NHS
Hull University Teaching Hospitals
NHS Trust

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST QUALITY ACCOUNT 2019/20

Remarkable people.
Extraordinary place.

Contents

Part 1: Introducing Our Quality Account

This section includes:

Statement on Quality from the Chief Executive

Welcome to Hull University Teaching Hospitals NHS Trust's 2019/20 Quality Account…

I am pleased to present Hull University Teaching Hospitals NHS Trust's Quality Account. The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2020/21. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients, their carers and their families. This means that it is essential that we focus on the right quality and safety priorities for the forthcoming year.

In Part 3 of this report we set out the quality and safety improvement priorities for 2020/21. These priorities were identified through consultation with staff, Trust members, Health & Wellbeing Boards, Healthwatch, Clinical Commissioning Groups and the local community. As a result, the following quality and safety improvement priorities were identified:

Safer Care (Patient Safety)

1. Reduction of inpatient falls of patients who have a diagnosis of Dementia and have an inpatient fall within the Department of Elderly Medicine
2. Development of a standardised safety brief framework
3. Reduction in line infections in our surgical specialities
4. Increase "stop the line" reporting and improve staff engagement and satisfaction with the new reporting process and increase measurable actions

Better Outcomes (Clinical Effectiveness)

1. Improve mental health triage in the Emergency Department
2. Empowerment of the non-registered workforce to improve the delivery of the SSKIN care bundle

Improved Experience (Patient and Staff Experience)

1. Improved framework of preceptorship for new registrants to ensure they are supported and develop in to confident and competent practitioners
2. Improve patient and public involvement across the Trust

Many staff and our stakeholders have been involved in the development of the Quality Account. Comments from the stakeholders on the content of the Quality Account are included in full in the Annex of this report.

We welcome involvement and engagement from all staff and stakeholders because their comments help us acknowledge achievements made and identify further improvements to be made.

I can confirm that the Board of Directors has reviewed the 2019/20 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

We hope that you enjoy reading this year's Quality Account.

Chris Long
Chief Executive

What is a Quality Account?

What is a Quality Account?

The Quality Account is an annual report published to the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

What should a Quality Account look like?

Some parts of the Quality Account are mandatory and are set out in regulations (NHS Quality Account Regulations 2010 and Department of Health – Quality Accounts Toolkit 2010/2011). This toolkit can be accessed via https://www.gov.uk/government/news/quality-accounts-toolkit.

The Quality Account must include:

Part 1 (Introduction)

- A statement from the Board (or equivalent) of the organisation summarising the quality of NHS services provided

Part 2 (Looking back at the previous financial year's performance)

- Organisation priorities for quality improvement for the previous financial year
- A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and the toolkit

Part 3 (Looking forward at the priorities for the coming financial year)

- A review of the quality of services in the organisation for the coming financial year. This must be presented under three domains; patient safety, clinical effectiveness and patient experience
- A series of statements from Stakeholders on the content of the Quality Account

What does it mean for Hull University Teaching Hospitals NHS Trust?

The Quality Account allows NHS healthcare organisations such as Hull University Teaching Hospitals NHS Trust to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities, how the organisation performed in other quality areas e.g. service delivery and to inform the public of its future quality plans and priorities.

What does it mean for patients, members of the public and stakeholders?

By putting information about the quality of services into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Accounts should assure the Trust's patients, members of the public and its stakeholders that as an NHS healthcare organisation it is scrutinising each and every one of its services, providing particular focus on those areas that requires the most attention.

How will the Quality Account be published?

In line with legal requirements all NHS Healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 15 December 2020*. Hull University Teaching Hospitals NHS Trust also makes its Quality Account available on the website: http://www.hey.nhs.uk/about-us/corporate-documents/

**Due to the National COVID-19 Pandemic Response, work on the annual Quality Accounts was temporarily stopped and the timeframe for publication set out in regulation was deferred.*

If you require any further information about the 2019/2020 Quality Account, please contact the Compliance Team on: 01482 482352 or e-mail us at: quality.accounts@hey.nhs.uk

About Us

We employ just over **7,000 whole time equivalent staff** and are supported by **300 volunteers**

We have **two** main hospital sites: **Hull Royal Infirmary** and **Castle Hill Hospital**

We have an **annual income** of circa **£560 million**

Secondary care services are provided to a to a catchment population of approximately **600,000** in the **Hull and East Riding of Yorkshire** area

The Trust also provides specialist and tertiary services to a catchment population of between **1.05 million and 1.25 million** extending from **Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire** respectively

We saw over **134,000** patients in our **Emergency Department** last year

We admitted over **160,000** patients into our **wards** last year

Over **780,000** patients attended an **Outpatient Department** last year

We delivered over **4700** babies in our **Women's and Children's Hospital** last year and over **500** of these in our **Fatima Allam Birth Centre**

The **vision** of the Trust is:
'Great Staff, Great Care, Great Future'

We have a set of **organisational values**:
'Care, Honesty, Accountability'

What Our Patients Said in 2019/20

"Being my first pregnancy I was really scared. The team there really helped me stay calm and relaxed"

"A ward where I felt my dad was safe and surrounded with professionalism"

"…took the time to reassure him and explain carefully his options…"

"…doing a fantastic job of providing quality care. We couldn't have felt more looked after at a difficult time…"

"The level of care received was of high quality and dignity was maintained throughout"

"Since arriving I have been treated with respect and excellent care. Thank you to all concerned"

"The staff members we met were so kind and it was so reassuring to get immediate answers to my questions. It's obvious how much care and pride they take in their work."

"…it was great to be cared for by such empathetic, conscientious and friendly staff…"

"The treatment my father received was timely, thorough, profession and kind."

"The whole team were responsive to not only my dad's medical needs but made a terrifying experience for him bearable and positive within their levels of care shown"

Celebrating Success in 2019/20

Greatix – Positive learning

Excellence in healthcare is everywhere; we believe that capturing excellence creates opportunities for learning and can improve our resilience and morale. It is important that we learn from things that do not go so well, but we can also learn when they do. So when a member of our staff sees some great teamwork, a new way around a problem, or want to tell us about someone who's been really helpful, they can fill out a Greatix excellence report. The person or team they have nominated are contacted to thank them and the Greatix will be disseminated to celebrate and to discuss what we can learn, both individually and as an organisation.

Almost 200 Greatix reports have been submitted over the last year. Below are some examples:

*"I have just finished my Nurse Training. My last placement as a 3rd year student was on Ward 30 at CHH with **Robert Holmes** as my mentor. Rob encouraged me to believe in myself when at times I doubted my abilities and knowledge as a soon to be qualified nurse. Alongside this the whole of Ward 30 made me feel like I had always been part of their team and treated me like one of their own; valuing my opinions and recognising me as a team member and not just as a student who was only there for a short time."*

*"Our housekeeper, **Michelle Baron**, on ward one is one in a million. She goes well above and beyond to help all staff especially when we are short staffed. She is there to sort out any problems we may have"*

Moments of Magic

The Moments of Magic is a Trust established recognition scheme, which acknowledges staff who go above and beyond to provide great care to patients, staff and visitors. Whether it is a friendly gesture, an act of kindness or simply a way of putting people at ease when they may be anxious or upset, these are the kinds of thing which can make a big difference to people in our care, and which make us all proud of our local hospitals and the wider NHS. Below is a sample of some of the over 900 'moments of magic' that were recognised within the last year:

*"**Maggie Moran**, Senior Physiotherapist was on our ward talking to a patient and their relative. The relative was concerned if the patient would receive some medication before discharge which had previously been discussed with them by the medical staff. Even though she was really busy Maggie went down to pharmacy to make sure the medication was available and the issue was quickly resolved. Her help was especially appreciated on this occasion by both patient and staff"*

*"**Emma Chaffer** went above and beyond her role to recover a patient's medical records. Without her help the patient would have missed the slot for the combined procedure they required"*

*"**Jamie MacGregor** was working a run of night shifts and a patient deteriorated on his first night quite rapidly, he accompanied them to Cardiothoracic (CT) and did not leave the patients side all night long, he was fantastic with the family members and sacrificed having a break in order to make sure the patients care came first. His quick recognition of the patient deteriorating ensured that family could be called to the hospital in order to be with their family member. Following this the same happened on the next night shift in a similar situation. In this particular case he accompanied the patient down to the Intensive Care Unit (ICU) even though it was after his shift had finished in the morning."*

Innovation and Good News

Patient Safety Campaign 'Stop the Line' launched to mark World Patient Safety Day

The campaign aims to encourage, empower and support every member of staff, regardless of job title, to speak out when they see something unsafe to prevent patient harm.

Success at Black, Asian and Minority Ethnic (BAME) Health awards

At the national BAME Health and Care Awards consultant obstetrician Uma Rajesh was named Clinical Champion of the Year and consultant gastroenterologist and Prof Shaji Sebastian won the award for 'Ground-breaking Researcher'. Also shortlisted for awards were Head of Patient Experience, Louise Beedle, Midwife Melanie Lee, Consultant Interventional Radiologist Raghuram Lakshminarayan, and Chief Executive Chris Long.

Bereavement midwife nominated by families wins prestigious national award

Specialist Bereavement Midwife Sue Cooper won the award from the Charlies-Angels-Centre Foundation after she was nominated by some of the families she has cared for when their babies have died. As well as her hard work and dedication in helping families whose children have died, Sue has also developed the Bereavement Service to ensure families in Hull and the East Riding get the best possible support. At a regional and national level, she has developed links with the Yorkshire Clinical Network and has played a major role after the Trust was chosen as a pilot site for the development of a National Bereavement Care pathway.

Justin achieves his nursing dream in Hull after seven years in a refugee camp, he's now been nominated for a national award for his outstanding contribution

Justin spent seven years in a refugee camp, watching the sick and dying suffer with little access to nursing or medical help. Justin Mwange fled to Zambia from the war-torn Democratic Republic of Congo as a teenager with his family and spent seven years living in abject poverty and deprivation. What he saw in the camp fuelled his passion to help the sick and vulnerable. Despite his lack of formal education or access to financial support to further his studies, he was determined to become a nurse. Justin has now been nominated for a Chief Nursing Officer's award in the category of BAME Student Diversity by Vicky Needler, Practice Learning Facilitator at the Trust after achieving his dream of becoming a nurse and impressing staff throughout his placements at Hull Royal Infirmary and Castle Hill Hospital.

First flight touches down on hospital's new £500,000 helipad

A five-person crew from Lincolnshire and Nottinghamshire Air Ambulance was the first to fly in and step foot on the completed helipad to the rear of Hull Royal Infirmary in August 2019. The Trust has undertaken a major construction project so patients seriously hurt in accidents across East and North Yorkshire and parts of Lincolnshire can be flown into the hospital grounds, the Major Trauma Centre (MTC) for the area. The helipad, situated behind Hull Royal Infirmary's £12m Emergency Department, has been funded entirely by the HELP (Helicopter Emergency Landing Pads) Appeal.

Radiotherapy Physics MPACE accreditation

The Radiotherapy Physics Team at the Queen's Centre at Castle Hill Hospital have become the first such team in

the country to achieve a new standard which assures cancer patients of quality care. The Medical Physics and Clinical Engineering (MPACE) accreditation scheme independently reviews all aspects of healthcare science which underpin the radiotherapy treatment provided to patients, including safety, treatment planning and equipment maintenance.

Emergency Department (ED) staff from Hull have inspired a new nationwide promotional campaign centred on patients with a learning disability

The Learning Disability (LD) pledge was promoted by the Makaton Charity as part of Learning Disability Awareness Week in June 2019. The pledge is based on a piece of work authored by Consultant, Dr Liz Herrieven and play specialist, Laura Burton. Their ED Pledge laid the foundations for the LD Pledge, a national movement which seeks to raise awareness of the needs and rights of people with a learning disability in accessing equitable health care.

Trust receives a share of £500K to create Changing Places for disabled visitors

Following a successful bid for capital funding, the Trust will receive £105,000 of Government money to create four new 'Changing Places' facilities across both Hull Royal Infirmary and Castle Hill Hospital. Hull is one of ten NHS Trusts to receive a share of half a million pounds for this purpose.

Shining bright at city's Health and Care awards

At the Hull Daily Mail Health and Care Awards, Hull University Teaching Hospitals NHS Trust (HUTH) teams claimed some of the most notable awards going after a total of seven teams and individuals were nominated. Storming to victory as 'Team of the Year' was our Neonatal Team. Outstanding Health Professional of the Year was awarded to Consultant in Rehabilitation Dr Abayomi Salawu, while Day Surgery Nurse Gilly Macleod was named Outstanding Nurse of the Year. John Drury, a familiar face at the front of the HRI tower block reception, was also named Volunteer of the Year.

Unused hospital wheelchairs to help landmine victims in Africa

deso
Disabled Equipment Sent Overseas

Old wheelchairs no longer required by hospital patients were sent to Africa to help children and adults who have had limbs blown off by landmines. The Trust transported 34 wheelchairs, once destined for recycling as scrap metal, to Disabled Equipment Sent Overseas (DESO). Environmental Support Officer Gavin Lee discovered the charity's work as he searched for a solution to prevent still-usable equipment being sent for scrap metal. Gavin is also sourcing crutches and walking frames which are no longer required by the NHS to add to the collection.

A member of the Facilities Team has been awarded the MBE for his services to the environment

Dawda Jatta joined the Trust as a monitoring officer, ensuring the hospitals meet environmental and hygiene standards and in 2019 celebrated after he was awarded the MBE in the Queen's Birthday Honours for Recycling and Energy Saving. Dawda founded BAMEEN (Black and Minority Ethnic Environment Network), a community organisation promoting recycling, energy saving, local food production and environmental educational training programmes to BAME groups in Hull and the East Riding.

health expo
hull and east riding

Performance against Priorities 2019/20 – summary

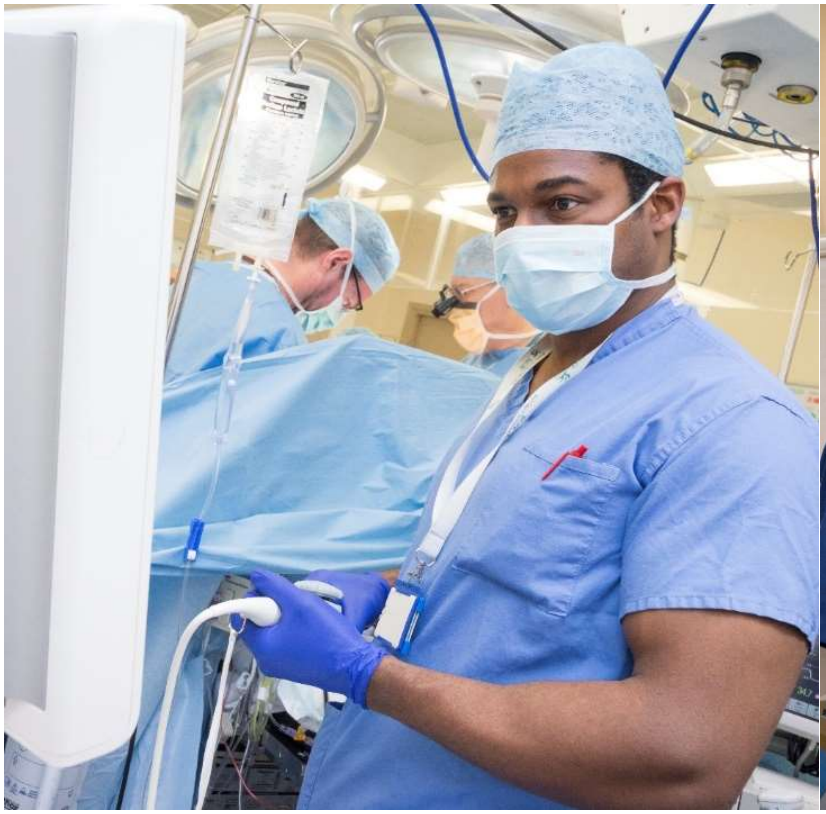
The Quality Improvement Plan (QIP) is a high-level plan which defines the improvement goals the Trust is working towards for improving quality and safety across the organisation. The plan includes the 'must do' and 'should do' actions from any Care Quality Commission (CQC) inspections alongside areas of work the Trust is pursuing to improve, quality and safety priorities as detailed in the Quality Account. This year the QIP had projects in place, all of which were linked to the 10 Quality and Safety Priorities as set out in the 2018/19 Quality Account, with the exception of VTE. The achievements of the VTE priority are detailed in section 2.1.

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	

	Project	Indicator	Achieved
▲Safer Care	Nutrition and Hydration	95% of patients weighed within 24hrs of admission	↗
		90% of patients weighed every 72hrs	↗
		95% of weighs plotted on weight graph	↗
		90% of weight recorded on Drug Chart	✓
		95% of daily Nutrition Risk Assessments	↗
		95% of appropriate referral to Dietician	X
		95% of care plan states "low, Medium or High Risk"	↗
		80% of hydration charts completed	↗
	Medicine Optimisation	70% of dispensing discharge prescriptions within an hour for patient lounge by March 2020	✓
		50% increase in referrals to "Transfer of Care Around Medicines Scheme" by March 2020	✓
	Deteriorating Patient	90% of patients that have a NEWS Score above 1 have evaluation which states actions taken or escalation documented	↗
	Pressure Ulcers	Completion of Root Cause Analysis (RCA) in 14 days	X
	Acute Kidney Injury (AKI)	Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition.	↗
		Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level ... monitored.	↗
		Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.	↗

	Priority	Indicator	Achieved
▲Better Outcomes	VTE	0 VTE Serious Incidents	✓
		95% compliance with assessment of all relevant patients to identify the risk of VTE no later than 24 hours following admission to hospital	↗
	Dementia	75% dementia / delirium screening pathway completed in the medical document	✓
		75% of online dementia/delirium screening tool completed	✓
		75% of dementia diagnosis documented in the medical notes	✓
		75% of Butterfly displayed at the bedside	↗
		75% of the Butterfly icon in place on Cayder	✓
		75% of Reach Out To Me document at the bedside	↗
		75% compliance with two members of staff able to articulate the meaning of Johns Campaign & Butterfly Scheme on each ward	✓
		75% of clinical areas displaying poster regarding Johns Campaign	✓
		75% of clinical areas displaying poster regarding Butterfly Scheme	✓
	Mental Health	95% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm	✓
		Established bi-monthly Mental Health Committee	↗
▲Improved Experience	Outpatient Services	90% of OP areas rated green or blue Patient Experience Fundamental Standard	✓
		90% of OP areas rated green or blue Staff Experience Fundamental Standard	✓
		Outpatient Governance Committee held	✓
		98% Friends and Family Test Scores for Outpatients	✓
		Increase in positive compliments or comments on NHS Choices	X
		Improved waiting times at clinics	↗
	Patient Experience	Reduce the number of reopened complaints due to dissatisfaction by 10%	X

Part 2: Priorities for Improvement and Statements of Assurance from the Board



This section includes:

2.1 Performance Against Priorities 2019/20:

This section covers:

- Safer care
- Better outcomes
- Improved experience

Safer Care: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To improve nutrition and hydration

Why was this important?

The provision and administration of nutritious food is essential to patient care; effective nutritional care is paramount to recovery and improved patient outcomes. Improving hydration brings well-being and better quality of life for patients. Being well-hydrated also helps medicines to work more effectively. The completion of nutrition and hydration risk assessments was identified as an area requiring improvement by the CQC in February 2018.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aims of this project were:

- To ensure patient's nutrition and hydration needs are risk assessed in accordance with Trust Nutrition and Hydration Policy (CP335)
- To ensure patients are weighed in accordance with Trust Policy (CP335)
- To ensure that patients are fasted pre-operatively in accordance with Trust Policy (CP335)

How did we perform?

The project completed a number of actions including:

To ensure patient's nutrition and hydration needs are risk assessed: The performance indicator for '95% of care plan states "Low, Medium or High Risk"' was not achieved in the year; however, a good improvement has been demonstrated from 79.7% in April 2019 to 85.3% in March 2020 and the average performance for the year was 82%. Therefore, progress is being made. It is expected that the rollout later in 2020 of electronic documentation will have a positive impact on the completion of forms.

Ensure that patients are weighed in accordance to Trust Policy (CP335): Compliance with has been less than optimum against target. The compliance against the targets have seen significant fluctuations, therefore, further improvements are required.

Ensure that patients are fasted pre-operatively in accordance with Trust Policy (CP335): This aim was linked to an action from the 2018 CQC inspection which found that a consistent and agreed approach to fasting was required. This remains on the work plan of the Surgery Health Group and a re-audit was completed in January 2020. The audit lead was able to provide some comparison against the 2018, 2019 and 2020 audits which suggested that there was an increase of 11.16% of patients fasting between 0-2 hours which is the optimum time for fasting. In addition, reductions were demonstrated in fasting over 4 hours by 20.6%. Therefore, further improvements are required.

Implementation of Monthly Ward Based Nutrition and Hydration Auditing: In 2019, the Trust continued to rollout a program of ward based monthly auditing, called the Matron's Handbooks. These audits include a range of key topics, including hydration and nutrition. The completion of the handbooks was a particular drive for nursing staff over the year, as completion of these audits provides up-to-date and accurate compliance data with a number of topics relating to the Quality and Safety Priorities, including the ones detailed in the following performance table.

Indicator	Baseline 2018/19	Performance 2019/20
95% of patients weighed within 24hrs of admission	84.5%	87.2% average ↗
90% of patients weighed every 72hrs	74.3%	80.2% average ↗
95% of weighs plotted on weight graph	74.4%	84.2% average ↗
90% of weight recorded on Drug Chart	88.3%	91.5% average ✓
95% of daily Nutrition Risk Assessments	92.4%	94.4% average ↗
95% of appropriate referral to Dietician	92.6%	88.1% average X
95% of care plan states "Low, Medium or High Risk"	77.4%	82% average ↗
80% of hydration charts completed	45.8%	69.6% average ↗

Assisted Feeding:

The Trust has an assisted feeding process, which has been in place for a number of years. This has been strengthened in 2019/20 by the use of red trays and lids to identify those who need assistance with feeding and drinking and ward personnel designated to support those patients at mealtimes. Family members are encouraged to support their relations at mealtimes and mealtimes are protected from ward rounds, nursing interventions or other medical or clinical care whilst patients eat. The Trust also introduced staggered ward services to allow more staff to be available to help those patients who need support at mealtimes.

'Cake and Shake' Rounds:

A 'Cake and Shake' round was introduced in 2019 on those wards with a high proportion of elderly and frail patients. Staff give patients a piece of cake and choice of milkshake every day. The cakes and milkshakes are provided to patients to increase their calorie intake, to aid their recovery and help improve their mental health. Some patients are often unable to finish meals and prefer to eat in a different frequency to those set out for the majority of patients, and this additional round helps increase essential high-calorie intake for those patients most in need. The project success was measured by the monitoring of several key indicators. These are detailed below along with how the Trust performed:

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

As the performance table demonstrates, not all the targets were achieved. It must be noted that all targets with the exception of one has made improvement demonstrating good progress achieved overall.

Going forward

This priority will be carried forward for further action and monitoring.

The delivery of optimum Nutrition and Hydration for our patients continues to have a high profile within the Trust and we are committed to finding new ways to improve patient's nutritional care whilst in hospital. Monitoring of the key indicators will continue as part of the Matron's Handbook audits as will the annual Nutrition Census and Fasting / Nil-by-mouth audit.

All residual actions will be monitored by the Trusts Nutritional and Hydration Steering Committee.

Safer Care: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To improve medicine optimisation

Why was this important?

Medicines optimisation is defined by the National Institute for Health and Care Excellence (NICE) as 'a person-centred approach to safe and effective medicine use, to ensure people obtain the best possible outcomes from their medicines.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aims of this project were:

- To improve key aspects of the medicines management discharge process by increasing referrals to the 'Transfer of Care around Medicines Scheme'
- Improve turnaround times of dispensing discharge prescriptions for the patient lounge
- Improved timeliness of Immediate Discharge Summary (IDS) from the Boots Pharmacy to the Queen's Centre wards
- Improved accessibility of oral nutritional supplements (SIP feeds) on wards

How did we perform?

The project completed a number of actions including:

Increasing the Number of Referrals to the 'Transfer of Care around Medicines Scheme':

The scheme focuses on patients in hospital who have been identified as requiring additional support with their essential medication. These patients are then referred through a secure digital system, to their local community pharmacy at the point of discharge.

This improves integration between care settings. It was first implemented in 2019 on the Cardiology Wards at Castle Hill Hospital before being rolled out to 17 wards in total across both sites. 100% of rotational pharmacists and pharmacy assistants have been trained following a launch event held in June 2019.

A user guide for community pharmacists and a Patient Information Leaflet was developed to provide guidance and information to support the delivery of the scheme. The target for the year was to improve the number of referrals to the scheme by 50%, from 84 to >126. This target has been met and the number of referrals increased exponentially to over 500.

Improving the percentage of Discharge Prescription Dispensed within One Hour with the Discharge Lounge:

Discharging patients from hospital can be a time consuming process and often results in patients waiting for their medicines. The Discharge Lounge is a safe place for patients to wait for transport to their home address or for medications. The Trust wanted to improve the length of time people were waiting for medications in the Discharge Lounge, so the aim to have 70% of mediations dispensed within one hour for those patients waiting in the lounge was agreed.

In June 2019 a Medicine's Management Assistant was placed in the Discharge Lounge to help facilitate this aim. A tracking system was also introduced to help identify not only the time taken to dispense the prescription but any issues that make the prescriptions take longer. The baseline figures showed 53% of prescriptions were dispensed within an hour.

Between May 2019 and March 2020 performance against this target achieved 72% of prescriptions were dispensed within one hour, demonstrating an improvement against the baseline and achievement of the target.

Improving Discharge for Queen's Centre Patients:
The third aim for this project was to complete a trial at the Queen's Centre in conjunction with the Boots Pharmacy based there. Currently, all prescriptions from the Oncology wards at the Queen's Centre at Castle Hill Hospital are sent electronically to the Boots Pharmacy on site.

In order to reduce delays for patients waiting in public areas at the Queen's Centre, the trial was established for a designated Trust Pharmacy staff member carrying a bleep, which would be used by the Boots Pharmacy staff to inform them that a patient's prescription was ready to collect. The Trust Pharmacy staff would then deliver the prescription directly to the patient thereby improving the patients discharge experience. This reduced the time patients were waiting. Further work and analysis is being completed to scope a future process where this can be in place permanently.

Improved availability of 'Sip Feeds' on Wards:
Oral Nutritional Supplements or 'sip feeds' are prescribed drinks that provide extra nourishment in an easy to take form. They can be prescribed for certain conditions for example, disease related malnutrition. They are frequently used in hospitals to support recovery and prevent further weight loss. These types of feed can be prescribed on discharge to patients.

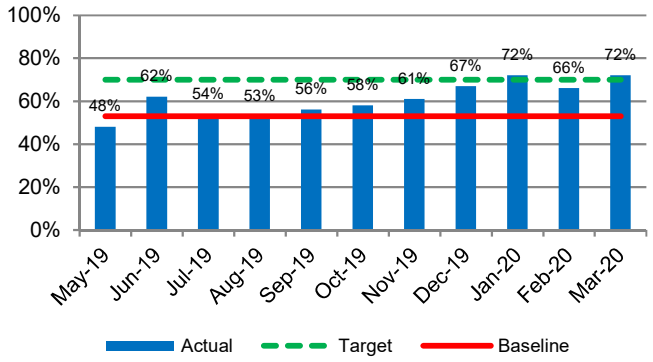
A project was commenced to review the number of feeds held 'in stock' on wards to see whether these can be increased and all relevant wards to hold a level of feeds that can be given to the patient at the point of discharge, rather than waiting for the feeds from pharmacy. An educational poster has been developed for wards and pharmacy staff to support the rollout of this amended process. Further work is required and therefore this will be carried forward.

The project success was measured by the monitoring of two key indicators. These are detailed below along with how the Trust performed:

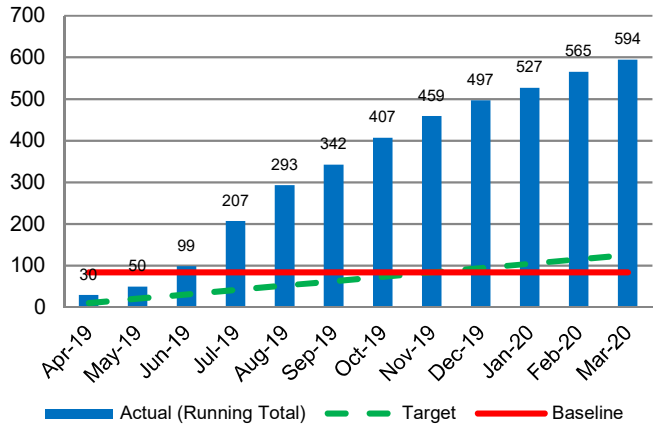
Indicator	Baseline 2018/19	Performance 2019/20
70% of dispensing discharge perceptions within an hour for patient lounge by March 2020	53% (annual)	72% (end of March 2020) ✓
50% (>126) increase in referrals to "Transfer of Care Around Medicines Scheme" by March 2020	84 (annual)	594 ✓

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

Achieve 70% of dispensing discharge prescriptions within an hour for the Patient Lounge:



Achieve 50% increase (>126) in referrals to the 'Transfer of Care around Medicines Scheme':



Going forward

This priority will be carried forward for further action and monitoring.

The delivery of all aspects of Medicines Management and Optimisation for our patients continues to have a high profile within the Trust and we are committed to finding new ways to improve our pharmacy service. Monitoring of the key indicators will continue as part of our Pharmacy Team's work plan and will be monitored by the Safer Medication Practice Committee.

Safer Care: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To improve care, management, detection and treatment of the deteriorating patient

Why was this important?

Early identification of a patient's deterioration, enabling rapid targeted management, can help reduce the need for transfer to higher acuity units, reduce hospital lengths of stay and improve survival rates.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to ensure all patients with an elevated National Early Warning Score (NEWs) to be escalated in line with Trust Recognition of the Deteriorating Patient Policy (which incorporates NEWS2).

How did we perform?

The project completed a number of actions including:

Embedding and Monitoring of NEWS2 across the Trust:

National Early Warning Score (NEWS) is based on a scoring system in which a score is allocated to six physiological measurements – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS). Following the publication of NEWS2, the Trust focused on embedding this tool into practice.

During 2018 and early 2019 a revised Recognition of the Deteriorating Patient Policy was developed, which is compliant with NEWS2 guidance, along with clinical guidance from the National Institute for Health and Care Excellence (NICE). The NICE CG50: Acutely Ill Adults in Hospital: Recognising and Responding to Deterioration is published national guidance with the aim to improve the recognition and response to the physical deterioration of patients with the objective to improve physical health provision and outcomes for patients. Following this policy revision, the corresponding deteriorating patient care bundle was devised for use with appropriate patients and allowed staff to record, monitor and escalate patients appropriately. To support this, a rollout of newly developed training package for staff to ensure full competency with the new processes.

The focus for the Trust this year has been to establish a robust audit process, which has been achieved through the establishment of a 'Recognise and Respond' Fundamental Standard Inspection programme and the Matron's Handbook audits. The Trust monitors on a monthly basis, the percentage of patients that have a NEWS Score above 1 and the actions taken or escalation documented.

The Trust identified the target of 90% of all patients to meet the aim; there was not a baseline from the previous year to compare it to. Performance has been varied throughout the year with three months achieving over 80% compliance and one month achieving over 90%, the average performance for this target was 76.8%. This has been identified as a continuing area of improvement for the Trust to focus on in 2020/21.

Development of a 'Recognise and Respond' Fundamental Standard Inspection programme:

The Fundamental Standard Inspections are a formal review process, which reviews objectively the quality of care delivered by our clinical teams.

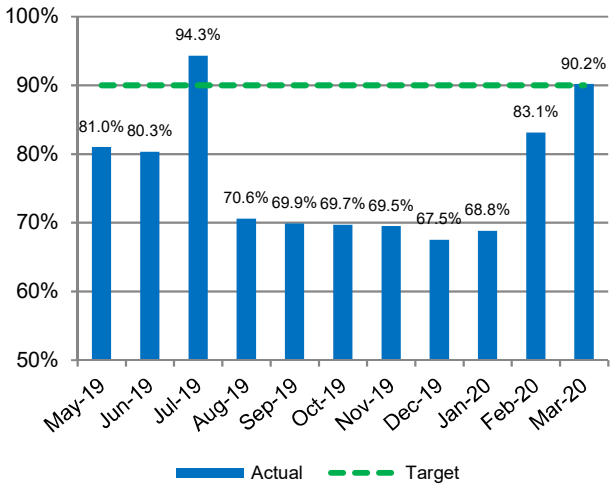
It is set around nine fundamental standards, with the emphasis on delivering high quality, safe effective care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care and are influenced by the CQC key lines of enquiry prompts used during inspections. The Recognise and Respond criteria includes questions for staff about their knowledge on fluid balance recording, sepsis screening and escalation. It also reviews the quality of the documentation for the Deteriorating Patient bundles, the sepsis pathway, fluid balance chart and ReSPECT forms (Recommended Summary Plan for Emergency Care and Treatment forms).

Ward oxygen cylinder storage and resuscitation boxes and trolleys are also checked to ensure they are in date and have been audited regularly. 39 wards across both Castle Hill Hospital and Hull Royal Infirmary have been audited at least once using the Recognise and Respond audit tool and over half of the wards have been rated either blue or green, which indicates outstanding and good performance and can be audited again within a 9 to 12-month period.

Rollout of Electronic Observations (e-obs):
During 2019 and 2020, the Trust commenced a rollout programme to use Electronic Observations (e-obs) for the electronic capture, calculations of Early Warning Scores and automated cascading escalations to ensure recognition is followed by appropriate and timely action. The system provides the electronic capture of patient information, via handheld devices, at the bedside, enabling timely and accurate data collection. This system includes automatic calculations and alerts for those patients who display concerning observations, as well as due and overdue reminders.

The project success was measured by the monitoring of the key indicator. The Trust target was to achieve 90% of patients that have a NEWS Score above 1 and the evaluation states actions taken or escalation documented monthly. The source of this indicator is the Trust's internal nursing auditing programme, called the Matron's Handbook.

As the graph demonstrates, compliance was not always achieved. The average for 2019/20 is 76.8% and therefore, this remains an area of improvement for next year. This will be used as the baseline for future monitoring against this target.



Going forward

This priority will be carried forward for further action and monitoring.

The care of deteriorating patients is and will always be important to the Trust. The continued rollout of e-obs across all wards and the monitoring of the 'Recognise and Respond' Fundamental Standard audit will be monitored throughout the coming year to ensure all patients with an elevated NEWS to be escalated in line with Trust Recognition of the Deteriorating Patient Policy.

Safer Care: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To reduce avoidable hospital acquired pressure ulcers

Why was this important?

The National Institute for Health and Care Excellence (NICE) Quality Standard for Pressure Ulcers states: “Pressure ulcers are caused when an area of skin and/or the tissues below are damaged as a result of being placed under pressure for long periods of time. All people are potentially at risk of developing a pressure ulcer. They are, however, more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, poor posture or a deformity, compromised skin or who are malnourished. Pressure ulcers are graded with increasing severity from category 1–4.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to be open and transparent skin damage reporters, improving safety and patient experience through robust assessment, care planning and evaluation by sharing best practice from areas with low reported incidents and to improve understanding of key themes and trends from all reported incidents.

How did we perform?

The project completed a number of actions including:

Compliance with the NHSI Recommendations:
NHS Improvement (NHSI) said “Our national ‘Stop the Pressure’ programme has developed a guide to support nurses and other healthcare professionals in preventing pressure ulcers. The recommendations in our guide will support an organisation’s ability to learn from reported incidents and looks at ways to improve the prevention of pressure damage.”
As part of this, Trusts were required to amend their reporting criteria and recommendations via their incident reporting tool, (Datix) which would in turn standardise the findings, themes and trends and allow Trusts to be benchmarked against each other. NHSI expected all Trusts to implement these recommendations from April 2019.

This year, following the publication of the recommendations, the Trust updated all training, policies and guidance related to the management of pressure ulcers and developed a communication strategy to ensure all staff were aware of the changes. Datix reporting criteria were amended as per the recommendations. From April 2020 the Trust will be able to review themes and trends from each month, along with the numbers of reported pressure ulcers or moisture damage against the performance during 2019.

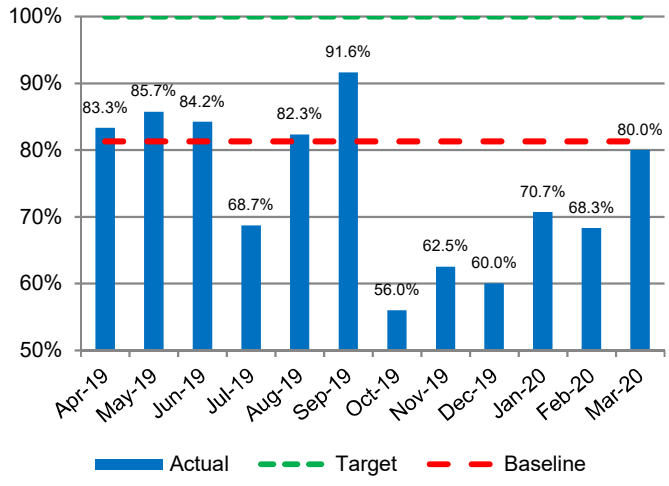
Review of SSKIN Care Bundle:
SSKIN is a five-element approach to preventing and treating pressure ulcers which includes:

- **S**urface,
- **S**kin inspection,
- **K**eep moving,
- **I**ncontinence/moisture,
- **N**utrition/hydration

The SSKIN Care Bundle was previously part of the Trust’s ‘Intentional Rounding’ documentation. Intentional Rounding is a process where nursing staff conduct regular checks on patients throughout the day to ensure their fundamental care needs including pain, comfort/positioning, toileting, water, temperate etc. are being addressed.

This year the Trust planned to develop a specific care bundle, with SSKIN as the basis, for the identification and management of pressure and moisture damage. Having a specific care bundle would mean that all staff who input into a patient's care, such as physiotherapist and dieticians, can contribute to the care bundle thereby ensuring a truly multidisciplinary tool. The Trust's Tissue Viability Matron invited all therapies staff to be involved in the development of the care bundle and the bundle is now in the testing stage.
A pilot is in underway in all Medical Elderly wards within Hull Royal Infirmary. Full rollout will be completed once the final tested care bundle has been agreed.

The project success was measured by the monitoring of one key indicator. The Trust monitored on a monthly basis, the percentage of Root Cause Analysis (RCA) completion within 14 days of all finally approved Hospital Acquired Pressure Ulcers (HAPU). The target was to achieve 100% of RCAs completed within 14 days. As the graph below demonstrates, the target was not achieved within the year. The average performance for the year was 74.4%, which is also deterioration from the baseline of 81.3% from 2018/19.



In addition, the number of pressure ulcers in each category was reported and monitored. The Trust was unable to compare these numbers against previous years due to the categorisation revision recommendations by NHS Improvement (NHSI) in June 2018 as part of their national Stop the Pressure programme for implementation in April 2019.

Indicator	2019/20
Category 2 Hospital Acquired Pressure Ulcers	162
Category 3 Hospital Acquired Pressure Ulcers	4
Category 4 Hospital Acquired Pressure Ulcers	1
Unstageable Hospital Acquired Pressure Ulcers	22
Deep Tissue Injury (DTI) Hospital Acquired Pressure Ulcers	70

Going forward

This priority will be carried forward for further action and monitoring.

The management and identification of pressure ulcers and moisture damage is a key factor of patient care for the Trust and will remain high on the monitoring and improvement agenda for the coming year.

Completion of RCA's as well as understanding themes and trends will continue to be monitored and actioned by all of the Health Groups within the Trust as well as the Wound Management Committee.

Safer Care: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To reduce avoidable acute kidney injury

Why was this important?

The National Institute for Health and Care Excellence (NICE) clinical guideline 169 states that: "Acute Kidney Injury (AKI) encompasses a wide spectrum of injury to the kidneys, not just kidney failure". Acute kidney injury is seen in 13–18% of all people admitted to hospital, with older adults being particularly affected. The number of inpatients affected by acute kidney injury means that it has a major impact on healthcare resources.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to increase compliance, specifically, with NICE Quality Standard 76; Acute Kidney Injury. This sets out the following aim for the standard: "This quality standard covers preventing, detecting and managing acute kidney injury in adults, young people and children". The aim of this project was to become compliant with the following three quality statements from the quality statement:

- **Quality statement 2:**
  People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition (baseline: not compliant)
- **Quality statement 3:**
  People in hospital who are at risk of acute kidney injury have their serum creatinine level monitored (baseline: not compliant)
- **Quality statement 4:**
  People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected (baseline: partially compliant)

How did we perform?

The project was designed to be a short-term project to support the completion of an audit against compliance with the above Quality Statements.

A number of actions were completed within the 2018/19 project to increase compliance with the three quality statements, including delivery of focussed kidney injury training in elected clinical groups within key areas of the Trust and an acute kidney injury toolkit was developed and implemented for use on the acute medical unit.

The audit that was completed at the end of the 2018/19 project and into the 2019/20 project evidenced some improvements, with quality statement two and three increasing from not compliant to partially compliant. Quality statement four remained partially compliant.

The lead identified two key areas for improvement. The first was the introduction of online and face to face mandatory training for the diagnosis and management of AKI for both junior and senior medical staff. From this, an excellent online training package has been made available. Secondly, the audit found that the introduction of an AKI care bundle in the initial patient clerking sheet would increase compliance with the three quality statements.

As the Trust is currently in the midst of a large-scale project to transfer all paper patient documentation onto electronic clinical systems, it was agreed that this will be taken forward as part of this wider project in the following year.

The project success was measured by the monitoring of three indicators as described in the aim.

These are detailed below along with how the Trust performed:

Indicator	Baseline 2018/19	Performance 2019/20
Compliant with Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition.	Not compliant	Partially compliant ↗
Compliant with Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level monitored.	Not compliant	Partially compliant ↗
Compliant with Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.	Partially compliant	Partially compliant ↗

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

Going forward

The management and identification of acute kidney injury remains an important issue for the Trust and further work has been identified for the following year. This work will be led by the AKI Consultant and monitored at the Trust's Clinical Effectiveness, Policies and Practice Development Committee.

Safer Care: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To ensure all appropriate patients are risk assessed for Venous Thromboembolism (VTE)

Why was this important?

VTE is an important cause of death in hospitalised patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with a considerable cost to the health service. In 2005, VTE was registered as the underlying cause of death in more than 6,500 patients, although this figure is likely to be an underestimate of the true incidence. The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and on any predisposing risk factors (such as age, obesity and concomitant conditions).

What did we aim to achieve?

The aim of this priority was to ensure all appropriate patients are risk assessed for VTE and where necessary receive the correct treatment.

How did we perform?

The project completed a number of actions including

- Detailed monthly reporting alongside completing the NHS Safety Thermometer audits. This ensures that the Trust is prescribing the right patients the right DVT (Deep Vein Thrombosis) treatment.
- Quality Improvement projects undertaken by junior doctors on surgical wards to improve compliance
- A sustained follow up of non-compliant areas through clinical leads-followed up at the Trust's Performance and Accountability Committee
- A monthly accountability meeting every month with Health Group Medical Directors

The project success was measured by the monitoring of two key indicators. These are detailed below along with how the Trust performed:

Indicator	Baseline 2018/19	Performance 2019/20
0 VTE Serious Incidents	1	0 ✓
95% compliance with assessment of all relevant patients to identify the risk of VTE no later than 24 hours following admission to hospital	88.5%	92.2% ↗

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

We have had a sustained 92% compliance through the year with some areas achieving the 95% compliance. Further analysis of the data revealed that when the patients who stayed less than 24 hours are removed from the non-compliant group it improved compliance to 95%.

Going forward

The aim of 95% of all relevant patients to be assessed for the risk of VTE no later than 24 hours following admission to hospital remains part of the performance measures in place by the Trust for patient safety requirements and will continue to be reported throughout the committee structures within the organisation.

Better Outcomes: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To improve the care of people with Dementia within the Trust

Why was this important?

Dementia is a progressive and usually irreversible syndrome, characterised by a widespread impairment of cognition. People with dementia can experience one or a combination of the following: Memory loss, Language impairment, Changes in personality, Disorientation and Self-neglect. There are 3 main types: Alzheimer's disease, Vascular Dementia and Dementia with Lewy Bodies. There are over 850,000 people with dementia in the UK according to Alzheimer's Research UK and an estimated 25% of acute hospital beds are occupied by people with dementia who often have a longer length of stay and poorer outcomes during their hospital admission. At Hull University Teaching Hospitals, a Trust-wide screening tool for all acute admissions over the age of 75years is used.

For patients with either confirmed or suspected dementia, or delirium (acute confusion) the Butterfly Scheme is used. The Butterfly Scheme is a system that enables staff to provide person centred care to patients with dementia. A butterfly symbol is placed above the patient's bed to act as a discreet reminder to staff that this patient has dementia. The scheme delivers skills based education to key staff based on a five-point response (REACH response - a summary of the skills the scheme teaches to staff) and also involves the use of a carer sheet to empower patients and their carers to personalise the care they receive. Every ward in the Trust now has a dedicated member of staff appointed as a Butterfly Champion who will promote the scheme and support staff in its use.

As an organisation, the Trust recognises the key role that relatives and carers have in helping staff to plan and to deliver person-centred safe and effective care and the Trust encourages their input at every point of the patient's journey. John's campaign establishes the right of partners/carers of people with a diagnosis of dementia, to remain in hospital with their loved one outside of regular visiting hours.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to ensure that the dementia bundle is embedded, all identified and relevant staff are trained in Dementia to the appropriate level and the dementia documentation is consistently completed to the appropriate level.

How did we perform?

The project completed a number of actions including:

Dementia Bundle:

The first aim of this project was to ensure that the dementia bundle was embedded across the Trust. The dementia care bundle is a set of interventions that, when used together, significantly improve patient outcomes and when multi-disciplinary and multi-agency teams work together there are proven benefits to patients and their carers. A significant amount of work has been completed in order to achieve this and the bundle has been reviewed, updated and tested. As the Trust is working towards a minimal paper patient records system, the bundle has been transferred into a compatible format for these electronic systems and is planned for launch in 2020.

Review and Development of Revised Dementia Training:

It was identified that in order to increase the consistency of completion of dementia related documentation, the existing dementia training would need to be updated and made available to a wider range of staff.

In 2019, a Training Needs Analysis (TNA) was completed to identify which staff members should be trained in dementia as part of a mandatory programme. This analysis identified 'tiers' of training, for different levels of staff. The training programmes for each staff tier has been completed and the revised training programmes are currently being approved by the relevant structures within the organisation.

In addition, there is an agreed list of 'Dementia Champions' across the organisation. These are members of staff with additional training in dementia who have the responsibility to promote the care and wellbeing of dementia patients and support the training and development of other staff members in dementia and cascade any new learning across the Trust.

Dementia Documentation Is Consistently Completed:

A series of performance indicators were agreed to monitor the completion of Dementia documentation as detailed in the table below. Whilst the monthly data fluctuated throughout the year, compliance was achieved against the targets for all except two; however, performance improved from the baseline from 2018/19 demonstrating further improvements made.

Indicator	Baseline 2018/19	Performance 2019/20
75% of dementia / delirium screening pathway completed in the medical document	85.7%	81.6% average ✓
75% of online dementia / delirium screening tool completed	76.2%	78.6% average ✓
75% of dementia diagnosis documented in the medical notes	100%	94.6% average ✓
75% of Butterfly Icon displayed at the bedside	66.7%	73.1% average ↗
75% of Butterfly Icon in place on Cayder board	100%	97.5% average ✓
75% of Reach Out To Me document at the bedside	40.9%	44.7% average ↗
75% compliance with two members of staff able to articulate the meaning of Johns Campaign & Butterfly Scheme on each ward	77.8%	88.3% average ✓
75% of clinical areas displaying poster for Johns Campaign	63.6%	77.8% average ✓
75% of clinical areas displaying poster for Butterfly Scheme	72.7%	78.4% average ✓

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

Part way through the project term, the following training indicators were discontinued due to the postponement of a revised Dementia Training Programme of which the indictors were linked.

- 30% of Trust Tier 1 staff have completed the relevant dementia
- 30% of Trust Tier 2 staff have completed the relevant dementia
- 30% of Trust Tier 3 staff have completed the relevant dementia

In addition, the indicators below were amended in June 2019 to reflect the new way of auditing dementia documentation that was introduced by the Trust part-way through the year. The indicators below were superseded:

- 75% compliance with dementia/delirium screening assessments undertaken
- 75% compliance on H8, H9, H90 and EAU with the use of the Butterfly Scheme which focuses on Butterfly Symbol and the Reach Form

- 75% staff awareness of John's campaign
- 75% relative/carer awareness of Johns campaign

Going forward

This priority will be carried forward for further action and monitoring.

The Trust has a Dementia Strategy in place and is being updated in 2020. The strategy covers all aspects of care for patients living with dementia during their care within the Acute Trust, whether inpatient or outpatient and also recognises the needs of their relatives and carers. This will continue to be delivered following its revision.

Better Outcomes: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To improve the governance of children and adult patients requiring Mental Health care within the Trust

Why was this important?

To provide appropriate care the Trust should document how the mental health needs of patients are met, including how the Trust works with other specialist agencies in the provision of mental health support and how staff are trained in mental health conditions.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was:

- to improve the sharing of patient information between the Acute Trust and Mental Health services;
- to ensure that all children with Mental Health needs have an individual care plan appropriate to their needs, including risk assessments undertaken to eliminate potential self-harm;
- to ensure that all mental health training is recorded centrally and to ensure the Service Level Agreement for Adults with Humber Teaching NHS Foundation Trust is monitored and delivered via the specific Mental Health Committee.

How did we perform?

The project completed a number of actions including:

Improve the sharing of patient information between the Acute Trust and Mental Health services:

The Trust's senior Paediatric Nursing Team, including the Nurse Director of the Family and Women's Health Group and the Paediatrics Matron meet with senior managers from Humber NHS Trust on a regular basis to discuss the mental health provision within the Trust and other relevant issues pertinent to CAMHS (Child and Adolescent Mental Health Services) provision within the Trust. In addition, CAMHS is an important feature in the patch wide Safeguarding Children's Board where CAMHS waiting times, service delivery and risks are all escalated and discussed.

The Trust's internal Safeguarding Committee manages, escalates and disseminates issues, risks and actions in relation to Mental Health and CAMHS across the organisation and facilitates the approval of policies and guidelines in relation to CAMHS.

All children with Mental Health needs have an individual care plan appropriate to their needs, including risk assessments undertaken to eliminate potential self-harm:

In 2016 the CQC instructed the Trust to put actions in place in relation to the completion of risk assessments for children with mental health concerns whilst in hospital. In 2018 and 2019 several audits were completed to review the quality of these risk assessments.

The audits undertaken during 2018/19 demonstrated a good level of performance; Q2 100%, Q2 85.5% and Q4 100%. The audit was undertaken again during Q1 of 2019/20 and it demonstrated 96.6% compliance. It was therefore agreed that these audits were not required to be completed every quarter and they would be transferred to an annual audit programme.

All mental health training is recorded centrally:
The teacher practitioners for Paediatrics records all the training, visits and ad hoc sessions delivered by the local CAMHS teams or Humber Mental Health NHS Trust to paediatric staff. This ensures there is a robust record of training.

The Service Level Agreement for adult Mental Health with Humber Mental Health Trust is monitored and delivered via the specific Mental Health Committee:
The first Mental Health, Learning Disabilities and Autism Committee was held in February 2020 and are scheduled to take place on a bi-monthly basis. The committee has a remit of assuring the Trust's Operational Quality Committee on the oversight and management of all matters relating to the care and treatment of patients with Mental Health Illness, Learning Disabilities and Autism. This also includes Perinatal Mental Health, Mental Health Liaison, and Dementia, CAMHS, Suicide Prevention and Acute care. The committee is also responsible for ensuring the delivery of the National and Local strategy for Mental Health, Learning Disabilities and Autism.

The indicators below were the measure for success for this aim, along with the other achievements detailed in this report:

Indicator	Baseline 2018/19	Performance 2019/20
95% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm	100%	96.6% ✓
Established bi-monthly Mental Health Committee	Held	Complete ↗

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

The following indicators were discontinued throughout the year as it was agreed that they were not required to provide assurance that the aim had been met:

- Quarterly operational working group with Child and Adolescent Mental Health Services leads and HUTH Children's Service held from August 2019
- 95% compliance with paediatric relevant staff trained in Child and Adolescent Mental Health Services (CAMHS)

Going forward

This priority will be carried forward for further action and monitoring.

The remit of the Mental Health, Learning Disabilities and Autism Committee will ensure that all of the aims detailed above will be monitored and re-visited if required.

Improved Experience: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To improve the experience of staff working in the Trust's outpatient areas

Why was this important?

NHS Employers says "How staff feel when they are at work is key to the successful delivery of high quality patient care. Evidence shows us that having engaged, healthy staff leads to increased productivity and an overall happier workforce". The Trust understands how important staff are and this is therefore reflected in the Trust's vision of 'Great Staff, Great Care, Great Future'.

NHS England's 'The Patient Experience Book' states that "Patient experience is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care." Therefore, the staff and patient experience within the Trust's outpatient areas are of specifically importance. In addition, following the 2018 CQC inspection the CQC instructed the Trust to put actions in place to ensure there were mechanisms in place to monitor patient waiting times in clinics.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to use learning tools such as staff and patient complaint and survey data to improve the outpatient service and improve the availability of data on wait times in clinics.

How did we perform?

The project completed a number of actions including:

Clinic Waiting Times Audit:

At the Trust's CQC inspection in February 2018, the Trust was issued an action to ensure that there was a mechanism in place to monitor clinic waiting times. An audit was implemented to monitor the percentage of outpatient clinics that were on time, early or late. The results of the audits were reported to the Outpatient Governance Committee for information and further action, where required.

Two clinic waiting times audits were undertaken in 2019, the first in May 2019 and the second in November 2019. The results indicate that over 70% of clinics start on time or early. The second audit showed a further increase from 71.6% to 74.8%. Although the target to achieve 85% improved clinic waiting times was not achieved, the results from these two audits demonstrate a good rate of progress and therefore, this will now be transferred to the organisation's annual audit plan.

Staff and Patient Experience:

Outpatient staff have taken part in a number of Trust and national surveys. The provisional results prompted the inclusion of several clinic staff attending the Trust's 'Great Leaders' programme. A more targeted staff survey will be completed next year to follow on from the initial survey and to identify additional actions to further improve staff experience within the Outpatient areas.

The results of the Patient Experience and Staff Experience Fundamental Standards for Outpatients were very positive, with consistent scores of between 95-100% wards rated green and blue (which are the highest pass ratings). This is supported by the Friends and Family scores over the year for outpatient services (98%). A patient representative is an active member of the Outpatient Governance Committee and remains a progressive link between our outpatient services and our patient council. Attendees of the committee

are encouraged to share positive or negative patient stories and complaints, to provide examples of good care or areas for improvements. This provides an excellent opportunity for processes to be updated and learning shared.

The project success was measured by the monitoring of a number of key indicators. These are detailed below along with how the Trust performed:

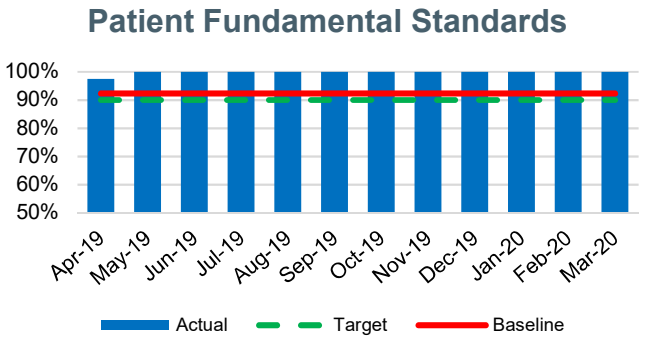
Indicator	Baseline 2018/19	Performance 2019/20	
90% of OP areas rated green or blue Patient Experience Fundamental Standard	92.3%	99.8% average	✓
90% of OP areas rated green or blue Staff Experience Fundamental Standard	92.5%	96.7% average	✓
Outpatient Governance Committee held monthly	Achieved	Achieved	✓
98% Friends and Family Test Scores for Outpatients	98%	98% average	✓
Increase in positive compliments or comments on NHS Choices	41	31	X
75% of clinics on time or early	No baseline	73.2% average	↗

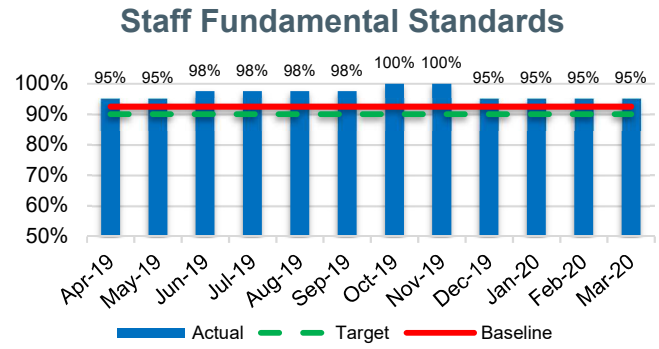
Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

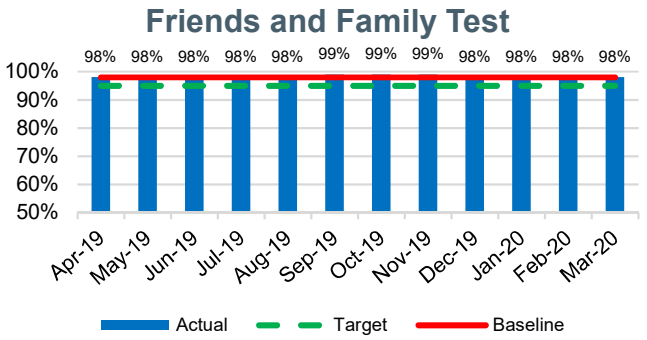
Going forward

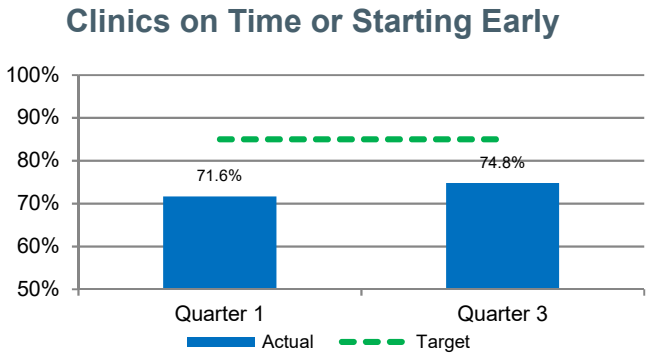
This priority will be carried forward for further action and monitoring.

The Trust's Outpatient Governance Committee will ensure this priority is taken forward throughout the coming year and be further developed as required.









Improved Experience: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

Priority: To listen to and act on patient experience to improve services

Why was this important?

The Trust welcomes all compliments, comments, concerns and complaints from users of the services provided, as this is essential to contribute to the highest standards of care for patients. Feedback, both positive and negative is valued, as this gives the Trust opportunity to review and implement changes to continually improve the delivery of care. In accordance with the NHS Constitution, the Trust is committed to providing a high quality of care, listening to the feedback received and learning from any mistakes made. All of this links to the Trusts vision of 'Great Staff, Great Care, Great Future' which is supported by the organisational values of 'Care, Honesty, Accountability'.

What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to reduce the number of re-opened complaints due to dissatisfaction and to facilitate a process to address all recommendations from the NHS Patient Survey 2018 and the Mersey Internal Audit Agency Complaints Management Review.

How did we perform?

The project completed a number of actions including:

Reducing the number of re-opened complaints due to dissatisfaction:
The Patient Experience Forum was disbanded and a formal Patient Experience and Engagement Committee was established. Its first meeting took place in January 2020.

NHS Patient Survey 2018:
A working group was established to address any actions from the NHS Patient Survey 2018. The results were received in June 2019, they were reviewed and an action plan was put into place to address the areas for further improvement. This is monitored by the Patient Experience and Engagement Committee. HUTH was rated 33 out of the 77 Trusts for positive feedback by Picker. The top five positive scores were linked to patients were able to discuss their concerns with staff, they did not wait for beds during admission, no noise at night, discharge arrangements and delayed discharge. The top five negative scores were linked to planned admissions, information received from staff within ED, hospital food, overall views and information regarding concerns.

Mersey Internal Audit Review:
The actions from the Mersey Internal Audit Agency Complaints Management Review are included in reporting at senior level committees against the Trust's targets for responding to complaints, lessons learnt and complaints outcomes. During 2019 these were included in the regular patient experience reports to the Trust Board.

The project also completed a number of additional actions including:

- The Patient Experience Team have recorded a significant reduction on Interpreter spend, particular from the introduction of remote interpreter services. The Electronic Video Link Interpreter system was nominated for an award with HSJ for Technology.

- The numbers of volunteers within the Trust continue to increase, with a number of projects established or gaining pace through the year. This includes; dining companions, which is a

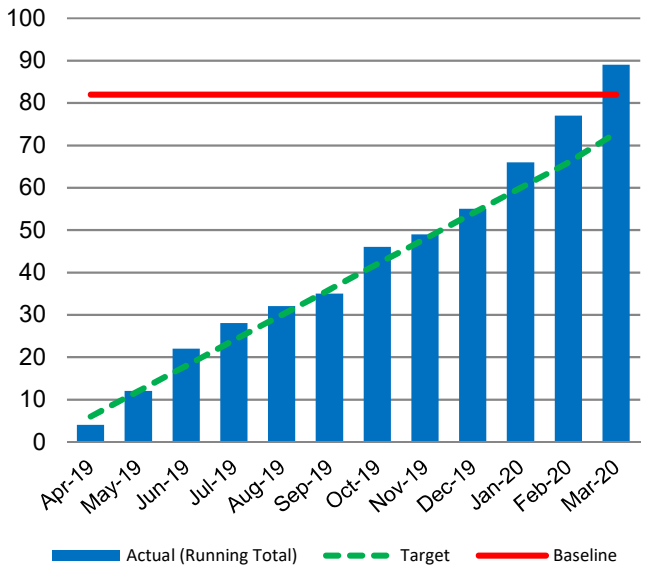
cohort of volunteers with a specific remit for nutritional support of patients, Reading Room volunteers to provide stimulation to patients and the re-distribution of volunteers to high risk areas across the Trust in busy times such as winter pressures to provide additional support.

The project success was measured by the monitoring of one key indicator

Indicator	Baseline 2018/19	Performance 2019/20
Reduce the number of reopened complaints due to dissatisfaction by 10% from the baseline (73.8)	82	89 X

Key			
Achieved	✓	Did not Achieve	X
Improvements made against baseline	↗	Discontinued	
All baselines were taken from March 2019 or as stated annually			

The Trust reported 89 complaints re-opened due to dissatisfaction which was over the target of no more than 73. The target was not achieved and demonstrated deterioration from the baseline.



Going forward

This priority will be carried forward for further action and monitoring.

The experience and engagement of our patients is of utmost importance to us and all work undertaken within 2019/20 will continue to be built upon and expanded, along with other new actions to improve patient experience and engagement over the coming year.

This will be monitored by the Patient Experience and Engagement Committee.

2.2 Performance Against Other Quality and Safety Indicators

This section covers:

- Seven day services within the NHS
- Patient Safety Incidents
- Serious Incidents and Never Events
- Patient Safety Alert compliance
- NHS staff survey results
- Whistleblowing and freedom to speak up
- Duty of Candour

Seven Day Services in the NHS

What does it mean to provide seven-day services?

Seven-day services in the NHS is ensuring all patients who are admitted to hospital as an emergency, receive high quality and consistent care no matter what day or time of the week they enter a hospital. The seven-day services programme is designed to improve hospital care with the introduction of seven-day consultant-led services that are delivered consistently over the coming years.

Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are the four standards that all NHS Trusts must adopt and implement by 2020. Implementation of these standards is monitored by NHS Improvement.

The four standards are:

- **Standard 2** – Time to first consultant review
- **Standard 5** – Access to diagnostic tests
- **Standard 6** – Access to consultant-directed interventions
- **Standard 8** – On-going review by consultant twice daily if high dependency patients, daily for others

What do seven-day services mean to patients?

Implementation of the four priority clinical standards will ensure patients:

- Do not wait longer than 14 hours to initial consultant review
- Get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
- Get access to specialist, consultant-directed interventions
- With high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

Monitoring of the Clinical Standards at Hull University Teaching Hospitals NHS Trust

The Trust has undertaken a stocktake of progress against compliance with the four priority clinical standards and is working to achieve full compliance.

Standard	Compliance	Actions to address
Standard 2 - Time to First Consultant Review	Non-compliant	• Explore opportunities to strengthen the electronic recording of consultant reviews through further development of Lorenzo. *It is noted that this action is on the roadmap for future upgrades to Lorenzo, but is not likely to take place within the next 1-2 years.* • Communicate to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity. *This action was undertaken following the March*

Standard	Compliance	Actions to address
		2019 audit and report and was reiterated prior to the most recent audit. • Undertake specific work with each specialty to address shortfalls in delivery. *It is proposed to target the Acute Medical Unit and General Surgery (H6/H60) during December with a service specific audit focusing on the patient pathway and documentation over a weekend (Friday to Sunday).* • Adoption of standardised model for the identification of those patients requiring/not requiring a consultant review. *The model was circulated to the Health Groups for adoption. The August 2019 audit has demonstrated a need for the delegation of daily reviews to be formally recorded in the patient record to enable the auditors to take the delegated review into account.*
Standard 5 - Diagnostic Services	Compliant	The latest results demonstrate a significant improvement on the previous position and reflect the work that has been done to increase CT and MRI capacity and reporting turnaround times, no further actions required.
Standard 6 - Consultant-directed interventions	Compliant	No actions required
Standard 8 - On-going review	Non-compliant	Actions are reported above in standard 2

Patient Safety Incidents

The Trust encourages incident reporting and believes that a strong incident reporting culture (i.e. a high level of incident reporting), is a sign of a good patient safety culture.

Figure 1 is taken from the latest NHS England National Reporting and Learning Service (NRLS) data report published March 2020. This shows our incident reporting rates compared to other acute Trusts of a similar size. Our Trust is highlighted below and shows no evidence for potential under-reporting of incidents.

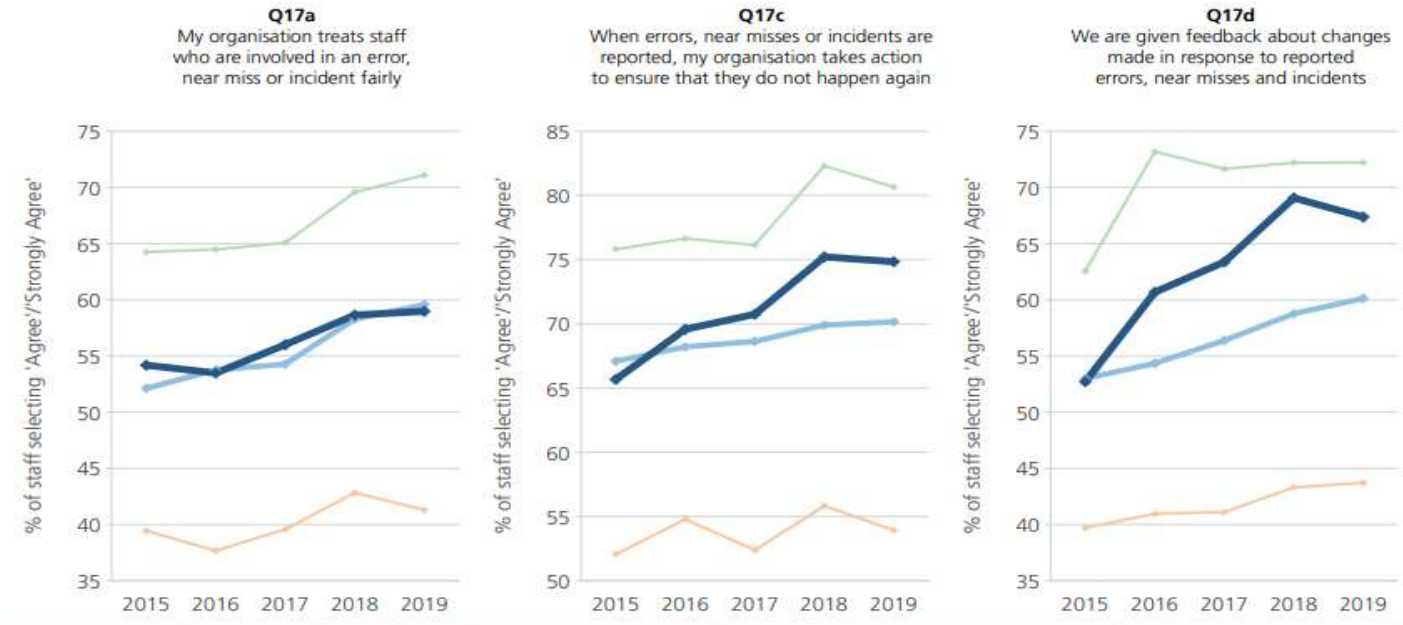
The NRLS report states that incident reporting patterns should be interpreted alongside other information such as the NHS Staff Survey results on reporting culture and practice.

The Trust's 2019 NHS Staff Survey results, again published in March 2020, has shown a slight deterioration in how staff feel about the Trust's patient safety culture, however the Trust is in line with national results and remains above national average.

The results continue to show that:

- ✓ ***We treat staff involved in an error, near miss or incident fairly***
- ✓ ***When errors, near misses or incidents are reported, we take action to ensure that they do not happen again***
- ✓ ***Staff are given feedback about changes made in response to reported errors, near misses and incidents***

Figure 2; extract from 2019 Staff Survey Results



	2015	2016	2017	2018	2019
Best	64.3%	64.5%	65.1%	69.6%	71.1%
Your org	54.2%	53.5%	56.0%	58.6%	59.0%
Average	52.1%	53.8%	54.3%	58.3%	59.6%
Worst	39.4%	37.7%	39.6%	42.8%	41.3%

	2015	2016	2017	2018	2019
Best	75.8%	76.7%	76.2%	82.3%	80.7%
Your org	65.7%	69.6%	70.8%	75.2%	74.8%
Average	67.1%	68.2%	68.6%	69.9%	70.2%
Worst	52.1%	54.8%	52.4%	55.8%	53.9%

	2015	2016	2017	2018	2019
Best	62.6%	73.2%	71.6%	72.2%	72.2%
Your org	52.7%	60.7%	63.4%	69.1%	67.4%
Average	53.0%	54.3%	56.4%	58.8%	60.1%
Worst	39.7%	41.0%	41.1%	43.3%	43.7%

Serious Incidents and Never Events

A Serious Incident (SI) is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. These are all events that the Trust believes to be worthy of investigation by an Independent Panel and/or fall into the category of an incident that must be reported to the local Commissioning agencies.

Some Serious Incidents are called Never Events (NE). Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Total number of Never Events and Serious Incidents (SIs) declared 2017/18, 2018/19 and 2019/20:

	2017 / 18	2018 / 19	2019 / 20
Total Never Events declared	6	0	8
Total Serious Incidents declared	60	71	58
Total*	**66**	**72***	**66**

** Excludes any which have been de-escalated from Serious Incident status*

The Trust declared 7 Never Events in 2019/20; more than in any other previous reporting period. During 2018/19 the Trust did not declare any Never Events. The way the Trust investigates Never Events has evolved this year with the introduction of simulation events. The simulation events allow for a scenario based investigation with the staff involved in the incident to re-enact the event and gain an understanding of why the incident happened. This allows staff to identify contributory factors and to establish what could be learned and actioned to prevent such Never Event's occurring again. Simulation events utilise the '5 whys' technique and cause and effect (fishbone diagram) to analyse the findings of the simulation and discussion.

One of the ways the Trust is improving its patient safety culture is by adopting the 'Just Culture' approach to staff involved in incidents. Just Culture is a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame. The Trust wants to ensure that staff feel supported when mistakes do happen, which will allow for lessons to be learned to prevent the same errors being repeated.

The Trusts approach to Serious Incident investigations continues to evolve, with this year a focus being on how patients and families are involved in the investigation process. Patients and their representatives are regularly invited to ask questions to the investigation panel, the answers to which are incorporated into the final report. Meetings are often held with patients and their representatives during and following investigations to allow them to be part of the investigation.

The Trust will continue to be open and honest when Serious Incidents, and Never Events, do occur, to ensure that these are fully investigated, with appropriate actions taken as a result. The Trust is committed to providing the best care to our patients and our responses to the Serious Incidents and Never Events are much improved and the learning and actions arising from the investigations is helping to improve the patient safety within the organisation.

Types of Serious Incident (SI) and ever Events declared during 2017/18, 2018/19 and 2019/20

Serious Incident type	2017 / 18	2018 / 19	2019 / 20
Treatment Delay	11	13	2
Treatment Delay – lost to follow up	8	0	0
Patient Fall	2	3	3
Delayed Diagnosis	1	8	16
Pressure Ulcer	8	7	7
Surgical/Invasive Procedure incident	7	3	4
Sub-optimal care of the deteriorating patient	3	6	2
12 hour Emergency Department trolley breaches	0	0	0
Drug Incident	1	4	3
Unexpected Death	10	8	11
Health Care Associated Infection (HCAI)/Infection Control Incident	1	0	0
Never Event – Retained Foreign Object	0	0	1
Never Event – Wrong Site Surgery	3	0	4
Never Event – Misplaced Naso-gastric Tube	0	0	1
Never Event – Wrong Implant	1	0	0
Never Event – Surgical Invasive Procedure	1	0	0
Never Event – Medication Incident	1	0	0
Never Event – Unintentional Connection to Air Flow meter	0	0	1
Retained dressing (not a Never Event)	0	0	1
Retained foreign object (not a Never Event)	0	1	0
Wrong Site Surgery (not a Never Event)	0	1	0
Unplanned NICU admission	4	1	0
Absconded Patient	0	0	0
Maternity/Obstetric Incident *(prior to 17/18 these SI's were reported under different categories)*	5	8	5
Others	0	9	4
Totals	**66**	**72**	**66**

2019/20 has seen an increase in the number of delayed diagnosis Serious Incidents declared and a reduction in the number of treatment delays. Some of the delayed diagnosis incidents then led to the patient not receiving timely treatment and therefore the incidents could fall into either category type. There is also a theme amongst the delayed diagnoses where test results were not acted upon in a timely manner, again resulting in treatment being provided as well as an increase in the number of wrong site surgery Never Events. A significant amount of improvement work has been undertaken as a result of the Never Events including re-enactments of the incidents with all staff members involved as a larger learning exercise, lessons learned have also been disseminated to all other areas via the Trust learning lessons newsletter.

Patient Safety Alerts Compliance

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued by NHS Improvement through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the National Reporting and Learning System (NRLS) and Strategic Executive Information System by NHS Trust and other health care providers and also from concerns raised by members of the public. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

NHS Improvement issue three types of alert, Warning Alerts issued in response to new or under-recognised patient safety issues which ask healthcare providers to take constructive action to reduce the risk of harm occurring; Resource Alerts issued in response to already well-known issues which ask health care providers to plan implementation of new resources and Directive Alerts, issued because a specific, defined action to reduce harm has been developed which can be widely adopted through standardisation of practice or equipment.

Coordination of patient safety alerts is carried out by the Quality Team who work with various Trust departments and Health Groups to facilitate compliance, and monitor on-going work or action plans used to address the issues raised.

NHS England NPSAS alerts issued 2019/20 and the Trust's progress

Reference	Alert Title	Issue Date	Deadline	Trust Response
NATPSA/2019/001/NHSPS	Depleted batteries in intraosseous injectors	05-Nov-19	05-May-20	Action complete and matter resolved
NATPSA/2019/002/NHSPS	Risk of death and severe harm from ingesting superabsorbent polymer gel granules	28-Nov-19	01-Jun-20	Action complete and matter resolved
NATPSA/2019/003/NHSPS	Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	13-Dec-20	11-Sep-20	Action complete and matter resolved
NATPSA/2020/001/NHSPS	Ligature and ligature point risk assessment tools and policies	03-Mar-20	23-Jun-20	Action complete and matter resolved

NHS Staff Survey Results

NHS Staff Survey Results

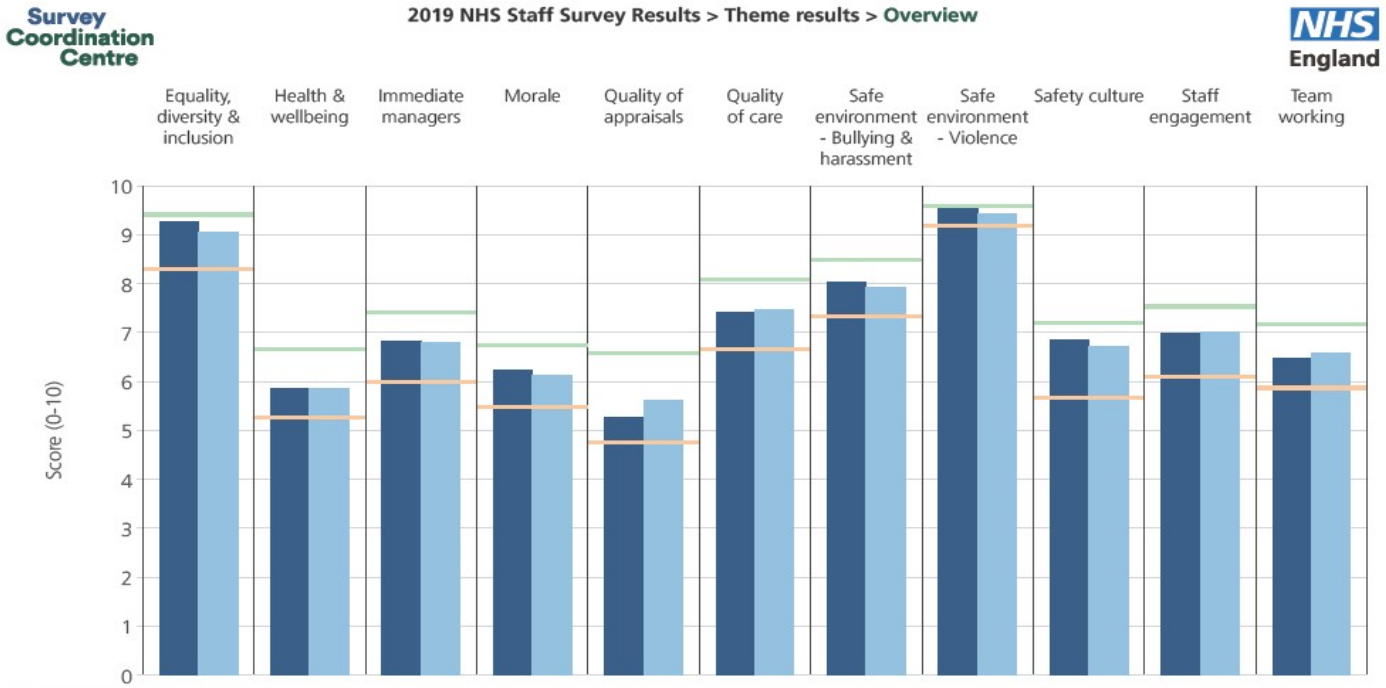
The 2019 NHS National Staff Survey ran during October and November 2019. This was a full census survey in which 3101 staff returned a survey, equating to 37% of the workforce. The response rate for the staff survey has decreased year on year since 2016 and the 2019 response rate was below the national average. An action plan is in place to further increase the response rate and engagement with the staff survey which is being monitored through the monitored via the Workforce Transformation Committee.

In the previous national staff surveys, 10 key themes were identified. This has been increased to 11 in the 2019 survey, with Team Working the new theme, the 11 themes are as follows:

- Staff Engagement
- Safety Culture
- Equality, Diversity and Inclusion
- Health and Wellbeing
- Immediate Managers
- Morale
- Quality of Appraisals
- Quality of Care
- Safe Environment – Bullying
- Safe Environment – Violence
- Team working

For each of the key themes, organisations receive a score out of ten.

Overall the Trust is better than or equal to the national average for eight of the eleven key themes in the National Staff Survey. Quality of Care, Team Working and Quality of Appraisals are worse scores than the national average. The following section of the report provides the Trust's performance compared with the national average, best score in the NHS and worst score in the NHS for each of the eleven key themes.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.3	5.9	6.8	6.2	5.3	7.4	8.0	9.5	6.8	7.0	6.5
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	3,089	3,098	3,094	3,088	2,669	2,757	3,076	3,090	3,091	3,101	3,073

Staff engagement:

This is a key indicator for the Trust which aspires to be in the top 20% of organisations in 2020 for staff engagement. The Trust has sustained a score of 7.0 in terms of engagement, while both the best and worst scores in the country have deteriorated.

Safety Culture:

While the Trust remains ahead of the national average for Safety Culture our score of 6.8 has deteriorated while the national average has improved.

Equality, Diversity and Inclusion:

For Equality, Diversity and Inclusion, the Trust's score of 9.3 has remained static since the 2017 survey. For the theme as a whole however, the Trust is performing better than the national average, and almost as well as the best performing Trusts in the country.

Health and Wellbeing:

For the Health and Wellbeing theme, the Trust is performing at the level of the national average, with a score of 5.9.

Immediate Managers:

The Trust score of 6.8 has remained the same and due to an improving national picture we are performing at the level of the national average.

Morale:

2019 is the second year that a theme for morale has featured in the staff survey. The Trust is ahead of the national average for this theme, with a score of 6.2, although our score has deteriorated slightly since 2018.

Quality of appraisals:

Overall the Trust is behind the national average for this theme, with a score of 5.3.

Quality of Care:

For the theme of quality of care, the Trust is performing slightly below the national average of 7.5, with a score of 7.4.

Bullying and harassment:

For the theme of bullying and harassment, the Trust has a score of 8.0, which is just slightly above the national average of 7.9, however both Trust and national performance has deteriorated slightly in the last year, although this is not a significant deterioration.

Violence:

For the theme of violence, the Trust is performing as well as the best organisations in the country with scores improving significantly in the last three years.

The National Staff Survey 2019 offers a clear indication of where the Trust needs to focus attention in the coming year. The following broad actions are included, amongst other, in the Trust's action plan which is monitored at the Workforce Transformation Committee:

- A number of waves of the Remarkable People Leadership Programme to be delivered in year
- Focus groups to be held with staff who identify themselves as having a disability or long-term condition
- Task and finish group established to address issues of concern regarding the quality of appraisals
- Review of staff networks for feeding back information to staff
- Register of networks to be established and a process for cascading information agreed
- Task and finish group established to address issues of bureaucracy and the difficulty staff have in delivering ideas for improvement

Whistleblowing and Freedom to Speak Up

Whistleblowing

In line with the NHS Constitution and Trust values, the Trust is committed to achieving the highest possible standards of quality, honesty, openness and accountability in all of our practices.

An important aspect of accountability and openness is a mechanism to enable employees, workers and volunteers to voice their concerns in a responsible and effective manner and for them to feel valued for doing so. Confidentiality is a fundamental term of every contract of employment, however, where an individual discovers information which they believe shows serious malpractice or wrongdoing within the Trust, this information should be disclosed without fear of reprisal.

Whistleblowing occurs 'when a worker raises a concern about dangerous or illegal activity that they are aware of through their work' (Public Concern at Work). A 'protected disclosure' is one where a worker must have a reasonable belief that their disclosure is in the public interest.

To qualify for the protection (a 'qualified disclosure') afforded by The Public Interest Disclosure Act 1998, staff must have a reasonable belief that one or more of the following matters is either happening, has taken place or is likely to happen in the future:

- a criminal offence
- the breach of a legal obligation
- a miscarriage of justice
- a danger to the health and safety of any individual
- damage to the environment
- deliberate attempt to conceal any of the above

In addition to the legal framework, in 2010 the NHS Staff Council agreed that 'Employees in the NHS have a contractual right and duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risk they consider to be in the public interest'. This change has been incorporated into the Terms and Conditions of Service Handbook for staff employees.

The Francis Report 'Freedom to Speak Up – A review of whistleblowing in the NHS' published in February 2015, clearly indicated that NHS staff did not feel safe raising their concerns about patient care that was being delivered. A key theme of the report was the requirement for openness, transparency and candour about matters of concern; the need for a 'just culture' as opposed to a 'no blame culture'.

Following on from the Francis Report, in April 2016 NHS England introduced 'The Freedom to speak up: raising concerns (whistleblowing) policy.' This policy was one of the recommendations from the Francis review and it aimed at improving the whistleblowing experience in the NHS.

The Trust's Raising Concerns policy incorporates the recommendations from the Francis Review stating that all staff are able to raise concerns at an any level, in the right way, and with the assurance that they will be dealt with properly. The Trust's Raising Concerns policy and governance arrangements are reviewed periodically by the Trust's Audit Committee to ensure the Trust continues to meet national requirements and expectations on supporting staff to speak up. Likewise, the Trust's policy has been subject to an internal audit review, which gave positive assurance that the Trust has effective arrangements in place to support staff to speak up.

Concerns may be raised via internal reporting processes, for example:

- DATIX (Incident Reporting tool)
- Line Manager
- Lead Clinician
- Matron
- Staff Side Representative
- Human Resources

- Occupational Health
- Chaplains
- Director of Corporate Affairs (Freedom to Speak Up Guardian)
- Staff Advice Liaison Service (SALS)
- Safeguarding Team

Concerns may be raised to the next level of management; for example:

- A member of a Health Group Triumvirate
- A Deputy/Assistant Director
- A Divisional General Manager/Divisional Nurse/Clinical Director
- Heads of Service
- Wellbeing Champions

Concerns may be raised to the most senior level of management; for example:

- A Chief/Director
- The Chief Executive
- A Non-Executive Director (NED) – the Senior Independent Director in particular has a role to support staff who need to blow the whistle
- The Director of Corporate Affairs (Freedom to Speak Up Guardian)

If the member of staff feels unable to report at any of these levels for any reason, or feels their concerns have not been addressed adequately at an earlier level, they may choose to report their concerns externally.

Concerns may be raised with an external regulatory body (which includes prescribed bodies or persons). The Trust would urge staff to allow the Trust the opportunity to investigate and resolve the concerns prior to reporting externally if at all possible. If the investigation finds the allegation is unsubstantiated and all internal procedures have been exhausted, but the member of staff is not satisfied with the outcome, the Trust recognises the lawful rights of employees to make disclosures to prescribed persons. In order to maintain the protection afforded by the Act, disclosure other than to the Trust must be made to prescribed bodies or persons and the Trust encourages staff to notify the Chief Executive of their intention to disclose their concerns externally. The Trust also encourages staff considering this course of action to seek advice from the Trust's Freedom to Speak up Guardian.

Freedom to Speak Up

In 2017, the Trust appointed Carla Ramsay as the Freedom to Speak up Guardian. Carla has worked for the Trust since 2016 and is the role of Director of Corporate Affairs. Carla in her role as the Freedom to Speak up Guardian is available to support any colleague who is concerned about an issue that affects patient care, and if they are not sure about how to raise this issue in the organisation.

Speaking up about colleagues' behaviours can be very difficult. Likewise, raising questions about patient safety can also be intimidating, as staff may be worried about the reaction from colleagues. If staff find themselves in this position, they are encouraged to contact the guardian, or the Staff Advice and Liaison Service (SALS), in confidence to talk through the issue and to receive support.

The Freedom to Speak up Guardian reports directly to the Trust Board on their work on a quarterly basis. This includes the types of concerns being raised through this role and through SALS, so that the Trust Board is sighted on the issues being raised up in the organisation. This information is published with the Trust's public Board papers and a full-year review is included in the Trust's Annual Report.

Freedom to Speak up Guardians is supported by the National Guardian's Office (NGO). The NGO's office undertakes Trust reviews of the culture of speaking up in individual Trusts and publishes these reviews as case studies for cross-NHS learning. These are reviewed by the Trust's Freedom to Speak up Guardian and included in the updates to the Trust Board. In addition, the NGO publishes a 'speaking up index', which measures positive speaking up cultures in each NHS organisation. Hull University Teaching Hospital NHS Trust's current index shows a positive speaking up culture and that staff know how to, and feel able to raise concerns.

Duty of Candour

What is Duty of Candour?

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing patients about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

How is the Trust Implementing Duty of Candour?

The Duty of Candour requires the provision of an apology, both verbal and written and feedback to the person affected, detailing the findings of the investigation and what actions are to be taken to avoid future occurrences of a similar nature. This requirement is detailed within the Trust's Being Open when Patients are Harmed Policy (Duty of Candour) for staff to follow, which states that the ten principles of Being Open must be applied to any incident, complaint or claim occurring as a result of healthcare treatment within the Trust resulting in harm to the patient. This policy is also supported by the Datix incident investigation training which is available for all staff to complete.

Duty of Candour is monitored within the Trust's Quality Governance and Assurance Department, who ensures that response to patients and their representatives, is sent in a timely manner, and to check the quality and content of letters, to ensure that information sent to the patient and their representatives is open and honest. Compliance is monitored and reported to the Health Groups and Operational Quality Committee for assurance and action.

What is the Trust's compliance with Duty of Candour with the CQC?

The CQC assessed the Trust in June 2016, February 2018 and March 2020 against the Duty of Candour requirements. The CQC found that staff were aware of their responsibilities under the Duty of Candour requirements and that the Trust is compliant with CQC Regulation 20: Duty of Candour.

The Trust expects that a verbal and written apology is given within 10 days of the incident occurring, and that a written explanation of the incident is sent within 10 days of the completion of the incident investigation. This compliance is monitored against a target of 90% compliance, allowing for those incidents which require more time to provide an open and honest apology and response.

Duty of Candour compliance rates

From April 2019 to March 2020 537 incident investigations were completed that required Duty of Candour. This is because they were rated moderate or above and fit the Duty of Candour requirements.

Verbal apology

A verbal apology was offered for 516 (96.1%) of the 537 incidents. Of the 516 apologies that were offered, 491 (95.2%) were within 10 working days.

Written apology

On 208 occasions, when offered verbal apologies the patient's/families expressed they did not a written apology or feedback letter. Of the 329 incident investigations that required a written apology, 305 (92.7%) were sent. Although written apologies are sent, when requested, many of these are not within the 10 working days' timeframe. Of the 305 written apologies sent, 188 (61.6%) were sent within 10 working days. On average the remainder were sent within one month of the incident occurring.

Further work is being undertaken during 2020/21 to ensure apologies are received within reasonable timescales.

Written feedback on completion of investigation
Although feedback letters are sent, many of these are not within the 10 working days of the investigation being concluded. Of the 329 incident investigations that required a written feedback, 279 (84.8%) were sent. Of the 279 written feedback letters sent, 257 (92.1%) were within 10 working days.

Overall monthly 10 working day compliance for April 2019 to March 2020 is detailed in the table below:

Duty of Candour	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Verbal	95.5%	94.8%	98.1%	91.8%	97.0%	90.6%	95.7%	97.5%	95.1%	96.7%	95.3%	94.4%
Written	70.0%	73.7%	60.0%	67.4%	68.2%	55.0%	64.0%	55.6%	60.9%	52.6%	46.9%	53.3%
Feedback	85.7%	93.3%	84.0%	95.1%	100.0%	63.2%	95.8%	100.0%	95.0%	100.0%	93.1%	100.0%

2.3 Statements of Assurance From the Board

This section covers:

- Review of services
- Participation in clinical audits
- Participation in clinical research
- Goals agreed with our commissioners: use of the CQUIN payment framework
- What others say about the Trust: CQC
- Secondary Uses Service: NHS number and general practice code validity
- Information Governance
- Payment By Results Clinical Coding Audit
- Data Quality Improvements
- Learning from Deaths Update
- Reporting against core indicators - NHS Digital

Review Services

During 2019/20 the Hull University Teaching Hospitals NHS Trust provided and/or sub-contracted 40 NHS services within 5 Health Groups and 14 Divisions.

The Hull University Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 40 of these NHS services.

The income generated by the NHS services reviewed in 2019/20 represents 100% of the total income generated from the provision of NHS services by the Hull University Teaching Hospitals NHS Trust for 2019/20.

Clinical Audits – Participation

During 2019/20, 55 national clinical audits and 5 national confidential enquiries covered NHS services that Hull University Teaching Hospitals NHS provides.

During that period Hull University Teaching Hospitals NHS Trust participated in 96% of the national clinical audits and 100% of the 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 Hull University Teaching Hospitals NHS Trust was eligible to, and participate in during 2019/20 are listed below.

The national clinical audits and national confidential enquiries that Hull University Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry is listed in the last column.

Audit:	Participated	% of Cases Submitted
Peri- and Neonatal		
National Neonatal Audit Programme (NNAP)	✓	100%
National Maternity and Perinatal Audit (NMPA)	✓	100%
Children		
Care of Children in Emergency Departments - College of Emergency Medicine)	✓	100%
National Paediatric Diabetes Audit (NPDA)	✓	100%
National Audit of Seizures and Epilepsies in Children and Young People	✓	100%
Acute care		
Mental Health – Care in Emergency Departments	✓	100%
National Emergency Laparotomy Audit (NELA)	✓	93%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	✓	100%
Adult Critical Care (Case Mix Programme – ICNARC)	✓	100%
National Asthma and COPD Audit Programme	✓	100%
National Audit of Seizure Management in Hospitals (NASH3)	✓	100%
National Audit of Care at the End of Life (NACEL)	✓	66%
Long term conditions		
Diabetes (National Adult Diabetes Audit)	✓	100%
Diabetes in Pregnancy Audit	✓	83%
Diabetes Footcare Audit	✓	100%
National Diabetes Inpatient Audit (NADIA)	✓	100%
NaDIA-Harms (Diabetic Inpatient Harms in England)	✓	100%
Inflammatory Bowel Disease Programme / IBD Registry	✓	Approval is waiting from the IT Programme Board. Once this has been granted, procurement of the system will take place. It is hoped the Registry will be up and running

Audit:	Participated	% of Cases Submitted
		later this year
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	✓	100%
British Association of Urological Surgeons (BAUS) Urology Audit – Female Stress Urinary Incontinence	✓	100%
UK Cystic Fibrosis Registry	✓	100%
National Smoking Cessation Audit	✓	100%
Neurosurgical National Audit Programme	✓	100%
National Audit of Dementia	✓	100%
UK Parkinson's Audit	✓	100%
National Ophthalmology Audit	X	The Trust does not have the relevant software but runs its own independent Departmental Cataract Surgery outcomes audit. Getting It Right First Time (GIRFT) was happy with this approach. The Trust is aiming to integrate the software and take part in the audit later in the year
Elective procedures		
National Joint Registry (NJR)	✓	100%
National Audit of Percutaneous Coronary Interventions (PCI)	✓	100%
National Vascular Registry	✓	99%
BAUS Urology Audit - Nephrectomy	✓	100%
BAUS Urology Audit – Radical Prostatectomy	✓	100%
BAUS Urology Audit - Cystectomy	✓	100%
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	✓	100%
Perioperative Quality Improvement Programme (PQIP)	✓	100%
Adult Cardiac Surgery Audit (ACS)	✓	100%
National Bariatric Surgery Registry (NBSR)	✓	66%
Heart		
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	✓	100%
National Heart Failure Audit	✓	69%
Cardiac Rhythm Management (CRM)	✓	100%
National Cardiac Arrest Audit (NCCA)	✓	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	✓	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	✓	100%
Oesophago-gastric Cancer (National O-G Cancer Audit)	✓	100%
National Prostate Cancer Audit	✓	100%
Head and Neck Audit (HANA)	✓	100%
Trauma		
Major Trauma (Trauma and Audit Research Network)	✓	100%

Audit:	Participated	% of Cases Submitted
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP)	✓	100%
National Audit of Breast Cancer in Older People (NABCOP)	✓	100%
Acute Stroke (Sentinel Stroke National Audit Programme - SSNAP)	✓	100%
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	✓	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Long Term Ventilation	✓	50%
Acute Bowel Obstruction	✓	75%
Dysphagia in Parkinson's Disease	✓	Ongoing
Out-of-Hospital Cardiac Arrest	✓	Ongoing
Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBBRACE – UK)		
Maternal Infant and Perinatal Programme (MBBRACE-UK)	✓	100%

Clinical Audits – Actions

The reports of 23 national clinical audits were reviewed by Hull University Teaching Hospitals NHS Trust in 2019/20 and Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Proposed Actions
National audit	
Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP)	• To undertake a local audit on Bronchopulmonary Dysplasia • Monthly breastfeeding statistics, including any learning points to be emailed out to all NICU staff
National Chronic Obstructive Pulmonary Disease Audit (COPD)	• To review current performance against the standard for oxygen performance (through the NACAP online tool
Lung Cancer (National Lung Cancer Audit)	• To contact the Multi-Disciplinary Team (MDT) Co-Ordinators to establish how Forced Expiratory Volume (FEV) is collected and recorded, in order to establish how data submission rates for this indicator can be improved.
Heart Failure (Heart Failure Audit)	• No further action required
National Diabetes Footcare Audit (NDFA)	• To share the results of the audit with Vascular Surgery, particularly in relation to the amputation rate.
National Diabetes Inpatient Audit (NaDIA)	• Implement a NaDIA Harms section on Datix (Incident Reporting Software) to ensure a more robust collection of diabetes-related harms data • To carry out a Trust-wide review on staff training relating to diabetes, as part of the Getting It Right First Time (GIRFT) programme • To implement the foot risk assessment tool • To continue with the development of a business case in order to provide 7-day cover by Diabetes Inpatient Specialist Nurses
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	• To implement a proforma to be completed by ward staff to ensure patients are screened for coeliac disease and carb counting on admission • To put together a business case to employ a dedicated paediatric diabetic dietician • To continue to work closely with patients with high HbA1c levels. Continuing one to one sessions in clinic and drop in sessions in schools. To review the high HbA1c policy with the MDT • To continue to do microalbumin tests at the time of the clinic appointment in paediatrics. This action was first implemented in 2018 and has already proven to be successful seeing figures rise from 49.1% in 2017/18 to 61.8% in 18/19
National Audit of Dementia – Spotlight Audit on Delirium Assessment	• To introduce the '4AT' test as part of the Trust wide delirium assessment • To include the '4AT' test in the medical clerking booklet alongside the 'SQiD' (Single Question in Delirium) • To introduce new dementia training across the Trust, for all staff members (including externally contracted staff). • To develop and distribute a dementia and delirium information leaflet for patients and carers • To raise awareness that finger food is available for dementia patients across the Trust • To establish a formalised network of Dementia Champions within the Trust • To establish a direct referral route to the Dementia Lead Nurse in order to provide support to patients/ carers and staff
National Cardiac Arrest Audit (NCAA)	• Continue to share learning from the NCAA dataset including ceilings of care and the prescription of appropriate resuscitation in the Consultant mandatory update training
Vital Signs in Adults (RCEM)	• No further action required
VTE Risk in Lower Limb Immobilisation (RCEM)	• To implement the VTE and Bleeding Risk Assessments • To review the content of the relevant Patient Information Leaflet
National audit	
Feverish Children (RCEM)	• To include various aspects of the sepsis tool and completion of observations within the mandatory sections of the new Electronic Patient Record through Lorenzo, to improve documentation

Audit	Proposed Actions
	• To raise awareness of the need to document wherever patients are provided with Patient Information Leaflets • To carry out an audit focused on paediatric patients that definitively require blood pressure monitoring, to establish compliance with the standards for these patients • To review the escalation processes in place for triage nurses, to provide quicker senior reviews where required
Myocardial Ischaemia National Audit Project (MINAP)	• To raise the issue of delays with both the Cardiac Network and the relevant Ambulance Services, particularly in relation to patients transferred into Castle Hill Hospital from other hospitals in the region
National Audit of Percutaneous Coronary Interventions (PCI)	• No further action required
Sentinel Stroke National Audit Programme (SSNAP)	• To explore potential opportunities for raising stroke awareness within the local GPs (e.g. through recorded lectures and posters to guide GP referrals) and communities • To ensure the attendance of the audit co-ordinator at the Multi-Disciplinary Team meetings, to ensure that rehabilitation goals are recorded for all patients • To carry out a patient survey seeking patient / carer views on stroke services • To gain agreement from MRI to provide a number of slots for use by Stroke Medicine, so that clinic attenders are able to access these tests in a timely fashion
National Prostate Cancer Audit (NPCA)	• To ensure all theatre notes are typed up onto Lorenzo. Each of the 6 key data items are to be recorded on typed operation notes or clinic letters for all new patients • To discuss with colleagues the potential over treatment of men with low-risk localised disease at the Urology Performance Meeting, however treatment received is down to patient choice
National Hip Fracture Database	• To establish a multidisciplinary group (including representatives from Orthopaedics, Orthogeriatrics, Elderly Medicine, Anaesthetics, Emergency Department, Nursing and Therapies), to ensure service improvements across all aspects of care for patients with hip fractures • To increase theatre capacity in order to improve the time to theatre for patients with hip fractures • To recruit and allocate increased resource to the collection of data for the National Hip Fracture Database, to improve overall data quality • To investigate the use of Sliding Hip Screw (SHS) in patients with intertrochanteric hip fractures • To investigate potential alternatives for reviewing patients 120 days post-surgery (e.g. telephone clinics) • To recruit further Orthogeriatric specialists • To ensure that physiotherapists record data on patient mobilisation in both physical and digital copies of the patient record • To discuss the use of nerve blocks in addition to general anaesthetic with the Neck of Femur group, to establish why HUTH use differs from the national data
National Oesophago-Gastric Cancer Audit	• To increase the proportion of patients that are managed endoscopically • To implement the guidance set out by NHS England in the 'Implementing a timed oesophago-gastric cancer diagnostic pathway' handbook
National Audit of Breast Cancer in Older People (NABCOP)	• No further action required
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	
Mental Healthcare in Young People and Young Adults	• Gap analysis to be presented at the CEPPD committee in October 2020
Pulmonary Embolism	• Gap analysis currently underway
Other Enquiries/Reviews	
MBRRACE-UK Perinatal Mortality Surveillance	• To introduce delayed cord clamping as standard practice • To increase compliance with antenatal steroids given before birth • To introduce the MBRRACE Perinatal Review Tool
Saving Lives, Improving Mothers' Care	• To develop a referral flowchart for the care of pregnant women with breast cancer and cardiovascular disease

Clinical Audits – Action Progress

An update regarding the implementation of the actions identified as a result of a national clinical audit report published in 2018/19 has been provided below. Actions taken in response to reports published in 2019/20 will be included in the Quality Accounts for 2020/21.

Proposed actions	Progress
Pain in Children (College of Emergency Medicine)	
To educate staff on carrying out and documenting pain scoring.	Training has been undertaken both face-to-face and via email. Posters have also been displayed
To educate staff on the documentation of analgesia given, and the importance of recording a reason wherever analgesia is not given.	
To amend the Casualty Card (CAS) card to include a section for documenting reasons for why analgesia has not been given	Action complete
To discuss the possibility of having pain scoring and analgesia added to the triage section of the patient's Lorenzo record	The pain score is part of the Lorenzo electronic system and will be on electronic observations when it is implemented in the Paediatric Emergency Department
To implement a system of patient-led evaluation of pain after analgesia. This will include education of nursing staff on the new system and the creation of posters to be shown in patient waiting areas to ensure that patients are aware of the system.	Action complete. Leaflets are given to patients at reception and at triage
To develop a business case for improved nursing cover, in order to improve triage times	Ongoing
To disseminate results to all Emergency Department staff, to raise awareness of the issues and key learning points	The results have been disseminated via email and presented at the senior staff executive forum
To undertake a re-audit and present the results to the Clinical Effectiveness, Policies and Practice Development Committee	This has been delayed until the new electronic observations system is in place
Procedural Sedation in Adults (College of Emergency Medicine)	
To introduce a proforma for patients undergoing sedation in the Emergency Department to ensure all relevant data is recorded	An electronic sedation proforma is now in use
National Diabetes Inpatient Audit (NaDIA)	
To explore the possibility of setting up a mandatory training module for all clinical staff on the subject of diabetes.	Ongoing
To communicate the importance of insulin timing and treatment to staff across the Trust (through Lessons Learned / Newsletter/ Pattie).	An insulin safety walk around the Trust was undertaken in December 2019 promoting correct injection technique and not omitting basal insulin. A Diabetes Safety Group has been set up to promote safe high quality care for in patients with diabetes. A quarterly newsletter will be launched in April 2020
To send a copy of the outcome form / report to the Trust Catering Services Manager, to ensure that the patient feedback included within the report (in relation to catering) is passed on.	Action complete
National Audit of Dementia (NAD)	
To carry out a Trust wide teaching session on delirium and dementia	Action complete
To re-audit the delirium screen and assessment	To be completed post phase 2 Lorenzo Digital Exemplar (LDE) switchover (digital/paperless working)
To arrange a meeting with the Lorenzo team to introduce a section on cognition on the Immediate Discharge Letter to enable transfer of information	Action complete. This work forms part of phase 2 LDE pathway
To undertake a junior doctor teaching session on delirium recognition and assessment (including history taking)	This has been completed as part of DME teaching, junior doctor induction and grand rounds
To provide a teaching session on the importance of filling out the dementia and delirium care bundle	This has been completed at numerous meetings including the nurse conference
National Hip Fracture Database (NHFD)	

Proposed actions	Progress
Theatre space will be increased as of February 2019. A further 7 theatre lists a week are to be available to the trauma service, including a dedicated hip fracture list every day. A new trauma consultant has also been employed.	The Trust now has an extra 7 trauma theatre lists and has appointed two substantive trauma consultants (starting June and August 2020). Two locums are currently in post
To speak to anaesthetic lead to determine whether the number of nerve blocks given during a General Anaesthetic (GA) can be increased.	Action complete
To remind the orthopaedic team that intertrochanteric fractures should be treated with a SHS as this is more cost efficient.	Action complete
To hold 'Time out' sessions to involving the various disciplines contributing to hip fracture care to review patient pathways.	A working group now meets monthly to develop the pathways
National Paediatric Diabetes Audit (NPDA)	
To liaise with HICOM and HEY IT Services to agree the pathology interface license for Twinkle system to improve data collection from Lorenzo to Twinkle.	IT Services have linked the systems and the new system will be up and running by Summer 2020
To ensure Micro albumin tests are now being done at the time of clinic appointment in the Paediatrics Department	The results of the most recent audit show that this figure has increased by 9% to 53%
To undertake a casenote audit to understand if there are any variances in practice between Hull CCG and East Riding CCG patient cohorts.	To be undertaken in Summer 2020
National Chronic Obstructive Pulmonary Disease Audit (COPD)	
To update the Trust Oxygen Policy, in line with RCP Guidance	The policy has been updated
To introduce a new Oxygen training package, in line with the new policy	This has been introduced and is mandatory for all clinical staff
A proforma for the initiation of non-invasive ventilation (NIV) in the Emergency Department has been introduced, featuring the NIV criteria, ceiling of care, time of initiation and other key information.	The proforma has been introduced in the Emergency Department
For the Acute Respiratory Assessment Service (ARAS) nurses to state clearly during reviews that follow-up arrangements should be clearly documented in the Immediate Discharge Letter (IDL), in order to improve data quality.	Action complete. ARAS initiate and arrange all follow up appointments to ensure patients are not missed
To explore the feasibility of visiting GP practices to assist in identifying patients that are receiving suboptimal care, in order to improve readmission rates	A pilot programme outreaching into GP practices to support asthma management has been undertaken. The results of this have been presented to the CCG
To pursue the possibility of Respiratory Medicine being able to have a protected bed base for Chronic Obstructive Pulmonary Disorder (COPD) patients	There is no protected bed base but COPD patients are admitted to respiratory where possible and if not, ARAS endeavour to review them
All spirometry results are now accessible from all desktop computers in the organisation. Further work is being carried out to ensure that spirometry results from tests carried out anywhere in the Trust are accessible via Lorenzo	Spirometry performed in Castle Hill clinics are available on Lorenzo, however this is not the case for spirometry performed in the chest clinic at Hull Royal Infirmary due to the equipment being used
Heart failure (Heart Failure Audit)	
To investigate the causes for low referral rate to Heart Failure Nurse follow up – particularly in patients with Left Ventricular Systolic Dysfunction (LVSD) patients	Patients are more frequently followed up by cardiology than by the Heart Failure nurses (this includes LVSD patients)
Sentinel Stroke National Audit Programme (SSNAP)	
To review cases where an eligible patient (according to the Royal College of Physicians guideline minimum threshold) is not thrombolysed	The Trust usually meets the standard for 100% of patients. However, there is a fortnightly meeting where patients who are not thrombolysed are discussed
To download Trust data prior to the submission deadlines, in order to review and ensure the quality of the thrombolysis data	This is routinely undertaken
To undertake an audit of swallow screening on the Stroke ward	An audit has been undertaken
To communicate with the Stroke Co-ordinators to highlight the need to refer all patients to Speech and Language Therapy that are marked as suffering dysarthria on the NIHSS (National Institutes of Health Stroke Scale)	Action complete

The reports of 114 local clinical audits were reviewed by the provider in 2019/20 and Hull

University Teaching Hospitals NHS Trust. For a full list of the proposed actions Hull University Teaching Hospitals NHS Trust intends to take following local audits reviewed during 2019/20, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address: quality.accounts@hey.nhs.uk or online via https://www.hey.nhs.uk/about-us/corporate-documents/#quality-account

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Hull University Teaching Hospitals NHS Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee or Health Research Authority was 3,137.

Commitment to research as a driver for improving the quality of care and patient experience

The Trust is committed to providing the best possible care to patients and recognises the value of high quality peer-review research as a fundamental tool in the successful promotion of health and well-being for the population it serves. To achieve this, the Trust has focused on research activities which addresses NHS priorities, is of national and international quality and is cost-effective.

Every study the Trust participates in will, in some way, have a direct or indirect benefit to institutions, staff, patients, carers, policy makers and academics. The collective benefits for our population of participating in research include more personalised, protocol driven care with often more frequent oversight of clinical outcomes and safety assessments. Frequently, research participation allows for increased interactions between clinical staff and patients, providing more time to make assessments of patients' needs and anxieties and therefore supporting a trusting relationship to flourish.

Research portfolio and activity

The Trust was involved in processing 103 new clinical research studies of which 84 commenced during the reporting period 2019/20. This compares with 127 new submissions and 73 commencing in 2018/19. Of the studies given permission to start, 94 were National Institute for Health Research (NIHR) portfolio adopted.

The Trust has 143 studies actively reporting patient recruitment under the NIHR Clinical Research Network (CRN) Portfolio, as compared to 142 portfolio studies reporting accruals for the period 2018/19.

The number of recruits into the Trust portfolio studies for the periods 2019/20 and 2018/19 was 2,493 and 4,210 respectively. The largest topic area of portfolio adopted studies across 2019/20 was Oncology (Cancer) and Haematology with 41 studies between them. The top five therapeutic areas of Trust research in 2019-20 (based on portfolio recruiting studies) were:

1) Oncology and Haematology (41)
2) Cardiovascular (26) (Cardiology Intervention + Academic, Cardiothoracic, Diabetes, Vascular, Respiratory)
3) Gastroenterology and Hepatology (16)
4) Musculoskeletal (7)
5) Trauma and Emergency Care (6); Surgery (6)

89% of commercial portfolio studies completed in 2019/20 recruited on time and to an agreed target. This has helped the Trust maintain a strong relationship with pharmaceutical and medical device companies that allows the Trust to be part of offering novel technologies and treatment to patients in more and more therapeutic areas.

Research Strategy

The Research and Innovation Strategy 2018-23 was approved by the Trust Board in July 2018. The Trust Research and Innovation Strategy will be delivered through three key priority themes:

A Research Aware Organisation

Achievements:

- Year 1 has focussed on generating institutional research awareness through metrics. The development of performance dashboards available on Pattie provides all staff with access to interactive, visually appealing reports that give

real-time data intelligence for planning and forecasting purposes.
- The dashboards have been operational from April 2019 with development work on-going to ensure they are robust and effective.
- Focus has been on involving Patient Research Ambassadors (PRAs) in co-design and review (via Trans-Humber Consumer Research Panel – hosted by HUTH).
- Excellent feedback in annual external Trust Research and Development R&D website review (2019).
- Patient Research Experience Survey (PRES) 2019 – Yorkshire and Humber (Y&H) CRN target reached.

Positive, Proactive Partnerships

Achievements:

- 'Cluster Arrangements' (clinical Synergies) for multi-morbidity research: Diabetes + Renal, ICU + Infectious Diseases, Cardiology + Interventional Cardiology + Cardiothoracic Surgery.
- 'Provisional' accreditation status for the Hull Health Trails Unit (HHTU) confirmed by the UK Clinical Research Collaboration (UKCRC). Full accreditation expected within 3 years.
- Formal contribution of R&D quality assurance support provided as part of development activities of HHTU including complex drug study setup.
- Supported the HHTU and University of Hull (UoH) Institute for Clinical and Applied Health Research (ICAHR) launch in March 2019
- HUTH currently sponsoring multiple NIHR grants with delegated management to HHTU.
- UoH acknowledged as core academic partner with Trust name change in March 2019.
- Strategic and operational support for HHTU and ICAHR.
- Aligned research focus (PET-CT, Palliative/Respiratory, Rehabilitation, Gastroenterology, Infectious Diseases supported as part of jointly funded 'Research Support Funding' initiative).
- Addictions Research Collaborative –support for development of alcohol addiction research (first joint study to be undertaken in Q4 2019/20).
- Y&H Academic Health Science Network (AHSN): (Innovate UK grant with Entia - medtech company (Renal Point of Care/telehealth/app), adoption of Accelerated Access Collaborative products (HeartFlow)).
- Y&N CRN - Strong focus in 'research relevant' specialties (Cardiovascular, Diabetes, Oncology, Respiratory and Renal).
- International Partnerships - HUTH signed an 'Agreement for Academic Exchange and co-operation' with Sri Ramachandra Institute of Higher Education and Research (SRIHER) Chennai, India in May 2019. This agreement has already yielded the following returns:
  - Overseas Simulation Fellow programme commenced in May 2019 with one SRIHER colleague visiting HUTH in May and June 2019.
  - Identification of 14 potential areas of research collaboration between the Trust and SRIHER (of which Microfluidics, Therapies/Rehabilitation, Infectious Diseases, Diabetes, Renal and clinical skills/simulation have already established strong links).
  - A Joint Research Conference in Chennai in February 2020. A delegation representing HUTH and UoH attended.

Reputation through Research

Achievements:

- 4 PhD Scholarships awarded in conjunction with UoH (2 Allied Health Professionals).
- 6 areas and individuals supported with protected time or methodological support following the award of 'Research Support Funding' from HUTH/UoH and Hull York Medical School (HYMS).
- 2 R&D Funded Clinical Research Fellows appointed (Renal and Cardiothoracic Surgery).
- 4 further Clinical Research Fellows (funded from NIHR RCF or other external sources – 2 in Orthopaedics, 1 in Gastroenterology (IBD)), 1 in Renal).
- Lead Research Nurse appointed October 2019.
- Vascular Allied Health Professional (AHP) leading an NIHR grant.
- Secured 1 NIHR Senior Investigator Award (Prof Chetter, Vascular Surgery)

- Secured multiple Academic Clinical Fellows (ACFs) in key clinical and academic areas for appointment in 2020.
- The Trust has continued to build capability and capacity with a number of new early career researchers and Principal Investigators. The NIHR have awarded the Trust with the following 5 ACF posts, for appointment in 2020:
  - ACF Clinical Oncology or Medical Oncology, under the Platform Science and Bioinformatics theme. To work under their supervision on molecular pathways of pancreatic cancer carcinogenesis from pancreatic cystic neoplasms to adenocarcinoma.
  - ACF Haematology, ST3 entry under the Therapeutics or Clinical Pharmacology theme. To work on targeted re-purposing of diabetes medicines to reduce thrombosis in patients with myeloproliferative neoplasms.
  - ACF Vascular Surgery, under the Older People and Complex Health Needs theme. To work on identifying changes in vascular inflammation associated with improved patient outcomes in peripheral arterial disease following structured exercise.
  - ACF General Surgery or Vascular Surgery (formula post, therefore, no theme and research plans not proposed in advance).
  - ACF Palliative Medicine (formula post therefore, no theme, and research plans not proposed in advance).

Goals Agreed With Our Commissioners: Use of the CQUIN Payment Framework

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience and improvements against outcomes.

Use of the CQUIN payment framework

A proportion of Hull University Teaching Hospitals NHS Trust income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Hull University Teaching Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

There are no local Clinical Commissioning Group (CCG) schemes as there are several national CQUIN schemes mandated to all Trust's to deliver in 2019/20.

The breakdown of the National CQUIN indicators is based on 1.25% of contract value.

National CQUIN schemes 2019/20 for CCGs include:

- Staff Flu Vaccinations
- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery
- Alcohol and Tobacco – Screening and brief advice
- Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia

NHS England Specialised Services (NHSE):

The Trust receives a CQUIN value of 1.25%. The CQUIN payment will be based on actual contract expenditure; however, CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Tariff Payment System and all other expenditure contracted on a "pass through" basis. CQUIN funding for the Hepatitis C Operational Delivery Network previously paid via a top up of 0.65%.

The NHSE specialised schemes of 2019/20 include:

- Hepatitis C Operational Delivery Network (ODN)
- Rethinking Conversations
- Medicines optimisation
- Enabling Thrombectomy
- Immunoglobulin stewardship

Public Health England (PHE) has used the national CQUINs for 2019/20.

Due to the COVID-19 pandemic, national guidance was produced advising Commissioners and Trusts to take a pragmatic approach to the agreement of the final payments amounts for the 2019/20 CQUIN schemes based on available data. There were no formal requirements for the Quarter 4 (Q4) 19/20 reports to be submitted and therefore, the Trust received its Q4 19/20 payments in full. With no data available for Q4 19/20, there was an assumption that schemes that had previously failed would also fail in Q4 19/20. The following table details the CQUIN's for 2019/20.

2019/20 National Achievement:

CQUIN Indicator / No.	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Expected £ 4,402,978	Under Achieved £
1a AMR Older People	Failed	Failed	Failed	Failed	550,407	550,407
1b AMR Colorectal Surgery	Failed	Achieved	Achieved	Achieved	550,352	137,602
2 Improving the uptake of flu vaccinations for frontline clinical staff **Annual target**	Not required	Not required	Not required	Achieved	1,100,813	
3a Alcohol and Tobacco Screen	Failed	Failed	Failed	Failed	366,901	366,901
3b Tobacco Advice	Achieved	Achieved	Achieved	Achieved	366,901	
3c Alcohol advice	Failed	Failed	Failed	Failed	366,901	366,901
11aSDEC pulmonary Embolism	Achieved	Achieved	Achieved	Achieved	366,901	
11b SDEC AF	Achieved	Achieved	Achieved	Achieved	366,901	
11c SDEC Pneumonia	Achieved	Achieved	Achieved	Achieved	366,901	
				Total	**4,036,077**	**1,421,811**

2019/20 NHS England Specialised Achievements:

CQUIN Indicator / No.	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Expected £ 2,114,573	Under Achieved £
PSS1 Medicines Optimisations Trigger 1	Not Required	Achieved	Achieved	Achieved	115,001	
PSS1 Medicines Optimisations Trigger 2	Achieved	Achieved	Achieved	Achieved	92,000	
PSS1 Medicines Optimisations Trigger 3	Achieved	Achieved	Failed	Failed	161,001	80,500
PSS1 Medicines Optimisations Trigger 4	Not Required	Achieved	Achieved	Achieved	92,000	
PSS2 Hepatitis C Trigger 1	Partially Achieved	Partially Achieved	Partially Achieved	Partially Achieved	528,501	84,560
PSS2 Hepatitis C Trigger 2	Achieved	Achieved	Achieved	Achieved	75,000	
PSS2 Hepatitis C Trigger 3	Achieved	Achieved	Achieved	Achieved	151,000	
PSS2 Hepatitis C Governance	Achieved	Achieved	Achieved	Achieved	150,000	
PSS9 Immunoglobulin Stewardship Trigger 1	Achieved	Achieved	Achieved	Achieved	141,001	
PSS9 Immunoglobulin Stewardship Trigger 2	Achieved	Achieved	Achieved	Achieved	23,500	
PSS9 Immunoglobulin Stewardship Trigger 3	Achieved	Achieved	Achieved	Achieved	58,751	
PSS9 Immunoglobulin Stewardship Trigger 4	Achieved	Achieved	Achieved	Achieved	11,750	
PSS9 Immunoglobulin Stewardship Trigger 5	Achieved	Achieved	Achieved	Achieved	0	
PSS12 Enabling Mechanical Thrombectomy Trigger 1	Achieved	Achieved	Achieved	Achieved	37,501	
PSS12 Enabling Mechanical Thrombectomy Trigger 2	Achieved	Achieved	Achieved	Achieved	37,501	
PSS12 Enabling Mechanical Thrombectomy Trigger 3	Achieved	Achieved	Achieved	Achieved	37,501	
PSS12 Enabling Mechanical Thrombectomy Trigger 4	Achieved	Achieved	Achieved	Achieved	37,501	
PSS13 Rethinking Conversations Trigger 1	Achieved	Achieved	Achieved	Achieved	40,001	
PSS13 Rethinking Conversations Trigger 2	Achieved	Achieved	Achieved	Achieved	40,001	
PSS13 Rethinking Conversations Trigger 3	Achieved	Achieved	Achieved	Achieved	60,001	
PSS13 Rethinking Conversations Trigger 4	Achieved	Achieved	Achieved	Achieved	60,001	
				Total	1,949,513	165,060

Further details of the agreed goals for 2019/20 and for the following 12 month period are available on request from the following email address: quality.accounts@hey.nhs.uk

Care Quality Commission

About the Care Quality Commission

The Care Quality Commission (CQC) regulates and inspects health and social care services in England. They check that services meet the Health and Social Care Act 2008 ('the Act') and the CQC Fundamental Standards. If they feel that an organisation provides good, safe care the CQC registers it without conditions. The CQC provides assurance to the public and commissioners about the quality of care through a continuous monitoring of a Trust's performance across a whole range of core services. The CQC Operating Model was revised and in June 2017 the CQC confirmed they will focus on eight core services and four additional services. The additional services may be inspected depending on the level of activity and risk.

The eight core services are:

- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity
- Services for Children and Young People
- End of Life Care
- Outpatients

The four additional services are:

- Gynaecology
- Diagnostic Imaging
- Rehabilitation
- Spinal Injuries

When inspecting these eight core services, the CQC will focus on the following five key questions:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive?
- Are services well-led?

The CQC continue to use the ratings as detailed in their Operating Model; they are an important element of the CQC approach to inspection and regulation. The ratings are outstanding, good, requires improvement and inadequate. You can find more about the CQC and the standards here: www.cqc.org.uk

Statement of compliance with the Care Quality Commission

Hull University Teaching Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has taken enforcement action against Hull University Teaching Hospitals NHS Trust during 2019/20.

Hull University Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Sexual Assault and Referral Centre Inspection

The CQC undertook a Sexual Assault and Referral Centre (SARC) inspection of the Trust's Child Sexual Assault Assessment Service (CSAAS) during the reporting period. The inspection was undertaken on 29 and 30 January 2020 in the Anlaby Suite at Hull Royal Infirmary.

The Trust received a Section 29a Warning Notice following this inspection because the systems and processes the Trust had in place did not ensure the effectiveness of decontamination procedures.

The Trust took immediate actions to address the concerns raised in the Section 29a Warning Notice and an action plan was developed to evidence this. A full response on actions taken and planned actions were submitted to the CQC in line within the agreed timescales and assurance was provided.

In March 2020, the CQC published the final report from the January 2020 SARC inspection.

The CQC reported that the service was providing safe, effective, caring and responsive care in accordance to the relevant regulations. However, the CQC reported that the service was not providing well-led care in accordance with the relevant regulations and as a result they have taken enforcement action in relation to the regulatory breaches. Regulation breach 17 – Good Governance was breached due to effectiveness of the decontamination procedures.

The Trust reviewed the published report and included the additional areas for improvement to the original action plan, which again was shared with the CQC for assurance on actions taken.

In May 2020, the SARC lead inspector completed a desk top review of the delivery against the Trust action plan, supporting evidence and additional photographic evidence to demonstrate improvements to the environment as the inspector was unable to re-visit the site due to the COVID-19 pandemic. The CQC have published an additional inspection report following the desk top review, which confirms the required improvements have been made and the breaches have been addressed. The CQC reported that the service was now providing safe, effective, caring, responsive and well-led care in accordance to the relevant regulations.

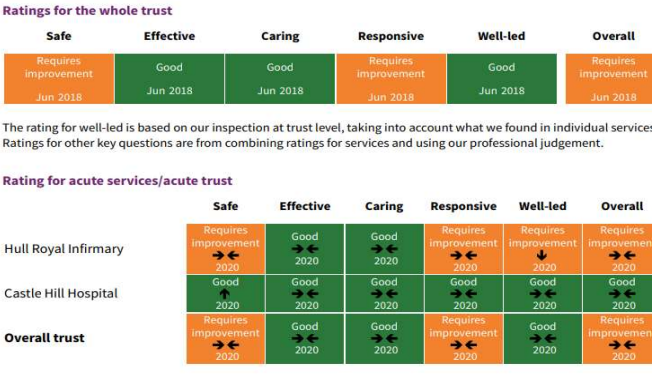
Trust Comprehensive Inspection; Current CQC Ratings

The CQC commenced the Trust's comprehensive inspection during the reporting period. The CQC undertook the unannounced element of the inspection process between 03 and 05 March 2020 across both Hull Royal Infirmary and the Castle Hill Hospital. The inspection covered the Emergency Department, Medical Care, Surgery and Critical Care. Due to the Covid-19 pandemic the CQC was not able to complete the well-led element of the inspection and therefore the comprehensive inspection was partially completed.
Following the inspection, the Trust received a Section 31 Initial Letter of Intent from the CQC in relation to nurse and medical staffing within the Paediatric Emergency Department. The Trust was required to provide an action plan to demonstrate how it would address the areas of concern and to submit a weekly information update to the CQC on medical and nurse staffing rotas and any actions taken to address any gaps. The Trust provided the information as required. A further letter was received in April 2020, stating that the CQC was satisfied that their concerns and mitigates patient safety risks highlighted. However, they do still have a duty to ensure patient safety is maintained and in response to the COVID-19 pandemic they changed the frequency of reporting to monthly. The Trust has also complied with this.

The Section 31 action plan is currently being implemented, which again was shared with the CQC for assurance on actions taken. This will continue to be monitored until fully delivered and the CQC have the relevant assurance and evidence that improvements have been made.

The CQC confirmed that they would still produce an inspection report of findings and ratings for the services inspected in March 2020; Emergency Department, Medical Care, Surgery and Critical Care. The inspection report and evidence appendix were published on 23 June 2020. The full inspection reports can be accessed via https://www.cqc.org.uk/provider/RWA

The Trust's overall rating remains as 'Requires Improvement' due to the non-completion of the



Trust well-led inspection. Although the overall rating for the Trust did not change, there were a number of improved ratings for the core services and domains across HRI and CHH. These are detailed in the rating tables on the next page.

Ratings for Castle Hill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020
Surgery	Good ↑ 2020	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good ↑ 2020
Critical care	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Good ↑ 2020
End of life care	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020

Ratings for Hull Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020
Medical care (including older people's care)	Requires improvement →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020
Surgery	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020	Good →← 2020
Critical care	Good ↑ 2020	Good →← 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Good ↑ 2020
Maternity	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Services for children and young people	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Requires improvement →← 2020	Good →← 2020	Good →← 2020	Requires improvement →← 2020	Requires improvement ↓ 2020	Requires improvement →← 2020

The CQC found areas of improvement including 11 areas of legal requirements. This translated into 8 must do actions in urgent and emergency services, 1 must do in medical care and 2 in critical care.

The Trust was also issued with a number of minor breaches which resulted in should do actions for medical care, surgery and critical care. The must do actions and that the Trust must address are as follows:

Urgent and Emergency Care

- The service must ensure the right care is received promptly when people access the service
- The service must ensure steps are taken urgently to facilitate the flow of patients through the emergency department
- The service must ensure initial assessment of paediatric patients includes the completion of a paediatric early warning score for each patient
- The service must ensure staff have the skills, competence and experience to provide safe care and treatment for children
- The service must ensure care and treatment is safe and timely for patients with mental health needs including children
- The service must ensure patient records are completed fully and consistently and include basic nursing tasks and assessments undertaken and on-going care of patients lodging in the department
- The service must ensure governance processes are operated which ensure the performance of the service is monitored and managed effectively
- The service must ensure governance processes are operated which ensure risks are monitored and mitigated effectively

Medical Care

- The service must ensure that all patients who trigger an alert using the National Early Warning Score (NEWS2) to show signs of deterioration are appropriately escalated for a medical review in line with the trust policy and this must be documented in the patient's record at HRI

Critical Care

- The service must ensure robust governance processes are introduced to maintain oversight of all of the key risks to the units and ensure actions are put in place to mitigate these risks effectively at HRI and CHH

The Trust has developed an action plan to address all areas of must and should do actions and corresponding regulatory breaches.

Outstanding practice

The CQC also identified a number of outstanding practices including:

Surgery

- Staff working and volunteering in neurosurgery on ward 40 clearly treated patients with outstanding compassion and kindness, taking into account each patients' individual needs. The specialist care, treatment and emotional support they provided to patients, families and carers to minimise their distress was exceptional, from writing cards to relatives of patients who had passed away, to developing new ways of providing services and encouraging working with volunteer organisations they were clearly committed to delivering high standards of care.

Critical Care

- Staff in the unit told the CQC about a number of initiatives they had in place for the families of patients who were receiving end of life care. This included providing moulds or hand prints, locks of hair, forget me not and poppy seeds. In addition, the unit had memory boxes for children which included trinkets and a teddy.
- The specialist nurses for organ donation explained they would be involved in the care of patients at the end of their life, regardless of the organ donation decision. This included being involved in conversations with the patients loved ones to determine any final wishes, for example if they wanted any specific music played, or the presence of a chaplain.
- The unit also had a lead for care at the end of life. This member of staff said the unit was striving to ensure patients and their families received a positive experience of the care

provided at end of life. A number of initiatives were in place, for example, completing Respect documentation to ensure patient's wishes were carried out, arranging visits to a local hospice if applicable, and ensuring patients preferred place of care was established and documented.

- The specialist staff also told the CQC that they would stay with family members throughout the withdrawal of treatment for organ donors or any patient who was at the end of their life.

NHS Number and General Medical Practice Code

Hull University Teaching Hospitals NHS Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: which included the patient's valid NHS number was:
Which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care
- 99.86% for admitted patient care;
- 99.95% for outpatient care; and
- 99.07% for accident and emergency care

Information Governance

The Information Governance Data Security and Protection Toolkit (DSP Toolkit) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance. It remains Department of Health policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage and destruction of data both within the organisation and between external organisations.

The Information Governance Assurance Statement is a required element of the DSP Toolkit and is re-affirmed by the annual submission to demonstrate that the organisation has robust and effective systems in place to meet statutory obligations on data protection and data security.

Hull University Teaching Hospitals NHS Trust's Information Governance Assessment Report overall score for 2019/20 was % unknown, (rated unknown). *

**The Trust is unable to complete this statement at this time (May 2020). Due to the National COVID-19 Pandemic Response, the Information Commissioner's Office (ICO) has announced that the 2019/20 DSP Toolkit Assessment submission deadline has been extended to 30 September 2020. The assessment can be accessed via the NHS Digital website https://www.dsptoolkit.nhs.uk/OrganisationSearch/RWA*

Payment by Results Clinical Coding Audit

Hull University Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

Data Quality Improvements

Hull University Teaching Hospitals NHS Trust will be taking the following actions to improve data quality. The actions have been taking from recommendations from specialty audits undertaken throughout 2019/20.

Recommendation	Priority	Progress update	Status
R1 – Engagement should be encouraged with clinicians across all specialities with examples of good and bad coding to highlight where any problems are occurring and why, and the impact this has on coding outcomes.	High	The number of validation sessions has increased. In addition to previous areas; Vascular, Oral Surgery and Paediatric Surgery have been keen to be involved in validations.	Improved, on-going
R2 - Achieve Mandatory level in all internal speciality audits.	High	An on-going audit and spot check programme is in place. Internal audits have shown a requirement for on-going training, a need for coders to spend more time reading documentation and better documentation.	Programme complete 2019/20. New programme commenced April 2020.
R3 – Ensure coders are maintaining standards and receive regular audit/spot check feedback.	Medium	Regular post audit/spot check feedback.	Feedback complete 2019/20
R4 – Ensure documentation is consistent and adequate for coding purposes.	Medium	Reviewed through audits and spot checks and when identified by individual coders. Some areas still to investigate and remedy.	On-going
R5 – Streamline coding processes to allow more time to review documentation	Medium	Continually assessing viability of electronic sources over case notes. Changes made where practicable.	On-going

Learning from Deaths Update

This section provides an update against the NHS England and NHS Improvement prescribed information for learning from deaths, as well as an update on other key areas of work that have taken place to identify quality improvement both within the Trust and across the wider, more complex system of health care providers.

During 2019/20, 2317 of Hull University Teaching Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 552 in the first quarter
- 516 in the second quarter
- 626 in the third quarter
- 623 in the fourth quarter

By 01 April 2020, 105 Structured Judgement case note reviews and 9 investigations have been carried out in relation to 2317 deaths. In addition to the Structured Judgement Review, a number of other case-note review methodologies are also implemented, for which we do not currently record figures for. All deaths discussed within a Speciality Morbidity and Mortality meeting receive a form of case-note review.

Any Serious Incident investigation where the patient has died incorporates a full case note review.

In 9 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 2 in the first quarter
- 3 in the second quarter
- 0 in the third quarter
- 4 in the fourth quarter

9 deaths, representing 0.39% of the total patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- representing 0.36% for the first quarter
- representing 0.58 % for the second quarter
- None for the third quarter
- representing 0.64% for the fourth quarter

These numbers have been estimated by consideration of all Serious Incidents that occurred within the reporting period, where patient death was deemed potentially due to problems in the care provided.

The following themes were identified from case reviews and investigations, where problems in care were more likely than not to have contributed to the patient's death:

- Delay in the administration of antibiotics
- Lack of compliance with Surgical checklists
- Issues relating to not repeating checks, e.g. ''stop before you block''

The Trust has taken a number of actions to contribute to the resolution of the themes identified, these include:

- Roll out of a Sepsis awareness campaign
- Introduction and completion of a monthly Surgery checklist audit to monitor improvement actions implanted from the themes and an external peer review
- Multi-agency reviews are undertaken with Clinical Commissioners and the Yorkshire Ambulance Service to ensure improved partnership working and shared learning
- Introduction of a 'Stop the Line' campaign to ensure an open and honest safety culture and empowering all staff to be able to 'stop' when they see something wrong

All actions that are implemented and shared learning, including the actions noted above, are assessed and reported on the Trust's monthly Shared Learning Report which is presented to the

Trust Board for assurance. The Trust Board papers can be accessed via https://www.hey.nhs.uk/about-us/trust-board-meetings/. Particular actions e.g. Safer Surgery and Stop the Line are reported to other committees within the Trust committee structure including the Operational Quality Committee and the Quality Committee.

There were 0 case record reviews and 0 investigations completed after 01/04/2018 which related to deaths which took place before the start of 2019/20.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

NHS Digital: Core Set of Indicators

Since 2012/13 Hull University Hospitals NHS Trust has been required to report on performance against a core set of indicators using data made available by NHS Digital. The core set of indicators are prescribed in the NHS Outcomes Framework (NHS OF) developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how NHS Trusts are performing and uses comparative data against the national average and other NHS organisations with the lowest and highest scores.

The Hull University Teaching Hospitals NHS Trust considers that this data is as described because performance information is consistently gathered and data quality assurance checks made as described in the next section.

The table below details performance against the Summary Hospital-level Mortality Indicator (SHMI):

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
The value of the SHMI for the Trust for the reporting period*	1.08	1.0430	1.00	0.691	1.268
The banding of the SHMI for the Trust for the reporting period*	2	2	2	1	3
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	27.9%	35%	37%	58%	9%

*Most recent data on NHS Digital for period April 2019 – March 2020

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Mortality and Morbidity Committee.

The table below details performance against the Patient Reported Outcome Measures (PROMs):

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
• hip replacement surgery EQ-5D Average health gain (Primary)*	0.448	0.42	0.468	0.731	0.104
• hip replacement surgery EQ-5D Average health gain (Revision)*	-- Insufficient records	-- Insufficient records	0.305	1.286	-0.175
• hip replacement surgery Oxford Hip score Average health gain (Primary)*	22.566	23.195	22.8	29.833	14.095
• hip replacement surgery Oxford Hip score Average health gain(Revision)*	7.853	9.667	14.3	39	-2
• knee replacement surgery EQ-5D Average health gain (Primary)*	0.35	0.324	0.342	0.59	-0.431
• knee replacement surgery Oxford Knee score Average health gain (Primary)*	18.138	17.172	17.4	24.4	-6
• knee replacement surgery EQ-5D Average health gain (Revision)*	0.35	0.324	0.314	0.945	-0.393
• knee replacement surgery Oxford Knee Score Average health gain (Revision)*	-- Insufficient records	-- Insufficient records	14.4	33.3	-4.5

*Most recent data on NHS Digital for period April 2018 – March 2019 Published February 2020

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Patient Experience and Engagement Committee.

The table below details performance against the Readmission rate into hospital within 28 days of discharge

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
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*	9.0%	11.4	12.5	1.8	69.2
The percentage of patients aged 16 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*	7.6%	12.9	14.6	2.1	57.5

*Most recent data on NHS Digital for period 01/04/2018 to 31/03/2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Health Group and Executive Performance and Accountability Meetings.

The table below details performance against the Trust's responsiveness to the personal needs of our patients

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
The Trust's responsiveness to the personal needs of its patients during the reporting period*	68.5	64.4%	66.7%	84.2%	59.5%

*Most recent data on NHS Digital for period Hospital stay: 01/07/2019 to 31/07/2019; Survey collected 01/08/2019 to 31/01/2020

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Health Group and Executive Performance and Accountability Meetings.

The table below details performance against the Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
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*	84%	70.6%	71.4%	90%	41%

*Most recent data on NHS Digital for period Hospital stay: 01/07/2018 to 31/07/2018; Survey collected 01/08/2018 to 31/01/2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Workforce and Transformation Committee.

The table below details performance against the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period*	92.04%	92.12%	95.33%	100%	71.59%

*Most recent data on NHS Digital for period October to December 2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Thrombosis Committee.

The table below details performance against the C.Difficile infection rate, per 100,000 bed days

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
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*	11.4	Data not available	Data not available	Data not available	Data not available

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Infection, Prevention and Control Committee.

The table below details performance against the number of patient safety incidents reported and the level of harm

Prescribed Information	2018/19	2019/20	National Average	Best performer	Worst performer
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,*	51.3	50.7	0.38	14.9	2.63
The number and percentage of such patient safety incidents that resulted in severe harm or death*	0.56	0.12	0.38	0	140.6

*Most recent data on NHS Digital for period October 2018 to March 2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Operational Quality Committee.

Part 3: Our Plans for the Future; Priorities for Improvement

This section includes:

- Our plans for the future – Consultation
- Quality and Safety Improvement Priorities 2020/21

Our Plans for the future – Consultation

Quality and Safety Improvement Priorities 2020/21 Consultation

For 2020/21 the Trust put together a list of potential quality improvement priorities by:

- Evaluating performance against the quality and safety priorities for 2019/20
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2019/20
- Looking at national priorities and local priorities that have been agreed with our commissioners (Clinical Commissioning Groups) as part of Commissioning for Quality and Innovation (CQUIN)
- Looking at what our regulators have identified as priorities, such as compliance with the CQC Fundamental Standards
- Areas we have identified as requiring improvement from incidents and patient feedback

In order to seek the views of our staff, Trust patient members, stakeholders and our local community on what they thought the priorities should be for 2020/21, the following actions were undertaken:

- An online survey was developed and circulated to all Trust staff, patient members and stakeholders to consult on the 2020/21 priorities in February and March 2020
- Relevant committees were also asked for their comments and ideas:
  - Operational Quality Committee for consultation on all priorities and approval of the 2020/21 priorities
  - Trust Board for ratification of the 2020/21 priorities
  - Quality Committee for approval of the 2020/21 priorities

Our chosen priorities

The Trust has identified these quality improvement priorities for 2020/21 because they are important to our staff, patients and stakeholders:

Safer Care (Patient Safety)

- Reduction of inpatient falls of patients who have a diagnosis of Dementia and have an inpatient fall within the Department of Elderly Medicine
- Development of a standardised safety brief framework
- Reduction in line infections
- Increase stop the line reporting and improve staff engagement and satisfaction with the new reporting process and increase measurable actions

Better Outcomes (Clinical Effectiveness)

- Improve mental health triage in the Emergency Department
- Empowerment of the non-registered workforce to improve the delivery of the SSKIN care bundle

Improved Experience (Patient and Staff Experience)

- Improved framework of preceptorship for new registrants to ensure they are supported and develop in to confident and competent practitioners
- Improve patient and public involvement across the Trust

Quality and Safety Improvement Priorities 2020/21 – Safer Care

►Safer Care ►Better Outcomes ►Improved Experience

Priority One: Reduction of inpatient falls of patients who have a diagnosis of Dementia within the Department of Elderly Medicine (DEM)

Aim:

To develop a Multi-Disciplinary Task and Finish group to complete an in-depth review of patients who have a diagnosis of Dementia and have an inpatient fall within DME.

Objectives:

- To understand the barriers that prevents the escalation of care for this group of patients.
- To develop a structured framework for the assessment and interventional care for this group of patients.
- To review the nursing documentation for both the Falls Prevention and Dementia/Delirium care (including IT options)
- To share finding across the organisation and plan a roll out of good practice
- To improve situational awareness of safety concerns.

Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented by the appropriate member of staff
- Staff Benefits - Provision of high quality care, improved education. Organisational Benefits – Supports the patient safety strategy and reduces patient harm

Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Governance Team. Delivery of the project will be monitored by the DME Task and Finish Group with reporting and escalation to the Falls Committee for support and Trust Quality Committee for assurance.

Priority two: Reduction in line infections

Aim:

To reduce the number of Methicillin-sensitive Staphylococcus Aureus (MSSA) line infections.

Objectives:

- To review the range of cases linked to line infections
- To identify one area to be used as a pilot
- To develop specialised training for the pilot area
- To learn lessons from the pilot and shared for up scaling

Planned outcomes:

- Patient Experience - improved length of stay
- Quality Experience - timely interventions / treatment will be implemented by appropriate staff member
- Staff Benefits - peer support, enhanced training and clinical supervision
- Organisational Benefits - Supports the patient safety strategy and reduces patient harm. Supports Ward to Board communication.

Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Infection, Prevention and Control Team. Delivery of the project will be monitored by the Surgery Health Group (SHG) Line Infection Task and Finish Group with reporting and escalation to the Device Committee for support and Trust Quality Committee for assurance.

Priority three: Increased stop the line reporting and improved staff reporting and satisfaction with the new reporting process and increase measurable actions

Aim:

By providing clear guidance on actions and process when a stop the line is called, reporting and investigating procedures and learning from the events we will see an increase in stop the lines reported, increase in staff engagement and satisfaction with the process, and an increase in measurable actions from stop the lines

Objectives:

- Increase stop the lines by 50% in a 6-month period
- Increase documented actions from stop the line investigations to a minimum of 2 a month

Planned outcomes:

- Patient Safety – By promoting an environment where staff can take steps to limit preventable harm and learn from those near misses, we will see a reduction in avoidable harm
- Quality Experience - Staff should feel more engaged with the policy and procedures around incident reporting and stop the line
- Staff Benefits - Improved moral and satisfaction with stop the line reporting and action feedback
- Organisational Benefits – reduction in avoidable harm

Monitoring arrangements:

The project will be led by the Chief Medical Officer, supported by the Governance Team. Delivery of the project will be monitored by the Operational Quality Committee with reporting and escalation to the Trust Quality Committee for assurance.

Priority four: Development of a standardised safety brief framework

Aim:

To develop a standardized safety brief framework to be used by ward areas and departments

Objectives:

- To develop a common language for the escalation of patients
- To develop a structured mechanism for effective communication
- To enhance teamwork through communication and co-operative problem-solving
- To share understanding of the focus and priorities of the day by all team member
- To improve situational awareness of safety concerns

Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented by the appropriate member of staff
- Staff Benefits - Mechanism for escalation, peer support and clinical supervision
- Organisational Benefits – Supports the patient safety strategy and reduces patient harm. Supports Ward to Board communication

Monitoring arrangements:

The project will be led by the Assistant Chief Nurse, supported by the Practice Development Matrons. Delivery of the project will be monitored by the Operational Quality Committee with reporting and escalation to the Trust Quality Committee for assurance.

Quality and Safety Improvement Priorities 2020/21 – Better Outcomes

►Safer Care ►Better Outcomes ►Improved Experience

Priority five: Improve mental health triage in the Emergency Department

Aim:

All adult patients attending ED will have a mental health triage by an ED nurse on arrival.

Objectives:

- To develop a comprehensive triage assessment
- To ensure all staff are educated in the use of the assessment with the relevant underpinning knowledge (Mental Health)
- To ensure the triage assessment is on a digital platform

Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented
- Staff Benefits - Improved knowledge of the assessments required for this patient group
- Organisational Benefits – Stratification of the number of patients accessing the Emergency Department with a Mental Health issue. The information gained will support the organisation to work with mental health services to improve patient pathways

Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Governance Team. Delivery of the project will be monitored by the Mental Health in ED Task and Finish Group with reporting and escalation to Mental Health, Learning Disability and Autism Committee for support and Trust Quality Committee for assurance.

Priority six: Empowerment of the non-registered workforce to improve the delivery of the SSKIN care bundle

Aim:

The aim of this project is to focus improvement in the delivery of the SSKIN care bundle.

Objectives:

- This project aims to empower the non-registered workforce to lead on the implementation, decision-making and communication to improve the quality of care and the safety of the patient.

Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented by the appropriate member of staff
- Organisational Benefits – Supports the patient safety strategy and reduces patient harm.

Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Tissue Viability Team. Delivery of the project will be monitored by the Wound Management Committee with reporting and escalation to the Trust Quality Committee for assurance.

Quality and Safety Improvement Priorities 2020/21 – Improved Experience

►Safer Care ►Better Outcomes ►Improved Experience

Priority seven: Improved preceptorship

Aim:

To provide a consistent framework of preceptorship for all of our new registrants, where they feel supported and are enabled to develop into confident and competent practitioners.

Objectives:

- To define preceptorship as an organisation
- To share the definition through an updated policy for preceptorship
- Work with key stakeholders to provide an educational package to support preceptors and to develop a more robust approach to preceptorship
- To reduce staff turnover rates
- To reduce clinical incidents/ SI's involving new registrants
- To improve the quality of care patients, receive.
- Improved staff experience/satisfaction which is shown with improved staff survey results for Registered Nurses (RNs) and newly qualified RNs
- Progression to consider wellbeing study and improved wellbeing for staff in this group for newly qualified staff

Planned outcomes:

- Seamless progression from preceptorship to clinical supervision

Monitoring arrangements:

The project will be led by a Nurse Director, supported by a Practice Development Nurse.

Delivery of the project will be monitored by the Preceptorship Task and Finish Group with reporting and escalation to the Nursing Workforce Committee for support and Trust Quality Committee for assurance.

Priority eight: Improved patient and staff experience

Aim:

To develop and implement a Public and Public Involvement (PPI) Strategy

Objectives:

- To scope existing PPI structures and processes internally and externally presenting a report on this with recommendations in line with National and Regulatory requirements and standards
- To develop a PPI strategy and action plan to deliver the strategy utilising the Trust Patient Experience and Engagement Committee
- To commence delivery and monitoring of the actions

Planned outcomes:

- Patient Experience – Using PPI to improve services and patient experience
- Quality Experience - Improve Trust services by having a robust strategy and action for PPI
- Staff Benefits - Improved knowledge of PPI and how to utilise for patient/service developments/assessments
- Organisational Benefits – Compliance with CQC and national standards and improved reputation with external stakeholders and the public

Monitoring arrangements:

The project will be led by the Head of Patient Experience and Engagement supported by the Governance Team.

Delivery of the project will be monitored by the Patient Experience and Engagement Committee with reporting and escalation to the Trust Quality Committee for assurance.

ANNEXES

This section includes:

- Annex 1:
  - Statements from Key Stakeholders
  - Trust response to Stakeholder Statements

- Annex 2:
  - Statement of Directors' Responsibility
  - Independent auditor's report

- Annex 3
  - Abbreviations and definitions
  - How to provide feedback
  - Other formats

Annex 1

This section includes:

- Joint Statement from NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group
- Healthwatch Kingston upon Hull
- Healthwatch East Riding of Yorkshire
- Hull City Council Overview and Scrutiny Committee
- East Riding of Yorkshire Overview and Scrutiny Committee
- Trust response to Stakeholder Statement

Statements from Key Stakeholders

Joint Statement from NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group

Firstly, NHS Hull and East Riding of Yorkshire Clinical Commissioning Groups would like to take this opportunity to thank all the staff at Hull University Teaching Hospitals, for their hard work and dedication during the COVID19 pandemic. The efforts taken in responding to this global health crisis have been truly impressive across the health system. We would like to extend our gratitude and appreciation to you all, for your part in the NHS response and local system response.

NHS Hull and NHS East Riding of Yorkshire Clinical Commissioning Groups welcome the opportunity to review and comment on the Hull University Teaching Hospitals Trust Quality Accounts for 2019/20. The report illustrates a focus and commitment to continuous improvement in the delivery of services and quality of patient care in 2019/20.

Commissioners would like to congratulate the Trust and staff on the many successes and awards achieved in 2019/20. We also note the introduction of the Greatix and the Moments of Magic scheme which identifies and publicise examples of good practice, high quality care within the Trust.

Commissioners recognise the achievements that have been made against the priorities set by the Trust for 2019/20 however note that of the 10 quality improvement plan project areas only 1 have been achieved in full; Medicine Optimisation. Furthermore, a total of 2 have not achieved on any of the improvement indicators, these being Pressure Ulcers and Patient Experience. It is acknowledged that a total of 7 did show improvements against baseline, however all remain incomplete at this time. The commissioners support the Trust in making further improvements as outlined in the Quality Account and in progressing these to full achievement by carrying these forward for further action and monitoring within the coming year.

As identified in the quality accounts, the Trust has undertaken further work to align its categorisation and reporting criteria for pressure ulcers; to further the achievement of the national standards introduced in April 2019. We note that the target for achieving 100% of Root Cause Analysis of Hospital Acquired Pressure Ulcers (HAPU) was not been achieved however we welcome the plans to introduce a multidisciplinary tool based on SSKIN; the identification and management of pressure and moisture damage that is being piloted in Medical Elderly Ward. Commissioners are pleased that the Trust are amending current incident reporting, so they are better able to identify and review themes and trends. Commissioners therefore hope this will address the reoccurring causal factors and result in a reduction in pressure ulcers within the Trust.

Commissioner's note the section in the Quality Accounts regarding the seven Never Events reported by the Trust in 2019/20 and remain concerned in relation to the overall number of serious incidents within the Trust, in particular within the areas of surgical services, maternity services and diagnostics whereby there have been reoccurring themes. Commissioners note the positive use of simulation events, however would have liked the Quality Account to provide more detail on how the Trust will prioritise a reduction in incidents. Commissioners do however acknowledge the "Just Culture" approach that the Trust continues to adopt which encourages staff to speak up when things go wrong and facilitates a culture of fairness, openness and learning.

In the 2019/20 Quality Account the Commissioners welcomed the introduction and roll out of the National Early Warning Score NEWS2 scoring system in the Trust. In 2019/20 the Trust set a target of 90% of all patients scoring above 1 but note performance against the target has been variable. Commissioners look forward to

receiving updates on the continued implementation of NEWS2 and the associated planned roll out of Electronic Observations (e-obs) due to their importance in identifying and managing deteriorating patients in the Trust.

Commissioners noted the details of the 2019 Staff Survey at the Trust and accept that whilst response rates were slightly down on previous years it is reassuring to note that staff morale scores are above the national average. The Trust has outlined and reported in the Quality Account a number of actions that are being undertaken in response to the survey results. Commissioners would have liked to have seen demonstrated within the Quality Accounts the work that has been undertaken in relation to recruitment and retention of staff and the challenges the Trust continues to face.

Within the quality account we are pleased to note that the Trust continues to prioritise clinical research, recognising its importance as a driver for improving the quality of care and patient outcomes. The importance of research to the Trust has been reflected in it name change to Hull University Teaching Hospital and we look forward to hearing more in the future about how the Trust is innovating practice through research and development.

In rounding up this review of the 2019/20 Quality Account Commissioners note the outcome of the most recent Care Quality Commission (CQC) inspection of the Trust. Whilst acknowledging the examples of improvement and outstanding practice the report also highlighted areas of regulatory practice whereby the Trust had not made the required improvements, or embedded change since the last inspection. The overall rating for the Trust remains unchanged and is as "Requires Improvement"; the inspection was unable to be concluded due to Covid-19. Commissioners continue to monitor the ongoing progress made by the Trust and its plans to address the regulatory issues raised by the CQC and ongoing improvements.

Commissioners acknowledge the challenges experienced by HUTH with regards to delivery of some NHS Constitution Targets. We also recognise that the COVID19 pandemic has further exacerbated these challenges. The commissioners remain committed to working with the Trust and its regulators to improve the quality, safety and effectiveness of services and in working with the Trust to continue to deliver better outcomes for all of our patients.

The Commissioners confirm to the best of their knowledge, that the information contained in the report is accurate against which has been shared with quality Commissioners.

Emma Latimer
Chief Officer
NHS Hull Clinical Commissioning Group & East Riding of Yorkshire Clinical Commissioning Group

Joint Statement from Healthwatch East Riding of Yorkshire and Healthwatch Kingston upon Hull

Healthwatch East Riding of Yorkshire and Healthwatch Kingston upon Hull welcome the opportunity to make a statement on the ***Quality Accounts for 2019/20 Hull University Teaching Hospitals NHS Trust.***

The report is well presented in a 'magazine style' easy to read format. Within the document it is easy to identify the key sections, and it is well ordered, bringing key issue to the front to give instant impact

Healthwatch was pleased to see how feedback and experiences, across the Trust, have made changes to services and practice, it is encouraging to see lots of positive patient feedback, although it may be beneficial to provide examples of some negative patient experience and feedback. This would demonstrate how these are used to develop solutions that improve the quality of services. Examples of how the Trust learns from complaints, and consequently how the quality of service and access to the complaints process is improved would demonstrate that the Trust is learning from complaints.

There is no mention of PLACE (Patient Led Assessment of Care and Environment) assessments, were the patients take the lead to provide feedback from their prospective. This would provide another example of invaluable patient participation and observation in improving the service.

It is concerning to learn of the poor response to staff surveys. Maybe demonstrating how their feedback is used to make changes or improvements may show them that they are valued, with the potential to increase uptake in the future, and welcome specific actions to address this.

Healthwatch is pleased to see the monitoring of the key indicators which allows the key areas to be assessed and patient outcomes to be reviewed. This makes it clear on what needs to be focused on to improve year on year.

We recognise the effort to continue to improve the quality and safety of services within the trust and we look forward in continuing to work more closely with Hull University Teaching Hospitals Trust in the future and seeing how their new priorities are developed.

Hull City Council Overview and Scrutiny Committee

Hull City Council's Health and Wellbeing Overview and Scrutiny Commission, considered the Hull University Teaching Hospital NHS Trust Quality Account 2019-20, on the 13th of November 2020.

The Commission noted the performance against the 2019/20 targets and the commitment to ongoing improvement, as well as endorsing the Quality and Safety Improvement Priorities for 2020/21. The Commission also welcomed the format of the report, including the use of case studies, and the Trust's approach to reporting and addressing areas of weakness within the organisation.

The Commission also acknowledged that this year's Quality Account had been produced in unprecedented times, and wished to thank the Trust and all their staff, for their continued hard work and dedication during the pandemic.

East Riding of Yorkshire Overview and Scrutiny Committee

East Riding of Yorkshire Overview and Scrutiny Committee confirmed that they would be providing a statement for the Quality Accounts 2019/20.

Trust response to Stakeholder Statement

The Trust would like to thank all stakeholders for their comments on the 2019/20 Quality Account. All statements received from our Stakeholders have been included in the Quality Account as provided.

We are pleased that the statements from our stakeholders demonstrate the collaborative commitment we share in improving the quality of services we provide and the outcomes for our patients and that stakeholders are in agreement that the quality and safety improvement priorities for 2020/21 are the right ones.

The Trust would also like to thank stakeholders on their positive comments and continued support towards Hull University Teaching Hospitals and our staff for their hard work and dedication during the COVID-19 pandemic.

The Trust has taken on board some of the comments regarding additional information stakeholders would like to see in the Quality Accounts. These have been taken forward and will be included in the 2020/21 accounts. This includes more information on:

- Incident reporting – learning from incidents including Serious Incidents and Never Events as well as actions the Trust has taken and/or plans to take to reduce the number of repeated incidents
- Learning from complaints – examples of poor practice from patient feedback and what actions the Trust has taken to use the feedback to inform service improvement and improve the quality of the services
- Duty of Candour – additional information to explain 'dips' in performance and actions taken to improve compliance with the Duty of Candour requirements and any internal improvement work on processes
- CQUIN – additional information to explain the reasons for the non-achievement of indicators and any actions the Trust has taken to address those areas of non-compliance
- Staffing – information on the Trust's approach to recruitment, staffing levels and retention
- Staff survey – additional information on the breakdown of staff groups who responded to the survey, action plans to address areas of poor performance and examples of how the feedback has informed service changes and improvements for staff

Annex 2:

This section includes:

Statement of Directors' Responsibility

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).

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

- the Quality Accounts 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
NB: sign and date in any colour ink except black

Chair:  Date: 14 December 2020

Chief Executive:  Date: 14 December 2020

Independent Auditor's Report

Due to the National COVID-19 Pandemic Response, the Quality Accounts has been able to undergo an independent review and NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2019/20.

Please see https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements/ for further information.

Annex 3:

This section includes:

Abbreviations and Definitions

Acute Kidney Injury (AKI)	Acute Kidney Injury is caused by reduced blood flow to the kidneys, usually in someone who is already unwell with another health condition. This reduced blood flow could be caused by: low blood volume after bleeding, excessive vomiting or diarrhoea, or as seen with severe dehydration.
Audit	An audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements.
Butterfly Scheme	The Butterfly Scheme is a system that enables staff to provide person centred care to patients with dementia.
C.Difficile	Clostridium difficile infection is a type of bacteria which may live in the bowel and can produce a toxin that can affect the digestive system.
Care Bundle	Care bundles help us to deliver safe and reliable care. They are research based actions for delivering care to certain patients. They are designed to ensure we deliver safe and reliable care to our patients at a certain point in their care e.g. on discharging, prescribing antibiotics, and preventing certain infections.
Care Quality Commission (CQC)	The organisation that regulates and monitors the Trust's standards of quality and Safety.
Cayder	Cayder is an electronic system monitoring and tracking patient flow in and out of the Trust.
CHH	Castle Hill Hospital
Chronic Obstructive Pulmonary Disease (COPD)	COPD is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used, but are now included within the COPD diagnosis. COPD is not simply a "smoker's cough" but an under-diagnosed, life-threatening lung disease.
Clinical Audit	This is a quality improvement process that looks at improving patient care and outcomes through a review of care against a set of criteria. This helps to ensure that what should be done in a Trust is being done.
Clinical Outcomes	A clinical outcome is the "change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions.
Clinical Research	Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.
Commissioning for Quality & Innovation (CQUIN)	A payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative.
DATIX	DATIX is the Trust wide incident reporting system
Duty Of Candour	Involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment.
ED	The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. Its open 24 hours a day, 365 days of the year.
Engagement	This is the use of all resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways and raise staff morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care.
eObservations	Electronic observation and decision support system designed to improve patient safety and outcomes, allows patient vitals to be viewed from any connected device.
ePrescribing	Electronic prescribing system

Friends and Family Test	The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.
Fundamental Standard Inspections	A formal review process, which reviews objectively the quality of care delivered by our clinical teams, is set around nine fundamental standards, with the emphasis on delivering high quality, safe effective care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care.
Greatix	Opportunity for staff to report where things have gone well and to share positive learning outcomes.
Health Groups	Health Groups are the areas of the Trust delivering care to our patients. There are four Health Groups; Clinical Support, Family and Women's, Medicine, and Surgery. These four Health Groups are headed by a Consultant (Medical Directors) who is the Accountable Officer. They are supported in their role by a Director of Nursing and an Operations Director.
HUTH	Hull University Teaching Hospitals NHS Trust
HRI	Hull Royal Infirmary Hospital
Intentional rounding	Intentional rounding is a process where nursing staff conduct regular checks on patients throughout the day to ensure their fundamental care needs including pain, comfort/positioning, toileting, water, temperate etc. are being addressed.
Johns Campaign	Johns Campaign is a national campaign with the aim to give the carers of those living with dementia the right to stay with them in hospital, in the same way that parents stay with their sick children.
Just culture	A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution.
Lorenzo	The Trust's electronic patient record system
MSSA	Methicillin-sensitive Staphylococcus Aureus (MSSA) is a type of bacteria (germ) which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.
National Patient Safety Agency Alerts	Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices.
Never Event	A Never Event is a type of serious incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.
NEWS2	National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service
NHS England	NHS England acts as a direct commissioner for healthcare services, and as the leader, partner and enabler of the NHS commissioning system.
NHSI	NHS Improvement (NHSI) is a non-departmental body in England, responsible for overseeing the National Health Service's foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
NHS Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient.

NIHR	The National Institute for Health Research commissions and funds research in the NHS and in social care.
NRLS	National Reporting and Learning Service is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted.
Pressure Ulcer	Open wounds that form when prolonged pressure is applied to the skin. Patients who spend prolonged periods of time in a bed are prone to such ulcers. A pressure ulcer can be avoided if the appropriate preventative actions are taken.
QIP	Quality Improvement Plan (QIP) - The purpose of this plan is to define, at a high level; the overall continuing quality improvement journey HEY is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO and SHOULD DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation, for example in relation to Quality Accounts.
Root Cause Analysis (RCA)	RCA is a method of problem solving that tries to identify the root causes of faults or problems.
Sepsis	Sepsis is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.
Serious Incident (SI)	An SI is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.
SHMI	Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
SSKIN	SSKIN is a five step approach to preventing and treating pressure ulcers. The five steps are: 1) **S**urface: make sure your patients have the right support, 2) **S**kin inspection: early inspection means early detection - show patients and carers what to look for, 3) **K**eep your patients moving, 4) **I**ncontinence/moisture: your patients need to be clean and dry and, 5) **N**utrition/hydration: help patients have the right diet and plenty of fluids
Stakeholders	A group of people who have a vested interest in the way Hull University Teaching Hospitals NHS Trust operates in all aspects. For example, the deliverance of safe and effective patient care.
Tissue viability	Tissue viability is a growing speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration.
Transfer of Care Around Medicines Scheme	The scheme focuses on patients in hospital who have been identified as requiring additional support with their essential medication. These patients are then referred through a secure digital system, to their local community pharmacy at the point of discharge.
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors.
VTE	Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).

How to provide Feedback

We would like to hear your views on our Quality Account

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information which is meaningful to you and reflects, in part, the aspects of quality that matter most to you.

If you have any feedback regarding the 2019/20 Quality Account please e-mail your comments to: quality.accounts@hey.nhs.uk

However, if you prefer pen and paper, your comments are welcome at the following address:

The Compliance Team
Quality Governance and Assurance Department
Medical Education Centre
Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

Other formats

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

For more information, you can contact Rebecca Thompson:

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