSA and E. coli) by 5% below the national trajectory
- Reducing incidence of *C. Difficile* by a further 11 cases compared to actual 2010/11 figures.

Monitored by: The DNQW is also lead Director for Infection & Prevention) weekly and monthly by the Board

Reported to: HIPACC and Trust Board monthly via DNQW Quality report

Priority Three
Aim: Improve Patient Experience & Satisfaction (Patient Experience)

a) Acute Trust
Measured by: Three performance indicators

- To increase the response to written complaints within 25 days to 75%
- To capture data on the number of compliments received by the Trust
- Responsiveness to patient needs (shown by five key questions in the patient survey 'Your Hospital, Your Choice')
- Each ward and clinical area to be adopted by a member of the executive team

Monitored by: Patient Experience Group, Back to Basic group

Reported to: Hospital Infection Prevention and Control Committee and Board of Directors, via monthly Quality report

b) Primary Care

Measured by: Three Performance Indicators

- To improve the Alternative Providers of Medical Services (APMS) performance against the Quality & Outcome framework by 10% compared to 2010/11 figures
- To reduce the use of agency staff within the Urgent Care Walk in Centre by 30%
- To implement a process for managing and reducing Dental waiting lists

Monitored by: Associate Director of Primary Care

Report to: Board of Directors Quarterly

Priority Four

Aim: To improve the discharge planning for acute medical admissions and reduce length of stay (Patient Safety and Experience)

Measured by: Three performance indicators

- Best practice urgent care models within A&E
- Best practice discharge practice at ward level
- Best practice elective care bed management

Monitored by: Director of Operations review of daily information, Operational meetings weekly

Reported to: Board of Directors Monthly

2.2 Statements of Assurance from the Board

2.2.1 Review of Services

During 2010/11 George Eliot Hospital NHS Trust provided NHS Services and / or sub-contracted 33 services.

The George Eliot Hospital NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS Services.

The income generated by the NHS Services reviewed in 2010/11 represents 86% of the total income generated from the provision of NHS Services by the George Eliot Hospital NHS Trust for 2010/11.

2.2.2 Participation in Clinical Audits and National Confidential Enquiries

During 2010/11 36 national clinical audits and 4 national confidential enquiries covered NHS services that George Eliot Hospital NHS Trust provides.

During that period George Eliot Hospital NHS Trust participated in 94% of national clinical audits and 100% of the national confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquires that George Eliot Hospital NHS Trust participated in, and for which data collection was completed during 2010/11, are detailed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Participation	% of Cases Submitted
National Clinical Audits		
Continuous Data Collection- All Patients		
Perinatal Mortality	Yes	100%
Neonatal Intensive Care and Specialist Care	Yes	0% Due to incompatible IT systems
Cardiac Arrest	No	-

Title	Participation	% of Cases Submitted
Heavy Menstrual Bleeding	Yes	Data collection in progress
Hip, Knee and Ankle Replacements	Yes	100%
Elective Surgery Patient Reported Outcome Measures (PROMs)	Yes	78%
Acute Myocardial Infarction and Other Acute Coronary Syndromes	Yes	70%
Heart Failure	Yes	100%
Lung Cancer	Yes	100%
Bowel Cancer	Yes	100%
Hip Fractures	Yes	100%
Defined Data Collection Period – All Patients		
Paediatric Pneumonia	Yes	100%
Paediatric Fever	Yes	100%
Childhood Epilepsy	Yes	Data collection in progress
Paediatric Diabetes	Yes	100%
Emergency Use of Oxygen	Yes	100%
Adult Community Acquired Pneumonia	Yes	100%
Non Invasive Ventilation	Yes	100%
Pleural Procedures	Yes	100%
Vital Signs in Majors	Yes	100%
Adult Critical Care	Yes	100%
Adult Diabetes	Yes	100%

Title	Participation	% of Cases Submitted
Chronic Pain	Yes	Data collection in progress
Ulcerative Colitis and Crohns Disease	Yes	Data collection in progress
Parkinson's Disease	No	-
Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
Adult Asthma	Yes	100%
Bronchiectasis	Yes	100%
Acute Stroke	Yes	92%
Stroke Care	Yes	100%
Renal Colic	Yes	100%
Falls and Non-Hip Fractures	Yes	100%
Defined Data Collection Period – Quota of patients seen		
Familial Hypercholesterolaemia	Yes	N/A no eligible patients
O Negative Blood Use	Yes	100%
Platelet Use	Yes	100%
National Confidential Enquiries		
Surgery in Children (including interventional procedures)	Yes	N/A no eligible patients
Cardiac Arrest Procedures	Yes	N/A no eligible patients
Cosmetic Surgery Study	Yes	N/A no eligible patients
Peri-Operative Care	Yes	0% Organisational questionnaire completed but no data submitted for individual patients

The Trust's audit strategy has been to prioritise support for participation in the National Clinical Audit and Patient Outcome Programme (NCAPOP), as agreed by the Department for Audit, Research and Evidence Based Practice (DARE), which is responsible for facilitating audit priorities in the Trust.

The NCAPOP consists of a series of audits commissioned and managed by the Healthcare Quality Improvement Partnership (HQIP), under the guidance of the National Clinical Audit Advisory Group (NCAAG) and are funded by the Department of Health.

The Trust is currently reviewing and prioritising its audit plan for 2011/12 to reflect clinical priorities and available resources.

The Trust's DARE facilitates the reporting and monitoring of Trust participation in national audits and actions taken in accordance with recommendations of national audit reports. This activity is reported to the DARE Group and the Patient Safety Group, which directs action to improve the quality of care. Exceptions are also reported to the Trust's Quality and Risk Committee.

2.2.3 Actions arising from Clinical Audits and National Confidential Enquiries

The Trust Board has delegated authority for clinical audit to the Trust's Quality and Risk Committee; the DARE Director is a regular attendee at meetings. The reports of national clinical audits were reviewed by the provider in 2010/11. In addition 11 local clinical audits were reviewed by the provider in 2010/2011 and the George Eliot Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit of Documentation in medicine
Standard required of authors when identifying themselves in entries made in cases notes will be reviewed'
Audit of VTE risk assessment on inpatients
Development of new VTE risk assessment forms and training packs for the completion of VTE risk assessments. Training packs will be made available on the wards.
Cannulation, Venepuncture and Catheterisation Equipment and Documentation audit
• *To review documentation for venepuncture to see if it can be improved* • *Catheterisation –A new form was designed for maternity and is currently in use.* • *Cannulation – To reinforce completion of documentation at Doctors induction and*

during all cannulation study days and updates, this is part of the lesson plan for all sessions and is delivered by all tutors. The cannulation documentation has been updated and improved by the company.

- *To explore issues with stores to ensure all stock is available when required to enable staff to follow policy*

Initial Assessment of patients diagnosis with Hyponatraemia

Guidelines will be developed for this condition

Audit of the Liverpool Care Pathway

Education and training to be provided in the initiation and completion of the Liverpool Care Pathway to be developed and provided to all medical staff.'

Malnutrition Universal Screening Tool audit

Increase training on the completion of MUST nutritional assessment forms'

Blood Transfusion Policy Audit

- *Reinforce Trust transfusion policy, including the importance of transfusion observations and Modified Early Warning Systems (MEWS) and fluid intake (in blood/blood components), via all training platforms including mandatory induction and ad-hoc update sessions*
- *Importance of independent checking highlighted throughout all training*
- *Invite Haematology ward to audit their own practice and feed results back.*
- *Mandatory training figures to be reported at quarterly PSG meetings*

Do Not Resuscitate Audit

- *The DNAR forms and completion notes used in Trust were updated in June 2010 and follow the current guidance issued by the Resuscitation Council (UK).*
- *The individual completed forms are audited to ensure they have been Consultant endorsed as per policy.*

Cardiac Arrest Audit

- *The current audit relies on data generated by clinicians completing the information on a paper based audit form. This data is collected on adult patients for whom a 2222 call has been made.*
- *There is an intention to work towards the Trust joining the National Cardiac Arrest Audit (NCAA). The Resuscitation Committee are currently exploring what resources would be required to participate.*

The Trust has further enhanced its processes and procedures to ensure that all relevant national clinical audits are reviewed in the future and that action plans are developed in order to derive as much learning as possible from these reports.

2.2.4 Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by GEH in 2010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 630. This represents a 47% increase on the number of patients recruited in 2009/2010.

The increasing participation in clinical research demonstrates the Trusts commitment to improving the quality of care we offer and to making our contribution to wider health improvement

George Eliot Hospital NHS Trust was involved in conducting 113 studies in 2010/11, 28 of which had been approved and opened using the National Institute for Health Research (NIHR) coordinated system for gaining NHS Permission.

There were over 50 clinical staff participating in research approved by a research ethics committee at George Eliot Hospital during 2010/11. These staff participated in research covering various medical specialities including diabetes and endocrinology, gastroenterology, cancer including haematology, oncology and general surgery, cardiology and dermatology.

2.2.5 Use of CQUIN Framework

A proportion of the George Eliot Hospital NHS Trust income in 2010/2011 was conditional on achieving quality improvement and innovation goals agreed between George Eliot Hospital NHS Trust and NHS Warwickshire through the Commissioning for Quality and Innovation Payment framework (CQUIN). Further details of the agreed goals for 2010/2011 and for the following 12 month period are available electronically at:
http://www.institute.nhs.uk/world_class_commisisoning/pct_portal/cquin.html
or the Trust's own site http://www.geh.nhs.uk/about-us/key-publications

During 2010/11 the total income associated with the achievement of quality improvement and innovation goals amounted to £1.4m.

An overview of the initiatives taken forward during 2010/11 and the rationale for choosing these goals is outlined in the table below. More information about their contribution to improving patient care is outlined in Section Three – Overview of the Quality of Care.

CQUIN Initiative	Aims & Objectives	Outcome of Achievement
Tissue viability reduction	• To undertake pressure sore risk assessments on at least 95% of patients within six hours; • For at least 98% of patients at risk of ulceration or who have a pressure ulcer, to have preventative actions taken that are documented in their care plan; • To reduce the numbers of health service acquired ulcers at grades 2 or 3 by 75% and at grade 4 by 40%; • To undertake root cause analysis of all health service acquired ulcerations of grade 3 and 4.	Partially met
Improving patient experience	Positive responses to 5 questions on the nationally co-ordinated patient survey programme: Involved in decisions about treatment / care; • Hospital staff available to talk about treatment / care • Privacy when discussing condition / treatment; • Informed about side effects of medication; • Informed about who to contact if worried about condition after leaving hospital	Met

CQUIN Initiative	Aims & Objectives	Outcome of Achievement
VTE risk assessment *	Undertake VTE (Venous-Thrombo-embolism, blood clot in the vein) risk assessment on admission on over 90% of patients.	Not met
Undertaking root cause analysis for pulmonary embolus admissions	Review over 90% of patients admitted with a pulmonary embolus and where they have been admitted within the last three months, undertake a root cause analysis.	Met
Maximising participation in end of life pathways	Improve by a quarter the number of patients who had followed the Supportive Care Pathway or the Liverpool End of Life Pathway for at least the last three days.	Met

*** see Section three for actual performance**

2.2.6 Registration with Care Quality Commission (CQC)

George Eliot NHS Trust Hospital is required to be registered with the Care Quality Commission and its current registration is unqualified. The George Eliot NHS Hospital Trust's has no conditions on registration.

The Care Quality Commission has not taken any enforcement action against the George Eliot NHS Hospital Trust as of 31 March 2011.

GEH has not participated in special reviews or investigations by the CQC during the reporting period.

The Trust is registered to carry out regulated activities as shown in the table below at :

George Eliot NHS Hospital,
Eliot Way, Nuneaton
CV10 7DJ

Camphill GP led Health Centre,
Ramesden Avenue,
Nuneaton
CV10 9EB

Regulated Activity	GEH	Camphill GP led healthcentre
Treatment of disease, disorder and injury	✓	✓
Assessment or medical treatment for people detained under the MHA 1983	✓	
Surgical procedures	✓	✓
Diagnostic and screening procedures	✓	✓
Maternity and mid-wifery services	✓	
Termination of pregnancies	✓	
Nursing care	✓	✓
Family planning services		✓

In 2010/11, George Eliot NHS Hospital carried out a self-assessment of compliance with CQC's 16 core standards. A broad range of evidence was taken into account. This included self-assessments at ward and department level, information extracted from performance indicators, information from three different patient surveys, CQC's Quality Risk Profile, and evidence relating to those NHS Litigation Authority Risk Management Standards which can be mapped to CQC standards. The evidence was critically reviewed by Executive Group and the Trust's Quality and Risk Committee and in February 2011, a recommendation was made to the Board of Directors that the Trust could be assured the it was compliant with all 16 core standards.

The Trust's methodology for self-assessment was audited by the Trust's internal auditors and found to be satisfactory and they also reported that the Board could take substantial assurance from the processes in place.

In 2011/12, the Trust will move to a continuous self assessment process through which evidence of compliance with CQC standards will be systematically reviewed by the Executive Group and Quality and Risk Committee at regular intervals. Major or serious incidents will trigger reviews of compliance with CQC standards.

2.2.7 Information on the Quality of Data

NHS Number and General Medical Practice Code Validity	George Eliot Hospital NHS Trust submitted records during 2010/11 to the secondary uses service for inclusion in the hospital episodes statistics which are included in the latest published data. - Records which included the patient's valid NHS number was: 99.8% for admitted patient care; 99.8% for outpatient care; and 99.0% for accident and emergency care - Records which included the patient's valid General Medical Practice Code was: APC: 100% (national comparator 99.8%) OP : 100% (national comparator 99.8%) A&E: 100% (national comparator 99.7%) Source : SUS Data quality dashboard, Month 11 2010/11.
Information Governance Toolkit Attainment Levels	George Eliot Hospital NHS Trust Information Governance Assessment Report score overall score for 2010/2011 was 75% and was graded green, satisfactory.
Clinical Coding Error Rate	George Eliot Hospital NHS Trust was subject to the payment by results clinical coding audit during the reporting period 2010/2011 by the Audit Commission and the error rates reported in the latest published audit for that period for the diagnoses and treatment coding were: Primary Diagnoses Incorrect 11.0% Secondary Diagnoses Incorrect 7.9% Primary Procedures Incorrect 12.2% Secondary Procedures Incorrect 4.3% (see 2.2.7.1 below for further information)
Improving Data Quality	George Eliot Hospital NHS Trust will be taking the following actions to improve data quality: • Ensuring that data is managed accurately and securely at the point of collection • Ensuring that where errors are identified they are rectified at source • Ensuring that the key corporate systems are used effectively to collect, store and report upon

	the data • Ensuring that those who need to use the data and reports can access them efficiently and in an understandable format. • Ensuring that all data is handled securely • Ensuring that the Trust continues to improve data quality through effective training, monitoring and governance structures that span all levels across the organisation.

2.2.7.1 Clinical Coding

During 2010/11 the Audit Commission undertook a coding audit at the Trust. The Trust has been audited in previous years. Therefore two areas were selected for follow up in this years audit so that we could provide assurance for commissioners on progress made in particular areas. These areas were Trauma and Orthopaedics and General Medicine.

A total of 300 Finished Consultant Episodes were audited in the 2010/11 audit. Following the replacement of HRG 3.5 with HRG 4 it was necessary to 'regroup' the data collected in 2008/2009 to enable a direct comparison of results.
The 2008/2009 audit found a 15% HRG error rate in Trauma and Orthopaedics (following the regrouping of information to HRG 4). The 2010/11 audit found a 8% HRG error rate. This represents a significant decrease in HRG errors and indicates that coding in this area is improving.
The 2009/10 audit undertaken by the Audit Commission found that the HRG error rate in General Medicine was 43%.The 2010/11 audit again performed by the Audit Commission found a 17% HRG error rate. This indicates that coding in this area is improving but still remains above the national average of 9.1% and further work to improve accuracy is required. The Trust responded positively to the recommendations contained in the report and have developed an action plan which is being implemented.

Section Three - Review of 2010/11 Quality Performance (Looking Back)

This section of the Quality Account aims to present an overview of progress against the quality improvement initiatives and of the quality of care provided during 2010/11 under the key headings of: Patient safety, Patient Experience and Effectiveness of Care

3. Progress against key priorities for Action 2010/11

The Trust has made some progress in relation to the following quality improvements during 2010/11. Progress made in 2010/11 against the quality improvements initiatives that contributed to the delivery of the Trust's overarching priorities identified for action are detailed below and are linked to the Trust's Quality strategy.

George Eliot Hospital NHS Trust adopted its quality strategy in July 2010 around 'Best Care, Best Outcome'. Our Quality Strategy sets out a framework that focuses on three core elements to deliver "Best Care, Best Outcomes" which are:-

3.1 Do No Harm (Executive Sponsor – Medical Director)

To successfully deploy this strategy we are creating an open and just culture that acknowledges "harmful events" happen. By doing so, the Board creates a climate in which our staff readily report harmful events, are open to understand why they occurred jointly with patients and family members, learning and taking action to ensure such harm does not happen in the future.

There may be thought to be a risk in adopting this approach through increased litigation claims, but research indicates that this is not the case, with high reporting organisations being associated with more favourable outcomes.

The philosophy and commitment of the Board is to be open and transparent about its strengths and weaknesses. This is a strategy that is coherent with the values of the Board and a key lever for improving quality.

The quality improvements for 2010/11 were:-

PRIORITY 1: PATIENT SAFETY (DO NO HARM)

- Mortality rates – Standard and actual
- Healthcare associated infections e.g. C-Diff & MRSA
- Venous Thromboembolism
- Patient falls
- Identification of deteriorating patients

3.2 Create a Positive Memorable Experience (Executive Sponsor- Director of Operations)

The second stream of our Quality Strategy is the creation of a positive memorable experience. The feedback we receive sets out great opportunities to improve access and the use of our services.

When we fail to get patient care right first time, frustration and anxiety may ensue for patients and staff.

Removing the elements of service provision that add no value for patients will reduce costs and increase satisfaction with the service provided by getting it right first time.

Executive sponsorship is important to lead the change at a pace that will balance and maintain high quality service provision through the transition.

The quality improvements for 2010/11 were:-

PRIORITY 2: PATIENT EXPERIENCE (MEMORABLE POSITIVE EXPERIENCE)

- National & Local Patient survey results
- Complaints
- Serious incidents requiring investigation (SIRI)

3.3 Apply Best Practice
(Executive Sponsor – Director of Nursing, Quality & Workforce)

There is a wealth of guidance and research published on how to organise care to achieve the best possible outcome for patients. Traditionally the NHS has been slow to adopt and implement best practice which has led to wide ranging targets with penalties for failure to adopt those standards.

“What has stopped us from embracing the best possible care for the people we serve?”For many it is the culture and mindset that stops progress. The question for us in applying best practice is what will it take to meet those standards. A “can do” approach, rather than stopping at first base. We know many of those improvements have been achieved without further expenditure. It requires leadership with an open mind and tenacity to influence others through small steps of change that lead to wide-spread sustainability.

The quality improvements for 2010/11 were:-

PRIORITY 3: EFFECTIVENESS OF CARE (APPLY BEST PRACTICE)

- Compliance with Stroke pathway
- Smoking during Pregnancy
- Compliance with NICE guidelines
- Audit of compliance with NICE recommendations

3.2 Analysis of Performance

Priority 1 Patient Safety

During 2010/11 the Trust has worked along side national and international agencies to support the development of safety initiatives across all services. In January 2011 the Trust was invited to participate in a Quality Innovation, Productivity and Prevention (QIPP) 'Safety Express' programme with an aim of working together to deliver a safer more reliable NHS within improved outcomes. The Trust will continue to maintain these relationships ensuring patient safety is central to everything George Eliot Hospital NHS Trust undertakes.

1.1 Mortality rates

Performance

Indicator	2009/10	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12
HSMR	98.6	90	104*	95

*as at January 2011

The Trust's Hospital Standardised Mortality Rate (HSMR) for 2009/10 was 98.6 which is below the national benchmark of 100. The Trust's current standardised year to date HSMR is 104. The Trust will be rebased by Dr Foster shortly and is awaiting final confirmation of data.

1.2 Healthcare Associated Infections

Performance

Infection Type	2009/10	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12
MRSA **(post 48 hour bacteraemia)** **MSSA** **E-Coli**	5 cases 12 cases	0 cases n/a n/a	0 cases 5 cases n/a	0 cases 4 cases 12 cases
Clostridium Difficile **(post 48 hour)**	79 cases	56 cases	40 cases	29 cases

2010/11 has been an excellent year with the numbers of both MRSA bloodstream infections and C. *Difficile* being lower when compared with 2009/10 data and in the case of C.diff being well below the agreed trajectories. There has been no reported case of hospital acquired MRSA since 14 January 2010.

Both of these organisms together with Methicillin-sensitive Staphylococcus aureus (MSSA) and Escherichia coli (E.Coli) remain a high priority for 2011/12. New trajectories have been set for the Trust for 2011/12 by the SHA. The Trust's

threshold for *C. Difficile* is 40 cases. The Trust will continue to reduce the number of C.*difficile* cases and has set an internal target of no more than 29 cases in order to continue the downward performance trend across the coming year.

MRSA Screening - The Trust has been in the vanguard in the fight to eliminate hospital acquired MRSA bloodstream bacteraemias. In October 2010 we started to screen all emergency patients for MRSA, over three months ahead of the Department of Health H deadline of 31 December 2010.

1.3 Venous Thromboembolism

Performance

Indicator	2009/10	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12
VTE (% of patients receiving a VTE risk assessment)	Not collected	100%	80%	90%

At George Eliot Hospital our performance through 2010/11 has steadily improved but is still under the 90% CQUIN required target. Although performance is no worse than many of the Trusts we benchmark with, our performance is poor in relation to larger teaching hospitals. In 2011/12 the Trust is looking at electronic capture of VTE assessments and is trialling such a system on one of our medical wards.

1.4 Patient falls

Performance

Indicator	2009/10	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12
Patient falls	571 falls	<30%	606 falls	To reduce the number of patients falls by 30% by 2012

The incidence of patient falls has a direct impact on patient length of stay, morbidity and mortality rates. 20-30% of all falls on average are preventable.

The Trust has implemented a number of known initiatives such as low beds, sensor pads, alarms etc which have been known to be successful in reducing the number of falls therefore it is disappointing to see the increase in the number of fall incidents. The Trust is currently working to understand the type of patient susceptible to falls, so it can reduce the number of preventable falls and maintain this trajectory reduction in 2011/12 onwards. The improvement in nursing staff levels especially at night may be helpful in reducing this unwelcome trend observed over the last twelve months.

1.5 Identification of deteriorating patients

Performance

Indicator	2009/10	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12
Identifying deteriorating patients (% of deteriorating patients are identified in a timely manner and action taken)	n/a	100%	89.3% (mean)	100%

In 2010/11 the Trust revised its Monitoring Early Warning System (MEWS) to help identify deteriorating patients. The Trust didn't meet its trajectory during 2010/11 and is currently trailing an electronic system which ensures that patients who are deteriorating are identified and treated. It will also make it easier to identify patients who are well enough to be discharged. Ongoing monitoring of MEWS score and actions taken by the ward staff is overseen by the Trust's Mortality Group. In 2011/12 the Trust will ensure a robust action plan is developed and implemented to ensure where deterioration is identified rapid action is taken.

Priority 2: Patient Experience

2.1 National & Local Patient survey results

Performance

Indicator	2009/10 National Response Rate	2009/10 GEH Response Rate	2010/11 National Response Rate	2010/11 GEH response rate
National & Local Patient survey results Inpatient survey	52%	52%	50 %	49%

The Care Quality Commission undertakes national surveys to find out the experience of patients when receiving care and treatment from healthcare organisations.

Results were published in December 2010 relating to Women's experiences of maternity care and in April 2011 on Adult inpatients at George Eliot Hospital NHS Trust and are summarised below: .

Summary Scores for Patient Survey Questions

- Women's experiences of Maternity care

During the summer of 2010 a questionnaire was sent to all women who gave birth in February 2010. Responses were received from 101 service users at George Eliot Hospital

	Based on patients responses to the survey, GEH scored:	**How our score compares with other Trusts**
Questions about care during pregnancy (antenatal care)	**8.2**/10	About the same
Questions about labour and birth	**7.3**/10	About the same
Questions about staff during labour and birth	**8.3**/10	About the same
Questions about care in hospital after the birth (post natal care)	**7.4**/10	About the same
Questions about feeding the baby during the first few days	**6**/10	About the same

- Adult Inpatients Experience

At the end of April 2010 a questionnaire was sent to 850 recent inpatients, responses were received from 408 patients at George Eliot Hospital NHS Trust.

	Based on patients responses to the survey, GEH scored:	**How our score compares with other Trusts**
Questions about emergency care? A&E department, answered by emergency patients only	**7.4**/10	About the same
Questions about waiting lists and planned admissions, answered by those referred to hospital	**6.5**/10	About the same
Questions about waiting to get to a bed on a ward	**7.3**/10	About the same
Questions about the hospital and ward	**7.9**/10	About the same
Questions about doctors	**8.1**/10	About the same
Questions about nurses	**8.1**/10	About the same
Questions about care and treatment	**7.1**/10	About the same
Questions about operations and procedures, answered by patients who had an operation or procedure	**8**/10	About the same
Questions about leaving hospital	**6.5**/10	About the same
Questions about overall views and experiences	**6.1**/10	About the same

Further information on the survey and results of questions is available from the CQC web site: http://cqc.org.uk

The Trust is committed to improving the patient experience and in September 2010 the Board of Directors approved a new strategy aimed at ensuring the experience we provide to our patients is amongst the best in the country. The 'Best Care, Best Outcome' patient experience strategy aims to pull together a range of methods already in place to measure patient satisfaction into one streamlined initiative. The ultimate objective is to be amongst the top 10%
of acute Trusts in the country in relation to patient satisfaction survey.

It will focus specifically on areas of concern raised by patients in relation to the services provided by the hospital and aim to build on areas of best practice locally and nationally, building a culture of continuous improvement.

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

2.2 Complaints Performance

Indicator	2009/10 Actual	2010/11 Actual	Ongoing Trajectory 2011/12
Total Complaints handled	289	323	1. To reduce the number of complaints 2. To achieve a 90% response rate by March 2013. - Incremental improvement target for 2011/12 set at < 75%
% of responses within 25 days	40% (115)	66% (214)	
% of responses where additional time agreed	60%	34%	To reduce the number of responses where additional time requested by no less than 10% 2011/12.
Referrals for independent review by Parliamentary and Health Service Ombudsman (PHSO)	5	6*	To have no upheld complaints

*Out of six referrals one is currently being formally investigated, five had an initial assessment by the Ombudsman who took the decision not to investigate any further.

In response to feedback from the patient survey in 2009 the Trust has actively promoted its complaints process and its Patient Advice and Liaison Service (PALS). The Trust has actively encouraged both patients and carers to report their experience, good or bad.

Since April 2010 the Board has regularly received a patient story detailing a patient or carers experience, be it positive or negative and ensuring any lessons learnt are shared across the whole of the Trust.

The increase in complaints is disappointing and needs to be improved by attention to detail revealed by the complainant and patient surveys. The Trust has also seen an increase in the number of contacts with the PALS service; 3726 contacts in 2010/11 compared to 2954 in 2009/10, a 20% increase.

Indicator – Attendances/Admissions	2010/11	2009/10	Diff

Inpatients & Day cases	46020	46192	-172
Outpatients	223202	221954	1248
A&E (inc WIC)	70073	66398	3675
Totals	339295	334544	4751

The top three trends in complaints are;
1. Clinical care and treatment
2. Nursing care and treatment and
3. Attitude of staff

Examples of actions taken following specific complaints and where trends/themes identified include:-

- Process now set up between GEH and UHCW Complaints Departments for sharing complaints data on a monthly basis around visiting consultants to and from both sites, to enable greater awareness of any concerns that may be arising in both Trusts
- Using anonymised complaint data for learning and development (training material).
- Re-launch of falling stars initiative.
- Introduction of '9 steps to safety' chart.
- Customer Care Training Programme implemented

2.3 Serious Incidents Requiring Investigation (SIRI) Performance

Indicator	2009/10	2010/11
Total number of Incidents	3160	3500
SIRIs requiring External reporting	37	101*

*64 related to pressure ulcers which were not a reportable requirement in 2009-10

The top five trends identified in 2010/11 are as follows:-

- Service acquired pressure sores
  (Pressure damage is the largest single group of incidents classified as SIRI's)
- C-diff related incidents
- Patient accidents while in hospital
- Unforeseen death
- Ward closure

Incidents are notified to executives immediately and a root cause analysis is undertaken for all SIRIs.

The Trust has reintroduced a Serious Incident Group (SIG) which meets monthly to oversee the interim reports and final investigation reports. The Group challenge

investigation teams on root causes identified, actions taken and the process for dissemination of lessons learnt throughout the Trust.

Priority 3: Effectiveness of Care

3.1 Compliance with Stroke pathway

Performance

Indicator	2009/10	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12
Compliance with Stroke pathway	37%	80% of admitted patients spending 90% of their time on a dedicated stroke ward	68%	80% of admitted patients spending 90% of their time on a dedicated stroke ward

In September 2010 a review of the process for stroke care at the Trust for patients admitted between 1 April 2010 and 30th June 2010 was undertaken by the Royal College of Physicians. The report showed strong performance by the Trust, performance being reported in the upper quartile (of 200 participating sites). The Trust is still aiming to ensure that 80% of admitted patients spending 90% of their time on a dedicated stroke ward.

3.2 Smoking during Pregnancy

Performance

Indicator	2009/10	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12
Smoking Cessation During Pregnancy				
Number of Women referred to smoking cessation advice	100%	100%	100%	100%
Number of Women smoking at delivery	16.1%	1% reduction per year	12.5%	1% reduction per year

The Trust actively encourages all pregnant mothers and their family members to cease smoking by referring all smokers to the Trust's own stop smoking cessation service.

The service provides an 'opt out' service for all women once a referral has been made to a smoking cessation service. It is evident from the information above that there has been a significant reduction in the number of women at delivery who are smoking.

3.3 Compliance with NICE guidelines Performance

During 2010/11 NICE published 123 separate guidelines. Of those 123 guidelines the Trust has determined that Sixty One of them are not relevant to the services that it provides.

The Trust has determined that 25 of the 123 guidelines are relevant to the services it provides and has implemented or is in the process of implementing these.

The Trust is still in the process of determining if the remaining 37 pieces of guidance are relevant to the services it provides.

49% (18/37) of these pieces of guidance are still within the consulting period set out within the Trust's policy for implementing and monitoring NICE guidance.

The Trust recognises that the process it has previously had in place for implementing and monitoring NICE guidelines could have been more effective. In order to improve the processes it has in place, the Trust has introduced the NICE Implementation and Monitoring Group and is also currently developing a new Trust wide policy to support this.

Appendix A

What Others Say About George Eliot Hospital

Risk Summit

In December 2010 the SHA led a multi-disciplinary team which reviewed patient safety and quality provided at the Trust. The feedback received from the risk summit was positive in that it commented the Trust was already aware of the issues they found and plans were already in place to address the issues. They also said the Trust was a safe environment for patients.

Awaiting commentary from Links, PCT, Overview and Scrutiny Committee and MAPS.

Appendix B

Glossary

Acute Care - Medical or surgical treatment usually provided in a district general hospital (also called an acute hospital)

Alternative Providers of Medical Services (APMS)- is a contractual route through which PCTs can contract with a wide range of providers to deliver services tailored to local needs. It offers substantial opportunities for the restructuring of services to offer greater patient choice, improved access and greater responsiveness to the specific needs of the community.

Audit Commission- an independent watchdog driving economy, efficiency and effectiveness in local public services, including the National Health Service, to deliver better outcomes for everyone.

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

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

Clinical Audit & Research Group (CARE) –

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

Clostridium *difficile*- an intestinal infection commonly associated with healthcare.

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

In order to earn CQUIN money, providers of acute, community, mental health & learning disability services using national contracts must agree a full CQUIN scheme with their commissioners. CQUIN schemes are required to include goals in the three domains of quality; safety, effectiveness and patient experience; and to reflect innovation.

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

Dr Foster Good Hospital Guide- Dr Foster is an independent organisation dedicated to making information about the performance of hospitals and medical staff as accessible as possible.

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

Healthcare Resource Group- Healthcare Resource Group (HRG) is a group of clinically similar treatments and care that require similar levels of healthcare resource

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

Length of Stay- the duration of a single episode of hospitalisation.

Local Involvement Networks(LINks)- are made up of individuals and community groups, such as faith groups and residents associations, working together to improve health and social care services.

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

NHS Litigation Authority (NHSLA)- The NHSLA handles negligence claims and works to improve risk management practices in the NHS.

National Patient Survey-The NHS national patient survey programme was established as a result of the Government's commitment to ensuring that patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services.

All NHS Trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. One main purpose of these surveys is to provide organisations with detailed patient feedback on standards of service and care in order to help set priorities for delivering a better service for patients. There are inpatient and outpatient surveys.

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

National Institute for Clinical Excellence (NICE)- an independent organisation responsible for providing national guidance on promoting good health and treating ill health.

NHS Number- is the only National Unique Patient Identifier, used to help healthcare staff and service providers match you to your health records.

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

Payment By Results - Payment by Results (PBR) is intended to support NHS modernisation by paying hospitals for the work they do, rewarding efficiency and quality

PALS- Patient Advice and Liaison Service. The service provides support to patients, carers and relatives, representing their views and resolving local difficulties speedily.

Parliamentary Health Service Ombudsman- The Parliamentary and Health Service Ombudsman can investigate complaints about government departments and agencies in the UK and the NHS in England

Primary Care Trusts (PCTs)- have the responsibility for improving the health of the community, developing primary and community health services and commissioning secondary care services.

Pressure Ulcers- Pressure ulcers, also sometimes known as bedsores or pressure sores, are a type of injury that affects areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure.

Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

Quality and Outcome Framework- Is a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement.

Quality, Innovation, Productivity & Prevention (QIPP) Programme- QIPP focuses on the NHS working in different ways to ensure that the highest quality care is delivered. It encourages efficiency and focuses on a 'joined up' approach to delivering healthcare.

Research Ethics Committee (REC)- Research Ethics Committees are independent committees that review the ethical issues within research projects that involve people as participants or their data or tissues

Service Level Agreement (SLA)- a formal agreement between two organisations that sets out the detail of the way in which one organisation will provide services to the other organisation in return for an agreed amount of money.

Smoking cessation- giving up smoking

Strategic Health Authority (SHA) - NHS West Midlands is the SHA for the region providing leadership of the NHS across the West Midlands. The role of NHS west Midlands is to relay and explain national policy, set direction and support and develop all NHS Trust bodies (acute, mental health and ambulance service)

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

Venous Thromboembolism (VTE)- a condition in which a blood clot (thrombus) forms in a vein.