NHS
Hull University Teaching Hospitals
NHS Trust

Great Staff - Great Care - Great Future

Quality Account 2018/19

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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

Providers are able to add additional sections and information; however the Quality Account must have an introduction, it must then look back at previous performance and then look forward at the priorities for the coming financial year.

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 30 June 2019. Hull University Teaching Hospitals NHS Trust also makes its Quality Account available on the website **http://www.hey.nhs.uk/about-us/corporate-documents/**

If you require any further information about the 2018/19 Quality Account please contact:
The Compliance Team on **01482 482352** or e-mail us at **quality.accounts@hey.nhs.uk**

Part 1: Introducing our Quality Account

This section includes:

- A statement on quality from the Chief Executive, Chris Long
- An overview of some of our success stories from 2018/19

Statement on Quality from the Chief Executive

Welcome to Hull University Teaching Hospitals NHS Trust's 2018/19 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 2019/20. 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 5 of this report (page 71) we set out the quality and safety improvement priorities for 2019/20. These priorities were identified through consultation with staff, Trust members, Health & Well Being 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)

- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce pressure ulcers
- To reduce avoidable acute kidney injury
- To ensure all appropriate patients are risk assessed for Venous Thromboembolism (VTE)

Better Outcomes (Clinical Effectiveness)

- To improve mental health care for adults and children
- To improve dementia care

Improved Experience (Patient Experience)

- To improve outpatient services
- To listen to and act on patient experience to improve services

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 Part 6 of this report (from page 77). 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 2018/19 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

Overview of 2018/19 – Celebrating Success

The following table provides an overview of our successes during 2018/19. Some of the year's highlights include:

April 2018	**Hessle Epilepsy Society Fundraising** A group of volunteers from Hessle Epilepsy Society raised funds to support people with epilepsy and presented thousands of pounds worth of equipment to the Trust.	
May 2018	**Whooping Cough Vaccine** Hull University Teaching Hospitals NHS Trust became one of the first hospital trusts in the country to offer women a vaccine to protect their new-born babies from whooping cough.	
June 2018	**More than three quarters of services rated as "Good"** NHS inspectors rated more than three-quarters of the Trust's services good. Of the services inspected, the Care Quality Commission rated 26 of the 33 areas at Hull Royal Infirmary and Castle Hill Hospital as good.	
July 2018	**The NHS Turned 70** The NHS Celebrated its 70th Anniversary. An event was held at the Double Tree Hilton, Hull, to celebrate.	
August 2018	**Quilt of Memories** A three year project designed to honour those lost to leukaemia and other cancers received its official unveiling at Castle Hill Hospital in Cottingham. Over two hundred pairs of hands were involved in making the 'Quilt of Memories', a giant patchwork quilt which includes 140 individually hand-crafted quilt blocks.	
September 2018	**Dementia Friendly A&E** Two frontline nurses spearheaded a drive to make Hull's A&E department a friendlier place for patients with dementia and their families. Carers are now able to stay with relatives when they are taken to the Emergency Department at Hull Royal Infirmary.	
October 2018	**Baby Loss Awareness Week** Midwives and child care experts staged a special event at Hull Women and Children's Hospital to mark the start of Baby Loss Awareness Week. Hull University Teaching Hospitals NHS Trust is supporting the 60 charities raising awareness of miscarriage, stillbirth and baby loss in the UK.	

November 2018	**Veteran Aware Hospital** As the nation marked the 100th anniversary of the end of the First World War, the NHS celebrated the first wave of new Veteran Aware hospitals. Hull University Teaching Hospitals NHS Trust is one of the 24 acute hospital trusts accredited by the Veterans Covenant Hospital Alliance (VCHA) to lead the way in improving NHS care for veterans and members of the Armed Forces community.	
December 2018	**Mental Health Crisis Support** Humber Teaching NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust teamed up to ensure people in mental health crisis are supported as much as those facing physical health emergencies this winter. Posters and social media platforms were used to highlight the different services in the community, saving people the anxiety of travelling to the Emergency Department at Hull Royal Infirmary.	
January 2019	**Dignity Action Day** Staff at the Queen's Centre celebrated Dignity Action Day, at the Queens Centre Castle Hill. The event showcased examples of how staff have been working to ensure patients are treated with both dignity and respect.	
February 2019	**Top Ten Trust for Flu Vaccine** Hull was named among the top ten NHS trusts in the country for protecting patients, staff and their families from flu last winter. Hull University Teaching Hospitals NHS Trust achieved the national target of 75% by mid-November 2018, the fastest it has been reached in the Trust's history. By January 2019, 6,500 staff – including 83% involved in direct patient care – had received the flu jab	
March 2019	**World Kidney Day** A specialist kidney team marked 50 years since the service was launched in Hull as part of this year's World Kidney Day. Hull has a dedicated kidney unit at Hull Royal Infirmary, satellite units led by nurses in Bridlington, Grimsby and Scunthorpe and patient outreach clinics at Bridlington, Goole, Grimsby and Scunthorpe. People who have undergone treatment for kidney treatment, including dialysis and transplants joined staff to mark the global awareness day.	

Part 2: Review of our Quality Achievements

This section includes:

- An overview of the 2018/19 Quality and Safety improvement priorities
- A detailed update on the performance, achievements and further improvements against the 2018/19 priorities

Overview of 2018/19 – Performance against Priorities

The following table provides an overview of performance against all targets during 2018/19. We recognise that not all of our quality and safety improvement priorities for 2018/19 have been achieved in full; however significant improvement in some areas is demonstrated and we will continue to work and further improve on these areas during 2019/20.

Key

	Target achieved
	Target was not achieved, but improvements were made on the previous year
	Target was not achieved, performance remained the same or deteriorated
	Targets were discontinued*

*The reasons why the targets were discontinued can be found on pages 11 to 26, detailed on the relevant priority area pages.

Quality and Safety Improvement Priority	Target	Status
Nutrition and Hydration	100% of Patients (whose current clinical condition allows) will have their weight recorded during their current in-patient episode	
	85% of Patients will have their Food Record Chart completed consistently & correctly	
	85% of patients will have had their nutritional screening tool completed daily in the last 5 days	
	85% of patients will have had their nutritional screening tool completed correctly	
	85% of appropriate patients will have snacks offered	
	85% of patients (with a Hydration chart) will have their FRC completed consistently & correctly	
	85% of patients will feel they have enough choice at meal times	
	85% of patients will feel that they get the right amount of food & drink	
Medicine Optimisation	80% of pharmacists to have undertaken e-learning module “VTE prevention in secondary care” (available on HEY247)	
Deteriorating Patient	Indicators removed in year to accommodate the launch of NEWS2	
Avoidable Hospital Acquired Infections	To have 0 Hospital acquired MRSA bacteraemia	
	To not exceed <=99% of threshold of 52 Hospital acquired Clostridium Difficile	
	To not exceed <=99% of threshold of 44 Hospital acquired MSSA	
	To not exceed <=99% of threshold of 73 Hospital acquired E. Coli	
Avoidable Hospital Acquired Pressure Ulcers	Achieve 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas	
	85% compliance for nursing staff with tissue viability bedside assessment in all clinical areas	
	To have no avoidable hospital acquired Stage 3 pressure ulcers	
	To have no avoidable hospital acquired Stage 4 pressure ulcers (target included July 2018)	
	To have no more than 8 avoidable hospital acquired unstageable pressure ulcers	
	To have no more than 23 avoidable hospital acquired SDTI	
	To have a 25% reduction in the number of avoidable hospital Acquired stage 2 pressure ulcers (no more than 39)	
	All root cause analysis investigations of hospital acquired pressure sores completed within 14 days	
	Fully quorate at Trust’s Wound Management Committee	
	100% compliance with duty of candour – written	

	100% compliance with duty of candour – verbal	
	100% compliance with duty of candour – feedback	
Acute Kidney Injury	Delivery of the AKI quality improvement project	
Patient Falls	To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	
	To further reduce the number of patient falls per 1000 bed days for patient falls	
	To reduce the number of falls resulting in a fracture neck of femur	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For H9	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For H90	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For H8/H80	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For EAU	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For C29	
	50% of registered and non-registered nurses to have completed the falls prevention e-learning For C31	
	50% of Allied Health Professionals to have completed the falls prevention e-learning	
Sepsis	2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis – Inpatient	
	2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis - Emergency Department	
	2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour - Inpatient	
	2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour - Emergency Department	
	To improve the number of staff completing SOBs training	
Avoidable Mortality	To review all deaths where family, carers or staff have raised a concern about the quality of care provision.	
	To review all deaths of patients who are identified to have a learning disability and/or severe mental illness	
	The Trust has signed up to the Learning Disabilities Mortality Review Programme (LeDeR). Deaths of patients with learning difficulties are reviewed under this framework, which was developed by the University of Bristol.	
	To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.	
Transition between Paediatric and Adult care	Review deaths where learning will inform the organisations planned or existing Quality Improvement work, for example a sample of deaths associated to Sepsis.	
Patient Experience	Continue to achieve =>85% of formal complaints closed within the 40 day target	
	To Reduce the number of repeat complaints by 20% <83	

The following section of the Quality Account provides a more detailed account on achievements and areas for further improvement for each of the priorities above.

Nutrition and Hydration

What we aimed to achieve in 2018/19:

The aim of this project was to improve patients' nutrition by completing the required actions and improvements from the March 2018 Nutritional Prevalence re-audit and to improve compliance with the Nutrition Fundamental Standards.

The priority aimed to achieve the following specific targets by the end of March 2019 however these were discontinued in December 2018:

- 100% of wards to achieve a minimum of 80% compliance on the Nutrition Fundamental Standard: Amber
- 100% of wards to achieve a minimum of 80% compliance with completion of Food Record Charts on the Matrons Handbook
- 100% of wards to achieve a minimum of 80% compliance with completion of Fluid Balance Charts (Paper Copies) on the Matrons Handbook

In January 2019, the project was amended to provide greater clarity and the following targets were included and agreed:

- 100% of Patients (whose current clinical condition allows) will have their weight recorded during their current in-patient episode (Data collected monthly via Classic Safety Thermometer)
- 85% of Patients will have their Food Record Chart (FRC) completed consistently & correctly (Data collected via Fundamental Standards)
- 85% of patients will have had their nutritional screening tool completed daily in the last 5 days (Data collected via Fundamental Standards)
- 85% of patients will have had their nutritional screening tool completed correctly (Data collected via Fundamental Standards)
- 85% of patients with a Hydration Record Chart (HRC) will have it completed consistently & correctly (Data collected via Matrons Hand Book Quarterly)
- 85% of patients will feel they have enough choice at meal times (Data collected via Matrons Hand Book Quarterly)
- 85% of patients will fell that they get the right amount of food & drink (Data collected via Matrons Hand Book Quarterly)

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
100% of Patients (whose current clinical condition allows) will have their weight recorded during their current in-patient episode	No baseline	88%	
85% of Patients will have their Food Record Chart (FRC) completed consistently & correctly	No baseline	68.9%	
85% of patients will have had their nutritional screening tool completed daily in the last 5 days	No baseline	89%	
85% of patients will have had their nutritional screening tool completed correctly	No baseline	94.8%	
85% of appropriate patients will have snacks offered	No baseline	98%	
85% of patients (with a Hydration chart) will have their FRC completed consistently & correctly	No baseline	50.7%	
85% of patients will feel they have enough choice at meal times	No baseline	89%	
85% of patients will feel that they get the right amount of food & drink	No baseline	91%	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

This project was reviewed part-way through the year to consider the impact it was having on improving nutrition and hydration. During the review it was noted that in order to consider if previous years improvements had been embedded, it was necessary to focus on gathering data using the Matron Handbook audits and the Nutrition Fundamental Standards to obtain a better understanding. Within year, the Teams also focused on the review and implementation of key policies, such as the Nutrition and Hydration Policy and a hydration guideline and the nutrition and hydration care bundle. The Care Bundle was further simplified and is one unified record which includes the nutritional screening assessment tool, weight record, hydration care plan and the individualised care plan to support staff in the completion of all aspects of nutrition records. The process for Food Record Chart completion was amended and a trial commenced for catering staff to be trained to complete certain areas of the food record chart, such as the morning and afternoon snack sections. Initial feedback from the trial is positive however the full benefits will be reviewed in 2019.

Further improvements identified:

Further improvements in Nutrition and Hydration have been identified and it is therefore a quality and safety priority for 2019/20 (see page 73) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 64-67.

The focus for further improvements will be:

- Focussed Task and Finish Group for key clinical areas such as Medical Elderly wards to review existing processes for supporting patients who require assistance
- Enhancement of existing nutritional training for non-registered nursing staff
- Nutrition Census, which is a type of audit looking at all processes around a specific area, completed and actions agreed to address any shortcomings
- Review of the Pre-Operative Fasting of Adults, Infants and Children process undergoing a general anaesthetic

Medicine Optimisation

What we aimed to achieve in 2018/19:

The aim of this project was to ensure our patients receive the right medicines, at the right dose at the right time as well as compliance with best practise guidance and regulations. This would be achieved by addressing any medicine management issues raised by the CQC and within the Trust Quality Accounts, as well as potential areas for improvement highlighted from Trust governance systems such as incident reporting, audits and others including the discharge liaison teams and patient feedback.

This priority aimed to achieve the following specific targets by the end of March 2019:

- 80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care" (available on HEY247) by March 2019 (Baseline 16%)

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care"	16%	100%	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project was measured by the attainment of 80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care". This was achieved in July 2018 at 88% and rose to 100% compliance in November 2018 and remained at this rate for the rest of the 2018/19 programme. In addition a number of other actions were implemented including:

- Introduction of a Biosimilar for Adalimumab to maximise resources in a safe manner. A biosimilar is a biologic medical product that is almost an identical copy of an original product that is manufactured by a different company. The use of which can usually save NHS Trusts a significant amount of money. Around 80% of patients on Adalimumab were transferred onto the biosimilar at the time of closure
- Additional support for adult cystic fibrosis patients by the introduction of an annual medication review
- Improving the knowledge and awareness on VTE prevention by the introduction of additional training around the topic; initially by Pharmacists however this will is being considered for roll out to other professions by the Trust Thrombosis Committee
- Review of current medication pre-packs available on wards to facilitate speedier discharge for patients
- Project on the 5th floor at Hull Royal Infirmary on utilising, and potentially expanding, the number of pharmacists transcribing discharge prescriptions to contribute to improving morning discharge figures was completed. The project concluded that the value of a prescribing pharmacist had shown to be advantageous to this clinical area and had shown to improve patient safety by reducing the number of prescribing errors and the addition of a prescribing pharmacist as part of the team helped to support discharge planning and discharge flow and offered support to the junior doctors to release their time for clinical duties
- A Task and finish group was established to identify and produce medicines management competencies for registered nurses. A number of competencies were developed however the group continues this aim into 2019/20 to review any further competencies or amendments to the existing competencies

Further improvements identified:

Further improvements in Medicines Optimisation have been identified and it is therefore a quality and safety priority for 2019/20 (see page 73) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 64-67. The focus for further improvements will be to improve key aspects of the medicines management discharge process which will in turn have a positive impact on the experience of many patients at the point of discharge.

Deteriorating Patient

What we aimed to achieve in 2018/19:

The aim of this project was to ensure that the Trust's Recognition of the Deteriorating Patient Policy is fully implemented ensuring patient's observations are completed in a timely manner and where deterioration is detected they are appropriately escalated for medical review and treatment. The project will also support the Trust-wide adoption of the revised National Early Warning Score (NEWS2) by March 2019.

At the start of the project, we aimed to achieve the following specific targets by the end of March 2019 however were discontinued in June 2018:

- Demonstrate improvement on the re-audit of the annual Census Clinical Observation Audit in 2018
- Continue to achieve >85% compliance with the Fundamental Standard Patient Centred Care

The following targets were included and agreed that these would be monitored until March 2019. However, during the year, NEWS2 was launched nationally. The Trust commenced the roll-out programme for NEWS2 and discontinued the performance indicators below whilst NEWS2 was embedded:

- Improve compliance with a NEWS Score 1-4 with documented escalation in the Census Audit
- Improve compliance with a NEWS Score 5-6 with documented escalation in the Census Audit
- Improve compliance with a NEWS Score 7+ with documented escalation in the Census Audit

Actual outcome:

As stated above, the targets for this project were discontinued in year and are therefore not reported within this review. It should be noted that whilst the specific performance indicators were not measured the improvements achieved are detailed in the following section e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project moved towards the focus on the delivery of NEWS2. Key improvements were:

- Rollout of NEWS2 across the Trust. 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.
- Development and ratification of a revised Recognition of the Deteriorating Patient Policy which is compliant with NICE CG50. NICE CG50 is published 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 our patients.
- Updated corresponding deteriorating patient bundle devised for use with appropriate patients
- Over 50% of relevant Trust staff have completed the newly developed NEWS2 training along with a high number of face-to-face training sessions delivered

Further improvements identified:

Further improvements in Deteriorating Patient have been identified and it is therefore a quality and safety priority for 2019/20 (see page 73) and will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 64-67. The focus for further improvements will be to improve the levels of required escalation of deteriorating patients measured by the reduction in the number of incidents rated moderate and above, by ward, Health Group and at Trust Level following the roll out of e-Observations. E-Observations is a system that records patient vital signs, via shared mobile devices which is being rolled out across the Trust during 2019.

Avoidable Hospital Acquired Infections

What we aimed to achieve in 2018/19:

The aim of this project was to reduce the number of avoidable hospital acquired infections by ensuring compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) by focussing on the review of the Trust's Infection Prevention and Control Care Bundle and participation in the NHS Improvement Urinary Tract Infection Collaborative Project.

This priority aimed to achieve the following specific targets by the end of March 2019:

- To have 0 Hospital acquired MRSA bacteraemia
- To not exceed the threshold of 53 for Hospital acquired Clostridium Difficile
- To not exceed the threshold of 44 for Hospital acquired MSSA
- To not exceed the threshold of 73 Hospital acquired E. Coli

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
To have 0 Hospital acquired MRSA bacteraemia	1	3	
To not exceed <=99% of threshold of 52 Hospital acquired Clostridium Difficile	38	32	
To not exceed <=99% of threshold of 44 Hospital acquired MSSA	36	59	
To not exceed <=99% of threshold of 73 Hospital acquired E. Coli	110	112	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

It was noted that the Trust achieved its target in relation to Clostridium Difficile with 32 reported which is a reduction on the 38 reported and well below the <=99% threshold of 52.

A working group was formed to focus on IV device insertion, reason for use and management as a significant number of hospital acquired infections can be attributed to poor management of devices. In addition, the Trust joined an improvement collaborative run by NHS Improvement to work with colleagues across the region to review practice in relation to urinary tract infections and device management. In addition, a review of previous 'Matching Michigan' principles (vascular access device management best practice standards) is in the early stages and will continue into 2019/20.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. This is due to the work that is still to be completed which will focus on embedding current practice rather than new quality improvement initiatives. The focus will be on a refreshed Infection Prevention and Control strategy and the completion and monitoring of an Infection Prevention and Control action plan which is a national requirement of all trusts to have in place. In addition, numbers of hospital acquired infections will continue to be monitored at the Trust Board.

Avoidable Hospital Acquired Pressure Ulcers

What we aimed to achieve in 2018/19:

The aim of this project was to reduce the number of avoidable hospital acquired pressure ulcers. It was also to embed the existing clinical and governance processes for the management of pressure ulcers by ensuring that nursing staff are compliant with training and that lessons are learnt from Root Cause Analysis investigations and incidents.

This priority aimed to achieve the following specific targets by the end of March 2019:

- Achieve 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas (Baseline 78.5%)
- All root cause analysis investigations of hospital acquired pressure sores completed within 14 days (Baseline 74.2%)
- Fully quorate at Trust's Wound Management Committee (Baseline - not quorate)

However additional targets were included within the 2018/19 programme:

- 85% compliance for nursing staff with tissue viability bedside assessment in all clinical areas
- To have no avoidable hospital acquired Stage 3 pressure ulcers
- To have no avoidable hospital acquired Stage 4 pressure ulcers
- To have no more than 8 avoidable hospital acquired unstageable pressure ulcers
- To have no more than 23 avoidable hospital acquired SDTI
- To have a 25% reduction in the number of avoidable hospital Acquired stage 2 pressure ulcers (no more than 39)
- 100% compliance with duty of candour – written
- 100% compliance with duty of candour – verbal
- 100% compliance with duty of candour – feedback

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Achieve 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas	78.5%	84.9%	
85% compliance for nursing staff with tissue viability bedside assessment in all clinical areas	62.4%	81.4%	
To have no avoidable hospital acquired Stage 3 pressure ulcers	1	0	
To have no avoidable hospital acquired Stage 4 pressure ulcers (target included July 2018)	0	0	
To have no more than 8 avoidable hospital acquired unstageable pressure ulcers	13	9	
To have no more than 23 avoidable hospital acquired SDTI	37	37	
To have a 25% reduction in the number of avoidable hospital Acquired stage 2 pressure ulcers (no more than 39)	52	61	
All root cause analysis investigations of hospital acquired pressure sores completed within 14 days	74.2%	81.3%	
Fully quorate at Trust's Wound Management Committee	Not quorate	Quorate	
100% compliance with duty of candour – written	100.0%	86.4%	
100% compliance with duty of candour – verbal	100.0%	95.5%	
100% compliance with duty of candour – feedback	93.6%	100%	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project had a number of milestones in place to review and update Health Group reports that were submitted to the Trust's Wound Management Committee in order to record and demonstrate learning which were implemented by the committee. In addition, a scoping exercise was completed to review the number of Tissue Viability link nurses which found that the numbers were sufficient for the Trust and no additional actions were required.

Further improvements identified:

Further improvements in pressure ulcers have been identified and it is therefore a quality and safety priority for 2019/20 (see page 74) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 64-67.

The focus for further improvements will be on the implementation of NHS Improvements national framework as well as to improve the care of patients within the Trust and to reduce the number of avoidable pressure care damage by ensuring that appropriate risk assessments, a plan of care and meaningful interventions are carried out on all relevant patients.

Acute Kidney Injury

What we aimed to achieve in 2018/19:

The aim of this project was to increase compliance with NICE Quality Standard 76 – Acute Kidney Injury (AKI), in order to have a positive impact on patient mortality, morbidity and length of stay, thereby reducing costs per patient. The project aims to increase compliance specifically the following Quality Statements from NICE Quality Standard 76:

- 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 and urine output monitored.
- Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.

This priority aimed to achieve the following specific targets by the end of March 2019:

- Delivery of the AKI quality improvement project

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Delivery of the AKI quality improvement project	No baseline	Partially delivered*	

* The project sustained some delays due to the case note review element of the re-audit taking longer than expected. As such, the project will be continued into 2019/20 to review the findings from the re-audit and additional milestones agreed if required. However, this project has been rated as Green due to all elements of improvement work having been completed within year.

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

During the project term, the lead delivered training on Acute Kidney Injury, and how it impacts on patient mortality, morbidity and length of stay, to selected clinical groups within key areas of the Trust, including, the Renal Department and Acute Assessment Unit, along with targeted training delivered to Junior Doctors at their induction. An Acute Kidney Injury toolkit was developed and implemented for use on the acute medical unit to be used alongside the training.

Further improvements identified:

Further improvements in Acute Kidney Injury have been identified and it is therefore a quality and safety priority for 2019/20 (see page 7) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 64-67.

The focus for further improvements will be the completion of the report following the re-audit to ascertain the improvements made by completing the training and developing the toolkit. Compliance with the NICE Quality Standard 76 Quality Statements 2, 3 and 4 will be assessed and additional actions if required will be part of the 2019/20 project.

Patient Falls

What we aimed to achieve in 2018/19:

The aim of this project was to achieve compliance with NICE guidance which will drive through the improvement in falls prevention through the improved completion of the Multi Factorial Assessment Tool (MFAT). It also focused on the outcomes for the patient following a fall to learn lessons from the root cause analysis investigations completed along with the achievement of compliance with the MFAT which will drive forward improvements in falls prevention.

This priority aimed to achieve the following specific targets by the end of March 2019:

- To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above (Baseline 0.17)
- To further reduce the number of patient falls per 1000 bed days for patient falls (Baseline7.47)
- Continue to achieve >50% of clinical staff in the identified high risk areas to have completed the falls prevention e-learning
- To reduce the number of falls resulting in a fracture neck of femur (Baseline 27)

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	0.17	0.161	
To further reduce the number of patient falls per 1000 bed days for patient falls	7.47	7.30	
To reduce the number of falls resulting in a fracture neck of femur	27	16	
50% of registered and non-registered nurses to have completed the falls prevention e-learning For H9	50%	100%	
50% of registered and non-registered nurses to have completed the falls prevention e-learning For H90	60%	47.1%	
50% of registered and non-registered nurses to have completed the falls prevention e-learning For H8/80	81%	78.8%	
50% of registered and non-registered nurses to have completed the falls prevention e-learning For EAU	61%	57.1%	
50% of registered and non-registered nurses to have completed the falls prevention e-learning For C29	16%	22.6%	
50% of registered and non-registered nurses to have completed the falls prevention e-learning For C31	62%	50%	
50% of Allied Health Professionals to have completed the falls prevention e-learning	17%	15.9%	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project, whilst not achieving all performance indicators, has achieved the overall aim, which is to be compliant with NICE guidance. This is evidenced by the annual achievement of a reduction in number of falls per 1000 bed days including those rated moderate or above, and a reduction in the number of fractured neck of femurs reported. The project also developed focussed action plans for high risk falls areas including Department of Medical Elderly and Oncology and a new Multi Factorial Assessment Tool (MFAT) documentation and review of falls prevention care bundle. Following this, the Falls NICE guidance was reviewed and compliance assured.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. However it was identified that auditing of compliance with NICE and subsequent falls documentation will form part of the focus for 2019/20 for the Trust Falls Committee.

Sepsis

What we aimed to achieve in 2018/19:

The aim of this project was to continue the education and increase awareness of staff within the Trust around sepsis and the management of patients on the sepsis pathway across the organisation. In addition, the focus will be on the development of appropriate coding for patients.

This priority aimed to achieve the following specific targets by the end of March 2019:

- The percentage of patients who met the criteria for sepsis screening and were screened for sepsis (Baseline of inpatient 92% and ED 87%)
- The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour (Baseline of inpatient 64.7% and ED 55.6%)
- To improve the number of staff completing Sepsis and Observations training (SOBs) training (target included in July 2018)

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis - Inpatient	92.0%	85.2%	
2a: 90% of patients who met the criteria for sepsis screening and were screened for sepsis - Emergency Department	87.0%	94%	
2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour – Inpatient	64.7%	73.5%	
2b: 90% of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour - Emergency Department	55.6%	52.2%	
To improve the number of staff completing SOBs training	1188	1705	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The aim of the project was to continue the education, increase awareness and understanding within the Trust of how to recognise sepsis and the management of patients using the sepsis pathway. The project has achieved the aim as demonstrated by the completion of the majority of agreed milestones around training of staff, the attendance and production of several key awareness events and the continued increase in nursing staff trained between April and December 2018:

- A number of training sessions and awareness events were facilitated or attended by the Trust Sepsis Team, including the Regional Conference and Patient Safety Congress
- Numbers of nursing staff trained rose from 1223 in April 2018 to 1705 in December 2018
- A coding project was commenced following discrepancies with the incidences of sepsis and the clinical reviews. This was contributed to by the over diagnosis of sepsis. The Sepsis Team wanted to further understand how the diagnosis made by clinicians is converted into coding and how it affects the funding for the patients care. A pilot was developed and the Sepsis and Coding Teams reviewed notes. This has resulted in a more accurate reporting of sepsis for the Trust and a greater understanding of sepsis
- Since the appointment of the Sepsis Team there have been dramatic improvements in the Trusts CQUIN figures resulting in the Trust receiving a letter from NHS England congratulating on the results.

The project did not meet a number of the targets for a number of reasons. During 2018/19 the way that the data was collected for the CQUIN audits changed and a wider more random s maple of patients were reviewed, using the criteria of patients scoring a NEWS of 5 rather than focusing on those which were admitted with 'sepsis'. In addition, the pressures which the Trust's Emergency Department managed during the winter period have impacted on the ability to deliver Intravenous (IV) antibiotics within the hour. The results show that whilst screening within inpatient areas was not optimum, the management of sepsis patients once identified has improved on last year's figures for the same time period. When the audit data was reviewed, it was found that, in general, the majority of patients received IV antibiotics within an acceptable time period although not within the hour.

The Trust's Sepsis Team are continuing to review the audit data to provide focused education for specific areas and clinical staff whilst promoting positive feedback to staff who have shown good sepsis identification or management. The introduction of more electronic clinical systems across the Trust over 2019/20 such as e-Prescribing and e-Observations will also improve audit results.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. However it was identified that some improvements are required around the CQUIN results. This will continue to be monitored by the Trust Sepsis Team and further projects considered if specific improvements are required.

Avoidable Mortality

What we aimed to achieve in 2018/19:

The aim of this project was to aid the organisation in the delivery of the national objective of a standardised approach to review of hospital mortality. This project prepared the organisation for a programme of work underway in NHS England's Patient Safety Domain, in relation to, standardising retrospective case record review (RCRR) for in-hospital deaths.

This priority aimed to achieve the following specific targets by the end of March 2019:

- Review all deaths where family, carers or staff have raised a concern about the quality of care provision.
- Review all deaths of patients who are identified to have a learning disability and/or severe mental illness
- Review all deaths of patients who are identified to have a learning disability, via the LeDeR Review
- Review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.
- Review deaths where learning will inform the organisations planned or existing Quality Improvement work, for example a sample of deaths associated to Sepsis.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
To review all deaths where family, carers or staff have raised a concern about the quality of care provision.	No baseline	100%	
To review all deaths of patients who are identified to have a learning disability and/or severe mental illness	No baseline	100%	
The Trust has signed up to the Learning Disabilities Mortality Review Programme (LeDeR). Deaths of patients with learning difficulties are reviewed under this framework, which was developed by the University of Bristol.	No baseline	100%	
To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.	No baseline	100%	
Review deaths where learning will inform the organisations planned or existing Quality Improvement work, for example a sample of deaths associated to Sepsis.	No baseline	58 cases reviewed	

The following sections provide details on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The avoidable mortality project has made significant progress during 2018/19. Key areas of improvement have focused on:

- Moved towards learning from patient morbidity, in addition to mortality. The Trust Mortality Committee was renamed, with a new terms of reference written to reflect this move towards learning from morbidity and mortality.
- Development of a standardised "quarterly themes and trends" report template, that is completed by Paediatric Emergency Medicine. Some of the key findings include:
  - Discharging children too early who have abnormal vital signs
  - Delays to triage and delays to see a clinician
  - Continual use of 2 steroid medications for croup, despite no evidence to suggest benefits.

    - Delay in receiving scan results
    - Delays in scans being received when transferred from Leeds General Infirmary
- Development and implementation of the Surgical Mortality Steering Group.
- System-wide reviews commissioned and undertaken by the Trust, collaborating with the Hull Clinical Commissioning Group (CCG) and City Health Care Partnership (CHCP), focusing on patients who died as a result of Atrial Fibrillation. Key findings were presented by the Clinical Outcomes Manager at the Hull Clinical Commissioners learning event, held at the KC Stadium in Hull. The main key finding related to the need for improving documentation when a decision is made not to commence a patient on oral anticoagulation. One positive result from this is that there is now an increased level of awareness of multi-agency reviews across the broad spectrum of the regions healthcare providers.
- Focussed Structured Judgement reviews commissioned and undertaken, focusing on the deteriorating patient, specifically on those patients who had an unplanned admission to ICU. Some of the key finding includes:
    - Delay in acting upon instructions present on DNACPR form
    - Inappropriate time of transfer to ICU (outside of acceptable hours).
    - Delay in acting upon abnormal observations.
- Initial Mortality Screening form developed and launched within selected Medicine Health Group Specialties.
- E-learning package designed and rolled out, for use in training Structured Judgement reviewers and implemented for all relevant staff to access on HEY247, which is a Trust internally managed education system for all staff to access and complete training.
- Further reviews commissioned and undertaken surrounding end of life planning, in particular, planning for end of life for patients who are admitted to the Trust from a care home. Detailed reports were submitted to the Trust Mortality and Morbidity Committee that highlighted the requirement for further reviews once the Trust ReSPECT form became embedded.
- Inclusion of palliative care Consultants at the Trust Mortality and Morbidity Committee.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority. The role of the upcoming Trust Medical Examiner will allow for full scrutiny to be applied to all in-hospital deaths. The Trust aims to implement the Medical Examiner role in 2019.

Transition between Paediatric and Adult care

What we aimed to achieve in 2018/19:

The aim of this project was to ensure there are effective and robust processes in place for young people who transition to the adult care services.

This priority aimed to achieve the embedding of the procedural document ensuring the effective transition for young people to adult services by the end of March 2019.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Procedural document ensuring the effective transition for young people to adult services embedded	No baseline	Assurance received	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The aim of this project was to ensure there are effective and robust processes in place for young people who transition to the adult care services following concerns raised at the February 2014 CQC inspection which required the Trust to improve its processes and services for the transition of children and young people to adult services. The report completed by the project leads evidenced compliance with the toolkit and Transition guideline, although numbers were minimal. One recommendation was made, which was to amend the current Trust Transition guideline to allow the use of other nationally recognised transition toolkits as required, for example 'Goals for Diabetes', which was implemented immediately. There are currently no other toolkits used other than the 'Goals for Diabetes' however the guideline now provides direction for staff if use is required. .

The key milestone for the project was to establish a baseline review of compliance following the implementation of the 'Ready Steady Go' toolkit within the Trust, which was completed, along with the amendment to the guideline which was identified as a recommendation of the review. The lead has also completed a re-review of the NICE Guidance for Transition and can confirm compliance, although a formal BCR will be completed at a later date.

Further improvements identified:

This project will not be carried forward into 2019/20 as a quality and safety priority due to the achievement of the aim.

Patient Experience

What we aimed to achieve in 2018/19:

The aim of this priority was to seek and act on feedback from our patients their relatives and carers. This will enable the Trust to learn what is working well and what requires further improvement and to use the feedback to inform those required services changes.

This priority aimed to achieve the following specific targets by the end of March 2019:

- Continue to achieve >85% of formal complaints closed within the 40 day target and actions recorded where appropriate
- To reduce the number of repeat complaints by 20% <83

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2017/18	Performance 2018/19	Status
Continue to achieve =>85% of formal complaints closed within the 40 day target	92.85%	8Patient6%	
To Reduce the number of repeat complaints by 20% <83	104	102	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The project performed well with 86% formal complaints closed within 40 days for 2018/19 and a total of 102 repeat complaints for 2018/19 which was a slight reduction on the baseline of 104 although did not meet the target of a reduction of 20%. The project completed a number of milestones throughout the year to increase volunteer numbers, which rose from 450 to 500 and volunteer contribution onto the ward and specific work streams including falls prevention. The Trust's Interpreter Services Policy was reviewed and updated, virtual British Sign Language interpretation is available in the majority of Outpatient areas across the Trust, including Surgical, Medicine, Chest, Eye and Orthopaedic at Hull Royal Infirmary and General Outpatients and Ear Nose and Throat at Castle Hill Hospital. As the rollout of Wi-Fi implemented across the remaining areas of the Trust in 2019/20, more iPads will be issued for staff to use. A reduction in spend was also reported for interpreter services; reducing spend for 2018/19 to £325.4k from £452.2k in 2017/18. The Trust Patient Experience Team provided a short 30 minute session explaining the difference between PALs and formal Complaints and includes scenarios from actual complaints received. Within 2018/19 over 20 wards and clinical departments were visited and the sessions provided. Feedback from staff has been positive and it is planned to be offered to all areas throughout 2019/20.

Further improvements identified:

Further improvements in patient experience have been identified and it is therefore a quality and safety priority for 2019/20 (see page 76) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2019/20. For more information on the QIP see pages 64-67.

The focus for further improvements will be:

- Improved patient engagement with new and existing groups
- Increased engagement with key staff groups to review how complaints can be prevented
- Focussed engagement with key wards and senior nursing teams to implement patient engagement initiatives
- Increasing the profile of the Staff Advice and Liaison Service (SALS) to disseminate learning, themes and trends
- Increasing the profile of existing interpreter provision

Part 3: Review of our Quality Performance

This section includes:

- Trust performance for 2017/18 and 2018/19 against the NHS Outcomes Framework quality indicators and planned actions the Trust intends to/has taken to improve performance
- Learning from Deaths
- Seven Day Services
- An overview of the patient safety incident reporting rates and actions taken to improve incident reporting across the organisation
- An overview of serious incidents and never events and actions taken to learn lessons
- Trust compliance with the national patient safety alerts
- NHS Staff Survey Results and Cultural Transformation

The NHS Outcomes Framework: Quality Indicators

What is the NHS Outcomes Framework?

Measuring and publishing information on health outcomes are important for encouraging improvements in quality. The White Paper*: Liberating the NHS* outlined the Coalition Government's intention to move the NHS away from focusing on process targets to measuring health outcomes.

The NHS Outcomes Framework reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. Performance against the quality indicators that are relevant to Hull University Teaching Hospitals NHS Trust are detailed below. They relate to:

- Summary hospital level mortality (SHMI)
- Patient reported outcome measures (PROMS)
- Readmission rate into hospital within 28 days of discharge
- The Trust's responsiveness to the personal needs of our patients
- Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends
- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism
- The C.Difficile infection rate, per 100,000 bed days
- The number of patient safety incidents reported and the level of harm

The Hull University Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:

- 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 (SHMI):

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
• the value of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period*	109	108	100	69	126
• the banding of the SHMI for the Trust for the reporting period*	2	2	2	3	1
• the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	26.7%	27.9%	33.6%	59.5%	14.3%

*Most recent data on NHS Digital for period October 2017 - September 2018, published in February 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:

- Avoidable mortality was a quality and safety priority in 2018/19. Actions taken and improvements achieved during 2018/19 can be found on page 23-24.
- The Trust has met all requirements of the NHS Improvement Learning from Deaths Outcome Framework. Further information on this can be found on pages 32-33.
- The Trust has prepared for the introduction of the Medical Examiner role which will commence in 2019.
- The Trust continues to monitor mortality rates and learning from deaths at the Mortality Committee and the Trust Board.

The table below details performance against the Patient Reported Outcome Measures (PROMs):
Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement, in England, based on responses to questionnaires before and after surgery. NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

Along with the evidence found in the consultation, the rationale for this decision is that:

- Surgical treatment of varicose veins is currently much less frequent and the condition is usually not a major cause of patient debility;
- Groin hernia surgery is offered mainly to reduce the risk of requiring emergency surgery, rather than to relieve symptoms, which are often relatively minimal. This, along with the fact that there is no condition-specific PROM for groin-hernia surgery, means that the existing PROM has limited value.

Prescribed Information	2017/18 Finalised Data	2018/19	National Average	Best performer	Worst performer
• groin hernia surgery EQ-5D Average health gain	0.131	--	--	--	--
• varicose vein surgery EQ-5D Average health gain	***	--	--	--	--
• hip replacement surgery EQ-5D Average health gain (Primary)*	0.476	0.454	0.468	0.566	0.372
• hip replacement surgery EQ-5D Average health gain (Revision)*	***	0.237	0.289	0.380	0.141
• hip replacement surgery Oxford Hip score Average health gain (Primary)*	22.9	22.8	22.7	26.3	18.3
• hip replacement surgery Oxford Hip score Average health gain(Revision)*	***	11.5	13.9	17.7	10.7
• knee replacement surgery EQ-5D Average health gain (Primary)*	0.302	0.32	0.338	0.417	0.233
• knee replacement surgery Oxford Knee score Average health gain (Primary)*	17.1	16.8	17.3	20.6	13.0
• knee replacement surgery EQ-5D Average health gain (Revision)*	***	0.272	0.292	0.328	0.196
• knee replacement surgery Oxford Knee Score Average health gain (Revision)*	***	13	13.1	15.6	9.4

* Most recent (Finalised) data From NHS Digital covers April 2017 – March 2018 published in February 2019
***Average health gain could not be calculated as there were fewer than 30 modelled records
-- NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

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:

- The Trust will focus its attention to improving compliance with the PROMs and improving outcomes for patients. A consultant lead and a Governance lead has been assigned to monitor compliance with the PROMS targets and to undertake improvement work. Further information on actions taken and achievements will be reported in next year's Quality Account.

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

Prescribed Information	2017/18	2018/19	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	9.1%	9.0%	8.8	0.2	16.8
• 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	7.3%	7.6%	7.7	0.4	11.1

* Taken from CHKS for period April 2018 to December 2018

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:

- The Trust will continue to monitor performance against this indicator and will undertake any improvement work if required.

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

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
The Trust's responsiveness to the personal needs of its patients during the reporting period.	66.0	68.5	68.6	85.0	60.5

* Most recent data from NHS digital covers August 2017 - January 2018, published in August 2018

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:

- Patient experience was a quality and safety priority in 2018/19. Actions taken and improvements achieved during 2017/18 can be found on page 26.
- Patient experience has been identified as a quality and safety priority again for 2019/20, which can be found on page 76.

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	2017/18	2018/19	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.	67.32%	84%	81%	100%	52%

* Most recent data from NHS England covers July 2018 – September 2018 (Cumulative), published in November 2018

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:

- The Trust continues to undertake improvement work to improve the NHS Staff Survey results for staff engagement, bullying and harassment and experiences of working for Hull University Teaching Hospitals NHS Trust. An update on the work undertaken during 2018/19 can be found on pages 39-41.

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	2017/18	2018/19	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.	90.34%	92.04%	95.59%	100%	71%

* Most recent data from NHS England covers April 2018 - December 2018 (Cumulative), published in 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:

- VTE was included on the Quality Improvement Plan (QIP) for 2018/19 and progress has been made. Coding of patients and relevant cohorting has been reviewed and the relevant changes were made to ensure that the relevant patients and services are monitored for reporting to be accurate. A number of reviews were also undertaken within the Health Groups to identify the barriers for completing the VTE risk assessment. The reviews demonstrated that patients who are admitted on a short term basis were showing as not complete, although this was incorrect and there were some discrepancies between the electronic patient record and the paper record. Action is being taken to resolve these issues.
- Health Groups and lead Medical Directors continue to monitor the position closely. In order to make further improvements, individual actions from wards are being managed through the medical leadership and via the Thrombosis Committee.
- VTE has been identified as a quality and safety priority for 2019/20, which can be found on page 74.

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

Prescribed Information	2017/18	2018/19	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.	13.2	11.4	13.7	0.0	91.0

* Most recent data from Gov.uk Statistics covers April 2017 - March 2018, published in July 2018

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:

- Avoidable hospital acquired infections was a quality and safety priority in 2018/19. Actions taken and improvements achieved during 2018/19 can be found on page 15.

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

Prescribed Information	2017/18	2018/19	National Average	Best performer	Worst performer
• the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,	58.5	51.3	45.5	158.3	14.9
• the number and percentage of such patient safety incidents that resulted in severe harm or death	0.10	0.56	0.27	0	4.34

* Most recent data from NHS Digital covers October 2017 – March 2018, published in November 2018

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:

- A breakdown of results can be found on page 35.

Learning from deaths update

This section provides an update against the 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.

Prescribed Information		Trust update
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure	During 2018/19, 2290 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: • 523 in the first quarter • 532 in the second quarter • 621 in the third quarter • 614 in the fourth quarter
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure	By 01 April 2019, 315 case record reviews and 12 investigations have been carried out in relation to 2290 of the deaths included in item 27.1. Any Serious Incident investigation where the patient has died will incorporate a full case note review. In 12 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: • 4 in the first quarter • 2 in the second quarter • 3 in the third quarter • 3 in the fourth quarter
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this	12 deaths, representing 0.52% 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 0.53% for the first quarter • representing 0.37 % for the second quarter • representing 0.48% for the third quarter • representing 0.47% 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 likely to be due to problems in the care provided.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3	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 death: • Sub-optimal care of deteriorating patient • Delay in the identification and treatment of Sepsis • End of life care
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see	The Trust has taken a number of actions to contribute to the resolution of the themes identified, these include: • Deteriorating Patient Quality Improvement Project commenced for 2019/20 • Revised policy, “CP326 – Recognition of the Deteriorating

Prescribed Information		Trust update
	item 27.4)	Patient Policy" • Sepsis Awareness Campaign launched • Introduction of the ReSPECT form
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period	Assessments of the impacts of actions mentioned in 27.5 are currently ongoing and will form part of the Quality Improvement Plan for 2019/20
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period	0 case record reviews and 0 investigations completed after 01/04/2018 which related to deaths which took place before the start of 2018/19.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this	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.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8	0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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.

10 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 10 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	Partial compliance	Review of medical staffing resource in key areas. Improved identification and flagging of patients within the electronic patient administration system. Undertake specific work with each specialty to address shortfalls in delivery.
Standard 5 Diagnostic Services	Partial compliance	Recruitment to vacant posts Outsourcing of radiology reporting and development of in-house overnight reporting services to improve reporting turnaround times. Increased CT/MRI capacity through redevelopment of the ground floor of the Tower Block and purchase of additional CT/MRI scanners
Standard 6 Consultant-directed interventions	Fully compliant	
Standard 8 On-going review	Partial compliance	Review of medical staffing resource in key areas, including recruitment to vacant posts and review of job plans. Adoption of a standardised model for the identification of those patients requiring/not requiring a consultant review.

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.

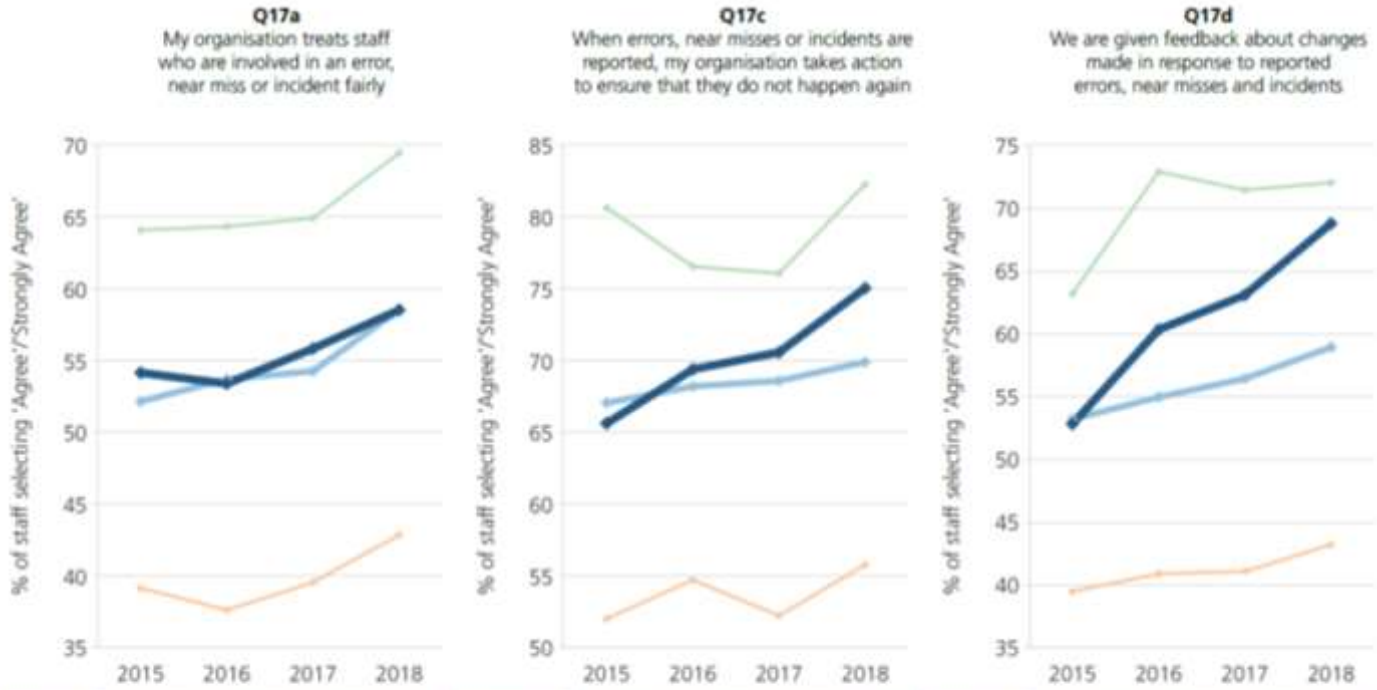
Figure 1 is taken from the latest NHS England National Reporting and Learning Service (NRLS) data report published March 2019. This shows our incident reporting rates compared to other acute Trusts of a similar size. Our Trust is highlighted below and shows no evidence for potential under-reporting of incidents.

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

The Trust's 2018 NHS Staff Survey results, again published in March 2019, has shown improvements around how our staff feel about our patient safety culture, including that more staff now feel 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 2018 Staff Survey Results



	2015	2016	2017	2018
Best	64.1%	64.3%	64.9%	69.5%
Your org	54.1%	53.4%	55.8%	58.5%
Average	52.1%	53.7%	54.3%	58.5%
Worst	39.1%	37.6%	39.5%	42.8%

	2015	2016	2017	2018
Best	80.7%	76.6%	76.1%	82.3%
Your org	65.6%	69.4%	70.6%	75.0%
Average	67.1%	68.2%	68.6%	69.9%
Worst	52.0%	54.7%	52.2%	55.8%

	2015	2016	2017	2018
Best	63.2%	72.9%	71.4%	72.0%
Your org	52.8%	60.3%	63.1%	68.8%
Average	53.2%	54.9%	56.4%	58.9%
Worst	39.5%	40.9%	41.1%	43.2%

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. 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 2016/17, 2017/18 and 2018/19:

	2016/17	2017/18	2018/19
Total Never Events declared	2	6	0
Total Serious Incidents declared	66	60	72
Total*	**68**	**66**	**72**

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

Types of Serious Incident (SI) and Never Events declared during 2016/17, 2017/18 and 2017/18

Serious Incident type	2016/17	2017/18	2018/19
Treatment Delay	17	11	13
Treatment Delay – lost to follow up *(extracted as own category from 2017/18)*	-	8	0
Patient Fall	8	2	3
Delayed Diagnosis	2	1	8
Pressure Ulcer	4	8	7
Surgical/Invasive Procedure incident	2	7	3
Sub-optimal care of the deteriorating patient	8	3	6
12 hour ED trolley breaches	0	0	0
Drug Incident	2	1	4
Unexpected Death	10	10	8
HCAI/Infection Control Incident	1	1	0
Never Event – Retained Foreign Object	0	0	0
Never Event – Wrong Site Surgery	1	3	0
Never Event – Misplaced Naso-gastric Tube	1	0	0
Never Event – Wrong Implant	-	1	0
Never Event – Surgical Invasive Procedure	-	1	0
Never Event – Medication Incident	-	1	0
Retained dressing (not a Never Event)	0	0	0
Retained foreign object (not a Never Event)	2	0	1
Wrong Site Surgery (not a Never Event)	0	0	1
Unplanned NICU admission	2	4	1
Absconded Patient	3	0	0
Maternity/Obstetric Incident *(prior to 17/18 these SI's were reported under different categories)*	-	5	8
Others	6	0	9
Totals	**68**	**66**	**72**

The Trust has not declared a Never Event in 2018/19. This is following the Trust declaring 6 Never Events in 2017/18; more than in any other previous reporting period. Following this increase in Never Events during 2018/19 the Trust put in place actions to improve our patient safety culture and minimise the possibility of a Never Event occurring, including developing a 'Stop the Line' policy which empowers all staff to stop a procedure if they witness unsafe acts.

The Trust believes that being able to achieve a year without a Never Event shows how we have learnt from our previous Never Events, and reflects improvements in our patient safety culture.

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 so that the same errors can be prevented from being repeated.

The Quality Governance and Assurance Department are launching a new way of supporting staff involved in Serious Incidents. Second Person Support Team is a group of Trust staff who will act as a support or listening ear to staff who have been involved in a Serious Incident/Never Event and would like someone to support them through the process, helping them understand about the investigation procedures. This does not replace line management or Occupational Health support. It can be very traumatic for staff to be involved in a serious incident, and then to have to go an investigation process and it is hoped this new service will act as some additional support to staff.

The Serious Incident investigations continue to improve in quality and in the outcome of investigations, including action plans which are implemented to prevent further incidents of harm occurring. The Quality Governance and Assurance Department have throughout the year, worked to improve how patients and their families are involved in the investigations. 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.

We 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.

Patient Safety Alert 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 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 2017/18 and the Trust's progress

Reference	Alert Title	Issue Date	Deadline	Trust Response
NHS/PSA/W/2018/002	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	17-Apr-18	31-May-18	Action complete and matter resolved
NHS/PSA/RE/2018/003	Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)	25-Apr-18	21-Jun-18	Action complete and matter resolved
NHS/PSA/RE/2018/004	Resources to support safer modification of food and drink	27-Jun-18	01-Apr-19	Action complete and matter resolved
NHS/PSA/RE/2018/005	Resources to support safer care for patients at risk of autonomic dysreflexia	25-Jul-18	25-Jan-19	Action complete and matter resolved
NHS/PSA/RE/2018/006	Resources to support the safe and timely management of hyperkalaemia (high level of potassium in the blood)	08-Aug-18	08-May-19	Action complete and matter resolved
NHS/PSA/RE/2018/007	Management of life threatening bleeds from arteriovenous fistulae and grafts	12-Nov-18	13-May-19	Action complete and matter resolved
NHS/PSA/RE/2018/008	Safer temporary identification criteria for unknown or unidentified patients	05-Dec-18	05-Jun-19	Action complete and matter resolved
NHS/PSA/W/2018/009	Risk of harm from inappropriate placement of pulse oximeter probes	18-Dec-18	18-Jun-19	Action complete and matter resolved
NHS/PSA/D/2019/001	Wrong selection of orthopaedic fracture fixation plates	11-Feb-19	10-May-19	Action complete and matter resolved

NHS Staff Survey and Cultural Transformation

NHS Staff Survey Results 2018

The 2018 NHS National Staff Survey ran during October and November 2018. This was a full census survey in which 3185 staff returned a survey, equating to 39% of the workforce. The response rate nationally for acute trusts was 44%.

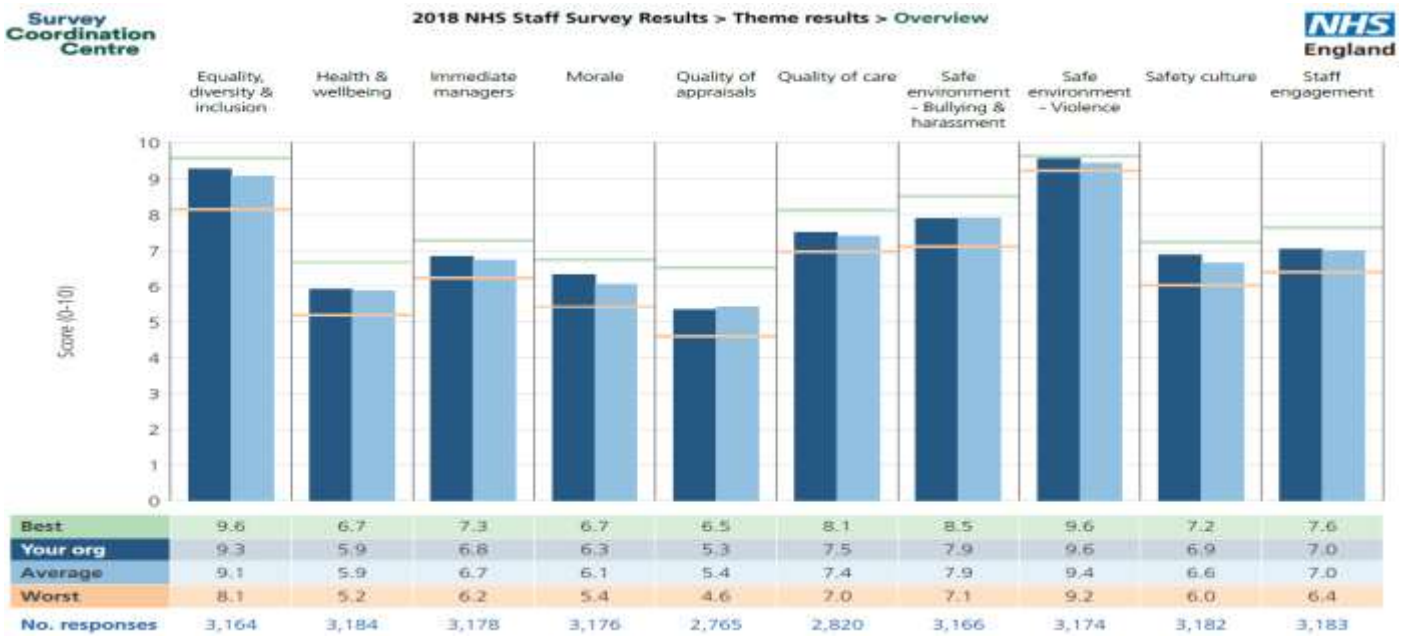
In previous national staff surveys 32 key themes were identified. This has been reduced to 10 in the 2018 survey; these are as follows. Each key finding is comprised of a cluster of questions, which can be found in the full version of the Trust's report, which was published in March 2019 via www.nhsstaffsurveys.com.

1. Staff Engagement
2. Safety Culture
3. Equality, Diversity and Inclusion
4. Health and Wellbeing
5. Immediate Managers
6. Morale
7. Quality of Appraisals
8. Quality of Care
9. Safe Environment – Bullying
10. Safe Environment – Violence

Overall the Trust is better than or equal to the national average for nine of the ten key themes in the National Staff Survey. Only Quality of Appraisals is a worse score than the national average. The Trust has taken a number of actions to improve this, as follows:

- The introduction of a quality key performance indicator (KPI) to ensure the quality of appraisal is now also measured alongside the appraisal completion rates.
- New appraisal format developed and to be introduced
- The four staff survey questions are being repeated in the quarterly staff survey, to ensure there is a quarterly check and for the identification of areas that might need a little more support
- Training activity will be increased and through the learning platform (also being revised) the managers who are responsible for appraisal will be "invited" to training
- The new appraisal form will also ask the four staff survey questions at the end of an appraisal for the appraise to complete, which will allow the Trust to monitor quality of each appraisal as well as the quarterly staff survey
- Performance against the appraisal compliance rates and quality will be reported in the Education and Development reports to Health Groups and Corporate Directorates

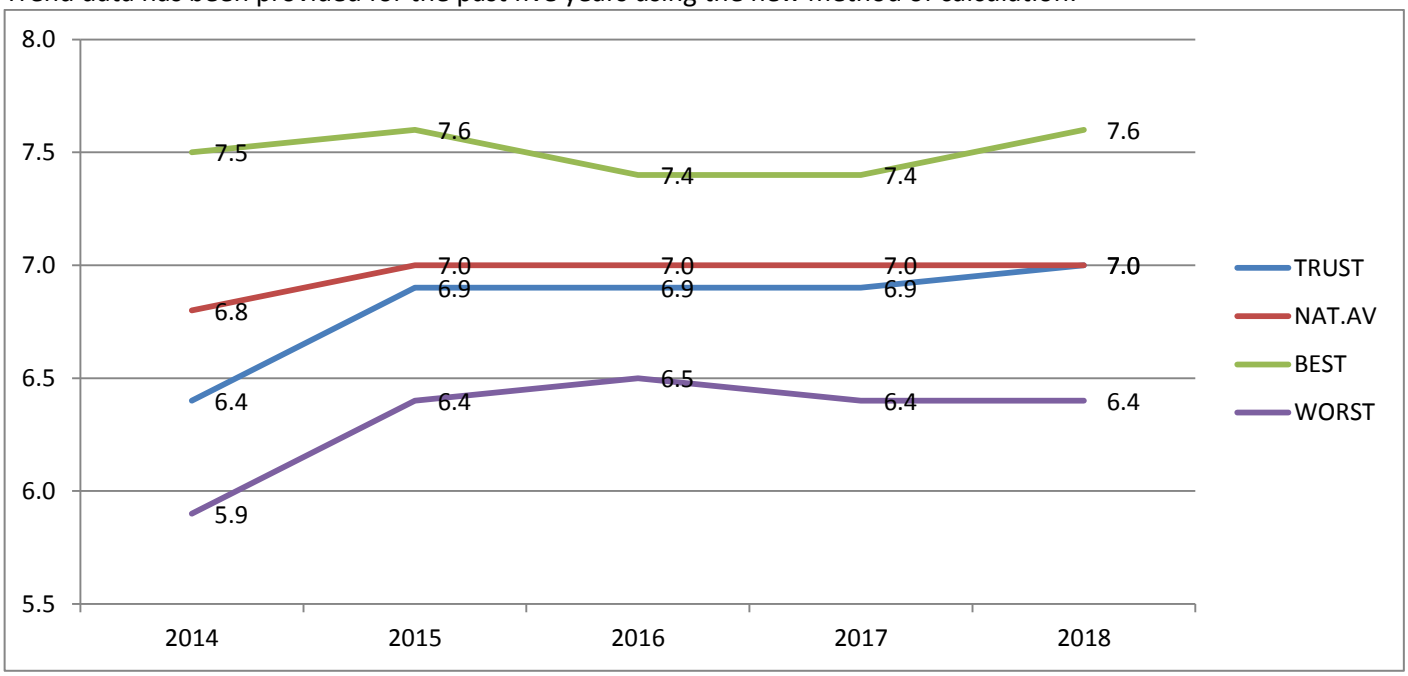
The following graph provides the Trust's performance compared with the national average, best score in the NHS and worst score in the NHS for each of the ten key themes.



	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
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.3	5.9	6.8	6.3	5.3	7.5	7.9	9.6	6.9	7.0
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	3,164	3,184	3,178	3,176	2,765	2,820	3,166	3,174	3,182	3,183

Staff engagement is a key indicator for the Trust which aspires to be in the top 20% of organisations by 2020 for staff engagement. The Trust has improved again in terms of the overall score for engagement and is equal to the national average. (Please note that previously organisations received a score out of five, this is now out of ten).

Trend data has been provided for the past five years using the new method of calculation:

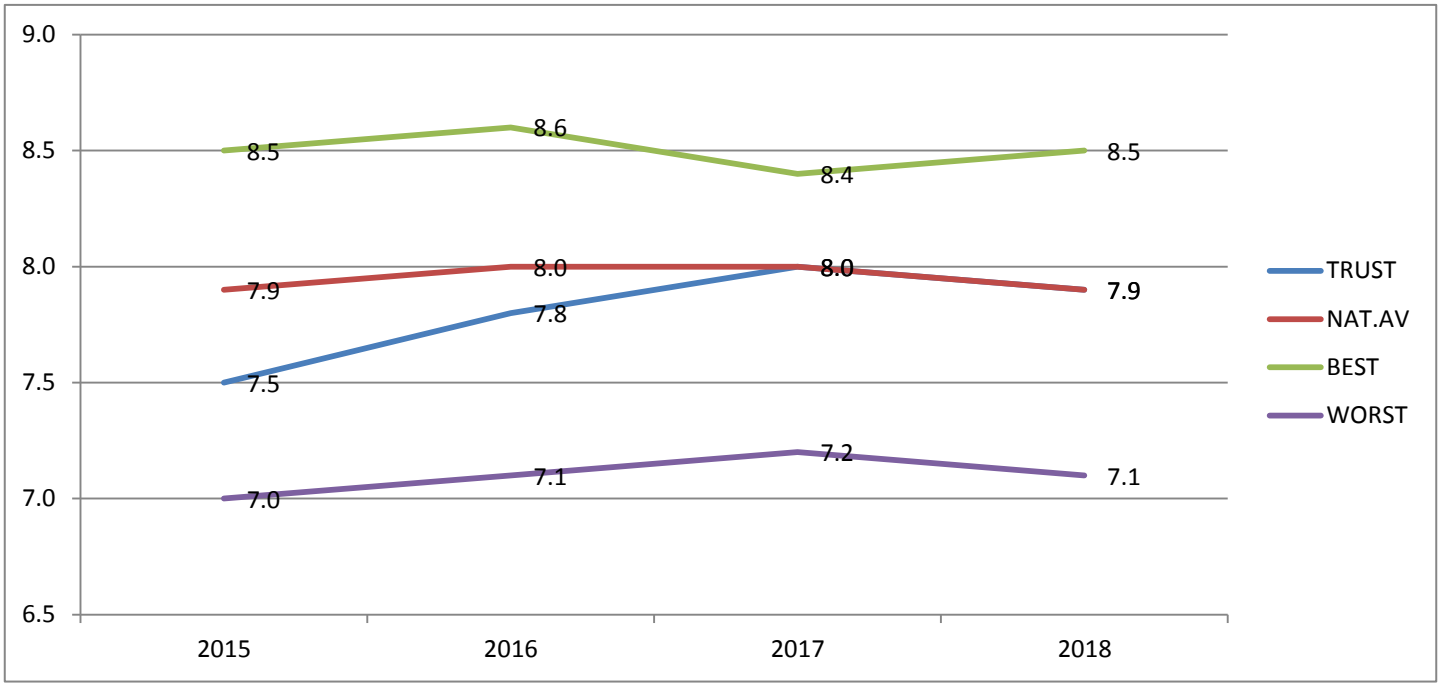


For the nine component questions the Trust improved on all but two. Once again the lowest score is staff saying they are able to make improvements happen, which correlates with the Trust's internal cultural survey in 2017 where staff described the Trust as overly bureaucratic and hierarchical. A task and finish group, led by the Programme Director for Improvement has been established to address the issues of bureaucracy and the difficulty staff have in delivering ideas for improvement. The aim of the task and finish group is to significantly improve the scores relating to improvement in the staff survey, and a reduction in the number of staff highlighting bureaucracy as a limiting value in the 2019 Barrett Survey.

Three scores are below the national average (highlighted in red in the table below). However the score for recommending the Trust as a place to work has significantly improved from 58.6 to 62.6. In 2017 the Trust was below the national average for this indicator. In 2018 the Trust is equal to the national average.

Nine component questions for Engagement	2018	2017	Diff
I look forward to going to work	**61.1**	**57.4**	**3**
I am enthusiastic about my job	**75.2**	**73.8**	**1**
Time passes quickly when I am working	**77.3**	**76.1**	**1**
There are frequent opportunities for me to show initiative in my role	**72.7**	**73.4**	**0**
I am able to make suggestions to improve the work of my team/department	**73.4**	**73.3**	**0**
I am able to make improvements happen in my area of work	**56.6**	**55.2**	**1**
Care of patients / service users is my organisation's top priority	**74.3**	**71.9**	**3**
I would recommend my organisation as a place to work	**62.6**	**58.6**	**4**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	**70.1**	**67.0**	**3**
OVERALL SCORE FOR ENGAGEMENT	**7.0**	**6.9**	

For the theme of bullying and harassment the Trust is performing in line with the national average, however both Trust and national performance has deteriorated slightly in the last year, as detailed in the graph below. However this is not a significant deterioration.



Three questions comprise this theme in the survey and for all indicators a low score is better than a high score. The Trust is below the national average for two of these (highlighted in red in the table below), and performance is deteriorating against two indicators.

Question (%)	2018	2017	Diff
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	**26.3**	**25.0**	**-1**
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	**15.5**	**14.7**	**0**
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	**22.0**	**20.0**	**-2**

All current interventions aimed at improving staff health and wellbeing, including stress management, bullying and harassment are to be reviewed. New actions are to be agreed at the Workforce Transformation Committee with the aim of significantly improving the theme of health and wellbeing and scores for bullying and harassment in the 2019 survey.

Part 4: Statements of Assurance from the Board

This section includes:

Statements of assurance from the Board (the contents of these statements are prescribed). Statements include:

- **Review of services**
- **Participation in clinical audit**
- **Participation in clinical research**
- **Goals agreed with commissioners**
- **What others say about the Trust – Care Quality Commission**
- **Quality Improvement Plan**
- **Care Quality Commission – Duty of Candour**
- **Data quality, information governance and clinical coding error rates**

Statements of Assurance from the Board

Review of services

During 2018/19 the Hull University Teaching Hospitals NHS Trust provided and/or sub-contracted 43 NHS services within 5 Health Groups and 15 Divisions.

The Hull University Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 43 of these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by the Hull University Teaching Hospitals NHS Trust for 2018/19.

Participation in clinical audits

During 2018/19, 54 national clinical audits and 2 national confidential enquiries covered NHS services that Hull University Teaching Hospitals NHS Trust 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.

For those national clinical audits and national confidential enquiries that Hull University Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2018/19, 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 are listed in the last column:

Audit	Participated	% of Cases Submitted
Peri- and Neonatal		
National Neonatal Audit Programme (NNAP)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
Children		
Feverish Children (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People	Yes	100%
Blood and Transplant		
Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children	Yes	100%
Management of Massive Haemorrhage	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	100%
Acute care		
Seven Day Hospital Services	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
Adult Critical Care (Case Mix Programme –	Yes	100%

Audit	Participated	% of Cases Submitted
ICNARC)		
Non-Invasive Ventilation – Adults (British Thoracic Society)	Yes	100%
National Asthma and COPD Audit Programme	Yes	78%
Vital Signs in Adults (care provided in Emergency Departments – College of Emergency Medicine)	Yes	100%
VTE Risk in Lower Limb Immobilisation (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
Adult Community Acquired Pneumonia (British Thoracic Society)	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	100%
Diabetes in Pregnancy Audit	Yes	100%
Diabetes Footcare Audit	Yes	80%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
NaDIA-Harms (Diabetic Inpatient Harms in England)	Yes	25%
Inflammatory Bowel Disease Programme / IBD Registry	No	The Trust is purchasing the software to take part in 2019/20
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	100%
BAUS Urology Audit – Female Stress Urinary Incontinence	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
Neurosurgical National Audit Programme	Yes	100%
National Ophthalmology Audit	No	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
National Audit of Dementia	Yes	100%
Elective procedures		
National Joint Registry (NJR)	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Data submission closes 30 June 2019
National Vascular Registry	Yes	99%
BAUS Urology Audit - Nephrectomy	Yes	100%
BAUS Urology Audit – Radical Prostatectomy	Yes	100%
BAUS Urology Audit - Cystectomy	Yes	100%
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	Yes	100%
Adult Cardiac Surgery Audit (ACS)	Yes	100%

Audit	Participated	% of Cases Submitted
National Bariatric Surgery Registry (NBSR)	Yes	66%
Heart		
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	100%
National Heart Failure Audit	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Arrest Audit (NCCA)	Yes	100%
Renal disease		
Renal Replacement Therapy (Renal Registry)	Yes	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Oesophago-gastric Cancer (National O-G Cancer Audit)	Yes	100%
National Prostate Cancer Audit	Yes	100%
Trauma		
Major Trauma (Trauma and Audit Research Network)	Yes	100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	100%
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
National Audit of Breast Cancer in Older People	Yes	100%
Acute Stroke (Sentinel Stroke National Audit Programme - SSNAP)	Yes	100%
Infection		
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Pulmonary Embolism	Yes	100%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBBRACE – UK)		
Maternal Infant and Perinatal Programme (MBBRACE-UK)	Yes	100%

The reports of 25 national clinical audits were reviewed by Hull University Teaching Hospitals NHS Trust in 2018/19 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 deliver a presentation to both Obstetric and Midwifery teams at the Perinatal Mortality Meeting, highlighting the importance of documenting and giving magnesium sulphate when possible • All staff on the Neonatal Unit and Labour ward should be made aware of the recent changes to equipment and the risk of overheating babies. To put in place practices to ensure the babies temperature is monitored on a regular basis on the labour ward before transferring to the Neonatal Unit • To highlight to nursing staff at the monthly Neonatal Unit Meetings the importance of recording parental presence on a ward round on the babies 'Daily Update Sheet.'
National Chronic Obstructive Pulmonary Disease Audit (COPD)	• To update the Trust Oxygen Policy, in line with Royal College of Physicians (RCP) Guidance • To introduce a new Oxygen training package, in line with the new policy • 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. • 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. • To explore the feasibility of visiting GP practices to assist in identifying patients that are receiving suboptimal care, in order to improve readmission rates. • To pursue the possibility of Respiratory Medicine being able to have a protected bed base for COPD patients • 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
Lung cancer (National Lung Cancer Audit)	• To establish when scan data is being logged by the National Team, to assist with identifying potential issues
National Bowel Cancer Audit (NBOCA)	• To add operation notes onto Lorenzo to help improve data capture and submission
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
National Diabetes Footcare Audit (NDFA)	• To disseminate results with Vascular Surgery and Imaging to highlight key areas for improvement.
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. • To communicate the importance of insulin timing and treatment to staff across the Trust (through Lessons Learned/ Newsletter/ Pattie). • 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.
Diabetes (Royal College of Paediatrics	• To liaise with HICOM and IT Services to agree the pathology interface

Audit	Proposed actions
and Child Health - RCPCH National Paediatric Diabetes Audit)	license for Twinkle system to improve data collection from Lorenzo to Twinkle. • To ensure Micro albumin tests are now being done at the time of clinic appointment in the Paediatrics Department • To undertake a casenote audit to understand if there are any variances in practice between Hull CCG and East Riding CCG patient cohorts.
National Audit of Dementia – Spotlight Audit on Delirium Assessment	• To carry out a Trust wide teaching session on delirium and dementia • To re-audit the delirium screen and assessment • To arrange a meeting with the Lorenzo team to introduce a section on cognition on the Immediate Discharge Letter to enable transfer of information • To undertake a junior doctor teaching session on delirium recognition and assessment (including history taking) • To provide a teaching session on the importance of filling out the dementia and delirium care bundle
National Cardiac Arrest Audit (NCAA)	• To continue to share learning from the NCAA (including ceilings of care and the prescription of appropriate resuscitation) in the Consultant mandatory update training • To continue the implementation and audit of the ReSPECT process
Fractured Neck of Femur (College of Emergency Medicine)	• To provide training for nurses, emphasizing the importance of documenting pain score on handover, as well as ensuring documentation of date and time within the NEWS score. • To implement a mandatory field for the documentation of pain assessment as part of the new Emergency Department digital documentation. • To re-audit against the same standards, incorporating nursing documentation (e.g. NEWS scoring), as this was not included initially. • Business Intelligence data shows that mean performance against the 4 hour target for admission for the past 12 months (ending August 2018) is 82.23% which is an improvement on the audit results of 61%. • To disseminate results of the audit to all Emergency Department staff.
Pain in Children (College of Emergency Medicine)	• To educate staff on carrying out and documenting pain scoring. • To educate staff on the documentation of analgesia given, and the importance of recording a reason wherever analgesia is not given. • To amend the CAS card to include a section for documenting reasons for why analgesia has not been given. • To discuss the possibility of having pain scoring and analgesia added to the triage section of the patient's Lorenzo record. • 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. • To develop a business case for improved nursing cover, in order to improve triage times. • To disseminate results to all Emergency Department staff, to raise awareness of the issues and key learning points. • To undertake a re-audit and present the results to the Clinical Effectiveness, Policies and Practice Development Committee.
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

Audit	Proposed actions
Myocardial Ischaemia National Audit Project (MINAP)	• No further action required
National Audit of Percutaneous Coronary Interventions (PCI)	• No further action required
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 • To download Trust data prior to the submission deadlines, in order to review and ensure the quality of the thrombolysis data. • To undertake an audit of swallow screening on the Stroke ward • 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)
National Emergency Laparotomy Audit (NELA)	• No actions identified as the data submission was low and the data therefore inaccurate. 100% of patients have been submitted for 2018.
National Hip Fracture Database	• 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. • To speak to anaesthetic lead to determine whether the number of nerve blocks given during a GA can be increased. • To remind the orthopaedic team that intertrochanteric fractures should be treated with a SHS as this is more cost efficient. • To hold 'Time out' sessions to involving the various disciplines contributing to hip fracture care to review patient pathways.
National Vascular Registry	• To present a paper at the Operational Quality Committee, seeking to address the Trust wide issues identified in the report
National Audit of Breast Cancer in Older People (NABCOP)	• No further action required
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	
Perioperative Diabetes	• For presentation at the July 2019 meeting of the Clinical Effectiveness, Policies and Practice Development Committee
Cancer Care in Children, Teens and Young Adults	• For presentation at the July 2019 meeting of the Clinical Effectiveness, Policies and Practice Development Committee
Acute Heart Failure	• To consider different ways to meet the two week from discharge follow up recommendation as currently, the department does not have the capacity to achieve this
Other Enquiries/Reviews	
MBRRACE-UK Perinatal Mortality Surveillance	• For presentation at the June 2019 meeting of the Clinical Effectiveness, Policies and Practice Development Committee
Saving Lives, Improving Mothers' Care	• For presentation at the June 2019 meeting of the Clinical Effectiveness, Policies and Practice Development Committee

An update regarding the implementation of the actions identified as a result of a national clinical audit report published in 2017/18 has been provided below. Actions taken in response to reports published in 2018/19 will be included in the Quality Accounts for 2019/20.

Audit	Proposed actions	Progress
National audit		
National Diabetes Inpatient Audit (NaDIA)	• To introduce a formalised foot risk assessment sheet	• Foot care documentation is currently being reviewed, supported by senior ward staff, vascular nurse specialists and podiatry
National Audit of Dementia (NAD)	• To implement 'John's Campaign', enabling carers to stay with patients beyond regular visiting hours (including meal times and overnight) • To carry out a Quality Improvement Programme to improve the recording of dementia / delirium screening on discharge documentation • To introduce nutritional assistants on the Department of the Medical Elderly wards, to better ensure that the nutritional needs of patients are met • To provide further training to ward staff to ensure that patients and carers are offered the Butterfly Scheme and John's Campaign • To raise awareness of the Butterfly Scheme and John's Campaign around the wards through the use of posters and communications • To meet with the intranet team to discuss options for publicising the Dementia Champions through the intranet	• This has been implemented Trustwide. Relatives are able to stay over in a room on floor 8 which has a sofabed and ensuite facilities. Carers are encouraged to stay with patients at mealtimes. • A Quality Improvement Programme has been undertaken and will be extended, once the screening process is recorded electronically • Nutritional assistants were introduced as part of a 1 year apprentice scheme. Currently, trained young volunteers are assisting with nutrition. The menu has been completely reviewed following patient feedback. • This training is ongoing, to ensure all staff are aware of the Butterfly Scheme and John's Campaign • Ward areas and lift lobbies display posters and the dementia action week 2019 will also be used to drive these campaigns forward • All the intranet pages have been reviewed and updated
National Audit of Inpatient Falls (NAIF) (Part of the Falls and Fragility Fracture Audit Project (FFFAP))	• To update the Falls Prevention and Mobility Care Bundle • To develop a tailored continence care plan for use in the Department of Medicine for the Elderly • To roll out training for issuing walking aids to patients on admission when appropriate • To carry out falls prevention training to raise awareness of the key issues as highlighted by the audit (lying and standing blood pressure; vision assessment; availability of mobility aids)	• This has been completed and is in use on the wards • A care plan is currently being developed to be used across the whole Trust • E- Learning is now available and some training has also been delivered face to face on the ward. A task and finish group to try and improve training is to be established • The new E-learning is almost completed. Training is delivered to specific staff groups if requested. All wards have instructions on how to complete lying and standing blood pressure. One of the Department for Medical Elderly consultants is going to undertake a small project on one ward to try to

		improve this
National Diabetes Audit	• To review the pathway for insulin pump patients, to ensure that insulin pumps are prescribed appropriately • To expand the Diabetes Specialist Nurse (DSN) team to release additional DSN resource and to support the management of complex Type 1 patients • To implement System One as a replacement to ProWellness. In relation to the National Diabetes Audit, this will make the data much more reliable and accessible and so improve the usefulness of the audit data	• The pathway has been reviewed and revised • The Diabetes Specialist Nurse team has been expanded (2 additional posts) using transformation bid funding • System One will be implemented on 1 April 2019
National Diabetes Footcare Audit	• To capture all cases of re-ulceration or multiple ongoing ulceration into the audit • To review the Lorenzo podiatry referral page to encourage output referrals and education to team • To review staff resource over next 24 months to aim to enable additional resource for ward foot checks	• Audit forms for all new ulcerations are being completed and all community podiatrists are being encouraged to send forms in • A referral flow chart for Diabetic foot referrals is being developed. Also, documentation for checking Diabetic inpatients feet is being developed. This will then be cascaded to all wards and the referral pathway promoted. • Staff training has been offered but there has been limited uptake due to staffing levels
National Hip Fracture Database (NHFD)	• To define criteria for 120 day follow up • To liaise with the anaesthetic lead regarding nerve blocks	• The criteria has been defined by the national team and the service is considering how best to meet the 120 day follow up • Action complete
National Neonatal Audit Programme (NNAP)	• To audit the group of patients that did not receive a timely parental consultation to identify the underlying reasons for this • To identify a more proactive way of recognising patients for review which will allow for real time data entry	• Processes to more effectively record the conversations with parents following admission have been implemented and results from this year's audit and ongoing monitoring of this metric by the Yorkshire and Humber Neonatal Operational Delivery Network (ODN) show improvement which has brought the Trust from 80% compliance (2016 audit) to 94.2% compliance (2017 audit), comparable with a national average of 94.6%. • A pilot of targeted 2 year follow ups in a specific clinic done by a neonatologist has been completed (August – December 2018). The outcome from this has resulted in a proposal to utilise some of the consultant neonatal outpatient capacity to provide targeted

	• To provide education and training to reinforce the prescription of Magnesium Sulphate in mothers who deliver babies < 30 weeks of gestation	developmental follow up for high risk patients in a specific access plan for this group of patients. • Attendance at regional joint maternity and neonatal quality forums by obstetric, midwifery and neonatal Trust representatives has promoted the need to increase the proportion of women offered MgSO4 prior to preterm delivery <30 weeks. The Trust rates of compliance with this metric are also monitored through the Yorkshire and Humber Neonatal ODN. This and the Trust results of the 2017 NNAP show significant improvement in compliance with this standard (11% (2016) increasing to 36% (2017) and 63% (2018 ODN data), national average 64% (2017). Ongoing work as identified in 2017 NNAP actions.
National Paediatric Diabetes Audit (NPDA)	• To plan a schedule of regular patient education sessions	• A schedule of patient education sessions have been programmed for the year
National Emergency Laparotomy Audit (NELA)	• To arrange a meeting with Department of the Medical Elderly (DME) regarding the assessments given to patients aged 70 years and over • To employ a data entry clerk	• A meeting has taken place but as yet, there is no funding available to pay for DME input • A clerk has been appointed and 100% participation has been achieved for 2018/19.
National Pregnancy in Diabetes Audit (NPID)	• To raise awareness amongst the team regarding preconceptual care and referral to the 'MOT' • To discuss the possibility of having a 'Diasend' machine in the clinic, to review glucose readings • To review the management of gestational diabetes patients, and to establish whether current arrangements are affecting the care of women with T1 / T2 diabetes	• One of the Consultants in General Medicine and Endocrinology spoke at the Diabetes Hot Topics Day for primary care in May 2018 to promote pre-conceptual care. The team produced small cards to hand out to women of child-bearing age to raise awareness • The Diasend transmitter has been purchased • The gestational diabetes maternity pathway remains under review. A meeting has been arranged between the diabetes and midwifery team to discuss how more time can be devoted to pre-existing T1/T2 patients as well as looking after the gestational diabetes patients.
Sentinel Stroke National Audit Programme (SSNAP)	• To remind all staff of the need to ensure documentation of the reasons for why a patient does not fit the Royal College of	• A recent report shows that the Trust now shows 100% compliance – the service has also

	Physicians criteria for thrombolysis, where applicable	reviewed and, where appropriate, made amendments to any patient where data quality has been an issue
	• To discuss the pathway for pre-alerts with the Ambulance Service.	• This has been discussed with the Ambulance Service
	• To implement a system to enable the Stroke Co-Ordinator to highlight any patients that have been unable to give a formal swallow assessment	• A standalone swallow audit has been undertaken. Recommendations from this are that a swallow screen should be checked as part of the Hyper Acute Stroke Unit admission, if this is not already undertaken by the Stroke Coordinator
	• To adjust working patterns to provide occupational therapy every day rather than Monday to Friday only	• A 7 day service with 5 day staffing is now provided
	• To remind staff of the importance of mood and cognition screening for each patient	• Occupational Therapists have changed their paperwork to appropriately record mood and cognition screen and performance has improved significantly, increasing from 58% in June 2018 to 93% in September 2018
	• To remind staff to discharge patients from the care of Speech and Language Therapy (SLT) promptly when no further therapy is required.	• This is one process, along with others, that is being reviewed on an ongoing basis to see how this affects SLT performance. Recent results have shown an improvement in performance.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Treat As One (Mental Health in General Hospitals)	• To develop an Enhanced Care Team (ECT) for 1 to 1 supervision including patients with mental health needs	• The ECT pilot service has been evaluated and agreement has been reached to roll this out across the Trust as a substantive service. The post of ECT Manager is currently being advertised.
Inspiring Change (Acute Non-Invasive Ventilation)	• To revise the operational policy to meet NCEPOD recommendations • To develop a proforma to ensure the use of acute non-invasive ventilation acts as a flag to consider referral to palliative care services	• The policy review is almost complete • The proforma is in development
Other Enquiries/Reviews		
Perinatal Mortality Surveillance Enquiry -Term, Singleton, Intrapartum Stillbirth and Intrapartum Related Neonatal Death	• To appoint a Bereavement Midwife as lead reporter • To appoint an Obstetric Lead for Stillbirths and bereavement care • To review all stillbirths using a local audit tool	• A bereavement midwife has been appointed as lead reporter • A Consultant has been appointed as lead for stillbirths and bereavement care • All stillbirths are reviewed using the Perinatal Mortality Review Tool
Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births	• To use a perinatal mortality review tool by the multidisciplinary team (MDT) for all stillbirths and related neonatal deaths.	• Perinatal Mortality Review Tool implemented and used by the MDT. Lessons learnt shared with the

from January to December 2015	From reviews, themes will be highlighted and action plans devised and disseminated	wider team and actions put in place. Quarterly report submitted to the board (as per CNST maternity incentive scheme).

The reports of 260 local clinical audits were reviewed by the provider in 2018/19 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 2018/19, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address: **quality.accounts@hey.nhs.uk** or reviewed online via the Quality Accounts page at: **www.hey.nhs.uk/qualityaccounts**

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Hull University Teaching Hospitals NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee or Health Research Authority was 5,317.

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 activity 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 127 new clinical research studies of which 73 commenced during the reporting period 2018/19. In total 99 studies opened in the reporting period. This compares with 105 new submissions and 96 commencing in 2017/18. The Trust used national systems to manage the studies in proportion to risk. Of the 99 studies given permission to start, 80 were National Institute for Health Research (NIHR) portfolio adopted.

The Trust has 142 studies actively reporting accruals (patient recruitment) under the NIHR Clinical Research Network (CRN) Portfolio, as compared to 171 portfolio studies reporting accruals for the period 2017/18.

The number of recruits into the Trust portfolio studies for the periods 2018/19 and 2017/18 was 4,210 and 7,312 respectively. A target of 6,000 patient accruals has been set for 2019/20. The largest topic area of portfolio adopted studies across 2018/19 is Oncology (Cancer) and Haematology with 39 studies between them. The top five therapeutic areas of Trust research in 2018-19 (based on portfolio recruiting studies) were:

1) Oncology and Haematology (39)
2) Cardiovascular (27) (Cardiology Int + Academic, Cardiothoracic, Diabetes, Vascular, Respiratory)
3) Gastroenterology and Hepatology (17)
4) Musculoskeletal (9)
5) Renal Disorders (8)

64% of commercial portfolio studies completed in 2018/19 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 us to be part of offering novel technologies and treatment to our patients in more and more therapeutic areas.

In the last year, over 168 publications, abstracts and book chapters have resulted from our involvement in portfolio and non-portfolio research across nine specialty areas (Vascular, Diabetes, Oncology, Haematology, Neurosurgery,

Ophthalmology, Dermatology, Neurology, Cardiology, Hepatology, Renal and microfluidics). This shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Research impact

Demonstrating specific project outcomes and impact through research for the population we serve is fundamental. Below are some examples of the difference research participation has made to patient outcomes and changes in service delivery at Hull University Teaching Hospitals NHS Trust:

Ophthalmology:
The teams' research successes are that they continue to deliver a large number of clinical trials within Ophthalmology including several industry funded IMP studies testing new therapies for wet AMD and diabetic maculopathy - both common causes of blind registration within the western world.

The team has an excellent track record of recruiting to time and target and have over-recruited to several studies whilst providing invaluable expertise in supporting the ophthalmology aspects of the management of a number of oncology research participants.

The main aim for the next 12 months is to expand the Ophthalmology substantive research team to avoid turning down many industry funded studies yearly due to lack of capacity. As part of this we aim to involve more newly appointed clinicians in research, building on our success this year of training and delegating two new SAS doctors and 2 FY3 doctors as co-investigators within RCTs.

Diabetes and Endocrinology:
There has been a considerable downturn in the number of commercial clinical trials in the UK as a whole, often with studies being withdrawn at short notice which impacts on resource planning; furthermore there has been a significant drop in the number of trials in Diabetes. However, the team have found strength in new relationships forged as a result of the downturn with a new working relationships, sharing of resource and best practice with the Renal research team and going forward we hope to build on this fresh coupling and are already working on new studies together which would otherwise not have been conducted in our Trust.

Despite the lack of studies, the team certainly performed extremely well with the studies we have, as an example, recruiting the highest number of patients in the UK for the SOTA- EMPAG Sanofi Aventis study randomising 11 patients. The nearest UK competitor only randomised 2.

In late 2018-19 the team have been successful in securing a £50,000 grant from the OSPREY charity to conduct a large cohort study in Osteoporosis which will also attract a good number of accruals for the Trust as a whole.

The year going forward looks even more promising with many new studies in the pipeline for 2019-20 with a key priority on maintain strong relationships with pharma companies and increasing output back to previous levels.

Academic Oncology and Haematology Research Department:
The Academic Oncology Trials Unit is now in its 20th year, and has experienced an exciting and successful year.

2018-19 saw the completion of the department's reconfiguration and the fruitions of newly implemented processes and practices that are now fully embedded. These initiatives have been successful in building on our distinguished reputation across the Yorkshire & Humber CRN, increasing capacity for studies both in terms of set up and delivery, and improved collaboration between PIs and research staff. Our prominence externally also continues to flourish in terms of preferred site choice for notably several of the largest pharmacological companies in the world.

In line with the Trust Research and Innovation Strategy, our key priority moving forward into the next year is to secure 'top 5' national status within the Unit as measured by CRN data and encouraging Research Nurse led studies.

The Haematology department led the recruitment of patients with rare diseases and cancer into the NHS 100,000 genome project enabling 236 local patients and their families to undergo advanced genetic diagnosis. This has led to patients with rare diseases with a previously unknown causation to receive a precise diagnosis and prognosis for their condition. In addition the Haematology department is also leading on the recruitment of patients with rare haematological and immunological conditions into an associated project; the 'NIHR BioResource - Rare Diseases

Programme' and has to date recruited 59 patients into these studies. The hope is that we can expand recruitment into the rare diseases programme to include patients with inherited eye disorders.

The department continues to recruit well into interventional phase II/III clinical studies and is amongst the leading 10% of sites recruiting to FLAIR and one of the top recruiters into the Mantle cell Biobank study. Additionally the Trust sponsored portfolio study, funded by Cancer Research UK, 'Cell shape recognition technology', is recruiting ahead of target with 116 participants.

We wish to continue to support phase II/III across all major haematological disease areas with an emphasis on increasing the number of commercial studies on our portfolio.

Vascular Surgery Research:
The Vascular department continues to be highly involved in research activities, key outputs include the production of a final report for Professor Ian Chetter's NIHR Programme Grant (Surgical wounds healing by secondary intention: characterising and quantifying the problem and identifying effective treatments). This important work summarizes seven years of wound research.

An AVSU led NIHR RfPB application has reached staged 2; High Intensity Interval Training In pATiEnts with intermittent claudication (INITIATE): a proof-of-concept prospective cohort study to assess acceptability and clinical efficacy.

In 2018 Professor Chetter became a NIHR Senior Investigator and was awarded an NIHR HTA grant (£1.7 million) for a pragmatic multicentre randomised controlled trial to assess the clinical and cost effectiveness of negative pressure wound therapy versus usual care for surgical wounds healing by secondary intention (SWHSI 2).

The department was successfully awarded a PhD cluster with HYMS and has subsequently welcomed three new PhD students who are currently conducting their own research projects. For the second and third year respectively the AVSU has hosted the Annual Specialist Registrar Educational (ASPIRE) ST7/ST5 programmes, these national training programmes were developed for the next generation of Vascular Surgeons. The core working group for the Vascular Research Collaborative, a National Steering Group, is based in the AVSU and continues to lead a national priority setting project; a list was created of the ten most important questions which needed to be addressed by vascular research in the UK, phase one results have been submitted for publication. Phase two will focus on gathering patient and carer perspectives over the next year. The AVSU undertakes a range of commercial and non-commercial studies and is recognised as the highest recruiting site on a number of studies.

Key priorities for the next year will be to set up / begin to successfully deliver SWHSI 2 and to complete the next phase of the national priority setting project which is focussed on patient and carer priorities.

Neurology:
Hull is the third biggest headache research centre in the UK after the National and Kings in London. The team is chosen to be the centre in all new agents in migraine and have been involved in both Phase IIb to Phase IV trials. The department has always recruited more than the given target and many patients have benefited from participating in the clinical trials. Some of the most benefited patients have been on national and regional television to discuss their success stories. The department also participates in original research and have a research fellow completing her PhD later this year. The unit is considered as being pioneer in the treatment of Migraine using Botox.

One of the key challenges is to raise funds to continue producing quality research from the centre. The team has been chosen to be the centre in many new clinical trials over the next year or two and this will help raise funds towards research physicians conducting both therapeutic aspect of the research and original scientific papers. Dr Fayyaz Ahmed is one of the specialty leads for the NIHR local CRN and is involved in many non-commercial NIHR funded research projects.

Neurosurgery:
The neurosurgery research team continues to build its research profile with limited resources contributing to several national studies including national cauda equina study, global neurotrauma outcome study and the national TBI transfer study.

Renal Research:
The PIVOTAL TRIAL published in the NEJM this year will impact clinical practice and NICE guidelines. PIVOTAL is the largest renal clinical trial ever undertaken exclusively in the UK, supported by Kidney Research UK. Proactive IV irOn Therapy in haemodiALysis patients (PIVOTAL). PIVOTAL compared proactive, high-dose and reactive low-dose courses of intravenous iron treatment. The trial demonstrated that a higher-dose of intravenous iron reduced the risk of death, heart failure, and reduced both erythropoietin (EPO) dose requirements and the need for blood transfusions in comparison to those receiving lower doses of iron.

In addition, the 'iron and the heart study' has been a huge landmark 3 centre study in collaboration with Kings College London and Salford Royal, the University of Hull and Academic Cardiology to successfully recruit to time and target. This study is currently in the analysis phase with results due in 2019-20.

The key priority for the renal research team is to rebuild the department after a challenging year of unfortunate and unexpected circumstances. The collaboration with Diabetes to form a cluster will be a first step towards strengthening and expanding the research department with cross-fertilization of expertise, jointing working in overlapping studies. This harmonisation will ultimately enhance the quality and quantity of the research.

Hepatology Research:
The Hepatology Research department has been incredibly active in raising the profile of research within the trust. They recently organised a liver teaching day for nurses and allied healthcare professionals to address management, treatment and symptom awareness of these patients. This was done in conjunction with a number of specialist nurses in the hope of optimising care. The event had a fantastic turnout, and received positive feedback. As a result they will be organising their second session in 2019 taking into consideration the feedback received.

The locally led COMMANDS study which closed last year led to a change in clinical practice. The liver service now uses the COMMANDS pathway for all community hepatology referrals via a new hepatology advice and guidance service. This was as a direct result of the benefits we observed during our interventional study.

One of the teams' research nurses (Bronwen Williams) was guest speaker at Barcelona Liver Clinic - one of the leading hepatology centres in Europe; where they were invited to speak on previous work in NAFLD research and service innovation (COMMANDs).

Another research nurse (Tania Nurun) presented at the name change event on 1st February to discuss the fantastic collaboration with the University of Hull.

The team Clinical Trials Assistant (Julie Wilcox) won an award for Gastroenterology research team member from the Yorkshire and Humber Clinical Research Network.

The teams' focus will be maintaining their portfolio activity, whilst further developing an investigator –led research portfolio. Particular emphasis will be placed on preventable liver disease (alcohol-related and fatty liver disease). Integrating research into the broader clinical service will be an important aspect of this work.

Dermatology:
The National reputation of the departmental research output has led us to supervise a Psychology PhD from the University of Hull on 'Attention bias in patients with Psoriasis'.

Our BADBIR study data collection shows our departmental performance in measuring PASI and DLQI scores above the national average scoring 100%.

Research Impact: the dermatology clinical protocols reflect change in practice based on our evidence based research in treating conditions like Psoriasis, Acne and Bullous Pemphigoid.

The key priority for development for dermatology over the forthcoming financial year is to take on more industry studies and continue to build on the success of the current BADBIR Study.

Microfluidics:

Academic researchers in Hull apply lab-on-a-chip technology for environmental analysis on-site, for clinical diagnostics at the point-of-care and for the synthesis of smart materials. The work of Professor John Greenman and colleagues in the University of Hull Daisy Laboratories has continued to expand in 2018-19 with a focus on the utilisation of samples across colorectal, lung, head and neck, brain and thyroid cancers. Around 70 tumour samples have been used in various microfluidic devices and the work is part of that for 3 PhD students and 1 MD student.

Research infrastructure developments

Daisy Tumour Bank:
Hull York medical School and the University of Hull, in partnership with the Trust, established the Daisy Tumour Bank. It provides a resource of tissue and blood samples for ethically approved cancer research across the UK and the European Economic Area, to benefit cancer patients in the future.

Licensed by the Human Tissue Authority, the Daisy Tumour Bank is located at Castle Hill Hospital allowing the timely collection of samples from patients undergoing procedures at the hospital.

Donations of very small amounts of tissue or blood can go a long way in generating lots of useful information, including improvements to cancer treatments, discovering new treatments, and determining the causes and mechanisms of cancer – helping to improve outcomes for those patients living with cancer. In 2018-19 the Trust continued to support this venture by facilitating research that contributes to this invaluable repository.

Hull Health Trials Unit:
The official launch of the Hull Health Trials Unit (HHTU) in 2018-19 signals the start of an exciting and hopefully impactful journey in which the Trust will be a major collaborator. HHTU has a growing portfolio of studies at various stages of the research process – design, funding application, set-up and management. The unit works with a mixture of internal and external collaborators across a range of disease areas. In conjunction with access to the University of Hull Institute for Clinical and Applied Health Research (ICAHR) and the Methods Hub, Trust researchers are now able to push forward strong research grant applications to national funding bodies and research councils supported by local infrastructure. In 2018-19 a number of National Institute for Health Research (NIHR) grants have successfully been awarded that will utilise these resources.

Goals agreed with our commissioners

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 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

There are no local Clinical Commissioning Group (CCG) schemes as there are several national CQUIN schemes mandated to all Trust's to deliver in 2017/18 which have continued into 2018/19.

The breakdown of the National CQUIN indicators is based on 2.5% of contract value of which:

- 1.5% mandated for 7 national schemes (£5m) equally weighted across each of the schemes
- 1% spilt (£3m) between 0.5% engagement with the Sustainability and Transformation Partnership (STP) and 0.5% of the CQUIN scheme will also be held within the risk reserve, If a provider delivers its control total in 2017/18

National CQUIN schemes 2018/19 for CCGs include:

- NHS Staff Health and Wellbeing
- Proactive and Safe Discharge

- Reducing impact of serious infections
- Improving services for people in A/E with mental health
- Advice and Guidance
- NHS e Referral
- Preventing ill health from tobacco/alcohol

Conclusion to CQUIN 2018/19 will not be known until June 2019
Assumptions have been made on the performance to date.
Underachievement in Sepsis has continued in 2018/19 to a value of 200k. There will be an expected underachievement in reduction of antibiotic assumption

2018/19 National Achievement:

CQUIN Indicator / No.	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Expected £ 8,057,808	Under Achieved £
1a Improvement of health and wellbeing of NHS staff	Achieved	Achieved	Achieved	expect to achieve	268,569	TBC
1b Healthy food for NHS staff, visitors and patients	Achieved	Achieved	Achieved	expect to achieve	268,569	
1c Improving the uptake of flu vaccinations for frontline clinical staff **Annual target**	Not required	Not required	Not required	achieved	268,569	
2a Timely identification of patients with sepsis in emergency departments and acute inpatient settings	Partial Achievement – 10% payment	Partial Achievement – 10%	Partial Achievement – 10%	expect underachieve	201,447	120k
2b Timely treatment of sepsis in emergency departments and acute inpatient settings	Partial Achievement – 10% payment	Partial Achievement – 10%	Partial Achievement – 10%	expect underachieve	201,447	120k
2c Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis	Achieved	Achieved	Achieved	expect to achieve	201,447	
2d Reduction in antibiotic consumption per 1,000 admissions	Achieved	Achieved	Achieved	expect part achievement	201,447	TBC
4 Improving services for people with mental health needs who present to A&E	Achieved	Achieved	Achieved	expect to achieve	805,789	
6 Advice & Guidance	Annual target	Annual target	Annual target	on track to deliver	805,789	
7 ASI (E-referrals**) Annual target**	Not required	Not required	Not required	Not required	-	-
9a Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Tobacco Screening	Achieved	Achieved	Achieved	expect to achieve	40,289	
9b Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Tobacco Brief Advice-	Achieved	Achieved	Achieved	expect to achieve	161,158	
9c Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Tobacco referral and medication	Achieved	Achieved	Achieved	expect to achieve	201,447	
9d Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Alcohol Screening **Annual Target**	Annual target	Annual target	Annual target	on track	201,447	
9e Preventing Ill Health by Risky Behaviours – alcohol and tobacco: Alcohol Brief Advice or Referral **Annual target**	Annual target	Annual target	Annual target	on track	201,447	

STP – annual value £1,594,872

NHS England Specialised Services (NHSE):
The Trust receives a CQUIN value of 2.8% (£3.04m)

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 "pass through" basis. CQUIN funding for Operational Delivery Networks previously paid via a 0.1% top slice of the 2.5% acute payment will continue to be made in addition to the 2.8% CQUIN payment outlined

The NHSE specialised schemes include a continuation of 2016/17 schemes: Hep C, HIV, spinal network, and haematrak. New schemes include medicines optimisation and local benchmarking of local prices in HIV.

Public Health England (PHE) has built into each of the screening services hosted by HUTH a CQUIN namely for Health Inequalities. Armed Forces (AF) CQUIN includes use of the covenant, systems and process to identify AF personnel, promote the Trust as AF friendly organisation, employment opportunity to AF in the Trust.

2018/19 NHSE Achievement:

Goal No	Goal Description	Trigger	Trigger Description	Goal Weighting %	CQUIN value 3,256,503	Under Achieved value at Q3
BI1	Improving HCV pathways through ODNs	Trigger A	Managed resources within indicative financial budget forecast	0.31%	360,743	
	Improving HCV pathways through ODNs	Trigger B1	ODN MDT decisions aligned to NHS England published run-rate	0.31%	360,743	300k
	Improving HCV pathways through ODNs	Trigger B2	ODN Treatment cost per patient relative to lowest acquisition cost	0.31%	360,743	
	Improving HCV pathways through ODNs	Trigger B3	ODN Prioritisation of patients with highest clinical need	0.31%	360,743	
	Improving HCV pathways through ODNs	Trigger B4	ODN Effectiveness in sustaining benefits of treatment	0.31%	360,743	
	Improving HCV pathways through ODNs		Governance and Partnership	0.09%	100,000	
BI2	Haemophilia Haemtrack Patient Home Reporting	Trigger 1	Regular Haemtrack versus registered against target/baseline	0.02%	27,333	-5,239
	Haemophilia Haemtrack Patient Home Reporting	Trigger 2	User who provide an update against target/baseline	0.02%	27,333	-5,239
	Haemophilia Haemtrack Patient Home Reporting	Trigger 3	Accuracy of records against target/baseline	0.02%	27,333	
CA2	Nationally standardised Dose banding Audit Intravenous Anticancer Therapy (SACT)	Trigger 1	Collection of baseline-data and quarterly updates of proportion of SACT that is wasted	0.04%	45,200	
	Nationally standardised Dose banding Audit Intravenous Anticancer Therapy (SACT)	Trigger 2	Reporting proportion / breakdown of SACT by volume that is bought in against prepared in-house with price comparisons	0.04%	45,200	
	Nationally standardised Dose banding Audit Intravenous Anticancer	Trigger 3	Publication of policy for the safe and robust re-utilisation of SACT that	0.04%	45,200	

	Therapy (SACT)		would otherwise have been wasted			
	Nationally standardised Dose banding Audit Intravenous Anticancer Therapy (SACT)	Trigger 4	Evidence of local process for routine implementation of dose-bands associated with new drugs to market	0.01%	15,067	
GE2	Activation system for patients with long term conditions.	Measure 1	Measurement and Reporting	0.01%	15,000	
	Activation system for patients with long term conditions.	Measure 2	Performance	0.04%	45,000	
GE3	Medicines optimisation	Trigger 1	Faster adoption of prioritised best value medicines and treatment regimens as they become available	0.09%	105,639	
	Medicines optimisation	Trigger 3	Cost effective dispensing routes	0.09%	105,639	
	Medicines optimisation	Trigger 5	Reporting of all NHS England excluded drugs data to allow upload to the Pharmex system	0.09%	108,840	
GE4	Local price benchmarking	Trigger 1	Achievement of Year Two milestones set out in the Business Case.	0.01%	16,000	
	Local price benchmarking	Trigger 2	Agreed signed contract variation for revised Price Schedule reflecting achievement of cost and price reduction as planned.	0.02%	24,000	
TR3	Spinal Surgery Networks Data, MDT, oversight.	Trigger 1	Regional Spinal Network	0.03%	33,333	
	Spinal Surgery Networks Data, MDT, oversight.	Trigger 2	Data	0.03%	33,333	
QIPP	Spinal Surgery Networks Data, MDT, oversight.	Trigger 3	MDT Governance	0.03% 0.52%	33,333 600,000	

Conclusion to CQUIN 2018/19 will not be known until June 2019. Assumptions have been made on the performance to date. There is under achievement in the Heamatrack to a value of £10k and approximately £300k for underachievement of the Hep C CQUIN Schemes. Total income loss of approx. £310k. The Trust has achieved all the PHE and Armed forces CQUIN schemes to date

Further details of the agreed goals for 2018/19 and for the following 12 month period are available on request from the following email address: **quality.accounts@hey.nhs.uk**

What others say about the Trust

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 on Compliance with the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Hull University Teaching Hospitals NHS Trust during 2018/19.

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

The Care Quality Commission rated Hull University Teaching Hospitals NHS Trust as 'Requires Improvement'

The Care Quality Commission (CQC) have not undertaken an inspection during the 2018/19 period. The CQC did undertake inspections in previous years that the organisation is progressing on improving ratings. The CQC undertook a well-led inspection in February 2018. The unannounced element was undertaken between 07 and 09 February 2018 and the announced element between 27 February and 01 March 2018. The inspection covered the Maternity, Medicine, Surgery and the Outpatient core services across Hull Royal Infirmary and the Castle Hill Hospital. The Trust has received an overall rating of 'Requires Improvement' when the reports were published on 01 June 2018.

A breakdown of the Trust's current ratings from the February 2018 inspection is detailed in the tables below.

Table 1 - Overall rating for Hull University Teaching Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led
Overall domain for the Trust	Requires Improvement	Good	Good	Requires Improvement	Good
Overall Trust rating	Requires Improvement				

Table 2 – Ratings for Hull Royal Infirmary (HRI)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency Care	Good	Good	Good	Requires Improvement	Good	Good
Medical Care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity	Good	Good	Good	Good	Good	Good
Children and Young People	Requires Improvement	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Requires Improvement	Good	Good
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for HRI	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

Table 3 – Ratings for Castle Hill Hospital (CHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Good	Inspected but not rated	Good	Requires Improvement	Good	Good
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for CHH	Requires Improvement	Good	Good	Good	Good	Good

Areas for improvement

Following the factual accuracy check of the draft report and receipt of the final reports from the February 2018 the Trust has accepted the areas for improvement. There are 11 'must do' actions and 17 'should do' actions. The areas for improvement are detailed below. All areas for improvement identified by the CQC are included in the Quality Improvement Plan (QIP) for action and monitoring. Further information on the QIP can be found on pages 64-67.

Medical care:

- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staffing line with best practice and national guidance taking into account patient's dependency levels. In particular the correct staffing levels for patients cared for in hyper acute stroke (HASU) beds and include nursing and medical staff.
- Ensure that patients are escalated for medical reviews in line with the trust policy when the trigger is alerted when using the National Early Warning Score (NEWS).

- Ensure that patient risk assessments are completed, in particular falls, nutrition and mental capacity assessments.
- Ensure that registered nurses follow the correct steps when administering medicines in line with their nurse policy and NMC regulations and sign medication charts after it has been given to patients
- Ensure that all medical outlier patients are moved in line with the referral criteria and are reviewed in line with the trust's policy
- Ensure that staff understand the principles of mental capacity and deprivation of liberty safeguards
- Ensure that a patient's lack of mental capacity is recorded within their records and reviewed
- Ensure that all staff groups meet the requirements for mandatory training and achieve the trust's set target over a 12 month period
- Continue to develop and embed the documentation in relation to dementia care

Surgery:
- Ensure the effective use and auditing of best practice guidance such as the five steps for safer surgery checklist within theatres.
- Ensure that all instruments used are clean, ready for use and stored in appropriate packaging to ensure traceability.
- Ensure that all patients' records are filed appropriately and stored securely
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patient's dependency levels. This includes both nursing and medical staff.
- Ensure that patients are fasted pre-operatively in line with best practice recommendations
- Ensure that action plans developed in response to national audit results clearly address all the concerns highlighted in the audit and the actions the trust has put in place
- Improve on national treatment performance standards
- Ensure that 85% of staff have up to date appraisals in line with their own target.
- Ensure that all patients' records are stored in an organised manner and ensure that loose entries are filed
- Ensure that all patients have weights recorded in their record
- Ensure mandatory training compliance for medical and dental staff meets their own target over a 12 month period
- Investigate and address the reasons for the number of cancelled operations to bring this in line with the England average
- Improve compliance with abbreviated mental test scores for patients over 75 who have been in hospital for longer than 72 hours.

Maternity:
- Ensure that all medical records are stored securely
- Continue to reduce the elective caesarean section rate in comparison with the England average
- Continue to address the lack of capacity in antenatal day unit and causes of regular long waits for women to be seen or receive results of scans and tests

Outpatients:
- Continue to take action to address the performance to meet the national standards for referral to treatment and care
- Ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment
- Ensure they develop processes to formally monitor patient waiting times

Outstanding practice

Examples of outstanding practice were identified by the CQC during the February 2018 inspection, including:
- A specialist bereavement midwife had been recruited and staff had raised funds to decorate a bereavement room in the antenatal day unit for use by families experiencing pregnancy loss.
- A midwifery led unit had been opened, utilising some labour ward rooms but with recruitment of separate staff. This had been developed with input from local women, midwives and other local services.
- The trust had a vulnerabilities midwife who was key in supporting women living with complex physical or psychological health needs. They based this service around "care of the complex woman with complex social factors perinatal guidelines (toolkit)". Examples of vulnerable women included, sex workers, women involved in abuse of drugs or alcohol, women living with learning disabilities and women living with HIV. The specialist vulnerabilities

midwife was involved from booking onwards, in development of birth plans, and worked closely with the perinatal mental health team.

- The perinatal mental health team concentrated on multi-agency working, and included the specialist midwives, substance misuse services and their wrap around services.
- The eye hospital was given an ophthalmology award in 2017, for the introduction of the virtual reviewing service for patients with glaucoma. These awards celebrate outstanding work within ophthalmology practice.
- The trust used a computer system that allowed staff to be aware of where bed availability was and this was updated by staff on the ward. In turn this then provided staff at the safety brief meeting a true reflection of the current issues.
- The system allowed the senior managers to review and plan where the risks were to nurse staffing and manage these safely and effectively. A record of the decision made were made during the meetings and logged onto the system to provide an audit trail.
- The trust had introduced different roles to support the patient pathway, these included discharge assistants and nutritional apprentices.

Quality Improvement Plan

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 the CQC re-inspection in May 2015, comprehensive inspection in June 2016, well-led inspection in February 2018, areas of work the Trust is pursuing to improve, quality and safety priorities as detailed in the Quality Account and the Trust's 'Sign up to Safety' Pledges.

The table below details the quality improvement projects for 2018/19:

Ref	QIP Project	Aim	Source	Status
QIP05	Medicines Optimisation	The aim of this project is to ensure our patients receive the right medicines, at the right dose at the right time as well as compliance with best practise guidance and regulations.	CQC Action, Quality Accounts and Sign up to Safety	Closed – aim achieved, new project opened for 2019/20
QIP06	Deteriorating Patient	The aim of this project is to ensure that the Trust's Recognition of the Deteriorating Patient Policy is fully implemented ensuring patient's observations are completed in a timely manner and where deterioration is detected they are appropriately escalated for medical review and treatment. The project will also support the Trust-wide adoption of the revised National Early Warning Score (NEWS2) by March 2019.	CQC Action, Quality Accounts and Sign up to Safety	Closed – new project opened for 2019-20
QIP08	Infection Control	The aim of this project is to reduce the number of avoidable hospital acquired infections by ensuring compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) by focussing on the review of the Trust's Infection Prevention and Control Care Bundle and participation in the NHS Improvement Urinary Tract Infection Collaborative Project.	Quality Accounts, Sign Up to Safety and Trust action	Closed – improvements made, aim not achieved fully
QIP09	Falls	The aim of this project is to achieve compliance with NICE guidance which will drive through the improvement in falls prevention through the improved completion of the Multi Factorial Assessment Tool (MFAT). It will also focus on the outcomes for the patient following a fall to learn lessons from the root cause analysis investigations completed along with the achievement of compliance	CQC Action, Quality Accounts and Sign up to Safety	Closed –aim achieved

		with the Multi Factorial Assessment Tool (MFAT) which will drive forward improvements in falls prevention.		
QIP10	Pressure Ulcers	The aim of this project is to embed the existing clinical governance processes for the management of pressure ulcers by ensuring that nursing staff are compliant with training and that lessons are learnt from Root Cause Analysis investigations and incidents. This will provide assurance that patients at risk of pressure damage are being provided with safe, high quality care to prevent avoidable hospital acquired pressure ulcers.	Quality Accounts, Sign up to Safety and Trust action	Closed – new project opened for 2019/20
QIP12	Children and Young People with Mental Health needs and CAMHS	The aim of this project is to improve the management of children and young people who have been admitted onto the 13th floor who are at risk of self-harm and suicidal intent.	CQC Action	Closed – improvements made, aim not achieved fully
QIP14	VTE	The aim of this project is to ensure patients are appropriately risk assessed for VTE on admission and to demonstrate that the Trust is compliant with the relevant contractual requirements.	Trust action	Closed – new project opened for 2019/20
QIP15	Sepsis	The aim of this project is to continue the education and increase awareness of staff within the Trust around sepsis and the management of patients on the sepsis pathway across the organisation. In addition, the focus will be on the development of appropriate coding for patients.	Quality Accounts and Sign Up to Safety	Closed – aim achieved
QIP19	Governance	The aim of this project is to continue to improve the governance arrangements across the organisation to ensure good governance and robust management of risk, performance and continuous improvement and learning.	Trust action	Closed - aim achieved
QIP22	Nutrition	The aim of this project is to improve patient's nutrition by achieving and monitoring the required actions / improvements from the March 2018 Nutritional Prevalence re-audit and developing any required actions to improve compliance with the Nutrition Fundamental Standards.	CQC Action, Quality Accounts and Sign up to Safety	Closed – new project opened for 2019/20
QIP23	Dementia	The aim of this project is to continue to review and promote Dementia Care across the Trust through a variety of multi - disciplinary events, policy review and further dementia friendly assignments.	CQC action and Trust action	Closed – new project opened for 2019/20
QIP26	Records	The aim of this project is to ensure all patients records are filed appropriately, stored securely and accessible for authorised people only in order to deliver safe care and treatment.	CQC action and Trust action	Closed - aim achieved
QIP28	Patient Experience	The aim of this project is to seek and act on feedback from our patients their relatives and carers. This will enable us to learn what is working well and what requires further improvement and to use the feedback to inform those required services changes.	Quality Accounts and Sign up to Safety	Closed – aim achieved, new project opened for 2019/20
QIP30	Avoidable Mortality	The aim of this project is to aid the organisation in the delivery and development of the national objective of a standardised approach to review of hospital mortality. This project will prepare the organisation for a programme of work underway in NHS England's Patient Safety Domain, in relation to, standardising retrospective case record review (RCRR) for in-hospital deaths.	Quality Accounts and Sign Up to Safety	Closed – aim achieved

QIP36	Transition from Children's to Adult Services	The aim of this project is to ensure there are effective and robust processes in place for young people who transition to the adult care services.	CQC Actions, Quality Account and Sign up to Safety	Closed – aim achieved
QIP37	ReSPECT	The aim of this project is to complete the launch of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and fully embed the process across the organisation.	Trust action	Closed – aim achieved
QIP38	Consent	The aim of this project is to review and strengthen the governance arrangements regarding the development, approval and the central monitoring of the Trust consent forms. The project will also commence the development work of the transfer of the Trust consent forms onto Lorenzo.	Trust action	Closed – aim achieved
QIP39	Outpatients	The aim of this project is to strengthen the existing governance arrangements with a particular focus on developing a robust central risk register for Outpatient Services. In addition, to include a further review of how incident and complaints information is escalated and managed via the existing governance structure to enable a cohesive and healthy learning culture.	CQC action and Trust action	Closed – aim achieved, new project opened for 2019/20
QIP41	Getting it Right First Time (GIRFT) – Paediatric Surgery*	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Paediatric Surgery.	Trust action	Closed – transferred to GIRFT Steering Group
QIP42	Getting it Right First Time (GIRFT) – Ophthalmology *	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Ophthalmology	Trust action	
QIP44	Getting it Right First Time (GIRFT) – Obstetrics and Gynaecology*	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Obstetrics and Gynaecology in December 2017.	Trust action	
QIP45	Safer Maternity Care (CNST incentive Scheme)	The aim of this project is to ensure the implementation of the 10 key elements of the Safer Maternity Care (CNST Incentive Scheme) and to provide assurance to the Trust Board that the Maternity standards meet the standards.	Trust action	Closed – aim achieved
QIP46	Handover*	The overall aim of this project is to develop a handover process that supports learning and integrates patient care with Junior Doctor training and development. The lead plans to create a daily handover session for Junior Doctors, with senior clinical involvement, across the medical services where admissions, cases and treatments are discussed and responsive actions put in place if concerns are raised.	Trust action	Closed – no longer required
QIP47	Acute Kidney Injury	The project aims to increase compliance specifically the following Quality Statements from NICE Quality Standard 76: • 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	Quality Accounts, Sign up to Safety and Trust action	Closed – new project opened for 2019/20

		risk of acute kidney injury have their serum creatinine level and urine output monitored. • Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.		
QIP48	Mental Health	Ensure that patients are legally detained under the Mental Health Act appropriately and patients are cared for without prejudice and staff are trained adequately to make adjustments accordingly. This will be achieved by the development of a robust governance system for Mental Health within the Trust which includes data collection, audit and evaluation of patient experience alongside a training programme for relevant staff.	CQC action and Trust action	Closed – new project opened for 2019/20
QIP49	Getting it Right First Time (GIRFT)	The specific objectives of the Trust level GIRFT Programme are to: • Lead and co-ordinate the Trust's response to the national GIRFT Programme • Oversee delivery across all existing GIRFT action plans • Identify opportunities to extrapolate or replicate improvements in other settings • Prepare for GIRFT re-visits/progress checks • Oversee delivery of the actions required through the Litigation in Surgical Specialties work stream • Provide cross group reporting to the Trust's Carter Group and QIP Committee	Trust action	Closed – transferred to GIRFT Steering Group

Underpinning the overall Quality Improvement Plan is a detailed work plan for each improvement area which sets out the objective of the project, the targets to be monitored and achieved, key milestones and improvement goals.

The Quality Improvement Plan is supported by robust governance arrangements which monitor the delivery of the plan and each of the improvement areas. Progress is reported by a monthly progress report submitted by the leads to the Trust's Operational Quality Committee chaired by the Chief Nurse on a monthly basis. This enables independent challenge and assurance. The Trust Board's Quality Committee maintains an overview of the delivery of the Quality Improvement Plan.

The areas identified in the 2018/19 Quality Improvement Plan were due to be improved by the end of March 2019. All improvement areas that achieved the improvement goals and targets were closed and signed off at the April 2019 Operational Quality Committee. Achievements made against the Quality Account priorities in the plan are all detailed in this Quality Account report (see pages 11-26).

All improvement areas which require further action and monitoring because they were either, not fully improved or some improvements were made but require further monitoring to ensure they are embedded into practice were all carried forward onto the 2019/20 Quality Improvement Plan. Further information on the 2019/20 Quality Improvement Plan will be provided in next year's Quality Account.

A full copy of the Quality Improvement Plan can be found on **http://www.hey.nhs.uk/about-us/cqc/**

Care Quality Commission - 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 people 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 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.

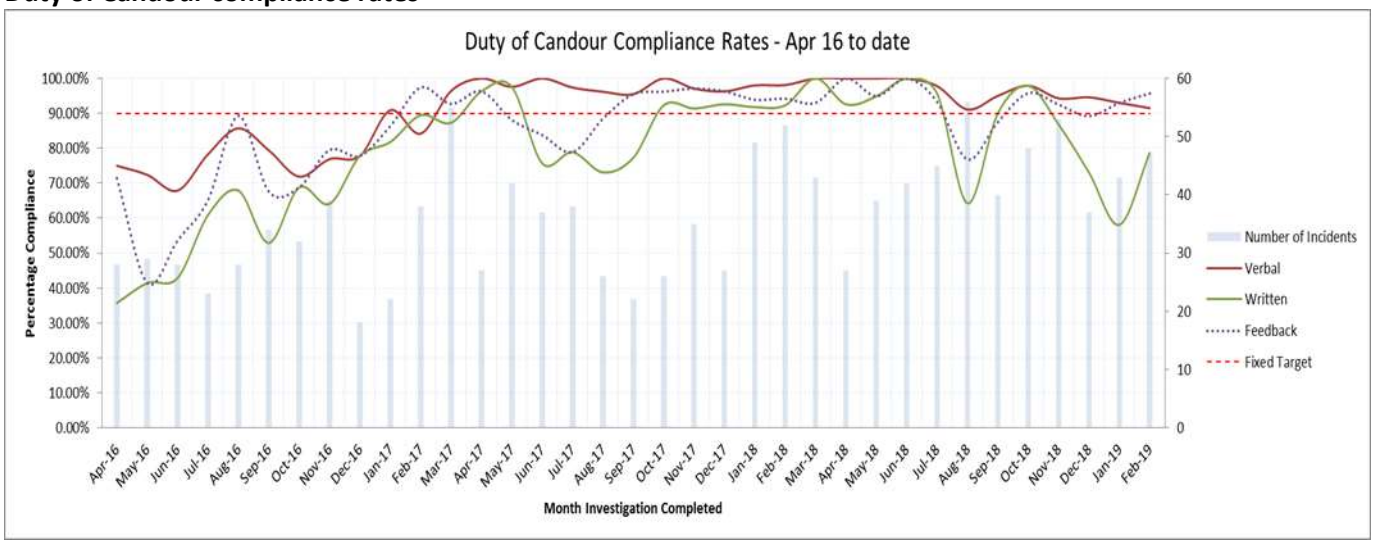
What is the Trust's compliance with Duty of Candour?

The CQC assessed the Trust in June 2016 and February 2018 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 apology is given within 10 days of the incident occurring, that a written apology is also 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 to a target of 90% compliance, allowing for those incidents which require more time to provide an open and honest apology and response.

This graph shows from April 2016 to March 2019; each element of the duty of candour compliance, monitored against the 90% target (fixed target).

Duty of Candour compliance rates



Data Quality

NHS number and general practice code validity

Hull University Teaching Hospitals NHS Trust submitted records during 2018/19 to the Secondary Users service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was:
99.86% for admitted patient care;
99.95% for outpatient care; and
99.01% for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

Information Governance Toolkit

The Information Governance Toolkit (IG 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 organisations and between organisations.

The Information Governance Assurance Statement is a required element of the IG Toolkit and is re-affirmed by the annual submission with a minimum of level two compliance demonstrating the organisation has robust and effective systems in place for handling information securely and confidentially.

Hull University Teaching Hospitals NHS Trust's Information Governance Assessment Report overall score for 2018/19 was 71%, satisfactory (rated green). Thirteen standards were reaching Level 2 and above, but further evidence was required for two standards. Action plans are in place for all of these.

The IG Toolkit was audited and assessed as achieving Significant Assurance.

There is a statement regarding data quality of Trust's waiting list data within the Annual Governance Statement in this annual report.

Clinical Coding Error Rate

Hull University Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. The recommendations below are drawn from the internal specialty audits performed during 2016/17. The following information provides an update on the implementation of the recommendations.

Recommendation	Priority	Progress Update	Status
R1 - Engagement should be encouraged with clinicians across all specialties with examples of good coding and bad coding to highlight where any problems are occurring and why, and the impact this has coding outcomes	High	Concentrate on surgical specialties and increasing the number of coding validation sessions being done. The number of validation sessions has remained steady however more clinicians are keen to assist and be contacted on an ad hoc basis.	Validations maintained in previous areas. Significant engagement from CTS and Cardiology this financial year
R2 - Continue to achieve 95% for flex and 100% for freeze dates of each month post implementation of Lorenzo.	High	Maintain targets throughout Lorenzo implementation phase. Flex dates took longer to come back to pre-Lorenzo	Complete

		levels than anticipated.	
R3 - Post Lorenzo implementation look to achieve higher levels of completion at flex 97% and be regularly 85-90% complete by early income reporting.	Medium	Targets met every month for 12 months	Complete
R4 - Improve case note quality by monitoring the state of the case notes and assessing the availability of information and report any issues.	Medium	Case note quality forms part of the audit reports and is reported to the speciality as part of audit feedback	Complete
R5 - Achieve Level 3 in all internal specialty audits. Level 3 = 95% primary diagnosis, 90% secondary diagnosis, 95% primary procedure, 90% secondary procedure.	Medium	To ensure coding quality regular audits should be of the highest standard achievable. Audits will assess the training needs of individual staff members and training will be delivered to fill knowledge gaps.	Consistently achieved level 2 – mandatory. Continue training programme to try and achieve Level 3 – Satisfactory - next financial year
R6 - Improve coding depth in all areas through regular coding audit and clinical engagement.	Medium	Where possible, coding depth across all specialties should meet or exceed peer. Where this is not the case investigations and audits should be carried out to ensure the level achieved is accurate.	Coding depth has improved or remained similar to peer across most specialities.
R7 – Ensure coders are maintaining standards and receive regular audit feedback	Medium	Regular feedback post audit	Audit programme complete for 18/19. New Audit programme for 19/20 will being April 2019
R8 – Histology results should be checked in a timely fashion.	Medium	Encouraged to make better use of daily histology report.	Ongoing issue highlighted at most audits. Continuing to work with team leaders to find effective process for ensuring histology reports are accessed in a timely manner.
R9 - Adjust proformas in preparation for HRG4+	Medium		Ongoing

Part 5: Looking forward – our plans for the future

This section includes:

- Information on how the Trust consulted on the 2019/20 quality and safety priorities
- Information on each quality and safety improvement priority, including what the Trust wants to achieve, what targets will be used to monitor performance and where progress and performance will be reported to

Our Plans for the Future – Consultation

For 2019/20 the Trust has put together a list of potential quality improvement priorities by:

- Evaluating our performance against our quality and safety priorities for 2018/19
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2018/19
- 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
- Review of the NHS Outcomes Framework (15 patient safety collaboration priority areas)

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 2019/20 the following actions were undertaken:

- An online survey was developed and circulated to all Trust staff and patient members and stakeholders to consult on the 2019/20 priorities in February and March 2019
- Relevant committees were also asked for their comments and ideas:
  - Operational Quality Committee for consultation on all priorities and approval of the 2019/20 priorities
  - Quality Committee for approval of the 2019/20 priorities
  - Trust Board for ratification of the 2019/20 priorities

The Trust has identified these quality improvement priorities for 2019/20 because they are important to our staff, patients and stakeholders:

Quality and Safety Improvement Priorities for 2019/20

Safer Care (Patient Safety)

- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce avoidable hospital acquired pressure ulcers
- To reduce avoidable acute kidney injury
- To ensure all appropriate patients are risk assessed for VTE

Better Outcomes (Clinical Effectiveness)

- To improve the care of people with Dementia within the Trust
- To improve the governance of children and adult patients requiring Mental Health care within the Trust

Improved Experience (Patient Experience)

- To improve the experience of staff working in the Trust's outpatient areas
- To listen to and act on patient experience to improve services

Safer Care (Safe, Caring, Responsive and Well-led)

1. Nutrition and Hydration

What do we want to achieve?

The aim of this project is to:

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

How will we measure this priority?

- Percentage of patients weighed within 24hrs of admission (baseline 84.8%)
- Percentage of patients weighed every 72hrs (baseline 75.8%)
- Percentage of weight recorded on Drug Chart (baseline 73.1%)
- Percentage of weighs plotted on weight graph (baseline 83.3%)
- Percentage of daily Nutrition Risk Assessments (baseline 91.9%)
- Percentage of appropriate referral to Dietician (baseline 94.0%)
- Percentage of care plan states "low, Medium or High Risk" (baseline 81.0%)
- Percentage of hydration charts completed (baseline 52.3%)

How will we monitor and report on progress?

This project will be monitored by the Nutritional Steering Group. It will be led by the Health Group Triumvirates and it is sponsored by the Deputy Chief Nurse.

2. Medication Optimisation

What do we want to achieve?

The aim of this project is to improve key aspects of the medicines management discharge process by: increased referrals to the Transfer of Care around Medicines Scheme, improved turnaround times of dispensing discharge prescriptions for the patient lounge, improved timeliness of IDSs from Boots to Queen Centre and improved accessibility of SIP feeds.

How will we measure this priority?

- 70% of dispensing discharge perceptions within an hour for patient lounge by March 2020 (baseline 53%)
- 50% (>126) increase in referrals to "Transfer of Care Around Medicines Scheme" by March 2020 (baseline 84)

How will we monitor and report on progress?

This project will be monitored by the Safer Medication Practice Committee and it is led by the Chief Pharmacist.

3. Deteriorating Patient

What do we want to achieve?

The aim of this project is to ensure all patients with an elevated NEWs score to be escalated in line with Trust Policy (which incorporates NEWS2).

How will we measure this priority?

- Percentage of patients that have a NEWS Score above 1 have evaluation states actions taken or escalation documented (Baseline to be established for 2019-20)

How will we monitor and report on progress?

This project will be monitored by the Operational Quality Committee. It will be led by the Health Group Triumvirates and it is sponsored by the Deputy Chief Nurse.

4. Pressure Ulcers

What do we want to achieve?

The aim of this project is 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 will we measure this priority?

- 100% completion of Root Cause Analysis of all Pressure Ulcer Serious Incidents within 14 days (baseline 81.3%)

How will we monitor and report on progress?

This project will be monitored by the Wound Management Committee. It will be led by the Health Group Triumvirates and it is sponsored by the Tissue Viability Nurse.

5. Acute Kidney Injury

What do we want to achieve?

The aim of this project is to increase compliance, specifically with the following Quality Statements from NICE Quality Standard 76:

- 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 will we measure this priority?

Compliance 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.
- 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.

How will we monitor and report on progress?

This project will be monitored by the Operational Quality Committee. It will be led by a Consultant Nephrologist and sponsored by another Consultant Nephrologist.

6. Venous Thromboembolism (VTE)

What do we want to achieve?

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

How will we measure this priority?

- 0 VTE Serious Incidents (baseline 1)
- Achieve 95% compliance with assessment of all relevant patients to identify the risk of VTE no later than 24 hours following admission to hospital (baseline 88.5%)

How will we monitor and report on progress?

This project will be monitored by the Thrombosis Committee. It will be led by the Health Group Medical Directors and sponsored by the Chief Medical Officer.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Better Outcomes (Effective, Safe and Caring)

1. Mental Health (Children and Adults)

What do we want to achieve?

The aim of this project is to improve the sharing of patient information between the Acute Trust and Mental Health services both internally and externally, to ensure that all children with Mental Health needs have an individual care plan appropriate to their needs and 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 will we measure this priority?

- Quarterly operational working group with Child and Adolescent Mental Health Services leads and HUTH Children's Service held from August 2019 (no baseline, working group established August 2019)
- 95% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm (baseline 100%)
- 95% compliance with paediatric relevant staff trained in Child and Adolescent Mental Health Services (CAMHS) (no baseline until training review completed)
- Bi-monthly Mental Health Committee held (no baseline, committee established August 2019)

How will we monitor and report on progress?

This project will be monitored by the Safeguarding Committee and it will be led by the Assistant Chief Nurse.

2. Dementia

What do we want to achieve?

The aim of this project is to ensure that the dementia bundle is embedded, all identified and relevant staff are trained in Dementia to the appropriate level and dementia documentation is consistently completed to the appropriate level.

How will we measure this priority?

- 30% of Trust Tier 1 staff complete the relevant dementia training (no baseline – training to be launched in July 2019)
- 30% of Trust Tier 2 staff complete the relevant dementia training (no baseline – training to be launched in July 2019)
- 30% of Trust Tier 3 staff complete the relevant dementia training (no baseline – training to be launched in July 2019)
- 90% compliance with dementia/delirium screening assessments undertaken (baseline 90.4%)
- 75% compliance on H8, H9, H90 and EAU with the use of the Butterfly Scheme which focuses on Butterfly Symbol and the Reach Form (baseline 73%)
- 75% staff awareness of John's campaign (baseline 100%)
- 75% relative/carer awareness of John's campaign (baseline 88%)

How will we monitor and report on progress?

To be monitored through the Operational Quality Committee and led by Department of Medical Elderly Consultant (DME) and Dementia Nurse.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Improved Experience (Caring, Responsive and Well-led)

1. Patient Experience

What do we want to achieve?

The aim of this project is to reduce the number of re-opened complaints due to dissatisfaction and facilitate a process to address all recommendations from the NHS Patient Survey 2018 and Mersey Internal Audit Agency Complaints Management Review.

How will we measure this priority?

- Reduce the number of reopened complaints due to dissatisfaction by 10% (baseline to be completed in June and July 2019 following review of all complaints in 2018/19)

How will we monitor and report on progress?

This project will be monitored by the Patient Experience Committee and will be led by the Head of Patient Experience.

2. Outpatient Services

What do we want to achieve?

The aim of this project is to use learning tools such as complaint and survey data to improve the outpatient service and improve the availability of data on wait times in clinics.

How will we measure this priority?

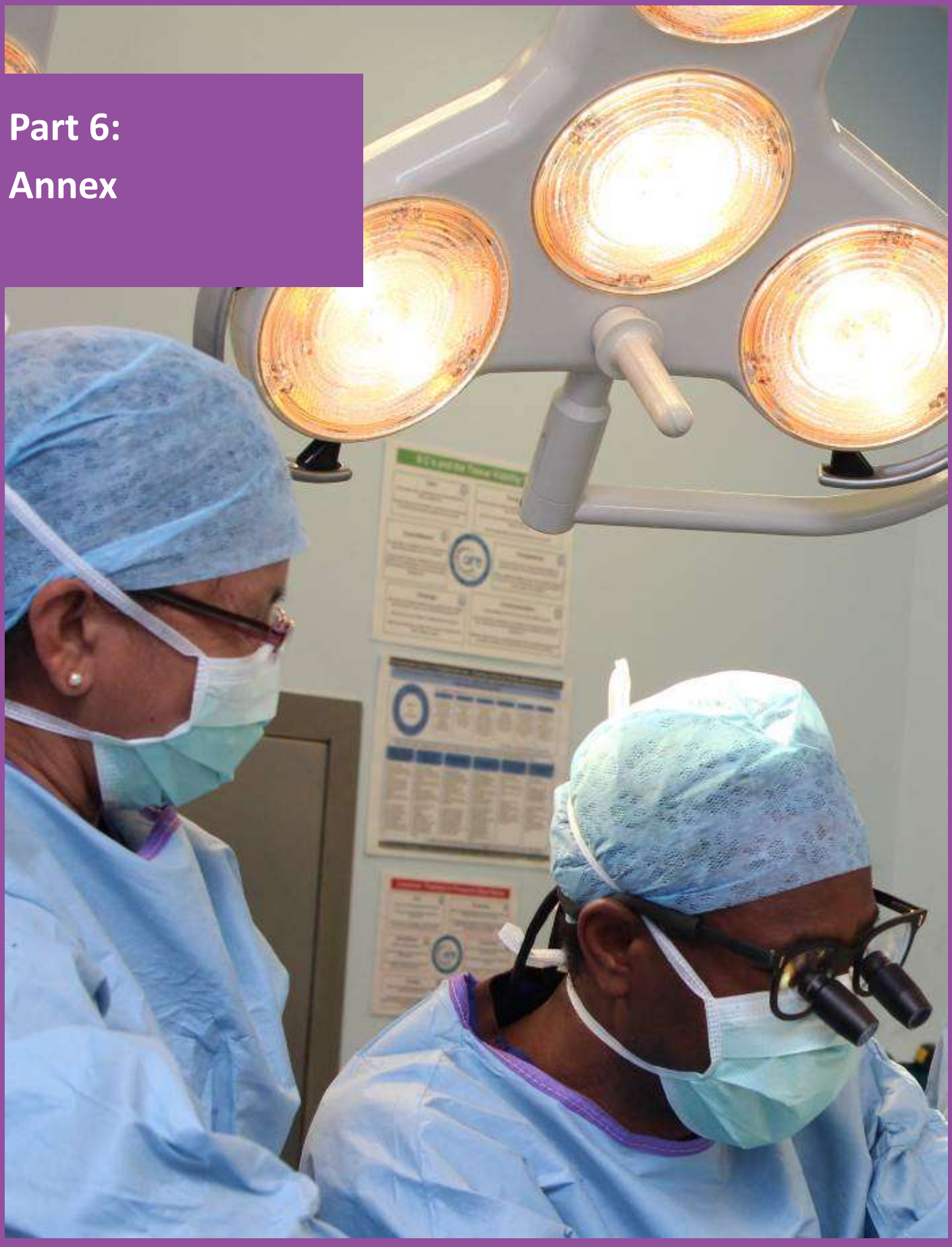
- 90% of Outpatient areas rated green or blue (scoring over 89%) on the Patient Experience Fundamental Standard (baseline 92.3%)
- 90% of Outpatient areas rated green or blue (scoring over 89%) on the Staff Experience Fundamental Standard (baseline 92.5%)
- Outpatient Governance Committee held (monthly)
- Friends and Family Test Scores for Outpatients above 95% (baseline 98% on NHS choices website)
- Increase in positive compliments or comments on NHS Choices (baseline 41)
- Improved waiting times at clinics (baseline to be identified following baseline audit completed May and June 2019)

How will we monitor and report on progress?

This project will be monitored by the Outpatient Committee and led by the Head of Outpatient Services.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Part 6:
Annex



This section includes:

- Statements on the content of the Quality Account from our Stakeholders
- Trust response to the Stakeholder statements
- Statement of Directors responsibility
- Statement of assurance from the Independent Auditors
- Abbreviations
- Information on how to provide feedback to the Trust on the Quality Account

Statements from Key Stakeholders

The Trust is required to send a copy of its quality account to the following organisations for their comments:

- The NHS England and relevant Clinical Commissioning Group (CCG) (where 50 per cent or more of the relevant health services that the Trust provides are provided under agreements with NHS England, the Trust should send its quality account to NHS England, otherwise to the relevant CCG)
- The appropriate Local Health watch organisation; and
- The appropriate Overview and Scrutiny Committee (OSC)

The first draft of the Trust's 2018/19 Quality Account was forwarded to key stakeholders on the 03 May 2019 with a request for statements of no more than 500 words to be received before the 31 May 2019. The key stakeholders are:

- NHS England and relevant CCGs - 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 (OSC)

As required in the Department of Health guidance, different organisations were requested to comment on specific questions.

The commissioners were asked to:

- Confirm in a statement, to be included in the provider's Quality Account, whether or not they consider the document contains accurate information in relation to services provided and set out any other information they consider relevant to the quality of NHS services provided;
- Take reasonable steps to check the accuracy of data provided in the Quality Account against any data they have been supplied during the year (e.g. as part of a provider's contractual obligations)

The Local Healthwatch and the Overview and Scrutiny Committees were asked to consider:

- Whether the Quality Account is representative
- Whether is gives a comprehensive coverage of the provider's services
- Whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to the Quality Account

The statements received can be found below. No amendments have been made to these statements.

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

NHS Hull and NHS East Riding of Yorkshire Clinical Commissioning Groups welcome the opportunity to review and comment on the Hull and East Yorkshire Hospitals NHS Trust Quality Accounts for 2018/19. The report illustrates a focus on improving the quality of patient care in 2018/19 and the actions taken.

We would like to congratulate the Trust on the successes that you have achieved in 2018/19 including having the majority of your services rated "Good" by the Care Quality Commission, working to make A&E Dementia Friendly with the introduction of two frontline nurses spearheading the project, your accreditation as a Veteran Aware Hospital becoming only one of 24 hospitals in the country to achieve this and uptake of flu vaccination by Trust staff making you one of the top 10 achieving Trusts in the country.

We also note the achievements with regards to nutritional screening, acute kidney injury, avoidable mortality and management of complaints. We look forward to further improvement in these and other areas during 2019/20.

Although there has been some good work with regards to nutrition and hydration, Commissioners note under performance with regards to recording on Food Record Charts. Commissioners hope to see some positive work and improvement with regards to this indicator in 2019/20.

Commissioners note varied achievement of targets with regard to prevention of pressure ulcers but acknowledge that the Trust is working with the multi-agency working group on pressure ulcers led by the two CCGs and we are pleased to continue our work with the Trust and other local service providers driving forward improvements in the prevention and management of pressure ulcers through the strategic delivery group. The CCGs will continue to monitor pressure ulcers reported by the Trust in compliance with the new NHSI Pressure Ulcer Framework and we hope to see improvement in 2019/20.

We are encouraged by the results the Trust has received from the Sentinel audits and opening of the additional HASU beds.

Regarding Infection Prevention and Control, the continued achievement of the Clostridium Difficile national target is noted and Commissioners will continue to support the work with the Trust in reducing MSSA and E.coli infection rates. The achievement of the target to screen patients for Sepsis in the Emergency Department is positive and Commissioners look forward to similar success on Inpatient Wards.

Commissioners note that no "Never Events" were reported by the Trust in 2018/19 and acknowledges the work the Trust has put into preventing Never Events from taking place including the "Stop the Line" policy. Learning from previous Never Events reflects the improvements made in the Trust in relation to its patient safety culture. In addition commissioners acknowledge the "Just Culture" approach the trust has adopted. Just Culture encourages staff to speak up when things go wrong and facilitates a culture of fairness, openness and learning.

Commissioners welcome the introduction of the National Early Warning Score NEWS2 scoring system as this will benefit and improve patient safety across the healthcare system.

Commissioners recognise the work the Trust has undertaken to review staffing across a range of services to ensure safe and adequate staffing levels. In particular the adoption of the new Nursing Associate role which has been developed and implemented in several departments within the Trust and the work the Trust is undertaking to increase non-medical student placements is also noted and we are sure this will make a contribution to developing healthcare workers of the future.

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, in addition to an update on the focused work that was undertaken around bullying and harassment following the 2017 staff survey.

While recognising a priority area for 2019/20 is the development of a robust governance system mental health provision for children and adults with oversight by the safeguarding committee, Commissioners would have liked to see a greater emphasis on Safeguarding Children and Adults in the Quality Account. However, Commissioners note development of the roles of specialist bereavement midwife and the midwife for patients with vulnerabilities which is a very positive step.

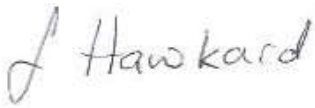
Commissioners acknowledge the challenges experienced by HUTH with regards to delivery of some NHS Constitution Targets. The CCGs continue to monitor the delivery of these closely and look forward to working with you over the next year to achieve their delivery.

The Trust has successfully made improvements in a number of their Quality Improvement Programme Plans that were identified in 2018/19 and we recognise the areas that need further improvement remain open and where appropriate new schemes will form part of your plans for continued patient safety and quality in 2019/20.

The commissioners remain committed to working with the Trust and its regulators to improve the quality of services available for our population and look forward to 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



Jane Hawkard
Chief Officer
NHS East Riding of Yorkshire Clinical Commissioning Group

Healthwatch Kingston upon Hull

The Healthwatch Kingston upon Hull did not provide a statement on the Quality Account 2018/19.

Healthwatch East Riding of Yorkshire

Healthwatch East Riding of Yorkshire welcomes the Quality Accounts from Hull University Teaching Hospitals. Healthwatch would like to praise the trust for the amount of progress that has been achieved in the last year. Although there are challenges ahead it has been extremely pleasing to see staff at the trust continue to reach out to Healthwatch in an effort to bring value to patient engagement and experience.

Hull City Council Overview and Scrutiny Committee

Hull City Council's Health Scrutiny Commission welcomes the Trust's Quality Account 2018/19. In doing so the Commission acknowledges the progress made against the 18/19 priorities but notes the desired level of progress had not been achieved in all areas. The Commission also supports the priorities identified for 2019/20, with a view to strengthening service delivery and improving patient care.

East Riding of Yorkshire Overview and Scrutiny Committee

The East Riding Health, Care and Wellbeing Overview and Scrutiny Sub-Committee were not in a position to provide a statement on the Quality Account 2018/19.

Trust Response to Stakeholder Statements

The Trust would like to thank all stakeholders for their comments on the 2018/19 Quality Account. 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 2019/20 are the right ones.

All statements received from our Stakeholders have been included in the Quality Account. The Trust has made a number of amendments to the Quality Accounts following additional comments and queries from the Stakeholders to further improve the information contained within the report.

Recommendation for change was noted from the formal stakeholder statements. The Trust would like to respond to these via this section of the Quality Account.

NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group	
Although there has been some good work with regards to nutrition and hydration, Commissioners note under performance with regards to recording on Food Record Charts. Commissioners hope to see some positive work and improvement with regards to this indicator in 2019/20.	A look back exercise was completed of the Nutrition Quality Improvement Plans for 2018/19 and 2017/18 which identified a number of areas that had actually improved that had not been captured. The Nutrition and Hydration update for 2018/19 has been amended to include more information on improvements achieved. Further work will continue during 2019/20 through the delivery of the Nutrition Quality Improvement Plans for 2019/20 and reported in next year's Quality Account.
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, in addition to an update on the focused work that was undertaken around bullying and harassment following the 2017 staff survey.	The NHS Staff Survey and Culture Transformation statement on pages 39-41 has been updated to include further information on actions taken as a result of the staff survey results.
Additional comments for the Trust to consider before publication	A number of factual accuracy changes have been made to the Serious Information data provided in the Serious Incident and Never Event statement on page 36-37.

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

24.06.19 .....Chair

24.06.19 .....Chief Executive

Independent Auditor's Report

Independent Practitioner's Limited Assurance Report to the Board of Directors of Hull University Teaching Hospitals NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Hull University Teaching Hospitals NHS Trust to perform an independent assurance engagement in respect of Hull University Teaching Hospitals NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Percentage of patients' risk assessed for venous thromboembolism
- Percentage of reported patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.
We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 27 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 27 June 2019;
- feedback from commissioners dated 30 May 2019;
- feedback from local Healthwatch organisations dated 5 June 2019;
- feedback from the Overview and Scrutiny Committee dated 5 June 2019;

- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, April 2019;
- the national staff survey dated March 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2019;
- the annual governance statement dated 28 May 2019;
- the Care Quality Commission's inspection report dated 1 June 2018.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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

Assurance work performed
We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:
- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

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

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

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

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Hull University Teaching Hospitals NHS Trust.

Our audit work on the financial statements of Hull University Teaching Hospitals NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as

having any effect on our separate duties and responsibilities as Hull University Teaching Hospitals NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Hull University Teaching Hospitals NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Hull University Teaching Hospitals NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Hull University Teaching Hospitals NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Hull University Teaching Hospitals NHS Trust and Hull University Teaching Hospitals NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Glasgow

27 June 2019

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.
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
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
e.Coli	is a bacterium usually found in the gut. Most strains are not harmful, but some produce toxins that can lead to illnesses
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.
e-Learning Package	A training programme that individuals or groups can complete online via an internal education system known as HEY247
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
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
Lorenzo	The Trust's electronic patient record system
MRSA	Methicillin-resistant Staphylococcus Aureus is a type of bacterial infection that is resistant to a number of widely used antibiotics
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.
Multi Factorial Assessment Tool (MFAT).	An **assessment** with **multiple** components that aims to identify a person's risk factors for falling.
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
NHS Outcomes Framework	This framework has been developed to provide national level accountability for the outcomes that the NHS delivers. Its purpose is threefold: to provide a national level overview of how well the NHS is performing, wherever possible in an international context; to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes
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 and our Sign Up to Safety Pledges.
Quorate	When a meeting is **quorate**, there are enough people there to make official decisions by voting
Root Cause Analysis (RCA)	RCA is a method of problem solving that tries to identify the root causes of faults or problems
SDTI	The National Pressure Ulcer Advisory Panel defines an **SDTI** as a "purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.
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.
Sign up to safety pledges	The Pledge made by the Trust to reduce all avoidable deaths and avoidable harm
SOBs	Sepsis and Observation Training
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
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 2018/19 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:

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