Adult Social Care and Health Overview and Scrutiny Committee

24 May 2012

Agenda

A special meeting of the Adult Social Care and Health Overview and Scrutiny Committee will be held at the **SHIRE HALL, WARWICK on THURSDAY, 24 MAY 2012 at 10:00 a.m.**

The agenda will be: -

1. General (From 10:00 – 10:15)

(1) Election of Chair

(2) Election of Vice Chair

(3) Apologies

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

Members should declare any interests at this point, or as soon as the interest becomes apparent. If the interest is prejudicial, and none of the exceptions apply, you must withdraw from the room. Membership of a district or borough council only needs to be declared (as a personal interest) if you wish to speak in relation to this membership.

(5) Chair's Announcements

2. Quality Accounts

2.1 George Eliot Hospital (From 10:15 – 11:25)

The Committee are asked to consider the 2011-12 Quality Account of the George Eliot Hospital.

2.2 Coventry and Warwickshire Partnership Trust (From 11:25 – 12:35)

The Committee are asked to consider the 2011-12 Quality Account of the Coventry and Warwickshire Partnership Trust.

2.3 Response to the Quality Account of South Warwickshire Foundation Trust and University Hospitals Coventry and Warwickshire (12:35 – 12:45)

The Committee is asked to agree the response to the Quality Account of South Warwickshire Foundation Trust following the meeting of the Quality Accounts Task and Finish Group on Monday 14 May 2012. As a Foundation Trust, the Quality Accounts have to be finalised earlier that the other Acute Trusts, which will be agreed by the Committee at their meeting on 19 June 2012.

The Committee is also asked to agree the response to the Quality Account of the University Hospitals Coventry and Warwickshire, which was considered by the Task and Finish Group at their meeting on 24 April 2012.

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 George Mattheou
Warwick District Council:	Councillor Michael Kinson OBE

General Enquiries: Please contact Ann Mawdsley on 01926 418079
E-mail: annmawdsley@warwickshire.gov.uk.

Item 2.1

George Eliot Hospital

George Eliot Hospital NHS
NHS Trust

George Eliot Hospital NHS Trust

Quality Account

2011/12

Acknowledgements & Feedback

Acknowledgements

The GEH wishes to thank corporate and divisional teams for their contribution to the production of the Quality Account 2011/12. Equally, the Trust would like to acknowledge the invaluable contribution of the Member's Advocacy Panel that gave their time to advise us on how to improve our services in an ongoing basis throughout the year.

We would like to acknowledge the helpful feed back from the PCT, LINKs Overview and Scrutiny committee .....

Feedback

Readers can provide feedback on the account and make suggestions for the content of future reports by completing the feed back form at Appendix D and returning it to the Trust.

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

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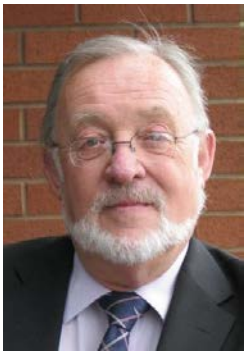
Chairman's Introduction & Welcome



I am pleased to present the Trust's third annual Quality Account and reflect on a year which has again been increasingly challenging. The impact of national and local changes in how we work with our health and social care partners, in particular with those who commission our services, has dominated decisions on how we ensure the delivery of safe and quality care for the patients from the communities we serve.

I feel from every level of the organisation we have risen to meet these challenges and been proactive and innovative in doing so. Quality remains high on the Board's agenda and improvements are acknowledged, monitored and applauded as targets set are reached and set measures are achieved.

The 'quality' of the service we provide to our local communities and beyond will shape the organisation we strive to become in the future and engaging with our patients, the public, our staff, service users and our commissioners on how this can best be achieved is paramount at all times.

Opportunities for engagement and involvement to review and improve the quality of health care services we provide continue to take place and the Board have been delighted to work with colleagues from a number of stakeholder organisations, in the primary and secondary care sector, on the issue of quality at every level of the patient pathway through the services, they and, we provide.

The Members Advocacy Panel (MAP), are the most active of our 10,000 plus strong membership base, who volunteer their time and are the catalyst to ensuring effective and meaningful engagement takes place at every opportunity.

A recently restructured Patients Advocacy Forum (PAF), consisting of Members Advocates and a number of the original Patient Forum members, has a robust and active work plan in place. Specific projects include looking at Discharge Arrangements, Communication, Frail, Elderly and Bereavement Services. The PAF also regularly attend meetings, workshops and other forums within the hospital to feed back and are part of group discussions on quality, patient safety and experience, nutrition, pharmacy, pathology, dignity, equality and diversity to name but a few. 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 to support and inform the decision-making process which takes place at Board level.

The work of the MAP is imperative to enable the Trust to gain the views and the opinions of our membership, patients and the public we serve as at every opportunity the Trust champions a more responsive and closer working relationship with its public, patient/carer and staff membership.

Over 2011/12 we have engaged with our membership carrying out surveys where a general questionnaire on services and what people think about us included key questions like 'what does quality mean to you?', 'what do we do well?' and 'what could we do better?' etc.

Other community based surveys have taken place - one focussing on the awareness of the future direction of the organisation and another looking at travel to the hospital from rural parts of the catchment population we serve i.e. North Warwickshire and Hinckley and

Bosworth areas. Results from these surveys are essential to the steer of the organisation and the forward plans we will make.

As in 2010, our members advocates have been instrumental in supporting our review of key priorities from 2011/12, the setting of key priorities for 2012/13 along with offering their views on the style, layout and look of this year's Quality Account. Their contribution is well received and key in the build up to the publication of the final Quality Account document, which I now commend to you for 2011/12.

Section 1 – Statement from Chief Executive

Over the past year I have been privileged to see at first hand on many occasions the remarkable services our hospital and community and primary services offers. Throughout this account we will share with you some examples of our work to improve safety and the quality of our patient care.

We set ourselves four priority areas for improvement in 2011/12. In this account we look back and describe progress against the following key elements:-

Do No Harm

Apply Best Practice

Create a Positive Memorable Experience

During the year we have reviewed our Trust vision, core values and strategic objectives. The core value pledges have been developed by staff and have been distilled into a simple mnemonic that will be used to engage both existing and new staff in the achievement of the Trust vision. They are:

Our Vision:

"*To Excel at Patient Care*."

Our Core Value Pledges:

Effective Open Communication

E**X**cellence in All That We Do

Challenge but Support

Expect Respect and Dignity

Local Healthcare that Inspires Confidence

The launch of the above will happen in early 2012/13 and is currently being planned. The Board agreed the launch will be led by our Non Executive Directors. Going hand in hand with the launch will be a review of the Trust's Quality strategy to ensure it reflects the revised vision and pledges. Our priorities for 2012/13 have been set with the above in mind.

A summary of some of our activities during 2011/12 are detailed below:-

Preventing infections in our hospital remains a very high priority. In 2011, the Trust was highlighted as one of just twenty five acute hospitals in the country to report no cases of hospital acquired MRSA blood stream bacteraemia between June 2010 and June 2011, which is to be commended. After a 23 month clear period we had our first MRSA bacteraemia in December 2011. However, despite this set back, it is important to stress how far the hospital has come in reducing such infections in recent years.

We have expanded our extensive safety programme, and introduced many innovative clinical practices (such as reducing preventable patient falls and pressure ulcers) , we have introduced a risk newsletter for staff, through which we share learning from serious incidents. We have done considerable work to improve the quality of care for patients with dementia, working closely with patients, and their carers and families.

The Trust has worked with Breakthrough Breast Cancer to produce a local Service Pledge for Breast Cancer. The aim of the Service Pledge is to ensure that patients know what to expect from their breast service. It sets out standards of service that can be expected in the organisation of services, waiting times for tests and treatment and the commitment to treating all patients as individuals, with an emphasis on clear explanations and a willingness to listen to patient views.

The breast care team has already started to implement some of the changes set out in the pledge. This included the launch of a new 'buzzer' system for patients waiting to receive chemotherapy, which enables patients freedom to walk around the site rather than sitting in the waiting area and they will be 'buzzed' when they are ready to be seen.

The Trust is working in partnership with the Nuneaton Training Centre to offer work experience to local youngsters as part of a new Access to Apprenticeship scheme. Ten students from the training centre have begun a five-month work experience programme in administration positions across the hospital.

The scheme aims to give the students valuable experience and training that can be used on their CV to improve their chances of finding permanent employment and the opportunity to continue with their apprenticeship.

Currently there is an acute focus on our mortality rate following the publication of two sets of data in Autumn 2011 which showed the Trust as having a higher than expected mortality rate. Following the release of the data the Trust's Board of Directors instructed an external organisation to conduct an independent review into the Trust's mortality indicators. The key findings and actions from the external review were shared at the Board meeting in February and the reduction of our mortality rate is one of our key priorities in 2012/13. Please see section 3 for further details.

We have introduced a new Compliance, Performance and Finance Board report which includes a set of indicators covering all aspects of the Trust's performance, including quality measures, safety and patient experience. We have also revised the monthly Quality Report to Board. Both reports give the public and staff better quality information about the performance of our hospital in the areas that matter to them.

In early 2011 the Board met a commitment to invest over £1 million pounds in increasing the ratio of qualified to unqualified nurses at the Trust to a 60:40 ratio. This project was completed in November and culminated in the creation of 32 nursing posts.

In the latter half of 2011 the Trust reviewed its divisional structures and also directors' portfolios with a view of making the Trust more clinically effective and efficient.

During 2011 there has been a big focus on engagement with staff and the community as a whole. It is important for as many staff as possible to access open sessions to hear the latest news from their most senior colleagues thus 'Chat with the Chairman and Chief Executive' were introduced to update and consult with staff, but also for staff to raise concerns in a friendly and informal setting. To date almost 200 staff have attended to

discuss key issues including mortality rates, women's and children's consultation, Foundation Trust and finances. Feedback received to date has been very positive.

A number of community engagement events have also been held which include visits to the Sikh Mission Centre and Anmol Day Care Centre supported by PALS Multi-lingual co-worker, as well as meetings with Leicestershire GP's, local Councillors and community forums. Key messages included the future of the George Eliot Hospital and local services.

We will continue our improvements in the areas identified in the 2010/11 Quality Account and this year we have engaged with both members and staff and identified another four areas to prioritise:

1. Reductions in hospital standardised mortality ratios
2. Ensuring high quality care for older people, including those who have fallen or are at high risk of falls, or have poor bone health and those suffering from dementia
3. Ensuring services are fair, personal and diverse to all our patients and staff
4. Improving the experience for all our patients

Our Quality Account is presented in three main sections. In the following section we set out our priorities for 2012/13, and describe (1) why we have chosen them and (2) how we will deliver and measure the improvement. In section three we look back over 2011/12 and summarise our performance against the priorities we set ourselves.

Section three includes detailed information on the safety and experience of patients in the range of services we provided through 2010/11 and our performance against national and local metrics. It sets out who has helped us determine the priorities and content of our Quality Account in line with current legislation and national requirements.

I am aware that this is a time of great uncertainty within the NHS nationally and also locally in relation to the work on securing a sustainable future for George Eliot Hospital. It is understandable that people and staff may worry at such a time but we are confident that we can face these challenges so our staff are secure and can continue to provide both high quality and safe care for our patients. The ethos of the Trust is and continues to be, that patient care is our highest priority and we will not lose sight of that.

Our Account includes statements about it from commissioning PCTs, the Local Involvement Network (LINk) and the local Overview and Scrutiny Committee (OSC), and details of changes we have made as a result of their feedback.

I hereby state that to the best of my knowledge the information within the quality account is accurate.

1.2 Statement of Director's Responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

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

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

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

By order of the Board

Chairman

Chief Executive

Section 2: Quality Improvement Priorities 2012/13

Guidance from the Department of Health suggests that organisations choose between three and five priorities for quality improvement based on clinical effectiveness, patient safety and patient experience.

How we prioritised our Quality Improvement Priorities

In order to identify the highest priorities for quality improvement in 2012/13, the Quality Account Review Group (QARG), chaired by the Medical Director considered performance on effectiveness of care, patient safety and patient experience.

Based upon information gathered from a wide range of sources e.g. our internal complaints system, what our patients, public, members advocacy panel and staff have told us, patient surveys, both local and national, performance information, such as the CQUIN outcomes views, considered the progress we have made during 2011/12 and analysed the wealth of information that is available both locally and nationally.

There are many areas where we want to make progress but we cannot address everything at the same time.

Therefore the Executives identified a small number of principles to help determine our top priorities.

- There must be a clear evidence base for delivering quality improvement
- There must be a clear measurable metric and a robust baseline available
- The priority must support delivery of the Trust's strategic objectives
- The priority area will support delivery of the Quality, Innovation, Productivity and Prevention (QIPP) agenda for the local health economy.

We have identified our top priorities for 2012/13 for improving quality and our aim will be to continue to demonstrate improvement in the following three headings:

Improving Quality

Clinical Effectiveness	Patient Safety	Patient Experience
		
1. Reductions in Hospital Standardised Mortality Ratio 2. Ensuring high quality care for older people, including those who have fallen or are at high risk of falls, or have poor bone health and those suffering from dementia	3. Ensuring personalised and responsive services are in place for all our patients and staff	4. Improving the Patient Experience for all Our Patients

Clinical Effectiveness
Priority 1: Reductions in Hospital Standardised Mortality Ratio

Why is this a priority area?

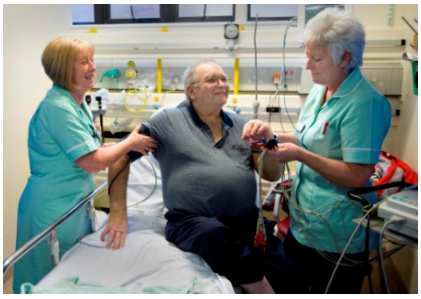
The Trust had set a target of reducing its HSMR to 95 in 2011/12. However, in 2011 two sets of data were released that showed the Trust as having a higher than expected mortality ratio. Dr Foster's Hospital Standardised Mortality Ratio (HSMR) released in November showed the Trust as having a rate of 117 against a baseline figure of 100. The Department of Health released its new mortality data called the Standardised Hospitality Mortality Indicator (SHMI) which showed the Trust as having a rate of 1.21 against a baseline figure of 1.

The Board recognised that mortality ratings are a helpful trigger to investigate any underlying issues, but they should not be used in isolation to rate the quality of patient care. Therefore the Trust's Board of Directors instructed an external organisation to conduct an independent review into the Trust's mortality indicators exploring three key areas to:

Understand the Quality of Care

To identify factors that may be adversely impacting on the quality and delivery of care and patient safety. The focus of the investigation was on processes, pathways, organisational structures and capabilities, clinical services and specialties, workforce deployment and cultural aspects.

Understand the Population and Environment



To examine external factors that may have an impact on both clinical outcomes and on the demand load and mix that the George Eliot Hospital experiences.

Assess information & systems that are used

To look at the Trust's processes for the management of information at clinical, operational and strategic levels, including clinical coding.

The four key recommendations that emanated from the review are as follows:-

- Require and support clinical responsibility for high quality care
- Improve patient flow
- Improve information to inform effective decision making
- Integration, co-operation and alignment with the wider health community

We have recognised following the mortality review that the ambition to achieve a HSMR of 95 in 2011/12 was over ambitious. The Board recognise that the reduction in HSMR is not a short term goal, but a long term one. The reduction in the mortality ratio will continue to be a priority for 2012/13 with a more realistic HSMR target being set which we will work towards by demonstrating an improvement which can be sustained year on year.

The Board have agreed that a HSMR target of 110 will be set in 2012/13, looking to achieve and sustain a HSMR of 95 within the next 5 years.

What will we do?

We will undertake focussed work in four areas:

- We will work to improve patient flow by ensuring patients are admitted to the appropriate ward and remain there
- We will develop an Information management strategy to improve and inform effective decision making
- We will address current issues in clinical coding as a priority
- We will align GEH, community services and capacity to the needs of the local population

Target for 2012/13

- By March 2013 we will be able to demonstrate that our HSMR mortality ratio and SHMI ratio have reduced by at least 5%
- Implementation and review of the action plan emanating from the mortality review
- By March 2013 a clear strategy will be in place which will improve access to key patient summary information at the point of care.

Director Lead: Medical Director

Monitored by: Mortality Group, Board of Directors

Priority 2: Ensure High Quality Care for Older People, including those who have fallen or are at high risk of falls, or have poor bone health and those suffering from dementia.

Why is this a priority area?

Population forecasts for the coming years indicate a significant increase in the number of people aged over 65 in the population serviced by George Eliot Hospital NHS Trust. As life expectancy increases, so does the likelihood of more patients spending more time in hospital due to ill health.

There have been significant developments in work at the George Eliot Hospital NHS Trust in terms of the Osteoporosis service and Falls clinic which are contributing to the enormous task of improving falls and bone health of the local population, but we want to take this further by developing and establishing a clear care pathway.

. A particularly vulnerable group of older people are those with dementia, and a National Audit Office Report in 2010 highlighted significant shortcomings in the care provided to these patients in acute hospitals. The national dementia strategy reports that people with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation. The results from the National Audit of Dementia Care in General Hospitals published in 2011 show that our performance is average for an acute Trust. We will work to ensure we continue to improve our care for patients with dementia.

What will we do?

We will undertake focussed work in five areas:

- We will ensure that assessment of older people and especially the frail elderly is robust and timely to ensure prompt and appropriate intervention from appropriate professionals.
- We will ensure that an effective falls and bone health care pathway is implemented by 2013.
- We will promote awareness in the general population that falls and poor bone health are not an inevitable part of getting older and enable people to be active in achieving good health & well-being.
- We will develop a strategy for how we will further improve services for patients with dementia. This will include a plan for how we ensure patients with dementia/delirium and their carers are identified and treated appropriately whilst in our care; and how we will ensure that staff have the necessary knowledge and skills through developing and implementing a robust awareness raising/training plan.
- We will implement a common system for information and performance management, including the implementation of a local falls register; participate in national and local audit programmes e.g. National Falls and Bone Health audits.

Target for 2012/13

- By March 2013 a clear strategy will be in place to improve the care of patients with dementia
- Adopt and implement the New Cross Hospital model for 'delivering excellence in dementia care in Acute hospitals'
- By March 2013 implemented an information and performance management system

Director Lead: Director of Nursing & Quality

Monitored by: Quality & Risk Committee

Patient Safety

Priority 3: Ensuring Services are Fair, Personal and Diverse to all our Patients and Staff

Why is this a priority area?

Social class, poverty, deprivation, autism and mental health etc are often closely related to the incidence of ill-health and the take-up of treatment. In addition, many people with characteristics afforded protection under the Equality Act 2010 are challenged by these factors. As a result, they experience difficulties in accessing, using and working in the NHS. For this reason, work which focuses on improving performance across the board and reducing gaps between groups and communities, is best suited to addressing health inequalities.

Central to the Equality and Diversity System are the following four core objectives:

1. Better health outcomes for all

2. Improved patient access and experience

3. Empowered, engaged and inclusive staff

4. Inclusive leadership

What will we do?

We will undertake focussed work in two areas:

- We will work to ensure the services delivered are fair and personal and that throughout the organisation, equality is everyone's business, with everyone expected to take an active part, supported by the work of specialist equality leaders and champions. This will not be a 'quick fix' but we are determined to demonstrate our commitment to delivery of services that are fair and personal.

- We will have developed and implemented a training programme to ensure staff have the necessary knowledge and skills for delivering fair and personal services.

Target for 2012/13

- Evidence of service improvement through our patient and staff surveys
- By March 2013 have implemented a training programme.

Director Lead: Associate Director of Community Services

Monitored : Equality and Diversity Group

Patient Experience
Priority 4: Improving the patient experience for all our patients

Why is this a priority area?

We see large numbers of people in both our hospital and community environment. In 2011/12 there were over 90,000 patients seen. The independent national inpatient survey for 2011 showed that overall patients had a similar experience in our hospital to last year.

Patient feedback indicates that there are areas we can improve in our outpatient services, in relation to wayfinding, information provision (prior to, during and after appointment) and reducing the level of rescheduled appointments. With so many people using our outpatient services, any improvements in this area will improve the patient experience for a large number of people.

The NHS Midlands and East SHA Cluster was established in October 2011 as a transition body. The 'patient revolution' was put at the heart of their work programme. From April 2012 the NHS Midlands and East SHA has endorsed the implementation of a headline metric for monitoring real time patient experience data across the NHS in its region. To this effect the following generic net promoter question is to be asked to a minimum sample of 10% of inpatients being discharged.

'How likely is it that you would recommend this service to friends and family?'

What will we do?

Currently we are focusing on our acute services and we will work to improve the patient's experience of using both our inpatient and outpatient services as follows:

Outpatients

We will undertake specific focussed work in the following two areas:

Improved way finding: we will work to ensure that the outpatient environment is as welcoming with enough chairs for patients/carers, tidy and relevant displays of patient information, professional friendly staff and adequate signage to departments and wards.

Improved information and communication: we will work to improve information and communication before, during and after the outpatient visit. We will do this by working with patients, patient groups, carers and staff to identify the specific actions that can be taken to further improve the patient experience.

Inpatients

We will undertake specific focussed work in the following area:

Net promoter question: we will work to ensure that patients at the end of their care e.g. on the day of discharge or up to 48 hours post discharge are asked the friends and family test. We will do this by working with staff, volunteers and patient forum members to improve the patient experience .

Target for 2012/13

- To improve our rating in the 2012 outpatient survey so that we are within the top 50% of Trusts in relation to overall satisfaction.
- To improve the number of positive comments made in our local patient experience feedback and where a written complaint is received, improve the length of time taken to resolve a complaint.
- To be in the top 50% of Trust's performance regarding the net promoter question.

Director lead: Medical Director

Monitored by: Patient Experience Group/ Board of Directors

Section Three: Looking Back on 2011/12:

In this section we compare what we actually did in 2011/12 with what we set out to achieve (described in our 2010/11 Quality Account).

We have made progress against the priorities and key performance targets we set ourselves for 2011/12 (as described in our 2010/11 Quality Account). Some of our key achievements are:

- We have developed an ongoing training programme addressing issues of care for older people
- We are successfully achieving our CQUIN target for reducing hospital acquired pressure sores and have not had a grade 4 pressure sore since June 2011.
- We have worked with patient and carer representatives to develop a new end of life care information leaflet.
- We have achieved the A&E four hour waiting time. Performance for the year is over 95%.
- Maternity Unit were successful in passing stage 1 of the UNICEF baby friendly initiative encouraging new mothers to breast feed and promoting health benefits of breast feeding
- Specific achievements relating to our cancer services include:
    - The successful launch of our breast cancer service pledge
    - Opening of the Macmillan Cancer Information Centre
    - 23 hour enhanced recovery introduced for breast care and colorectal
    - Development of an acute oncology service on site supported by Macmillan
    - End of life and care of the dying service developed
    - Trust has employed a nurse specialist who supports the palliative care consultant and Liverpool care pathway.

Priority One - To reduce unavoidable harm (at GEH)

✗ *Reducing our HSMR to 95*

The Hospital Standardised mortality ratio (HSMR) is a measure of a hospital's death rate compared to the average. For each year the average will be a 100. Our latest annual Dr Foster HSMR was 117. During 2011 the Standardised Hospital Mortality Indicator (SHMI) was introduced, the trust performance was 1.2 against an average of 1. Both Dr Foster and SHMI indicate a higher than expected mortality rate.

Following the release of the HSMR and SHMI data, the Trust's Board of Directors instructed an external organisation to conduct an independent review into the Trust's mortality indicators. The review explored key areas:

- Quality of information recorded by clinical and coding teams regarding each patient's condition, treatment and care
- Quality and safety of care being provided to patients and whether any improvements can be made
- What if any aspect, can be attributed to external factors outside the Trust's control

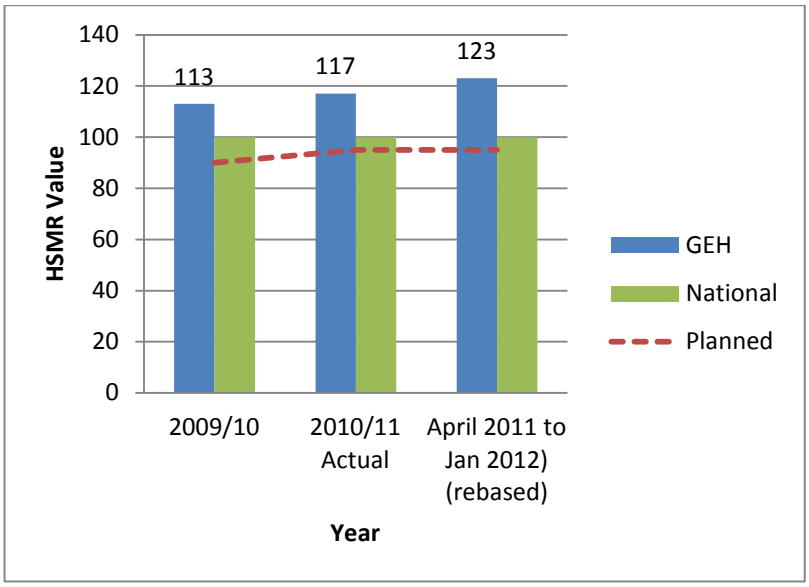
From November 2011 we have introduced a weekly retrospective case note review of all deaths by a multi disciplinary team to improve the accuracy, depth and identification of co-morbidities to ensure data and coding is of good quality.

The Board receives regular updates via the Quality report on the Trust's HSMR data. In 2012 the Trust has introduced a programme whereby a representative from Dr Foster will be invited to meet with the Board of Directors

We received the final report in February 2012, and we have already initiated an action plan to reduce our HSMR, which we have shared with both Commissioners and the SHA and is being monitored monthly by the Board. The reduction of our HSMR will continue to feature as a key priority for 2012/13.

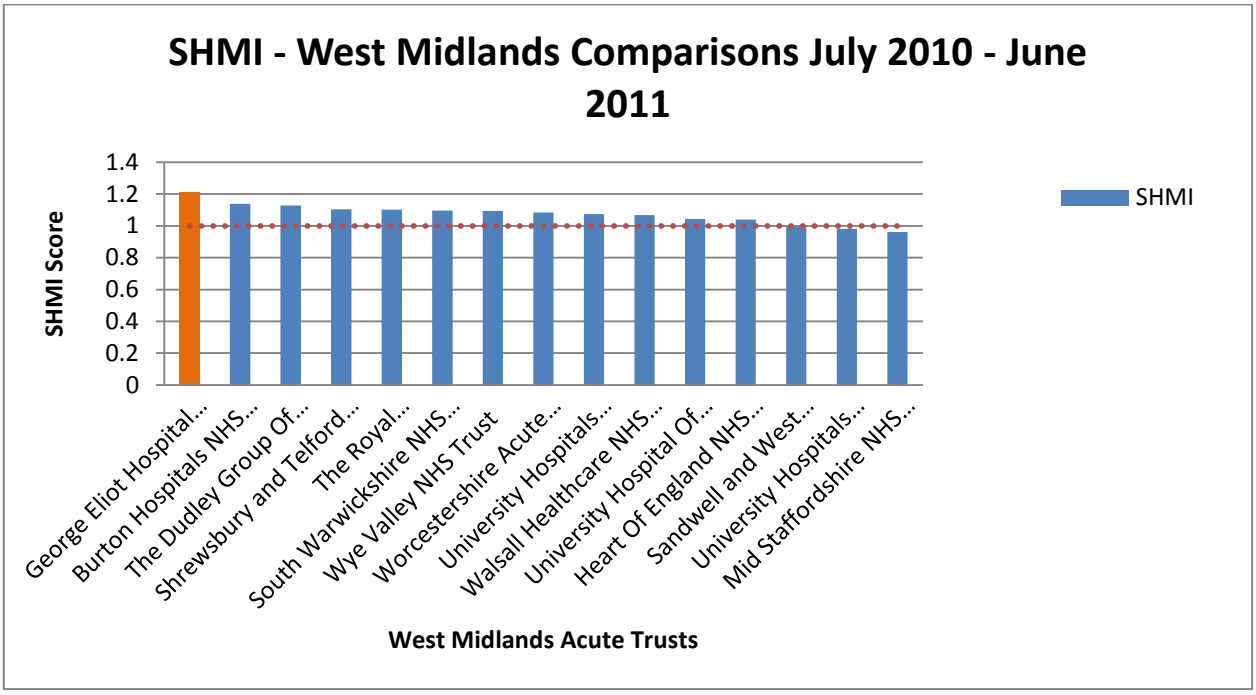
Below is a table which compares the Trust's performance with the national performance and shows our performance against our internal HSMR of 95 for 2011/12.

The HSMR figure for the month of December fell for the first time below 100 (94.8). The Trust is looking to sustain and embed this improvement, recognising that it is not going to happen in the short-term. The Trust is going to set a target for 110 for 2012/13 and look to achieve and embed processes within the next five years to achieve a rate of 95.



Source: Dr Foster's Real Time Monitoring (RTM) – 2009-2012

The graph below shows the GEH SHMI performance against West Midlands Acute Trusts SHMI



✗ *Reduce the percentage of moderate or severe clinical incidents by 20% by 2012*

The Trust set a target of reducing its percentage of incidents by 20%, i..e. reduce the amount of incidents resulting in harm reported.

In 2011/12 there was a reduction in the number of incidents reported compared to last year of 44 (1%), but the number of externally reportable incidents increased by 16.8%.

Indicator	2009/10	2010/11	2011/12
Total number of Incidents	3160	4135	4091
SIRIs classed as severe requiring external reporting SIRIS classed as moderate (not externally reportable) Ratio of incident to total activity	37 N/a	101 n/a	118 113* Tbc

*Analysis of incident data by moderate categories only started to be collected for the full year in 2011/12.

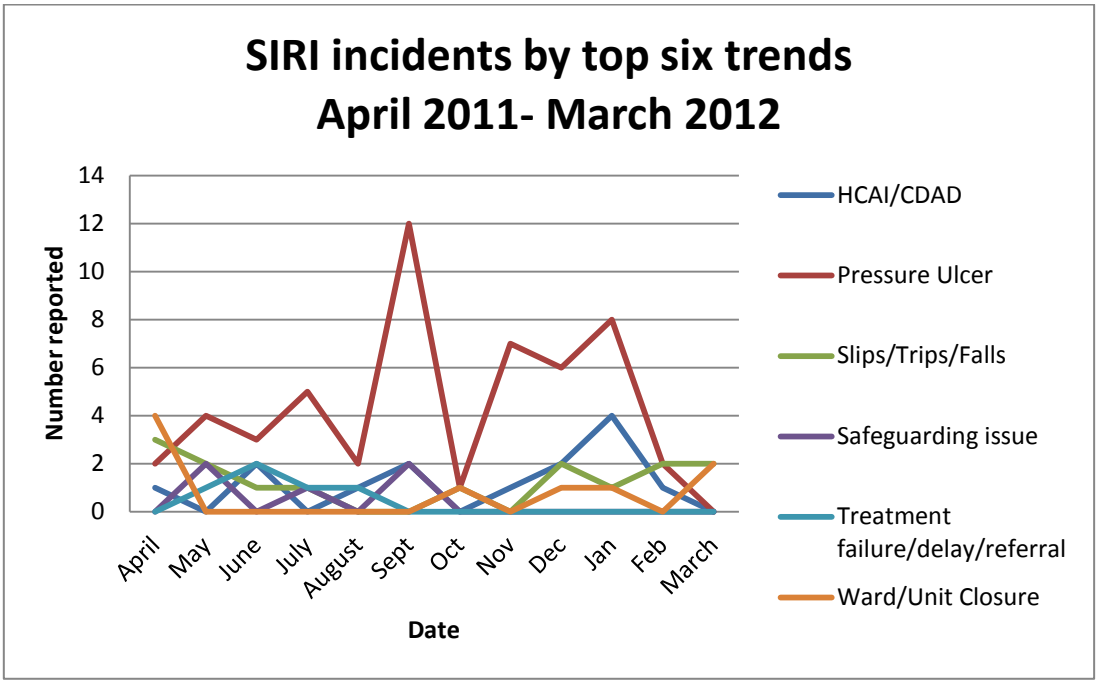
In late 2010/11 organisations were required to report slips/trips and falls that resulted in a fracture or a head injury as an externally reportable incident. In 2010/11 the Trust reported only 6 incidents under this revised category, whereas in 2011/12 the Trust reported 15.

In addition, the Trust experienced the closure of a number of wards due to norovirus in April 2011 and March 2012, which equated to a total of 9 incidents being reported.

From April 2011 all incidents were date stamped to clearly identify the cut off point for the year end as 31 March 2012. Any incidents received after this date even if it is an incident that occurred prior to the 31 March will be reported in the new reporting year. This may affect the total number of incidents reported for the year but allow a consistency in reporting going forward. This may explain why there appear to be less incidents reported in 2011/12 compared to 2010/11.

During 2011 the Trust revised its incident reporting mechanism to make it more efficient and user friendly. On-line incident reporting was introduced and a new carbonated paper system introduced for those areas that may not have access to computers or who have staff that prefer a paper system.

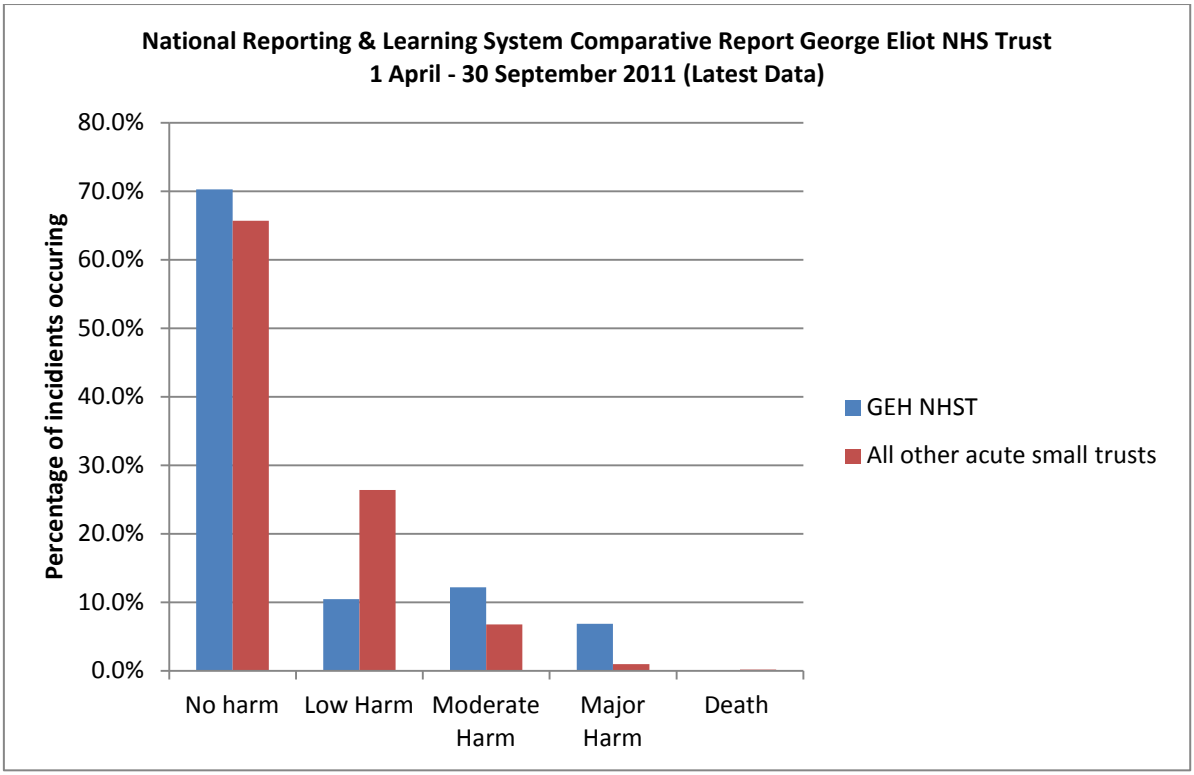
The graph below identifies the top six external reporting trends for the year 2011/12



The national criteria for reporting never events increased from 7 in 2010 to 25 in 2011. In February 2012 the Trust reported 4 never events, the findings from these investigations is still awaited. This is the first time the Trust has reported an incident as a never event.

During 2011 the Trust set up a Serious Incident Group (SIG) chaired by the Medical Director with membership consisting of both clinical and non clinical staff. This group meets monthly and reports to the Quality and Risk Committee. The group acts as the principal source of advice and expertise to the Trust Board on serious incidents and is responsible for supporting the Trust Board in assuring them that serious incidents are investigated, reviewed and acted upon appropriately and that lessons learned are implemented and monitored.

All patient safety incidents are monitored by the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS) on a weekly basis. Every six months the NRLS produce a comparative report comparing the Trust with 30 similar sized acute Trusts. This data is published on the NPSA website. The graph below is the latest comparative reporting rate summary which provides an overview of incidents reported by the Trust to the NRLS between April 2011 and September 2011. This data is the most recent available, published in March 2012. In comparison to previous data the Trust has made significant improvements in no harm, a slight improvement in death and we have remaining work to do in moving severe and moderate to low.


National Reporting & Learning System Comparative Report George Eliot NHS Trust
1 April - 30 September 2011 (Latest Data)
Percentage of incidients occuring
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
No harm
Low Harm
Moderate Harm
Major Harm
Death
GEH NHST
All other acute small trusts

Achieve the national Commissioning for Quality and Innovation (CQUIN) target for venous thromboembolism (VTE) risk assessment (the standard is for 90% of eligible patients over the age of 18 to be risk assessed within 24 hours of admission to hospital)

The Trust receive 1/12th of funding from the Commissioner for each month it achieves over 90%. The Trust's performance for 2011/12 is 91.95%. There was one month (April) where the Trust's performance was below 90% (89.06%).

Indicator	2009/10	2010/11 Actual	Trajectory 2011/12	2011/12 (March 2012) TBC
VTE (% of patients receiving a VTE risk assessment)	Not collected	80%	90%	91.95%

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.

The Trust is hitting its performance (CQUIN) targets for reduction in pressure sores and no concerns have been raised by regulatory bodies with regards to our performance in this particular area. A definition of pressure sores can be found in the glossary.

The Trust has a policy of recording all hospital acquired (post 72 hours from admission) pressure ulcers, regardless of whether they are considered 'avoidable' or 'unavoidable' and regardless of grade. Some organisations will not record avoidable pressure ulcers or 'grade one' ulcers. The Trust has chosen to take this approach to ensure patients receive appropriate treatment as quickly as possible, thereby preventing and reducing the most serious ulcers.

During 2010 the Trust launched its pressure ulcer programme (P.U.P.s) campaign to highlight to staff not only the causes of pressure sores, but also the impact on patient care. In its second year, the campaign continues to thrive and in February 2012 awards were given for the:

Supreme Champion – Melly Ward

Reserve - Coronary Care Unit and

Rising Star – Felix Holt

Tissue Viability has shown an improvement in the numbers of grade 2 pressure sores for 2011/12 being reporting compared to the same period in 2010/11. The Trust was set a threshold of 264, and the Trust reported 213.

The Trust reported 7 hospital acquired grade 4 pressure ulcers (the most serious) in 2011/12 with the last case recorded in June 2011 compared to 10 in 2010/11.

The Trust reported 9 hospital acquired grade 3 pressure sores in 2011/12 compared to 33 in 2010/11. The Trust had its first quarter (January - March 2012) without a grade 3 pressure ulcer being recorded .

Despite this success the Trust was highlighted in the national media in January 2012 as having a high percentage of patients developing hospital acquired pressure sores. At the time the Trust raised serious concerns about the way the data was being reported as there is no standard way for reporting such data at a national level and therefore we believed it was not an accurate comparison.

Priority Two - Infection prevention and control

Reducing incidence of bacteraemia (MSSA and E-Coli) by 5% below the national trajectory

The DH extended mandatory surveillance to include Meticillin-sensitive Staphylococcus aureus (MSSA) and *Escherichia (E.coli)* bacteraemia from the 1st January and 1st June 2011 respectively.

There were no objective levels set for 2011/12 but it is envisaged that this may be introduced from 2012/13 onwards. However, the Trust has appropriate recording processes in place.

MSSA Bacteraemia

Meticillin-sensitive Staphylococcus aureus (MSSA) is a strain of the bacteria (germ) staphylococcus aureus. It is commonly found on human skin and mucosa (lining of mouth, nose etc). The bacteria lives completely harmlessly on the skin and in the nose of about one third of normal health people. This is called colonisation or carriage. *Staphylococcus aureus* causes abscesses, boils and it can infect wounds - both accidental wounds such as grazes and deliberate wounds such as those made when inserting an intravenous drip or during surgery. These are called local infections. It may

then spread further into the body and cause serious infections such as bacteraemia (blood poisoning). [Health Protection Agency, 2009].

From 1st April 2011 to date the Trust has had 9 cases apportioned to the Trust (i.e. Blood cultures taken and confirmed MSSA bacteraemia post 48 hours of admission).

Escherichia coli (E.coli) bacteraemia

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

From 1st April 2011 to date the Trust has had 22 cases apportioned to the Trust (i.e. Blood cultures taken and confirmed E. coli bacteraemia post 48 hours of admission)

✓ *MRSA Bacteraemia*

In 2011, the Trust was highlighted as one of just 25 Acute Trusts in the country to report no cases of hospital acquired MRSA Bloodstreams bacteraemia between June 2010-June 2011.

In 2011/12, The Trust's national threshold for 2011/12 was set at no more than **one** post 48 hour MRSA bacteraemia case. Unfortunately, in December 2011 almost two years after the last reported case, the Trust has reported one incident.

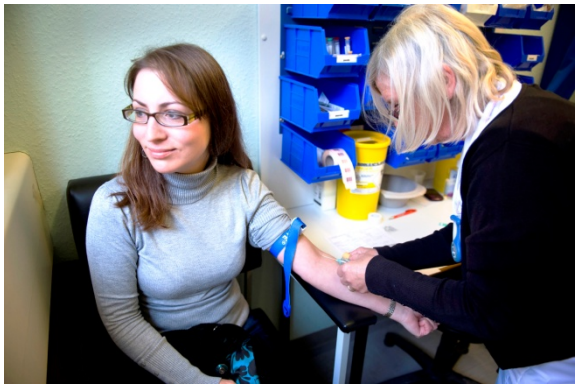
Despite this, it is important to stress how far the hospital has come in reducing such infections in recent years. The Trust carried out a full root cause analysis of the reported infection to identify all contributory factors and lessons to be learnt and shared. We are pleased to confirm that the patient made a full recovery from the bloodstream infection.

✓ *Reducing incidence of Clostridium.difficle (C.diff) by a further 11 cases compared to actual 2010/11 figures.*

The trajectory for 2011/12 agreed with the SHA and PCT was no more than 40 cases for the year and the Trust set its own internal threshold of no more than 29 cases.

In October, the Trust adopted a new method of screening *C.diff* that has improved detection of the bacteria associated with the infection. The introduction of this 'dual' testing is in line with national best practice and it is anticipated that patients will benefit from improvements to treatment brought about by improvements in detection.

In the short term, the introduction has lead to an increase in the number of *C. diff* cases the Trust reports, which has also been the case at other hospitals. However, the improved detection means that all patients are receiving the optimum standard of care.



To date, we have reported 38 cases; the threshold set by the SHA was 40.

We will continue to:

- undertake a full root cause analysis for all cases,
- monitor the impact of dual testing,
- monitor antibiotic prescribing and ensure it remains in line with policy.

Outbreaks of Diarrhoea and Vomiting

In October we had a ward closed due to diarrhoea and /or vomiting. A total of seven patients and eleven staff were affected. The ward was closed for a total of seven days and twelve beds were closed during this time. This outbreak was later confirmed not to be due to Norovirus.

Norovirus

During 2011/12 the Trust experienced 9 occasions where wards were fully closed due to a confirmed Norovirus outbreak. Over the year, 95 patients and 23 staff were affected, with a total of 67 closed beds during this time.

Priority Three: Improve Patient Experience & Satisfaction

The Trust believes it is important that the learning from both complaints and compliments' is shared, not just with those directly involved in the care but with the managers who have responsibility for the services being complained or complimented about. Our aim is to share all complaints in as wide a forum as possible to ensure there is appropriate learning from the issues raised and since 2010 there has been a regular item on the public trust board agenda where both positive and less than positive patient experiences are shared with the trust board.

Below details our performance against the agreed indicators.

To increase the response rate to written complaints within 25 days to 75%

In October 2011 the ombudsman review of complaint handling by the NHS in England 2010-11 was published.

(http://www.ombudsman.org.uk/__data/assets/pdf_file/0019/12286/Listening-and-Learning-Screen.pdf)

It reported that in 2010/11 eighteen complaints were received relating to the George Eliot Hospital NHS Trust , of which the Ombudsman requested patient records and complaint files in six cases. The Ombudsman was satisfied with the Trust's investigation in five of the cases and in the other case, it carried out an official investigation which partially upheld the initial complaint. This represented a significant reduction to the cases reported in the 2009/10 financial year and compared favourable to Trusts of a similar size.

The number of complaints received for 2011/12 has seen a positive reduction compared to the number of complaints received in 2010 /11 and in 2009/10

Indicator	2009/10 Actual	2010/11 Actual	2011/12	Achieved
Total Complaints handled	289	323	266	
% of responses within 25 days	40% (115)	66% (214)	tbc	
% of responses where additional time agreed	60%	34%	tbc	
Referrals for independent review by Parliamentary and Health Service Ombudsman (PHSO)	6	6*	3 *	

*Three cases referred but not investigated

The table below records the actual activity for 2011/12 compared to the number of complaints received and PALS contacts recorded.

	2009/10 Actual	2010/11 Actual	2011/12 March 2012
Inpatients	46192	46020	tbc
Outpatients	221954	223202	tbc
A&E	66398	70073	tbc
Total	334544	339295	tbc
Total PALS contacts	2954	3726	4414
Ratio of Complaints against total activity			tbc
Ratio of PALS contacts to total activity			tbc

Performance for the Trust overall has improved. Support to the divisions is being provided by the customer services department in order to improve the response time for both the Surgery Division, Medicine Division and Women's and Children's

We believe that 90% of complaints should be responded to within 25 days and that our performance in 2010/11 was below par. Therefore we set an incremental target of 75% of all complaints being responded to within 25 days for 2011/12 with this moving to 90% in 2012/13. This target of achieving 90% by March 2013 still remains although complaints are getting more complex and are covering more than one area.

In the latter part of 2011/12 the Trust has implemented a system whereby a sample of anonymised responses to complaints which have been signed off by the Medical Director will be shared with non executive directors. This will provide non executive directors with an assurance on the quality of responses sent when answering a complaint and also provide them an oversight into the areas of complaints.

During 2011/12 the Trust has had three complaints referred for independent review by the Health Service Ombudsman, 1 has been rejected by them for investigation, 1 has been referred back to the Trust for further resolution and 1 is in the initial assessment process by the Ombudsman.

Examples of what we have done in response to feedback include:

✓ Trust re- launched ward night charter

✓ Smoking shelters reinstated on site

✓ Signage improved

PALS

Contacts with PALS continues to increase. Contacts for the year 2011/12 equated to 4414, compared to 3726 for the whole of 2010/11.

PALS staff are available should patients/relatives wish to meet outside of normal working hours and a 24hr answering service is also in place.

The Trust reports to the Trust Board and to the Patient Experience Group details of our complaints, both those dealt with locally and any that are considered by the Parliamentary and Health Service Ombudsman (PHSO)

✓ ***To capture data on number of compliments received by the Trust***

Compliments and 'thank you's'' continue to be directly acknowledged by the Chief Executive with copies being provided to the relevant staff. Wards now have comment

books which reflect the high level of satisfaction shown by our patients. A system to record this analysis has been developed and an analysis for all wards will be available in the final patient experience report for the year.

Smiley face feedback cards

In October 2010 the Trust launched its 'smiley face' feedback cards to enable all patients and visitors the opportunity to complete a ' smiley face' feedback card to rate the standard of care they or their friend/relative receive. During 2011/12 the Trust updated its smiley card posters and ensured each public area/ward had a prominent smiley card collection box. 3109 completed the cards with 74% saying they were happy with the care and the service the hospital provides.

For 2011/12 we have received 3109 feedback cards

= 2291 = 74%

= 254 = 8%

= 564 = 18%

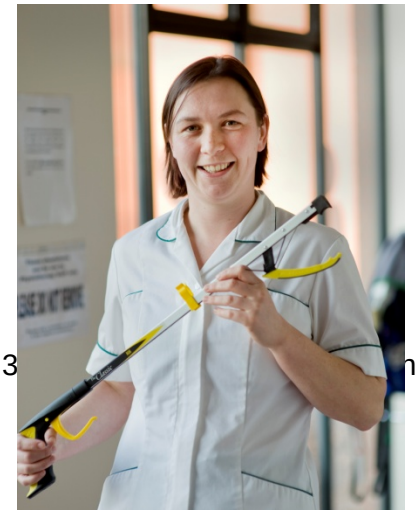
Comments continue to reflect that patients and relatives are in the main satisfied with the care, treatment and support received whilst at the Trust.

Comment from Day Procedure Unit Discharge Lounge.

'*Excellent patient care..... The nurse and doctor were very caring and thoughtful..... The procedure was fine and after care was excellent..... The receptionist was extremely professional and efficient..... No hanging around waiting..... Excellent care.'.....*

Comments about waiting times and delays in clinics and departments are the main theme

'My husband had an appointment at 8:00 it was now 13:15 and I'm still waiting for him to come out of dpu. I appreciate everyone is very busy but 5 hours is an unacceptable time to wait. I fully support the nhs but I believe this should be sorted'



All amber and red comments are referred to General Managers and Matrons for investigation and action.

The above data will continue to be reported in the monthly Quality Report presented by the Director of Nursing and Quality to the Board.

Compliments to the Trust are also captured through a variety of other routes as the following table demonstrates.

Measure	**Total 2011/12**
Compliment/Thank you letters received by the Chief Executive	113
Extra Care slips (where staff are recognised for 'going the extra mile for patients' received by PALs	26
Ward scheme: Melly Ward (started 1/7/11): Thank you cards Food/ Chocolates	 68 122

Responsiveness to patient needs (shown by five key questions in the patient survey 'Your Hospital, Your Voice'.

The Trust has developed innovative ways of capturing and acting upon real-time feedback on its services. The Trust currently has five methods of gathering patient views. These are:

- Local Inpatient Survey conducted by volunteers
- GEH Web based survey- self completion (Impressions)
- Smiley cards available on all wards
- National patient survey programme
- NHS Choices
- Patient Opinion

During 2011/12 the Trust replaced the 'Your hospital, Your Voice' survey with 'Impressions'. Our online feed back survey 'Impressions' is a continuous tool which allows us to see in real time what our patients, carers and visitors are saying at George Eliot Hospital. In 2011/12 the results to date are as follows:-

Category	No of respondents	Overall Impression (%)
Cleanliness	542	98%

Premises & Facilities	450	97%
Privacy & Dignity	534	97%
Safeguarding your wellbeing	391	98%
Our Staff	602	95%
Getting to/from hospital	416	96%
Care & treatment	581	93%
Food & Drink	481	87%
Written & spoken information	498	90%%
Timeliness	485	86%
Discharging you from hospital	104	81%
Parking	304	71%
Total to date	5388 87	

Patient Satisfaction results from 'Impressions' 2011/12

Impressions is also available on a freepost paper version that was introduced to enable people without online access to feedback their experience. Impressions information is fed back on a monthly basis to all specialities in the Trust via the Patient Experience Group and is also reported to the Trust Board via the monthly quality report.

The positive responses to the Impressions questions are extremely welcoming with the lowest satisfaction levels (71%) being for parking. Part of this is we know linked to the ongoing issues we are having with our car parking ticket machines. The Trust is currently seeking funding form the capital budget to replace the existing ticketing machines with an alternative solution which will be introduced in 2012/13.

Each ward and clinical area to be adopted by a member of the executive team

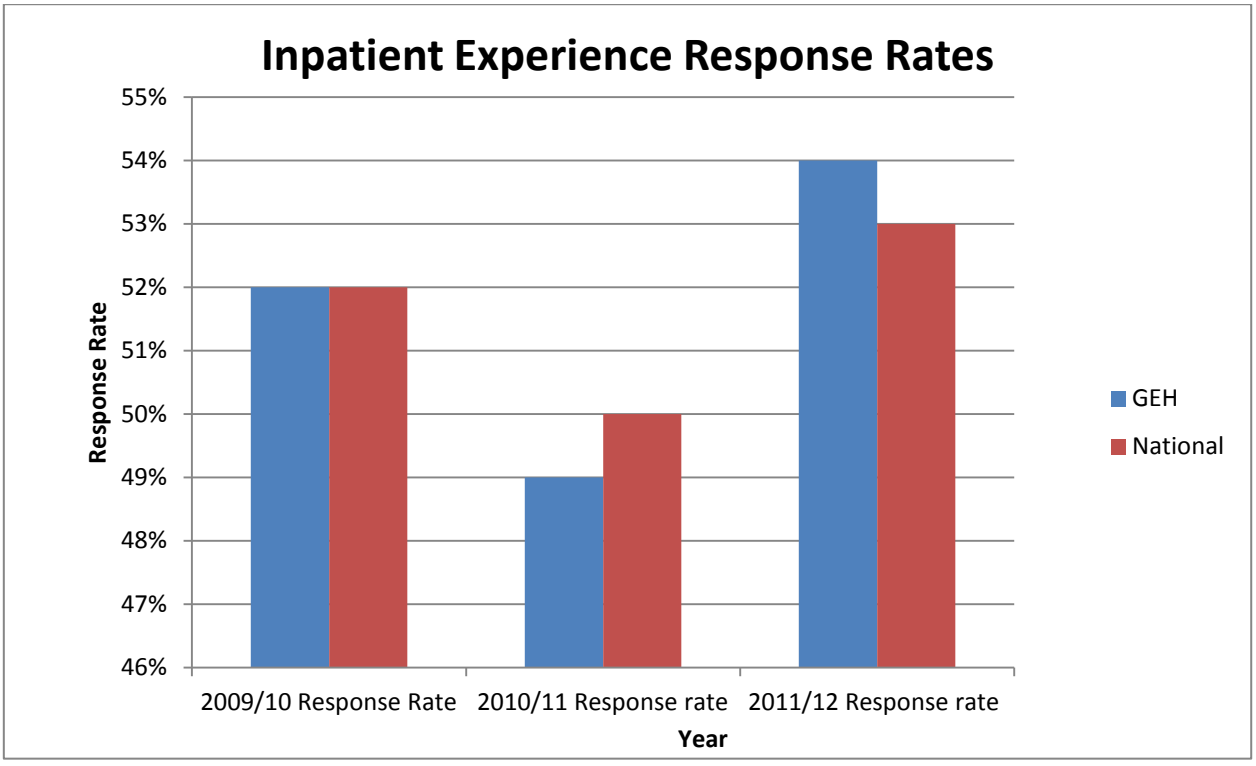
Research has shown that regular walkabouts are a regular factor in developing a safe culture and improving patient safety. These visits are not about inspection or monitoring but more about support, guidance and two way feedbacks. Incorporating patient experience and satisfaction into the executive walkabouts is a strategy which not only provides frontline staff with the opportunity to share safety concerns with senior leaders but also provides the opportunity for staff to engage with members of the Board and will support informed debates at board level.

Executive and non executive director 'walkabouts' were re-launched in 2011. These take place each month. The Board agreed a code of engagement along with a purpose of the visits, messages picked up from the visit are fed back by the Executive Director to the executive team to identify and initiate appropriate actions.

An example of feedback includes the development and initiation of a ward standard checklist of equipment to be held

Patient Survey

The annual inpatient survey was undertaken between October 2011 and January 2012 and targeted 850 inpatients treated between June and August 2011. 445 usable responses were received from a final sample of 823. A response rate of 54%.



The target response rate for the survey set nationally was to achieve at least 60% from the usable sample, and the number of useable response should be at least 500.

Overall 88% of those surveyed rated the quality of care as good broken down as follows;- Excellent 28%, Very Good 41% and 19% as Good.

Areas where the Trust scored particularly well include:

- The Trust's ability to provide single sex ward and bathroom areas, with several related scores better than the national average.
- Patients who require help to eat always receiving that help (69% compared to 61% nationally)

Improvements on scores last year include the information and explanations provided to patients prior to an operation or procedure and the number and the number of delayed discharges relating to patients waiting for medicines (although further improvements are still required).

On the whole, patients responded positively around their trust and confidence in the nursing staff, although their perceptions were that nurse staffing levels could be improved.

Other key areas for improvement, or where the Trust falls behind the national averages include:

- The amount of time patients consider they wait in A&E is longer than the national response
- Availability of doctors to answer questions or provide information
- Pain management for patients
- Information provided to patients prior to their discharge
- Copies of letters/communication between the hospital and a patient's GP

Post Discharge Survey

Members of the Patient Advocacy Forum (PAF), a sub group of the Trust's Members Advocacy Forum, are currently reviewing the Trust's procedures and practices for discharging patients from hospital back into the Community to ensure a smooth transitional journey for the patient, their relatives and carers. To undertake this the PAF members are:

Reading and understanding the current discharge policy used throughout the Trust

Discussing with 'trainers' the frequency, availability and uptake of courses relating to the discharge of patients from hospital

Speaking to patients/relatives/staff and others to obtain details of the discharge procedures used, identifying any problems which may delay the process

Where appropriate, identify any problems that may exist when discharging patients to care homes etc.

They will report their findings to the sponsoring executive director in the first instance, the MAP and then the Trust Board.

Improve the APMS performance against QOF by 10%

To improve the Alternative Providers of Medical Services (APMS) performance against the Quality & Outcome framework by 10% compared to 2010/11 figures

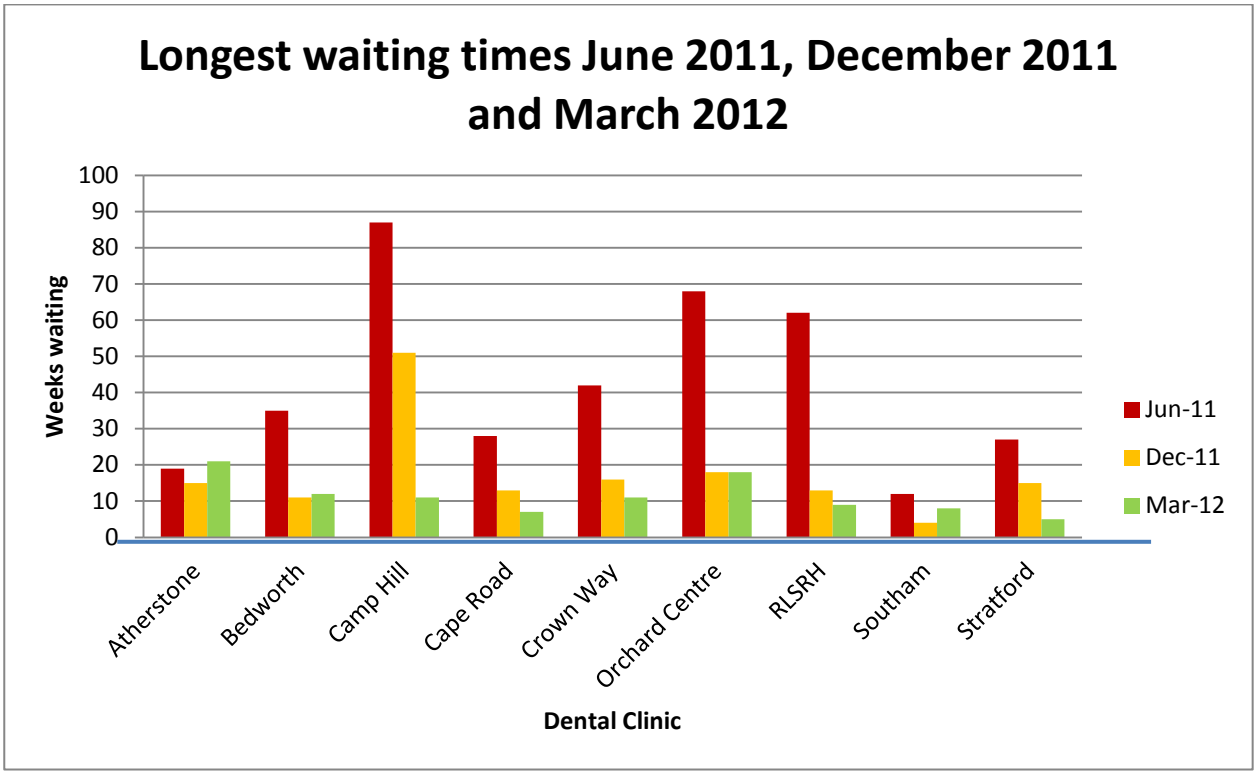
Data is not available until June 2012, but early indicators are the Trust met this objective.

To reduce the use of agency staff within the Urgent Care Walk in Centre – currently appointing to GP Bank.

The Trust have successfully recruited to a number of posts which has reduced the need for agency staff and has implemented a GP bank which it can call on 'as and when' necessary.

Implement a process for managing and reducing dental waiting lists

The Trust took over community dental services from April 2011. The Trust inherited a waiting list where a large number of patients were waiting more than 18 weeks. The Trust has worked hard in order to bring down waiting times below the 18 weeks, and going forward is looking to maintain the effort put in to achieve this with regard to new patient referrals.



Priority Four: To improve the discharge planning for acute medical admissions and reduce length of stay

Improve discharge planning for acute medical admissions and reduce length of stay by:

Best practice urgent care model within A&E

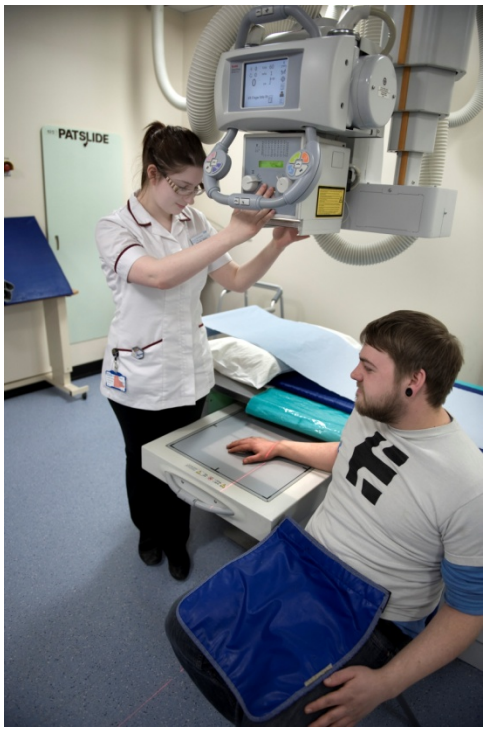
Best practice discharge practice at ward level

Best practice elective care bed management

In April 2011 the Trust launched two transformation programmes relating to Emergency and Elective Care. The Emergency Care Programme has delivered the following outcomes over the year.

The Trust has historically reported high numbers of Delayed Transfers of Care (DTOC) with patients being delayed by a number of weeks. In 2011 whilst the numbers of patients remained high and exceeded the national target of 3.5%, 90% of these patients are now delayed by only a week. The objective in 2012 is to work collaboratively with our partner agencies in community health and social care to reduce the numbers below the national

The Trust has, in association with community health services implemented a programme entitled '5 a day'. This model of integrated working has supported patients with intermediate health care needs to be discharged into the community with enhanced multidisciplinary support. The impact for patients has been to reduce their length of stay and be discharged home sooner than traditionally possible, this service has to date been positively evaluated by both patients and their carers.



The Elective Care programme has delivered the following outcomes over the last financial year:

The main outpatient department has been modernised with a new waiting area and reception desk, and with the redesign of the outpatient workforce we have ensured that we have the right staff, in the right place with the right skills at the right time and this has resulted in improved patient flow and the reduction of queues at the reception desks.

The environment now provides a better experience for patients especially for children with a new play area and televisions in situ.

Development of nurses within outpatients has resulted in:

- A post operative nurse led foot clinic for elective patients
- Expansion of the nurse led Plastic dressings clinics
- Ophthalmology nursing team have undertaken extensive training to enhance their skills and this has improved the patient flow and experience

We have developed new pathways to ensure certain groups of Orthopaedic patients are no longer required to attend the hospital post operatively and can have their care closer to home. This has been partially responsible for, alongside other initiatives, reduced delays in clinic and shorter waiting times for appointments, thereby improving patient's experience.

Enhanced recovery programme was launched in September 2010, and we have continued with the improvement work during 2011/12, the full year effect has demonstrated that we have achieved the national standard in Hips, Knees and Hysterectomy for length of stay and are reducing the length of stay for Colectomy overall.

Section 4 : Statements of Assurance from the Trust Board

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

4.1 Review of Services

During 2011/12 George Eliot Hospital NHS Trust provided and/or sub-contracted 49 NHS services. The Trust has reviewed all the data available to us on the quality of care in 27 of these NHS services and no concerns have been identified.

The income generated by these 27 NHS services reviewed in 2011/12 represents 84% of the total income generated from the provision of NHS services by the Trust in 2011/12. The service reviews for 2011/12 do not cover the 4 GP practices or any of the community services such dental and stop smoking. A service improvement plan was in place for all services, which was agreed with both Leicester and Warwickshire PCTs.

We review the quality of services in a variety of ways. Examples from 2011/12 are shown below:

Methods used by George Eliot Hospital NHS Trust to review the Quality of its Services

Review process	Description
Integrated performance reporting	The Board of Directors considers key quality indicators performance and financial indicators at each monthly meeting. This enables the totality of the organisation's performance to be reviewed to ensure that all targets and priorities are being addressed.
Quality Report	The Board of Directors considers key quality indicators at each monthly meeting. This enables any potential variation that will impact on the quality of care experienced by patients and the clinical outcome from the treatment and care provided to be addressed.
External reports and visits	The Trust receives feedback on its services from a wide range of external organisations. Examples of such reviews in 2011/12 include: Mott Macdonald mortality review, CQC , Royal College of Surgeons, Royal College of Paediatrics and Child Health and PCT Nursing Review.
Complaints & Compliments	Complaints and PALS enquiries provide a rich source of feedback on the quality of services provided to patients. Data is presented monthly to the Board of Directors via the Quality report where any trends and lessons learnt are discussed.
Matrons rounds	Matrons and senior nurses regularly conduct unannounced visits/ inspections of clinical areas in the Trust
Board rounds	Executives and non executives regularly conduct 'walkabouts' of clinical areas in the Trust
Patient experience reporting	Smiley cards are now available within the Trust for patients, carers and relatives to record their real-time experience in addition to the internal surveys that take place and use of impressions.
Membership surveys	Over 2011/12 we have engaged with our membership carrying out surveys where a general questionnaire on services and what people think about us included key questions like 'what does quality mean to you?', 'what do we do well?' and 'what could we do better?' etc. Other community based surveys have taken place - one focussing on the awareness of the future direction of the organisation and another looking at travel to the hospital from rural parts of the catchment population we serve i.e. North Warwickshire and Hinckley and Bosworth areas. Results from these surveys are essential to the steer of the organisation and the forward plans we will make.

4.2 Participation in Clinical Audits and National Confidential Enquiries

Clinical audit provides a vehicle for professionals to assess clinical practice and its outcomes against the current evidence base.

The value of clinical audit to patients lies in its ability to:

- Provide evidence of good quality care
- Highlight inadequacies in care to enable health professional to take measures to remove or control them
- Provide a learning opportunity for health professionals by focusing on best practice and the evidence base and assessing practice against them

The Department of Health describes 51 national clinical audits which Trusts should consider in their 2011/12 Quality Account.

During that period the Trust participated in 32 of the 37 (86.5%) national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

14 audits were not relevant to the Trust and for the 5 national clinical audits where the Trust did not register in time, these have been carried forward into the 2012/13 local audit programme.

National clinical audits and National Confidential Enquiries that the Trust was eligible to participate in during 2011/12 detailed below:

Title	Did GEH participate (submit data) in 2011/12	% of cases submitted
Peri and Neo-natal		
Neonatal Intensive Care and Special Care	✓	100%
Perinatal Mortality (CMACE) Centre for Maternal and Child Enquiries	✗	Did not register in time
Elective Procedures		
Hip, Knee and Ankle Replacements	✓	100%
Elective Surgery Patient Reported Outcome Measures (PROMs)	✓	78%
Cardiovascular Disease		
Acute Myocardial Infarction and Other Acute Coronary Syndromes	✓	80%
Heart Failure	✓	100%
Cardiac Arrhythmia	✓	100%
Acute Stroke	✓	92%
Cancer		
Lung Cancer	✓	100%
Oesophago-gastric Cancer	✓	100%
Bowel Cancer	✓	100%
Head and Neck Cancer	✗	Did not register in time

Title	Did GEH participate (submit data) in 2011/12	% of cases submitted
Trauma		
Hip Fracture	✓	100%
Children		
Paediatric Pneumonia	✓	100%
Paediatric Asthma	✓	100%
Childhood Epilepsy	✓	100%
Pain Management	✗	Did not register in time
Diabetes	✓	100%
Acute Care		
Cardiac Arrest	✓	100%
Emergency Use of Oxygen	✓	100%
Adult Community Acquired Pneumonia	✓	100%
Non Invasive Ventilation-adults	✓	100%
Pleural Procedures	✓	100%
Adult Critical Care	✓	100%
Severe Sepsis and Septic Shock	✓	100%

Title	Did GEH participate (submit data) in 2011/12	% of cases submitted
Potential Donor Audit	✓	100%
Seizure Management	✗	Did not register in time
Long Term Conditions		
Adult Diabetes	✓	100%
Heavy Menstrual Bleeding	✓	TBC
Ulcerative Colitis and Crohn's Disease	✓	85%
Chronic Pain	✓	TBC
Adult Asthma	✓	100%
Bronchiectasis	✓	100%
Blood Transfusion		
Bedside Transfusion	✓	100%
Medical Use of Blood	✓	100%
End of Life		
Care of Dying in Hospital	✓	TBC
Health Promotion		
Risk factors* A local audit has been carried out using the same tool and the Trust intends to take part in the next audit in 13/14.	✗	Did not register in time
Audits in which GEH did not participate in as not relevant to the services		

Title	Did GEH participate (submit data) in 2011/12	% of cases submitted
provided by the Trust.		
Paediatric Cardiac Surgery	Not relevant	
Paediatric Intensive Care	Not relevant	
Intra Thoracic Transplantation	Not relevant	
Parkinson's Disease	Not relevant	
Liver Transplantation	Not relevant	
Coronary Angioplasty	Not relevant	
Peripheral Vascular Surgery	Not relevant	
Carotid Interventions	Not relevant	
CABG and Valvular Surgery	Not relevant	
Renal Replacement Therapy	Not relevant	
Renal Transplantation	Not relevant	
Severe Trauma	Not relevant	
Prescribing in Mental Health Services	Not relevant	
Schizophrenia	Not relevant	

4.3 Actions arising from clinical audits

The reports of 11 national clinical audits relevant to the Trust were reviewed in 2011/12. Below is a table highlighting some of the actions taken to improve the quality of healthcare as a result of national clinical audits.

National Audit Title	Description of actions following national audit
Renal Colic:	• Focus on pain score recording and re-audit as part of CEM audit programme • Focus on time to analgesia in order to show improvement in the next round of audits
National Audit of Falls and Bone Health:	• Leaflet to be produced on the risk factors for falls
Care of dying in hospital:	• An education and training programme in the care of the dying to be developed and made mandatory for all staff
Diabetes (Adult):	• Improve the communication to GPs and specialist

	nurses in respect of the patient's condition

The reports of 31 local (not national) clinical audits were reviewed by GEH in 2011/12. Below is a brief summary of some of the key actions we have taken to improve the quality of healthcare provided for 10 of the local audits:

Local Audit Title	Description of actions following national audit
Audit of Stroke Driving Status: .	• Modify the medical proforma to include driving status. • Modify the Electronic Discharge Summary to include additional information and advice given.
9 Processes for Diabetes Care:	• Develop a poster as a reminder for all elements of assessment of diabetic patients.
Documentation Audit:	• Guidance document produced for junior doctors to be given out at junior doctor induction
Lost Kardex Audit	• Colour coded unique ward location stickers to be used on Kardex's.
Prescribing in A&E:	• Education and Feedback to Junior Doctors regarding the quality of prescribing in A&E.
Audit on the use of red blood cells for fractured neck of femur:	• Incorporate findings into the neck of femur pathway and the maximum surgical blood order schedule
Offer and uptake of HIV test in GUM clinics:	• Develop training for staff for Pre HIV test counselling • Improve documentation around offering of HIV test and reasons for patient declining
Consent for Laparoscopic Cholycystectomy:	• Patient information leaflet developed to be given to patients in pre op assessment clinic • Patient satisfaction survey to be carried out to further inform audit results • A poster with a reminder of the expected level of documentation is to be displayed in relevant areas.
Audit of peripheral venous cannulae being removed within 72 hours: .	• Continued emphasis on the improvement of cannula care pathways during mandatory training and practical demonstration of cannula care
Emergency Colectomy Audit:	• Ensure chest physiotherapy and early mobilisation with high level of suspicion for early detection and treatment of pneumonia

The Trust's CARE 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 CARE 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.

National clinical audits are distributed to relevant GEH divisions or departments. In 2011/12 national clinical audit reports were not systematically reviewed by the GEH Board, but were reviewed by the CARE Group and several formed part of relevant annual reports.

As part of an improvement programme for audit and effectiveness the relevant committee structure has been strengthened, and the Board will receive an annual audit report which will include details of GEH activity in (and response to) national audits.

Assurance of clinical audit systems

The Trust's internal audit providers (RSM Tenon) reviewed the Trust's clinical audit systems and processes in September 2011. This independent audit provided assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective, action needs to be taken to ensure risks in this area are managed.

Whilst a number of issues have been identified in this review, this opinion is reflective of the changes introduced by the CARE team for 2011/12.

For more information on National or local clinical audits please contact the clinical audit and research department on 02476 351351.

4.4 Participation in Clinical Research

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).

The number of patients receiving NHS services provided or sub-contracted by George Eliot Hospital NHS Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was **110** . By the end of the financial year this number is projected to reach **163**.

Year	Studies	Patients recruited
2008-09	16	178
2009-10	19	754
2010-11	32	534
2011-12	20	**127** (27/2/12)

This represents a **69**% decrease on the number of patients recruited to studies matching the same criteria in 2010/11.

This decrease is likely to have resulted from a number of factors; the absence of a Research Champion at the Trust for a large part of the year, a shortage of dedicated Research & Development staff following the resignation of the Research & Development Manager and Research & Development Administrator, along with a new Research & Development Director and general restructuring within the Trust as well as the decrease in the number of observational studies which involve high recruitment of patients. However, in 2012/13 there will be a number of studies which will compensate for the above as they will have a high recruitment rate.

With effect from April 2012 the Trust has appointed two research champions – Dr V Patel and Dr M Ranganathan and from 2012/2013 the West Midlands (South) Comprehensive Local Research Network (CLRN) will support George Eliot Hospital NHS Trust to appoint suitable Research Champions to engage George Eliot Hospital NHS Trust Clinicians with the research endeavour. The West Midlands (South) CLRN will also be providing Research Management & Governance support from their central CLRN team, under the terms of a Service Level Agreement.

Patients receiving NHS services provided or sub-contracted by George Eliot Hospital NHS Trust in 2011/12 participated in research covering cancer, critical care, dermatology, diabetes, gastrointestinal, genetics, hepatology, and metabolic and endocrine.

To date George Eliot Hospital NHS Trust has been involved in conducting **50** individual studies in 2011/12, all of which had been approved and opened using the National Institute for Health Research (NIHR) co-ordinated system for gaining NHS Permission. **20** of these studies are actively recruiting and reporting recruits to the national system. George Eliot Hospital NHS Trust has been involved in conducting **3** individual studies in 2011/12 which were not approved and opened using the National Institute for Health Research (NIHR) coordinated system for gaining NHS Permission (non-portfolio studies).

In the last two years there have been 37 publications with authors affiliated to George Eliot Hospital which shows our commitment to transparency and desire to improve patients outcomes and experience across the Trust. Trust diabetes specialist Dr Saravanan has been leading research into the risks of developing obesity, diabetes and heart conditions.

Received mrc funding find out details

4.5 Use of the CQUIN Payment Framework

2011/12 Goals agreed with Commissioners

The Commissioning for Quality & Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS Services, by embedding quality at the heart of commissioner and provider discussions. It is an important lever supplementing Quality Accounts; to ensure that local quality improvement priorities are discussed and agreed at board level within – and between – organisations. It makes a proportion of our income dependent on achieving locally agreed quality and innovation goals

A proportion of GEH's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between GEH, NHS Coventry and NHS Warwickshire (Arden Cluster). Further details of the goals for 2012/13 and for the following 12 month period are available on request from the Trust and are available electronically at:

www.institute.nhs.uk/world class commissioning/pct portal/cquin.html

During 2011/12 the total income associated with the achievement of quality improvement and innovation goals amounted to £1.4m. We had a total of 10 general CQUIN measures (8 local, and 2 national) , for 2011/12. Both national and local CQUINS are listed below, with a commentary on their achievement by GEH

Achieved	CQUIN Description
✓	VTE % of all adult inpatients who have had a VTE risk assessment on admission to hospital
✓	Patient Experience Survey The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme "responsiveness to personal needs of patients": 1) Involvement in decisions about treatment/care, 2) Hospital staff being available to talk about worries/concerns, 3) Privacy & Dignity when discussing condition/treatment, 4) Informed about side effects of medication, 5) Informed who to contact if worried about condition after leaving hospital.
TBC	Implementation of DVT ambulatory emergency care pathway Establishment of a 7 day DVT ambulatory management pathway by 1st October 2011 with a reduction in admitted patients during quarters 3 and 4.
✓	Implementation of cellulitis ambulatory emergency care pathway Establishment of a 7 day cellulitis ambulatory management pathway by 1st October 2011 with a reduction in admitted patients during quarters 3 and 4 . It is recognised that this indicator is dependent on NHSW agreeing the commissioning of the ambulatory treatment element to avoid admission of these patients.
✓	Implementation of pleural effusion ambulatory emergency care pathway Establishment of a 7 day unliateral pleural effusion ambulatory management pathway by 1st October 2011 with a reduction in admitted patients during quarters 3 and 4

Achieved	CQUIN Description
✓	Tissue Viability 30% reduction in grade 2 pressure ulcers.
✓	All OPA letters to include a treatment plan where the patient has been discharged at the OPA.
TBC	All outpatient clinic letters to include a treatment plan where the patient has been discharged at the outpatient All outpatient clinic letters to GP practices should, where the patient has been discharged from further hospital review as a result of the appointment, include a treatment plan for the GP to follow.
✓	Compliance with preferred prescribing list 75% of prescriptions for newly initiated outpatient medicines which fall into a drug group included on the Preferred Prescribing List (PPL).
✗	Emergency readmissions of emergency patients rate.

4.6 Registration with the Care Quality Commission

In April 2011 the Trust acquired 2 PMS practices, 1 GP practice and also took over the management of the Urgent Care Centre in Leicester. The Trust updated its registration with the CQC to reflect these additions. Our current registration status is registered without any compliance conditions and licensed to provide services. The Care Quality Commission has not taken any enforcement action against GEH during 2011/12.

GEH participated in a Dignity and Nutrition Inspection on 19th April 2011 as part of a targeted inspection programme by the Care Quality Commission to assess how well older people are treated during their hospital stay. The Trust were found to be fully compliant with the essential standards of quality and safety reviewed.

In July 2011 the Care Quality Commission undertook an unannounced visit and they assessed the Trust as delivering, safe good quality care. The review examined the following six essential standards of quality and safety and found that the Trust is fully compliant with:

Consent to care and treatment
Care and welfare of people who use services
Safeguarding people who use services from abuse
Cleanliness and infection control
Staffing
Assessing and monitoring the quality of service provision

The review involved the checking of hospital records, observations of patient care, talking to staff, reviewing information from stakeholders and talking to service users. The review team commented

" during the course of the two day visit we spoke with patients using the service and received a lot of positive comments about the care provided by George Eliot Hospital".

The review went on to say:

" …the trust ensures the environment is kept clean and the risk of infection is monitored. Patients are protected against identifiable risks of acquiring a healthcare associated infection because of the effective operation of systems and the maintenance of good standards of cleanliness and hygiene".

In 2011/12, George Eliot Hospital NHS Trust 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 the Executive Group and the Trust's Quality and Risk Committee and in February 2012, the Board agreed with the self declaration of compliance with all 16 CQC outcomes.

4.7 Information on the Quality of Data

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

The National Data Quality Dashboard is available to help monitor and drive improvement in the quality and completeness of data. The GEH benchmarks well against other Trusts as the average results of the overall commissioning dataset (CDS) data validity is x% for all CDS submitters and the results of the GEH was .

TBC

George Eliot Hospital NHS Trust will be taking the following actions to improve data quality:

- Ensuring that data is managed accurately and securely and is recorded in a timely manner.
- Ensuring that where errors are identified they are rectified at source
- Ensuring that 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 the Trust continues to improve data quality through effective training, monitoring and governance structures that span all levels across the organisation.

NHS Number Code Validity

The patient NHS number is the key identifier for patient records and the quality of NHS number data has a direct impact on improving clinical safety.
George Eliot Hospital NHS Trust submitted records during 2011/12 to the secondary uses service for inclusion in the hospital episodes statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99.8% for admitted patient care
99.9% for outpatient care
99.5% 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 8 2010/11.

Information Governance Toolkit Attainment Levels

The Trust has completed the self-assessment of the IG Toolkit V9, and has rated itself as a minimum of Level 2 for all requirements .

As part of our internal assurance, we requested internal audit to undertake an interim review of progress. Recommendations and associated management actions from this audit are being implemented and monitored via the Trust's Audit Committee.

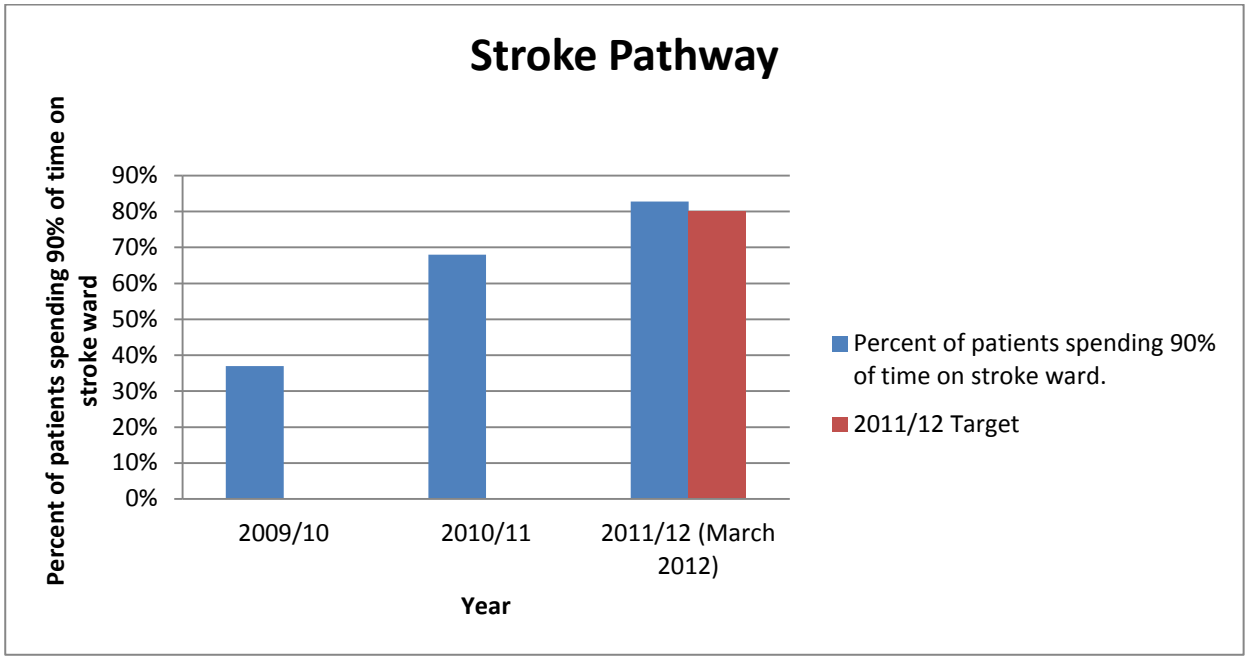
Clinical coding error rate

Payment by results – TBC

4.8 External Assurance and Performance Indicators

Domain	Indicator	Standard	Actual Performance 2011/12 To be validated	Achieved/ Not Achieved
Safety	C Difficile infections	*SHA =40*	38	✓
	MRSA bacteraemia infections	*SHA =0*	1	✓
Quality	Cancer 2 weeks - suspected	*93%*	95.90%	✓
	Cancer 2 weeks - symptomatic breast	*93%*	96.30%	✓
	Cancer 31 days	*96%*	99.40%	✓
	Cancer 31 days - drug	*98%*	100.00%	✓
	Cancer 31 days - surgery	*94%*	98.30%	✓
	Cancer 62 days	*85%*	85.40%	✓
	Cancer 62 days - from screening service	*90%*	97.60%	✓
	A&E 4 hrs	*95%*	95.76%	✓
	Stroke - CT < 24 hours	*100%*	99.38%	
	Stroke - time on stroke ward	*80%*	83.54%	✓
Patient experience	Refer to Treat waits 95th percentile - admitted	*23 wks*	22 weeks	✓
	Refer to Treat waits 95th percentile - non-admitted	*18.3 wks*	16.1	
	National & Local Patient survey results Inpatient survey	*>10/11*		
	Mixed sex accommodation breaches	*0*	5	✗
Patient Safety	Never events	*0*	4	✗
	VTE	*90%*	92.94%	✓
	Patient Falls		561	

Graph below shows the trust's compliance with Stroke pathway



Indicator Smoking Cessation During Pregnancy	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12	2011/12 Actual
Smoking at booking stage*	n/a		n/a	XX%
Number of Women referred to smoking cessation advice	100%	100%	100%	XX%.
Number of Women smoking at delivery	<1% per year	12.5%	<1% per year	XX%

*It is important to have the number smoking at booking as well as number smoking at delivery, as the 1% reduction should be from the eligible smoking population, so is included in this data. It should be noted that smoking at booking is outside our control (and more prevalent in the case of first pregnancies).

Indicator	Trajectory 2010/11	2010/11 Actual	Trajectory 2011/12	2011/12 Actual
Identifying deteriorating patients (% of deteriorating patients are identified in a timely manner and action taken)	100%	89.3% (mean)	100%	96.42%

Appendix B – Statements from stakeholders
Appendix C – Amendments

Appendix C - Glossary

Acute Care: Medical or surgical treatment usually provided in a district general hospital (also called an acute hospital)

Arden Cluster - is a management arrangement which brings together the expertise of Coventry PCT and Warwickshire PCT to commission health services in Coventry and Warwickshire for a population of 909,762.

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: 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.

Delayed Transfer of Care - is defined as a patient who is medically fit and safe to be discharged. The latter describes a situation whereby a physiotherapist assesses the patient as being able to mobile independently or supported with specific adaptations/equipment.

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.

Equality & Diversity Council (EDC)

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

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.

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

- **Moderate -** an incident resulting in moderate medical attention e.g. sutures, staff injury sustained at work resulting in more than 3 lost days from work or disruption to services, actual damage to property: Examples: - Recurrent slips, trips and falls, injuries needing treatment such as sprains, strains and burns, damage to property, with obvious cost implications to the Trust, verbal aggression, physical violence, or intimidation, incident resulting in fire brigade attendance, clinic treatment or surgical cancellations.
- **Severe -** any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. For example these could be incidents that occur within the Trust or on one of the Primary care services managed by the Trust that result in serious injury, long bone / skull fractures, loss of multiple services in an area, loss of sight or a fatality

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.

Methicillin-Susceptible Staphylococcus Aureus (MSSA) &

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

MSSA Bacteremia - Meticillin-sensitive Staphylococcus aureus (MSSA) is a strain of the bacteria (germ) staphylococcus aureus. It is commonly found on human skin and mucosa (lining of mouth, nose etc). The bacteria lives completely harmlessly on the skin and in the nose of about one third of normal health people. This is called colonisation or carriage. *Staphylococcus aureus* causes abscesses, boils and it can infect wounds - both accidental wounds such as grazes and deliberate wounds such as those made when inserting an intravenous drip or during surgery. These are called local infections. It may then spread further into the body and cause serious infections such as bacteraemia (blood poisoning). [Health Protection Agency, 2009].

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

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

- Delivering for today
- Building for the future
- Supporting staff

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.

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

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

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.

Definitions

"Avoidable" pressure ulcer means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

An **Unavoidable Pressure Ulcer**: “Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person’s clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence”.

An **Unstageable Pressure Ulcer** is one that when first presented the grade cannot be determined against the grades 1-4, but continues to be monitored whilst the patient is in hospital care until a point in time when it can be graded and reported accordingly.

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

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.

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.

Appendix D Quality Account Questionnaire Feedback form

We hope you have found this Quality Account interesting and helpful.

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

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

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

Email: pals@geh.nhs.uk

How useful did you find this report

Very Useful

Quite useful

Not very useful

Not useful at all

Did you find the contents

Too simplistic

About right

Too complicated

Is the presentation of data clearly labelled?

Yes, completely

Yes, to some extent

No

If no, what would have helped?

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

Comments

Item 2.2

Coventry and Warwickshire Partnership Trust

Coventry and Warwickshire Partnership NHS Trust

Quality Account 2011/12

CONTENT

Statement on Quality from the Chief Executive

Narrative to be included once all data/information in place.

The Trust Board is confident that this account presents an accurate reflection of quality across Coventry and Warwickshire Partnership Trust and confirm to the best of my knowledge that the information contained within this Quality Account is accurate.

Introduction to Coventry and Warwickshire Partnership Trust's (CWPT) Quality Account

This Quality Account covers the period 1st April 2011 to 31st March 2012 and looks at how we have performed against the targets we set in last years Quality Account. In addition, the account looks at other measures of quality and safety as well as setting our quality priorities for the coming year.

1. Progress against 2011/12 Priorities for Quality Improvement

Our 2010/11 Account detailed a number of priorities under three quality improvement headings; patient safety, clinical effectiveness and patient and staff experience which were based on the CQUIN framework which is designed to promote quality improvement by linking a proportion of the Trust's income to the delivery of agreed quality goals. The content of local schemes is agreed between the Trust and its PCT Commissioners prior to the start of the financial year, and may include nationally-defined CQUIN indicators. The following table lists our CQUIN goals for 2011/12 and provides a summary of achievement.

1.1. Progress against priority 1 – Patient Safety

Priority - To support the national initiative to reduce the number of suicides

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
Demonstrate full compliance with the NPSA 'Preventing Suicide Toolkit' in inpatient mental health settings that provide services to working age adults.	Two audits were carried out, one in April 2011 and another in March 2012, using the NPSA Preventing Suicide Toolkit. The second (follow-up) audit demonstrated the required improvements in all standards contained within the Toolkit, with over 70% compliance in all areas.	 Target Met

Priority – To promote safe, rational and cost effective prescribing within mental health – a co-ordinated approach between primary and secondary care

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
Devise a Coventry and Warwickshire wide Preferred Prescribing List (PPL) covering the main mental health drugs used within primary and secondary care.	The Trust has developed a Preferred Prescribing List which was agreed with GP leads and the PCT. The list has been promoted internally to prescribers and refined in-year in consultation with primary and secondary care. Target levels of prescribing have been set for the most expensive drugs.	 Target Met
Devise joint primary and secondary care prescribing guidance on prescribing of antipsychotics and antidepressants.	Prescribing guidance for anti-depressants and anti-psychotics was drawn up. Following consultation with primary and secondary care prescribers, formal approval to the guidance was given by the Area Prescribing Committee in January, three months ahead of schedule.	 Target Met
Produce standard cost charts of medicines costs (e.g. per treatment course or month) for the top 10 class of drugs used within the Trust, to inform prescribing practices.	Prescribing cost charts have been produced and distributed to a wide range of stakeholders using multiple methods and media.	 Target Met
Issue benchmarked prescribing information to teams and clinical areas. The Trust will support distribution and discussion of relevant primary care mental health prescribing indicators.	Information on a range of key prescribing indicators has been collected and distributed across the main therapy areas in mental health services. Reports have been reviewed and refined during the year in response to feedback from stakeholders.	 Target Met

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
The Trust should devise and implement guidance, to be used by CWPT prescribers, requiring justification of use of escitalopram and pregabalin.	The rationale for prescribing escitalopram and pregabalin was drawn up and clarified in consultation with prescribers. The Medicines Management Team will continue to review inpatient prescriptions and make recommendations at the point of prescribing to ensure the most appropriate treatment options are considered.	Status to be confirmed

1.2 Progress against priority 2 – Clinical Effectiveness

Priority – To improve the transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) for service users.

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
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. 75% transfers involve CAMHS/AMS handover with Robust Care Plan / monitoring of the numbers of children who are 16 and 17 accessing CAMHS services	The Trust developed and implemented a Transitions Policy, which included details of the processes to be used for handover between children's and adult mental health services. The policy was rolled out with training for all relevant staff. Data collected throughout the year demonstrated that robust handovers had taken place in over 75% of transition cases. Work continues to embed and monitor care planning for young people moving to adult services.	 Target Met

Priority - To develop a health economy wide Eating Disorder pathway

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
To create a health economy Eating Disorder pathway which starts with an appropriate triage and moves through to offer a range of community based, therapeutic interventions, both individual and group based, which are predicated on ensuring individuals will not need an in-patient bed.	A review of the current Eating Disorder services within Coventry and Warwickshire has been undertaken, to support a move towards full implementation of a revised pathway.	 Target Met

Priority - Implementation of Case Management for out of area placements

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
To develop clear assessment, reviewing criteria and case management for all out of area clients with clearly established review periods.	A dedicated Clinical Review Team for Out of Area placements was established. The team are responsible for assessing individuals and managing their repatriation. The reviewing criteria have been formalised as a Review Assessment Framework. A full governance structure is in place to provide assurances on changes to patterns of care.	 Target Met

Priority - Development and delivery of a clinical supervision programme for the Health Visiting Service

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
To develop a clinical supervision programme for the health visiting service to ensure safe, competent practitioners and supporting the workforce to deliver the Healthy Child Programme.	A clinical supervision programme was devised and delivered to Health Visiting staff . Supervision sessions were carried out throughout the year by a Clinical Psychologist with a team of Consultant Supervisors, all with a background in Health Visiting.	 Target Met

Priority - The delivery of Healthy Child Programme using an agreed Family Assessment Tool

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
To develop and pilot the use of a Family Assessment Tool within the Health Visiting Service.	The finalised Family Assessment Tool was produced and agreed with Commissioners and was well received within the service. The tool was piloted and introduced across the service in-year.	Status to be confirmed

Priority - The delivery of the Healthy Child Programme within 3 Children's Centre's

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
Health Visitors will lead on the development and delivery of the 0-5 years Healthy Child Programme through action plans targeted at 3 of the most needy Children's Centres in Coventry.	The health needs in each of the three areas were identified using evidence from health informatics. Joint discussion with partners resulted in the creation of jointly agreed action plans. All service improvements were delivered to agreed timescales.	 Target Met

Priority - Review of case managed patients who attend or are admitted to hospital due to an exacerbation of their long term condition

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
Roll out a mini Root Cause Analysis (RCA) process for all 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.	An RCA process was agreed and rolled out across the relevant services. Reviews of completed RCAs were conducted during the year and evidence of actions taken and lessons learned has been shared with Commissioners.	 Target Met

Priority - Co-ordination/integration of all clinical care interventions to support avoidance of admissions

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
All long term condition patients known to the Trust will have an integrated care plan for all nursing and therapy services. Patient plans are to be contained in one file and updates contemporaneously written in continuation notes.	Preliminary work identified a cohort of patients who were required to have an integrated care plan. A trajectory was agreed for the numbers of patients from the cohort who would be transferred to the new care plan each quarter. All of the quarterly targets were achieved.	 Target Met

Priority - Improve integrated work within primary care

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
Establish multi-disciplinary meetings between key worker (community matron / care co-ordinator) and GP / primary care clinician for patients with long term conditions.	Each GP practice was offered a visit to agree the preferred methods of communication and these arrangements were implemented by the teams. Heads of Terms documents detailing the names of the nurses linked to each practice and the agreed form of communication were issued. By these means, reviews of care of patients with long term conditions have been facilitated.	 Target Met

1.3 Progress against priority 3 – Patient and Staff Experience

Priority - Improvement in patient feedback to support the development of the delivery of care and treatment

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
Two questionnaire-based audits (one baseline and one follow up) to be carried out twice across the two main settings for the delivery of MH services (community and hospital based). Provide the baseline and follow-up audit findings, descriptive data and any common themes identified. Evidence to be supplied that the findings have been used in planning service quality improvements (e.g. via local care forums) and reported to the Trust Board and PCT.	Comparisons between the baseline and follow-up surveys showed that the Trust achieved improvements in all of the issues surveyed. Focus groups have been used to further explore the detail of patient responses. Action plans have been implemented to bring about service changes for the benefit of both inpatient and community clients. Findings have been shared both internally and externally.	 Target Met

Priority - Delivery of an enhanced 6-8 week development review service

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
To pilot an enhanced Healthy Child Programme 6-8 week developmental assessment through a home visiting programme.	An enhanced programme was introduced which provided a combination of home and clinic visits Evidence provided by regular audit demonstrated that the introduction of the new pathway resulted in significant reduction in the rates of clients who did not attend appointments.	 Target Met

Priority - Development and delivery of the maternal mental health pathway

Description of indicator (what we agreed to do)	Summary of Achievement (What we did)	Final Outcome (Did we meet the target?)
Pilot within a nominated area the maternal mental health pathway and achieve 95% compliance by year end.	The maternal mental health pathway was piloted and an evaluation carried out. The pilot was rolled –out to other Health Visiting teams in-year.	Status to be confirmed

2. Review of quality performance and assurance in 2011/12

2.1 Patient Safety

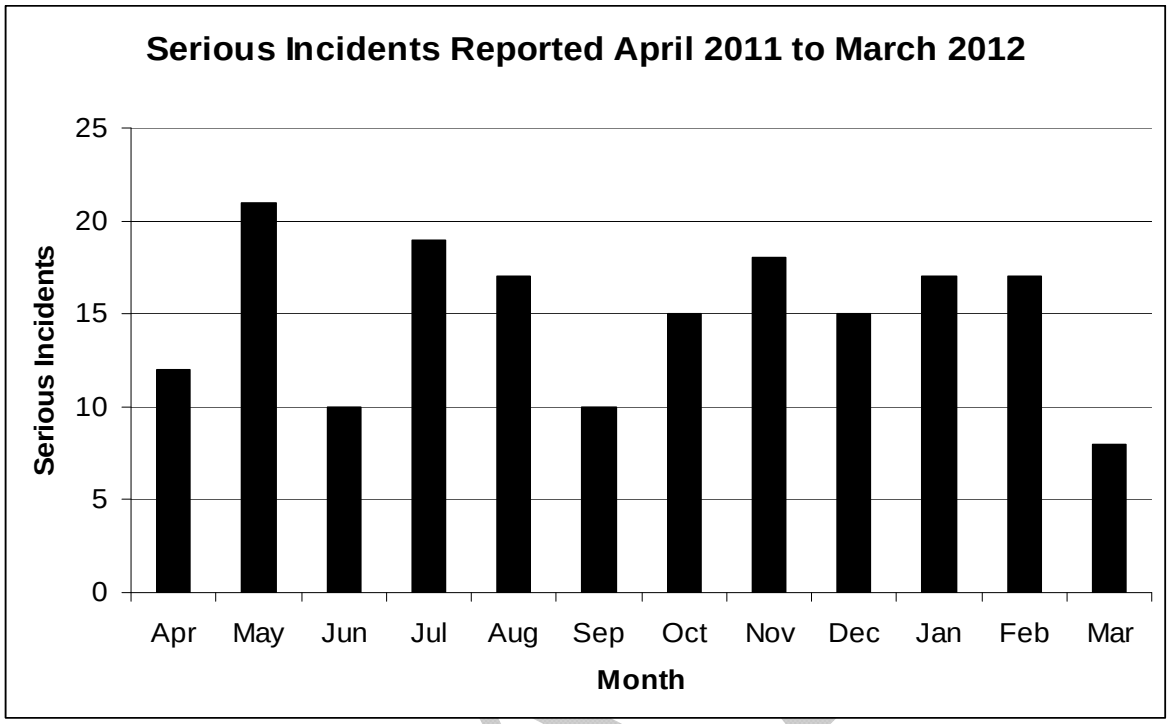
CWPT seeks to be a learning organisation and we have processes in place to report and manage incidents in line with national requirements and these have been reviewed and approved by our commissioners.

Our annual staff survey for 2011 showed that 98% of staff who responded had reported an error, near miss or incident within the last month. The survey also showed the view of staff regarding the fairness and effectiveness of incident reporting procedures had also improved.

Incidents which meet the definition of a Serious Incident Requiring Investigation (SIRI) as set out in the National Patient Safety Agency (NPSA) National Framework

for the Reporting and Learning from Serious Incidents Requiring Investigation (2010) are regularly reviewed to identify improvements.

Table 1 Serious Incidents reported by month April 2011 to March 2012



All SIRIs are reviewed by an Investigating Officer who is independent to the area where the incident occurred. In line with national good practice, the Investigating Officer uses Root Cause Analysis techniques to identify where systems and processes could be improved and any actions required to remedy these. Reports from each investigation are approved at the regular Serious Incident Group (SIG), made up of senior members of the Governance team and operational representatives. Once approved, the outcomes of investigations are fed back to families and to staff and copies provided to the Trust's commissioners, who assess the adequacy of each report. During 2011/2 the Trust maintained 100% compliance with the national requirement to complete SIRI investigations in 45 working days.

If a review identifies action is required this action is made the responsibility of specific individuals. Implementation of the action is monitored within each directorate and is overseen by SIG. During 2011-12 systems have been further improved to provide an update report to each meeting of the Safety and Quality Committee to detail actions identified as a result of investigations and the status of each action. This ensures a high level of transparency of work to follow up incidents.

We have also introduced a monthly learning alert which is cascaded to all staff via our Core Brief meeting process. This raises awareness around the number and type of incidents reported each month and includes details of learning from incidents which are relevant to staff who were not involved in the original incident. This will be expanded during 2012-13 to include learning from complaints. During 2012-13 it is also planned to develop the Trust's patient safety web portal so staff have more access to information about learning from incidents.

Examples of lessons learned and agreed action are set out in the table below.

Issue	Action
A patient recently transferred from a PICU failed to return from their first period of unescorted leave. On review staff confirmed that escorted leave had been trialled prior to unescorted leave, however this was not confirmed by the records.	Systems changed to ensure staff document the outcome of all leave in the notes in line with section 4.7 of s17 Leave policy
Patients at risk of pressure ulcers refused to comply with district nurse instructions to help prevent a pressure ulcer developing but this advice was not documented in the notes	Work with staff to ensure they documented that that they had explained the risks/consequences of non-compliance and to ask the patient to sign the care plan to show this has been discussed and agreed
A number of incidents occurred where the patient was receiving care from both IAPT primary care services and secondary mental health services	Work to ensure good communication pathways between these services undertaken
A patient was referred by their GP to mental health services but failed to attend appointments and was discharged in line with the Non-attendance (DNA) Policy	Policy to be amended to clarify how staff should try to ensure the attendance of a new patient, taking into account the level of risk.
Grade 1 pressure ulcers were identified by staff and then covered with dressings, contrary to good practice.	Issue fed into community-wide pressure ulcer study day and learning alert.

2.2 West Midlands Quality Themed Review

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

CWPT, in conjunction with the local heath economy was evaluated by WMQRS over a seven day period. The review of Coventry and Warwickshire health economy covered Coventry and Warwickshire and, for health services for people with learning disabilities, Solihull. The visit identified several areas of excellent practice and some areas where further work was needed. Across the health economy there were good working relationships and good insight into the issues which needed to be addressed.

The conclusions from the report showed that reviewers were particularly impressed by the Coventry and Warwickshire Partnership NHS Trust approach to care planning, with a good policy, training and a pilot of hand-held electronic recording. A robust approach to medicines management was in place, especially on in-patient wards. Good use was made of quality dashboards which covered all CQUINS, infection control, NICE implementation, safety metrics, medication errors, violence to patients and staff, and slips trips and falls. There was also a monthly matron's quality report which was well-publicised in clinical areas. Very active use was being made of the 'productive series'.

Reviewers were impressed by many aspects of Early Intervention services across Coventry and Warwickshire and by the way in which these services were working together. It was also noted that In-patient services at the Caludon Centre, Coventry and St Michael's, Warwick were both welcoming and provided a good environment for in-patient care. Reviewers saw several examples of good practice, including the work of the discharge liaison nurses and the training programme for Health Care Assistants.

The report also found that the Crisis Resolution / Home Treatment teams for working age adults were aware of the challenges they faced and were working together to

tackle these. A good range of alternatives to admission was available. The service was still working on agreeing staff training, clinical guidelines, including for medical review of patients.

In addition, it was reported that Assertive outreach services were working well and working hard to ensure that service users were not admitted to hospital unnecessarily. Services users were very positive about the care they received although the amount of Psychology input was considered low in the Coventry team.

We provide a wide range of services for older people with mental health problems and the reviewers were impressed by several aspects of the services offered but were concerned about the lack of data collection. Further work was suggested on reducing fragmentation of the patient pathway, arrangements for CT scanning and reducing reliance on institution-based care.

The reviewers found that Community teams for people with learning disabilities and the Gosford in-patient unit provided a generally high standard of care with several examples of good practice and health facilitation and work with general practices were particularly strong. It was noted that the Community teams were in a process of transition and whilst the four teams worked very differently they were moving towards a single point of entry in each locality. It was also noted that work on care clusters and service re-design was also taking place.

In addition a number of learning points and suggestions for improvement were identified by the reviewing team from which we developed and have progressed the following action plans

Learning Point/Suggestion for Improvement	Action Taken
Mental health liaison services in acute Trusts were identified as a health economy concern. In South Warwickshire there was no acute liaison service and, in practice, across the health economy there was no out of hours service for people aged over 65	The Arden Cluster (commissioner) has developed, in conjunction with hospital provider services a health economy wide action plan for ongoing management of the Hospital Liaison arrangements.

as crisis teams were only commissioned to provide care for adults of working age	
Inconsistencies in the way community mental health teams worked across Coventry and Warwickshire were identified.	Community Mental Health teams have been undergoing a staged change of model which has include, combining a number of teams, locating the teams on one site and a review of the current management model to improve consistency.
Review arrangements for management of Deprivation of Liberty Safeguards.	Joint review with Social Services completed and strengthening of current arrangements undertaken.
IAPT services were available across Coventry and Warwickshire and reviewers were impressed by the range of initiatives targeted at different groups within the community and the group feedback at the end of each session. Concerns were raised about the low proportion of appropriate referrals, long waiting times and relatively low recovery rates.	summary to be confirmed

2.3 PALs, Complaints, and Compliments

Patient feedback

Putting people at the heart of everything we do, and working with them as Equal Partners, will ensure that we develop quality services, based around people's individual needs and aspirations, valuing the contributions they can make. Equal Partnerships will ensure that every voice is heard, individual choice and wellbeing is promoted, and people are enabled to have the best possible experience of our service.

When patients or carers contact us with concerns about our services we aim to resolve these as soon and as close to source as possible. Where it is not possible for staff to resolve the issues immediately further advice and assistance is available from the Customer Services Department which incorporated the Patient Advice and Liaison Service (PALS) and Complaints.

PALS provide advice, information and support to patients and carers to help to resolve issues. This may take the form of signposting to other services, providing information for example how to access services, or supporting someone in a ward round, outpatient appointment or case conference to assist them in getting their views heard. PALS often provide a speedy resolution to an issue or concern and for many provides a better option than making a formal complaint.

During 2011-12 PALS had 336 contacts. These are broken down by reason for contact, by service and by outcome in the tables below.

Reason for Contact	No of Contacts (n336)
Rights	84
Information	55
Nursing Care And Treatment	48
Staff Attitude	29
Admission/Discharge	28
Communication	26
Waiting Lists	18
Domestic (Cleanliness/Food)	14
Medical Care (Doctor)	14
Change Of Consultant/2nd Opinion	10
Other Agency	7
Unknown	3

Contacts by Service	No of Contacts (n336)
Mental Health	207

Other (including Community Health)	110
Unknown	19

Outcome of Contacts	No of Contacts (n336)
Resolved	250
Abandoned by Contact	32
Unknown	20
Referred To Complaints	15
Ongoing	6
Referred To Other Agencies	5
Resolved Not Happy	4
Closed	3
Formal Complaint to be Raised	1

Complaints

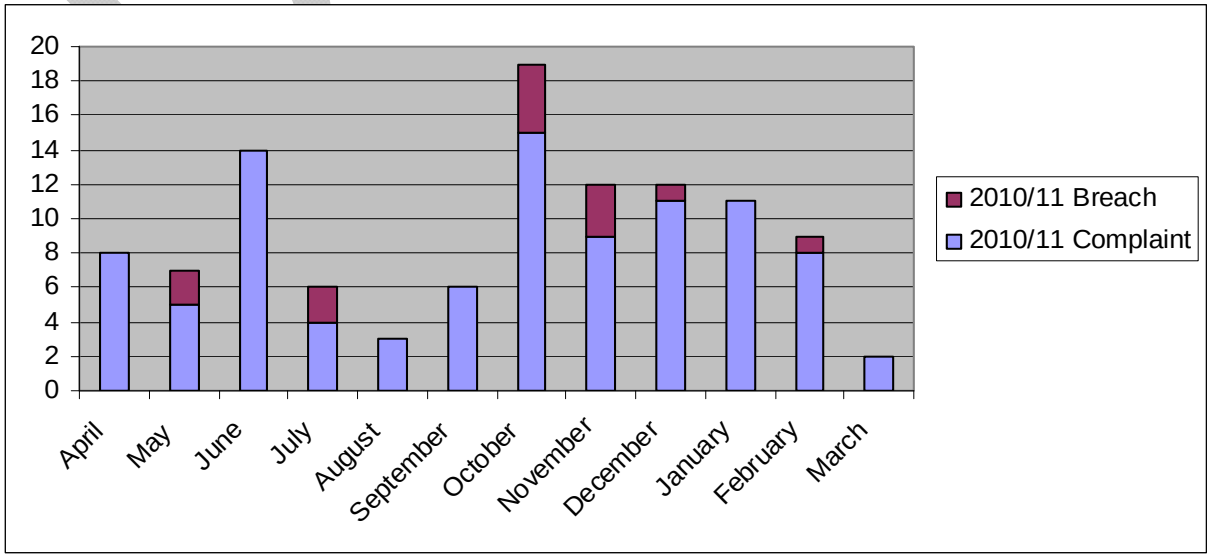
The Trust tries to address complaints in a fair, open and transparent way; admitting we were wrong, when fault is found and taking action to put it right across the whole organisation so that lessons are both learned and shared.

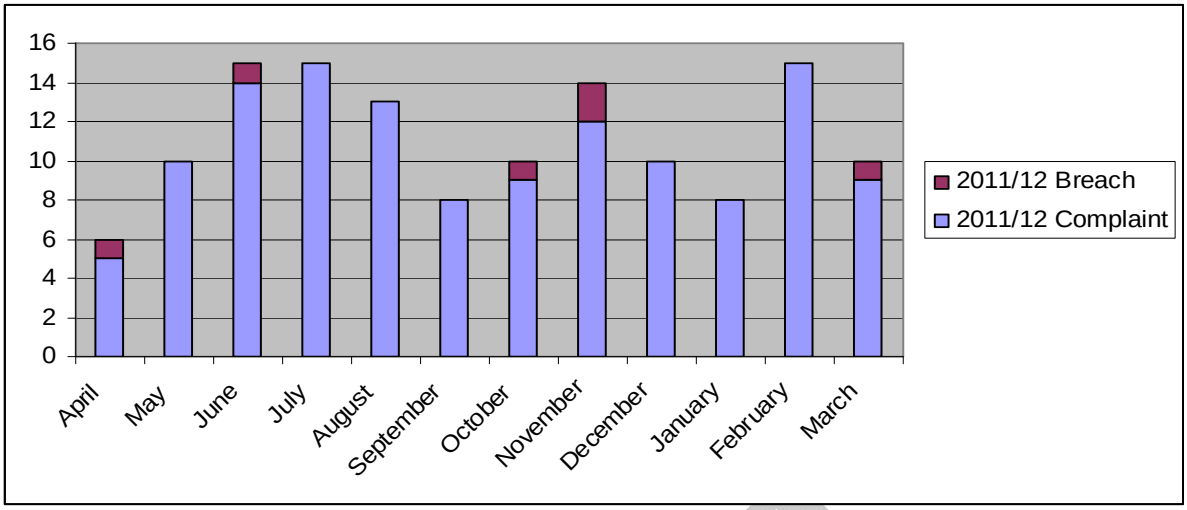
The merger of Coventry Community Health Services (CCHS) with the Trust In April 2011 affects the direct comparison of complaints data across the two years. The table below provides a comparison of Trust complaint data for 2010/11 and 2011/12 but also identifies CCHS data and mental health / learning disability (MH/LD) data separately so that a direct comparison can be made for 2011/12 MH/LD services with 2010/11.

Reason for Complaint	2010/11	2011/12
Admissions/Transfers	8	3 (2 MH/LD and 1 CCHS)
Attitude of Staff	5	18 (11 MH/LD and 7 CCHS)
Cancellation of appointments	1	0
Clients Rights	28	43

		(35 MH/LD and 8 CCHS)
Communications	14	10 (10 MH/LD)
Confidentiality	4	0
Change of Consultant	2	0
Information		1 (1 MH/LD)
Medical Care from Doctor	17	18 (13 MH/LD and 5 CCHS)
Nursing Care	9	20 (9 MH/LD and (11 CCHS)
Other direct Care ie CPN	7	7 (7 MH/LD)
Waiting times	1	7 (7 MH/LD)
CWPT Totals	**96**	**127**

It is important that complaints are investigated and responded to in a timely manner. The first graph below shows the number of complaints received and number not responded to within the time scale for 2010/11 and the second graph compares the number of complaints received and number not responded to within the time scale for 2011/12.





The Trust's complaint arrangements incorporate the key principles outlined by the Parliamentary Health Ombudsman from ensuring that complainants are informed about how their complaint will be dealt with to the identification of where improvements to services need to be made as a result of the issues raised by complainants. Each complaint is reviewed and responded to by the Chief Executive and reported to the Trust Chair. In addition Trust Board members lead in-depth reviews of a sample of complaints to independently assure the Board that the appropriate response and actions have been taken.

At the end of each complaint complainants are invited to feedback on how their complaint was handled. Any recommendations made as a result of the complaint investigation are actioned by the service involved and this is reported to General Managers to ensure that lessons are learnt and disseminated across services. We are currently working to strengthen the reporting of progress and completion of actions undertaken by services as a result of complaints through the governance structure to Trust Board in order to provide additional assurance.

Compliments

During the course of the year individual members of staff, teams and services receive many compliments form patients wishing to say thank you fro the way in which they or their loved one's have been cared for and treated.

Where complainants have a formal process to follow, those who compliment tend to do it informally by sending a letter or card, or verbally and collecting this data across

the Trust is much harder to do. Staff are encouraged to send evidence of compliments to the customer Services department so that this can be reported but we know that the data is far from complete.

The table below shows the number of compliments received by CWPT compared to the last 2 years.

Compliments		
2009/10	2010/11	2011/12
73	151	177

2.4 Patient Experience

In addition to local service patient experience surveys, CWPT are required to undertake the annual Care Quality Commissions (CQC) Community Mental Health survey. The results from the 2011 survey have been reported to and discussed at the Safety and Quality Committee, the Safety and Quality Operational Committee and at the Equal Partners Committee.

There were a number of positive areas reported in the survey. Service users told us that:

- They could easily contact their care co-ordinators
- Care co-ordinators organise their care well
- Services are good at helping people achieve their goals

There were also a number of areas for improvement highlighted by service users who said they needed to:

- Know more about their medication – purposes, side effects, easy to understand information and progress
- Know who their service users care co-ordinator or lead professional is
- Understanding their care plan
- Have at least one review in the last 12 months, and to be aware that they can bring a friend or advocate with them
- Know of an out of hours contact number

- Have support with physical health and care responsibilities

Action plans have been developed and implemented to address each of the areas for improvements and include for example the introduction of contact cards to ensure that all service users are provided with arrangements for contacting the service out of hours and this is further supported by the addition of Helpline Posters in all waiting rooms.

The 2012 CQC Community Mental Health survey is currently being undertaken and in addition we have also chosen to undertake the CQC Inpatient Survey in 2012.

During 2011/12, we also undertook patient experience surveys for the Patient Experience CQUIN, in inpatient and community mental health and in Community health services. An initial baseline survey was undertaken followed by improvement activity. The survey was then repeated to verify that patient experience had improved.

INPATIENT MENTAL HEALTH SERVICES	Baseline Survey	Follow Up Survey	Improvement Demonstrated
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?	52%	70%	18%
You should be given enough time to discuss your condition with healthcare professionals.	79%	80%	1%
The purpose and side effects of medications should be explained to you.	56%	68%	12%
Hospital staff should take your family or home situation into account when planning your discharge from hospital.	78%	95%	17%
Sufficient activities should be available for you to do during your stay.	54%	45%	-9%

% rounded up/down to whole numbers

Improvement actions undertaken by the inpatient mental health service between the baseline and follow up surveys included making information folders relating to antipsychotic medications available on all wards, the development and implementation of a hotel pack to give patients relevant information about the ward

on admission. In addition a carers pack has been developed and implemented and there has been a further review and development of provision of activities, with the introduction of an Activities Co-ordinator in St Michaels

COMMUNITY MENTAL HEALTH SERVICES	Baseline Survey	Follow Up Survey	Improvement Demonstrated
You should be told about possible side effects when a new medication is prescribed for you.	67%	79%	12%
You should be given a written or printed copy of your care plan.	59%	84%	27%
Your views should be taken into account when deciding what is in your care plan	84%	95%	11%
Whether you need to continue using mental health services should be discussed with you.	73%	74%	1%
You should be given the number of someone from your local NHS Mental health Service that you can phone out of office hours.	83%	100%	17%

% rounded up/down to whole numbers

Improvement actions taken by Community Mental Health Services between the baseline and follow up surveys include the development of a Care Plan folder which is issued to clients by the Care Co-ordinator. The folder contains a printed copy of the care plan together with other useful information such as PALS, Medicine's Management flyers etc. In addition contact cards have been introduced which detail the name of the clients Care Co-ordinator and out-of-hours contact details.

COMMUNITY HEALTH SERVICES (Tissue Viability, Continence, Diabetes, Children's Services and Rehabilitation Team)	Baseline Survey	Follow Up Survey	Improvement Demonstrated
Have you been involved as much as you wanted to be in decisions about your care and treatment?	91%	97%	6%
Were you given enough time to discuss your condition with healthcare professionals?.	90%	97%	7%
Did staff clearly explain the purpose of any medication and side effects in a way that you could understand	87%	98%	11%
Did you know what number/ who to contact if you needed support out of hours (after 5pm)	61%	96%	35%
Overall are you satisfied with the personal care and treatment you have received fro community services?	92%	98%	6%

% rounded up/down to whole numbers

The improvement actions taken by Community Health services between the baseline and follow up surveys have included strengthening communication methods with users and carers where they have told us areas for improvement i.e. the development of patient leaflets including information on medication and what to do if there are problems out of hours which are included in every patient information folder. There has also been increased involvement of users in care planning.

Services have also been proactive in providing feedback to all users and carers changes that have happened as a result of their comments made and this has been implemented using "You said …..We did…" posters and patient news letters.

2.5 NHLSA

The NHS Litigation Authority (NHSLA) is a Special Health Authority that handles negligence claims made against NHS organisations and works to improve risk management practices in the NHS.

The NHSLA has produced risk management standards for NHS organisations providing acute, community or mental health & learning disability services and non-NHS providers of NHS care. These standards have been designed to address organisational, clinical, and non-clinical or health and safety risks.

NHS organisations must demonstrate compliance with the standards and are assessed every two years. The Trust successfully achieved Level 1 accreditation in

its last assessment in March 2011. The 2012/13 Standards have been updated to incorporate the acquisition of Community Services, therefore work remains ongoing to ensure we maintain our Level 1 accreditation in our forthcoming assessment in March 2013.

2.6 Equal Partners Strategy

We have developed an Equal Partners Strategy which was agreed at Trust Board in June 2011 and is now leading to many accomplishments in ensuring people are able to get involved with the Trust, share their experiences and have more control over what happens in their lives.

The strategy provides a framework and action plan to build on existing good practice, and develop strong foundations and opportunities to improve all aspects of our engagement activity. It underpins our Vision, Values, Aims, and Strategic Objectives which include: working for the wellbeing of people; providing excellent care, supporting person centred outcomes, and partnership working.

5 key areas for development were identified in the strategy; Policies, People, Partners, Projects and Patient Experience and our achievements in 2011/12 include:

POLICIES
Development of a Volunteer Policy to ensure there is a consistent approach to the use of volunteers
Development of a database to capture both existing and planned user involvement and experience across the Trust and to support the recreation of successful activities..

PEOPLE
Raising awareness of involvement and engagement by presentation of the Equal Partners strategy at a number of events within Coventry and Warwickshire to raise which has resulted in an increase in the number of local survey, focus groups and involvement activity across services
A Patient Experience and Involvement Committee has been established to drive forward and monitor the 5 key areas for development identified within the Equal Partners Strategy. The committee has representation from a wide range of services and departments across the Trust.

We have developed a library of patient stories that are used both in staff training and to deliver key messages. Stories are provided in a variety of formats from written word through to delivery in person by users

PARTNERS
Following an issue raised by a number of service users, we have worked closely with Coventry LINks to look at and improve access to activities available to the adult patients on our wards.
We worked with Coventry and Warwickshire LINks to deliver a Quality event to inform and engage the local community in the development of this Quality Account as well as developing and shaping the Equal Partners Strategy.

PROJECTS
We are continuing to work with and increase the number of services who are engaging with collecting patient's stories and developing knowledge of how to use the stories to improve services
We are working with other services within the Trust to gain maximum promotion of the Equal Partners Strategy to community groups within Coventry and Warwickshire.
Service users and carers formed part of the assessment team for the Trusts annual Patient Environment Action Team (PEAT) assessments and both users and the organisation reporting benefits.
We are continuing to work to embed service user involvement in clinical research and wider research activities within the Trust and have made progress in the development of research advisory groups within specific services eg Early Intervention Services and plan to roll this model out to other services within the Trust

PATIENT EXPERIENCE
We review what patients tell us about their experiences of our services in both national and local surveys to highlight areas for improvement and to develop and implement improvement plans where required
From April 2012 that each Director of Operations will present to Board, results from surveys or patient stores relevant to their service areas to provide evidence of and assurance of change as a result of service user feedback.

2.7 Staff Survey

In 2007 the Department of Health in conjunction with Ipsos MORI, conducted a piece of research, referred to as 'What Matters to Staff in the NHS' , which looked to identify the major factors contributing to staff engagement and motivation to provide high quality patient care. This research led to the development of four pledges that sets out what the NHS expects from its staff and what staff can expect from the NHS as an employer.

The Annual NHS Staff Survey is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and contribute to local and national assessments of quality, safety, and to the delivery of the NHS Constitution. The Survey has 38 questions, the responses of which are used by the Department of Health to measure our performance against other mental health and learning disability trusts. The Information collected from the annual Staff Survey is also used to improve working conditions and practice, and to monitor against the pledges made to staff. Our results are also used by the Care Quality Commission as part of its ongoing monitoring of our registration compliance.

All staff within CWPT were invited to participate in the survey, of which 58.32% responded. This is a marked improvement on our 48% response rate for the 2010 staff survey.

Key Findings

The percentage of staff reporting errors, near misses or incidents witnessed in the last month was 98% which placed us in the best 20% of Trusts nationwide.

Whilst we were amongst the lowest 20% of Trusts for 11 issues an improvement has been seen in 9 of these since the previous 2010 survey. Of the remaining 2 issues, there was no change reported for the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. There was also a 4% decrease in the number of staff appraised with a personal development plan within the last 12 months.

Since 2010 we have improved on a further 11 key findings. These include the percentage of staff feeling satisfied with the quality of work and patient care they are

able to deliver and the quality of job design (i.e. clearer job content, feedback and staff involvement. There was also a positive reduction the number of staff reporting discrimination at work and an increase in the number of staff who would recommend the trust as a place to work or receive treatment

The Next steps

The findings from the survey will be presented to the Trusts Leadership Team and cascaded to all staff through our internal communication methods. Work is underway with General Managers and their teams to review the data relevant to their services and to assist with the development of action plans to address the key findings relevant to their area.

It is also proposed to contact other similar Trusts who have scored well in their key findings to share good practice to improve our results further. The Social Partnership Forum will take responsibility for monitoring and reviewing all the action plans as well as being asked to select two key findings from the bottom 20% of topics on which to focus attention and to develop action plans.

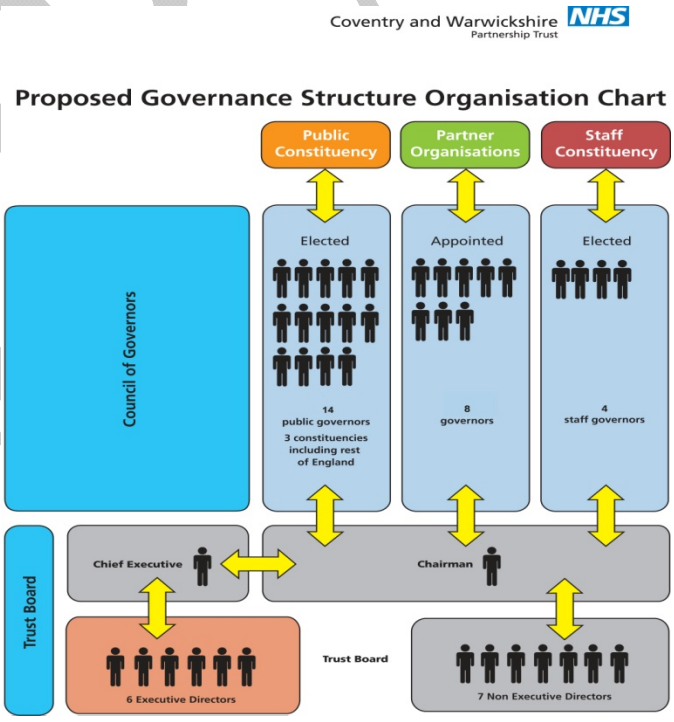
2.8 Foundation Trust Status

We have made significant progress with our FT application during the past year. We have now signed a Tripartite Formal Agreement with the Trust Board, Department of Health and Strategic Health Authority. This sets out the agreed timeline for our application and means that we are on track to become authorised/licensed by Monitor, the independent Regulator for Foundation Trusts, within 2012

The key milestones for our application are as follows and we are on track to deliver all requirements by these dates.

- Submit final Business Plan to SHA - June 2012
- Governor Election – Commences June 2012
- Monitor Assessment (up to four months) - August 2012
- Trust Board and Monitor Board - Board to Board Assessment – September 2012
- Authorisation as a Foundation Trust - Quarter 3 or 4 2012/13
- First Council of Governors meeting - Once approved as a Foundation Trust

One of the requirements to become a Foundation Trusts is that we have an active Council of Governors who will work alongside the Trust Board and who are drawn from and elected by members. The Council of Governors will become operational once the Trust is authorised/licensed as a foundation trust. We have undertaken and concluded a formal Foundation Trust Public Consultation and in response to the comments we received, we have amended our draft Constitution to increase the number of elected Governors to improve representation of patients and carers. Our agreed Governor Constitution is as follows:



We have successfully recruited approximately 13,179 members made up of 4,238 staff and 8,941 public members and have a comprehensive programme of events to ensure members voices are heard and they have opportunity to contribute to further developing the Trust. The election of our Governors will commence in June 2012.

Another key part of applying to become a Foundation trust was the requirement for a comprehensive business plan supported by an approved business model which describe how our business plans align with our Quality Goals and Quality priorities. We have produced and submitted our five year Integrated Business Plan and associated financial model to the Strategic Health Authority for their consideration prior to our formal submission to the Secretary of State, who will process our application during the summer.

As part of our formal application we have also been subject to significant independent review to provide assurance on our readiness to become a foundation Trust. To date we have received favourable reports from both the Strategic Health Authority on quality, safety and governance arrangements and from SHA appointed independent assessors who have completed two Due Diligence exercises to review our financial record, financial plans and financial governance arrangements for the future. In addition a further independent assessment of our Trust Board's capacity and capability to manage the Trust as a foundation Trust has taken place and they were assured that the Board can take full advantage of the freedoms that being a foundation trust provides for the benefit of our service users, carers and staff.

2.9 Patient Environment Action Team

All patients and service users have the right to expect to be cared for in clean, well maintained environments, with good quality food and where their privacy and dignity is respected.

The aim of the Patient Environment Action Team (PEAT) Assessments is to provide a view on the quality of non-clinical services we provide to both in-patients and other services users across our in-patient units where there are 10 beds or more. The assessment looks at:-

- Cleanliness including general cleanliness, toilet and bathroom cleanliness

- Condition and appearance of the general environment and toilet and bathroom areas including décor, tidiness, furnishing, floors and floor coverings and heating and ventilation facilities
- Additional services including lighting, waste management, linen, provision of suitable arrangements for personal possessions and odour control
- Access, way finding and information
- Food, , nutrition and hydration services
- Privacy and dignity

Scoring is on a scale of one to five where 1 = unacceptable and 5 = excellent and is based on the conditions at the time of the assessment. The assessment team is made up of a number of people including the Facilities Manager, infection control nursing, non executive directors and a patient/carer representative, and where possible the assessments take into account the views of patients and ward staff.

The table below compares 2011 scores to 2010 for all our areas which are required to have an assessment undertaken.

Site Name	Environment Score **2010**	Environment Score **2011**	Food Score **2010**	Food Score **2011**	Privacy & Dignity Score **2010**	Privacy & Dignity Score **2011**
The Manor Hospital	Good	Good	Good	Excellent	Excellent	Good
Hawkesbury Lodge, Longford	Good	Good	N/A*	N/A*	Excellent	Excellent
The Caludon Centre, Coventry	Good	Good	Excellent	Excellent	Excellent	Excellent
Harry Salt House, Coventry	Good	Good	N/A*	N/A*	Excellent	Excellent
St Michael's Hospital	Good	Good	Good	Good	Good	Good
Woodloes House, Warwick	Excellent	Excellent	Excellent	Excellent	Excellent	Excellent
Stratford Building 2, Loxley Building	Good	Good	Good	Excellent	Excellent	Excellent
Woodleigh Beeches Centre, Warwick	Good	Good	Excellent	Excellent	Excellent	Excellent
Brooklands Hospital (Janet Shaw Clinic)	Good	Good	Excellent	Excellent	Excellent	Excellent

N/A* - self catering units.

2.10 Elimination of Mixed Sex Accommodation

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are 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 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. Women only lounges are available, where appropriate, within our wards. Sharing with members of the opposite sex should only happen by exception based on clinical need, for example where patients need specialist observation and care, or when patients choose to share. If our care should fall short of the required standard, we will report it.

2.11 Quality in Nursing – Year 2

2011/12 was year 2 of the CWPT Nursing Strategy. Over the last 12 months our nurses have undertaken a wide variety of projects and initiatives focused on improving patient safety, service quality and user/carer experience. In relation to the national high impact actions we have set consistent standards across the Trust for unexpected weight loss, rolled out a new falls protocol that reflects best practice and instigated several initiatives to meet the challenge of eliminating avoidable pressure ulcers. Alongside this, the Modified Early Warning System used to structure the monitoring of physical health of patients, has been embedded in inpatient Mental Health services. Other achievements include significant investment in the emerging profession of Assistant Practitioners and the implementation of the Royal Collage of Psychiatrists Learning Disability Accreditation scheme at Brooklands, a scheme in which the Trust acted as a national pilot during its development.

Looking forward to next year some of our key goals relate to the Safety Thermometer. Whilst we are developing systems to ensure successful implementation of the national Safety Thermometer the Trust is also leading the national piloting of a version developed specifically for Mental Health and Learning Disabilities. A second work stream is the development of some quality bench marks

linked to the MH & LD safety thermometer that bring together guidance and policy to provide structure for a detailed review of practice where necessary.

2.12 Quality Priorities Framework and 5 year plan

CWPT has a Quality Priorities Framework (approved August 2011) which works alongside our Risk Management Strategy (approved December 2010) to provide a cohesive infrastructure and programme of work which enables us to deliver against our safety and quality commitments.

Our Corporate Quality Goals are:

	Trust Quality Goal	Outcome
1	Delivering our Equal Partners Strategy	Years one and two of the Equal Partners Strategy will be successfully implemented.
2	Ensuring Protected Learning Time for our staff	All our staff will receive Protected Learning Time appropriate to their role.
3	Implementing Outcomes Frameworks for all service users	An Outcome Framework will be in place for all our operational services speciality areas.
4	Using Safety and Quality and Performance Dashboards from Board to Ward/Team	Safety and Quality and Performance Dashboards will be in place and used effectively in every ward/team.
5	Developing and implementing our Estates Strategy	A fit for purpose Estates Strategy will be in place and year one plans implemented.
6	Positive Staff Engagement	Positive staff engagement will be evidenced through a wide range of approaches.
7	The delivery of 'Value' based, user focussed services.	Successful use of value based approaches in our service integration and transformation programmes.
8	Effective Workforce Planning and Development	A workforce planning and development strategy will be in place and year one plans implemented.
9	Developing and implementing our IT Strategy	An IT Strategy will be in place and year one plans implemented.

Progress to be reported against.

2.13 Review of Performance

Management information on performance and contracting activity is reported on a number of organisational levels. Strategic reports are issued monthly to the Trust Board, providing a summary of performance against business-critical indicators and targets and highlighting key areas of success or concern. Trust-wide data is further subdivided at General Manager, operational, ward and team level, which facilitates the provision of relevant information to operational staff. In this way, managers are able focus on performance trends in their area of responsibility, in the context of the performance of the organisation as a whole.

The Trust is committed to the early identification of problems and instigation of corrective action to address performance failings. Equally, celebration of success is integral to rewarding staff for their efforts in delivering local and national priorities, as exemplified in the annual 'Q Award' Ceremonies and 'Thank You' cards for recognition of individual contributions.

Performance against key indicators of Safety and Quality, 2011/12

Indicator	2010/11	2011/12
Percentage of Level 1 SIRI's complying with 45 days closure	95%	100%
% of Level 2 SIRI's complying with 60 days closure	100%	100%
Number of formal complaints completed outside of the agreed timescale	18%	0
Information Governance Toolkit compliance	Met	Met
Average scores reported from monthly Cleanliness Audits	94%	97%
Average scores reported from monthly Hand Hygiene audits	96%	98%
Number of complaints about cleanliness of service areas	0	0
Compliance with Hygiene Codes	100%	100%

Narrative to be added

3. Statements of Assurance from the Trust Board

During 2011/12, CWPT provided NHS services. CWPT has reviewed all the data available to them on the quality of care in all the NHS services it provides.

The income generated by the NHS Services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by CWPT for 2011/12.

3.1 Participation in Clinical Audit

During 2011/12, 7 national clinical audits and 1 national confidential enquiry covered NHS services that CWPT provides. During that period, CWPT participated in 75% 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 CWPT was eligible to participate in and for which data collection was collected during 2011/12, are listed in the table below. 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 is also given.

Eligible audits / confidential enquiries applicable to CWPT	Eligible to participate	Participation in 2011/12?	% of cases submitted 2011/12	Reason for non-participation
Schizophrenia (National Schizophrenia Audit)	✓	✓	100%	
Childhood Epilepsy (Epilepsy 12)	✓	✓	100%	
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	✓	✓	79%	
11a Prescribing antipsychotics for people with dementia	✓	✓	100%	
6c Assessment of side effects of depot antipsychotic medication	✓	✓	100%	
7c Monitoring of patients prescribed lithium	✓	✘	NA	Local clinical audit undertaken.
10b Use of antipsychotic	✓	✘	NA	POMH membership had

medicine in CAMHS				expired during data collection period

Eligible Audits applicable to CWPT	Eligible to participate	Participation in 2011/12?	% of cases submitted 2011/12	Additional information
1f and 3f Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards and forensic wards	✓	✓	Unknown	The Royal College of Psychiatrists intend to include participation in 2012/13 data. However, CWPT have acknowledged participation in the Quality Account as data collection was submitted in March 2012. The report is expected in May 2012, therefore falling into 2011/12 and 2012/13 reporting.

The reports of 2 national clinical audits were reviewed by CWPT in 2011/12 and CWPT intends to take the following actions to improve the quality of healthcare provided.

National audit title	Description of actions following National audit
National audit of psychological therapies	Plans are in place to provide a more inclusive service which is representative of the local community. A review of waiting times will be undertaken. Performance indicators are consistently monitored and improving to ensure service users receive the minimum number of recommended sessions recommended by NICE. Development of a patient questionnaire to assess service users' experience of the service to aid further service development.

National audit title	Description of actions following National audit
National audit of falls and bone health	It was only appropriate to submit data to the organisational audit. The findings highlighted that the Trust had the appropriate structures, staffing, policies and procedures in place. To strengthen this, a system of monitoring adherence to the local Trust Policy has set up. A Falls Clinic has also been established.

The reports of 78 local clinical audits were reviewed by CWPT in 2011/12. The following have been selected as examples of how services have used clinical audit to improve the quality of care delivered.

Re-audit of Suicide Prevention

The Trust under the CQUIN scheme was required to demonstrate compliance with the National Patient Safety Agency 'Preventing Suicide Toolkit' in inpatient mental health settings that provide services to working age adults.

Following the clinical audit dual diagnosis training sessions have been put in place, providing staff with the skills and knowledge to identify and support patients with both mental health and substance misuse needs.

A discharge information pack has been developed which is given to patients on discharge to help their transition back into the community and to offer contact numbers and advice of where they can seek support.

To ensure carers are provided with the appropriate information and support a carer's information booklet and involvement plan have been developed and are in use.

Physical Health Monitoring of Patients Receiving Clozapine

This clinical audit was undertaken to evaluate current practice against NICE guidance.

To ensure regular and systematic monitoring of physical health throughout treatment

the Clozapine data monitoring sheet has been revised and is in use in clinic.

ECG machines and BMI calculators are now available in Clozapine Clinics and staff have been trained in their use.

Audit of Risk Assessments for Home Visits by Members of the Community Rehabilitation Team

This clinical audit was undertaken to evaluate the use of the newly introduced evidence based risk assessment form.

The findings highlighted that the form was not being completed in full and pathways were not being written into the care plans. The risk assessment form has been re-designed to simplify it and to make it more user friendly.

A re-audit of the new documentation following introduction is planned.

Sexual Health Advice Given to Looked-After Children (LAC)

The joint Trust and Council policy recommends that young people are given sexual health advice. Looked-after children are particularly vulnerable, especially those aged between 15 and 16.

Just under half of the looked-after children reviewed as part of this clinical audit were given advice by the Looked-after Children's Nurse or by a Paediatrician in the Looked-After Children's Clinic.

Working in conjunction with the Council, a sexual health advice pack has been created. This will be discussed with all children in this age range at their clinic appointment. The pack also includes a referral form to the Outreach Nurse should the need arise. The pack has been included in training given to medical staff and prospective foster parents.

3.2 Participation in Clinical Research

Narrative to be provided by CRMC regarding how many research projects have been agreed during the past 12 months; whether there has been an increase in the number of grant applications submitted and hosted by the Trust, and how many publications have resulted from our involvement in HISH research In addition, need to include where we have seen a positive improvement/change in any of the areas where research has occurred (ie what speciality, what was the research and what was the related improvement?)

By actively participating in clinical research, CWPT demonstrates its continuing commitment to testing and offering the latest medical treatments and techniques to improve the quality of care we provide and to make our contribution to wider health improvement. Participating in research ensures our clinical staff stays abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. There were XX clinical staff participating in research approved by the XX research ethics committee during 2010/11. These staff participated in research covering xx specialties.

MANDATORY STATEMENT - The number of patients receiving NHS services provided or sub-contracted by CWPT in 2011/12 that were recruited during this period to participate in research approved by the research ethics committee was XX. (CRMC to provide figure).

3.3 Commissioning for Quality and Innovation Schemes (CQUIN)

A proportion of CWPT income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between CWPT and any person or body they entered into a contract, agreement of arrangement with for the provision of NHS services, through the Commission for Quality and Innovation (CQUIN) payment framework.

Progress against CQUIN indicators is reported to Trust Board, the papers from which are publicly available on the Trust's website which can be found at http://www.covwarkpt.nhs.uk/TrustBoard.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available at :

http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

3.4 Care Quality Commission (CQC)

CWPT is required to register with the Care Quality Commission and its current registration is registered. CWPT are registered with no conditions. The Care Quality Commission has not taken enforcement action against CWPT during 2011/12.

CWPT has participated in the Special Review undertaken by the Care Quality Commission relating to In-patient Learning Disabilities during 2011/12. The CQC also completed 2 inspections as part of their routine schedule of planned reviews during 2011/12 and 1 inspection in response to concerns that had been raised.

CWPT intends to take the following action to address the conclusions or requirements reported by the CQC:-

- Strengthen monitoring mechanisms in relation to reviewing the documentation of care
- Introduction of therapeutic activity programmes for in-patients
- Introduction of additional user friendly / easy to read information and care plans for patients with Learning Disabilities
- Improving patient environments
- Introduction of standardised care records
- Introduction of additional clinical management tools to enhance the care provided.

CWPT has made the following progress by 31st March 2012 in taking such action

Action Required	Progress as of 31st March 2012
Strengthen monitoring mechanisms in relation to reviewing the documentation of care	A programme of regular audit has been implemented to review documentation and the results are reported and reviewed at Team meetings.
Introduction of therapeutic activity programmes for in-patients	A therapeutic timetable of activity has now been developed by Wards where the need was identified.
Introduction of additional user friendly / easy to read information and care	Speech and Language Therapy services have worked with units and ward areas

plans for patients with Learning Disabilities	to adapt care plans to be user friendly to promote patient involvement and understanding of their content.
Improving patient environments	A programme of environmental improvements has been developed in those areas where a need was identified which includes both internal and external areas.
Introduction of standardised care records	Care records have now been standardised and have been rolled out across the Trust.
Introduction of additional clinical management tools to enhance the care provided.	A Privacy and Dignity Care Plan, Exercise Risk Assessment tool and a 72 Hour Evaluation sheet have been developed and introduced.

Completed action plans have been submitted to the CQC and where any actions remain outstanding, services continue to work to deliver them and progress is regularly monitored by the Safety and Quality team.

3.5 Data Quality (HES Data upto February – March data not available until May)

Over the last year CWPT has reviewed some of the processes for data capture and quality and to take into account the introduction of new datasets. We are currently working on improving our current data quality on the system and have recently introduced new action plans to show the work needed for the new version of the dataset, as well as maintaining our work on current action plans. Last year we developed an action plan to improve our HES data quality which has also led to improvements in our Information Governance toolkit.

CWPT will be taking the following actions to improve quality. Over the next year our priority is to work on data quality within the datasets and returns that we submit externally, by looking at this level of data quality we will be working on improving performance within the datasets, improving accuracy, completeness and timeliness

of data on the systems which will then also improve clinical data to support client care.

Business units will continue to get a suite of data quality reports, called a data quality metrix to address data quality issues and we have reviewed where data quality is discussed and actions agreed and this is now part of the Business Rules Work Stream. We will have the opportunity at this meeting to discuss internal data quality reports, review benchmarking information on external data for us to understand how we perform against other Trusts and what we can do to improve this.

NHS Number and General Medical Practice Code Validity

CWPT submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. There percentage of records in the published data which included the patients valid NHS number was:

99.6% for admitted patient care;
100% for out patient care

The percentage of records in the published data which included the patients valid General Medical Practice code was:-

94.5% for admitted patient care;
99.9% for out patient care

3.6 Information Governance Toolkit

Information Governance is a priority for the Trust to ensure that information is kept confidential and secure. Furthermore Information Governance is underpinned by legal requirements and the Trust endeavours to ensure people's rights under both the Data Protection Act 1998 and the Freedom of Information Act 2000 are recognised, that the obligations as set out in these Acts are complied with and that the Trust ensures that information (about both staff and patients) is handled appropriately.

In terms of breaches of confidentiality or other information security breaches in 2011/12 the Trust had 3 breaches risk rated at level 1 or 2 in line with the Department of Health guidance. These were escalated to the Strategic Health Authority. Learning from such events has been fully implemented and the organisation is continually looking for ways of improving practice to reduce the likelihood of any such breaches in the future.

In the next 12 months the Trust will continue to further embed the six initiatives of Information Governance (as set out in the Information Governance toolkit) throughout the Trust and also aim to improve our Information Governance compliance score as assessed by the Information Governance toolkit

CWPT Information Governance Assessment Report score overall score for 2011/12 was 71% and was graded 'satisfactory' with all standards being at level 2 or above which means that we passed the assessment criteria.

3.7 Clinical Coding Error Rate

Payment by Results (PbR) is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. The two fundamental features of PbR are nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.

Equity and Excellence: Liberating the NHS commits organisations to introducing the mental health care clusters as the contract currency for 2012-13 with local prices. The Partnership has undertaken a significant amount of work so far on care clusters and continues to develop a system for operating in a PbR environment.

CWPT was not subject to the Payment by Results clinical audit coding during 2011/12 by the Audit Commission. Need to include reflection of cluster activity/work.

4. Priorities For Quality Improvement In 2012/13

CQUIN priorities for the new contract year were agreed through a process of negotiation involving the Trust, PCT and Specialist Commissioners and Clinical Commissioning Groups. Suggestions for quality improvement were taken from all stakeholders, and through open discussion, areas of commonality and shared priority were agreed. The priorities (covering Mental Health, Learning Disability and Coventry Community Health services) were sub-divided into three themes of Patient Safety, Clinical Effectiveness and Patient and Staff Experience. The rationale for inclusion of the priorities was based on links with national, regional and local quality improvement programmes, as well as local influences which included input from the new GP commissioning leads and a particular focus on integrated teams and services for frail elderly clients. The Trust has an established governance process for delivery of CQUIN work programmes which will be continued for 2012/13. Project teams will take forward specific actions and documentary evidence will be reported at regular intervals to demonstrate achievement against milestones, both internally and externally to Commissioners through Clinical Quality Review meetings.

4.1 Priority 1 – Patient Safety

Indicator	Description	Rationale	Intended outcome
Safety Thermometer	Improve the collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and Venous Thromboembolism (VTE).	National CQUIN designed to reduce harm by collection of data which will inform local improvement and health care planning.	Three consecutive quarterly submissions of monthly survey data for all relevant patients and settings using the NHS Safety Thermometer, uploaded to the NHS Information Centre.
Call to Action – the Empowered Workforce	Scope and implement a programme of individual and team development for Health Visitors to support the Call to Action recruitment plan.	To identify Coventry as an Employee of Choice and increase the numbers of Health Visitors joining the service, to provide the necessary additional healthcare support commensurate with the needs of the local population.	The majority of Health Visitors to participate in the development programme, alongside the development and implementation of an external marketing plan.
Integrated teams and Root Cause Analyses (RCAs)	A range of innovative integrated team working practices will be agreed for each cluster team. Mini-RCAs will be undertaken jointly by integrated teams for patients whose long term condition has contributed to an emergency admission. Communication across teams is to be optimised.	To reduce avoidable emergency admissions and Accident and Emergency attendances in this group of patients. To promote communication, validation of caseloads, sharing of responsibility and proactive approach to quality care across integrated teams.	Integrated teams are able to demonstrate that a quarterly RCA process has been implemented, actions and learning are being taken forward, and proactive liaison with general practice is in place.

4.2 Priority 2 – Clinical Effectiveness

Indicator	Description	Rationale	Intended outcome
Out of Area	To continue 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 to a care co-ordinator 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.
Psychiatric Liaison (MH)	Support the implementation of a comprehensive psychiatric liaison service. This is aimed at reducing the incidence of self-harm, reducing the waiting time for a mental health assessment, and reducing the length of hospital stay for dementia patients, in Acute provider settings.	This indicator forms part of a complementary set of CQUINs across the local health economy in response to regional and local priorities to deliver a co-ordinated approach to care for patients moving between acute Trusts and mental health services.	To establish an integrated Rapid Assessment Interface and Discharge team to co-ordinate care of appropriate patients; to carry out training for acute staff and evaluate outcomes against agreed targets, financial model and liaison service pathway.
Primary and Secondary Care communication (MH)	Improve communication and integrated working with primary care, developing protocols for shared care and shared prescribing and a support / training package for primary care.	The Trust is to support primary care to promote the need to recognise and provide timely and appropriate response to patients who suffer from a mental illness.	To pilot and develop the role of a Senior Relationship Manager across Integrated teams and Clinical Commissioning Groups; to develop a training programme to support general practice in the management of people with long term conditions, with an underpinning caseload

			data set for practices.
Case Management of Patients Identified through Risk Stratification	Develop and implement a case management approach which uses a predictive risk stratification tool, for patients on the community nursing caseload with a long term condition.	To reduce avoidable emergency admissions and Accident and Emergency attendances in this group of patients, and support the achievement of QIPP (Quality, Innovation, Productivity and Prevention) targets.	To develop and pilot the use of the risk stratification tool in three integrated teams, to evaluate the results and to work towards the city-wide roll-out of the approach.
Telehealth – Use of Simple Telehealth for COPD, diabetes and heart failure patients	Development and implementation of the Simple Telehealth approach for the remote monitoring of appropriate COPD, diabetes and heart failure patients.	There is evidence to suggest that this approach will improve productivity in community nursing teams, thus enabling high risk patients to be managed to avoid potential emergency admissions.	To identify and pilot the Simple Telehealth model across three integrated teams, culminating in a full evaluation report and with a view to city-wide roll out.

4.3 Priority 3 – Patient Experience

Indicator	Description	Rationale	Intended outcome
Patient Experience – Patient Revolution: collecting real time feedback and acting on what you hear (CS)	Development of real time and non-real time systems to monitor patient experience in specific areas of community services. This will include development of the net promoter methodology and collecting and acting upon patient stories.	'The Patient Revolution' is one of the 5 ambitions of NHS Midlands and East and responds to the need to drive improvements in patient and customer experience.	To demonstrate that real time systems are in place to capture patient experience, to establish methodologies to elicit patient stories, and provide evidence that patient feedback has influenced improvements to the services.

Patient Experience – dementia care	Use patient experience to inform the redesign of the dementia care pathway, including the integration with physical health services	The analysis of patient stories will identify areas for service development and improvement within dementia services, leading to redesign of the pathway that is in line with the needs and wishes of carers and patients.	To develop the methodology for collecting and acting upon patient and carer stories; to collect stories and report on how they have been used in service redesign.

5. Statements from 3rd Parties

5.1 Coventry Local Involvement Network (LINk)

A copy of this Quality Account will be sent to Coventry Local Involvement Network (LINk) for comment prior to its publication.

5.2 Warwickshire Local Involvement Network (LINk)

A copy of this Quality Account will be sent to Warwickshire Local Involvement Network (LINk) for comment prior to its publication.

5.3 Coventry City Council Health Overview and Scrutiny Committee

A copy of this Quality Account will be sent to Coventry City Council Health Overview and Scrutiny Committee for comment prior to its publication.

5.4 Warwickshire Adult Social Care and Health Overview and Scrutiny Committee

A copy of this Quality Account will be sent to Warwickshire Adult Social Care and Health Overview and Scrutiny Committee for comment prior to its publication.

5.5 NHS Coventry and NHS Warwickshire Combined Statement

A copy of this Quality Account will be sent to NHS Coventry and NHS Warwickshire Combined Statement for comment prior to its publication.

6. How To Provide Feedback

Thank you for taking the time to read this Quality Account. We hope that you have found it useful and informative and would welcome any feedback or suggestions on how we could improve this further for next year, be it either layout, style or content.

If you would like to make a comment or suggestion then please contact us using any of the methods listed below:-

e:mail: enquiries@covwarkpt.nhs.uk

letter: Chief Executive
Coventry and Warwickshire Partnership Trust
Wayside House
Wilsons Lane
Coventry
CV6 6NY

Phone: 02476 368944

Item 2.3

South Warwickshire Foundation Trust and University Hospitals Coventry and Warwickshire

Item No 2.3

Adult Social Care and Health Overview and Scrutiny Committee

24 May 2012

Quality Accounts - South Warwickshire Foundation Trust and University Hospitals Coventry and Warwickshire

Recommendations

(1) That the Committee agree the response of the Quality Account Task and Finish Group on:

- the South Warwickshire Foundation Trust Quality Account for 2011-12 as set out in Appendix A.

- the University Hospitals Coventry and Warwickshire Quality Accounts for 2011-12 as set out in Appendix B.

1.0 Key Issues

1.1 The Quality Account Task and Finish Group was set up by the Adult Social Care and Health Overview and Scrutiny Committee to consider the Quality Accounts of South Warwickshire Foundation Trust, University Hospitals Coventry and Warwickshire and the West Midlands Ambulance Trust.

1.2 The membership of the Task and Finish Group was Councillor Martyn Ashford, Councillor Penny Bould, Councillor Angela Warner and Councillor Claire Watson.

1.2 The Task and Finish Group has held two meetings to consider the three sets of Quality Accounts, A report will be considered by the Adult Social Care and Health Overview and Scrutiny Committee on 19 June 2012, setting out the responses to the Quality Accounts of:

- Coventry and Warwickshire Partnership Trust
- George Eliot Hospital
- University Hospitals Coventry and Warwickshire
- West Midlands Ambulance Trust.

1.3 Due to the earlier timescales for completion of the Quality Accounts on Foundation Trusts, the Committee is asked to agree the response of the Task and Finish Group to the South Warwickshire Foundation Trust Quality Account set out in Appendix A.

1.4 The response to the Quality Account for University Hospitals Coventry and Warwickshire is also attached for consideration as Appendix B to meet that Hospital's timescales for producing their final Quality Account.

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Appendix A

Warwickshire County Council - Adult Social Care and Health Overview and Scrutiny Committee Commentary for South Warwickshire Foundation Trust Quality Account for 2011-12

A Task and Finish Group of the Adult Social Care and Health Overview and Scrutiny Committee considered the draft Quality Account of the South Warwickshire Foundation Trust on 14 May 2012.

The committee would wish the following points noted.

- The South Warwickshire NHS Foundation Trust Quality Report 2011-2012 was clear and easy to follow, but the final document should include the following:
  - table of contents
  - reference to the Annual Account.

- Members acknowledged the difficulty in producing comparative data with the integration of the Warwickshire Community Services into South Warwickshire Foundation Trust, and sought assurances that future Quality Account reports would include benchmarking data.

- Members welcomed the priority “to ensure that there are no single sex accommodation breaches”, which was linked to other work being carried out in the hospital, such as achieving A&E targets and reducing the number of moves between wards.

- Members welcomed the work being done towards the programme of care “Delivering Excellence in Dementia Care in Acute Hospitals”, which had been identified as a priority for the Hospital.

- The continued underperformance on Ambulance Handover was highlighted and the work being done to analyse the reasons for the changing patterns of numbers presenting to A&E (particularly by ambulance and self-referrals) was noted.

- The challenge for the Hospital continued to be the increasing numbers of elderly and frail elderly. Members highlighted the importance of health and social care working together to prevent inappropriate admissions and to shorten the length of hospital stays through prevention and reablement services.

- There needed to be more detail given in relation to pressure ulcers, with a clear distinction between inherited and hospital acquired ulcers, and giving patient numbers. The need for more emphasis to be placed on prevention of pressure ulcers was also agreed.

- Members congratulated the Hospital on the reduction in the number of hospital acquired CDiff cases.

- The information provided on Staff Experience (Page 60 of 72) on sickness and appraisal rates should be expanded to a table form to include target figures and national figures.

- Members agreed that the Quality Account should make reference to the role of Monitor in relation to performance monitoring and the results of any inspections.

Appendix B

Warwickshire County Council - Adult Social Care and Health Overview and Scrutiny Committee Commentary for University Hospitals Coventry and Warwickshire NHS Trust – 2011- 2012

A Task and Finish Group of the Adult Social Care and Health Overview and Scrutiny Committee considered the draft Quality Account of the University Hospitals Coventry and Warwickshire NHS Trust on 24 April 2012.

The committee would wish the following points noted.

- The task and finish group felt that the document was well presented and encouraged the use of visual aids such as ticks and crosses for ease of reference.

- Members agreed the three priorities chosen for the next year, and in particular the continued focus on pressure sores. The group agreed that the Quality Account should include:
    - the grade of pressure sore being recorded
    - a clear distinction between inherited and hospital acquired pressure sores
    - an indication of successful treatments – split between inherited and hospital acquired.

- The priority for 2012/13 – "Clinical Effectiveness – Effective Discharge from Hospital" sat well with the work of Warwickshire County Council in developing community care and virtual wards, and helping people to maintain their independence.

- Members acknowledged the work carried out by UHCW to involve patients, the public and staff. They were however, disappointed that the results of the staff survey were not included in the draft quality account again this year and referred to their comments in 2011 that the results of the staff survey were "key to our understanding of the relationship between the trust and its staff. It is understood that the results will be included in the final version but it would help if in the future the timing of the staff survey was changed to ensure that earlier drafts include the results".

- The task and finish group welcomed the inclusion of trend and benchmarking data, although the draft Quality Account did not include any detailed information yet. The group agreed that there should also be clear narrative to indicate where there had been improvement.

- The sample for inpatient surveys was small. The group felt that the final Quality Account should include actual numbers of patients over the year and actual numbers of patients taking part in the survey.

- Members felt strongly that there needed to be a reference to access to UHCW included in the Quality Account as this had a negative impact on patients and relatives and was an issue raised consistently by elected members, patients and relatives, constituents and in-patient feedback.

- Members agreed that there needed to be an addition under the “We Care” section on bed occupancy in order to evidence any impacts of the closure of Birch Ward at Rugby St Cross in December 2011.

- Members agreed that the Quality Accounts should be expanded to include more outcomes to demonstrate the benefits of the work and improvements carried out by UHCW.

- The group were impressed at the scale of research that had been undertaken and felt that it would be useful to expand this with some detail of the research undertaken.

- Members welcomed the continued work that the trust has undertaken around dementia and highlighted this as an area for further reporting to the HOSC outside of the Quality Accounts process.

- Members highlighted the usefulness of the Quality Accounts for HOSC to identify areas for further scrutiny.