Hull and East Yorkshire Hospitals NHS
NHS Trust

Quality Account 2017/18

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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 and East Yorkshire Hospitals NHS Trust?

The Quality Account allows NHS healthcare organisations such as Hull and East Yorkshire 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 2018. Hull and East Yorkshire 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 2017/18 Quality Account please contact:
The Compliance Team on **01482 468098** 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 2017/18

Statement on Quality from the Chief Executive

Welcome to Hull and East Yorkshire Hospitals NHS Trust's 2017/18 Quality Account…

I am pleased to present Hull and East Yorkshire Hospitals NHS Trust's sixth 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 2018/19. 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 (pages 77 to 82) we set out the quality and safety improvement priorities for 2018/19. These priorities were identified through consultation with staff, Trust members, Health & Well Being Boards, Health watch, 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 avoidable hospital acquired infections
- To reduce avoidable hospital acquired pressure ulcers
- To reduce avoidable acute kidney injury
- To reduce avoidable patient palls

Better Outcomes (Clinical Effectiveness)

- To improve the early recognition and treatment of people with sepsis
- To reduce avoidable mortality
- To improve the process of transition between paediatric and adult care services

Improved Experience (Patient Experience)

- 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 (pages 84 to 87). 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 2017/18 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 2017/18 – Celebrating Success

The following table provides an overview of our successes during 2017/18. Some of the year's highlights include:

June 2017	**Regional Arthroplasty Centre opened** A new, international centre of orthopaedic excellence opened at Castle Hill Hospital. The Trust worked alongside long-time partner and multi-award winning healthcare company, JRI Orthopaedics, to establish its first UK Centre of Excellence for joint replacement. The Hull and East Yorkshire Regional Arthroplasty Centre (HEYRAC) will have a key role in clinical research, sharing of best practice and the development of new hip replacement products and surgical techniques.	
July 2017	**Dementia Friendly Garden** The Southwood Dementia Friendly Garden was opened and is located between wards 8 and 9 at Castle Hill Hospital; the courtyard area has been transformed to provide a tranquil and picturesque area for patients to take time out, spend time with relatives and visitors, and for staff to spend their breaks. The garden incorporates a 'Wizard of Oz' theme and is complete with lion, tin man, and scarecrow and ruby slippers.	
September 2017	**Cosy Makeover for Fracture Clinic, HRI** The Fracture Clinic waiting room might not be the first place you'd expect to find antique furniture and a fireplace but thanks to the creative efforts of one member of staff, these additions are helping to enhance the care we provide.	
December 2017	**The Ophthalmology Team scooped top prize in prestigious awards** The Ophthalmology team scooped a top award in a prestigious ceremony celebrating clinical excellence in the UK. The multi-disciplinary retinal team based at the Eye Hospital at HRI won best ophthalmology service improvement in the Bayer annual awards. Staff nurse Anna Sanders was also highly commended in the outstanding ophthalmology nurse category for her 35 years of dedicated service. The award recognises improvements in eye unit to improve and enhance patient care, save money and minimise the effect of reduced budgets as well as improving patient experience, quality of life and outcomes.	
January 2018	**Final panel unveiled for "Born Into a City of Culture" artwork** The final panel in a major piece of art to celebrate the births of babies born during Hull's year as City of Culture was unveiled. Handprints from midwives were used to create the tree trunks and the branches for the artwork while thousands of footprints of babies were taken to create the leaves.	
	Hull surgeon filmed by TV documentary crew after rebuilding girls' faces Mr Kelvin Mizen was filmed by a television documentary crew after saving children whose faces were ravaged by a deadly infection. Mr Kelvin Mizen, a maxillofacial consultant, travelled to Ethiopia for 10 years to help children with Noma, a bacterial infection caused by extreme poverty and chronic malnutrition which can lead to gangrene. The Captive Minds documentary team, working for Channel 5's Extraordinary People series, filmed Mr Mizen saving two young women aged 14 and 20 during his most recent visit to Ethiopia.	

February 2018	**Hospitals work with British Red Cross to get patients home sooner** Patients well enough to be discharged from hospital are returning home sooner after the launch of a new seven-day service. The Trust teamed up with the British Red Cross and now offers the assisted discharge scheme to patients ready to be discharged from Hull Royal Infirmary and Castle Hill Hospital. For the first time, the service is operating seven days a week between 10am and 6pm and patients with East Riding GPs are now also benefiting from the extended service as well as those living in Hull.	
March 2018	**15th Anniversary for the Women and Childrens Hospital** Hull Women and Children's Hospital celebrated the 15th anniversary since its opening of the hospital providing maternity, gynaecology and children's services for families. Since the hospital opened in 2003, centralising maternity and women's health in Hull and the East Riding, 80,202 babies have been born including one set of quads, 11 sets of triplets and 1,163 sets of twins. The heaviest baby to be born at the hospital was a baby girl, weighing in at 16lbs 5oz, and 19,730 babies have been born by caesarean section.	
April 2018	**Record year for Organ Donation** The Trust is marking its most successful year after a record number of families agreed to save lives. 35 families agreed their loved one's organs could be used to save a life in 2017/18 compared to 13 in 2016/17. This meant 54 life-saving transplants could be carried out. Trust staff also referred more patients to the organ donation team than other hospitals in the country, achieving a referral rate of 94% compared to a national rate of 90%.	

Part 2: Review of our Quality Achievements

This section includes:

- An overview of the 2017/18 Quality and Safety improvement priorities
- A detailed update on the performance, achievements and further improvements against the 2017/18 priorities

Overview of 2017/18 – Performance against Priorities

The following table provides an overview of performance against all targets during 2017/18. We recognise that not all of our quality and safety improvement priorities for 2017/18 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 2018/19.

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 10 to 29, detailed on the relevant priority area pages.

Quality and Safety Improvement Priority	Target	Status
Medication Safety	Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hours	
	Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	
	10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy	
	Introduction of a 'safety net' system to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled	
Deteriorating Patient (Adult)	Improved results against the baseline clinical observation audit of the recognition of the deteriorating patient	
	Reduction in failure to escalate Serious Incidents	
Avoidable Hospital Acquired Pressure Ulcers	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	
	100% compliance with 14 day completion of the root cause analysis investigation	
	100% compliance with duty of candour - written	
	100% compliance with duty of candour - verbal	
Nutrition and Hydration	90% of wards rated amber or above using the Trust's Fundamental Standards audits	
	100% of wards to achieve 90% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration	
	85% of wards achieve compliance with the monthly census audit for fluid balance management	
	85% of wards achieve compliance with the monthly census audit for flood and hydration chart	
Avoidable Patient Falls	To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	
	50% of clinical staff in the identified high risk areas to have completed the falls prevention e-learning by the end of March 2018. The following wards were identified as the high risk areas:	
	HRI Ward 9	
	HRI Ward 90	
	HRI Ward 8	

	HRI Ward 80	
	HRI Elderly Assessment Unit (EAU)	
	CHH Ward 29	
	CHH Ward 31	
	Allied Health Professionals	
Venous Thromboembolism (VTE)	Achieve 95% compliance with the VTE Risk Assessment	
	Achieve 0 VTE Serious Incidents	
	To increase the number of doctors completing the VTE e-learning module	
Avoidable Hospital Acquired Infections	To have 0 hospital acquired MRSA bacteraemia	
	To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53	
	To continue to reduce the number of Hospital acquired MSSA to <=46	
	To continue to reduce the number of Hospital acquired E. Coli to <=95	
Sepsis	2a(i) – Timely identification of sepsis in emergency departments	
	2a(ii) – Timely identification of sepsis in acute inpatient settings	
	2b(i) – Timely treatment for sepsis in emergency departments and acute inpatient settings	
	2b(ii) – Timely treatment for sepsis in emergency departments and acute inpatient settings	
	2c - Antibiotic review	
	2d – Reduction in antibiotic consumption per 1,000 admissions	
Resuscitation Equipment and Checklists Compliance	Achieve 95% compliance with the completion of the daily resuscitation equipment checks	
	Achieve 95% compliance with the completion of the weekly resuscitation equipment checks	
	Achieve 95% compliance with the completion of the monthly resuscitation equipment checks	
	Achieve 0 incidents reported relating to missing equipment	
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	
	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	
	To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis	
Compliance with National Standards for Interventional Procedure Checklists	Achieve full implementation of the improvement project	
Learning Lessons	Baseline established for cultural survey with expected improvements made on baseline by year end	
Patient Experience	Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate	

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.

Medication Safety

Medication errors can occur with the prescribing, dispensing, storage, handling or administration of medicines. Medicines remain the most common therapeutic intervention in healthcare. It is important that individual patients get as much benefit out of medicines as possible and resources are used wisely and effectively.

What we aimed to achieve in 2017/18:

The aim of this project is to ensure a multi-disciplinary, person-centred approach to ensuring our patients receive the right medicines, at the right dose at the right time. This will be supported by an accurate record of medications on admission to the hospital by ensuring medicines are reconciled as soon as possible, ideally within 24 hours of admission. This will reduce the potential for harm and contribute to the delivery of a safe and effective medication process for our patients.

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hours*
- Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time
- 10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy
- Introduction of a 'safety net' system to help focus resource on those patients admitted more than 72 hours ago whose medicines have not been reconciled

*The target was discontinued in December 2017 because medicines reconciliation is continually monitored and reported each day, and any patients whose medicines have not been reconciled are targeted individually to ensure medicines reconciliation is completed. Pharmacy resources have to balance a range of roles including support with in-patient medication issues as well as safe & timely discharge.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve reconciliation of medicines on admission to hospital for 70% of our patients within 24 hours	46%	53% (Dec 17)	
Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	81%	89% (Sept 17)	
10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy	1 hr 43 mins	1hr 45 mins	
Introduction of a 'safety net' system to help focus resource on those patients admitted more than 72 hours ago whose medicines have not been reconciled	No baseline	Introduced	

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 Trust has continued to implement the medication safety improvement project during 2017/18 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2016/17 quality improvement plan. This was to ensure that patients receive medicines reconciliation in a timely manner, improving the discharge process to ensure timely and safe supply of medicines prior to leaving hospital by trained staff supported by the Trust Drug Policy, and a range of other projects introduced to improve the safe and effective use of medicines within the Trust. The changes made were embedded with pharmacy support to ward areas and to continue to improve the management of medicines across the Trust.

Although the target of 70% for medicines reconciliation on admission to hospital within 24 hours was not achieved, it is important to recognise that medicines reconciliation for patients during their hospital stay is regularly above 90%. The Trust has also introduced a safety net system to help focus resource on those patients admitted more than 72 hours ago

whose medicines have not been reconciled. Along with the introduction of a monthly medicines management ward audit undertaken jointly by the ward pharmacist and senior nurse, and embedded a system of reporting and governance for the results.

Other achievements include:
- Electronic prescribing was successfully introduced to ward 29 at the Queens Centre, CHH.
- All pharmacy audits were completed and signed off in the required timescale
- The Trust discharge policy was reviewed and ratified
- Improvement work on ward 9 at HRI was undertaken with pharmacy support on the morning drug administration round to identify any drugs not available and facilitate ordering in a timely manner. This resulted in a reduce number of missed doses.
- Working with the HEY Improvement team, Pharmacist transcribing was piloted on ward 9 at CHH and showed improvements in discharge planning & patient flow, and an increase in the number of morning discharges.
- A medicines management technician was introduced in the surgical admissions lounge at CHH to undertake medicines reconciliation.
- A new piloted report from Cayder was trialled to identify patients who have been admitted for <20 hours, this enabled pharmacy teams to target patients and improve medicines reconciliation.
- The reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time target has been achieved.

The project for reducing dispensing errors by improving the working environment in the pharmacy at HRI has been closed due to the need for detailed plans and infrastructure costs.

The target of reducing by 10% the average waiting times for discharge prescriptions dispensed in the hospital pharmacy has not been achieved. The reasons for this are multifactorial but include an increased intake of new staff requiring training, temporary shortage of Accuracy Checking Technicians in the dispensary, and later arrival of discharge prescriptions into the pharmacy. We plan to improve this by:
- Training more Accuracy Checking Technicians to perform the ‘final check’ on discharge prescriptions
- Promoting the role of the dispensary co-ordinator bleep holder, so wards can contact pharmacy on a dedicated number to assist with discharges
- Proposing the purchase of a customised tracker system to help us capture and report more accurate data
- Using pharmacist prescribers to help write discharge prescriptions
- Newly trained pharmacists being part of ward teams to screen discharge prescriptions on the ward, facilitating the discharge process
- Increasing the number of trained Pharmacy Assistants to dispense discharge prescriptions
- Closely monitoring discharge prescription turnaround times to identify improvements
- Introducing e-rostering to ensure staff working hours are matched to demand

Further improvements identified:

Further improvements in medicine optimisation have been identified and it is therefore a quality and safety priority for 2018/19 (see page 78) and it will also be included in the Trust’s Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be:
- Extension of electronic prescribing to the wards in the Queen’s Centre at CHH supporting efficiency and patient safety, including a review of infusion functionality
- Review of current pre-packs available on wards to facilitate a more efficient discharge. ‘ Pre-pack’ items of medication are already stored on the ward ready to be supplied to the patient and are used in some areas if appropriate (following training) so that the prescription doesn’t need to be sent to pharmacy for dispensing to facilitate a more efficient and timely discharge for the patient.
- Project to assess if more patient’s own drugs can be used whilst in hospital

- Project (5th floor at HRI) on utilising, and potentially expanding, number of pharmacists transcribing discharge prescriptions to contribute to improving morning discharge figures and improving patient experience
- Improving the knowledge and awareness on VTE prevention by pharmacists undertaking an e-learning package, with a view to roll out to other professions by the Thrombosis Committee
- Improve safe use and prescribing of insulin
- Support adult cystic fibrosis patients by the introduction of an annual medication review
- Introduction of Biosimilar Adalimumab to maximise the use of resources. This is a drug provided by injection for the treatment of arthritis and other conditions, and a new biosimilar version has become available. A biosimilar is a drug that is similar in terms of quality, safety and effectiveness to the original licensed product. Using a biosimilar will enable us to use our resources more effectively.

Deteriorating Patient – Adult

Early recognition of a patient's deterioration through better assessment, escalation and early treatment of patients will enable appropriate planning and improved patient care.

What we aimed to achieve in 2017/18:

The aim of this project is to ensure early identification of a patient's deterioration and to ensure the correct treatment and escalation plans are in place and documented.

This priority aimed to achieve the following specific targets by the end of March 2018:

• Improved results against the baseline clinical observation audit of the recognition of the deteriorating patient*

** Due to the nature of the audit and the range of elements reviewed a decision was made in-year to assess this element against the number of serious incidents linked to deteriorating patient.*

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Improved results against the baseline clinical observation audit of the recognition of the deteriorating patient	13	No data	
Reduction in failure to escalate Serious Incidents	=<12	11	

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 Trust continued to focus on training and awareness raising as part of the deteriorating patient project. Over 3,000 relevant and available staff were trained on NEWS (National Early Warning Score – assessment and escalation) and over 1,000 on sepsis and Observations (SOBs). Whilst this has not seen the desired reduction in Serious Incidents, progress has still been made. It is however, acknowledged that this has not been at the pace expected across all areas of the organisation. Key achievements however, have included the launch of face to face and online training tools, an outreach link established on each ward and a review of the relevant policies and procedures in line with new national guidelines.

Further improvements identified:

It has been identified that further improvement on the early recognition of deteriorating patients is required and it is therefore a quality and safety priority for 2018/19 (page 78) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be:

- Continued roll-out of e-observations at the same time as the installation of WiFi across the hospital sites
- Continued focus on the development of the training and awareness packages available across the Trust

Avoidable Hospital Acquired Pressure Ulcers

Pressure ulcers occur when an area of skin is placed under pressure and the skin and tissue starts to break down. Pressure ulcers can cause great pain, skin damage and can be very distressing for patients. They are proven to represent a major burden of sickness and impact on the individual's quality of life.

What we aimed to achieve in 2017/18:

The aim of this project is to prevent all patients developing avoidable hospital acquired pressure ulcers.
This project aims to ensure that appropriate risk assessments, plans of care highlighting required nursing interventions and meaningful evaluations are undertaken by knowledgeable staff, for every patient, and that, through this avoidable skin damage is prevented.

This priority aimed to achieve the following specific targets by the end of March 2018:

- 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 suspected deep tissue injury (SDTI)
- To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers
- 100% compliance with 14 day completion of the root cause analysis investigation
- 100% compliance with duty of candour - written
- 100% compliance with duty of candour - verbal

Actual outcome:

The following table provides performance data against the targets:

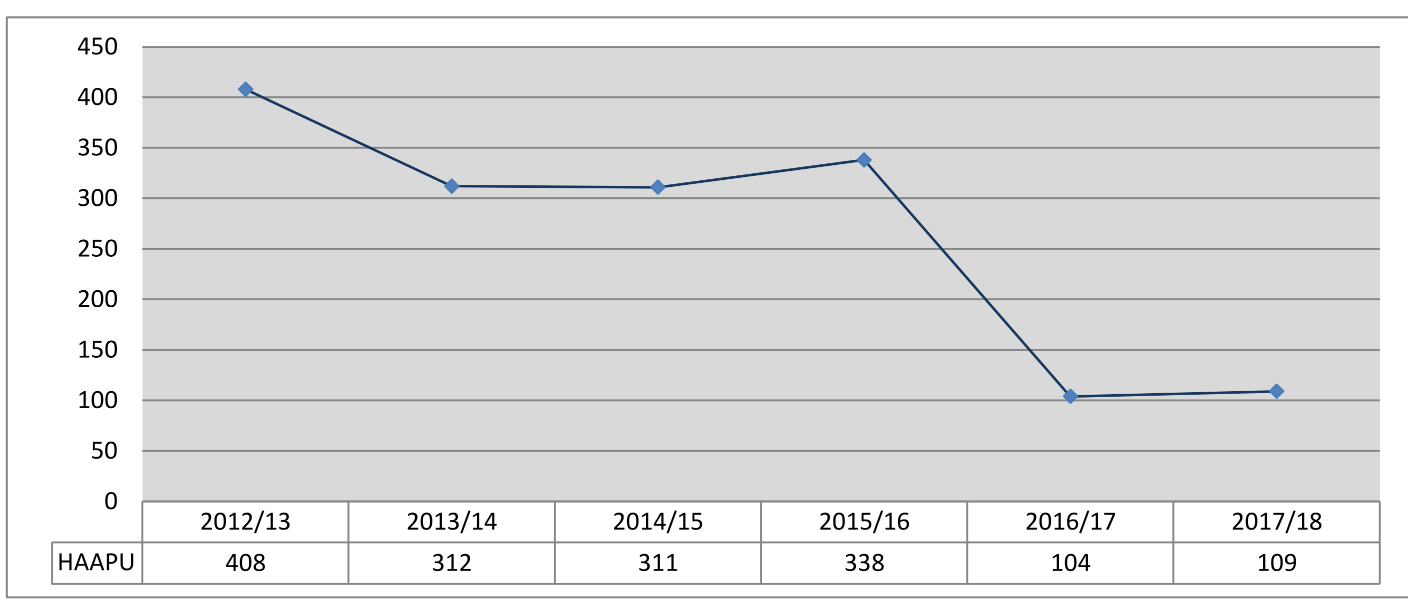
Target	Performance 2016/17	Performance 2017/18	Status
To have no avoidable hospital acquired grade 3 pressure ulcers	1	4	
To have no avoidable hospital acquired grade 4 pressure ulcers	0	1	
To have no more than 8 avoidable hospital acquired unstageable pressure ulcers	13	12	
To have no more than 23 avoidable hospital acquired SDTI	35	34	
To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers	52	56	
100% compliance with 14 day completion of the root cause analysis investigation	81%	67%	
100% compliance with duty of candour – written	83.3%	80%	
100% compliance with duty of candour - verbal	93.3%	92%	

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:

This project monitored the Care Quality Commission (CQC) Duty of Candour requirements to improve the patient's experience of open and honest communication should a hospital acquired pressure ulcer occur.

Whilst not all performance measures were met for this project a significant reduction in pressure ulcers has been seen over the life of this project, as detailed in the following graph:



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
HAAPU	408	312	311	338	104	109

Further improvements identified:

It has been identified that further improvement on reducing the number of avoidable pressure ulcers is required and it is therefore a quality and safety priority for 2018/19 (page 79) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be:

- The review of specific mattresses – pilot and then tendering process in 2018
- Storage and tracking of mattresses
- Surgical Site Infections in Maternity
- Leg Ulcer training and competencies
- Threshold of the Tissue Viability Fundamental Standards audits increased to drive up quality of care
- Student Nurse training and the development of the 'High Five' Ward Rounds (now including medical staff)
- Training Needs Assessment for all Sisters and Senior Matrons amended to include the requirement to complete the higher level tissue viability training on an annual basis
- The development of a strategic local group (chaired by the Hull and East Riding Clinical Commissioning Groups) reviewing a joint approach to improving skin care across health and social care
- Wound Management process amended to include the requirement that all patients with pressure damage, either community or hospital acquired is reviewed by a Sister/Senior Matron daily

Nutrition and Hydration

Nutrition and hydration are essential elements of patients' care. Adequate nutrition and hydration helps to sustain life and good health. It reduces the risk of malnutrition and dehydration while patients are receiving care and treatment in hospital and provides patients with the nutrients they need to recover.

What we aimed to achieve in 2017/18:

The aim of this priority is to ensure patients have an appropriate personal nutritional needs assessment completed and receive an appropriate care plan or referral to a dietician where required.

This priority aimed to achieve the following specific targets by the end of March 2018

- 90% of wards rated amber or above using the Trust's Fundamental Standards audits
- 100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration*
- 85% of wards achieve compliance with the monthly census audit for fluid balance management*
- 85% of wards achieve compliance with the monthly census audit for flood and hydration chart*

**targets were discontinued because the methodology changed in-year to become more integrated with the Trust's Fundamental Standard audits*

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
90% of wards rated amber or above using the Trust's Fundamental Standards audits	79.6%	91.3%	
100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration	89.5%	No data	
85% of wards achieve compliance with the monthly census audit for fluid balance management	No baseline	No data	
85% of wards achieve compliance with the monthly census audit for flood and hydration chart	No baseline	No data	

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:

In March 2017 a Nutritional Prevalence Audit (census) was completed, with a specific aim of reviewing the compliance with Trust nursing staff in relation to their requirements within the HEY Nutrition and Hydration Policy. A number of actions were identified, all of which have been completed. When the audit was completed again in March 2018, improvements were noted in several areas, including a 10% improvement in weighing patients daily.

The Trust's Nutrition Policy was also updated and amended to reflect required changes identified by the census and this was approved in December 2017.

The Trust also undertook a review of the questions included in the Nutrition and Hydration Fundamental Standards and provided increased support and training by senior nursing staff to those wards scoring poorly. The Trust achieved 91.3% of wards rated amber or above using the Trust's Fundamental Standards audits at the end of the year, which was an improvement on the baseline of 79.6%.

Further improvements identified:

It has been identified that further improvements on nutrition and hydration are required in order to ensure further and sustained improvement. It is therefore a quality and safety priority for 2018/19 (see page 78) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be 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.

Avoidable Patient Falls

A fall is defined as an unplanned or an unintentional descent to the floor, with or without injury, regardless of the cause. A patient falling in hospital is one of the most common patient safety incidents reported to the National Reporting and Learning System (NRLS). Patient falls in hospital are a common cause of injury; increased length of stay, hospital acquired infections and can have a longer term impact on a person's well-being. Some falls cannot be prevented without unacceptable restrictions to patients' rehabilitation, privacy and dignity; many falls can and should be prevented.

What we aimed to achieve in 2017/18:

The aim of this project will be to focus on the outcomes for the patient following a fall and to learn lessons from the root cause analysis investigations completed. This project will also aim to achieve compliance with the Multi Factoral Assessment Tool (MFAT), which will drive forward improvements in falls prevention through the completion of e-learning.

This priority aimed to achieve the following specific targets by the end of March 2018:

- To reduce further the number of patient falls per 1000 bed days for patient falls rated moderate or above
- 50% of clinical staff to have completed the falls prevention e-learning by the end of March 2018*

*In December the target was revised to focus on the high risk areas only

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	6.39	0.17	
50% of clinical staff to have completed the falls prevention e-learning by the end of March 2018. The high risk areas were identified as follows:			
Ward 9 HRI	No baseline	50%	
Ward 90 HRI	No baseline	60%	
Ward 8 HRI	No baseline	80.6%	
Ward 80 HRI	No baseline	51.3%	
EAU HRI	No baseline	61%	
Ward 29 CHH	No baseline	16%	
Ward 31 CHH	No baseline	62%	
Allied Health Professionals	No baseline	17.3%	

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 Trust has continued to implement the avoidable patient falls improvement project during 2017/18 following further embedding of the falls improvement work and continuing to reduce the number of avoidable falls and increase the learning from incidents, resulting in significant improvements.

Achievements against the delivery of this project have been identified through compliance with National Institute for Health and Care Excellence (NICE) guidance which has driven through the improvement in falls prevention through the improved completion of MFAT and the completion education along with the focusing on the outcomes for the patient following a fall and to learn lessons from the root cause analysis.

The falls e-learning staff training package target was set at achieving 50% of clinical staff to have completed this initially, however this training was not a compulsory element for all staff and was therefore proving difficult to achieve due to other education demands and clinical demands. It was also felt that a more targeted approach was required and that it should target the high risk areas (areas with more falls) and the allied health professionals staffing group who work with these patients on a daily basis. Seven wards were identified along with the staffing group (as reported in the table above).

The reduction in the number of patient falls per 1000 bed days (rated moderate harm or above) has been mostly successful with only two out of the twelve months not meeting the target. The full roll-out of the weekend mobility plan was completed, also.

A review of medical records for patients who had experienced a fall with a harm level of moderate or above was completed. The review was to ensure the escalation process for the declaration of Serious Incidents related to falls was robust. The review accepted the decisions made not to declare an SI for the cases reviewed, with the exception of 1 case which is currently undergoing further consideration within the Senior Corporate Nursing Team. On the basis of this review and the recommendations of the report to the Falls Prevention Committee, further processes to obtain ongoing assurance have been developed, trailed and escalated for approval. This includes the development of falls specific serious incident decision form.

Various audits were undertaken including looking at the processes for the monitoring of the checks for injury and medical examination after a fall. Datix was altered to capture the level of medical/clinical intervention post falls. The requirement to analyse this data has been added to the Falls Prevention Committee work plan once sufficient data has been collected.

Further improvements identified:

It has been identified that further improvements reducing the number of avoidable patient falls are required in order to ensure further and sustained improvement. It is therefore a quality and safety priority for 2018/19 (see page 79) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be:

- Re-audit undertaken using the census tool to identify compliance with the accurate completion of falls risk assessment, clinical appropriateness use of the bedrails and individualised care plans
- Development of 'fall prevention' poster campaign
- Auditing processes for the monitoring of the checks for injury and medical examination after a fall established
- Complete the re-evaluation of the falls prevention care bundle, which includes redesign of the MFAT and the introduction of an improved bed rails assessment
- Revised documentation to be tested in various areas
- Meeting with patient experience to explore the use of volunteers to work with patients in prevention of falls
- Explore a method of ensuring mobility aids are available 24/7
- Development of a staff information poster
- Approval and introduction of a falls specific Serious Incident Decision (SID) form. This form captures the information required to enable informed decision making when considering incidents for potential escalation to Serious Incidents
- Review of NICE guidance to ensure compliance
- Bedside vision assessment to be developed in a proportionate format
- Update e-learning in line with changes to nursing documentation

VTE

Venous Thromboembolism (VTE) is a blood clot within a vessel. It happens when a blood clot forms and blocks a vein or an artery, obstructing or stopping the flow of blood. It most commonly occurs in the deep veins of the legs. This is known as Deep Vein Thrombosis (DVT).

What we aimed to achieve in 2017/18:

The aim of this project is to ensure patients are risk assessed appropriately for VTE within 24 hours of admission and to demonstrate that the Trust is compliant with the relevant contractual requirements.

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve 95% compliance with the VTE Risk Assessment
- Achieve 0 VTE Serious Incidents
- To increase the number of doctors completing the VTE e-learning module

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve 95% compliance with the VTE Risk Assessment	92.5% (Q4)	89.48% (Q4)	
Maintain 0 VTE Serious Incidents	2	0	
To increase the number of doctors completing the VTE e-learning module	986	1541	

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 patients are risk assessed appropriately for VTE within 24 hours of admission and to demonstrate that the Trust is compliant with the relevant contractual requirements. This project has been in the Quality Accounts and part of the Quality Improvement Plan (QIP) for two years. Whilst progress has been made and Health Groups have implemented changes performance fluctuates between 85-90%. The Trust must comply with a target of 95% and this has not been achieved. Following escalation and discussion at the Operational Quality Committee it was felt that they have exhausted the possibilities available to them to reach this target and need further support to understand barriers and it was agreed that dedicated improvement support is required from the HEY Improvement Team (HIP) skills and knowledge to determine the barriers to progressing to achieving the target of 95%. Therefore this was closed as a quality and safety priority and the Quality Improvement Plan for 2017/18 and transferred to the HEY Improvement Team.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However, there are still improvement activities that will take place during 2018/19 which will be led by the Chief Medical Officer and it will be delivered by the HEY Improvement Team (HIP).

The focus for further improvements will be:

- Determine what the barriers are to achieving the target of 95% of patients receive a VTE risk assessment within 24 hours of admission to hospital and working with the Health Groups to take the required steps to address the barriers identified and progress towards achieving the target

Avoidable Hospital Acquired Infections

What we aimed to achieve in 2017/18:

The aim of this project is to ensure compliance with the updated Health & Social Act (2012): code of practice on the prevention and control of infections and related guidance (2015) which will then reduce the number of avoidable hospital acquired infections.

This priority aimed to achieve the following specific targets by the end of March 2018:

- To have 0 Hospital acquired MRSA bacteraemia
- To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53
- To continue to reduce the number of Hospital acquired MSSA to <=46
- To continue to reduce the number of Hospital acquired E. Coli to <=95

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
To have no hospital acquired MRSA bacteraemia	2	1	
To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53	45	38	
To continue to reduce the number of Hospital acquired MSSA to <=46	44	36	
To continue to reduce the number of Hospital acquired E. Coli to <=95	81	110	

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 key improvements achieved for this project were based on the improvement and review of several processes related to infection and prevention and control, including staff engagement and training. These included reviewing the process and documentation for VIP charts, continence management training scoping, development of two new policies for IPC in Theatres and current intranet content review.

Further improvements identified:

It has been identified that further improvements on Avoidable Hospital Acquired Infections are required and it is therefore a quality and safety priority for 2018/19 (see page 78) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be to continue to reduce hospital acquired infections by focussing on the review of the Trust's Infection Prevention and Control Care Bundle and participation in the NHSi Urinary Tract Infection Collaborative Project.

Sepsis

Sepsis occurs when the body's response to an infection causes damage to its own tissues and organs which can lead to shock, organ failure and death, especially when Sepsis is not identified in a timely manner and treated appropriately.

The Sepsis Six is a series of actions that must be taken within an hour when a patient is diagnosed with Sepsis. The Sepsis Six are designed to treat the condition and if they are applied quickly, they enhance the chance of survival.

What we aimed to achieve in 2017/18:

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 leading to the implementation of the sepsis pathway across the organisation. The focus of the project will be on all patients meeting the new definition of sepsis, completing the sepsis 6 bundle within an hour.

This priority aimed to achieve the following specific targets by the end of March 2018:
The Commissioning for Quality and Innovation (CQUIN) Indicators:

- 2a – Timely identification of sepsis in emergency departments and acute inpatient settings
- 2b – Timely treatment for sepsis in emergency departments and acute inpatient settings
- 2c - Antibiotic review
- 2d – Reduction in antibiotic consumption per 1,000 admissions

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
2a(i) – Timely identification of sepsis in emergency departments	96%	87%	
2a(ii) – Timely identification of sepsis in acute inpatient settings	92%	92%	
2b(i) – Timely treatment for sepsis in emergency departments	80%	55.6%	
2b(ii) – Timely treatment for sepsis in acute inpatient settings	80%	64.7%	
2c - Antibiotic review	No baseline – new performance indicator for 2017-18	95%	
2d – Reduction in antibiotic consumption per 1,000 admissions 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions - 2% reduction on baseline 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions - 1% reduction on baseline 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions - 1% reduction on baseline	1. 54926.73 per 1,000 admissions 2. 643.53 per 1,000 admissions 3. 782.89 per 1,000 admissions	1. 3% increase - not achieved 2. 12% reduction - achieved 3. 27% reduction - achieved	

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:

Significant progress has been made on this project through the year. Sepsis pathways have been introduced Trust-wide, including the more recent launch of the paediatric pathway. This has been accompanied by bespoke training sessions and supplemented with increased awareness with partners, for example, Yorkshire Ambulance Service (YAS).

Throughout the year the project has progressed strongly with all milestones being met. As well as completing the milestones, evidence suggests that these have had a positive impact on sustained performance and in meeting the overall aim of the project.

It is evident from participation in regional and national forums and meetings that other Trusts have non clinical data collectors managing the CQUIN. The CQUIN data within Hull and East Yorkshire Hospitals NHS Trust (HEYHT) is only collected and validated by clinicians. This policy has been validated, as the Medical Director for Clinical Effectiveness for NHS England has recently written to the Trust's Chief Executive congratulating the Trust on being one of the Trusts in England to have achieved the most significant improvement in Sepsis care and outcomes.

The unique training package on Sepsis and basic observations introduced last year by the Sepsis Team has now been made mandatory for all qualified nurses and midwives within the Trust. This is a key element in achieving the Trust's vision for improving the care of the deteriorating patient and to our knowledge. In recognition of this the Trust has recently been asked to present at the Westminster Health Forum. The Team have also presented a poster at a national Sepsis conference and an international patient safety conference.

In the absence of national guidelines as part of this project the Trust has developed specific Sepsis pathways for Paediatrics and Maternity incorporating the early warning scores relevant to these areas. The maternity pathway was rolled out in September 2017 and the Paediatric pathway was launched in March 2018. A specific set of Maternity antibiotic guidelines have also been developed to ensure that their infection management is in line with the antibiotic stewardship principles of the rest of the Trust.

Further improvements identified:

It has been identified that further improvements on sepsis are required and it is therefore a quality and safety priority for 2018/19 (see page 81) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be:

- The consolidation of training and awareness both internally and with partner organisations. In addition, the project will seek to improve coding of sepsis.

Resuscitation Equipment and Checklists Compliance

What we aimed to achieve in 2017/18:

The aim of this project is to improve and monitor the completion of resuscitation equipment checklist compliance on all wards.

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve 95% compliance with the completion of the daily resuscitation equipment checks
- Achieve 95% compliance with the completion of the weekly resuscitation equipment checks
- Achieve 95% compliance with the completion of the monthly resuscitation equipment checks
- Achieve 0 incidents reported relating to missing equipment

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve 95% compliance with the completion of the daily resuscitation equipment checks	93%	79% (Sept 17)	
Achieve 95% compliance with the completion of the weekly resuscitation equipment checks	No baseline	79% (Sept 17)	
Achieve 95% compliance with the completion of the monthly resuscitation equipment checks	95%	100% (Sept 17)	
Achieve 0 incidents reported relating to missing equipment	0	0 (Sept 17)	

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:

During the year, the Trust developed and implemented a new template for monthly and daily resuscitation checks and supported the implementation of several 'bespoke' audits for various departments within the Trust that require a slightly different resuscitation trolley. In addition, a review of incidents reported found that there had been none reported within the year that related to missing or out of date equipment on a resuscitation trolley.

The results from the monthly audits were reviewed and showed an increase in daily check compliance from 45% in May 2015 to 79% in September 2017, with nine months in that period achieving over 90% compliance and one month meeting the target of 95% compliance. Monthly check compliance remained high from 96% compliance in May 2015 to dropping to 79% in September 2017, however of the 29 months within the project time period, 21 months achieved the 95% compliance rate with eight months achieving 100% compliance. It was agreed that the audit results in general showed an overall improvement in compliance with the daily and monthly checks since the monthly audits. In addition, the Trust received further assurance from the CQC during their inspection in February 2018 which found that checks were completed in line with Trust policy.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However the focus for further improvements will be to continue to embed the new processes which should, in turn, show improvement in performance overall and a further period of review in 2017/18, against the same standards, will allow the Trust to compare and determine the success of the improvements made during this period. The Resuscitation Committee will continue to monitor the results of the annual audit and address any concerns that are highlighted through Datix, training sessions or an arrest.

Avoidable Mortality

What we aimed to achieve in 2017/18:

The aim of this project is to aid the organisation in the delivery 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.

This priority aimed to achieve the following specific targets by the end of March 2018:

- 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*
- 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.
- To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis.

*Learning Disabilities Mortality Review (LeDeR) review undertaken separately to Structured Judgement Review (SJR)

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	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	No data	
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%	
To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis.	No baseline	100%	

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 avoidable mortality project has made significant progress during 2017/18. Key areas of improvement have focused on:

- Engagement into the project from all Trust specialities; incorporating 90 trained reviewers that can undertake Structured Judgement Reviews
- Identifying patients that meet the national minimal criteria for case-note review, via the Business Intelligence system
- The publication of the first Themes and Trends report which provides information Trust wide and at Health Group level to improve patient care
- Development of a family/Next of Kin engagement questionnaire to inform of the Trust approach to mortality to review.
- The development and utilisation of an internal "Learning from Deaths Policy"
- The development and trial of a mortality "initial screen" form, on trial in Diabetes and Stroke – feedback from the trial will be reviewed as part of the 2018/19 programme
- A feedback mechanism designed to ensure all relevant Consultants and Doctors involved in a patients care receive a completed mortality review, for reflection and learning purposes.

- A mechanism to allow all monthly death statistics to be sent to the mortality lead for each speciality, for discussion within the Morbidity and Mortality meeting.
- Development and implementation of "Problems in Healthcare" section of mortality proforma utilised into Lorenzo
- Process developed and implemented on the completion of multi-agency mortality reviews.
- A new process in place to ensure all elective surgery deaths are reviewed, as per the national requirement.
- The procurement of a dedicated governance analyst role to support the Clinical Outcomes Manager and to assist in the development of learning lessons.
- The creation and implementation of the Trust Learning from Death dashboard.

Further improvements identified:

It has been identified that further improvements on avoidable mortality are required and it is therefore a quality and safety priority for 2018/19 (see page 81) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be:

- Development of a standardised "Quarterly themes and trends" report template, to be completed by each Speciality on a quarterly basis
- Mortality Review-Quality Assurance Process embedded
- Process agreed and implemented to allow the identification of patients who match the "Deteriorating Patient" criteria
- Initial Mortality Screening form developed and trialled within a number of specialties. Following review and approval by the Health Groups this screening form will then be rolled out within the Health Groups
- E-learning package designed for use in training Structured Judgement reviewers and implemented for all staff to access on HEY247, which is a Trust internally managed education system for all staff to access and complete training

Compliance with National Standards for Interventional Procedure Checklists

What we aimed to achieve in 2017/18:

The aim of this project is to review processes for the completion of any relevant clinical checklists used within the Trust which compliance rates require improvement. The main focus for 2017/18 will be the review current local processes for invasive procedures and ensure that they are compliant with the national standards (National Safety Standards for Invasive Procedures (NatSSIPs).

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve full implementation of the improvement project*

**Target discontinued due to the closure of this project in September 2017*

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve full implementation of the improvement project	No baseline	No data	

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:

This project was initially aimed at overall clinical checklist compliance however early in the year it was agreed that this was too wide a remit and the aim modified to focus only on WHO Checklist compliance and a separate Quality Improvement Project was developed to focus on reducing mortality and morbidity, including wrong site surgery, haemorrhage and infection, through full creation and implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) Project in all specialities across the Trust. Following further review by the Trust, it was agreed that the HEY Improvement Team would lead on a project for the creation and implementation of NatSSIPs across the organisation, termed as Phase 1. Phase 1 included:

- Project scope for the rollout and sustainability of NatSSIPs
- Governance process in place for the ratification of local checklists (LocSSIPs)
- Agreed Key Performance Indicator (KPI) for expected level of compliance organisationally
- Local Safety Standards for Invasive Procedures Policy
- Standardised core surgical checklist (NatSSIP)
- NatSSIPs training programme
- Auditing process and programme

Phase 1 was delivered successfully in February 2018 with sustainable processes in place for the continuation of NatSSIPs within the organisation.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However there are still improvements activities that will take place during 2018/19 which will be led by the SSIPs Steering Group and it will be monitored by the Surgery Health Group.

The focus for further improvements will be the delivery of Phase 2 of the project will ensure the continual compliance and education of NatSSIPs within the organisation by ensuring the auditing programme for NatSSIPs performance

continues with remedial actions in place where standards are not being met, continual engagement with teams regarding their performance of NatSSIPs against the corporate standards and ongoing support for teams providing advice, training and information on the use of NatSSIPs.

Learning Lessons

What we aimed to achieve in 2017/18:

The aim of this project is to assist the organisation with a change in culture from one of assurance to one of enquiry.

The priority aimed to achieve the following specific targets by the end of March 2018:

- Baseline established for cultural survey with expected improvements made on baseline by year end

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Baseline established for cultural survey with expected improvements made on baseline by year end	No baseline	Completed	

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 Trust has continued to develop and deliver a number of mechanisms for learning lessons, including monthly Safety Bulletins and Lessons Shared newsletters. The Trust launched a new Intranet site during the year. A section was created to provide an in house resource to assist staff learning. In addition, training programmes have been developed including the Learning, Candour and Accountability programme as well as developments through the Hey Improvement Team of structured and bespoke improvement methodology. The Trust has undertaken training with the Improvement Academy on the Measuring and Monitoring Safety Framework. This has been utilised in a number of projects throughout the year including Avoidable Mortality, Falls, Pressure Ulcers and Sepsis.

The Trust continues to investigate Serious Incidents, Claims and Complaints which have been utilised internally to develop robust governance reports to assist Health Groups and specialities in their learning. Themes and trends reports are being produced and work is ongoing with the Organisational Development Team to review the culture of learning in the Trust.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However there are still improvements activities that will take place during 2018/19 which will be led by the Quality Governance Lead.

Patient Experience – listening to patients and acting on their feedback

Patient, family and carer experience is very important to the Trust. Listening to and acting on the feedback provided by patients, relatives and carers is crucial to learning lessons and to further improve our services. The Trust wants all patients to have the best possible experience when they come in contact with any of our services.

What we aimed to achieve in 2017/18:

The aim of this priority 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.

The priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate	61.60%	92.85%	

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 Trust has continued to implement the Patient Experience improvement project during 2017/18 aiming to seek and act on feedback from our patients their relatives and careers. Many improvements have been made during 2017/18 to enhance how the Trust encourages, listens to the patient's voice and deals with feedback from patients, relatives and carers. The patient and public council are now linked to each individual health group to ensure the patient's voice is heard.

A survey was undertaken regarding complaint handling; from this a database was created to ensure a quality of the service by reviewing regularly, looking at themes and trends to show areas for improvements and key areas which have already improved. Unfortunately the number of returned surveys is very low; however the team are reviewing different methods of collecting this information to improve response rates. The Patient Experience Strategy was presented to the Trust Board and incorporated into the Trust People Strategy and a supporting work plan was developed to ensure the delivery of the Patient Experience Strategy objectives. The work plan has reached its requirements and will develop further during the next 12 months. The Falls Committee is utilising the volunteer's service to support its work to reduce avoidable patient falls on the wards. Positive and negative patient stories are shared at each Trust Board meeting as a different way of providing feedback to the Executive Team on patient experiences and to set the scene for the Board meeting. The patient stories have also been shared with Yorkshire Humber and Patient Experience Network (PEN) who welcomed the ideas and asked for the network to feedback.

The new providers for the interpreting service has been agreed and embedded. Development of interpreters using telephone interpreting service and 'Browse Aloud' service for the visually impaired has been completed and applied to most hand held devices throughout outpatients. The interpreters policy has been ratified and supporting tools will be implemented from the 1st April 2018 including a further 6 Ipads for use in departments.

The Trust continues to grow its list of valued volunteers, surpassing the target set, which is extremely encouraging. At the start of 2015, the Patient Experience Team embarked on a major piece of work to improve our volunteer service. It was recognised the added value that volunteers bring into our organisation and provided opportunities for the public to volunteer in different departments other than clinical areas.

Patient Experience has been working to ensure the recruitment process is clearer and quicker for volunteers whilst remaining safe and that core principles of the Lampard enquiry (2015) are upheld when recruiting. Recent advertising at the local job centres, GP surgeries, health clubs and the NHS jobsite has seen an increase of 500 volunteers since the new approach has been adopted.

The Trust has also introduced a Volunteer Induction which is run every month to give reassurance to the volunteer and the departments. The Induction includes a talk from the infection control team and the fire safety team. Each volunteer has access to the Trusts education website which includes mandatory training.

The Emergency Department (ED) has also welcomed the volunteers who provide support and reassurance to the patients and their families, providing refreshments and offering reassurance to them during what can be a very stressful time. The main reception at Hull Royal Infirmary has its own bank of volunteers, Monday to Friday providing sign posting and reassurance. Some patients find added value from the volunteers who help them with the check in service.

Initiatives run by the volunteers to receive feedback to improve our services at the Trust include:

- Friends and Family Test
- Patient Reporting and Action for Safe Environment (PRASE)
- Patient Led Assessment of the Care Environment (PLACE)
- Secret Shopper
- Patient Council – improving the range of involvement of Patient Council members
- Patient Information Leaflets (PILS)
- Signage Group and Way finding

Further improvements identified:

The patient experience priority has been identified as a quality and safety priority for 2018/19 (see page 82) and it will also be included in the Trust's Quality Improvement Plan (QIP) for 2018/19. For more information on the QIP see page 69.

The focus for further improvements will be:

- Reduce the spend on interpreters by 15%
- To re-introduce 'you said, we did' boards around the Trust
- To maintain a level of 450 active volunteers within the Trust
- Develop a bank of volunteers to support wards and patients with the tower block
- Introduction of virtual British Sign Language (BSL) interpretation
- Liaise with the Falls lead nurse to consider how the volunteer service can support staff effectively in minimising falls
- Complaints team to provide bespoke training for each ward on the handling of concerns from patients and visitors to reduce the number of formal complaints

Making a difference through the Voice of the Patient

Part 3: Review of our Quality Performance

This section includes:

- Trust performance for 2016/17 and 2017/18 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 and East Yorkshire 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 and East Yorkshire 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	2016/17	2017/18	National Average	Best performer	Worst performer
• the value of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period*	112	109	100	72	124
• the banding of the SHMI for the Trust for the reporting period*	1	2	2	1	3
• the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	24.6%	26.7%	31.5%	59.8%	11.5%

*Most recent data on NHS Digital for period October 2016 - September 2017, published in March 2018

The Hull and East Yorkshire 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 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 25.
- Avoidable mortality has been identified as a quality and safety priority again for 2018/19. Key areas for improvement which the avoidable mortality project will focus on are detailed on page 81.

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, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

Prescribed Information	2016/17 Finalised Data	2017/18	National Average	*Best performer	*Worst performer
• groin hernia surgery EQ-5D Average health gain**	0.096	0.131	0.089	0.136	0.029
• varicose vein surgery EQ-5D Average health gain**	0.145	***	0.096	0.134	0.034
• hip replacement surgery EQ-5D Average health gain (Primary)*	0.412	0.476	0.48	0.541	0.392
• hip replacement surgery EQ-5D Average health gain (Revision)*	***	***	0.286	0.354	0.221
• hip replacement surgery Oxford Hip score Average health gain (Primary)*	20.6	22.9	23	25.3	19.2
• hip replacement surgery Oxford Hip score Average health gain(Revision)*	***	***	14.4	15.8	12.7
• knee replacement surgery EQ-5D Average health gain (Primary)*	0.322	0.302	0.343	0.429	0.253
• knee replacement surgery Oxford Knee score Average health gain (Primary)*	16.5	17.1	17.4	20.4	13.0
• knee replacement surgery EQ-5D Average health gain (Revision)*	***	***	0.308	***	***
• knee replacement surgery Oxford Knee Score Average health gain (Revision)*	***	***	13.3	***	***

*Most recent (Provisional) data From NHS Digital covers April 2017 - December 2017, published in June 2018
** Most recent (Finalised) data From NHS Digital covers April 2017 – September 2017, published in June 2018
***Average health gain could not be calculated as there were fewer than 30 modelled records

The Hull and East Yorkshire 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	2016/17	2017/18	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	9.6%	9.1%	8.1%	0.2%	16.7%
• 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%	7.3%	7.7%	0.4%	11.3%

* Taken from CHKS for period April 2017 to February 2018

The Hull and East Yorkshire 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	2016/17	2017/18	National Average	Best performer	Worst performer
The Trust's responsiveness to the personal needs of its patients during the reporting period.	67.5	66.0	68.1	85.2	60.0

* Most recent data from NHS digital covers April 2016 - March 2017, published in August 2017

The Hull and East Yorkshire 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 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 30.
- Patient experience has been identified as a quality and safety priority again for 2018/19. Key areas for improvement which the avoidable mortality project will focus on are detailed on page 82.

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	2016/17	2017/18	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.	79.3%	67.32%	69.77%	85.71%	46.84%

* Most recent data from NHS England covers October 2017 – December 2017 (Cumulative), published in March 2018

The Hull and East Yorkshire 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 and East Yorkshire Hospitals NHS Trust. An update on the work undertaken during 2017/18 can be found on page 47.

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	2016/17	2017/18	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.	82.8%	90.34%	95.27	100%	77.43%

* Most recent data from NHS England covers April 2017 - December 2017 (Cumulative), published in March 2018

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- VTE was a quality and safety priority for 2017/18 and whilst progress has been made and Health Groups have implemented changes performance against the target for 95% of patients receive a VTE risk assessment within 24 hours of admission to hospital fluctuates between 85-90%. It was felt that the Health Groups have exhausted the possibilities available to them to reach this target and need further support to understand barriers and it was agreed that dedicated improvement support is required from the HIP teams skills and knowledge to determine the barriers to progressing to achieving the target of 95%. Therefore this was closed as a quality and safety priority and the Quality Improvement Plan for 2017/18 and transferred to the HEY Improvement Team. During 2018/19 the HEY Improvement Team will focus on identifying what the barriers are to achieving the target and work with the Health Groups to take the required steps to address the barriers identified and progress towards achieving the target.

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

Prescribed Information	2016/17	2017/18	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.	12.9	13.2	13.0	0	82.7

* Most recent data from Gov.uk Statistics covers April 2016 - March 2017, published in July 2017

The Hull and East Yorkshire 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 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 21.
- Avoidable hospital acquired infections has been identified as a quality and safety priority again for 2018/19. Key areas for improvement which the avoidable mortality project will focus on are detailed on page 78.

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

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
• the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,	32.71	58.5	46.0	174.6	14.8
• the number and percentage of such patient safety incidents that resulted in severe harm or death	0.4%	0.10	0.24	0	1.91

* Most recent data from NHS Digital covers April 2017 – September 2017, published in May 2018

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- Learning lessons was a quality and safety priority in 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 29.

Learning from Deaths

What is learning from deaths?

While most hospitals undertake some form of mortality review, historically there has been a wide variation in terms of methodology, scope, data analysis, and contribution to learning. The establishment of a consistent process of reviewing care through a structured analysis of patient records it aims to improve the quality of care by helping hospitals to learn from problems that contribute to avoidable patient death and harm.

How is the Trust implementing learning from deaths?

In October 2016 Hull and East Yorkshire Hospitals NHS Trust adopted the Structured Judgement Review (SJR) methodology to undertake case note reviews.

Developed by the Improvement Academy and Royal College of Physicians, Structured Judgement Review (SJR) blends traditional, clinical-judgement based, review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but a rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The object of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where there may be gaps, problems or difficulty in the care process.

The SJR has been designed to aid current review and investigation methodologies, rather than to replace. The Trust has a robust Serious Investigation framework that incorporates the Structured Judgement case note review; therefore a number of investigational techniques are adopted in order to determine if sub-optimal care contributed to a patient's death.

Learning from deaths update

This section provides an update against the prescribed information for learning from deaths as detailed in the 'Detailed requirements for quality reports 2017/18' which was published in January 2018. This was as a result of the publication of the revised 'National Health Service (Quality Accounts) (Amendment) Regulations 2017'.

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 2017/18, 2418 of Hull and East Yorkshire Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 546 in the first quarter • 518 in the second quarter • 607 in the third quarter • 747 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 April 1st, 2018, 353 case record reviews and 10 investigations have been carried out in relation to 2418 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 10 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:

Prescribed Information		Trust update
		• 3 in the first quarter • 2 in the second quarter • 5 in the third quarter • 0 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	10 representing 0.41% of the 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 0.12% for the first quarter • representing 0.08 % for the second quarter • representing 0.20% for the third quarter • representing 0% 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: • Failure in Communications – including inadequate communication systems. • Delay in the recognition of a deteriorating patient. • Lack of awareness of agreed policy/procedure
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 item 27.4)	The Trust has taken a number of actions to contribute to the resolution of the themes identified, these include: • Lessons learned newsletters and global emails circulated to inform staff of lessons learned • Lesson learned seminars held • Focused audits on case note documentation standards • Introduction of Advanced Care Practitioners to grand ward-rounds
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	No assessment of impact of the actions as described in 27.5 was completed.
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 01/04/2017 which related to deaths which took place before the start of 2017/18.
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.

Learning Lessons

Identifying good practice is equally as important as identifying poor practice. Good practice should be celebrated and shared, as it can often be replicated and utilised elsewhere in the Trust. The following good practice processes have been identified within the Surgery Health Group mortality reviews:

Multidisciplinary input sought and available in good time. Including fast access to Specialist input whilst the patient is in the Emergency Department.

Excellent, Multi-disciplinary care delivered in ICU, including comprehensive family involvement.

Excellent communication with the patient's family during the End of Life care phase, involving the family when necessary and showing a good degree of compassion.

Themes and trends identified from the review of Surgery Health Group deaths follow the same themes and trends that are identified by other review methodologies, such as Serious Incident Investigations and patient complaints. The main themes and trends identified are summarised below:

A lack of staff communication evident within the patient case-notes

Patchy, inconsistent documentation within the patient case-notes during the patient stay.

A delay in the recognition of patient deterioration

Improving Quality

Quality Improvement must remain at the heart of the SJR. The Trust has undertaken over 300 reviews which has allowed for themes and trends to be identified. An example of issue identification and quality improvement is as follows:

Issue Identified – Documentation

One of the recurring themes identified from the SJR is the lack of proper and consistent documentation within the patient case-notes.

Investigation

To further explore possible solutions for improvement, the Clinical Outcomes Manager undertook a small-scale, focussed documentation audit on a sample of patients on the Orthopaedic ward, who had a fractured neck of femur. The audit examined the quality of documentation within the case-notes specifically on the 4th, 5th and 6th day post-operatively.

Results

It was found that documentation was up to standard up until the 4th or 5th day post-operatively, after which, documentation became patchy and inconsistent. The audit results and summary were shared with the Orthopaedic team for discussion.

Action/Change

Changes are now being made to the Orthopaedic documentation booklet to improve the consistency of regular documentation. Advanced care practitioners are now utilised within grand ward rounds and this has improved the culture around proper and consistent documentation, in-line with national standards. This has had a very positive impact on the culture of ward-rounds.

Re-audit

A re-audit is planned to ensure that the implemented changes have had a positive impact on documentation on the Orthopaedic ward. The possibility of replicating this method throughout the Trust could have a positive impact on documentation standards for other Specialities.

Next Steps

The Trust has made a considerable amount of progress on improving how it learns from patient death. The Structured Judgement Review methodology has embedded and flourished across the Specialities and provided a platform for mortality to be discussed in a structured and transparent way.

MIAA (Mersey Internal Audit Agency) awarded the Trust "Significant Assurance" after undertaking a mortality review baseline assessment and recognising the positive steps taken by the Trust to not only align itself with national recommendations, but also to exceed.

To maintain this positive momentum the Trust will continue to actively review patient death and explore further ways to improve the quality of care delivered to patients, including further collaborative work with the Clinical Commissioning Groups, including General practice and mental health services.

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 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:

- don't 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 and East Yorkshire 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.

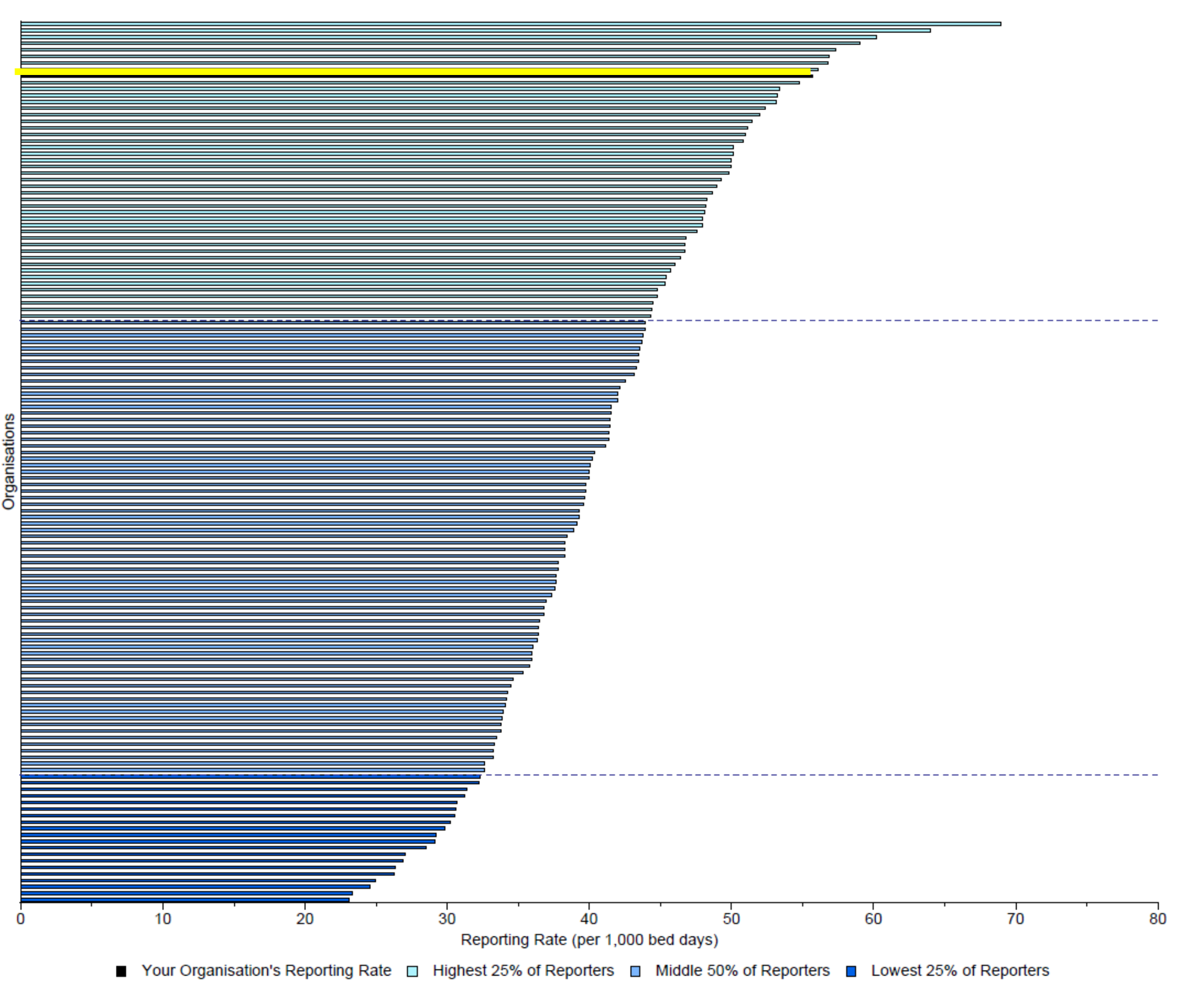
Standard	Compliance	Actions to address
Standard 2 Time to First Consultant Review	Partial compliance	Review of medical staffing resource in key areas. Improved identification and flagging of patients within the electronic patient administration system.
Standard 5 Diagnostic Services	Partial compliance (critical and urgent care times met, only partially compliant for non-urgent patients)	Recruitment to vacant posts and review of staffing rotas to enable extension of diagnostic services.
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.

Patient Safety Incidents

The Trust aims to provide care that is safe, effective and high quality for all patients and service users. One of our priorities is 'Lessons Learned' with the aim to actively learn lessons from patient safety incidents, Serious Incidents (SIs) and never events. Learning lessons allows us as an organisation to understand the causes of the incidents and to take the appropriate action to avoid reoccurrence. To be able to learn lessons from patient safety incidents we need to ensure the organisation has a strong incident reporting culture (i.e. a high level of incident reporting), which is a sign of a good patient safety culture.

Figure 1 is taken from the latest National Patient Safety Agency National Reporting and Learning Service (NRLS) data report published September 2017 and shows the Trust to be in the highest quartile of reporters having previously been below average for reporting of patient safety incidents. This increase in reporting is due to a review into the incidents the Trust reports to the NRLS and a review of the coding within the Risk Management System.

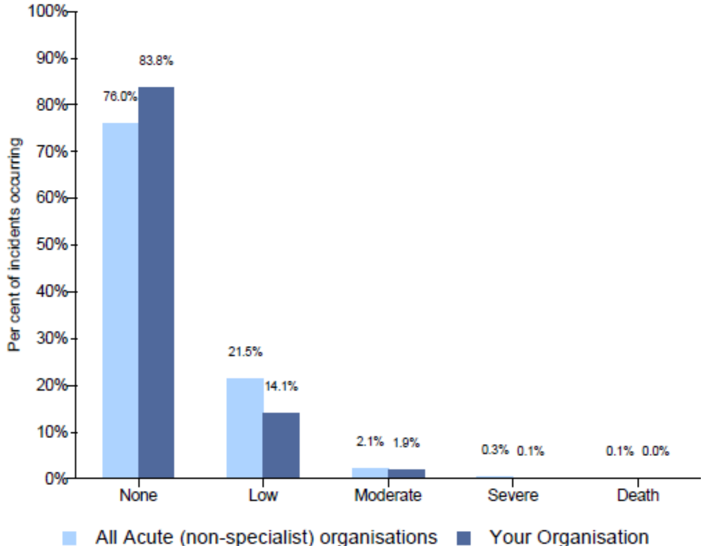
Figure 1: Patient safety incidents per 1000 admissions for the period of 1 October 2016 to 31 March 2017



*Hull and East Yorkshire Hospitals NHS Trust is highlighted in above

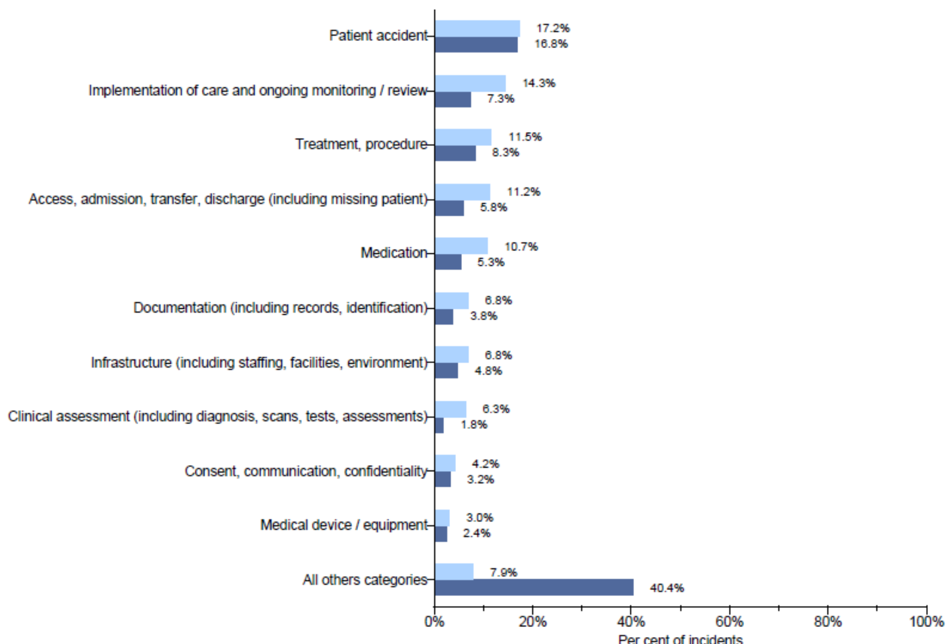
Figure 2 shows the incidents reported by degree of harm, comparing Trust performance with that of Acute (non-specialist) organisations and is taken from the latest NRLS data report published September 2017.

Figure 2: Incidents reported by degree of harm for Large Acute organisations for the period between October 2016 and March 2017



The Trust appears to be reporting in line with the cluster on degree of harm. The top 10 types of patient safety incident reported between October 2016 and March 2017 are detailed in **Figure 3** below showing the top 10 types of incidents reported within our reporting cluster compared against the number reported by the Trust.

Figure 3: Top patient safety incidents reported by %



Your Organisation

All Acute (non-specialist) organisations

The above graphs are taken from the recently published NRLS report.

During 2017 significant work was undertaken to review the incident reporting process within the organisation however this will not be apparent until the NRLS report to be published in 2018 has been released. The work included a review of the incident form, coding and how incidents are investigated. The changes have resulted in

- Reduction in the number of incidents with investigations taking more than 28 days
- Review and revision of coding structures within the system
- Review of the types of incidents reported to the NRLS and the mapping to the NRLS codes
- Review of the incidents coded to 'other' to the correct type of coding.

Serious Incidents and Never Events

In organisations as large and complex as the NHS, things will sometimes go wrong. Incident reporting is one of the key methods for alerting other parts of the organisation to issues that, if left unattended, may pose a risk in future to service users or the health and safety of staff, visitors, contractors and others that may be affected by its operations.

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 on 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.

Total number of Never Events and Serious Incidents (SIs) declared in each year:

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total Never Events declared	3	4	5	4	2	6
Total Serious Incidents declared	8	32	88	107	67	63
Total*	**11**	**36**	**93**	**111**	**68**	**69**

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

Types of Serious Incident (SI) and Never Events declared during 2015/16, 2016/17 and 2017/18

Serious Incident type	2015/16	2016/17	2017/18
Treatment Delay	19	17	11
Treatment Delay – lost to follow up *(extracted as own category from 2017/18)*	0	0	8
Unexpected Death	3	9	10
Patient Fall	18	8	2
Sub-optimal care of the deteriorating patient	9	8	8
Pressure Ulcer (3 or 4)	11	4	8
Absconded Patient	0	3	0
Delayed Diagnosis	17	2	1
Drug Incident	3	2	1
Retained foreign object (not a Never Event)	1	2	0
Surgical/Invasive Procedure incident	10	2	7
Unplanned NICU admission	0	2	4
HCAI/Infection Control Incident	2	1	1
Intrapartum Death	2	1	0
Never Event – Misplaced NG Tube	0	1	0
Never Event – Wrong Site Surgery	2	1	3
Never Event – Wrong Implant	0	0	1
Never event – Surgical Invasive Procedure	0	0	1
Never Event – Medication Incident	0	0	1
Never Event – Retained Foreign Object	2	0	0
Retained dressing (not a Never Event)	2	0	0
Wrong Site Surgery (not a Never Event)	1	0	0
12 hour ED trolley breaches	7	0	0
Others	2	5	2
Totals	111	68	69

The Trust reported more SIs in 2015/16 than in any previous year. After this peak, the numbers of SIs (including Never Events) reduced during 2016/17 and 2017/18. The Trust feels that this shows a balance of reporting, and increased confidence that we are reporting the right incidents.

The Trust declared 6 Never Events in 2017/18 more than in any other reporting period; four relating to wrong site surgery, one a wrong implant and one a wrong route administration of medication. Following this increase in Never Events the Chief Executive delivered a briefing to the Trust's Clinical teams in April 2018, which included plans to deliver a 'Stop the Line' campaign to enable and empower all staff to stop a procedure if they witness unsafe acts.

During 2017/18 the Trust has further developed on the improvements made during 2016/17 in regards to their Serious Incident processes and methods for investigation. The Trust continues to put in place new processes for escalation and declaration of serious incidents, have reviewed templates for serious incident reports, and improved relations with our Commissioners to create a more open, transparent and honest dialogue on our SIs.

The Trust believes, at the end of 2017/18 that while we still have Serious Incidents and Never Events occurring, it remains 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 Risk Management 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

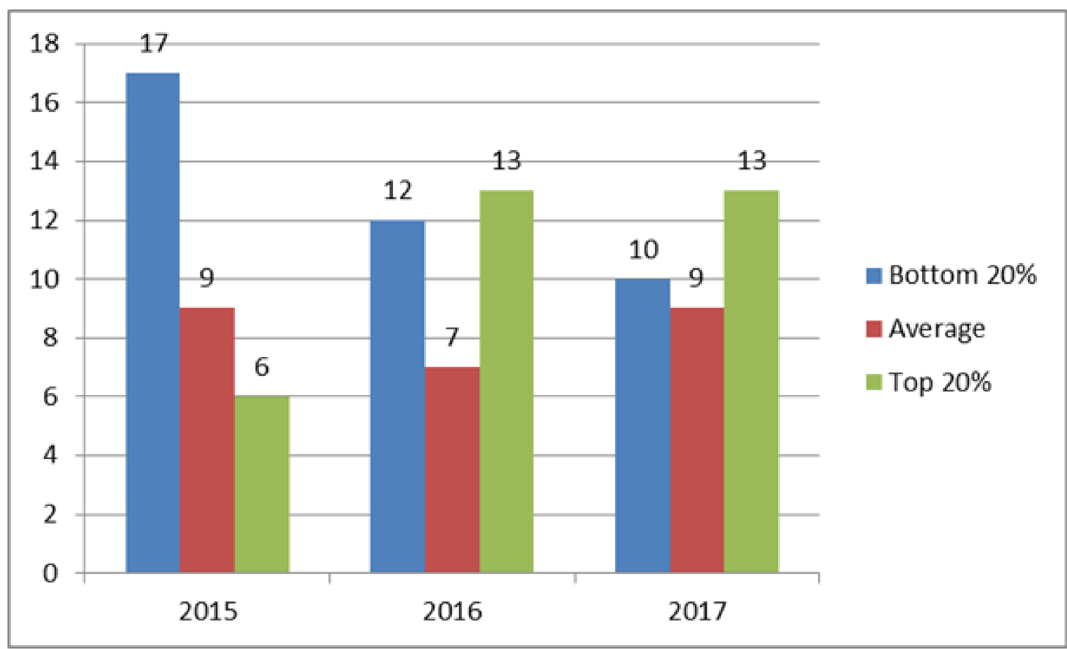
Reference	Alert Title	Issue Date	Deadline	Trust Response
NHS/PSA/RE/2017/002	Resources to support the safety of girls and women who are being treated with valproate	06-Apr-17	06-Oct-17	Action complete and matter resolved
NHS/PSA/W/2017/003	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	05-Jul-17	16-Aug-17	Action complete and matter resolved
NHS/PSA/RE/2017/004	Resources to support safe transition from the Luer connector to NRFit for intrathecal and epidural procedures, and delivery of regional blocks	11-Aug-17	11-Dec-17	Action complete and matter resolved
NHS/PSA/W/2017/005	Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies	27-Sep-17	08-Nov-17	Action complete and matter resolved
NHS/PSA/D/2017/006	Confirming removal or flushing of lines and cannula after procedures	09-Nov-17	09-Aug-18	Action required: On-going
NHS/PSA/W/2018/001	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders	09-Jan-18	20-feb-18	Action complete and matter resolved

NHS Staff Survey Results 2017

The Trust undertook the NHS National Staff Survey 2017. The survey was undertaken between 9 October and 1 December 2017. The response rate for the Trust was 42% (3451 staff), against a national average of 43%.

The National Staff Survey comprises 32 key findings and a measure of staff engagement. 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 2018. Performance against these key findings has improved significantly over the past three years. Trusts can see how they benchmark against other organisations and whether their scores are in the worst 20% of organisations, average or in the top 20% of organisations.

Our performance in 2018 shows that fewer of our key findings feature in the bottom 20% of organisations while those in the top 20% have remained the same. Performance against the 32 key findings over the past three years is summarised in the graph as follows:



Top five ranking scores:

1. % staff experiencing discrimination at work
2. % staff believing the organisation offers equal opportunities for career progression or promotion
3. % staff experiencing bullying harassment or abuse from patients
4. % staff experiencing physical violence from patients
5. Fairness and effectiveness of procedures for reporting errors

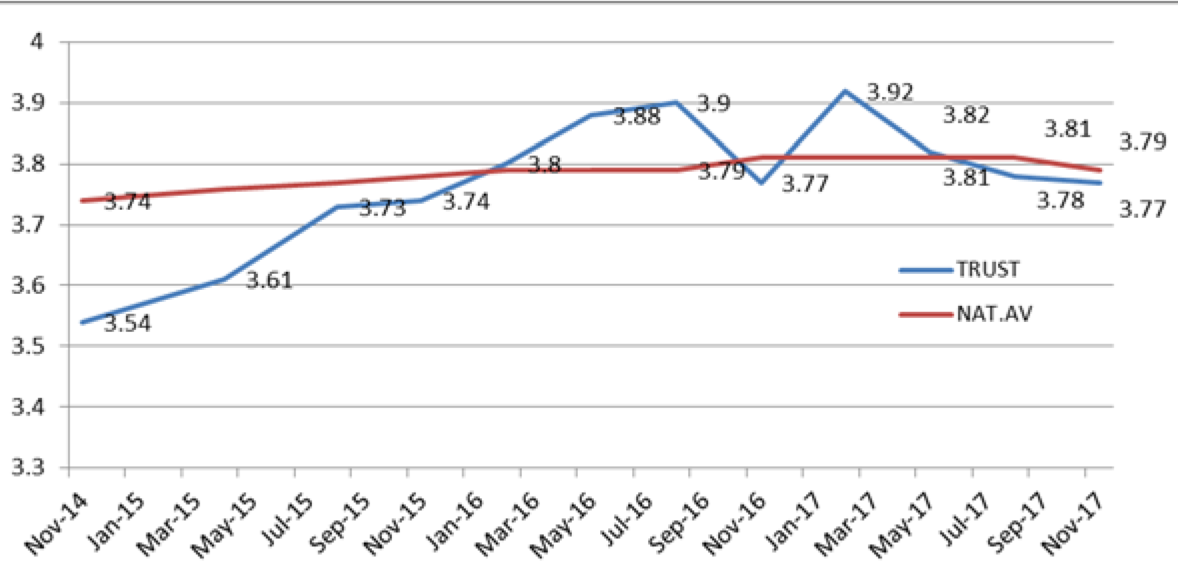
Bottom five ranking scores:

1. Effective use of patient/service user feedback
2. % staff reporting most recent experience of bullying and harassment
3. % staff reporting most recent experience of physical violence
4. % staff experiencing bullying or harassment from staff
5. % staff agreeing that their role makes a difference to patients

The Trust's overall score for engagement in 2017 (3.77) has remained the same as in 2016 and is just below the national average for Trusts, 3.79. It is worth noting however that while the Trust's score has stabilised the national score has deteriorated from 3.81, as many organisations struggled to maintain their position.

The overall score for engagement comprises nine questions with the maximum score possible being five. The Trust has improved against the three questions relating to pride in the organisation, remained the same against those relating to staff ability to improve their services and deteriorated against motivation and enthusiasm at work.

The trend scores for overall engagement since 2014 are as follows, where this graph shows the Trust average compared with the national average.



The Trust is required to report the results against the two following key findings:

Staff Survey Question	Ranking compared with Acute Trusts in 2016	Ranking compared with Acute Trusts in 2017
KF26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months (lower the score the better)	31% Highest (worst) 20%	28% Although the Trust score has improved from 2016 it remains in in the bottom 20% for this question
KF21 - % of staff believing that the Trust provides equal opportunities for career progression or promotion (higher the score the better)	88% Top 20% (higher than average)	89% Remains in top 20% (higher than average)

Cultural Transformation

At the March 2015 Trust Board meeting an approach to Transforming the Culture of the Trust was agreed. Since that time the CQC which had previously identified cultural issues, including bullying, has specifically noted improvements to the working culture at the organisation. The report from the June 2016 described the organisation as being on the cusp of good. Furthermore, a cultural assessment tool, the Barrett Values Indicator has described the cultural improvement at the Trust as twice that which they would have expected to see in the 30 months since we last ran the Barrett survey in 2015.

The Trust has a People Strategy 2016/18 which sets out the vision for our workforce. It outlines how the Trust is working with partners manages, leads and develops the workforce in order to deliver the Trust's vision, values and priorities as set out in the Trust Strategy 2016/21. The Strategy covers seven strategic workforce themes. Underneath each theme are set actions which form part of the People Strategy programme plan for 2017/18 which is led and managed by the Workforce Transformation Committee. The seven themes are:

- Recruitment and retention of staff
- Leadership capacity and capability
- Innovation, learning and development
- Equality and Diversity
- Health and wellbeing
- Employee engagement, communication and recognition
- Modernising the way we work

An update against the work undertaken against the delivery of the People Strategy programme plan for 2017/18 is detailed as follows.

Recruitment and retention of staff

- The remarkable people recruitment campaign has resulted in successful recruitment of a significant number of nurses locally and internationally
- The Trust has an award winning apprenticeship programme. The Trust has over 200 members of staff utilising an apprenticeship standard in a wide range of services (Pharmacy, Nutrition, Business Administration, Physiotherapy, Estates, Pathology and Mortuary). 93% of our apprentices secure employment or a place within higher or further education. Since the introduction of the Apprenticeship Levy (April 2017), over 100 apprenticeships have commenced, which demonstrates a committed investment of over £1m so far
- The Trust has an excellent volunteer and young volunteer programme which has over 500 people participating in. Volunteers contribute to a number of departments across the organisation and undertake various roles including the completion of friends and family test with patients, Patient Reporting and Action for Safe Environment (PRASE), Patient Led Assessment of the Care Environment (PLACE), reviewing of Patient Information Leaflets (PILS) and attendance at the Signage Group
- The shortage of NHS professionals is well documented and in addition to recruiting and trying to improve retention, the Trust has put in place a number of new roles to enable doctors, nurses and therapists to focus on their registered duties. New roles include Nutritionist, Recreational Assistants, Discharge Assistants, Patient Trackers, increased the scope of Ward Administrators and Advanced Clinical Practitioners covering Junior Doctor shortfalls

Leadership capacity and capability

- Three new leadership development programmes have launched in 2017/18 to support our existing and aspiring leaders, building upon previous programmes. These are the Great Leaders Annual Development Programme, New Leaders Programme and the Talent Development Programme
- The Trust has 15 accredited coaches and is developing 32 more. A new Mentorship programme also commenced in January 2018

Innovation, learning and development

- Newly reconfigured library service and facilities were opened at HRI in May 2017
- New Learning and Development Centre opened in September 2017 at Castle Hill Hospital
- A new Surgical Skills Training Centre is due to commence building works in May 2018

Equality and Diversity

- A key improvement area for the Trust since 2014 has been staff reporting issues of bullying and harassment. This work has also been enhanced with the development of the Equality and Inclusion Strategy 2017/20 which is being delivered by the Equalities Steering Group and the adoption of the Workforce Race Equality Standard (WRES), which seek to ensure no member of the workforce is disadvantaged based on the ethnic background, gender, sexual orientation, disability or age. The Trust has an agreed action plan to deliver the WRES standards
- Over time the Trust has seen its performance improve against these indicators. In 2015 38% of staff reported that they had experienced some form of bullying and harassment from colleagues. In 2016 this dropped to 31% and in 2017 it is it was 28%. This is one of the most improved scores for the Trust in the 2017 survey. Despite this it remains worse than the national average, which is 25%.
- In an organisation where we have a zero tolerance policy on bullying and harassment this is an area that continues to require focus as we strive to provide a positive working environment for staff. In terms of reporting of bullying and harassment issues, in 2016 43% of staff said they had reported issues and in 2017 this has fallen to 42%, but again it remains below the national average of 45%, which suggests more work is required to encourage staff to come forward.
- Where discrimination is concerned only 8% of staff survey respondents (282 people in total) say they have experienced some form of discrimination from colleagues in the last 12 months, ahead of the national average of 12%. 89% of staff reported that they believe the Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, sexual orientation, disability or age. This is better than the national average, 85%.
- The Trust established the Black Minority Ethnic (BME) Staff Network in 2016 and the membership has increased to 50. The Trust has also commenced an Lesbian, Gay, Bisexual and Trans (LGBT) Staff Network

- The Trust continues to deliver the Equality, Diversity and Inclusion training programme and it forms part of the Trust's recruitment and selection training and the Trust's mandatory training programme

Health and wellbeing

- The Health and Wellbeing programme is well developed and is being managed by the Health and Wellbeing Committee. The Trust surveyed staff and asked what they would like to see within the health and wellbeing programme. The programme is designed largely to provide staff with information so they can "self-help" but also signposts them to various regional and national activities and information sources
- The Trust has also provided meditation, salsa, mindfulness, weight management and yoga classes
- The Trust has a choir and various sporting teams such as football and running
- The Trust has focussed on healthy eating and reducing the number of patients and staff that smoke
- The Trust offers "health checks" for staff and are undertaking some work specifically on managing and reducing stress
- A fast track physiotherapy service is available for staff experiencing musculoskeletal problems. 150 staff have accessed the service so far which has also improved staff attendance
- 73% of frontline staff is vaccinated. The Trust has always achieved the national target for flu vaccination.

Employee engagement, communication and recognition

- The Chief Executive held nine culture and leadership briefings during the 2017/18 for all Trust managers. The sessions covered the Trust's progress to date and areas of development, as well as setting out the Trust's goal to be rated as 'Outstanding' by the CQC by 2022. The sessions also reinforced the expectations of a HEY Leader and the positive working culture needed to maintain and continually improve our services.
- The Trust is one of very few Trusts nationally that enables staff to receive two days additional annual leave per year (one day for the flu jab and one day for completion of all mandatory training and 100% attendance)
- The Golden Hearts awards were celebrated in June 2017. Over 300 staff attended the event which recognised individuals and teams in 16 categories including best leader, team and service improvement
- Moments of Magic nominations continue to increase. In 2017 the Trust received more nominations from staff recognising their colleagues for good work than in any previous year. These are now shared with the Trust Board in every public meeting.
- To enhance the recognition of good work and share important learning from excellence the Trust has launched Greatix, as the antidote to Datix. Staff have begun posting their examples of good project work and service improvement on the Trust intranet and a formal process for sharing this work has been agreed

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

Statements of Assurance from the Board

Review of services

During 2017/18 the Hull and East Yorkshire Hospitals NHS Trust provided 43 NHS services within 4 Health Groups and 15 Divisions.

The Hull and East Yorkshire 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 2017/18 represents 100% of the total income generated from the provision of NHS services by the Hull and East Yorkshire Hospitals for 2017/18.

Participation in clinical audits

During 2017/18, 46 national clinical audits and 4 national confidential enquiries covered NHS services that Hull and East Yorkshire Hospitals NHS Trust provides.

During that period Hull and East Yorkshire Hospitals NHS Trust participated in 96% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below details the national clinical audits and national confidential enquiries that Hull and East Yorkshire Hospitals NHS Trust was eligible to participate in and those which we participated in during 2017/18. For those national clinical audits and national confidential enquiries that Hull and East Yorkshire Hospitals NHS Trust participated in 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		
Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
Children		
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	Yes	100%
Paediatric Pneumonia (British Thoracic Society)	Yes	100%
Blood and Transplant		
National Comparative Audit of Transfusion Associated Circulatory Overload	Yes	100%
Re-Audit of the 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	Yes	100%
Acute care		
National Emergency Laparotomy Audit (NELA)	Yes	10%
Adult Critical Care (Case Mix Programme – ICNARC)	Yes	100%
Sentinel Stroke National Audit Project (SSNAP)	Yes	100%
Procedural Sedation in Adults (RCEM)	Yes	100%
Fractured Neck of Femur (RCEM)	Yes	100%
Pain in Children (RCEM)	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit)	Yes	100%

Audit:	Participated	% of Cases Submitted
Diabetes in Pregnancy Audit	Yes	100%
Diabetes Footcare Audit	Yes	100%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Ulcerative Colitis and Crohn's Disease (National Inflammatory Bowel Disease - IBD Audit)	No	The Trust will be taking part in this audit during 2018/19
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Yes	100%
UK Parkinson's Audit	Yes	100%
Stress Urinary Incontinence Audit (BAUS)	Yes	100%
National Ophthalmology Database 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
Neurosurgical National Audit Project	Yes	100%
Elective procedures		
Hip, Knee, Ankle, Elbow and Shoulder Replacements, Implant Performance, Hospital Performance and Surgeon Performance (National Joint Registry)	Yes	100%
National Bariatric Surgery Registry	Yes	66%
National Vascular Registry (elements include Carotid Interventions Audit, National Vascular Database, Abdominal Aortic Aneurysm, Peripheral Vascular Surgery/VSGBI Vascular Surgery Database)	Yes	100%
Adult Cardiac Surgery Audit (ACS)	Yes	100%
Nephrectomy Audit (BAUS)	Yes	100%
Percutaneous Nephrolithotomy (PCNL) (BAUS)	Yes	100%
Radical Prostatectomy Audit (BAUS)	Yes	100%
Heart		
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	100%
National Audit of Percutaneous Coronary Interventions (NAPCI) / Coronary Angioplasty	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%

Audit:	Participated	% of Cases Submitted
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Oesophago-gastric Cancer (National OG 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	80%
Older People		
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Dementia	Yes	100%
National Audit of Inpatient Falls (Part of the Falls and Fragility Fracture Audit Programme (FFAP))	Yes	100%
National Hip Fracture Database (Part of the Falls and Fragility Fracture Audit Programme (FFAP))	Yes	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Cancer in Children, Teens and Young Adults	Yes	100%
Heart Failure	Yes	80%
Peri-Operative Diabetes Study	Yes	70%
Maternal, Newborn and Infant Clinical Outcome Review Programme		
MBRRACE-UK surveillance data collection system	Yes	100%

The reports of 25 national clinical audits were reviewed by provider in 2017/18 and Hull and East Yorkshire Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Proposed actions
National Diabetes Inpatient Audit (NaDIA)	• To introduce a formalised foot risk assessment sheet
National Audit of Breast Cancer in Older People (NABCOP)	• No further action required
National Audit of Cardiac Rhythm Management (CRM) Devices	• To meet with the Cardiac Physiologists to discuss the best method of ensuring that acute complications are recorded and uploaded • To disseminate the results of the audit to the Cardiac Physiologists and to remind staff of the importance of submitting complete data
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
National Audit of Inpatient Falls (NAIF)	• To update the Falls Prevention and Mobility Care Bundle

Audit	Proposed actions
(Part of the Falls and Fragility Fracture Audit Project (FFFAP))	• 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 BP; vision assessment; availability of mobility aids)
National Bowel Cancer Audit	• No further action required
National Diabetes Audit : Core Audit	• To review the pathway for insulin pump patients, to ensure that insulin pumps are prescribed appropriately • To expand the Diabetes Specialist Nurse team to release additional DSN resource and 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
National Heart Failure Audit	• No further action required
National Hip Fracture Database (NHFD) (Part of the Falls and Fragility Fracture Audit Project (FFFAP))	• To define criteria for peri-operative medical assessment, delirium assessment and 120 day follow up • To liaise with the anaesthetic lead regarding nerve blocks
National Joint Registry (NJR)	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in June 2018
National Lung Cancer Audit (NLCA)	• To investigate the data submission issues relating to the work of the Lung Cancer Nurse Specialists and multi-disciplinary team discussion
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 • To provide education and training to reinforce the prescription of Magnesium Sulphate in mothers who deliver babies < 30 weeks of gestation
National Oesophago-Gastric Audit	• To continue to review all patient deaths to determine if there are any lessons to be learnt
National Paediatric Diabetes Audit (NPDA)	• To plan a schedule of regular patient education sessions
National Prostate Cancer Audit	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in July 2018
National Diabetes Footcare Audit (NDFA)	• 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
National Emergency Laparotomy Audit (NELA)	• To arrange a meeting with Department of the Medical Elderly regarding the assessments given to patients aged 70 years and over • To employ a data entry clerk

Audit	Proposed actions
National Pregnancy in Diabetes Audit (NPID)	• To raise awareness amongst the team regarding preconceptual care and referral to the 'MOT' • To improve glycaemic outcomes in pregnancy by reviewing processes of care in clinic • To discuss the possibility of having a 'Diasend' machine in the clinic, to review glucose readings • To raise the issue of pre-conceptual diabetes care with Public Health, through the Diabetes Network Board • To review the management of gestational diabetes patients, and to establish whether current arrangements are affecting the care of women with T1 / T2 diabetes
Paediatric Intensive Care Audit Network (PICANET)	• No further action required
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 Physicians criteria for thrombolysis, where applicable • To discuss the pathway for pre-alerts 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. • To adjust working patterns to provide occupational therapy every day rather than Monday to Friday only • To remind staff of the importance of mood and cognition screening for each patient. • To remind staff to discharge patients from the care of Speech and Language Therapy promptly when no further therapy is required.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	
Treat As One (Mental Health in General Hospitals)	• To develop an Enhanced Care Team for 1 to 1 supervision including patients with mental health needs
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
Maternal, Newborn and Infant Clinical Outcome Review Programme	
Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15	The Trust has implemented all elements of the Saving Babies Lives Care Bundle:- Foetal Growth Surveillance • To fully implemented the Growth Assessment Protocol (GAP) • To recruit a Healthy Lifestyle Midwife to work closely with the smoke free team on smoking cessation • To provide a reduced foetal movements leaflet to all women at 16 weeks. To update the local protocol with reference to the Royal College of Obstetricians guideline • To provide standardised training on cardiotocography monitoring and use of K2 for all staff. Fresh eyes and fresh eyes stickers will be used in intrapartum monitoring
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
Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births from	• To use a perinatal mortality review tool by the multidisciplinary team for all stillbirths and related neonatal deaths. From reviews, themes will be

Audit	Proposed actions
January to December 2015	highlighted and action plans devised and disseminated

An update regarding the implementation of the proposed actions identified as a result of a national clinical audit reports published in the 2016/17 Quality Account is provided below to demonstrate the improvements made to quality. Actions taken in response to reports published in 2017/18 will be included in the Quality Account for 2018/19.

Audit	Proposed actions	Progress
National audit		
Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP)	• To review the process for documentation of first consultation with parents	• The process has been reviewed and potential changes are currently being discussed within the team
National Emergency Oxygen Audit	• To liaise with Education and Training to establish how safe use of oxygen training could be made mandatory and available to be completed online • To create a safety bulletin on the subject of oxygen prescribing, in order to raise awareness of the issue • To discuss a potential pilot scheme with the Acute Medical Unit and Ward 1, which would involve attaching laminated signs to every oxygen point to serve as a reminder to ensure that all oxygen is prescribed in accordance with the Trust Oxygen Therapy Policy. • To carry out an audit in order to establish whether the above results in an improvement • To review and update the Trust Oxygen Therapy Policy	• An e-learning package has been developed and is awaiting final approval • This will be produced to coincide with the launch of the e-learning package and revised oxygen policy • This has been discussed but has not been implemented to date • This will be undertaken once the pilot in the Acute Medical Unit has taken place • The policy has been updated in line with the British Thoracic Society guidelines and recommendations
National Bowel Cancer Audit	• To undertake a review of 2 year mortality data	• Data has been collected and is awaiting analysis
Cardiac Arrhythmia (Cardiac Rhythm Management)	• To provide ongoing education to highlight the importance of primary prevention in suitable patients. • To hold fortnightly multi-disciplinary team meetings (MDT) to discuss patients that may be suitable for CRM	• There is a monthly Journal club where all cardiology trainees and consultants meet • There is a weekly MDT to discuss patients that may be suitable for ICD therapy
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	• To review how insulin pumps are recorded on the Twinkle database and through the National Paediatric Diabetes Audit. • To provide a training session for users of Twinkle at a multi-disciplinary team meeting	• This has been communicated to the whole team • A ‘how to’ guide has been written to ensure data is entered correctly
National Pregnancy in Diabetes Audit	• To carry out a local audit of glucose control • To contact Public Health, Clinical Commissioning Groups and Family Planning clinics to discuss potential further actions	• An audit is underway • The results are to be discussed at the local maternity network board
National Diabetes Footcare Audit	• To clarify the definition of ‘ischemia’ with the national audit team, to	• The national team have provided a clearer definition

	better understand our figures • To ensure that patients who present direct to the Emergency Department or ward are captured in the audit • To raise awareness of the audit with community staff in order to increase participation • To raise a query with the national team around amputation as an outcome	• Actions complete
National Diabetes Inpatient Audit	• To reduce prescription errors through the introduction of a new drug chart incorporating a specific section on insulin and highlighting the importance of giving oral agents with meals • To reduce the number of hypoglycaemic events through the introduction of a new prescription chart to emphasise the correct timing of diabetes medication • To highlight patients on insulin in hospital, to ensure timing of insulin is with a meal • To improve the timeliness of diabetes foot assessments and ensure that they are properly completed and documented	• A new drug chart (incorporating a specific section on insulin and highlighting the importance of giving oral agents with meals) has been implemented. This aims to reduce the number of hypoglycaemic events – data is awaited to determine if this has happened • There is a diabetes specific foot check document in use on Ward 7
National Cardiac Arrest Audit (NCCA)	• To share learning from the NCCA dataset, including ceilings of care and the prescription of appropriate resuscitation in the Consultant mandatory update training. • To develop links with Primary Care to improve communication relating to DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions. • To develop a strategy for the Trust and local healthcare providers to implement the ReSPECT (Recommended Summary Care Plan for Emergency Treatment) document	• The ReSPECT process was released nationally at the end of February 2017. The Trust as the lead organisation, has worked with other local healthcare providers to develop an implementation strategy for ReSPECT within the Hull and East Riding locality. Partner organisations include Both Hull and the East Riding Clinical Commissioning Groups (CCGs), City Health Care Partnership, Dove House Hospice and Humber Foundation Trust. To allow adequate time to train staff and develop policies and procedures the launch date of the 9 April 2018 was agreed. • It is planned to utilise the patient records system (Lorenzo) within the Trust to document that a ReSPECT decision is in place. This will aid communication to primary care via the Immediate Discharge Summary, alert Emergency Department staff via the Emergency Department records if readmitted and have an alert icon on the patients records to inform all staff. This is to allow staff to begin conversations about previous ReSPECT decisions and to ask for the patient held records.

		• With developments in the Advanced Summary Care Records it is hoped communication of decisions in Primary Care can be communicated to the acute setting by utilising this facility
Paediatric Asthma (British Thoracic Society)	• To provide asthma pathway education at junior doctor induction • To undertake nursing education via specialist nurses and teacher practitioners on the use of asthma treatments.	• Training has been provided at junior doctor induction • 2 training sessions have been provided
Vital Signs in Children (College of Emergency Medicine)	• To produce and distribute laminated cards that include reference ranges for paediatric vital signs • To remind the paediatric charge nurse of the need to complete full observations within 15 minutes of triage • To ensure that staff members circle any abnormal vital signs, and clearly document any actions that are taken to rectify them • To ensure that staff members record the time that observations are carried out on the door of the cubicle and also in the comments section of Lorenzo • Any questions that juniors ask regarding a patient's care are now recorded on a question form, which is kept with the patient notes • To reconsider the use of an early warning score when more validation work has been carried out	• All nursing and medical staff members now carry vital signs cards for reference • The paediatric charge nurse actively encourages prompt observations to be completed following triage. • Both the paediatric charge nurse and the paediatric emergency medicine consultant actively encourage and regularly monitor that abnormal vital signs are documented and rectified, and that the time of observations is recorded appropriately. • The paediatric emergency medicine consultant reminds junior medical staff of this process on a regular basis. • There is still no Early Warning Score validated for use in children, however validation is ongoing for the Paediatric Observation Priority Score (POPS), developed in Leicester
Procedural Sedation in Adults (College of Emergency Medicine)	• To disseminate results, highlighting areas for improvement • To design a new sedation proforma for use with both adults and children • To design a new Patient Advice Sheet to be given for Adult patients • To design a new Patient Advice Sheet to be given for Paediatric patients • To re- audit once the new proforma has been implemented	• A sedation pathway has been designed and implemented within the Emergency Department. Staff have been educated on how to use the pathway. The pathway also includes a patient advice sheet for adults. A separate Standard Operating Procedure for children was developed at the same time – the proforma is the same, as is the advice sheet. Emergency Department staff completed the RCEM Sedation audit in January 2018.
VTE Risk in Lower Limb Immobilisation (College of Emergency Medicine)	• To discuss an appropriate anti-coagulation for patients waiting longer than 48 hours to be seen in the fracture clinic	• Update awaited from lead
PICANET (Paediatric Intensive Care Audit Network)	• To discuss a business case for providing family psychological support at the Paediatric Governance meeting	• Various options for psychological support are currently being considered
End of Life Care Audit	• To include a section in the End of Life	• The updated Trust Guideline for the

	guidance regarding the recognition that a patient may be dying • To develop an individualised End of Life care plan or prompt sheet featuring sections on communication with nominated persons, needs and concerns of the patient/ nominated person, and the holistic assessment • To discuss the possibility of having a lay member on the Trust Board with a responsibility for End of Life care with the Chief Nurse • To introduce the 7 day face-to-face (i.e. non-telephone) service • To discuss opportunities for the funding of an end of life facilitator post with commissioners • To implement Sage and Thyme Communication skill training across the Trust to improve the level of basic communication skills	Management of the Dying Patient was ratified in May 2017, which includes a section on the recognition of likelihood of dying. • The care plan has been developed and through a series of consultations. Awaiting final ratification of the document before implementation • A Non-Executive Director is now responsible for End of Life Care. • Since September 2016, the Palliative Care Team have operated 7 days a week (including bank holidays) from 8am until 6pm, with out of hours cover being provided via bleep. • Currently, there is no funding available • Sage and Thyme Communication Sklill training is held monthly, with courses being accessed via online booking
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	• To perform a local re-audit on standards 2 – 5 in order to better establish how the service is performing • To recruit another nurse to assist with providing the helpline and emergency clinics	• A local audit has been undertaken, which showed the Trust performed well against NICE guidance • An additional nurse has been recruited
Sentinel Stroke National Audit Programme (SSNAP)	• To design and implement a patient survey aimed specifically at Stroke patients • To undertake a peer review, to better understand staff shortages • To develop business cases to address staffing shortfalls, as identified by both the organisational audit and the peer review	• Survey is currently being designed • A peer review has been undertaken. The number of Hyper Acute Stroke Unit beds will be increased from 4 to 8 with additional nurses recruited to fully staff these beds. Funding has been agreed for an additional stroke consultant and three new speech and language therapists have commenced in post. Two new nurses commenced in post in January 2018.
National Hip Fracture Database	• To liaise with the Elderly Medicine Consultants with regard to the perioperative assessment and middle grade medical position • Nerve blocks can be performed by trauma coordinators. Arrange training for other co-ordinators to conduct nerve block procedures. • To liaise with the Elderly Medicine consultants with regard to hip fractures as an inpatient • To define what follow-up arrangements are, as per best practice tariff, at 120 days	• Action complete • Action complete • Action complete • Follow up arrangements have been confirmed with the NHFD team – they can be by letter or telephone call to the patient

National Vascular Registry	• To review the pathway for Abdominal Aortic Aneurysm care • To review the pathway of carotid care • To review the pathway of critical limb ischaemia care	• The department is currently redesigning the whole service to prioritise and maximise efficiency with existing resources and to make the case for the significant additional resources required

The reports of 202 local clinical audits were reviewed by Hull and East Yorkshire Hospitals NHS Trust in 2017/18. For an update on the progress of the actions identified as a result of local clinical audits completed in 2017/18 and proposed actions for 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 Account page at http://www.hey.nhs.uk/about-us/corporate-documents/

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Hull and East Yorkshire Hospitals NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 7,312.

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 105 clinical research studies of which 96 commenced during the reporting period 2017/18. This compares with 177 new submissions and 133 commencing in 2016/17. The Trust used national systems to manage the studies in proportion to risk. Of the 96 studies given permission to start, 76 were National Institute for Health Research (NIHR) portfolio adopted.

The Trust has 231 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 2016/17.

The number of recruits into the Trust portfolio studies for the periods 2016/17 and 2017/18 was 9,118 and 6,599 respectively. A target of 6,000 patient accruals has been set for 2018/19. The largest topic area of portfolio adopted studies across 2017/18 is Oncology (Cancer) and Haematology with 39 studies between them. The top five therapeutic areas of Trust research in 2017-18 (based on portfolio recruiting studies) were:

1) Oncology and Haematology (39)
2) Cardiovascular (23)
3) Gastroenterology and Hepatology (11 each)
4) Musculoskeletal (9)
5) Renal Disorders (9)

70% of commercial portfolio studies completed in 2017/18 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 140 publications, abstracts and book chapters have resulted from our involvement in portfolio and non-portfolio research across nine specialty areas (Vascular, Diabetes, Oncology, Haematology, Dermatology, Rheumatology, Cardiology, Hepatology and Renal). 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 and East Yorkshire Hospitals NHS Trust:

Public Health Cohort studies:
For the second year running, the Trust was the top recruiter in Yorkshire and Humber for the 'Yorkshire Health Study' with over 3,600 participants in 2017/18. The study will continue to run until December 2018 and is the largest long term health study in Yorkshire. It aims to capture information on a large scale with the hope of finding the best treatments to keep Yorkshire healthy, and prevent and treat disease in the future. It focusses specifically on eating, drinking, and smoking habits as well as current illnesses and mobility in the context of locality and socio-economic status.

Diabetes and Endocrinology
In collaboration with local Diabetes charity the Trust has led work looking into the Service Users' Perspectives on Accessing Type 2 Diabetes Mellitus Services within Hull and East Riding. Capturing the perceptions of nearly 3,000 type 2 diabetes service users in Hull and the East Riding has provided further insight into the reasons for not meeting NICE guidelines on reducing the risk of associated diabetes complications.

The study report was published in September 2017 and the combination of questionnaire and focus group data provides a detailed insight into the views and perspectives of services users who may not be satisfied with their T2DM services, who may experience challenges managing their T2DM and who want to provide a more detailed and experiential account of their interaction with health professionals. Issues such as mental wellbeing, isolation and loneliness were just some of the themes to emerge.

A series of recommendations have been put forward for consideration by healthcare providers and commissioners including; ensuring clear support and guidance is made available to the patient and family at the point of diagnosis, providing consistent and up to date information on self-care management, ensure all patients are given access and opportunities to participate in clinical research in T2DM, improving access to specialist services, provide automatic feedback on blood tests and a clear explanation of the results, increasing and embracing the use of technology, a focus on joined up care and training of staff within care homes as well as ensuring a focus on people with T2DM under the age of 40.

Alongside the large cohort studies, the team have continued to successfully recruit to time and target in a number of commercial clinical trials available.

Academically the research unit continues to attract high quality medical staff and PhD students to work as research fellows but also have a real presence nationally as a centre that delivers high quality research.

Haematology Research Department:
The haematology department run several ongoing basic science projects investigating risk factors for leukaemia and developing novel therapeutic approaches for leukaemia.

In collaboration with chemistry the team have obtained £10k from 'help for health' to continue to support the in-house study, portfolio-adopted "Cell separation technology" which is recruiting ahead of schedule (71 patients).

Dr Sahra Ali has submitted and been awarded a Bloodwise Grant and has been working with her team to set up 'A National Prospective Registry-Based cohort study to monitor the diagnosis and management of acute leukaemia in Pregnancy'. The developmental work has been undertaken in 2017/18 and the registry will be open to collect data later in 2018.

Vascular Surgery Research:
Professor Ian Chetter, Chair of Surgery Hull York Medical School continued to undertake the appointment as Royal College of Surgeons Surgical Specialty Lead for Vascular Surgery.

The role acts as key link between designated Surgical Trials Centres and National Clinical Research Networks within Vascular surgery and is supported by funding for three years to develop multi-centre clinical trials and act as a conduit for interested clinicians and to provide a forum for discussion of proposals that can be processed through funding bodies.

Dan Carradice and George Smith, Senior Lecturers in Vascular Surgery, HYMS have secured from HYMS 3 PhD Students in the Vascular Lab to be appointed for 3 years from October 2018. Further to this, Dan Carradice was awarded an NIHR Public and Patient Involvement Grant to support the development of future diabetic foot research.

Amy Harwood, Postdoctoral Research Fellow won the 20th Annual Journal of Vascular Nursing Writing Award for article "*Intermittent claudication a real pain in the calf*"—Patient experience of diagnosis and treatment with a supervised exercise program published in the September 2017 issue of the *Journal of Vascular Nursing*.

The award was established in 1999 to recognize excellence in writing. The editor, in collaboration with the JVN Editorial Board, nominates articles based on the following characteristics: Content, Originality, Clarity, Applicability/Practicality, and Significance.

Cardiothoracic Surgery Research:
The Cardiothoracic research and clinical department have won three national awards from the Society for Cardiothoracic Surgery in the UK (SCTS) for 2018.

Mr Zaheer Tahir, a cardiothoracic research fellow undertaking his higher doctorate degree at HYMS, won the Ronald Edwards Medal for the best scientific oral presentation for his work looking at the In-vitro effect of dichloroacetate on human internal mammary arteries. The project, part of a larger project looking at the pharmacological properties of drugs used in samples taken from cardiac surgery patients, is supervised by Professor Mahmoud Loubani, Mr Chaudhry and Dr James Hobkirk from the University of Hull.

Mr Ahmed Habib, a senior thoracic surgical registrar at Castle Hill, won the best thoracic surgical movie prize for a short film on keyhole Diaphragmatic Plication surgery performed by Professor Loubani. The procedure helps to improve the breathing symptoms caused by diaphragm muscle paralysis in selected thoracic patients.

Finally, Saumil Shah, a medical student at HYMS won the Patrick G. Magee Student Prize for his work looking at outcomes following emergency re-opening of cardiac surgical patients at Castle Hill Hospital. The study was supervised by both Mr Yama Haqzad (a cardiothoracic trainee in the Yorkshire Deanery) and Prof Loubani. The results of the project will help determine predictors of post-operative short and long-term outcomes in patients following cardiac surgery.

The academic and clinical department have collected over ten national and international awards for their work in the last five years and the support it has for the next generation of surgeons indicate that this trend will likely continue for many years to come.

Academic Cardiology:
Projects making a difference: the report from the HOT study (home oxygen therapy in heart failure)led by Professor Andrew Clark has been picked up by Department of Health and being considered as part of evidence reviews informing the next iteration of NICE guidance on heart failure.

Renal Research:
Professor Sunil Bhandari and his research team at Hull & East Yorkshire Hospitals NHS Trust have continued to lead on the hugely important multi-centre STOP-ACEi study in which 39 sites in the UK contribute participant recruitment. In the STOP-ACEi trial, 410 patients with CKD stage 4 or 5 who are receiving treatment with ACEi and/or ARBs are randomly allocated to either continue their ACEi/ARB treatment or to stop their ACEi/ARB treatment. This study is needed before this treatment strategy can be put into routine clinical practice. This study is supported by an NIHR HTA grant and co-ordinated by Birmingham Clinical Trials Unit. Nephrologists worldwide are eagerly anticipating the final results soon with nearly 400 of the target 410 patients already achieved.

Research suggests that in some people with advanced CKD (stage 4 or 5) who are progressing to complete kidney failure and are receiving treatment with an ACEi and/or ARB, stopping these drugs leads to stabilisation and improvement of kidney function and can decrease or delay the need for dialysis treatment. This indicates that in some patients the very tablets that are being used to protect the kidneys may be contributing to a harmful decline in their function by some currently unknown mechanism.

Professor Bhandari was also a co- author of Renal Association UK Anaemia Guidelines 2017.

Hepatology Research:
Dr Lynsey Corless and her team instigated and led the recent COMMANDS study. The study has led to a change in clinical practice for non-alcoholic fatty liver disease (NAFLD).

The study showed that using a care pathway and rational investigations to guide community diagnosis and risk assessment is beneficial to patients and acceptable and useful for general practitioners. The team has now successfully rolled out the service change to all GP practices in the Trust catchment area.

Dr Corless was awarded an Early Career Leadership award by the NIHR national Hepatology specialty group in February 2018, for her work leading development of a trainee clinical research curriculum. This initiative aims to ensure that tomorrows Consultants have the necessary skills to offer their patients participation in clinical research, wherever they practice.

Top Recruiting sites:
Many of our research team are able to offer more opportunities for our patients to get involved in clinical research and this is helping position our Trust amongst the top recruiting sites in some of this research. For example: Oncology – ARISTOTLE, Neo-AEGIS and SCOPE 2 trials, Cardiology – HOMAGE trial, Renal – STOP-ACEI trial, Rheumatology – ACHILLES trial

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 and East Yorkshire Hospitals NHS Trust income in 2017/18 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 and 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 STP and 0.5% of the CQUIN scheme will also be held within the risk reserve, If a provider delivers its control total in 2016/17

National CQUIN schemes 2017/18 and 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

2017/18 National Achievement:
As at the end of Quarter 3 the Trust has achieved the majority of its National CQUIN schemes with the exception to Sepsis scheme. There are four parts to the species scheme and the Trust has received partial payment due to failing to deliver on all 4 elements: Timely treatment of sepsis in the Emergency Department and acute inpatient settings. The Trust has lost a small amount of income every quarter in this scheme to the value of £90k to date. Submission at Quarter 4 due 30th April 2018 the Trust believes it will achieve most schemes with an underachievement in Sepsis as per previous quarters. Sepsis has only slightly missed the required percentage achievement and has received acknowledgment nationally for a Trust that has seen significant improvements in Sepsis across the Trust. The Trust failed to deliver the Health and Well-being CQUIN scheme as it did not make the necessary improvements in the 3 staff survey questions re stress and MSK problems. The loss income associated with this scheme was 200k

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, enhanced supportive care, and haematrak. New schemes include medicines optimisation and local benchmarking of local prices in HIV.

Public Health England (PHE) has built into the screening services hosted by HEYHT a CQUIN reporting Health Inequalities for each programme. 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.

2017/18 NHSE Achievement:
The Trust has achieved all the PHE and Armed forces CQUIN schemes to date and the majority of the NHSE specialised CQUIN schemes to date. There is under achievement in the Heamatrack to a value of £5000, Medicines optimisation at £10.5k and approximately £330k for underachievement of the Hep C CQUIN Schemes. Total income loss of approx. £350k.

Further details of the agreed goals for 2017/18 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 and East Yorkshire 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 and East Yorkshire Hospitals NHS Trust during 2017/18.

Hull and East Yorkshire Hospitals NHS Trust has not participated in special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission rated Hull and East Yorkshire Hospitals NHS Trust as 'Requires Improvement'

The Care Quality Commission (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 and East Yorkshire 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 as follows:

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 Sign up to Safety Pledges are:

1. Put Safety First - Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally
2. Continually Learn - Make our organisation more resilient to risk, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are
3. Honesty - Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. Collaborate - Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. Support - Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress

The table below details the quality improvement projects for 2017/18 and those that are linked to the pledges.

Key

Colour	Description
Green	Improvements achieved – objectives achieved and or project closed
Amber	Improvement made compared to last year. Project carried forward onto the 2018/19 plan for further monitoring
Red	No improvements made. Project carried forward onto the 2018/19 plan for further action and monitoring

Ref	QIP Project	Aim	Source	Status
QIP02	Learning Lessons	The aim of this project is to assist the organisation with a change in culture from one of assurance to one of enquiry	Sign up to safety and Quality Account	Closed
QIP04	Safeguarding	The aim of this project is to build on the improvement work undertaken during 2016/17 and continue to further improve the safeguarding arrangements for Adults and Children	CQC	Closed
QIP05	Medication Safety	The overall aim of this project is to ensure a multi-disciplinary, person-centred approach to ensuring our patients receive the right medicines, at the right dose at the right time. This will be supported by an accurate	Sign up to safety, Quality Account and CQC	Re-opened

		record of medications on admission to the hospital by ensuring medicines are reconciled as soon as possible, ideally within 24 hours of admission. This will reduce the potential for harm and contribute to the delivery of a safe and effective medication process for our patients		
QIP06	Deteriorating Patient (Adult)	The aim of this QIP is to ensure that all Registered Nurses have undertaken both the NEW's on-line training and have been assessed as competent to complete Clinical observations on patients and can demonstrate an awareness of the importance of accurate fluid balance recording	Sign up to safety and Quality Account	Re-opened
QIP08	Infection Control	The aim of this project is to ensure compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) which will then reduce the number of avoidable hospital acquired infections	CQC	Re-opened
QIP09	Falls	The aim of this project will be to focus on the outcomes for the patient following a fall and to learn lessons from the root cause analysis investigations completed. This project will also aim to achieve compliance with the Multi Factorial Assessment Tool (MFAT) which will drive forward improvements in falls prevention through the completion of e-learning	Sign up to safety and Quality Account	Re-opened
QIP10	Avoidable Pressure Ulcers	The aim of this project is to prevent all patients developing avoidable hospital acquired pressure ulcers. This project will aim to ensure that appropriate risk assessments, a plan of care highlighting required nursing interventions and meaningful evaluations are undertaken by knowledgeable staff, for every patient	Sign up to safety and Quality Account	Re-opened
QIP11	Maternity Services	The aim of this project is to ensure the improvement work undertaken to address the areas for improvement identified following the June 2016 CQC inspection are embedded across the service.	CQC	Closed
QIP12	Children and Young People with Mental Health Needs	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	Re-opened
QIP14	VTE	The aim of this project is to ensure patients are appropriately risk assessed for VTE within 24 hours of admission and to demonstrate that the Trust is compliant with the relevant contractual requirements	Sign up to safety and Quality Account	Re-opened
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 leading to the implementation of the sepsis pathway across the organisation. The focus of the project will be on all patients meeting the new definition of sepsis, completing the sepsis 6 bundle within an hour	Quality Account and CQC Mortality Outlier Alerts	Re-opened
QIP16	Resuscitation Equipment and Checklists Compliance	The aim of this project is to improve and monitor the completion of resuscitation equipment checklist compliance on all wards	CQC	Closed
QIP22	Nutrition and Hydration	The aim of this project is to ensure that all wards are rated amber and above using the Trust's Fundamental Standards Ward audits which will ensure that all patients have an appropriate personal nutritional needs	Sign up to safety, Quality Accounts and CQC	Re-opened

		assessment completed and receive an appropriate care plan or referral to a dietician where required		
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	CQUIN and CQC	Re-opened
QIP24	Children and Young People Services	The aim of this project is to continue to improve the overall children and young people services and facilities on the 13th floor	CQC	Closed
QIP28	Patient Experience	The aim of this priority 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	Sign up to safety, Quality Account and CQC	Re-opened
QIP30	Avoidable Mortality	The aim of this project is to aid the organisation in the delivery 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	Sign up to safety and Quality Account	Re-opened
QIP34	Critical Care	The aim of this project is to ensure that the Critical Care Service provides a high quality, fit for purpose facility by ensuring the service is adequately staffed with an appropriate skill mix in line with relevant national requirements	CQC	Closed
QIP35	Five Steps for Safer Surgery (WHO Checklist)	The aim of the project is to reduce mortality and morbidity, including wrong site surgery, haemorrhage and infection, through full creation and implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) in all specialities across the Trust.	CQC	Closed
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.	Sign up to safety and CQC	Re-opened
QIP37	ReSPECT	The aim of this project is to implement the new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) with a supporting education package to ensure the ReSPECT process is fully embedded across the organisation	Trust action	Re-opened
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	Re-opened
QIP39	Outpatients	To ensure the Trust has a robust leadership and governance structure for all Outpatient Services to deliver consistent, high quality care and address all concerns relating to Outpatients from the 2015 and 2016 CQC Comprehensive Inspections	CQC	Re-opened
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	Re-opened
QIP42	Getting it Right	The aim of this project is to ensure there is an effective	Trust action	Re-

	First Time (GIRFT) – Ophthalmology	and well led response to the recommendations and actions arising from the GIRFT review of Ophthalmology		opened
QIP43	Getting it Right First Time (GIRFT) – ENT	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 ENT	Trust action	Closed

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 the lead for each improvement area at a monthly Quality Improvement Programme meeting chaired by the Chief Medical Officer. This is subsequently reviewed at 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 2017/18 Quality Improvement Plan were due to be improved by the end of March 2018. All improvement areas that achieved the improvement goals and targets were closed and signed off at the April 2018 Operational Quality Committee. Achievements made against the Quality Account priorities in the plan are all detailed in this Quality Account report (see pages 10 to 30).

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 2018/19 Quality Improvement Plan. Further information on the 2018/19 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 new 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.

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.

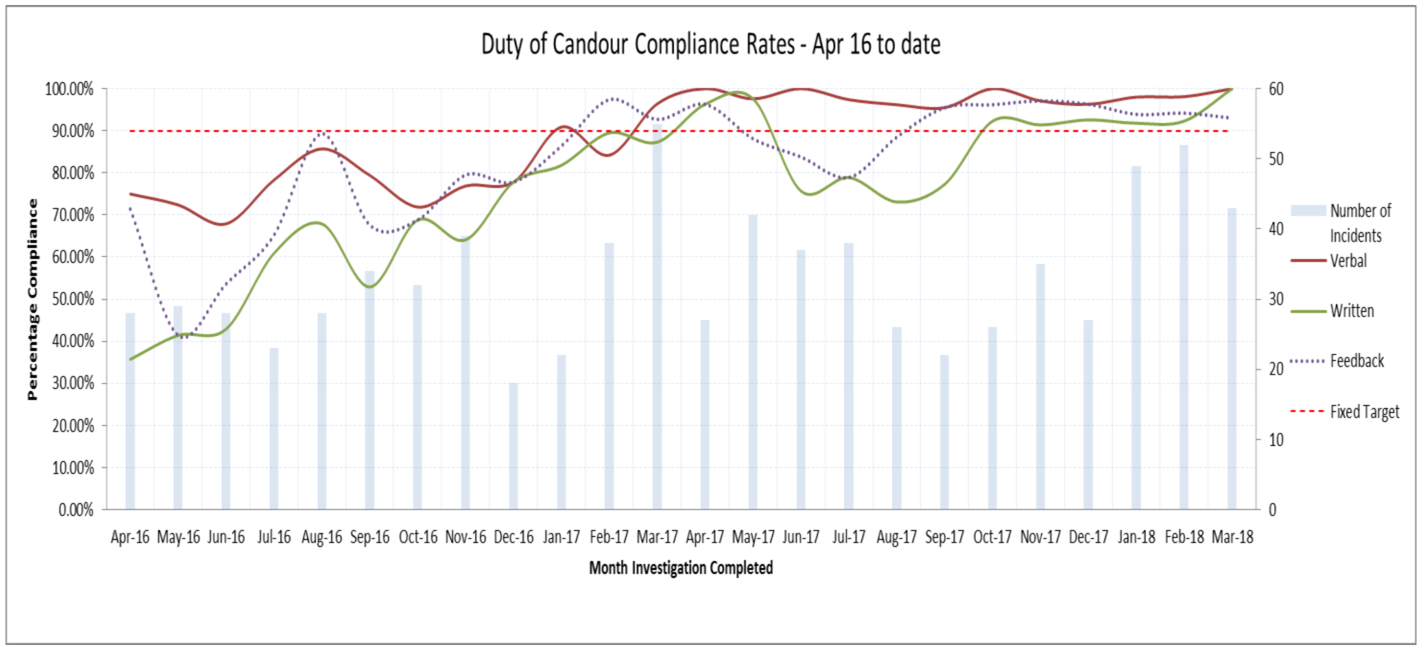
What is the Trust's compliance with Duty of Candour?

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. 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 2018; each element of the duty of candour compliance, monitored against the 90% target (fixed target).

Chart 1: Duty of Candour compliance rates



Data Quality

NHS number and general practice code validity

Hull and East Yorkshire Hospitals NHS Trust submitted records during 2017/18 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:
99.11% for admitted patient care;
99.86% for outpatient care; and
99.94% 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

Hull and East Yorkshire Hospitals NHS Trust has taken the following actions during 2017/18 to improve data quality. These actions will also be undertaken during 2018/19 to further improve data quality:

- Introduction of revised reporting schedule to further enhance the checking of data. This includes 65 reports run on a daily basis as well as 4 reports run on a weekly basis by the commissioning support team and actioned as and when needed
- Introduction of a monthly meeting to discuss data quality reports produced by CHKS and take action as and when needed
- Monthly monitoring against national data quality dashboards and take action as and when needed
- Monthly Data Quality Operational group
- Regular dialog with Patient Administration managers and supervisors regarding data quality items identifying name of person responsible and action needed
- Monthly meeting with Maternity services to help with missing data quality items

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 and East Yorkshire Hospitals NHS Trust's Information Governance Assessment Report overall score for 2017/18 was 73%, satisfactory (rated green). Thirteen standards were reaching Level 2 and above. The IG Toolkit was audited and assessed as achieving Significant Assurance.

Clinical Coding Error Rate

Hull and East Yorkshire Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2017/18. The recommendations below are drawn from the internal specialty audits performed during 2016/17 and 2017/18.

The following table provides an update on the implementation of the recommendations from 2016/17:

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.	On-going but with good engagement in Cardiothoracic Surgery, Urology, Oral surgery, Colorectal
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 levels than anticipated.	Complete
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.	Incomplete
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.	Complete. Trust average risen from 5.1 to 5.7 throughout 2017/18
R7 – Ensure coders are maintaining standards and receive regular audit feedback	Medium	Regular feedback post audit	Complete

R8 – Histology results should be checked in a timely fashion.	Medium	Encouraged to make better use of daily histology report.	Incomplete
R9 - Adjust proforma in preparation for HRG4+	Medium		Complete

The following table provides an update on the implementation of the recommendations from 2017/18:

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.	Ongoing but with good engagement in CTS, Urology, T+O, Oral surgery, Stroke, Colorectal
R2 - Achieve Level 3 in all internal specialty audits. Level 3 = 95% primary diagnosis, 90% secondary diagnosis, 95% primary procedure, 90% secondary procedure.	High	To ensure coding quality regular audits should be of the highest standard achievable. More regular spot checks introduced to identify and address training needs more quickly.	On-going
R3 – Histology results should be checked in a timely fashion.	High	Encouraged to make better use of daily histology report. Introduced as a specific objective for team leaders to achieve on appraisal.	Incomplete
R4 - Improve coding depth in targeted areas through regular coding audit and clinical engagement.	High	Trust wide coding depth has risen, some areas however remain low, and Obstetrics in particular, and regular meetings to address documentation are being introduced.	On-going
R5 – Improve coding extraction skills, for primary and secondary diagnoses.	High	Training in extraction skills given to staff	Complete
R6 – Improve quality of documentation in T+O to include patient history, post-surgery documentation and typed op notes.	Medium	Encouraged to make better use of daily histology report.	Complete
R7 – Improve communications with Stroke team to avoid conflicting information between case notes and discharge letters	Medium	Introduce regular validations and case note checks	Complete

Part 5: Looking forward – our plans for the future

This section includes:

- Information on how the Trust consulted on the 2018/19 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 2018/19 the Trust has put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our quality and safety priorities for 2017/18
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2017/18
- 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) and sign up to safety priorities

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 2018/19 the following actions were undertaken:

- An online survey was developed and circulated to all Trust staff and patient members and stakeholders, for their feedback on the content of the 2017/18 Quality Account and to consult on the 2017/18 priorities. This year 192 people completed the online survey in February and March 2018.
- Relevant committees were also asked for their comments and ideas:
  - Operational Quality Committee for consultation on all priorities and approval of the 2018/19 priorities
  - Quality Committee for approval of the 2018/19 priorities
  - Trust Board for ratification of the 2018/19 priorities

The Trust has identified these quality improvement priorities for 2018/19 because they are important to our staff, patients and stakeholders:

Quality and Safety Improvement Priorities for 2018/19

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 infections
- To reduce avoidable hospital acquired pressure ulcers
- To reduce avoidable acute kidney injury
- To reduce avoidable inpatient palls

Better Outcomes (Clinical Effectiveness)

- To improve the early recognition and treatment of people with sepsis
- To reduce avoidable mortality
- To improve the process of transition between paediatric and adult care services

Improved Experience (Patient Experience)

- 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 improve patients' 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.

How will we measure this priority?

- 100% of wards to achieve a minimum of 80% compliance on the Nutrition Fundamental Standard: Amber (Baseline 91.3%)
- 100% of wards to achieve a minimum of 80% compliance with completion of Food Record Charts on the Matrons Handbook (No baseline)
- 100% of wards to achieve a minimum of 80% compliance with completion of Fluid Balance Charts (Paper Copies) on the Matrons Handbook (No baseline)

How will we monitor and report on progress?

This project will be monitored through the Nutrition Steering Group Committee with leadership from the Senior Nursing Team, Surgery Health Group.

2. Medicine 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.

How will we measure this priority?

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

How will we monitor and report on progress?

The project will be monitored by the Safer Medication Practice Committee with leadership from the Chief Pharmacist.

3. Deteriorating Patient

What do we want to achieve?

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.

How will we measure this priority?

- 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 (Clinical Observations)

How will we monitor and report on progress?

The project will be monitored by the Operational Quality Committee with leadership from the Nurse Director, Surgery Health Group.

4. Avoidable Hospital Acquired Infections

What do we want to achieve?

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.

How will we measure this priority?

- To have 0 Hospital acquired MRSA bacteraemia (Baseline 1)
- To not exceed the threshold of 53 for Hospital acquired Clostridium Difficile (Baseline 38)
- To not exceed the threshold of 44 for Hospital acquired MSSA (Baseline 36)
- To not exceed the threshold of 73 Hospital acquired E. Coli (Baseline 110)

How will we monitor and report on progress?

The project will be monitored by the Infection Prevention and Control Committee with leadership from the Director of Infection Prevention and Control and Lead Nurse Infection Prevention and Control.

5. Avoidable Hospital Acquired Pressure Ulcers

What do we want to achieve?

The aim of this project is to reduce the number of avoidable hospital acquired pressure ulcers. It is 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.

How will we measure this priority?

- 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 55.6%)
- Fully quorate at Trust's Wound Management Committee (Baseline - not quorate)

How will we monitor and report on progress?

The project will be monitored by the Wound Management Committee with leadership from the Health Group Nurse Directors.

6. Acute Kidney Injury

What do we want to achieve?

The aim of this project is to increase compliance with NICE Quality Standard 76 – Acute Kidney Injury, which if successful will 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.

How will we measure this priority?

- Delivery of the AKI quality improvement project (No baseline – new project for 2018/19)

How will we monitor and report on progress?

This project will be monitored through the Operational Quality Committee with leadership from the Consultants in Renal.

7. Patient Falls

What do we want to achieve?

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 with the MFA which will drive forward improvements in falls prevention.

How will we measure this priority?

- 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)

How will we monitor and report on progress?

The project will be monitored by the Falls Committee with leadership from the Assistant Chief Nurse and the Chair of the Falls Committee.

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. Sepsis

What do we want to achieve?

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.

How will we measure this priority?

- 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%)

How will we monitor and report on progress?

This project will be monitored through the Operational Quality Committee with leadership from the lead consultant and nurse for Sepsis.

2. Avoidable Mortality

What do we want to achieve?

The aim of this project is to aid the organisation in the delivery 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.

How will we measure this priority?

- Continue to review all deaths of patients where family, carers or staff have raised a concern about the quality of care provided (Baseline 100%)
- Continue to review all deaths of patients who are identified to have a learning disability and / or severe mental health (Baseline 100%)
- Continue to review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected (Baseline 100%)
- Continue to review all deaths of patients that underwent elective procedures during their last episode (Baseline 100%)
- Continue to review a sample of 10 deaths per month where learning will inform the organisations quality improvement work (Baseline 100%)

How will we monitor and report on progress?

This project will be monitored through the Mortality Committee with leadership from the Chief Medical Officer and the Clinical Outcomes Manager.

3. Transition between Paediatric and Adult care

What do we want to achieve?

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.

How will we measure this priority?

- Embedding of the procedural document ensuring the effective transition for young people to adult services (Baseline of implemented)

How will we monitor and report on progress?

This project will be monitored through the Transition Steering Group with leadership from the Head of Outpatient Services.

Improved Experience (Caring, Responsive and Well-led)

1. Patient Experience

What do we want to achieve?

The aim of this priority 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.

How will we measure this priority?

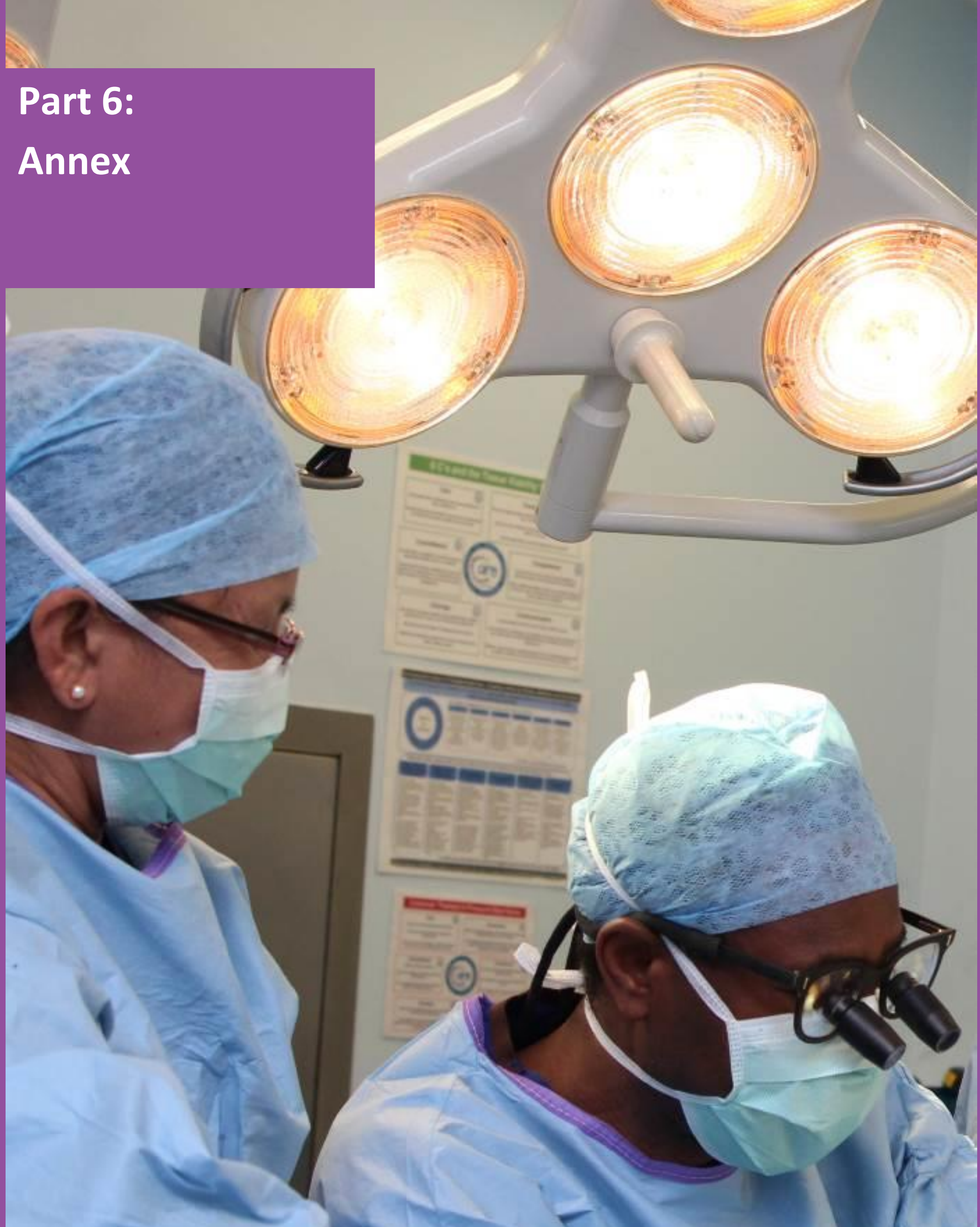
- Continue to achieve >85% of formal complaints closed within the 40 day target and actions recorded where appropriate (Baseline 92.85%)
- To reduce the number of repeat complaints by 20% <83 (Baseline 104)

How will we monitor and report on progress?

This project will be monitored through the Patient Experience Committee with leadership from the Deputy Director of Governance and Assurance and the Head of Patient Experience and Engagement.

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 2017/18 Quality Account was forwarded to key stakeholders on the 08 May 2018 with a request for statements of no more than 500 words to be received before the 05 June 2018. 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 (ERoY) Clinical Commissioning Groups (CCGs) welcome the opportunity to review and comment on the Hull and East Yorkshire Hospitals NHS Trust (HEYHT) Quality Accounts for 2017/18. The report illustrates the continued focus on improving the quality of patient care and safety in 2017/18 and the actions taken to sustain improvements.

We would like to congratulate the Trust on the successes that you have achieved in 2017/18 with the Accreditation for GO Physiology, the opening of your new regional Arthroplasty Centre (the first UK Centre of Excellence for joint replacement) and your Dementia Friendly Garden.

We note the achievements that have been made in relation to avoidable patient falls, mortality and medication safety. We recognise the targets for no Avoidable Hospital Acquired Pressure Ulcers was not achieved. However, we are aware of the work that has resulted in the significant reduction in the number of pressure ulcers experienced by patients. The CCG is pleased to see the plans to include Student Nurses and medical students in future pressure ulcer management and awareness training. We are pleased to be working with the Trust and other local service providers on the development of a strategic delivery group to review a joint approach to improving skin care across health and social care.

We acknowledge that the Trust has been unable to meet its targets for VTE Risk assessment of 95%, and welcome the Operational Quality Committee's endorsement that further help from the HEYHT Improvement Team is required in order to understand the barriers that are preventing the Trust achieving this target.

Commissioners are pleased to see that the Trust has made significant progress in its Sepsis project and that this is a priority for 2018/19 to ensure that it is fully embedded into practice and to ensure future improvements.

Commissioners acknowledge that the Trust has had six Never Events in 2017/18 including four wrong site surgeries. However, we welcome the Trust's work in addressing the issues raised during the investigations, the undertaking of a thematic review to identify any common themes and look forward to seeing the results of the proposed work plan on "stop the line".

The Trust has successfully made improvements to all of the Quality Improvement Programme Plans that were identified in 2017/18 and we recognise the areas that need further improvement remain open and will form part of your plans for continued patient safety and quality in 2018/19.

We welcome the commitment the Trust has shown with its involvement with the national and local audits and its participation in clinical research. This demonstrates the areas for future development to improve the quality of patient care.

The Commissioners recognise the work that has been undertaken at the Trust to improve recruitment and retention and also the work initiated in relation to improving the organisational culture. Work has focused around bullying and harassment, the outcome of which has being reflected in the improved staff survey results for 2017.

The Trust has achieved at the end of Q4, the majority of the CQUIN schemes for 2017/18, with the exception of the Improving Staff Health and Wellbeing, Sepsis and Supporting Safe and Proactive Discharge schemes which have been partially achieved.

Commissioners note the Trust is awaiting the draft Care Quality Commission inspection report from February 2018. We would like to receive a copy of the report and a plan for any additional actions that have not been identified in the Quality Improvement Plan 2018/19.

We understand that you are committed to your priorities for 2018/19 and we commend your continued focus on patient quality and safety. We concur with the priorities the Trust has identified for 2018/19. However, we would like to see

stretching targets for the seven priority areas in safer care. There is also limited evidence in relation to any improvements in the safeguarding arrangements for adults and children.

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 2017/18.

Healthwatch East Riding of Yorkshire

Healthwatch East Riding of Yorkshire accept the HEYHT Quality Accounts as a good representation of the on-going work and challenges being taken on by the organisation.

The accounts present a good clear understanding of future priorities and current practice as well as a comprehensive review of the standard of performance of HEYHT.

It is clear that the organisation has ambitious plans for the future and will continue to address areas of development along the way to strive for continued improvement.

Healthwatch support the future plans laid out in the accounts and look forward to an on-going working relationship with HEYHT.

Hull City Council Overview and Scrutiny Committee

Hull City Council's Health and Wellbeing Overview and Scrutiny Commission notes the findings of the recent CQC Inspection and supports the production of the Trust's Draft Quality Account 2017/18, with a view to improving service delivery and patient care across the organisation.

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 2017/18.

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

25.06.18 ....Chair

25.06.18 ....Chief Executive

Independent Auditor’s Report

Independent Practitioner's Limited Assurance Report to the Board of Directors of Hull and East Yorkshire Hospitals NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Hull and East Yorkshire Hospitals NHS Trust to perform an independent assurance engagement in respect of Hull and East Yorkshire Hospitals NHS Trust’s Quality Account for the year ended 31 March 2018 (“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 2018 subject to the limited assurance engagement consist of the following indicators:

- Percentage of patients risk assessed for venous thromboembolism (VTE)
- Rate of Clostridium Difficile infections.

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 April 2017 to 27 June 2018;
- Papers relating to quality reported to the Board over the period April 2017 to 27 June 2018;
- Feedback from commissioners dated 5 June 2018;

- Feedback from local Healthwatch organisations dated 6 June 2018;
- Feedback from the Overview and Scrutiny Committee dated 6 June 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated June 2018;
- The national patient survey dated May 2018;
- The national staff survey dated March 2018;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2018;
- The annual governance statement dated 24 May 2018;
- The Care Quality Commission's inspection report dated 1 June 2018;
- Any other information obtained during our limited assurance engagement.

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 and East Yorkshire 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 and East Yorkshire 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 and East Yorkshire Hospitals NHS Trust.

Our audit work on the financial statements of Hull and East Yorkshire 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 and East Yorkshire Hospitals NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Hull and East Yorkshire 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 and East Yorkshire 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 and East Yorkshire 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 and East Yorkshire Hospitals NHS Trust and Hull and East Yorkshire 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.

Basis for qualified conclusion

The indicator reporting the percentage of patients risk assessed for venous thromboembolism (VTE) did not meet the six dimensions of data quality in the following respects:

- Accuracy - Our testing identified three out of 30 cases where the occurrence of VTE assessments were incorrectly recorded.
- Completeness – Our testing identified three out of 30 cases where the occurrence of VTE assessments were incorrectly recorded, resulting in the total population of cases risk assessed for VTE being understated.

Conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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

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27 June 2018

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.
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
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
CHH	Castle Hill Hospital
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
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
Care Quality Commission (CQC)	The organisation that regulates and monitors the Trust’s standards of quality and safety
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
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly.
e-Learning Package	A training programme that individuals or groups can complete online via an internal education system known as HEY247
ED	The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. It's open 24 hours a day, 365 days of the year.
Engagement	This is the use of all resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways and raise staff morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care

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
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
HEYHT	Hull and East Yorkshire Hospitals NHS Trust
HRI	Hull Royal Infirmary Hospital
HSMR	Hospital Standardised Mortality Ratio – is an indicator of whether death rates are higher or lower than would be expected
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.
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'
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
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
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.
PALS	Patient Advice and Liaison Service – where patients, carers and or relatives are able to raise concerns regarding care and treatment and other services provided by the Trust
Sign up to safety pledges	The Pledge made by the Trust to reduce all avoidable deaths and avoidable harm
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.
Root Cause Analysis (RCA)	RCA is a method of problem solving that tries to identify the root causes of faults or problems
Sepsis	Sepsis is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection
SHMI	Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
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
Stakeholders	A group of people who have a vested interest in the way Hull and East Yorkshire Hospitals NHS Trust operates in all aspects. For example, the deliverance of safe and effective patient care.
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors

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.

We would appreciate it if you could spare 10 minutes to complete our feedback survey which can be found on our website: **www.hey.nhs.uk/about-us/quality-accounts**

Alternatively you can 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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