Coventry City Council

Agenda

Health and Social Care Scrutiny Board (5)

Time and Date
2.00 pm on Wednesday, 10th September, 2014

Place
Committee Rooms 2 and 3 - Council House

Public Business

1. **Apologies and Substitutions**

2. **Declarations of Interest**

3. **Minutes**

   (a) To agree the minutes of the meeting held on 30th July, 2014 (Pages 5 - 10)

   (b) Matters Arising

2.05 p.m.

4. **Coventry Safeguarding Adults Board Annual Report 2013/14** (Pages 11 - 38)

   Briefing Note of the Assistant Director, Safeguarding, Performance and Quality

   The Chair and Vice-Chair of the Safeguarding Board have been invited to the meeting for the consideration of this item, and for item 5 below

2.35 p.m.

5. **Adult Social Care Annual Report 2013/14 (Local Account)** (Pages 39 - 88)

   Report of the Executive Director, People

3.00 p.m.

6. **University Hospitals Coventry and Warwickshire Quality Account 2013/14** (Pages 89 - 174)

Briefing note of the Scrutiny Co-ordinator

To consider the Quality Account, Mark Radford, Chief Nursing Officer, UHCW has been invited to the meeting for the consideration of this item

3.30 p.m.

7. **Review of the Winter and Patient Discharge from University Hospitals Coventry and Warwickshire (UHCW)** (Pages 175 - 192)

Joint presentation

David Eltringham, Chief Operating Officer, UHCW and Sue Davies, Head of Partnerships, Coventry and Rugby CCG have been invited to the meeting for the consideration of this item.

4.00 p.m.

8. **Outstanding Issues**

All outstanding issues have been picked up in the Work Programme

9. **Work Programme 2014-15** (Pages 193 - 198)

Report of the Scrutiny Co-ordinator

10. **Any other items of Public Business**

Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

11. **Meeting Evaluation**

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Tuesday, 2 September 2014

Notes: 1) The person to contact about the agenda and documents for this meeting is Liz Knight, Governance Services, Council House, Coventry, telephone 7683 3073, alternatively information about this meeting can be obtained from the following web link: http://moderngov.coventry.gov.uk

2) Council Members who are not able to attend the meeting should notify Liz Knight as soon as possible and no later than 1.00 p.m. on 10th September, 2014 giving their reasons for absence and the name of the Council Member (if any) who will be attending the meeting as their substitute.

3) Scrutiny Board Members who have an interest in any report to this meeting, but who are not Members of this Scrutiny Board, have been invited to notify

the Chair by 12 noon on the day before the meeting that they wish to speak on a particular item. The Member must indicate to the Chair their reason for wishing to speak and the issue(s) they wish to raise.

Membership: Councillors M Ali, K Caan (By Invitation), J Clifford, A Gingell (By Invitation), P Hetherton, D Howells, J Mason (Co-opted Member), J Mutton, J O'Boyle, D Skinner, K Taylor and S Thomas (Chair)

Please note: a hearing loop is available in the committee rooms

If you require a British Sign Language interpreter for this meeting OR it you would like this information in another format or language please contact us.

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Minutes of the Meeting of Health and Social Care Scrutiny Board (5) held at 2.00 p.m. on Wednesday, 30th July, 2014

Present:

Scrutiny Board Members:	Councillor Thomas (Chair)
	Councillor J Clifford Councillor P Hetherton Councillor J Mutton Councillor Skinner Councillor Taylor Councillor Welsh (substitute for Councillor O'Boyle)
Co-opted Member:	Mr J Mason, representing Mr D Spurgeon
Other Members:	Councillor Gingell (Cabinet Member (Health and Adult Services))
Employees (by Directorate):	
People:	S. Brake
Resources:	S. Bennett, S. Symonds
Apologies:	Councillors Ali, Howells and O'Boyle
Others present:	
Coventry and Warwickshire Partnership Trust:	P. Masters, T. Wrench
Coventry and Rugby Clinical Commissioning Group:	Dr S Allen, M. Gilks
West Midlands Ambulance Service:	M. Gough, J. Kavanagh, S. McLeod, H. Patel

Public Business

1. **Declarations of Interest**

There were no declarations of interest.

2. **Minutes**

The minutes of the meeting held on 30th April, 2014 were signed as a true record.

There were no matters arising.

3. **Quality Accounts 2013/14**

The Scrutiny Board considered a Briefing Note of the Scrutiny Co-ordinator which introduced the Board to the 2013-14 Quality Accounts produced by local provider NHS Trusts. The Quality Accounts for the Coventry and Warwickshire Partnership Trust (CWPT) and West Midlands Ambulance Service (WMAS) were set out in appendices to the note and it was noted that the Quality Accounts for University Hospital Coventry and Warwickshire would be scheduled for a future meeting. Representatives from CWPT and WMAS attended the meeting for the consideration of this item. Councillor Gingell, Cabinet Member (Health and Adult Services) also attended the meeting for the consideration of the issue.

The Department of Health introduced the requirement for NHS trusts to issue Quality Accounts in 2009. The purpose was to encourage boards and leaders of healthcare organisations to assess quality across all the healthcare services they provided and to engage in the wider processes of continuous quality improvement. The Scrutiny Board had the opportunity to provide a commentary on the local Trusts. During this year, a quality accounts task and finish group made up of representatives from Warwickshire County Council, the City Council, Healthwatch Coventry and Healthwatch Warwickshire had met to provide a joint commentary on the Quality Accounts for Coventry and Warwickshire Partnership Trust and University Hospitals Coventry and Warwickshire.

Paul Masters, Assistant Director of Governance and Tracey Wrench, Director of Nursing, introduced the Quality Account for CWPT. Attention was drawn in the Quality Accounts to the following:-

- Work undertaken in respect of Vision and Value
- The response to the Robert Francis Inquiry
- Learning from complaints
- Work undertaken towards transforming how care and treatment are delivered

The Board questioned the representatives on a number of issues and responses were provided. Matters raised included:-

i) The effectiveness of the Quality Accounts in providing all of the necessary information for appropriate and interested parties

ii) Whether mental health services provided were fit for purpose

iii) Work being carried out on the early diagnosis of dementia and the impact that early diagnosis has on services

iv) Inpatient activity, including low level physical activity

Ham Patel, General Manager and Joanne Cavanagh, Clinical Support Manager, introduced the Quality Account for WMAS. Attention was drawn in the Quality Accounts to the following:-

- Increase in the number of frontline clinical staff, which will further increase in the next 12 months
- Completion of the rollout of the Make Ready Hubs, which means vehicles are refuelled, cleaned and restocked for use by staff when they arrive for duty.

- The successful taking over of the NHS 111 service across the majority of the West Midlands
- Work undertaken with commissioners and stakeholders to make improvements to the service by addressing service demand increases, hospital turnaround delays and underfunding
- Improvements in the collection of evidence and data
- Increasing engagement with both staff and the public

The Board questioned the representatives on a number of issues and responses were provided. Matters raised included:-

i) Staff training and development, particularly in the area of data and evidence collection

ii) Waiting time at hospitals

iii) The difference between paramedics and Community First responders

iv) Outcomes for cardiac arrests patients

The Board also noted, with concern, that the Trust had recently decided to allow the Chief Executive of the West Midlands Ambulance Service to go part-time.

RESOLVED:-

1) That the Quality Accounts for the Coventry and Warwickshire Partnership Trust and the West Midlands Ambulance Service be received and noted.

2) That, in light of the organisational challenges highlighted, the Chair of the Scrutiny Board, Councillor Thomas, be requested to write to the Trust, on behalf of the Board, regarding their recent decision to allow the Chief Executive of the West Midlands Ambulance Service to undertake his role on a part-time basis.

4. **Patient Transport Services**

The Scrutiny Board received a presentation from Dr Steve Allen, Accountable Officer and Matt Gilks, Head of Contracting and Procurement, Coventry and Rugby Clinical Commissioning Group (CCG), on a review of the current Patient Transport Services (PTS), following concerns raised regarding the requirements and delivery of the existing contract.

The presentation provided information on:-

- The service background, including the historical contract and KPI's; the demand for the service outside of CCG control (ie Renal Patient Allocation); outside factors affecting service delivery; and regular monitoring and contract review meetings

- How the service has been reviewed, by undertaking a phased approach, with an initial focus on Renal PTS; an Action Plan, agreed with the West Midlands

Ambulance Service; a "Deep Dive" data analysis exercise; and an escalation of the lack of on-going engagement from the Renal Service

- Findings to date and an interim taxi service solution agreed on a 3 month trial basis, which commenced 1st June, 2014; data recording issues identified for outward journey target (60 minutes); and the fact that the renal service is now more engaged

The Scrutiny Board questioned the representatives on a number of issues and responses were provided. Matters raised included:-

i) Clarification that the Acute PTS Service and the Renal PTS Service would be two separate contracts, commencing on 1st April, 2015

ii) Concerns raised by Healthwatch

iii) Initial feedback from the outcome of the trial interim taxi service

iv) Confirmation that patient users would be included in the tendering process

v) The patient experience

RESOLVED that the presentation be noted and that, in relation to the comments and concerns raised by Coventry Healthwatch, the Clinical Commissioning Group be requested to contact Coventry Healthwatch directly at key points through the contract process.

5. **Adult Social Care Peer Review and Commissioning and Personalisation Plan**

The Scrutiny Board considered a report of the Executive Director, People, which had been considered and approved by the Cabinet Member (Health and Adult Services), (Minute 7/14 refers) and which indicated that a significant number of local and national financial and policy challenges were being experienced across Adult Social Care. Further reductions in the local government settlement, along with increased demand on resources through changes introduced through the Care Act, means Adult Social Care has to continue to improve the way services are provided in line with managing the increasingly challenging financial position.

The Local Government Association launched its approach to Sector Led Improvement in 2011 following the removal of national targets and assessments with the aim of driving improvement through self-regulation and innovation. A regional Adult Social Care Sector Led Improvement Board, chaired by Martin Reeves, is responsible for driving and monitoring progress of a Sector Led Improvement programme and as part of this regional approach, each of the 14 local authorities had agreed to participate in a Peer Review. Coventry City Council's Adult Social Care was subject to a Peer Review in March 2014. The scope of this review was the City Council's approach to Commissioning and how this could reduce demand for traditional services through the use of community assets, families and friends. Five key lines of enquiry were identified to give focus to the review.

Following the conclusion of the Peer Review, the findings outlined strengths and

areas for consideration. As a response to this, an Adult Social Care Commissioning and Personalisation Plan 2014-16, had been developed to outline the key areas and to provide a strategy to progress the responses to the findings of the Peer Review along with the other financial and service challenges facing Adult Social Care.

The Scrutiny Board questioned officers on aspects of the report and welcomed the fact that a Briefing on the new Care Act, which was due for implementation during 2015/16 and 2016/17 and which was likely to lead to a significant increase in demand on Adult Social Care, had been arranged for all Elected Members.

RESOLVED:-

1) That the outcome of the Peer Review and the proposed actions as encapsulated in the Commissioning and Personalisation Plan be noted.

2) That the Scrutiny Board receive further updates on this issue as and when appropriate.

3) That the following two issues, identified by the Peer Review Team, be added to the Scrutiny Board's Work Programme:-

i) There was not an understanding of the reasons behind the low alert and referral rates for adult safeguarding.

ii) Commissioners did not have a clear understanding of their role on quality assurance following Winterbourne View and the Concordat

6. Outstanding Issues

The Scrutiny Board noted that all outstanding issues had been included in the Work Programme for the current year.

7. Work Programme

The Scrutiny Board considered the Work Programme for 2014-2015. It was agreed that, in addition to the items identified in Minute 5 above, to include the following item in the Work Programme:-

Report back on the work of the Health and Wellbeing Board

8. Any Other Items of Urgent Public Business

There were no other items of urgent public business.

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Coventry City Council

Briefing note

To Health and Social Care Scrutiny Board (5) **Date 10 September 2014**

Subject: Coventry Safeguarding Adults Board Annual Report

1 Purpose of the Note

To inform Scrutiny Board of the content of the Annual Report of the Coventry Safeguarding Adults Board 2013/2014. A full copy of the report is attached as an appendix.

2 Recommendations

The Scrutiny Board is asked to:

a) Consider the contents of the Coventry Safeguarding Adults Board Annual Report 2013/2014 and make any comments on the report which may assist the Safeguarding Board in assuring itself of the effectiveness of safeguarding for adults in Coventry.
b) Note the analysis of the low rate of conversion of alerts to referrals which relates to a previous Scrutiny Board discussion following on from the Adults Social Care Peer Review in March 2014.

3 Information/Background – The Board and the Annual Report

The Coventry Safeguarding Adults Board is a multi-agency partnership made up of statutory sector member organisations and other non-statutory partner agencies. An Elected Member also attends the Board as an observer. Under the Care Act, it will become a statutory requirement for each area to have a Safeguarding Adults Board. Coventry has had one in place for a number of years.

The Board has strategic responsibility for the development, co-ordination, implementation and monitoring of multi-agency policies and procedures that safeguard and protect vulnerable adults in Coventry. Through its work, the Board promotes the welfare of adults at risk and their protection from abuse and harm. The Annual Report aims to summarise the key messages around safeguarding and progress made during the year in making improvements and addressing any emerging concerns.

Coventry Safeguarding Adults Board meets quarterly to provide strategic leadership and to set direction. The work of the Board is supported by a number of Sub-Groups that are responsible for developing and managing the delivery of activity to achieve the Board's priorities.

The Coventry Safeguarding Adults Board Sub-Groups for 2013-4 were:

- Executive
- Partnership and Practice Development
- Policy and Procedures
- Quality and Audit
- Serious Case Review
- Workforce Development
- Mental Capacity Act and Deprivation of Liberty Safeguards Steering Group

To achieve the Board priorities subgroups have drawn up action plans for the year which set out what they plan to do. The Board regularly reviews progress against these priorities and sets new priorities for the year ahead to ensure that safeguarding arrangements in Coventry are effective and that positive outcomes are achieved for those people in need of safeguarding.

The Annual Report for 2013-14 explains what safeguarding adults means and introduces the implications of the Care Act 2014, much of which will become effective from April 2015. It also highlights the work of the Board, its partners and sub groups over the previous year and the Board's priorities for the year 2014/15. The five key priorities for the coming year are:

1. **Prevention -** Raising awareness about adult abuse (and the thresholds for abuse) and communicating better with the public.
2. **Quality** - Continuing to focus on quality and auditing services to continually improve the way we work to improve the lives of vulnerable adults in Coventry.
3. **Care Act 2014** -The Board needs to ensure that this legislation is implemented effectively.
4. **Domestic violence and abuse -** Working with the Coventry Police and Crime Board to ensure that knowledge and awareness of domestic violence is embedded in safeguarding adults work and those dealing with domestic violence recognise and respond to the needs of vulnerable adults.
5. **Synergies between safeguarding boards -** Ensuring that it learns from and works effectively with, the Children's Safeguarding Board.

4. Background – Alerts and Referrals

There is an appendix to the Annual Report which includes key data and statistics in relation to Adults Safeguarding. Much of this data is reported quarterly to Board as part of the performance management processes of the Board.

When Scrutiny Board considered the Peer Review report earlier in the year, the issue of the low proportion of alerts which proceed to referrals was raised as a potential concern. Members of the Board will notice that in the report (appendix 2) the rate of conversion of alerts to referrals fell again in 2013/14. There has been some additional analysis of this following on from the publication of the statistics at year end.

Over the five year period, the conversion rate has reduced year on year to the lowest rate of 26% in 2013/14. The 2012/13 England conversion rate was 50%. Within the West Midlands, the average conversion rate is 58% but individual authorities have significantly different rates from a high of 83% of alerts becoming referrals in Telford and Wrekin to a low of Coventry's current figure of 26%. Solihull is the next lowest rate at 29% for this year. This wide variance

does suggest that this process is not being recorded consistently in different areas and so does make comparison more difficult,

Investigation of these figures has highlighted that pressure ulcers make up the second highest proportion of alerts (255 alerts last year 25% of all alerts) yet they result in the lowest conversion rate to referrals at 12%. This may be due to previous policy decisions within Coventry that all pressure ulcers of a certain severity are to be treated as potential safeguarding issues and alerted as such pending further work. This is actually a practice which ensures cases are not missed.

If pressure ulcer alerts were removed from the conversion rate, Coventry's overall conversion rate would increase to 34% for last year, which is above that in Solihull and in line with that in Walsall.

Further analysis of the conversion rate by source of the alert has highlighted a potential issue around low conversion rates for alerts from the ambulance service and hospital ward staff. This may require further investigation and possibly more awareness raising of thresholds in these groups.

Both the City Council and the Safeguarding Adults Board will continue to monitor the rate of conversion of alerts to referrals. The Quality and Audit sub group of the Board includes this indicator within its indicator set and will be reporting quarterly to the Board on any areas of concern.

AUTHOR'S NAME, DIRECTORATE AND TELEPHONE NUMBER

Isabel Merrifield
Assistant Director, Safeguarding, Performance and Quality

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COVENTRY SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2013/2014

Coventry Partnership

Working Together to Safeguard Adults

BOARD PARTNERS

Coventry and Warwickshire NHS Partnership Trust

Coventry City Council

Staffordshire and West Midlands Probation Trust

Coventry NHS Teaching Primary Care Trust

University Hospitals Coventry and Warwickshire NHS Trust

NHS Coventry

Coventry Partnership
Towards a safer, more confident city

WEST MIDLANDS FIRE SERVICE

CONTENTS

FOREWORD FROM THE CHAIR

"THE CARE MINISTER NORMAN LAMB, HAS REAFFIRMED HIS COMMITMENT TO PLACE ADULT SAFEGUARDING ON THE SAME FOOTING AS CHILDREN'S SAFEGUARDING, AND THE ENACTMENT OF THE CARE ACT GIVES THE ADULT SAFEGUARDING BOARD A FRESH IMPETUS TO REVIEW THE WAY WE WORK."

Welcome to the 11th annual report of Coventry Safeguarding Adults Board. It has indeed been a very busy year since the last annual report, and I am sure you will all be aware of the challenges that face all partner organisations in ensuring that we work together to protect vulnerable adults and keep them safe.

There have been high profile cases concerning adult abuse over the last year which readers will not have failed to notice.

At the time of writing this report, the case of Orchid View care home in West Sussex reinforces the need for all of us to be vigilant and attentive to the feedback we receive from adults about the services they receive. The Care Minister Norman Lamb, has reaffirmed his commitment to place adult safeguarding on the same footing as children's safeguarding, and the enactment of the Care Act gives the Adult Safeguarding Board a fresh impetus to review the way we work.

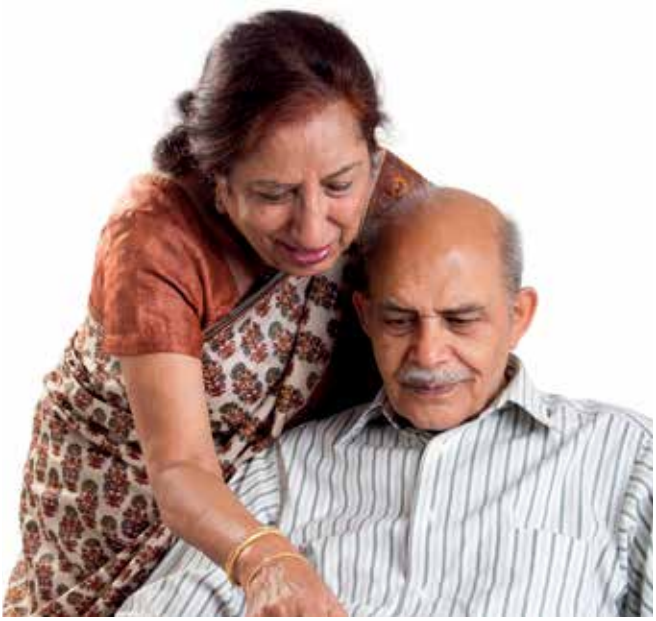
With the appointment of an Independent Chair for the Adults Safeguarding Board, and the imminent appointment of the new Chair of the Safeguarding Board for Children, there is a real opportunity to make sure that we learn from each other about safeguarding activity across children's and adults' services and do our very best to work closely together to ensure the safety of citizens in Coventry.

Brian M Walsh
Chair, Coventry Safeguarding Adults Board

SAFEGUARDING IS EVERYBODY'S BUSINESS

Coventry Safeguarding Adults Board believes that safeguarding is everybody's business, and that by working together across organisations and communities we can make a real difference in preventing and protecting adults from abuse.

This diagram illustrates how safeguarding adults at risk is everybody's business. Although Coventry City Council has lead responsibility, this responsibility is shared by professionals, the public and each and every one of us. But what does this mean in practice? We want to ensure that everyone in Coventry knows what adult abuse is and what to do if they suspect it.



WHAT IS SAFEGUARDING?

Safeguarding describes a range of responses that seek to **prevent** or **respond** to abuse and neglect. It is an umbrella term for both 'promoting welfare' and 'protecting from harm'.

PROMOTING WELFARE

Every person has a right to live a life free from harm and abuse. All of us need to act as good neighbours and citizens in looking out for one another and seeking to prevent isolation, which can easily lead to abusive situations and put adults at risk of harm.

If you provide a service to adults, this means acting in a caring, compassionate, and professionally competent manner. This is about giving adults you support as much choice and control as possible, treating them with respect at all times, and promoting their dignity to enhance their quality of life.

PROTECTING FROM HARM

Alongside the responsibility to promote the welfare of the people we support, we also need to ensure that they are protected from harm or abuse. Adults at risk should be given information, advice and support in a form that they can understand; and their views and what they want from their lives should remain central to safeguarding decisions about them.

It is important that work to keep adults safe focuses on working with the person being harmed to ensure that they stay safe and happy.

WHAT IS ABUSE AND WHO IS AT RISK?

Everybody has the right to be safe and live their life free from threats, intimidation or abuse. People can be made to feel unsafe or threatened in a number of different ways, and in a variety of different circumstances.

- Physical abuse
- Emotional or psychological abuse
- Sexual abuse
- Neglect
- Financial abuse (for example theft or fraud)
- Institutional abuse (in a care home, for example)
- Hate crime or other forms of discrimination

The definition of abuse is based not on whether someone's intention was to cause harm but on whether harm was caused, and on the impact of the harm (or risk of harm) on the person.

Failing to act to prevent harm being caused to a person you have responsibility for, or acting in a way that results in harm to a person who relies on you for care or support, is also abuse.

Abuse and neglect can happen anywhere – in someone's own home or supported housing; a day centre; an educational establishment; and in residential or nursing homes, clinics and hospitals.

Safeguarding needs to be proportionate and balanced so that an individual's right to make choices and decisions about their own lives is respected and supported.

WHEN DOES ABUSE HAPPEN?

A vulnerable adult may be subject to abuse when they are neglected, persuaded to agree to something against their will or taken advantage of because they do not fully understand the consequences of their choices or actions. It can be a single act or repeated over time. It may be deliberate but it may also happen as a result of poor care practices or ignorance.

Anyone can come across an abusive situation Sometimes we come across potential abusive situations and we don't know whether to say something, stay silent, take action, or do nothing.

Sometimes we are unsure about what we have seen but fear that there is something 'not quite right' and we are not sure who to talk to about it.

WHO IS AN ADULT AT RISK?

An 'adult at risk' is defined as an adult (a person aged 18 or over) who 'is or may be in need of community care services by reason of mental or other disability, age or illness; and who is, or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'.

'I THINK ONE OF THE ELDERLY GENTLEMEN I LOOK AFTER IS BEING ABUSED BY HIS SON. HE HAS BRUISES HE CAN'T EXPLAIN, AND I HAVE SEEN HIS SON BEING VERY VERBALLY AGGRESSIVE TOWARDS HIM. I AM VERY WORRIED.'

Comment from a home carer

'MY NEXT DOOR NEIGHBOUR HAS LEARNING DIFFICULTIES, AND I HAVE NOTICED A LOT OF PEOPLE COMING AND GOING WHICH IS NOT USUAL. I'M WORRIED MY NEIGHBOUR IS BEING TAKEN ADVANTAGE OF, BUT WHEN I ASK HER IF EVERYTHING IS OK, SHE SAYS IT IS. I REALLY THINK I SHOULD REPORT THIS TO THE AUTHORITIES BUT I'M NOT SURE WHO TO TALK TO.'

Comment from a member of the public

WHAT IS THE LEGAL AND NATIONAL FRAMEWORK?

The Care Act received royal assent in May 2014, and, amongst other changes, will usher in a range of measures designed to keep vulnerable adults safe. The Act is mostly due to come into force in April 2015, and will mean that:

- Local Authorities will have a statutory duty to have Safeguarding Adults Boards;
- Local Authorities will have a statutory duty to make, or cause to be made, enquiries when it is thought that an adult with care and support needs in its area, may be at risk of abuse or neglect;
- Serious case reviews will be mandatory when certain triggering situations have occurred and the parties believe that there is cause for concern over the way relevant parties worked together to safeguard an adult, and Boards will have the discretion to undertake reviews in other circumstances;
- Agencies will have a duty to co-operate over the supply of information;
- Local authorities will have a duty to fund advocacy for assessment and safeguarding for people who have substantial difficulty in being involved in the process and do not have anyone else to speak up for them;
- The power to remove people from insanitary conditions under section 47 of the National Assistance Act 1948 will be abolished;
- Existing duties to protect people's property when in residential care or hospital will be re-affirmed;
- There will be a duty of candour on providers of health or adult social care about failings in specified circumstances, and a new offence will be created of supplying false or misleading information, in the case of information they are legally obliged to provide.

ABOUT COVENTRY SAFEGUARDING ADULTS BOARD

The Coventry Safeguarding Adults Board (CSAB) is a multi-agency partnership made up of statutory sector member organisations and other non-statutory partner agencies. The Board has strategic responsibility for the development, co-ordination, implementation and monitoring of multi-agency policies and procedures that safeguard and protect adults at risk in Coventry.

The Board is supported by a network of professional advisers and safeguarding leads. Through the partnership, the Board has access to a large network of health, housing and social care service providers from over 100 organisations in the statutory, voluntary and private sectors. The Board promotes the welfare of adults at risk and their protection from abusive behaviour. It provides strategic leadership for agencies providing services to adults at risk and seeks to ensure that there is a consistently high standard of professional responses to situations where there is actual or suspected abuse.

The Board meets quarterly to lead and oversee progress towards an improved Coventry-wide system of response, to develop multi-agency strategies and to monitor working practices and standards.

Under the Department of Health "No Secrets" (2000) (1) guidance Local Authorities have responsibility to lead adult safeguarding. The new Care Act 2014 makes this a legal duty, and also means that the Local Authority, Clinical Commissioning Group and Police become statutory Board members.

PRIORITIES FOR 2014–2015

The Board has agreed the following priorities for the next year:

1. PREVENTION

Raising awareness about adult abuse (and the thresholds for abuse) and communicating better with the public.

2. QUALITY

Continuing to focus on quality and auditing services to continually improve the way we work to improve the lives of vulnerable adults in Coventry.

3. CARE ACT 2014

The Board needs to ensure that this legislation is implemented effectively.

4. DOMESTIC VIOLENCE AND ABUSE

Working with the Coventry Police and Crime Board to ensure that knowledge and awareness of domestic violence is embedded in safeguarding adults work and those dealing with domestic violence recognise and respond to the needs of vulnerable adults.

5. SYNERGIES BETWEEN SAFEGUARDING BOARDS

Ensuring that it learns from and works effectively with, the Children's Safeguarding Board.

BOARD SUB GROUPS

Coventry Safeguarding Adults Board has a number of sub groups who are responsible for developing and managing work to deliver priorities. The first of these is the Executive Group which meets every six weeks and manages the Board's performance overseeing actions agreed at Board meetings and taking urgent decisions that cannot wait until the next full meeting of CSAB. The following sub-groups sit under the Executive Group:

- Partnership and Practice Development
- Policy and Procedures
- Quality and Audit
- Serious Case Review
- Workforce Development
- Mental Capacity Act and Deprivation of Liberty Safeguards

Attendance at both Board and sub groups has been very good, and the work of the sub groups has delivered important improvements to protect vulnerable adults.

The Partnership and Practice sub group has:

- Worked with service users and the Policy and Procedures sub group to produce two leaflets http://www.coventry.gov.uk/downloads/download/729/safeguarding_adults_leaflet (see Policy and Procedures below).
- Led five Champions' Group seminars, which focused on improving multi-agency working, and one Safeguarding Forum via the Champions' Group.
- The role of the Champions' Group was reviewed, and a new programme established for 2014 designed to widen the audience. As a result, four Champions' seminars are scheduled and four Safeguarding Fora. The first seminar in January 2014 was an adult safeguarding refresher course. It was a great success and was attended by 40 people from a wide range of agencies.

The Policy and Procedures sub group has:

- Produced an easy read safeguarding awareness leaflet for people with learning disabilities working together with the Partnership and Practice Sub Group.
- Produced an information leaflet for people who are subject to safeguarding procedures http://www.coventry.gov.uk/downloads/download/729/safeguarding_adults_leaflet
- Finalised a large scale investigation procedure in conjunction with the West Midlands Regional Safeguarding Co-ordinators Network (this has yet to be published)

The Quality and Audit sub group has:

- Commissioned and undertaken a multi-agency case file audit
- Reviewed key performance indicators, challenged poor performance and worked to better understand performance.
- Commenced a review of information-sharing protocols
- Initiated the development of a risk register

The Serious Case Review sub group has:

- Completed a Serious Case Review and implemented all of the actions
- Contributed to a review of Serious Case Review methodology for the West Midlands
- Developed review processes for those cases which do not meet the criteria for a serious case review but would benefit from a multi-agency review

The Workforce Development sub group has:

- Commissioned a Disclosure and Barring Service (DBS) referral briefing in March 14. The DBS delivered an update about the scheme to local employers.
- Commissioned a two-day Investigating Skills course. The feedback indicated that the course increased delegate confidence,

knowledge and skills around interviewing, case conferences and the West Midlands Procedures,

- Commissioned a programme for managing officers, commencing with 'Chairing Skills in Safeguarding Adults'.
- Ensured that when policies and learning and development activities are reviewed and updated, safeguarding is an explicit consideration.
- Promoted the sharing of learning and development and quality assurance tools to promote best practice in safeguarding. An example of this is the use of 'learning logs' which encourage practitioners to demonstrate how they have put their learning into practice.
- Delivered and planned a number of multi-agency events, using leads and champions to both promote learning and to model inter-agency commitment to working together.

PARTNER CONTRIBUTIONS

COVENTRY CITY COUNCIL

There has been a major drive to improve the Provider Escalation Panel. This is a monthly multi-agency meeting which monitors providers where there are emerging issues in terms of quality and performance. Improvements include better information sharing and a stronger focus on safeguarding, with more joint work with our partners, especially Health Commissioning and Clinical Support Unit, Care Quality Commission and Health and Safety.

WEST MIDLANDS FIRE SERVICE

West Midlands Fire Service refreshed its safeguarding policies and procedures. This included the creation of a safeguarding pocket guide that has been issued to all staff. The service took a back to basics approach to safeguarding and the whole workforce attended a role-specific combined safeguarding adults, children and young people level one training session. Three of West Midlands Fire Service's Vulnerable Person's Officers have become Safeguarding Champions.

WEST MIDLANDS POLICE

West Midlands Police established a Vulnerable Adult Hub that offers a single point of contact allowing the force to respond to referrals from partners for primary investigations to be completed before cases are passed through to Public Protection Teams. The Hub has been recognised as best practice and is based in Sandwell with a team of 14 officers.

The process to increase staffing levels in Public Protection to 800 from 480 began in June. West Midlands Police is the only force in the country to have a dedicated Vulnerable Adult Team, and it will be expanded to 25 officers, three support staff and four business support officers. A number of other forces are keen to learn from this best practice.

All sergeants and inspectors across the force, regardless of role, received a full day's training in vulnerable adult abuse; honour-based violence; female genital mutilation; human trafficking; child sexual exploitation; and child protection.

Multi-agency partners received a day's training on forced marriage, and Operation Sentinel, the Force's strategy to protect vulnerable people, focused on a different public protection issue each month and offered training to partners focusing on the victim's perspective.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE

The Safeguarding Adult and Children Team has been running for a year, and is co-located giving significant benefits in terms of operational functionality and individual team support. The team now includes a Support Midwife and has additional administration support. This additional input has allowed it to incrementally improve the training compliance figures month on month throughout 2013/14 and will support the delivery of the 90% compliance target figure by September 2014.

The e-alert system has resulted in the team being able to respond promptly to the needs of at-risk individuals who attend University Hospitals Coventry and Warwickshire. This has meant that:

- Service users get rapid protection
- Staff supporting cases are aware of the risk factors and can get immediate support and advice from the safeguarding team.
- There is corporate assurance that at-risk individuals attending University Hospitals Coventry and Warwickshire receive timely, needs-assessed protection.

An example of the difference this has made is the ability to track and respond promptly to domestic violence and abuse referrals. All multi-agency risk assessment conference (MARAC) referrals are added to the system.

COVENTRY AND WARWICKSHIRE PARTNERSHIP TRUST

The Trust reviewed and further developed its bespoke electronic safeguarding alert and referral form. Other key achievements included:

- The completion of safeguarding training and the development of safeguarding competence learning logs.
- The completion of the annual audit plan.
- Reviewing and developing staff guidance within the organisation in the form of a booklet about safeguarding adults.
- Reviewing and further developing safeguarding training at level 2 to include domestic abuse, stalking and harassment (DASH).
- 87% of trust staff received PREVENT health WRAP training.
- Developing a new Safeguarding Link Group for operational staff.
- Completing the relevant Local Safeguarding Board's Section 11 audits.
- Producing an annual safeguarding newsletter.
- Reviewing and refreshing/amending the following trust safeguarding polices:
    - Safeguarding adults policy
    - Safeguarding children policy
    - Section 75 safeguarding operational (for Coventry and Warwickshire Services)
    - Sexual safety in in-patient settings,
    - Clinical domestic abuse policy,
    - Child protection supervision policy,
    - Missing persons' policy.

LEARNING LESSONS FROM SERIOUS CASE REVIEWS

After two cases highlighted the risks to vulnerable adults from the poor care of pressure ulcers, The Pressure Ulcer Protocol (PUP) has been revised, the new protocol implemented, and extensive training delivered to staff. This has resulted in a more consistent response to pressure ulcers and increased numbers of information checklists received from nursing staff which inform safeguarding decisions.

A series of multi-agency events to disseminate lessons learned from Serious Case Reviews are planned for next year. In addition, to raise awareness about adult safeguarding, there will be Safeguarding Champions' events and an event for providers.

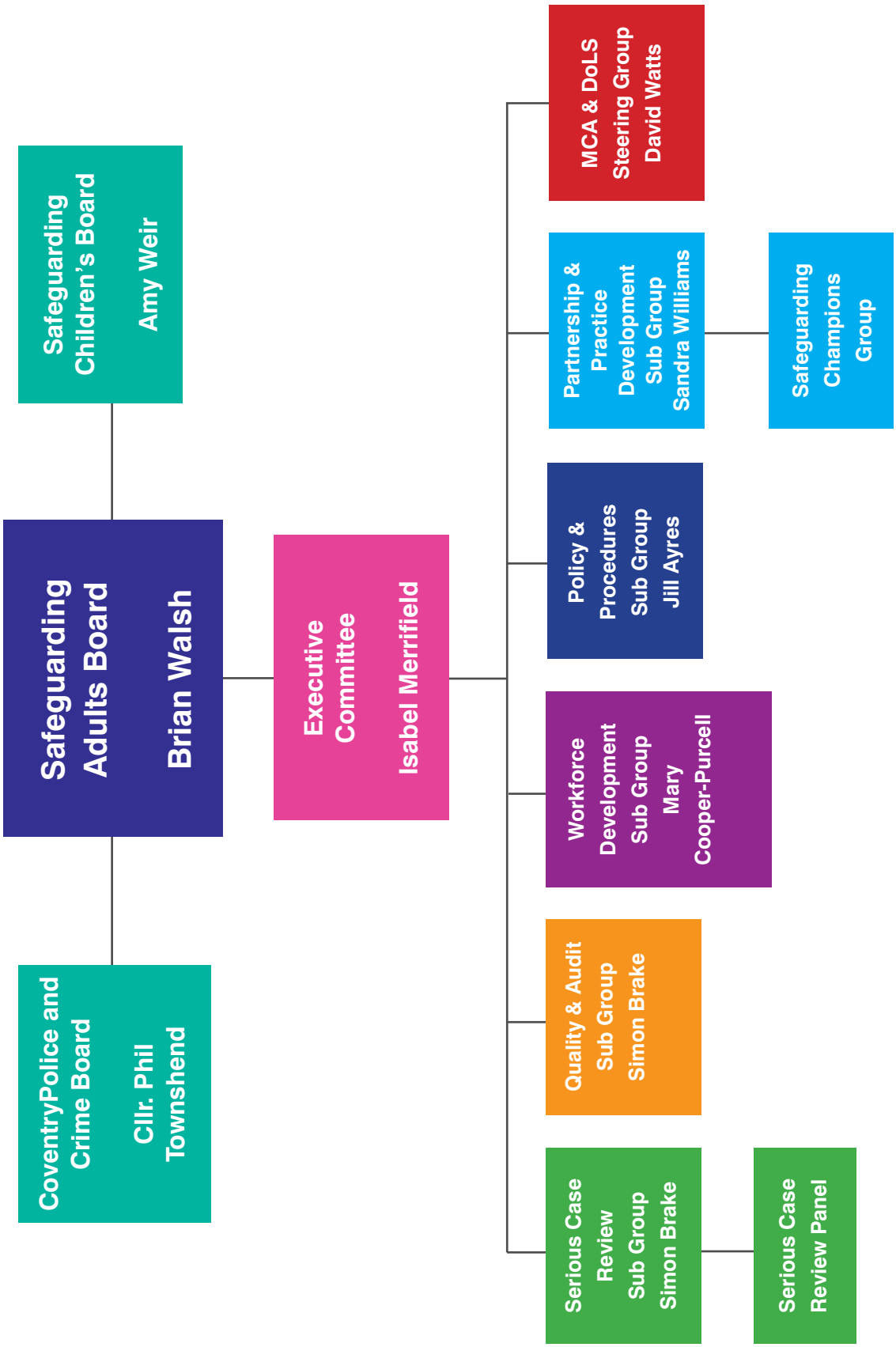
CHALLENGES FOR THE YEAR AHEAD

At their annual development event in March 2014, Board members agreed the following issues were the challenges for the coming year.

- Raising standards with fewer resources
- Continuing to ensure that there is an appropriate and proportionate safeguarding response to pressure ulcers
- Achieving Care Act compliance
- Developing joined-up working across safeguarding services for children and adults
- Maintaining Organisational resilience, consistency and capacity around safeguarding leadership

Board members and the sub groups will continue to work during the year to mitigate these challenges.

APPENDIX 1 – THE SAFEGUARDING BOARD STRUCTURE



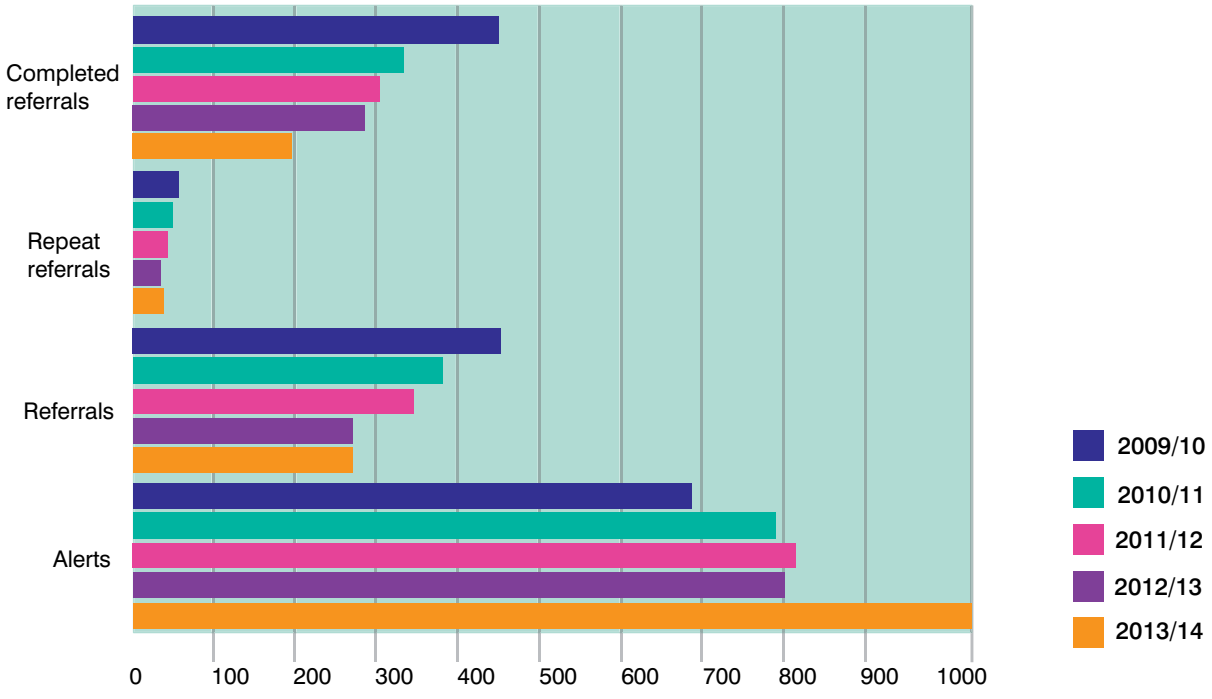
APPENDIX 2 – SAFEGUARDING ADULTS ANNUAL REPORT DATA

The Board is reviewing its performance reporting approach to ensure it can monitor performance and assure itself that safeguarding is effective across the city. During the 2013/14 year, indicators were reported to Board regularly in line with the information presented below. The data is the end of year data and shows a comparison with previous years.

Table 1 – Number of Alerts, Referrals and Completed Referrals for 2013/14 and comparison with previous years

	Alerts	Referrals	Repeat referrals	Completed referrals
2013/14	1003	265	24	195
% difference (2012/13 - 2013/14)	24.60%	0.76%	4.35%	-32.01%
Value difference (2012/13 - 2013/14)	198	2	1	-92
2012/13	805	263	23	287
% difference (2011/12 -2012/13)	0.98%	-24.64%	-28.13%	-6.51%
Value difference (2011/12 -2012/13)	-8	-86	-9	-20
2011/12	813	349	32	307
% difference (2010/11 -2011/12)	3.20%	-7.45%	-6.25%	-11.73%
Value difference (2010/11 -2011/12)	26	-26	-2	-36
2010/11	787	375	34	343
% difference (2009/10 - 2010/11)	13.09%	-23.47%	-29.41%	-31.78%
Value difference (2009/10 - 2010/11)	103	-88	-10	-109
2009/10	684	463	44	452

Chart 1 alerts/referral activity (2009/10 – 2013/14)



In 2013/14 the numbers of alerts increased by 25%. Coventry's preferred methodology for benchmarking alerts is by using the median average which eliminates the large discrepancies in the minimum and maximum values across England. The result of 1003 is similar to the 2012/13 West Midlands median average rate of 1000.

Table 2 - Alerts and referrals (2009/10 – 2013/14)

	2013/14	2012/13	2011/12	2010/11	2009/10
Alerts	1003	805	813	787	684
Referrals	265	263	349	375	463
% of alerts converting to referrals	**26.42%**	**32.7%**	**42.9%**	**47.6%**	**67.7%**

The conversion of alerts to safeguarding referrals continued to fall for the fifth successive year. In 2010/11 concern was expressed that too many alerts went on to become referrals when this wasn't appropriate. Consequently, there was a concerted effort to ensure that appropriate and proportionate decisions were being made about which cases go into the process by the appropriate and consistent application of the Threshold Guidance. Feedback received from the Service is that there have been no examples of cases which should have been investigated and were not and therefore there is confidence that the Thresholds are being correctly applied.

Completed referrals (2013/14)

The numbers of completed referrals have reduced from 287 in 2012/13 to 195 in 2013/14.

Table 3 - Completed referrals (2013/14)[1]

Primary client group	Alerts		Referrals		Repeat referrals		Completed referrals	
	Number	%	Number	%	Number	%	Number	%
Physical disability, frailty & sensory impairment	73	7.28%	11	4.15%	0	0.0%	4	2.05%
Mental Health Needs	59	5.88%	31	11.70%	2	8.33%	18	9.23%
Learning Disability	137	13.66%	72	27.17%	13	54.17%	52	26.67%
Substance Misuse	3	0.30%	0	0.00%	0	0.00%	0	0.00%
Other Vulnerable People	16	1.60%	1	0.38%	0	0.00%	3	1.54%
Older People	715	71.29%	150	56.60%	9	37.50%	117	60.00%
Totals	**1003**		**265**		**24**		**195**	

The number of completed referrals has exceeded the number of new referrals for the first time.

Client category breakdown

The table above helps to break down table 1 by primary category type. 71.3% of total alerts and 56.6% of referrals are raised about older people which is relative to the size of the service area.

[1] All completed referral in the period are recorded irrespective of when the referral was made.

Alerts by Age and Gender Breakdown (2013/14 only)

Coventry has more alerts and referrals for females than males, compared to the 2012 Mid-Year Estimate population; this is also the case when examined against the number of people receiving an adult social care service in Coventry.

Table 4 - Alerts and referrals by age and gender (2012/13)

	Alerts					Referrals				
	F	%	M	%	Total	F	%	M	%	Total
Age group 18 - 64	146	50.7%	142	49.3%	288	48	41.7%	67	58.3%	115
Age group 65+	487	68.1%	228	31.9%	715	104	69.3%	46	30.7%	150
Total Age groups	**633**	**63.1%**	**370**	**36.9%**	**1003**	**152**	**57.4%**	**113**	**42.6%**	**265**

Age of client	Female Number	%	Male Number	%	Total clients (P7)
18 - 64	1308	48.5%	1388	51.5%	2696
65+	3065	67.6%	1466	32.4%	4531
All ages	4373	60.5%	2854	39.5%	7227

2012 Mid Year Estimate	Female	Male
18-64	49.1%	50.9%
65 +	55.4%	44.6%
18+	50.3%	49.7%

Referrals by Ethnicity Comparison (2009/10 to 2013/14)

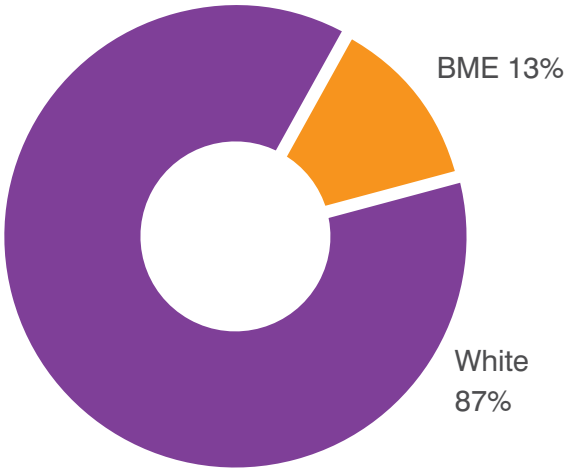
Table 5 breaks down the number of referrals for the last five years by ethnicity.

In 2013/14, 13% of safeguarding referrals were recorded for people in minority ethnic groups, which is an increase from 8.7% in 2012/13. The 2011 census reports that 23.8% of the 18+ population is from the minority ethnic community (compared with 14.5% in 2001 Census).

Table 5 - referrals by ethnicity (2009/10 – 2013/14)

Ethnicity	2013/14		2012/13		2011/12		2010/11		2009/10	
White British	213	93.4%	230	95.8%	286	94.7%	310	92.5%	378	94.5%
White Irish	9	3.9%	6	2.5%	11	3.6%	16	4.8%	13	3.3%
Any other White background	6	2.6%	4	1.7%	5	1.7%	9	2.7%	9	2.3%
Total	**228**		**240**		**302**		**335**		**400**	
White and Black Caribbean	1	2.9%	2	8.7%	4	9.5%	0	0.0%	2	3.2%
White and Black African	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	1.6%
White and Asian	1	2.9%	0	0.0%	1	2.4%	1	2.5%	1	1.6%
Any other mixed background	2	5.9%	0	0.0%	0	0.0%	3	7.5%	0	0.0%
Indian	4	11.8%	13	56.5%	13	31.0%	15	37.5%	22	34.9%
Pakistani	4	11.8%	1	4.3%	3	7.1%	7	17.5%	8	12.7%
Bangladeshi	1	2.9%	2	8.7%	2	4.8%	0	0.0%	1	1.6%
Any other Asian background	3	8.8%	2	8.7%	8	19.0%	1	2.5%	9	14.3%
Caribbean	6	17.6%	1	4.3%	7	16.7%	3	7.5%	7	11.1%
African	2	5.9%	0	0.0%	3	7.1%	5	12.5%	1	1.6%
Any other Black background	1	2.9%	0	0.0%	0	0.0%	2	5.0%	3	4.8%
Chinese	1	2.9%	1	4.3%	1	2.4%	0	0.0%	0	0.0%
Any other ethnic group	8	23.5%	1	4.3%	0	0.0%	2	5.0%	5	7.9%
Total	**34**		**23**		**42**		**40**		**63**	
Information not yet obtained	3		0		5		1		3	

Chart 2 - Percentage of BME referrals 2013/14



Source of referral comparison 2009/10 to 2013/14

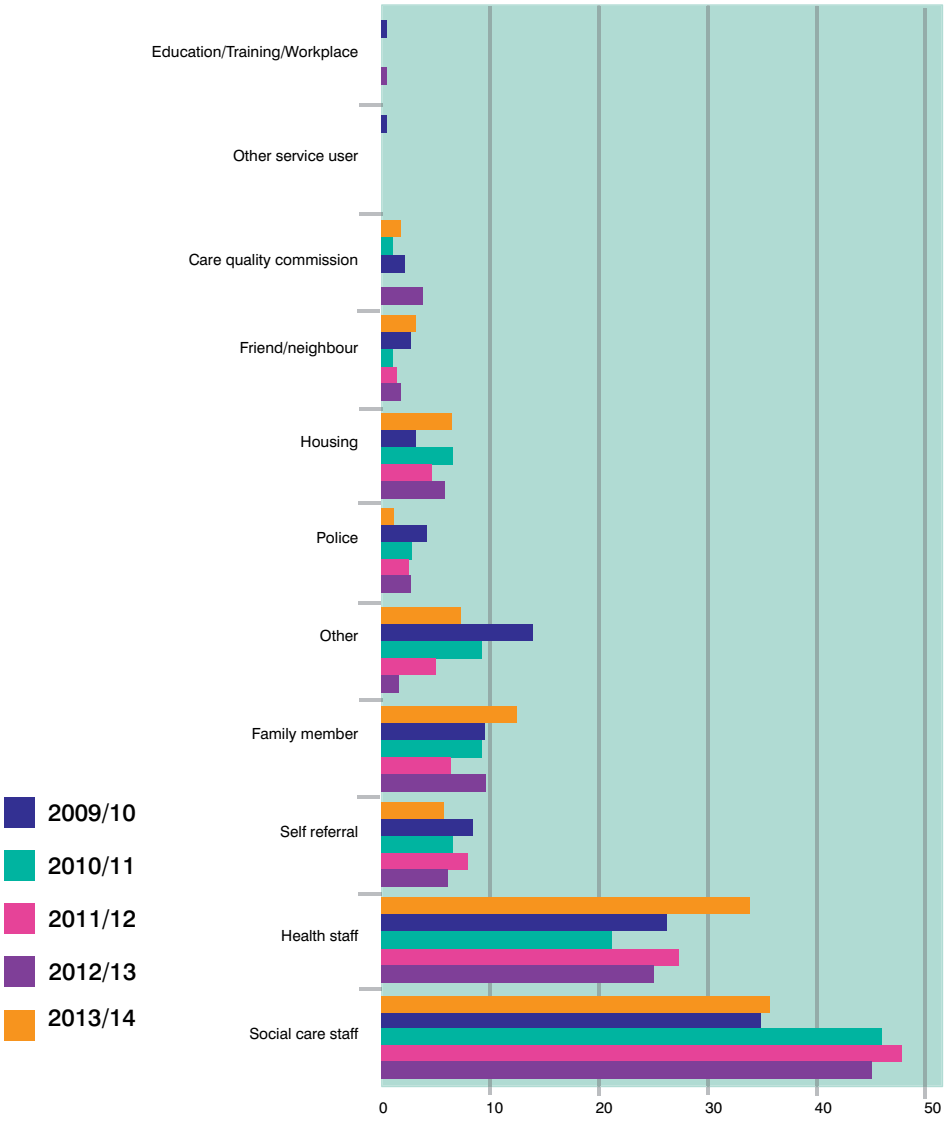
Social care staff and health staff continue to be the highest sources of safeguarding referrals. This is to be expected as they will have the most contact with vulnerable adults. There has been an increase in health staff referrals in 2013/14. This is encouraging as it shows increasing awareness and action in respect of adult safeguarding.

Table 6 – source of referral comparison (2009/10 to 2013/14)

Source of Referral	2013/14		2012/13		2011/12		2010/11		2009/10	
Social Care Staff	93	35.1%	120	45.6%	165	47.3%	173	46.1%	159	34.3%
Health Staff	89	33.6%	65	24.7%	92	26.4%	80	21.3%	119	25.7%
Self-Referral	14	5.3%	17	6.5%	28	8.0%	25	6.7%	39	8.4%
Family member	30	11.3%	26	9.9%	24	6.9%	36	9.6%	45	9.7%
Friend/neighbour	5	1.9%	4	1.5%	3	0.9%	2	0.5%	7	1.5%
Other service user	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.2%
Care Quality Commission	3	1.1%	8	3.0%	0	0.0%	2	0.5%	7	1.5%
Housing	15	5.7%	14	5.3%	13	3.7%	22	5.9%	13	2.8%
Education/Training/ Workplace	0	0.0%	1	0.4%	0	0.0%	0	0.0%	1	0.2%
Police	2	0.8%	4	1.5%	5	1.4%	7	1.9%	14	3.0%
Other	14	5.3%	4	1.5%	19	5.4%	28	7.5%	58	12.5%
Overall Total	**265**	**100%**	**263**	**100%**	**349**	**100%**	**375**	**100%**	**463**	**100%**

Chart 3 – comparison of referral source (2009/10 to 2013/14)

Comparison of referral source (2009/10-2012/13)



The table below breaks down the referral source for social care and health staff to understand more clearly where in each area the sources are coming from.

Table 7 – referral source – social care and health staff

Social Care Staff (CASSR & Independent)	2013/14		2012/13		2011/12		2010/11		2009/10	
Domiciliary Staff	20	21.5%	38	31.7%	48	29.1%	44	25.4%	32	20.1%
Residential Care Staff	37	39.8%	56	46.7%	52	31.5%	63	36.4%	54	34.0%
Day Care Staff	4	4.3%	9	7.5%	21	12.7%	15	8.7%	12	7.5%
Social Worker/Care Manager	10	10.8%	10	8.3%	24	14.5%	41	23.7%	30	18.9%
Self-Directed Care Staff	1	1.1%	0	0.0%	0	0.0%	0	0.0%	1	0.6%
Other	21	22.6%	7	5.8%	20	12.1%	10	5.8%	30	18.9%
Total	**93**		**120**		**165**		**173**		**159**	

Health Staff	2013/14		2012/13		2011/12		2010/11		2009/10	
Primary/Community Health Staff	36	40.4%	26	40.0%	49	53.3%	43	5.4%	61	51.3%
Secondary Health Staff	47	52.8%	35	53.8%	32	34.8%	22	2.8%	55	46.2%
Mental Health Staff	6	6.7%	4	6.2%	11	12.0%	15	1.9%	3	2.5%
Total	**89**		**65**		**92**		**80**		**119**	

Referrals by alleged abuse type comparison 2009/10 – 2013/14

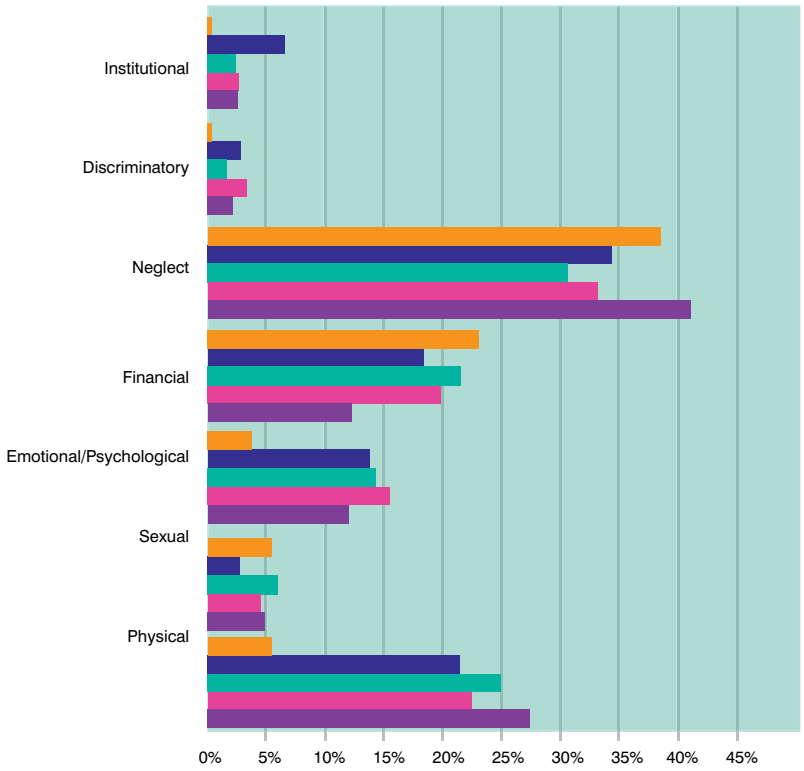
Neglect remains the most common abuse type at 42% in 2013/14, with physical (21%) and financial (16%) which is the same order as in 2012/13. This is a different order to the 2012/13 England averages that identified that Physical (28.4%) and Neglect (27.5%) followed by Financial (18%) were the most common abuse types. This same order is consistent with 2012/13 West Midlands and Similar councils benchmarking.

In 2013/14 there were 255 alerts regarding pressures ulcers of those 31 (12%) went onto a safeguarding referral.

Table 8 – referrals by alleged abuse type comparison (2009/10 – 2013/14)

Alleged abuse	2013/14		2012/13		2011/12		2010/11		2009/10	
Physical	54	21.3%	86	27.0%	98	22.3%	114	25.2%	124	21.5%
Sexual	16	6.3%	16	5.0%	21	4.8%	26	5.7%	17	2.9%
Emotional/psychological	27	10.6%	37	11.6%	67	15.2%	67	14.8%	82	14.2%
Financial	41	16.1%	39	12.3%	88	20.0%	97	21.4%	106	18.4%
Neglect	107	42.1%	130	40.9%	146	33.2%	138	30.5%	200	34.7%
Discriminatory	2	0.8%	5	1.6%	13	3.0%	5	1.1%	12	2.1%
Institutional	7	2.8%	5	1.6%	7	1.6%	6	1.3%	36	6.2%
Total	**254**		**318**		**440**		**453**		**577**	

Chart 4 – Type of alleged abuse for referrals (2009/10 – 2013/14)



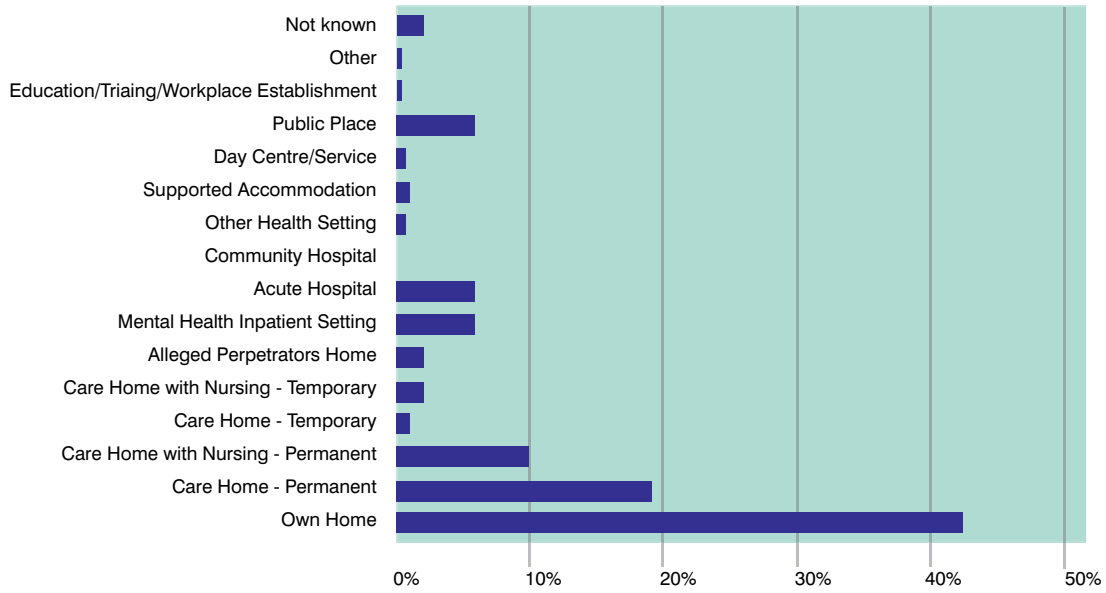
Location of Alleged Abuse comparison 2009/10 – 2013/14

Table 9

Location alleged abuse took place:	2013/14 Number	%	2012/13 Number	%	2011/12 Number	%	2010/2011 Number	%	2009/2010 Number	%
Own Home	111	41.9%	95	36.1%	175	50.1%	160	42.7%	254	46.9%
Care Home - Permanent	51	19.2%	60	22.8%	56	16.0%	78	20.8%	94	17.3%
Care Home with Nursing - Permanent	27	10.2%	24	9.1%	17	4.9%	20	5.3%	26	4.8%
Care Home - Temporary	3	1.1%	6	2.3%	6	1.7%	7	1.9%	13	2.4%
Care Home with Nursing - Temporary	6	2.3%	3	1.1%	0	0.0%	2	0.5%	6	1.1%
Alleged Perpetrators Home	6	2.3%	3	1.1%	14	4.0%	9	2.4%	16	3.0%
Mental Health Inpatient Setting	14	5.3%	3	1.1%	2	0.6%	2	0.5%	2	0.4%
Acute Hospital	14	5.3%	23	8.7%	22	6.3%	25	6.7%	37	6.8%
Community Hospital	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Health Setting	2	0.8%	0	0.0%	0	0.0%	0	0.0%	2	0.4%
Supported Accommodation	5	1.9%	15	5.7%	18	5.2%	38	10.1%	29	5.4%
Day Centre/Service	3	1.1%	4	1.5%	17	4.9%	6	1.6%	3	0.6%
Public Place	15	5.7%	11	4.2%	9	2.6%	9	2.4%	17	3.1%
Education/Training/Workplace	1	0.4%	1	0.4%	1	0.3%	0	0.0%	2	0.4%
Other	1	0.4%	6	2.3%	7	2.0%	6	1.6%	11	2.0%
Not Known	6	2.3%	9	3.4%	5	1.4%	13	3.5%	30	5.5%
Total	**265**		**263**		**349**		**375**		**542**	

In Coventry victim's homes and care homes are the most common places for abuse to take place. In 2013/14, 41.9% of abuse took place in the home and 19.2% occurred in care homes.

Chart 5 - abuse by location 2013/14



Alleged Perpetrator Relationship comparison 2009/10 – 2013/14

Over the five year period the most common alleged perpetrator relationship was social care staff followed by other family member.

Table 10

Relationship of alleged perpetrator	2013/2014		2012/13		2011/12		2010/11		2009/10	
Partner	21	8.0%	20	7.6%	17	4.9%	27	7.2%	32	7.0%
Other family member	29	11%	38	14.4%	61	17.5%	65	17.3%	89	19.4%
Health Care Worker	4	1.5%	23	8.7%	26	7.4%	24	6.4%	33	7.2%
Volunteer/ Befriender	1	0.4%	0	0.0%	1	0.3%	1	0.3%	0	0.0%
Social Care Staff	121	46.0%	106	40.3%	126	36.1%	105	21.3%	178	38.8%
Other professional	14	5.3%	6	2.3%	17	4.9%	14	3.7%	15	3.3%
Other Vulnerable Adult	22	8.4%	25	9.5%	28	8.0%	36	9.6%	16	3.5%
Neighbour/Friend	26	9.9%	13	4.9%	22	6.3%	27	7.2%	19	4.1%
Stranger	4	1.5%	8	3.0%	16	4.6%	12	3.2%	6	1.3%
Not Known	20	7.6%	20	7.6%	33	9.5%	51	13.6%	53	11.5%
Other	3	1.1%	4	1.5%	2	0.6%	13	3.5%	18	3.9%
Total	**265**		**263**		**349**		**375**		**459**	

Alleged Perpetrator Relationship (2013/14 only)

Of the 121 social care staff identified as the alleged perpetrator, 80 were named residential care staff, 29 were home care staff, 3 were day care staff members, 2 were self-directed support staff and 7 were reported in other establishments.

Chart 6 – Perpetrator: breakdown of social care staff in 2013/14

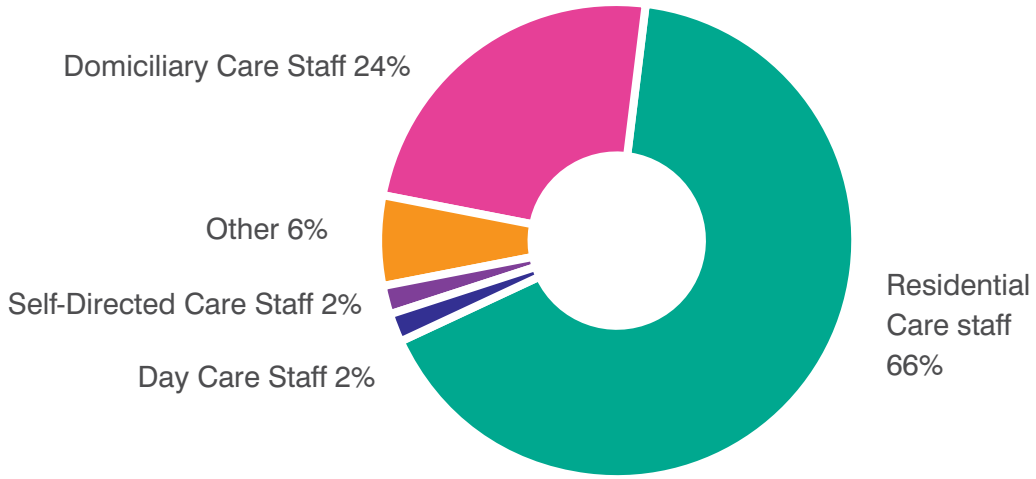


Chart 7 - Case conclusion comparison (2009/10 to 2013/14)

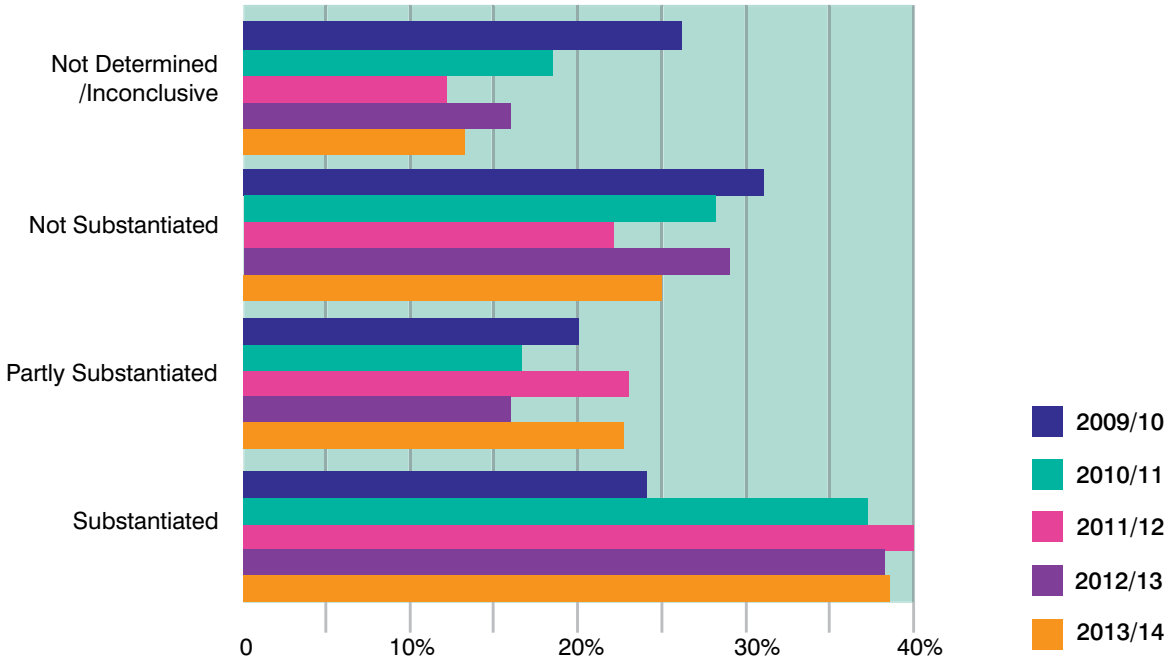


Table 11 – case conclusion comparison (2009/10 to 2013/14)

	2013/14		2012/13		2011/12		2010/11		2009/10	
Substantiated	72	36.9%	109	38.0%	123	40.1%	126	36.7%	106	23.5%
Partly Substantiated	42	21.5%	47	16.4%	73	23.8%	57	16.6%	90	19.9%
Not Substantiated	48	24.6%	83	28.9%	73	23.8%	96	28.0%	138	30.5%
Not Determined / Inconclusive	26	13.3%	48	16.7%	38	12.4%	64	18.7%	118	26.1%
Investigation creased at individuals' request	7	3.6%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total	**195**	**100%**	**287**	**100%**	**307**	**100%**	**343**	**100%**	**452**	**100%**

In 2013/14, 58.4% of cases were substantiated or partially substantiated compared with 54.4% in 2012/13 which is a higher than the 2012/13 England average of 43%. Coventry has a lower percentage of cases where a conclusion could not be determined (13% for 2013/14) compared with the England 2012/13 average figure of 27%. This suggests that only those cases that meet the threshold are going onto referral/further investigation.

Table 12 - Result of Action Taken to support management of risk (2013/14 only)

Result of Action Taken to Support Management of Risk	Social Care Support or Service paid, contracted or commissioned	Other		Total	
		Known to Individual	Unknown / Stranger	Number	%
Where 'No Further Action Under Safeguarding'	8	5	2	15	7.7%
Where 'Action Under Safeguarding'					
Risk Remains	4	10	3	17	9.4%
Risk Reduced	46	44	12	102	56.7%
Risk Removed	28	28	5	61	33.9%
TOTAL 'Action under Safeguarding'	78	82	20	180	100%

Out of the 195 completed referrals, 15 (7.7%) resulted in no further action under safeguarding.

163 (90.6%) of referrals which resulted in action under safeguarding, resulted in the risk being removed or reduced.

Chart 8 Percentage of completed safeguarding referrals where the adult at risk feels safer (2013/14 only)

90% of people felt safer after the completion of the safeguarding referral during 2013/14.

This report is available online at:
www.coventry.gov.uk/safeguarding

If you require this report in another format
or language please contact:
Telephone: 024 7683 2346
e-mail: safeguarding.adults.team@coventry.gov.uk

14-0499-NH

Coventry City Council

Public report
Cabinet Report

Health and Social Care Scrutiny Board (5) 10 September 2014
Cabinet 7 October 2014

Name of Cabinet Member:
Cabinet Member (Health and Adult Services) – Councillor Gingell

Director Approving Submission of the Report:
Executive Director, People

Ward(s) affected:
All

Title:
Adult Social Care Annual Report 2013/14 (Local Account)

Is this a key decision?
No. The provision of Adult Social Care is city wide; this is a performance report and does not in itself significantly affect residents.

Executive Summary:

The Adult Social Care Annual Report 2013/14 (Local Account) describes the performance of Adult Social Care and the progress made against the priorities set for the year.

Although there is not a statutory requirement to produce a Local Account, it is considered good practice as the Local Account provides a public record of the performance of Adult Social Care to local citizens. It provides an opportunity to be open and transparent about the successes and challenges of the year and to show how outcomes are improving for the people Adult Social Care supports.

In the completion of this year's annual account engagement activity has been undertaken with Partnership Boards across Adult Social Care, to obtain feedback about our progress on last year's priorities and enable discussion on priorities for the coming year. Feedback on style and content was also noted. As a direct result of feedback received a summary version of the report will be made available.

The report will be shared with local people, people who use services, carers and partner agencies. Their feedback will inform the approach to producing next year's report.

Recommendations:

1. Health and Social Care Scrutiny Board (5) is asked to:

(i) Consider the report and advise Cabinet of their agreement of the proposals and recommendations and/or submit any further recommendations to Cabinet for their consideration.

2. Cabinet is asked to:

(i) Consider comments from the Health and Social Care Scrutiny Board (5)

(ii) Approve the publication of the report.

List of Appendices included:

Adult Social Care Annual Report 2013/14

Background papers:

None

Has it been or will it be considered by Scrutiny?

Yes – Health and Social Care Scrutiny Board (5) on 10 September 2014.

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?

No

Will this report go to Council?

No

Report title: Adult Social Care Annual Report 2013/14 (Local Account)

1. Context (or background)

1.1 In November 2010 it was announced that the Care Quality Commission (CQC) would no longer require an Annual Performance Assessment from adult social care commissioners and providers, and that no replacement assessment of performance would be implemented. As a mechanism for reflecting and communicating the performance of Adult Social Care, the first annual report was produced for 2010/11, describing the successes and challenges of the year. Feedback received from reports of previous years has been taken into account in producing the report for 2013/14.

2. Options considered and recommended proposal

2.1 The production of a Local Account is not statutorily required, nor has any statutory guidance been issued by central Government on its content or style. The expectation that a Local Account is produced by all local authorities with Adult Social Care responsibilities was set out by the Department of Health in the Adult Social Care Outcomes Framework (ASCOF) 2011/12. The concept of a Local Account is supported by the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) through its programme to help councils improve their performance in Adult Social Care.

2.2 It is considered that a Local Account provides the opportunity to reflect on and communicate Adult Social Care's performance in an accessible and transparent way and it is recommended that the Council chooses to present a Local Account for the people of Coventry.

2.3 The Local Account will be called an Annual Report in Coventry. It is considered that 'Annual Report' is more easily recognisable and accessible language than 'Local Account'.

The Annual Report describes the performance, reflects on achievements and considers the challenges for Adult Social Care, and its partners, in 2013/14. It is intended to provide assurance to the people of Coventry, Elected Members and partners, that Adult Social Care is delivering its objectives and is achieving positive outcomes for people. The report is available to local people, people who use services, carers and partner agencies, empowering them to understand, challenge, and commend local services where they see appropriate. Their feedback throughout the year will inform the approach to producing next year's report.

2.4 It is important that the Council understands whether the support offered to people is making a difference. Adult Social Care is committed to ‘Making it Real’, a national, sector-wide commitment that sets out what people who use services and their carers expect to see and experience when support services are personalised. The Annual Report is structured around the ‘Making it Real’ themes:

- Information and advice: having the information I need, when I need it
- Active and supportive communities: keeping friends, family and place
- Flexible integrated care and support: my support, my own way
- Workforce: my support staff
- Positive risk enablement: feeling in control and safe
- Personal budgets and self-funding: my money

2.5 To ensure that the report is informed by what people who receive services tell the Council about their care and support, information is used from the Adult Social Care Survey. A number of case studies and direct quotes have been used to demonstrate the impact Adult Social Care, and its partner agencies, have on individuals and their families. People and partners who have commented on previous reports have consistently stated that case studies are a much valued aspect of the report, as they help to demonstrate positive outcomes for individuals and the difference it has made to their lives. The report also identifies the key challenges for Adult Social Care including the introduction of the Care Act in April 2015, the Better Care Fund, and continuing to manage with a reducing financial resource.

3. Results of consultation undertaken

3.1 The content of the Annual Report has been developed using feedback from people who use services, and their carers, about the support they receive from the Council and other partner organisations in the city.

3.2 During the development of the Annual Report, views on potential content, feedback on 2013/14 priorities and suggestions for 2014/15 priorities were obtained from the Older People's Partnership, Learning Disabilities Partnership Board and the Physical and Sensory Impairment Partnership. Healthwatch Coventry was also invited to comment on early drafts of the report.

4. Timetable for implementing this decision

4.1 Once approved, the Annual Report will be published on the Council's internet pages and shared with partners.

5. Comments from the Executive Director, Resources

5.1 Financial implications

There are no direct financial implications arising from the Annual Report. The cost of issuing the report will be met from within existing budgets.

5.2 Legal implications

There are no direct legal implications arising from the Annual Report.

The publication of the report is in accordance with the 2011 the Department of Health recommendation that all local authorities' Adult Social Care directorates publish an annual Local Account. This shows how the local authority performed against quality standards, and what plans have been agreed with local people for the future.

The way that councils are assessed has changed and there is no longer a requirement to report to Central Government, however the Local Account gives the residents an opportunity to read about the achievements through the year, and priorities going forward.

6. Other Implications

6.1 **How will this contribute to achievement of the Council's key objectives / corporate priorities (corporate plan/scorecard) / organisational blueprint / Local Area Agreement (or Coventry Sustainable Community Strategy)?**

This Annual Report demonstrates the progress of Adult Social Care in maintaining and improving outcomes for the population of Coventry. This progress contributes to the Council's core aim of citizens living longer, healthier, independent lives and contributes to the priorities in the Council Plan to protect the city's most vulnerable people.

6.2 **How is risk being managed?**

A range of risks are presented in the delivery of Adult Social Care services which are managed through the directorate and corporate risk registers, in conjunction with partners across the city. Regular reviews of each risk are undertaken, and mitigating actions put in place to ensure the overall risks are reduced as much as possible.

6.3 **What is the impact on the organisation?**

There is no direct impact on the organisation.

6.4 **Equalities / EIA**

An Equalities Impact Assessment is not appropriate for this report. Equality impact assessments have been built into the delivery of work within Adult Social Care. There has been a continued drive to embed equality and diversity within operational practice, commissioning plans and performance monitoring.

6.5 **Implications for (or impact on) the environment**

N/A

6.6 **Implications for partner organisations?**

There are no direct impacts for partner organisations. The Annual Report provides an overview of Adult Social Care's performance and provides assurance to partners that objectives are being achieved.

Report author(s):

Name and job title:
David Watts, Assistant Director, Adult Social Care (Operations)
Pete Fahy, Assistant Director, Commissioning and Transformation

Directorate:
People

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Enquiries should be directed to the above person.

Contributor/approver name	Title	Directorate or organisation	Date doc sent out	Date response received or approved
Contributors:				
Mark Godfrey	Deputy Director, Early Intervention and Social Care	People	22.08.14	28.08.14
Gemma Tate	Policy Analyst	People	11.08.14	12.08.14
Liz Knight	Governance Services Officer	Resources	11.08.14	13.08.14
Names of approvers for submission: (Officers and Members)				
Ewan Dewar	Finance Manager	Resources	11.08.14	12.08.14
Janice White	Senior Solicitor	Resources	11.08.14	20.08.14
Brian Walsh	Executive Director	People	22.08.14	27.08.14
Councillor Gingell	Cabinet Member (Health and Adult Services)		22.08.14	28.08.14

This report is published on the Council's website:
www.coventry.gov.uk/meetings

Appendices
Adult Social Care Annual Report 2013/14 (Local Account)

Adult Social Care

Annual Report for 2013/14 (Local Account)

Produced September 2014

Foreword

I welcome this annual report as an important part of Coventry City Council's commitment to be transparent with local people about what we do and what we have achieved for those who use our services and their carers.

Since our last annual report, the Care Act 2014 has finished its legislative journey through Parliament. The Care Act is a significant stepping stone to wider reform of care and support, and underlines the importance for Councils to promote wellbeing, prevention and independence. In Coventry, we have always strived to support people to keep hold of their independence, in their own homes, for as long as possible. This remains important.

During 2013 we consulted on a range of proposals affecting adult social care services in the city. The consultation exercise undertaken by the Council was extensive and spoke to many people who were directly affected by the proposals. This enabled my Cabinet colleagues and I to fully understand the potential impact of the difficult decisions we were asked to make.

We will need to continue to review the way we deliver our services so we can ensure quality care and value for money is given to those who need it most by extending the reach of Telecare, drawing on the support of families and the wider community.

The challenging financial climate in which we are working will see adult social care take more and more difficult decisions about how we can best use our shrinking resources. I will ensure that any further proposals for changes to services are subject to a robust public consultation.

Our success depends heavily on our ability to work with our many partners including the local NHS, the voluntary sector, private companies, service users and their carers.

I look forward to working even more closely with all our partners in the coming year to ensure that vulnerable people in Coventry are able to live as independently as possible, within their communities, with their care and support needs being met in ways that they choose.

Councillor Alison Gingell
Cabinet Member (Health and Adult Services)

I am pleased to present our fourth annual report on the performance of adult social care. This report is a public statement of our progress, our achievements and our challenges during 2013/14 and the coming years.

As Executive Director of the People Directorate, I remain committed to the City Council priorities of improving the health and wellbeing of residents and protecting and supporting the most vulnerable people. The People Directorate was formed a year ago and this has provided opportunities to work more closely and effectively with children's social care.

The financial challenges facing adult social care remain and during the year we made a number of changes to our services through the 'A Bolder Community Services' Programme.

Looking forward, the implementation of the Care Act is likely to lead to a significant in demand for adult social care. We will need to continue to manage demand for our services by preventing or significantly delaying the need for long term support. Redesigning our short term service to maximise independence in partnership with the Coventry and Rugby Clinical Commissioning Group will enable us to do this. For those people that do require long term support, we need to ensure our personalised approach to support planning enables people to think creatively to meet individual outcomes and make best use of family and community networks.

The annual report is intended to be easy to read and is aimed at both people who use social care services and the wider community. You can help us improve future reports by giving us feedback on this document and telling us about the type of performance information which is of most interest to you. In response to your previous feedback, a summary version of this report will be made available.

Our contact details are provided at the end of the report, and we very much welcome any comments you may have.

Brian M. Walsh
Executive Director, People Directorate

Healthwatch Coventry commentary to be written by Healthwatch

Contents

What it means to receive adult social care support in Coventry

Adult social care is part of the People Directorate of the City Council. It works across the Council and with partners to support adults over the age of 18 and older people who may need social care or support to remain independent. In early 2014, a new vision for adult social care in Coventry was developed. This vision is *"to enable people in most need to live independent and fulfilled lives with stronger networks and personalised support".* The aim of the vision is to reflect the required emphasis on prevention, early intervention and enabling people to maintain their independence within their chosen community. This annual report is a way of communicating to the people of Coventry about how we and our partners are meeting the needs of people who require social care and support and our plans for the future.

Facts and figures 2013/14
During the year…

- 9,208 people contacted Adult Social Care compared to 8,600 people in 2012/13 – a 7% increase;

- 4,313 were signposted to sources of information, advice or support, or had their needs met compared to 3,863 people in 2012/13 – an 12% increase;

- 4,895 had an assessment of their needs – compared to 4,737 people in 2012/13 – a 3% increase

- Of these 3,347 received short term support and did not require on-going support compared to 2,876 people in 2012/13. This is an increase of 16%.

- The remaining 1,548 received on-going support compared to 1,861 people in 2012/13. This represents a 17% decrease in the number of people who required on-going support following assessment

We supported….

- 7,227 people received support from Adult Social Care during the year in comparison to 8,517 people in 2012/13

- We support people who are assessed as having 'critical' or 'substantial' needs

- 6,251 people received their support in the community in comparison to 7,526 people in 2012/13

- 56% of people had a personal budget

- 16% received their personal budget in the form of a direct payment

- 1,974 carers were assessed and received information, advice or support

- Of the people we support aged 18-64, 51.5% are male and 48.5% are female. 19% identify as Black, Asian and Minority Ethnicity (BAME). This is under-representative of Coventry's BAME population for this age group (27%).

- Of the people we support aged 65+, 32% are male and 68% are female. 9% identified as Black, Asian and Minority Ethnicity, which is slightly under-representative of the city's BAME population for this age group (10%).

More detailed information on our performance is on page 41-44.

Our Staff

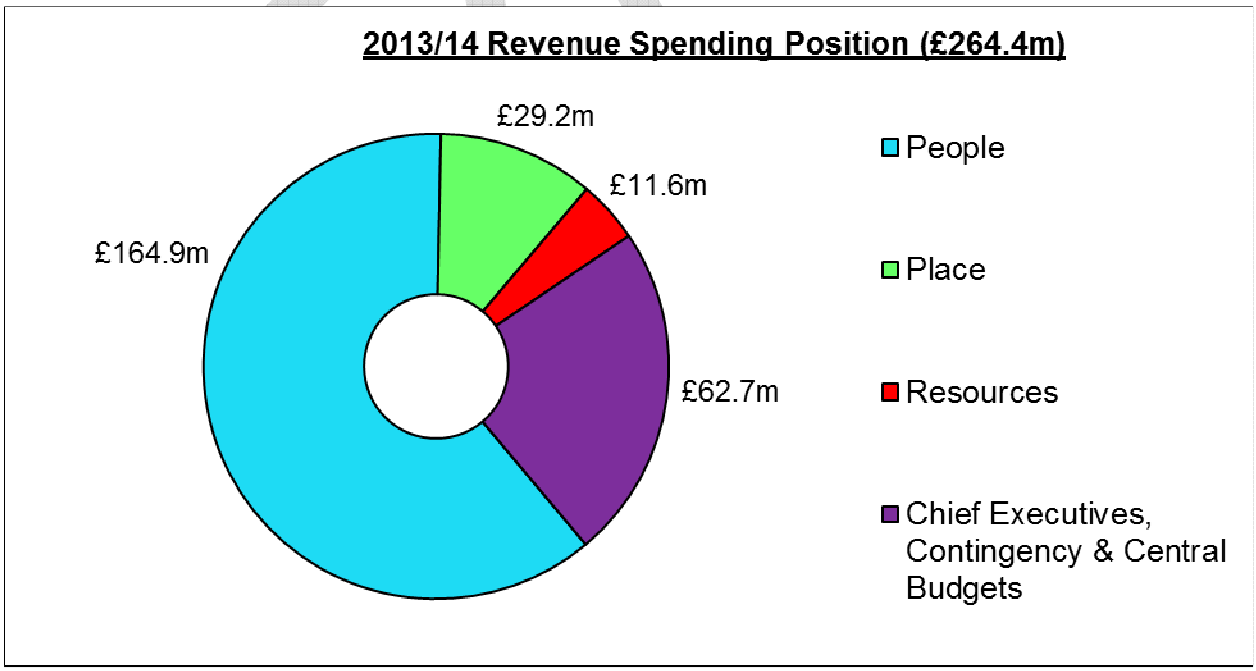
Each year the Council collects adult social care workforce data as part of the Skills for Care National Minimum Data Set for Social Care (NMDS-SC). As at 31 August 2013, the latest data available, there were 1,335 people employed within Adult Social Care. 19% of staff are from a BAME group; this is broadly ethnically representative of the local community. 85% of the workforce are female and 52% of staff are in part time posts.

Money

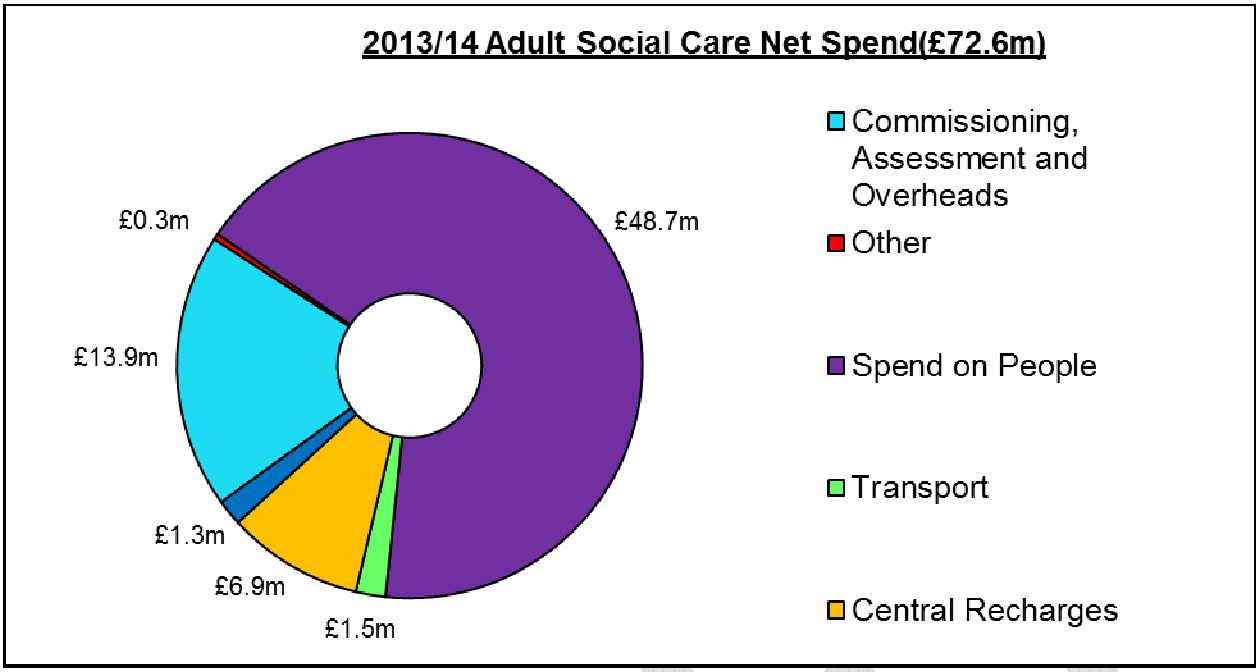
The City Council had a net budget of £268.4m (excluding schools) for 2013/14. Each year the City Council reviews its budget plans in light of existing and new legislation, its priorities and available resources.

In September 2013, the City Council has operated in four directorates, People, Place, Resources and Chief Executives, which includes Public Health. Adult Social Care is part of the People Directorate which is the largest single directorate with a net budget of £165m for 2013/14.

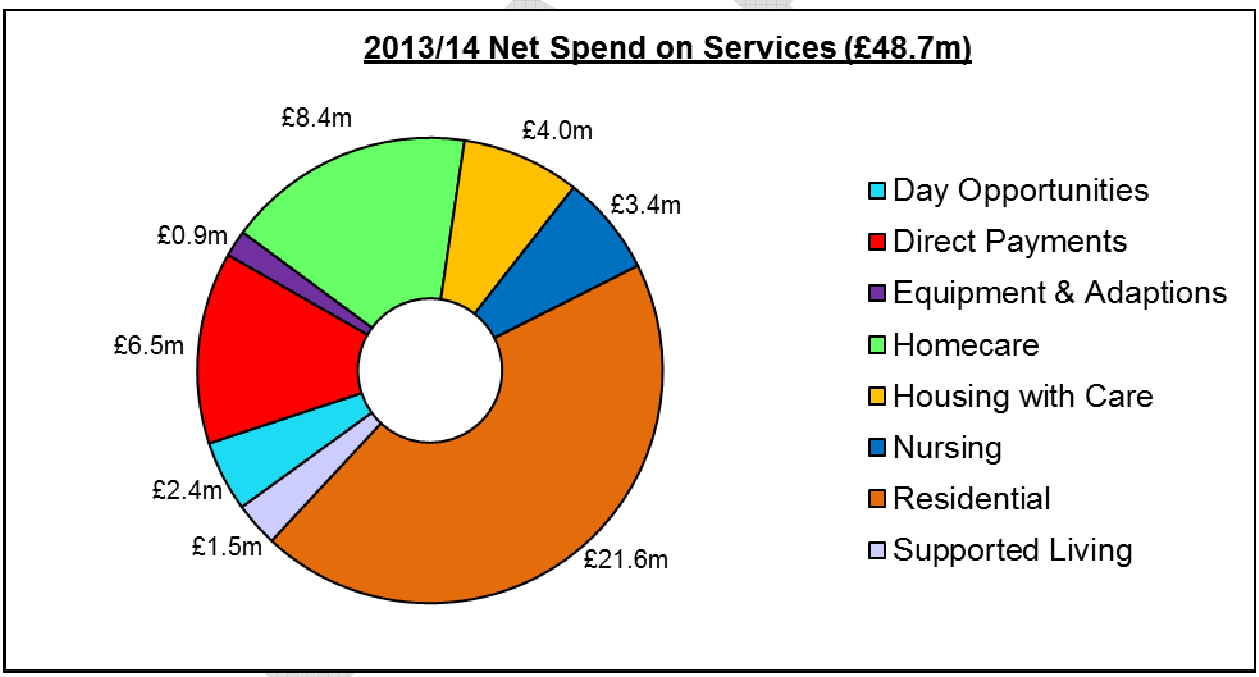
This chart below identifies the areas of spend across the Council during 2013/14



Of the total above, £72.6m was spend on Adult Social Care. The chart below shows how this was spent.



The amount spent on people was spent across the following services:



Our Annual Report

This Annual Report describes Adult Social Care's performance for 2013/14. By acknowledging what we have done well and where we need to improve, we aim to be transparent and accountable to the people who live in Coventry. It is important to communicate how the focus of adult social care is changing, and how it will continue

to change to meet the challenges the Directorate faces, not least those heralded by the introduction of the Care Act on 1 April 2015.

It is vital that we understand whether the support we offer to people is making a difference. **Think Local, Act Personal (TLAP)** is a group of over 30 national organisations working together with people who use services and their carers to improve adult health and social care through personalised and community based support. Their *Making it Real* themes set out what people who use services and their carers expect to see and experience when support services are personalised. These themes help us monitor our progress towards enabling people to have more choice and control so they can live full and independent lives. This report is structured using *Making it Real* themes:

- **Information and advice**: having the information I need, when I need it
- **Active and supportive communities**: including friends and family
- **Flexible integrated care and support**: my support, my own way
- **Workforce**: my support staff
- **Risk enablement**: feeling in control and safe
- **Personal budgets and self-funding**: my money

Working in partnership is important to us and those that we work with, including the providers that we commission services from, our health partners, people that use services and their carers and representatives. Increasingly, and with the introduction of the Better Care Fund, we will integrate closer with our colleagues in years to come.

Key Challenges

By 2016 Coventry City Council will have had its government funding cut by nearly a half since 2010. We must use these diminishing resources in the best way we can to support Coventry citizens and deliver the objectives set out in the City Council 10-year plan, 2014.

Adult Social Care is in the People Directorate of the Council. It is the biggest Directorate within the Council and as a consequence will be required to make significant savings in order for the Council to balance the budget.

Therefore, change is needed to accelerate the ability of Adult Social Care to respond to the population, policy and financial challenges it faces. This means both change to system and process through to increasing integrated approaches with our health partners and changes to the delivery of personalised support to meet the requirements of Think Local, Act Personal.

In the years to come there will be:

- An increasing number of people aged 85 and above
- More people with long-term health conditions and conditions related to old age i.e. dementia
- More people aged over 65 unable to manage at least one self-care activity
- More people reliant on the support of family networks and carers

The financial position means that:

- In order to support our population we will need to ensure that people are making use of all the resources available to them
- Support should be tailored to personalised outcomes making best use of peoples own assets and the assets available to them
- Delivering effective support that prevents the need for on-going services is both good practice and more sustainable.
- More creative use of support planning, integrated fully within the Adult Social Care workforce

Feedback from users has told us the following:

- They are frustrated at the lack of cohesiveness between health and social care
- They want to be able to access support at the time it is required in the manner in which it is required
- They want to be supported in the most appropriate setting that maximises independence
- People do not aspire to be long-term users of social care or health services where this could be avoided

- They want more control over their daily lives
- They want services that address their cultural needs

To support the delivery of change, a **Commissioning and Personalisation Plan** has been developed which includes an action plan on what changes we plan to make, how these changes will be delivered, and most importantly what improvement we will expect to see as a result over the next two years.

The action to be taken across Adult Social Care to meet the challenges described will be delivered through progressing three key areas of activity:

- **Managing Demand:** Actions to stop or significantly delay the requirement for on-going care and support services
- **Managing the Support System:** Actions to ensure care and support is arranged effectively with appropriate degrees of user choice, control and effective use of resources
- **Managing Supply:** Actions to ensure there is an appropriate supply of a range of social care and support services to meet the needs of people who will require them.

The plan has been presented to our Cabinet Member and relevant Scrutiny Board. The plan is publically available here.

Despite the challenges we face, Adult Social Care is committed to supporting the most vulnerable and ensuring personalised support provides people with choice and control over their lives.

Adult Social Care Peer Review

In March 2014 a Peer Review was undertaken within Adult Social Care as part of the Local Government Association's (LGA) Improving Social Care and Transforming Public Services agenda. The Peer Review involved a team of professionals and experts meeting with a wide range of stakeholders including staff, partners and service users. This enabled them to build an informed assessment of current practice and service delivery within Adult Social Care. The review focussed on the City

Council's approach to Commissioning and how this could reduce demand for traditional services through the use of community assets, families and friends.

A summary of the findings from the Peer Review are as follows:

Strengths

- Partnerships with health colleagues are good and these facilitate close working and integrated approaches to service delivery;
- The POD mental health recovery service demonstrates an excellent example of a recovery model and was reconfigured by the Peer Review Team as one that offers a comprehensive personalised approach;
- Local political leadership from the Cabinet Member was recognised as being strong and well respected;
- A one organisation approach was observed by the Peer Review team. Staff interviewed were enthusiastic and positive about changes in services;
- Partnership Board Structures – members, including service users and family carers, informed the Peer Review Team that the Boards provided an opportunity to engage, shape and influence service provision.

Areas for consideration

- Whilst engagement with stakeholders highlighted a positive experience the Peer Review Team felt that there could be a greater role for co-production with people who use services and their family carers;
- Development of a single referral pathway for social care and health clients was proposed along with a single point of access to assist with timeliness of signposting, triage and assessments;
- The Peer Review Team recommended that the Council and commissioners consider how providers and the voluntary sector can be involved in the development of community asset based approaches;
- Consideration should be given to how personalisation is fully integrated into the everyday business of Directorate staff and activities. It is proposed that workforce development support is provided to improve innovation in support planning and service user outcomes.

The outcome of this review has been invaluable in helping the Council plan for the future. Key recommendations from the review are incorporated into the Council's **Commissioning and Personalisation Plan.**

'A Bolder Community Services' (ABCS)

The 'A Bolder Community Services' Programme was created in 2012 to assist the former Community Services Directorate (now part of the People Directorate) to meet savings targets to enable the City Council to set a balanced budget.

During 2013/14 the programme oversaw the development of a number of proposals to deliver the required savings of £3m for 2013/14 and £8m for 2014/15 and manage pre-existing budget pressures facing the Directorate.

Prior to developing formal proposals for consultation, engagement sessions were held with staff, partnership forums, partner organisations and the voluntary sector to explain the challenges faced by the Council and how these could potentially affect Adult Social Care services. These sessions took place from early 2013 and helped to inform proposals for formal consultation.

Between 27 August 2013 and 15 November 2013 the City Council consulted on six proposals about changing, reducing and closing some Council services. These were:

- Reducing funding to housing related support services;
- Closing two Council-provided housing with care schemes;
- Changing and reducing the number of day opportunities services provided by the Council for older people, people with dementia and people with learning disabilities;
- Reducing funding to information, advice and support services;
- Changing the funding responsibility for The Aylesford (reablement centre) or closing the service
- Changing home support reablement services which included ceasing the Council provided Home Support Short Term Service (HSSTS)

An extensive consultation exercise was undertaken. The City Council is committed to ensuring that the views of the people of Coventry, current users of our services and their carers are taken into account when making important decisions. It is only by

gaining these views and experiences that the Council can understand the potential impact of any service changes.

During the consultation period, 8,500 people were contacted, 90 meetings held and over 1,100 people spoken to. 536 survey response forms were complete and 262 additional letters were received. Two formal petitions were also received in respect of the housing related support and information, advice and support proposals.

As a result of the consultation a number of proposals were amended or changed including retaining weekend day services provision for older people with dementia and taking an organisation by organisation approach to the implementation of required changes.

Full details of the ABCS consultation can be found here

Understanding your views and experiences

We want the people who use our services and carers to be at the centre of the decisions we make about Adult Social Care. To do this we need to understand people's experiences of care and support, involve them when we need to make changes and take on board their views to inform decisions that are made. Throughout 2012/13 we undertook a range of activity to understand these views and experiences including:

The Adult Social Care survey - between January and March 2014. 406 people responded to the Adult Social Care Survey (a 35% response rate). You will see what people told us about their support throughout this document.

Another Adult Social Care Survey and a Carers' Survey will be conducted during 2014/15. We will use the results to track our progress in delivering services that make a real difference.

Partnership meetings - co-ordinated by the City Council (Older People, Learning Disability and Physical and Sensory Impairment) are attended by a wide range of stakeholders, and provide regular opportunities for engagement and consultation.

Carers Forums - held throughout the year to offer a specific opportunity for family/informal carers to share their views with the Council.

Learning from when things don't go so well

Local Authorities are required by law (National Health Services and Community Care Act 1990) to have a system for receiving representations by or on behalf of people in need of Adult Social Care support who have a range of support needs due to a disability or frailty.

Where we can, issues are resolved at a local or provider level and if this is not possible, then a formal complaint is logged. The overall number of complaints received in 2013/14 was 61 (80 in the previous year). The complaints can be quite complex and usually involve different aspects of the care and support provided to them.

The most common themes were service and communication/information which accounted for 82% of the complaints. Apologies and explanations are a standard basis for resolution and a feature of formal responses.

However, other complaint outcomes have also involved re-assessment, reimbursement, change of worker, change of care provider, changes to a leaflet, reassessment of Direct Payment, and improving the collection of data within commissioning.

Each year an annual report is produced, which provides further information and statistical analysis of the complaints and representations for the year. This will be presented to the Cabinet Member (Health and Adult Services) in November 2014 and will be available here.

During the year two Serious Case Reviews (SCRs) were undertaken. The learning from these reviews has enabled us to improve our consistency in responding to pressures ulcers.

Progress on last year priorities

In last year's annual report we committed to a number of priorities for 2013/14 and said we would improve in a number of areas. Here is the progress we have made:

We said we would… Support people with care and support needs and their carers, as early as possible with information and advice. For example, by increasing the availability and quality of information available in libraries and increasing the awareness in the community of specialist conditions, such as autism and dementia.	**We have…** Commissioned a local Healthwatch, as required by the Health and Social Care Act 2012, and appointed a Healthwatch Liaison Officer to develop the remit of our libraries in providing quality information and signposting. Launched Adult Social Care Direct which aims to reduce the number of access points to adult social care and make it easier for the public to obtain information, advice and signposting. The Dementia Friends initiative has been adopted in Coventry. The purpose of Dementia Friends is to raise awareness and reduce stigma of dementia. Over 350 people have attended information sessions.
We said we would… Work with community organisations to understand how we can support them to support more people in their local community who are experiencing social isolation.	**We have…** Established a Community Development Service and secured funding to develop and implement the World Health Organisation's Age Friendly Cities initiative in Coventry, in partnership with Age UK Coventry and Coventry University. A key aim of Age Friendly Cities is to ensure older people have the best possible quality of life.
We said we would… Review the offer to carers, focussing on support that has the greatest impact and sustains carers'	**We have**… Started to review the support and services available for carers in Coventry. During the summer of 2014, a

ability to continue caring.	survey of carers and staff across health and social care will be conducted to gather further information to help inform future commissioning activity to ensure that carers have access to support that sustains their ability to continue caring.
We said we would… Improve performance across a number of organisations.	**We have…** Continued to develop the Coventry's Provider Escalation Panel (PEP). The purpose of the panel is to manage health and social care provider performance at an early stage when issues arise and ensure that good quality services are provided.
We said we would… Agree a plan for integrated health and social care, to be signed off by the Health and Wellbeing Board by 31 March 2014.	**We have…**Developed a draft Better Care Fund Plan and this was signed off by Health and Wellbeing Board in April 2014. More details can be found on page 38.
We said we would… Embed the principles from the Winterbourne Review and Francis Report across the social care workforce.	**We have…** All internally provided services have embraced the principles of the Social Care Commitment with majority having formally signed up.
We said we would… Target support with health colleagues to improve standards in care homes	**We have…** In conjunction with Coventry and Rugby Clinical Commissioning Group, established key relations and joint working protocols with health colleagues to improve standards across the care home sector. For example, nurses now undertake quality monitoring visits with staff from the Council's commissioning team
We said we would… Support Coventry Safeguarding Adults Board to achieve their priorities.	**We have…** Appointed a Head of Adults and Children's Safeguarding. A number of procedures have been updated and an easy read leaflet developed to increase

	the awareness of safeguarding. The training programme has been revised.
We said we would… Improve the experience of people with personal budgets and direct payments, including carers, with the support of a regional project.	**We have…** Through our links to the regional project been able to gain access to tools and guidance that have supported us to review our current offer and enable people to have more choice and control over their support. This work will be further developed over the next year.

Introduction from Assistant Director

2013/14 has been a challenging year, but I am proud of how both internal and commissioned services have continued to support vulnerable people. The work over the last year demonstrates our commitment to improving our information and advice offer, including our priority about raising awareness of and providing information and advice about dementia. The formation of the Coventry and Warwickshire's Dementia Action Alliance will provide a great platform for the continuation of this work.

Developing active and supportive communities continues to be an exciting area of work for us. In March 2014 the Community Development Service was launched. This service will have a key role, alongside local residents, to build confident and resilient communities. The service will also work alongside community organisations and faith groups to maximise available support in local areas. In 2013 the Council was successful in obtaining £370,000 of Central Government funding to improve the physical environments across five social care settings, including Eric Williams House, a residential home for people with dementia to make them more dementia friendly. This will have a great impact on improving people's quality of life within their home.

The Adult Social Care Peer Review highlighted our positive working relationship with our health partners as a key strength which we are keen to build upon over the coming year, as we develop our Better Care Fund Programme to accelerate health and social care integration.

As part of the drive to re-energise the personalisation agenda, we need to be more creative in our support planning process over the coming year. To enable people with long-term care and support needs to meet their individual outcomes for a fulfilling life, whilst utilising both family and community resources in the area they live.

Workforce development is critical to ensuring the delivery of quality services and ensuring that vulnerable people are protected from harm. Over the course of the year a range of training programmes have been delivered to staff across health and social care.

Two Serious Case Reviews during the year taught us important lessons which, as a result, led to the Pressure Ulcer Protocol being revised, the new protocol implemented, and extensive training delivered to staff. This has resulted in a more consistent response to pressure ulcers and increased numbers of information checklists received from nursing staff which inform safeguarding decisions.

Preparing for the implementation of the Care Act in April 2015 and the Better Care Fund programme are our key priorities in 2014/15. Some of the key actions are outlined on pages 38-40.

Information and advice: having the information I need, when I need it

Adult Social Care has an important role in ensuring that advice and information is available to people living in the city. 76% of people who use services and carers told us that they found it easy to find the information they need. This is an improvement on last year where only 70% of people were able to easily find information they needed.

However, we know that this is not the experience of everyone and that people need quality information to understand their options and reliable advice upon which to make decisions about their care and support.

Working with our partners, we have achieved a number of improvements to the information and advice we offer.

- **Adult Social Care Direct** launched in March 2014. The purpose of Adult Social Care Direct is to reduce the number of access points to adult social care and make it easier for the public to obtain information, advice, signposting and, where a potential need is identified, ensure that a referral is made to the most appropriate team for an assessment of need to take place. The initial phase of development reduced the number of access points from six to four; work will be undertaken over the coming year to reduce this further within Mental Health and Learning Disability Services. More information about Adult Social Care Direct can be found at http://www.coventry.gov.uk/info/200050/help_for_adults or phone Adult Social Care Direct on 024 7683 3003.

- Information on the City Council website has been updated to make it easier for **carers** to access the advice they need about support for them and the person they care for.

- **Coventry Carers' Centre** trialled and subsequently introduced their telephone helpline on a Saturday from February 2014. The helpline is available between 10am and 2pm. The increase in the availability of this service will support all carers, but will be especially useful for working carers seeking information, advice and support.

- **Dementia Friends** is a national initiative by the Alzheimer's Society which has been adopted in Coventry. The purpose of Dementia Friends is to raise awareness and reduce stigma of dementia. Information sessions have been held for social care senior management team, elected members, third sector colleagues, all library staff, Maymorn Resource Centre (dementia day care), Public Health, and social work students on placement at the City Council. Two public sessions have also been held. Over 350 people have attended these information sessions.

- Further improvements have been made to the **Coventry and Warwickshire Dementia Portal** which provides a one-stop shop web portal for people, professionals and family members, to learn more about dementia. Coventry University were commissioned to develop pages, specifically designed for use by people with dementia to enable them to use self-management techniques to regain / retain their independence. The portal has been widely promoted in

libraries and amongst professionals. You can find the portal here: http://www.livingwellwithdementia.org/

- **The Coventry and Warwickshire Dementia Partnership Twitter account** continues to be successful. The account has almost 1,400 followers, meaning that we are able to deliver messages via social media and inform people with dementia, and their family members, about services and support available in the local area.
- We have continued to make good progress towards implementing the national strategy for adults with autism. Following the success of the Dementia Portal, an **Autism Portal** is currently in development, working with people with autism to decide what information should to be available on the portal to help people, family members and professions learn more about autism.

Healthwatch Coventry, has an important role, alongside our voluntary sector partners, to provide information about local health and social care services in the City. A new full Healthwatch Information Service was created from October 2013 by Coventry Citizens Advice Bureau (CAB) and it dealt with a total of 115 enquiries between 1 October 2013 and 31 March 2014. In order to reach more people **Healthwatch Coventry** is currently developing community-based Healthwatch Information Access Points. Work began in January 2014 and four local libraries have been identified to pilot the service.

Coventry Libraries have continued to develop the range of information related to health and social care available for Coventry residents. Health and wellbeing zones are being developed in a number of our larger libraries, places which allow libraries to focus the information available and to act as a hub for various health partners to access the library and promote access to their services. Staff can support visitors to libraries with navigating NHS Choices or other available tools to help them access local services.

Books on Prescription and Mood Boosting Books are available within our libraries. These books are nationally recognised as a means of support which can help people manage illness or long-term conditions or generally help to raise levels of health and wellbeing. In 2013/14 we lent over 3,500 such books, a 60% increase over the year for books of this type.

The availability of e-books, e-audio, online newspapers & e-magazines has increased; these items can be accessed on library computers or downloaded from home free of charge to library members. **The Library Service** is currently working with **Age UK Coventry** to develop a pilot project to enable housebound residents to access e-books, e-audio and e-magazines.

Active and supportive communities, including friends and family

Having meaningful connections to people and places in the local community is an important way that people who need care and support can maximise their independence and improve their quality of life.

92.1% of service users surveyed told us their quality of life is 'good' or 'alright'. This is a marginal improvement on last year when 91.9% of people felt this way.

48% of service users surveyed told us they have as much contact as they want with people they wished to in their social life, whilst 33% have an adequate amount of contact. 19% of respondents do not feel they have enough contact with people.

Tackling loneliness and isolation amongst older people was identified by the Council and its partners as a priority area. During 2013, a partnership between Coventry University, Coventry City Council and Age (UK) Coventry has been established to lead the development and implementation of the World Health Organisation's Age Friendly Cities initiative in Coventry. By becoming an Age Friendly City, Coventry will work to promote the opportunities available to improve health, participation and security as people age, thereby increasing quality of life for all residents.

68% of respondents to the Adult Social Care survey said they are able to spend enough of their time as they choose and do things they value and enjoy.

There is a strong link between employment, accommodation and an enhanced quality of life. There has been an increase in the number of people with learning disabilities and people who have contact with secondary mental health services (people who are receiving treatment from a Mental Health NHS Trust) in paid employment and who live in their own home, or with family. This improves social and economic outcomes and reduces the risk of social exclusion for these groups.

We want to make sure that people are supported to maintain their community life and that there are a range of activities for people to access. Here is some of what we have achieved…

- This year members of staff from the **Learning Disability Day Opportunities Service** have supported people with learning disabilities to create a group for people who share an interest in performing arts. A rehearsal space was found within a local church and a faith group are activity involved in the project, supporting with the provision of refreshments on performance days. The group is open access and people in receipt of direct payments, members of the church and other local performance artists have become involved. This is a great example of how local community assets can be used to make a positive contribution to people's lives. The whole performance group were finalists at this year's "National Learning Disabilities Awards" in the category for "the People's Award".
- **Carers** are supported to take a break from their caring roles and maintain their social and community lives. There was an increase of 29% in the average number of carers using the **Carers' Short Break Scheme** during this year. An average of 107 carers a month used the service and received an average of 4.75 hours of support per month. 421 carers accessed a personal budget, via a direct payment to support them in their caring role.
- In our continuing efforts to support family carers across Coventry we have completed nearly 2,000 separate carers' assessments and reviews this year and a high percentage of those carers accessed carers' services.
- The number of people registered with the **Carers Response Emergency Support Service (CRESS)** continues to increase and the use of this service has doubled in the last year providing much needed support to families at a time of crisis. At the end of March 2014, 960 people were signed up to the CRESS Service. CRESS emergency plans were instigated on 68 occasions for 47 people, providing 1,120 hours of support plus 142 sessions of support during the night. 31% of carers and cared for using this service were over the age of 85.
- **Carers' training** continues to be an important part of the support package to carers and during the next year the City Council will be taking part in a

regional survey to find out carers' views of the training and learning opportunities they have experienced and what ideas they have for the future.

- One carer explains the positive effect training, provided by **Coventry Crossroads,** has played in her role as a carer but also in supporting key family relationships and community connections to be maintained *"The Crossroads Trainer showed me and my daughter to hoist my mum. This has been invaluable to us. My mum cannot move herself and spends most of her time in bed. Because we can move her safely we were able to take her out to see my daughter receive a bowling champion trophy, something my mum has always wanted her to aspire to. It meant a lot to my daughter as her Nan taught her to bowl"*
- We celebrated International **Older People's Week 2013** by working with Age UK Coventry and Coventry University to host an information and activities day, attended by over 130 people. The majority of people that attended engaged with stall holders in the information and advice market place. A wide range of activities were on offer for people to try out, including Tai Chi, Beetle Drive, plus a theatre workshop and history walk. One Older Person commented *"it was good to have the student interaction" demonstrating the value of social interaction between different age groups in developing community connections".*
- **The Employment Support Service (TESS)** is part of the Council's Employment Team. TESS specialises in providing supported employment services for disabled adults and young people in Coventry, this includes people with learning disabilities, autism and people with severe and enduring mental ill health. You can find out more about TESS here: http://www.coventry.gov.uk/tess

- TESS worked with us to develop Raising Expectations to Employment – Coventry's Employment Pathway for disabled people eligible for support through Adult Social Care. You can find out more here: http://www.coventry.gov.uk/pathways

- During the year, TESS received 75 referrals and supported 38 people into employment (10 people with learning disabilities, 22 people with severe and enduring mental ill health and 6 people with autism).

- TESS also supported 38 people to access work experience and voluntary work opportunities (16 people with learning disabilities, 17 people with severe and enduring mental ill health, 2 people with autism and 1 person with a sensory impairment).
- TESS supported an average of 99 people per month to maintain their employment and engaged with a total of 88 new employers during the year as part of working with local employers to help them to successfully employ, train and retain more disabled people.

- Through the work of TESS the Council has increased the number of people known to the Council with a learning disability and in employment by 30%.
- A case study on the impact of the Tess Service is below.

Case Study – Carl's Story

Background: Carl is 57 years old and lives with his long term partner. Carl was made redundant and struggled to find a new job despite applying for lots of jobs. The frustration of being unemployed began to affect Carl's mental well-being and he suffered a breakdown.

Action: Carl was referred to Community Mental Health Team for support. The Community Psychiatric Nurse made a referral to TESS as Carl was clear that getting back into work would help him recover from depression. Through TESS Carl was able to access a work trial with a local company, as a warehouse operative, instead of going through a normal interview process. Carl was anxious about his journey to work so TESS helped him practice his journey. Carl also had a Job Coach to support him to learn the new job.

Impact: Carl has now been in the job for over a year. He has been given a permanent contact for 40 hours per week. Since starting the job he has never missed a day's work - he doesn't even like taking holiday because he loves the job so much. Carl and his family are very grateful to the TESS Team as without their support he feels he would still be doing voluntary work and not in paid employment.

The Age UK, Coventry Fit as a Fiddle programme continues to be successful within our Housing with Care schemes, a type of specialist housing where 24-hour care and support is provided to tenants. The Fit as a Fiddle programme runs in all

Housing with Care schemes across the city, offering fun and relaxing activities to improve physical and mental wellbeing. Due to the success of this initiative, Age UK Coventry and the Housing with Care Service are working together to develop another programme, which will focus on supporting tenants with long-term health conditions, who are looking to increase their physical activity. The programme will also aim to increase confidence and self-esteem amongst participants and reducing the number of visits to the GP or hospital admissions. It is hoped the programme will also help to alleviate loneliness.

The Pod is a Council resource for people working to improve their mental health. **Active Reach** is a partnership project between the Pod and Groundwork West Midlands. It is funded by Comic Relief and directed by an Advisory Panel consisting predominately of people supported by the Pod. Active Reach is aimed at improving people's sense of mental wellbeing and physical health through sustaining engagement in citywide sporting activities. To date over 40 people have benefitted from the project working with numerous sports organisations and providers in the city. Scott was supported to re-connect to rock climbing at Warwick University climbing facility. Scott describes his experience and the impact it has had on his life: "*I was nervous to go along to the first session as I have been out of practice for a while, then half way through the first session my confidence began to increase and I felt a buzz in excitement and motivation. Week by week I felt more confident with my climbing and also in my personal life. When I first came to the Pod and started on the Active Reach programme I was low in confidence and now I feel like I am in a better place*".

Flexible integrated care and support: my support, my own way

People who use services and carers should be able to exercise choice over how they are supported. Options should be available across a range of settings – either in a person's own home, the community, or in supported living or residential care. People should experience co-ordinated support and that support should be responsive to changes in people's lives.

When we asked people about their care and support in our Adult Social Care Survey, 92% of service users said they are satisfied with the care and support they receive, of which 64% were very satisfied.

Being able to choose what to do and when to do it and having control over daily life is important for a person's overall quality of life. 80% of service users said they have control over their daily life. This suggests that 20% feel they do not have control over their daily lives; this is an area for us to explore and improve upon.

We want to make sure that, wherever possible, people have choice and control over their support.

- Following the completion of the National Joint Improvement Programme **(Winterbourne View) Stocktake**, a local register of people currently in hospital placements was developed for the Coventry and Warwickshire area. In April 2013, eight Coventry people were currently in a hospital setting; four of these placements were out of the city. During the year, all eight people were reviewed by a multi-disciplinary team and future plans identified for them.
- The following outcomes had been received by March 2014:

Total number of people living within hospital setting as at 1st April 2013	**Number who left a hospital setting by 31st March 2014**	**Outcome**
8 people (4 people in City and 4 people placed out of City)	4 people (3 people in City and 1 person returned home from an out of city placement)	2 people moved home with a package of support. 2 people moved into residential care

- The local register will be maintained and further developed over the next year to include adults, young people and children placed out of city, in other residential establishments.
- The City Council and our heath partners are committed to supporting people currently living in a hospital setting to return home with the required care and support to enable them to independent lives within their chosen community.

- Home environments can create barriers to maintaining an individual's independence and roles within their family life. **Disabled Facilities Grants** enable adaptations to a person's home, aimed at providing easier access in

and out of the property and to essential facilities such as bathing, toileting and lifts. In the last year, the Council provided 376 Disabled Facilities Grants and continued to maintain last year's increase in performance levels.

- The Council is committed to ensuring that accommodation, care and support is delivered to individuals in ways that maximise their independence and reduces the need for on-going services. **Axholme House** in Wyken is a Council-run step-down recovery service for people with long-term and enduring mental ill health. The Axholme House building has a number of structural issues and did not offer accommodation conducive to promoting independence.

- In light of this, in January 2014, the decision was taken to cease services at Axholme House and then relocate occupants to Clifton House in Foleshill. All six occupants overwhelmingly supported the move to new improved accommodation. In total Cliffton House can offer 10 people transitional support for up to two years to gain the required skills to live independently. People moved into their new accommodation in April 2014.

- A consultation process regarding ceasing to use **Dick Crossman House**, a shared supported accommodation for eight adults with learning disabilities, offering tenants the opportunity to move to new build accommodation on Chace Avenue, Willenhall, was undertaken over the last year. The overwhelming outcome that all tenants at Dick Crossman House would like to move to the new accommodation which offers each tenant their own private bedroom, lounge, kitchen and bathroom. Tenants moved in July 2013. The case study below describes one person's journey to their new home.

Case study – John's Story

Background: John has lived at Dick Crossman House for over 20 years, most of his adult life and was comfortable living there. Although John had his own room, it wasn't very big. John had privacy but it did get noisy sometimes, which he didn't like.

Action: When John found out he would be moving away and to somewhere

different he got very worried of what might happen and how much my life would change. It took him a while to understand what his flat would be like. He went to the tenants team meetings and staff told everyone about what was going to happen which started to put his mind at rest.

Everyone would get a brand new flat with their own lounge, bathroom, bedroom and kitchen.
As moving day got closer he started to buy items for his new flat, he knew straight away what colour he wanted he kitchen to be, so he brought everything in red, microwave, tea towels, tea/coffee pots. John was very clear that he wanted a 'chocolate brown leather recliner sofa and chair' and a memory foam mattress for my new double bed. Staff helped him go to local shops to choose furniture.

Impact: John said: *"Now that I am finally moved in I am absolutely loving my new flat. I like the intercom with a little TV so I can see who is at the door and my mum says she likes it as well. My life is really relaxed now and very quiet, I have something to call my own and it is so much better not having to share a kitchen and bathroom with someone else."*

Workforce: my support staff

- When people receive support it should be from staff who are competent and have the values, attitude, training and tools to make sure that people achieve the outcomes they want from their lives. People who receive direct payments and those who self-fund their care should be supported to recruit, employ and manage personal assistants.
- The Council's Social Care Development Centre ensures that staff working in social care are highly trained and competent in their roles. Courses that focus on person-centred planning, dignity, and communication are delivered to care and support staff across the city, not only Council staff. This training reinforces the values and attitudes we expect care and support staff to hold and is essential for improving the experience of people who use our services.
- The City Council, in conjunction with Coventry and Rugby Clinical Commissioning Group, have established key relations and joint working protocols with health colleagues to improve standards across the care home

sector. In particular, a range of posts have been established to work jointly across care homes to improve quality standards. For example, qualified nurses support quality assurance activity within the nursing home sector.

- The quality function within the Council Commissioning Team continues to provide support to the care market through concentrated work and resources to improve service levels whilst providing information on training, development opportunities and new national care standards.

- In addition to the Council's monitoring work, **Healthwatch Coventry** has undertaken 'enter and view' visits with a number of care homes in the City. Healthwatch Coventry visited 13 residential care homes during March and April 2013. The visits focussed on choices at meal times, refreshments and activities. Healthwatch Coventry found that there were variations around food, interaction between staff and residents, types and number of outings, involvement of the local community and roles of staff (having an activity worker or not) between the different care homes. The size and space available to the care home also impacted on the type and range of activities available to residents. Healthwatch identified positive practice where the individual choices of residents were met and creative ideas for activities were implemented. These visits have proved valuable in assessing quality standards and user views. Due to the success of this work, Healthwatch Coventry plans to continue carrying out further care home visits.

- **Grapevine** increases user involvement in the setting of standards and monitoring of statutory services including day opportunities, supported living, residential care, carer breaks services by undertaking peer review visits. People with learning disabilities visited 30 providers and made 22 post-audit visits during the year. The focus of the visits is to look at the quality of life of those people using or living in their services. Through this work Grapevine is finding that providers and their staff are becoming more aware of the need to give people genuine choice in all aspects of their lives. The post-audit visits have proved to be a successful mechanism to support providers to understand the recommendations and how to make suggested improvements.

- Both Healthwatch Coventry and Grapevine produced reports about each visit which has been shared with both the providers and the City Council, as the commissioner of these services to ensure learning is embedded into practice.

- A multi-agency training programme involving people with autism was developed and delivered to over 300 staff members across health, social care and the third sector. This training programme has raised awareness of autism and how to effectively work with people on the autistic spectrum.

- Staff from the **Council's Social Care Employee Development Unit** provided training to **Coventry and Warwickshire Partnership Trust (CWPT)** staff on the subjects of Mental Capacity Act and Deprivation of Liberty Safeguards. The aim was to support CWPT in meeting its registration and inspection requirements and to give ward staff some practical advice around how the Acts affected their services, recording and compliance. Over 40 staff attended these training sessions. (Choose between this and next paragraph)

- **The Opal Assessment and Demonstration Centre** delivered a range of training to colleagues from **Coventry and Warwickshire Partnership Trust and two external providers** on developing competency and awareness on manual handling techniques and equipment aimed at improving user experience, as improved equipment provision often leads to less intrusive care being delivered. In total over 75 people received training

- We launched new supervision guidance for social care staff working in Adult Social Care. The guidance aims to ensure that through effective supervision social work staff and occupational therapists develop good practice and make sure that decisions are based on sound evidence and assessment of risk. It also provides the opportunity to ensure national and local policies are understood and correctly applied.
- We continue to make improvements which support staff to do their jobs and are achieving recognition for the quality of the Council's support staff. The Pod is a Council resource for people working to improve their mental health. The

Pod manager was successful in winning the National Mental Health Leader award at the National Positive Practice Awards in Mental Health.

- **The Social Care Commitment** developed by Skills for Care is the sector's promise to provide people who need care and support with high-quality services. Employers and employees, across the whole of the Adult Social Care sector, sign up to the commitment pledging to improve the quality of the workforce. All internally provided services have embraced the principles of the Social Care Commitment with the majority having formally signed up. As an example one service is working closely with individuals to engage them in the setting of the standards, establishing what they expect from our services.
- We work with providers to consistently maintain and improve workforce standards across the city. Regular provider forums provide an opportunity to deliver refresher training through expert speakers. For example, the **Coventry Cares Learning Network** supports the learning and development of the workforce in external social care provision, such as care homes and home support agencies. A number of training events are run by the learning network, including two full day training events. In the last year one of these events was focussed on working with people with visual or hearing impairments, this included a presentation at the Bionic Ear Show and provided an opportunity for staff attending to experience life without sight in the sensory tunnel and training in how to be a sighted guide.
- The Learning Network was successful in obtaining funding from the National Skills Academy Registered Managers Programme to establish networking group for registered managers in Coventry. The group meetings are an opportunity for managers to network and share good practice, learn from expert speakers, and develop tools and templates which will enable more effective working and improve standards. To date 67 Registered Managers have been actively involved in this group.
- An on-going development theme for the Learning Network is that of dignity in care. Workshops for frontline staff have been developed and are currently running (from April 2014). At these workshops staff will be encouraged to become Dignity Champions. A Coventry Dignity Network will also be launched in late 2014 to continue to support this key area of work to ensure that everyone who receives care and support are treated with dignity and respect.

- Since 2012, we have actively offered **apprenticeship** opportunities for young people to gain experience and qualifications to work in the adult social care sector. The scheme has proved to be successful in providing a career path for young people. Rebecca started as a health and social care apprentice in May 2013 and has recently secured a permanent post providing assisted care to enable older people to live independently. She describes below her role and the impact it has had on her life.

Rebecca said: "I assist elderly people with a range of care, talk to them and try to build up trust. Getting an apprenticeship has really helped. I didn't work for seven months before securing my apprenticeship. I'm now working full time after getting a permanent post and I'm doing my NVQ Level 2. So it is a big thumbs up from me."

Positive Risk enablement: feeling in control and safe

People who use services should expect to feel safe and secure. This means being free from abuse, falling or other physical harm. In the Adult Social Care survey, 95% of service users said they felt safe as they wanted or adequately safe.

63% of people say that the way they are helped and treated makes them feel better about themselves and ensures their dignity. This is up by 6% on last year and therefore demonstrates some improvement in this area.

Following the survey, people who said they did not feel safe at all were contacted by Council staff to investigate their responses further.

People who use Adult Social Care are supported to assess risks and benefits and plan for problems that may arise. Safeguarding processes are well co-ordinated with everyone understanding their role. People, carers and family members should know how to raise any concerns they have.

We received 1,002 safeguarding alerts in 2013/14 representing a 24% increase from the previous year. This indicates that there is further improvement in the general awareness of safeguarding across the city and that people know how to raise an alert.

The **Coventry Safeguarding Adults Board** produces an annual report, which describes the achievements and challenges of the year. We were committed to supporting the Board in its priorities for 2013/14. The Board agreed three key priority areas:

1. Responding, listening and acting on concerns (including learning lessons from reviews)

2. Continuing and strengthening multi-agency working

3. Reducing harm, by preventing harm, recognising risk and harm and dealing with it when it occurs.

Here are some of our achievements that help people to remain safe…

- There has been a major drive to improve the **Provider Escalation Panel**. This is a monthly multi-agency meeting which monitors providers where there are emerging issues in terms of quality and performance. Improvements include better information sharing and a stronger focus on safeguarding.

- Introduced electronic discharge notifications to GPs to ensure that consistent and relevant information is shared quickly to support the continuous care and support for people following discharge from hospital.

- **West Midlands Police** established a vulnerable adult hub that offers a single point of contact allowing the force to respond to referrals from partners for primary investigations to be completed before cases were passed through to public protection teams. The hub has been recognised as best practice.

- The e-alert system has resulted in the Safeguarding Team at **University Hospital Coventry and Warwickshire** being able to respond promptly to the needs of at-risk individuals who attend the hospital. This has had a positive impact for all involved; the person gets rapid protection and staff members supporting the person are aware of the risk factors and can get immediate support and advice from the Safeguarding Team.

- The City Council has started trailing the use of **GPS trackers for people with dementia**, to support them to walk safely and remain in their own homes for longer. They also provide reassurance to family members and care staff that they will be able to trace people's movements if needed. This has enabled people with dementia to remain at home for as long as possible,

delaying the need for residential care. A case study on the impact of using GPS Trackers can be found below.

Case study – Catherine's Story

Background: Catherine lived in a Housing with Care Scheme and has dementia. Catherine had left home on two occasions without returning at her normal time. Both times the Police were called to assist. A door exit sensor had proven ineffective and the Care Provider no longer felt able to meet her needs.

Action: At a review meeting, it was identified that Catherine may benefit from a GPS Tracker. Both Catherine and the Care Provider agreed and the Buddi GPS System was chosen.

Outcome: The Buddi system was used on three occasions to enable Catherine to be returned home safely by the Police. The use of Buddi enabled Catherine to remain at home and delayed her admission to residential care for three months. This meant that her admission to residential care could be planned over a period of time rather than by an emergency admission.

- **Grapevine,** in partnership with the Council and the Community Safety Partnership launched **Safe Places** in March 2014, a scheme to help people with disabilities to be part of their community and feel safe using shops, cafes and entertainment venues. Working with local businesses, Safe Place logos are clearly displayed and staff within participating businesses will provide help where required, this may involve contacting a named person on their contact card or if a crime has been committed, contacting the Police. The scheme will initially focus of the city centre, during the first year of operation.

- Adult Social Care will continue to support the Safeguarding Adults Board to achieve their priorities. The Safeguarding Adults Board Annual Report for 2013/14 is available here (add link). The report also provides details of their 2014/15 priorities.

Personal budgets and self-funding: my money

- 56% of people receiving social care support during the year received a personal budget. This has increased from 55% in 2012/13. 16% of people received their personal budget via a direct payment, increasing from 15% in 2012/13.
- During the year the City Council has been involved in a regional project to explore ways to increase the numbers of personal budgets and direct payments. The overarching aim is to ensure more choice and control for people in receipt of personal budgets and to improve the experience of people receiving direct payments. Through this project we have begun to review our personal budget and direct payment offer, as part of our drive to re-energise personalisation agenda in Coventry.
- During the year, a new service was trailed with **Penderels Trust**, a local voluntary organisation paid by the Council to support people in managing their personal budget or direct payment. The new **Suitable Person Service** provided the opportunity for some people with physical disabilities to have their personal budget managed by a 'suitable person', a member of staff from Penderels Trust. The role of the suitable person is to take on the legal responsibility of managing the direct payment and the care arrangement for example, signing the contractual agreement with the care providers and ensuring the support is meeting their needs.
- The new service has enabled two people to move into their own home. This had not been possible before, due to concerns about their vulnerability and their ability to manage their care and financial arrangements. The outcome achieved, is that these people are now able to have the support of their choice, delivered flexibly to meet their needs and enable them to access further education. Due to the ability of having different hours of support during term-time and holiday periods. This is an outcome that traditional services would have struggled to provide.
- Below is a further case study which demonstrates how the use of Direct Payments can greatly improve outcomes for people with complex disabilities.

Case Study

Background: William is a 19-year-old-man with significant learning disabilities and complex autism. He lived in the family home where he was supported by his family. William has high support needs and requires assistance with all aspects of his daily living and support to make decisions.

Action: William and his family used a direct payment to employ a consistent staff team who they felt would be able to meet the agreed outcomes for William and enable William to begin to build trusting and valued relationships with an increasing circle of support. William's staff members are able to really understand what is important for William and therefore maximise his opportunities to exercise real choice and control on a day-to-day basis whilst living in the family home.

Outcome: William has now moved into a supported tenancy and remains in his own home with appropriate support. William is developing skills as a young adult, taking increased, measured and appropriate responsibility over his life choices.

Summary of key priorities for 2014/15:

For 2014/15 our key priorities are linked to two major policy developments from Central Government, which will change the way adult social care services are delivered from April 2015 onwards. These are the Care Act 2014 and the Better Care Fund Programme.

Care Act 2014

During 2013/14 Central Government consulted upon changes to the law which governs Adult Social Care. In May 2014 the Care Act received Royal Assent.

The central objective of the Care Act will be to create a single statute for adult care and support in England.

*The Act is **built around people**, it:*

- ensures that people's **well-being**, and the outcomes which matter to them, will be at the heart of every decision that is made;
- puts **carers** on the same footing as those they care for;

- creates a new focus on **preventing and delaying needs for care and support**, rather than only intervening at crisis point, and building on the strengths in the community;
- embeds rights to choice, through care plans and **personal budgets**, and ensuring a range of high quality services are available locally.

*The Act makes care and support **clearer and fairer**, it:*

- extends financial support to those who need it most, and protects everyone from catastrophic care costs though a **cap on the care costs** that people will incur;
- will ensure that people do not have to sell their homes in their lifetime to pay for residential care, by providing for a new **deferred payments** scheme;
- provides for a **single national threshold for eligibility** to care and support;
- supports people with **information, advice and advocacy** to understand their rights and responsibilities, access care when they need it, and plan for their future needs;
- gives new guarantees to ensure **continuity of care** when people move between areas, to remove the fear that people will be left without the care they need;
- includes new protections to ensure that **no one goes without care if their provider fails**, regardless of who pays for their care.

The Care Act is largely due to come into force in April 2015.

Priorities linked to the Care Act are:

Priority	Action	Outcome	Timescale
Implementation of Care Act			
Prepare for Care Act 2014 implementation	The Care Act Implementation Board has responsibility for Care Act implementation. The Board will oversee key areas of activity on: • Information, Prevention and Advice	Be reform ready.	By 1st April 2015 (excluding funding reform provisions within the Act) By 1st April 2016 for funding reform provisions

	• Assessment, Eligibility, Support Planning and Personalisation • Care Markets • Charging / Paying for Care • IT		
Theme – Supporting Carers			
Continue to support carers to enable them to continue caring	Complete the review of Carers' Services with the Coventry and Rugby Clinical Commissioning Group, in consultation with carers. This will enable us to understand what type of support has the greatest impact on carers' lives.	New Multi-Agency Carers' Strategy produced. This strategy will provide details about the future services that will provide support to carers in line with the Care Act.	Strategy produced by April 2015 New services commissioned by October 2015
Theme – Supporting People with Disabilities			
Develop an all age disability approach for supporting children, young people and adults with disabilities	Create a new All Age Disability Service. This multi-disciplinary team will include children and adult social workers, community nurses, therapists and education staff who specialise in working with children with special educational needs (SEN)	The new service will ensure a co-ordinated support across education, health and social care which takes a whole life approach to care and support planning. Long term aim is improve people's quality of life and reduce the number of out of city placements	By September 2014

Better Care Fund

The £3.8 billion Better Care Fund (formerly Integration Transformation Fund) was announced by Central Government in the June 2013 spending round to accelerate integration in health and social care. The Better Care Fund is a single, pooled budget to support health and social care services to work more closely together in local areas.

The aim of the Better Care Fund is to deliver better services to older people and those with long-term conditions by ensuring they receive the right support, in the right place and at the right time.

During the year we have jointly developed our draft Better Care Fund plan for Coventry with our health partners. Our shared Better Care Fund vision is that **'Through integrated and improved working, people will receive personalised support that enables them to be as independent as possible for as long as possible'.**

There are three work streams within the plan:

1. **Short-Term Support to Maximise Independence** (Older People aged 75+)
2. **Long-term care and support** (including joint packages & NHS Continuing Health Care - NHS CHC)

There are two strands to this work:

- Long-Term Care and Support For Learning Disabilities & Mental Health (all ages)
- Long-Term Care and Support for Older People (75+)

3. **Dementia** (Older People aged 75+)

A Better Care Plan was submitted to Central Government in April 2014. These plans will continue to be worked upon during 2014. The Better Care Fund budget will formally begin from April 2015.

More information about the Better Care Fund is available here

Priorities linked to the Better Care Fund Programme are:

Theme - Short Term Care To Maximise Independence (Reablement)			
Priority	**Action**	**Outcome**	**Timescale**
Increase use of technology to enable people to live independently in their own homes	Develop and implement an enhanced Telecare offer, initially for older people, as part of a reablement package	Enhanced Telecare operational and enabling people to maximise their independence and reduce the requirement for long-term support.	By September 2014

Theme - Supporting People with Dementia			
To enable people with dementia and their carers to be as independent as possible, for as long and possible	Undertake a review of post-diagnostic support available to people with dementia and their carers. People with dementia and their carers will be involved in the review via a public consultation	A revised 'menu' of post-diagnostic support to be developed following the consultation. Post-diagnostic support will be tailored to the individual's needs.	Review completed by April 2015

These priorities will need to be achieved within the context of emerging policy and the large-scale savings to be made by Adult Social Care in the coming years. As we make the required savings we will ensure we make best possible use of remaining resources.

Contact Us

You can contact us about this report at: abpd@coventry.gov.uk

You can contact Adult Social Care Direct at:

E-mail: ascdirect@coventry.gov.uk

Or

Tel: 024 7683 3003

Any comments, compliments or complaints can be made by contacting Coventry Direct on 0500 834 333, or in person at any of the Council's reception or enquiry areas, or by filling in an online form here.

You can visit the Opal Assessment and Demonstration Centre:

Monday-Thursday: 9:30am – 4:30 pm,

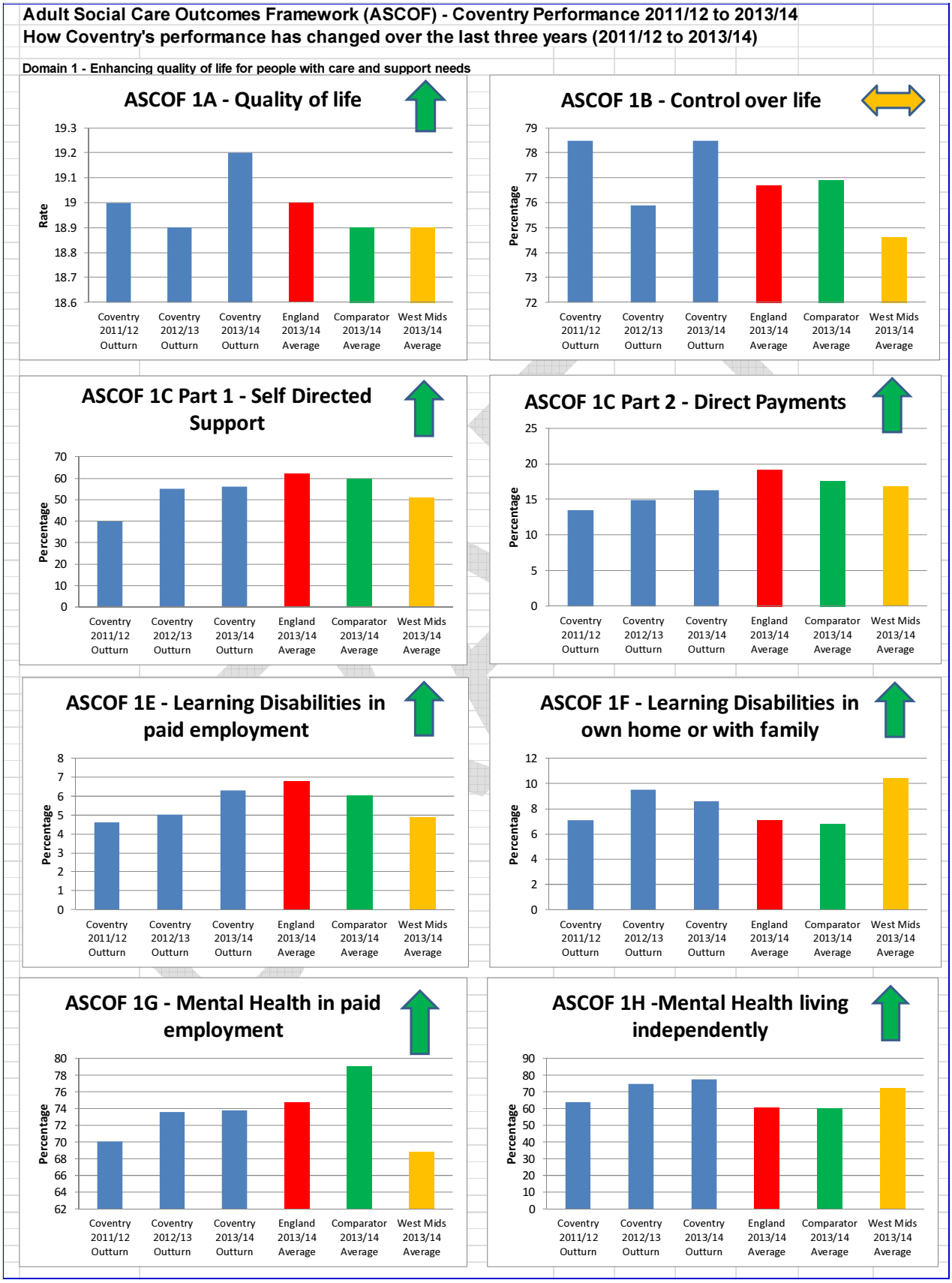
Friday 9:30am – 4:00pm

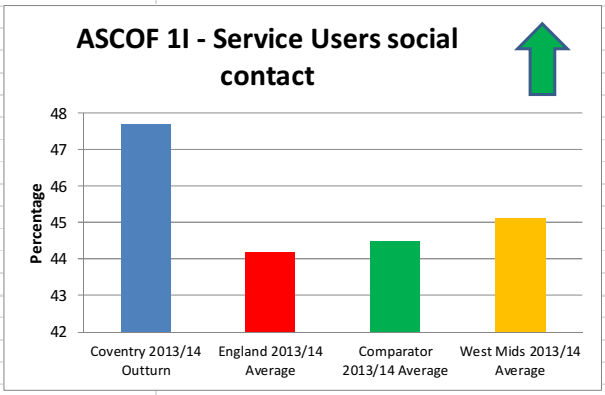
Unit 17-18, Bishopsgate Business Park, Widdrington Road, Coventry, CV1 4NA

Tel: 024 7678 5252

More information about Adult Social Care can be found here

Detailed Performance Data 2013/14



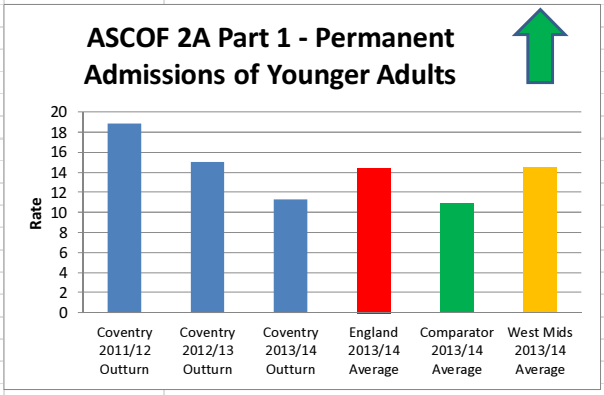


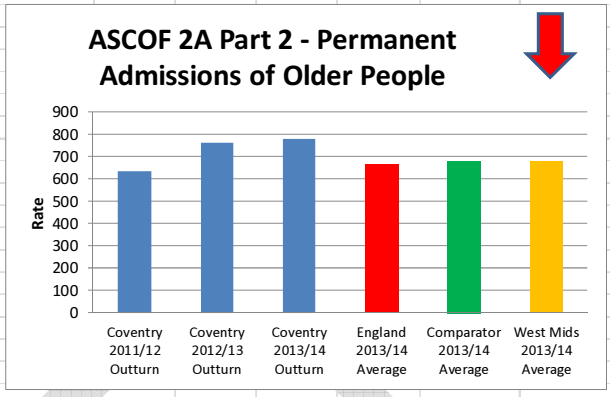
Domain 1 - Enhancing quality of life for people with care and support needs		Coventry 2011/12 Outturn	Coventry 2012/13 Outturn	Coventry 2013/14 Outturn	England 2013/14 Average	Comparator 2013/14 Average	West Mids 2013/14 Average
ASCOF 1A	Social care-related quality of life	19	18.9	19.2	19	18.9	18.9
ASCOF 1B	life	78.5	75.9	78.5	76.7	76.9	74.6
ASCOF 1C Part 1	Proportion of people using social care who receive self-directed support	40	55.1	56.2	62.1	59.5	51
ASCOF 1C Part 2	Proportion of people using social care who receive direct payments	13.5	14.9	16.3	19.1	17.6	16.8
ASCOF 1D	Carer-reported quality of life	N/a	7.7	N/a	N/a	N/a	N/a
ASCOF 1E	Proportion of adults with learning disabilities in paid employment	4.6	5	6.3	6.8	6	4.9
ASCOF 1F	Proportion of adults in contact with secondary mental health services in paid employment	7.1	9.5	8.6	7.1	6.8	10.4
ASCOF 1G	Proportion of adults with learning disabilities who live in their own home or with their family	70.1	73.6	73.8	74.8	79.1	68.8
ASCOF 1H	Proportion of adults in contact with secondary mental health services living independently, with or without support	63.8	75	77.8	60.9	60.4	72.2
ASCOF 1I	Proportion of people using services reporting they had as much social contact as they would like	N/a	N/a	47.7	44.2	44.5	45.1

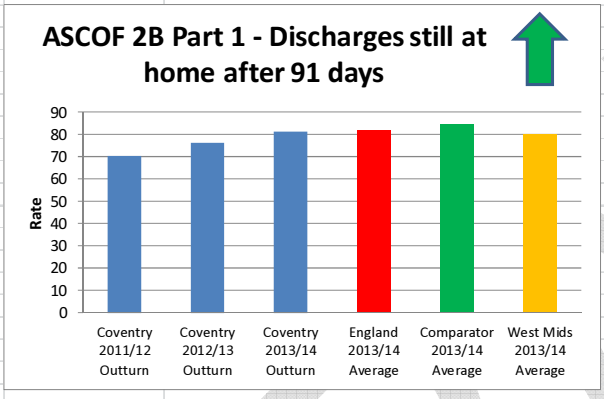
Adult Social Care Outcomes Framework (ASCOF) - Coventry Performance 2011/12 to 2013/14

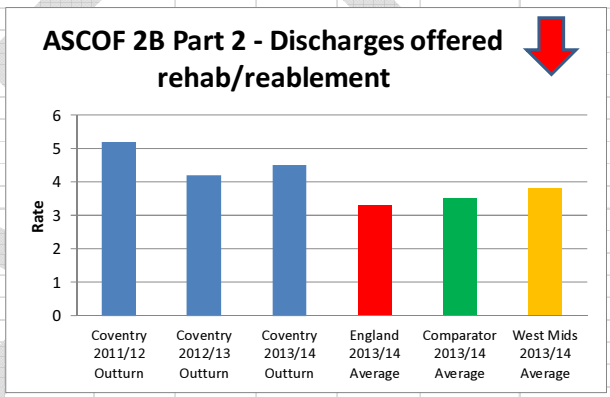
How Coventry's performance has changed over the last three years (2011/12 to 2013/14)

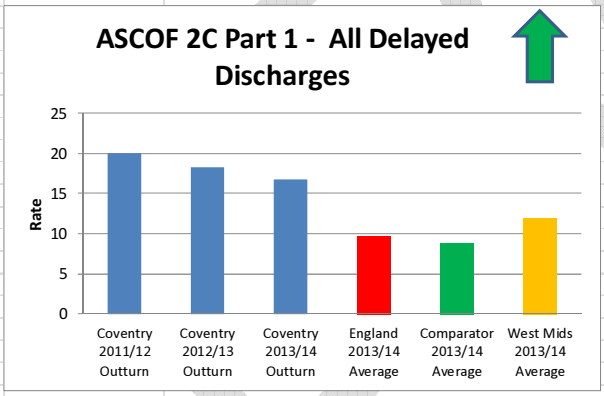
Domain 2 - Delaying and reducing the need for care and support

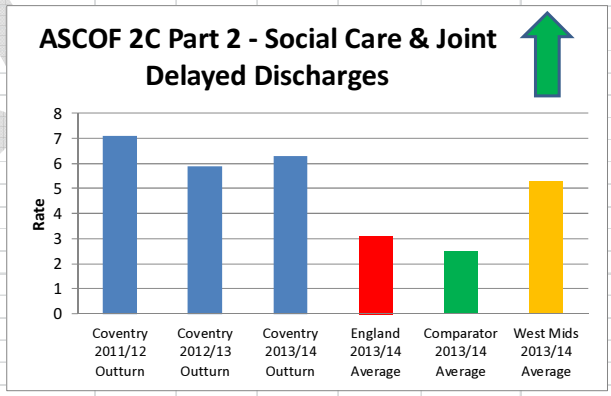








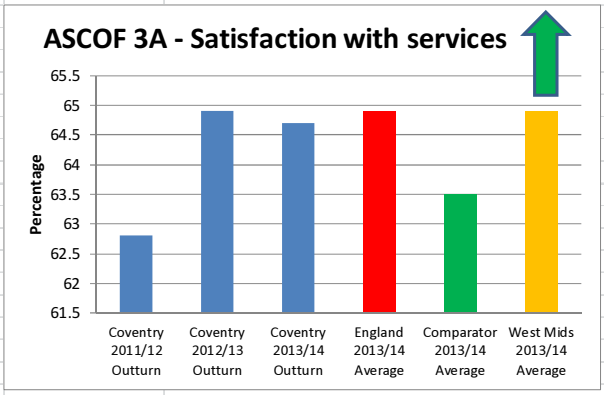


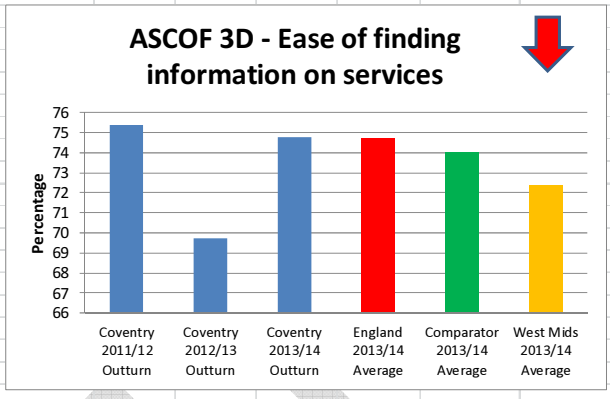


Domain 2 - Delaying and reducing the need for care and support		Coventry 2011/12 Outturn	Coventry 2012/13 Outturn	Coventry 2013/14 Outturn	England 2013/14 Average	Comparator 2013/14 Average	West Mids 2013/14 Average
ASCOF 2A Part 1	Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population	18.9	15	11.3	14.4	10.9	14.5
ASCOF 2A Part 2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	636.2	761.7	782.2	668.4	678.5	678.3
ASCOF 2B Part 1	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation (effectiveness of the service)	70.4	76.1	81.2	81.9	84.6	79.7
ASCOF 2B Part 2	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (offered the service)	5.2	4.2	4.5	3.3	3.5	3.8
ASCOF 2C Part 1	Delayed transfers of care from hospital per 100,000 population	20.1	18.3	16.7	9.7	8.8	12
ASCOF 2C Part 2	Delayed transfers of care from hospital which are attributable to joint health/adult social care and adult social care only per 100,000 population	7.1	5.9	6.3	3.1	2.5	5.3

Adult Social Care Outcomes Framework (ASCOF) - Coventry Performance 2011/12 to 2013/14
How Coventry's performance has changed over the last three years (2011/12 to 2013/14)

Domain 3 - Ensuring that people have a positive experience of care and support

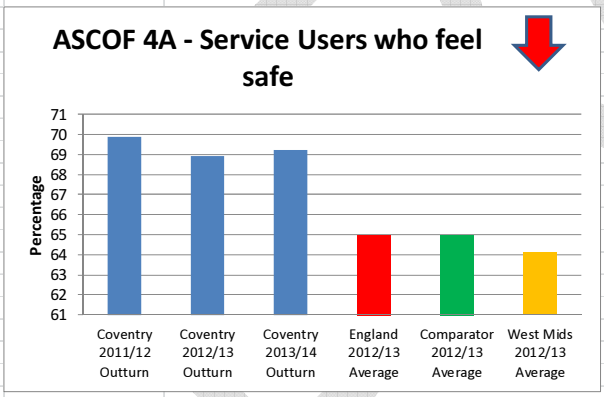


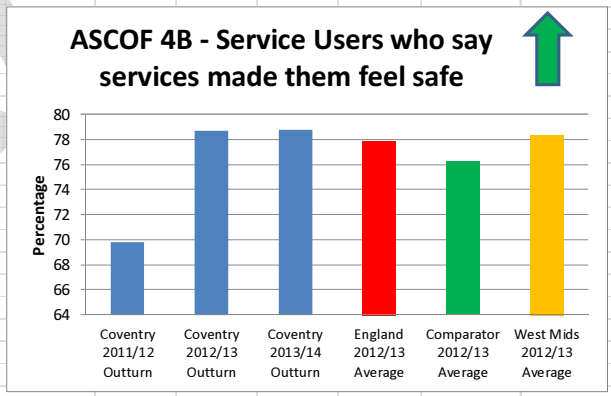


Domain 3 - Ensuring that people have a positive experience of care and support		Coventry 2011/12 Outturn	Coventry 2012/13 Outturn	Coventry 2013/14 Outturn	England 2012/13 Average	Comparator 2012/13 Average	West Mids 2012/13 Average
ASCOF 3A	Overall satisfaction of people who use services with their care and support	62.8	64.9	64.7	64.9	63.5	64.9
ASCOF 3B	Overall satisfaction of carers with social services	N/a	40.6	N/a	N/a	N/a	N/a
ASCOF 3C	Proportion of carers who report that they have been included or consulted in discussion about the person they care for	N/a	67.5	N/a	N/a	N/a	N/a
ASCOF 3D	Proportion of people who use services and carers who find it easy to find information about services	75.4	69.7	74.8	74.7	74	72.4

Adult Social Care Outcomes Framework (ASCOF) - Coventry Performance 2011/12 to 2013/14
How Coventry's performance has changed over the last three years (2011/12 to 2013/14)

Domain 4 - Ensuring people are safe and protected from avoidable harm





Domain 4 - Ensuring people are safe and protected from avoidable harm		Coventry 2011/12 Outturn	Coventry 2012/13 Outturn	Coventry 2013/14 Outturn	England 2012/13 Average	Comparator 2012/13 Average	West Mids 2012/13 Average
ASCOF 4A	Proportion of people who use services who feel safe	69.9	68.9	69.2	66	65.7	67.1
ASCOF 4B	Proportion of people who use services who say that those services have made them feel safe and secure	69.8	78.7	78.8	79.2	78.3	79.9

KEY

↑ Improved Performance Over Last 3 Years

↔ Performance Maintained Over Last 3 Years

↓ Performance Declined Over Last 3 Years

2013/14 is provisional data. Final data to be published by the Health and Social Care Information Centre in December 2014.

Local Account 2013/14 Performance & Information Team 12 August 2014

Coventry City Council

Briefing note

To: Health and Social Care Scrutiny Board (5) **Date: 10 September 2014**

Subject: Quality Accounts 2013/14

1 Purpose of the Note

1.1 This Briefing Note is intended to introduce the Board to the 2013/14 Quality Accounts produced by local provider NHS trusts.

2 Recommendations

2.1 That the Board consider the Quality Account as supplied by local University Hospitals Coventry and Warwickshire.

3 Information/Background

What Are Quality Accounts?

3.1 The Department of Health introduced the requirement for NHS trusts to issue quality accounts in the Health Act (2009). Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. This publication mirrors providers' publication of their financial accounts.

3.2 The purpose of Quality Accounts is to encourage the boards and leaders of healthcare organisations to assess quality across all the healthcare services they provide, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality:

- Patient experience
- Safety
- Clinical Effectiveness

3.3 This both reinforces transparency and helps persuade patients and stakeholders that organisations are committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements, which focus on essential standards instead engaging with patients and stakeholders to ensure that the organisation is constantly seeking to improve and achieve higher standards of care.

What Are Quality Accounts Used For?

3.4 Quality Accounts are published on the NHS Choices website, as well as being available in hospitals and other locations to illustrate providers' commitment to quality.

3.5 They are used by the Care Quality Commission (CQC) to understand how providers are engaging with patients and stakeholders about quality and the need for improvement.

3.6 They can also be used by those monitoring or scrutinising providers to assess the risks of an organisation and monitor the services provided.

What is the Scrutiny Board's role?

3.7 This forms part of general efforts by the Department of Health to increase engagement and participation in the health service, and is seen as complementary to the existing role of overview and scrutiny committees regarding the operation and planning of local NHS services.

3.8 The Department of Health sees the overview and scrutiny committees' role as building confidence in the accuracy of data and the conclusions drawn from it. Without some form of independent scrutiny, service users and members of the public may not trust in what they are reading.

3.9 Overview and Scrutiny has the opportunity to provide a commentary on the local Trusts Quality Accounts which the Trusts are required to publish unedited and in full. The commentary is required to be no more than 1000 words long. During this year, a quality accounts task and finish group made up of representatives from Warwickshire County Council, Coventry City Council, Healthwatch Coventry and Healthwatch Warwickshire has met to provide a joint commentary on the Quality Accounts for Coventry and Warwickshire Partnership Trust and University Hospitals Coventry and Warwickshire. The Board has not traditionally made an individual response to the West Midlands Ambulance Service.

Trusts Providing a Quality Account to the Scrutiny Board

3.10 The Quality Accounts from the Coventry and Warwickshire Partnership Trust (CWPT) and West Midlands Ambulance Service (WMAS) were considered by the Scrutiny Board at its meeting on 30 July 2014. Today's agenda includes the report for the University Hospitals Coventry and Warwickshire (UHCW) at Appendix

3.11 The Board should note that at present primary care providers are not required to produce Quality Accounts, although this is something which has been discussed by the Department of Health. Were this to be the case then the requirement for commentaries from Health Scrutiny bodies would become more onerous.

Background information

Quality Accounts – a Guide for Overview and Scrutiny Committees, produced in April 2012, DH website accessed 18 August 2014.
https://www.gov.uk/government/publications/quality-accounts-mini-guides-for-quality-accounts-a-guide-for-local-involvement-networks-link-and-overview-and-scrutiny-committees-oscs

Author:
Su Symonds
Scrutiny Co-ordinator, Health and Social Care Scrutiny Board (5)
Tel: 024 7683 1145
18 August 2014

University Hospitals Coventry and Warwickshire NHS Trust

2013–2014
Quality Account

We Care, We Achieve, We Innovate

Contents

Part 1

A Welcome from our **Chief Executive Officer**

Welcome to our 2013-2014 Quality Account, which gives a great opportunity to look at how we've performed on our priorities over the last year and what we will look to achieve over the next.

The three priorities we focused on last year were:

- **Patient Safety:** Reducing the risk of harm from falls;
- **Clinical Effectiveness:** Discharging patients in a safe and timely way;
- **Patient Experience:** Using patient feedback to improve care.

In this report you will be able to judge for yourself how we have tackled these and the difference it has made to patients. Looking forward I am also pleased to announce that for 2014–15 the priorities we will be focused on are:

- **Patient Safety:** Ensuring effective handover of care between healthcare professionals;
- **Clinical Effectiveness:** Ensuring that patients flow easily through our hospitals to improve efficiency in elective theatres across the hospital;
- **Patient Experience:** Ensuring that we work together towards providing a world class patient experience.

The Board was keen to theme this year's priorities under the banner of 'Getting Emergency Care Right'. A campaign which has seen clinical and managerial teams work together to implement practical changes in order to ensure that emergency patients receive the very best experience and care in a timely manner. The priorities also fit in with our new organisational development programme Together Towards World Class (TTWC) and our associated values which I launched in March 2014. My aim is to lead the Trust to be a national and international leader in health care in five years.

I passionately believe that this is what our patients, staff and community want and deserve and that we will achieve this.

Those of us in the NHS have had tough lessons to listen to and learn from over the last two years but I am confident that from this we can build a stronger, more patient focused service which we can all continue to be proud of.

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

Andrew Hardy
Chief Executive Officer
UHCW NHS Trust

Part 2

Introduction to Quality

2.1 Introduction to the Annual Quality Account

University Hospitals Coventry and Warwickshire NHS Trust (UHCW) has quality as the organising principle across all our services, meaning that patient safety and harm-free care, excellent clinical outcomes and high quality patient experience is central to all that we do. Our annual Quality Account provides an opportunity for us to take stock of our achievements and progress to date and to look forward to the year ahead.

Our Vision as a provider of healthcare is to deliver the best care for our patients, achieve excellence in education and teaching, and innovate through research and learning. The illustration [right] shows this vision.

On March 3rd 2014 we launched an ambitious organisational development programme across the Trust called Together World Class. We recognise that the culture of an organisation has a significant impact on the quality and safety of the services provided, and our intention is that this programme will help us reach our aspiration of becoming a national and international leader in healthcare over the next five years.

We will do this by focusing on five key areas:

- World class experience
- World class services
- World class conversations
- World class leadership
- World class people

VISION

A national and international leader

MISSION

Care - Achieve – Innovate

STRATEGIC AIMS

To be an international leader in tertiary supra-regional services – by providing services that, due to clinical safety and effectiveness, need a degree of centralisation and can only be carried out in designated centres

To provide World class healthcare for the local populations of Coventry and Warwickshire – by utilising the Teaching Hospital and academic links to offer the best quality and efficiency to be the provider of choice by improving models of care in the community

Enhance patient and staff experience – across the whole patient experience from first point of contact, through to access, treatment and discharge. It will include both the clinical and non clinical elements and will encompass staff experience.

To be a research and innovation driven organisation – by building on existing resources and networks and enhancing further through innovation champions, increasing partnership working, promoting publications and participating in trials

STRATEGIC OBJECTIVES

1. **To deliver excellent patient care and experience**
2. **To deliver value for money**
3. **To be an employer of choice**
4. **To be a research based healthcare organisation**
5. **To be a leading training and education centre**

Underpinning this are our six new values, that were created after asking our staff for their views on what they thought the Trust values should be. They told us:

Clinical leadership and engagement is already deeply embedded within the organisation with our Clinical Directors, who are also practicing clinicians, and Modern Matrons directly running services across the hospital. In 2014 we will work towards changing the quality and patient safety infrastructure to ensure that it meets the changing needs of the quality agenda and so that we are capable of challenging and scrutinising quality across the Trust.

The publication of the Francis Report in February 2013 was a major event in the history of the NHS. It was the first in a series of reports that have challenged every NHS trust to examine practice and culture. It is important to acknowledge that the Francis report and the other reports listed to the right are a number of external drivers that seek to set out guiding principles around quality and safety.

What the reports looked at:

- Francis reported on events at mid-Staffordshire NHS foundation Trust, making 290 recommendations
- Keogh investigated high mortality rates at 14 hospitals
- Cavendish made recommendations on the recruitment and training of non-registered staff in Health and Social Care
- Berwick explored how the NHS could improve the safety of patients and move forward as a learning organisation
- Clwyd and Hart reviewed how the NHS responds to and learns from complaints.

All of the reports have emphasised that safe, high quality services depend on organisations listening to and acting on feedback from patients and committing to transparency and openness: the 'duty of candour'.

A report for our Trust Board in April 2013 outlined a four step approach to the Francis Report: identifying the recommendations directly relevant to our Trust; undertaking a gap analysis to assess the level of assurance appropriate to each recommendation; identifying executive and action leads, and planning a detailed process for implementing change. The Chief Executive Officer provided briefings for staff and the Patient's Council and also presented a report to Coventry Council's Health and Social Care Scrutiny Committee.

In November 2013 NHS England published the Government's formal response Hard Truths: the journey to putting patients first. This reinforces the three themes that we have been developing:

1. Foster and sustain a culture that is safe, caring, effective, responsive and well-led and based on constructive engagement between staff and management and between staff, patients and carers.
2. Collect, appraise and use data in ways that support learning across the Trust and provide assurance to regulators, commissioners and public that services are safe and of high quality.
3. Use feedback, comment and complaints to improve practice and patient experience. Listening to and acting upon the patient's voice is at the heart of the Francis report and the Board will demonstrate how they achieve this.

The Trust has established a broad-based Francis Steering Group to oversee this complex change agenda. Regular reports have been made to the Trust Board and the Quality Governance Committee, which monitor progress against our action plan. As further reports have been published, they have been evaluated and the relevant recommendations mapped into an integrated plan. The Steering Group also provides updates for Coventry City Council's Health and Social Care Scrutiny Committee.

2013–14 Quality Highlights

Trust Values and Vision

During the year we developed and launched our 'Together Towards World Class' programme, and our associated values that were developed in conjunction with our staff. This links with our vision of becoming a leader in national and international healthcare and:

- To deliver excellent patient care and experience.
- To deliver value for money.
- To be an employer of choice.
- To be a research based healthcare organisation.
- To be a leading training and education centre.

Dr Foster and Good Hospital Guide Global Comparators

Dr Foster publishes the Good Hospital Guide as an independent assessment of NHS hospitals, highlighting variations in care. The Guide includes measures by NHS Hospital site and NHS Trust level, and for 2013 also included metrics at Clinical Commissioning Group (CCG) level. In comparison to the other Trusts, we performed lower than expected (green) on the following metrics:

- Palliative care coding rate (crude rates)
- Fractured neck of femur: no operation within 2 days of admission (crude rates)

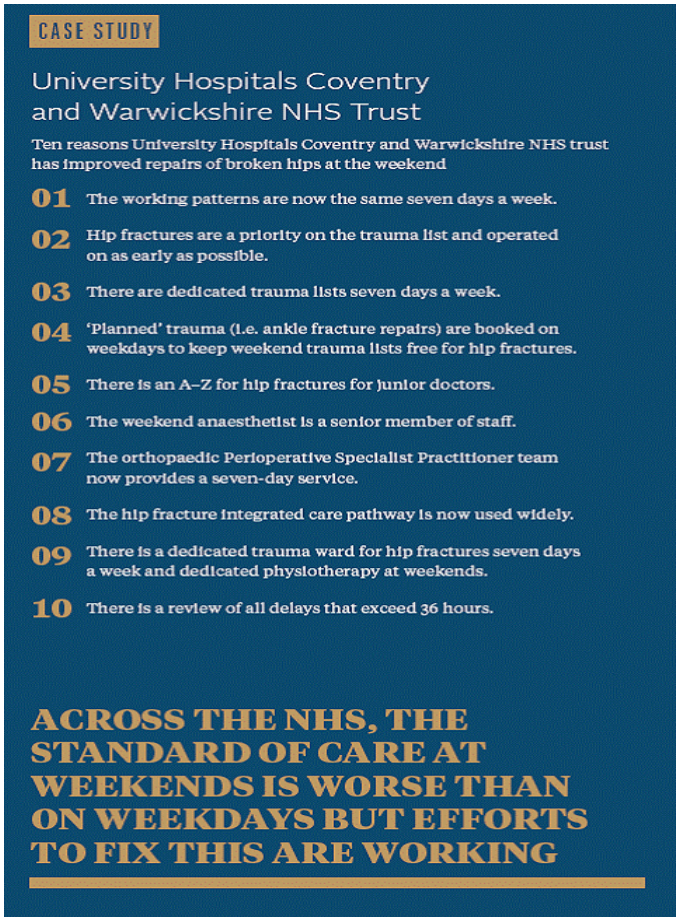
We were also highlighted for best practice in a case study on weekend working.

Care Quality Commission (CQC) Inspections

We have been inspected twice in 2013–14 and both reports were positive and found no immediate risks or areas lacking. We have also been placed in the lowest risk band across all NHS Trusts. For further information on the CQC outcomes that we have been inspected against please see Appendix 2.

Refurbishments to enhance wellbeing

Through our feedback mechanisms we have listened to patients and have placed seating along our main corridors and enhanced day rooms with comfortable seating and art at University Hospital. The hospital of St Cross has developed a dementia lounge called the Bluebell Room (pictured) and a room for bereaved families called the Sunflower room. St Cross has also introduced new, bespoke pressure relieving chairs to accommodate patients of differing heights.



Improvement in our Family and Friends Test Score

Since April 2013 the Trust's Family and Friend Score for the Emergency Department (ED) has increased from 22 to our highest score of 63 in December 2013. This demonstrates that patients attending our ED are 'extremely likely' to recommend it to a friend or family member should they require similar treatment or care.

Launch of Getting Emergency Care Right (GECR)

In response to not meeting the national 4 hour standard set for Emergency Departments, our Chief Medical, Nursing and Operating Officers launched a campaign that saw 1600 staff trained in the FREED principles (see page 14 for further details) and a new operational structure to ensure patients transition from admission to discharge was effective . The results demonstrate a rapid and sustained improvement in responding to bed pressures and the 4 hour standard.

Our Brilliant Staff

Below are just some of the awards that our staff have been shortlisted, nominated or won in 2013–14.

- Carmel McCalmont, Head of Midwifery, won the Healthcare Hero and Lifetime Achievement Award at the Coventry Telegraph's Pride of Coventry and Warwickshire Community Awards.
- The Lucina team has been shortlisted for a national MaMa award for promoting normal birth (announced April 26/27).
- Getting Emergency Care Right – A Change Program was shortlisted in the Changing Culture category for the Patient Safety and Care Awards, which is supported by the Nursing Times, Health Service Journal and NHS Employers (results announced July 15).
- The Research and Development team won the PharmaTimes 2014 clinical research site of the year.
- Professor Siobhan Quenby was nominated for a Tommy's Healthcare Hero Award by a couple who she helped become parents.
- Joe Colby, Clinical Nutrition Nurse Specialist, won second place in the National Nursing Awards for his dedicated work and development of the technique of fistula feeding (fistuloclysis) in UHCW.
- The Trust's Communications team won the Golden Hedgehog 2013 Internal Communications Campaign of the Year Award for its 100 Days Free campaign.
- The Trust won the Centre for Sustainable Healthcare NHS Forest's Award for Best Community Engagement. This was for its work around the Jubilee Nature Reserve at University Hospital in Coventry.
- ICT has been shortlisted for the UK IT Awards 2013 for the best Not for Profit IT Project for its work on introducing wifi across University Hospital.
- The Infection Prevention and Control Team were shortlisted in the Nursing Times Award 2013 Continence Promotion and Care category for their campaign 'Get Stool Smart'.
- The Infection Prevention and Control Team were shortlisted in the Nursing Times Award 2013 Infection Control and Prevention category for their campaign 'Get Stool Smart'.
- The ICT team (with the C&W Partnership Trust) was a finalist for the EHI Awards 2013 in the Excellence in Mobile Healthcare category for its Reciprocal Wireless Access.
- Our partnership with Age UK to improve the discharge of elderly patients was commended for a Coventry Compact 2013 award.
- Isatu Kargbo, Specialist Sister in critical care won joint first place in the critical care category in the 2013 Kimberley Clark HAI Watchdog Awards. It's an international award and Isatu entered the Big 2 communication tool to tackle infection control and cleaning issues in critical care.
- Our Trust Tissue Viability Team was shortlisted for the Nursing Times Patient Safety Award 2013.
- The Infection Prevention and Control team won the Infection Prevention Society's 2013 Team of the Year.
- Darren Wheldon from the Infection Prevention and Control Team was runner-

up for the 2013 Schulke Healthcare Champion.
- The Maternity March campaign, which used Twitter, Facebook and web chats to reach out to a larger audience, was shortlisted for the 2013 Social Impact Awards.
- Natalie Dean (third year student physiologist) has been awarded the Sue Davies Award at the 2013 Association of Respiratory Technology and Physiology (ARTP) Annual Conference.

Although the above details some of our achievements, there have been areas where we would have liked to improve the outcomes.

National Maternity Survey

We were disappointed to receive a rating of 'worse' compared to trusts that took part in the survey for Labour and Birth and our staff. The Maternity Services team have developed a clear action plan to improve on low scoring areas in order to ensure that women experience a world class birth. This includes promoting birthing aids in both the Lucina Birth Centre and Labour suite, the recruitment of additional staff and a redesign of the information pack given out to women at antenatal appointments. The full action plan can be accessed via the March 2014 Trust Board papers that are located on the 'About us' section of our website.

Meeting the 95% A&E 4 hour target for 2013–14

Unfortunately the trust scored 94% against the 95% standard to see and treat patients within the 4 hour target. The introduction of the Getting Emergency Care Right (GECR) Campaign made significant improvement for the last 5 months of the year where we did meet 95%. Further details on our GECR campaign are available on page 12.

2.2 Quality Account Improvement Priorities
A progress update

The below details progress and achievements against the Quality Improvement Priorities outlined in our 2012-13 Quality Account.

Priority 1 - Reducing Harm because of falls

Rationale for inclusion - fall were consistently the largest number of Clinical Adverse Events reported. Each fall has the potential to cause harm to our patients and the need to improve our performance is being supported through the implementation of the NHS Safety Thermometer and a range of other measures.

Achievements

- Implementation of FallSafe bundle onto all wards
- All newly qualified staff receive falls prevention and medicines management training.
- Falls prevention education is targeted to those clinical areas with a high incidence of reported falls
- Our internal staff website has been updated to include a section on falls
- All patients seen by the REACT team who are at risk of falling, are offered advice and information on falls prevention.
- The Chief Nursing Officer is the named lead for Falls
- All falls reported as Clinical Adverse Events (CAEs) which result in serious harm are investigated using root cause analysis methodology with action plans and monitoring put in place.
- Reduction in the rate of falls as measured by the NHS Safety thermometer

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of 'harm' once a month. Harm is defined as pressure ulcers, falls, urinary infection in patients with catheters and treatment for venous thromboembolism (VTE). It is called the NHS Safety Thermometer because it uses only a minimum set of data to help signal where individuals, teams and organisations might need to focus more detailed measurement, training and improvement.

The Safety Thermometer records the severity of any fall that a patient has experienced within the previous 72 hours in a care setting (including at home if the patient is on a district nursing caseload). A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause (slip, trip, fall from a bed or chair, whether assisted or unassisted). Patients 'found on the floor' should be assumed as having fallen, unless this can be confirmed as an intentional act. We reported the following against all falls in the Safety Thermometer:

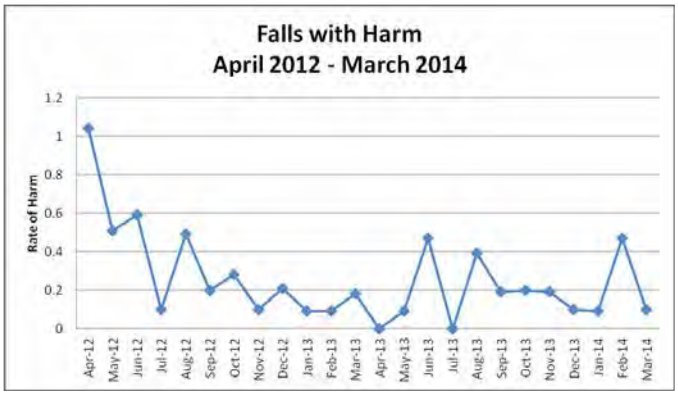


Figure 1: All Falls recorded with Harm from April 2012-March 2014

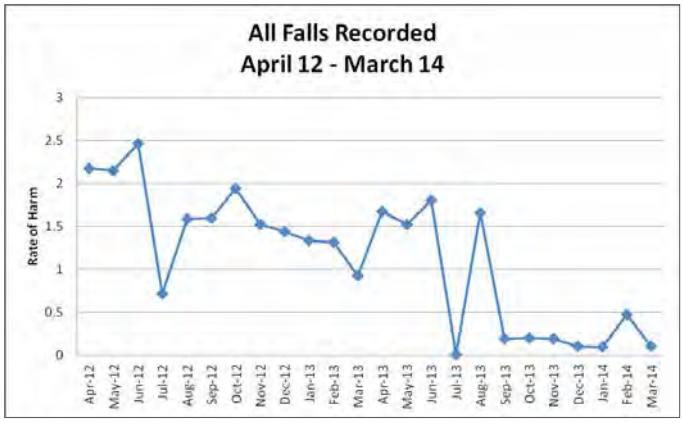


Figure 2: All Falls recorded from April 2012-March 2014

Priority 2 – Hospital Discharge

Rationale for inclusion - this was included in 2011-12 Quality Account and was still an issue of concern highlighted in patient feedback and by external stakeholders. Building on existing work, the plan encompassed how the hospital communicates with patient's relatives and GPs in planning discharge and follow-up at out-patients

Achievements

- Discharge Policy updated to reflect organisational restructure and changes that have been implemented to improve the discharge planning and processes.
- Effective and Efficient discharge planning sessions are included in the training programme for all newly qualified nurses, junior doctors and are delivered as ward based sessions.
- Implementation of FREED as part of the Getting Emergency Care right campaign clearly highlights the roles and responsibilities of frontline staff in relation to effective discharge.
- Wards are performance managed against agreed discharge targets, and weekly rates. Ward performance is also displayed on our intranet homepage.
- All wards undertake a daily discharge round 5-days a week and a number of wards have moved to 7-day rounds.
- Using "Impressions" our real-time feedback system we are able to demonstrate that satisfaction rates from patients around discharge rose from 84% in Quarter 1 of 2013–14 to 87% by Quarter 4. The overall satisfaction rate for 2013–14 was 87% compared to 2012 where satisfaction with discharge was down at 82%.

Priority 3 - Using patient feedback to improve experience

Rationale - There was national and regional focus around use of 'real time data capture' – the focus needs to move on from recording feedback to using it to drive changes that improve the actual experience of patients.

Achievements

- We increased the percentage of patients wishing to offer feedback across our A&E and inpatient services.
- We launched the 'We are listening Campaign' encouraging patients, relatives and carers to leave feedback.
- All comments left via 'Impressions' are sent directly to key staff email addresses so that ward staff can take immediate action.
- Wards are invited to the Patient Experience and Engagement Group to discuss patient experience improvements.
- We have redefined the role of the Patients' Council so that patient advisors are now directly aligned to clinical specialties.

2.3 Quality Improvement Priorities for 2014–15

After both internal and external consultation, the Board has agreed three Quality Priorities for 2014-15. We have continued to listen and engage with our partner local authorities, Healthwatch in Coventry and Warwickshire and the Clinical Commissioning Groups (CCGs) and we appreciate their help as well as the feedback from our foundation trust members, staff and patients for helping to identify these areas. We know that by focusing on ensuring progress in these areas the experience of being a patient at our hospitals will significantly improve.

This year the Board agreed that the three priorities should be themed under the banner of Getting Emergency Care Right (GECR); a considerable campaign that we launched to improve the care, experience and safety of patients coming to our hospital for emergency care. The GECR team are pictured below.

The campaign has five key principles which make up our FREED message:

1. Facilitate effective discharge.
2. Right person, right place.
3. Early specialist input.
4. Eliminate unnecessary tests.
5. Daily senior review.

Within two weeks of the launch, 1,600 clinical staff had been trained in these principles. Simple measures, which were published on our intranet site, were used to track key aspects including daily discharges, readmissions, mortality, and the numbers of patients admitted from our Emergency Department.

By January 2014 our Friends and Family test score, which measures whether patients would recommend our services to their loved ones, had improved from 52 in September 2013 to 57.

The national target is that 95% of patients should be seen, admitted or discharged within four hours of arriving at A&E. For October to December 2013, our performance against the four hour standard was 96.7% and for January to March 2014 was 95.19%, which was the first time in several years that we had met the standard in tow consecutive quarters. This was despite March being our busiest ever month for patients coming to A&E, with three of the busiest ever days that we have experienced, including a peak of 669 patients on March 10, 2014.

A survey sent out to all those who had taken part in the programme demonstrated that 96.3% were aware of it, 92.5% agreed with it and 81.7% think patient care in the emergency care pathway has improved since it was launched.

Mark Radford, Chief Nursing Officer and Meghana Pandit, Chief Medical Officer said: "This campaign has improved the care we give to patients and proves culture change does not take years to implement. We have shown that by working together, practical changes that improve

patient experience can happen quickly and be sustained."

Our three quality priorities all have a link to Getting Emergency Care Right, and we are confident that improvement in these areas will have a big impact on the care and experience patients receive. The Board will regularly review progress in delivering these quality improvements as part of its work, not just at board meetings but through participation in our Walkrounds Programme.

Summary:

Patient Safety	Rationale
Ensuring effective handover	Analysis of clinical incidents and complaints highlighted communication and handover as an issue that could have a significant impact on patient safety. The need to improve our performance will be supported through a range of measures identified in the actions
Clinical Effectiveness	
Ensuring patient flow in order to improve theatre efficiency	To make improvements to the way operating theatres are utilised to ensure that patients receive their procedures as planned.
Patient Safety	
Introducing a World Class Patient Experience Programme	To put in place additional actions to ensure that we gather and learn from patient feedback, that the Trust embeds training and education for staff and that the Trust openly displays how we act as a result of feedback.

Quality Priority 1 - Patient Safety

Getting Emergency Care Right - Ensuring Effective Handover between Healthcare Professionals

Why is it a priority?

The aim of any clinical handover is to achieve the efficient transfer of high quality, comprehensive information when responsibility for a patients changes. Shift handover plays a central role in clinician to clinician communication and is fundamental to the continuity of patient care and safety. Practice of handover varies across specialties and between disciplines, reflecting that no single handover system is suitable for all. Inadequate handover of clinical information carries significant risks for patients, individual clinicians,

and for the organisation as a whole. Poor handover can also lead to fragmentation and inconsistency of care resulting in poor patient experience.

Achieving consistency and the accurate conveyance of knowledge and information between all multidisciplinary team members requires mechanisms to be in place, which support the transfer of information across shift changeovers.

These should incorporate:

- clear leadership
- adequate time to share information, and clarify responsibility for ongoing care and outstanding tasks
- Exchange of relevant information to ensure patient safety.
- Identification of unstable patients and escalation process
- briefing on concerns from previous shifts
- adequate information technology support

Our Goal

Good handover benefits patients and staff by ensuring less discontinuity and inconsistency in care. In 2014-15 we will ensure that there is consistent utilisation of the electronic handover tool available to all ward staff. The advantages of consistently using one system to record handover will include; ability to archive and formally record handovers, improved confidentiality, ability to be able to access information from all locations and the ability to maintain accurate information in one place.

Our starting Point – baseline

Current Handover practices vary between wards and specialties and in most cases there is a lack of formal processes. Handover can also occur in various formats, handwritten lists, computer generated lists and taped handovers. This variation results in a lack of ability to archive handover documentation for either governance or audit purposes.

Task/Action	By When
Develop a robust Handover policy	August 2014
Communicate and roll out training and education across all in patient wards, nursing and medical staff on new handover policy	March 2015
Rollout implementation of CRRS handover tool	March 2015
Improve compliance with use of the handover tool by including usage on the performance scorecards of specialties	October 2014

How will we achieve our Goal?

How will we monitor and report progress

A project team consisting of Electronic Patient Record (EPR)'champions' from both medical and nursing professions will oversee the delivery of the above actions. The team will report to the EPR Steering Committee and through the EPR board to the Trust Board.

For more information on this priority or on EPR please contact Dr Alec Price-Forbes, Consultant Rheumatologist and EPR Lead and Michelle Linnane, Associate Nurse Director – Professional Standards and Patient Experience

Quality Priority 2 - Clinical Effectiveness

Getting Emergency Care Right - Ensuring patient flow through the hospital in order to improve efficiency in elective theatres

Why is it a priority?

Operating theatre efficiency is a crucial component in ensuring patients receive timely access to planned and emergency surgical procedures. It has been shown that delays in treating emergency surgical patients result in additional complications and higher mortality. (Royal College of Surgeons Feb 2011). Furthermore poor flow of admitted patients throughout the hospital has a negative impact on elective (planned) admissions for surgical operations because planned surgery has to be cancelled if there are no beds available. This negative impact on efficiency of elective operating theatres happens as follows:

- Planned cases are cancelled at short notice as the bed capacity is taken up by emergency cases
- Theatre demand increases over time as a result of large waiting lists building
- Available pre and post operative ward capacity is diminished due to increased length of stay of emergency patients, and patients who have had their elective and emergency procedure postponed.
- Theatre capacity is an extremely expensive resource which requires measures to be in place to ensure that it is utilised appropriately.

Our Goal

To improve theatre efficiency by:

- Changing the function of the holding bay to reduce the risks of delayed starts to theatre lists;
- Improved scheduling by using a tool which reliably and accurately predicts under-runs and over-runs of theatre lists; thereby improving utilisation and reducing cancellations;
- Reduction in 'closed theatre time' by improving consultant availability through cross-cover arrangements, thereby eliminating need for additional theatre lists at weekends or in the evenings;
- Reducing cancellations due to patients being deemed unfit on the day of surgery by improving pre-assessment;
- Opening a 2nd emergency theatre.

Our starting Point – baseline

- Approximately 395 elective cases cancelled per year due to emergencies taking priority
- 11% of high risk patients operated on within 1 hour. (UHCW Emergency Surgery Audit, 2013)
- 80–83% utilisation at University Hospital Main theatres.
- 5.1% of theatre sessions planned for elective use are not used.

How will we achieve our Goal

Action	Target
1. Establishment of a second dedicated emergency theatre.	75% reduction in elective cancellations due to emergencies taking priority >75% of high risk cases operated on within 1 hour
2. Regular reconfiguration of the theatre rota to maximise use of capacity	<3% closed elective sessions
3. Effective booking processes integrated with the pre-operative assessment process and scheduling	>85% utilisation at UH Main theatres >75% utilisation in Day Case theatres
4. Measuring efficiency Efficiency = [{fraction of scheduled time utilised} - {fraction of scheduled time overrunning}]x fraction of scheduled operations completed (Pandit JJ, Westbury S, Pandit M, The Concept of Surgical Operating list 'efficiency'; a formula to describe the term. Anaesthesia 2007)	Increase theatre efficiency to >85%

How will we monitor and report progress

Theatre efficiency is reported to the Board via the Integrated Performance Report (available via Board papers at www.uhcw.nhs.uk). The Emergency Surgery Audit will also be repeated to monitor the timeliness of treatment of non-elective patients. Short notice cancellations, closed sessions and utilisation are monitored and reported daily.

Leads: Jonathan Brotherton, Director of Performance and Programme Management Office, Jon Barnes, Deputy Chief Operating Officer, Paula Seery, Modern Matron Theatres and Day unit.

Quality Priority 3 – Patient Experience

Getting Emergency Care Right –Together Towards World Class patient experience

Why is it a priority?

Currently we are below the national average for the Family and Friends Test (FFT) Question score as benchmarked against other NHS trusts in England. We are 'about the same' (CQC terminology) as other NHS Trusts who take part in the National Inpatient, Outpatient and A&E surveys and our 2013 score has dropped to 91% from 93% in 2011 & 2012. We want to transform the experience at UHCW into a beacon of excellence, recognised at both a national and international level. Improving the patient experience is a principal part of the Together Towards World Class Programme. Ensuring we give each patient a world class experience is of course subjective; however we believe that by meeting the goals described overleaf, there will be measurable benefits for our service users. We also recognise this is going to take time and so for the purposes of the Quality Account the actions listed cover only those that will be delivered in 2014-15.

Although our FFT Score may be slightly lower than the average, our response rate for people

leaving feedback through our internal mechanism is higher than the average. We have analysed and collected thousands of pieces of patient, carer and relative feedback and have listened to what our patients are telling us. The Patient Experience Team has identified three key work streams; gathering and learning from feedback, improving knowledge and training for staff and acting and improving on feedback. The activities will benefit both patients undergoing emergency as well as planned care.

Our Goals in 2014-15

- To improve our 'mainly good' Impressions score
- To implement Patient Information Boards across our hospitals
- To improve the patient information we provide
- To become top rated nationally , and to promote our patient experience activities internationally
- Implement a phased approach to adopting the use of a proven Patient Experience Innovation Model to improve patient experience within specialties;
- Commence training for staff in the basic principles of how to provide an excellent patient experience;
- Cohesive working across the Trust in activities relating to transforming patient experience

Our Starting Point

Ward Staff are able to access the real time patient feedback system 'Impressions' to see what patients, carers and relatives are saying about their care and experience. Emails are sent directly to ward staff so that appropriate action can be taken where required. Not all wards have a space where they can communicate this to patients so the implementation of Patient Information Boards across ward areas will ensure that there is a space to display basic ward information about staff, contact numbers, mealtimes, a ' you said we did section' and latest FFT and Impressions scores. This enables patients to see openly how service users are "rating" that ward for both care and experience.

There is mounting evidence that there is a causal link between good levels of satisfaction amongst staff, particularly nursing staff, and patients' [satisfaction levels]. General studies of organisations also describe the effect that an organisation's culture can have on staff behaviour, thus impacting on the patient experience. Together Towards World Class will, for the first time, bring both patient experience and staff experience work streams together to ensure there is improvements in both areas.

In late 2012, we successfully applied to NHS Midlands and East to become one of five Patient Revolution Pathfinder Sites selected to work with a management consultancy to improve patient experience. TMI, a well know expert in service-based culture change within the public and private sectors (with large scale clients such as Marks and Spencer, National Express, Stena Line and British Airways) duly led a three month Patient Improvement Project at the Trust between January – March 2013.

TMI, after reviewing our patient experience feedback, decided to focus on the following four areas:

- The welcome in A&E
- The welcome in Main Out-patient Department
- Some elements of the Imaging Department

The model used by TMI involved the key stages noted below (summarised) and is be known as the Patient Experience Innovation Model. We will revisit these areas and adopt a phased approach to rolling out this methodology across the Trust.

Stage	Practice
Immersion	Observational audit of practices in the area. Assessment of data available regarding patient and staff experience
Co-production	Stakeholders meet to discuss all aspects of the service which includes the emotional and functional mapping of both the patient and staff journey within the area. Tasks are identified and associated actions agreed.
Change in practice trials	The tasks identified for action are trialled for a specified period
Evaluation & Implementation	The changes are evaluated and those which evaluate well are adopted as business as usual.

Figure 3 - Patient Experience innovation Model, TMI

How will we achieve our Goal

Work stream	Task	Target/Commentary
Gathering and Learning from Patient & staff Feedback	Implement further FFT as per national guidance in Outpatients and Day case Unit	To ensure compliance with National CQUINs and guidance that these patients are offered the opportunity to answer the FFT question and leave feedback. Full Implementation across services by April 2015.
	Set appropriate improvement goals for the key patient experience indicators	Ensure specialty groups own the target and it is built in the performance management framework Inpatient areas attain feedback from 50% of discharges A&E attain feedback from 25% of discharges
	Develop Quality Intelligence Profiles	To ensure that data pertaining to experience both staff and patients are triangulated to understand the reasons for performance and to drive the tasks required in the other work streams
	Develop and expand 'We are Listening Campaign'	To drive feedback response rates and to ensure key messages around how we are improving are disseminated.
	Implementation of Speciality Patient Advisors	Dedicated patient Advisors working with specialty groups with set objectives to provide challenge and opinion.
	Ensure Patient Stories are utilised to their full potential and implement a bank of Digital stories	Patient stories are heard at Board and their stories are utilised for training and education purposes for both staff and patients via the Health Information Centre
Training and Education	Undertake Training needs analysis	Understand current training environment and plan for delivering tailored Patient Experience training
	Deliver training on the Patient Experience Innovation Model Modules (PExIM) to key staff	To ensure that staff are appropriately and formally trained in being able to give a world class patient experience.
	Develop a Patient Experience Toolkit for staff and training packages to support it.	Staff have a usable resource available in hard and soft copy to aid them in aiming to provide a world class experience.
	Hold an Annual Patient Experience Conference	Bring together good practice and speakers to congratulate and learn from each other

Work stream	Task	Target/Commentary
Acting and Improving on Feedback	Consolidate and embed work already done in areas using the PExIM	To complete the recommendations from the previous work done in Imaging, A&E and OPD.
	Implementation of patient Information boards across ward areas	To ensure important ward information and information relating to Experience and care is displayed. All wards by March 2015
	Develop World Class Patient/Health Information	To develop patient information in a variety of innovative ways to enhance the patient experience

How we will Monitor Progress?

The Patient Experience and Engagement Committee will oversee progress against the key projects tasks described above and will report to the Quality Governance Committee and to the Trust Board. Progress will also be monitored by the Together Towards World Class Programme Board.

For more information on Patient Experience please contact Anita Kane or Julia Flay at Feedback@uhcw.nhs.uk

2.4 Statements of Assurance from the Board

2.4.1 Review of Services

During 2013-14 UHCW provided and/or sub contracted 66 relevant health services*. UHCW has reviewed all the data available to them on the Quality of Care in 66 of these relevant health services. The income generated by the relevant health services reviewed in 2013-14 represents 87% of the total income generated from the provision of relevant health services by UHCW for 2013-14.

*this number represents the number of services as detailed in the Trust's Acute Contract 2013-14

2.4.2 Participation in Clinical Audits

During 2013-14 42 national clinical audits and 4 national confidential enquiries covered relevant health services that UHCW provides.

During 2013-14 UHCW participated in 97% of national clinical audits and 100% of 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 UHCW was eligible to participate in during 2013-14 are listed in the table below. The national clinical audits and national confidential enquiries that UHCW participated in, and for which data collection was completed during 2013-14 are indicated with a green tick, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. The Clinical Audit and Effectiveness Annual Report details those audits which UHCW were eligible to take part in but did not and the rationale for non-participation.

Eligible audits applicable to UHCW as published in the Department of Health's Quality Account List	Did UHCW participate in 2013–14?	Participation 2013–14
National Comparative Audit of patient information and consent	✔	100%
NCEPOD Lower Limb Amputation	✔	100%
NCEPOD Tracheostomy Care	✔	78%*
NCEPOD Subarachnoid Haemorrhage	✔	100%
NCEPOD Alcohol Related Liver Disease	✔	100%
CEM Moderate or severe asthma in children 2013–14	✔	100%
CEM Paracetamol Overdose 2013–14	✔	100%
CEM Severe Sepsis and Septic Shock 2013–14	✔	100%
Chronic Obstructive Pulmonary Disease	✔	Data Collection Ongoing until May 2014
National Paediatric Diabetes Audit 2013–14	✔	100%
National clinical audit of rheumatoid and early inflammatory arthritis	✔	100%

Eligible audits applicable to UHCW as published in the Department of Health's Quality Account List	Did UHCW participate in 2013–14?	Participation 2013–14
Paediatric Asthma	✓	100%
Paediatric Bronchiectasis	✓	100%
BTS Emergency Oxygen 2013	✓	100%
National Comparative Audit of the use of Anti-D	✓	100%
National Audit of Seizure Management (NASH)	✓	100%
National Diabetes Inpatient Audit (NADIA) 2013	✓	100%
National Diabetes Audit (NDA) 2012/13	✓	100%
National Emergency Laparotomy Audit	✓	100%
Acute Myocardial Infarction & other ACS (MINAP)	✓	100%
Coronary angioplasty (Adult cardiac interventions audit)	✓	100%
Heart Failure	✓	100%
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	✓	100%
Congenital Heart Disease Audit	✓	No procedures carried out, therefore no cases to be submitted
Adult cardiac surgery audit (CABG and valvular surgery)	✓	100%
Trauma Audit & Research Network (TARN)	✓	95%
Adult critical care (Case Mix Programme)	✓	100%
Head & neck cancer (DAHNO)	✓	100%
National Joint Registry (NJR)	✓	100%
Falls and Fragility Fractures Audit Programme (inc National Hip Fracture Database)	✓	100%
Maternal, Infant and Perinatal programme / MBRRACE (previously CEMACH)	✓	100%
Child Health Review	✓	100%
National Neonatal Audit Programme (NNAP)	✓	100%
Renal Replacement Therapy (Renal Registry)	✓	100%
National Lung Cancer Audit	✓	100%
National Cardiac Arrest Audit (NCAA)	!	0% *
Sentinel Stroke National Audit Programme (SSNAP)	✓	94.5%

Eligible audits applicable to UHCW as published in the Department of Health's Quality Account List	Did UHCW participate in 2013–14?	Participation 2013–14
National Bowel Cancer Audit Programme (NBOCAP)	✔	0%* HCSIS currently updating the national audit dataset therefore data cannot be submitted until this has been done. Data for period 01.04.13 to 31.03.14 is on track to be submitted by the national deadline which is 01.10.14.
National Oesophago-gastric (NAOGC) Cancer Audit	✔	100%
National Vascular Registry (NVR)	✔	National Vascular Registry developers (Northgate) are in the process of creating the reporting functionality for the NVR participation rate cannot be confirmed until this is done. Scheduled to "go live" in 2014.
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✔	100%
Inflammatory Bowel Disease inc. Ulcerative colitis & Crohn's disease and paediatric IBD (UK IBD Audit)	✔	100%

UHCW has investigated why participation was lower than expected in some audits, identified with an asterisk (*). Further information can be found in the Clinical Audit and Effectiveness Annual Report 2013-14 available at www.uhcw.nhs.uk.

The reports of 18 national clinical audits and 42 local audits were reviewed by UHCW in 2013–14 and UHCW intends to take the following actions to improve the quality of healthcare provided:

- Share clinical audit outcomes with relevant clinical areas
- Undertake follow-up audits to measure progress
- Provide training and support where required to improve care standards or compliance with best practice

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

2.4.3 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by UHCW in 2013–14 that were recruited during that period to participate in research approved by a research ethics committee was 4571.

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

We are one of the leading research centres within the West Midlands, with a proven track

record of delivering high quality research. We have developed our research base in recent years, moving from being almost research inactive to very research active. Since 2008, we have recruited more patients into National Institute of Health Research (NIHR) portfolio trials than any other NHS Trust in the West Midlands. Our ambitious commercial strategy has resulted in a growth in income from commercial research from £971k to £1.5million over the last year. We have actively developed our external collaboration academic and industry organisations, thereby attracting significant research income which has risen to £4.9 million for 2013–14 (£6.8million 2012/13).

This year, our Research, Development and Innovation team were awarded the national NIHR and Pharmatimes award for 'NHS Clinical Research Site of the Year'.

With over 300 ongoing research projects led by staff across a wide range of specialities, our patients are given many opportunities to take part in research.

Patient involvement and representation is demonstrated throughout our research infrastructure and we have a nominated Trust lead for research engagement. Open Days, work experience opportunities and multi-media communications enable us to engage with people inside and outside of the Trust.

Our current major research themes are metabolic and cardiovascular medicine, reproductive health, musculoskeletal and orthopaedics and cancer. These are complemented by additional areas of clinical research activity (for example stroke and respiratory medicine). Research activity continues to increase. There are over 50 research nurses, midwives and allied health professionals assisting with research projects and increasing numbers of staff are undertaking research, higher degrees and PhDs. We provide free research training for all staff. This increasing level of participation in clinical research demonstrates our commitment to improving the quality of care that we offer, and to making our contribution to wider health improvement.

In the last three years, over 500 publications have resulted from our involvement in research, helping to improve patient outcomes and experience across the NHS. Our mission, Care - Achieve - Innovate, is explicit in that we will deliver the best care for our patients, achieve excellence in education and teaching and innovate through research and learning.

As such, we have a clear strategy to develop research and innovation. The key areas for delivery are to 'instil and embed a culture of research and innovation' and 'grow investment in, and revenue from, research and innovation'. By delivering on our research and innovation strategy, we also contribute to the delivery of our other strategic priorities. Our Innovation section shows some of the ways that research can be used to create immediate benefits in patient care.

For a list of all the publication titles please contact Library and Knowledge Services on 02476 968827; you can follow UHCW research on Twitter: https://twitter.com/UHCW_RDandI

2.4.4 Goals agreed with Commissioners (CQUIN)

A proportion of our income in 2013–14 was conditional upon achieving quality improvement and innovation goals agreed between us and any person or bodies that we entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013–2014 and for 2014–2015 can be found in Appendix 3.

2.4.5 Care Quality Commission

UHCW is required to register with the Care Quality Commission and its current registration status is Registered (without any compliance conditions) and licensed to provide services.

The Care Quality Commission has not taken enforcement action against UHCW during 2013–14.

UHCW has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The CQC has conducted two inspection visits since April 2013

On 17 September 2013 inspectors made an unannounced visit to Mulberry Ward at the Hospital of St Cross, Rugby in response to concerns. Whilst we were found to be compliant with all essential standards of care, Inspectors identified several ways in which the service might be improved. We have since developed an improvement plan which is being monitored. The full inspection report is available on the CQC website at www.cqc.org.uk.

On 15 January 2014 we were inspected as part of CQC's Thematic Review of dementia care. Inspectors were generally impressed with the standards of dementia care whilst again identifying ways in which the service might be improved; these have also been incorporated into an Improvement Plan. The full report is also available on the CQC website at www.cqc.org.uk.

Improvement Plans are monitored by Chief Officers and the Patient Safety Committee. Progress is also reviewed by the Quality Governance Committee, a committee of the Board. CQC also ask for updates to ensure that we are implementing planned changes.

The CQC is changing its approach to inspection. We have not yet had a 'comprehensive' inspection under the new rules, but the CQC has compiled two 'Intelligent Monitoring' reports relating to our organisation. These help the CQC take a view of safety and quality and inform their decisions about inspection priorities, and are publicly available on the CQC website at www.cqc.org.uk.

2.4.6 Data Quality

A number of the requirements of the Information Governance Toolkit encompass data quality. To ensure that we meet the required attainment levels, the Data Quality Team provide training and advice to users of the Patient Administration System that is used to record information to support the provision of patient care and data submissions.

A suite of data quality reports for data reported both internally and externally are routinely produced. These are reviewed, areas of concern highlighted and appropriate actions taken to rectify any issues. The Data Quality Committee meet on a monthly basis where items such as the data quality risk log are discussed and action plans are developed.

UHCW submitted records during 2013–14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

That included the patient's valid NHS number was:

- 99.3% for admitted patient care
- 99.7% for outpatient care
- 97.8% for accident and emergency care

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

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

The Trust will be undertaking the following actions to improve data quality:

The data quality assessment indicator that is currently included within the Trust's balanced performance scorecard, which underpins the Integrated Quality, Performance and Finance report received at Board each month is being updated to ensure adequate assurance of the quality of data that is being used to inform performance reporting. The Audit Commission identified six dimensions of data quality; Accuracy, Validity, Reliability, Timeliness, Relevance and Completeness. The Data Quality Indicator will be based on these six dimensions.

Data for each indicator will be summarised by describing what the data represents. The methodology behind target setting will also be included. Responsibilities will be clearly defined and all definitions will be transparent regarding any data exclusions that have been applied.

Each distinct key steps/stages from data collection through to reporting are to be mapped and assessment against the six data quality dimensions made. This demonstrates whether each dimension can be assured through evidence of effective controls in place.

2.4.7 Information Governance Toolkit

The UHCW Information Governance Assessment Report overall score for 2013-14 was 74% and was graded Not Satisfactory.

We maintained our performance from the previous year of 74% and achieved level 2 or above in 44 of the 45 requirements. The exception was the requirement for all staff to complete the annual mandatory Information Governance competency assessment, using the online Department of Health training tool. Not achieving this requirement meant that we were unable to achieve the overall rating of satisfactory. Although significant improvements were made from last year, achieving the required target still remains a challenge. It is anticipated that the formation of our new Information Governance unit in April 2014 will address the additional work that we need to do going forward.

2.4.8 Clinical Coding Error Rate

UHCW was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses incorrect 6.4 %
- Secondary Diagnosis incorrect 14.6%
- Primary Procedures incorrect 3.4%
- Secondary procedures incorrect 3.8%

Orthopaedics

- Primary diagnosis 90%
- Primary procedure 99%
- Secondary diagnosis 88.4%
- Secondary procedure 95.5%

Neonatology

- Primary diagnosis 98 %
- Primary procedure 85.7%
- Secondary diagnosis 80.9%
- Secondary procedure 100%

General Medicine

- Primary diagnosis 91.6%
- Primary procedure 81.8%
- Secondary diagnosis 79.8%
- Secondary procedure 100%

2.5 **Performance against NHS Outcomes Framework 2013–14**

There are five domains within the national NHS outcomes framework. These are areas of performance for which there are agreed national indicators. We provide information to the Health and Social Care Information Centre which, in turn, provides us with a comparison against other Trusts. By publishing these figures you can compare our performance with the best, the worst and the average performing trusts in the NHS.

The Five Domains are:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Related NHS Outcomes Domains – 1 and 2					
Indicator: Mortality Rates [source: Dr Foster]	Jul 2011 – June 2012	Oct 2011-Sept 2012	July 2012 – June 2013	National Average	Lowest & Highest reported Trust
a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period;	1.0338 (Band 2)	1.03 (Band 2)	0.9867 (Band 2)	1.00	0.6259 1.1563
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	15.6%	14.6%	9.81%	19.2%	0.0% 44.09%

We consider that this data is as described for the following reasons:

- We monitors mortality rates using the national Hospital Standardised Mortality Ratio (HSMR) and Summary Level Hospital Mortality Indicator (SHMI), which measures mortality as to whether it is higher or lower than that which would have been expected. Figure 5 [overleaf] compares our HSMR and SHMI rates against a peer group of similar university hospitals within the Midlands and East area.
- There has been a slight decrease in the SHMI scores for the latest period. The score is now below the national benchmark, and within the expected range (Band 2). The Hospital Standardised Mortality Ratio (HSMR) for March 2013 to February 2014 is 91.6 (this is the latest available data). This is within expected range and below the national benchmark of 100.

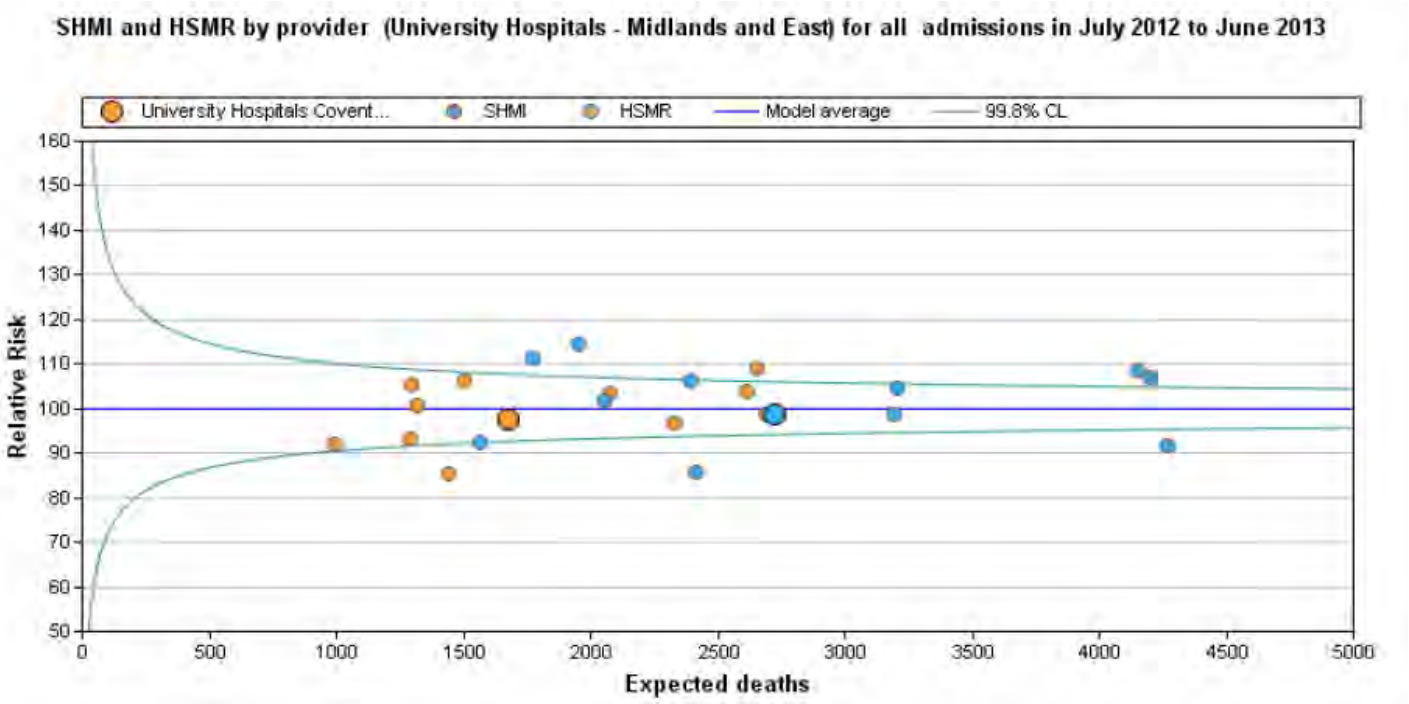


Fig. 5 - SHMI and HSMR by Provider for all admissions in July 2012 to June 2013

There has been a decrease in the number of patient deaths coded as palliative. This has been investigated and the coding accuracy has been checked. The coding of palliative care is being carried out accurately in accordance with the strict rules concerning the use of palliative care coding which dictate that patients must be seen by a clinician specialising in palliative care.

The Trust has taken the following actions to improve this score and so the quality of its services:

During 2013/2014 there has been an expansion of the Palliative Care Team and there is ongoing an education programme to promote the services of the team within the Trust. Furthermore we are involved with the Transform Programme and we are implementing the use of the AMBER care bundle, which will continue to improve the care these patients receive.

Related NHS Outcomes Domain 3					
Indicator : Patient reported outcome measures scores (PROMS) [Source: HSCIC]	**2011-2012**	**2012-2013**	**2013-2014**	**National Average**	**Lowest & Highest Reported Trust April-December 2013**
Groin Hernia surgery	0.076	*	*	0.086	0.013-0.157
Varicose Vein surgery	*	*	*	0.102	0.020- 0.158
Hip replacement surgery	0.422	0.462	*	0.447	0.301-0.527
Knee Replacement surgery	0.297	0.323	0.337	0.339	0.193-0.416

PROMS Adjusted Health Gain Scores. Items marked with an asterisk are due to low numbers of patient records being submitted and therefore this information is suppressed on HSCIC

The Trust considers that this data is as described for the following reasons: Patients are asked to complete a feedback form post-operatively, following a nationally agreed protocol. The Trust intends to take the following actions to improve this score and so the quality of its services, by sharing feedback and liaising with the relevant clinical areas to ensure information about the questionnaire is given to patients.

Related NHS Outcomes Domain 3 **Indicator: emergency readmissions to hospital [source: HSCIC, UHCW]**	**Year**	**UHCW**	**NHS England Average**	**lowest reported Trust**	**highest reported Trust**
The percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	2011–12	8.23	*	*	*
	2012–13	7.58+	*	*	*
	2013–14	7.87+	*	*	*
The percentage of patients aged 15 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	2011–12	12.03	11.45	0.00	17.15
	2012–13	7.73+	*	*	*
	2013–14	7.76+	*	*	*

*Indicates the information is not available on the HSCIC portal,
+ Indicates data is UHCW Data

The Trust considers that this data is as described for the following reasons: The consistency and accuracy of the data collection has been evaluated by internal audit and is monitored by the Trust Performance Management Office.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services: by continuing to implement actions around improving effective and safe discharge.

Related NHS Outcomes Domain 4 **Indicator: A positive experience of care [source HSCIC]**	**2011–12**	**2012–13**	**2013–14**	**National Average 2013**	**Lowest and Highest Reported Trust**
The trust's responsiveness to the personal needs of its patients during the reporting period.	74.1%	73.5%	74.2%	78.9%	67.7–87.8
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	64%	68.2%	62.4%	62%	39-93%

The Trust considers that this data is as described for the following reasons: Data is collected as part of a national survey managed by the Care Quality Commission.

The Trust intends to take the following actions to improve this percentage , and so the quality of its services: by implementing the actions described in Quality Priority 3.

Related NHS Outcomes Domain 5 **Indicator: avoiding harm [source HSCIC]** The indicator is expressed as a percentage of all adult in-patients that have received a VTE risk assessment upon admission to the Trust using the clinical criteria of the national VTE tool	Year by quarters	UHCW	National average	Trust with highest/ lowest score
The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (VTE) during the reporting period (Domain 5)	2011–12	91.5%	84.10%	100%
	Q1			Nil return
	Q2	91.7%	88.20%	100%
				20.4%
	Q3	93.3%	90.70%	100%
				2.4%
	Q4	94.1%	92.50%	100%
				69.8%
	2012–13	93.0%	93.40%	100%
	Q1			80.8%
	Q2	93.0%	93.80%	100%
				80.9%
	Q3	93.4%	94.1%	99.9%
				84.6%
	Q4	95.1%	94.2%	100%
				87.9%
	2013–14	95.8%	95.4%	100%
	Q1			78.8%
	Q2	95.9%	95.6%	100%
				81.7%
	Q3	96.1%	95.8%	100%
				74.1%
	Q4	96.2%	96.0%	100%
				78.9%

The Trust considers that this data is as described for the following reasons: the consistency and accuracy of the data collection has been evaluated by internal and external audit and is monitored by the Trust Performance management office.

The Trust intends to take the following actions to improve this percentage: continue to monitor compliance and identify gaps and put in corrective action where necessary.

The Trust intends to take the following actions to improve this percentage: continue to monitor compliance and identify gaps and put in corrective action where necessary.

Related NHS Outcomes Domain 5 **Indicator: Reducing Infection [source HSCIC]** The Trust is deemed responsible for a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one)	2011–12	2012–13	2013–14	National Average	Lowest to Highest Reported Trust
The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	24.1	20.1	12.7*	Not yet published	Not yet published

*2013-14 bed day data is not publicly available on the 2013–14 HSCIC , therefore the Trust has used the data available from the HSCIC for the number of C Difficile cases and used its own KH03 bed day data to determine the rate.

The Trust considers that this data is as described for the following reasons: Reporting of data on C.difficile infection is mandatory; data quality is monitored through infection control and subject to audit and reporting to commissioners. UHCW has submitted its mandatory return, but this has not yet been published nationally.

The Trust intends to take the following actions to improve this percentage: by continuing to implement its infection control and prevention strategy.

Related NHS Outcomes Domain 5 Indicator: Incident reporting [source HSCIC]	Oct 2011 – March 2012	April 2012 – Sept 2012	Oct 2012 – Mar 2013	April 2013-Sep 2013	National Average (Acute Teaching Trusts) April 2013-Sep 2013	Lowest and Highest reported Trust April 2013-Sep 2013
The Number of Patient safety Incidents reported within the Trust within the Reporting Period	5294	4869	5334	5350	5663	11,573 2,235
Rate of Patient Safety Incidents reported within the Trust within the reporting period	7.8	7.19	7.9	7.72	8	12.84 4.87
The number of such incidents that resulted in severe harm or death	11	14	16	21	19	46 1
Percentage of such patient safety incidents that resulted in severe harm or death	0.2%	0.3%	0.3%	0.4	0.3%	0.9% 0.0%

The Trust considers that this data is as described for the following reasons: UHCW assesses data quality before submission to the National Patient Safety Agency (NPSA) National Reporting and Learning System (NRLS). The NPSA monitor the data and inform UHCW of anomalies and errors.

The Trust has taken the following actions to improve this reporting rate: Continued to increase awareness of reporting and provide immediate feedback to reporters. UHCW will continue to monitor the sharing of actions and outcomes across the Trust to ensure learning.

Related NHS Outcomes Domain(s) - 5 Indicator: Friends and Family Test (source HSCIC)	2011–12	2012–13	2013–14		National Average	Lowest to Highest Reported Trust
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	64	68.2	62.4		62	39–93
The percentage combined **response rate**, and **score** for Inpatients and A&E who would recommend the trust as a provider of care to their family or friends.	N/A	N/A	A&E	**19.7** **49**	**18.6**	**3.2–49.2** **7–8.9**
			IP	**23.3** **62**	**55**	**13.6–74.0** **33–90**
Combined response rate	N/A	N/A	20.84		23.82	Not available

The Trust considers that this data is as described for the following reasons: the submission of data is mandatory as per the national CQUIN. Consistency and accuracy of the data collection is monitored by the Trust Performance management office before submission on UNIFY. The Trust has taken the following actions to improve this [reporting] rate: by implementing the actions as described in the Quality Priority – world class experience.

Part Three

Overview of Organisational Quality

3.1 Patient Safety

We continue to encourage our staff to report all incidents, from the very minor, mostly "no-harm" incidents that we manage in-house to the more complex serious incidents that we are required to share with our commissioners. To promote further incident reporting we advocate the use of "trigger lists". Specialties draw up an agreed list of events relating to their specialism that they will report as a minimum. This encourages standardised reporting, provides trend analysis and learning and is used to drive improvements (see Figure 6).

All of our staff can report incidents knowing that they will be supported throughout the process of investigation and involved in making recommendations and developing action plans. By creating an open, learning culture across the organisation staff are able to report when things go wrong and we can learn, and share improvements, both internally and externally.

We use an online incident reporting system (Datix) which facilitates early detection of trends and alerts the central Quality & Patient Safety Team to any serious incidents. This allows us to escalate issues and investigate them swiftly. Overall incident reporting continues to show an upward trend towards the 10% of all admissions rate, which is quoted as the average for hospitals in England.

In our peer group of acute teaching hospitals a recent National Patient Safety Agency (NPSA) report shows us as being in the middle 50% in terms of our reporting rate (see below), which indicates an open safety culture that supports improvement. The black line represents our organisation.

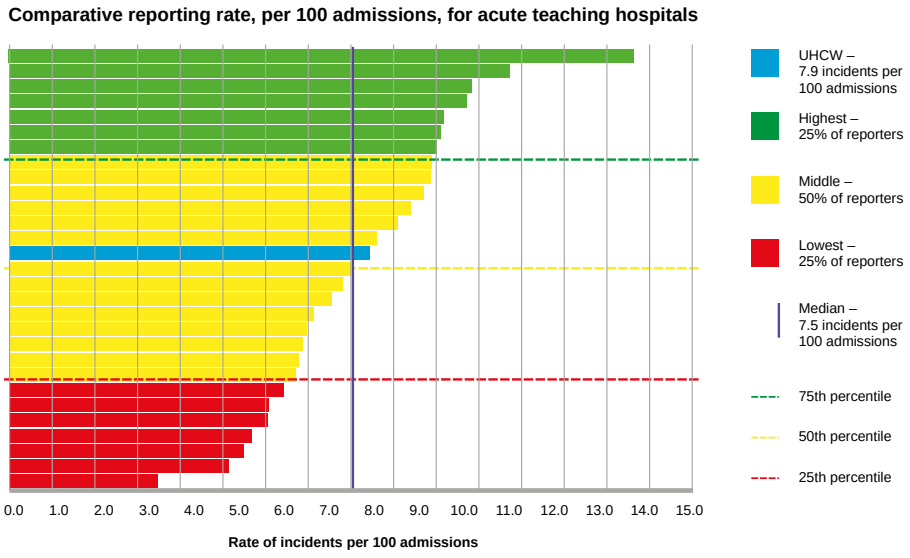
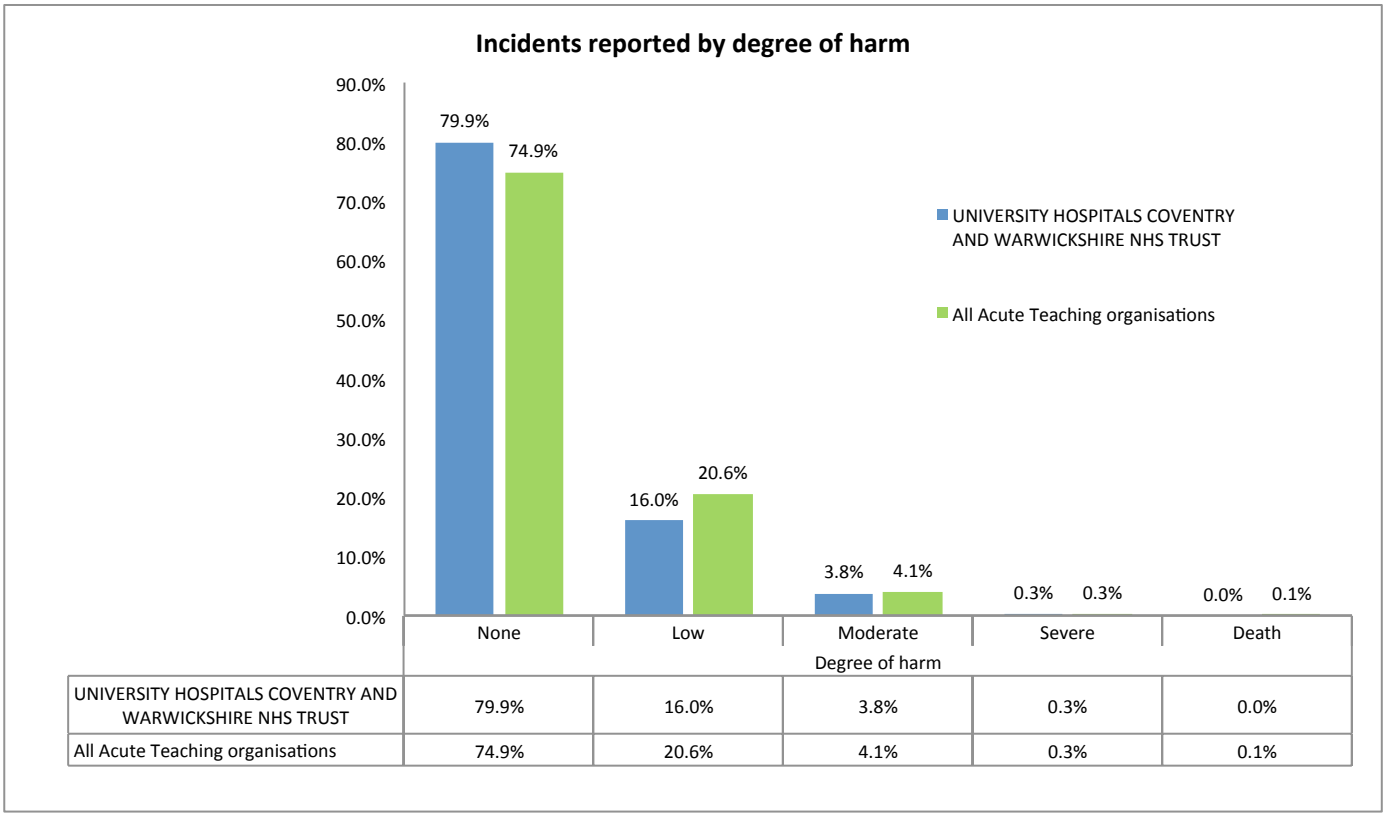


Figure 6: Chart demonstrating comparative reporting rates for 2013-14

The vast majority of reports are "no harm" incidents as indicated below



	None	Low	Moderate	Severe	Death
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	79.9%	16.0%	3.8%	0.3%	0.0%
All Acute Teaching organisations	74.9%	20.6%	4.1%	0.3%	0.1%

Figure 7: Chart demonstrating incidents reported by degree of harm 2013-14

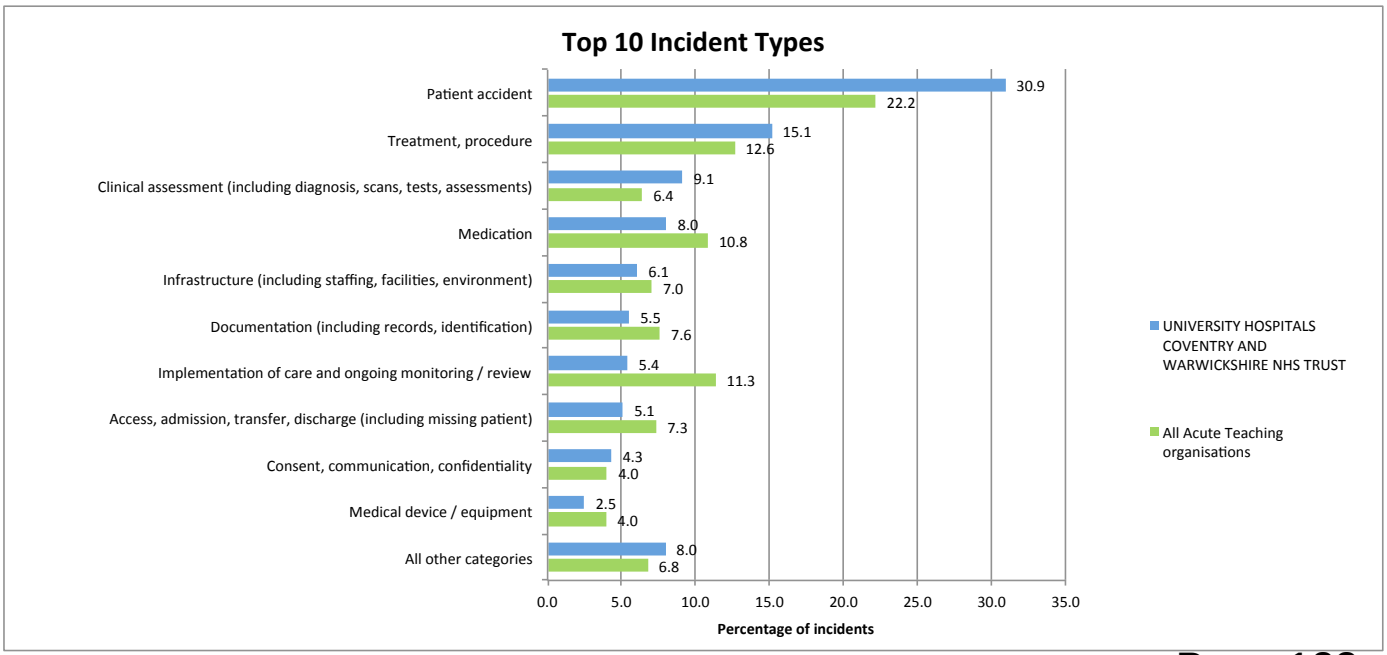


Figure 8: Chart demonstrating top 10 incident reporting types 2013-14

Serious Incidents Requiring Investigation (SIRIs)

We reported a total of 169 SIRIs in 2013–14. Some specific types of incident are automatically reported as SIRIs; examples of these are Infection Control incidents (e.g. MRSA bacteraemia, C Difficile associated deaths and infection outbreaks such as Norovirus), 'never' events, pressure ulcers and certain Maternity-related incidents. See Fig. 6 below. The peak in February was due to a number of Norovirus incidents on different bays of our wards.

Each SIRI is reviewed and monitored by our weekly Significant Incident Group (chaired by the Director of Governance), which ensures that investigations are thorough, that the process conforms to the National Patient Safety Agency standards and that actions are completed by their agreed deadlines.

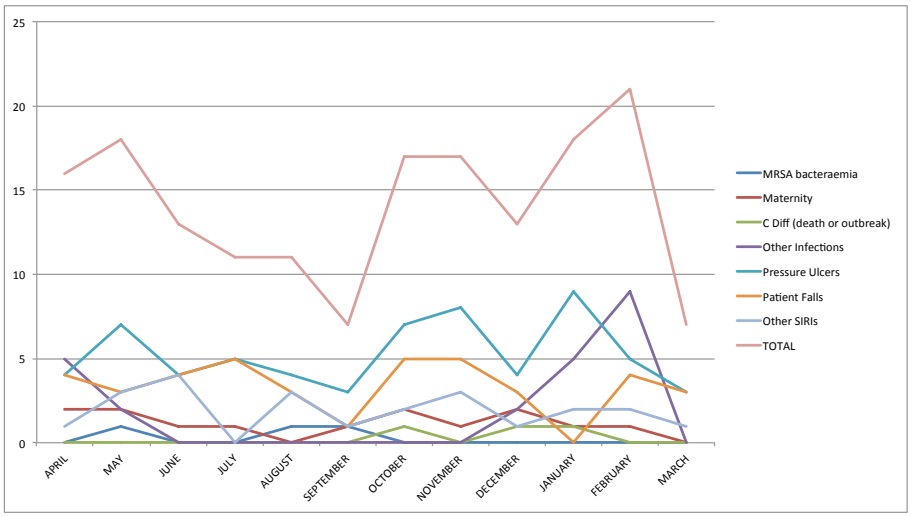


Figure 9: Chart demonstrating SIRIs by type 2013–14

As a result of SIRIs we have implemented many measures, some examples of which are:

- We developed an action card for all staff with information on how to manage a serious incident
- We have used SIRIs for interactive teaching sessions with trainees as part of Core Medical Training
- We have developed a Renal Services Medication Steering Group
- We have created and introduced audio surgical checklists in Theatres
- We have published 'Good practice guidance' for Maternity staff on the use of interpreting tools and ensuring patients understand information given to them

Never Events

During 2013–14 we reported four 'never' events. This is obviously a cause of great concern and regret.

We reported one case of "wrong-site surgery" relating to an operation that was undertaken at the incorrect level of a patient's spine. We also reported two incidents under the category "retained foreign object post-procedure", which occurred despite the use of the World Health Organisation's (WHO) Safer Surgery checklist.

The fourth never event reported was a "wrong implant/prosthesis" that occurred in the Orthopaedic specialty.

In every case we have explained the error to the patient involved and provided corrective treatment with their consent. In the spirit of "being open" we have reassured them that an investigation will be undertaken and offered to share our findings with them in person.

We continuously strive to learn from our mistakes and try to

eradicate these incidents both proactively and in response to actual incidents.

Proactively we

- review our processes and procedures against best practice
- take action as required by safety alerts and recommendations arising from the National Reporting & Learning System (NRLS)
- raise awareness of never events with our staff
- monitor incidents relating to any of the defined never events and implement solutions to minimise their impact
- spot-check wards to review compliance with safety policies
- use WHO surgical safety checklists and monitor their use across the Trust. Identify any shortcomings are acted upon immediately
- recruited the support of Human Factors experts to review Theatre processes and team interactions

in response to each never event we:

- select a senior clinician to lead the investigation
- investigate them thoroughly by root cause analysis methodology
- generate comprehensive reports and action plans that are approved by the Trust's Significant Incident Group
- share the learning with our staff and with our commissioners
- follow up each action plan to ensure completion
- Report each occurrence to the Trust Board

A Quality Review in Theatres was undertaken by our commissioners and their feedback was very positive.

The NHS Safety Thermometer

The NHS Safety Thermometer has now been fully implemented and in use across the Trust since January 2012, with the exception of the Emergency Department, Theatres, Day Surgery and Outpatients. There are now 44 wards using the thermometer each month to survey all patients, with the exception of paediatrics, as only those aged 2 and above are included.

Fig.10 highlights that since collecting data we have steadily improved and performance is currently at 96%, which is above the national average. More information on the NHS Safety Thermometer is available at www.england.nhs.uk

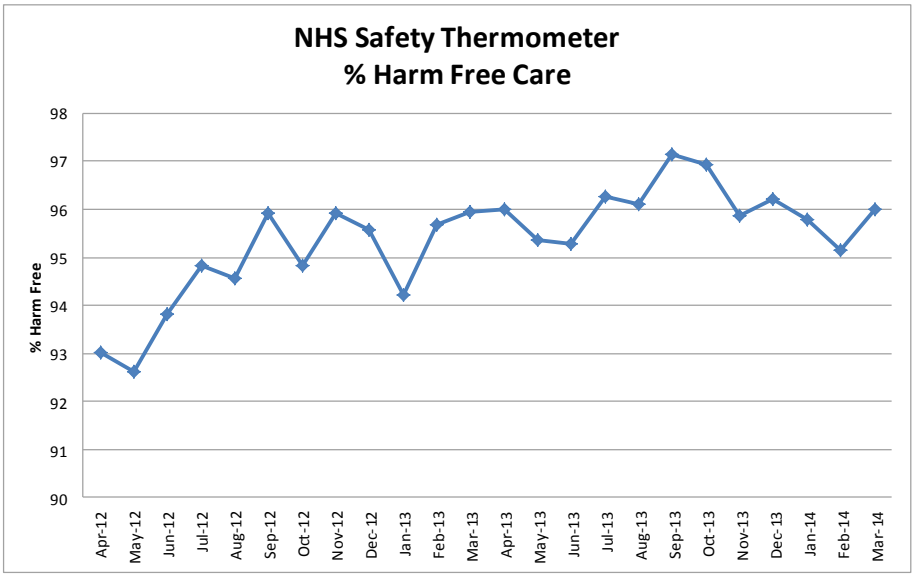


Figure 10: chart illustrating % of Harm free care April 2012 – March 2014

3.2 Claims

In the financial year 2013–14 we reported 106 clinical negligence claims to the National Health Service Litigation Agency (NHSLA) and the NHSLA, on behalf of the Trust, settled 46 claims. Further details on the Trust's claims history can be obtained via the NHSLA website www.nhsla.com. We can confirm that the Trust's clinical negligence claims history is within the national average for Acute Trusts providing a maternity service.

The Trust is committed to minimising the opportunity for human error in medicine and with this aim has committed substantial resources in implementing its Clinical Governance Framework. Clinical Adverse Events are actively reported and as appropriate investigated; with identified actions implemented to avoid similar incidents occuring again.

3.3 REACT TO RED - Reducing Pressure Ulcers

We have a proactive approach to the prevention of avoidable hospital acquired pressure ulcers. Pressure ulcer development is monitored utilising the Patient Safety Thermometer, which records the number of patients on a specific day who have develop pressure ulcers whilst in hospital, and all pressure ulcers which include the number of patients admitted with a pressure ulcer.

As part of the CQUIN for 2013–14 we were required to sustain prevalence at 0.5% or below for hospital acquired pressure ulcers and reduction to below 3% for all pressure ulcers and both of these were achieved

During 2013–14 a number of campaigns were run aimed at raising awareness of pressure ulcer prevention. The first of these was Heel Watch aimed at preventing pressure ulcers to heels, the approach included the use of Twitter, roving board, posters, slogans 'Protect the feet Un-tuck the sheet, and staff were provided with mirrors and heel balm to check patients heels.

The 'React to Red Skin' Campaign was launched in November. It was initially aimed at patient families and carers to raise awareness of early signs of pressure ulcer development. A logo was developed and displayed on posters, the patient bedside television screens, visitor's car park tickets, it has now been incorporated into all Tissue Viability documentation. Stands providing visitors with information on prevention were held. The campaign has moved on at pace and is now also being used for staff education and awareness. Staff were invited to sign a pledge wall to react to red skin. This was then linked to "NHS Change Day" and is on their web site.

We have been working collaboratively with commissioners, primary

care and social services to reduce the number of people developing pressure ulcers. It was recognised that education and training of staff and carers in all settings is an important element of prevention.

Working in partnership with 'Your Turn' a national campaign that was launched in June 2006 with the aim of raising public awareness about the dangers of pressure ulcers, a programme of education and training for carers is being developed with initial focus aimed at nursing and residential care home staff. The React to Red Skin is going to be the brand and the logo will be incorporated on all of the literature.

3.4 Safeguarding and Child Protection

The Safeguarding Team has been strengthened by the closer working of the Named Nurse for Children and the Named Nurse for Adults, who now share an office. Additional resource is provided through a support midwife, and a full time administrator.

Adult Safeguarding Training is delivered at level 1 via our induction package that all new staff are required to attend, with refreshers due 3 yearly thereafter. Updates are accessed on line, or are available as bespoke face to face sessions upon request. Training compliance has risen from 72.73% in March 2013 to 78.24% in February 2014.

Safeguarding Training regarding children is also delivered at level 2 at induction. Updates are available online, or as bespoke sessions, upon request. Compliance has risen to 100% for level 1, Level 2 has risen from 47.03% in March 2013 to 79.43% in February 2014

There is a training strategy in place to achieve 90% compliance for 2014-15. There are 4 training events at level 3, combining adults and children, training planned. The theme will be learning from recent Serious Case Reviews, for both children and adults.

Both Named Nurses support their respective Safeguarding Board sub groups and remain committed to strengthening the work within the organisation. Support, advice and guidance is required by staff on a daily basis and participation in professional development with students is also offered.

3.5 Medical Revalidation

Medical revalidation was confirmed as a statutory requirement, by the Secretary of State for Health, on the 3rd December 2012; and was introduced nationwide from April 2013. The purpose of medical revalidation is to demonstrate that licensed doctors are up-to-date and fit to practice and provide greater assurance to patients, the public, employers and other healthcare professionals. It is based on a local assessment undertaken through a doctor's formal link with an organisation, known as a designated body, which provides them with a regular appraisal. Each designated body has a Responsible Officer (RO) who doctors are accountable to as prescribed connections. Our RO is Mrs Meghana Pandit, Chief Medical and Quality Officer. The RO is able to manage their prescribed connections and submit recommendations via the General Medical Council (GMC) Connect website.

There are three types of submission that an RO can make:

a) **Positive recommendation** – confirms that a licence to practise should be continued

b) **Request for deferral** - made where there are no unaddressed concerns about an individual's fitness to practise, but there is insufficient evidence to support a recommendation or where there are concerns being investigated.

c) **Notification of non-engagement** - the medical practitioner has failed to engage in local processes to support revalidation.

Medical appraisals and impact on patient safety

A recommendation for revalidation is based primarily on the outcome of regular annual appraisal; hence effective annual appraisal is at the heart of revalidation. Annual appraisals include a review of the scope and nature of the doctor's work, information about clinical outcomes, feedback from patients and colleagues, evidence of continuing professional development and any significant events or complaints; aligned to principles set out in the GMC's Good Medical Practice guidance. Enhanced appraisal ensures a link and reflection on complaints, incidents and patient safety concerns. It also ensures discussion of personal development and the setting of personal development plans each year. This process involving every doctor should contribute to improving patient safety in the longer term.

The Trust currently has 70 trained appraisers who are registered to conduct 'revalidation ready' appraisals. The 'top-up' training delivered through the NHS Revalidation Support Team, in October and November 2012, is no longer being funded and arranged centrally. In order to replenish appraisers and allow new appraisers to be appropriately trained, an in-house revalidation-ready training programme is in development and once established will run biannually.

Revalidation at UHCW

We currently have 520 prescribed connections, for which our RO is responsible.

To date, she has made 162 recommendations for these connections, 136 of which have been positive. In total, 25 requests for deferral have been submitted due to incomplete paperwork. The majority of these have now had a positive recommendation made with only one postponement now listed on the GMC Connect site. Deferral rates nationally have been at 6% (NHS RST, September 2013). We initially experienced a higher level of

deferral (18%) due mainly to doctors not having ensured they had met revalidation requirements in a timely manner. Nevertheless, this has reduced over the last 6 months. Currently 7 doctors are shown as recommended for deferral on GMC connect.

Framework for Quality Assurance (FQA)

In previous years every designated body has completed Organisational Readiness Self-Assessment (ORSA), to demonstrate its level of preparedness for delivering revalidation. Results of the ORSA for the year ending 31st March 2013 resulted in us being RAG rated 'Green'.

Now that revalidation is progressing, there is a similar need to provide assurance that the systems and processes in place comply with the requirements of the RO Regulations. This has led to the development of the FQA which includes an Annual Organisational Audit (AOA) exercise and Statement of Compliance.

The aims of the AOA is to provide a tool that helps RO's assure themselves and their boards that the systems underpinning the recommendations they make to the GMC on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place. This will also provide a mechanism for assuring these systems are effective and consistent. We submitted our first AOA on 16th May 2014 and answered unfavourably to the following two sections:

- Every doctor with a missed or incomplete medical appraisal has an explanation recorded.
- Appraisers are supported in their role to calibrate and quality assures their practice.

In order to address these points an action plan is being developed and will be presented to the Board in July 2014.

3.6 Promoting Equality and Diversity

We continue to demonstrate commitment to promoting equality, by working towards eliminating discrimination, embracing diversity and developing services and a workforce that is representative of the communities that utilise our healthcare services. We continue to fulfil our legislative requirements such as ensuring that we have equality objectives in place, which have been developed in partnership with a range of internal and external stakeholders, and the annual publication of equality information.

An expectation of the NHS Equality Delivery System (EDS) framework is that all Trusts annually RAG rate (See glossary) their progress against actions identified within their plan. In order to comply with this, a RAG rating event was held in March 2013 involving our staff, community members and representatives from local community groups and organisations. After scrutinising progress against our plan and associated activities, it was agreed that our overall rating should be amber. This reflected the consensus that the majority of actions were developing with some that were under-developed and a number of actions that we considered to be achieving. The ratings and all the supporting comments and suggestions have been made publicly available via our internet site after Board

approval on 29th May 2013. This will provide the wider community, partners and stakeholders with a clear transparent sense of how we a progressing against the actions set out in our plan.

Independent Advisory Group (IAG) for Equality and Diversity

A key element within the action plan was to form an IAG for E&D. The group was formed in March 2013 and is made up of external and internal representatives and meets quarterly. Membership of the group includes representation from:

- Healthwatch
- Coventry City Council
- Coventry Carer's Centre
- African Caribbean Community Organisation Limited
- Tamarind Centre - Black Mental Health
- Coventry Refugee and Migrant Centre
- Community individual (gay/lesbian community)
- Community individual (older people)
- Faith Centre
- Grapevine (people with physical/sensory/learning disabilities)
- Patient's Council
- PALS
- Communications
- Patient Information Centre
- Modern Matrons
- Ward Managers
- Staffside
- Volunteer Services
- Patient Involvement.

The IAG has agreed its Terms of Reference which will be reviewed after one year. Their role is to:

- **To influence and oversee the development and operation of Equality, Diversity and Human Rights matters (or issues) for the Trust and anyone involved (or participating) in the care and services we deliver.**
- **To act as a source of expertise and reference point for the organisation on Equality, Diversity and Human Rights related matters.**

By ensuring meaningful consultation, involvement and participation of the wider community, we have enabled them to influence and shape our plans; and assess our progress against the actions identified. Policies, key changes and consultations are reviewed and assessed by the IAG so that we are able to demonstrate that issues regarding equality of access and equality of outcome are considered and integrated in to the Trust's core business. For governance purposes, the IAG reports to the Human Resources, Equality and Diversity (HRED), then onwards to the Quality Governance Committee.

Equality Plan 2014 to 2017 - Dragons' Den

The current Equality Plan ends in April 2014 and therefore it was the right time for us, in partnership with the wider community, partners and stakeholders to agree which priorities and actions should be progressed for the period 2014 to 2017.

The IAG took a more interactive and inclusive approach in deciding on the content of the next E&D plan, using an adapted Dragons' Den format. The event took place on Monday 17th February 2014 and enabled groups, individual, organisations, staff, patients to influence our future Equality and Diversity plans, actions and community engagement activities to meet the health needs of all groups.

The process was adopted to enable individuals and groups to participate in a way that is appropriate for them. Proposals were requested and were outlined using a SMART (Specific, Measurable, Achievable, Relevant, Time-bound) objectives template. This was to ensure that they were able to provide "pitches" that would have a positive impact on patients and/or staff in an Acute setting. Proposals were then elaborated on with

a "pitch" (presentation, video, play etc.) where Chief Officers acted as "Dragons".

The IAG and Dragons were there to act as "critical friends" and to clarify and challenge pitches to ensure their robustness and feasibility. Pitches were reviewed and scored with all successful pitches appearing as objectives in the new action plan.

For more information on Equality and Diversity please contact Barbara Hay, Head of Diversity Barbara.hay@uhcw.nhs.uk

3.7 Clinical Evidence Based Information System (CEBIS)

CEBIS is a service provided by our Library & Knowledge Services. From its initiation in 2004 it has built a reputation at local, national and international level as a leading and innovative service in the provision and use of knowledge management for research based healthcare.

CEBIS provides us with a service infrastructure for the referral of queries in a timely and efficient manner. Referrals are managed by qualified and experienced health librarians (CEBIS Specialists) who undertake comprehensive reviews of research literature and work in partnership with staff to assess any impact of the evidence located. Now linked to our electronic patient record system (CRRS) CEBIS provides a searchable interface to access the increasing bank of information produced and knowledge acquired from referrals to be shared with clinicians and patients alike.

Since going live in February 2013 CEBIS has dealt with 594 referrals: 112 made directly via CRRS and the remaining via CEBIS Specialist integration with clinical teams at a Specialty level. Evaluations of CEBIS over the years have demonstrated impact of value at multiple levels:

Revised clinical practice	**Revised service delivery**	**Research based recommendations to inform patient choice and well being**
Provision of a model of practice to facilitate the use and education of knowledge skills at the point of care	**Provision of seamless access to information to the point of care**	**Saved money**

More recently CEBIS has been selected as one of the NHS Local 'Editors Choices' Best Practice Showcase 2012-2013 and featured in Global Comparators :improving healthcare across the world in November 2013. In December 2013 CEBIS embarked on a new journey in securing a contract with Soutron via MidTech NHS Innovations to prepare CEBIS for the global health market.

For more information on CEBIS please contact our Head of Library & Knowledge Services, Jacqui Le May Jacqui.lemay@uhcw.nhs.uk

3.8 **Supporting and Facilitating Innovation to improve patient care**

Innovation and excellent clinical practice already exists across the organisation. The rate of adoption has however been variable and there is a need to identify and share best practice. The report, Innovation Health and Wealth: accelerating adoption and diffusion in the NHS, sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. This, together with the development of the West Midlands Academic Health Sciences Network (AHSN) has been an opportunity to develop and lead the Innovation agenda within our organisation.

As part of our Research, Development and Innovation Strategy we have appointed 5 Innovation Champions and 3 Innovation Faculty Leads to promote and facilitate innovation throughout. These newly developed roles focus on supporting staff to develop ideas and build networks both internally and externally. While the Champions are internally focused, the Faculty Leads have been appointed to concentrate on building collaborations with Warwick University. They have been an integral part of identifying ideas, improving communications, and building the capacity of staff to conduct innovative activities.

We have developed a clear and simple process for identifying and addressing innovation ideas, receiving over 100 novel ideas in the first year. 30 items of Intellectual Property were disclosed and 4 license deals were secured during 2013–14; a significant increase from 9 disclosures and 1 license in 2011/12.

To acknowledge and reward innovative practice we have introduced an innovation recognition scheme. A badge and certificate of achievement is awarded to employees or service users of the Trust whom they believe have made a significant contribution to the improvement/innovation of a product, process or service. So far we have given 13 awards to our staff.

3.9 Patient Experience

Patient Experience and Engagement Committee

The Patient Experience and Engagement Committee continues to be our main forum for overseeing the patient experience agenda. However, in February 2014 it was agreed that the Chair of the Committee would be changed from the Chief Nurse to the Chief Medical Officer. It was agreed that the Managers of the lowest scoring Wards in the FFT would attend the Committee to outline what they were doing to improve results. In addition, members of the then Patients' Council (now Patient Advisors' Team) met with the Ward Managers to review what measures they were taking to address the issues highlighted as a result of feedback received via the FFT. This practice will continue in 2014–15.

We continue to utilise our real time feedback system 'Impressions' to capture feedback from patients, relatives, carers and visitors. Respondents are asked whether they had a mainly good or mainly bad impression of the Trust and its services. Our results for 2013–14 are set out below:

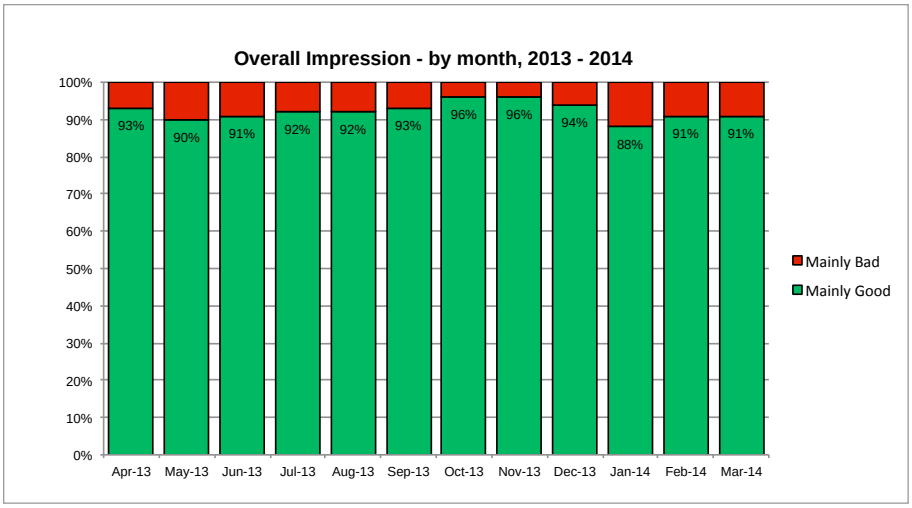


Figure 11 - Impressions overall score 2013–14

The Trust is encouraged that overall experience of the Trust remained mainly good during 2013–14. The table below indicates that scores were consistently in the 90% + range for all months apart from October 2013. It should also be noted that Impressions allows patients, relatives and carers to give feedback in their own words and also asks for suggested improvements. These comments/suggestions are sent to relevant members of staff on a daily basis.

Family and Friends Test (FFT)

FFT for In-Patients was introduced at the Trust in April 2012. In line with national guidance, the FFT was expanded into A&E in April 2013 and Maternity Services in October 2013. For the patients responding to the Friends and Family Test the areas affording the highest and lowest satisfaction were:

Highest:

- Staff respecting [the patient's] privacy and dignity
- Staff treating [the patient] with kindness and compassion
- Staff treating [the patient] with politeness and respect

Lowest:

- Parking

- The standard of food and drink
- Timeliness – doing things on time

As the year progressed we were extremely pleased to see both our score and response rate exceed the national average in A&E. However, this was tempered by the fact that, despite several initiatives, we remain below the national average in both score and response rate for the In-Patient FFT. Our family and friends scores for 2013-14 are within our Patient Experience Annual Report which is available at www.uhcw.nhs.uk

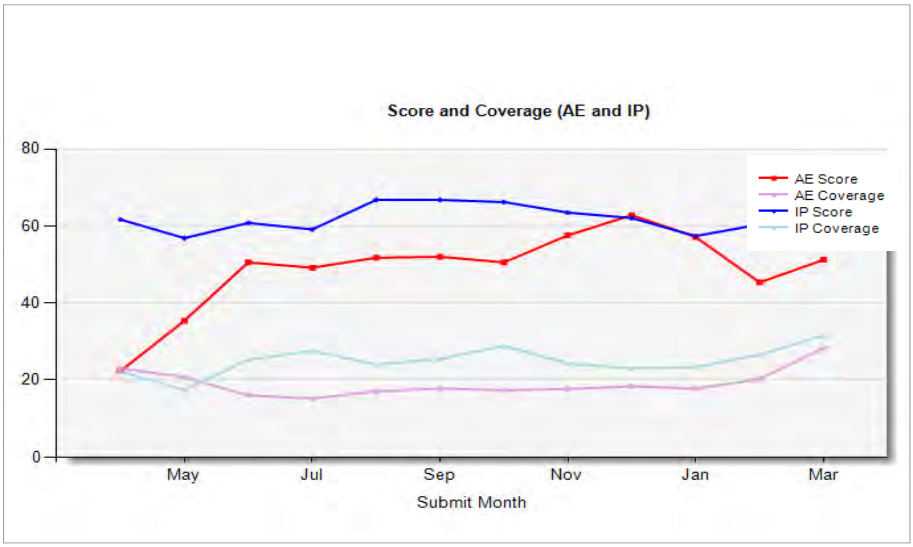


Figure 12 - Family and Friends Test Score and Coverage

Surveys undertaken as part of the national NHS Survey Programme:

During 2013–14 two surveys were carried out as part of the Care Quality Commission's NHS Survey Programme, the annual In-Patient Survey and Maternity Services Survey which is usually carried out every 2/3 years.

With regard to the results of both the In-Patient Survey and Maternity Services Survey, action plans have been developed.

To summarise, the analysis of all the surveys undertaken during 2013–14 allows us to conclude:

- Overall, patient, relative and carers satisfaction levels with services remains good
- Patients, relatives and carers indicate high levels of satisfaction with our staff respecting their privacy and dignity and treating them with kindness, compassion, politeness and respect;
- Patient, relatives and carers indicate high levels of dissatisfaction with parking, timeliness and discharge processes;
- Some patients/relatives/carers experience variable level of experience during an episode of care at the Trust: some aspects may be of an exceptionally high standard with other aspects being not so good;
- Certain wards, departments and processes consistently provide a better patient experience than others.
- We must continue to strive to deliver a consistently high quality patient experience in all wards, departments and processes.

Patient Advisor Team

We initiated a 12 month pilot (to run from January 2014 to December 2014) whereby members of the Patient's Council have become Patient Advisors working at Specialty Group level, providing a lay perspective on issues relating to the various specialities within each Clinical Group. This allows the Advisors to work closely with front line staff and enables them to influence service developments that are directly linked to patients. In effect, they should become the voice of the patient at Specialty Group level.

In addition, the Patient Advisors meet as a Group, known as the Patient Advisors' Team on a monthly basis to share experiences, provide support and promote ideas and good practice. At the end of the year-long pilot, an evaluation will take place and a decision taken as to whether to roll this out to the other Specialty Groups. For more information on patient experience activities please see the Patient Experience Annual Report on our website.

L-R front row: Mr Ian Crich, Mrs Margaret Emerson, Mrs Diane Devine, Mrs Rosemarie Tonkinson (Chair of the PAT). L-R back row: Mr Malcolm Gough, Mr Stephen Snart, Mr David Hardiman, Mr Bob Wright, Mrs Margaret Brassington, Mrs Kate Harvey)

You Said, we Did

During 2013-2014, we continued to listen and act on the views of our patients and of their relatives and carers. We continued to use 'Impressions', listening events were held, forums were re-designed and the Patient Story Programme at Trust Board continued (whereby patients and staff attended the Trust Board to give accounts of their experience of the care that we provide).

To complement these activities, and in light of the expansion of the Friends and Family Test, June 2013 saw the launch of the Trust's 'We Are Listening Campaign'.

The campaign is an ongoing programme of events and initiatives with the two-fold aim of making our patients, relatives and carers aware of the various mechanisms available to them to feedback on their experiences, and increasing the amount of feedback we receive.

With this wealth of information on patient, relative, and carer experience, we have worked hard during 2013–14 to bring about improvements in line with what is important to those who use our services. Based directly on feedback from patients, relatives and carers, we have carried out the following in the past 12 months:

Arm Warmers

Additional arms warmers have been purchased for use by patients undergoing chemotherapy. Source - Patient Story

Chairs

New chairs have been purchased for main reception. Source – FFT

Seating along the corridors

Seating has been installed along the corridors for those patients and visitors who may have mobility/health conditions which make walking long distances difficult. Source – Impressions.

Visiting hours

Visiting hours for partners of women on the Labour Ward has been extended.
Source – FFT.

For more information please access the Patient Experience Annual Report 2013-14 at www.uhcw.nhs.uk

Complaints

During 2013-14 we registered 490 formal complaints compared with 483 the previous year.

The Parliamentary and Health Service Ombudsman (PHSO) is the second and final stage in the complaints process. From April 2013 to March 2014, 16 of our files were requested. Of these 14 were investigated, with 1 upheld, 7 partially upheld, 2 closed with no action required and 1 returned for further local resolution. 5 complaints were not concluded by 31 March 2014.

Complaints have been used for our Patient Stories Programme at Trust Board, where the patients speak about their experience directly to members of the Board. We also regularly meets with patients and relatives on the wards to help with their concerns, and on the spot resolution is very much encouraged. In addition to this, the Complaints Service and key staff met with 44 complainants between April 2013 and March 2014 in an effort to resolve their registered complaints. Below are a few examples of Patient Complaints and the action taken in reponse.

Total Number of Complaints	2011/12	2012/13	2013–14
Total Number of Complaints University Hospital, Coventry	450	431	459
Total Number of Complaints Hospital of St. Cross , Rugby	44	42	26
Total Number of Complaints - Other	3	10	5
TOTALS	497	483	490
Total number of complaints referred to the PHSO	25	23	16
Ratio of Complaints to Activity	911,206	914,700	966,763
	0.05%	0.05%	0.05%

Top Five Complaint Categories as prescribed by the NHS IC K014a	
All aspects of clinical treatment	263
Communication/information to patients	61
Attitude of staff	51
Admissions, discharge and transfer arrangements	45
Appointments, delay/cancellation (out-patient)	26

Concern raised	Action taken
Work up for Renal transplant patients	Full investigation undertaken and meeting offered with family. Work up to be extended to include the abdominal aorta as part of the checklist for transplant assessment.
Pressure area care in Maternity	Full investigation undertaken and meeting held that resulted in a Tissue Viability Review and appointment with Consultant Obstetrician so further assurance could be given.
Dignity and Privacy	Full investigation undertaken into Last Offices and staff approach. Meeting held to go through concerns first hand and nurses to attend and advanced communication course. Complainant invited to come back to give a talk to the nursing staff on her experience.

For further information about complaints and about how the Trust is responding to the national recommendations of the Francis and Clwyd/Hart publications please access the Patient Experience Annual Report on our Website.

Foundation Trust Membership

Although we are not yet a Foundation Trust, we have 9,200 public members who we regularly keep in touch with via email and post. A monthly email is sent with latest news and upcoming events and we are piloting a hard copy newsletter called In Touch+ for patients, visitors, volunteers, staff and members that cover new initiatives, improvements and introductions to new members of the Board.

Our Medicine for Members' events which are organised monthly on a range of topics suggested by staff and public members and are regularly attended have proved very successful. Popular topics from last year included heart health, back pain and dementia. We also provided a tour of the recently opened Lucina Birthing Unit which proved very popular.

We wrote to all our male members aged 65 and above about our Abdominal Aortic Aneurysm (AAA) screening service to make sure they were aware this was available to them. The AAA service had a fantastic take up of 200 men and they believe approximately 175 of these were a direct result of our member communications. The detection rate in this group was more than 3% compared to 1.25% standard detection rate which means more AAA's were found than expected.

Our membership has a healthy comprehensive representative of our communities with enough members interested in stading for election as governor in all of our public constituencies in preparation for foundation trust status.

PLACE (Patient Led Assessment of the Care Environment)

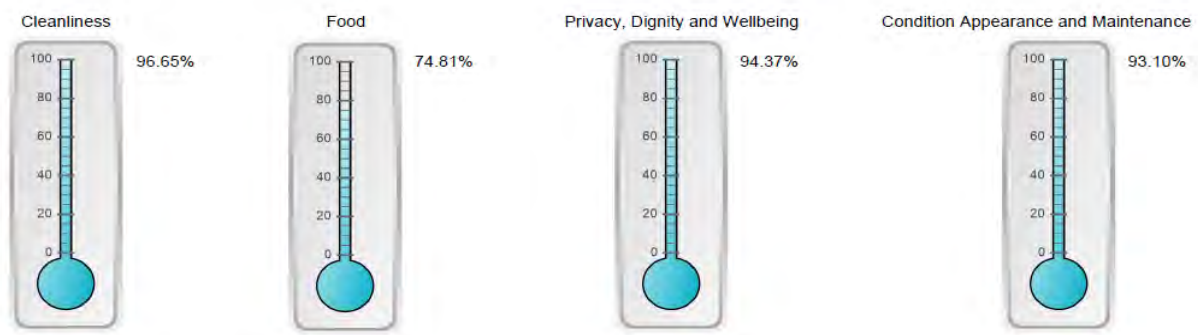
PLACE replaced the former PEAT environmental inspection system from 1 April 2013. It assesses our two hospital sites against a range of common environmental standards. The scores awarded must reflect what was seen on the day and no allowance is made for the age of facilities. At least half of those undertaking the assessments must meet the definition of a patient which is anyone whose relationship with the Trust is as a user rather than a provider of services. Current or recent employees or those providing services to the Trust are ineligible.

Each PLACE visit scores against four areas: cleanliness, food, privacy and dignity, and general maintenance/décor. The results must be published locally with accompanying action plans that set out how the organisation expects to improve the services before the next assessment.

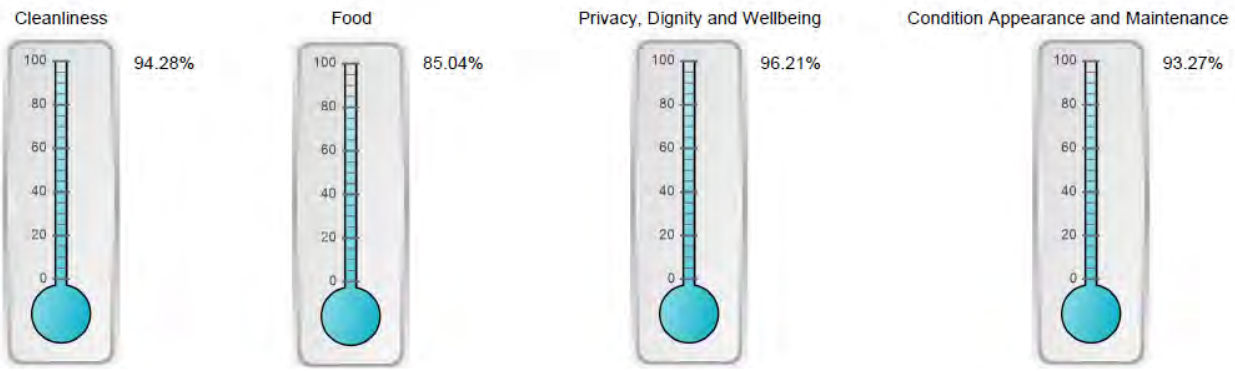
Under the new system we are no longer able to determine the date on which assessments will be carried out. Instead, the Health and Social Care Information Centre (HSCIC) will give us six weeks notice of the week in which our assessments should be undertaken. We will however be free to select the day of the week on which to organise the assessment.

In 2013 our PLACE assessments took place in April and June (results below)

University Hospital



Hospital of St Cross



Actions from the assessments have included the following:

- Introduction of new patient menus across both sites, introduced in January 2014
- A redecoration programme of the main corridors, lobby area and outpatient areas, this has also included some replacement floor coverings.
- An ongoing planned programme of replacement of the single glazed windows in ward areas with double glazed units.

On the University Hospital site:

A new cleaning pathway is being trialled on the fourth floor ward areas. This changes the way the Domestic staff clean the areas by the introduction of teams for specific tasks. This approach not only reduces any possibility of cross contamination but is also a more efficient way of cleaning. We have also this year revisited our enhanced maintenance programme to wards and departments. For areas like Accident and Emergency and Critical Care we carry out a redecoration programme twice a year which also includes a full terminal clean along with decontamination with Hydrogen Peroxide.

We are piloting the use of Ultra Violet Light technology as a further aid to the cleaning process in certain areas.

For this year's PLACE assessments we have engaged with Healthwatch Coventry who will form part of the assessment team.

Site Access & Car Parking

Work has been progressing during 2013–14 with the planned on site improvements to address ongoing car parking and congestion issues.

Planning permission was granted in May 2013 for a series of on-site works that include:

- Additional car park decks to increase public parking capacity
- An upgraded bus interchange facility that will increase capacity
- Modified road and car park access layouts to enable better traffic flow
- Automated car park signage indicating location of available spaces
- New larger main entrance patient drop off zone

Two elements of these improvement works have already been completed this financial year. These are a new taxi rank and a new main entrance patient drop off zone as depicted below.

The remaining elements of these improvement works are planned to be commence this summer with completion in 2015.

In conjunction with the onsite works, a successful application was submitted to the Department of Transport in partnership with Coventry City Council for £3.9m of funding to address pinch point issues to junctions on roads approaching the hospital. These works are currently in the planning stage but are due to commence this summer with completion in 2015. These works consist of:

- Major enhancements to the Ansty Road/Clifford Bridge Road gyratory junction including the main hospital site access.
- Additional lanes at the Ansty Road/Halll Lane crossroads to increase vehicular capacity and relieve delays particularly in Woodway Lane.
- A new junction arrangement at the Hinckley Road/ Brade Drive roundabout to increase vehicular capacity, reduce delays and improve pedestrian crossing facilities.

3.10 **Staff Experience**

We employ a total of 6571 staff that were eligible to receive the 2013 national NHS Staff Survey. A random sample of 850 staff were extracted from our Electronic Staff Record (ESR) and were sent questionnaires. We have higher ranking scores than other acute trusts nationally in five key areas, including the number of staff being appraised, and the number of staff receiving health and safety training.

Our response rate for the national Staff Survey has however seen a continual decrease over the past three years from 51% in 2011, to 39% in 2012 and 37% in 2013. The response rate is in the lowest 20% of acute Trusts in England. Reminders were automatically generated and sent to staff that had not completed the survey, and in addition, prior to the survey closing, an additional all user e-mail was sent to those randomly selected from the Chief Executive Officer requesting urgent completion and encouragement to provide feedback.

The overall stated purpose of the survey is to:

a) gauge the degree of staff engagement and

b) to find out the effects of 4 staff pledges within the NHS Constitution

Staff Pledges

The 4 staff pledges contained in the NHS constitution are:

Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

Staff Pledge 2: To provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.

Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

Staff Engagement

From a review of all the national result, there is a national improvement in 21 out of 28 indicators, including in many key areas and overall levels of staff engagement have improved from 3.68 in 2012 to 3.71 in 2013. Nationally the results have shown that staff are increasingly willing to recommend the NHS as a place to work or be treated, and almost two thirds of NHS staff would recommend the NHS as a place to work or for their friends or family to be treated.

Our results on staff engagement have seen a slight reduction in the staff engagement score as set out below.

Staff Engagement Score	
Trust Score 2013	3.66
Trust Score 2012	3.73
National 2013 average for acute trusts	3.74

The survey identifies key areas where staff involvement and staff engagement require further improvement and it is anticipated that the Together Towards World Class programme will develop detailed actions to address these issues.

Top Five Ranking Scores

We scored higher than the national average of acute trusts in the following five key indicators:

Top Five Ranking Scores	UHCW score 2013	National 2013 average score for acute trusts
Percentage of staff appraised in the last 12 months	90%	84%
Percentage of staff reporting errors, near misses, or incidents witnessed in the last month	92%	90%
Percentage of staff receiving health and safety training in the last 12 months	80%	76%
Percentage of staff suffering work-related stress in the last 12 months	35%	37%
Percentage of staff working extra hours	69%	70%

Bottom Five Ranking Scores

The national report also details our bottom five ranking scores for the trust and suggests that these are the key areas where further detailed recommendations need to be developed.

Bottom Five Ranking Scores	UHCW score 2013	National 2013 average score for acute trusts
Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell	36%	28%
Effective team working	3.64	3.74
Percentage of staff reporting good communication between senior management and staff	22%	29%
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	17%	15%
Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives or the public in the last 12 months	32%	29%

Recommendations

Following the results of the 2013 NHS Staff Survey, a number of priorities have been identified for action:

Embedding effective appraisal processes

Whilst 90% of staff stated that they have had an appraisal, the results show that increased numbers (compared to 2012 Staff Survey results) did not find that their appraisal helped them to improve how they do their job (54%), they did not agree that clear objectives were set (21%) and did not feel that their work is valued as a result (41%).

Our revised non-medical appraisal paperwork was launched in September 2013, along with 'Effective PDR workshops' for managers, 3 months prior to the completion of the Staff Survey. Whilst it is anticipated that employee experience will improve as those appraisals undertaken in the next 12 months will utilise the new paperwork, in light of the survey results, the content of the training will be reviewed and consideration will be given as to how to offer training or guidance for employees.

Management and Leadership Development

The survey identifies several areas in which further management development is required, as staff have identified a reduction in the satisfaction of the support received from their immediate manager. The TTWC work stream on Leadership and

Management Development will focus on ensuring that our managers have the skills and behaviours required to lead and manage our workforce.

Health, Wellbeing and Safety

The survey identifies that several areas require improvement, including the personal experience and reporting of physical violence, harassment and discrimination. An ongoing review of Conflict Resolution Training provision go some to way to address personal experience of physical violence and harassment, as we ensure that staff receive adequate training in how to de-escalate situations.

The results relating to experience of discrimination from colleagues will be considered and acted upon by the Trust's Human Resources Equality & Diversity Committee and Independent Advisory Group. The Trust's Health & Wellbeing Group will continue to promote and support staff wellbeing.

In relation to the key areas of improvement there has been a reported increase in the number of appraisals undertaken as reported at the Quarterly Performance Reviews, and an increase in Statutory and Mandatory Training as reported in the Mandatory Training Committee.

Staff Family and Friends Test

From April 2014, NHS England is introducing the Staff Friends and Family Test (FFT) in all NHS trusts. It is anticipated that Staff FFT will help to promote a big cultural shift in which staff will have further opportunity and confidence to speak up, and where the views of staff will be heard and are acted upon. It has been shown that we have made improvements following the introduction of the patient FFT, as a result of us listening to, and acting on, patient, relative and carer feedback.

We have taken the decision to incorporate the Staff FFT into the Staff Impressions engagement surveys which will support the Together Towards World Class (TTWC) Programme. The use of the Staff Impressions engagement surveys will allow us to review the embedding of our values and behaviours, and provide feedback on the progress achieved on a quarterly basis. The surveys will be run on a quarterly basis and will enable the TTWC Programme Board to gain regular feedback.

3.11 Performance against National Priorities 2013–14

Quality and Patient Safety Indicators give Trusts, Commissioners and the General Public, comparable data on how we are performing. Because the indicators are standardised, and have to be measured in specific ways, they provide an opportunity for performance to be compared over time and across the NHS. The local indicators are agreed by the Trust Board and where appropriate agreed with our Commissioners. The below table of indicators (except for those shaded grey) are ones where we are required to submit information nationally.

Indicators	Target 2013–14	2013–14	2012–13	2011–12	Rating
CQC Essential Standards	n/a	Licensed without conditions	Licensed without conditions	Licensed without conditions	✓
CQC acute hospital rating (Band 6 - Lowest Risk, Band 1- High risk)	n/a	Band 6 (March 2014)	n/a	n/a	✓
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	91.84%	94.51%	92.20%	✓
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	97.55%	97.89%	96.50%	✓
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	94.01%	94.23%	95.90%	✓
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	93.93%	91.46%	93.95%	!
All cancers: 62-day wait for first treatment from: - from urgent GP referral for suspected cancer	85%	85.01%	85.57%	87.11%	✓
- from NHS cancer Screening Service referral	90%	95.92%	96.91%	97.99%	✓
All cancers: 31-day wait for second or subsequent treatment, comprising: - surgery	94%	99.08%	99.42%	99.66%	✓
- anti cancer drug treatments	98%	100.00%	100.00%	100.00%	✓
- radiotherapy	94%	95.80%	96.95%	97.66%	✓
All cancers: 31-day wait from diagnosis to first treatment	96%	99.49%	99.60%	99.67%	✓
Cancer: two week wait from referral to date first seen, comprising: - all urgent referrals (cancer suspected)	93%	94.41%	94.51%	94.20%	✓
- for symptomatic breast patients (cancer not initially suspected)	93%	94.57%	94.78%	94.22%	✓
Clostridium Difficile – meeting the Clostridium Difficile objective	57	47	76	90	✓
Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia – meeting the MRSA objective	0	2	2	1	!
Certification against compliance with required access to healthcare for people with learning disability	Green	Green	Green	Green	✓

Performance against locally agreed priorities

Indicators	Target 2013–14	2013–14	2012–13	2011–12	Rating
Numbers of acquired avoidable Pressure Ulcers Incident reporting	Fewer or equal to previous year	Grade 2:43 Grade 3:16 Grade 4:0	Grade 2: 61 Grade 3: 13 Grade 4: 1	Grade2:32 Grade 3:41 Grade 4:28	✓
Incidence of 'Never Events'	0	4	4	3	!
Hospital standardised mortality ratio (HSMR)	100	96.1 Mar 13–Feb 14	98.77	94.00	✓
Delayed transfers of care	4%	4.81%	4.85%	5.45%	!
Breaches of the 28 day readmission guarantee	5%	11.81%*	5.40%	4.52%	!
Friends and Family Test inpatient score	61	63.75	44.3	n/a	✓
Friends and Family Test A&E score	22	50.97	n/a	n/a	✓

*Breaches of the 28 day readmission guarantee: This indicator reports the number of patients whose operation was cancelled, by the hospital for non-clinical reasons, on the day of or after admission, who were not treated within 28 days. The processes in place are overseen via the weekly access meeting that scrutinises and challenges the re-scheduling of cancelled patients. The twice daily reviews of the planned operating lists

with each specialty provides a high degree of rigour in ensuring these patients are not cancelled for a second time. The high numbers of cancelled operations in conjunction with some of the capacity issues faced by certain specialties create significant difficulties in eliminating breaches.

Sustainable solutions required to achieve this KPI lies within the elective care transformation programme and involve:

- Improved scheduling
- Increasing the amount of day case procedures undertaken in day surgery by converting activity from main theatres
- Theatre rota reconfiguration
- Availability of a second emergency theatre

Part Four

An Invitation to comment and offer feedback

Your views - Your involvement

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

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

You can also share your views by

- emailing us at communications@uhcw.nhs.uk or
- Visiting our website www.uhcw.nhs.uk and completing the Impressions survey or
- Visiting the NHS Choices website at www.nhs.uk

We look forward to hearing your comments and suggestions.

Annexes

Statements from Partners

Response on behalf of the Quality Accounts Task and Finish Group set up by Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee with Coventry City Council, Rugby Borough Council, Coventry Healthwatch and Warwickshire Healthwatch.

We welcome the opportunity to comment on the Trust's 2013-14 QA and would like to put on record the thanks of the Task and Finish for the work that has been done with the Trust over the past year on their QA, which has built on the pilot that was introduced locally in September 2012. The decision to approach quality accounts in a different way. establishing working groups with partner organisations to look in-depth at Warwickshire and Coventry's Trusts' Quality Account – both in monitoring performance over the year and in working with the Trusts to identify priorities for the year ahead has led to a more meaningful process and to enable stakeholders to work together to develop a better understanding of quality within the Trusts delivering services to the people of Coventry and Warwickshire.

This commentary, although formally presented by Warwickshire County Council, reflects the views, input and contributions of those members of Warwickshire County Council and Warwickshire Healthwatch, Coventry City Council and Coventry Healthwatch and Rugby Borough Council.

Reflecting on Quality Priorities for 2012/13 and 2013–14

The Group was pleased to see the updates on the 2012/13 priorities and the ongoing work that is being done to reduce harm because of falls, hospital discharge and using patient feedback to improve experience. It was felt that the work being done to improve hospital discharges would go some way to addressing the breaches on readmission rates.

It is concerning to see the rating in relation to Maternity Services, and the Group will monitor the action plan for improvement over the next year.

The Group noted their concern regarding the A&E environment, particularly for paediatrics, and agreed that this was an area that warranted attention from both a patient experience and patient safety perspective.

The Group acknowledges the awards that the UHCW staff have been shortlisted for, nominated for or won, which highlights the good work being done at the Trust. It is disappointing to see, however that aside from the welcome work being done to identify and address innovation amongst staff, that there is still work to be done around staff engagement and ensuring that staff felt they about to talk openly about patient experience.

The Group welcomed the results that had been achieved in relation to infection control (MRSA and C.Difficile).

Quality Priorities set for 2014/15

The Group was pleased to be able to feed suggestions to the Board on proposed Quality Priorities, with the intention of ensuring that there was a local focus on the patient experience in delivering Priorities, and not a focus on areas that were

already covered by national targets that are monitored by a number of organisations.

The approach used for each priority – setting out the reasons for selection, the goal, starting point and how the goal will be achieved and monitored is an excellent and transparent way of showing the public how improvements will be made.

The Group welcomes the inclusion of Getting Emergency Care Right – Ensuring Effective Handovers between Healthcare Professionals content and the overall focus on improving patient handovers across the hospital. The Group feels that this approach should be extended to transfers and working between different organisations as well, such as mental health and social care.

The focus on transforming patient experience is central to the different areas of improvement and this is fully endorsed by the Group. There needs to be an ongoing focus on demonstrating what changes and improvements have been made as a result of listening to patients and staff to measure patient experience.

The Group look forward to building on the strong foundations that have been laid this year to bring about improvement and to continue to work with the Trust to ensure that the needs and experiences of the staff and patients of UHCW continue to be a focus within the priorities for local organisations across the region to integrate services, improve general practice and help people to live independently for longer. The joint work of the different members of the Task and Finish Group working with the Trust has also given the QA a wider focus, looking at the Trust as a local general hospital provider as well as a centre of excellence.

In order to succeed in the Trust's clear ambition to become "a world class place in which to be cared for and to work", UHCW needs to have strong working relationships with other Trusts and stakeholders across the region, and this is not evident from the QA. Two further areas of focus needed to be issues of non-compliance and the variability of IT services across the Trust.

Comment by UHCW:

We welcome the response by the Task and Finish Group and look forward to continuing to collaborate into 2014-15. With regards to the Children's Emergency Department UHCW recognise this needed updated. Funds raised by UHCW Charity and Touch Radio will contribute to the waiting area being significantly refurbished with an under the sea this year. Healing arts will be involved in sourcing artist commissions for three assigned spaces. The theme is under the sea.

We are keen to improve the visibility of information to patients and visitors about improvements the Trust have made following feedback. We will be promoting 'You said, We did' throughout the We are Listening Campaign 2014-2015. A bi-annual report will also be presented to our Trust Board.

We try and improve the content of the Quality Account year on year and we welcome your input and feedback around how we can emphasise in the account the work Trust staff do in working collaboratively with stakeholders both regionally and nationally.

Healthwatch Coventry commentary on the University Hospitals Coventry and Warwickshire Quality Account

Healthwatch Coventry is the consumer champion for local health and social care services, working to give local people and users of services a voice in their NHS and care services. Local Healthwatch welcomes its role in producing commentaries on NHS Trusts' Quality Accounts. The version of this document we received in order to draft this commentary was not entirely complete, which inhibits our ability to comment. It seems to have been a feature of this year's quality account cycle that all Trusts have found it difficult to produce completed documents to send out for comment.

We found the style of this document to be clear and easy to read. Along with colleagues from Warwickshire we have been involved in a task group to follow up on last year's quality priorities and discuss the priorities and content of this document. We asked for more information to be included to highlight the actions taken in particular more of a 'you said, we did' element in order to stop the document being so focused on process.

Quality highlights

The information provided in this section seems fair and reflects both positives and areas for improvement.

The Friends and Family Test is a national initiative requiring Trusts to ask the same questions of people who use their services. UHCW has had the lowest friends and family test in-patient rating in the Herefordshire, Worcestershire and Arden area this year. The score for A&E patients improved and then fell back somewhat in February 2014. However methods of asking the questions and response rates vary between trusts. UHCW also seems to have a higher proportion of neutral scores.

The information regarding the national maternity survey rating would benefit from some context and information about what is being done to address the issues.

Progress report

This section would benefit from data on the amount of falls, ie were there fewer falls as a result of the work undertaken. Information about changes made as a result of patients feedback would also be welcome. All wards should move to 7 day discharge rounds as this was included in the policy some time ago.

Improving quality section

There is no data included regarding Patient Advice and Liaison Service (PALS) work this year and understand that this is due to a data gap resulting from a period when the service was experiencing staffing difficulties. Issues regarding the delivery of the PALS service were one reason that Healthwatch carried out work to talk to patients about how they would go about raising a concern with the hospital and to look at what information was available about doing this. We produced a report and recommendations to the Trust. We would like to see actions to develop the delivery of this important function be included in the quality priorities along with work to make the complaints process more accessible. It was pleasing to see some progress regarding access to the hospital site this year and we hope that the next phase will progress quickly. It is a slight concern that the response rate to the staff survey is declining and now in the lowest 20% in England. This should be looked into as it is important to find ways for staff to raise issues and ideas.

Quality priorities for coming year

We support the inclusion of a priory regarding effective handover as this is vital for patient care and experience and it is a concern that staff

are not complying with current handover sheet use. However we wonder how progress will be monitored and how the Trust will ensure that family/ carers are involved. We also support the efficient use of operating theatres. We hope to work with the trust regarding good patient public engagement in the coming year. From the information given we are not sure what the patient innovation model is and what world class patient/health information will be defined. Healthwatch can contribute as one of the stakeholders for this work. Training for staff on providing an excellent patient experience is welcomed.

Agreed at Healthwatch Coventry Steering Group 3/6/14

Comment by UHCW:

We are grateful to Healthwatch Coventry for its response to our Quality Account. We acknowledge that the version reviewed still had some content outstanding. Since that version and following a meeting held with the Quality Account Task and Finish Group, of which Healthwatch is a member, held on the 8 May 2014 we hope you find the gaps around 'you said we did' , falls data and the extra detail around the Maternity Survey have been filled.

The Friends and Family test is only one way of assessing patient experience. UHCW uses a range of methods to collect feedback and turn listening into action. Although UHCWs score remains below the national average for inpatients our response rate to the question is one of the highest. It is unfortunate that people who respond 'Likely' to the test question are not a promoter and are classed as passive (neutral), as UHCW has a high proportion of users who would be likely to recommend us.

We are keen to continue to improve our collaborative work on quality improvement with you and look forward to the coming year.

NHS Coventry and Rugby Clinical Commissioning Group Commentary

NHS Coventry and Rugby Clinical Commissioning Group (CRCCG) welcome the opportunity to comment on University Hospitals Coventry and Warwickshire (UHCW) NHS Trust Quality Account for 2013-14.

It has been reviewed by the Clinical Quality and Governance Committee (CQGC) and it is our view that it complies with the guidance set out by the Department of Health and provides a good account of the quality of services at UHCW with a strong emphasis on patient experience and we are pleased with the user friendly presentation which will make it accessible to our local population. We are unable to verify the achievement of CQUIN schemes, as this had not been finalised in time for the commentary.

We recognise the Trust has made good progress in a number of areas during 2013-14 and in particular with the A&E four hour target. This has been very challenging and the Trust is to be congratulated on the excellent work that has been done. We will continue to watch this with close interest as they expand their Getting Emergency Care Right programme in the coming year.

We are really pleased with the growing integration of services across the local health and social care economy during this year, which help to build the foundations for a more

joined-up system of care and the introduction of the Better Care Fund. In particular the integrated approach to the reduction of pressure ulcers, which is an excellent example of effective partnership working between acute and community health providers, local authority and care homes. The expansion of the UHCW 'React to Red' campaign across the local health and social care economy with the support of 'Your Turn' has set an ambitious target of a 40% reduction in pressure ulcers over the next year across care homes and we will watching this with interest as it progresses.

We were also pleased with the six month secondment of a member of the infection control team to work with care homes to improve identification and management of norovirus and reduce unnecessary hospital admissions. This has been well received and sets the scene for further work in this area over the next year.

It is disappointing that UHCW had four 'Never Events' during the past year, all of which were related to surgery. Patient safety is of paramount importance to the CCG and we are committed to ensuring lessons are learnt when things go wrong. We will continue to work with UHCW to gain assurance that robust systematic processes are in place to ensure the safety of patients and continue to monitor and review Serious Incidents and Never Events to ensure that lessons are learnt and shared.

During the year the Trust has had a very positive CQC review which recognises the considerable work that has been undertaken to support dementia patients and their carers. In addition, the Trust has been given the lowest risk rating by CQC's new national scheme which measures hospitals against a wide range of factors, including death rates, serious errors and patient surveys using a method known as 'intelligent monitoring'. However, we continue to monitor some areas of performance closely, in particular achievement of stroke and cancer targets which have slipped slightly.

We fully support the priorities for 2014-15 which have a strong focus on patient experience; the Trust is working hard to strengthen user and carer engagement including implementing real time feedback to front line staff to facilitate responsive improvements to the quality of care. There is good evidence that motivated and empowered staff improve the quality of services.

The maintenance of high quality care whilst delivering efficiencies is a key challenge going into 2014-15. In addition the implementation of seven day working to ensure consistency of quality across weekends will require effective collaborative working with partner organisations building on the successful initiatives of this year. As a CCG we are committed to supporting UHCW to achieve continuous improvements in the quality of services they provide for our local population and key to this is working in collaboration with them as well as monitoring their performance. We will continue to work with them to develop a relationship of trust, openness and transparency.

UHCW Comment:

We welcome the helpful and considered response from our Commissioner colleagues, and agree that a continued committed relationship to support continuous improvement is crucial. We look forward to the engaging with the CCG more on the Quality Account process for 2014-15 and working to deliver a CQUIN programme that will improve the safety and care of our patients.

Coventry City Council, Health and Social Care Scrutiny Board

The Health and Social Care Scrutiny Board (5) of Coventry City Council met with UHCW on a number of occasions during 2013–14 to discuss a range of issues from the Francis inquiry through to the detailed preparations made by the Trust for the expected pressures on services during the recent Winter. The Board has a continuing dialogue with the Trust and is grateful for the support UHCW provides in the Board performing its statutory duty.

The City Council acknowledges the progress made in this year's Quality Account, and notes the challenges identified for 2014/15. This year the City Council once again worked closely with colleagues in Warwickshire County Council, Rugby Borough Council and both Coventry Healthwatch and Warwickshire Healthwatch to scrutinise and inform this Quality Account. The City Council is grateful for the support of colleagues in Warwickshire for co-ordinating this group and drafting the detailed comments which are repeated below:

We welcome the opportunity to comment on the Trust's 2013-14 QA and would like to put on record the thanks of the Task and Finish for the work that has been done with the Trust over the past year on their QA, which has built on the pilot that was introduced locally in September 2012. The decision to approach quality accounts in a different way. establishing working groups with partner organisations to look in-depth at Warwickshire and Coventry's Trusts' Quality Account – both in monitoring performance over the year and in working with the Trusts to identify priorities for the year ahead has led to a more meaningful process and to enable stakeholders to work together to develop a better understanding of quality within the Trusts delivering services to the people of Coventry and Warwickshire.

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The Group was pleased to see the updates on the 2012/13 priorities and the ongoing work that is being done to reduce harm because of falls, hospital discharge and using patient feedback to improve experience. It was felt that the work being done to improve hospital discharges would go some way to addressing the breaches on readmission rates.

It is concerning to see the rating in relation to Maternity Services, and the Group will monitor the action plan for improvement over the next year.

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The approach used for each priority – setting out the reasons for selection, the goal, starting point and how the goal will be achieved and monitored is an excellent and transparent way of showing the public how improvements will be made.

The Group welcomes the inclusion of Getting Emergency Care Right – Ensuring Effective Handovers between Healthcare Professionals content and the overall focus on improving patient handovers across the hospital. The Group feels that this approach should be extended to transfers and working between different organisations as well, such as mental health and social care.

The focus on transforming patient experience is central to the different areas of improvement and this is fully endorsed by the Group. There needs to be an ongoing focus on demonstrating what changes and improvements have been made as a result of listening to patients and staff to measure patient experience.

The Group look forward to building on the strong foundations that have been laid this year to bring about improvement and to continue to work with the Trust to ensure that the needs and experiences of the staff and patients of UHCW continue to be a focus within the priorities for local organisations across the region to integrate services, improve general practice and help people to live independently for longer. The joint work of the different members of the Task and Finish Group working with the Trust has also given the QA a wider focus, looking at the Trust as a local general hospital provider as well as a centre of excellence.

In order to succeed in the Trust's clear ambition to become "a world class place in which to be cared for and to work", UHCW needs to have strong working relationships with other Trusts and stakeholders across the region, and this is not evident from the QA. Two further areas of focus needed to be issues of non-compliance and the variability of IT services across the Trust.

UHCW Comment:

We welcome the response by our Coventry City Council partners, and will continue to engage with them throughout the year. We value your input and feedback around how we can continue to improve the Quality Account process year on year.

Statement of **Director's Responsibilities** in Respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012)).

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, and 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

Chair

Date: 25 June 2014

Chief Executive Officer

Date: 25 June 2014

*Vice Chair and Deputy Chief Executive Officer signed the Statement in the absence of the Chair and Chief Executive Officer at the June Trust Board Meeting.

External Auditors
External Assurance Report

Independent auditors' limited assurance report to the directors of University Hospitals Coventry And Warwickshire NHS Trust on the Annual Quality Account

We are engaged by the Audit Commission to perform an independent assurance engagement in respect of University Hospitals Coventry and Warwickshire NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Rate of Clostridium Difficile infections [page 30]
- Percentage of patients risk assessed for venous thromboembolism (VTE) [page 30]

We refer to these two indicators collectively as "the specified indicators".

Respective responsibilities of Directors and auditors

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

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to

our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the information requirements prescribed in the Schedule referred to in Section four of the Regulations ("the Schedule");
- the Quality Account is not consistent in all material respects with the sources specified below; and
- the specified indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account have not been prepared in all material respects in accordance with Section 10c of the NHS (Quality Accounts) Amendment Regulations 2012 and the six dimensions of data quality set out in the NHS Quality Accounts - Auditor Guidance 2013–14 issued by the Audit Commission in February 2014 ("the Guidance").

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

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

- Board minutes for the period April 2013 to May 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners NHS Coventry and Rugby Clinical Commissioning Group (CRCCG) dated 05/062014;
- feedback from Local Healthwatch, Healthwatch Coventry, dated 03/06/2014;
- the Trust's complaints report, contained within the Patient Experience Annual Report 2013-14 which will be published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated May 2014;
- feedback from other named stakeholders; the Health and Social Care Scrutiny Board of Coventry City Council and the Quality Accounts Task and Finish Group set up by Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee with Coventry City Council, Rugby Borough Council, Coventry Healthwatch and Warwickshire Healthwatch, involved in the sign off of the Quality Account;
- the latest national Care Quality Commission patient survey dated 08/04/2014 and the maternity survey dated 11/12/2013;
- the 2013 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2014;
- the annual governance statement dated 02/06/2014;
- Care Quality Commission quality and risk profiles dated 31/07/2013;
- Care Quality Commission Intelligent Monitoring Reports dated 21/10/2013 and 13/03/2014;
- the results of the Payment by Results coding review dated February 2014; and
- Care Quality Commission inspection reports dated 05/11/2013 and 14/03/2014.

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

This report, including the conclusion, is made solely to the Board of Directors of University Hospitals Coventry and Warwickshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities

of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and University Hospitals Coventry and Warwickshire NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with the Guidance. Our limited assurance procedures included:

- reviewing the content of the Quality Account against the requirements of the Regulations;
- reviewing the Quality Account for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties ;
- considering significant judgements made by the management in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading documents.

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

Limitations

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

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

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

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University Hospitals Coventry and Warwickshire NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the requirements of the Regulations and the prescribed information in the Schedule;
- the Quality Account is not consistent in all material respects with the sources specified above; and
- the specified indicators in the Quality Account subject to limited assurance have not been prepared in all material respects in accordance with Section 10c of the NHS (Quality Accounts) Amendment Regulations 2012 and the six dimensions of data quality set out in the Guidance.

PricewaterhouseCoopers LLP
Chartered Accountants
Cornwall Court
19 Cornwall Street,
Birmingham
B3 2DT

30 June 2014

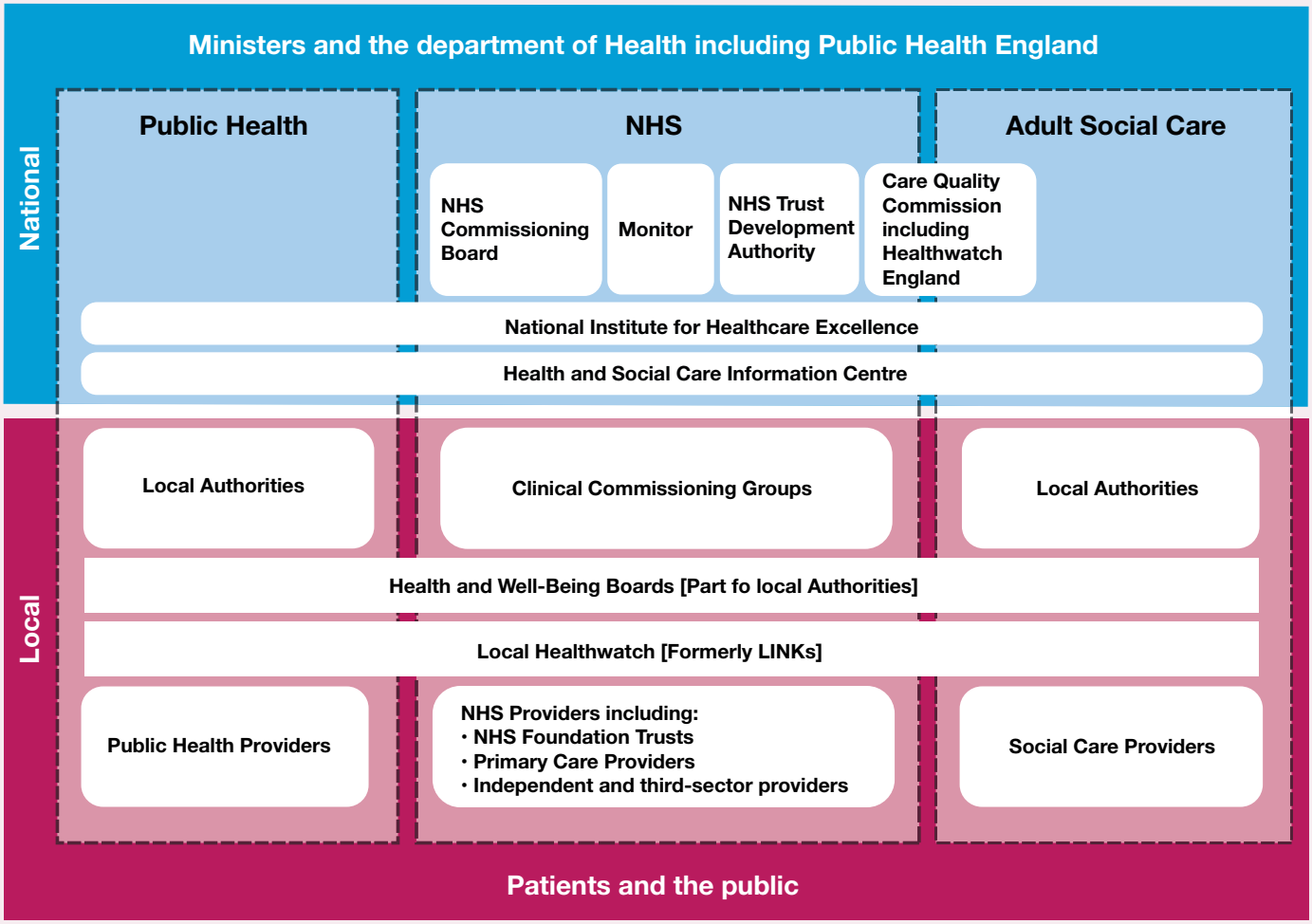
The maintenance and integrity of the University Hospitals Coventry and Warwickshire NHS Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendices

Appendix 1

The health and social care system in England

Overview of health and social care structures in the Health and Social Care Bill. April 2013



For more information on the new structure of NHS England visit www.nhs.uk

Appendix 2: CQC Inspections in 2013-14

Essential Standard: outcomes for quality and safety	Last inspected against this outcome	Status
Outcome 1: Respecting and involving people who use services People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.	17 September 2013	✓
Outcome 2: Consent to care and treatment Before people are given any examination, care, treatment or support, they should be asked if they agree to it.	7 January 2013	✓
Outcome 4: Care and welfare of people who use services People should get safe and appropriate care that meets their needs and supports their rights.	15 January 2014	✓
Outcome 5: Meeting nutritional needs Food and drink should meet people's individual dietary needs.	14 March 2011	✓
Outcome 6: Cooperating with other providers People should get safe and coordinated care when they move between different services	15 January 2014	✓
Outcome 7: Safeguarding people who use services from abuse People should be protected from abuse and staff should respect their human rights.	7 January 2013	✓
Outcome 8: Cleanliness and infection control People should be cared for in a clean environment and protected from the risk of infection.	7 January 2013	✓
Outcome 9: Management of medicines People should be given the medicines they need when they need them, and in a safe way.	7 January 2013	✓
Outcome 10: Safety and suitability of premises People should be cared for in safe and accessible surroundings that support their health and welfare.	7 January 2013	✓
Outcome 11: Safety, availability and suitability of equipment People should be safe from harm from unsafe or unsuitable equipment.	7 January 2013	✓
Outcome 12: Requirements relating to workers People should be cared for by staff who are properly qualified and able to do their job	7 January 2013	✓
Outcome 13: Staffing There should be enough members of staff to keep people safe and meet their health and welfare needs.	17 September 2013	✓
Outcome 14: Supporting workers Staff should be properly trained and supervised, and have the chance to develop	7 January 2013	✓
Outcome 16: Assessing and monitoring the quality of service provision The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.	15 January 2014	✓
Outcome 17: Complaints People should have their complaints listened to and acted on properly	7 January 2013	✓
Outcome 21: Records People's personal records, including medical records, should be accurate and kept safe and confidential	20 March 2012	✓

Key: ✓ Compliant ✗ Requires improvement ⊘ Enforcement action taken

Appendix 3: CQUIN Schemes 2013-14, 2014-15

The CQUIN framework was introduced in April 2009 as a National Framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of healthcare provider's income to the achievement of local quality improvement goals. The Framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis.

2013-14

National/ Local	CQUIN Description	Target
National	Friends and Family Test – phased expansion to maternity services	Roll out by end of October 2013
National	Friends and Family Test – increased response rate	Q1 to Q3 - increase on baseline (which must be at least 15%) Q4 – 20%
National	Friends and Family Test – improved performance on the Staff Friends and Family test	Provider having a better result in 2013–14 Staff Survey in comparison with the 2012/13 Staff Survey (which was a score of 68%) or remaining in the top quartile
National	NHS Safety Thermometer – improvement	Maintain a reduction in incidence of all new pressure ulcers at less than 0.50% (based on median value for the last 6 months of 2012/13) Reduce prevalence (all pressure ulcers) to 3% or below
National	NHS Safety Thermometer – Intergrated Approach to Prevalence reduction	To work with community providers to ensure a common approach to RCA for pressure ulcers in line with SHA best practice and to share learning in order to identify opportunities to further reduce prevalence
National	Dementia – Find, Assess, Investigate and Refer	Number of patients >75 admitted as an emergency who are reported as having: known diagnosis or dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding questions; 2. Number of above patients reported as having had a diagnostic assessment including investigations; 3. Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners
National	Dementia – Clinical Leadership	Provider must confirm named lead and planned training programme for dementia for coming year. Payment made on evidence planned training programme occurred
National	Dementia – Supporting Carers of People with Dementia	Demonstrate monthly audit of carer of people with dementia undertaken to test whether they feel supported and report results to Board
National	VTE Risk Assessment - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool.	Achievement of agreed target for both risk assessment and RCA for each month during that quarter (95%)
National	VTE Root Cause Analyses - The number of root cause analyses carried out on cases of hospital associated thrombosis	Achievement of agreed target for both risk assessment and root cause analysis for each month during that quarter

National/ Local	CQUIN Description	Target
Local	Discharge and Flow - reducing delays in imaging Increase the number of patients who experience a timely discharge by reducing delays in imaging (particularly CT scans, MRI and ultrasound).	Agree imaging modalities (inc. CT, MRI, Ultrasound) to be included in CQUIN indicator, confirm the baseline against each modality & agree quarterly trajectory. Delivery against agreed quarterly trajectory.
Local	Discharge and Flow - reducing delays receiving TTOs. Increase the number of patients who experience a timely discharge by reducing delays receiving TTOs.	Agree quarterly trajectory. Delivery against trajectory for each quarter
Local	Discharge and Flow - reducing delays – therapy Increase the number of patients who experience a timely discharge by reducing delays in discharge patients awaiting therapy assessment	Agree quarterly trajectory. Delivery against trajectory for each quarter Quarterly milestones to be delivered
Local	Discharge and Flow - reducing the number of medical outliers. Increase the number of patients who experience a timely discharge by reducing the number of medical outliers	Daily data collection Agreement of seasonal trajectory for the reduction in the number of medical outliers. Delivery against the quarterly trajectories
Local	Discharge and Flow - 7 day Board Rounds (2013–14 Extension of 2012/13 Indicators 7a and 7b)	progress delivery of 7-day board rounds across the majority of wards (to be agreed) at the University Hospital and Rugby sites to scope and agree delivery plans for the remaining wards, by exception for 7-day board rounds in all wards in 2014/15
Local	Discharge and Flow - 7 day Board Rounds (Clinical Audit and Scoping)	Implement Clinical Audit across all wards delivering morning, 5-day board rounds (7-day board rounds for 5f.1 section a wards) and scope the next phase of the development of board rounds in 2014/15
Local	Discharge and Flow - Escalation to MDT	Implement weekly senior complex discharge meetings – cases escalated from ward MDTs
Local	End of Life Care (EOLC) (Acute Hospital)	To participate in the national TRANSFORM programme for EOLC Quarterly milestones to be delivered
Local	Gerontology - Improving outcomes for elderly surgical patients	Improve the outcomes of elderly surgical patients by involving the gerontologist in their care in order to reduce mortality and morbidity Quarterly milestones to be delivered
Local	Gerontology - Improving the assessment and care of frail elderly	Increase the numbers of frail elderly patients cared for by gerontology Quarterly milestones to be delivered
Local	Frequently admitted patients MDT review	Implement the delivery of cross organisational multidisciplinary reviews of patients who are frequent attenders/admissions to UHCW and to put in place arrangements to support patients in the community and reduce the number of admissions Quarterly milestones to be delivered

National/ Local	CQUIN Description	Target
Local	Enhanced Recovery Programme for Arthroplasty Patients	Reduction in length of stay for lower limb primary arthroplasty patients Quarterly milestones to be delivered
Local	Reduced Length of Stay for Fracture Neck of Femur Patients	Reduction in median length of stay for fractured neck of femur patients Quarterly milestones to be delivered
Local	Advanced Fluid Monitoring (formerly CQUIN 10)	Delivery against quarterly uptake trajectory Quarterly milestones to be delivered
Local	Reduction in avoidable hospital cancellations of outpatient appointments	Quarterly milestones to be delivered
Local	Psychiatric Liaison (Staff Training)	UHCW to ensure 100% of eligible staff are released for mental health awareness training in line with the development of the Arden Mental Health Acute Team Quarterly milestones to be delivered
Regional	Implementation of clinical dashboards for specialised services - Cardiac dashboard	Quarterly milestones to be delivered
Regional	Implementation of clinical dashboards for specialised services - Cardiology dashboard	Quarterly milestones to be delivered
Regional	Implementation of clinical dashboards for specialised services - Renal Dialysis dashboard	Quarterly milestones to be delivered
Regional	Implementation of clinical dashboards for specialised services - Haemophilia dashboard	Quarterly milestones to be delivered
Regional	Implementation of clinical dashboards for specialised services - NNIC dashboard	Quarterly milestones to be delivered
Regional	Implementation of clinical dashboards for specialised services - Trauma dashboard	Quarterly milestones to be delivered
Regional	NIC 1 - Improved Access to breast milk	Quarterly milestones to be delivered
Regional	NIC 2- Timely Admin of TPN	Quarterly milestones to be delivered
Regional	NIC 4 - Retinopathy Screening	Quarterly milestones to be delivered
Regional	Cardiac Surgery	Quarterly milestones to be delivered
Regional	Dialysis RPV	Quarterly milestones to be delivered
Regional	Transplant Cold Ischaemia	Quarterly milestones to be delivered

Appendix 4: Glossary

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

Advocacy
Independent Advocacy is available to people who want support in making a complaint about NHS services. Contact details are available from your local Healthwatch

Algorithm
A specific set of instructions for following a procedure or solving a particular problem

AMBER Care Bundle
The AMBER care bundle is a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery; while talking openly about people's wishes and putting plans in place should the worst happen.

Appraisal
The process by which a manager or consultant examines and evaluates an employee's work behaviour by comparing it with preset standards, documents the results of the comparison, and uses the results to provide feedback to the employee to show where improvements are needed and why.

Audit Commission
The Audit Commission regulates the proper control of public finances by Local Authorities and the NHS in England and Wales. The Commission audits NHS organisations to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service. It works with the Care Quality Commission to produce national value-for-money studies .

Benchmark
A standard or set of standards used as a point of reference for evaluating performance or level of quality. Benchmarking is used to compare one organisation with others

Berwick Report (see Francis report) Board (of Trust)
The role of the Trust's Board is to take corporate responsibility for the organisation's strategies and actions. The Chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the board is properly supported to govern the organisation and to deliver its clinical, quality and financial objectives.

Board Round
A simple and effective process used daily in wards to support the safe and timely discharge of patients, helping to address the risks inherent in prolonged admissions.

Care Quality Commission
The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. It makes available reports and information on all healthcare providers, and anyone can use their website to comment on services. Visit www.cqc.org.uk

From August 2013 the CQC began to change the way that it assesses the quality of hospital

services. Longer inspections with larger teams (including professionals and patients) evaluate quality and contribute to the 'Rating'; ultimately every health and social care service will have such a rating.

Care Quality Review Group
A meeting held monthly between UHCW and our Commissioners to discuss clinical quality issues at the hospital.

Chief Inspector of Hospitals (CiH)
CQC appointed Professor Sir Mike Richards as the first Chief Inspector of Hospitals, tasked with implementing the CQC's new way of inspecting hospitals. He is responsible for leading the inspection service and assessing the extent to which hospitals are delivering quality care.

Clinical Audit
Clinical audit measures the quality of care and of services against agreed standards and suggests or makes improvements where necessary. It tells us whether we are doing what we should be doing. In addition to information in the Quality Account, the Trust publishes a detailed Clinical Audit Supplement on its website at www.uhcw.nhs.uk

Clinical Coding
Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of coding is an indicator of the accuracy of the patient health records. Incorrect coding can have potentially serious consequences for the commissioning of health services, as well as misleading managers and clinicians by falsely representing the prevalence of particular health problems. The Trust is assessed annually on the accuracy of its coding system.

Clinical Commissioning Group (CCG)
Since 1 April 2013 CCGs have been responsible for ensuring adequate care is available for their local population by assessing need and purchasing services. They commission services (including acute care, primary care and mental healthcare) for the whole of their local population, with a view to improving health and well-being. CCGs commission emergency and urgent care, including ambulance and out-of-hours services. See also Commissioning

Clostridium Difficile (C.diff)
A species of Gram-positive bacteria that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

Commissioning
Commissioning is the process of ensuring that health services meet the needs of the population. It is a complex process that includes assessing the needs of the population, procuring health care services and ensuring that services are safe, effective, patient-centred and of high quality.

NHS Specialised Services is a national organisation responsible for the commissioning of specialised services that help to improve the lives of children and adults with very rare conditions. See also Clinical Commissioning Group

All primary care is commissioned by NHS England

Commissioning for Quality and Innovation (CQUIN)
High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The Trust has to meet agreed national and local performance targets; a proportion of our budget is only handed over by Commissioners if the Trust can show that it has met the targets. Detailed information on CQUIN and our performance is available as a supplement to the Quality Account and is available on the Trust website www.uhcw.nhs.uk

Dashboard

A visual tool that gives clinicians relevant and timely information they need to inform those daily decisions that improve quality of patient care. The tool gives clinicians easy access to a wealth of data that is captured locally, whenever they need it. It also provides straightforward comparisons between local and national performance for some activities

Discharge

Complex discharge concerns patients' who have continuing healthcare needs after leaving hospital and who may have social care needs requiring specialist equipment to support them in a community environment

Simple discharge concerns patients going home or to residential care who need intermediate care services, renewed short term packages of care and access to rehabilitation facilitates in the community.

Dr Foster

An independent provider of healthcare information in the United Kingdom; it monitors NHS performance and provides information on behalf of the public. Dr Foster Intelligence is a joint-venture with the Department of Health and was launched in February 2006. Visit www.drfosterhealth.co.uk for more information

Equality Act 2010

The act replaced many separate pieces of legislation concerned with discrimination. It requires NHS Trusts to meet various obligations, most importantly to act in ways that do not discriminate against any patient or employee on the grounds of nine defined 'special characteristics'. The nine groups are:

- **Age:** Where this is referred to, it refers to a person belonging to a particular age (e.g. 32 year olds) or range of ages (e.g. 18 - 30 year olds).
- **Disability:** A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.
- **Gender reassignment:** The process of transitioning from one gender to another.
- **Marriage and civil partnership:** Marriage is defined as a 'union between a man and a woman'. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters.
- **Pregnancy and maternity:** Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
- **Race:** Refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.
- **Religion and belief:** Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
- **Sex:** the gender of a person (man or a woman)
- **Sexual Orientation:** Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

The Francis Report

The second report by Sir Robert Francis into events at Mid-Staffordshire Hospital resulted in 290 recommendations grouped into six broad areas. The Trust has been reviewing the recommendations to determine what can be learnt and what needs to change as a result. The report underlines the importance of integrating

Quality Management, transparency in practice, decision-making and listening to patients and carers into the everyday practice of the NHS.

The secretary of State for lHealth subsequently commissioned reports on mortality outliers (Professor Sir Mike Keogh) and Don Berwick into changing NHS culture.

The Friends and Family Test (FFT)

Launched on 1 April 2012, the FFT is part of a national initiative requiring that patients are asked whether they would recommend the ward or department to their friends and family. The trust already has an established patient experience feedback process, but this national requirement asks the key national question on which we will be compared with other hospitals across the UK.

The new Friends and Family Test question is: How likely are you to recommend our ward/Minor Injury Unit to friends and family if they needed similar care or treatment? Answers chosen from the following options: Extremely likely; Likely; Neither likely nor unlikely; Unlikely, Extremely Unlikely or Don't know.

The Friends and Family Test gives patients the opportunity share their views of the care or treatment they have received providing us with valuable feedback. We use the feedback, alongside other information, to identify and tackle concerns at an early stage, improve the quality of care we provide, and celebrate our successes. From July 2013, and monthly thereafter, our FFT results will be published on NHS Choices allowing the public to compare us with other hospitals and assess whether we are improving over time.

For more information on the Friends and Family Test, please visit www.nhs.uk/friendsandfamily

General Medical Council

Independent regulator for doctors in the UK. The purpose is to protect, promote and maintain the health and safety of the public by making sure that doctors meet our standards for good medical practice. www.gmc-uk.org

Health Act

The Health Act 2009 received Royal Assent on 12 November 2009. It is the legislation that underpins organisational arrangements and responsibilities within the NHS in England

The Health and Social Care Information Centre

HSCIC is a data, information and technology resource for the health and social care system. It provides support to everyone striving for better care, improving services and the best outcomes for patients. It supports the delivery of IT infrastructure, information systems and standards helping to ensure that clinical and organisational information flows efficiently and securely through health and social care systems. Visit www.hscic.gov.uk

Health and Wellbeing Boards

Every 'upper tier' local authority has a Health and Wellbeing Board to act as a forum for local commissioners across the NHS, social care, public health and other services. The boards are intended to:

increase democratic input into strategic decisions about health and wellbeing services

strengthen working relationships between health and social care

encourage integrated commissioning of health and social care

Both Coventry City Council and Warwickshire County Council have Health and Wellbeing Boards

Healthcare

Healthcare includes all forms of healthcare provided for individuals, whether relating to physical or mental health, and includes other procedures that are not necessarily provided as

a result of a medical condition such as cosmetic surgery.

Healthwatch
Healthwatch is the consumer champion for the NHS and social care services. Local Healthwatch enables local people and voluntary groups to work for the improvement of NHS and social care services by collecting the experiences of the local community and make recommendations to service providers.

High Quality Care for All
High Quality Care for All, published in June 2008, was the final report of the NHS Next Stage Review, a year-long process led by Lord Darzi, a respected and renowned surgeon, and around 2000 frontline staff, which involved 60,000 NHS staff, patients, stakeholders and members of the public. It was this report that described quality as having three components: Patient Safety, Clinical Effectiveness and Patient Experience.

Hospital Standardised Mortality Ratio (HSMR)
The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity. HSMR is quoted as a percentage and is equal to 100; this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

Information Governance Toolkit
The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards.

Intellectual Property
Broad description for the set of intangibles owned and legally protected by a company from outside use or implementation without consent. Intellectual property can consist of patents, trade secrets, copyrights and trademarks, or simply ideas.

The concept of intellectual property relates to the fact that certain products of human intellect should be afforded the same protective rights that apply to physical property.

Intentional Rounding
This involves reviewing all patients at set intervals for key safety issues e.g. repositioning, toileting, food, fluid and pain management; its use has contributed to the continuing low level of avoidable harms for patients such as pressure ulcers and dehydration.

ISS
ISS Facility Services manage the recruitment of cleaning, patient hospitality, security, portering and catering staff and provide these services at UHCW

IV (Intravenous)
A procedure in which a hypodermic needle inserted into a vein provides a continuous supply of blood plasma, nutrients, or medicine directly to the bloodstream

Keogh Report (see Francis)

Key Performance Indicator (KPI)
A type of performance measurement, KPIs are commonly used by an organisation to evaluate its success or the success of a particular activity in which it is engaged

Major Trauma
Defined as multiple, serious injuries that could result in death or serious disability, these might include serious head injuries, severe gunshot wounds or road traffic accidents.

MEWS (Modified Early Warning System)
Utilisation of the MEWS scoring system is now the recommended assessment of vital signs. The aim of these systems is to identify patients at risk

/ deteriorating status which triggers an immediate response through scoring points for abnormal physiological values

MRSA and MSSA Bacteraemia

Staphylococcus aureus is a bacterium found on the skin and a proportion (up to 30%) of the healthy population carry Staph. aureus in their nose or in other moist parts of the body.

Commonly Staphylococcus aureus causes infections such as boils and infected skin wounds. It can cause pneumonia, urinary tract infections and bacteraemia both in the community and in hospital practice.

Some types of Staph. aureus have become resistant to various antibiotics. These are known as methicillin resistant Staph. aureus or MRSA. Those types that are not resistant to certain antibiotics are known as methicillin sensitive Staph. aureus or MSSA.

National Patient Safety Agency (NPSA)

The National Patient Safety Agency was an arm's-length body of the Department of Health, responsible for promoting patient safety wherever the NHS provides care. It's role has been taken over by NHS England.

National Patient Surveys

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

National Research Ethics Service

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

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Confidential enquiries help maintain and improve standards of medical and surgical care for the benefit of the public. Using anonymised data from confidential surveys and research, they review the clinical management of patients, publishing reports and making recommendations for improvement. By respecting confidentiality, they maximise the compliance of medical and surgical staff in sharing information on clinical outcomes.

Never Event

Never Events are serious, often preventable patient safety incidents that should not occur if available preventative measures have been implemented. NHS England publishes a full list of Never Events each quarter.

NHS Choices

A website for the public containing extensive information about the NHS and its services; go to www.nhs.uk

NHS Next Stage Review

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

NICE - National Institute for Health and Care Excellence

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Clinicians are generally expected to follow guidance unless they have good cause.

NVQ - National Vocational Qualification

Overview and Scrutiny Committees

Since January 2003, every local authority with responsibilities for social services has had the opportunity to scrutinise local health services. Overview and Scrutiny Committees review the planning, delivery and operation of Health services as well as the appropriateness of major service changes. They bring democratic accountability into decisions about the delivery of healthcare helping the NHS to be more publicly accountable and responsive to local communities.

Pathway

A tool used by all healthcare professionals in treating patients, in which the different tasks involved in the patient's care are defined. A pathway will clarify staff roles and responsibilities, and what factors should be considered in determining when and how patients move to the next stage of care and treatment. Healthcare can be more effective and efficient when well-designed and patient-centred pathways are used.

Patient flow

A term used to describe how efficiently hospitals use resources. Ideally patients are admitted, treated and discharged in the shortest possible time consistent with safe practice and best available treatment. Disruption to patient flow may result in delay at any point, from arrival at A+E to discharge, causing concern or distress to patients and carers. Delay increases the risk of harm to patients.

Patient-led assessments of the care environment (PLACE)

A new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments will apply to hospitals, hospices and day treatment centres providing NHS funded care. They will look at how the environment supports patient privacy and dignity, the meeting of dietary needs, cleanliness and general building maintenance.

Results from the Annual assessments are reported publicly to help drive improvements in the care environment; they will show how we are doing locally and by comparison with other Trusts across England. For more information visit www.england.nhs.uk/ourwork/qual-clinlead/place

Periodic reviews

Periodic and thematic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term 'review' refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services. The CQC will increase the proportion of unannounced reviews; there have been two of these in the Trust over the last year

Pressure Ulcer

Also sometimes known as bedsores or pressure sores, they are a type of injury that affects areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

- **Avoidable pressure ulcer:** 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.
- **Unavoidable pressure ulcer:** means that the individual developed a pressure ulcer even though the individual's condition and pressure ulcer risk had been evaluated; goals and recognised standards of practice that are consistent with individual needs has been implemented. The impact of these interventions

had been monitored, evaluated and recorded; and the approaches had revised as appropriate.

- **Inherited pressure ulcer:** A patient is admitted to the Trust with pressure damage and this is identified or becomes apparent within 72 hours of admission
- **Acquired pressure ulcer:** the patient develops a pressure ulcer whilst a hospital in patient after the first 72 hours of admission
- **Grade 1 pressure ulcer:** The skin at this point is red and on the application of fingertip pressure the skin remains red.
- **Grade 2 pressure ulcer:** the superficial layer of the skin is damaged. It presents as a blister, abrasion or shallow crater and any of these can have blue / purple / black discoloration.
- **Grade 3 pressure ulcer:** full thickness skin loss involving damage or necrosis to subcutaneous tissue
- **Grade 4 pressure ulcer:** full thickness skin loss with extensive destruction extending to underlying structures; i.e. bone, muscle, tendon, or joint capsule.

Prescribed Connection

A licensed doctor with a formal connection (e.g. contract of employment) to the organisation for the purposes of regular appraisal and supporting them in the process of revalidation

Primary Care Trusts were replaced by Clinical Commissioning Groups (CCGs) from 1 April 2013

Protected Characteristics Groups

See Equality Act

RAG Rate

Traffic light system is used as a coding system for good or bad performance - usually known as a 'RAG rating'. For example in relation to the workload performance, red would mean inadequate, amber would mean reasonable, and green would mean ideal. The letters R, A and G are used in addition to swatches of colour.

REACT

This multi-disciplinary team provides assessment for the over 65 year age group in the Emergency Department. The aim is to prevent unnecessary hospital admissions by working closely with Intermediate Care, Social Services and Primary Care. REACT make referrals to in-patient services for patients needing therapy or who have specialist needs. This has a direct impact on hospital lengths of stay.

Registration – licence to provide health services

From April 2009, every NHS Trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC). UHCW is licensed to provide healthcare services without conditions

Research

Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve people in good health as well as those undergoing treatment. Research and Trials help clinical staff learn the best ways of treating patients, but can also be useful in showing what works less well, or not at all.

Root Cause Analysis (RCA)

Every day a million people are treated safely and successfully in the NHS. However, when incidents that result in harm to patients (or that are 'near misses') do happen, it is important that lessons are learned to prevent the same incident occurring again. Root Cause Analysis investigation is an established way of doing this.

Investigations identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver improved services

to our patients. The Trust has clinicians trained in the use of RCA techniques.

Secondary Uses Service

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

Serious Incident Requiring Investigation (SIRI)

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of 'Never Events' as updated on an annual basis and currently including:
  - Wrong Site Surgery
  - Wrong Implant/prosthesis
  - Retained foreign object post-operation
  - Wrongly prepared high-risk injectable medication
  - Maladministration of potassium-containing solutions
  - Wrong route administration of chemotherapy
  - Wrong route administration of oral/enteral treatment
  - Intravenous administration of epidural medication
  - Maladministration of Insulin
  - Overdose of midazolam during conscious sedation
  - Opioid overdose of an opioid-naïve patient
  - Inappropriate administration of daily oral methotrexate
  - Falls from unrestricted windows
  - Entrapment in bedrails
  - Transfusion of ABO-incompatible blood components
  - Transplantation of ABO or HLA-incompatible organs
  - Misplaced naso- or oro-gastric tubes
  - Wrong gas administered
  - Failure to monitor and respond to oxygen saturation
  - Air embolism
  - Misidentification of patients
  - Severe scalding of patients
  - Maternal death due to post partum haemorrhage after elective caesarean section

Special Review

A special review is conducted by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national-level findings based on the CQC's research.

Summary Hospital Mortality Indicators (SHMI)

The SHMI is like the HSMR, a ratio of the observed number of deaths to the expected number of deaths. However, this is only applied to non-specialist acute providers. The calculation is the total number of patient admissions to the hospital which resulted in a death either in hospital or within 30 days post discharge. Like all mortality indicators, the SHMI shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant.

Teaching Trusts

A hospital that is affiliated to a medical school and provides the students with teaching and supervised practical experience; UHCW has close ties with the University of Warwick Medical School

Transform Programme

"Transforming end of life care in acute hospitals: Route to Success" –

This is the implementation of key enablers: Advance care planning AMBER care bundle, rapid discharge for patients in the terminal stages of their disease, care in the last days of life EPaCCS (Electronic Palliative Care Co-ordination System), supporting the collaborative development and implementation of a clinical electronic register of patients approaching the end of life across different care settings.

If you need this information in another language or format, we will do our best to meet your need. Please contact the Health Information Centre on 024 7696 6051.

University Hospital
Clifford Bridge Road
Coventry CV2 2DX

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www.uhcw.nhs.uk
024 76964000

NHS
Coventry and Rugby
Clinical Commissioning Group

University Hospitals Coventry and Warwickshire NHS Trust

Coventry City Council

Coventry and Rugby Review of the Winter and Discharges

David Eltringham
UHCW

Sue Davies
CRCCG

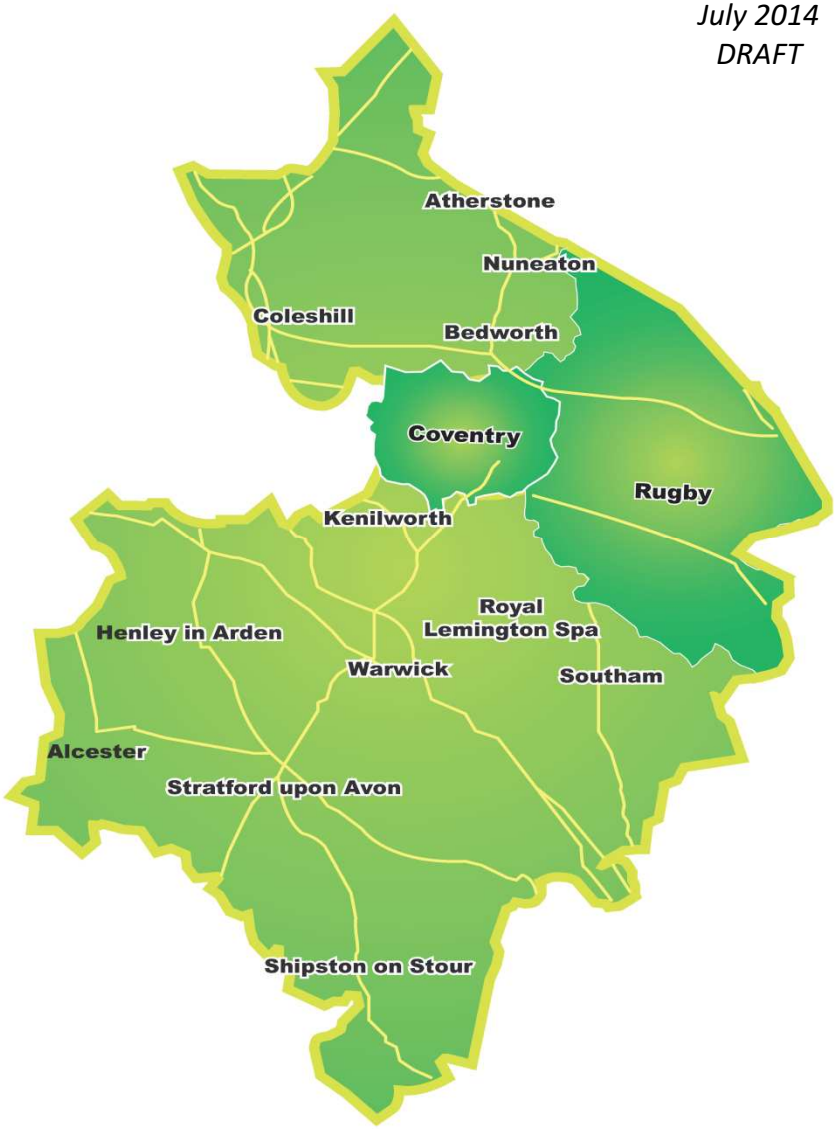
Simon Brake
CCC

September 2014

Coventry & Rugby Local Health Economy

Capacity & Resilience Plan

July 2014
DRAFT



NHS
Coventry and Rugby
Clinical Commissioning Group

University Hospitals NHS
Coventry and Warwickshire
NHS Trust

Coventry and Warwickshire Partnership NHS
NHS Trust

South Warwickshire NHS
NHS Foundation Trust

Coventry City Council

Warwickshire
County Council

UHCW 147,752m2 gross internal site floor

Rugby St Cross 24,294m2 gross internal site floor

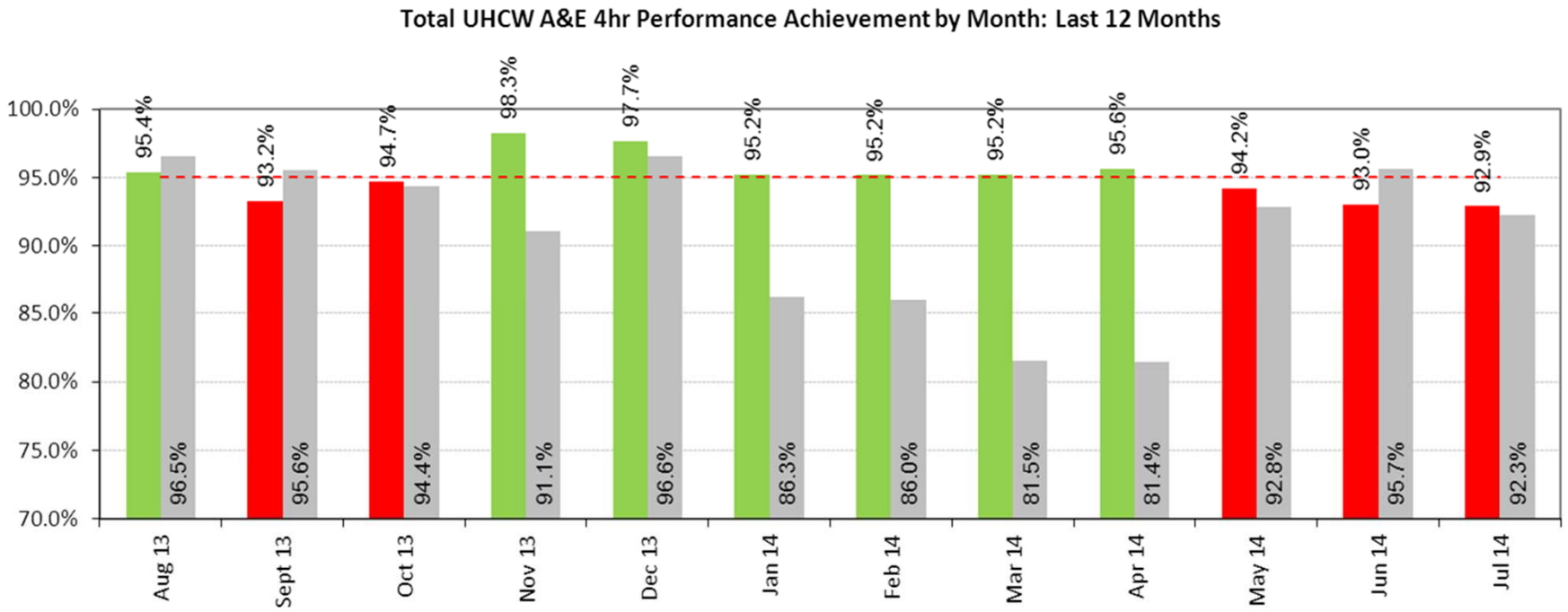
180,000 ED Attendances

38,000 Elective Procedures

680,000 OPD appointments

University Hospitals Coventry and Warwickshire NHS Trust

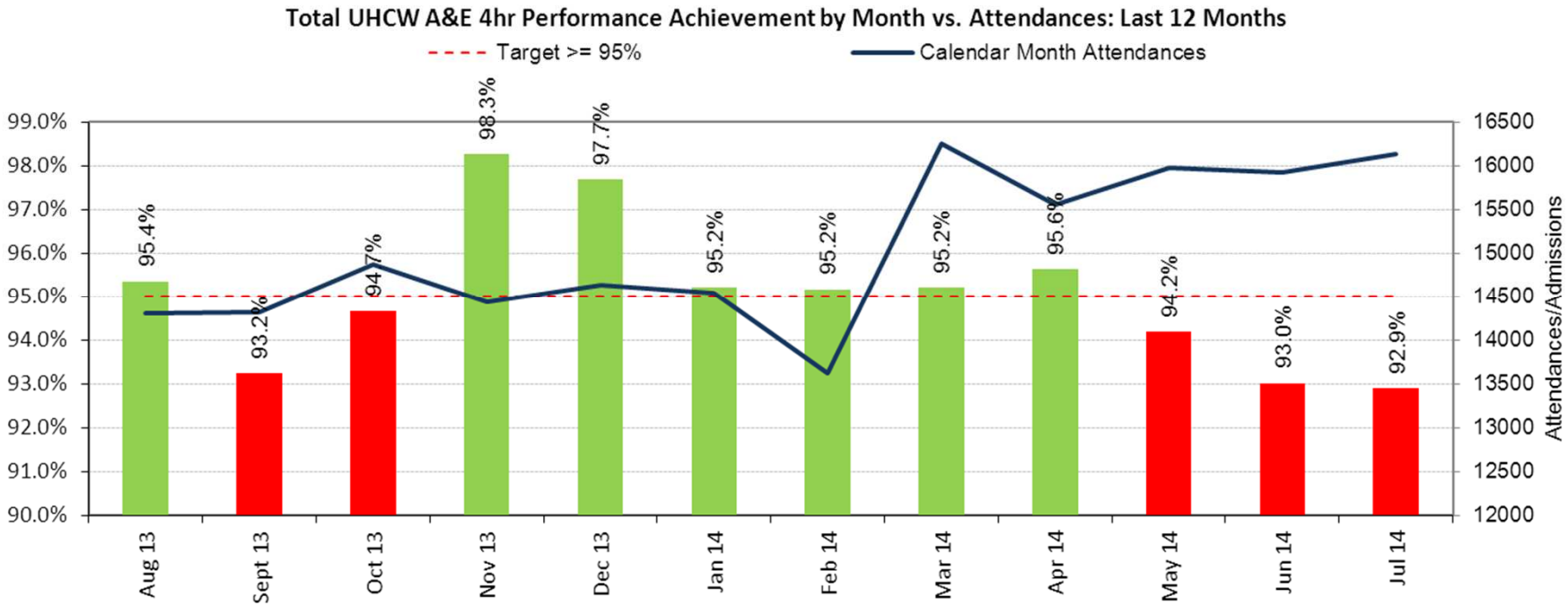
ED Performance – 4 Hour Standard



Grey bars indicate previous years performance. Green and Red indicate the annotated months performance.

University Hospitals Coventry and Warwickshire NHS Trust

4 Hour Standard vs. Attendances



University Hospitals Coventry and Warwickshire NHS Trust

Getting Emergency Care Right

University Hospitals Coventry and Warwickshire NHS Trust

GECR

University Hospitals Coventry and Warwickshire NHS Trust

FREED Metrics

F acilitate effective discharge

R ight person, right place

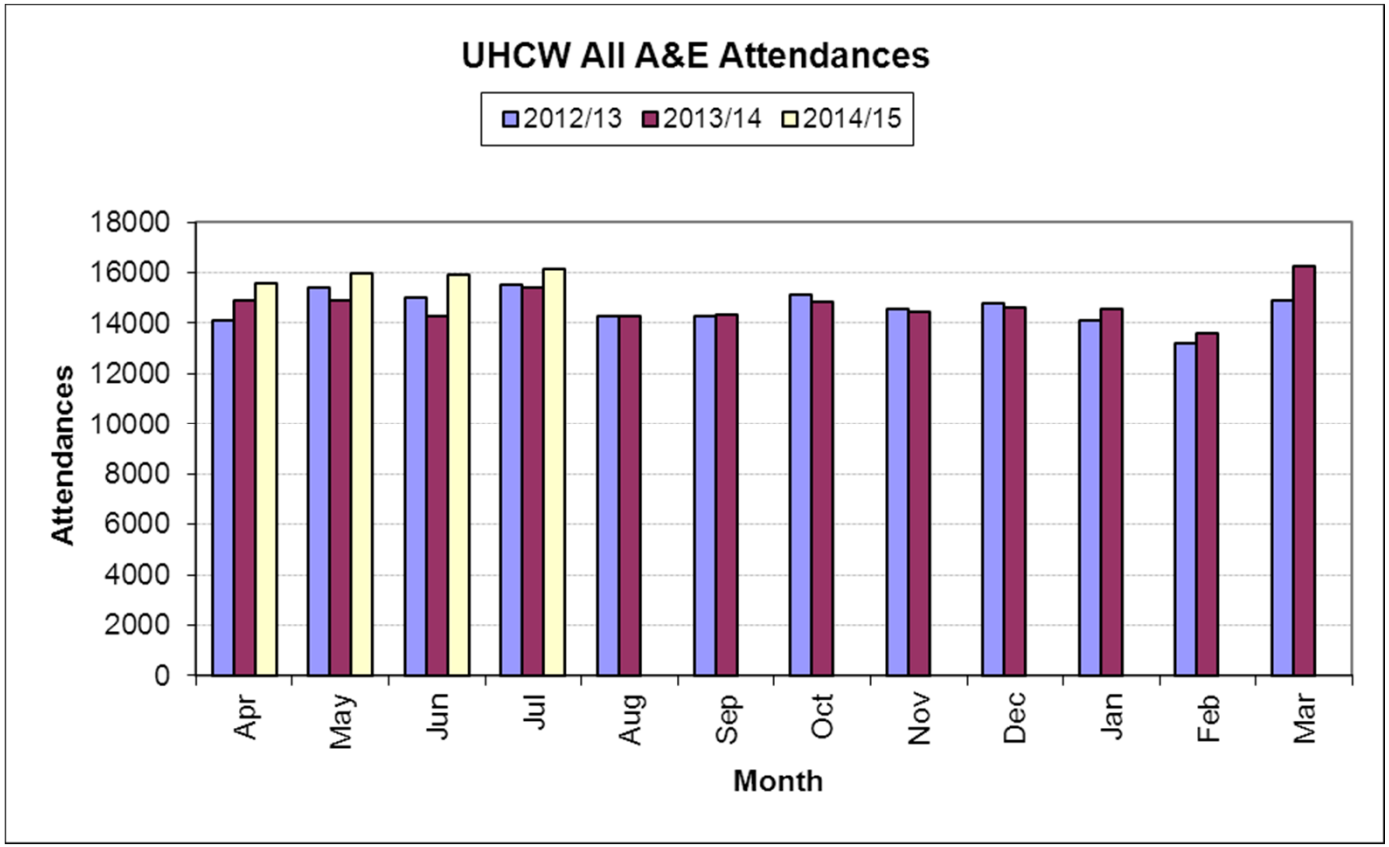
E arly specialist input

E liminate unnecessary diagnostics

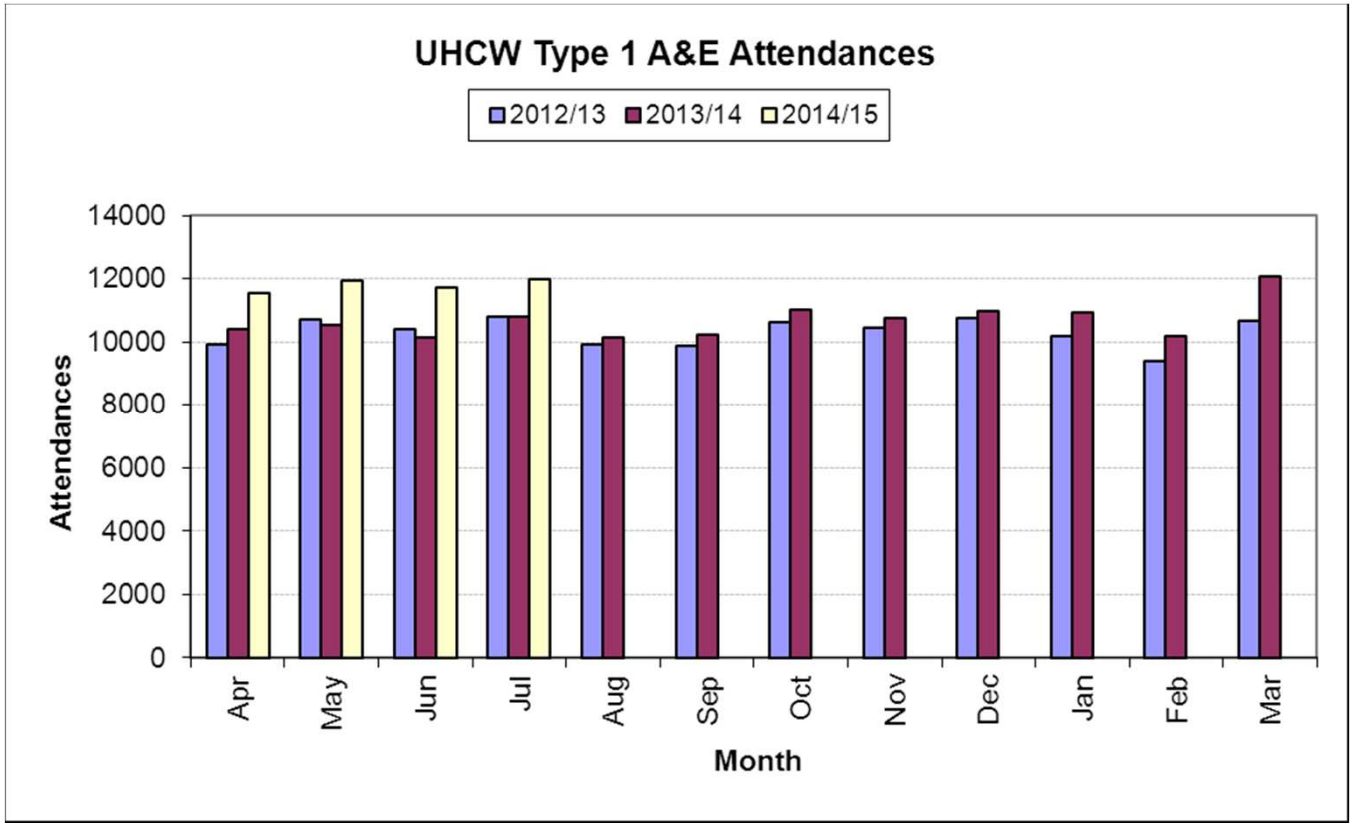
D aily senior review

University Hospitals Coventry and Warwickshire NHS Trust

Attendances

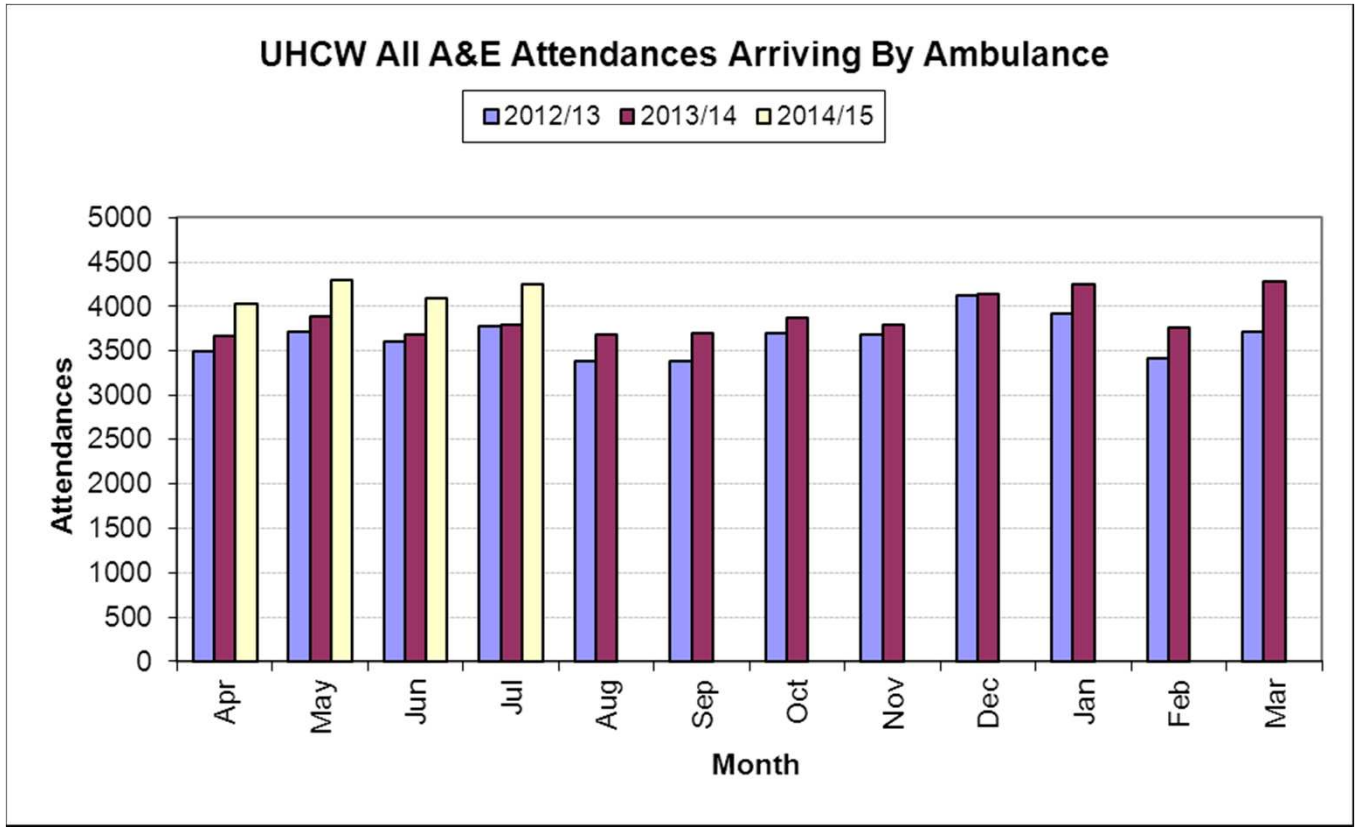


Type 1 Attendances

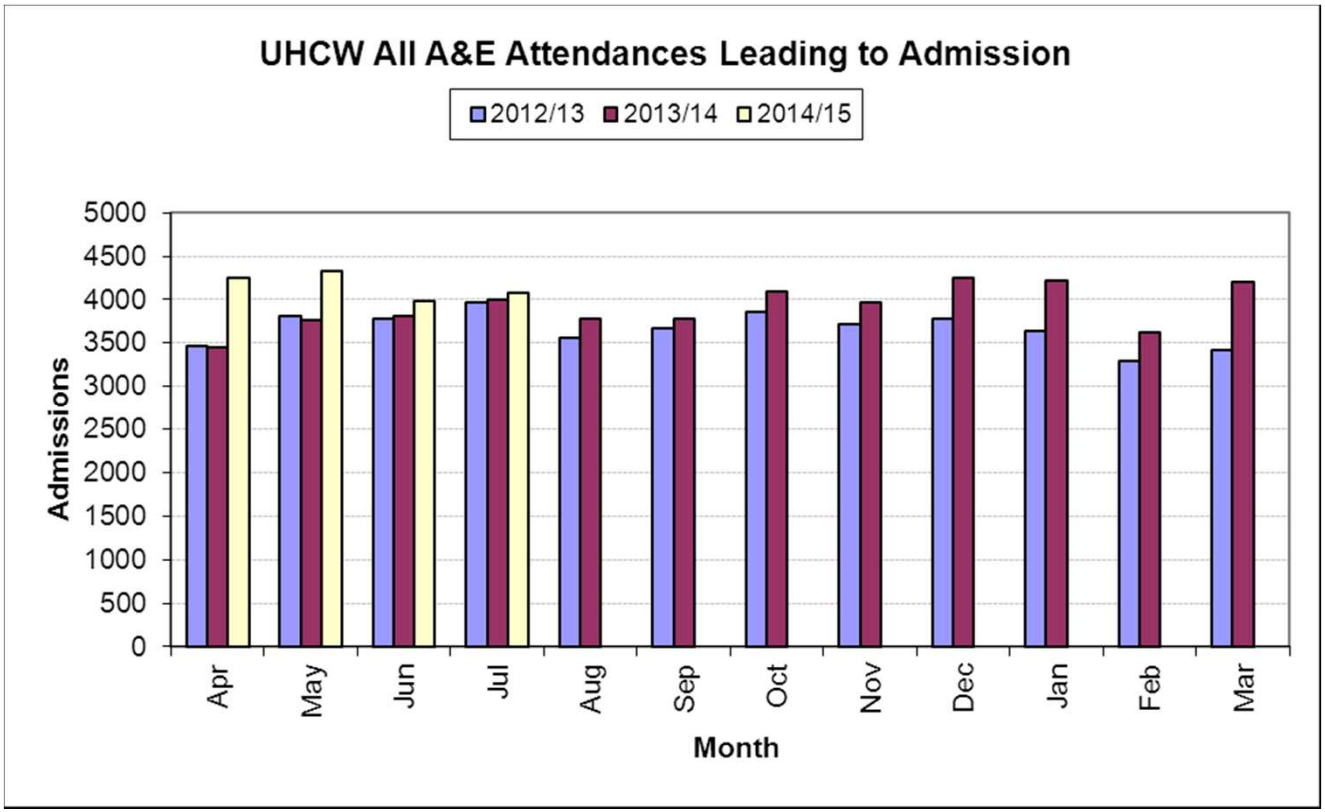


University Hospitals Coventry and Warwickshire NHS Trust

Ambulance Conveyances

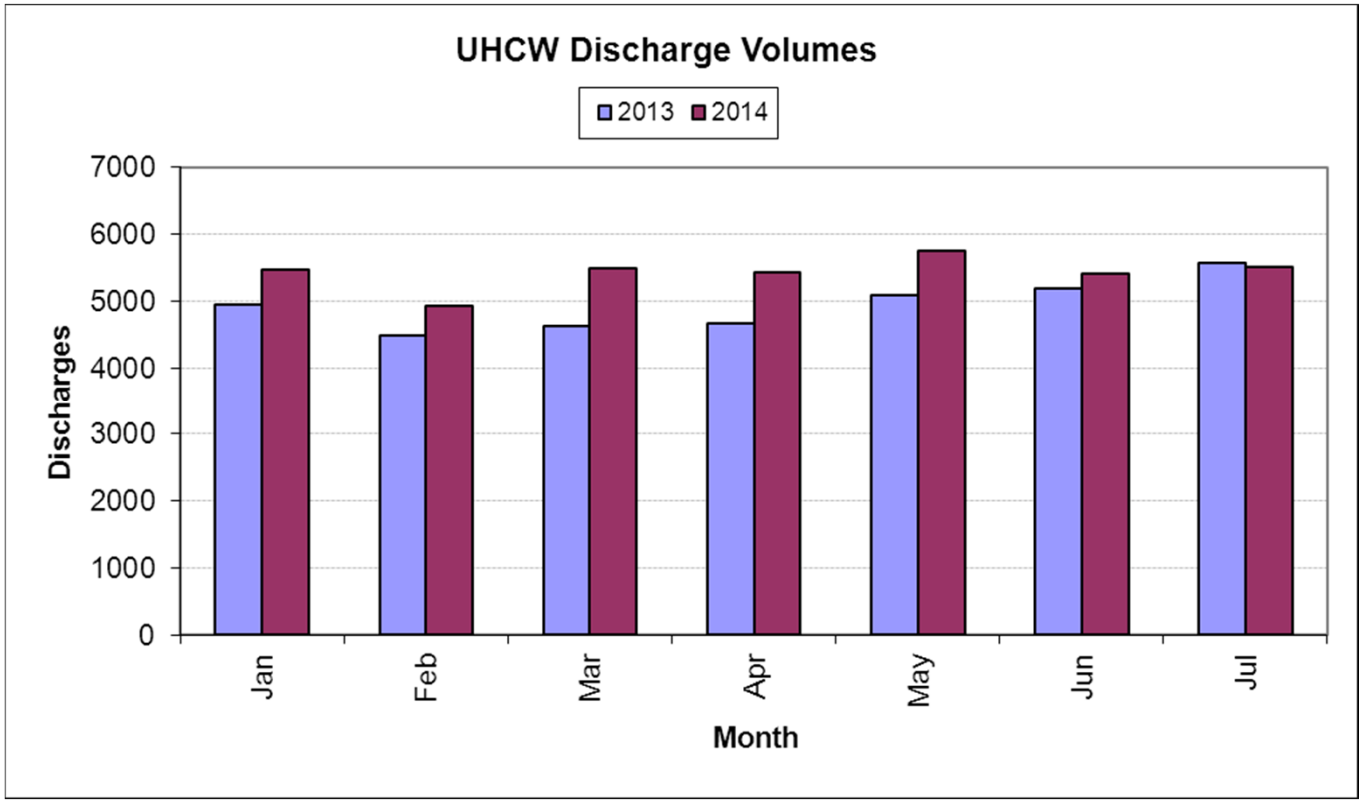


Admissions

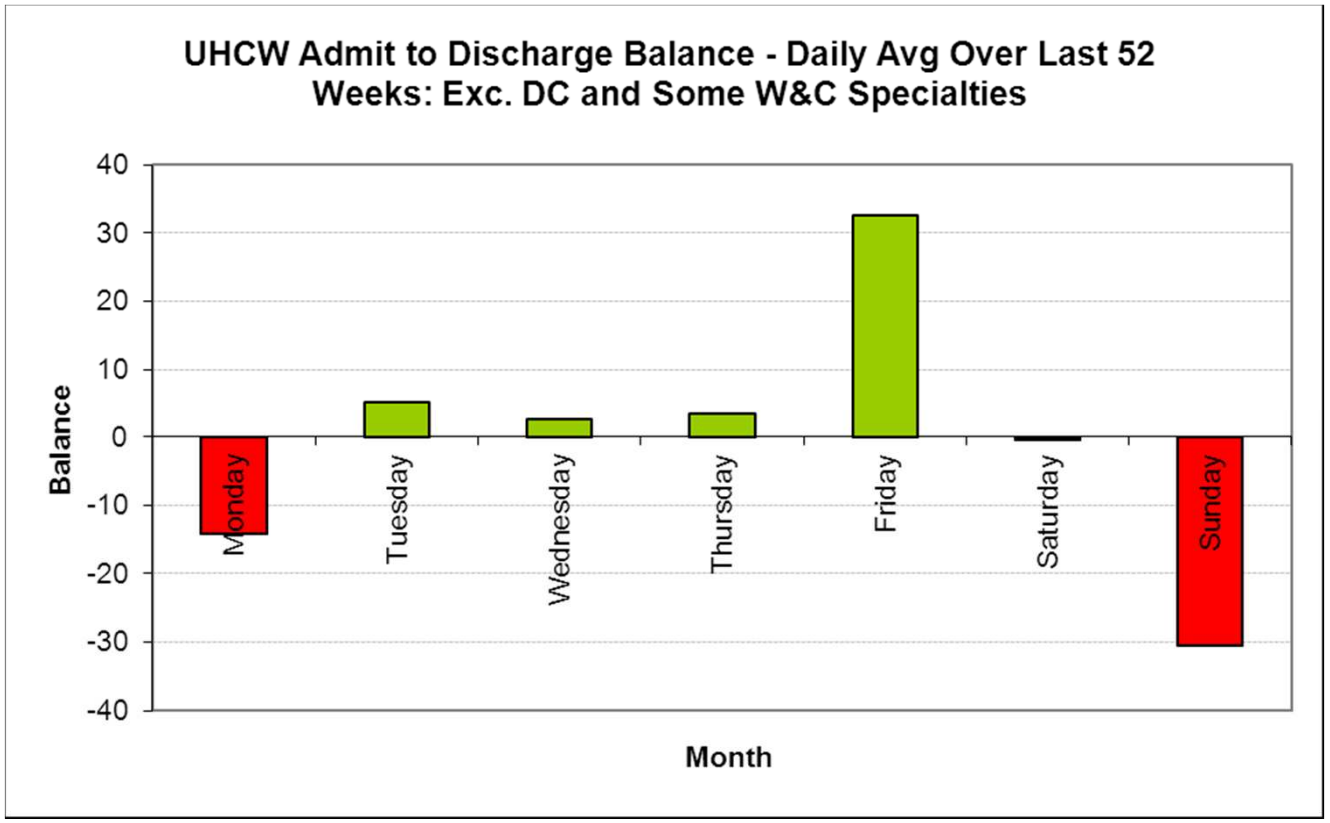


University Hospitals Coventry and Warwickshire NHS Trust

Discharges

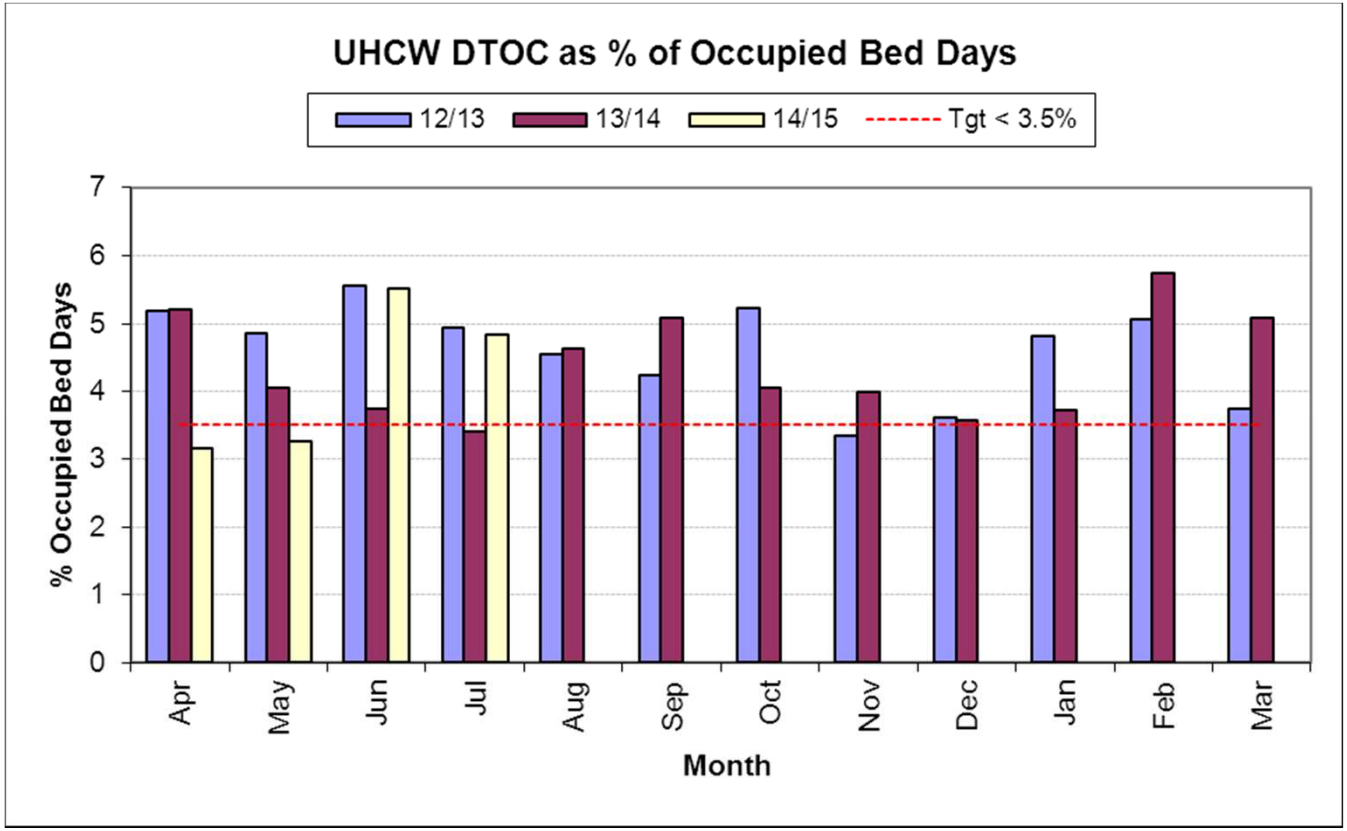

UHCW Discharge Volumes
2013
2014
7000
6000
5000
4000
3000
2000
1000
0
Discharges
Jan
Feb
Mar
Apr
May
Jun
Jul
Month

Net Admit/Discharge Position



University Hospitals Coventry and Warwickshire NHS Trust

Delayed Transfer of Care

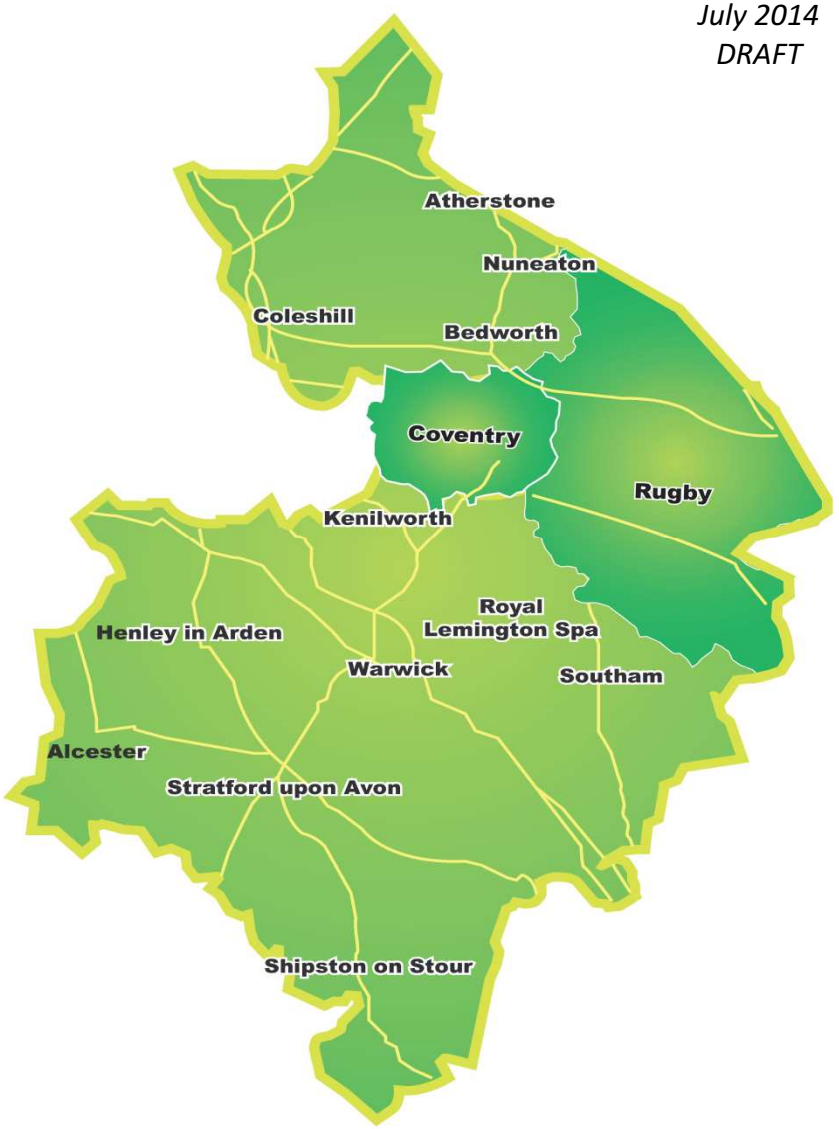


Coventry & Rugby Local Health Economy

Capacity & Resilience Plan

July 2014

DRAFT



NHS
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Coventry and Warwickshire Partnership
NHS Trust

South Warwickshire
NHS Foundation Trust

Coventry City Council

Warwickshire
County Council

Winter 13/14

Capacity & Surge Plan

- ✓ Updated the Arden-wide Capacity & Demand management Plan
- ✓ Revised escalation triggers & action cards
- ✓ Training in place across Arden

Improving Hospital flow

- ✓ "Getting Emergency Care Right" campaign with hospital staff
- ✓ Hospital at Home
- ✓ Contingency Capacity
- ✓ Command and Control
- ✓ Outlier teams
- ✓ Discharge Teams
- ✓ 3 times weekly multiagency calls to manage DTOC.

Community Flow

- ✓ Targeted public campaign
- ✓ GP responder service in place over winter reducing ambulance conveyances
- ✓ Additional home care & care home capacity

Care Home Programme

- ✓ GP Enhanced Primary Care Support Pilot
- ✓ Telehealth scheme with 20 care homes & 4 GP Practices
- ✓ Robust joint quality monitoring in place

Infection Control

- ✓ Infection Prevention & Control Nurse providing training & education to care homes
- ✓ Study day in May 2014 to reinforce messages around the management of Noro Virus & prevention of pressure ulcers
- ✓ Communication strategy in collaboration with Public Health England

Winter 14/15 – in addition to 13/14

Improving Hospital flow

- More Hospital at Home
- Vanguard Theatre
- Frail Elderly Assessment Unit
- Improved Discharge Planning >21 days LOS
- Integrated Discharge Team

Urgent Care Hot House

- ✓ Hot House event June 14 to design pre-hospital urgent care model
- ✓ 90 day implementation – 1st Dec 14
- ✓ Focus on providing a real alternative to A&E and understanding the populations behaviour and how to change that behaviour

Integrated Neighbourhood Teams (INT)

- ✓ Go Live INT on 11th July 2014 focussing on hospital prevention
- ✓ Planned roll out to cover Coventry & Rugby by October 2015
- ✓ Community Development Workers

In Summary…

- Winter 2013/14 – Successful
- Money's tight
- Strong links with the Better Care Programme
    - Enhancing Primary and Community care
- Absolute focus on delivery
    - Quality and Safety
    - 4 Hours
    - 18 Week RTT
    - Getting Emergency Care Right
    - Long term sustainability
- Strong partnerships – honesty and integrity
- If anyone can do it we can!

10th September, 2014

Health and Social Care Scrutiny Board (5)
Work Programme 2014/15

For more details on items, please see pages 2 onwards

30 July 2014
- Coventry and Warwickshire Partnership Trust (CWPT) Quality Account
- West Midlands Ambulance Services (WMAS) Quality Account
- Patient Transport Services
- Follow up to Peer Review of Adult Social Care

10 September 2014
- Coventry Safeguarding Adults Board Annual Report
- Adult Social Care Local Account
- Patient discharge from UHCW
- UHCW Quality Account

15 October 2014
- Coventry and Warwickshire Partnership Trust – progress following CQC Inspection
- Learning Disabilities Strategy
- Director of Public Health Annual Report
- Winterbourne
- Increased Community Support through Telecare

19 November 2014
- Public Health – progress since joining the Council
- Sexual Health Services – proposed re-commissioning
- Overview of the Care Bill and Coventry's Preparations for when this becomes Legislation
- ABCS Implementation

10 December 2014
- Mrs D – Progress following SCR

7 January 2015
11 February 2015
18 March 2015
22 April 2015
Date to be determined
- Impact of different Models of Primary Care delivery
- Clinical management of large scale chronic diseases
- Complaints Management
- Social Isolation
- NHS Targets

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
30 July 2014	Coventry and Warwickshire Partnership Trust (CWPT) Quality Account	Tracy Wrench (Director of Nursing)	NHS Provider Trusts are required to produce annual statements of quality and outcomes. The Board has a role in providing a short commentary on progress.	Annual Report
	West Midlands Ambulance Services (WMAS) Quality Account	Anthony Marsh, CEX	The Board has asked to receive a short presentation from WMAS on its Quality Account 2014/15, with commentary on measures being taken to address improvements to targets not achieved. They are also interested to have information about the "make ready" process, its impact on the service and patient care in terms of efficiency, effectiveness and financial considerations.	Annual Report and informal Scrutiny meeting 02/07/14
	Patient Transport Services	Steve Allen/ Clare Hollingworth CCG	Review of progress since the Board discussed at its 5 March 2014 meeting the delayed plans to re-commission Patient Transport Services in Coventry and Warwickshire following concerns raised by Healthwatch. West Midlands Ambulance Service to be invited to attend.	SB5 05/03/14
	Follow up to Peer Review of Adult Social Care	Mark Godfrey	Review of progress on the recommendations arising from the Peer Challenge of Adult Social Care that took place in March 2013, including a focus on personalisation, client centred care and managing the adult social care budget. NB The Peer Challenge report specifically recommended that some increased scrutiny on adult social care such as commissioning, transformation and budget plans, and progress on personalisation would now seem timely and that the Board consider further which adult social care matters should be the subject of scrutiny in its programme for 2014/15.	Recommendations from Peer Challenge
10 September 2014	Coventry Safeguarding Adults Board Annual Report	Brian Walsh / Sara Roach/ Isabel Merrifield	This multi-agency Board is responsible for co-ordinating arrangements to safeguard vulnerable adults in the City. The Annual Report sets out progress over the 2013/14 municipal year and provides members with some data to monitor activity. Representatives of the Safeguarding Board to be invited.	Annual Report

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Adult Social Care Local Account	Brian Walsh / Mark Godfrey/ Pete Fahy/ David Watts/ Gemma Tate	This is the annual report of the Council related to services provided to Adult Social Care clients. The report summarises performance, provides commentaries from key partners and representatives of users and sets strategic service objectives for the future.	Annual agenda item
	Patient discharge/winter pressures from UHCW	Rebecca Southall (UHCW) / CCG/ ASC	To include review of effectiveness of 2013/14 winter arrangements and preparations for 2014/15. To include CCG, provider organisations and social care.	Annual item
	UHCW Quality Account	Andy Hardy (Chief Executive)	NHS Provider Trusts are required to produce annual statements of quality and outcomes. The Board has a role in providing a short commentary on progress.	Annual Report c/f from 30/07/14
15 October 2014	Director of Public Health Annual Report	Dr Jane Moore / Ruth Tennant/ Tanya Richardson	The DPH has a statutory opportunity to issue Annual Reports which provide a commentary of local public health profiles and priorities. (Depending on focus of the report, this could be considered by Scrutiny Co-ordination Committee instead)	Annual agenda item
	Learning Disabilities Strategy	Mark Godfrey/ David Watts/ Lavern Newell	To contribute to the planned review of the strategy	c/f from 2013/14
	Increased Community Support through Telecare	Pete Fahy/ Michelle McGinty	To review the delivery of the high level strategy agreed with health partners, with recommendations to be made to CM (Health and Adult Services) on how the delivery of the strategy is progressed. The Board is interested to hear about the impact with regard to the Aylesford and its proposed cessation; and to understand any changes to the impacts identified.	CM(Health and Adult Services) 17/06/14 Cabinet 17/06/14

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Winterbourne	Pete Fahy/ Jon Reading	To consider the report prior to its sign-off by the Health and Well Being Board in November 2014	
19 November 2014	Public Health – progress since joining the Council	Dr Jane Moore / Ruth Tennant	Public Health transferred from the NHS to the Council in April 2012. A report has been prepared highlighting progress and achievements since the transfer and the Board would like to review this.	Informal work planning meeting 18/06/14
	Sexual Health Services – proposed re-commissioning	Dr Jane Moore / Nadia Inglis	The Council's Public Health service is re-commissioning sexual health services for the City in partnership with colleagues in Warwickshire. This will provide an opportunity for the Board to review progress once the new contract has been awarded, including how recommendations made at its 2 April 2014 meeting have been followed up.	SB5 02/04/14
	Overview of the Care Bill and Coventry's Preparations for when this becomes Legislation	Mark Godfrey/ Emma Bates	Progress report be submitted to a future meeting of the Board in six months including information on the financial implications (Steve Mangan and Mark Godfrey to attend)	SB5 30/04/14 and 30/07/14
	ABCS Implementation	Pete Fahy	The People Directorate is undertaking a significant programme of transformation affecting local people, the organisation, partners and resources. The Board would like to review progress with implementation and understand the impacts, particularly in relation to the way we have worked with partners.	Informal work planning meeting 18/06/14
10 December 2014	Mrs D – Progress following SCR	Brian Walsh / Simon Brake	To review progress against the action plan put in place following the Serious Case Review into the death of a vulnerable adult Mrs D, considered by the Board on 18 December 2013.	SB5 18/12/13

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Adult Social Care Peer Review and Commissioning and Personalisation Plan	Pete Fahy	Further to considering the Adult Social Care Peer Review and Commissioning and Personalisation Plan, the Board wanted to understand comments made in the report: i) There was not an understanding of the reasons behind the low alert and referral rates for adult safeguarding ii) Commissioners did not have a clear understanding of their role on quality assurance following Winterbourne View and the Concordat	SB5 30/07/14
7 January 2015				
11 February 2015				
18 March 2015	Review of the Health and Wellbeing Board		The Board would like to review the effectiveness of the working of the HWBB organisationally and corporately.	SB5 30/07/14
22 April 2015	Coventry and Warwickshire Partnership Trust – progress following CQC Inspection	CWPT	To review progress against the action plan put in place following the Care Quality Commission's review of the Trust, particularly in relation to the enforcement notice and issues relating to Quinton Ward.	SB5 30/04/14
Date to be determined	Impact of different Models of Primary Care delivery	Sue Price (Local Area Team) / Ruth Tennant/ CCG	Review of what good primary care looks like and whether different models of provision produce better outcomes. Invite 2 or 3 GP practices and patient panel representatives and Healthwatch in relation to patient engagement. (Needs to link with any Health and Well-being Board work)	c/f from 2013/14
	Clinical management of large scale chronic diseases	CCG	To review how pathways are being managed in primary care for a range of challenges including diabetes	
	Complaints Management		To review levels of complaints, the way they are managed and how they are used to learn lessons and deliver improvements.	c/f from 2013/14

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Social Isolation		The Board would like to understand the extent of social isolation in the city and particularly how this is addressed when people are being supported to live in their own homes. This may involve discussions with representatives of the third sector.	Informal work planning meeting 18/06/14
	NHS Targets		Performance against NHS targets has been raised as a national concern this year, particularly in relation to waiting times for cancer. The Board would like to understand the extent to which targets are being met locally.	Informal work planning meeting 18/06/14